

# Psychological Trauma: Theory, Research, Practice, and Policy

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# Mental Health as the Cornerstone of Effective Medical-Legal Partnerships for Asylum-Seekers: The Terra Firma Model

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**Objective:** Challenges and traumas faced by asylum-seekers before, during, and after migration are compounded by the stressors of the asylum-seeking process, potentially compromising mental health (MH). Poor MH outcomes, in turn, complicate asylum-seekers' capacity to navigate the asylum-seeking legal process (e.g., hindering an individual's ability to provide an organized statement of their premigration experiences). Medical-legal partnerships are models of care that address legal problems as social determinants of health. However, when implementing medical-legal partnerships for asylum-seekers, standard definitions focusing on physical health do not appropriately capture the crucial role of MH services. Since 2013, the Terra Firma Program has provided services for asylum-seekers in the South Bronx, New York, by integrating MH, medical, and legal services along with enrichment activities, and concrete services. The present paper describes the benefits of this approach to working with asylum-seekers; highlights the importance of the MH component, including MH staff's dual therapist-evaluator role as a trauma-informed and ethical vehicle to support clients' asylum cases; and advocates for these partnerships to be recognized as MH-medical-legal partnerships. **Method:** Drawing from Terra Firma's experience with over 800 asylum-seekers, the authors provide a framework for addressing asylum-seekers' needs through MH-medical-legal partnerships. **Results:** Terra Firma's work with asylum-seeking children and families provides evidence in support of the establishment of MH-medical-legal partnerships and highlights the importance of the MH component in addressing asylum-seekers' legal needs. **Conclusions:** MH-medical-legal partnerships are proposed as effective models for working with asylum-seekers, with potential benefits to MH, physical health, and legal outcomes.

## Clinical Impact Statement

This paper details the ways in which the inclusion of a MH component in a medical-legal partnership designed to meet the complex needs of asylum-seeking children and families, increases the effectiveness of the medical-legal partnership service model. Collaborating with legal and medical providers toward the goal of overall improvement in health and legal outcomes of the asylum-seeking population, colocated MH staff have the bidirectional role of providing behavioral health services (multimodal MH interventions) and legal advocacy (affidavits, letters of support, testimony). This novel and refined health care model holds both clinical ethics and the distinct needs of asylum-seekers in mind.

**Keywords:** asylum-seekers, mental health, medical-legal partnerships, affidavits, trauma

Asylum-seeking children and families accumulate a myriad of traumatic experiences and challenges before, during, and after migrating to the United States. As it has been widely documented (Sawyer & Márquez, 2017; Tello et al., 2017), violence, poverty,

corruption, and fleeing for survival have become the primary reasons for migration of people from Honduras, El Salvador, and Guatemala, a region commonly known as the Northern Triangle of Central America. For years, the Northern Triangle has consistently ranked among the deadliest regions in the world outside of a war zone (Robins, 2018). The elevated murder rates are attributed to the gangs or *maras* (Chishti & Hipsman, 2015). In order to survive, some see no other option than to migrate to the United States, where they believe their lives will be less at risk. The journey is frequently characterized by life-threatening experiences. Once on U.S. soil, migrants typically turn themselves into immigration authorities or are apprehended by immigration officials. Those under 18 years old who entered the country without inspection and without a biological parent or a legal guardian are deemed "unaccompanied children" (UC), and transferred to facilities overseen by the Office of Refugee Resettlement (ORR; de la Peña et al.,

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2019). After they are released into their new life, both adults and children typically face many new kinds of challenges, including legal, academic, emotional, medical, financial, linguistic, relational, and so forth. Understandably, these experiences commonly impact the overall functioning of asylum-seekers (AS), including their mental health (MH). A literature review synthesizing information across 25 articles (2014–2019) regarding the MH outcomes of AS, found greater prevalence and severity in posttraumatic stress disorder (PTSD), depression, anxiety, and suicidality for AS when compared to immigrants with refugee status or legal permanent residency, and further, resident status itself was found to be a significant predictor of MH status (Posselt et al., 2020).

Both the asylum-seeking population and the MH providers working with them have reported that it is less likely for AS to connect to MH services, citing factors such as poor or limited information about MH services (Bartolomei et al., 2016), as well as barriers such as language and stigma, and elements particular to the refugee experience itself (Byrow et al., 2020). In this paper the authors will detail the substantial benefits of including a MH component in medical-legal partnerships (MLP/MLPs) as models of care for AS, and how it may significantly and effectively improve the MH, medical, and legal outcomes of this population. The innovative bidirectional role of the therapist as an evaluator in support of the patient's asylum case will be discussed.

### The MLP: Function and Design

MLPs embed legal services and expertise into a health care setting for collaboration with medical providers, to both screen for and address social and legal issues that negatively affect and perpetuate health inequities. In MLPs, lawyers are essential players in the health care system, which improves patient health outcomes, increases the likelihood of patients connecting to care, and allows for greater patient satisfaction (Yue et al., 2019). MLPs shed light on service use patterns and gaps and advocate for change and advancement in local and/or state policies, which can lead to refinement of care approaches for communities beyond their own (National Center for Medical Legal Partnership [NCMLP], 2019a; 2019b).

### Gaps in MLP Service Provision for the Asylum-Seeking Population

While there are MLPs that focus on the immigrant population, colocated MLPs for the population are rare within the larger number, and there are even fewer MLPs that focus particularly on the asylum-seeking population (League et al., 2021). Yet, colocated MLPs have distinct advantages. For undocumented immigrants, it is their undocumented status (and on a larger scale, exclusionary immigration policies) that primarily causes and/or exacerbates inequities that affect health, such as access to quality health care, housing, education, employment opportunities, and structural/cultural racism and discrimination; and this happens even with mediating resiliency factors such as family and social support (Ayalew et al., 2021). While undocumented immigrants often avoid or hesitate to engage with government or formal systems of care, they are more likely to connect with existing programs in their local community health centers where they have established medical care

(Castañeda et al., 2015), supporting the MLP approach for the asylum-seeking population.

Although many MLPs have established referral pathways to MH services, to the authors' knowledge, very little has been published in the literature on the existence of colocated MH services within an MLP. The lack of data to understand the impact of integrating MH into an MLP was echoed in a recent communication with a representative from NCMLP (D. Rahajason, personal communication, October 21, 2021). The only relevant study found in the literature (Lawton et al., 2020) refers to a Medical-Legal-Psychology Partnership at Cincinnati Child Health-Law Partnership, which found that each of the teams—medical, legal, psychology—were necessary in meeting the complex and nuanced needs of the families and children they served to optimize overall health outcomes. Additionally, the psychologist team added a crucial layer to the understanding of presenting problems and behavior in the context of complex trauma.

### The Terra Firma Model

The Terra Firma Program (TF) was created as a trauma-informed MLP specifically designed to provide colocated and coordinated services to UCs. TF was created in 2013 in partnership with Catholic Charities New York (CCNY), The Children's Health Fund, and The Children's Hospital at Montefiore, and is embedded in the Bronx Health Collective (BHC), a federally qualified health center in the South Bronx in New York City, a community abundant with new immigrant families. Because of shifts in immigration trends in recent years (i.e., increase in arrival of family units), in addition to UCs, TF now also provides MH, medical, and legal services to family units. Since its inception and to the time of this writing, TF has provided services to 860 patients: 537 UC, 126 adults in family units, and 197 children in family units. The program is funded through a combination of medical reimbursements, grants, private donations, and federal funds.

The program aims to facilitate access to long-term health care, enhance the role of medicine and MH in legal services, and to care for other complex needs of its patients. Its core components are: (a) comprehensive primary care services (a medical home model); (b) integrated MH services; (c) colocated pro bono legal services through attorneys from CCNY; (d) close collaboration with patients' attorneys (from CCNY and others) in support of their immigration cases; (e) social services and case management (such as support with college applications, housing issues, distribution of food pantry, clothes, and other basic needs during the COVID-19 pandemic); (f) enrichment programming (such as year-round English language and mindfulness classes, workshops, soccer, educational support, field trips, etc.); and (g) advocacy at various levels. This multidisciplinary model is based on the idea that health care, legal, and other professionals can work closely together to support immigrant children and families, not only to address their medical and MH needs and attain legal status, but to minimize the risk of retraumatization, assist them in navigating the different systems of their new life (school, housing, immigration, etc.), and promote their healthy adjustment (de la Peña et al., 2019).

### MH as the Cornerstone of the MLP

The authors argue that a MH component added to the MLP model is crucial in supporting and improving AS' wrap-around health and

obtaining positive legal outcomes while preventing retraumatization. As it will be discussed, some of the unique contributions of the MH component are: educating professionals (medical, legal, and other MH providers) on best practices to provide trauma-informed services to the asylum-seeking population; working closely with their medical providers to improve patients' medical outcomes; improving patients' legal outcomes, not only by increasing their ability to share their story in detail with their attorney and immigration judge/asylum officer, but by identifying experiences that may substantiate their legal case. MH providers also facilitate patients' stabilization and adaptation to their new life and assist them in processing their traumatic experiences and in learning healthy coping mechanisms.

### Education

TF MH providers engage in interprofessional education of attorneys and medical providers, not only on the psychological impact of the migration experiences of AS, but on their needs, and key considerations to providing effective trauma-informed services to them. This training may include effective ways to obtain a more complete trauma history while upholding safety and stabilization. Colocated MH providers infuse the culture of patient care with tenets of the MH discipline, such as trauma-informed thinking and unconditional positive regard.

### MH-Medical Relationship

At TF, the medical providers have the first clinical interaction with a patient. During that first encounter, medical providers routinely administer normed and validated self-report MH scales to the patient, and based on those results, referral information, as well as clinical observation, the medical provider makes the determination of whether to refer the patient to MH services within TF.

MH providers working closely with medical providers support connections to preventive and interventional care such as nutrition, sexual health, and other specialty care. For example, one client, Yuri,<sup>1</sup> regularly attended MH services and had a strong therapeutic alliance with her therapist. The medical provider requested assistance to engage and educate Yuri on the need for reproductive health care. Despite being a young adult, reporting a history of chronic pelvic pain, and having been sexually active for over 5 years, Yuri had never had a gynecological exam or Pap test. Yuri avoided calls from the clinic to schedule these appointments, citing fears of both the physical and emotional impact of the exam. Her therapist was able to review these concerns in depth with her, provide psychoeducation about the process with the support of the medical team, then facilitate interaction with the women's health specialist to learn more about the exam at a slower pace. Yuri was able to complete the exam and remain connected to reproductive health care. On several occasions MH providers have even walked with the patient to the medical providers office across the hall as a way of providing emotional support.

### MH Services

#### MH Outcomes of the AS Population

Based on TF's experience, AS face formidable stressors and challenges related to navigating the immigration system that is often difficult to understand and quite complex in nature. Recently

arrived children and families are placed in a proceeding to adjudicate their claims for asylum and to decide if they may remain in the United States. They often go to their first hearing by themselves (parents or sponsors of UCs frequently are afraid to accompany them and be deported themselves). They must also engage in the ever-difficult task of finding an attorney to represent them as no free or legal aid attorneys are appointed by the court in any immigration proceeding regardless of the immigrant's age or mental capacity, and there is a shortage of competent immigration attorneys representing this population. AS must convey their trauma story over and over again: while detained at the processing centers near the border after being apprehended; to a legal professional who screens legal cases for potential representation; to the representing attorney several times throughout the legal process; to their medical and MH providers; and to the immigration judge and/or asylum officer who will determine whether to grant immigration relief or order them deported. They are often fearful of what may happen to their family and loved ones left behind if the information they provide makes it back to their community. Patients have also expressed having a constant fear of deportation while their immigration case is decided, which typically takes several years.

In the authors' experiences at TF, the asylum-seeking population commonly presents with the MH conditions of depression, anxiety, PTSD with symptomatology across the criterion of intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity (American Psychological Association, 2013), and Complex Posttraumatic Stress Disorder (cPTSD), which includes, beyond the criterion of PTSD mentioned above, disturbance in self-organization in 3 key areas: affective regulation, self-concept, and interpersonal relationships (Maercker et al., 2013). As a consequence of the trauma and particularly when exposed to traumatic material, a person may present with avoidance, incongruence between affect and the events described (e.g., may be giggling or have flat affect while discussing traumatic events), inability to tell their story in a linear way or with detailed elaboration (Cummins, 2013), and have emotional dysregulation and/or dissociative responses (Van der Kolk & Fislser, 1995) such as an unfixed gaze. This may be overly detrimental to the AS, given that asylum is the only form of legal relief that is based on a feeling-fear-and as the burden of proof is on the asylum applicant, they have to be able to explain their fear in a credible and persuasive way, both the past events that fuel it and how the fear manifests psychologically in the present. According to U.S. law (8 U.S.C. § 1158), asylum claims must be based on a person's experience being a victim of past persecution or having a well-founded fear of future persecution on account of race, religion, nationality, membership in a particular social group (e.g., tribes or ethnic groups, gender, sexual orientation), or political opinion. MH interventions at TF seek to improve the capacity of the individual to tell their story, as well as identify salient elements of their story to highlight.

#### MH Interventions at TF

The MH approach at TF is multisystemic: trauma-informed and evidence-based psychotherapeutic interventions address

<sup>1</sup> All identifying data has been modified.

the impact of compounded trauma, while concrete services and informal MH interventions relieve psychosocial stressors and facilitate stabilization.

Beyond performing a trauma-informed interview and administering a traumatic events screening tool, MH providers use validated clinical measures to identify the existence and severity of symptomatology. During the assessment phase, MH providers pay particular attention to immediate and present stressors, as well as patients' trauma exposure and functioning over the four phases relating to migration: pre-/peri-migration, migration, post-migration, and resettlement/reunification.

A TF patient engaged in individual MH services will typically have weekly 45- to 60-minute sessions with their therapist. Depending on the patient's needs, sessions may occur biweekly or monthly and, regardless of frequency, treatment may include sessions with the patient's family members. There is no restriction to the length of treatment other than what is clinically appropriate, and/or patients' desire and willingness to continue to engage in treatment. Weekly group psychotherapy is also provided at TF, for interested preteen, teen, and adult caregivers/sponsors, all of which have both psychoeducational and process-oriented elements.

While studies have shown that evidence-based interventions, such as cognitive-behavioral therapies and exposure-based therapies, in both individual and group modalities, have been found effective for this population (Tribe et al., 2019), it has also been found that best practices suggest use of these interventions as part of multimodal approaches that address psychosocial stressors, focus on stabilization, and are culturally responsive. According to Drożdżek (2015), this multimodal approach is particularly important when the individual presents with significant avoidance or disturbance in overall functioning as the primary trauma response, in addition to experiencing psychosocial stressors, as it also allows consideration of alternate explanations of behavior that may not be consistent with one's own culture and scientific knowledge. It is this approach, within treatment program design for refugee trauma survivors, that may reduce psychopathology, both immediately and at more remote follow up (Drożdżek et al., 2014). Courtois & Ford (2013) also identify stabilization as the primary goal when working with those impacted by trauma, more specifically those presenting with cPTSD, followed by trauma processing and targeting the barriers to creating a fuller and more satisfying life. Considering culture and having cultural humility in the approach also increases the intervention's effectiveness (Karatzias et al., 2019).

In addition to psychodynamic psychotherapy, evidence-based MH interventions utilized at TF include Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Cognitive Processing Therapy (CPT), which have been shown to be effective for this population when incorporating linguistic and cultural modifications (Bernardi et al., 2019; Unterhitzberger et al., 2015; Unterhitzberger & Rosner, 2016). The common elements across these psychotherapeutic interventions include psychoeducation about trauma and traumatic stress, learning emotion identification and regulation skills, engagement in gradual exposure to traumatic details, and identification and maintenance of safe and supportive interpersonal relationships. This may include addressing emotional barriers (e.g., social anxiety) to engagement in TF enrichment programming, first exploring and planning in session and then supporting the individual through in-vivo exposure.

Adan, a 17-year-old from Guatemala, presented to TF suffering from debilitating social anxiety, intense feelings of worthlessness related to severe abuse and neglect suffered in his family of origin, and a history of discrimination based on a medical condition that affected his physical appearance and for which he had never received medical intervention. The therapist was able to leverage the trust in the therapeutic alliance to encourage Adan's engagement in supportive social settings, such as TF adolescent psychotherapy group and enrichment, where he was able to experience social acceptance and support for the first time in his life. This decreased his overall avoidance of social settings and interactions, and coupled with exposure-based therapy, contributed to the result of being able to testify to the long-standing history of discrimination and persecution, both within his own nuclear family and his larger community, which he came to know he did not deserve. Adan's asylum application was approved, which catapulted his overall sense of self-efficacy, motivating him to achieve other goals such as entering college.

TF adolescent groups utilize a group psychotherapy protocol that combines Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), a manualized and evidence-based group intervention, and Immigrant Child Affirmative Network (ICAN), an open-ended group protocol used in ORR facilities. SPARCS aims to improve the overall functioning of traumatized adolescents that continue to live in stressful environments, and targets problems in the domains of affect regulation, relationships, dissociation, avoidance, and meaning making (DeRosa et al., 2005). The ICAN protocol promotes resiliency, facilitates social support, mitigates acculturative stress, bolsters ethnic identity, and improves the child's experience both during and postshelter (ICAN, 2013).

### Nonclinical MH Interventions at TF

Research shows that while this population has poor MH outcomes, it does not necessarily mean they require extensive psychotherapeutic approaches; their overall well-being can be significantly improved by access to resources and safe, supportive relationships, in which they can experience cohesion, explore their identity, and share about their journey to the United States (Aldarondo & Becker, 2011). Enrichment programming at TF provides this, allowing UCs to resume their developmental trajectory, learning and practicing social skills within safe and supportive interpersonal relationships. Activities such as photography classes allow for self-expression and prosocial engagement.

While any member of the health care staff at TF may identify the need to connect a patient with concrete services, such as food pantry or housing assistance, the MH provider may, in a less formal MH intervention, independently identify through the course of their work and due to their therapeutic alliance, needs the individual would not disclose or share with others. For TF MH providers, this has also included coaching around items such as bill payments and navigating the school system and the ever-changing migration policies, all of which cause distress and are associated with potential loss of security and stability.

### MH-Legal Relationship

With patients' verbal and written consent, therapists communicate and collaborate closely with patients' immigration attorneys. A qualitative study (Baily, 2014) found that close and regular communication between attorneys and MH providers improved legal outcomes.

During interviews, a group of immigration attorneys working with UC indicated the MH provider was essential in obtaining the information from the applicant needed to substantiate the legal relief case (Baily, 2014). These interviews also found that attorneys made referrals to MH services for both therapy and expert testimony, and that the established MH diagnosis as part of the testimony assists in acquiring immigration relief (Baily, 2014). Not only can therapists assist patients in better understanding the status of their asylum claim, the implications of that status, and what to expect next, but they can also support the patient and their attorney's legal relief claims (asylum and otherwise) in several other ways:

### **MH Support of AS' Legal Needs**

#### ***Identifying Traumatic Experiences Helpful in Substantiating the Asylum Claim***

The therapist and attorney may discuss the core claims the attorney is making on the asylum case (e.g., patient's persecution or fear of persecution based on gender, race, sexual orientation, etc.). During the course of treatment patients share their experiences in their country of origin, and therapists may identify those experiences or patterns as important or even crucial for their asylum case. Sometimes those experiences further substantiate the attorney's core claims, and other times they are yet to be known by the attorney, either because the patient did not consider the experiences to be relevant to their asylum case, or because guilt, shame, sadness, confusion and/or fear may prevent full disclosure to their attorneys (especially common in cases that involve sexual abuse).

#### ***Assisting Patients in Communicating Their Traumatic Experiences to Their Attorneys***

A therapist is in a unique, privileged position to assist patients in articulating and processing their trauma histories and their pre, during, and postmigration experiences. These events are processed in therapy (as described earlier) with the double aim of improving the patient's MH, as well as their ability to communicate those events to their attorney. With the therapeutic alliance as the vehicle, and through gradual exposure to traumatic material paced by the patient and nurtured by the MH provider, avoidance decreases, additionally allowing a more complete and linear telling of their story. This process is facilitated by learned coping mechanisms to manage distress associated with exposure to traumatic material (e.g., emotional regulation, distress tolerance, improved self-concept, and future outlook), both in general and during the moment of testifying.

In exceptional cases, the patient may not be able to articulate the events to their attorney even with therapy. If the therapist deems it appropriate and important for the asylum case, with the patient's consent, the therapist may communicate the events in question to the attorney. In at least one case, a patient agreed to the therapist sharing the events with the attorney under the condition that the attorney did not ask the patient follow-up questions. The patient's challenges in communicating traumatic events, even to their attorney, may be included in the psychological evaluations described below. On occasion, the therapist has advised the asylum officer against interrogating the patient about a particular event to avoid potential retraumatization, and the asylum officer noted and complied with the request.

Sara was a 15-year-old Salvadoran female referred to MH services by her attorney when her asylum application was denied, following an asylum interview in which she was unable to share any part of the story of why she came to the United States. Through the course of therapy, Sara engaged in an exposure-based approach, which yielded significant decrease in posttraumatic and depressive symptomatology, improved the quality of her interpersonal relationships, and her ability to verbalize the details of why she fled: her stepfather had repeatedly sexually abused her and threatened to kill her and her mother if she ever told anyone. Although Sara remained unable to tell this story in court, her MH provider agreed to offer expert testimony, and the appeal was approved.

#### ***Emotionally Preparing Patients for Rendering Testimony***

As Meffert et al. (2010) explained, "[a]ttaining credibility can pose a challenge to AS, because the hallmarks of credibility in the legal system do not take into consideration the way in which the trauma [...] affects their ability to provide believable testimony" (p. 481). Research shows that denial of the asylum application is correlated with higher overall levels of distress and poor MH outcomes in UC (Jakobsen et al., 2017). A judge/asylum officer may use the patient's behavior when in their presence to determine the veracity of the claim. Not displaying what a layperson would consider *normal* or *expected* behavior, consistent with having experienced trauma (e.g., crying when discussing an assault), or not being able to tell their story in the exact same way and with the same level of detail on each attempt, may be misinterpreted and may jeopardize the petition.

Therapists can help patients manage the emotional part of their experience in court or asylum offices. Patients have consistently reported to us feeling worried, anxious, and nervous about what will happen the day of their hearing/interview. Therapists can help patients further identify and explore the specifics of their distress (e.g., being laughed at, not being believed, being deported immediately if they say the wrong thing, being so nervous that they cannot speak). Therapists can also help patients develop tools to manage those fears the day of the hearing/interview (for example, providing psychoeducation about the process and the respective roles of those present at the hearing/interview, challenging patients' negative thoughts, teaching and practicing breathing and grounding exercises, creating a stress-ball in session for a patient to hold during their hearing).

#### ***Providing Psychological Evaluations as Evidence***

While medical affidavits can substantiate the physical evidence of the story of why an asylum seeker is unable to return to their home country (e.g., a bullet lodged in a patient's spine), a psychological affidavit describing the MH presentation and diagnoses further substantiates the impact of the experiences that may warrant asylum (*see* Meffert et al., 2010). By working in coordination with attorneys, therapists assist judges and asylum officers in better understanding *who* the asylum-seeking adult or child in front of them is, and *why* they are in front of them.

**Content of MH Evaluations.** The psychological evaluations that the MH providers at TF write, typically include the following elements:

1. A short professional biography of the MH clinician, their credentials, and their experience working with the asylum-seeking population;

2. How long the clinician has known the patient and in what context;
3. Their treatment modality (i.e., frequency of sessions, individual/group therapy);
4. As many details as possible about the reasons and traumatic experiences that led them to flee their country of origin, focusing on the merits of the asylum case, if known, including attempts made by them to seek protection in their country of origin;
5. Any relevant cultural observations (for example, “in my years of experience working with the Garifuna community in New York City, I have learned that it is not unusual for Garifuna children to be placed with different nonparental caretakers from a young age, and to be assigned to a new caretaker often” or “the fact that the patient has endorsed believing in magic and being convinced that his mother was killed by the neighbor through *magia negra* [black magic], is congruent with the patient’s community beliefs);
6. The trauma screen and validated symptom measures the therapist used to evaluate the patient at the beginning of treatment;
7. The psychological impact of the traumatic experiences on the patient in the present: any MH diagnosis that the patient meets criteria for (as classified by the *DSM-5*), the specific symptoms that the patient presents with that support the diagnosis/diagnoses, and any relevant clinical observations (e.g., “during the course of treatment Ruth has consistently expressed distrust in people in general and men in particular”);
8. The patient’s mental status and presentation in detail (for example, “Juan’s speech is often disorganized”; “often uses laughter as a coping mechanism when nervous”; “his affect is typically flat”; “has extreme difficulty in making eye contact and remembering certain details of his experiences”), and the reasons why the patient is considered to be a reliable historian (e.g., “the narrative of his story has been consistent throughout treatment”; “has been invested in treatment”).
9. Psychoeducation about the diagnoses and the patient’s presentation from a trauma-informed perspective (for example, explaining PTSD and its presentation in the particular patient: “Gabriela is easily triggered by sounds that even slightly resemble a gunshot, and goes into hiding immediately after hearing such”; and why there may be incongruity between the patient’s affect and the expected affect as a common effect of trauma: “the fact that Gabriela may giggle when asked about her rape experience does not mean that she did not experience it or suffer from it, it is likely a form of affective avoidance”);
10. Progress made in treatment, including the results of any follow-up measures administered after baseline or recently

before submitting the evaluation, and clinical observations (for example, “after a year of treatment and working on building trust and processing her traumatic experiences, Rosa is now able to make eye contact with the therapist and to discuss some aspects of her assault without dissociating like she did before; Rosa’s PTSD measure total score has decreased from 68 to 45, which indicates that even though some of the symptoms have decreased in frequency or severity, they remain above the clinical cutoff”). The therapist may also recommend psychological testing to rule out or further explore a suspected developmental delay or learning disorder (which may additionally place the patient in a particular social group potentially eligible for asylum);

11. Highlight their resilience: engagement with a social support network and professionals or other supportive adults, attending MH services, school, afterschool and enrichment activities; and
12. Clinical opinion on how being deported might impact a patient’s MH (for example, “it is my assessment that forcing Berenice to return to El Salvador could severely damage her psychological and emotional health, as she would be directly and permanently exposed to people and places that abused her in so many ways, which would likely trigger and worsen her PTSD symptoms and sense of safety, and would put her life and MH at grave risk. It is my understanding that she would likely not have access to the health services she receives in New York”).

**Rendering in-Vivo Testimony.** Therapists may be asked by the attorney to testify as expert witnesses if the judge or asylum officer deems it necessary. When that happens, therapists answer questions related to the patient, their MH diagnosis, and their MH treatment.

### The Therapist as the Evaluator: The Bidirectional Role

The authors understand that the bidirectional role of the therapist as both the evaluator for asylum-seeking (and other immigration relief) purposes and MH therapist, may be controversial. The authors are aware of the potential assumption that, since the therapist already has a relationship with the patient, the therapist cannot possibly be fully objective or as objective as a forensic evaluator. The authors would be remiss in not addressing whether the bidirectional role is in direct conflict with the guidelines of forensic evaluations, which share many elements of the description written above, and in which the evaluator is expected to provide independent and scientifically informed information rather than advocacy, and to not have any other relationship with the person being evaluated. The authors believe there is no conflict as evaluations by TF providers should not be considered forensic for the following reasons:

In its Guidelines for Forensic Psychology, the American Psychological Association (APA, 2013) does not qualify this work as forensic psychology or defiance of the guidelines themselves:

Providing expert testimony about a patient who is a participant in a legal matter does not necessarily involve the practice of forensic psychology even when that testimony is relevant to a psychological issue

before the decision-maker. For example, providing testimony on matters such as a patient's reported history or other statements, mental status, diagnosis, progress, prognosis, and treatment would not ordinarily be considered forensic practice even when the testimony is related to a psycholegal issue before the decision-maker.

The guidelines also clarify that "psychological testimony that is solely based on the provision of psychotherapy and does not include psycholegal opinions is not ordinarily considered forensic practice" (APA, 2013). The psychological evaluations written by TF MH providers are not psycholegal opinions; they are clinical recommendations based on expertise and informed opinions, and issued as a protective measure to prevent decompensation and bolster the likelihood of recovery. This is consistent with Meffert et al. (2010), who suggest that even a forensic evaluation of quality for AS should include recommendations for treatment, such as psychotherapy modalities and medications if appropriate, as well as an explanation of the potential impact of repatriation, estimated availability of the recommended treatment in country of origin, and how exposure to reminders of the event, or a repeat of the event itself, could impact overall MH of the asylum-seeker. Consequently, TF's psychological evaluations are not forensic practice.

Furthermore, this dual role of therapist and evaluator has as its aim clinically ethical advocacy: the psychological evaluation is the organic outcome of the advocacy approach, that holds both equity in health care (increased access to professional psychotherapy and legal support) and clinical ethics as paramount.

The following are arguments to support this thesis and further substantiate the therapist being the *best* and *most reliable* evaluator of the patient for asylum purposes.

First and foremost, it may take a long time for a patient to feel comfortable with sharing their experiences with anyone. Those who survive trauma often struggle with establishing trust especially when there is hierarchy (Courtois & Ford, 2013), such as with an attorney or a judge. The access for patients at TF to long term MH treatment allows for the development of a one-of-a-kind, trusting relationship, one that allows the therapist to get to know the patient in depth. As explained above, not only can therapists document their life experiences, but also *how* those experiences have affected the patient and shaped who the patient is today, and attest to their fears and potential consequences of returning to their country of origin. As the psychotherapy process is narrative in nature, the therapists are best positioned to obtain the information that will support a patient's petition for legal relief, while simultaneously actively working to improve the individual's ability to tell their own story when testifying.

Second, in the psychological evaluation, MH providers represent what has been told by the patient accurately and completely, identifying it clearly as the patient's report to us, free of distortion or withholding. Therapists provide an explanation for why they believe their story to be genuine, based on both the experience of working with the asylum-seeking population and how the individual patient presents to us. Conversely, if the clinician does not deem the story to be genuine, or the patient to be credible, the clinician may decline to provide the evaluation to both the patient and the referral source, and explain why.

Third, the evaluation is based on the science and the literature in the field of trauma, its related diagnoses, and the asylum-seeking population. Therapists use clinical measures normed and validated for this population, perform trauma-informed clinical interviews,

provide a mental status exam, and include any observations of behavior (we are privy to informal interactions of patients as well, when they engage in other activities in the clinic).

Fourth, the patient is the identified client in the process, not the court, legal system, or attorney. MH providers state in the evaluation that they provide psychotherapy for and represent the patient. They identify the referral sources, which may be the attorney and/or their physician and include reasons for the referral (i.e., endorsed or observed symptomatology).

Moreover, MH providers clearly explain their role to the patient (including its bidirectionality), informed consent, and confidentiality. They explain the rationale, process, content, use of clinical measures, and the potential harm, benefit, and limitations of the psychological evaluation provided. These essential items are reviewed periodically with the patient. Therapists also detail the time commitment, their experience, who will have access to the evaluation, and remind the patient that they can opt out of the process at any time. The evaluation is provided free of charge to all TF patients. The patient and MH provider together review the drafted evaluation and any other supportive documentation prior to submission to the attorney and check for understanding.

Furthermore, MH providers' experience with this population allows them to engage in this role with cultural humility and professional competence, including awareness of systemic oppression and power differential dynamics (even within the therapeutic relationship), and to better understand the stories patients share of their traumatic experiences, which may sound completely outlandish to an evaluator that does not have knowledge of the experiences that are common across asylum-seeking populations.

In order to promote the quality and consistency of the assessments, both for clinical and for advocacy purposes, attempts are usually made to include multiple sources of information, such as parent or caregiver report, medical information when appropriate, prior MH records, and school records.

Self-care, promotion of healthy boundaries, and ongoing attention to the emotional impact of this work on professionals, are paramount in order to provide sensitive treatment and prevent secondary trauma and burnout. Each MH provider has access to clinical supervision, crucial for MH professionals to work with and evaluate asylum-seeking individuals.

### Effectiveness of TF's MH Evaluations

The best argument to support the validity and effectiveness of these evaluations is the impact they have had on patients' asylum cases. From the 148 evaluations/letters of support that have been written by TF's medical and MH providers in support of patients' asylum claims,<sup>2</sup> from TF's inception to date, 108 have been written by mental health providers, of which 53 have been granted and 55 are still pending; from the 40 written by medical providers, 18 have been granted and 22 are still pending.<sup>3,4</sup> From the asylum

<sup>2</sup> This number does not include evaluations written in support of other forms of immigration relief for TF patients, such as U and T visas, or Special Immigrant Juvenile Status.

<sup>3</sup> "Pending" cases include cases in which patients disconnected from care, therefore outcomes are unknown.

<sup>4</sup> The closure of courts and asylum offices due to the COVID-19 pandemic greatly delayed an already backlogged immigration system.

cases that have known outcomes, no cases for which either a medical or a MH evaluation was provided, have been denied, in other words, a 100% approval rate. To provide context, the nationwide total asylum grant/denial rates for fiscal year (FY) 2019 were 20.62% and 49.56%, respectively;<sup>5</sup> for FY 2020 19.14% and 54.52%; and for FY 2021 15.96% and 30.88% (Executive Office for Immigration Review, 2021).

It is not the assumption that the extremely high asylum grant rate of TF patients' cases is solely the result of the MH care they received, but that it at least legitimizes the effectiveness and validity of TF's nonforensic MH evaluations.

## Conclusions

Multidisciplinary models that are based on close collaboration of professionals who tend to the wide array of needs of the asylum-seeker, promote improved outcomes in several domains, and minimize the risk of retraumatization (de la Peña et al., 2019). The MH lens is crucial in making a program and its providers and services trauma-informed. MH evaluations conducted by a patient's therapist in support of their asylum case are not only ethical and efficacious advocacy conduits for patients' asylum claims, but for the multitude of reasons discussed above, they provide more reliable assessments than traditional forensic evaluations.

Given the tremendous positive impact that receiving MH services may have not only on the asylum-seeker's overall MH and well-being, but on their ability to identify and effectively communicate the traumatic events that led them to seek asylum, incorporating a MH component into MLPs that provide services to the asylum-seeking population is crucial, and should become standard practice. Furthermore, identifying them as mental health-medical-legal partnerships would properly acknowledge the unique, stand-alone MH contributions to the partnership.

<sup>5</sup> The remaining percentage were abandoned, not adjudicated, other, or withdrawn.

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