



## The Mental Health of Refugee Claimants and Undocumented Migrants

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For over two decades successive international crises and political instability have forcibly displaced over 100 million people, the largest number on the United Nations High Commissioner for Refugees record.<sup>1</sup> Migrants currently make up one in seven of the global population,<sup>2</sup> which includes refugees and asylum seekers, also known as refugee claimants.<sup>3</sup> Refugee claimants are persons whose requests for asylum have yet to be processed by Canada's Immigration and Refugee Board. Undocumented migrants include a heterogeneous group of people who have "no authorization to reside and/or work in Canada."<sup>4</sup> The majority do not meet eligibility criteria for existing immigration programs after lawful or irregular entry into the country, or after staying beyond the authorized period. A growing body of research makes it increasingly clear that forcibly displaced people, such as refugees, refugee claimants, as well as undocumented migrants experience significant mental health-related morbidity.<sup>2</sup> As per the World Health Organisation, refugee claimants and undocumented migrants are of special concern given the adversity associated with their migration experience.

All types of migrants and refugees, including refugee claimants and undocumented, face risks to their mental health during the premigration, perimigration, and postmigration periods. During the perimigration period, risk factors include exposure to life-threatening situations (e.g., violence and war), human rights violations, persecution and deprivation of basic needs (e.g., starvation). Postmigration factors include barriers to accessing health services, separation from family, precarious immigration status, insecure housing and barriers to employment all impacting mental health. The kind of postmigratory reception migrants receive in a host country is a key determinant of mental health.<sup>5</sup> Reception policies themselves are often reflective of the ambivalent or polarized views of refugees and asylum seekers in public discourse that vacillates between fear and resentment and humanitarian sentiments. During integration and resettlement, additional factors impacting mental health include racism, xenophobia, socioeconomic deprivation, low family cohesion and social isolation.<sup>6,7</sup>

Immigrants are generally considered to be healthier upon arrival in the host country (i.e., the "healthy immigrant

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effect”).<sup>8,9</sup> With respect to disparities in mental health conditions, the incidence of psychoses is generally higher among migrant populations as compared to host countries.<sup>6</sup> Among refugee claimants and refugees, the prevalence of depression, anxiety and posttraumatic stress disorder (PTSD) is higher than in the host population or voluntary immigrants.<sup>6,10</sup> Refugee claimants are also at elevated risk of suicide.<sup>6,9,10</sup> Recent literature on undocumented migrants suggests they have the same elevated rates of mental health problems as refugee claimants.<sup>11</sup> Due to their insecure residency status, many undocumented migrants live in fear of being detected and deported, thereby limiting their access to necessary services such as health care.<sup>4</sup>

In the face of the worsening international crisis of forcibly displaced persons, psychiatrists and psychiatry trainees in Canada are increasingly tasked with caring for refugee claimants and undocumented migrants, which requires taking into account their specific social, cultural and structural predicament. This position paper seeks to outline the key reception issues impacting the mental health and well-being of refugee claimants and undocumented migrants in Canada and makes recommendations to inform clinical care, training, advocacy, policy and research.

## Reception Policies and Practices

### *Refugee Claims Process*

The refugee claim process takes on average two years in Canada.<sup>12</sup> Notably, procedures governing the migration process are constantly evolving in response to political and economic imperatives, but in recent years have trended towards limiting access to Canada, often legitimized because refugee protection and well-being are seen as competing with the societal needs of the majority population.<sup>13</sup>

The hearing process for asylum claims can itself be considered a significant postmigration stress. In preparation for one’s hearing, a claimant must gather extensive evidence, which is often unavailable, to produce both a written and verbal narrative for their protection claim. Claimants, including families with children, recount traumatic stories and are expected to prove their credibility in the adversarial tribunal system, wherein the prosecution and defence compete against each other while the judge acts as a referee for the process. The hearing itself may be postponed multiple times and claimants do not know if they will receive a decision on the spot or wait several months for a decision.<sup>8</sup> While a hearing is delayed, claimants continue to experience stress from the precarity of the legal situation and its myriad implications. In fact, the outcome of the

claims hearing may independently have a direct impact on the recovery from trauma-related psychiatric symptoms.<sup>14</sup>

While awaiting an Immigration Refugee Board decision, a claimant can access some services including social assistance, education (for minors), and legal aid via provincial/territorial supports. Access to these services is sometimes delayed or denied, either because service providers do not understand claimants’ entitlements,<sup>15</sup> or, for example, because claimants are unhoused.<sup>16</sup> In several provinces, access to legal counsel is limited.<sup>17</sup> Health-care services for claimants are covered under the Interim Federal Health Program (IFHP), although systemic barriers (particularly reimbursement issues) contribute to health-care provider reluctance to provide services for claimants.<sup>18</sup>

### *Insecure Residency Status*

Existing research demonstrates that insecure residency status is associated with negative mental health outcomes, as compared to migrants with secure residency status. In a recent systematic review, Côté-Olijnyk et al.<sup>11</sup> found that insecure status was associated with greater rates of mental illness as compared to migrants with secure status. Insecure status can contribute to reduced health-care usage, due to fear of repercussions such as deportation. Insecure status can also restrict employment opportunities, and therefore economic resources for housing and childcare.<sup>5</sup> Similar to the adult population, children and adolescents with an insecure status demonstrate higher rates of mental health problems as compared to those with a secure status.<sup>19,20</sup>

Unaccompanied minors are migrants under the age of 18 years who have entered Canada unaccompanied by either a parent or a legal guardian. They may be undocumented or refugee claimants and face intersecting vulnerabilities both due to their insecure status and their status as minors.<sup>19,20</sup> Unaccompanied minors and children who are victims of trafficking are particularly vulnerable to poorer mental health outcomes. Child trafficking is the recruitment and movement of people aged younger than 18 for the purposes of exploitation.<sup>21</sup> Victims of child trafficking may enter Canada as either a country of destination or transit. They are at greater risk of experiencing violence, both physical and sexual in nature. They appear to be at greater risk of PTSD and affective disorders as compared to other migrant children.<sup>21</sup>

### *Immigration Detention*

Canada’s immigration detention practices and their repercussions on mental health have come under

increasing scrutiny in recent years by advocacy groups and health professionals. Experiences such as handcuffing, searching, solitary confinement, restriction to small spaces, as well as constant surveillance are cited as detrimental to mental health.<sup>22</sup> Immigration detainees, especially those with mental health problems, may also be held in provincial jails, alongside criminally accused or convicted persons.<sup>22</sup> Further, Canada is one of the few countries without a legal limit governing the length of immigration detention. Consequently, some detainees may be detained for years and all are detained with a sense of limbo and indefinite waiting.<sup>23</sup>

Cleveland and Rousseau<sup>24</sup> found that adults held in Canadian detention centres, even for relatively brief periods, had higher rates of PTSD, depression and anxiety as compared to nondetained adults. Detainees described detention as a retraumatizing experience.<sup>25</sup> A 2018 systematic review found that both detention duration and greater trauma exposure prior to detention positively correlate with the severity of mental health symptoms.<sup>26</sup>

There are also inequities in detention practices: (1) detainees who are Black are more likely to be detained in provincial jails for longer periods; (2) detainees with mental health conditions are more likely to be held in provincial jails; put in solitary confinement; to have tribunal-appointed substitute decision-makers; and to face onerous release conditions within the community. Amnesty International and Human Rights Watch have characterized the Canadian immigration detention practices as discriminatory and in breach of international human rights law.<sup>23</sup>

During the COVID-19 pandemic, immigration detainees were released at unprecedented rates demonstrating the arbitrary nature of immigration detention and the availability of alternatives. Since then, immigration detention rates have again risen with approximately 6,000 held in the 2022–2023 fiscal year.<sup>27</sup> Since 2000, there have been 17 deaths, including suicides in immigration detention in Canada.<sup>28</sup>

Children experiencing immigration detention require particular attention. Child migrants are regularly detained in Canada, though numbers have decreased in the past five years. Research in Canada and abroad has demonstrated the detrimental consequences of the detention of migrant children.<sup>29</sup> Kronick et al.<sup>30</sup> found that detained children reported high rates of emotional distress, including separation anxiety, selective mutism, mood and posttraumatic symptoms. In Canada, children and mothers are detained separately within a center, such that they are separated from other family members in the men's

section. Children who have experienced separation from migrating parents are at elevated risk for developing depression, anxiety, suicidal ideation, conduct disorders and substance use problems.<sup>6,7</sup> In response to concerns about child detention in 2017, the Canadian Psychiatric Association, along with other signatories, called on the federal government to cease the practice of placing children in immigration detention.<sup>31</sup>

### *Protracted Family Separations*

Child–parent separation is another hazard of precarious migration trajectories. A Québec study has shown that, in some migrant communities, the mean parent–child separation duration was approximately five years.<sup>32</sup> Asylum-seeking and undocumented children may be separated on account of multiple policies and practices,<sup>33</sup> including immigration detention, years-long bureaucratic delays in family sponsorship applications and deportations of parents. The consequences of child–parent separations are not benign, and decades of research on the protective and buffering effects of parent–child attachment, and the international standards on children's rights to family reunification, bolster concerns about the harms of such practices.

## **Racism, Discrimination, Socioeconomic Marginalization**

### *Inaccessibility of Mental Health-Care Services*

Many newcomers who have been forcibly displaced face a myriad of barriers to accessing mental health services. Factors such as inaccessibility of interpreters, stigma, lack of cultural safety, racism and fears of consequences for immigration proceedings contribute to underutilization of services.<sup>7</sup> Specifically, access to interpretation services is an important impediment to mental health care. Refugee claimants, while entitled to the IFHP, are regularly denied care because health providers or administrators do not understand the coverage to which they are entitled.<sup>34</sup> Undocumented migrants are frequently denied health-care coverage, including in Ontario where Ontario Health Insurance Program Coverage for All was recently revoked by the government, despite health-care providers' concerns.<sup>35</sup> Canadian literature has established that immigrant, refugee, and ethnocultural or racialized groups, seek help for mental health less frequently than the general Canadian population.<sup>36</sup> When they do present, it is more often in acute or intensive settings (i.e., emergency department and inpatient), thus resulting in poorer mental health outcomes.<sup>36</sup> Several studies

demonstrate that literacy, trust in services, cultural competence and targeted health promotion, all improve care access for this patient population.<sup>36</sup>

### *Social Exclusion and Belonging*

Migrants' sense of belonging in their country and community of residence has direct effects on their health and well-being. Community-level factors such as cultural, social, linguistic and racial/ethnic factors, can shape the sense of belonging experienced by migrants.<sup>37</sup> Although key to individual resilience, they are rarely emphasized in clinical settings which feel ill-equipped to evaluate and enhance their public health importance. Interestingly, the COVID-19 pandemic demonstrated that engaging migrant and minority communities is not only possible but also effectively increases adherence to public health guidelines and facilitates access to services,<sup>38</sup> but this has yet to be integrated into overall practices.

## **Recommendations**

1. Clinical practices and programs:
  - (a) Psychiatrists should provide culturally safe and trauma-informed care to migrants presenting with mental health concerns. The initial focus of care should be on immediate resettlement needs and emotional support that promotes a sense of safety. Thereafter, should symptoms persist, then specialized interventions such as referral to mental health services for migrants, pharmacotherapy and/or psychotherapy should be considered.<sup>7</sup>
  - (b) Migrants presenting with mental health concerns need access to professional, trained interpretation services across the continuum of care, ideally in person. Family members, and particularly children, should never be used as informal interpreters, nor should computer-based translation applications be considered a safe substitute for trained interpreters.
  - (c) Given the disproportionate barriers migrants face in accessing mental health care, where possible, rapid access should be implemented for migrants presenting with mental health concerns to offset inequities in care.
  - (d) Specialized health-care programs, including mental health, should be designed in collaboration with all stakeholders, including representation from those with lived experience of migration and refugeehood.
  - (e) Psychiatrists should establish partnerships anchored in community networks with local community organizations, schools, faith-based organizations,
- and other social actors, to facilitate the provision of nonstigmatizing mental health support and ensure that care addresses the social determinants of migrant health.
2. Structural advocacy:
  - (a) Although often considered as beyond the clinical realm, psychiatrists have a responsibility to provide structurally competent care and to intervene through an ecosystemic approach. This includes:
    - (i) providing treatment that takes into consideration the legal trajectory migrants may experience (e.g., understanding clinical symptoms within the context of a patient's legal trajectory and advocating for patients during their claims' hearing);
    - (ii) advocacy for patients' clinical needs, including the need for security when recovering from trauma or when undergoing immigration proceedings; and
    - (iii) advocacy to protect individual patients from reception conditions that are harmful to mental health (e.g., poverty, discrimination, lack of health-care coverage, and embodied exclusion). These can be considered forms of abuse, and much as it would be unethical to only help a victim of abuse endure these conditions, clinicians must try to advocate for a more humane treatment.
  - (b) Psychiatrists and other mental health providers should advocate for health insurance for all migrants.
  - (c) All psychiatrists in Canada should be registered as IFHP providers to ensure that they do not inadvertently deny access to care to refugee claimants.
  - (d) Institutions, including hospitals and clinics, should ensure that all migrants, including undocumented ones, are entitled to mental health care, irrespective of insurance or ability to pay.
  - (e) Psychiatrists and other mental health providers should engage in intersectoral advocacy to ensure that forcibly displaced newcomers are protected from prolonged family separations, visa insecurity, immigration detention, and all forms of social exclusion that come at the detriment of their mental health.
3. Education:
  - (a) Psychiatry training programs should ensure trainees receive clinical exposure in caring for migrants with mental health concerns, including

- supervision providing culturally safe and trauma-informed care.<sup>39</sup>
- (b) Psychiatry training programs should train staff and residents to use the DSM5 Cultural Formulation Interview on a regular basis. Such training should include opportunities for learners to reflect critically on their own positionality, privilege and identity in order that the tool is applied reflectively and not as a checklist.
4. Policy:
    - (a) Governments across jurisdictions should seek to provide access to all public services for migrants, given the impact of postmigratory stressors on mental health outcomes.
    - (b) Governments and the media should be aware of the impact of the negative public portrayal of migrants and seek to redress this through explicit antiracist policies and practices.
    - (c) Refugee determination and family reunification administrative processes should be fair and expedited to ensure the right to family reunification and the upholding of the best interests of the child. All immigration processes should ensure that personnel are trained in trauma-informed and culturally competent frameworks.
    - (d) The Canadian government should end the practice of immigration detention and family separation.
  5. Research:
    - (a) Governmental and health-care agencies across Canadian jurisdictions should seek to bolster the collection of health service data for migrants presenting with mental health concerns, as well as facilitate access to this data for researchers studying this field.
    - (b) Research programs should seek to better contextualize various migrant groups to enable policy decision-makers to understand the heterogeneity that exists within these groups and identify specific social determinants to inform health-care service delivery models and community-based prevention programs to enhance migrants' well-being.
    - (c) Funding agencies should prioritize funding of evaluative research that examines health service models for the mental health of migrant patient populations in terms of outreach and outcomes.
    - (d) Research funders and research ethics boards should support and receive training in participatory research methodologies with refugee and migrant populations.

**Table 1.** Clinical Approach to Working With Interpreters and Culture Brokers.<sup>a</sup>

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**Before the interview**

- Meet with the interpreter to explain the goals of the interview.
- Discuss whether the interpreter's social position in country of origin and local community could influence the relationship with the patient.
- Explain the need for especially close translation in the mental status examination (e.g., to ascertain thought disorder, emotional range and appropriateness, suicide risk).
- Ask the interpreter to indicate when a question or response is difficult to translate.
- Discuss any relevant etiquette and cultural expectations.
- Arrange seating in a triangle so that the clinician is facing the patient and the interpreter is to one side.

**During the interview**

- Introduce yourself and the interpreter and explain your roles.
- Discuss confidentiality and ask for the patient's consent to have the interpreter present.
- Look at and speak directly to the patient; use direct speech (e.g., "you" instead of "she" or "he").
- Avoid jargon or complex sentence constructions; use clear statements in everyday language.
- Slow down your pace; speak in short units to allow the interpreter time to translate.
- Do not interrupt the interpreter; keep looking at the patient while the interpreter is speaking.
- Clarify ambiguous responses (verbal or nonverbal) and ask the patient for feedback to make certain that crucial information has been communicated clearly.
- Give the patient a chance to ask questions or express concerns that have not been addressed.

**After the interview**

- Discuss the interview and ask the interpreter to assess the patient's degree of openness or disclosure.
  - Consider translation difficulties and misunderstandings and clarify any important communication that was not translated or was unclear, including nonverbal communication.
  - Ask the interpreter if he or she had any emotional reactions or concerns of his or her own during the interview.
  - Plan future interviews; whenever possible, work with the same interpreter or culture broker for the same patient.
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<sup>a</sup>Retrieved from "Common mental health problems in immigrants and refugees: general approach in primary care" by LJ Kirmayer, L Narasiah, M Munoz, et al. *Canadian Medical Association Journal (CMAJ)*, 183(12):E959–967. 2011 by the Canadian Medical Association.

## Resources

See Table 1 for more details.

The Multicultural Mental Health Resource Center highlights several resources which may help mental health providers in caring for multicultural patient populations, including resources relevant to the care of migrants such as locating interpreters or culture brokers: <https://multiculturalmentalhealth.ca/>.

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