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Challenges to Addressing Mental Health Repercussions of Large-Scale Immigration Worksite Raids in the Rural United States

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Abstract

Immigration worksite raids–in which dozens to hundreds of individuals are detained–often target food processing plants or other warehouse-based operations, primary sources of employment for immigrants in rural communities. Drawing on interviews with 77 adults who provided support following six worksite raids, we describe three challenges to identifying resultant mental health impacts: 1) amid poverty and family disappearance, mental health is not the priority; 2) untrained practitioners misidentify signs of declining mental health; and 3) mental health care is linguistically limited, expensive, and inaccessible to working families. We end by discussing how practitioners and advocates can address these challenges.

Keywords

Mental health; family; Latino; deportation; rural health

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Compliance with Ethical Standards

The authors have no conflicts of interest to disclose.

All human subjects research was approved by the Institutional Review Boards of the Universities of Michigan (HUM00146458) and Iowa (201811206).

Informed consent was received from all participants in a manner approved by the above stated Institutional Review Boards.

Introduction

Immigration enforcement–or the surveillance, detention, and deportation of noncitizen immigrants–is detrimental to health (Fleming, Novak, & Lopez, 2019). Immigration worksite raids have been used by various presidential administrations throughout history (Goodman, 2020) to arrest noncitizens, especially those without work permits. These raids are typically carried out by dozens to hundreds of immigration agents, who surround a central facility, block all available exits, corral workers in a central location, and request documents of those they suspect of being undocumented. Military equipment, sometimes including Blackhawk helicopters, and Homeland Security buses to transport those arrested, are commonly seen outside of raided facilities (Novak, Geronimus, & Martinez-Cardoso, 2017). Worksite raids occur at food processing plants, gardening centers, or other large warehouse-based operations such as trailer or precast concrete manufacturing (National Immigration Law Center, 2020). These industries contribute to the financial security of rural communities, and often employ a large percentage of the rural Latino immigrant population in these new destination towns (Carr, Lichter, & Kefalas, 2012).

Some emerging research documents the harmful health impacts of immigration worksite raids. Novak, Martinez-Cardoso, and Geronimus (2017) found that infants born to Latina mothers were more likely to be low birth weight than infants born to white mothers the year after the Postville, IA, raid. Juby and Kaplan (2011) interviewed nine key informants impacted by the same raid, and considered how the raid harmed children, adults, and the surrounding community. The authors found that many in the community expressed symptoms of post-traumatic stress disorder (PTSD) and nearby school personnel reported behavioral problems among students. A study using the current data set [Lopez et al., 202] details the mechanisms by which immigration worksite raids result in family separation, financial crisis, and family role rearrangement, which in turn harm the health and well-being of those detained and many connected to them.

Other research illustrates the mental health impacts of immigration enforcement broadly, including depression, anxiety, and substance abuse (Garcini et al., 2016). Raids, as conglomerations of multiple immigration enforcement strategies, are likely to amplify these negative outcomes, and given their frequency in rural communities, are positioned to uniquely harm rural immigrant and Latino populations (Gómez Cervantes & Menjívar, 2020). Yet little research considers the mental health impacts of these raids nor how to mitigate the damage they cause.

We investigated community responses to large-scale immigration worksite raids (Lopez et al., 2022). While we queried successful efforts to mitigate raid impacts (e.g., bond projects, ride shares), interviewees occasionally addressed mental health repercussions and challenges to addressing them. In this Brief Report, we describe three challenges to identifying and addressing the mental health impacts of immigration worksite raids and discuss implications, especially in rural environments.

Methods

This Brief Report is part of a larger study that sought to better understand impacts of and community responses to large-scale immigration worksite raids. The study involved the participation of advocates, allies, and community members at six communities impacted by large-scale worksite raids in 2018 that resulted in the arrests of over 30 individuals in a single operation. We confirmed the enforcement events that fit into this criteria by reviewing ICE press releases, media reports, and conversation with activists who responded in each location (Lopez et al , 2022). Collaborators at each site guided recruitment and analysis. Eligible participants were age 18 and older and had been part of responding to the raid, which was defined as providing material (food, financial support, shelter, transportation), professional (legal or health services), or emotional support following one of the six large-scale worksite raids. Eligible participants were given information about the study and invited to schedule an interview at a time and place in which they were comfortable. We began each interview with informed verbal consent to avoid collecting names to protect participant confidentiality.

We did not limit participation based on race/ethnicity, gender, immigration status, or personal involvement in each raid. Therefore, some participants provided support the day of the raid, while others, for example, may have been involved weeks after. Participants also varied in their degree of proximity to individuals detained in the raid: some participants had provided direct support to members of their own family who were detained, or were detained themselves, others, for example, supported the children of those detained or may not have a personal connection to a noncitizen in the community. While some research dichotomously divides study samples into the impacted community versus those who provide them with services (e.g., Hacker, Chu, Arsenault, & Marlin, 2012), such as physicians or service providers, we chose not to do so to allow the data to reflect an observation made during fieldwork and advocacy: those who are impacted by immigration raids often also organize to address the harm raids cause. Interview participants spanned five sectors including 1) education (e.g., teachers); 2) faith (e.g., pastors and congregants); 3) legal (e.g., attorneys and legal support organizations); 4) advocacy (e.g., organizers); and 5) other volunteers (e.g., health and counseling professionals, drivers).

We visited each community and conducted, recorded, and transcribed 77 interviews in participants' preferred language (Spanish or English). Most (82%) interviews were conducted face-to-face, though when this was not possible, participants completed interviews via phone or video chat. Participants used pseudonyms. We used a semi-structured interview guide to query participants' community roles, knowledge of the raid, and vision for progress. Interviews lasted about half an hour. All participants consented to be interviewed.

Inductive coding was used to develop a codebook and code transcripts. After initial site visits, the PIs considered dominant literature, media, and conversations in each community to develop the codebook, which we refined after visiting remaining communities. This resulted in seven parent codes and twenty-two subcodes. The study PIs coded transcripts using Nvivo 12. When coding discrepancies arose, we discussed, took notes, and came to a

resolution. Additional codes were added when necessary. The code most used for the current analysis include “mental-physical health,” a subcode of the “raid impacts” parent code.

Mental health was not the central focus of this study, but the topic emerged frequently enough in interviews that the study team reviewed the “mental-physical health” code and identified three common challenges that occurred across multiple communities. As such, data described here, in context with emerging research, provide guidance for future studies and practitioner implications. We present in this Brief Report the “challenges” to be addressed if mental health is to be prioritized after large-scale worksite immigration raids in rural communities. The Institutional Review Boards of the Universities of Michigan (HUM00146458) and Iowa (201811206) approved the study.

Results

Challenge 1: Mental health is not the priority.

Purposefully clandestine, it is never clear when worksite raids end nor if they will extend to other locations. Consistent with other research (Stuesse, 2016), participants compared worksite enforcement to 9/11 and natural disasters such as tornadoes. Amid the chaos, the goal was not caring for health, but locating those who disappeared.

Laura, a social worker, shared, “My immediate thought was, ‘We need to help these people. Talk them through their feelings. See what they need emotionally and mentally.’ But everybody else’s thoughts were, ‘No. They need legal counsel. They need representation.’ I think the families didn’t know what they needed. They just knew they needed help.” Destiny, a Latinx organizer who was herself undocumented and responded to the raid in Sumner, TX, shared, “I guess the biggest need within the community is getting my loved one out [of detention]. That was the first immediate need…”

Enforcement actions resulted in the detention of financial providers or, upon their release, work restrictions. Other family members thus prioritized work to purchase essentials, such as food or diapers. Susan, a retired nurse, shared, “I’ve noticed in working with this group of folks, health kind of gets put on the back burner; work is foremost.”

Challenge 2: Untrained health practitioners miss signs of declining mental health.

In a review of mental health among immigrants in primary care, Kirmayer et al. (2011) described that patients present with physical complaints or use “culture-specific bodily idioms” to express mental distress. Flynn and colleagues (2021) consider Spanish translations of health survey items, and argue that Spanish-speakers may not consider mental health issues as distinct from physical ailments.

Alicia, a bilingual psychologist, suggested that many of her patients could not identify their emerging mental health issues: “We were working with anxiety, sleeping issues, depression…. So, people that have never experienced what was anxiety, what was depression, they didn’t even know what was happening to their body, what was happening to their mind.” Sonia, a nurse, said similarly: “I think that things like depression and anxiety were new for them because they’re very resilient people, you know. So, for something to

really shake them, it has to be something of high magnitude, which is what it [the raid] was." Research shows that multiple parts of the immigration journey are highly traumatic (Kirmayer et al., 2011), so it is unlikely that community members were experiencing mental health issues for the first time. Regardless, for most, this likely is the first time they attempted to describe these symptoms in the US or English-speaking context.

Challenge 3: Mental health care is linguistically limited and expensive.

Mental health care is, in the best of times, inaccessible to immigrant communities. Language barriers are an established challenge to obtaining treatment (Kirmayer et al., 2011). Gricelda, a Latina organizer, described how community members would come into her organization to complete paperwork and tell her about their feelings: "And I'm just like wait... You need a therapist. You need someone to talk to." Here, Gricelda identified a mental health issue, even if the community member did not. But, Gricelda says, "[W]e did have individuals or therapists who wanted to help, but they didn't speak the language." She summarized: "The biggest thing was interpreters."

Mental health, when correctly identified and prioritized over finding loved ones and working, then must be paid for. Undocumented immigrants often work jobs in which they are not offered employment-based insurance, and while the Affordable Care Act (ACA) increased mental health access for the U.S. population in general, undocumented immigrants are not eligible for Marketplace coverage of the ACA. As sliding-scale fees are rare or insufficient for low-wage laborers, out-of-pocket costs become prohibitive. Within families, children may have insurance, but undocumented parents may be too fearful of government surveillance to apply to receive these benefits.

Conclusion

This Brief Report explores the challenges to addressing mental health issues after large-scale immigration worksite raids, an immigration enforcement strategy that targets the industries–such as manufacturing and food processing –often unique to rural environments. While we did not specifically query identifying or addressing mental health issues, findings emerged that merit further study and advocacy, especially in rural communities and new immigrant destinations. Addressing mental health after immigration raids is challenging at best, particularly given the substantial shortages in formal mental health services in rural areas (Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009). Following worksite raids, community members are more concerned with locating family, paying rent, and feeding children than in addressing their own mental health. Later, community members may begin to reflect upon health concerns, but are likely to explain mental health issues with references to physical health, leading to alternative diagnoses from untrained health professionals. Further, without culturally-sensitive, bilingual counselors available free or at low-cost–especially in new destination communities (Graefe, De Jong, Howe Hasanali, & Galvan, 2019)–mental health care in the aftermath of raids is unlikely. In rural environments, distance, exposure, and cultural competency can also be limited, which severely impacts the capacity of Latino and immigrant populations to receive adequate care (Gómez Cervantes & Menjívar, 2020; Lanesskog, Piedra, & Maldonado, 2015).

Three implications emerge from these findings. First, advocates should align their prioritization of mental health care with that of the community, focusing first on locating relatives and providing necessities. Second, mental health practitioners must be culturally and linguistically capable of communicating with the immigrant community, including the ability to identify mental health issues from physical health symptomatology or when patients are unaware of mental health issues at all. Third, mental health treatment must be free, or, at a minimum on a sliding scale accessible to low-wage workers.

The mental health challenges experienced by rural immigrant communities are compounded by immigration raids. However, even when these highly visible immigration enforcement actions do not occur, the health and well-being of immigrant communities are shaped by the constant fear of deportation experienced during daily life tasks. Routine driving, coupled with fear of racial profiling and deportation, and seeking basic health services that require personal documents become causes for concern. Media representations of immigration enforcement across the country further spreads fear across immigrant communities, regardless of proximity to the actual event. While immigration worksite raids are one particularly egregious form of immigration enforcement, the day-to-day lives of immigrants in rural immigrant communities include a number of stressors that augment mental health challenges while making their treatment exceptionally difficult. Public health efforts must address not only the barriers that prevent mental health treatment, but the aggressive immigration enforcement tactics that harm mental health to begin with.

Lastly, we argue that a narrow focus on mental health concerns that involves individual, one-on-one therapeutic interactions is inefficient and, and worst, disempowering to rural immigrant communities. Advocates must expand our notions of mental health to include addressing aspects fundamental to our humanity, such as family togetherness. Community organizing, as a form of group therapy, may allow community members to share their trauma with others while simultaneously working to address a political system that funds immigration raids while limiting routes to mitigate the damage that comes after.

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