VIOLENCE AT THE BORDER

HELPING MIGRANTS AND ASYLUM SEEKERS RECOVER FROM TRAUMA WHILE THEY AWAIT ENTRY TO THE U.S.

MEAGAN THOMPSON

FRANK BATTEN SCHOOL OF LEADERHSIP & PUBLIC POLICY

UNIVERSITY OF VIRGINIA, 2021

ACKNOWLEDGMENTS

I would like to thank Professor Lucy Bassett for introducing me to the complex situation on the border last spring, for taking me on as a research assistant, and for your wisdom, guidance, and persistently calming presence over the past year as I have continued to learn about policy and life. I owe so much of my graduate school experience to you and I will be forever grateful. I would also like to thank Professor Kirsten Gelsdorf for your guidance in the fall, and for your candor and unwavering ability to put things in perspective to focus on what is important. I would like to thank Amanda Nguyen and Molly Lasater for giving me the opportunity to help on your review of psychosocial interventions – this project would not have been possible without you.

To Kristin Owen of International Justice Mission, thank you for your time and for giving me this chance to work with you. I would like to thank my classmates, Joy Kim, Kate Cronin, Landon Webber and Sarah Robinson. Without your pep-talks, support, edits, and head clearing walks this report would not have come together. And finally, to Sarah Lapp and Sarah Poole, thanks for getting me to the finish line.

CLIENT

International Justice Mission (IJM) is a global leader in protecting against and seeking justice for human rights violations. With a specific focus on impoverished populations, IJM partners with local authorities to combat trafficking, violence against women and children, and abuse of power. IJM achieves this mission through three different channels: 1) rescuing and restoring victims, 2) bringing criminals to justice, and 3) strengthening justice systems. This report will focus on an element of the organization’s first core competency, restoring victims, and how IJM can use that channel to mitigate problems faced by asylum seekers encamped along the U.S.-Mexico border face.

DISCLAIMER

The author conducted this study as part of the program of professional education at the Frank Batten School of Leadership and Public Policy, University of Virginia. This paper is submitted in partial fulfillment of the course requirements for the Master of Public Policy degree. The judgments and conclusions are solely those of the author, and are not necessarily endorsed by the Batten School, by the University of Virginia, or by any other agency.

HONOR PLEDGE

On my honor as a student, I have neither given nor received unauthorized aid on this assignment.

Megan Thompson

TABLE OF CONTENTS

ACKNOWLEDGEMENTS..1
CLIENT..1
DISCLAIMER..1
HONOR PLEDGE...2
ACRONYMS 4
KEY TERMS..5
EXECUTIVE SUMMARY..7
PROBLEM BACKGROUND...9
Current Conditions in and Migration from the Northern Triangle..9
Important Recent U.S. Policy..11
Resultant Conditions at the U.S.-Mexico Border...11
The Problem...16
Literature Review...17
Trauma...17
Psychosocial Interventions: Research & Limitations...19
Evaluative Criteria 22
Alternatives...23
Alternative #1 Therapeutic Art Intervention: Common Threads 23
Alternative #2 Group-Based Self-Help Intervention: Self-Help Plus..................................26
Alternative #3 Mobile Gender-Based Violence Support Delivery.......................................28
Recommendation...30
Implementation..31
Recruiting and Training the Necessary People...31
Guiding Principle of MHPSS Programming..32
Conclusion...33
References...34
Appendix A: Cost to Society...42
Appendix B: Art Therapy Effectiveness...43
Appendix C: Guiding Principles of MHPSS Programming 44

ACRONYMS

ACT	Acceptance and commitment therapy
GBV	Gender-based violence
IJM	International Justice Mission
IRC	International Rescue Committee
MHPSS	Mental health and psychosocial support
MPP	Migrant Protection Protocol
OECD	Organization for Economic Co-operation and Development
PTSD	Post-traumatic stress disorder
SH+	Self-Help Plus
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

KEY TERMS

Term	Definition
Asylum Seeker	A person who has left their country and is seeking protection from persecution and serious human rights violations in another country, but who hasn't yet been legally recognized as a refugee and is waiting to receive a decision on their asylum claim.
Gender-based violence	Physical, sexual, verbal, emotional, and psychological abuse that is directed at an individual based on his or her biological sex or gender identity. Women and girls are most at risk of gender-based violence.
Forced Migration	The movements of refugees, migrants, and internally displaced people (those displaced within their home countries) as a result of natural, environmental, chemical, or nuclear disasters, famine, conflict, and/or development projects.
Migrant	There is no internationally accepted legal definition of a migrant, but generally migrants are understood to be people staying outside their country of origin, who are not asylum-seekers or refugees. Some leave their countries for work, study or to join family, while others leave because of poverty, political unrest, gang violence, natural disasters or other serious circumstances.
Mental Health and Psychosocial Support	Any type of local or outside support that aims to protect or promote psychosocial well-being or prevent or treat mental disorders.
Migrant Protection Protocol	Trump immigration policy, also known as the "Remain in Mexico" program, that required Northern Triangle families seeking refuge to remain in Mexico while their asylum cases are processed.
Northern Triangle	The three Central American countries of Guatemala, Honduras, and El Salvador.

Refugee	A legal status for a person residing outside his or her country of nationality, who is unable or unwilling to return because of a 'well-founded fear of persecution on account of race, religion, nationality, membership in a political social group, or political opinion'.
Title 42 Process	Expulsions by the U.S. government of persons who have recently been in a country where a communicable disease was present. Authority for contagion-related expulsions is set out by law in 42 U.S.C. § 265. During the COVID-19 pandemic, the Trump Administration used this provision to generally block land entry for many migrants and this has been largely continued by the Biden Administration.
Trauma	The response to a deeply distressing or disturbing event that overwhelms an individual's ability to cope, causes feelings of helplessness, diminishes their sense of self and their ability to feel a full range of emotions and experiences

EXECUTIVE SUMMARY

This report focuses on possible actions for International Justice Mission to take regarding the violence perpetuated against asylum seekers at the U.S.-Mexico border. ***There were over fifteen hundred publicly reported cases of murder, rape, torture, kidnapping, and other violent assaults against asylum seekers and migrants awaiting entry at the US-Mexico border in the past year (Delivered to Danger, 2020), a rate estimated to be double what it was in 2018 (Medicins San Fronters, 2020), and little is being done to help migrants recover from experiences of violence.*** Due to the alignment of their mission, organizational competencies, and existing Latin American presence, my client, International Justice Mission (IJM) is uniquely positioned to address this problem.

The Northern Triangle's social, political and economic instability is driving tens of thousands of its citizens to flee. When they reach the United States' southern border, U.S. immigration policies and new COVID-19 precautions are blocking asylum seekers from entering the United States. Migrants and asylum seekers are forced to remain in turbulent Mexican border communities, where they live in inhospitable conditions—many in makeshift tent camps. Apart from being dangerous from a public health standpoint, this has left migrants and asylum seekers vulnerable to violent crime and kidnapping.

The consequences of these acts of violence, when considered on an individual, familial, and societal level are severe. Trauma incurred from violence can have lasting impacts on a person's mental and psychological health. These effects can also be passed onto future generations. Societally, even with the most conservative of estimates, the cost of violence against asylum seekers and migrants at the border totals approximately 2.8 million USD annually.[1] Although migrants and asylum seekers are already a particularly vulnerable population, within this group some, including women and children, are more at risk for harm and therefore disproportionally bear the brunt of these costs.

In considering how to address this violence, this report evaluates three possible mental health and psychosocial interventions: 1) Common Threads, a therapeutic art intervention, 2) Self-Help Plus, a group-based self-help intervention, and 3) mobile gender-based violence support delivery, on the criteria of *feasibility, speed,* and *effectiveness*. Alternatives are evaluated in each as either low, moderate, or high. Based on these evaluations, implementing Self-Help Plus is the recommended course of action for IJM. It is the most feasible alternative of those

[1] For an explanation of cost calculations see Appendix A.

presented, as it is designed for low-resource humanitarian settings, its low resource and personnel requirement means that it can be rolled out quickly, and, though it is a relatively new intervention, it has the most rigorous study of effectiveness that shows a significant reduction of psychological stress both immediately and 3 months post intervention. For successful implementation IJM will need to focus on recruiting and training the necessary people and following the UNHCR's guidelines for MHPSS programing.

PROBLEM BACKGROUND

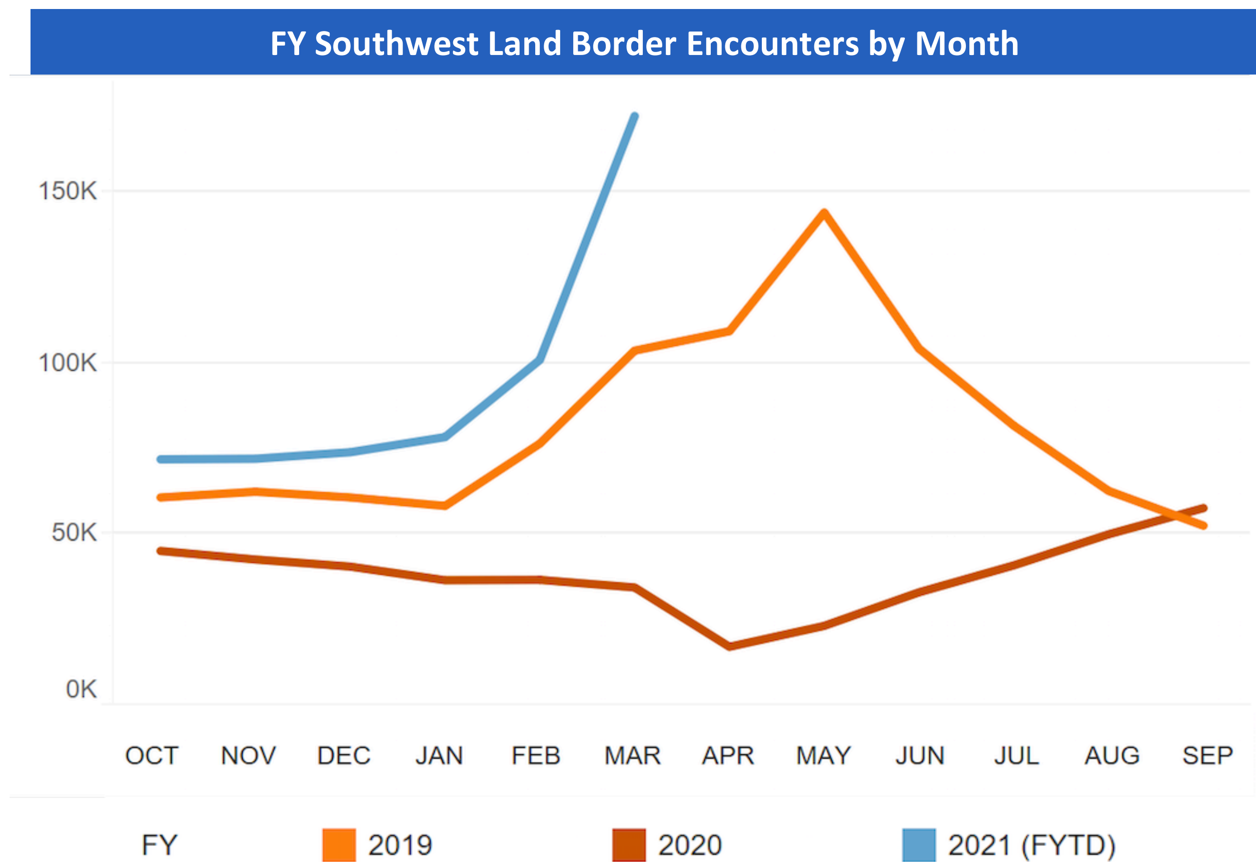
One of the world's busiest migration corridors runs from Central America through Mexico to the United States. This channel carries a flow of migrants from the countries of the Northern Triangle – El Salvador, Guatemala and Honduras – to the U.S. as they flee life-endangering violence and search for economic opportunity.

CURRENT CONDITIONS IN AND MIGRATION FROM THE NORTHERN TRIANGLE

This year, violence, climate change, rising poverty, and COVID-19 are forcing people to flee northern Central America at staggering rates. Currently, residents of the Northern Triangle are facing worsening conditions in a region that has for years suffered from extreme poverty and some of the world's highest murder rates outside of warzones (*Central America's Turbulent Northern Triangle*, 2019). The economic impacts of the COVID-19 pandemic have been catastrophic, forcing an estimated additional 45.4 million Latin Americans into poverty in 2020 (Bárcena, 2020). The region was then struck by a record-breaking hurricane season in November when hurricanes Eta and Iota made landfall within three weeks of one another, leaving 3.4 million people in need of urgent assistance (FAO, 2021). In addition, reports of

gender-based violence, already pervasive in the region, have also continued to rise. In El Salvador, reports of gender-based violence have increased by 70% in the past 12 months (*Increase in Reports of Gender-Based Violence across Latin America*, 2020) and in Honduras, the Latin American country with the highest rate of femicide, statistics so far in 2021 record a femicide every thirty-six hours, consistent with rates from the last two year each of which saw over 400 femicides (Lakhani, 2021). All together, these conditions are driving people from the Northern Triangle to the United States at notably elevated rates. The U.S. Border Patrol came in contact with almost 85,000 migrants from the Northern Triangle attempting to cross the southern border in March 2021, an increase of 89% from February 2021 (*Southwest Land Border Encounters*, 2021). Figure 1 below highlights how drastically migration has increased in the past few months, as compared to last year with unprecedently low migration and the year before when migration was more typical.

Figure 1:



Source: US Customs and Border Protection, 2021

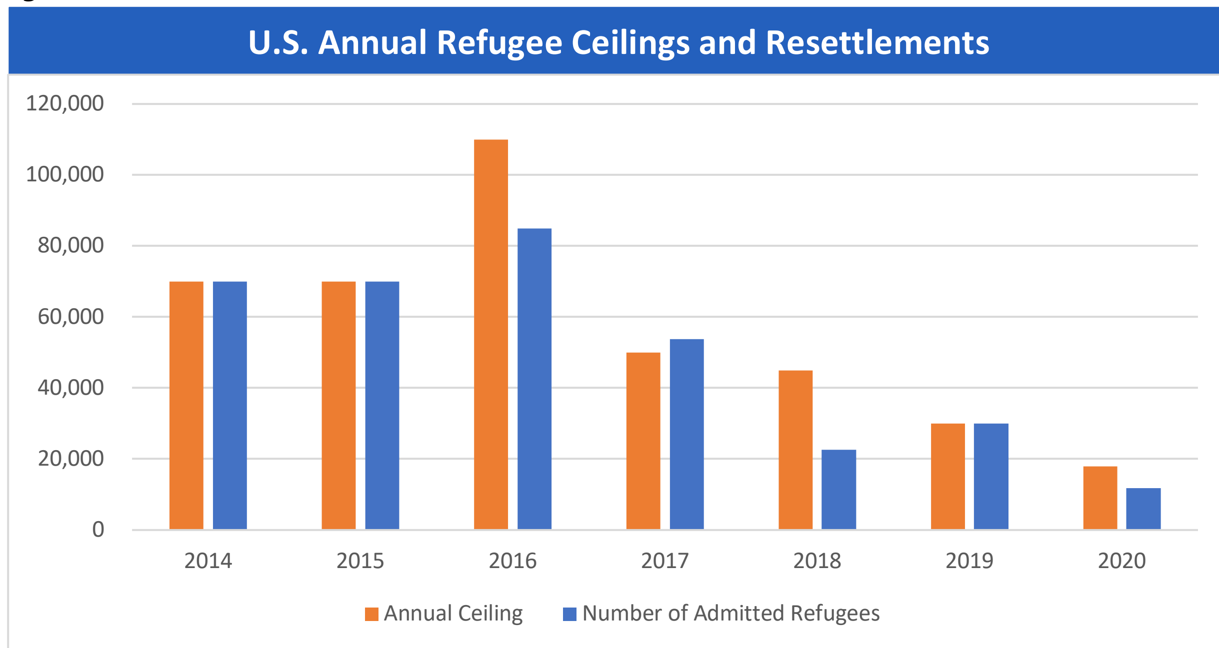
IMPORTANT RECENT U.S. POLICY

The influx of asylum seekers from this region has overwhelmed U.S. immigration services in the past, and in 2014 then-President Barack Obama named then-Vice President Joe Biden as the White House point person for the crisis. Biden worked with the governments of El Salvador, Guatemala, and Honduras to improve economic development and reduce violence and corruption. Together they developed the Alliance for Prosperity, which pledged $750 million in U.S. funding while requiring each regional country to commit its own domestic resources (Runde & Sandin, 2021). The goal of these funds was to address the underlying conditions driving the migration spike which included violence, drought, and a lack of economic opportunity. By helping citizens of the Northern Triangle lead successful lives in their own communities, the Alliance for Prosperity hoped to reduce the need for many to migrate.

Additionally, to accommodate the crisis, the United States expanded access to the U.S. Refugee Admissions Program for vulnerable individuals and families from El Salvador, Guatemala, and Honduras. This expanded access to refugee resettlement for those fleeing the region offered another legal alternative to asylum for entry. The refugee designation was also able to better address the needs of those threatened by criminal gang violence and domestic violence and human rights defenders who have been targeted, among others (Hiskey et al., 2016).

This approach, however, was abruptly halted by President Donald Trump when he assumed the presidency in 2016. The Trump Administration focused U.S. immigration policy on the building of a border wall to keep refugees and migrants out of the country. As illustrated in Figure 2 below, in 2017 the Trump administration capped the maximum number of refugees for the year at 50,000, less than half the number set by former President Barack Obama (Rosenberg & Alper, 2019). In 2019 this number was further cut to 18,000 refugees, an almost 85% decrease in only four years (Toosi & Kim, 2016).

Figure 2:



Source: Pew Research Center, 2020

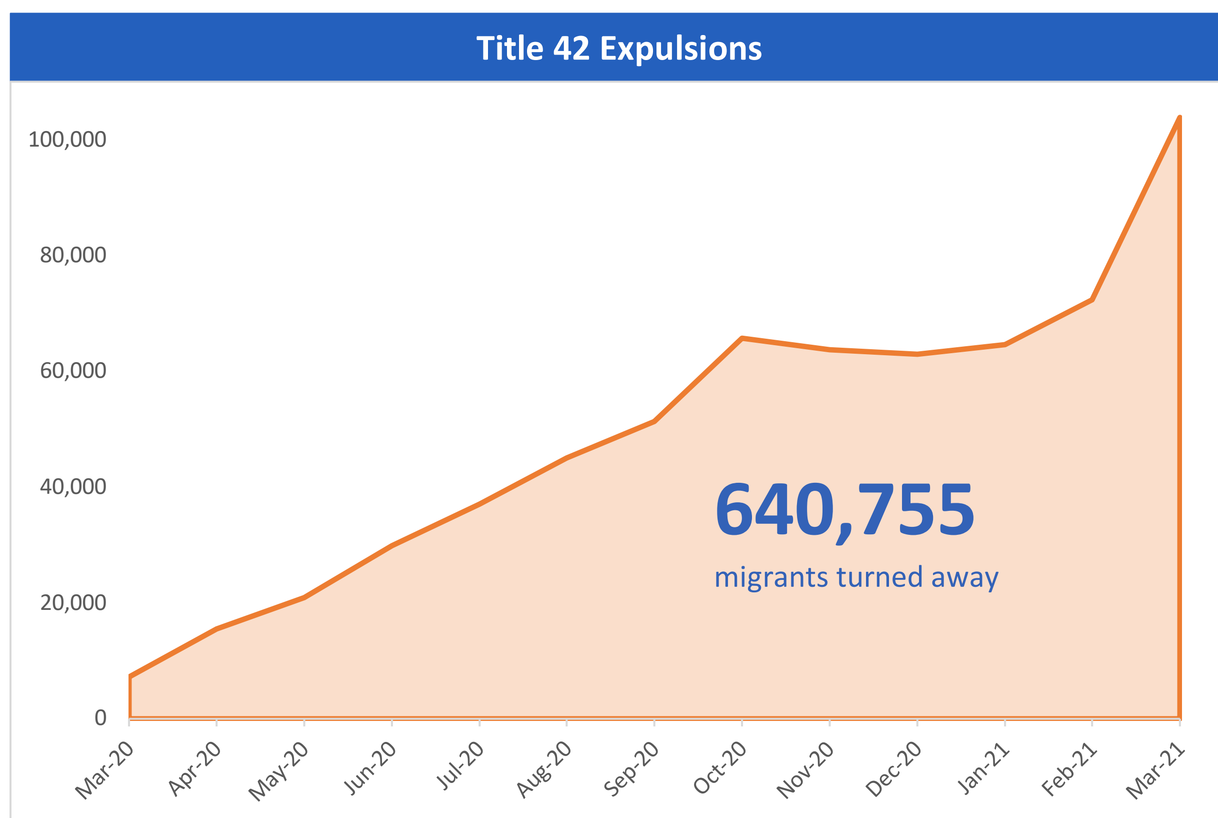
Additionally, in 2019 the Trump administration ended the Alliance for Prosperity, cutting off foreign assistance to the Northern Triangle until migration numbers decreased (Finnegan, 2019). As part of the Trump administration's "safe third country" agreements, signed by the U.S. and Northern Triangle Countries, asylum seekers from the region must first seek refuge in those countries before applying for asylum in the United States (Alper, 2021).

In 2019, the Trump Administration also launched the Migrant Protection Protocol (MPP). This new immigration policy, also known as the "Remain in Mexico" program, required Northern Triangle families seeking refuge from violence in their home counties to remain in Mexico while their asylum cases are processed instead of in the U.S. as has historically been the case. Since the policy went into effect in January 2019 more than 70,000 asylum seekers were sent back to Mexico where tens of thousands more were already residing still waiting for the opportunity to apply for asylum (DeChalus, 2020).

Finally, U.S. immigration protocol has been significantly affected by the COVID-19 pandemic. In March 2020, the Trump Administration relied on a rarely used public health rule to more drastically restrict immigration at the United States' land borders. Because COVID-19 was present in Mexico and Canada, President Trump determined that there was a serious and present danger that migrants might further introduce the coronavirus into the United States. Under Title 42 of the United States Code Section 265, those attempting to enter the United States without documentation at the border have been, and continue to be, summarily

expelled.[2] Instead of being held in detention centers or some other area for immigration processing, as is usual procedure, immigrants are now immediately expelled to their country of last transit (Sandhu, 2020). This process, frequently referred to as the "Title 42 Process," ignores the statues that ordinarily governing border arrivals and disregards the protections and procedures mandated by international humanitarian law for immigrants, especially unaccompanied minors and those seeking asylum. The Biden Administration has continued this process despite widespread criticism by public health experts of its disregard for alternative measures that could both preserve public health and ensure access to asylum and other protection (*Public Health Experts Urge U.S. Officials to Withdraw Order Enabling Mass Expulsion of Asylum Seekers | Columbia Public Health*, 2020). From March 2020 to March 2021 over 640,000 people have been expelled from the United States under Title 42 (*FY 2020 Nationwide Enforcement Encounters*, 2020).

Figure 3:



[2] Whenever the Surgeon General determines that by reason of the existence of any communicable disease in a foreign country there is serious danger of the introduction of such disease into the United States, and that this danger is so increased by the introduction of persons or property from such country that a suspension of the right to introduce such persons and property is required in the interest of the public health, the Surgeon General, in accordance with regulations approved by the President, shall have the power to prohibit, in whole or in part, the introduction of persons and property from such countries or places as he shall designate in order to avert such danger, and for such period of time as he may deem necessary for such purpose. *(July 1, 1944, ch. 373, title III, § 362, 58 Stat. 704.)*

RESULTANT CONDITIONS AT THE U.S.-MEXICO BORDER

The combination of the growing violence and worsening economic conditions in the Northern Triangle and the recent changes to U.S. immigration policy have resulted in a humanitarian crisis in 2019 as thousands of asylum seekers were forced to live in spontaneously formed makeshift tent camps along the already dangerous U.S.-Mexico border. The U.S. State Department recognizes the danger of this region, having already designated many Mexican border cities as level 4 threats—the same danger assessment as for Afghanistan, Iraq, and Syria (*Mexico Travel Advisory*, 2021).

Mexico is a fairly dangerous country: it is the OECD county with the highest homicide rate, homicide is the leading cause of death for 15 to 44-year-olds, the rate of organized crime rose by 24% last year, and the measure of peacefulness has fallen 27% over the past five years (IEP, 2020). In the border state of Baja California, these numbers are even more alarming. Tijuana, just south of the border from San Diego, is the deadliest city in Mexico with an estimated 2,185 homicides in the past year (IEP, 2020). Last year the rate of violent crime in the state of Baja increased by 2.5%, primarily driven by increases in the rates of sexual assault, and the rate of extortion rose by nearly 90% (IEP, 2020). The resurgence of violence in Baja California, particularly in the city of Tijuana, is attributed to intense fighting over key drug trafficking routes to the United States (IEP, 2020). Organized crime-related violence, largely concentrated in Tijuana, has caused the state's homicide rate to increase by over 200% since 2015 (IEP, 2020).

These areas rife with violence pose a particular thereat to those who are already vulnerable. Migrants are targeted by and coerced to cooperate with cartels, sometimes committing crimes on the cartel's behalf including drug trafficking and assassinations (*UTRGV | Gulf Cartel*, n.d.). Many migrants are intercepted by criminal groups at border crossings, bus stations, and elsewhere in border cities where they are sexually assaulted, abducted for ransom, extorted, robbed at gunpoint, and subjected to other crimes (*Mexico*, 2021).

Additionally, corruption of Mexican authorities poses a threat. There are many reports of Mexican police and immigration agents targeting migrants for extortion. Some asylum seekers report that Mexican immigration agents or police threatened to deport them, have them detained, or hand them over to cartels if they did not pay a bribe (*Mexico*, 2021).

The changes in U.S. immigration policy that are turning thousands of people from the Northern Triangle away every day have left migrants and asylum seekers to remain in these turbulent border communities. There many live in recreational camping tents that offer little protection while they wait for immigration court hearings.

When President Biden came to office in January of this year, he ended MPP and promised entry to those who had remined in Mexico under the policy, thus disbanding what was the largest tent encampment in Matamoros, Mexico. However, now more people are coming and as they continue to be turned away under Title 42, new encampments are forming. Currently Tijuana, Mexico, has a tent encampment of more than 1,500 waiting for asylum entry to the United States (*Mexico*, 2021).

Makeshift camp of migrants in Tijuana, Mexico, Wednesday, March 17, 2021.
Source: Boston Herold

THE PROBLEM

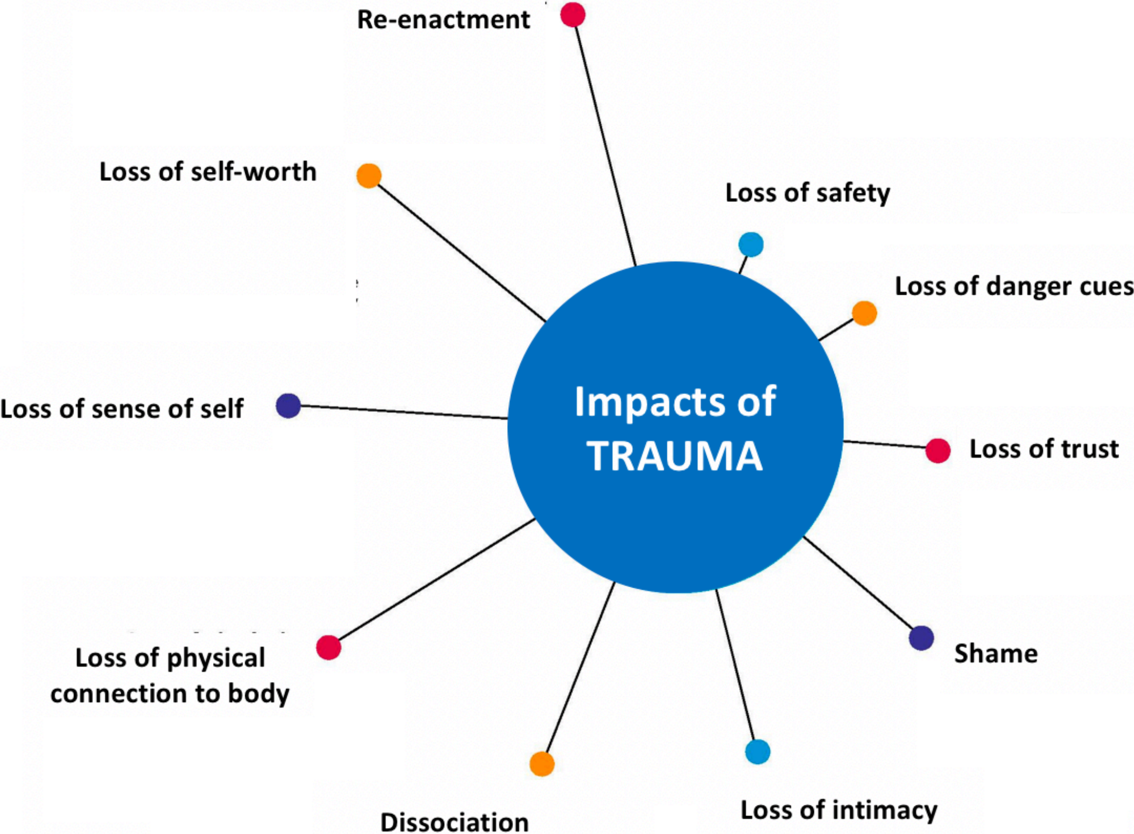
One of the problems with life in these makeshift tent encampments is that they leave migrants and asylum seekers, already a vulnerable group, more susceptible to violence. Children and women especially are at risk for sexual and other violence due to the crowded conditions, lack of secure sleeping and living areas, and lack of access to protected bathroom facilities.
As of February 19, 2021, there are at least 1,544 publicly reported cases of murder, rape, torture, kidnapping, and other violent assaults against asylum seekers and migrants forced to return to Mexico under MPP (*Delivered to Danger*, 2021). These figures are likely only the tip of the iceberg, as displaced asylum seekers are highly unlikely to report many violent crimes, given their vulnerable state. As migrants continue to be forced to reside in tents along the border under Title 42, instances of violence will only persist. ***At the current rate of violence, which is already double what it was in 2018 (Medicins San Fronters, 2020), thousands of migrants will be victims of violence. Presently there are few accessible options to help them recover from these traumatic experiences.*** Due to the alignment of their mission, organizational competencies, and existing Latin American presence, International Justice Mission is uniquely positioned to address this problem.

LITERATURE REVIEW

TRAUMA

Violent crime, like that perpetrated against asylum seekers at the U.S.-Mexico border, incurs trauma. Trauma is the response to a deeply distressing or disturbing event that overwhelms an individual's ability to cope. Trauma often causes feelings of helplessness and diminishes an individual's sense of self, limiting their ability to feel a full range of emotions and experiences. Evidence shows that the consequences of trauma brought upon by violent crime are severe (Costa, 2017).

Figure 4:



Trauma, whether from one-time, multiple, or long-lasting repetitive events, affects everyone differently. Some people who experience traumatic events develop post-traumatic stress disorder (PTSD), a psychiatric condition that affects 5% to 10% of the general population and

causes those who suffer from it to re-experience the trauma through intrusive distressing recollections of the event, flashbacks, and nightmares, emotional numbness and avoidance of places, people, and activities that are reminders of the trauma, and increased arousal such as difficulty sleeping and concentrating, feeling jumpy, and being easily irritated and angered (Harvard Health, 2021). PTSD is more common in women as they are more likely to experience gender-based violence. It occurs more frequently in people who have certain risk factors, including living in poverty. PTSD can develop after a person experiences violence or the threat of violence, as these events are considered outside the ordinary and are exceptional in their intensity.

However, even those who do not develop PTSD often experience negative impacts from trauma that can be subtle, insidious, or outright destructive. Immediately after a traumatic event, individuals can experience exhaustion, confusion, sadness, anxiety, agitation, numbness, dissociation, confusion, physical arousal, and blunted affect (Treatment (US), 2014). Longer term reactions include unpredictable emotions, flashbacks, and strained relationships (Treatment (US), 2014). Trauma can cause persistent fatigue, sleep disorders, nightmares, fear of recurrence, anxiety, depression, and avoidance of emotions, sensations, or activities that are associated with the trauma. In addition, somatic symptoms like headaches and nausea are common (Treatment (US), 2014).

How an event affects an individual depends on many factors, including characteristics of the person affected, the type and characteristics of the traumatic event, developmental processes, and sociocultural factors like the accessibility of natural supports and healers, the coping and life skills of immediate family, and the responses of the larger community in which they live (Treatment (US), 2014).

Tragically, the effects of trauma can impact the children and even grandchildren of victims. Studies on intergenerational trauma show that traumatic events in someone's life can change the way their DNA is expressed, and that change can be passed on to the next generation (Yehuda et al., 2016). In this process, known as epigenetics, small chemical tags are added to or removed from DNA in response to changes in one's living environment and experiences. These tags turn genes on or off, offering a way of adapting to changing conditions (Henriques, 2019).

> *"There's a malleability to the system. The die is not cast. For the most part, we are not messed up as a human race, even though trauma abounds in our environment."*
>
> - Diaz & Ressler (2014)

This means that one's life experiences – particularly traumatic ones – can have a very real impact on their family

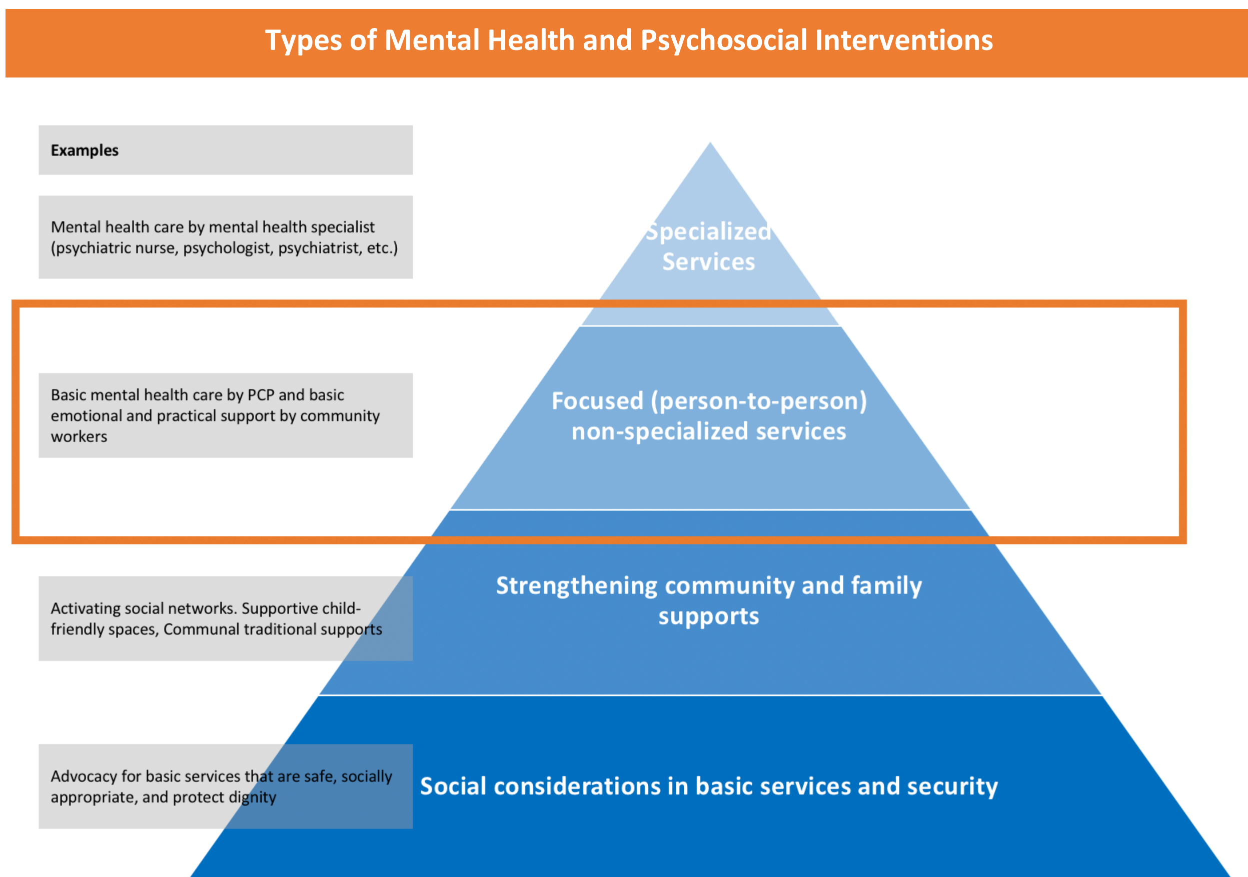
for generations to come (Costa, 2012). There are a growing number of studies that support the idea that the effects of trauma can echo down generations through epigenetics (Yehuda et al., 2016) (Dias & Ressler, 2014). For example, the children and grandchildren of people who experience trauma may have weaker immune systems and be more likely to develop cancer in their lifetimes (CDC, 2020).

There is, however, hope as even trauma that results in DNA changes can be effectively addressed. Even if people inherit trauma, the effect on DNA can be undone using therapeutic techniques like cognitive behavioral therapy (Aoued et al., 2019). Healing the effects of trauma in our lifetimes can put a stop its echo into future generations.

PSYCHOSOCIAL INTERVENTIONS: RESEARCH & LIMITATIONS

In looking at how to offer trauma recovery to migrants at the U.S.-Mexico border I concentrated my study on reviewing mental health and psychosocial interventions (MHPSS) that have been used in the humanitarian context of forced migration, and specifically interventions that offered focused, non-specialized services. The conditions that drove Northern Triangle asylum seekers from their homes were already considered a crisis, and the trauma from those experiences is only compounded by the uncertainly and violence they face awaiting entry to the U.S. in temporary encampments. All together, these types of experiences are commonly associated with substantial psychological and social suffering. As discussed above, the mental health and psychosocial impacts on individuals, families, and communities have the possibility of being extensive yet highly diverse and can vary from quick recovery to long-term negative impacts (Ventevogel et al., 2015). MHPSS interventions address these impacts in a variety of ways including being socially considerate in the provision of basic needs and services, strengthening community and family supports, focused, non-specialized services, and specialized services as illustrated in Figure 5 below. While social consideration in basic services, like providing nutrition in a way that is safe, socially appropriate and protects people's dignity, is something everyone needs, focused, non-specialized interventions are necessary for a smaller number of people who require additional, more targeted programs by trained care providers for specific issues. These care providers are usually community workers who may not have years of specialized care training (IASC, 2007).

Figure 5:



There are limitations on MHPSS research and there are gaps between research and practice. As is the case in other humanitarian fields (Checchi et al., 2017), the most rigorously studied MHPSS interventions are not often commonly implemented in humanitarian settings, while those most commonly implemented in humanitarian settings have received comparatively little examination (Tol et al., 2011). Although many researchers and practitioners operate in both academic and implementation settings, gaps in knowledge are exacerbated by the lack of broadly sustained interaction between scholars and humanitarian practitioners. Differences persist between interventions that exhibit scholarly "excellence" vs. practical "relevance" (Tol et al., 2012).

A 2021 systematic review of psychosocial interventions in forced migration contexts found that a major limitation of research in the field comes from a lack of comparative study design (Nguyen et al., 2021). Less than half of MHPSS interventions included a control group. This is important because without a group to give an understanding of how people would fare without

the intervention, it is difficult to say whether any observed changes were a result of the intervention itself or just a result of other factors that could change with time. Additionally, nearly a quarter of the studies reviewed collected information at a single point in time, meaning there was no ability to measure change (Nguyen et al., 2021).

By and large, however, MHPSS interventions targeting forced migrants, asylum seekers, and refugees have a positive impact. Eighty-five percent of studies find generally positive trends toward improvement, or perceptions of improvement, related to psychosocial interventions when judging by positive stakeholder perceptions or small measured positive changes (Nguyen et al., 2021). Even using a more conservative approach and limiting positive impact to studies that had meaningful statistically significant results, 60% of interventions were found to be effective (Nguyen et al., 2021).

EVALUATIVE CRITERIA

This report examines three intervention options that International Justice Mission can implement to help migrants and asylum seekers at the U.S.-Mexico border recover from these traumatic experiences. The following criteria are used to evaluate each policy option.

FEASIBILITY

Given the complex and shifting political and economic situation that has created the proliferation of tent encampments along the U.S.-Mexico border, the feasibility of any action is important to consider. Ascribed feasibility scores of low, moderate or high will be informed by implementation challenges faced by similar programs in comparable environments. This report will also consider unique challenges each alternative would face in the border context.

SPEED

Because of the acute nature of the crisis, the speed with which an alternative can be enacted will be a consideration for evaluation. Scored on a low, moderate or high scale, speed will be determined by the time frame in which similar programs have been implemented elsewhere and the adaptably to the U.S.-Mexico border.

EFFECTIVENESS

The effectiveness of each alternative, measured as either low, moderate or high, will be determined by how well the alternative is able to improve the psychosocial wellbeing of migrants and asylum seekers. This will be calculated by observing the effectiveness of similar programs in other contexts and considering how those outcomes may translate to the affected migrant population at the U.S.-Mexico border.

ALTERNATIVES

The following three possible courses of action for IJM to take regarding the violence perpetrated against asylum seekers at the U.S.-Mexico border were selected after examining 162 different mental health and psychosocial interventions that have been implemented in humanitarian contexts. These three were chosen for being the most relevant and applicable in considering both the target population of migrants and asylum seekers from the Northern Triangle, and the environment of the temporary border encampments.

ALTERNATIVE #1 THERAPEUTIC ART INTERVENTION: COMMON THREADS

Common Threads was developed to respond to the complex needs of women who have suffered gender-based violence (GBV), especially in the context of forced migration and armed conflict. The approach integrates elements of current trauma treatment, art therapy techniques, and the benefits offered by traditional sewing collectives. In Common Threads participants design and sew textiles in order to share and process their stories and engage in additional psychotherapeutic activities to support their recovery.

Since its pilot project in Ecuador with 28 women in 2012, Common Threads Project has expanded programs to the DRC, Bosnia, and Nepal where they work with a total of 296 women who have experienced GBV, often in the context of forced migration (*Common Threads*, n.d.).

Common Threads groups seek to draw women out of social isolation and encourage them to re-establish trust and connection with others. Making textiles allows women to safely explore distressing events. Women who have experienced GBV frequently suffer from anxiety and often struggle to find ways to quiet a nervous system that has functioned for long periods on 'high alert.' Stitching offers a way to slow down, focus, and engage in a repetitive, rhythmic motion that helps to regulate arousal levels (Cohen, 2013).

In the Common Threads program, the textile making process is coupled with additional therapeutic activities in order to promote participants' psychosocial skill development in order to build a foundation of coping to help maintain stability. Techniques such as: somatic awareness (i.e. paying express attention to physical sensations) ;muscle relaxation; breathing exercises; enhancement of self-care routines; psycho-education on the potential impact of traumatic experiences; effective management of hyperarousal, intrusion, and constriction; and identifying and encouraging self-soothing practices are all included in the workshops (Cohen, 2013).

> ***"This is difficult to put into words."***
>
> *-Anonymous Colombian Refugee (2013)*

Arpillera made by a Colombian refugee. She flees her home while a man wields a machete.
Source: Common Threads Project

Feasibility

This alternative is rated **moderately** feasible. Although it requires a limited number of resources and could be adapted to operate in a variety of different physical spaces, implementation is reliant on a team of specialized facilitators. The materials required to operate Common Threads (e.g. fabric and other sewing supplies) can be locally sourced and are easy to obtain. Similar groups have been conducted with success in temporary community structures including tents (Rowe et al., 2017) so finding an appropriate space should not be a limiting consideration. The biggest obstacle faced in feasibility is the specialization of staff required to run a successful program. Other similar programs have required facilitation by staff members with counselling experience, an artist, an anthropologist, and a seamstress, and the training of those facilitators by an expert (Cohen, 2013). Finding staff with relevant experience who are already on the border or willing to relocate poses a notable challenge.

Speed

Implementation of this alternative is rated **moderately** fast. Facilitators must undergo a two-week intensive training course, in which they engage in informational and experiential learning. This training is targeted at deepen facilitator understanding of the strengths and struggles of their clients (Cohen, 2013). The program itself would run for a minimum of 12 to 14 weeks, making the total time required approximately 4 months.

Effectiveness

Demonstrates Improvement in:

- Connection to others
- Self-expression
- Stress reduction
- Working through traumatic experiences
- Self-esteem

This alternative is rated **moderately** effective. Although art therapy is an emerging field, studies on its success with adult clients finds a growing apparent impact (Regev & Cohen-Yatziv, 2018), and this is particularly true in the context of adults who have experienced trauma. Common Threads specifically has been found to have a positive impact on the mental health of participants though quantitative studies in Nepal and Bosnia (Mitschke et al., 2013) and a qualitative review of the Ecuador pilot program. Participating women report forging bonds of trust with one another, experiencing hand sewing as an effective method for self-calming, and finding a safe place to express themselves freely. Participants also report being able to process memories and then move forward, feeling a relief from depression, less anxiety, and more ability to regulate emotions. Many spoke about the confidence they gained through their participation in the groups (Cohen, 2013). It is expected that the program would have a similar effect with asylum seekers at the U.S.-Mexico border regardless of age and sewing experience, as few women in past programs had hand sewing experience and none were familiar with or had ever made narrative textiles. Further information on the effectiveness of art therapy and Common Threads specifically can be found in Appendix B.

ALTERNATIVE #2 GROUP-BASED SELF-HELP INTERVENTION: SELF-HELP PLUS

Self-Help Plus (SH+) was developed by the World Health Organization (WHO) to meet the challenges of delivering evidence-based mental health support to large numbers of people, both with and without mental disorders, in hard-to-reach conflict- or disaster-affected areas. SH+ is a group-based self-help intervention guided by non-specialist facilitators with minimal training (Epping-Jordan et al., 2016).

The SH+ package has two components: a pre-recorded course and a self-help book. The locally adapted pre-recorded audio material is delivered across five 2-hour sessions and in groups of up to 30 people. This audio material gives key information about stress management and guides participants through individual exercises and small group discussions. The program package includes a written facilitator guide that helps briefly trained, non-specialist facilitators conduct the course using these audio materials. Additionally, to supplement the audio materials, an illustrated self-help book reviews all essential content and concepts. The book – informed by existing illustrated self-help guides – contains more than 400 illustrations and in order to communicate key points with minimal text. The illustrated self-help book is written to be useful both as a standalone product and as a key resource for those participating in the course (Tol et al., 2020).

SH+ is based on acceptance and commitment therapy (ACT), a form of cognitive-behavioral therapy, with particular features. ACT is based on the idea that continuous attempts to repress unwanted feelings and thoughts can paradoxically make these problems worse. Instead, ACT emphasizes learning new ways to accommodate difficult feelings and thoughts – primarily through mindfulness approaches – without letting them dominate (Hayes et al., 2011). ACT guides people to take proactive steps towards living in a way that is consistent with their values (Hayes et al., 2011), and it has been shown to be useful for a range of mental health issues, particularly in a guided self-help format (French et al., 2017).

Feasibility

Designed specifically to meet the needs of those in low-resource, humanitarian settings, the feasibility of this alternative is rated as **high**. The goal of SH+ is to provide a scalable solution that has the potential to reach many individuals currently without access to mental health treatment (Brown et al., 2018). For that reason, it is highly adaptable to a variety of contexts, including the U.S.-Mexico border. The resources required to implement the SH+ program are few: the program materials themselves (audio recordings and illustrated books) and a sound system on which to play the recordings. Additionally, facilitators do not need to have any

particular expertise. In the past they have only needed to have a secondary education and are not required mental health training or work experience (Brown et al., 2018).

Speed

The speed of this this alternative is rated **high**. Facilitator training can be effectively accomplished in only 5 days where facilitators listen through the audio curriculum and participate in practice SH+ sessions (Tol et al., 2020). The program itself then is conducted in 5 weekly 2-hour sessions (Brown et al., 2018). The entirety of the program can be completed in less than 6 weeks.

Effectiveness

The effectiveness of this alternative is rated **moderate**. As a relatively new intervention, SH+ has not been implemented in many settings, however, it was designed with the review of 43 external experts (Tol et al., 2020). Randomized control trials also show its effectiveness in reducing psychological stress for refugee women both immediately and 3 months post intervention.[3] The same study reports that explosive anger and functional impairment decreased while and subjective wellbeing increased immediately after women were a part of SH+. Although the long-term effects are yet to be determined, SH+ is increasingly being implemented in a variety of crisis contexts globally and could be quite useful for asylum seekers and migrants at the U.S.-Mexico border.

Demonstrates Improvement in:

- Post-traumatic stress and depressive symptoms
- Explosive anger
- Functional impairment
- Subjective wellbeing

[3] A single-blind, parallel-group cRCT of 14 villages and 694 female South Sudanese refugees in Rhino Camp settlement in northwestern Uganda found that SH+ led to significantly greater reductions in psychological distress immediately after intervention (β –3·25, 95% CI –4·31 to –2·19; p<0·0001; d –0·72) and 3 months after intervention relative to the enhanced usual care (β –1·20, –2·33 to –0·08; p=0·04; d –0·26). The 3-month effect (our primary endpoint) was not moderated by gender-based violence exposure, exposure to trauma, length of stay in settlement, or levels of initial psychological distress (Tol, 2020).

ALTERNATIVE #3 MOBILE GENDER-BASED VIOLENCE SUPPORT DELIVERY

Mobile delivery models are those in which health service providers travel to patients' own communities. In this alternative a mobile team of staff provides psychosocial support activities including crafts and emotional support groups, risk mitigation activities including safety planning, service mapping, and individual case management to refugees and asylum seekers. Mobile delivery models have been used in a variety of settings to provide primary care and emergency care to remote, underserved and vulnerable populations including immigrants and refugees. Although mobile approaches have rarely been used to implement psychosocial support response services, in particular those for addressing gender-based violence (Kohli et al., 2012) due to high levels of risk if security standards and strict confidentiality measures are not adhered to, in 2014 the International Rescue Committee (IRC) tested a mobile approach for GBV response and risk mitigation service delivery in Wadi Khaled, Akkar District, Lebanon among Syrian refugees (Lilleston et al., 2018).

The IRC's approach in Lebanon consisted of mobile teams of staff who rotated between sites with large refugee populations. Each team was comprised of three women: a community mobilizer, a caseworker, and an adolescent girls' assistant. There was also a single male community mobilizer who rotated between the teams (Lilleston et al., 2018). Together, these staff provided services to migrant and host community members, with specific activities being selected by participants based on their needs and interests. The community mobilizers engaged the community in the program through a variety of outreach activities including tea and coffee information sessions with community members, meetings with community leaders, and door-to-door visits (Lilleston et al., 2018). The mobile teams also identified female 'focal points' among the refugee population who were tasked with engaging community members, sharing information about the mobile services, and providing referrals for GBV survivors (Lilleston et al., 2018).

Feasibility

The feasibly of this alternative is **low**. First, it requires a highly skilled team with extensive prior training and experience in both GBV support and community mobilization. Additionally, implementation of the GBV mobile support services requires a physical space where women and girls feel comfortable, safe, and know they can receive caring, confidential assistance – a challenge in an area where the majority of structures are tents with thin walls and flap entrances that allow onlookers to see and hear program activities from outside or enter while sessions are in progress.

Speed

The speed of this alternative is **low**. Successful mobile delivery of mobile GBV support requires a high level of community buy-in – something that is only built through trust and sustained community engagement. Unlike health mobile teams who can conduct a single medical mission to a location to provide services, GBV- focused mobile teams require ongoing relationship and trust- building with communities, which are established through regular visits to the same locations (Lilleston et al., 2018). In order to successfully achieve this, a mobile GBV support program would need to run for a minimum of 6 months before reaching effectiveness.

Effectiveness

The effectiveness of this alternative is **moderate**. Evaluation of similar programs show individual and social wellbeing are positively influenced by women's and girls' participation in the GBV mobile services. These improvements include: social connectedness, social opportunities and positive relationships with others; social support; family bonds; reduced distress; self-efficacy; and knowledge and strategies to improve their safety and health.[4] However, because of the sensitive nature of the work, and the continued taboos surrounding GBV (García-Moreno et al., 2015), community push-back based on deeply entrenched norms and values can limit the effectiveness of GBV mobile health service delivery (Aljasir & Alghamdi, 2010).

Demonstrates Improvement in:

- Social connectedness
- Social support
- Family bonds
- Distress
- Self-efficacy
- Knowledge and skills

[4] From an evaluation of a similar program working with Syrian refugees in Lebanon that served 283 site visits in which over 1000 PSS activities and 100 community mobilization activities were implemented. During this time period, caseworkers saw 50 unique clients (Lilleston, 2018).

RECOMMENDATION

OUTCOME MATRIX

	Feasibility	*Speed*	*Effectiveness*
Alternative 1: **Common Threads**	**Moderate**	**Moderate**	**Moderate**
Alternative 2: **Self-Help Plus**	**High**	**High**	**Moderate**
Alternative 3: **Mobile Gender-Based Violence Support Delivery**	**Low**	**Low**	**Moderate**

The outcome matrix summarizes the relative merits of the three proposed alternatives under each evaluative criterion. This matrix ultimately suggests that offering Self-Help Plus represents the most promising means by which IJM can successfully address the traumatic experiences of migrants and asylum seekers at the U.S.-Mexico border. First, it is the most feasible alternative of those presented, as it is designed for low-resource humanitarian settings. Second, its low resource and personnel requirement means that it can be rolled out quickly. And lastly, though it is a relatively new intervention, it has the most rigorous study of effectiveness that shows a significant reduction of psychological stress both immediately and 3 months post intervention.

IMPLEMENTATION

A thoughtful implementation strategy will play a vital role in the SH+ program's success. To do this well IJM will need to focus on recruiting and training the necessary people and following the UNHCR's guidelines for MHPSS programing (see Appendix C for more detail).

RECRUITING AND TRAINING THE NECESSARY PEOPLE

GUIDING PRINCIPLES OF MHPSS PROGRAMING

The UNHCR, the United Nation's agency dedicated to aiding and protecting refugees and forcibly displaced peoples, has 10 guiding principles for the implementation of MHPSS programming that IJM will need to ensure and monitor alignment with (Refugees, 2013). Some these will be more difficult than other to follow in the implementation of SH+ on the U.S.-Mexico border. For example, using a systems approach, a UNHCR recommendation, will be a challenge given the limited scope of the SH+ intervention. While the ideal MHPSS program would be a system of holistic, integrated care, the best way to achieve this principle without building the entire system will be to ensure that SH+ is integrated within other pre-existing community services and networks. To do this it will be essential for IJM to build relationships with other individuals and organizations that are currently working in the area and cooperate with them.

Also, the most important principle of MHPSS is to do no harm. It is essential to be aware of potentially negative impacts of humanitarian programs and activities, including those with the aim to improve mental health and psychosocial support, and to prevent inadvertent harm. There are a few potential sources of harm with the SH+ program. First, it is paramount that participants' safety is protected. To do this finding a secure space where participants are offered the necessary amount of privacy will be essential. Additionally, having people who are currently living in unstable conditions themselves operating in the role of facilitator might prove to be more than they can or should do. To prevent harm from occurring in this regard it will be necessary for the intervention team leader to maintain close contact with the facilitators and lead regular post-session debriefs.

CONCLUSION

The problem of violence at the U.S.-Mexico border is a multi-layered crisis that has arisen from the confluence of violence and instability in the Northern Triangle, climate change, changes to U.S. immigration policy, an already turbulent Mexican border region, and a global pandemic. When I began examining into this issue I was interested in offering a solution to mitigate some of the damage, particularly to the most vulnerable group affected: migrants and asylum seekers. A group-based self-help intervention like Self-Help Plus, implemented by International Justice Mission, a seasoned responder to similar human rights violations, can offer recognizable reduction in psychological stress which can have long term implications and bring hope to a devastating situation.

REFERENCES

Aljasir, B., & Alghamdi, M. S. (2010). Patient satisfaction with mobile clinic services in a remote rural area of Saudi Arabia. *Eastern Mediterranean Health Journal = La Revue De Sante De La Mediterranee Orientale = Al-Majallah Al-Sihhiyah Li-Sharq Al-Mutawassit*, *16*(10), 1085–1090.

Alper, A. (2021, February 7). Biden administration suspends Trump asylum deals with El Salvador, Guatemala, Honduras. *Reuters*. https://www.reuters.com/article/us-usa-immigration-centralamerica-idUSKBN2A702Q

Aoued, H. S., Sannigrahi, S., Doshi, N., Morrison, F. G., Linsenbaum, H., Hunter, S. C., Walum, H., Baman, J., Yao, B., Jin, P., Ressler, K. J., & Dias, B. G. (2019). Reversing Behavioral, Neuroanatomical, and Germline Influences of Intergenerational Stress. *Biological Psychiatry*, *85*(3), 248–256. https://doi.org/10.1016/j.biopsych.2018.07.028

Brown, F. L., Carswell, K., Augustinavicius, J., Adaku, A., Leku, M. R., White, R. G., Ventevogel, P., Kogan, C. S., García-Moreno, C., Bryant, R. A., Musci, R. J., van Ommeren, M., & Tol, W. A. (2018). Self Help Plus: Study protocol for a cluster-randomised controlled trial of guided self-help with South Sudanese refugee women in Uganda. *Global Mental Health (Cambridge, England)*, *5*, e27. https://doi.org/10.1017/gmh.2018.17

CDC. (2020, August 3). *What is Epigenetics? | CDC*. Centers for Disease Control and Prevention. https://www.cdc.gov/genomics/disease/epigenetics.htm

Central America's Turbulent Northern Triangle. (n.d.). Council on Foreign Relations. Retrieved April 7, 2021, from https://www.cfr.org/backgrounder/central-americas-turbulent-northern-triangle

Checchi, F., Warsame, A., Treacy-Wong, V., Polonsky, J., van Ommeren, M., & Prudhon, C. (2017). Public health information in crisis-affected populations: A review of methods and their use for advocacy and action. *Lancet (London, England)*, *390*(10109), 2297–2313. https://doi.org/10.1016/S0140-6736(17)30702-X

Cohen, R. A. (2013). Common Threads: A recovery programme for survivors of gender based violence. *Intervention*, *11*(2), 157–168. https://doi.org/10.1097/01.WTF.0000431118.16849.0c

Common Threads. (n.d.). Common Threads Project. Retrieved April 7, 2021, from https://commonthreadsproject.org/what-the-data-shows

Costa, D. L. (2012). Scarring and Mortality Selection Among Civil War POWs: A Long-Term Mortality, Morbidity and Socioeconomic Follow-Up. *Demography*, *49*(4), 1185–1206. https://doi.org/10.1007/s13524-012-0125-9

Delivered to Danger. (n.d.). Human Rights First. Retrieved September 30, 2020, from https://www.humanrightsfirst.org/campaign/remain-mexico

Dias, B. G., & Ressler, K. J. (2014). Parental olfactory experience influences behavior and neural structure in subsequent generations. *Nature Neuroscience*, *17*(1), 89–96. https://doi.org/10.1038/nn.3594

Finnegan, C. (2019, March 30). Trump cuts all direct assistance to Northern Triangle countries Honduras, El Salvador, Guatemala. *ABC News*. https://abcnews.go.com/Politics/trump-cuts-direct-assistance-honduras-el-salvador-guatemala/story?id=62051082

French, K., Golijani-Moghaddam, N., & Schröder, T. (2017). What is the evidence for the efficacy of self-help acceptance and commitment therapy? A systematic review and meta-analysis. *Journal of Contextual Behavioral Science*, *6*(4). https://doi.org/10.1016/j.jcbs.2017.08.002

FY 2020 Nationwide Enforcement Encounters: Title 8 Enforcement Actions and Title 42 Expulsions. (n.d.). U.S. Customs and Border Protection. Retrieved April 7, 2021, from https://www.cbp.gov/newsroom/stats/cbp-enforcement-statistics/title-8-and-title-42-statistics-fy2020

García-Moreno, C., Zimmerman, C., Morris-Gehring, A., Heise, L., Amin, A., Abrahams, N., Montoya, O., Bhate-Deosthali, P., Kilonzo, N., & Watts, C. (2015). Addressing violence against women: A call to action. *Lancet (London, England)*, *385*(9978), 1685–1695. https://doi.org/10.1016/S0140-6736(14)61830-4

Harvard Health. (2021, February 12). *Past trauma may haunt your future health*. Harvard Health. https://www.health.harvard.edu/diseases-and-conditions/past-trauma-may-haunt-your-future-health

Hayes, S. C., Villatte, M., Levin, M., & Hildebrandt, M. (2011). Open, aware, and active: Contextual approaches as an emerging trend in the behavioral and cognitive therapies. *Annual Review of Clinical Psychology*, *7*, 141–168. https://doi.org/10.1146/annurev-clinpsy-032210-104449

Henriques, M. (2019, March 26). *Can the legacy of trauma be passed down the generations?* https://www.bbc.com/future/article/20190326-what-is-epigenetics

Hiskey, J., Cordova, A., Orcés, D., & Malone, M. F. (2016). *Understanding the Central American Refugee Crisis*. Ammerican Immigration Council. https://www.americanimmigrationcouncil.org/research/understanding-central-american-refugee-crisis

Increase in reports of gender-based violence across Latin America. (2020, June 9). International Rescue Committee (IRC). https://www.rescue.org/press-release/irc-data-shows-increase-reports-gender-based-violence-across-latin-america

Kohli, A., Makambo, M. T., Ramazani, P., Zahiga, I., Mbika, B., Safari, O., Bachunguye, R., Mirindi, J., & Glass, N. (2012). A Congolese community-based health program for survivors of sexual violence. *Conflict and Health*, *6*(1), 6. https://doi.org/10.1186/1752-1505-6-6

Lakhani, N. (2021, February 12). *Death of nurse detained over Covid curfew highlights violence faced by Honduran women | Honduras | The Guardian*. The Guardian. https://www.theguardian.com/world/2021/feb/12/honduras-femicide-keyla-martinez-women-violence

Lilleston, P., Winograd, L., Ahmed, S., Salamé, D., Al Alam, D., Stoebenau, K., Michelis, I., & Palekar Joergensen, S. (2018). Evaluation of a mobile approach to gender-based violence service delivery among Syrian refugees in Lebanon. *Health Policy and Planning*, *33*(7), 767–776. https://doi.org/10.1093/heapol/czy050

Mexico: Abuses Against Asylum Seekers at US Border. (2021, March 5). Human Rights Watch. https://www.hrw.org/news/2021/03/05/mexico-abuses-against-asylum-seekers-us-border

Mexico Travel Advisory. (n.d.). Retrieved October 5, 2020, from https://travel.state.gov/content/travel/en/traveladvisories/traveladvisories/mexico-travel-advisory.html

Mitschke, D. B., Aguirre, R. T. P., & Sharma, B. (2013). Common Threads: Improving the Mental Health of Bhutanese Refugee Women Through Shared Learning. *Social Work in Mental Health*, *11*(3), 249–266. https://doi.org/10.1080/15332985.2013.769926

Public Health Experts Urge U.S. Officials to Withdraw Order Enabling Mass Expulsion of Asylum Seekers | Columbia Public Health. (2020, May 18). https://www.publichealth.columbia.edu/public-health-now/news/public-health-experts-urge-us-officials-withdraw-order-enabling-mass-expulsion-asylum-seekers

Refugees, U. N. H. C. for. (n.d.). *Operational guidance, mental health & psychosocial support programming for refugee operations*. UNHCR. Retrieved April 8, 2021, from https://www.unhcr.org/protection/health/525f94479/operational-guidance-mental-health-psychosocial-support-programming-refugee.html

Regev, D., & Cohen-Yatziv, L. (2018). Effectiveness of Art Therapy With Adult Clients in 2018-What Progress Has Been Made? *Frontiers in Psychology*, *9*, 1531. https://doi.org/10.3389/fpsyg.2018.01531

Rivlin-Nadler, M. (2021, March 16). *Inside Migrant Camp In Tijuana, Asylum-Seekers Are Waiting On A Plan*. KPBS Public Media.

https://www.kpbs.org/news/2021/mar/16/inside-migrant-camp-tijuana-asylum-seekers-are-wai/

Rosenberg, M., & Alper, A. (2019, September 27). Trump administration plans to slash number of refugees for U.S. resettlement. *Reuters*. https://www.reuters.com/article/us-usa-immigration-idUSKBN1WB2XH

Rowe, C., Watson-Ormond, R., English, L., Rubesin, H., Marshall, A., Linton, K., Amolegbe, A., Agnew-Brune, C., & Eng, E. (2017). Evaluating Art Therapy to Heal the Effects of Trauma Among Refugee Youth: The Burma Art Therapy Program Evaluation. *Health Promotion Practice*, *18*(1), 26–33. https://doi.org/10.1177/1524839915626413

Runde, D., & Sandin, L. (2021, January 28). *An Alliance for Prosperity 2.0*. https://www.csis.org/analysis/alliance-prosperity-20

Sandhu, M. (2020, December 26). *Unprecedented Expulsion of Immigrants at the Southern Border: The Title 42 Process* [Harvard Law]. https://covidseries.law.harvard.edu/unprecedented-expulsion-of-immigrants-at-the-southern-border-the-title-42-process/

Southwest Land Border Encounters. (2021). U.S. Customs and Border Protection. https://www.cbp.gov/newsroom/stats/southwest-land-border-encounters

Tol, W. A., Barbui, C., Galappatti, A., Silove, D., Betancourt, T. S., Souza, R., Golaz, A., & van Ommeren, M. (2011). Mental health and psychosocial support in humanitarian settings: Linking practice and research. *Lancet (London, England)*, *378*(9802), 1581–1591. https://doi.org/10.1016/S0140-6736(11)61094-5

Tol, W. A., Leku, M. R., Lakin, D. P., Carswell, K., Augustinavicius, J., Adaku, A., Au, T. M., Brown, F. L., Bryant, R. A., Garcia-Moreno, C., Musci, R. J., Ventevogel, P., White, R. G., & van Ommeren, M. (2020). Guided self-help to reduce psychological distress in South Sudanese female refugees in Uganda: A cluster randomised trial. *The Lancet Global Health*, *8*(2), e254–e263. https://doi.org/10.1016/S2214-109X(19)30504-2

Tol, W. A., Patel, V., Tomlinson, M., Baingana, F., Galappatti, A., Silove, D., Sondorp, E., van Ommeren, M., Wessells, M. G., & Panter-Brick, C. (2012). Relevance or excellence? Setting research priorities for mental health and psychosocial support in humanitarian settings. *Harvard Review of Psychiatry*, *20*(1), 25–36. https://doi.org/10.3109/10673229.2012.649113

Toosi, N., & Kim, S. M. (n.d.). *Obama raises refugee goal to 110,000, infuriating GOP*. POLITICO. Retrieved April 9, 2021, from https://www.politico.com/story/2016/09/obama-refugees-228134

Treatment (US), C. for S. A. (2014). Understanding the Impact of Trauma. In *Trauma-Informed Care in Behavioral Health Services*. Substance Abuse and Mental Health Services Administration (US). http://www.ncbi.nlm.nih.gov/books/NBK207191/

UTRGV | Gulf Cartel. (n.d.). Retrieved September 30, 2020, from https://www.utrgv.edu/human-trafficking/blog/northern-mexico/gulfcartel/index.htm

Ventevogel, P., van Ommeren, M., Schilperoord, M., & Saxena, S. (2015). Improving mental health care in humanitarian emergencies. *Bulletin of the World Health Organization*, *93*(10), 666-666A. https://doi.org/10.2471/BLT.15.156919

Yehuda, R., Daskalakis, N. P., Bierer, L. M., Bader, H. N., Klengel, T., Holsboer, F., & Binder, E. B. (2016). Holocaust Exposure Induced Intergenerational Effects on FKBP5 Methylation. *Biological Psychiatry*, *80*(5), 372–380. https://doi.org/10.1016/j.biopsych.2015.08.005

APPENDIX A: COST TO SOCIETY

The economic cost of violence perpetrated against migrants and asylum seekers at the U.S.-Mexico border is high. Even with the most conservative of estimates, the cost of this violence at the border cost is approximately 2.8 million USD annually, as calculated using data from the 2020 Mexico Peace Index.

The 2020 Mexico Peace Index found that the economic impact of violence in Mexico was, on a per person basis, 36,129 pesos, which for context is equivalent to more than five times the average monthly salary of a Mexican worker (IEP, 2020). This economic impact estimate model includes direct costs, which are expenditures incurred by the victim, the perpetrator and the government, as well as indirect costs accrued after the fact including the present value of long-term costs arising from incidents of crime. Examples of indirect costs to violence include lost future income, physical, and psychological trauma. Direct and indirect costs are multiplied by a multiplier effect to account for opportunity cost, the lost economic benefits that would have been generated if all relevant expenditure had been directed into more productive alternatives. Using this economic impact estimate, the past year's 1,544 publicly reported violent assaults against asylum seekers and migrants at the border cost nearly 56 million pesos or 2.8 million USD. This, however, is a highly conservative estimate since most instances are not reported and the model is not able to accurately incorporate all of the losses imposed by the cartels, in particular, human trafficking, commodity theft, or drug-trade related economic activity, as data on these types of crimes are extremely difficult to capture.

APPENDIX B: ART THERAPY EFFECTIVENESS

Since the field of art therapy is still rather young, the scope of research is limited and the quality of research is varied, which makes it difficult to draw thorough conclusions on how effective the Common Threads program would be. Regev's 2018 systematic review of the effectiveness of art therapy with adult clients included 27 studies showed largely encouraging results and that there is a growing trend toward conducting more carefully designed studies on art therapy that lend themselves to validation and replication.

Within this review there were two studies on clients coping with trauma which would be applicable for examination for the U.S.-Mexico border context. While there have been few studies in this field, all of them are in a higher level of evidence. Although the first study (Pizarro, 2004) did not confirm the effectiveness of art therapy, it was only a two-session program. The limited number of sessions with each client may have been a major factor in its limited effectiveness as in dealing with trauma there is a need for thorough processing of the experience. The second study (Kopytin and Lebedev, 2013) reported that art therapy was beneficial and the intervention lasted longer.

In another review of six controlled comparative studies on art therapy for trauma in adult patients, half reported a significant decrease in depression. Although there are limitations in the number of included studies, the number of participants, the diversity of included studies, and the quality of their methodology, half of the included studies showed a significant decrease in psychological trauma symptoms in the treatment groups. One study reported a significant decrease in depression.

As far as the impact of the Common Threads program, results are positive, but limited as they lack a control group. A mixed method pilot study of 30 participants in Bosnia showed significant improvement from baseline to post Phase I (14 weeks of treatment) and post Phase II (28 weeks of treatment). Participants exhibited clinically and statistically significant reductions in anxiety, depression, and PTSD symptoms. Additionally, the pilot study of 36 refugee women in Nepal demonstrates a significant decrease in depression ($p < .001$, $d=0.85$), anxiety ($p < .001$, $d=0.53$), and trauma-related stress ($p <.001$, $d=0.73$) from baseline to post-intervention (T-3) (Rowe, 2017). There is, however, some concern to how representative these findings are of the participants' true experiences as it was the facilitators themselves that conducted the interviews to collect their feedback on the program. General trends in the field as well as studies on subsequent programs do support these findings though.

APPENDIX C: GUIDING PRINCIPLES OF MHPSS PROGRAMING

1. **Use Rights-based, Community-based and Participatory Approaches**
    - The intervention should prioritize the interests of the refugees (or in this case migrants and asylum seekers), show respect for their decisions, and be guided by principles of confidentiality, safety, security, respect, dignity and non-discrimination.
        i. A *participatory approach* seeks to link migrant/asylum seeker participation to program design and feedback.
        ii. A *community-based approach* recognizes the resilience, capacities, skills and resources of the migrants/asylum seekers, and focuses on identifying and building on community capacities for self-protection.
        iii. A *rights-based* approach requires actively working towards the realization of human rights of migrants/asylum seekers, seeking to redress discriminatory practices and unjust distributions of power that impede development progress and ensuring that plans, policies and processes of development are anchored in a system of rights and corresponding obligations established by international law.
    - In this context, this principle can be fulfilled by regularly consulting with the community, before, during, and after the SH+ program to ensure that it is appropriately contextualized for the population.
2. **Ensure equity of care and access**
    - There are a lot of potential reasons why some groups of people may not receive the assistance they need. In the case of a program like SH+ this may be due to stigmatization and shame or social marginalization.
    - To combat this, it will be important to be aware that no particular group is being excluded from care and to take measures to actively combat stigma.
3. **Assess needs and resources**
    - This should be done to provide a better understanding of the context and problems at the U.S.-Mexico Border, migrants/asylum seekers' ability to deal with these problems, the resources that are already available, and the kind of response required to strengthen these resources.

4. **Use a systems approach**
    - Given the limited scope of the SH+ intervention this poses something of a challenge.
    - While the ideal would be a system of holistic, integrated care, the best way to achieve this principle without building the entire system will be to ensure that psychosocial support is integrated within other pre-existing community services and networks.
    - To do this it will be essential to build relationships with the other individuals and organizations that are currently working in the area and cooperate with them.
5. **Strive for integrated service provision**
    - A similar concept to the point above, this too can be best achieved by strengthening partnerships.
6. **Adapt services to the stages of the refugee displacement cycle**
    - While much of the existing guidance for MHPSS is designed for refugee camp settings, it is important to adapt interventions to the setting in which you are working.
    - One of the best features of SH+ is its adaptability, and although not a refugee setting, the border has the markers of a humanitarian crisis.
    - It will be important to build a contingency plan should the context change unexpectedly due to changing conditions in the Northern Triangle, changing U.S. immigration policies, or changing conditions within temporary encampments themselves.
7. **Build capacity**
    - Service provision should be accompanied by a strategy for capacity building and knowledge management through partnerships and includes systems for follow-up training and supervision.
    - A major component of capacity-building is the appropriate training of staff and facilitators. SH+ comes with specific training instructions so this should be attainable.
    - Another element is installing supervision systems. This will be achieved by the inclusion of both the SH+ consultant who will oversee the operation as a whole, and the intervention team leader who will oversee facilitators.
8. **Use appropriate and systematic monitoring and evaluation**
    - Systematic monitoring and evaluation is imperative, which is why a monitor/evaluator is one of the essential personnel.
    - To the this well it will be necessary to find a locally validated monitoring system.
9. **Ensure compliance with UNHCR policies and strategies and national and international standards and guidelines**

- SH+ does meet international standards and guidelines, but it will be important to ensure that all national and local national guidelines and policies.

10. Do no harm

- Finally, it is important to be aware of potentially negative impacts of humanitarian programs and activities, including those with the aim to improve mental health and psychosocial support, and to prevent inadvertent harm.
- There are a few potential sources of harm with the SH+ program.
    i. It is paramount that safety is protected. Finding a secure space where participants are offered the necessary amount of privacy will be essential.
    ii. Having people who are currently living in unstable conditions themselves operating in the role of facilitator might prove to be more than they can or should do. To prevent harm from occurring in this regard it will be necessary for the intervention team leader to maintain close contact with the facilitators and lead regular post-session debriefs.