A Culture Of Cruelty

Post-Deportation Health: A Humanitarian Assessment

December 2012

Executive Summary:

Objective: This report explores the health impact of US repatriations on people returned to northern Mexico through interviews with adults in the border town of Nogales. The objective of the humanitarian assessment was to describe the perceptions of post-deportation health and the variables linked to higher risk or distress for deported men and women.

Background: Nogales, Sonora, Mexico is a small city abutting the international boundary and adjacent to Nogales, Arizona (see map). This region is known for migration-related deaths and increased enforcement measures. Repatriations from the interior US increased in recent years, placing deported immigrants into unfamiliar and volatile border settings, such as this. There is limited understanding of the safety or risk perceptions and health status for this displaced population. Since 2006, the humanitarian organization No More Deaths (NMD) has worked in bi-national partnership to provide basic care and aid to those repatriated in Nogales.

Methods: From June 2010 to April 2011, NMD volunteers completed 105 *Deportation Impact Surveys* with recently repatriated individuals, utilizing convenience sampling. Verbal consent was gained for a thirty-minute one-to-one interview, which took place in several facilities in Nogales that assist repatriated persons.

Results: The assessment provided evidence for the association of strong ties to the US, such as length of residence and familial relationships, abuse by authorities or poor conditions in detention, and exposure to insecurity at the border with declining self-reported health status after deportation. The sample included 92 men and 13 women, the majority (97/105) originally from Mexico. The median age was 33 years, and the sample lived an average of 15 years in the US, representing homes in 17 different states. The vast majority (94%) has family members currently living in the US. Two-thirds of respondents have children in the US, an average of 2.5, and for 81% of these respondents all of their children are US citizens. 58% reported an abrupt removal from their life in the US, and only 9% reported no abuses while in detention. 60% have witnessed acts of violence and insecurity in the borderlands since their deportation.

A linear regression model revealed that the compounding impact of variables from pre-arrest life in the US, to arrest and detention experiences, to post-deportation exposure to insecurity is predictive of 45% of post-deportation mental distress and 47% of physical distress. The findings also demonstrate significant relationships among physical symptoms of distress while detained, experiences of abuse in detention, and continued mental distress after deportation.

Implications: US immigration enforcement is an issue of public health and safety. This study is a step toward offering enhanced health services, particularly for mental health, for this population. The public health and social impacts of deportation should be considered in advocacy efforts for determining optimal changes in immigration policy. The US deportation process represents a culture of cruelty that impacts deported men and women and their US-based families and communities. See the report for recommendations.

Key Terms to Define:

Deportation: signifies a formal legal proceeding and removal that could be either administrative or criminal. In contrast, **voluntary departure** is a civil procedure, and **repatriation** refers generally to all forms of removal.(1)

Health: defined by the World Health Organization (WHO) is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." **Emotional Distress** is used in this report as an indicator of **Mental Health** and signifies a state of psychological well-being that includes the ability to cope with stressors.(2)

Subjective Health Status: is an individual's perception about their physical/mental health, determined through **self-report of health** in this report. Self-report is a simple measurement recommended by WHO for low-resource settings and provides a globally validated and reliable predictor to identify persons at high risk for adverse health outcomes, including mortality.(3) For this study, **impact** is generally defined by the self-report of health status.

Traumatic Stress: refers to a highly stressful event(s) causing feelings of intense **distress** that overwhelms an individual's ability to cope with threats to life, physical integrity and cognitive or emotional health.(4)

Undocumented Immigrant: refers to not having authorization for legal entry or residence, which is more accurate than other terms.(5) In this report, the term immigrant **or migrant** refers to people in transition or displaced from one geographic residence to another either by personal necessity or by force, e.g. through repatriation.(1) For most in this sample, their migration to the US occurred many years ago, but they have become (im)migrants once again through their removal.

Acronyms:

DIS- Deportation Impact Survey

NMD- No More Deaths

US- United States of America

I. Background

This section provides pertinent background related to the border context and trends of state and federal interior immigration enforcement.

For more than a decade, unauthorized migration through southern Arizona has been at the epicenter of humanitarian crisis along the Mexico-US border. From 2000-2012, there were more than 2,466 known deaths of migrants in the desert of Arizona, with thousands uncounted.(6) In recent years, the risk of dying while crossing north into Arizona was higher than ever before, with a record-setting death rate (2011 record: 154 deaths per 100,000 apprehensions) even as apprehensions of unauthorized immigrants declined to historic lows.(7) US border enforcement policy has utilized the hazardous and remote desert region as part of its deterrence strategy. The risk to migrants continues to intensify as migration pathways are funneled to more dangerous areas in response to unprecedented levels of federal agents, troops, technology and barriers along the 210 miles of Arizona's southern border.(7-10)

Also in recent years, there has been an increase in state and federal enforcement measures aimed at detecting and prosecuting undocumented immigrants. In border states, Operation Streamline was implemented starting in 2005, in which hundreds of apprehended immigrants each week have been criminally prosecuted for illegal entry; the individuals face numerous years in prison if they re-enter and are arrested again.(11) This process of intensified prosecution and criminal removal is intended as a deterrent to re-entry.[1]

Interior US immigration enforcement was enhanced in 2003 with the aim to remove "criminal aliens," those with a criminal record in addition to undocumented status. Analysis has shown that nearly one quarter of people arrested from 2003-2008 by fugitive operation teams had no criminal record.(12) The Obama administration

[1] First time illegal entry into the US is classified as both a civil and criminal violation (8 USC 1325), but until implementation of Operation Streamline, it was rarely prosecuted.

has continued the overall trend of criminalizing undocumented immigrants and irregular migration. It has expanded the Secure Communities program, which screens for documentation in jails and prisons, and more aggressively targeted employers hiring unauthorized workers.(13) Deportations from around the US set a record in 2010 (392,862 deportations) and continued this fast pace in the two subsequent years. Nearly half of the deportees had no prior criminal convictions.(13, 14) The record of removals was sustained despite the 2011 memo released by ICE Director John Morton outlining criteria for the "prosecutorial discretion" of cases.(15) According to fiscal year 2011 figures, formal deportation now accounts for 55% of total removals, compared to 10% a decade ago.(14, 16)

Recent reports document how these deportations have impacted both US citizen children in state custody and the "disappearing parents" caught in the detention system.(17-19) Deportation has long-term consequences for any future hopes of legalization and family reunification.

In view of this multi-pronged enforcement strategy at the border and the interior, there has been the possible effect of more organized crime activity in the region while aggravating the desperation to cross for migrants. Strengthened organized crime in the Americas, with revenues from human smuggling and trafficking ($6 billion annually), is linked to the enforcement-only border policy.(9, 20) The result is more risk of suffering and abuse of migrants in Mexico and Central America and at the border.(20) In recent years organized crime violence has increased due to territorial disputes for drug and human smuggling routes.(21) The National Human Rights Commission of Mexico reported more than 11,000 abductions of migrants in Mexico during a six-month period of 2010, including torture, extortion and murder, nearly a third occurring in northern Mexico.(22) In a more volatile border region, those who suffer the most are the people who hope to work or join their families in the United States.

Photo: DIS Interview, photo taken with expressed consent

II. Framing the Assessment

In 2006, when the humanitarian organization No More Deaths began aid work at the Nogales ports of entry, the vast majority of repatriations to Mexico were from US Border Patrol custody and through voluntary departure. Since most of the repatriated persons in Nogales had just returned from the desert crossing and apprehension by Border Patrol, NMD volunteers and partners focused efforts on providing basic first aid and documentation of treatment in short-term custody.

In September 2008, NMD published *Crossing the Line: Human Rights Abuses of Migrants in Short-Term Custody on the Arizona/Sonora Border*(1) and presented the findings before a briefing of the US Congress. NMD has collaborated with national partners to frame policy language for enforceable short-term custody standards and remains in contact with the Department of Homeland Security Office of Civil Rights and Civil Liberties to file ongoing documentation. In fall 2011, NMD released a follow-up report and advocacy campaign, *A Culture of Cruelty*, that documents more than 30,000 additional cases of abuse in Border Patrol custody.(23)

While NMD continues to advocate for enforceable standards in Border Patrol custody, the themes of the documentation have broadened. Nogales continues to be one of the top repatriation sites along the border (along with Tijuana,

Mexicali, Nuevo Laredo, Matamoros, and Ciudad Acuña), receiving more than 6,000 individuals in the month of March 2012, which is a steady figure in comparison to the same season in previous years.(24, 25) On a daily basis, NMD volunteers document reports of deported immigrants who resided in the United States for numerous years and are now separated from their children, homes and jobs. Undocumented immigrants arrested in the interior may spend weeks or even years in a detention center before being bused to the international boundary. This population may be characterized as established US residents who may have spent the majority of their lives in the US and have few connections to their country of origin.

Health issues and social needs are more complex for this population. This study is designed to describe the toll on human safety and well-being behind the deportation of immigrants—particularly those who have lived in the US multiple years. This sample only includes two cases of residence in the US less than two years; the majority (82%) are in the range of 3-21 years.

Related research: Given the border realities and enforcement trends, there is a growing need to understand the post-deportation determinants of health and survival for people who have lived in the interior US for numerous years and are repatriated through Arizona. There is limited health- and safety-related knowledge about this displaced, vulnerable, and mobile population, in part because of the challenges of obtaining reliable data; this report will help fill that gap. A review of other studies that examine migrant health is helpful for formulating a more complete picture of the compounding impact of pre-arrest, arrest and detention, and post-deportation stressors.

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For instance, Cavazos-Rehg et al. used a regression model to show concern about deportation as a significant predictor[2] of poorer subjective health status for undocumented immigrants living in the Midwest.(26) This 2007 landmark study demonstrates that self-reported poor health status increases with deportation concern or anxiety. On a global scale, a literature review of more than 20 empirical studies on asylum seekers in ten Westernized societies found that levels of Post-Traumatic Stress Disorder (PTSD), anxiety, and depression increased—even doubled—over time for individuals with more than two years of residence, if their legal status remained uncertain; separation from minor children was also associated with poorer mental health in this study.(27)

Next, there has been increasing awareness of the lack of primary health care and other poor conditions in long-term immigration detention.(28, 29) Focus on substandard care, particularly through spotlighted deaths of detainees, has sparked investigations and revealed systemic problems with health care delivery, evaluation and monitoring in such facilities.(30) Inappropriate mental health care, if any is received at all, is also a cause for concern throughout detention. The mental health of 70 asylum seekers interviewed in US detention worsened as time progressed, with 86% presenting significant symptoms of depression, 77% with anxiety, and 50% with PTSD.(31) Until mandatory reporting of health outcomes is enacted, little will be known of the true rates of morbidity and mortality linked to US immigration detention.(30)

Finally, in the context of the border, health disparities in US border communities are among the poorest in the country. Border communities on both sides of the boundary have higher levels than the general US population of communicable and chronic diseases as well as exposure to environmental hazards.(32-34) In addition, numerous studies from the large border city of Tijuana, Baja California suggest that disease rates are significantly higher among intravenous-drug users with a deportation history than those without, including tuberculosis (twice as likely)(35) and HIV rates (four times as likely for men).(36, 37) In all, the trends in interior enforcement, the substandard care in detention,

[2] (p=0.022)

and deportation to the volatile border region have been established as contributing to health risks.

Study objectives: The main aim of this assessment was to enhance the humanitarian and public health understanding of the impact of deportation from the US, and to discuss opportunities for improved care and enhanced advocacy. This study objective was explored by assessing repatriation-related determinants of health distress in the following areas:

1) Pre-arrest linkages to the US
2) Conditions of arrest and detention
3) Post-deportation exposure to insecurity
4) The compounding impact of all areas: 1-3

The dependent variables included post-deportation responses to ten-point scales of physical and mental health. The scale contained descriptors from "very poor" to "very good" (Note: for analysis and reporting the scale has been reversed with 1=no distress to 10=most distress). Self-report of health and perceived stress scales are validated and reliable global indicators.(3, 38) Basic demographic data (age, gender, city of last residence, partner status, occupation, etc.) was also collected; the survey was kept anonymous.[3]

III. Methods

From June 2010 to April 2011, NMD volunteers collected 105 *Deportation Impact Surveys* through one-on-one interviews with recently deported individuals in Nogales, Sonora. Among the inclusion criteria, individuals had to have previously lived in the US and been removed; also, only adults (over age eighteen) were included. Verbal consent was gained for a 30-minute interview in a semi-private location. These interactions took place in multiple facilities in Nogales offering services to the majority of immigrants recently repatriated to the area, including non-governmental migrant shelters, the offices of federal and state migrant-assistance agencies, a bus company providing government-subsidized transportation to migrants returning south, and a clinic space and dining hall operated by the Catholic church. For several years, these locations have been visited regularly by NMD volunteers to provide basic medical care, phone call services to family, and other basic aid.

Translation, piloting and revisions of the survey took place in June 2010. Humanitarian volunteers and partners of NMD were trained to administer the questionnaire with consenting individuals who met the inclusion criteria for the study. The data were entered into a secure online system by the interviewer and analyzed using PASW 18.0 statistical software. (See the appendix for discussion of limitations).

IV. Results

(i.) **Demographics**: The sample included 105 cases. 92 respondents were males and 13 females, and 97 respondents were originally from Mexico, seven from Honduras and one from Guatemala. More than half of the respondents were currently married or partnered (56%). The median age was 33 years.[4] The sample shows that the average individual had lived in the US for 15 years.[5] The states where respondents had most recently lived included Arizona (37%), California (33%) and Florida (5%), among 14 other states, covering nearly every region of the US.[6] Occupations while in the US varied: construction, landscaping, house cleaning, farm and factory work, electrical, computer repair, and management in restaurants or apartment buildings; some were students. Nearly four out of five respondents (79%) stated positively that they have a religious faith. These results, and those to follow, are comparable to population data of the Pew Hispanic Center.(39)[7]

[3] The individual could choose to give his/her name for the purpose of referral to humanitarian services, but this information was disaggregated from the data collection.

[4] (SD: 9.93, Range 18-65)
[5] (SD: 8.11, Range: 1-42)
[6] (AR, CO, DE, GA, IA, MN, NC, NV, NY, PA, TX, UT, VA, WA)
[7] According to estimates in December 2011, nearly two-thirds of all unauthorized adult immigrants in the US have lived in the US ten years or more, the median age is 36 years and almost half are parents of minor children. Also, about 81% report regularly practicing a religious faith.

(ii.) Pre-Arrest Life in the US:

"I am feeling very emotional and right now not feeling good. It has been over a month since I have seen my children."[8]

This respondent lived in Los Angeles for 12 years. He has a spouse and four young citizen children in the US (10, 8, 4 and 2 years), and they were completely dependent on his income prior to arrest. He rated his physical distress as moderate 6/10 and mental distress as high 10/10.

The vast majority (94%) of respondents have family members other than children currently living in the US; this includes spouses or partners (58%), siblings (46%), parents (27%) and others (27%), such as aunts, uncles, grandchildren or cousins. Most respondents (64%) also have children in the US, 2.5 children on average.[9] Of these respondents, more than a third (36%) have at least one US-based child who is five years old or younger, and over half (57%) have at least one US-based child who is a minor (<18 yrs). And of those with children in the US, a large majority (81%) reported that *all* of their children are US citizens, while only two reported that none have citizenship.

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On a five-point scale from "None" to "Completely," respondents indicated how dependent their family in the US was on their income prior to their arrest. The respondents' families were most likely (44%) to have depended "A lot" to "Completely" on their income before arrest, while about a quarter of respondents (26%) reported that their family in the US was dependent on "less than half" to "none" of their income. When asked how they believed their families were supported in their absence, 35% reported their spouse or partner was working and 30% understood other family members to be assisting with paying the bills; some (10%) did not know how their family was surviving. Only 6% reported the use of public assistance. In respondents' absence, the primary caretaker for their children in the US was their spouse/partner or relatives; in one case the respondent believed the state had already taken custody of the children at the time of the interview.[10]

(iii.) Conditions of Arrest and Detention:

"I was in a car accident in Mesa, Arizona and the police officer noticed that I am Mexican and that I don't have the papers to be there."

This respondent reported the highest level of distress (10/10) for both physical and mental health. He also reported physical abuse and signing documents he did not understand while detained for a few weeks, in which he experienced feeling nervous/anxious, general pain, and not breathing or sleeping well.

For more than half of respondents (58%), their deportation was a result of an abrupt or unexpected arrest; commonly, an interaction with local authorities that led to immigration status review, such as being pulled over for speeding or lights out, or a raid by Immigration and Customs Enforcement agents at the workplace or the home. These cases are more abrupt than receiving a deportation order after lengthy immigration proceedings, for instance, and this study hypothesized that the level of abruptness adds to the accumulation of stress. It is also important to understand how their families in the US became aware of their arrest. Half of the time they were able to call from detention, and for nearly one in five cases (19%) a family member was present or observing the arrest. But for 15%, the family was not informed until after their removal.

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[8] For open-ended responses the interviewers recorded notes in the first person, and at the end of the interview a case summary was provided in third person.

[9] (SD: 1.53)

[10] The number of children in US state custody is likely to increase with more time since the parents' removal.

Nearly one third (32%) of respondents reported being in detention for less than one week, while an equal percentage were detained for one to three months, and one-fifth of respondents remained in detention for longer than six months. Most individuals were transferred at least once (63%) and up to five times. Of the ten types of short-term custody abuses outlined in previous reports by NMD, only 9% of respondents reported having experienced "None" (either prior to deportation or after deportation and re-arrest),[11] and 63% experienced two to four different types of abuses. See Table #1 for reported abuses.

Table #1: Detention Abuses	Count	Percent
1. Verbal abuse	47	45%
2. Too hot/too cold	45	43%
3. Overcrowded	42	40%
4.Lack of food/water	38	36%
5. Signed documents they did not understand	26	25%
6. Unsanitary Conditions	23	22%
7. Signed documents they did not want to sign	21	20%
8. Medical care was needed but not received	20	19%
9. Physical abuse	13	12%
10. Psychological abuse (humiliation, etc.)	10	10%

As the respondents understood the legal proceedings concerning their removal, three of five respondents believed they received a bar/ban to prohibit their re-entry or a criminal sentence, while 12% were unsure or confused about their legal standing as a result of deportation. Finally, the respondents were asked what physical symptoms they experienced while detained. Of nine common psychosomatic symptoms ranging from getting upset easily to stomachache and weight gain/loss, only 2% of respondents experienced "None." One-third experienced two to three symptoms and nearly a third experienced four to six symptoms.

[11] The survey sought to distinguish immigration detention from subsequent Border Patrol custody, yet some mix of results does not hinder overall analysis of detention impact.

(iv.) Post-Deportation Exposure to Insecurity:

"As I was walking to Grupo Beta with others who had just been deported, men in a truck (not police) with machine guns pulled up and asked us if we were from the mountains. When we said no, we were not, the gun was fired in the air and pulled away."

This respondent reported the highest level of both physical and mental distress (10/10). His primary reason to cross is "la familia" though he reports being banned for 20 years from re-entering the US.

Most individuals had been repatriated within a few days of the interview (63%). Nearly one-third of respondents (32%) did not receive all of their personal belongings upon removal, such as ID or wallet. Two-thirds of respondents reported having some resources or relationships in Mexico, whether a distant relative or friend. One in ten reported that their family in the US did not know where they were at the moment of the interview; presumably this figure is as low as it is in part because of phone services offered by NMD volunteers at the locations of the interviews. Perceived family disintegration was a concern for deported immigrants. Nearly one in four (24%) respondents separated or divorced at the time of the interview believed it was in part due to their immigration problems and removal. When asked about their primary reason to cross again, 70% of responses involved being with and supporting family in the US; only 8% mentioned the necessity to support family in their place of origin.

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Safety and insecurity in the borderlands are challenging issues for the whole migrant population, including deported immigrants. 60% of respondents reported having witnessed some types of violence or abuse since their removal. It can be expected that this number is artificially low because of time since repatriation and social desirability bias or fear of reporting. Reporting witness to violence, though, should be considered less threatening than reporting experiences of

violence, as the individual does not admit to being victim. The types and frequency of violence and abuses witnessed are listed in Table #2.

Table #2: Witness to Border Violence or Abuse	Count	Percent
General Violence in the Area	23	22%
Robbery	19	18%
Physical Violence	14	13%
Shooting/Armed Violence	13	12%
Disrespect to Migrants	12	11%
Abuse by Smugglers	10	10%
Sexual Assault	4	4%
Abuse by Mexican Officials	3	3%

Despite the bias just mentioned, 38% of individuals reported having been a victim of some abuse or violence since their repatriation to the borderlands, and two-thirds reported having felt unsafe since arriving to Nogales. Nearly one in five (18%) respondents reported having been asked to do something illegal or something they might not want to do in exchange for resources or "help" from organized crime. Overall, it is not surprising that the primary problems most people reported facing since deportation were basic survival and safety (59%). For three of every four individuals, their biggest concern about the future involved how to return to the US.

(v.) Self-Reported Health Status:

"In general, the migrant expressed being mentally distressed and complained of acute stomach pain."

Note of Interviewer, July 2010

Table #3: Self-Report of Health "On this scale, how have you been feeling since arriving in Nogales?"		
(N=99)	Physical	Mental[12]
Mean	5.95	8.27
Std. Deviation	3.13	2.57

Perceived post-deportation mental and physical health status was clearly impacted by the sequence of variables included with pre-arrest life in the US, arrest and detention conditions, and post-deportation exposure to insecurity. In general, the average physical health rating was 6/10 and the average mental health rating was 8/10. See Table #3 for the sample results for self-reported health and the summary in Table #4 of the key variables most associated with physical and mental distress for each category.

Table #4: Summary of Key Variables of Distress

Key Variables	Physical Distress	Mental Distress
Pre-Arrest Life in the US	▪ More years lived in the US ▪ Family income dependence ▪ Older age	▪ More years lived in the US* ▪ Family income dependence* ▪ Citizen children* ▪ Younger children* ▪ Spouse/partner* ▪ Younger age*
Arrest & Detention Conditions	▪ Abrupt arrest* ▪ < 3 months ▪ Too hot/cold & verbal abuse	▪ All abuses ▪ All physical symptoms of distress
Post-Deportation Exposure to Insecurity	▪ > 3 months since deportation* ▪ No resources in Mexico ▪ Doesnt feel safe* ▪ Experience or witness violence* ▪ Needs healthcare*	▪ < 3 months since deportation ▪ Linkages to US as primary reason to cross* ▪ Witness to all forms of violence

*Significance at p=<0.05, but all variables linear in cross-tabulations with health status decline.

Pre-arrest: Cross-tabulation of pre-arrest variables with post-deportation health status identified the key variables associated with higher distress ratings. For post-deportation physical health, higher distress was reported for more years lived in the US (up to 16-20 years), greater economic dependence by their family, and older age (to be expected). For mental health, higher distress was also reported for more years lived in the US (80% for 16-20 years) and greater family economic dependence as well as for individuals with all US-citizen children, younger children in the US, younger age of the respondent, and for respondents who were currently married or partnered. A notable trend in both mental and physical health was that distress heightened for

[12] The direct translation deemed to be most understood by respondents used "emotional" to indicate mental health.

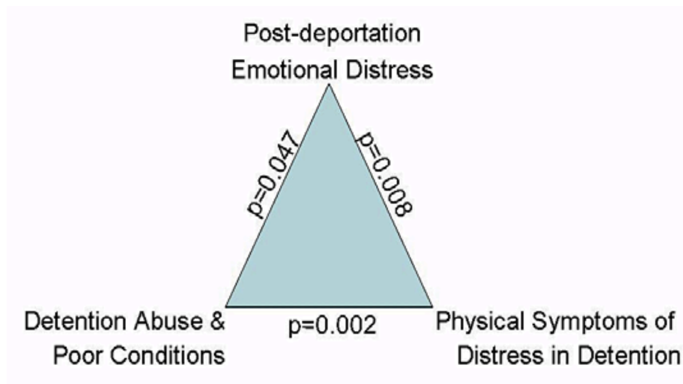
increasing years lived in the US, up to 20 years, then eased slightly. This may be explained by the fact that if an individual has lived more than a few decades in the US, their children are more likely grown and family would be less dependent on their income.

The linear regression model validated the finding that these key variables impact the post-deportation report of mental and physical distress. For mental health, 24% of the variability in distress can be explained by the identified pre-arrest variables. For physical health, though not statistically significant, nearly 12% of the variability in post-deportation distress can be attributed to the same pre-arrest variables.[13]

Arrest and Detention: Cross-tabulation of arrest and detention variables with post-deportation health status identified the key variables associated with higher distress ratings. For physical health, higher distress was associated with a more abrupt arrest, less than three months detained, and with detention conditions that were too hot or too cold and involved verbal abuse. For mental health, higher distress was linked to all abuses in detention as well as to all of the physical symptoms of distress.

The linear regression validated these key variables as adding to post-deportation distress. For mental health, 8% of distress experienced by the respondents may be attributed to these variables. The physical symptoms of distress experienced while detained were significantly related to higher ratings of mental distress post-deportation,[14] which shows that the physical symptoms were not just acute ailments in detention, but signals of accumulating stress. For physical health, the key arrest and detention variables accounted for a smaller rate (3%) of post-deportation distress.[15] It is also notable that more physical distress symptoms were associated with increased experiences of abuse.[16] See Figure #1 below, which diagrams the statistically significant relationships between experiences of abuse, physical symptoms in detention, and poor self-report of mental health after deportation.

Figure #1: Significant Associations with Detention Conditions and Health Status



Post-deportation Exposure: Cross-tabulation of post-deportation exposure variables reveals the following key stressors for physical and mental health. For physical health, longer time since deportation (more than three months) was associated with high distress as well as having no resources in Mexico, not feeling safe, witnessing physical violence, and needing but not receiving medical care. Higher mental distress was most associated with less time since deportation (less than three months), strong linkages to the US as the primary reason to attempt to cross, and witnessing all types of insecurity.

The regression model for post-deportation exposure shows that 11% of mental health impact can be attributed to these variables and almost double that for physical health, accounting for 21% of variability in distress.[17] This reveals that concern about family and how to return to the US were more likely to impact mental health, while experiencing insecurity accounted for more physical distress. Also, experiencing various forms of violence or abuse and feeling unsafe at the border were significantly related variables.[18]

Compounding Impact: In all, physical distress was most associated with post-

[13] Physical (r=0.339, p=0.210) & Mental (r=0.493, p=0.006)
[14] (p=0.042)
[15] Physical (r=0.174, p=0.781) & Mental (r=0.285, p=0.235)
[16] (p=0.004)
[17] Physical (r=0.455 p=0.003) & Mental (r=0.334, p=0.041)
[18] (p= <0.0001)

deportation variables and mental distress with pre-arrest variables. (See Table #5) To test the compounding impact, a final linear regression model utilized variables from each of the three categories shown to have the strongest relationship with either physical or mental health. The compounding impact model for physical health accounted for 45% of post-deportation physical distress.[19] The compounding impact model for mental health contributed to 47% of post-deportation mental distress.[20]

These results show that the compounding impact of accumulated stress accounts for more variability in post-deportation health than the cumulative total of the individual categories. See Table #5 that shows the regression results for the individual categories and the compounding impact.

Table #5: Results of Regression Models and Compounding Impact

Regression Models	Physical	Mental
Pre-Arrest	12%	24%
Arrest & Detention	3%	8%
Post- Deportation	21%	11%
Compounding Impact	**45%**	**47%**

Case examples: Adding to the quantitative evidence just described, the following case summaries exemplify the complex and interrelated variables that impact health after deportation:

1.) "This man is a painter in his late thirties who has been living in the bay area of California for twenty years. He has a daughter with an American citizen, but they are not legally married and he never obtained papers to be in the country legally. He has been arrested and deported twice in the past month and is currently uncertain about his next action. His relationship with his partner is strained as a result. He said his main concern is 'My family. I don't have any future here. I know maybe I could get a job, but I want to be with my family.' He expresses a deep feeling of loss whenever he speaks of his daughter, who has a heart condition."

This respondent experienced six physical distress symptoms in detention. He reports feeling unsafe in Nogales but has not experienced any violence. He rated his health 10/10 for mental distress and 7/10 for physical distress.

2.) "This young woman age 24 spoke excellent English and preferred to answer in English. I am certain she will try again to return to her children."

This respondent lived in Los Angeles for 20 years where she cleaned houses, and her parents, siblings and children await her return; her children are three years and eight months old. She reported the highest levels of physical and mental distress (10/10). She has already tried crossing the desert but was injured and returned after short-term custody.

3.) "This man was living near San Francisco, California with his wife and four-year-old son when he was pulled over while driving. Because he didn't have proper documents, he was deported to Nogales. When he attempted to cross again, he was apprehended by Border Patrol agents. He was put through Operation Streamline and held in custody for almost two months before being deported back to Nogales. He is distraught over being separated from his family and he is desperate to be reunited with them."

This respondent reported 9/10 for both physical and mental distress.

V. Discussion

The health issues and social needs are inter-related for this population of deported men and women, who have substantial lives in the US and have faced the harsh trends of immigration enforcement. The deported immigrants on the streets of Nogales are experiencing increased trauma due to abrupt separation from family and established lives in the US, longer periods of detention that may be abusive or characterized by poor conditions, the physical and legal risks of crossing to return, and pervasive violence and insecurity in northern Mexico. These stressors—compounded with the deportation process—weigh heavily on the mental and physical health of

[19] The compounding impact model for physical health: ($r=0.670$, $p=0.001$, $F=4.183$)

[20] The compounding impact model for mental health: ($r=0.688$, $p=0.000$, $F=6.028$)

deportees. These findings suggest that there is a complex interplay of factors that account for the higher mental and physical distress following deportation.

For mental health, a few of the same pre-arrest variables were associated with both mental and physical distress, yet accounted for more variability and significance with mental health. Mental health was also more impacted by detention abuses, manifested through physical symptoms, and by length of time detained. In addition, higher mental distress was associated with a shorter timeframe since deportation and stress related to crossing again and returning to support family in the US.

An interpretation may be that longer periods in detention allow for more solitary time to worry about familial or other practical circumstances (financial, etc.) while also incurring more detention-related abuse, and thus more distress symptoms. Yet when the individual is released and repatriated, there is more mental distress within the first few months as they have a sense of urgency to return. Also for mental health, distress was associated not with the individual's own physical security but primarily with their outward focus on family well-being and how to return to their life in the US. These deported immigrants have faced multi-faceted strategies to deter their return; yet, in a special communication of the Journal of the American Medical Association, practitioners are urged to advocate against "excessively harsh policies of deterrence" towards migrants because of the detrimental affect on their mental health.(40)

While a greater predictor of post-deportation mental health involved pre-arrest and detention conditions, physical health was mostly related to post-deportation exposure to insecurity—including lack of resources, the need for medical care, and longer time spent in the border region after repatriation. Post-deportation physical health was also associated with more abrupt arrest situations and less time in detention, which may signify shorter-term custody in jails and holding cells with poorer standards for the conditions. In all, for physical health, proximate issues of personal safety, security, and survival were most likely to be manifested in perceived physical distress.

For post-deportation health as a progressively compounded status, these findings point to the need to view the entirety of the deportation process, which is grounded in social exclusion and insecurity, as a compelling community and public health issue.

For post-deportation health as a progressively compounded health status, these findings point to the need to view the entirety of the deportation process, which is grounded in social exclusion and insecurity, as a compelling community and public health issue. The policies and practices of US deportations are part of the *culture of cruelty* impacting the health of immigrants with strong ties to the US. The compounding impact model accounted for nearly half of post-deportation physical and mental distress; the remaining variability may be attributed to pre-existing health conditions or other factors not assessed here.

Furthermore, there is profound need for enhanced medical care for migrants in Nogales, particularly as persons stay in the border region and are impacted by the insecurity with little resources to survive. It is also clear that mental health services are needed for this population. Considering the poor self-reported health ratings and high level of physical distress symptoms, stress disorders may be prevalent. Immigrants exposed to traumatic stress and not treated are more likely to suffer from chronic disease and to have a substance abuse disorder.(41) Studies have shown that the perceived need for mental health services by Latino/a immigrants increases after the cumulative stressors of immigration and exposure to violence.(41) The results of this assessment show the willingness of deported men and women to disclose their perceived distress and demonstrate their readiness to access these services.

The healthcare and services that immigrants receive after deportation can have a significant impact on the rest of their life and their ability to one day be reunited with their families in good

health. While pathways to legalization for undocumented immigrants living in the US is a straightforward solution to preventing these health issues, US immigration reform is likely not to include people with previous criminal records. Thus, the previously deported population and sample of this assessment may be excluded, since those repatriated without a criminal record may incur one by attempting to re-enter without authorization. This is a humanitarian crisis for the health of families, divided across this border. There is an urgent need for recognition of these human realities by practitioners and policymakers.

VI. Conclusion

It is apparent that there is a fundamental need to enhance healthcare for the immigrant population in northern Mexico as a bi-national effort, particularly mental health services, with a deeper understanding of determinants to post-deportation health status. However, the responsibility of concerned humanitarians and health practitioners should not end at temporary treatment. The findings of this assessment lead to the following general recommendations for addressing the implications of harmful US deportation policy and practice.

Recommendations:

1. An immediate **suspension of deportations (and alternatives to detention) for immigrants with strong family ties in the US**, especially as immigration reform is anticipated and because deported immigrants experience pervasive insecurity and threats to their safety as a vulnerable population at the border.
2. Advocacy efforts for immigration policy that will include **legalization for immigrants who have settled in the US and have a criminal record due to removal or re-entry charges**. This should include re-examination of current exclusions.
3. **Education for communities in border states and beyond**, emphasizing the health and family impacts of current border enforcement and immigration policies.
4. Increased involvement and **capacity of competent primary healthcare providers** in the border region to offer services for this population.
5. **Access to mental health services** in the border region for migrants, including cultural and linguistic competence in care.
6. Increased capacity for humanitarian and community groups to **use new technologies to connect displaced individuals** with their cross-border families and communities.
7. Establishment of **deported immigrant-focused family housing at the border and employment** that would allow bi-national families to safely reside together.
8. **Future studies should examine the longitudinal impact on health** for both the deported immigrants and their families in the US. The health, socio-economic, and environmental issues confronting deported women and men may influence their US citizen children, mixed-status families, and communities throughout the US.

Significance for border health & beyond: The borderlands of the United States of America and Mexico, the largest land border in the world between economically disparate countries, will continue to be both a symbolic and literal testing ground for policies that impact the health and well-being of migrants. These health determinants impact health outcomes for communities in the US and Mexico (or other countries of origin) linked by these immigrants. From experiences of abuse and mental distress to disintegration of family, the health of deported people is of particular interest for humanitarian and community groups, health practitioners and policymakers in the borderlands and beyond. Finally, the results of this assessment confirm that US policies of deterrence and exclusion not only harm individuals with strong linkages to the US, but also have repercussions for the health and safety of communities that expand across borders.

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Appendix:

Limitations: The main limitations of this study involved the sampling, namely the lack of random selection and limited sample size. The sampling used a convenience method, with the interviewers conducting the survey with qualifying individuals who volunteered to talk about their experiences and were asked to participate in a location where services were being received. It was made clear that humanitarian services were in no way contingent on participation in the survey. Nonetheless, the NMD interviewers were associated with an organization known to give assistance to migrants and could not be seen as completely independent of humanitarian aid. This method also allowed the bias that the individuals who were interviewed were somehow more expressive and articulate about their experiences than others who were not interviewed. The relatively small sample size presented another limit to the generalizability of the findings.

Social desirability bias should also be mentioned as a possible limit, as measuring and controlling for this bias was not specifically conducted. Similarly, there was the issue of self-serving bias, also common for interviews with particularly sensitive questions. Yet, the results showed that these biases may not have been overwhelming issues for this assessment because (a) there was nothing to gain by telling (or not) the truth, for instance, if special services were offered for those who reported poor health or exposure to abuse or crime, and (b) social desirability in reporting mental and physical health issues for this population would mean *under*-reporting to avoid stigma. But overall, under-reporting was not a problem with the perceived health results, evidenced by the high levels of poor self-reported health status.

The only instance in which under-reporting appeared to be the main consideration for the results was for reports of witness to sexual assault at the border (with zero reports of experiencing this abuse). Sexual assault is widely understood as one of the most stigmatized and under-reported health issues known to be prevalent in the borderlands and throughout migration. These results have shown that to be true, with 3.8% reporting as a witness to sexual violence versus 13.3% for other physical abuse.

Despite the potential limitations from sampling and bias, the results still offered profound building blocks for understanding this topic, which is significantly understudied—in part because of the challenges of utilizing an experimental design with a highly mobile and vulnerable population. In a review of empirical literature of the past 20 years, convenience samples and cross-sectional surveys are the most common study designs for non-detained unauthorized migrant or asylum seeker populations.(27) Ryan et al. concluded that "We do not need sophisticated research to tell us that humans suffer in toxic social environments," and that the challenges of receiving protections and basic human rights for unauthorized immigrants has become an environment inducing psychological suffering.(27) Thus, this assessment adds to this field and should spur action on behalf of immigrant health.