United We Dream

NLPA
NATIONAL LATINX
PSYCHOLOGICAL ASSOCIATION

SUPPLEMENTAL COVID-19 NEEDS ASSESSMENT OF U.S. LATINX IMMIGRANTS

JUNE 2021

TWO PANDEMIC SNAPSHOTS: IMMIGRANT HEALTH IN THE TIME OF COVID

THIS REPORT WAS PREPARED BY THE LATINX IMMIGRANT HEALTH ALLIANCE (LIHA) FOR THE NATIONAL LATINX PSYCHOLOGICAL ASSOCIATION (NLPA) AS PART OF THE COVID-19 NEEDS ASSESSMENT OF U.S. COMMUNITIES OF COLOR, SPONSORED BY THE NATIONAL URBAN LEAGUE. THESE RESULTS ARE COMPLEMENTARY TO THOSE PRESENTED IN THE COVID-19 NEEDS ASSESSMENT OF U.S. LATINX COMMUNITIES REPORT BY NLPA.

COLLABORATIVE PARTNERSHIP

This report is part of a collaborative partnership between the National Latinx Psychological Association (NLPA), United We Dream (UWD), and the Latinx Immigrant Health Alliance (LIHA). UWD leaders and a select group of NLPA scholars, united by their participation in the Undocumented Special Interest Group established a partnership in 2017 aimed at addressing mental health and wellbeing in undocumented communities.
When the COVID-19 pandemic hit, the partners came together to discuss how we could support the undocumented community at a time of increased and compounding stress. Not only was the undocumented community facing a pandemic but also serious threats to the Deferred Action for Childhood Arrivals (DACA) legislation. The work grew to meet unmet demands, leading to the creation of the Latinx Immigrant Health Alliance as a space to advance scholarship, services, and policy recommendations. Among other initiatives, we gathered data to understand the physical and mental health in the undocumented community during the COVID-19 pandemic.

TWO PANDEMIC SNAPSHOTS: SURVEY DETAILS

We collected data through recruitment led by United We Dream. The survey was developed collaboratively. The Utah State University Institutional Review Board reviewed and approved this research. We completed reliance agreements with Lehigh University, University of Texas, Rio Grande Valley, University of Texas Health Sciences Center, San Antonio, and Yale University IRBs.

The survey was available in English or Spanish. Data were collected at two points in time. In spite of efforts to connect the two sets of participants, the unique identifiers revealed very little or no overlap in participants. Data collected represent snapshots in time rather than longitudinal data.

The first data collection (Time 1) took place between **June 16 and August 20, 2020**. The second data collection (Time 2) took place between **January 19 and April 4, 2021**.

PARTICIPANT CHARACTERISTICS

We report on predominant participant characteristics here. Detailed data is available. **Participants were relatively young**. At Time 1, 67.5% were between 18 and 30 years of age; at Time 2, 56.9% were between 18 and 30 years of age. The samples were mostly comprised of **cisgender women**, **heterosexual**, and **Latinx** people.

National samples. At Time 1, respondents lived in 37 different states with most respondents in California (n = 109), Texas (n = 39), New York (n = 28), and Illinois (n = 22). At Time 2, respondents lived in 34 states with most respondents in California (n = 47), Texas (n = 23), Oklahoma (n = 16), and New York (n = 10).

TABLE

Participant Characteristics

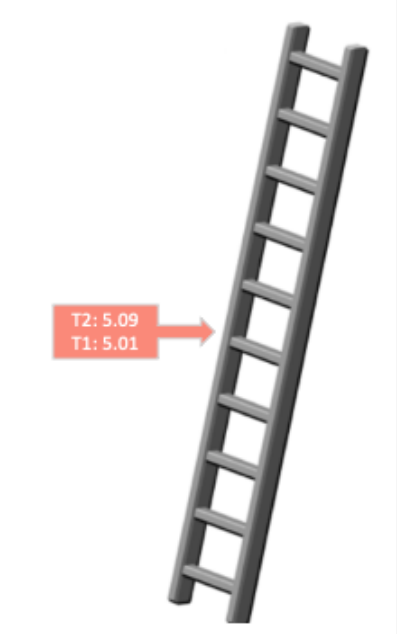
	Time 1 (n = 450)	Time 2 (n = 216)
Age		
Range	18 to 73	18 to 86
Mean and SD	$M = 28.38$, $SD = 7.80$	$M = 29.95$, $SD = 9.25$
Gender		
Cisgender women	74.7% (n = 336)	77.8% (n = 168)
Sexual Orientation		
Heterosexual	72.9% (n = 328)	66.2% (n = 143)
Ethnicity		
Latinx	94.4% (n = 425)	88.4% (n = 191)
Generational Status		
1 or 1.5 generation	97.1% (n = 437)	90.3% (n = 195)
Educational Achievement		
Some college	34.2% (n = 154)	31.9% (n = 69)
Completed college	45.6% (n = 205)	40.3% (n = 87)
Work Status		
Full Time Work	52.44% (n = 236)	55.1% (n = 119)
Full Time Student	14.44% (n = 14.67%)	13.9% (n = 30)
Relationship Status		
Single/Never married	60.0% (n = 270)	55.1% (n = 119)
Parental Status		
No children	71.1% (n = 320)	66.7% (n = 144)

Note: Percents reported in this table are a percent of total sample to ensure that missingness did not artificially impact results.

SUBJECTIVE ECONOMIC STATUS

- Participants were asked to rate themselves from "best off" to "worst off" (money, education, and jobs).

- **Participants rated themselves "about the same" as others like them.**
  - Time 1 mean of 5.09 (SD = 1.67, n = 428)
  - Time 2 mean of 5.01 (SD = 1.86, n = 202)



DOCUMENTATION STATUS

The majority of participants were DACA recipients (T1 = 74%, T2 = 55.1%). The next largest group was undocumented immigrants who did not have DACA (T1 = 14%, T2 = 21.8%). There were also permanent residents (T1 = 3.3%, T2 = 3,3%) as well as U.S. citizens in the study (T1 = 2.4%, T2 = 2.4%). Participants reported on the status of "people in your household, immediate family or emotional or financial support system you depend on?" Participants could select as many answers as applied. The table below shows the diversity within households.

TABLE

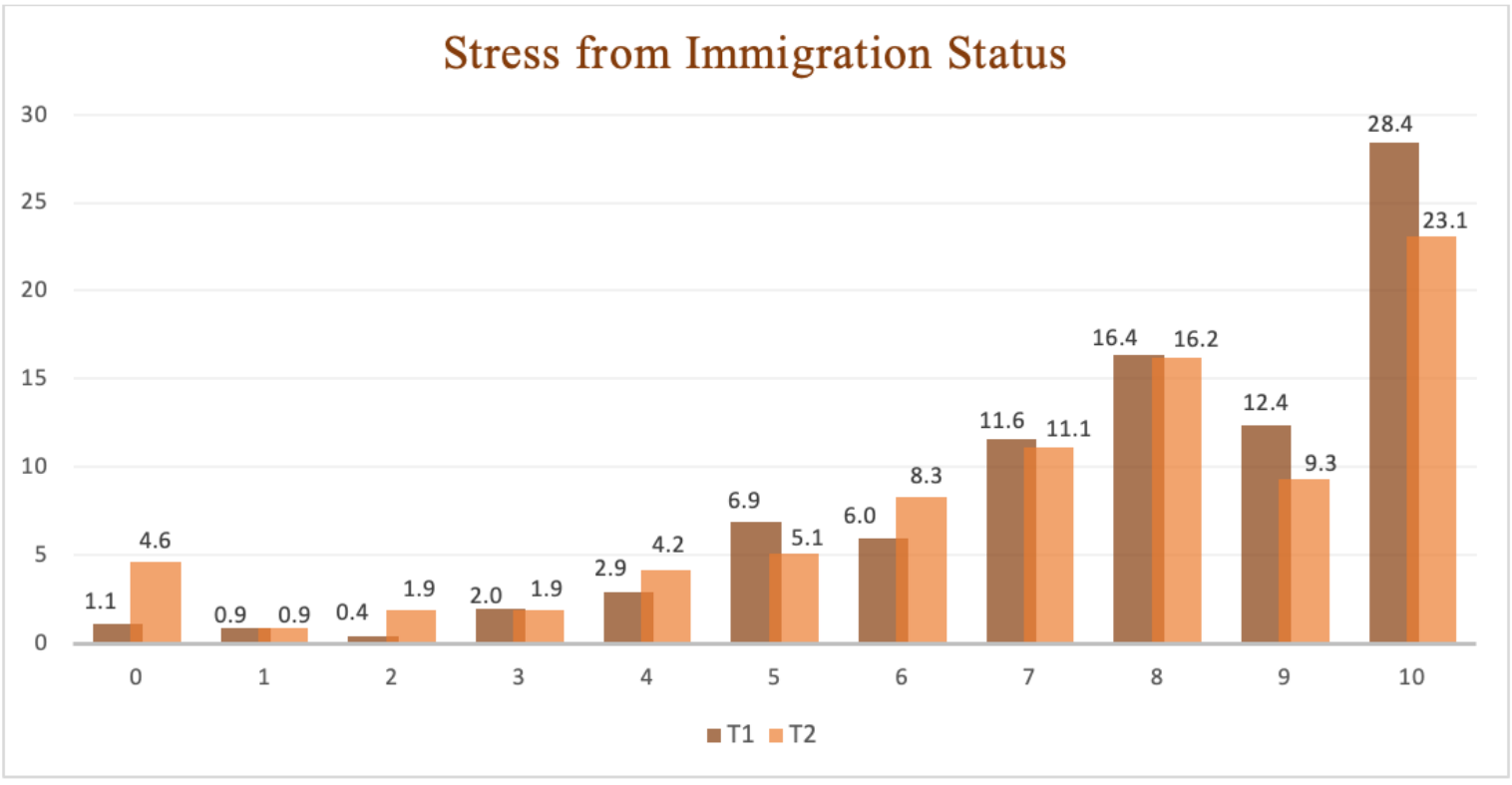
Documentation Context as Reported by Participants

	Time 1 (n = 450)	Time 2 (n = 216)
Documentation Status: Self		
"DACAmented"	74.0% (n = 333)	55.1% (n = 119)
Undocumented	14.0% (n = 63)	21.8% (n = 47)
Documentation Status: Family		
"DACAmented"	35.1% (n = 158)	30.6% (n = 66)
Undocumented	67.6% (n = 304)	62.5% (n = 135)
Permanent resident	17.6% (n = 79)	18.5% (n = 40)
U.S. citizen	52.4% (n =236)	51.9% (n = 112)

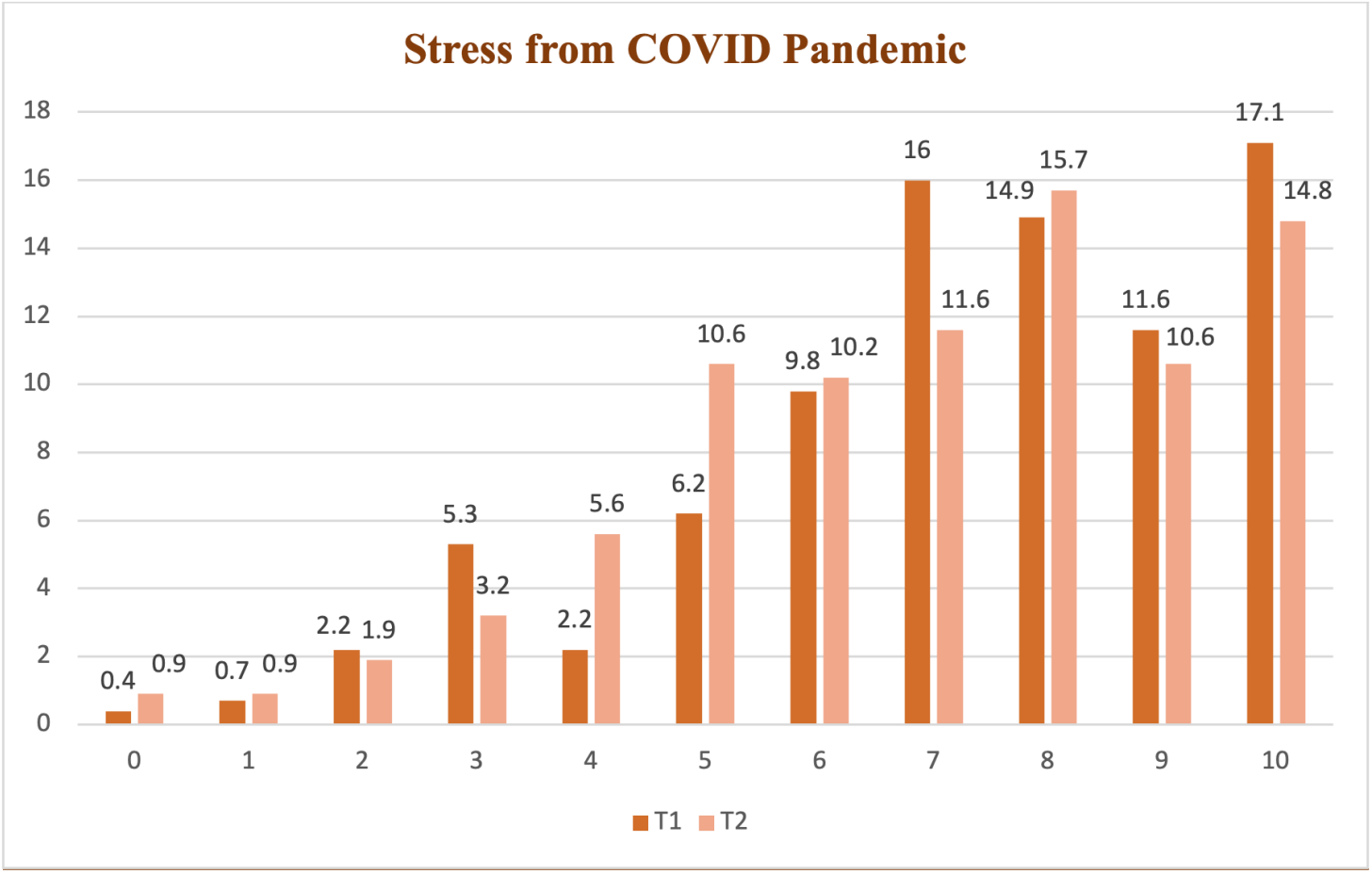
STRESS

PARTICIPANTS REPORTED HIGH LEVELS OF STRESS STEMMING FROM THEIR LEGAL IMMIGRATION STATUS:

- TIME 1 (M = 7.84, SD = 2.25)
- TIME 2 (M = 7.21, SD = 2.77).



Note: Values are percentages

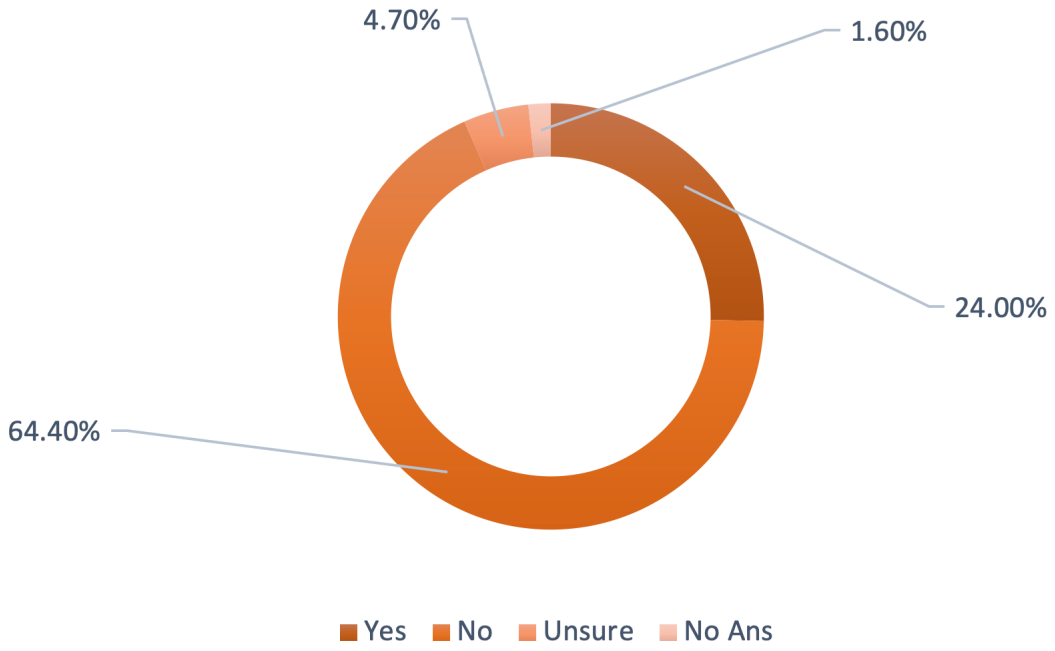


Note: Values are percentages

PARTICIPANTS REPORTED HIGH LEVELS OF STRESS EXPERIENCED FROM THE COVID-19 PANDEMIC:

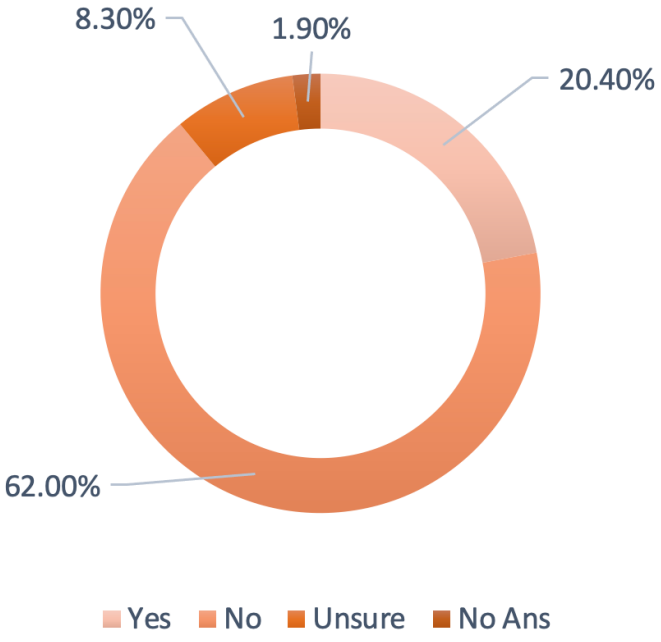
- TIME 1 (M = 7.24, SD = 2.29)
- TIME 2 (M = 6.99, SD = 2.35)

T1

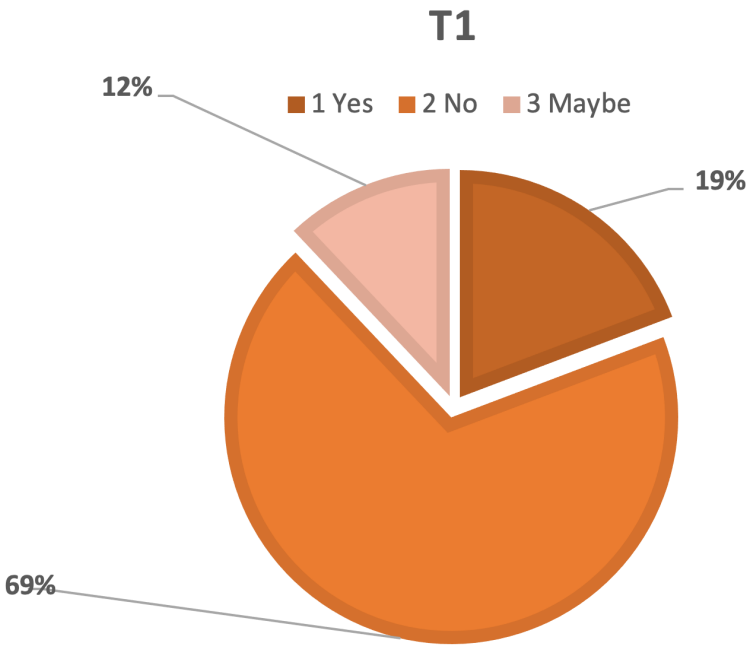


PARTICIPANTS EXPERIENCED THE DEPORTATION OF "A LOVED ONE OR SOMEONE WITH A SIGNIFICANT ROLE IN YOUR LIFE."

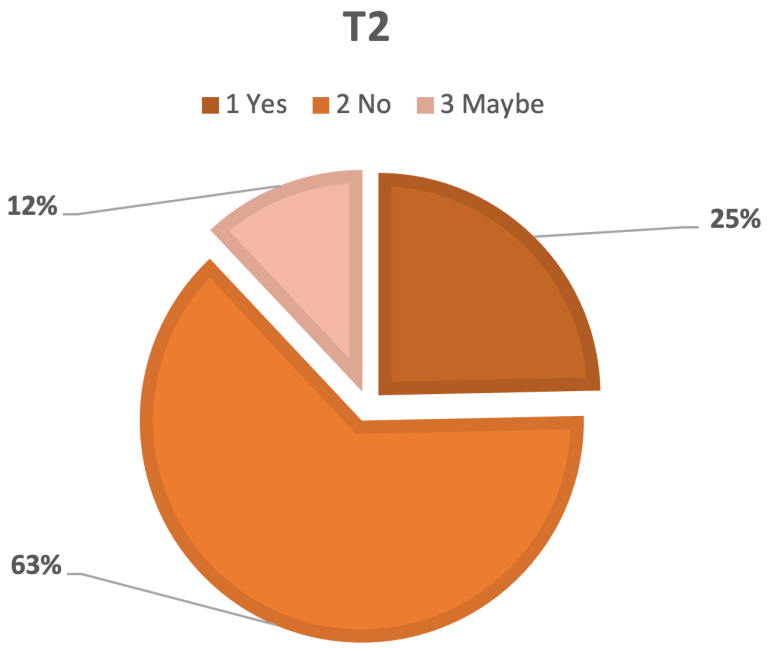
T2



HEALTH



PARTICIPANTS REPORTED EXPERIENCING CHRONIC PAIN AT BOTH TIME POINTS.



COVID

Areas of Life Affected by COVID

	T1	T2
Work	43.60%	41.20%
School	29.10%	20.40%
Home Life	37.60%	37.50%
Social Activities	59.80%	56.00%
Economic Stability	34.00%	31.50%
Emotional Health	62.90%	61.60%
Physical Health	42.70%	43.50%

- Participants reported being affected by COVID in work, school, home, social activities, economic stability, emotional and physical health.
- The number of positive COVID tests was relatively low for the sample (n = 32 at Time 1 and n = 33 at T2).
- Only two participants reported being hospitalized at each of the two time points.
- For the Time 1 sample, 12 had experienced the death of a family member due to COVID and at Time 2, 26 respondents had experienced the same.

MENTAL HEALTH

- Participants provided their mental health ratings on the Brief Symptom Inventory – 18. The scores in the table are standardized T scores.
- **An alarming number of participants reported symptoms in the clinical range, from 38.2% to 52.8%.**

1 IN 2 PEOPLE HAD CLINICALLY SIGNIFICANT DISTRESS

Brief Symptom Inventory Ratings

	N	Min	Max	*M*	*SD*	Clinically Significant *n* (%*)
T1: Somatization T-Score	323	41	80	57.32	10.84	130 (40.2%)
T1: Depression T-Score	323	40	80	61.81	10.73	170 (52.6%)
T1: Anxiety T-Score	324	38	80	62.19	11.15	164 (50.6%)
T1: Global Severity T-Score	318	33	80	62.26	10.82	168 (52.8%)
T2: Somatization T-Score	165	41	80	58.32	10.91	63 (38.2%)
T2: Depression T-Score	165	40	80	62.78	9.71	85 (51.5%)
T2: Anxiety T-Score	164	39	80	63.11	9.31	79 (48.2%)
T2: Global Severity T-Score	161	36	80	63.32	9.32	85 (52.1%)

Note: The percent reported is the valid percent so that the remainder is the percent of people that did not meet clinical significance on the subscale

COPING STRATEGIES

TABLE

Coping Strategies

	Time 1			Time 2		
Coping Domains	*N*	*M*	*SD*	*N*	*M*	*SD*
Brief COPE: Denial	318	2.89	1.30	161	3.24	1.65
Brief COPE: Substance Use	319	2.88	1.54	161	3.32	2.54
Brief COPE: Behavioral Disengagement	314	3.30	1.43	161	3.68	1.83
Brief COPE: Venting	312	4.38	1.58	161	4.67	1.66
Brief COPE: Self Distraction	319	6.02	1.55	161	6.22	1.46
Brief COPE: Active Coping	318	5.42	1.61	161	5.71	1.67
Brief COPE: Emotional Support	318	4.82	1.74	161	5.02	1.83
Brief COPE: Positive Reframe	318	5.32	1.77	161	5.40	1.72
Brief COPE: Planning	317	5.46	1.65	161	5.75	1.58
Brief COPE: Acceptance	316	6.05	1.55	161	6.22	1.46
Brief COPE: Religion	317	4.63	2.13	161	4.71	2.16

- Participants shared important coping strategies. Higher scores indicate higher endorsement of the coping strategy.
- Participants used effective coping strategies including acceptance, active coping, self-distraction, planning, and positive reframe.
- Participants reported lower levels of ineffective coping strategies such as denial, substance use, or behavioral disengagement.

RESPONDENTS GENERALLY USED HEALTHY COPING BUT THERE IS ROOM TO IMPROVE HEALTHY PRACTICES AND REDUCE HARMFUL COPING.

DISTRESS & COPING

Generally ineffective coping strategies were significantly positively correlated with somatization, depression, anxiety, and general distress symptoms.

COPE Scales	Time 1: BSI T Scores				Time 2: BSI T Scores			
	Som.	Dep.	Anx.	GSI	Som.	Dep.	Anx.	GSI
Denial	.325**	.251**	.330**	.315**	.192*	.189*	.229**	.213**
Substance Use	.169**	.274**	.303**	.286**	.228**	.219**	.123	.216**
Behav. Disengage	.386**	.477**	.341**	.443**	.235**	.372**	.257**	.323**
Venting	.169**	.268**	.281**	.268**	.309**	.247**	.242**	.301**
Self Distraction	.152**	.211**	.197**	.232**	.161*	.241**	.206**	.223**

At Time 1, sample size was 305 to 316; at Time 2, sample size was 153 to 156.

PROVIDING RESOURCES AND SKILLS FOR REDUCING THE USE OF INEFFECTIVE COPING STRATEGIES AND INCREASING THE USE OF POSITIVE COPING STRATEGIES MAY SUPPORT IMPROVED WELL BEING.

POLICY RECOMMENDATIONS

The following five recommendations are provided as practical means of addressing the impact of the COVID-19 pandemic on immigrants in the United States through policy change:

- Support efforts to eliminate the harsh rhetoric, exclusionary and discriminatory policies, inhumane treatment, and violations of human rights against immigrants. **The negative impact of anti-immigration policy has been studied and concluded to be harmful** (Cervantes & Walker, 2017; Wood, 2018). Evidently, these harmful effects were present during the beginning and end of the pandemic as our data suggests.

- **Support policies that fund the creation of innovative programs that aim to bolster immigrants' wellbeing.** Specialized programs, such as resource centers that have been pioneered in higher education (Cisneros & Rivarola, 2020), may be developed within K-12 schools, healthcare delivery systems, and in community organizations with the support of federal funding.

- **Contribute to building a mental health workforce equipped to recognize and meet the needs of at-risk immigrants.** Policies need to be aimed at increasing funding to support the training of mental health professionals who are equipped in culturally-responsive and competent practices, and developing a mental health workforce that is more reflective of the cultural make up of immigrants.

- **Expand federal programs that assist scientific research efforts to focus on immigrant communities.** Knowledge about the complex needs of undocumented immigrants is limited. This information is essential to inform interventions, advocacy, and most importantly, policy efforts. Federally sponsored opportunities to build interdisciplinary collaborations to advance research in this area are much needed, along with funding to support community-based research and clinical services.

- **Create federal programs that leverage opportunities to build community alliances.** Immigrant communities often engage with numerous organizations and systems. In addition to health care providers and schools, faith-based institutions and churches can represent natural partners in this work (e.g., Parra-Cardona et al., 2016). Creating new strategic federal programs to strengthen these alliances may help establish vehicles to address the unmet needs of immigrants post-pandemic.

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