

UNDOCUMENTED IMMIGRANTS in NEW JERSEY'S STATE & COUNTY PSYCHIATRIC HOSPITALS

I. Introduction

Within state and county psychiatric hospitals in New Jersey, there are over 1,000 mental health consumers who remain hospitalized even though they are clinically appropriate for discharge. This status is known as "conditional extension pending placement" [CEPP], because such patients stay in New Jersey's state and county psychiatric facilities because there is a lack of affordable housing with appropriate supports for them in the community.

The Department of Human Services' Division of Mental Health Services [DMHS] does fund group homes and supportive housing for mental health consumers who are leaving hospitals, but the demand for such housing is much greater than the availability. The Division of Mental Health Advocacy, within the Department of the Public Advocate, has recommended that one way to decrease the number of patients on CEPP is to place consumers in residential health care facilities [RHCFs] while they await vouchers for supportive apartments. For an immigrant who is undocumented or even lawfully present but ineligible for federal benefits, however, no such options are available.

Because undocumented immigrants are not eligible for any federal benefits or subsidies, consumers who are undocumented do not have the resources necessary to live in an RHCf and are not eligible for other forms of housing assistance, medical benefits, or other subsidies, if they are in any way supported by federal funds. These additional challenges in obtaining community placement for consumers who are undocumented have resulted in patients being on CEPP status for long periods of time. This is clinically inappropriate, potentially causing patients to decompensate or demonstrate institutional behavior and making movement into the community far more difficult.¹ This is also inconsistent with the aspirations embodied in *Olmstead v. L.C.* 527 U.S. 581 (1999), in which the U.S. Supreme Court held that people with mental illnesses and developmental disabilities have a right to live in the least restrictive setting possible. But simply from a fiscal perspective, the current situation makes little sense. It costs considerably more to house a patient in a psychiatric hospital than it does to place them in an appropriate community setting. While this is largely the result of a failure in federal policy, New Jersey taxpayers are unnecessarily burdened with those additional costs.

Immigrants in psychiatric hospitals who have limited English proficiency must also rely upon interpreters to communicate with their treatment providers. The New Jersey

¹ Witkin, M., Atay, J., Manderscheid, R., and others. "Highlights of Organized Mental Health Services in 1994 and Major National and State Trends." Chapter 13 in Mental Health, United States, 1998, edited by Ronald Mandersheid and Marilyn Henderson. Washington DC: US-GPO, US-DHHS Pub. No. (SMA) 99-3285, 1998

Division of Mental Health Services has ordered that mental health provider agencies "shall assure that services provided to clients are culturally sensitive, culturally competent and in a language sufficiently well understood by the client to assure comprehension" (N.J.A.C. 10:37D 2.3, Service Accessibility). Some consumers have stated that their treatment providers did not sufficiently understand them. Such misunderstandings have an effect not only on the consumer's clinical status, but also on their immigration status. During interviews with consumers, our bilingual staff found that some patients who had been believed to be undocumented are not actually undocumented, but that they had not maintained their legal immigration status. This appears to be due, in part, to patients not having the assistance of hospital staff that are knowledgeable about immigration issues.

This project identified the barriers to discharge planning and placement that undocumented immigrants (UI) and those with limited English proficiency (LEP) face, and offers recommendations to remediate some of these issues.

II. Survey Tools & Methods

In order to obtain baseline information about the UI and LEP populations at each of the state and county hospitals, we began by mailing a description of the project and a survey to the social services directors at four of the state psychiatric facilities: Ancora Psychiatric Hospital, Trenton Psychiatric Hospital, Hagedorn Psychiatric Hospital, and Greystone Park Psychiatric Hospital. We did not include Ann Klein Forensic Hospital in our survey because, as a large forensic hospital, the issues faced by patients there are unique and not necessary related to our work on this issue. We also requested this information from each of the six county hospitals.

Following receipt of the survey information, we conducted visits to state psychiatric hospitals and extensive conversations with social workers and other hospital staff, DMHA advocates, and attorneys. During the visits, an appraisal form was used to gather relevant information from the consumer's chart. Patient interviews were conducted, as well, to corroborate relevant information from the chart and obtain the consumer's perception of his/her treatment and discharge plan. Copies of the survey and appraisal form are attached.

During the interview process, we found a significant share of these CEPP consumers had immigrated to the United States from Cuba, some of whom were part of the Mariel Boatlift in 1980. They were not granted refugee status, as the previous Cubans immigrants had been.² Instead, they were labeled by the INS as "new immigrant entrants," which did not give them refugee status or benefits. They were granted a parole status that could be changed after a year based on a clean criminal record. Those admitted by the Attorney General to parole status are lawfully present in the United States,³ but not admitted as refugees and not eligible for federal benefits. Further information on this group, informally known as *Marielitos*, follows in a later section. Members of this group may be eligible for federal benefits if they gain refugee status.

² Pedraza, Bailey. S. 1986 Political and Economic Migrants in America: Cubans and Mexican
Austin: University of Texas Press

³ 8 U.S.C. § 1182(d)(5)(A) (1982)

II. Findings

Undocumented immigrants in New Jersey's state hospitals comprise about 3.2% of the total number of patients in each of the four state hospitals surveyed. While this is a small number of patients, their care at state psychiatric facilities is costly, and is not subsidized by any federal funds. At a state cost of approximately \$130,000 per year per patient, keeping the 61 known undocumented immigrants hospitalized costs the state almost \$8 million per year⁴. Fifty-five of these patients are on CEPP, and the cost to the state for their care is about \$7 million, which is far more than it would cost to allow these patients to live in the community, even if the State of New Jersey paid all of their expenses.

CHART 1: UNDOCUMENTED IMMIGRANT CONSUMERS IN STATE HOSPITALS

Name of Hospital	Number of Undocumented Immigrants on CEPP (non-Mariel Boatlift)	Number of Cubans/Mariel Boatlift on CEPP	Total
Ancora	10	4	14
Trenton	8	2	10
Hagedorn	4	1	5
Greystone	21	5	26
TOTAL	43	12	55

DMHS does not have a written repatriation policy that hospital staff may refer to when assisting consumers with immigration issues. In practice, DMHS reports that it assists those who wish to return to their country of origin by contacting the appropriate consulate and seeking assistance in setting up a discharge plan in the consumer's country of citizenship. Some consumers who have expressed a desire to return to their countries of origin, however, have not been able to achieve this -- perhaps because of their clinical needs and the system of care in their home country -- and may require greater effort on the part of DMHS. Assisting in repatriation would relieve DMHS of its duty to care for these patients, and would likely be in the patient's own best interest, as they could possibly be reunited with their families.

UI consumers comprise an even smaller share of total patients in county hospitals. This is largely due to the fact that, since it is extremely difficult to develop a viable discharge plan for undocumented immigrants, they are better served at a long-term state psychiatric facility rather than an at a short term county facility and so are discharged to state hospitals. The county hospitals also indicated that they do not keep information regarding a patient's immigration status, and therefore do not always know when they have a patient who is undocumented. From our information requests, we were told of only four known undocumented immigrants in county hospitals, three of whom are on CEPP status.

IV. Cuban Immigrants and the Mariel Boatlift

⁴ Department of Human Services estimate, NJ State Budget 2007

Cuban citizens who entered the United States as part of the Mariel Boatlift in 1980 were not granted citizenship, but did receive a legal status that essentially allowed them to have a new start in this country. Some of these immigrants suffered from mental illnesses, and are now among the patients in psychiatric hospitals in New Jersey. These immigrants are in limbo, with neither the rights of citizenship nor a well-defined immigration status. These mental health consumers did not update their records with Immigration and Customs Enforcement [ICE, formerly known as Immigration and Naturalization Services], so while they may have had appropriate documentation at some point, they no longer do.] During interviews, we found that several *Marielitos* knew their alien registration numbers, and stated that they had asked hospital staff to intervene on their behalf with ICE, but that staff did not take any action on this issue.

The Mariel Boatlift took place between April and October of 1980, when approximately 125,000 Cubans entered the United States via Miami, Florida. Cuban leader, Fidel Castro opened the Port of Mariel for the Cubans who wanted to escape his Communist regime, which is why those who participated are known as *Marielitos*. The massive migration overwhelmed United States Immigration and Naturalization Services, and there were rumors, which were later found to be only partially true, that Fidel Castro encouraged inmates in Cuba's prisons and patients in mental institutions to come to this country. It is now believed that only about 800 to 900 of the 125,000 fit this description⁵. The United States government responded to these rumors by interning all new arrivals.

Due to political pressure, the federal government began releasing those immigrants who were not considered a threat, with others staying in detention camps for any number of reasons, including false allegations by other refugees. Following a long process, the remaining detainees were transferred to the Atlanta Federal Penitentiary, and have been held in detention longer than their criminal sentences would warrant.

Christine Dahs, an attorney from Oregon representing four Mariel Cubans in detention stated: "many Mariel Cubans have died while in detention because they did not receive any medical treatment. Although the Supreme Court decision was meant to hold the refugees beyond 90 days only if they were considering deportation arrangements, since Cuban Mariel refugees could not be sent back to Cuba, authorities kept the refugees in detention for nearly a quarter of a century without any rights."⁶

Much like detainees in other settings, Mariel Cubans who are in our state psychiatric hospitals have also been unnecessarily detained and remain in limbo because of their status.

V. Consumers from the Mariel Boatlift

P.V.

P.V. is 60 years old, Spanish speaking man who is currently on CEPP status at Ancora Psychiatric Hospital, where he was admitted in 1999. P.V. entered the United

⁵ Ojito, M. *Finding Mañana: A Memoir of Cuba Exodus*, Penguin Publisher, 1996

⁶ Engstrom David W, *Presidential Decision Making Adrift: The Carter Administration and the Mariel Boatlift*, Rowman and Littlefield, 1997

States at Key West in 1980, and was granted parole status. P.V moved to New York in search of employment.

According to P.V., he found work in New York, and was issued a social security number in addition to the alien number he had been issued by INS. He also said he received welfare and medical care. P.V. reported no psychiatric history, but stated that one day he left his residence and became disoriented on the streets of New York and got lost. He was picked up by the police and hospitalized in several psychiatric facilities. P.V. is not clear how he came to New Jersey.

For the past nine years, P.V has been at Ancora, where he was diagnosed with schizoaffective disorder, paranoid type. His treatment includes three types of psychotropic medication to control his psychiatric symptoms. P.V. has also been diagnosed with Hepatitis C, cirrhosis, and hypertension. Because of his medical problems, it is likely that he will die on the grounds of Ancora.

P.V. has expressed a desire to return to Cuba, and realizes that he may again be incarcerated if he goes there. He stated, "I don't care if end up in jail again, at least I will have my family to visit me." Hospital staff have been in contact with P.V.'s sister via letter, explaining the situation and requesting P.V.'s birth certificate.

According to Ancora staff, a Cuban passport has been issued to P.V. At this time, however, P.V. remains hospitalized while staff attempts to contact the family to ensure that P.V. has a residence and secure a legal flight for him to Cuba. DMHS is closely monitoring P.V.'s progress.

R.L.

R.L is 52 years old and in need of ongoing skilled nursing care. However, because of his status as another of the Mariel Cubans, he remains on CEPP status at Greystone. He has no access to Medicare or Medicaid, and so has been unable to secure a bed in a nursing home.

His records indicate that a process to apply for a resident alien card was initiated in 1999. The application was sent to GPPH, but the client's records indicate that no action was taken by staff to follow up. On April 4, 2008, his new social worker at Greystone submitted papers again to change his immigration status. The application is currently pending, and is being delayed because required medical tests must be taken in the Newark ICE office. R.L.'s current fragile health and difficulty walking may impede his ability to take these tests.

J.C.

Our review of undocumented immigrant patients led us to one individual who was not undocumented, although his immigration status was questionable because of a change in federal immigration policy in 1996. Hospital staff believed him to be undocumented, although he had refugee status at one time.

J.C is a 55 year old, Spanish speaking male who entered the United States at the age of 27. He has been a patient at Trenton Psychiatric Hospital since December 15, 2005 and has been on CEPP status since December 20, 2007. A patient in a psychiatric facility in Cuba, J.C. reports that he had a wife and two children at the time of his departure from Cuba, but left his country because he felt it was his best opportunity to gain freedom, and so "ran to the door with the other patients" when he heard the announcement of the Mariel boatlift.

J.C. traveled to New York and New Jersey seeking employment. While interviewing J.C, we learned that he got married in 1994 in Paterson, and lived with his wife and stepdaughter there for about 5 years. He was charged and convicted as a sex offender under Megan's Law in 1997, and was sent to Ann Klein Forensic Hospital.

J.C. has all his documents, including a parole card issued when he immigrated and a marriage certificate. He also has a copy of his social security card, and had previously given the hospital staff this number. J.C. has a girlfriend that he met at a psychiatric facility and upon discharge would like to live with his girlfriend. She, however, is unsure if she can take on the responsibility for his care.

Because J. C has a social security number, he would have been able to receive social security benefits and perhaps other benefits, such as housing assistance or food stamps, as well. However, he missed an immigration hearing in 2005, which resulted in a final order of removal, and his status is now such that he appears to be ineligible for benefits. Since J.C. remains hospitalized, DMHS is working with his attorney from Lutheran Social Ministries to have his case reopened. J.C.'s Megan Law charges further complicate his discharge, although hospital staff continue to investigate placement for him.

VI. Other Immigrants

N.B.

Immigrants from other countries also remain hospitalized. One of these is N.B., a 65 year old man from Albania, who speaks Gheg, a relatively rare Albanian dialect, as his primary language. There is only one certified interpreter in New Jersey who speaks this dialect, which is a challenge to N.B.'s treatment.

N.B.'s records indicate that he escaped from Albania when he was 19 years old, because, he reports, the communist party killed every member of his family. He reports that he walked hundreds of miles through Albania and Yugoslavia,

swam across bodies of water and walked to Greece where he took a boat to America. While in America, N.B. managed to survive and learn limited English. N.B. was arrested and charged with car jacking and assault, but he disputes the details of his arrest. N.B.'s limited English proficiency, his lack of understanding of the United States legal system, and the judiciary system's inability to deal with diverse populations at that time, may have contributed to misunderstandings during his trial.

N.B. has spent approximately half of his life in America in a restrictive facility. Currently, N.B. is diagnosed with advanced dementia and would have difficulty living in the community outside of a restricted setting. N.B. was transferred to Hagedorn in July, 2008, where he will receive the medical and psychiatric care that he needs. N.B. may have been eligible for asylum when he arrived in this country, because of the persecution of his family. However, no asylum application was made and he languished for many years in a psychiatric facility, although that level of care may not have been necessary because he had at one time been classified as CEPP.

M.H.

Another patient who wants to return to his home country is M.H., a 35 year old man from Xuahaca, Mexico. He is currently at Trenton Psychiatric Hospital where he has been on CEPP status since March, 2007. M.H. reports he was originally diagnosed with a mental illness in Mexico and was hospitalized there, and later came to the United States via Texas. M. H. moved to New Jersey to seek employment and was found disoriented and wandering around Monmouth County. M.H.'s English is very limited, and he has no family in the United States. When he was placed on CEPP status, M.H. had expressed the desire to return to Mexico. M.H. does not qualify for benefits since he is undocumented. M.H.'s wife, who still lives in Mexico, is reluctant to have him come back because she alleges that he has a history of domestic violence. M.H. acknowledges this, and has agreed not to contact his wife if he returns to Mexico and to continue mental health and substance abuse treatment there.

Staff at Trenton Psychiatric Hospital are currently working with a mental health facility in Mexico to set up an appropriate discharge plan.

VII. Treatment and Placement Barriers

Each of these cases illustrates the problems in finding appropriate placement settings for individuals who are undocumented. Although DMHS policy requires treatment be provided in a culturally competent manners, it is clear that for some patients in state and county psychiatric facilities, staff that provide treatment are unable to meet the linguistic and case management needs of the patients. The Department of the Public Advocate recognizes that DMHS facilities are compliant with licensing requirements, and utilizes interpreter

services when available, but due to the diversity within the state, a case can be made that more such services are needed. We also recognize that this is a challenge that confronts all acute care hospitals in New Jersey. In the case of a patient like J.C., who has a social security number, staff should have investigated his status over the past 8 months to determine whether he was eligible for federal assistance programs. For other patients, assisting them with being repatriated to their country of origin is far more humane than allowing them to remain hospitalized unnecessarily.

The cost to the state alone of keeping patients in state psychiatric facilities in New Jersey is \$130,000 annually. For those patients who wish to return to their countries of origin, assisting them in returning home will result in a cost savings. It is, of course, necessary to link them with available and appropriate supports in their home countries so that they may continue mental health treatment. It may well be true that treatment available in those countries does not meet standards established in this country, but in such cases deference should be given to an individual's desire to return home to the treatment that is available and acceptable in their native country.

A.A. - A Better Outcome

The case of A.A., a consumer who was recently hospitalized in a community hospital, illustrates the positive outcomes that can occur for a consumer who has limited English proficiency and in danger of becoming undocumented.

A.A. came to the United States from Japan in June 2008. She had a visitor's visa only, which was due to expire in August 2008. Although A.A. came from Japan, and had a Japanese passport, she had been born and raised in China, and her family still resided there. Her husband, who had purchased her plane ticket, lived in Japan but did not want her to return to him; she did not wish to return to him, either.

A.A. had an extensive psychiatric history, for which she was treated in both Japan and China, which hospital staff learned about in speaking with her husband and family through the use of an interpreting service. She had a fixed delusion regarding a United States presidential candidate, and so was also the subject of a Secret Service investigation. A.A. was represented by the Division of Mental Health & Guardianship.

At a hearing at which she was determined to be clinically appropriate for discharge, hospital staff found themselves in the position of potentially sending A.A. to Greystone, merely because there was no suitable housing option for her in this country. Had that taken place, A.A.'s visa would have expired while she was hospitalized, making her another undocumented immigrant in a state facility. Her attorney at the Department of the Public Advocate contacted the Secret Service on her behalf, and federal authorities arranged transport for her

to China on a commercial airline. Discharge plans were made with A.A.'s family, to ensure that her psychiatric care would continue.

In this instance, all parts of the system worked collaboratively to make sure that A.A. would have an appropriate discharge plan, and that her care would continue.

Recommendations

Although each of the cases involving consumers who are limited in English or are undocumented immigrants is unique, there were several themes that emerged as we examined their cases. Communication problems and a lack of knowledge by staff of the existence of an unwritten repatriation policy were found to be major obstacles to effective placement. Given the significant interests in these cases – in which the patients' freedom and civil liberties are at stake – DHS repatriation policies should be committed to writing so there is clarity and broad understanding of what those policies are.

Undocumented immigrants are unable to access services that are fully or partially funded with federal funds, so there are few discharge placements for this population. DMHS has provided assistance to hospital professional staff through its office of the legal liaison, which assists in reviewing the cases with hospital based staff. More education of staff about immigration policies would likely help staff to ensure that individuals with unclear immigration status do not languish, and that such cases are referred to the legal liaison in a timely manner. Not all undocumented immigrants have a status that can be converted to a legal status, but in such cases where that can happen, the legal liaison is best equipped to deal with this process.

A more cost-effective solution than keeping patients on CEPP status indefinitely is to design programs that meet the needs of undocumented individuals. The cost in state funds alone to keep a patient in the hospital is about \$130,000 annually. Rather than keep these patients in a hospital setting, designing a system that would allow them to live in the community and access services in the community while working on obtaining or regaining legal status is more humane and would relieve some of the burden on the hospital system. However, one impediment to implementing such a system is that it would have to be solely state funded.

Because the immigration system in the United States is difficult to navigate, we recommend that specific staff be assigned to work exclusively with this population. The Department of the Public Advocate recognizes that state and county hospital staff members have large caseloads, but removing the undocumented immigrants, whose cases are lengthy and time consuming, could be helpful. Additionally, if additional staff were specially trained to assist the undocumented immigrants, these patients would not languish for years in a

facility that is not helping them in their recovery. As stated above, the legal liaisons do handle these matters, and other professional staff in each hospital can assist. The staff within the Department of the Public Advocate has worked with DMHS staff on immigration issues, and stands ready to continue that work in partnership with the hospitals.

In 2006, DMHS conducted a forum on immigration issues, which was attended by staff of the Public Advocate, members of the advocacy community, and hospital staff.

With changes in federal legislation and corollary welfare reform, discharges have become much more difficult. DMHS reviews discharge opportunities on a case by case basis to determine if individuals wish to return to their country of origin, if immigration status can be adjusted to a legal status, or if the presenting problem is truly an immigration problem or merely an administrative problem that can be resolved with appropriate documentation.

In addition to providing appropriate staff to work with undocumented immigrants, our other recommendations are as follows:

1. Social workers and other staff who participate in discharge planning must either be fluent in the patient's language or use trained interpreters or interpretation services for every contact with the patient. This is absolutely necessary, as we now know that some relevant information is not captured due to language issues. Language lines are available at all of the hospitals, and staff may need to be educated to about utilizing them more frequently.
2. Consumers must be educated about their options regarding treatment and placement, including repatriation and naturalization. This could be accomplished by the use of the specialized staff that we recommend.
3. Consumers with limited English proficiency should receive Basic Therapeutic English as a Second Language [BTESL] training as part of their treatment, in keeping with DMHS' Wellness & Recovery Initiatives.
4. The Patient's Bill of Rights should be amended to include the right to a professional interpreter, if a bilingual clinician or other bilingual staff person with knowledge of mental health issues is not available.

Hospital staff also can reach out to diverse community agencies or faith communities to develop support for patients who are LEP/UI. This would be therapeutic for the patient, and would provide them with an additional outlet to learn about their options from peers.

Given the diversity of New Jersey, the Division of Mental Health Services must better recognize the needs of undocumented immigrants and those with limited English proficiency so that appropriate plans may be made for them. Because of the complexity of immigration issues, and the shortcomings of federal

immigration policies, DMHS cannot be expected to solve all immigration problems for consumers. However, the development of written policies, staff education, and ensuring that information about naturalization is delivered to patients so that their rights are protected and they can receive the services they need and to which they are entitled would alleviate many of the problems that we found.