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Ethical Considerations in Providing Psychological Services to Unaccompanied Immigrant Children

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Abstract

Over 50,000 youth, mostly between the ages of 13 and 17 years, migrated to the United States (US) without familial accompaniment in fiscal year 2018. The tripartite process of pre-flight, flight, and resettlement exposes these unaccompanied immigrant children (UIC) to multiple, and often ongoing, traumatic events that can significantly and adversely impact their mental health into adulthood. However, the ethical considerations for psychologists working with this growing population, with limited exceptions, remain largely unaddressed. As more and more UIC flee their home countries due to violence, abuse, and economic instability only to experience further stressors during the processes of detainment, custodial placement, and acculturative adjustment in the US, there is an increasing need for psychological services; thus, the importance of preparation of mental health providers is increasingly significant. Psychologists must have the requisite skills and knowledge of the complex experiences of UIC, and of how these intersect with salient cultural, developmental, and systemic factors, as a means of providing competent and ethical mental health treatment. The present article highlights several ethical issues that arise when providing psychological services to UIC, with particular consideration paid to the embeddedness of UIC in various organizational entities with which psychologists will likely need to interface when working with this population. Implications and recommendations for practicing psychologists and training programs are discussed.

Keywords

ethics; psychology; immigration; children; youth

Introduction

Unaccompanied immigrant children (UIC) comprise a notable subgroup of people migrating to the United States (US) in flight of violence, abuse, and economic instability. An UIC is a minor who has neither lawful immigration status nor a legal parent or guardian in the US who is able to take custody and provide physical care (American Immigration Council [AIC], 2015). Over 50,000 UIC, mostly between the ages of 13 and 17 years, arrived at the southwest border in fiscal year 2018, primarily migrating from El Salvador, Guatemala, Honduras, and Mexico; as of its seventh full month, fiscal year 2019 has seen the arrival of 45,000 UIC (Customs and Border Patrol, 2018; Customs and Border Patrol, 2019; Office of

Refugee Resettlement [ORR], 2018). This staggering number of UIC migrating to the US represents a consistently growing population of children who may experience ongoing trauma stemming from violence, family separation, and acculturative adjustments, and are in need psychological services. Psychologists engaging with UIC must be equipped with an understanding of the complex and nuanced ethical issues relevant to this group as a means of providing competent and effective care. However, the ethical considerations for psychologists working with UIC, with limited exceptions, remain largely unaddressed. The present article addresses ethical considerations in providing psychological services to UIC in the midst of a highly politicized and volatile sociocultural context; these include value systems and bias, competence, informed consent, confidentiality, assessment considerations, balancing demands of ethics, law, and organizations, and public statements and advocacy. The application of these ethical issues to clinical work with UIC is discussed within the framework of APA's Ethical Principles of Psychologists and Code of Conduct (American Psychological Association [APA], 2017), heretofore referred to as the Ethics Code, and recommendations for practitioners and training programs are offered. While in-depth treatment considerations are beyond the scope of this paper, references to treatment guidelines are provided.

Psychological Impact of Migration on UIC

Experiences before, during, and after migration have traumatic consequences and place UIC at risk for post-traumatic stress disorder (PTSD), depression, anxiety, and other psychological problems (Alvarez & Alegría, 2016; Franco, 2018; Lustig et al., 2004). As UIC often flee their homes due to violence and/or abuse (AIC, 2015; Alvarez & Alegría, 2016; Becker Herbst et al., 2018), they may begin their journey having experienced one, many, or ongoing traumatic events. Further, UIC are likely to be exposed to further stress and trauma during travel, at arrival, and during resettlement (Becker Herbst et al., 2018; Franco, 2018; Lustig et al., 2004). Most UIC encountered by Customs and Border Patrol are immediately detained (AIC, 2015), despite evidence that even short-term detainment has lasting deleterious effects on minors' mental health (APA, 2018; Linton, Griffin, & Shapiro, 2017).

It has been reported that conditions in Customs and Border Patrol detainment facilities are poor, that abuse is common, and that detainees are denied access to adequate medical care (American Civil Liberties Union [ACLU], 2018; Linton et al., 2017). UIC are required to be transferred from the Customs and Border Patrol facilities to Office of Refugee Resettlement care within 72 hours of apprehension at the border, although this maximum is known to be exceeded (ACLU, 2018). Many UIC are transferred to housing in Office of Refugee Resettlement-contracted facilities, where they not uncommonly experience abuse and neglect and frequently do not receive adequate mental health care (Associated Press, 2018; Bidgood, Fernandez, & Fausset, 2018; Taxin, 2018), although most are placed with a community sponsor. The sponsor is most often a family member, but in some cases is a stranger to the child (Linton et al., 2017). However, recent policy changes that permit Immigration and Customs Enforcement to use family members' sponsorship efforts to identify and deport undocumented relatives of UIC have strengthened barriers to family reunification. This has also resulted in lengthened stays in detention centers while another

sponsor is found (Blitzer, 2018). It is in these arrangements that UIC await their immigration trials and when they typically receive services from a mental health professional as required by law. UIC in the care of a sponsor may also begin attending school during this time, and school-based settings represent another context in which psychologists may encounter and provide services to UIC. UIC often approach this new school context and its potential resources with neither proficient English skills nor certainty that they will not be deported (AIC, 2015; Collier, 2015).

Mental Health Needs of UIC

UIC often evidence symptoms of depression, anxiety, and/or PTSD upon their arrival in the US and during detainment (Alvarez & Alegria, 2016; APA, 2018; Vervliet, Lammertyn, Broekaert, & Derluyn, 2014). Rates of these disorders are higher in UIC than in accompanied immigrant youth (Huemer et al., 2009), indicating unique stressors and psychological distress among UIC. Further, longitudinal research indicates that the mental health of UIC who do not receive mental health services does not improve over time post-resettlement (Vervliet et al., 2014), making treatment accessibility an important ethical consideration (General Principle D- Justice; APA, 2017). While there is a relatively limited evidence base of treatments developed or adapted for UIC, the National Latino/a Psychological Association's (NLPA) guidelines for working with unaccompanied asylum-seeking minors indicate that Liberation Psychology, Narrative Therapy, Family Therapy, and Trauma Focused Cognitive Behavioral Therapy are developmentally appropriate, culturally informed, and adequately evidence-based approaches (Torres Fernández, Chavez-Dueñas, & Consoli, 2015). The Mental Health for Immigrants Program has also demonstrated effectiveness as a school-based intervention (Franco, 2018).

Ethical Considerations, Principles, and Standards

Value Systems, Bias, Discrimination, and Personal Conflicts

The politicized nature of immigration places UIC in a position of heightened vulnerability to values conflict, bias, and discrimination by healthcare professionals. The hot-button and increasingly polarized nature of this issue, as well as its seeming omnipresence in the news and national discourse, is likely to influence both the client and the therapist. Psychologists are not immune from the sway of their own opinions on such issues, and implicit bias may seep into therapy even among the most well-intentioned of clinicians (Burgess, Van Ryn, Dovidio, & Saha, 2007). As such, psychologists have a responsibility to monitor how their personal values and opinions can influence their work with UIC, evaluate the role of such values and opinions in their professional practice, and make the necessary modifications to ensure the provision of ethical care (Kaslow, 2004).

The importance of this process is reflected in many General Principles and Standards of the Ethics Code (APA, 2017). General Principle A (Beneficence and Nonmaleficence) encourages psychologists to be "alert to guard against personal, financial, social, organizational, or political factors that might lead to misuse of their influence." Similarly, General Principle D (Justice) states that psychologists should take precautions to prevent their potential biases from leading to unjust practices, and General Principle E (Respect for

People's Rights and Dignity) encourages psychologists to be "aware of and respect cultural, individual, and role differences...psychologists try to eliminate the effect on their work of biases based on those factors." Many of these cultural, individual, and role differences apply to working with UIC, who may share few, if any, of these aspects of identity with their mental health provider. Thus, psychologists working with UIC must not only closely monitor their personal biases and attitudes that could potentially lead to discriminatory or biased behavior (Standard 3.01- Unfair Discrimination), but also try to eliminate it from their therapeutic work. Working to eliminate bias is particularly salient in providing services to UIC, who are adjusting to a context in which they have been abruptly transitioned into minority status with respect to race, ethnicity, culture, national origin, and language, and are susceptible to experiencing discriminatory attitudes and behaviors linked to deleterious mental health outcomes (Barajas-Gonzalez et al., 2018; Costello, 2016). Given the capacity for harm that bias can inflict on UIC, it is important to consider that Standard 3.04 (Avoiding Harm) dictates that, "psychologists take reasonable steps to avoid harming their clients/patients....and to minimize harm where it is foreseeable." Maintaining awareness of how one's personal values and biases can influence therapeutic work with UIC is imperative for minimizing harm and providing competent, ethical care.

Self-monitoring is also important for addressing potential personal problems and conflicts (Standard 2.06- Personal Problems and Conflicts; APA, 2017). Personal problems can stem from numerous sources, ranging from tension between the personal values and political positions of the therapist and those of their client to vicarious trauma and burnout (Franco, 2018). These tensions and their associated distress can adversely impact psychologists' professional competence, which in turn has the potential to negatively impact UIC clients. As such, this type of self-monitoring is an important component of avoiding harm (Standard 3.04) and striving to benefit clients while minimizing harm (General Principle A- Beneficence and Nonmaleficence).

Competence and Culturally Competent Treatment

Many psychologists do not have direct training in or experience with providing services to UIC. However, it is an ethical imperative that psychologists practice only within the boundaries of their competence (Standard 2.01- Boundaries of Competence; APA, 2017). Competent practice involves both foundational knowledge and functional therapeutic skills (Rodolfa et al., 2005) and an ongoing process of applying these to specialized skill development, critical thinking, self-reflection, and self-modification (Kaslow, 2004; Rodolfa et al., 2005). Applying these components of competent practice to be relevant for UIC involves culturally competent treatment as a critical component of ethical care. Culturally competent treatment encompasses cultural knowledge, positive attitudes and beliefs toward culturally diverse clients, self-understanding of these attitudes and beliefs, and skillful use of culturally appropriate interventions (APA, 2013).

The knowledge and skills necessary to provide culturally competent treatment extend beyond rote knowledge and empathic care, and are acquired through appropriate training. Due to the unique experiences and needs of UIC, psychologists must obtain specific, targeted training to work effectively with this population (Torres Fernández et al., 2015).

Highlighting the importance of this is Standard 2.01 (Boundaries of Competence), which specifies that to work ethically and effectively in treatment contexts in which cultural and individual differences arise, “psychologists must have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services” (APA, 2017). A challenge is posed by the relative lack of interventions tailored to UIC (Franco, 2018; Unterhitzberger et al., 2015), as well as the fact that many psychologists have not previously encountered UIC and may avoid work with this group altogether due to lack of knowledge, training, or experience. Standard 2.01 also delineates that “in those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect clients/patients...from harm.” Thus, psychologists must take care to ensure their competence to the extent possible by carefully considering what existing treatments are the most appropriate for application to work with UIC and how to most effectively implement them. This includes seeking adequate and ongoing consultation, even after training and experience have been acquired.

In addition to acquiring competence, psychologists are ethically obligated to maintain competence (Standard 2.03- Maintaining Competence; APA, 2017). An intuitive component of this process is to stay abreast of new developments in the field and to continue to pursue additional training and consultation. In the case of UIC, current events and sociopolitical developments in an ever-changing political, social, cultural, and legal landscape represent external forces that impact UIC mental health (Barajas-Gonzalez et al., 2018; California Psychological Association [CPA]: Immigration Task Force, n.d.). Thus, maintaining awareness of current sociopolitical issues and immigration policy in addition to new developments in treatment itself is an essential component of competency in working with UIC. As such, work with this population may require an approach to maintaining competence that is perhaps more fluid and constant than it is for approaches to treatment with other groups.

Ensuring Competence of Colleagues.—Although it is ideal for services to be provided by bilingual, bicultural professionals (Torres Fernández et al., 2015), an interpreter or translator may be needed to facilitate treatment. Such an approach requires additional competencies, although most psychologists do not receive training in effectively utilizing interpreters in therapy (Singer & Fuentes, 2018). Using an interpreter also highlights the ethical issue of delegation of work to others, as Standard 2.05 directs psychologists who use the services of interpreters to both ensure the competence of the interpreter in terms of their education, training, experience, and supervision, and to avoid delegating work to an interpreter who has a multiple relationship with the client that could lead to exploitation or loss of objectivity (APA, 2017; Boness, 2016; Singer & Fuentes, 2018). Thus, use of an interpreter requires that the psychologist not only monitor their own competence, both in treatment itself and the integration of an interpreter into treatment, but also to monitor the competence of the interpreter with whom they are working.

Informed Consent

Psychologists are required to obtain informed consent about the nature and course of therapy from their clients “as early as is feasible in the therapeutic relationship” (Standard 10.01-Informed Consent to Therapy; APA, 2017). The process of informed consent requires special considerations for work with minors, who are, in general, incapable of autonomous consent. Standard 3.10 (Informed Consent) specifies that when a client is legally incapable of giving informed consent, psychologists must provide an appropriate explanation of services, seek assent, consider the client’s preferences and best interests, and obtain consent from a legally authorized person if permitted or required. While most UIC are teenagers rather than young children (ORR, 2018) and are therefore more likely to understand the implications of informed consent issues, their minor status and potential lack of an adult advocate who holds their best interest in mind places them in a position of vulnerability. General Principle E (Respect for People’s Rights and Dignity) highlights that, “special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making.” However, even when working with clients whose autonomy is impaired, psychologists seek to obtain assent and work to respect “the rights of individuals to privacy, confidentiality, and self-determination” (General Principle E- Respect for People’s Rights and Dignity).

Informed consent is an ethical concern of particular note with regard to the minor status of UIC under organizational care. Because UIC are not only unable to legally consent due to their minor status, but are also in the custody of Customs and Border Patrol, Office of Refugee Resettlement, or a community sponsor, the organization or adult holding custody is likely the entity consenting to their care. It is paramount that the psychologist accurately ascertains and clearly explains who the identified client is, as well as who has access to treatment records, and to do so in a developmentally appropriate way. Per Standard 3.11 (Psychological Services Delivered to or Through Organizations), “psychologists ...provide information beforehand to clients...about which of the individuals are clients...the relationship the psychologist will have with each person and the organization...who will have access to the information, and the limits of confidentiality” (APA, 2017). It is also recommended that psychologists inform UIC as to how long records will be kept and where they will be stored, as these issues are critical to explaining confidentiality and its limitations (Torres Fernández et al., 2015).

Linguistic Considerations in the Consent Process.—A notable consideration for providing ethical treatment to UIC is ensuring that materials and services are available in the appropriate language, both in terms of preferred language and developmental stage (Singer & Fuentes, 2018). Ideally, a bilingual therapist is available to accomplish this, but an interpreter may be necessary. Standard 3.09 states that, “when indicated and professionally appropriate, psychologists cooperate with other professionals in order to serve their clients/patients effectively and appropriately” (APA, 2017). Providing access to such services when a bilingual clinician is not available is the only way to ethically progress through the informed consent process with UIC, as Standard 3.10 (Informed Consent) mandates that informed consent must be obtained in language the client can “reasonably understand.” Psychologists must also “provide sufficient opportunity for the client/patient to ask questions

and receive answers (Standard 10.01- Informed Consent to Therapy), and an interpreter may, in some circumstances, be the only avenue by which to provide such opportunity. Further, providing access to interpretive services when therapeutically indicated is a necessary component of providing ethical and culturally competent care (Standard 2.01- Boundaries of Competence; APA, 2013; APA, 2017).

Confidentiality

Not only is confidentiality a primary obligation psychologists have to their clients, per Standard 4.01 (Maintaining Confidentiality; APA, 2017), but it is also widely viewed as a cornerstone of the therapeutic process (Fisher, 2008). Confidentiality is laden with challenging nuance when working with populations such as UIC, who are limited in their confidentiality rights by virtue of being both of minor status and under organizational care; further, their confidentiality is vulnerable due to their involvement in the legal system and the associated potential for the introduction of treatment records into court proceedings. Psychologists are bound by Standard 4.02 (Discussing the Limits of Confidentiality) to discuss these “relevant limits of confidentiality and the foreseeable uses of the information generated through their psychological activities” with UIC, regardless of their capacity to legally provide informed consent. Given the complexity of the circumstances surrounding work with UIC, the limits of confidentiality can be unclear and psychologists may find valuable assistance in consultation with legal representatives as a means of providing clients with the most accurate information.

Access to Records.—Psychologists have a responsibility to clarify the access professional agencies, government officials, and/or sponsors have to records (APA, 2017; Torres Fernández et al., 2015). The minor status and organizational involvement of UIC can entitle their legal guardian and, potentially, governmental entities to their records. As such, treatment records for UIC may be more widely accessible than for minor clients who are in the custody of their parent(s). This is an important consideration in balancing minimization of intrusions on privacy (Standard 4.04- Minimizing Intrusions on Privacy) with upholding record keeping guidelines (Standard 6.01- Documentation of Professional and Scientific Work and Maintenance of Records). Should an organizational entity hold custodial rights and/or facilitate services for UIC, it may be entitled to authorize disclosures and release records against the wishes of the UIC patient (Standard 4.05- Disclosures). With this in mind, psychologists should provide UIC with a description of how detailed treatment notes will be as a means of protecting confidentiality and minimizing intrusions on privacy. This is particularly important in light of the potential for treatment records to be introduced into future legal proceedings (Torres Fernández et al., 2015).

Financial Arrangements.—UIC are not eligible for federal healthcare coverage (Linton et al., 2017; Raymond-Flesch, Siemons, Pourat, Jacobs, & Brindis, 2014). As such, the cost of providing mental health services to UIC is often covered by state government organizations (Alvarez & Alegría, 2016; Linton et al., 2017). The issue of remuneration is intricately tied to confidentiality and access to records, and may entitle government agencies to access treatment records for UIC whose services they fund. For many citizen minors, payment is arranged simply with a legal guardian and/or third-party payor, such as an

insurance company, and operates under clear-cut guidelines of who may access treatment records and for what purpose. Conversely, the law surrounding ownership of UIC health records is muddy, at best. Thus, it is important for psychologists to be mindful in how they safeguard the confidentiality of their clients, including the language they apply in their clinical documentation (e.g., using “immigration status” rather than “illegal alien” or “undocumented” can help protect clients against subpoenas; CPA, n.d.).

Some services, such as the mental health evaluations UIC typically receive upon transfer from detainment facilities (ORR, 2015), may fall under the umbrella of third-party requests for services and therefore permit wider access to records. Psychologists are bound by Standard 3.07 (Third-Party Requests for Services) to “clarify at the outset of that service the nature of the relationship with all individuals or organizations involved,” including who the client is (APA, 2017). In such cases, UIC may, in fact, not be the clients. This is further complicated by the nature of the payor, such that the third-party is compensating the psychologist for services. Psychologists must be aware of the complexity that arises from the nature of the payment circumstances for UIC and how this dynamic dictates treatment record accessibility as a means of maintaining the confidentiality of UIC clients.

Assessment, Diagnosis, and Evaluation

Thorough assessment is critical to providing ethical treatment. Competent assessment of UIC should include not only relevant demographic and diagnostic batteries, but also background information on the individual and their family, as separation from family and the threat of deportation are often tied to symptom presentation (Barajas-Gonzalez et al., 2018). Standard 9.01 (Bases of Assessments) specifies that “psychologists base the opinions contained in their recommendations, reports, and statements, including forensic testimony, on information and techniques sufficient to substantiate their findings” (APA, 2017). The complex histories of UIC likely will require particular attention, and psychologists must be aware of what types of information to gather as a means of adequately assessing UIC clients, formulating accurate conceptualizations and diagnoses, and developing effective treatment plans. Psychologists must also be aware of the referral source and question, carefully considering the standards of mental-health based inadmissibility for residency applications and how their assessment reports could be harmful to their client’s immigration case should the assessment be requested for forensic testimony or should their records be subpoenaed.

Cultural and Linguistic Considerations.—Cultural considerations are important in assessment as well as intervention. Standard 9.02 (Use of Assessments) indicates that, “psychologists use assessment instruments whose validity and reliability have been established for use with members of the population tested” and that “psychologists use assessment methods that are appropriate to an individual’s language preference and competence, unless the use of an alternative language is relevant to the assessment issues” (APA, 2017). The issue of using valid and reliable tests, and using them in the appropriate language, highlights the intersection of a number of salient considerations in working with UIC: developmental stage, cultural considerations, and linguistic considerations. Standard assessment protocols may not be adequately normed in youth or individuals from non-US cultural backgrounds, nor translated and validated in languages other than English (Torres

Fernández et al., 2015). This creates challenges for providing ethical assessment to UIC, and highlights the importance of recognizing and describing the limitations of using such assessments (Standard 9.02- Use of Assessments).

Beyond administration of assessments, Standard 9.06 (Interpreting Assessment Results), states that, “when interpreting assessment results...psychologists take into account the purpose of the assessment as well as the various test factors...such as situational, personal, linguistic, and cultural differences, that might affect psychologists’ judgments or reduce the accuracy of their interpretations” (APA, 2017). In addition to integrating the cultural, linguistic, and contextual factors of UIC when interpreting assessments, it is important for psychologists to consider the substantial recent and ongoing trauma experienced by UIC when drawing conclusions. For example, conduct problems are common in UIC but may be more symptomatic of trauma than of an externalizing disorder per se (Barajas-Gonzalez et al., 2018; Franco, 2018; Torres Fernández et al., 2015). Such factors have the capacity to influence assessment interpretation, particularly in instruments that have not been established for use in UIC (Singer & Fuentes, 2018). In short, psychologists must be aware of the many complex individual and contextual factors influencing UIC when making diagnostic and evaluative determinations that guide the course of treatment, and must ensure that their potential biases do not influence assessment interpretation (General Principle E- Respect for People’s Rights and Dignity).

Balancing Demands of Ethics, Law, and Organizations

Psychologists are likely to encounter conflicts between their ethical responsibilities and the demands of organizations with which they work, as the organizations with which UIC are involved are not beholden to the Ethics Code. General Principle B (Fidelity and Responsibility) addresses the importance of cooperating with other professionals and organizations to best serve their clients (APA, 2017). The Ethics Code also makes clear that psychologists are to remain committed to its Standards when ethical responsibilities conflict with organizational demands (Standard 1.03- Conflicts Between Ethics and Organizational Demands) or with the law, regulations, or other governing legal authority (Standard 1.02- Conflicts Between Ethics and Law, Regulations, and Other Governing Legal Authority). Should such conflicts arise, psychologists are directed to clarify the conflict and attempt to resolve it in a manner consistent with the Ethics Code. Because the Ethics code permits concession to the law (Frey, 2016), it explicitly clarifies that legal regulation and organizational demands cannot be used to justify or defend human rights violations. UIC are particularly vulnerable to human rights violations (ACLU, 2018). An exemplary case is that of Office of Refugee Resettlement mental health providers, although not psychologists, forcibly injecting detained minors with psychotropic medication, threatening indefinite detainment to force compliance, and/or provoking anger to justify administering sedative medication (Smith & Bogado, 2018). While the organization may have demanded this treatment, such behavior is clearly in violation of Standard 1.03, among many others.

Public Statements and Advocacy

As more and more information surrounding the harmful experiences and conditions imposed on UIC comes to light (e.g., ACLU, 2018), the ethical responsibility of psychologists to

investigate, evaluate, and disseminate the long-term adverse impact of practices such as detainment on the mental health of immigrant youth has become a topic of discussion. For example, APA has released public statements against the detainment of children (Collier, 2015; APA, 2018) within the bounds of empirical evidence demonstrating its deleterious effects (Standard 2.04- Bases for Scientific and Professional Judgments; APA, 2017). With the field taking a definitive stance on the issue comes the question of the ethical responsibility of individual psychologists to assist in disseminating this position, engage in public discourse on the subject, and actively work to dismantle such policies (General Principle A- Beneficence and Nonmaleficence; APA, 2017). It has been suggested that psychologists educate the public only to the extent that it does not harm their professional relationships (Haeny, 2014).

Psychologists are guided by General Principle E (Respect for People's Rights and Dignity) to respect the dignity and worth of all individuals, to be aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities may impair autonomous decision making, and to not condone activities of others that are based upon prejudice (APA, 2017). This may be elaborated to the community and system levels, such that psychologists may demonstrate respect for rights and dignity and protect vulnerable communities, such as UIC, on a broader scale by opposing harmful practices, prejudicial policies, and systemic discrimination. Standard 5.04 (Media Presentations) mandates that, in providing public comments, psychologists take precautions to ensure that such statements align with the psychological literature and are consistent with the Ethics Code. This may limit the capacity for psychologists' involvement in public advocacy in some contexts, and psychologists should make such considerations while striving to provide culturally competent care that often entails advocacy in some form (Singer & Fuentes, 2018; Torres Fernández et al., 2015).

In considering taking on the role of an advocate, psychologists are guided by General Principle B (Fidelity) to "clarify their roles and obligations" (APA, 2017), and it is recommended that they assess the potential dual roles that can arise when acting as both a clinician and an advocate (Singer & Fuentes, 2018). However, General Principle D (Justice) encourages psychologists to recognize that all persons are entitled to "access to and to benefit from the contributions of psychology and to equal quality in the...services being conducted by psychologists"; this can be interpreted as advocacy for and promotion of treatment accessibility to underserved groups. Young immigrants without documentation are severely underserved in the US healthcare system (Linton et al., 2017; Raymond-Flesch et al., 2014), and it is important to work to reverse this trend as a means of promoting General Principle D (Justice). Further, promoting access to treatment is a core component of culturally competent care (APA, 2013) and it has been recommended that psychologists providing services to UIC be committed to social justice (Torres Fernández et al., 2015). With these considerations in mind, psychologists must also monitor their own biases associated with immigration policy, detainment of UIC, and treatment accessibility issues as a means of providing a course of treatment that is within the best interest of the client, promotes empowerment, and instills hope (APA, 2017; Singer & Fuentes, 2018; Torres Fernández et al., 2015).

Recommendations

The ethical issues addressed in this paper provide a starting point from which to conceptualize the nuanced issues relevant to working with UIC. Part of providing ethical care to UIC is applying professional standards, both aspirational and enforceable, to mitigate barriers to treatment; recognize, understand, and integrate intersectional aspects of identity; and provide culturally competent treatment while monitoring one's own self-awareness of personal identities and their impact on treatment (Singer & Fuentes, 2018). The following recommendations aim to support treatment providers and training programs in providing ethical, competent, and effective care to UIC.

1. APA should develop overarching professional guidelines for working with UIC, addressing the variety of contexts in which services are provided and the integration of interpreters into service provision. Until such guidelines are developed, psychologists should refer to the NLPA's Clinical Guidelines for working with unaccompanied asylum-seeking minors (Torres Fernández et al., 2015), APA's (2003) Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations, APA's (2013) updated report on working with immigrant-origin clients, APA's (2017) updated Multicultural Guidelines, and the Australian Psychological Society's (2013) Practice Guide for Working with Interpreters to develop an informed basis for working with UIC.
2. Training programs should develop and offer coursework for skill development in the areas of culturally competent therapy, bilingual therapy, and use of interpreters in therapy. Training programs may consider permitting language courses to be taken for credit to encourage more psychology trainees to become capable of providing bilingual services, particularly as the demand for these services increases.
3. Psychologists should continue to encourage, facilitate, and conduct research into effective treatments tailored to the needs of UIC, including promotion of culturally adaptive interventions and strengths-based approaches (APA, 2017). A systemic, ecological perspective (Bronfenbrenner, 1977) has been recommended for providing ethical and effective care to immigrant and refugee populations (APA, 2013; Singer & Fuentes, 2018). Using such an approach promotes General Principles D (Justice) and E (Respect for People's Rights and Dignity) by facilitating access to appropriate interventions, and considering and respecting individual differences such as age, race, ethnicity, culture, national origin, and language (APA, 2017; Barajas-Gonzalez et al., 2018; Singer & Fuentes, 2018).
4. Psychologists should address the inequities experienced by UIC through interventions rooted in social justice, as an important component of cultural competency and ethical treatment is acknowledgment of the power imbalance between UIC and the greater contextual system in which they live (APA, 2013; Singer & Fuentes, 2018). This type of social justice approach represents an

aspirational goal for psychologists in its relevance to General Principle E (Respect for People's Rights and Dignity; APA, 2017).

5. Psychologists should increase and maintain competence by engaging in ongoing education, training, consultation, and supervision. Psychologists should also acquire the knowledge and skills relevant to current standards of treatment for UIC.
6. Psychologists should develop and use assessments validated for use in UIC, and, if not possible, interpret the results within the confines of the limitations of the assessment's validated applications.
7. Psychologists should be aware of the importance of assessing personal bias, values, and beliefs, and how these can impact clinical work. Psychologists should not make assumptions about the experiences, values, beliefs, and traditions of UIC clients. The opportunity for clients to discuss these aspects of their identity should be integrated into treatment, and this information should be considered in case conceptualization and intervention implementation.
8. Psychologists should work in collaboration with agencies that provide services to UIC, such as legal aid and connection to social services (e.g., Refugee and Immigrant Center for Education and Legal Services [RAICES], Kids in Need of Defense). Psychologists should also advocate, to the extent possible, for systemic change in the accessibility and provision of healthcare services to UIC. This may include providing pro bono services to UIC.

Summary

UIC represent a growing population with ongoing and unmet needs for psychological services. As such, psychologists are increasingly likely to encounter opportunities to provide services to this population. Adequately and ethically serving a group such as UIC requires knowledge, skill, and training across a number of competencies. While issues of social justice are often viewed as within the purview of social work, it is becoming increasingly clear that psychologists are well-poised to contribute to service provision and advocate for accessibility of services within the scope of their practice as a means of upholding their ethical duties.

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