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MENTAL HEALTHCARE FOR IMMIGRANTS AND FIRST- GENERATION FAMILIES: ERASING THE STIGMA AND CREATING SOLUTIONS

CLAUDIA FENDIAN*

I. INTRODUCTION

In the U.S., one in four people suffer from some sort of mental illness.¹ Additionally, in the U.S., one in four people are immigrants or first-generation Americans.² Tens of millions of people in the U.S. are in need of mental healthcare resources, and many of them are immigrants or first-generation individuals.³ With immigrants facing their own set of unique challenges, it is safe to label mental health and healthcare, particularly for immigrants and first-generation Americans, as a topic of urgent discussion.

Although studies and scholarship analyzing the accessibility and use of mental healthcare services by immigrants, as compared to their U.S.-born

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1. *E.g.*, David Chorney, Note, *A Mental Health System in Crisis and Innovative Laws to Assuage the Problem*, 10 J. HEALTH & BIOMED. L. 215, 237 (2014) (citation omitted).

2. *See* Amelia Seraphia Derr, *Mental Health Service Use Among Immigrants in the United States: A Systematic Review*, 67 PSYCHIATRIC SERVS. 265, 265 (2016) (“Because immigrants and children of immigrants constitute 24 percent of the U.S. population, their mental health concerns have implications for the overall health of the nation.”); *see also* Jie Zong et al., *Frequently Requested Statistics on Immigrants and Immigration in the United States in 2016*, MIGRANT POL’Y INST. (Feb. 8, 2018), <https://www.migrationpolicy.org/article/frequently-requested-statistics-immigrants-and-immigration-united-states-2016> (“... immigrants in the United States and their U.S.-born children now number approximately . . . 27 percent of the overall U.S. population.”).

3. *See* Derr, *supra* note 2, at 265 (describing the mental health issues that many immigrants in the U.S. experience, including anxiety and depression from the changes in their life; also discussing the reasons that first generation immigrants are less likely to access the mental healthcare that they need).

counterparts, are less common, the consensus remains that immigrants are significantly less likely than nonimmigrants to know of, use, or take advantage of available mental healthcare resources.⁴ From this fact, two questions arise. First, what factors contribute to this disparity in access to and use of mental healthcare resources for immigrants? Second, what proactive, feasible policy changes can be implemented that may significantly bridge the gap between immigrants and their mental health treatment options?

This paper seeks to address both questions. First, along with other cultural norms and migration-related experiences, stigma is the number one cultural barrier to accessing mental healthcare resources facing immigrants and first-generation individuals.⁵ In addition to stigma, structural barriers such as environmental and systemic issues also uniquely affect immigrants and their ability to take advantage of mental healthcare resources.⁶ Such barriers include lack of insurance, cost of mental health services, and struggles with language.⁷ Second, specialized, immigrant-specific solutions need to be offered to immigrants and first-generation Americans to target their unique barriers and lack of access to resources. This can include a multitude of policy changes or expansion of current available options, including offering more digital and remote mental health resources, diversifying the professionals in the mental health field, and incentivizing more first-generation individuals to pursue careers focused on mental health. With forward-thinking and creative solutions, the gap between immigrants and first-generation individuals and mental healthcare resources in the U.S. can be bridged for good.

Part II of this paper details the circumstances experienced by many immigrants upon arrival in the U.S.⁸ This part sets the stage for immigrants with mental health issues and how they may proceed after settlement and acculturation. Part III addresses stigma, the most noteworthy barrier to mental healthcare resources for immigrants and within immigrant communities.⁹ Part IV discusses additional barriers immigrants face to mental healthcare, including a variety of systemic, racial and discriminatory, and financial barriers.¹⁰ Part V incorporates case study interviews of immigrants and first-generation individuals within the legal community to offer real-life perspectives and experiences related to mental health.¹¹ Lastly, Part VI provides recommendations and targeted policy changes that aim to mitigate the disparity between the growing number of

4. *Id.* at 269.

5. *Id.* at 268 (“Stigma was the most frequent cultural factor reported as a barrier to services.”).

6. *Id.* at 269.

7. *Id.*

8. *See infra* Part II.

9. *See infra* Part III.

10. *See infra* Part IV.

11. *See infra* Part V.

immigrants in the U.S. and their disproportionate access to and utilization of mental healthcare.¹²

II. CIRCUMSTANCES UPON ARRIVAL AND FIRST REACTIONS

Although no immigrant experiences one uniform set of circumstances upon arriving in the U.S., many experience similarities initially. For many, the immediate, obvious disparities are in linguistic and cultural literacy.¹³ Less than half of all immigrants to the U.S. have a good command of the English language upon arrival, and only about half of these immigrants have been able to take English classes in the U.S.¹⁴ While assimilation to U.S. society is the ultimate objective for most immigrants, it can be hard to reconcile physically abandoning one's country of origin and culturally safeguarding the values of that country.¹⁵ Close to 50 percent of immigrants regularly phone friends and family in their home country—even wiring money to these family members and friends on occasion—and remain up-to-date with current events in their country of origin.¹⁶

The other major disparity is financial. It is no secret within the immigrant community that finances can be the deciding factor regarding survival in the U.S. At least 80 percent of immigrants feel that “a person has to work very hard in [the U.S.] to make it” and that nothing is provided free of charge.¹⁷ Despite being willing to work hard,¹⁸ those with no visa or green card may find that jobs are not readily available. Difficulty in procuring a well-paying job with benefits such as health insurance can lead to extreme financial hardship. Yet, few are able to rely on public aid such as Medicaid or food stamps¹⁹ and fewer still are fortunate enough to receive free services or donations from a charity or church.²⁰ In fact,

12. *See infra* Part VI.

13. *See* Steve Farkas, *What Immigrants Say About Life in the United States*, MIGRATION POL'Y INST. (May 1, 2003), <https://www.migrationpolicy.org/article/what-immigrants-say-about-life-united-states> (examining how immigrants find it difficult to be understood and adjust to life in the U.S. without knowing English, exacerbated by only 37 percent feeling they have a good grasp of the language upon arrival).

14. *Id.*

15. The value systems in different parts of the world can often be in stark contrast of one another, leading immigrants in the U.S. to battle with reconciling two cultures. *See, e.g.*, Claudia Fendian, Note, *Now What? A New Direction for U.S. Businesses and Law in the Wake of the General Data Protection Regulation*, 29 S. CAL. INTERDISC. L.J. 129, 149–52 (2020) (noting that there are cultural differences between Europe and the U.S., specifically with regard to placing value on certain rights or privileges, that can sow unrest and tension between the two continents and subsequently their societies).

16. Farkas, *supra* note 13.

17. *Id.*

18. *Id.* (“Immigrants show deep commitment to [a strong] work ethic”).

19. *Id.* (“Only 18 percent [of immigrants] report that they or their families had received food stamps.”).

20. *Id.* (“Fewer (10 percent) [immigrants] say they had received donations or free services from a charity or church.”).

some immigrants are desperate for U.S. citizenship in part because they could qualify for government aid programs.²¹

Thus, struggles with language, acculturation, and finances—among others—impede the path to U.S. citizenship and assimilation for most immigrants.²² These struggles are furthered by pervasive discrimination and exposure to anti-immigrant rhetoric.²³ “As a foreign-born population, immigrants . . . are frequently exposed to stigmatizing language in political and social discourse in today’s anti-immigrant climate.”²⁴ Being on the receiving end of a disproportionate amount of discriminatory language and behavior, immigrants become further marginalized in American society and can be significantly more likely to experience emotional distress.²⁵

To add to these challenges, the predicament of identifying and addressing mental health issues could be considered a suicide mission for many; when the metaphorical plate in front of oneself already overflows with roadblocks to a comfortable life in the U.S., mental healthcare can be the last thing on a person’s agenda of challenges to overcome.

III. ANALYSIS OF STIGMA

Although stigma surrounding mental healthcare is a barrier experienced by many in the U.S. and not just by immigrants or first-generation Americans, it is a particularly impactful barrier to accessibility of mental healthcare resources for immigrants specifically because stigma is often heightened in foreign cultures.²⁶ Stigma and cultural norms about mental health are the most frequent cultural barrier to accessing mental healthcare services.²⁷

In a study by Amelia S. Derr of multiple ethnicities and cultural groups, nearly every immigrant group reported stigma as the most pervasive barrier to mental healthcare.²⁸ Traditional beliefs held by many cultures about mental health point to many misconceptions and stigma, such as that “only crazy people seek mental healthcare.”²⁹ Because cultural stigma is more persistent in

21. *See id.* (“Twenty-two percent say that qualifying for government programs like Medicaid or food stamps is or was a major reason for them to become a citizen.”).

22. Kai Wei et al., *The Role of Language in Anti-Immigrant Prejudice: What Can We Learn from Immigrants’ Historical Experiences?*, 8 SOC. SCI. 93, 93–94, 96 (2019).

23. *Id.* at 94.

24. *Id.* at 93; *see also* Katherine Ponte, *Mental Health Challenges in Immigrant Communities*, NAT’L ALLIANCE ON MENTAL ILLNESS (July 22, 2019), <https://www.nami.org/Blogs/NAMI-Blog/July-2019/Mental-Health-Challenges-in-Immigrant-Communities> (“Immigrant communities encounter many challenges including discrimination such as being told to ‘go back to your own country’ . . .”).

25. Wei et al., *supra* note 22, at 94.

26. Derr, *supra* note 2, at 268.

27. *Id.*

28. *Id.*

29. *Id.*

immigrants and first-generation Americans than in individuals whose families have been in the U.S. for multiple generations, immigrants from a given cultural background can be up to 40 percent less able to access mental healthcare resources than individuals from the same cultural background whose families have been in the U.S. for multiple generations.³⁰ As a result, immigrants are particularly susceptible to multiple sources of stigma, including external stigma from their ethnic group, immediate family members, and friends.³¹ Additionally, immigrants also face internal stigma stemming from a culturally-reinforced obligation to manage stressors, emotions, and mental concerns on an individual level.³² As a result, immigrants with mental health conditions often feel even more isolated than their U.S.-born counterparts do.³³ In fact, a Canadian study led by Bukola Salami emphasized that shame and stigma overwhelm immigrants and can dissuade them from seeking out mental healthcare.³⁴ The study notes that even if immigrants:

acknowledge they have a problem[,] they will not seek mental health support because they feel ashamed doing that . . . [and] they still feel that people who go to ask for mental health services or treatment are kind of crazy. They don't want to acknowledge that. Even if they do, it is still in secret. They don't mention it even in front of their family members.³⁵

Thus, family members may not even become aware of a mental health condition of an immigrant loved one.³⁶ And, even if the immigrant's family is made aware, they may feel the need to conceal the information from members of their ethnic community because the stigma reaches beyond the afflicted immigrant.³⁷ Often, family members of an immigrant with mental illness are ashamed and may say, "[o]h you know he's sick, he has back pain, he has some chronic disease but it's not a mental health issue."³⁸ Immigrants are already low within the social hierarchy, so the stigmatization accompanying a mental illness or a family

30. *Id.* at 266.

31. Bukola Salami et al., *Access and Utilization of Mental Health Services for Immigrants and Refugees: Perspectives of Immigrant Service Providers*, 28 INT'L J. MENTAL HEALTH NURSING 152, 155 (2019).

32. *Id.*

33. *See id.* (discussing different experiences with clients seeking therapy to understand that asking for and receiving help is acceptable, as immigrant communities lacked these discussions and recognition).

34. *See id.* (noting that immigrants will actively avoid seeking mental health treatment if they are aware that they need help because of the perceived shame of doing so).

35. *Id.*

36. *Id.*

37. *Id.*

38. *Id.*

member with mental illness “could mean loss of social status, social exclusion and discrimination.”³⁹

Beyond traditional immigrants who often migrate with their families and settle into ethnic communities with similar cultural and world views, stigma particularly affects nontraditional immigrants. These include immigrants who may have migrated illegally, by themselves, or to an area where there are little or no other culturally or ethnically similar individuals.⁴⁰ If an immigrant has worked tirelessly to acclimate to a new country and seek out members of a similar ethnic community, the risk of stigmatization resulting from mental illness can seem too great after such efforts.

Immigrants from varying cultural backgrounds experience different degrees of stigma toward mental health. Though it is not entirely clear why some cultures experience heightened stigma compared to others, several factors can be considered. First, cultures with strongly defined gender roles can perpetuate heightened levels of stigma surrounding mental health.⁴¹ In strongly patriarchal cultures, men and women may be expected to conform to certain traditional roles that would dissuade them from expressing mental health concerns.⁴² Women who express emotional or mental health concerns are quickly dismissed as they may be expected to simply fulfill household duties without complaint or hiccup.⁴³ Men who express such concerns may be shunned for defying the cultural community perception that men are the strong leaders of their families and communities who cannot be seen as “weak” in any way.⁴⁴

Furthermore, there may be sub-cultural differences resulting from differences in geography or community size. Even if an immigrant comes from a cultural background unlike the aforementioned patriarchal society, certain cultural lifestyles can lead to similar outcomes. Consider the following hypothetical: two immigrants from the same country with the same cultural values and religious views arrive in the U.S., but one comes from a highly populated major city in the country of origin and the other comes from a rural area with a small, tightly-knit community. All other factors being equal, the immigrant from the rural area will almost certainly face greater stigma

39. *Id.*

40. See Abby Budiman, *Key Findings about U.S. Immigrants*, PEW RES. CTR.: FACTTANK (Aug. 20, 2020), <https://www.pewresearch.org/fact-tank/2020/08/20/key-findings-about-u-s-immigrants/>. Although the majority of immigrants are legal, traditional immigrants to the U.S., 23 percent are unauthorized and fall within the category of “nontraditional” immigrants. *Id.* Three million additional migrants arrive to the U.S. as refugees, another “nontraditional” type of immigrant. *Id.* Furthermore, over 50 percent of immigrants settle in one of three states—California, Florida, and Texas; those who settle outside these states or in regions where there are fewer immigrants in general can also be considered “nontraditional” immigrants. *Id.*

41. Ponte, *supra* note 24.

42. *Id.*

43. *Id.*

44. *Id.*

surrounding mental health because of the closeness of the community and the weight of its expectations.⁴⁵ In a close-knit community or among extended family members, gossip can be abundant because everyone is at least acquainted with one another.⁴⁶ This facilitates behaviors such as being more guarded or secretive, and refraining from discussing potential health concerns with others.⁴⁷

Ultimately, stigma and lack of knowledge about mental illness can create nearly insurmountable barriers to mental healthcare access for immigrants and first-generation Americans.⁴⁸ Cultural traditions and values encourage stigmatization of mental health;⁴⁹ this can be difficult to counteract when an immigrant has recently migrated to the U.S., a place where, although stigma persists, mental health is treated with more respect and understanding.⁵⁰

IV. ADDITIONAL BARRIERS AND CONSIDERATIONS

In addition to stigma, immigrants and first-generation individuals face unique challenges that can impact mental health. For immigrants, this may include language barriers and adjusting to cultural changes.⁵¹ For first-generation individuals, this includes heightened discrimination, peer aggression, and socioeconomic disadvantage.⁵²

A. Language and Acculturation

After stigma, Salami's study identified linguistic and cultural differences as one of the most significant barriers to immigrants' access to mental healthcare.⁵³ For example:

Many mental health programs, service providers, don't speak the language of newcomers and that is a big issue. When newcomers finally acknowledge that they have an issue and they want to see a psychiatrist or a psychologist[,] somebody else has to go with them to

45. *Id.* (highlighting differences among immigrant communities).

46. *Id.* ("Family members also heavily gossiped in our close-knit community. . . .").

47. *Id.* ("Talking about mental health outside the home was prohibited. Family members also heavily gossiped in our close-knit community, causing people to be guarded or secretive.").

48. Salami et al., *supra* note 31, at 158 (citations omitted).

49. *See id.* at 158.

50. *See* Nicole Spector, *Mental Health: How We've Improved and Where We Need to Do Better in 2020*, NBC NEWS (Jan. 10, 2020, 3:53 PM), <https://www.nbcnews.com/better/lifestyle/mental-health-how-we-ve-improved-where-we-need-to-ncna1108721> ("[O]ver the course of the past decade, there's been increased willingness to recognize mental health as an essential part of one's well-being.").

51. Nicole Filion et al., *Immigration, Citizenship, and the Mental Health of Adolescents*, 13 PLOS ONE, May 3, 2018, at 1, 2 (citation omitted).

52. *Id.* (citation omitted).

53. Salami, et al., *supra* note 31, at 154.

translate[,] and then you have to wait for that somebody to be available.⁵⁴

It can be challenging to seek mental health treatment for an immigrant if he or she lacks the requisite English language fluency skills needed to communicate with mental health professionals⁵⁵ or to even commence the process of searching for mental healthcare resources.⁵⁶

Additionally, a significant part of successful mental healthcare treatment is receiving support from family, friends, and social groups.⁵⁷ In fact, the “[l]ack of social support . . . that often accompan[ies] the migration and settlement process ha[s] been found to exacerbate mental ill health.”⁵⁸ Moreover, “[i]mmigrants might have less access to social supports and underutilize mental health services . . . due to language difficulties”⁵⁹ Being unable to communicate freely in English can have detrimental effects on immigrants’ abilities to interact with both mental healthcare professionals and their peers.⁶⁰ Adjusting to English and achieving the fluency needed to adequately express oneself to a mental health professional can be a time-consuming process. Waiting to seek out mental healthcare until a certain level of language fluency has been achieved can be detrimental to one’s mental health and further aggravate existing mental illness.

Even if an immigrant has mastered the English language, he or she faces cultural difficulties that can present further challenges to accessing mental healthcare. This is referred to as acculturation, defined by Dr. Elysha Greenberg and Arialda Fejzic as follows:

Acculturation is a multidimensional process that may occur in stages and can be psychological and behavioral. It refers to the process of adaptation, or lack thereof, which occurs when two cultures come into contact with one another. This adaptation process is one of the central tasks for immigrants and refugees. Immigrant and refugee families must learn to function in new cultures and make major adjustments. Often this process comes with the added burden of finding adequate

54. *Id.*

55. *Id.*

56. Elysha Greenberg & Arialda Fejzic, *Immigrant and Refugee Mental Health*, WILLIAM JAMES C. INTERFACE REFERRAL SERV., <https://interface.williamjames.edu/topic/immigrant-refugee-mental-health> (last visited Dec. 1, 2020) (“ . . . the language barrier impacts refugee and immigrant individuals and families’ abilities to receive proper health care.”).

57. See Usha George et al., *Immigrant Mental Health, A Public Health Issue: Looking Back and Moving Forward*, 12 INT’L J. ENVTL. RES. & PUB. HEALTH 13624, 13629 (2015) (noting that lack of social support tends to exacerbate mental health issues).

58. *Id.*

59. *Id.* at 13630.

60. See *id.* (“Proficiency in English as well as participation in cultural activities have been found to be positively associated with social competence”).

resources for basic needs. Adjusting to a new society and managing challenging financial situations can be a particularly difficult experience This difficulty with acculturation often exacerbates mental health issues⁶¹

In addition to language and stigma, acculturation to western lifestyles leads to significant consequences for immigrants who need to access mental health resources.⁶² Like stigma, the pressures of acculturation force immigrants into a situation of competing and conflicting identities.⁶³ For immigrants in the U.S., acculturation presents the challenge of adjusting to not only general cultural differences but also specific cultural attitudes toward mental health. Even if immigrants can successfully acculturate, their ethnic background and cultural experiences have influenced their mental state and largely still define who they are. Mental health professionals and peers who fail to understand the cultural differences immigrants experience and the acculturation process they must endure cannot adequately help immigrants address their mental health. “[P]eople are less likely to seek help if they think their doctor can’t understand or empathize with their background or cultural differences and experiences.”⁶⁴ Thus, different linguistic and cultural backgrounds serve as powerful barriers to immigrants’ access to mental healthcare.

B. Other Barriers

Stigma and acculturation account for much of the difficulty immigrants experience in accessing mental healthcare, but a multitude of other barriers exacerbate the situation. The following analysis showcases some of the additional prevalent barriers, notably lack of insurance, fear of deportation, economic disadvantages, and discrimination and bias.

1. Lack of Insurance

One of the most common barriers to mental healthcare cited by immigrants is lack of insurance.⁶⁵ The question of insurance remains unanswered for many in the U.S.—both immigrants and citizens alike.⁶⁶ For example, in 2018, close to

61. Greenberg & Fejzic, *supra* note 56.

62. George et al., *supra* note 57, at 13629.

63. *Id.*

64. *Top 5 Barriers to Mental Healthcare Access*, SOC. SOLS.: SOC. SOLS. BLOG, <https://www.socialsolutions.com/blog/barriers-to-mental-healthcare-access/> (last visited Dec. 1, 2020).

65. See Derr, *supra* note 2, at 269 (indicating in Table 3 that lack of insurance was the most cited barrier to mental healthcare for immigrants).

66. Insurance reform in the U.S. is beyond the scope of this paper, but it is worth noting that political factions in the U.S. have repeatedly debated the issue of healthcare and insurance and how to best meet the medical needs of U.S. citizens and immigrants. For further reading on healthcare policy and debates in the U.S., see Cindy Jajich-Toth & Burns W. Roper, *Americans’ Views on Health Care: A*

10 percent of all people in the U.S. had no health insurance.⁶⁷ Lack of health insurance can mean that mental healthcare is almost impossible to access. Even those with health insurance can find themselves struggling to access mental healthcare because of the limited services covered by a given policy.⁶⁸ This can be a result of the type of plan an insured person carries. For example, many private plans with expensive premiums are more inclusive.⁶⁹ Because of the cost associated with private plans, policyholders can often afford more tailored and consistent mental healthcare. Yet one-third of the insured U.S. population are insured through a public healthcare plan (e.g., Medicaid).⁷⁰ For many people insured through such a public plan, “[c]ommunity-based mainstream mental health services are . . . not always covered by public health insurance” and can be too expensive to pay for out-of-pocket.⁷¹

Access to health insurance is a particularly complex barrier to mitigate for many immigrants because of citizenship status. An immigrant who is in the U.S. illegally or is in the process of applying for or obtaining a green card may not have the same employment opportunities as a U.S. citizen.⁷² As a result, forgoing more stable jobs with employers who can afford to provide employees with a private health insurance plan forces many immigrants to choose between subscribing to a limited public plan or remaining uninsured entirely. Legal status may prevent some from subscribing to a public plan, and even those who are able to secure coverage may be hesitant to do so out of fear of being deported.⁷³

Study in Contradictions, 9 HEALTH AFF. 149 (1990) (discussing American views on healthcare policy) and Matthew Fiedler & Christen Linke Young, *Current Debates in Health Care Policy*, BROOKINGS: VITALS (Oct. 15, 2019), <https://www.brookings.edu/policy2020/votervital/current-debates-in-health-care-policy-a-brief-overview/> (discussing how to fund health care costs and increase coverage).

67. EDWARD R. BERCHICK ET AL., U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2018 2 (2019), <https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf> (“In 2018, 8.5 percent of people, or 27.5 million, did not have health insurance at any point during the year.”).

68. Guin Becker Bogusz, *Health Insurers Still Don’t Adequately Cover Mental Health Treatment*, NAT’L ALL. ON MENTAL ILLNESS (Mar. 13, 2020), <https://www.nami.org/Blogs/NAMI-Blog/March-2020/Health-Insurers-Still-Don-t-Adequately-Cover-Mental-Health-Treatment>.

69. *See generally id.*

70. BERCHICK ET AL., *supra* note 67, at 2, 3.

71. Salami et al. *supra* note 31, at 156.

72. *See* Octavio Blanco, *Immigrant Workers Are Most Likely to Have These Jobs*, CNN BUS. (Mar. 16, 2017, 7:30 PM), <https://money.cnn.com/2017/03/16/news/economy/immigrant-workers-jobs/index.html> (giving an overview of typical jobs immigrants have and how they compare to employment of citizens or multi-generation Americans).

73. SONAL AMBEGAOKAR, NAT’L HEALTH L. PROGRAM, OPPORTUNITIES FOR MAXIMIZING REVENUE AND ACCESS TO CARE FOR IMMIGRANT POPULATION 1–4, <https://www.astho.org/Public-Policy/Public-Health-Law/Access-to-Care-for-Immigrant-Populations-Overview/> (last visited Dec. 1, 2020).

2. *Fear of Deportation*

Fear of deportation is a barrier that manifests in several ways. First, fear of deportation can lead an immigrant—particularly when his or her citizenship status is in flux—to refrain from enrolling in a public health insurance plan. In at least one study, researchers found that immigrants were afraid to seek healthcare or mental health services because they feared doing so would lead to deportation based on their immigration status.⁷⁴

Second, immigrants have a heightened awareness of the requirement that they be desirable and able to contribute to U.S. society. For many immigrants, their ability to stay in the U.S. depends on their usefulness to American society.⁷⁵ Some immigrants may only be allowed to remain in the U.S. because of a certain skillset or mental or physical competence.⁷⁶ Many immigrants fear that a mental health diagnosis or treatment would jeopardize their ability to remain in the country.⁷⁷ In one study, an immigrant described the feeling of being constantly consumed by “the fear of being deported or [that] somehow . . . [their] immigration status would be compromised if [they are] diagnosed with mental illness.”⁷⁸ This fear is paralyzing for most; in general, immigrants would rather suffer in silence with a mental illness than seek treatment and risk deportation.⁷⁹ Lack of information perpetuates this problem; many immigrants who are unaware of how the various parts of the government interact with one another fear that once a health condition is diagnosed, the information is instantly in a government record of some sort that can target them when deportations occur.⁸⁰

Thus, the fear of deportation can prevent immigrants (1) who are uninsured from seeking out and subscribing to a public healthcare plan, and (2) who are already insured from seeking out mental healthcare services altogether. Consequently, fear of deportation is one of the most destructive barriers to mental healthcare for immigrants.

74. See Derr, *supra* note 2, at 269.

75. See AM. IMMIGR. COUNCIL, DEFINING “DESIRABLE” IMMIGRANTS: WHAT LIES BENEATH THE PROPOSED MERIT-BASED POINT SYSTEM? 1 (Mar. 2013), https://www.americanimmigrationcouncil.org/sites/default/files/research/defining_desirable_immigrants_what_lies_beneath_the_proposed_merit-based_point_system.pdf (“ . . . a minimum of 120,000 foreign-born people would be able to obtain immigrant visas each year by accumulating points mainly based on their skills, employment history, and education credentials.”).

76. *Id.* at 1–4 (noting that immigrants can obtain employment visas by “accumulating points mainly based on their skills, employment history, and education credentials.”).

77. See Salami et al., *supra* note 31, at 155.

78. *Id.*

79. See, e.g., *id.* (explaining that immigrant services providers reported immigrants feared seeking mental health treatment because they worried that they may lose custody of their children or face other negative societal repercussions).

80. See *id.* (“Especially in the hospitals and the health system, you go and then the information would be entered. So, they feel like once it’s entered it’s everywhere.”).

3. *Economic Disadvantages*

An immigrant or first-generation American may experience economic hardship upon arrival to the U.S., which may prevent him or her from even considering mental healthcare. It is no secret that immigrants often face prolonged periods of low socioeconomic status upon arrival in the U.S.⁸¹ Paired with other barriers such as lack of insurance, this forces immigrants and first-generation Americans to prioritize feeding their families over addressing their mental health needs.⁸² In one study, several immigrants cited the need to pay bills and rent as barriers to mental healthcare.⁸³ Unless mental healthcare is covered by a health insurance plan, few immigrants are willing to pay as much as two hundred dollars per hour to “talk to a stranger” when they are facing more dire responsibilities.⁸⁴

4. *Discrimination and Bias*

Assuming that an immigrant or first-generation American can overcome all the aforementioned barriers and seeks out and successfully obtains mental healthcare, they are often faced with yet another barrier: discrimination and bias.⁸⁵ This is different from stigma in that the discrimination is experienced at the point of obtaining mental healthcare, rather than from peers or one’s cultural community after obtaining treatment. Currently, many mental healthcare professionals are not equipped to mitigate immigrant-specific barriers such as language and cultural differences.⁸⁶ This can contribute to experiences of racism and discrimination.⁸⁷

Enduring the mental exercise of prioritizing one’s mental health and summoning the courage to successfully seek out treatment can be futile if the individual experiences feelings of discrimination during treatment. Furthermore, these instances of discrimination can have long-lasting, detrimental effects. A study led by Su Yeong Kim notes that there is “evidence that parental experiences of discrimination influence the mental health of children of

81. *E.g.*, George et al., *supra* note 57, at 13631 (noting that immigrants to Canada also experience a prolonged period of lower socioeconomic status).

82. *See* Salami et al., *supra* note 31, at 156 (explaining that Canadian immigrants often prioritize the immediate needs of their families over their own mental health).

83. *See id.*

84. *See id.*

85. While discrimination and bias can be felt across societal groups, it is important to emphasize that discrimination is a particularly more intense and prevalent issue for immigrants and first-generation Americans. “First generation immigrants are more likely than non-immigrant U.S.-citizens and second or third generation immigrants to experience discrimination, peer aggression and socioeconomic disadvantage, factors that have been shown to decrease psychosocial wellbeing.” Filion et al., *supra* note 51, at 2.

86. Derr, *supra* note 2, at 6–7.

87. *See* George et al., *supra* note 57, at 13632 (“Racial discrimination has been found to be an important risk factor for the mental health of diverse immigrant groups.”).

immigrants.”⁸⁸ Describing the impact of parental experiences of discrimination on children, the study further notes that, “[t]he intergenerational transmission of parents’ discrimination experiences can have an indirect influence on adolescent mental health through erosion of family processes.”⁸⁹ Many may be unaware of the risk of discrimination during treatment, let alone the risk of hurting loved ones indirectly through such experience. And for parents who are aware of the damaging effects even indirect experiences of discrimination can have on their children and families, the risk of experiencing discrimination through mental healthcare treatment may be enough to deter them from seeking out treatment in the first place.

V. CASE STUDIES

After understanding and analyzing the various immigrant-specific barriers to mental healthcare, it is important to learn whether the described experiences of immigrants and first-generation Americans are synonymous with their actual experiences. To this end, interviews were conducted with several immigrants and first-generation Americans within the legal community, soliciting their sentiments on mental healthcare, stigma, other barriers, and possible solutions.⁹⁰ Overall, every interviewee echoed what this paper has articulated thus far, with many identifying barriers, issues, and cultural stigmas that scholars and research studies have not yet contemplated.⁹¹

Interviewees gave examples of barriers like language and shared personal experiences with this particular barrier.⁹² For example, one interviewee who had been seeking therapy in her home country had trouble continuing treatment upon arriving in the U.S.⁹³ She noted that she hesitated to start therapy in the U.S. because she could not imagine herself going to therapy and speaking in English.⁹⁴ She noted a particular difficulty with expressing certain cultural norms and linguistic mannerisms and doing so in a language other than her native tongue.⁹⁵ She said that while a simultaneous translator can be helpful, “not only a literal translation but also a cultural translation” is required.⁹⁶ Additionally, she touched

88. Su Yeong Kim et al., *Culture’s Influence on Stressors, Parental Socialization, and Developmental Processes in the Mental Health of Children of Immigrants*, 14 ANN. REV. CLINICAL PSYCHOL. 343, 352 (2018).

89. *Id.*

90. The interviews were limited to members of the legal community, as they have a heightened level of awareness and expertise regarding systemic problems and the feasibility of possible solutions.

91. Interview with Daniela Hernandez, Staff Att’y, Immigrant Defs. Law Ctr., in L.A., Cal. (Nov. 14, 2019) (recording on file with author) [hereinafter D.H. Interview].

92. *Id.*

93. *Id.*

94. *Id.*

95. *Id.*

96. *Id.*

upon other barriers such as economic disadvantage and lack of insurance, stating that despite the fact her insurance partially covers mental healthcare, she has had to pause her treatment in the U.S. for upwards of six weeks because reimbursements from the insurance company were not being processed quickly enough.⁹⁷

Overwhelmingly, however, the discussion with interviewees centered around heightened cultural stigma toward mental healthcare in immigrant and first-generation families. Interviewees expressed that it can be hard to override the pre-existing notions toward mental health ingrained by one's culture—even after being in the U.S. for decades.⁹⁸ Multiple interviewees noted that the simple availability of resources and mental healthcare is insufficient and that “people need to want to be treated.”⁹⁹ One interviewee stated that “it's not enough to refer [a] person to services [and] it's not enough for the services to be available,”¹⁰⁰ and another echoed that, because of the general attitude toward mental health in her culture, she may not seek out mental healthcare resources if she needed them because she may not be able to recognize at a fundamental level that she is experiencing a mental health problem.¹⁰¹ One went further by noting that even if he were able to self-identify a mental health issue, he would conduct a cost-benefit analysis of sorts to determine whether treatment is truly necessary, and stated that “even now, a lot of things that are troubling me psychologically; I feel like I should be able to just somehow work through it [on my own] because I got [sic] so far without using any of the mental health resources.”¹⁰²

In conclusion, the consensus across all interviewees was that the mere existence of a conversation surrounding mental health is a step in the right direction.¹⁰³ One interviewee expressed the thought that her home country has no one with mental health issues because the topic is never discussed.¹⁰⁴ Even if mental health is not viewed negatively, the topic is simply not one which would enter the realm of discussion.¹⁰⁵ Because of this, the topic of mental health can be met with fervent stigma in many immigrant communities.¹⁰⁶ One interviewee

97. *Id.*

98. *E.g.*, Interview with Jin Oh, Assoc. Att'y, Goldberg Segalla, in L.A., Cal. (Nov. 11, 2019) (recording on file with author) [hereinafter J.O. Interview].

99. D.H. Interview, *supra* note 91.

100. *Id.*

101. J.O. Interview, *supra* note 98.

102. Interview with Eunsuk Yang, J.D., Univ. of S. Cal., in L.A., Cal. (Nov. 8, 2019) (recording on file with author) [hereinafter E.Y. Interview] (noting that, in his home country, mental health is “not something that needs an intervention or outside assistance” such as psychological counseling).

103. *Id.*; J.O. Interview, *supra* note 98; D.H. Interview, *supra* note 91.

104. Interview with Maria Lyutskanova, LL.M., Univ. of S. Cal., in L.A., Cal. (Nov. 6, 2019) (recording on file with author).

105. J.O. Interview, *supra* note 98.

106. *E.g.*, D.H. Interview, *supra* note 91 (speculating that mental illness is more stigmatized outside of the U.S. because within the U.S., it is at least part of the public debate).

stated that even if the conversation surrounding mental health and healthcare is “not as loud as it should be,” at least it exists in the public sphere.¹⁰⁷ With regard to furthering the discussion in the U.S. and finding ways to help immigrants and first-generation Americans in particular, one interviewee suggested an emergency room equivalent for mental healthcare¹⁰⁸—where no one could be refused treatment in an emergency situation based on lack of insurance or inability to pay¹⁰⁹—and another emphasized the need for diversity, speculating that seeing more people like oneself within the mental health arena would encourage one to explore and consider it further.¹¹⁰

VI. PROPOSED SOLUTIONS

This paper proposes a three-pronged solution for combatting the described barriers to mental healthcare for immigrants and first-generation Americans: first, tackle stigma as the most pervasive and inhibiting barrier; next, increase the availability of immigrant-specific resources; and finally, encourage the continued growth and development of the mental healthcare field through incentives and cultural diversity.

A. Address the Stigma First

Even beyond immigrant and first-generation American populations, addressing stigma surrounding mental health is challenging.¹¹¹ So far, “[t]here remains little evidence of successful approaches to addressing stigma, especially in culturally and linguistically diverse groups, both self-stigma that relates to internalizing negative perceptions of self and public stigma that relates to discrimination and the tangible impacts on a person’s life.”¹¹² This is due in part to the fact that traditional “[b]eliefs and perceptions of mental illness . . . not recognizing mental illness as a valid condition” are part of cultural identities.¹¹³ It is subsequently challenging—and arguably unfair—to ask an immigrant to the U.S. to, in essence, reject part of his or her cultural values or understanding of mental health and treatment.¹¹⁴ Thus, rather than a rejection of cultural traditions, a possible solution is a reframing of mental health and its significance.¹¹⁵

107. *Id.*

108. E.Y. Interview, *supra* note 102.

109. *Id.*

110. J.O. Interview, *supra* note 98.

111. Salami et al., *supra* note 31, at 158 (citation omitted).

112. *Id.* (citation omitted).

113. *Id.* (citation omitted).

114. *See id.* (discussing the challenges of reducing mental illness stigma in culturally and linguistically diverse groups).

115. *See id.* (discussing the use of cultural brokers as a means of reducing mental health stigma through awareness).

Members of ethnic communities who have successfully sought out mental healthcare, and are comfortable speaking about the subject, can play a critical role in stepping up and raising awareness.¹¹⁶ These community members can help destigmatize mental healthcare by framing it as a necessary component of success in the U.S.¹¹⁷ For example, an immigrant who has resided in the U.S. for some time is better acclimated and likely living more comfortably than more recent immigrants from the same cultural or ethnic community.¹¹⁸ If the immigrant who is more established can frame mental healthcare as essential to his or her success in the U.S., he or she may engender comfort surrounding the topic and perhaps inspire fellow members of the community to address their own mental health concerns. A community leader with status and a comfortable lifestyle who can assert that mental health treatment is a significant factor of his or her success can help reduce public stigmatization across his or her community.¹¹⁹ Mitigating external stigma can reduce both externally and internally felt stigma about mental health.¹²⁰ Immigrants will likely be less averse toward mental healthcare if they believe addressing mental illness will help them advance in U.S. society.

A change in mindset and perspective cannot happen overnight.¹²¹ But even if the change is slow, it can be effective.¹²² Beyond the initial step of admitting to oneself that one has a mental illness, fears surrounding the seriousness of the illness, the necessary treatments, and the potential effects on one's ability to succeed and "make it" in the U.S. can be crippling.¹²³ Using community members as success stories to encourage a collective acceptance of mental health would take away much of the mystery and uncertainty immigrants feel regarding mental health.

Stigma can also be alleviated at the initial stages of immigration by means of the U.S. government. When an immigrant is first considering a move to the

116. Patrick W. Corrigan et al., *The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care*, 15 PSYCH. SCI. PUB. INT. 37, 45, 51 (2014).

117. *Id.* at 51.

118. *See id.* at 45 (discussing how stigma interacts with other "socially important topics categories such as culture and ethnicity").

119. *See* Patrick W. Corrigan & Amy C. Watson, *Understanding the Impact of Stigma on People with Mental Illness*, 1 WORLD PSYCHIATRY 16, 17 (2002) (noting that interaction and contact with community members who are successful despite mental illness helps diminish stigma).

120. *See id.* at 16–18 (explaining that stereotype, prejudice, and discrimination perpetuate both public and self-stigma).

121. *See* Corrigan, et al., *supra* note 116, at 50–51 (discussing how the use of public programs to enhance mental health education involves a multi-faceted approach that requires prolonged efforts to affect stigma toward mental illness).

122. *See id.* (finding that campaigns to reduce public stigma of mental illness correspond with increases in mental health providers in virtual and physical settings).

123. *See* Salami et al., *supra* note 31, at 155 (noting that immigrants fear negative repercussions when experiencing "significant mental health symptoms" or a potential diagnosis).

U.S., he or she has to undergo an extensive process of paperwork, interviews, and more.¹²⁴ Throughout the immigration process, and particularly once an immigrant has been approved for entry in the U.S., the U.S. government should emphasize the importance of mental healthcare and the availability of resources in the U.S.¹²⁵ This can mitigate stigma in two ways. First, the dissemination of information regarding mental health by the U.S. government or immigration officials and candor with which it is discussed—and within written documents provided by these parties to new immigrants—can encourage immigrants to adopt the perspective on mental health of the country to which they are arriving rather than the one from which they are departing. Second, it can help dissipate fear of negative repercussions of having mental illness, such as community backlash, ineligibility for employment, and even deportation. If the U.S. government and immigrant community leaders combine their efforts, it can be enough to jumpstart the enduring process of reframing foreign views of mental health.¹²⁶

B. Specialized Mental Healthcare Resources for Immigrants

One of the proposed solutions to create better access to mental healthcare across the board in the U.S. is by offering more telecommunications-based healthcare options.¹²⁷ This option may be especially helpful for immigrants and first-generation individuals considering the specific barriers they face to mental healthcare accessibility.¹²⁸

Many of the financial limitations experienced by immigrants, and the consequences of these limitations, can be mitigated if not overcome with the use of telecommunications-based healthcare options.¹²⁹ Because of a systemic lack

124. See generally *Directory of Visa Categories*, TRAVEL.STATE.GOV: U.S. DEP'T ST.—BUREAU CONSULAR AFF., <https://travel.state.gov/content/travel/en/us-visas/visa-information-resources/all-visa-categories.html> (last visited Dec. 1, 2020) (stating that interested applicants must meet certain requirements, fill out paperwork, and must be eligible to receive a visa to the U.S.).

125. The dissemination of mental health information by the U.S. government or others may be helpful beyond simply helping to mitigate stigma; however, this paper's discussion of this solution is limited to stigma.

126. See Corrigan et al., *supra* note 116, at 50–51 (discussing the use of protest, education, and contact as tools to reduce public stigma of accessing mental health services in immigrant communities).

127. E.g., Scott Breiting, *3 Ways to Expand Access to Mental Health Care Beyond Adding More Psychiatrists*, STAT: FIRST OP. (Apr. 20, 2018), <https://www.statnews.com/2018/04/20/expand-access-mental-health-care/> (“Using video conferencing to hold mental health ‘visits’ ... can overcome some of the problems associated with the inequitable distribution of mental health practitioners.”).

128. See Derr, *supra* note 2, at 270 (noting the barriers faced by immigrants, including stigma, costs, and discrimination).

129. See Breiting, *supra* note 127 (suggesting the use of telecommunications to create accessible mental healthcare would help provide more efficiency and resolve inequitable distribution of mental health practitioners).

of mental healthcare professionals,¹³⁰ telecommunications can make mental health resources available even to those who have no means of otherwise physically accessing mental health resources.¹³¹ For example, if immigrants have migrated to a part of the U.S. that is underserved by mental health professionals, they can teleconference with a licensed professional rather than scramble to find a way to travel sometimes enormous distances to meet with a professional in person.¹³² Some immigrants and first-generation individuals cannot afford the financial cost of traveling long distances to seek mental health services.¹³³ Some may not have a car; others may not be able to take time away from their jobs to make the trip.¹³⁴ Telecommunication mental health services can mitigate some of these obstacles.¹³⁵

Furthermore, there is no decrease in quality of care with electronic or digital services as compared to in-person services.¹³⁶ In a study led by Erik Hedman analyzing the effects of Internet-based cognitive behavioral therapy on patients with Social Anxiety Disorder (“SAD”), results showed that patients who received Internet-based treatment for SAD experienced long-term improvement over the course of the first year of treatment and several years afterward.¹³⁷ Results also showed that Internet-based treatment was more cost-effective, enabled more widespread accessibility of mental healthcare treatment, and received an approval rating of more than 90 percent among patients.¹³⁸ Although

130. See Chorney, *supra* note 1, at 233 (“Given the lack of access to mental health services in many hospitals and health care settings . . . , [t]he use of real-time teleconferencing would allow for specialty consultation in areas that are relatively devoid [of] mental health services.”).

131. See Breiting, *supra* note 127 (“Using video conferencing to hold mental health ‘visits,’ for example, can overcome some of the problems associated with the inequitable distribution of mental health practitioners.”).

132. See Gary W. Shannon et al., *Distance and the Use of Mental Health Services*, 64 MILBANK Q. 302, 311 (1986) (“Utilization patterns for the less seriously ill and outpatients were strongly influenced by residential proximity to the clinic.”). In a collection of studies analyzing use of mental health services in relation to distance from these services, results showed a statistically significant decrease in the number of mental health patients when the distance the patient had to travel to access the services was 44–50 miles or more. *Id.* at 313.

133. Salami et al., *supra* note 31, at 156 (“Taking time away from work was difficult for many . . . who were primary bread winners with low-pay or precarious employment”).

134. *Id.*

135. See Chorney, *supra* note 1, at 247 (“Telemental health services have the potential to provide access to mental health care in areas and facilities that currently lack the resources to provide such services.”).

136. Breiting, *supra* note 127 (“Software-based tools that deliver standard cognitive behavioral therapy have been shown to be as effective as in-person therapy.”) (citation omitted).

137. Erik Hedman et al., *A 5-Year Follow-up of Internet-Based Cognitive Behavior Therapy for Social Anxiety Disorder*, J. MED. INTERNET RES., 1, 7 (June 2011) (“The results of this study indicate that participants receiving Internet-based [cognitive behavioral therapy] for SAD are moderately improved immediately following treatment but make further improvements within the following year. Improvements made at 1-year follow-up are, in turn, long-term enduring.”).

138. *Id.* at 8.

these results were from patients who are not all necessarily immigrants or first-generation individuals, one can expect similar results with immigrants. Telecommunications solutions would broaden the opportunities for immigrants to meet with mental health professionals who speak their own language or come from a relatable cultural background. For example, in immigrant communities where the predominant language may not be English, individuals may have digital access to bilingual mental health professionals whose services would otherwise be too far away to access. In addition to teleconferencing and digital mental health services, immigrants may also benefit from community-based solutions.¹³⁹ This means that the values, cultural traditions, and language fluencies of immigrant and first-generation American communities should be considered in the design and implementation of solutions expanding access to mental health resources.¹⁴⁰ Community-based mental health accessibility solutions must “be flexible, address complex[, long-term] needs beyond immediate mental health concerns, and be situated within [immigrant] communities”¹⁴¹

First, mental health services should be more readily available to immigrants and should be offered in conjunction with immigrants’ schedules. Currently, few evening or weekend mental health services are available in general, let alone to immigrants specifically.¹⁴² Because immigrants, at a significantly higher rate than their U.S.-born counterparts, often find themselves in time-consuming, low-pay, and sometimes cash-only employment, it can be nearly impossible to dedicate any normal business hours to mental health treatment.¹⁴³ Offering services at more flexible times can help mitigate the pressures many immigrants feel as primary breadwinners to prioritize work over all else—including mental health.¹⁴⁴

Second, flexibility in professional outlets is critical. A community-based model needs to incorporate not only traditional mental health professionals, but also culturally traditional community leaders.¹⁴⁵ Because immigrants tend to feel more comfortable approaching community or religious leaders as opposed to mental health professionals with concerns or to receive support, giving local religious or cultural leaders basic training on how to identify potential mental illnesses and conditions can help close the gap between immigrants and access

139. *E.g.*, Salami et al., *supra* note 31, at 156, 158 (discussing the use of community based delivery methods including community liaisons, outreach programs, and parenting education programs).

140. *See id.* at 156 (noting that a community-based model addresses language barriers, economic and financial barriers, and acculturation and adjustment barriers).

141. *Id.* (citation omitted).

142. *Id.* at 155.

143. *Id.* at 156.

144. *Id.*

145. *Id.*

to care.¹⁴⁶ While these individuals would not be certified mental health professionals, they can serve as a familiar and trustworthy initial point of contact for immigrants, making them the perfect link from immigrants to mental health resources. If they are properly trained on how to encourage an individual to seek out professional treatment and refer one to nearby professional services, they can foster a sense of safety and mitigate stigmas associated with seeking help.¹⁴⁷

Lastly, culturally appropriate terminology, media, and promotions should be used for every immigrant community. “Effective mental health promotion must consider the social determinants of health, and integrate the principles of social inclusion, access and equity into practice. . . . Culturally appropriate public education and media campaigns should be developed and targeted to specific communities, using imagery and messages that are acceptable to community members.”¹⁴⁸ Mental health is perceived differently by every community; tailoring services and promotion of these services to fit within the value systems of individual immigrant communities will increase the odds that immigrants will utilize the services available to them.¹⁴⁹

C. Promotion of Mental Health Education and Careers

Mental health education and the promotion of mental health careers are arguably the most fruitful source of mental healthcare accessibility for immigrants. Education of immigrant and first-generation students during formative years paired with well-managed incentive programs for young adults to pursue mental health professional careers can: (1) dissipate stigmas surrounding mental health, (2) ease the acculturation process for immigrants, (3) expand availability of multicultural and bilingual mental health professionals, and (4) ultimately encourage them to increase their use of available mental health resources.

The first step in using education to promote mental healthcare to immigrants is infusing mental healthcare into primary and secondary education systems. First, states should allocate funding for public schools to employ more trained, certified psychologists. As of 2012, the National Association of School Psychologists recommends that school districts employ one psychologist for every 500 to 700 students.¹⁵⁰ However, with no endorsement or enforcement of

146. *See id.* at 154 (stating that “participants reported that many clients believed mental illness to be a Western concept used by healthcare professionals.”).

147. *Id.* at 156 (noting that effective community-based models can account for specific challenges faced by immigrants without the stigmatized label of being a “mental health service”).

148. George et al., *supra* note 57, at 13633.

149. *Id.*

150. Kristen Weir, *School Psychologists Feel the Squeeze*, AM. PSYCHOL. ASS’N. (Sept. 2012), <https://www.apa.org/monitor/2012/09/squeeze>.

this recommendation by most states, this ratio in reality has become as severe as one school psychologist to 3,500 students.¹⁵¹

Increasing the number of school psychologists can increase mental healthcare accessibility for immigrants dramatically.¹⁵² Many immigrant and first-generation families will send their children to public schools because of financial constraints.¹⁵³ As a result, the most dependable source of mental healthcare resources for immigrant and first-generation children will be their schools.¹⁵⁴ Because of the heightened stigma surrounding mental health seen in many foreign countries and cultures, mental health is not a priority or likely even a topic of discussion in the typical immigrant or first-generation household.¹⁵⁵ In fact, family beliefs, expectations, cultural norms, and attitudes, as well as systemic barriers such as availability of services, transportation, and insurance, can all get in the way of discovering and treating children's mental health.¹⁵⁶ Consequently, immigrant families can:

. . . [be] unaware of the signs that a child may have mental health issues, or they may refuse to recognize the fact that their child is mentally ill. They may not be aware of the potential for mental illness in their child and may be unaware of the symptoms. . . . Many parents may not be capable, mentally or physically, of scrutinizing their children for signs of mental illness.¹⁵⁷

Thus, immigrant parents and families are often “unaware of and unequipped to deal with the complexities of mental illness.”¹⁵⁸

The second way to incorporate mental healthcare into primary and secondary education is directly through the curriculum. Physical education and health are already required in some capacity by most states as part of the curriculum in public schools.¹⁵⁹ States can simply incorporate mental health into the curriculum as well.¹⁶⁰ Starting as early as fifth grade, “students are mature

151. *Id.*

152. Tessa Heller, Note, *Mandatory School-Based Mental Health Services and the Prevention of School Violence*, 24 HEALTH MATRIX 279, 302 (2014).

153. See generally Lidia Farre et al., *Immigration and the Public-Private School Choice*, 51 LAB. ECON. 184 (2018) (finding that with an influx of immigrants, immigrant populations in public schools increase).

154. See Heller, *supra* note 152, at 296 (“Schools are an unparalleled resource for monitoring children’s mental illness . . .”).

155. See *supra* notes 101–02 and accompanying text.

156. Heller, *supra* note 152, at 290 (citation omitted).

157. See *id.* (explaining how families in the U.S. are unaware of their children’s mental illness).

158. *Id.* at 296.

159. *Id.* at 302–03.

160. See *id.* at 302 (stating that the public does not have an adequate understanding of mental illness, and this lack of knowledge increases the shame associated with mental conditions).

enough to comprehend the concept of mental illness.”¹⁶¹ A curriculum incorporating mental health can teach students to shed stigma from an early age by broadly defining mental health and encouraging students to remain nonjudgmental of people with mental illness because it is nobody’s “fault.”¹⁶² Furthermore, if students are taught to recognize signs and symptoms of various types of mental illnesses, they will likely become more self-aware and attentive to the mental health needs of family members.¹⁶³

Incorporating mental healthcare into primary and secondary education will raise awareness of mental health in immigrant and first-generation children, who can then bring a refreshed, less stigmatized perspective on mental health to their immigrant families.¹⁶⁴ Immigrant and first-generation families may by default consider mental health conversations shameful, taboo, or inappropriate.¹⁶⁵ However, this outlook will likely shift if their child or children have experience with mental health. Through mental health education and accessibility to mental health professionals at school, first-generation and immigrant children can gently chip away at the stigma perceived by their families surrounding mental health. Immigrants can learn more about the resources available to their children, and ultimately, they can encourage and achieve greater accessibility to such resources.

After educating immigrant and first-generation students about mental health, the next step in using education to expand mental healthcare is to promote mental health careers to immigrants and first-generation individuals at the higher education level. Currently, there is a shortage in the U.S. not only of mental healthcare professionals in general,¹⁶⁶ but also of multicultural and bilingual professionals within the mental health field.¹⁶⁷ Even if immigrants can overcome systemic barriers to access mental health resources, language and cultural gaps can also impede effective treatment.¹⁶⁸

161. *Id.*

162. *Id.* at 302–03.

163. *See id.* at 303 (explaining how children would be taught that mental illness, like any other disease, is no one’s “fault” and mentally ill people should not be judged or ridiculed based on their illness).

164. *See Salami et al., supra* note 31, at 155 (explaining how the lack of discussion and recognition of mental illness in immigrant and refugee communities means individuals and families often suffer in silence and are unable or unwilling to access available mental health resources).

165. *See id.* at 154–55 (discussing the heightened stigma surrounding mental health felt by immigrants compared to their U.S. born peers, emphasizing that many immigrants feel “a personal responsibility” to just “deal with it”).

166. *Top 5 Barriers to Mental Healthcare Access, supra* note 64.

167. *Id.*

168. *See Salami et al., supra* note 31, at 154–55 (stating that “language barriers were one of the biggest impediments to accessing and utilizing mental health services seen across immigrant serving agencies.”).

The best way to address this issue is by making more multilingual mental healthcare professionals available. Creating scholarships that specifically target first-generation American and immigrant students interested in pursuing mental health careers can expand the accessibility of diverse mental health professionals. Studies have shown that scholarships are one of the best indicators of student success at the collegiate level.¹⁶⁹ Thus, creating and maintaining scholarships for college-aged immigrant and first-generation American students pursuing careers in mental health will not only incentivize these types of individuals to enter the field but also more importantly help ensure their success in achieving this goal.

The aforementioned solutions in this subsection succeed based on a critical assumption: the individuals are first-generation Americans or have already immigrated to the U.S. But mental health education and the promotion of mental health careers can target immigrants before they even arrive in the U.S. This can be done by creating an opportunity for non-U.S. citizens interested in immigrating to the U.S. to obtain priority visas if they either (a) are mental health professionals in their country of origin and interested in practicing in the U.S., or (b) do not have such a degree but are interested in becoming licensed mental health professionals in the U.S. Incentivizing immigrants who are or wish to become mental health professionals will not only diversify the field but will ultimately have a positive impact on underserved immigrant and first-generation American communities.

Currently, the two primary categories of visas for immigrants to the U.S. are relative- and family-sponsored and employer-sponsored.¹⁷⁰ Included under employer-sponsored visas are categories for highly trained professionals.¹⁷¹ Often these professionals must have at least several years of professional or vocational experience, and priority is given to individuals who are renowned in their respective fields.¹⁷² Inherently, this will exclude mental health professionals from dozens of countries who may be qualified professionals but may lack the requisite years of experience or fame in their field due to stigma against mental health which is prevalent in countless foreign cultures.

For example, perhaps an individual from a foreign country in which there is heightened stigma surrounding mental health has decided to study mental

169. See, e.g., Natasha M. Ganem & Michelle Manasse, *The Relationship between Scholarships and Student Success: An Art and Design Case Study*, EDUC. RES. INT'L, 1, 6 (2011) ("Institutional scholarships significantly impacted student success across all measures: hours attempted, hours earned, and graduation within six years of entry. In fact, the impact of institutional scholarships was stronger than all other variables . . .").

170. *Directory of Visa Categories*, *supra* note 124 (navigate to "Immigrant Visa Categories").

171. *Id.* (navigate to "Immigrant Visa Categories").

172. *Employment-based Immigrant Visas*, TRAVEL.STATE.GOV: U.S. DEP'T ST.—BUREAU CONSULAR AFF., <https://travel.state.gov/content/travel/en/us-visas/immigrate/employment-based-immigrant-visas.html> (last visited Dec. 1, 2020).

health and pursue a career as a mental health professional in her native country. She receives the equivalent education only to discover that the stigma is preventing her from making a comfortable living because her client base is small and utilizes mental health services discreetly. This individual, desperate to make a difference and utilize her degree, decides to migrate to the U.S. An employer-sponsored visa is nearly impossible to obtain because no employer wants to sponsor a migrant with less than the requisite experience or expertise, or who lacks an equivalency exam or certification.

Though the example above is a hypothetical, it does suggest that the U.S. is likely turning away potential immigrants who could add diversity, perspective, and expertise to the mental health arena over what seem like arbitrary requirements. This could easily be resolved if a new visa category were added, specifically targeted at attracting foreign mental health professionals. This would allow professionals with an interest in serving U.S. clients the opportunity to migrate and make a positive difference in the U.S. More importantly, adding these professionals to the current mental health arena creates a greater supply of multilingual and multicultural professionals who can better serve non-English-speaking, immigrant, and first-generation American communities.

As an alternative or additional measure, an addition to the student subcategory of visas could be created to target foreign students interested in pursuing first an education in the U.S. followed by a mental health career in the U.S. The student visa system is not designed to be a permanent track to citizenship; these visas are specifically designated as “non-immigrant” visas by the U.S. Department of State.¹⁷³ In fact, it can be difficult for students to remain in the U.S. after completing their degrees unless they become employed and can obtain an employer-sponsored visa.¹⁷⁴ This should not be the case for immigrants interested in becoming mental health professionals and using those skills to help U.S. citizens, first-generation Americans, and immigrants in the U.S. The addition of a new visa category or a subcategory within student visas that preferences students studying mental health would incentivize immigrants of various backgrounds to migrate to the U.S. and pursue careers in mental health. As a result, these professionals could be motivated to help the communities of people with similar cultural backgrounds and experiences as theirs. Meeting with a mental health professional who can speak one’s language and/or understand the cultural stigma and barriers surrounding mental health that one has

173. *Directory of Visa Categories*, *supra* note 124 (navigate to “Non-Immigrant Visa Categories”).

174. See *Student Visa*, TRAVEL.STATE.GOV: U.S. DEP’T ST.—BUREAU CONSULAR AFF., <https://travel.state.gov/content/travel/en/us-visas/study/student-visa.html> (last visited Dec. 1, 2020) (“Foreign students in the United States with F visas must depart the United States within 60 days after the program end date listed on Form I-20, including any authorized practical training.”). Students may only apply for an immigrant status visa if they marry a U.S. citizen or receive an offer of employment from an employer who is able to sponsor the individual. *Id.*

experienced would increase the comfort and accessibility surrounding mental health for immigrants.

VII. CONCLUSION

Mental health has a history as a complex topic in the U.S., but access to mental healthcare is particularly challenging for immigrants and first-generation Americans. From the moment an immigrant arrives, or a first-generation American is born, the system seems to be designed to challenge them. Many barriers experienced by U.S. citizens, such as stigma, lack of insurance, discrimination and bias, and economic disadvantage, are experienced ten-fold by immigrants, often a result of differences in cultural values. Furthermore, immigrants and first-generation Americans experience unique barriers such as language, acculturation, and fear of deportation. Immigrants and first-generation Americans have experienced such circumstances for years and, based on the experiences of immigrants today, there seems to be no end in sight. But viable solutions exist that can be implemented at fundamental levels in American government and society that will benefit immigrants and citizens alike. These solutions are not without their risks and inevitable pushback from certain groups, but they can be implemented to benefit the greater good and create long-lasting, institutional change. As long as immigrants continue coming to the U.S., and as long as mental health remains a concern for all people, there will remain a need for reform.