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Dreams deferred: Contextualizing the health and psychosocial needs of undocumented Asian and Pacific Islander young adults in Northern California

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ABSTRACT

There are currently 1.5 million undocumented Asians and Pacific Islanders (APIs) in the US. Undocumented API young adults, in particular, come of age in a challenging political and social climate, but little is known about their health outcomes. To our knowledge, this is the first study to assess the psychosocial needs and health status of API undocumented young adults. Guided by social capital theory, this qualitative study describes the social context of API undocumented young adults (ages 18–31), including community and government perceptions, and how social relationships influence health. This study was conducted in Northern California and included four focus group discussions (FGDs) and 24 in-depth interviews (IDIs), with 32 unique participants total. FGDs used purposeful sampling by gender (two male and two female discussions) and education status (in school and out-of-school). Findings suggest low bonding and bridging social capital. Results indicate that community distrust is high, even within the API community, due to high levels of exploitation, discrimination, and threats of deportation. Participants described how documentation status is a barrier in accessing health services, particularly mental health and sexual and reproductive health services. This study identifies trusted community groups and discusses recommendations for future research, programs, and policies.

1. Introduction

The Patient Protection and Affordable Care Act (ACA) promises to expand health coverage to an additional 32 million individuals but leaves out an estimated 11.3 million undocumented immigrants (Krogstad et al., 2017). Although the percentage of uninsured Americans dropped to historic lows under the ACA, nearly 40% of undocumented immigrants still remain uninsured (Fabi and Saloner, 2016). The lack of social services and access for undocumented immigrants run in contrast to their contributions to the U.S. economy. In 2010 undocumented workers contributed as much as $13 billion in payroll taxes to social security, but received only $1 billion in benefits (Gross et al., 2013).

A federal program known as Deferred Action for Childhood Arrivals (DACA) changed the landscape of healthcare options for undocumented young adults. The Obama Administration established DACA in 2012 with 1.2 million young adults eligible for the program. This policy defers deportation and grants a work permit and temporary Social Security Number for eligible undocumented young adults. Although the DACA program is not a pathway to citizenship, the legal status it provides allows for participation in the healthcare exchanges. For undocumented young adults, navigating critical life milestones such as applying to college, entering the workforce, or obtaining driver's licenses, pose unique political challenges from those who migrate as adults (Gonzales et al., 2013). The inability to legally work, receive financial aid for college, drive, and obtain health care are constant stressors (Suárez-Orozco et al., 2011).

Moreover, the last few years have marked a significant

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demographic shift in which Asian and Pacific Islanders (APIs) are now the fastest growing immigrant population in the US (US Census Bureau, 2011), including 1.5 million undocumented APIs (Migration Policy Institute, 2015), 29% of whom live in California (Wallace et al., 2012). Undocumented immigration from Asia has tripled from 2000 to 2013, with the number of undocumented immigrants from China, Korea, and India increasing four-fold, eight-fold, and ten-fold, respectively. The impetus for migration from Asia varies greatly, ranging from education and employment to family reunification. While processes by which API immigrants become undocumented have not been fully elucidated, contributing factors include problems arising from family and employment sponsors (Rosenblum and Soto, 2015). Despite the rapid growth in immigration, little is known about the unique challenges undocumented API young adults face in the current literature. Among API immigrants in general, studies find they are less likely to use mental health services due to stigma, and are less likely to use mental health services compared to their US-born counterparts (Abe-Kim et al., 2007). Much less is known about API undocumented young adults and their psychosocial health needs.

Research is critically needed to examine the health of undocumented APIs, particularly as these young adults are coming of age and transitioning to adulthood in a challenging social and political context. While they seek to develop identities as part of normative adolescent developmental processes, critical milestones in their lives are precluded due to their documentation status (Gonzales et al., 2013).

1.1. Linking social and community contexts to health among undocumented: social capital theory

We adopt social capital theory to examine the social and community contexts of undocumented API young adults and the influence on health. Social capital is defined as the resources that people access through their networks and social relationships (Berkman and Kawachi, 2000). Social capital theory is an important lens through which to examine health among undocumented populations given that the strength of social ties are particularly important for migrant populations (Aguilera and Massey, 2003; Massey, 1987). Social capital and social ties are strong predictors of health and access to healthcare (Kawachi and Berkman, 2001). Factors such as community cohesiveness, familiarity, and trust facilitate the spread of health information, with the ability for health norms to be adopted more quickly in tight social networks (Rogers, 2010).

Different types of social capital include bonding, bridging, and linking social capital (Szreter and Woolcock, 2004). First, “bonding” social capital refers to the resources derived from social networks between similar groups of people (i.e. class and race). While this may provide a sense of solidarity, it may also reproduce social disadvantage depending on the resources and norms in the community. Disadvantaged communities, for example, may rely on one another for support; however, if youth are only exposed to other poor neighbors, it may result in communities feeling “trapped.” On the other hand, “bridging” social capital refers to the resources accessed across networks that cross class, race/ethnicity, or other social characteristics. Bridging social capital is generally associated with better health outcomes, including increased access to health information (Putnam, 1995). “Linking” social capital is defined as social ties between individuals with differing levels of power. Neighborhood institutions serve as important examples of linking social capital, such as community-based organizations, and across generation from elderly to youth organizations (Fried et al., 2004; Glass et al., 2004).

Berkman and Kawachi (2000) suggests three potential mechanisms for which social capital may influence health: 1) influencing health-related behaviors, by promoting rapid diffusion of health information or adoption of healthy norms; 2) access to services and amenities; and 3) affecting psychosocial processes, such as social support and social engagement. For the undocumented community, social capital may be limited. Social stigma, fear related to deportations, and factors such as occupational exploitation may all lead to increased social isolation and loss of social capital for the undocumented (Hagan et al., 2015).

Intersections of race, culture, and immigration may produce disparities between different undocumented communities in relation to social capital. For example, APIs are less likely to apply for DACA compared to other populations −21% application rates of eligible Asians compared to 77% of Latinos (Rusin, 2015). Community-based organizations and legal service providers in API and Latino immigrant communities have attributed this disparity to API's increased sense of shame and stigma, loss of status within their communities due to their documentation status, and mistrust in governments (Rusin, 2015). Undocumented young adult Latinos, on the other hand, have been found to have high community social support (Siemons et al., 2016). Undocumented immigrants, and APIs in particular, live in the shadows of society, and there is a need to better understand how social ties to families and communities impact health access and status.

Guided by social capital theory, this paper seeks to understand how social and community contexts influence health for undocumented immigrants. This study assesses both the potential positive and negative influences of social relationships due to documentation status. We explore the limits and possibilities of social capital to overcome rigid and political barriers to care. This study, to our knowledge, will be the first study to contextualize the health status of API undocumented young adults.

2. Methods

The manuscript uses data from the BRAVE Study (Building community Raising API Voices for health Equity), which includes qualitative data, including focus group discussions (FGDs) and in-depth interviews (IDIs). The purpose of the study was to examine the health status and health needs of undocumented APIs and how DACA influences health access and behaviors. This study was guided by principles of community-based participatory research (CBPR) by developing a Community Advisory Board (CAB) and engaging three interns from the community to assist all research activities, including participant recruitment (Wallerstein and Duran, 2006). Eight CAB members, representing community institutions such as universities, policy organizations, undocumented youth organizations, and community health services, contributed to the design of the study and supported development of field guides and interpretation of data.

In total, the BRAVE Study conducted four focus group discussions (FGD) and 24 in-depth interviews (IDI) between October 2015 and March 2016, with 32 unique study participants.

2.1. Study participants and recruitment

Four FGDs (n = 16) used purposeful sampling by gender and education status (in school/out of school) in order to provide more homogenous groups, allowing for greater group discussions (Ulin et al., 2004). Past studies have found that school vs. work environment changes the undocumented immigrant experience, with school mostly being a safe space while work environments can be discriminatory (Abrego, 2011). We recruited participants for IDIs from those who participated in FGDs as well as individuals who were not able to attend a scheduled FGD. Sampling IDIs from the