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The Influence of Deferred Action for Childhood Arrivals on Undocumented Asian and Pacific Islander Young Adults: Through a Social Determinants of Health Lens

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A B S T R A C T

Purpose: There is an urgent need to provide evidence-based policies to address the health of the 11.7 million undocumented immigrants in the United States. Deferred Action for Childhood Arrivals (DACA) offers temporary relief to qualified undocumented immigrants. Asians and Pacific Islanders (APIs), in particular, are the fastest growing immigrant population; yet, little is known about their health challenges. This article examines the influence of DACA on the health of API undocumented young adults.
Methods: In total, 32 unique participants participated in 24 in-depth interviews and four focus group discussions. Participants were aged 18–31 years and identified as undocumented API.
Results: DACA potentially improves health outcomes through four potential social determinants: economic stability, educational opportunities, social and community contexts, and access to health care. These determinants improve the mental health and sense of well-being among undocumented young adults.
Conclusions: Targeted outreach and education in communities should be informed by these research findings with an eye toward promoting the economic, education, and health benefits of enrolling in DACA. Social policies that address the social determinants of health have significant potential to address health inequities.

IMPLICATIONS AND CONTRIBUTION

This study assesses the influence of Deferred Action for Childhood Arrivals on the social determinants of health among Asians and Pacific Islanders. Results identify the benefits and challenges of Deferred Action for Childhood Arrivals for the 11.7 million undocumented immigrants in the United States.

There are currently 11.7 million undocumented immigrants in the United States [1]. Undocumented immigrants live in the shadows, facing fear of deportation, and lack of health access, all leading to increased health concerns for this group [2], including mental health [3]. Undocumented youth, in particular, come of age in a context of uncertainty and vulnerability, many growing up unaware of their status and then later needing to navigate the stigma and legal repercussions associated with their identity [4]. There is an urgent need to provide evidence-based policies to address health concerns for the undocumented young adult population.

Deferred Action for Childhood Arrivals (DACA) stands to change the landscape of public health options for the undocumented. On June 15, 2012, President Obama signed a memo for DACA, a

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Table 1
Eligibility criteria for Deferred Action for Childhood Arrivals program

- Must be under 31 years as of June 15, 2012
- Must have arrived in the United States before 16 years
- Must have resided in the United States continuously since June 15, 2007
- Must have no felony convictions, serious misdemeanors, and fewer than three misdemeanors
- Must currently attend school, have a high school diploma or General Equivalency Diploma, or have been honorably discharged from the U.S. military

program that offers temporary relief from deportation and allows individuals to apply for temporary work permits (see Table 1 for eligibility criteria) [5]. California has the most potential beneficiaries overall (approximately 30%), and most Asians and Pacific Islanders (APIs) eligible for DACA live in the state [6].

A recent study with Latino DACA-eligible populations have identified that even after receiving temporary legal status, barriers to health and well-being persist [3]. Participants reported gaps in mental health care services, lack of culturally competent and bilingual providers, and limited financial resources to pay for medical care [2]. The extent to which these findings apply to APIs has not been explored. It is important to note that APIs have noticeably applied for DACA less than expected, accounting for only 4.2% of applicants although Asians make up 11% of undocumented immigrants [1,6]. One report suggests that APIs may be less likely to apply for DACA compared with other groups because of the prevailing sense of shame and stigma associated with undocumented status [7]. Lack of open discussions about documentation status in the API community, low coverage in ethnic media, and heightened fear among parents may contribute to these findings [7]; however, this phenomenon has not been fully explored in formal literature. Studies examining the influence of DACA on health have either focused on or solely recruited from Latino populations [2,3].

APIs are oftentimes left out of the immigration reform debate; yet, they represent the fastest growing immigrant population in the United States [8], with 1.5 million undocumented APIs [9]. APIs are particularly heterogeneous, with distinct ethnic groups and political histories, and over 33 API languages are spoken in the United States [10]. It is critical to understand the health of this growing and diverse population through an in-depth, qualitative lens. This study contributes to the broader literature on undocumented immigration and social policies by examining potential pathways that DACA may influence health and well-being among APIs in California.

Social determinants of health

To guide our understanding of potential pathways in which DACA may influence health, we turn to the social determinants of health framework. Social determinants of health are defined as the "complex, integrated, and overlapping social structures and economic systems…that are responsible for most health inequities" [11,12]. The Centers for Disease Control's Healthy People 2020 highlights five domains: economic stability, neighborhood and built environment, health and health care, social and community context, and education [13]. Based on study results, DACA potentially expands four areas within this framework: economic, education, community and social contexts, and health care. This manuscript examines how DACA may influence immigrants' social determinants of health, including mental health.

Methods

We developed the Building Community Raising API Voices for Health Equity (BRAVE) Study, aimed to determine the impact DACA had on health access, status, and behaviors of API undocumented young adults. The study, guided by community-based participatory research methods, took place between October 2015 and March 2016 [14]. A Community Advisory Board (CAB) was engaged throughout the project and represented professionals in education, health, undocumented youth organizations, and policy. A CAB meeting was held in the beginning of the project to review recruitment strategies and field guides. We also hired three community interns, two females and one male, who were from the API undocumented community. Study interns recruited participants, developed social media presence, reviewed study questions, were trained in qualitative data collection, and conducted focus group discussions (FGDs) and in-depth interviews (IDIs). A second meeting included both CAB members and study interns, and the study team presented results to validate findings.

Study participants and recruitment

Recruitment took place in Northern California and strategies were both passive (using flyers, a Web site, and a social media page) and active (venue-based recruitment, snowball sampling, and tapping into the social networks of study interns). Eligible individuals were (1) aged 18–31 years; (2) identify as Asian/Pacific Islander; (3) undocumented; and (4) able to participate in discussions in English. In total, 32 unique individuals participated in the study, including 24 IDIs and four FGDs. FGDs (consisting of three to six participants) were conducted with purposeful sampling by gender and education status [15], including both in-school and out-of-school young adults [16]. The IDIs included participants recruited from FGDs as well as those unable to attend FGDs.

Data collection

Participants filled out demographic forms and gave verbal consent to participate. Two researchers (one discussion facilitator and one note taker) conducted FGDs while one interviewer conducted IDIs. FGDs lasted approximately 2 hours, and IDIs lasted approximately 1 hour. All sessions were face-to-face and followed a field guide that included information on immigration narratives, health and health care, and DACA-related experiences (see Table 2). Participants received financial compensation following participation. All audio was transcribed to a word document, which was later uploaded to the qualitative analysis software.

Analyses

FGDs and IDIs were coded by four trained researchers using a collaborative process that combined thematic analysis and grounded theory [17]. The grounded theory approach allowed us to inductively develop a theory to guide our understanding based on study findings [17]. A coding scheme was developed first using open coding, followed by collaboration to finalize the codebook. Three trained researchers first coded the same five documents, developed codes, discussed where codes differed, and finalized the codebook. Through an iterative process, a final codebook was agreed upon. Axial coding was used to identify how codes related to one another. Analytical codes were

Table 2
Selection of questions used in BRAVE Study field guides

Documentation status
• What does documentation mean to you? (FGD)
• When did you first find out about your documentation status? (IDI)
Health status and health access
• Where do you think that DACA-eligible and other undocumented young adults first go to get health care? (FGD)
• What barriers exist that might prevent DACA-eligible or other undocumented young adults from seeking care? (FGD)
• What do you do if you get sick? (IDI)
• Are there specific health challenges that you have faced? (IDI)
Community resources
• Are there particular programs in your area that serve immigrants without documentation? (FGD)
• Are there particular programs or organizations in your area that serve immigrants without documentation? (IDI)

BRAVE = Building community Raising API Voices for health equity; DACA = Deferred Action for Childhood Arrivals; IDI = in-depth interview; FGD = focus group discussion.

developed, codes were sorted into border themes, and relationships between codes and themes were identified in an iterative process. Theme frequencies, co-occurrence, and team discussions were used when interpreting data. Finally, selective coding was used to identify specific experiences, such as individuals who reported mental health issues and sexual encounters [18]. Data were collected until "saturation" was reached, or rather, when no new themes emerged [17].

We took a number of steps to ensure the trustworthiness of the data and validate findings [19–21]. To ensure credibility of data, we first conducted key informant interviews with 18 experts and community members. These key informant interviews helped us establish questions and familiarity with the subject even before we began data collection with study participants. Throughout data collection, we also took a number of steps to ensure that participants were answering honestly. Study interns, who were themselves from the undocumented community, built rapport with participants and were able to elicit frank responses. We also triangulated our data. First, we found similar codes and themes in FGDs and IDIs. While FGDs are used to describe cultural normative patterns of behaviors among groups, IDIs are used to explore more sensitive topics to maximize privacy [15]. Similar codes and themes were yielded from these two data sources. The CAB members and undocumented young adults were also involved in validating study findings, including reviewing all themes, discussing any surprising findings, and contextualizing results from their own personal experiences. From the data, the social determinants of health framework emerged as a useful approach to organizing the benefits and challenges of the policy. ATLAS.ti software (ATLAS.ti Scientific Software Development GmbH, Berlin, Germany) was used to conduct all analyses.

All study procedures were approved by the University of California, San Francisco's Institutional Review Board.

Results

Demographic characteristics

The study population consisted of 32 unique individuals from four FGDs and 24 IDIs (Table 3). The average age was 22.9 years (standard deviation: 3.3), and half were male. All participants were high school graduates, and of these 40.6% had a college degree. Almost all participants (90.6%) have lived in the United States for at least 10 years, and most reported moving to the United States with their family (59.4%), for work (46.9%), and/or educational opportunities (43.8%). The top countries of birth for individuals were South Korea (34.4%) and Philippines (21.9%) (Table 4). Most participants were either a DACA recipient (87.5%) or DACA eligible (6.3%), with the remaining being DACA ineligible (6.3%).

Table 3
Characteristics of the BRAVE Study population

Characteristics (n = 32)	
Gender, n (%)	
Male	16 (50.0)
Female	16 (50.0)
Age, mean (SD)	22.9 (3.3)
DACA status, n (%)	
Recipient	28 (87.5)
Eligible (not a recipient)	2 (6.3)
Ineligible	2 (6.3)
Highest level of education completed, n (%)	
High school	19 (59.4)
College or higher	13 (40.6)
Mother's education level, n (%)	
Less than high school	7 (21.9)
High school	10 (31.3)
College or higher	15 (46.9)
Household yearly income, n (%)	
<$10,000	3 (9.4)
$10,000–$19,999	4 (12.5)
$20,000–$29,999	6 (18.8)
$30,000–$39,999	4 (12.5)
$40,000–$49,999	6 (18.8)
$50,000–$59,999	2 (6.3)
$60,000–$69,999	2 (6.3)
$70,000–$79,999	3 (9.4)
$80,000+	2 (6.3)
Length of stay in the United States, n (%)	
5–10 years	3 (9.4)
10+ years	29 (90.6)
Reasons for immigrating, n (%)	
Moved with family	19 (59.4)
Moved for family's work/labor opportunities	15 (46.9)
Moved for education	14 (43.8)
Moved to live near other family	4 (12.5)
Other	3 (9.4)

BRAVE = Building community Raising API Voices for health equity; DACA = Deferred Action for Childhood Arrivals; SD = standard deviation.

Challenges of being Asian and Pacific Islander and undocumented

While APIs make up a substantial portion of undocumented immigrants, participants felt that "sometimes being an API undocumented student can also feel alienating…it's culturally harder for a lot of API students to come out" (male, DACA recipient, FGD). Many participants cited misconceptions of

Table 4
Country of birth (n = 32)

Country	n (%)
South Korea	11 (34.4)
Philippines	7 (21.9)
China	2 (6.3)
Indonesia	2 (6.3)
Other Asian/Pacific Islander country	6 (18.8)
Other non-Asian country	4 (12.5)

undocumented immigration as solely a Latino issue, the model minority myth as to why legal status complicates their identities as undocumented API immigrants and produces silence in their communities. As one participant framed it:

> This idea that we don't need help, that we're ok, that we're perfect. It's not true… the narrative of [undocumented] immigration revolves around Latin American folk… there's still a huge neglect (female, DACA ineligible, IDI).

Stemming from the external perception and internalization of APIs as the model minority, many participants described also experiencing intraracial and ethnic stigma against both themselves and their family for being undocumented, which ultimately contributed to reluctance to seek and engage with community resources. Tensions and mistrust of the API community arise from the past experiences of exploitation at the hands of people from the same ethnic group:

> My mom told me… don't talk to other Filipinos, they'll take advantage. We got scammed… there's this guy who works for the social security who can get us social security numbers for like $6000… we paid it off and those people disappeared (male, DACA recipient, IDI).

As more policies and legislation open doors for undocumented young adults, these new opportunities can be catalysts for contentious family dynamics. A participant who reached out to his high school guidance counselor about DACA remembers: "I told… my parents and my parents got so upset and they just yelled at me all night." This Korean participant learned that his parent's vehement response had been conditioned by the trauma of being blackmailed by members of the Korean community.

Social determinants of health and Deferred Action for Childhood Arrivals

Educational attainment and economic stability. Many participants often discussed educational attainment within the same context as economic opportunities and stability. By providing eligibility for reduced in-state tuition, work-study programs, and state financial aid programs, participants stated that DACA helped to alleviate the financial barriers that are common for undocumented young adults. For many participants, these changes profoundly empowered them to envision their future life trajectories.

Economic stability itself was also a critical component of post-DACA changes for our participants, mainly as a result of increased work opportunities. For some participants, the ability to legally gain employment meant that they no longer had to work under the table jobs, where they are vulnerable to exploitation. Participants found this change "liberating" and a relief to their personal and financial burdens:

> [DACA] helped me not be concerned about being a burden for my family, because I felt like I was just a financial sink for the longest time (male, DACA recipient, FGD).

Social and community integration. Participants noted that DACA provided a critical form of legal identification that increased access to economic, social, and political empowerment. For example, the ability to obtain a driver's license under DACA not only provided practical benefits but also can significantly impact identity and self-perception.

In addition, DACA and its protections against deportation have empowered undocumented young adults to engage in their communities. One participant reflected on how her family's immigration status subjected them to poverty, resulting in her mother's untimely death:

> I couldn't do anything for my mom because of my status when she was alive… Now I have DACA, I'm gonna take advantage of this… fight for immigrant rights and fight for folks, so they wouldn't have to go through this. (female, DACA recipient, IDI).

Health care access and mental health. DACA recipients in our study stated that their "pre-DACA period" was characterized by gaps in primary care, use of alternative methods, or by simply ignoring their health issues. One of the main barriers to health care services was the financial cost, a prevailing theme across all our FGDs and IDIs. DACA can help to reduce some of the reluctance in accessing health care by alleviating fears of legal repercussions, particularly in these urgent situations:

> Now that I have DACA and I have paperwork I'm not afraid of getting deported like in the hospital (male, DACA recipient, IDI).

Participants also discussed how DACA directly improved their sense of well-being after having to cope with stressors in their daily lives. The stressors that were mentioned in the FGDs and IDIs include documentation status, fear of deportation, the uncertainty of the future, and the financial burdens that participants and their families bear. For some, conflicts at home (e.g., separation due to deported family members) also add to their high levels of stress.

Many participants echoed how mental health is a particularly challenging issue for undocumented young adults due to the pervasive stigma that exists in API communities: "something that's perpetuated in Asian culture is… suffering in silence… you have these struggles but you're expected to handle them and not even talk about it" (female, DACA recipient, FGD). The reticence surrounding mental health, in light of the traumas of migration, further complicates generational rifts among participants, their parents, and their siblings. With DACA, participants described a general sense of "emotional and psychological peace" (female, DACA recipient, IDI).

Shortcomings of Deferred Action for Childhood Arrivals

Those left behind: Undocumented parents and other family members. Overwhelmingly, undocumented API young adults discussed how DACA did not extend to family members, which is particularly concerning for young adults living in mixed-status families. This caused some to not apply despite being eligible, with one participant saying, "I was actually worried because my brother is also undocumented but he was not eligible [for DACA] because he was over the age limit. My concern was if I give my information away, would that jeopardize my brother in some way?" (male, DACA recipient, FGD).

Many participants were also concerned that parents were ineligible. One DACA recipient described her mixed feelings with DACA—the fact that it would defer deportation but ignore problems that her mother faced, including growing health bills and ineligibility for relief. This young woman's mother ended up dying from congestive heart failure. The multiple barriers to realizing her family's full potential—including not having stable

housing, financial resources, and access to health care—had her questioning the notion of the "American Dream":

> People would always talk about the "American Dream." What is it? You have people living here in the United States but there's no American dream for them. But I would kind of like lay awake there crying and wish like, "why can't I have that house? Why can't I have that white picket fence? Why can't I have the green grass? Why can't my family have that benefit of getting healthcare?" (female, DACA recipient, IDI)

In addition to family members being left out of DACA, some participants were also ineligible. Ineligible participants paid for higher education out of pocket and reported obstacles with financial aid and scholarship eligibility. One participant explained that she knew "some schools will accept students with DACA" but "didn't know what the policies were for students without DACA" (female, DACA ineligible, IDI).

Importantly, discussions revealed community divisions stemming from the policy. Participants described how DACA has been detrimental to activism stating that "once [DACA recipients] have DACA, they feel they have no need to engage in activism" and "just because you have DACA doesn't mean you can forget about the rest of your community" (female, DACA ineligible, IDI). While some participants reported how DACA empowered their community, others felt that this policy left DACA-ineligible participants disempowered and created divisions within their community.

Discussion

This is the first study to assess the influence of DACA among API undocumented immigrants using a social determinants of health framework. This study highlights four potential determinants that DACA positively influences: economic stability, education, social and community contexts, and expansion of health access. It demonstrates that the concrete benefits of DACA reported by Latino beneficiaries are similarly perceived by API populations, which found that access to larger institutions such as education, health, and employment were concrete benefits of the policy [3,22,23]. Similar to studies with Latino participants, API DACA recipients experience increased financial stability and are able to obtain driver's license, health insurance, and jobs [22,24]. This study builds upon past research by demonstrating that DACA may improve mental health in API DACA populations by decreasing stress through education/employment opportunities and deferring deportation. Past studies find that DACA recipients have improved mental health outcomes compared with nonrecipients, with 14% reporting that their legal status caused them stress compared with 36% of nonrecipients [25]. By lessening barriers that once restricted undocumented immigrants to the margins of society, DACA helped create a different outlook for their future and allowed them to be more proactive about their lives.

While the benefits of DACA are largely consistent across Latino/API populations, this study identifies differences in terms of community and social integration across the two groups and unique challenges associated with being API and undocumented. Siemons et al. (2016) found that Latino DACA recipients reported increased social support, social integration, and positive sense of self. While our study similarly found that there were societal benefits of DACA, it also resulted in community divisions within the API undocumented community. Shame, stigma, and silence against undocumented immigrants are particularly pervasive in the API undocumented community [7]. In particular, the model minority myth may perpetuate stigma and silence as it undermines the heterogeneity in experiences among different Asian groups. Studies among APIs find that the model minority stereotype contributes to psychological distress and negative attitudes toward mental health services [26,27]. The stress of stereotypes for being a "model minority" may thus lead to lack of open discussions and weakened social cohesion in the API community. Chronic fear plays an integral role in the vicious cycle that perpetuates mistrust, isolation, and silence. Future research should examine the influence of such stereotypes among API undocumented young adults and how this may influence applying for DACA or seeking health services.

There are a several limitations in this study. First, this is a qualitative study of APIs living in the Bay Area, California. As a study focused on the effects of DACA on health, our inclusion criteria was initially derived from the original eligibility requirements of DACA. We recruited participants who felt comfortable participating in English, which could have biased our sample in regard to socioeconomic status. DACA eligibility itself, including age, education, and duration in the U.S. requirements, selects for those who are proficient in English (see Table 1). Despite this, we were able to recruit participants coming from a wide variety of socioeconomic backgrounds. Certainly in regard to the DACA-ineligible population, language may remain a barrier that should be carefully considered. Additional research is needed to validate the extent to which these findings may be applied to other populations, including those living in rural areas. Second, while we attempted to recruit undocumented young adults ineligible for DACA, we were only able to recruit two participants. Undocumented participants who are not eligible may be more vulnerable given their lack of identification, resources, and opportunities. Concerted efforts are needed for future studies to recruit this population to further understand their health care needs and challenges. Finally, we are aware that APIs are extremely heterogeneous, with multiple cultural practices, perspectives, languages, and countries of origins. However, due to limited sample size, we were unable to analyze our data by country of origin or conduct FGDs with groups from specific ethnic origins.

Despite these limitations, a number of recommendations can be made for future research and for community partners, providers, and policymakers. These results may be important for community-based organizations working with API populations. Organizations should pay particular attention to having open discussions around the model minority myth, misconceptions about DACA and enrolling in health services, and supporting both DACA-eligible and DACA-ineligible populations. Because of stigma associated with mental health services, particularly in the API community, a concerted effort can also be made to identify immigrant-friendly service providers.

It is clear that DACA is only a partial solution—most importantly, by leaving out parents and dividing the undocumented population. API participants in this study reported additional concerns regarding the health needs of their parents. Future work is needed to examine the health care needs and health-seeking behaviors of parents of undocumented young adults. Community programs and health programs should be strengthened to also include undocumented parents. Ultimately, social policies that address the social determinants of health have

significant potential to address health inequities across populations.

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