THE IMMIGRANT PARADOX: PROTECTING IMMIGRANTS THROUGH BETTER MENTAL HEALTH CARE

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I. INTRODUCTION

In recent years, disturbing stories of mentally ill people facing deportation have found their way into mainstream media, and have brought to light problems they face in our immigration system.[1] In detention, without medication, support or professional help, these individuals reveal just how helpless someone can become. The stories tell of being trapped in a series of holding facilities, unable to understand the legal proceedings that face them, with their mental health deteriorating so that they are unable to communicate without representation.[2] The stories also reveal a legal system that is not prepared to cope with mental illness.

A whole host of issues arise when it comes to the treatment of the mentally ill in our immigration system including exclusion from admission,[3] due process issues when it comes to removal,[4] and

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1 *See, e.g.*, Andrew Becker, *2 Immigrants Held in Violation of Rights, Lawsuits Contend*, L.A. TIMES (Mar. 30, 2010), http://latimes.com/news/local/la-me-detain30-2010mar30,0,1462388.story; Nina Bernstein, *Disabled Immigration Detainees Face Deportation*, N.Y. TIMES (Mar. 29, 2010), http://www.nytimes.com/2010/03/30/us/30immig.html [hereinafter *Disabled Immigrant Detainees*]; Nina Bernstein, *Mentally Ill and in Immigration Limbo*, N.Y. TIMES (May 3, 2009), http://www.nytimes.com/2009/05/04/nyregion/04immigrant.html [hereinafter *Mentally Ill and in Immigration Limbo*]; Emily Ramshaw, *Mentally Ill Immigrants Have Little Hope for Care When Detained*, DALLAS MORNING NEWS (July 13, 2009), https://www.justice.gov/sites/default/files/eoir/legacy/2014/08/15/Emily%20Ramshaw%2C%20The%20Dallas%20Morning%20News%2C%20July%2013%2C%202009.pdf.

2 *See* Ramshaw, *supra* note 1; *Disabled Immigration Detainees*, *supra* note 1.

3 *See, e.g.*, Andrew Solomon, Opinion, *Shameful Profiling of the Mentally Ill*, N.Y. TIMES (Dec. 7, 2013), http://www.nytimes.com/2013/12/08/opinion/sunday/shameful-profiling-of-the-mentally-ill.html.

4 *See* ORGANIZATION OF AMERICAN STATES, INTER-AMERICAN COMMISSION ON HUMAN RIGHTS, REPORT ON IMMIGRATION IN THE UNITED STATES: DETENTION AND DUE PROCESS 85–86, 138, 144 (2010), https://www.oas.org/en/iachr/migrants/docs/pdf/migrants2011.pdf.

access to treatment while in detention.[5] Upon looking into each of these issues, it becomes clear that the stigma attached to mental illness is alive and well in our immigration system.[6] As the news stories above reveal, procedural issues—such as the overuse of detention, assessing competency, and the right to representation—moved to the forefront of concern for those advocating for fairness in our immigration system.[7] There is good reason for this focus given the widespread human rights violations that are transpiring in our system.[8]

This situation raises other compelling and overlooked issues: to what extent has mental illness placed a person into the removal system in the first place? Can better access to mental health care help immigrants avoid conduct that leads to removal? This article will explore these issues, looking at developments in mental health care in the United States generally, the particular needs of immigrants to mental health care, and the barriers they face. A review of the literature on the mental health treatment of immigrants reveals an interesting phenomenon: immigrants arrive in the United States with better mental health overall when compared to the general population of the United States.[9] This phenomenon has been dubbed by psychologists and scholars studying the issue as the "immigrant paradox," and runs contrary to perceptions, both historical and contemporary, that immigrants are

[hereinafter REPORT ON IMMIGRATION] (explaining how the United States overused detention in the immigration system, how it did not provide adequate medical and mental health care, and how it deprived immigrants of due process).

[5] *See id.* at 95, 142; *see also* HUMAN RIGHTS WATCH, SYSTEMIC INDIFFERENCE: DANGEROUS & SUBSTANDARD MEDICAL CARE IN US IMMIGRATION DETENTION 71 (2017), https://www.hrw.org/sites/default/files/report_pdf/usimmigration0517_web_0.pdf.

[6] *See, e.g.*, Becker, *supra* note 1; Ramshaw, *supra* note 1; *Disabled Immigration Detainees*, *supra* note 1; *Mentally Ill and in Immigration Limbo*, *supra* note 1.

[7] *See* AM. CIVIL LIBERTIES UNION & HUMAN RIGHTS WATCH, DEPORTATION BY DEFAULT: MENTAL DISABILITY, UNFAIR HEARINGS, AND INDEFINITE DETENTION IN THE U.S. IMMIGRATION SYSTEM 64 (2010), https://www.aclu.org/files/assets/usdeportation0710_0.pdf [hereinafter DEPORTATION BY DEFAULT]; JUSTICE FOR IMMIGRATION'S HIDDEN POPULATION: PROTECTING THE RIGHTS OF PERSONS WITH MENTAL DISABILITIES IN THE IMMIGRATION COURT AND DETENTION SYSTEM 12–14 (2010); *see also* Helen Eisner, Comment, *Defenseless, Disabled and Still Deportable: Why Deportation Without Representation Undermines Due Process Rights of Mentally Disabled Immigrants*, 14 U. PENN. J. CONST. L. 511, 512–13 (2012).

[8] *See* REPORT ON IMMIGRATION, *supra* note 4, at 85–86. The Inter-American Commission on Human Rights, the primary investigative mechanism of the Organization of American States, found that the United States' overused detention in the immigration system, that the conditions of detention did not comport with standards of respect for human dignity, that it did not provide adequate medical and mental health care and that it deprived immigrants of due process. *See id.* at 85–86, 138, 144.

[9] Margarita Alegría et al., *Prevalence of Mental Illness in Immigrant and Non-Immigrant U.S. Latino Groups*, 165 AM. J. PSYCHIATRY 359, 363–64 (2008).

more likely to be impaired and a burden.[10] Studies show, however, that over time many immigrants' mental health deteriorates, generating behavior—such as drug use or low-level criminal activity—that might place them into the immigration removal system.[11] If this is the case, then improved mental health care can prevent behavior leading to deportation.

Part II of this article provides an overview of mental health care in the United States. The story is one of de-institutionalization and an increasing overlap between those in need of mental health care and negative behaviors leading to involvement in the criminal justice system.[12] Part III will focus on the particular mental health challenges of immigrants in the United States. The article details the barriers to receiving mental health care, such as social and cultural barriers, economic barriers such as poverty and a lack of access to insurance, that account for the result that immigrants are underserved and underutilize mental health services.[13]

Part IV connects how immigrants' mental health issues can lead to removal from the United States. It starts with the history of excluding those deemed to be mentally or physically deficient or likely to become a public burden. Reflected in these exclusive grounds is a deeply rooted belief that other countries would send those who are feeble, incompetent or criminal to the United States.[14] While there are strains of that thinking still present in our public debate,[15] the evolution of the mental health system and

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[10] PRESIDENTIAL TASK FORCE ON IMMIGRATION, CROSSROADS: THE PSYCHOLOGY OF IMMIGRATION IN THE NEW CENTURY 10–11 (2012), http://www.apa.org/topics/immigration/immigration-report.pdf [hereinafter CROSSROADS: THE PSYCHOLOGY OF IMMIGRATION IN THE NEW CENTURY].

[11] *See id.*; *see, e.g.*, Ronald C. Kessler et al., *The Epidemiology of Co-Occurring Addictive and Mental Disorders: Implications for Prevention and Service Utilization*, 66 AM. J. ORTHOPSYCHIATRY 17, 17 (1996) [hereinafter R. Kessler et al.]; Darrel A. Regier et al., *Comorbidity of Mental Disorders with Alcohol and Other Drug Abuse*, 264 J. AM. MED. ASS'N. 2511, 2511 (1990); *see* Alegría et al., *supra* note 9, at 363.

[12] *See* David Hoort, *Mental Illness and the Courts*, MICH. B. J., June 2012, at 29.

[13] *See* CROSSROADS: THE PSYCHOLOGY OF IMMIGRATION IN THE NEW CENTURY, *supra* note 10, at 72; Amelia Seraphia Derr, *Mental Health Service Use Among Immigrants in the United States: A Systematic Review*, 67 PSYCHIATRIC SERVICES 265, 266 (2016).

[14] *See* HIDETAKA HIROTA, EXPELLING THE POOR: ATLANTIC SEABOARD STATES AND THE 19TH CENTURY ORIGINS OF AMERICAN IMMIGRATION POLICY 193–94, 195(2017) ("Honest, intelligent, and industrious immigrants from all parts of the globe are always welcome, . . . but this country should not be made the dumping ground of European crime, pauperism, and idleness.").

[15] *See* Janell Ross, *From Mexican Rapists to Bad Hombres, the Trump Campaign in Two Moments*, WASH. POST: THE FIX (Oct. 20, 2016), https://www.washingtonpost.com/news/the-fix/wp/2016/10/20/from-mexican-rapists-to-bad-hombres-the-trump-campaign-in-two-moments/?utm_term=.07bec94368ea (illustrating President Donald Trump's comments about Mexican immigrants on this point).

the immigration removal system toward a criminal enforcement approach suggests that today many immigrants who do not receive adequate mental health treatment face removal for a wide variety of actions and offenses that grow out of the untreated mental issues.[16] In fact, what has happened is that the modern removal grounds for drug use and criminal behavior have replaced the traditional mental health exclusion grounds as means of deporting those deemed deficient.[17]

Lastly, Part V offers that the states may be the best location for re-framing the issue as one of access to mental health care. This is the case for two reasons. First, with the tone of the Trump administration at the federal level, there is scant reason to hope for reform that would address the mental health needs of immigrants.[18] Second, the states are the main actors in the provision of mental health services and the political environment in several states may be more open to viewing the problem as one of access to care.[19] Using states as a proving ground, we can evaluate how much improved access disrupts the cycle of removal.[20]

A few terms used in this piece should be explained. A mental illness is a condition that affects a person's thoughts, mood or behavior.[21] There are several broad categories of mental illness, which reveal the complexity of human psychology: anxiety disorders, attention deficit disorders, mood disorders such as depression, personality disorders, and schizophrenia are some of the categories identified by the major entities and organizations that study mental health.[22] This article will focus on the full range of

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[16] *See* DEPORTATION BY DEFAULT, *supra* note 7, at 14–15.

[17] *See* Caroline Easton, *Commentary: Substance Abuse and Criminality in the Mentally Disordered Defendant*, 33 J. OF THE AM. ACAD. PSYCHIATRY AND THE L. 196, 197 (2005); Juliet Stumpf, *The Crimmigration Crisis: Immigrants, Crime, and Sovereign Power*, 56, AM. U. L. REV. 367, 382–84.

[18] *See* Ross, *supra* note 15.

[19] *See 2016 State of Mental Health in America: Access to Care Data*, MENTAL HEALTH AM., http://www.mentalhealthamerica.net/issues/2016-state-mental-health-america-report-overview-historical-data (last updated 2016); *see also The Federal and State Role in Mental Health*, MENTAL HEALTH AM., http://www.mentalhealthamerica.net/issues/federal-and-state-role-mental-health (last visited Sep. 4, 2017).

[20] *See* L. ARON ET AL., NAT'L ALLIANCE ON MENTAL ILLNESS, GRADING THE STATES 2009: A REPORT ON AMERICA'S HEALTH CARE SYSTEM FOR ADULTS WITH SERIOUS MENTAL ILLNESS xii (2009), http://www.nami.org/About-NAMI/PublicationsReports/Public-Policy-Reports [hereinafter GRADING THE STATES 2009].

[21] *Mental Health Conditions*, NAT'L ALLIANCE ON MENTAL ILLNESS, https://www.nami.org/Learn-More/Mental-Health-Conditions (last visited Sept. 4, 2017). The National Alliance on Mental Illness is a leading non-profit, grassroots organization that promotes understanding about mental health. *See id.*

[22] *See, e.g.*, *Mental Disorders and Mental Health Topics*, NAT'L INST. OF MENTAL HEALTH,

these disorders and how they may bring an immigrant within the removal system. Further, this article uses the term "immigrant" and "immigrants" to discuss those who are not citizens, including those who entered without permission or who overstayed the permission they received.[23] Finally, this article will discuss refugees and asylum seekers, defined as those seeking protection from persecution or fear of persecution in their own country because of their race, religion, nationality, membership in a particular social group or their political opinion.[24]

II. THE OVERALL STATE OF MENTAL HEALTH CARE IN THE UNITED STATES

A. Overall Developments

Studies by mental health organizations have given the country a failing mark when it comes to our national mental health care system.[25] States, as the primary providers of services,[26] do not keep comprehensive statistics on what percentage of the population in need of services are helped, but estimates are that less than half of those with serious mental illness receive treatment.[27] This situation is partly an issue of funding and partly an issue of how our country has decided to provide treatment.[28]

The funding of mental health care is largely left to the states,[29]

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https://www.nimh.nih.gov/health/topics/index.shtml (last visited Sep. 4 2017); *Diseases and Conditions: Mental Illness*, MAYO CLINIC, http://www.mayoclinic.org/diseases-conditions /mental-illness/basics/definition/con-20033813 (last visited Sept. 4, 2017) (listing categories of mental illness).

[23] 8 U.S.C. § 1101(a)(15) (2012) (demonstrating that U.S. immigration law makes a basic distinction between immigrants and those coming temporarily for a specific purpose such as students, tourists, or those coming to fulfill some need in a specialized occupation. Those coming for limited time and purpose are known as nonimmigrants).

[24] *Id.* § 1101(a)(42) (defining the term "refugee"); *Id.* § 1158(a) (defining "asylum seekers" as those who are already present in the United States at the time of requesting protection).

[25] *See* GRADING THE STATES 2009, *supra* note 20, at ix.

[26] *See The Federal and State Role in Mental Health*, *supra* note 19. However, there is some federal oversight such as the Substance Abuse and Mental Health Services Administration (SAMHSA), part of the Department of Health and Human Services, which is the federal agency directly responsible for monitoring and promoting mental health. *See About Us*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., https://www.samhsa.gov/about-us (last visited Sep. 4, 2017).

[27] *See* GRADING THE STATES 2009, *supra* note 20, at 16; *see also More Americans Continue to Receive Mental Health Service, But Substance Use Treatment Levels Remain Low*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., https://www.samhsa.gov/news room/press-announcements/201509170900 (last updated Sept. 17, 2015).

[28] *See* GRADING THE STATES 2009, *supra* note 20, at ix.

[29] NAT'L ALLIANCE ON MENTAL HEALTH, MEDICAID EXPANSION & MENTAL HEALTH CARE 2

with support from the federal government through the matching dollars provided by Medicaid.[30] Medicaid plays the largest role in paying for services, providing coverage for mental health services as long as the recipient meets strict federal eligibility requirements.[31] States' Medicaid plans vary greatly in terms of how they define mental illness, which results in inconsistent coverage.[32] Additionally, federal rules prohibit the use of Medicaid funds to pay for inpatient services in mental health hospitals.[33]

Outside of the publicly funded programs, private insurance is the second major source for covering costs.[34] For those that can afford to pay for private insurance or receive it through their employer, up until the recent changes in parity requirements, private health plans could exclude or limit coverage for mental health services.[35] Private health insurance has consistently treated mental illness differently from physical illness.[36] There is no established definition of what constitutes a mental illness, allowing private insurers to exclude groups of people,[37] as do the states under Medicaid.[38]

When it comes to providing treatment, the overall arc of the treatment for the mentally ill in this country has been one of de-institutionalization, in which those with mental illness no longer receive their care in the structured environment of a hospital or similar facility.[39] This move was seen as an improvement over the inhumane conditions of the system that evolved from the nineteenth century up until the 1950s, shifting to a system that focused on patients' rights.[40] But, as states have moved toward

(2013), (https://www.nami.org/getattachment/About-NAMI/Publications/Reports/2013MedicaidReport.pdf) [hereinafter MEDICAID EXPANSION & MENTAL HEALTH CARE].

[30] *See id.*, at 1–2; GRADING THE STATES 2009, *supra* note 20, at 6.

[31] *See* GRADING THE STATES 2009, *supra* note 20, at 6; *see also* Suann Kessler, *Mental Health Parity: The Patient Protection and Affordable Care Act and the Parity Definition Implications*, 6 HASTINGS SCI. & TECH. L.J. 145, 150 (2014) [hereinafter S. Kessler].

[32] *See* S. Kessler, *supra* note 31, at 151.

[33] *See* GRADING THE STATES 2009, *supra* note 20, at 6. This is an antiquated restriction from the 1960s when the view of mental health professionals was that community treatment was the better and cheaper approach to institutionalization. *See* MEDICAID EXPANSION & MENTAL HEALTH CARE, *supra* note 29, at 6.

[34] *See* S. Kessler, *supra* note 31, at 151.

[35] *See id.*

[36] *See* Olukunle Fadipe, Note, *Affordable Mental Care in the Post Healthcare Reform Era*, 57 WAYNE L. REV. 575, 579–80 (2011).

[37] *See id.* at 576–77.

[38] *See id.* at 591–92.

[39] *See* Alexander Gralnick, *Build a Better State Hospital: Deinstitutionalization Has Failed*, 36 HOSP. AND COMMUNITY PSYCHIATRY 738, 738 (1985); Hoort, *supra* note 12, at 29.

[40] *See* Gralnick, *supra* note 39, at 738. *See also* John Monahan & Henry Steadman, *Toward a Rejuvenation of Risk Assessment Research*, *in* VIOLENCE AND MENTAL DISORDER:

deinstitutionalization, they have operated disjointed systems of care that leave gaps, not adequately balancing outpatient services with the reduction in inpatient beds.[41]

B. The Consequences

For over thirty years scholars have explored the impact of deinstitutionalization on the mentally ill population, in which they have moved from institutions to living on the street, engaging in behavior seen as deviant, and being drawn into the criminal justice system.[42] Studies correlate mental illness with an increased likelihood of a series of negative living conditions: the increased likelihood of being persistently homeless;[43] of having drug and alcohol addiction;[44] and being incarcerated.[45] The connection between mental illness and behaviors such as drug and alcohol use and criminality is complex. Surveys and studies identify a correlation between mental illness and negative behaviors but are careful not to assign causality. However, they do note consistent observations.[46]

First, there is a high degree of co-occurrence (comorbidity in psychological parlance) of mental health issues and substance abuse disorders.[47] A major nationwide survey of mental health in the United States in the 1990s revealed this connection as well as that co-occurring addictive and mental disorders had fairly low rates of treatment,[48] and that mental disorders usually appear in people

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DEVELOPMENTS IN RISK ASSESSMENT 1, 1 (John Monahan & Henry Steadman eds., 1994).

[41] *See* GRADING THE STATES 2009, *supra* note 20, at 32.

[42] *See* John R. Belcher, *Are Jails Replacing the Mental Health System for the Homeless Mentally Ill?*, 24 COMMUNITY MENTAL HEALTH J., no. 3, Fall 1988, at 185. *See also* Megan Testa, *Imprisonment of the Mentally Ill: A Call for Diversion to the Community Mental Health System*, 8 ALB. GOV'T L. REV. 405 (2015).

[43] Dale McNiel et al., *Incarceration Associated with Homelessness, Mental Disorder, and Co-occurring Substance Abuse*, 56 PSYCHIATRY SERVICES 840, 844–45 (2005).

[44] *See, e.g.*, R. Kessler, et al., *supra* note 11, at 17; Regier et al., *supra* note 11, at 2511.

[45] *See, e.g.*, McNiel et al., *supra* note 43, at 840; Lilian Gelberg et al., *Mental Health, Alcohol and Drug Use, and Criminal History Among Homeless Adults*, 145 AM. J. PSYCHIATRY, no. 2, Feb. 1988, at 194.

[46] *See, e.g.*, R. Kessler et al., *supra* note 11, at 28.

[47] *See id.* at 17.

[48] *See id.* at 17–18, 24. The major study was called the Nation Comorbidity Survey (NCS), Baseline, which was conducted from 1990–1992 and was followed by a re-interview in 2001 to 2002. There have been a few other follow-up surveys as well. *See Questions and Answers About the National Comorbidity Survey Replication (NCSR) Study*, NAT'L INST. OF MENTAL HEALTH, https://www.nimh.nih.gov/health/topics/ncsr-study/questions-and-answers-about-the-national-comorbidity-survey-replication-ncsr-study.shtml (last visited Oct. 6, 2017).

first followed by an addictive disorder.[49] Those drawing on the study noted that temporal order does not imply causal relation nor does occurrence of one predict the occurrence of the other.[50] However, there are several explanations for the connection, including that people are self-medicating with alcohol and drugs, and are in social contexts that promote addictive behavior or do not offer support to avoid it.[51]

Second, studies connecting mental health problems to criminality observe that the mentally ill are overrepresented in the incarcerated population.[52] Minor norm violations reflective of a disordered mental state, as well as more serious crimes, result in those with mental health problems having greater contact with law enforcement.[53] While recognizing concerns that the mentally ill are being criminalized because of their condition, scholars acknowledge that the mentally ill have elevated rates of violence[54] although the absolute rate of violence is not very high.[55] Studies reveal that co-occurring substance abuse together with mental illness increases the risk of violent behavior.[56] A lack of training on the part of law enforcement agencies can also result in arrest for people with mental illness rather than counseling.[57] Studies show that people with mental illness are twice as likely to be arrested than others for the same conduct, because law enforcement officers believe arresting them is better than leaving them on the street, easier

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[49] *See* R. Kessler et al., *supra* note 11, at 21.

[50] *See id.* at 28.

[51] *See id.* at 28–29.

[52] *See, e.g.*, McNiel et al., *supra* note 43, at 840.

[53] *See* Belcher, *supra* note 42, at 187, 192.

[54] *See* Patricia Brennan et al., *Major Mental Disorders and Crime in the Community, in* VIOLENCE AMONG THE MENTALLY ILL 3 (Sheilagh Hodgins ed., 2000); *see also* Bruce G. Link & Ann Stueve, *Psychotic Symptoms and the Violent/Illegal Behavior of Mental Patients Compared to Community Controls, in* VIOLENCE AND MENTAL DISORDER: DEVELOPMENTS IN RISK ASSESSMENT, *supra* note 40, at 154, 137.

[55] *See* Jeffrey W. Swanson, *Mental Disorder, Substance Abuse, and Community Violence: An Epidemiological Approach*, *in* VIOLENCE AND MENTAL DISORDER: DEVELOPMENTS IN RISK ASSESSMENT, *supra* note 40, at 101, 132.

[56] Brennan et al., *supra* note 54, at 13. Most of the large-scale studies looking at mental illness and violence, involving broad population surveys, come from European countries such as Sweden, Denmark, Finland. *See id.* There are several important studies conducted in the United States, such as the Epidemiological Catchment Area (ECA) survey conducted in the 1990s. *See id.* at 7. Also, the MacArthur Violence Risk Assessment Study, conducted in the late 1990s, looked at the connection to violence. *See id.* Each of these studies used different methods for studying this issue but aimed at capturing data from a large cohort of people. *See id.*

[57] *See* Tammy Seltzer et al., *Mental Health Courts: A Misguided Attempt to Address the Criminal Justice System's Unfair Treatment of People with Mental Illnesses Mental Health Courts*, 11 PSYCHOL. PUB. POL'Y & L. 570, 572–73 (2005).

than trying to address their mental health issues, or because officers simply do not want to continue to encounter the person on a daily basis.[58]

Today, "[n]early 2 million people with mental illness are detained in jails [and prisons] across the United States."[59] Nearly three quarters of this two million also have drug or alcohol use problems,[60] which creates significant immigration issues for those who are not citizens.[61] Half of all inmates and more than half of the youth (at least sixty-five percent) in the criminal justice system have mental health issues.[62] Studies particularly examining the homeless with a co-occurring mental illness and substance abuse problem note that jail stays are longer and are more likely to occur multiple times for this population.[63] Today, contact with mental health treatment occurs in jails and prisons to a large degree.[64] Historically, treatment has been fragmented, with addiction recovery funded and operated separately from mental health programs.[65] The mentally ill population is less likely to make use of outpatient mental health treatment, particularly if homeless,[66] and can be resistant to treatment.[67] Treatment opportunities are not evenly distributed across socio-economic classes and ethnic groups, with ethnic minorities having less access.[68] There are significant disparities among the states in assuring cultural competency of mental health care providers, meaning that providers may lack sensitivity to race, national origin, religion, age and a variety of other personal characteristics.[69]

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[58] *See id.* at 573.

[59] NAT'L ALLIANCE ON MENTAL ILLNESS, STATE MENTAL HEALTH LEGISLATION 2015: TRENDS, THEMES & EFFECTIVE PRACTICES 14 (2015) [hereinafter STATE MENTAL HEALTH LEGISLATION 2015].

[60] *The Problem*, THE STEPPING UP INITIATIVE, https://stepuptogether.org/the-problem (last visited Oct. 8, 2017).

[61] *See* CROSSROADS: THE PSYCHOLOGY OF IMMIGRATION IN THE NEW CENTURY, *supra* note 10, at 9.

[62] STATE MENTAL HEALTH LEGISLATION 2015, *supra* note 59, at 14.

[63] *See, e.g.*, McNiel et al., *supra* note 43, at 843.

[64] *See, e.g.*, *id.* at 841 (demonstrating that inmates have access to licensed health professionals).

[65] *See* Fred C. Osher & Robert E. Drake, *Reversing a History of Unmet Needs: Approaches to Care of Persons With Co-Occurring Addictive and Mental Disorders*, 66 AM. J. ORTHOPSYCHIATRY, no. 1, Jan. 1996, at 6 (explaining the history of the federal response to mental and addictive disorders).

[66] *See* McNiel et al., *supra* note 43, at 840*; see also* Gelberg et al., *supra* note 45, at 194–195.

[67] *See* GRADING THE STATES 2009, *supra* note 20, at 4.

[68] *Id.* at 33.

[69] *Id.* at 36.

C. Recent Developments

There have been notable improvements in the past several years. With regard to access, Medicaid expansion, mandates for insurance coverage, and parity requirements have significantly improved the landscape.[70] The 2010 Patient Protection and Affordable Care Act ("ACA")[71] provided states with the opportunity to expand their Medicaid programs by covering anyone earning 138 percent or less of the federal poverty level.[72] Thirty states and District of Columbia have taken this step, improving the numbers of poor people receiving assistance including mental health care.[73] These Medicaid-run programs must now provide coverage that includes the provision of mental health treatment.[74] This requirement also extends to non-Medicaid plans identified in the ACA.[75]

The ACA also established an individual mandate, requiring anyone not covered by an employer plan to obtain an insurance policy.[76] To facilitate options, the ACA set up health insurance marketplaces (also known as exchanges), operated either by the individual states or, in the absence of state involvement, by the federal government.[77] The markets provide both individual and small business policies.[78] Policies on these exchanges are significantly restricted by the ACA.[79] Insurance companies can no longer discriminate on the basis of preexisting conditions, including mental illness.[80] High premiums may not be charged to similarly situated participants, although there is no cap on the maximum premium an insurance company may charge.[81] Policies may not be rescinded except in cases of fraud, nor may premiums go up when a participant must use the policy.[82]

Parity requirements mean that health care plans from certain

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[70] *See* Fadipe, *supra* note 36, at 586–87.
[71] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).
[72] *See* MEDICAID EXPANSION & MENTAL HEALTH CARE, *supra* note 29, at 1.
[73] *See* STATE MENTAL HEALTH LEGISLATION 2015, *supra* note 59, at 5.
[74] *See* Fadipe, *supra* note 36, at 585.
[75] *See* Kathleen G. Noonan & Stephen J. Boraske, *Enforcing Mental Health Parity Through the Affordable Care Act's Essential Health Benefit Mandate*, 24 ANN. HEALTH L. 252, 268 (2015).
[76] *See* S. Kessler, *supra* note 31, at 158.
[77] *See id.* at 158–59; *see also* Namrata K. Uberoi et al., Cong. Research Serv., *Overview of Health Insurance Exchanges*, Report for Congress, R44065, 5–8 (2016)
[78] *See* S. Kessler, *supra* note 31, at 158.
[79] *See* Uberoi, *supra* note 77, at 6.
[80] *See* Fadipe, *supra* note 36, at 583.
[81] *Id.*
[82] *Id.* at 583–584.

employers must provide mental health and substance abuse treatment coverage on par with other health insurance coverage.[83] Parity requirements developed over a number of years[84] with the ACA finally mandated that public and private insurance policies provide mental health services as part of essential health benefits.[85] The policies on the exchanges are also subject to the parity requirement.[86] The essential health benefit provision was particularly singled out for attempted elimination in the most recent attempted repeal of the ACA.[87] From the perspective of those advocating for greater access to mental health care, its survival is a good thing.

There are important limitations to the parity mandate. Plans in existence prior to the passage of the ACA in 2010 were not required to provide basic mental health coverage.[88] Under the law prior to the ACA, a health plan is under a parity requirement only if it offered mental health coverage.[89] Nor are plans for small employers (between one and one hundred employees) subject to the parity requirement.[90]

While enforcement of parity requirements and monitoring the provision of essential health benefits is shared between the federal government and the states, primary responsibility has been left to the states alone.[91] The record is not good on enforcement because of ambiguities in the law that lack an enforcement framework, as well as a lack of resources and will on the part of the states.[92] Generally speaking, it appears that no one is monitoring any of the

[83] *See* STATE MENTAL HEALTH LEGISLATION 2015*, supra* note 59, at 6; *see also* S. Kessler, *supra* note 31, at 154.

[84] The initial law on this subject was the 1996 Mental Health Parity Act (MHPA), which prohibited insurance plans from setting different lifetime spending limits for physical versus mental health services. *See* S. Kessler, *supra* note 31, at 153–154. Next came the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), which prohibited more restrictive treatment and financial limits for mental health treatment as compared to other coverage. *See id.* at 156. Neither Act, however, required that private insurers provide mental health coverage. *See id.* at 157.

[85] *See id.* at 159.

[86] *See* Fadipe, *supra* note 36, at 585.

[87] Haeyoun Park, *The 'Essential Health Benefits' Conservatives Are Pushing to Cut*, N.Y. TIMES (Mar. 24, 2017), https://www.nytimes.com/interactive/2017/03/24/us/essential-health-benefits.html.

[88] *See* S. Kessler, *supra* note 31, at 150.

[89] *See id.* at 160–61.

[90] *See id.*

[91] *See, e.g.*, Noonan & Boraske, *supra* note 75, at 266–67.

[92] *See id.* at 270–71. Some states are passing statutes to mirror federal parity requirements. *See* STATE MENTAL HEALTH LEGISLATION 2015, *supra* note 59, at 6.

enforcement efforts that are taking place.[93]

Lastly, at the time of the writing of this article, the ACA remains a target of attempts to undermine or repeal it.[94] So, the gains in mental health coverage could be short-lived depending on what replacement Congress fashions.

When it comes to spending on mental health care, states are slowly improving after huge reductions caused by financial struggles.[95] They are investing in integrated services that address acute care and track the need of services such as inpatient psychiatric beds.[96] There are innovations occurring in the delivery of mental health care, driven by a shortage of mental health professionals.[97] Given the significant number of people entering the criminal justice system with mental health issues, some states have begun training law enforcement officers in crisis intervention and created mental health courts to divert some defendants into treatment programs instead of incarceration.[98] For those in detention, there have been some attempts by states to improve access to mental health services.[99]

Our national attention on the treatment of mental illness has been refocused by the tragedy of recent mass shootings.[100] The recent positive developments noted above take place in the larger context of a mental health system that does not even come close to meeting the needs of our population and a legal system that still sees aspects of mental illness and drug addiction as a personal

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[93] *See* Noonan & Boraske, *supra* note 75, at 270–71.

[94] *See* Wilson Andrew & Haeyoun Park, *The Senate Is Close to a Health Care Bill, But Do Republicans Have the Votes?,* N.Y. TIMES (June 19, 2017), https://www.nytimes.com/interactive/2017/06/19/us/where-senators-stand-on-health-care.html?mcubz=0&_r=0; *see* Byron York, Opinion, *No, House Republicans Haven't Voted 50 Times to Repeal Obamacare*, WASH. EXAMINER (Mar. 15, 2014), http://www.washingtonexaminer.com/no-house-republicans-havent-voted-50-times-to-repeal-obamacare/article/2545733.

[95] *See* STATE MENTAL HEALTH LEGISLATION 2015, *supra* note 59, at 3–4.

[96] *See id.* at 12.

[97] *See id.* at 7.

[98] *See id.* at 14–15. Some studies have shown mental health court to be effective at reducing recidivism and avoiding incarceration. *See* Heidi Herinckx et al., *Rearrest and Linkage to Mental Health Services Among Clients of the Clark County Mental Health Court Program*, 56 PSYCHIATRIC SERVICES 853, 853 (2005); Dale E. McNiel & Renee L. Binder, *Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence*, 164 AM. J. PSYCHIATRY 1395, 1395 (2015). However, there are also criticisms, such as how the presence of the courts "makes it more difficult to generate political will to address the root of the problem." *See* Seltzer et al., *supra* note 57, at 570.

[99] *See* STATE MENTAL HEALTH LEGISLATION 2015, *supra* note 59, at 15.

[100] *See* Tom Wiehl, *The Presumption of Dangerousness: How New York's SAFE Act Reflects Our Irrational Fear of Mental Illness*, 38 SETON HALL LEGIS. J., 35, 42 (2013).

failure rather than an illness.[101] As the next section demonstrates, immigrants have particular mental health needs as they encounter this disjointed system. While the positive impact of some these developments will be noted in the next Part, there are still parts of the immigrant population that have significant unmet needs.[102]

III. MENTAL HEALTH CHALLENGES OF IMMIGRANTS IN THE UNITED STATES

A. A General Description of the Mental Health Challenges

The psychological health of immigrants is a very complicated subject, with significant variations in health depending upon a multitude of factors: country of origin, length of time in the United States, family and community relations in the United States, and socio-economic status.[103] There are plenty of psychological studies in the academic literature about immigrants and mental health issues.[104] Overall, two important facts should be noted. First, immigrants show remarkable resiliency in the face of the challenges they confront in the process of migration.[105] Some immigrant groups, notably Mexican immigrants, initially report lower incidents of mental issues such as depression, anxiety and substance abuse problems as compared to United States-born Latino and non-Latino populations.[106] As noted above, psychologists call this the "immigrant paradox" in that immigrants tend to be healthier when initially confronting the challenges of immigration, discussed below.[107] This runs contrary to popular misperceptions and is reflected in earlier studies that asserted

[101] *See, e.g.,* Roberta Leis & David Rosenbloom, Special Issue, *The Road from Addiction Recovery to Productivity: Ending Discrimination Against People with Drug and Alcohol Problems*, 47 FAM. CT. REV. 274, 279 (2009); Stephanie Desmon & Susan Morrow, *Drug Addiction Viewed More Negatively than Mental Illness, Johns Hopkins Study Shows*, JOHNS HOPKINS UNIVERSITY: HUB (Oct. 1, 2014), https://hub.jhu.edu/2014/10/01/drug-addiction-stigma/.

[102] *See* CROSSROADS: THE PSYCHOLOGY OF IMMIGRATION IN THE NEW CENTURY, *supra* note 10, at 9.

[103] *See id.*

[104] *See id.* at 11–18 (showing that the list of references at the end of APA report on immigration report reveals the remarkable number of studies undertaken concerning the mental health of immigrants).

[105] *See id.* at 3.

[106] *See* Alegría et al., *supra* note 9, at 359.

[107] *See id.* There is some disagreement over the term, with some studies referring to a Latino Paradox, or an epidemiological paradox. *See* CROSSROADS: THE PSYCHOLOGY OF IMMIGRATION IN THE NEW CENTURY, *supra* note 10, at 10.

immigrants were at higher risk for mental health problems.[108]

It should be noted that not all studies agree with the description of the immigrant paradox,[109] and some have concluded that it is more limited and qualified.[110] But overall there is agreement (in the United States and other immigrant-receiving countries such as Canada) that migration bestows some limited protective effect on the physical and mental health of immigrants.[111] However, studies show that over time the overall mental and physical health of many immigrants deteriorates to reflect the mental and physical health problems of the U.S. general public.[112] Along with deteriorating mental health, studies concerning comorbidity (co-occurrence of mental illness and substance abuse) show an increase in drug and alcohol disorders as mental health declines.[113] Another aspect of the paradox is that the second generation born in the United States fares worse than the first immigrant generation for major mental health issues such as depression[114] and substance abuse problems.[115]

A second important fact is that immigrant populations tend to underutilize mental health services,[116] and mental health care providers tend to underserve immigrant mental health needs due to a variety of factors that will be explored below. In spite of their resiliency, immigrants face a host of unique stressors that can lead to the need for mental health services.[117] Needs range from counseling to far more serious intervention, and it is the

[108] David Takeuchi et al., Editorial, *Immigrant and Mental Health: Diverse Findings in Asian, Black, and Latino Populations*, 97 AM. J. PUB. HEALTH, no. 1, Jan. 2007, at 11.

[109] *See* CROSSROADS: THE PSYCHOLOGY OF IMMIGRATION IN THE NEW CENTURY, *supra* note 10, at 9–10.

[110] Alejandra Casillas et al., *A Long Way from Home: Comparing Mental Health Measures between Foreign and U.S.-born Latino in the Multi-Ethnic Study of Atherosclerosis (MESA)*, 23 J. HEALTH CARE FOR THE POOR AND UNDERSERVED, no. 4 (forthcoming 2012) (manuscript at 2) (on file with HHA Public Access).

[111] Laurence J. Kirmayer et al., *Common Mental Health Problems in Immigrants and Refugees: General Approach in Primary Care*, 183 CANADIAN MED. ASS'N J., no. 12, Sept. 6, 2011, at E960.

[112] *See, e.g.*, Alegría et al., *supra* note 9, at 364–65.

[113] *See, e.g.*, William Vega et al., *Co-occurring Alcohol, Drug, and Other Psychiatric Disorders Among Mexican-Origin People in the United States*, 93 AM. J. PUB. HEALTH 1057, 1058, 1062 (2003).

[114] *Cf. The Latino Paradox: Mental Health Appears to Not Be an Exception*, NAT'L ALLIANCE ON MENTAL ILLNESS (Oct. 15, 2013), http://www.nami.org/Blogs/NAMI-Blog/October-2013/The-Latino-Paradox-Mental-Health-Appears-to-Not-B (discussing how certain areas of health deteriorate among immigrants in the years following their arrival).

[115] *See id.*; Vega et al., *supra* note 113, at 1062.

[116] *See* Derr, *supra* note 13, at 266.

[117] *See id.* at 265.

shortcoming in meeting these needs that prompts the question of how untreated mental illness might impact immigration status.[118]

As a group, most immigrants suffer the ordinary strains of dislocation and acculturation.[119] The process of acculturation is stressful even though it does not necessarily result in negative mental health consequences.[120] A recent report by the American Psychological Association studying the psychology of immigrants and immigration identified the multifaceted ways that this process impacts immigrants.[121] A whole host of changes such as negotiating a new language, shifting employment options, altered gender roles, and changes in relationship to one's children, effect fundamental aspects of identity.[122] There are particularly vulnerable groups that have extraordinary challenges. Those whose migration was prompted by, or resulted in, traumatic experiences, such as refugees, and other victims of violence, are a prime example.[123] The APA Study identified these groups as likely to be underserved.[124] Other vulnerable groups the report identified included women and girls, minors, LGBT immigrants and those with physical disabilities.[125] The mode of migration can also impact the degree of mental distress suffered as with undocumented immigrants, especially for those who are victims of human trafficking or are unaccompanied minors.[126] Studies confirm what one would expect: fear of deportation generates increased anxiety and poorer mental health.[127]

The APA Study discusses the critical role the larger social context plays in this process. A variety of larger societal changes have added to the stresses faced by immigrants in the immigration process.[128] Since the 1960's, the migratory flow to the United States

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[118] *See id.* at 267–68, 270.

[119] *See* CROSSROADS: THE PSYCHOLOGY OF IMMIGRATION IN THE NEW CENTURY, *supra* note 10, at 26.

[120] *See id.* at 28.

[121] *See id.* at 28, 29.

[122] *See id.* at 27, 29.

[123] *See id.* at 38.

[124] *See id.* at 32.

[125] *See id.* at 32, 33, 38, 40.

[126] *See id.* at 35–36.

[127] *See, e.g.*, Karen Hacker et al., *The Impact of Immigration and Customs Enforcement on Immigrant Health: Perceptions of Immigrants in Everett, Massachusetts, USA*, 73 SOC. SCI. MED. 586, 591 (2011). Interestingly, this study showed that feeling of vulnerability and negative health consequences arose regardless of whether someone had lawful status. *See id.* at 592–93.

[128] *See* CROSSROADS: THE PSYCHOLOGY OF IMMIGRATION IN THE NEW CENTURY, *supra* note 10, at 21, 23.

has shifted from Europe to Asia, Latin America and elsewhere changing the racial complexion of the United States.[129] The percentage of the U.S. population that is foreign born has risen significantly in the last forty years.[130] The aftermath of September 11, 2001 has stimulated fears about this increasingly large population that is distinct from the majority culture of the United States.[131] All of these factors produce an environment of heightened xenophobia, leading to discrimination and racism.[132] Stereotypes, particularly of Muslim, Latino and Asian immigrants, have measurable negative impact on the physical and mental health of these populations.[133]

In the face of these factors that implicate mental health, studies of migrant access and use consistently reveal both that immigrant populations are underserved and they underutilize mental health services.[134] Studies focusing on the Latino population, given its significant growth in size,[135] note that even with the lower occurrence of mental disorders in the recently arrived population, Latinos are far less likely to use mental health services when in need than the population as a whole.[136] This is particularly true for Mexican immigrants as compared with native-born Mexican Americans.[137] The degree of underutilization may vary among different immigrant groups but it is clearly a phenomenon affecting all immigrant groups.[138]

B. Barriers to Treatment

Those studying the phenomenon of immigrant underutilization of mental treatment have offered a variety of explanations for the underutilization of services by immigrants.[139] There are social-cultural barriers, such as language differences, which can result in

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[129] *See id.* at 18.
[130] *See id.* at 9, 17 fig.2.
[131] *See id.* at 21.
[132] *See id.* at 7, 21.
[133] *See id.* at 65.
[134] *See id.* at 66.
[135] *See, e.g.*, Susan Caplan & Steven Buyske, *Depression, Help-Seeking and Self-Recognition of Depression Among Dominican, Ecuadorian and Colombian Immigrant Primary Care Patients in the Northeastern United States*, 12 INT'L J. OF ENV'T. RES. & PUB. HEALTH, 10450, 10451 (2015).
[136] *See, e.g.*, *id.*
[137] *See* William A. Vega et al., *Help Seeking for Mental Health Problems Among Mexican Americans*, 3 J. IMMIGRANT HEALTH, no. 3, 2001, at 133, 134.
[138] *See, e.g.*, Derr, *supra* note 13, at 266.
[139] *See id.* at 268–69.

misunderstandings about the description of problems and conflicting views about causes.[140] Perhaps more prominently, the social stigma attached by some cultures to mental health problems contributes to lower usage.[141] Studies of the Muslim and the Latino immigrant communities detail the significant role that religious belief and family may play in directing individuals away from seeking treatment.[142] Cultural norms may lead those in need of mental health services to turn to other sources for treatment such as leaders in their religious community, their family, or friends.[143] They also reveal distrust by immigrants of mental health counselors who are perceived as not sharing their values, a feeling which is compounded by feelings of discrimination or rejection of those cultural values.[144]

There are also structural barriers in which the availability and the delivery of the services may prevent immigrant access.[145] Studies note a lack of culturally sensitive mental health services, and a lack of financial support to obtain services.[146] Poverty plays an important role in some immigrants lacking access to mental health services.[147] A systematic review of the use of mental health by immigrants shows cost as a leading barrier to access.[148] One study showed that the uninsured rate was three times higher among immigrants than among native-born Americans.[149] Part of this story of the lack of insurance for immigrants is tied to the famous "welfare reform" law signed by President Bill Clinton, the 1996 Personal Responsibility and Work Opportunity Reconciliation Act ("PRWORA").[150] This law cut off approximately 935,000 noncitizens from federally means-tested benefits, including

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[140] *See id.*

[141] *See id.* at 268; *see also* Saara Amri & Fred Bemak, *Mental Health Help-Seeking Behaviors of Muslim Immigrants in the United States: Overcoming Social Stigma and Cultural Mistrust*, 7 J. MUSLIM MENTAL HEALTH, no. 1, 2013, at 49–50.

[142] *See, e.g.*, Amri & Bemak, *supra* note 141, at 50; *see also* Caplan & Buyske, *supra* note 135, at 10452.

[143] *See* Derr, *supra* note 13, at 267.

[144] *See* Amri & Bemak, *supra* note 141, at 51.

[145] *See* Derr, *supra* note 13, at 268–69.

[146] *See id.*

[147] *See* CROSSROADS: THE PSYCHOLOGY OF IMMIGRATION IN THE NEW CENTURY, *supra* note 10, at 72.

[148] *See* Derr, *supra* note 13, at 269 tbl. 3.

[149] *Id.*

[150] *See* Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, § 402(b)(1), 110 Stat. 2262–63 (1996) (codified 8 U.S.C. § 1612 (2012)); *see also* Amanda Levinson, *Immigrants and Welfare Use*, MIGRATION POLICY INSTITUTE (Aug. 1, 2002), http://www.migrationpolicy.org/article/immigrants-and-welfare-use (discussing the impact of PRWORA on immigrants).

Medicaid, the primary federal program for providing health care to the poor.[151]

The PRWORA established strict eligibility requirements for immigrants entering on or after August 22, 1996[152] and established that only qualified immigrants could receive Medicaid.[153] To be qualified, an immigrant had to be a lawful permanent resident, a refugee or someone granted asylum,[154] or hold another specific immigration status listed in the statute.[155] In addition, the law required that qualified immigrants reside in the United States for five years before becoming eligible.[156] Like other parts of the PRWORA, there are lists of exceptions to this five-year bar.[157]

This law gave states the power to add further eligibility requirements in order to receive federally funded Medicaid,[158] or

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[151] *See* Levinson, *supra* note 150. The PRWORA made several other changes to several programs. For example, it ended Aid to Families with Dependent Children. *See* KEVIN R. JOHNSON ET AL., UNDERSTANDING IMMIGRATION LAW 83–84 (2d ed. 2015). It cut off all lawful permanent residents from food stamps and Medicare's Supplemental Security Income (SSI) unless the lawful permanent resident worked forty quarters as defined by the Social Security Act. *See* 8 U.S.C. §§ 1612(a)(2)(B) (2012), 1612(a)(3)(A) (2012). Refugees and asylees can also receive these benefits for the first 7 years. *See id.* § 1612 (a)(2)(A). Veterans and immigrants on active duty are also exempted from being cut-off. *See id.* § 1612(a)(2)(C)(i–ii). However, the PRWORA did preserve some federal benefits for immigrants regardless of whether they are qualified, such as emergency Medicaid coverage for everyone regardless of legal status. *See id.* § 1611(b)(1)(A).

[152] *See* Levinson, *supra* note 150.

[153] *See* Personal Responsibility and Work Opportunity Reconciliation Act §§ 402(b)(1), (b)(3)(C), 431(b).

[154] *See* 8 U.S.C. § 1101(a)(42) for the definition of refugee. *See id.* §§1158(a)(1), (c)(1) for the qualifications to be granted asylum.

[155] *See id.* § 1641(b). The list includes people granted parole (allowed to remain in the United States even though not lawfully admitted) for one year or more, Cuban and Haitian entrants, an immigrant whose deportation has been withheld and certain immigrants battered by a spouse or parent. *See id.* §§ 1641(b), (c)(2)(A).

[156] *See id.* § 1613(a).

[157] *See id.* § 1613(b)(1). Those not subject to the five-year bar include refugees, asylees, those whose deportation was withheld (now called Cancellation of Removal), Cuban and Haitian entrants, and aliens admitted as an Amerasian immigrant. *See id.* § 1613(b)(1)(A), (B), (D). Immigrants who are veterans or on active duty in the Armed Forces of the United States and their spouses and unmarried dependent children enjoy exemption as well. *See id.* § 1613(b)(2). Also exempted are those who have been the victim of trafficking. *See* Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, § 107(b)(1)(A), 114 Stat. 1474 (2000) (codified as 22 U.S.C. § 7105 (2012)).

[158] *See* 8 U.S.C. § 1612(b)(1), (2)(A), (B). *See also* JOHNSON, *supra* note 151, at 83 (explaining that the federal government limited benefits to legal immigrants and allowed state and local governments to act similarly). As with all other section of the PRWORA, there is a lengthy list of fairly narrow exceptions. Refugees and asylees may receive Medicaid for seven years after they are admitted in that status, immigrants whose deportation has been withheld (now called Cancellation of Removal), Cuban and Haitian entrants, those designated as an Amerasian immigrant for five years after entry. *See* 8 U.S.C. § 1612(b)(2)(A)(i)(IV), (V). Lawful permanent residents who have worked forty qualifying quarters under the Social Security Act are also eligible under all circumstances for Medicaid. *See id.* § 1612(b)(2)(B).

state funded benefits.[159] States also have flexibility in extending coverage as well for those not facing the five-year bar.[160] As a result, the law is remarkably complicated. Undocumented immigrants, although never technically eligible for benefits, were explicitly cut out by the federal law.[161]

The PRWORA's changes are relevant for this topic because Medicaid is the single largest payer for mental health care in the country,[162] and having health insurance has been positively linked to obtaining mental health services in the majority of studies.[163] The program is particularly focused on providing health care for the poor so the impact on immigrant families was particularly significant.[164] Since the PRWORA, low-income immigrants have had significantly lower participation rates in Medicaid than low-income citizens.[165]

The flexibility provided to the states through the PRWORA produced variations by state in Medicaid coverage when comparing the immigrant population with the native born population.[166] Studies show that states with more exclusive eligibility rules produced larger gaps in coverage between native born and immigrant populations and these inequalities were strengthened in states with lower immigrant density.[167] Larger immigrant populations were seen to alleviate the stigma of seeking welfare benefits and provided immigrants with information networks in their communities to go through the steps of applying for benefits to which they were entitled.[168] There are of course exceptions to this

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Lastly immigrants who are veterans or on active duty in the U.S. Armed Forces and their spouse sand unmarried dependent children are eligible under all circumstances for Medicaid. *See id.* § 1612(b)(2)(C).

[159] *See id.* § 1622(a).

[160] *See* Soskin v. Reinertson, 353 F.3d 1242, 1245 (10th Cir. 2014); Jacqueline Hagan, *The Effects of Recent Welfare Reform on Immigrants' Access to Health Care*, 37 INT'L MIGRATION REV. 444, 446 (2003); Gregory T.W. Rosenberg, *Alienating Aliens: Equal Protection Violations in the Structures of State Public Benefit Schemes*, 15 U. PA. L. 1417, 1429 (2014); Ling Zhu & Ping Xu, *The Politics of Welfare Exclusion: Immigration and Disparity in Medicaid Coverage*, 43 POL'Y STUDIES J. 456, 459 (2015).

[161] *See* Levinson, *supra* note 150.

[162] *See Behavioral Health Services*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/benefits/bhs/index.html (last visited Oct. 12, 2017).

[163] *See* Derr, *supra* note 13, at 269. Although, the comprehensive review of studies by Dr. Derr did note that some studies found a positive correlation only with private insurance and some studies found no correlation at all. *See id.* at 269–70.

[164] *See* Levinson, *supra* note 150.

[165] *See* Zhu & Xu, *supra* note 160, at 459.

[166] *See id*. at 459, 460.

[167] *See, e.g.*, *id*. at 458.

[168] *See id*. at 460–461.

general description.

States such as California, Illinois, Massachusetts, New York and Pennsylvania have high levels of immigrant inclusion in their Medicaid programs.[169] Alabama, Arizona, South Dakota, Texas and Wyoming are among those identified in studies as having low immigrant inclusion levels, providing very limited Medicaid coverage.[170] This listing shows that large immigrant populations do not necessarily result in immigrant-friendly policies, as demonstrated by Arizona and Texas.[171] But overall, studies reflect the fact that states serving as gateways to immigrant populations tend to be more inclusive and states with smaller and more recently arrived immigrant populations tend to be more exclusive.[172]

Disparities are also reflected in purely state funded programs other than Medicaid.[173] Several counties in California, for example, began providing health care benefits to undocumented immigrants,[174] thus joining the District of Columbia in providing health insurance to all adults, regardless of immigration status.[175] Some states allow children and pregnant women regardless of immigration status to receive state funded health care (Massachusetts, Illinois, New York, Washington) but most states require lawful presence before extending coverage in order to receive federal support under federal law.[176] A listing of the variety of programs shows the remarkable complexity and diversity of state benefits regimes, which reinforces the observation that information networks are critical to immigrant access.[177]

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[169] *See id*. at 466.

[170] *See id*.

[171] *See id*. at 466, 467 fig. 3; *U.S. Unauthorized Immigration Population Estimates*, PEW RES. CTR. (Nov. 3, 2016), http://www.pewhispanic.org/interactives/unauthorized-immigrants/.

[172] *See, e.g.*, Zhu & Xu, *supra* note 160, at 475.

[173] *See, e.g.*, Derr, *supra* note 13, at 266.

[174] *See* Hudson Sangree, *Health Coverage Expanded to Undocumented Immigrants in 35 California Counties*, SACRAMENTO BEE (June 25, 2015), http://www.sacbee.com/news/local/health-and-medicine/article25525903.html. One of the provisions of the PRWORA prohibited states from extending state and local benefits to undocumented immigrants except through affirmative legislative action. 8 U.S.C. §1621(a), (d) (2012).

[175] *See* Farida Jhablava Romero, *California Counties Add Health Care for Immigrant Adults*, NPR (Sept. 24, 2015), http://www.npr.org/health-shots/2015/09/24/442805047/california-counties-add-health-care-for-immigrant-adults. Most states have decided to extend health care coverage to lawfully present children and pregnant women, allowed under law regardless of whether they qualify under the PRWORA. *See, e.g.*, *Medical Assistance Programs for Immigrants in Various States*, NAT'L IMMIGR. L. CTR., https://www.nilc.org/wp-content/uploads/2015/11/med-services-for-imms-in-states.pdf (last revised Aug. 2017).

[176] *See Medical Assistance Programs for Immigrants*, *supra* note 175.

[177] *See* PEW CHARITABLE TR., MAPPING PUBLIC BENEFITS FOR IMMIGRANTS IN THE STATES 11–12 (2014), http://www.pewtrusts.org/~/media/assets/2014/09/mappingpublicbenefitsforimm

These gaps in coverage among the states can be seen as a reflection of the relative strength in each state of the motivations behind the PRWORA.[178] As has been noted by those reviewing the 1996 law, the decision to cut off most legal immigrants was unprecedented and was the product of several articulated policy goals: requiring immigrants to be self-sufficient; placing responsibility on family and friends to support them,[179] preventing welfare from acting as a magnet to draw immigrants; and relieving a cost burden on public support systems.[180] But also underlying the stated purposes, one can see a larger narrative at play: that immigrants are not worthy of support. This view has a well-established pedigree in our national discourse with immigrants seen as being potentially weak, lazy, or defective.[181] Concerns reached a crescendo in the 1990s with efforts such as California's Proposition 187, a ballot initiative which attempted to cut off undocumented immigrants from using non-emergency healthcare and public education.[182] The PRWORA and several other immigration restrictive laws are a product of this time.[183]

The decision by various states to discriminate against immigrants in providing Medicaid and other health benefits also produced legal challenges.[184] These cases arose in states that ended or limited

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igrantsinthestatesfinal.pdf (showing a brief tracking map for the various state programs).

[178] *See* 8 U.S.C. §1601.

[179] *See* Steven M. Dawson, Comment, *The Promise of Opportunity - And Very Little More: An Analysis of the New Welfare Law's Denial of Federal Public Benefits to Most Legal Immigrants*, 41 ST. LOUIS U. L.J. 1053, 1053, 1060 (1997); *see also* TANYA BRODER ET AL., OVERVIEW OF IMMIGRANT ELIGIBILITY FOR FEDERAL PROGRAMS 1 (Dec. 2015) ("[T]he 1996 federal welfare and immigration laws introduced an unprecedented new era of restrictionism."). This policy can be seen in the provision of the PRWORA requiring U.S. and lawful permanent residents who are petitioning for a family member to come to the United States to file a legally binding document called and Affidavit of Support, which obligates them to provide support to the sponsored immigrant at 125 percent of the federal poverty line. *See* 8 U.S.C. § 1183(a)(1), (f)(6)(A)(iii) (2012).

[180] *See* Dawson, *supra* note 179, at 1060, 1060 n.52.

[181] *See* Kevin R. Johnson, *Public Benefits and Immigration: The Intersection of Immigration Status, Ethnicity, Gender, and Class*, 42 UCLA L. REV. 1509, 1519–20 (1995).

[182] *See* PRATHEEPAN GULASEKARAM & S. KARTHICK RAMAKRISHNAN, THE NEW IMMIGRATION FEDERALISM 51, 54–55 (Cambridge Univ. Press ed., 2015).

[183] *See id.* at 50. It is fascinating to note the distance California's public policies toward immigrants have traveled in twenty years. For a good analysis challenging the justifications behind welfare restrictions, *see, e.g.*, Stephen Legomsky, *Immigration, Federalism, and the Welfare State*, 42 UCLA L. REV. 1453, 1453 (1995); *See generally* Janet L. Dolgin & Katherine R. Dieterich, *When Others Get Too Close: Immigrants, Class, and the Health Care Debate*, 19 CORNELL J. L. & PUB. POL'Y 283 (2010).

[184] *See* Mel Cousins, *Equal Protection: Immigrant's Access to Healthcare and Welfare Benefits*, 12 HASTINGS' RACE & POVERTY L.J. 21, 22 (2015); Shannon Fruth, *Has the Federal Government Insulated the States from Equal Protected Norms through Welfare Reform?*, 35 J. LEGAL MED. 467, 491–93 (2014); Gregory T.W. Rosenberg, *Alienating Aliens: Equal Protection*

Medicaid coverage for immigrants.[185] The immigrants losing their health benefits argued that this was discrimination on account of their alienage, violating the Equal Protection Clause of the Fourteenth Amendment and state constitutional provisions.[186] Ordinarily, state classifications based on alienage are inherently suspect resulting in strict scrutiny analysis under the U.S. Supreme Court's decision in *Graham v. Richardson*.[187] Yet, state and federal courts covering Colorado, Connecticut, Hawaii, Maine, New Jersey, and South Dakota concluded that the PRWORA's provisions cutting off immigrants from federally funded Medicaid, or giving states the option to provide coverage, allowed the states to do so.[188] Their reasoning varied. Some courts concluded that the states were carrying out a federal policy when cutting off immigrants and therefore the proper standard of review should be rational basis review.[189] This reasoning follows from another U.S. Supreme Court case, *Mathews v. Diaz*, holding that when it comes to matters of immigration, the federal government has great latitude in discriminating between aliens and citizens.[190] Other courts concluded that the challenged state policy did not discriminate on the basis of alienage because the state program in question was only for aliens, not a program distinguishing between aliens and citizens.[191]

The opposite conclusion was reached by state and federal courts

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Violations in the Structures of State Public Benefit Schemes, 16 U. PA. J. CONST. L. 1417 (2014); Jennifer Seo, *Justice Not for All: Challenges to Obtaining Equal Access to Health Care for Non-Citizen Immigrants in the United States*, 3 GEO. J. L. & MOD. CRIT. RACE PERSP. 143, 163 (2011).

[185] This occurred because immigrants had not met the five-year residency requirement. *See, e.g.*, A.B. v. Div. of Med. Assistance & Health Serv., 407 N.J. Super 330, 971 A.2d 403, 408–09, 416–17 (N.J. Super. Ct. App. Div. 2009). Alternatively, it occurred because federal law otherwise permitted the state to decide whether to provide coverage. *See* Soskin v. Reinertson, 353 F.3d 1242, 1254–55 (10th Cir. 2004) (citations omitted).

[186] *See id.* at 409.

[187] Graham v. Richardson, 403 U.S. 365, 372 (1971). Arizona and Pennsylvania both tried to exclude lawful immigrants from state welfare support. *See id.* at 367–70.

[188] *See* Bruns v. Mayhew, 750 F.3d 62, 64 (1st Cir. 2014); Korab v. Fink, 748 F.3d 875, 878, 886–87 (9th Cir. 2014); *Soskin*, 353 F.3d at 1254–55 (citing Lewis v. Thompson, 252 F.3d 567, 582 (2d Cir. 2001)); City of Chicago v. Shalala, 189 F.3d 598, 603–05 (7th Cir. 1999); Rodriguez by Rodriguez v. U.S., 169 F.3d 1342, 1346–50 (11th Cir. 1999)); Hong Pham v. Starkowski, 16 A.3d 635, 646, 654 (Conn. 2011); Guaman v. Velez, 74 A.3d 931, 943 (N.J. Super. Ct. App. Div. 2013), *aff'd* 110 A.3d 927, 927 (N.J. 2015); Cid v. S.D. Dep't Soc. Servs., 598 N.W.2d (S.D. 1999).

[189] *See e.g.*, *Soskin*, 353 F.3d at 1255 (citing Mathews v. Diaz, 426 U.S. 67, 78–83 (1976)).

[190] *See Matthews*, 426 U.S. at 81. This case addressed a challenge to Congress' decision to cut off Medicare to immigrants aged 65 who lived in the United States less than five years while providing those benefits to citizens. *Id.* at 69, 70 (citations omitted).

[191] *See, e.g. Hong Pham*, 16 A.3d at 646.

in Maryland, Massachusetts, and New York, holding that it would violate equal protection principles under federal and state constitutional law to fail to provide welfare benefits to qualified immigrants.[192] These courts rejected the assertion that rational basis review was appropriate. Instead they applied strict scrutiny review because Congress did not set a policy for states to follow when it came to covering qualified immigrants or because the immigrants in question were exempted from the five-year bar for Medicaid benefits.[193] Further, several of these courts questioned whether PROWRA's devolving authority to the states to decide whether to cover or deny immigrants was consistent with the Supreme Court's admonition in *Graham* that Congress cannot authorize states to violate the Equal Protection Clause.[194]

It is not clear how much the Affordable Care Act[195] has or will impact immigrant access to mental health care although it is logical to think there is a positive impact. Overall, the uninsured rate has dropped from twenty percent to thirteen percent nationally.[196] Lawful permanent residents are under the law's mandate to have health insurance and they have access to the state insurance exchanges under the ACA.[197]

Therefore, it is reasonable to believe that some lawful immigrants have obtained insurance and access to mental health care. However, the ACA does not cover undocumented immigrants and they remain a very vulnerable population.[198] This fact partly explains why forty percent of the twenty-four million uninsured

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[192] *See* Ehrlich v. Perez, 908 A.2d 1220, 1244 (Md. 2006); Finch v. Commonwealth Health Ins. Connector Auth., 959 N.E.2d 970, 984 (Mass. 2012); Aliessa v. Novello, 754 N.E.2d 1085, 1098–99 (N.Y. 2001).

[193] *See Ehrlich*, 908 A.2d at 1241 (citing *Aliessa*, 754 N.E.2d at 1098); *Aliessa*, 754 N.E.2d at 1098.

[194] *See Ehrlich*, 908 A.2d at 1240 (citing Graham v. Richardson, 403 U.S. 365, 382 (1971); Shapiro v. Thompson, 394 U.S. 618, 641 (1969); Saenz v. Roe, 526 U.S. 489, 508 (1999)); *see also Aliessa*, 754 N.E.2d at 1098 ("[T]itle IV goes significantly beyond what the Graham Court declared constitutionally questionable. In the name of national immigration policy, it impermissibly authorizes each State to decide whether to disqualify many otherwise eligible aliens from State Medicaid.").

[195] Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 et seq. (2010).

[196] Abby Goodnough, *Six Years into Obama's Health Care Law, Who Are the Uninsured?,* N.Y. TIMES (Aug. 18, 2016), https://www.nytimes.com/2016/08/18/us/six-years-into-obamas-health-care-law-who-are-the-uninsured.html?mcubz=0.

[197] *See* NAT'L. IMMIGRATION LAW CTR., IMMIGRANTS AND THE AFFORDABLE CARE ACT (ACA) (revised Jan. 2014), https://www.nilc.org/issues/health-care/immigrantshcr/.

[198] *See id.*; *see also* Kathryn Pitkin Derose, José J. Escarce & Nicole Lurie, *Immigrants and Health Care: Sources of Vulnerability*, 26 HEALTH AFF., no. 5, 2007, at 1258 ("Immigrants are often identified as a 'vulnerable population'.").

adults in the United States are identified as Hispanic.[199]

The other major part of the ACA involved the Medicaid expansion, in which states could increase the qualification for Medicaid from those earning at or below the federal poverty level to those earning up to 138 percent of the federal poverty level.[200] However, the ACA does not alter the limitations immigrants face in relying on the program, requiring lawful presence for five years.[201] This is unfortunate, given the essential role that Medicaid plays in providing mental health care to the poor.[202]

Studies prior to the ACA have shown that only 50% of immigrant full-time employees had employer-sponsored health insurance compared to eighty-one percent of U.S. citizen full-time employees.[203] Not surprisingly, therefore, immigrants showed significantly less likelihood of health care utilization, such as physician visits or use of prescription medication, as compared to naturalized or native born citizens.[204] The ACA should be seen as a positive step to alleviate this disparity and as will be discussed below a step towards avoiding negative immigration consequences due to untreated mental health problems.

The gap in Medicaid and other health care coverage between immigrants and citizens is not solely the product of state eligibility policies and court decisions.[205] Studies have shown that many immigrants, who were otherwise authorized to receive public benefits, voluntarily withdrew from receiving them following the PRWORA out of fear of immigration repercussions.[206] That is, they feared being barred from sponsoring family members or otherwise

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[199] *See* Goodnough, *supra* note 196. The most recent estimate puts the total undocumented population at eleven million people. Roughly half are from Mexico, with immigrants from Latin America making up the next largest group. *See* Jeffrey Passel & D'Vera Cohn, *As Mexican Share Declined, U.S. Unauthorized Immigrant Population Fell in 2015 Below Recession Level*, PEW RES. CTR. (Apr. 25, 2017), http://www.pewresearch.org/fact-tank/2017/04/25/as-mexican-share-declined-u-s-unauthorized-immigrant-population-fell-in-2015-below-recession-level/.

[200] *See* MEDICAID EXPANSION & MENTAL HEALTH CARE, *supra* note 29, at 1.

[201] *See* NAT'L IMMIGRATION LAW CTR., *supra* note 197.

[202] *See* MEDICAID EXPANSION & MENTAL HEALTH CARE, *supra* note 29, at 1; John V. Jacobi, *Multiple Medicaid Missions: Targeting, Universalism, or Both?*, 15 YALE J. HEALTH POL'Y L. & ETHICS 89, 103 (2015).

[203] *See, e.g.*, Jie Chen & Arturo Vargas-Bustamante, *Estimating the Effects of Immigration Status on Mental Health Care Utilization in the United States*, 13 J. IMMIGRANT & MINORITY HEALTH 671, 672 (2011).

[204] *See id.* at 673–75.

[205] *See* Julia C. Prentice et al., *Immigration Status and Health Insurance Coverage: Who Gains? Who Loses?*, 95 AM. J. PUB. HEALTH, no. 1, Jan. 2005, at 109.

[206] *See, e.g.*, Hagan, *supra* note 160, at 445, 453, 454–55.

accessing immigration benefits.[207] Others who had benefits taken away but then restored could not meet the paperwork requirements to re-enroll.[208] This chilling effect has been demonstrated in several studies.[209] As will be discussed in Part IV, there are several provisions of our immigration law that substantiate this fear.

The overall result is under-utilization and underservice to groups facing mental health challenges brought on by their immigrant experience: anxiety, depression, severe mental illness, substance abuse, and posttraumatic stress disorder ("PTSD").[210] This has been a particular problem for the largest immigrant group in the United States, Latinos.[211] The consequences of untreated and undertreated mental health issues can be severe, as noted above in Part II. For immigrants, there are additional vulnerabilities through their involvement in the immigration system as discussed below.

IV. INTERPLAY BETWEEN MENTAL ILLNESS AND THE IMMIGRATION REMOVAL SYSTEM

This section explores the connection between mental health challenges of immigrants and how untreated or undertreated mental health issues create problems that lead to removal from the United States. Some provisions of our immigration law make mental illness the basis for removal.[212] Others result in removal because mental illness has not been addressed, even though the grounds are focused on other issues such as becoming a public charge, drug use or criminal behavior.[213]

It should be noted that our immigration law has undergone some changes in terminology.[214] Our law used to have grounds of exclusion for those we did not want to let in, those whom we wished to deport.[215] As will be explained below, our law went through a significant change in 1996, changing terminology so that today

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[207] *See id.* at 453, 455.

[208] *See id.* at 453.

[209] *See* Zhu & Xu, *supra* note 160, at 460.

[210] *See* CROSSROADS: THE PSYCHOLOGY OF IMMIGRATION IN THE NEW CENTURY, *supra* note 10, at 8, 61.

[211] *See* Caplan & Buyske*, supra* note 135, at 10450–52.

[212] Karen Hacker et al., *Barriers to Health Care for Undocumented Immigrants: A Literature Review*, 8 RISK MGMT. AND HEALTHCARE POL'Y, 175, 178 (2015).

[213] *See, e.g.*, DEPORTATION BY DEFAULT, *supra* note 7, at 1, 2.

[214] *See* STEPHEN LEGOMSKY & CRISTINA RODRIGUEZ. IMMIGRATION AND REFUGEE LAW AND POLICY, 427-8 (6th ed., 2015).

[215] *Id.*

immigrants face removal from the United States, either because they are inadmissible (the old exclusion grounds) or because they are deportable (the old deportation grounds).[216]

A. Mental Disorder Exclusion Grounds

While the focus of this article is on untreated mental health issues of immigrant who are already in the United States, mental illness has been a very long standing basis for exclusion from the country, and can provide some explanation for the lower rates of mental illness among the immigrant population.[217] Concern about the mentally ill goes back to the founding of our immigration system.[218] Once the federal government began consistently regulating immigration in the late nineteenth century, the second major piece of legislation addressing European immigration excluded lunatics.[219] Prior to federal law the states forbade their entry under its laws prohibiting paupers or the indigent from landing.[220]

This ground for exclusion was continued through the establishment of the modern U.S. immigration law in 1952 when the Immigration and Nationality Act ("INA") was created to codify all existing immigration laws.[221] Under the INA the first four grounds for exclusion concerned mental disabilities: "(1) Aliens who are mentally retarded; (2) Aliens who are insane; (3) Aliens who have had one or more attacks of insanity; (4) Aliens afflicted with psychopathic personality, or sexual deviation, or a mental defect."[222]

Reflected in this history of exclusion is the long standing view that immigrants are more likely to have mental illnesses and are

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[216] *See* Jacqueline Pearl Ulin, *A Common Sense Reconstruction of the INA's Crime-Related Removal System: Eliminating the Caveats from the Statue of Liberty's Welcoming Words,* 78 WASH. U. L. REV., 1549, 1551–52 n.10 (2000).

[217] U.S. DEP'T OF JUSTICE IMMIGRATION AND NATURALIZATION SERV., 1997 STATISTICAL YEARBOOK OF THE IMMIGRATION AND NATURALIZATION SERVICE 187 (Oct. 1999) [hereinafter 1997 STATISTICAL YEARBOOK OF THE IMMIGRATION AND NATURALIZATION SERVICE].

[218] *See* Charles Gordon et al., *Immigration Law and Procedure*, § 2.02(2) (Matthew Bender ed., 2016).

[219] *See id.*

[220] *See* DANIEL KANSTROOM, DEPORTATION NATION: OUTSIDERS IN AMERICAN HISTORY 94 (2007).

[221] The INA was called the McCarran-Walter Act, and it set the structure for the current U.S. immigration law. *See* Gordon et al., *supra* note 218, §§ 2.02(2), 2.03(1); *see* LEGOMSKY & RODRIGUEZ, *supra* note 214, at 16; Alison E. Clasby, Comment, *The McCarran-Walter Act and Ideological Exclusion: A Call for Reform*, 43 U. MIAMI L. REV. 1141, 1141–42 (1989).

[222] 8 U.S.C. § 1182(a)(1)–(4) (1990), *amended by* 8 U.S.C. § 1182 (1991).

therefore more likely to be a burden on society.[223] This view was partly created and sustained by the U.S. government's poor data collection and errors in calculating crime rates for immigrants versus the native born population.[224] Also reflected in these vague terms was a method for excluding groups of people seen as undesirable for other reasons, such as people who identify as homosexual.[225]

Professor Polly Price, in a thorough article on mental health exclusions, noted that this ground for exclusion could be applied to an immigrant after entry if it was determined within a certain number of years afterward that the immigrant should not have been allowed in.[226] This is because there was a separate ground for deportation that created a window in which an immigrant could be deported if he or she manifested a mental illness at the time of entry.[227] This became ensconced in immigration law in the 1952 INA by allowing deportation for those who become institutionalized at public expense due to mental disease after admission to the United States.[228] However, it was limited to a window of five years after entry and the immigrant could avoid deportation by demonstrating the mental illness was not present at entry.[229] In effect, these provisions served to correct the mistakes made at entry.[230] As Professor Daniel Kanstroom has described it, it was a process of extended border control.[231]

Today's version of the INA is more nuanced, limiting inadmissibility to those whose have a mental disorder and behavior, or a history of behavior, "that may pose, or has posed, a threat to property, safety, or welfare of the alien or others[.]"[232] There is no ground for deportability based solely on mental illness.[233] But the

[223] *See* Polly J. Price, *Infecting the Body Politic: Observations on Health Security and the "Undesirable" Immigrant*, 63 U. KAN. L. REV. 917, 935–36 (2015).

[224] *Cf.* Carolyn Moehling & Anne Morrison Piehl, *Immigration, Crime, and Incarceration in Early Twentieth-Century America*, 46 DEMOGRAPHY 739, 739–41, 760–61 (2009).

[225] *See* Price, *supra* note 223, at 947; *see also* Jorge L. Carro, *From Constitutional Psychopathic Inferiority to AIDS: What Is in the Future for Homosexual Aliens?*, 7 YALE L. & POL'Y REV. 201, 206–08, 209 (1989).

[226] *See* Price, *supra* note 223, at 938.

[227] *See* 8 U.S.C. § 1182(a)(1)(A)(iii) (2012); *see also id.* § 1227(a)(1)(A) ("Any alien who at the time of entry or adjustment of status was within one or more of the classes of aliens inadmissible by the law existing at such time is deportable.").

[228] *See* Price, *supra* note 223, at 938.

[229] *See id.*

[230] *See id.*

[231] *See* KANSTROOM, *supra* note 220, at 124–25.

[232] 8 U.S.C. § 1182(a)(1)(A)(iii).

[233] *See id.* § 1227(a).

same principle of extended border control still applies: if the immigrant should have been inadmissible on mental health grounds at the time they arrived in the United States, they face deportation.[234]

Statistics from the U.S. Department of State, which handles the issuance of visas to come to the United States, track the number of times there is a denial of a visa on the basis of the various inadmissibility grounds.[235] Over the past fifteen years the inadmissibility ground for physical or mental health cited above has been a small but consistent basis for denying a visa allowing someone to travel to the United States.[236] This screening may in part account for the immigrant paradox, the relative mental health of immigrants compared to the general population.[237]

However, mental illness can lead to removal for an immigrant already in the United States, even if he or she was not mentally ill at the time of entry.[238] In 1996 Congress changed the law making lawful admission rather than physical entry the key event in deciding whether the grounds for inadmissibility should apply.[239] So, someone may have physically entered the United States, not suffering a mental illness at time and then subsequently fell into mental distress. If he or she had never been inspected and admitted, the government could charge him or her with being inadmissible due to the mental disorder even if he or she has been in the United States for decades.[240]

Historically, the extended border control approach of deportation for mental illness produced significant numbers of deportations from 1908 until 1960.[241] Data on removals since the 1960's show

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[234] *See* 8 U.S.C. § 1227(a)(1)(A).

[235] *See* U.S. Dep't of State, Bureau of Consular Aff., Report of the Visa Office 2016, Table XX: Immigrant and Nonimmigrant Visa Ineligibilities (2016).

[236] The U.S. Department of State's website contains yearly statistics on visa ineligibilities found in Table XX of the annual reports. *See* U.S. Dep't of State, *supra* note 235 (links to Reports of the Visa Office for 2000-2016 are available on the "Visa Statistics" page each with their own hyperlink for the respective year's data).

[237] Screening out those with physical and mental disabilities makes the stream of immigrants healthier as a general matter so it is not surprising that their mental health statistics are better than the general population.

[238] LEGOMSKY & RODRIGUEZ, *supra* note 214, at 420–21.

[239] *Id.*

[240] Statistics on the charges of removal reveal that immigrants are held inadmissible based on physical and mental disorders, although not very frequently. *See* TRANSACTIONAL RECORDS ACCESS CLEARINGHOUSE, CHARGES ASSERTED IN DEPORTATION PROCEEDINGS IN THE IMMIGRATION COURTS: FY 2002–FY 2011 (Syracuse University ed., 2011), http://trac.syr.edu/immigration/reports/260/include/detailchg.html [hereinafter TRAC].

[241] *See* U.S. IMMIGRATION AND NATURALIZATION SERV., DEP'T OF JUSTICE, IMMIGRATION AND NATURALIZATION SERVICE ANNUAL REPORT 90 (1974). Nearly half of the deportations

that mental disorder grounds are now rarely the basis for removal.[242] Once admitted to the United States, there is currently no specific ground of deportation for an immigrant who subsequently becomes mentally ill.[243] So, it seems the INA provides some protection for immigrants who experience mental illness after they are admitted.[244] However, several other provisions of the INA have and continue to stand in as a means for removing those with mental disorders as an undesirable class.[245]

B. Public Charge

The ground most closely affiliated with mental disorders is also one of the oldest grounds for exclusion, and now inadmissibility, and remains a separate ground for deportation after admission; the "public charge" ground.[246] Like the mental health exclusions of the past, it reflected a belief that many immigrants coming to this country may become a burden on public resources.[247] The original language and the 1952 INA also used the terms "pauper" as well as "professional beggar" and "vagrant."[248] The language changed in 1990, to reflect a somewhat greater acceptance of immigrants with disabilities.[249]

However, the public charge inadmissibility ground became more stringent in the 1996 reforms in that an immigrant's sponsor is required to file a legally-binding document called an affidavit of support.[250] The sponsor of the immigrant[251] attests in the affidavit

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between 1908 and 1910 were for physical and mental defects. *Id.* Almost ten percent of the deportations occurring in 1926 were for "insanity[,] "epilepsy," or "other mental health issues" (1,053 out of 11,000 deportations). *See* Price, *supra* note 223, at 941.

[242] *See* TRAC, *supra* note 240. Between 2002 and 2011, forty-nine immigrants were removed from the United States for a physical or mental disorder, out of 2.3 million removals over this time period. *See id.*

[243] *See* Price, *supra* note 223, at 941, 950, 951; 8 U.S.C. § 1227(a)(5) (2012).

[244] *Cf.* Price, *supra* note 223, at 941, 945, 951 ("In general, the classes of undesirable aliens retained in the bill were made more definite, including medical grounds for exclusion.").

[245] *See id.* at 950.

[246] The public charge exclusion ground, like the grounds for mental defects, goes back to the first federal immigration laws. *See* Price, *supra* note 223, at 941; Mark C. Weber, *Opening the Golden Door: Disability and the Law of immigration*, 8 J. GENDER, RACE & JUST. 153, 156 (2004).

[247] Kanstroom, *supra* note 220, at 33, 34, 35, 37, 38, 39, 132.

[248] *See* Immigration and Nationality Act, Pub. L. 414, Ch. 477 § 212(a)(8), 66 Stat. 163, 182 (1952) (prior to 1990 amendment).

[249] *See* 8 U.S.C. §1182(a)(4); *see also* Weber, *supra* note 246, at 162–63 ("In 1990, Congress deleted the provisions excluding paupers, beggars, vagrants, persons with some health impairments, and those with physical diseases or defects affecting their ability to earn a living.").

[250] 8 U.S.C. §1182(a)(4)(C)(ii); *see* Veronica Tobar Thronson, *'Til Death Do Us Part:*

that he or she had a sufficient income[252] to support the immigrant and that he or she will reimburse any public or private entity that ended up giving support to the immigrant.[253] Looking at the visa ineligibility statistics maintained by the Department of State, public charge grounds serves as one of the most frequent bases for denying a visa.[254]

Unlike the mental disorder ground, the INA retains a separate ground of deportability for becoming a public charge.[255] It continues the extended border control concept of the 1952 INA by stating that if an immigrant becomes a public charge within five years of entry, removal may occur.[256]

However, the current provision still has the same limitation as the 1952 version,[257] because it provides that an immigrant who can affirmatively show that the conditions causing him or her to become a public charge arose after entry, can avoid deportation.[258] As with the mental disorder ground, it is infrequently invoked today as a reason for deportation.[259] The great decline in its use as a ground of deportation happened in the 1940s.[260]

Therefore, it appears the grounds historically used to rid the nation of immigrants with mental illness are rarely used today. This does not lead to the conclusion that we are more permissive toward immigrants with mental health issues. Rather, it is the theory of this article that these grounds have been to a significant

Affidavits of Support and the Obligations to Immigrant Spouses, 50 FAMILY CT. REV. 594, 594 (2012).

[251] *See* Thronson, *supra* note 250, at 595. The sponsor must be a U.S. citizen or a lawful permanent resident and have a relationship with the immigrant, such as spouse, child or parent that allows them to file a petition. *Id.*

[252] The sponsor must earn 125 percent of the federal poverty annual guidelines. 8 U.S.C. §1183a(a)(1)(A); *see* Thronson, *supra* note 250, at 599.

[253] *See* Thronson, *supra* note 250, at 595–96.

[254] *See* U.S. Dep't of State, *supra* note 235. The Department of State website reveals an interesting development in which visa ineligibility on public charge grounds has shrunk over the past fifteen years from being the most dominant basis for denial (10,869 out of a total of 353,834 ineligibility findings in 2010) to one of several significant grounds of ineligibility (897 out of 325,410 ineligibility findings in 2015). *See id.*

[255] *See* 8 U.S.C. § 1227(a)(5).

[256] *Id.*

[257] *Compare id.* § 1227(a)(5), *with* Immigration and Nationality Act, Pub. L. 414, Ch. 477 § 241(a)(3), 66 Stat. 163, 183 (1952).

[258] *See* 8 U.S.C. § 1227(a)(5) (2008).

[259] *Compare* TRAC, *supra* note 240, *with* Price, *supra* note 223, at 941 (showing that after entry, forty-nine immigrants between 2002 and 2011 have been removed from the United States on public charge grounds, out of a total of nearly 2.6 million people removed). According to a historical review of the public charge ground, it comprised nearly ten percent of all removals in 1926 and 1930 (887 out of 11,000 in 1926). *See id.*

[260] *See* U.S. IMMIGRATION AND NATURALIZATION SERV., *supra* note 241, at 90.

extent replaced by removal grounds related to drug use and criminal behavior.

C. Drug Use and Criminal Grounds for Deportation

Since the late 1980s there has been a growing overlap between the criminal justice system and the federal immigration deportation system,[261] just as there has been a developing overlap between the criminal justice system and the mental health system.[262] These increasing overlaps result in immigrants with untreated or undertreated mental health issues being drawn into the removal system through the criminal justice system.[263]

Congress started adding to the list of deportable offenses about thirty years ago, as part of a larger project of importing a criminal control model into the immigration removal process.[264] This expansion included offenses that are minor and involve drug use or possession.[265] For example, there was a very limited ground for deportation connected to drug offenses beginning in 1922.[266] Congress expanded this ground of deportation significantly and eliminated any sentence requirement and made it applicable at any time after admission.[267] In 1988, Congress also added a new ground for removal, the "aggravated felony" as part of the Anti-Drug Abuse Act.[268] The Act added a long list of relatively minor crimes and expanded the drug ground for deportation by adding any offense considered drug trafficking.[269] In addition, minor crimes and drug offenses have been included in one of the oldest grounds for removal, crimes involving moral turpitude.[270] All of these crime-

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[261] *See* Stumpf, *supra* note 17, at 383.

[262] *See* Belcher, *supra* note 42, at 187.

[263] *See* DEPORTATION BY DEFAULT, *supra* note 7, at 16–17.

[264] *See* Stephen H. Legomksy, *The New Path of Immigration Law: Asymmetric Incorporation of Criminal Justice Norms,* 64 WASH. & LEE L. REV. 469, 483–86 (2007); Teresa A. Miller, *Citizenship & Severity: Recent Immigration Reforms and the New Penology*, 17 GEO. IMMIGR. L. J. 611, 614 (2003).

[265] *See* Terry Coonan, *Dolphins Caught in Congressional Fishnets-Immigration Law's New Aggravated Felons*, 12 GEO. IMMIGR. L. J. 589, 599–600 (1998); Legomsky, *supra* note 264, at 484–85.

[266] *See* LEGOMSKY & RODRIGUEZ, *supra* note 214, at 573.

[267] *See* Legomsky, *supra* note 264, at 483–84

[268] *See* Coonan, *supra* note 265, at 592.

[269] *See* 8 U.S.C. § 1227(a)(2)(A)(iii) (2012); Coonan, *supra* note 265, at 592–93.

[270] 8 U.S.C. § 1227(a)(2)(A)(i)–(ii); Mary Holper, *Deportation for a Sin: Why Moral Turpitude is Void for Vagueness*, 90 NEB. L. REV. 647, 649 (2012) (explaining that crimes involving moral turpitude originally became grounds for exclusion in 1891). There are limitations to this ground of removal. If there is only one offense it must occur within five years of entry and the immigrant must be sentenced to one year or more of imprisonment.

based removal categories include state as well as federal cases in which an immigrant was convicted, or pled guilty or no contest and had some form of punishment imposed.[271]

This has led to growth in the amount of immigrants placed into deportation based upon criminal conduct, particularly as related to drug use or offenses.[272] Looking back over the twentieth century, narcotics violations started to appear as a basis for removal in the 1930s,[273] and by the 1950s had eclipsed the mental health and public charge grounds as a reason for deportation.[274] But the most dramatic growth in removals happened in the 1980s and corresponded to the changes Congress made in the INA.[275] The number of deportations related to drug use grew tenfold, from 3,626 in the 1970s to 30,630 in the 1980s.[276]

Data gathered between 2000 and 2013 show this trend continuing.[277] Records on removals carried out by Immigration and Customs Enforcement ("ICE") between October of 2002 and January of 2016 reveal the impact of drug possession and minor criminal charges on the immigrant population.[278] A database maintained by the Transactional Records Access Clearinghouse ("TRAC"),[279] grouped the over two million immigrants deported for crimes during that timeframe into three categories of seriousness using ICE criteria.[280] Fifty percent of these offenses fell into category three,

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But two or more convictions at any time after entry leads to removal. See 8 U.S.C. § 1227(a)(2)(A)(i)–(ii); *see also* Annotation, *What Constitutes "Crime Involving Moral Turpitude" Within Meaning of § 212(a)(9) and 241(a)(4) of Immigration and Nationality Act (8 U.S.C.A. § 1182(a)(9), 1251(a)(4)), and Similar Predecessor Statutes Providing for Exclusion or Deportation of Aliens Convicted of Such Crime*, 23 A.L.R. FED. 480 (1975) (listing offenses determined to be a crime involving moral turpitude).

[271] The term conviction for immigration purposes is much broader than the common understanding of the term. *See* 8 U.S.C. § 1101(a)(48)(A).

[272] *See* U.S. DEP'T OF HOMELAND SEC., 2009 YEARBOOK OF IMMIGRATION STATISTICS 97–105 (Office of Immigration Statistics, 2010) [hereinafter 2009 YEARBOOK OF IMMIGRATION STATISTICS].

[273] *See* Juliet Stumpf, *Fitting Punishment*, 66 WASH. & LEE L. REV. 1683, 1718 (2009).

[274] 1997 STATISTICAL YEARBOOK OF THE IMMIGRATION AND NATURALIZATION SERVICE, *supra* note 217, at 187.

[275] *See id.*

[276] *Id.*

[277] *See* U.S. HOMELAND SEC. OFFICE OF IMMIGRATION STATISTICS, 2015 YEARBOOK OF IMMIGRATION STATISTICS 107–15 (Dec. 2016).

[278] *See* TRAC, TRACKING IMMIGRATION AND CUSTOMS ENFORCEMENT REMOVALS (2016), http://trac.syr.edu/phptools/immigration/remove/ (last visited Oct. 15, 2017); *see also* TRAC, FEW ICE DETAINERS TARGET SERIOUS CRIMINALS (Sep. 17, 2013), http://trac.syr.edu/immigration/reports/330/ (last visited Oct. 15, 2017).

[279] TRAC is a nonprofit organization that has reviewed all removals by Immigration and Customs Enforcement ("ICE") through Freedom of Information Act requests. *Id.*

[280] *See* TRAC, *supra* note 278.

the least serious level involving misdemeanors and petty offenses.[281] Other than immigration fraud and traffic offenses, the top five offenses in the level three category were driving under the influence, drug possession charges and public order crimes.[282]

Even for removal grounds that are supposedly aimed at the most serious immigrant criminal conduct, we see the same trend.[283] The aggravated felony ground has emerged as the most frequently relied-upon basis for removal, which is significant because it virtually eliminates any possibility of an immigrant remaining in the United States or returning after being deported.[284] As has been noted by many others, this removal ground is a misnomer since it includes many offenses which are neither aggravated, nor a felony.[285] Using the same database as the above paragraph, about thirty percent of aggravated felony convictions for which immigrants were removed involved drug offenses, such as possession or driving under the influence.[286]

At the same time, there is a recognized and very complicated link between mental illness, drug use, and criminality as revealed above in Part II B.[287] The large number of those incarcerated with mental health problems shows the frequency of overlap with drug and alcohol issues.[288] Thus, it is not surprising to see the prevalence of drug possession and public order crimes in the crime-based removal statistics as those are the types of crimes that coincide with mental health issues.[289] Case studies of the removal system and examples

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[281] *Id.*

[282] *Id.* Of the 1,015,292 removals fitting into the level 3 category, 181,961 were for driving under the influence, 54,627 were for dangerous drugs, 49,192 for cocaine possession, 38,695 for marijuana possession, 19,546 for public order crimes, 15,758 for more general drug possession. *Id.* Only immigration violations (unlawful reentry, 318,134 and fraudulent immigration documents, 37,829) account for more level 3 convictions. *Id.*

[283] *See id.*

[284] *See* LEGOMSKY & RODRIGUEZ, *supra* note 214, at 575.

[285] *See* Nancy Morawetz, *Understanding the Impact of the 1996 Deportation Laws and the Limited Scope of Proposed Reforms*, 113 HARV. L. REV. 1936, 1939 (2000).

[286] *See* TRACKING IMMIGRATION AND CUSTOMS ENFORCEMENT REMOVALS (2016), *supra* note 278. There were 271,837 immigrants removed for aggravated felonies between October 2002 and January 2016. *Id.* 82,688 involved a drug offense, excluding those explicitly identified as conviction for selling, trafficking or smuggling. *Id.* Unfortunately the category of "Dangerous Drugs" cannot be disaggregated from the information on the website and includes possession as well as manufacturing, distribution, and sale. *See Id.*

[287] *See* Easton, *supra* note 17, at 197.

[288] *See* McNiel et al., *supra* note 43, at 840.

[289] *See, e.g.*, 1997 STATISTICAL YEARBOOK OF THE IMMIGRATION AND NATURALIZATION SERVICE, *supra* note 217, at 187; *see also* NAT'L. INST. ON DRUG ABUSE, COMORBIDITY: ADDICTION AND OTHER MENTAL ILLNESS 2 (2008) ("Many people who regularly abuse drugs are also diagnosed with mental disorders and vice versa.").

in mental health journals give anecdotal evidence of how untreated mental illness can lead to behavior that could result in immigration troubles.[290]

Other evidence from the removal system shows the extent to which mental health issues play a role. Immigrants facing deportation on crime-based grounds are usually detained,[291] and studies of detention system show that a significant number have undiagnosed and unaddressed mental health issues.[292] Estimates that fifteen percent of immigrant detainees having serious mental health problems are cited in reports on the sprawling network of 350 federal facilities, state and local jails, and privately operated prisons.[293] Many studies assert that estimate is low and that statistics are uncertain because of poor screening, diagnosis and treatment.[294] In at least one facility, a mental health worker estimated thirty-five to forty percent of the population suffered from mental illness.[295] The impact of their condition has also been clearly and tragically detailed in studies of particularly vulnerable groups such as asylum seekers.[296] The issue of how to treat mental illness in removal proceedings became such a pressing problem that the Board of Immigration Appeals ("BIA"), the final administrative body for hearing removal cases, had to direct immigration judges to use safeguards to protect the mentally ill.[297] Otherwise, there are

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[290] The American Civil Liberties Union together with Human Rights Watch engaged in a study of the treatment of the mentally ill in the removal system. Their report is full of examples of mental illness leading to arrest and the risk of removal. *See* DEPORTATION BY DEFAULT, *supra* note 7, at 4–5, 37. *See also* Amri & Bemak, *supra* note 141, at 54–55 (discussing a case study in which a Muslim immigrant from Afghanistan who found the transition with his family to be extraordinarily difficult was unable to find employment was arrested for a domestic incident—though not charged, if he had been, he could have been found deportable.). *See* 8 U.S.C. §1227(a)(2)(E)(i) (2012).

[291] The INA requires detention of aliens on most of the crime-based deportation grounds. *See* 8 U.S.C. §1226(c)(1)(A).

[292] The size of the detained population has hovered just above 30,000 for the last ten years. *See* Joanne Faryon, *U.S. Government Holding Fewer Immigrants in Detention,* INEWSOURCE (Apr. 6, 2015) http://inewsource.org/2015/04/06/fewer-immigrants-in-detention/; *see also* JUSTICE FOR IMMIGRATION'S HIDDEN POPULATION, *supra* note 7, at 16–17.

[293] *See* JUSTICE FOR IMMIGRATION'S HIDDEN POPULATION, *supra* note 7, at 11.

[294] *See, e.g.*, *id.* at 24–27, 41.

[295] *See, e.g.*, *id.* at 26.

[296] *See, e.g.*, PHYSICIANS FOR HUMAN RIGHTS & BELLEVUE/NYU PROGRAM FOR SURVIVORS OF TORTURE, FROM PERSECUTION TO PRISON: THE HEALTH CONSEQUENCES OF DETENTION FOR ASYLUM SEEKERS, at 10–14 (2003); *see* ELEANOR ACER & ARCHANA PYATI, HUMAN RIGHTS FIRST, IN LIBERTY'S SHADOW: U.S. DETENTION OF ASYLUM SEEKERS IN THE ERA OF HOMELAND SECURITY 33–34 (2004).

[297] *See In re* M-A-M, 25 I. & N. Dec. 474, 484 (B.I.A. 2011). The BIA required immigration judges to make inquiry into the competency of an alien appearing in front of them and formulate appropriate safeguards if the alien is incompetent. *See id.*

very few statutory and regulatory protections.[298]

These steps, though, were not enough to address the due process concerns that kept arising for immigrants who were seriously mentally ill.[299] Class action litigation finally forced the Department of Homeland Security and the Department of Justice (which is in charge of removal proceedings and houses the BIA and all immigration judges)[300] to create a whole set of protections, particularly focused on the detainee population.[301] These protections include: improved screenings for mental disorders for those in detention; more use of competency evaluations and reliance on independent psychiatric exams when the immigration judge is unable to determine competency; providing legal representation for detainees who are incompetent and otherwise without counsel; and bond hearings for those in detention who are mentally ill and have been held for six months.[302] These tragic cases have spawned piercing scholarship on the effects of detention on the mentally ill and the deprivation of due process rights in the removal process.[303]

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[298] *See, e.g.*, 8 U.S.C. § 1229a(b)(3) (2012) (providing that, if an alien's mental incompetency makes it impractical for his or her attendance at a removal hearing, the Attorney General will provide safeguards to protect the alien's rights); *see also* 8 C.F.R. §1240.10(c) (2017) (forbidding an immigration judge from receiving an admission of removability from an unrepresented alien who is incompetent).

[299] *See* DEPORTATION BY DEFAULT, *supra* note 7, at 49.

[300] *See* Exec. Office for Immigration Review, *EOIR at a Glance*, DEP'T OF JUSTICE, https://www.justice.gov/eoir/eoir-at-a-glance (Sept. 9, 2010).

[301] *See* Press Release, Exec. Office for Immigr. Rev., Dep't of Just., Department of Justice and the Department of Homeland Security Announce Safeguards for Unrepresented Immigration Detainees with Serious Mental Disorders or Conditions (Apr. 22, 2013), https://www.justice.gov/eoir/pr/department-justice-and-department-homeland-security-announce-safeguards-unrepresented.

[302] *See* Memorandum from Brian M. O'leary, Chief Immigration Judge, to All Immigration Judges (Apr. 22, 2013) (on file with the Executive Office for Immigration Review); Memorandum from John Morton, Dir., to Thomas D. Homan, Acting Exec. Assoc. Dir. of Enf't & Removal Operations, Peter S. Vincent, Principal Legal Advisor, Kevin Landy, Assistant Dir. of the Office of Det. Policy and Planning (Apr. 22, 2013) (on file with U.S. Immigration and Customs Enforcement).

[303] *See* Alice Clapman, *Hearing Difficult Voices: The Due Process Rights of Mentally Disabled Individuals in Removal Proceedings*, 45 NEW ENG. L. REV. 373, 377 (2011); Aliza B. Kaplan, *Disabled and Disserved: The Right to Counsel for Mentally Disabled Alien in Removal Proceedings*, 26 GEO. IMMIGR. L.J. 523, 525–26 (2012); Fatma E. Marouf, *Incompetent but Deportable: The Case for a Right to Mental Competence in Removal Proceedings*, 65 HASTINGS L.J. 929, 934–35 (2014); Aimee L. Mayer-Salins, *Fast-Track to Injustice: Rapidly Deporting the Mentally Ill*, 14 CARDOZO PUB. L. POL'Y & ETHICS J. 545, 546–47 (2016); Riddhi Mukhopadhyay, *Death in Detention: Medical and Mental Health Consequences of Indefinite Detention of Immigrants in the United States*, 7 SEATTLE J. SOC. JUST. 693, 694–95 (2009); Bill Ong Hing, *Systemic Failure: Mental Illness, Detention, and Deportation*, 16 U. C. DAVIS J. INT'L L. & POL'Y 341, 342 (2010); Sarah Sherman-Stokes, *Sufficiently Safeguarded?: Competency Evaluations of Mentally Ill Respondents in Removal Proceedings,* 67 HASTINGS L.J. 1023, 1031–33 (2016); Molly Bowen, Note, *Avoiding an*

There are several pieces to this puzzle: the attested link between mental illness, drug use, and criminal behavior;[304] the challenge of immigrants receiving mental health care;[305] the overall increase in the use of criminal behavior to justify removal;[306] the significant number of deportations based on drug possession and minor criminal behavior;[307] and the growing challenge of mentally ill immigrants in the removal process.[308] Putting those together, it is reasonable to extrapolate that a significant number of immigrants facing deportation, because of drug use or criminal conduct, also have an untreated mental illness connected to that behavior. The question is what is to be done about this phenomenon.

V. WAYS TO ADDRESS THE PROBLEM

The main challenge to advocating for expanded access to mental health care for immigrants comes in the age-old framing of the issue as one of unworthy immigrants draining national resources.[309] For opponents of increased expenditures for mental health, the removal statistics above only strengthen the argument for having a more aggressive removal system.[310] Their belief is that immigrants are more likely to be dependent and commit crimes that disrupt the fabric of our society.[311] The reasons for these misperceptions stretch back to the beginnings of this country and reappear with particular force at particular times.[312]

"Unavoidably Imperfect Situation": Searching for Strategies to Divert Mentally Ill People Out of Immigration Removal Proceedings, 90 WASH. U. L. REV. 473, 475 (2012).

[304] *Cf., e.g.*, Eric B. Elbogen & Sally C. Johnson, *The Intricate Link Between Violence and Mental Disorder: Results from the National Epidemiologic Survey on Alcohol and Related Conditions*, 66 ARCHIVES OF GEN. PSYCHIATRY, no. 2, Feb. 2009, at 159 (discussing the complexity of the link between mental illness and violence).

[305] *See* GRADING THE STATES 2009, *supra* note 20, at 33.

[306] *See* WALTER A. EWING ET AL., THE CRIMINALIZATION OF IMMIGRATION IN THE UNITED STATES 10 (2015).

[307] *See* HUMAN RIGHTS WATCH, FORCED APART (BY THE NUMBERS): NON-CITIZENS DEPORTED MOSTLY FOR NONVIOLENT OFFENSES 33 (2009).

[308] *See* Max Siegelbaum, *Detention Centers, Bracing for Flood of New Arrivals, Are 'Set up to Fail' Immigrants with Mental Illness*, STAT (Dec. 16, 2016), https://www.statnews.com/2016/12/16/immigrants-mental-health/.

[309] *See Ten Myths About Immigration*, TEACHING TOLERANCE (Spring 2011), https://www.tolerance.org/magazine/spring-2011/ten-myths-about-immigration.

[310] *See* Tal Kopan, *DHS Memos Describe Aggressive New Immigration, Border Enforcement Policies*, CNN POLITICS (Feb. 20, 2017), http://www.cnn.com/2017/02/18/politics/kelly-guidance-on-immigration-and-border-security/index.html.

[311] *See Ten Myths About Immigration*, *supra* note 309.

[312] *See* KANSTROOM, *supra* note 220, at 6–8 ("The current deportation system is best understood within a long historical frame. It has grown slowly, incrementally, and reactively."). *See also* JOHN HIGHAM, STRANGERS IN THE LAND: PATTERNS OF AMERICAN

It is a bitter irony that professional psychological studies show exactly the opposite of the above assumptions.[313] Immigrants arrive in the United States with stronger mental health statistics and a lower-than-average manifestation of mental problems and substance abuse problems. Their mental health and substance abuse problems increase the longer they are in the United States.[314] Likewise, the perceptions about criminality are contradicted by voluminous data showing that crime does not increase with immigrant concentration and, overall, the crime rate among immigrants is lower than among native-born Americans.[315] There are plenty of sources attempting to strengthen these misperceptions,[316] including the Trump administration's efforts at portraying immigrant crime as particularly bad by directing the U.S. Department of Homeland Security to post anecdotal numbers on the crimes committed by immigrants.[317]

There is also a tragic loop of consequences. As noted in the psychological studies, immigrants are less likely to turn to mental health assistance for a variety of reason, including the fear that it

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NATIVISM, 1860–1925 (2d ed., 1988) (explaining the causes of nativism and opposition toward immigrants over the course of fifty-five years of American history).

[313] *See* INTERNATIONAL DOCTORS FOR HEALTHIER DRUG POLICIES, FAQ: WHAT ARE THE SUBSTANCE ABUSE RATES AMONG IMMIGRANTS? 3 [hereinafter IDPHDP]; *see* Jacob I. Stowell et al., *Immigration and the Recent Violent Crime Drop in the United States: A Pooled, Cross-Sectional Time-Series Analysis of Metropolitan Areas*, 47 CRIMINOLOGY 889, 893 (2009) (explaining the results of studies that indicate immigrants are less likely to be involved in crime than non-immigrants).

[314] *See* IDPHDP, *supra* note 313, at 3.

[315] *See* Stowell et al., *supra* note 313, at 891, 893. This article summarizes past scholarly work looking at the impact of immigration on crime in metropolitan areas, cities, and neighborhoods. The results consistently reveal immigrants (both lawfully present and undocumented) are less likely to commit crimes. *See id.* at 896–98. An entire edition of the journal *Homicide Studies* evaluates the connection between immigration and homicide. The overall conclusion of the various reports is that immigration does not increase rates of homicide. *See, e.g.*, Ramiro Martinez, Jr., *Immigration and Homicide Studies*, 13 HOMICIDE STUDIES, no. 3, Aug. 2009, at 207–09; *see also* Graham C. Ousey & Charis E. Kubrin, *Exploring the Connection Between Immigration and Violent Crime Rates in U.S. Cities, 1980–2000*, 56 SOCIAL PROBLEMS 447, 466 (2009) (asserting that crime is not a byproduct of increased immigration). *Contra* STEVEN A. CAMAROTA & JESSICA VAUGHAN, CTR. FOR IMMIGR. STUDIES, IMMIGRATION AND CRIME: ASSESSING A CONFLICTED ISSUE 26 (Ctr. for Immigr. Studies ed., Nov. 18, 2009), https://cis.org/sites/cis.org/files/articles/2009/crime.pdf (arguing that there is not enough evidence to show that crimes rates are higher or lower for immigrants).

[316] One website shows pictures of people killed by, what they describe as, "[i]llegal [a]liens." *See* THE REMEMBRANCE PROJECT, http://theremembranceproject.org (last visited Sept. 17, 2017).

[317] *See* Exec. Order No. 13768, 82 Fed. Reg. 8,799, 8,801 (Jan. 30, 2017). The executive order creates the Office for Victims of Crimes Committed by Removable Aliens and orders a quarterly report to be posted on the Department of Homeland Security's website identifying victims of crimes committed by immigrants. *See id.*

will be used against them in the immigration system.[318] At the same time, immigrants are perceived as having a greater reliance on public support programs that would include mental health care.[319] Untreated issues result in behavior that reinforces misperceptions about immigrants, promoting the belief that they commit more crimes.[320] Immigration law's emphasis on low-level offenses such as drug possession completes the cycle by requiring their removal.[321]

For those seeking to remedy this situation, reform at the federal level looks unlikely at this point.[322] Aside from recent steps taken by the government to recognize how mental illness may render an immigrant incompetent in removal proceedings, the movement of the Trump administration has been toward reinforcing false perceptions about immigrant criminality and the need to remove immigrants as a result.[323] A restoration of health benefits taken away under the PRWORA also seems highly unlikely in a political environment in which Congress is debating how to repeal parts of the ACA.[324]

The current administration's approach is tragic, given the very good arguments recommending a return to full immigrant coverage, including undocumented coverage.[325] Poor immigrant health leads to spillover economic costs because there are risks to public health for untreated immigrants. For example, pregnant immigrant

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[318] *See, e.g.*, Hacker et al., *supra* note 127, at 591, 592.

[319] *See* STEVEN A. CAMAROTA, WELFARE USE BY IMMIGRANT HOUSEHOLDS WITH CHILDREN 2 (2011); Alexander N. Ortega et al., *Health Care Access, Use of Services, and Experiences Among Undocumented Mexicans and Other Latinos,* 167 ARCHIVES INTERNAL MED., 2354, 2354 (2007).

[320] *See* Bowen, *supra* note 303, at 500 ("The increasing connections between immigration enforcement and the criminal justice system mean that a large proportion of individuals in the immigration adjudication system will have criminal convictions and also mental illness.").

[321] *See, e.g.*, 8 U.S.C. § 1227(a)(2)(B)(i) (2012); Coonan, *supra* note 265, at 592–93.

[322] *See* Press Release, Office of the Press Secretary, President Donald J. Trump Taking Action Against Illegal Immigration (Jun. 28, 2017) (on file with White House Office of the Press Secretary) ("Immigration and Customs Enforcement (ICE) has seen nearly 40 percent more Enforcement and Removal Operations compared to the same time last year."); Graham Lanktree, *New Trump Immigration Order Has Led to the Arrest of Hundreds of Undocumented Immigrants for Minor Crimes*, NEWSWEEK (Apr. 11, 2017), http://www.newsweek.com/trumps-immigration-raids-round-367-us-illegally-582489.

[323] *See* Laura Carlsen, *Trump's New Initiative Is a Front for Anti-Immigrant Propaganda*, FORTUNE (Mar. 6, 2017), http://fortune.com/2017/03/06/donald-trump-executive-order-immigration-steve-bannon-breitbart-deportation/.

[324] *See* Thomas Kaplan & Robert Pear, *Senate Votes Down Broad Obamacare Repeal*, N.Y. TIMES (July 25, 2017), https://www.nytimes.com/2017/07/25/us/politics/senate-health-care.html.

[325] *See* Patrick Glen, *Health Care and the Illegal Immigrant*, 23 HEALTH MATRIX 197, 224 (2013).

mothers have particular needs while giving birth to U.S. citizen children, there is a chilling effect on immigrants who are otherwise authorized under the law to receive benefits, and there are particularly vulnerable groups such as the elderly and immigrants who already suffer from mental health issues, whose denial of coverage is unjust.[326] There has been good scholarship advocating for the expansion of publicly-financed health benefits, including mental health benefits for undocumented children.[327] The particular vulnerability of children has been highlighted, since children are covered by a separate federal program, the Children's Health Insurance Program ("CHIP"), which also has a five-year bar for immigrants.[328]

What is needed is a re-framing of the issue in a political context likely to respond to the counter-narrative that it is sound public policy to extend coverage. States are more likely be the place for having an impact because the provision of mental health care and drug treatment is predominantly a state responsibility and the political environment in several states seems more likely to accept the re-framing of immigrant mental health care. Several states have pushed back against the current heavy-handed enforcement approach.[329] This can be seen as part of a recent, larger shift at the state level in which advocates for immigrant-friendly policies are gaining an upper hand and passing pro-integrationist legislation.[330]

More to the point, as noted above, California recently made the choice to provide insurance to both documented and undocumented immigrants.[331] California also petitioned the federal government to include undocumented immigrants in its state-run insurance exchange.[332] There are examples of mental health programs

[326] *See* Anahí Viladrich, *Beyond Welfare Reform: Reframing Undocumented Immigrants' Entitlement to Health Care in the United States, A Critical Review*, 74 SOC. SCI. & MED. 822, 825–26 (2012).

[327] *See, e.g.*, Patrick D. Murphree, *For the Least of These Brothers and Sisters of Mine: Providing Mental Health Care to Undocumented Immigrant Children*, 15 SEATTLE J. SOC. JUST. 65, 66 (2016).

[328] *Id.*

[329] For example, several states have filed suit to stop some of the more offensive aspects of President Trump's executive orders. *See, e.g.*, Washington v. Trump, 847 F.3d 1151, 1156, 1157 (9th Cir. 2017). There are several counties and cities that have filed suit to protect their right not to cooperate in immigration enforcement. *See, e.g.*, Cty. of Santa Clara v. Trump, No. 17-cv-00574, 2017 U.S. Dist. LEXIS 113407, at *10–11(N.D. Cal., July 20, 2017).

[330] *See* GULASEKARAM & RAMAKRISHNAN, *supra* note 182, at 119, 122–23.

[331] *See* Sangree, *supra* note 174.

[332] *See* Jennifer Medina, *California Moves to Allow Undocumented Immigrants to Buy Insurance*, N.Y. TIMES (Sept. 15, 2016), https://www.nytimes.com/2016/09/16/us/california-moves-to-allow-undocumented-immigrants-to-buy-insurance.html.

developed in other states that try to meet the needs of the poor immigrant population.[333] There are networks of low and no-cost providers that are spread throughout the United States that serve immigrant communities.[334] Recent news reports of universities paired with mental health providers to operate clinics illustrate some efforts to address the large unmet need for low and no-cost mental health services.[335]

There is an opportunity to evaluate the effectiveness of state programs providing broader more effective mental health to immigrants. Research for this article has not turned up any studies that track the state of residence of immigrants at the time they are charged as removable from the United States. The thesis of this article suggests that there should be a reduction in the number of immigrants found removable due to drugs or criminal convictions in those states that provide better health care access. By tracking removal charges against residents in those states with significant inclusion of immigrants in their Medicaid programs or with programs aimed at low-income immigrant populations, we can evaluate the impact of more effective mental health care on outcomes in the immigration system. There are plenty of resources offered by organizations such as the American Psychological Association[336] to improve the quality of access and guide decisions about treatment that are culturally sensitive and fully cognizant of barriers confronting treatment to immigrant populations. Their effectiveness may be judged, at least partly, by whether there are more immigrants avoiding removal from the United States.

States taking this route must consider the extent to which an enforcement-minded administration will want to try to use state funded programs to level the public charge grounds to justify removal. As noted above, we have grounds for inadmissibility that

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[333] *See, e.g.*, Stacey Kaltman et al., *Meeting the Mental Health Needs of Low-Income Immigrants in Primary Care: A Community Adaptation of an Evidence-Based Model*, 81 AM. J. ORTHOPSYCHIATRY 543, 545 (2011).

[334] *See, e.g.*, *Finding Therapy*, MENTAL HEALTH AMERICA, http://www.mentalhealthamerica.net/finding-therapy (last visited Sept. 17, 2017).

[335] *See, e.g.*, Michael Tomsic, *Students Fill a Gap in Mental Health Care for Immigrants*, NPR (June 7, 2016), http://www.npr.org/sections/health-shots/2016/06/07/480285726/students-fill-a-gap-in-mental-health-care-fr-immigrants.

[336] *See* AM. PSYCHOLOGICAL ASS'N., WORKING WITH IMMIGRANT-ORIGIN CLIENTS 7 (2013), http://www.apa.org/topics/immigration/immigration-report-professionals.pdf. This report recommends the use of an "Ecological Framework" which recognizes the "reciprocal interactions between individuals and their environments." *Id.* The larger culture, as well as the local community, interacts with immigrants' own strengths and vulnerabilities to place them in situations of need or independence. *Id.*

apply to those seeking admission and those who are already admitted and face deportability. Immigrants already admitted face the more narrow ground of deportability with a time limit and the opportunity to show that conditions arising after admission caused their dependence on public assistance.[337] For those not yet admitted the broader ground of inadmissibility may make the use of publicly supported mental health care more risky.[338] The inadmissibility (formerly exclusion) grounds are broader and consider a number of factors such as age, health, family status, assets, education and skills.[339] However, if being sponsored by a family member, the affidavit of support discussed above can overcome this basis for denying admission.[340]

There are other innovations at the state level, such as special courts to divert people out of the criminal justice system if a mental health or drug addiction problem is the cause of the legal violation.[341] Again, however, those advocating for states to aid immigrants must be aware of hidden traps in the immigration system. These courts may also require immigrants to plead guilty.[342] Some operate on a suspended sentence approach, or provide for an expungement after successful completion of a program.[343] The INA has a far more expansive definition of the term "conviction" than is commonly understood.[344] Any plea or admission of facts sufficient for a finding of guilt coupled with "some form of punishment, penalty, or restraint" is a conviction for immigration purposes.[345] Moreover, the BIA has decided that post-conviction relief, such as expungements or deferred adjudication, does not count to erase a conviction if it is granted to alleviate consequences in the immigration system.[346] Therefore, while under

[337] *See* Price, *supra* note 223, at 938.

[338] *See id.*

[339] 8 U.S.C. § 1182(a)(4)(B)(i)(I)–(V) (2012).

[340] *See* IRA J. KURZBAN, KURZBAN'S IMMIGRATION LAW SOURCEBOOK 78 (15th ed., 2016). Even if an employee is a lawful permanent resident, employers "must comply with the employment verification requirements." *Information for Employers and Employees*, U.S. CITIZENSHIP AND IMMIGR. SERV., https://www.uscis.gov/working-united-states/information-employers-employees/information-employers-and-employees (last updated Oct. 6, 2017).

[341] *See* McDaniel M. Kelly, Note, *Rehabilitation Through Empowerment: Adopting the Consumer-Participation Model for Treatment Planning in Mental Health Courts*, 66 CASE W. RES. 581, 583 (2015).

[342] *See id.* at 591–92.

[343] *See* Seltzer et al., *supra* note 57, at 576.

[344] *See, e.g.*, 8 U.S.C § 1101(a)(48)(A)(ii).

[345] *Id.*

[346] *See In re* Pickering, 23 I. & N. Dec. 621, 622 (B.I.A. 2003) (citing *In re* Roldan, 22 I.& N. Dec. 512, 528 (B.I.A. 1999)); Andrew Moore, *Criminal Deportation, Post-Conviction Relief and*

state law there is no conviction, under federal immigration law there is and that conviction can support deportability on criminal grounds.

The above example captures the unfortunate approach by the federal immigration system to work at cross purposes to state attempts to protect and rehabilitate those with mental health and addiction issues. It is particularly unfortunate given the proven effectiveness of mental health and drug courts.[347] Therefore, states must be careful if they want to re-craft diversionary programs to truly aid immigrants, which has already been proposed outside of the immigration context.[348] Most importantly, such programs should operate at the earliest pre-trial stages to avoid plea requirements of any kind.

VI. CONCLUSION

Our struggling mental health care system is working in conjunction with our criminalized immigration system to place many immigrants into removal, reinforcing a belief that many immigrants are burdens on our society and predisposed to commit crimes. These beliefs are undercut by the immigrant paradox. Studies reveal that immigrants have better-than-average mental health and that they do not have an increased likelihood of criminality. As time goes on, the protective effect of immigration disappears, leaving immigrants with the same levels of mental health challenges as the general U.S. population. Barriers to accessing mental health care, such as cost, cultural and language barriers, exacerbate the challenges of dealing with mental health problems that lead to criminal behavior and drug problems. It is in this area that our immigration system has seen the greatest expansion in removing immigrants.

Improving access to mental health and drug counseling would provide a way to counteract this effect and avoid the increasingly punitive operation of our immigration system to remove immigrants. A number of mechanisms within the control of the states, such as health insurance, culturally sensitive mental health care that reduces barriers to access, and diversionary programs within the courts, can mitigate this system. The states should take

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the Lost Cause of Uniformity, 22 GEO. IMMIGR. L.J. 665, 668, 677–78 (2008).

[347] *See* Kelly, *supra* note 341, at 586–87.

[348] *See id.* at 598; Seltzer et al, *supra* note 57, at 581.

them up.