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Mental Health Service Use Among Immigrants in the United States: A Systematic Review

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Abstract

Objective—Immigrants face stressors unique to the experience of migration that may exacerbate or cause mental health problems but access care at rates far below the general population, leaving them at risk of untreated mental health conditions. This review synthesizes current findings on mental health service utilization among immigrants to inform future research efforts addressing disparities in access to care.

Methods—A systematic literature search of seven databases yielded 62 articles that met inclusion criteria: peer-reviewed reports of empirical studies based in the United States with an explicit focus on immigrant mental health service use. Each article was evaluated, and information was extracted by using a structured abstracting form.

Results—Studies have shown that immigrants from Asia, Latin America, and Africa use mental health services at lower rates than nonimmigrants, despite an equal or greater need. Lower usage has been found to be more pronounced among men, the uninsured, and the undocumented. Structural barriers to service use reported included lack of insurance, high cost, and language barriers. Studies have shown that social support is particularly important for immigrants and that those who seek help for mental health concerns tend to turn first to family, friends, or religious leaders.

Conclusions—Important areas for future research on disparities in mental health service use among immigrants include expanding research and analytic design to emphasize understudied groups and the heterogeneity of immigrant experiences over time, studying interventions that foster collaboration between formal and informal service sectors, and examining the role of social support in problem recognition and treatment initiation.

There are 40 million immigrants in the United States (1) and 35 million children whose parents are foreign born (2). Because immigrants and children of immigrants constitute 24% of the U.S. population, their mental health concerns have implications for the overall health of the nation. Immigrants face challenging postmigration circumstances, such as separation from family, cultural and linguistic barriers, and adjustment to a new, and sometimes unwelcoming, environment. These stressors may exacerbate existing mental health problems or initiate new concerns (3–7). For instance, immigrants who experience acculturative stress, a term used to describe postmigration challenges, are more likely to become anxious or

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depressed (8,9). Treatment is effective in alleviating distress (10); however, immigrants are much less likely than nonimmigrants to use mental health services from the formal or informal sector (5,11–13). Mechanisms underlying disparities in mental health service use have yet to be firmly established.

Several influential national reports in the early 2000s drew attention to disparities in use of formal mental health services (14–17). These reports stimulated a large body of research examining patterns of service use among underserved racial and ethnic communities (18–20). This literature documented disparities in mental health service use among Latino, Asian and Pacific Islander, Native American, and African-American populations, despite a demonstrated need for services. Rates of service use for these communities are consistently lower than the national averages of 13% of the general public, 59% of adults with serious mental illness, and 71% of adults with depression (21).

Eliminating health and mental health disparities in underrepresented racial-ethnic communities requires addressing disparities among immigrants because immigrants constitute a large portion of some racial-ethnic groups: 46% of all Latinos and 74% of all Asians are foreign born (22,23). Although scholarly attention has focused on documenting disparate rates of psychiatric diagnoses and outcomes among immigrants (6,24–30), studies addressing service use disparities are less common. However, this growing body of literature shows that immigrants may face additional challenges germane to the experiences of migration that lead to patterns of help seeking that differ from those of nonimmigrants (16,31). The purpose of this systematic review was to synthesize current scholarship regarding factors that uniquely affect mental health service use among immigrants in order to identify commonalities and differences across diverse groups and inform future research efforts to increase health equity and effectiveness of mental health services for immigrants in the United States.

Methods

A systematic review of the literature was conducted in March 2013. Search terms related to immigrant mental health service utilization, such as “immigrant AND mental health AND service use,” were entered into seven databases: PsycINFO, PubMed, Social Service Abstracts, Social Work Abstracts, Sociology Abstracts, Web of Science, and Annual Reviews. (A full list of search terms is available from the author.) The search yielded 5,020 studies, spanning from 1999 to 2013, that were reviewed according to the following inclusion criteria: empirical and peer reviewed; based in the United States; and explicitly focused on immigrants, mental health, and service utilization. Studies that examined both formal and informal providers of mental health services were included. Studies that used qualitative and quantitative approaches were retained in order to include findings gathered from a variety of epistemological perspectives.

In the first round of review based only on titles, 1,364 reports were excluded because the study occurred outside the United States. The review sought to inform understanding of access to the U.S. mental health care system. In the second round of review based on abstracts and titles, studies were excluded if they focused exclusively on service use for

general medical concerns, documented disorder rates without examining service use, explored treatment interventions or practitioner cultural competence rather than issues of service use, or focused on service use without explicit consideration of immigrants. Many studies were excluded at this stage because they did not address mental health or because they documented mental health status and outcomes without addressing service use. Each article was assessed for its inclusion of measures related to immigration (for example, birthplace, length of time in the United States, and language proficiency). Studies that did not include any consideration of immigrant status, either in conceptualization or analyses, were excluded from this review because it was impossible to interpret the findings as they related to immigrants. Finally, the remaining 73 reports received a full-text review. Eleven were found not to meet inclusion criteria. After the full-text review, 62 articles remained and are reviewed in this study. [A figure detailing the literature search process is available in an online supplement to this article.]

Each report was evaluated in chronological order by using a structured abstracting form with the following general topics: journal or discipline, research questions, conceptual framework, data source, sample characteristics (size; age; gender; country of origin; and inclusion of immigrants, refugees, or asylum seekers), methodological design, measurements (demographic factors, controls and covariates, service use, type of service providers, need and diagnosis, and immigration factors), results (rates, barriers, attitudes, correlates, predictors, and other findings), and notes. This abstraction file became the basis for the analysis and synthesis of findings. [A general overview of the characteristics of the articles, such as methodologies, measures used, and sample size and composition, is available in the online supplement.]

Results

The 62 articles (31–92) presented important findings in four areas: rates of mental health service use, service use patterns and provider preferences, barriers to service use, and factors associated with service use.

Rates of Mental Health Service Use

Of the 62 articles, 32 included research questions that compared rates of mental health service use for specific groups. In general, immigrants had lower rates of use compared with persons born in the United States (32–36). For instance, one study of Asian and Latino immigrants found that only 6% of immigrants had ever received mental health care, making them 40% less likely than U.S.-born participants to access services (35). Likewise, a study of Caribbean immigrants showed that foreign-born status had the greatest effect of any correlate on rates of mental health service use (34).

In several studies, researchers did not disaggregate the immigrant and nonimmigrant participants when reporting rates of service use, even though they measured immigration factors in their sample (37–43). These aggregated studies showed very low service rates compared with national averages (21). Only 4% of Asian respondents sought any mental health services in the past year (37); 3% of a Vietnamese sample saw a mental health specialist in the past three years (41); only 3% of Filipino respondents had ever used formal

mental health care (44); and 10% of women of African or Latino ancestry were using mental health care, although 45% of them met clinical criteria for depression (45). Reporting rates of service use without consideration of immigration status can give a general sense of service use rates among underrepresented racial and ethnic groups, but it can also obscure differences and make it difficult to understand immigrants' unique experience with mental health services. Table 1 presents rates of mental health service use only for those studies that disaggregated rates for immigrants. These studies are discussed in the remainder of this section.

Most studies showed lower use rates among Latino immigrants compared with U.S.-born Latinos. For example, 15% of Mexican immigrants with a psychiatric diagnosis used services, compared with 38% of U.S.-born Mexicans with a similar need (43). Latino and Asian immigrants used mental health specialty services at half the rate of U.S.-born members of the same racial-ethnic groups (35). However, another study reported that 22% of Latino immigrant participants with a psychiatric diagnosis had accessed formal mental health services, compared with 19% of U.S.-born Latinos with a diagnosis (38). Another study found that preschool-age Latino immigrant children were more likely than U.S.-born Latino children of the same age to have received needed mental health services and that adolescent Latino immigrant children were significantly less likely to receive needed care (46). Undocumented Latino immigrants had lower rates of service use than any other group; they had fewer mental health appointments and lower lifetime in-patient and outpatient service use rates than U.S.-born Latinos and Latino immigrants in the United States with legal documents (47).

For Asian immigrants, findings more consistently showed lower use rates than U.S.-born Asians. For example, U.S.-born Asians with a psychiatric diagnosis used mental health services at twice the rate of Asian immigrants with a similar diagnosis (36); 14% of Asian immigrants with a psychiatric diagnosis had used mental health services in the past year, compared with 20% of U.S.-born Asians (38); and only 5% of Asian immigrants had used any mental health services (48).

Few studies reported service use rates for African or Caribbean immigrants. One article examined mental health service use among Somali immigrant adolescents and found that only 8% of the sample reported that they sought help from formal service providers for mental health issues (49). Another study found that 11% of Caribbean immigrants with a psychiatric diagnosis used any mental health services (versus 47% of U.S.-born Caribbeans) (34). No studies reporting mental health service use rates for European or Middle Eastern immigrants were found.

Eight of the studies included specific data about refugees or asylum seekers. Their findings highlight an increased need for mental health services and, for some groups, a higher service use rate than for other immigrant and nonimmigrant groups (50–53). Because refugees, asylum seekers, and undocumented immigrants have potentially more need for mental health services (6), understanding their unique and diverse service use patterns is critical. However, relatively little research is available on the needs of these populations.

Service Use Patterns and Provider Preference

Of the 62 studies, 26 considered the formal service system (for example, psychologists, social workers, mental health specialists, and physicians), and one focused on informal services (for example, alternative medical care and religious leaders). Twenty-seven studies measured the use of both formal and informal providers, and eight of the 62 studies did not specify provider type. [A table listing provider types measured is available in the online supplement.] Thirteen of the studies included research questions about preferences for specific types of mental health service providers.

Informal mental health care providers—Several studies found that participants turned to family, religious leaders, and friends first (39,43,45,54,55), sometimes delaying treatment with mental health professionals or physicians (56–58). For example, in two studies of Chinese immigrants, informal help from relatives or friends was most often preferred, followed by help from other informal sources and, finally, help from medical and mental health practitioners (39,59). In a sample of Korean immigrants and nonimmigrants, 52% preferred to go to family and friends for help with mental health problems, 40% preferred religious consultation, and 9% preferred a mental health professional (54).

Religion, in the form of consultation with religious leaders and support from coreligionists or religious practices, emerged as an important avenue of informal mental health care across various immigrant groups (37,39,44,45,54,56). Among Latino immigrants, 36% of one sample consulted religious leaders for psychological problems (60), and in another study, participants reported that they were more likely to seek help from a priest, minister, or rabbi rather than from other sources (56). The most frequently cited treatment strategy for African immigrants was spiritual healing; it was endorsed by 22% of Ethiopian immigrants and 23% of Nigerian immigrants (61). Eighty-one percent of a sample of Latina and African immigrant women endorsed faith as a means to cope with mental health problems (45). This tendency to seek help from religious sources was more pronounced for those with a psychiatric diagnosis. In one study, 38% of Hispanic youths with a diagnosis, versus 13% of those without a diagnosis, turned to religious advisors for help (62). Similarly, in a Filipino sample in which 80% of participants were immigrants, high levels of emotional distress and greater somatic symptoms were associated with higher probability of help seeking from clergy (44).

The use of alternative treatment for mental health issues, such as acupuncture, naturopathy, and traditional healers, was the subject of several studies; in particular, these studies examined whether such use decreased the likelihood of receiving care from general medical providers or formal mental health providers. Findings suggest that use of alternative services did not result in decreased use of mental health services from general medical providers or mental health specialists. For Cambodian refugees, alternative service use was positively associated with seeking Western medical services, and only 5% of the sample used alternative medicine exclusively (51). In a study of Chinese immigrants, the use of alternative medicine was unrelated to other mental health service use (63).

Formal mental health care providers—Some participants expressed a preference for using formal service providers for mental health needs. For example, in a study of Latina immigrants, mental health specialists and primary care physicians were the most preferred mental health care providers (64). Likewise, in a study of Vietnamese immigrants, seeking help from physicians was the most preferred treatment for mental health problems (65). People with a psychiatric diagnosis and those living in rural areas were more likely than those without a diagnosis or those living in urban areas to use physicians for mental health problems (43,62,66). A potential explanation for the use of general medical providers for mental health care was the focus of one study, which found that Chinese immigrants commonly interpreted mental health symptoms as general medical issues and, therefore, sought help from physicians (67). Somatization was refuted in another study, which found that increased physical symptoms did not decrease service use from mental health specialists (68). Even though immigrants sometimes use general medical practitioners for mental health concerns, immigrants were significantly less likely than nonimmigrants to take psychotropic medication (33,57,69).

Barriers to Mental Health Service Use

Of the 62 articles, 23 examined barriers to accessing mental health care. Barriers were common and varied across immigrant groups. In one study, 77% of Cambodian refugees experienced two or more barriers, and only 7% reported no barriers (70). In general, barriers to mental health care were either cultural (that is, stigma, norms, and attitudes) or structural (that is, cost, transportation, lack of insurance, and discrimination). Both structural and cultural factors were identified as barriers by a group of first-generation immigrants from Cambodia, Eastern Europe, Iran, Iraq, Africa, and Vietnam (71). Some studies attempted to determine whether cultural or structural barriers were more relevant to service use disparities. Table 2 lists the most common barriers reported, arranged by frequency of reports. Table 3 presents the most common barriers reported by immigrant group.

Cultural barriers—Some researchers echoed the 2001 Surgeon General's report (17) and stressed that cultural factors, such as stigma and norms about mental health in immigrant communities, contribute to lower service use in these populations. Stigma was the most frequent cultural factor reported as a barrier to services. In two studies that included both African and Latina women, a third of the sample cited stigma as a barrier, with stigma most likely to be cited by African immigrants (45,72). Chinese immigrants also named stigma as an obstacle (67), and in a study of Korean immigrants, elders were more likely to report misconceptions and stigma about mental illness (73). Similarly, Iranian immigrant elders expressed the attitude that “only crazy people seek mental health care” (69). Traditional beliefs were also identified as a barrier to formal mental health care. For instance, elder Iranian immigrants endorsed a more holistic concept of mental health that included the spirit; therefore, physicians' attempts to focus only on the mind as the source of healing (for example, by prescribing medication) were not effective (69). Despite the prevalence of the idea that cultural factors are important barriers to mental health care, some studies showed very little endorsement of such barriers (37,70,74,75). These findings are explained, in part, by studies that explored structural barriers to mental health care.

Structural barriers—Some research shifted focus away from the service user and on to structural factors related to service use disparities. Environmental and systemic issues, such as lack of insurance, cost of services, language barriers, and accessibility, were the most common structural barriers reported. For example, a study of diverse racial and ethnic groups showed that immigrants were 15% less likely than U.S.-born individuals to have a source of health care and that the uninsured rate was three times higher among immigrants (33). Structural barriers were common for Latino immigrants in the form of lack of insurance, cost, long wait times, and a low supply of local providers (56,60,64,74,76). Nearly 60% of participants in one study identified cost as a prohibitive factor (60), and language barriers were problematic in many communities (56,58,60,64,70,77).

Another common barrier was lack of knowledge about mental health services (37,56,75,77,78). In one study, fewer than 25% of all respondents indicated knowledge of mental health resources (78), and another study reported that 35% of immigrants were unaware that they had a diagnosable mental disorder (75). Finally, being in the United States without documentation prohibited some immigrants from seeking treatment (57,60). In one study, undocumented immigrants reported reluctance to seek help because of anxiety about being asked for documentation (79). In another study, Latina immigrants were afraid to seek services because they thought they would be denied or deported based on their immigration status (64).

Despite real and persistent barriers to care, immigrants expressed a desire to seek help for mental health issues. For example, in one study, 75% of Latino immigrants had positive attitudes toward mental health care (75), and in another, a sample of Vietnamese immigrants had favorable attitudes toward receiving mental health care (48). This was not always the case, however; 49% of a sample of East Asian immigrants were not willing to seek help for mental health concerns (80).

Factors Associated With Mental Health Service Use

Of the 62 articles, 38 reported variables associated with mental health service use. These factors included demographic correlates, self-perceived mental health need, immigration issues, and social support. Certain demographic correlates were more frequently associated with service use: age, gender, education level, marital status, and insurance status. Across all immigrant groups, those more likely to use services were women (39,43,50,52,63,80,81); those with higher education levels (35,43,82); and those who were divorced, widowed, or separated (40,82). In general, service use was positively associated with age (35,40,52,63,80,83), although one study found a negative association (48). Having insurance was positively associated with service use in many studies (35,38,40,50,52). However, one study showed that private insurance had this effect, whereas public insurance did not (66), and another reported no relationship between insurance status and mental health service use (82).

Need for services—Perceived and diagnosed need had the strongest relationship to mental health service use. Those with a psychiatric diagnosis, poor self-rated mental health, or former exposure to traumatic experiences were more likely than others to use services

(35,38,39,43,52,66,81,82,84). Low self-rated health and mental health was also associated with greater use of care (63,82). In fact, perceived mental health need was commonly the most robust factor associated with service use (38,48,74,81,84). For example, immigrant Latino men's perceived need for mental health services was the strongest correlate of any mental health service use (81), and self-rated mental health was the strongest predictor of service use for Latino and Asian immigrant elders (84).

Immigration-related factors—Immigration factors, such as English proficiency and acculturation, were closely related to service use. Several studies showed that those with greater English proficiency were more likely to use services (40,58,80–82). For example, non-English speaking immigrants in one study had lower odds of receiving needed services; 51% of those who expressed a need and spoke only English received services, compared with 8% of those who needed care but did not speak English (85). However, two studies found no relationship between language ability and service use among Latino and Asian immigrants (31,35), and another reported that increased service use was associated with limited English proficiency among Cambodian refugees (50). Similarly, several studies reported that immigrants who were more acculturated were more likely to use mental health services (35,39,40,80), and another showed that Chinese immigrants who were less acculturated were more likely to use services (63).

Social support—Family, friends, and other social contacts were important influences on help seeking, problem recognition, and treatment initiation. For instance, Chung (67) found that for Chinese immigrants who had attempted suicide, family support was crucial to their help-seeking behavior and that the loss of familial support was a factor in their suicide attempts. Other studies found that friends and family served as important referral sources into mental health treatment (52,56,58).

Discussion

Main Findings

Sixty-two articles were reviewed for their findings on mental health service use among immigrants to the United States. A consistent finding was that immigrants access mental health services at lower rates than nonimmigrants. With some exceptions, rates of use were especially low for undocumented immigrants, men, younger individuals, and those without insurance. Service use among immigrants with a psychiatric diagnosis ranged from 5% to 40%. In studies that did not consider diagnostic criteria, the rates ranged from 3% to 6%. These levels are well below those for U.S.-born counterparts in the same samples and below the national average for mental health service use of 13% for the general public, 59% among adults with serious mental illness, and 71% among adults with depression (21). For immigrants who did use services, informal channels such as family, friends, and religious communities played an important role in problem recognition and treatment initiation. Findings regarding provider preference were mixed. Some studies reported that participants preferred accessing mental health care through general medical providers, and others indicate that religious leaders were more accessible and trusted confidants. Structural issues, such as lack of insurance, high cost and inaccessibility of services, and language barriers,

were important deterrents to service use. Cultural issues, such as stigma and norms in regard to mental health, were also reported as barriers. Important demographic factors related to service use included gender, age, education level, and employment, marital, and insurance status. Perceived need and social support were found to be strong correlates of service use.

Recommendations for Future Research

Although research on mental health service use among immigrants has yielded important findings about barriers to care and factors related to service use, attempts to decrease mental health disparities among immigrants and, therefore, among underserved racial and ethnic communities as a whole would be aided by further research in three areas discussed below.

Expansion of research and analytic design—To develop an empirical understanding of the relationship between migration and mental health service use, research in this area should be designed to examine this process over time and with heterogeneous groups. All the studies in this review were cross-sectional, making it impossible to determine causal links. Future research should consider longitudinal design or more intensive case studies that follow immigrants who are new to the United States to see how accessing mental health services unfolds over time.

Research on service use among immigrants should also consider the diversity in the immigrant experience, including demographic factors, such as racial, ethnic, religious, age, and gender diversity, as well as the diversity of pre- and postmigration experiences of social support, acculturation, and acculturative stress and premigration experiences with the mental health service systems in countries of origin. Understanding this heterogeneity may provide insights into discrepant findings (28). For example, discrepancies in service use rates among Latino immigrants, such as those reported above, could result from aggregating findings from diverse ethnic groups. Certain Latino groups (for example, Puerto Ricans) have been shown to have higher rates of mental health service use than other Latino groups, whereas others (for example, Mexicans) have been found to have lower rates (40). Emphasizing heterogeneity within immigrant groups is necessary to identify underserved subgroups and to more comprehensively understand the factors that influence mental health service use. To build on current knowledge and develop a more complete empirical explanation of the relationship between migration and service use, four methodological suggestions are discussed below.

First, research should disaggregate samples that include both immigrants and nonimmigrants. Aggregated samples can obscure differences that are essential to understanding service use patterns. Disaggregating samples on the basis of foreign-born status and other immigration-related factors is crucial to furthering knowledge.

Second, research should focus on underresearched demographic categories—specifically, undocumented immigrants, refugees and asylum seekers, men, youths and elders, and immigrants from geographically underrepresented areas, such as Africa and the Middle East.

Third, future researchers should use methods designed to explore heterogeneity, such as mixture modeling or qualitative methods. In addition, longitudinal research on immigrant

mental health service use would facilitate an understanding of service use changes over time and potentially illuminate mechanisms of that change.

Fourth, uniform measures of immigration-related factors should be used. Conceptualization and operationalization of immigration-related factors are not consistent across this body of literature. Immigration-related measures included premigration indicators, such as nativity or birthplace, age at immigration, country of origin, and year of immigration, as well as postmigration issues, such as years in the United States, generational status, experiences of discrimination, acculturation, family reunion, social contacts, cultural identity, and feelings about the immigration process. Other common immigration-related measures included English and native language proficiency, primary and preferred language, and measures of immigrant status, such as whether the individual had citizenship or legal documents. To increase our capacity to capture the diverse experience of a wide range of immigrants, more uniform measurements are needed. For example, collapsing the experience of new immigrants with that of long-established immigrant communities may partly underlie the divergent findings on service use.

Research on collaborations between formal and informal services—This review showed that informal services play an important role in addressing mental health concerns among immigrants. Therefore, another area for further examination is collaborations between formal and informal service sectors. Partnerships between religious leaders and mental health specialists, for example, could raise awareness of both parties about mental health challenges for immigrants. In fact, as noted above, religious providers were an important source of informal mental health support for immigrants (37,39,44,45,54,56) and, therefore, may be a conduit for referrals and a promising partner for collaborations with formal service systems. The effectiveness of partnerships between service sectors is an important area for further examination.

Research on social support, perceived need, and treatment initiation—Changes in social support after migration may be one of the unique differences between immigrant-specific mental health service use and more general mental health service use. As noted, social systems influence how immigrants perceive their need for mental health services and can facilitate access to those services (40,52,56,58,67). Current research has not established what happens for immigrants who are forming new and different support systems, or who are isolated from support networks, in terms of accessing services when they need them. Future research that explores the variety of types of social support experienced by immigrants, as well as the influence of disruption of regular support systems, may help illuminate mechanisms that connect social support to mental health service use for immigrants.

Conclusions

Effectively addressing mental health disparities requires consideration of the unique service use experiences of immigrants. Research addressing immigrant mental health care has demonstrated important unmet mental health needs and factors related to service use. Future research should focus on understudied groups and seek to understand heterogeneity and

longitudinal relationships between immigrants and mental health service use in order to explain differing service use patterns and inform effective interventions. To increase mental health service use and effectiveness among immigrants, intervention programs that integrate formal and informal service sectors should be examined and mechanisms that explain the relationship between social support and service use should be explored.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1

Rates of service use for mental health problems among immigrants to the United States reported in the reviewed studies

Groups	Rate (citation)
African or Caribbean	8%[a,b,c] (49); 11% (vs. 47% of U.S. born)[a,d,e] (34); 5%[a,f] (45)
Latino	4%[a,f] (45); 5%[a,c,d] (43); 15%[a,d,e] (43); 22%[a,d,e] (38); 26%[a,d] (46); 36%[a,g] (83); 40% (vs. 71% of U.S. born)[a,c,d] (47)
Asian and Latino	6% (40% less likely than U.S. born)[d,e,h] (35)
Asian	3%[c,d,h] (31); 5%[c,d,h] (48); 14%[a,d,e] (38); 15%[a,b,c] (39); 23% (vs. 40% of U.S. born)[a,b,c] (36)
Refugee or asylum seeker	16% of asylum seekers[b,c,h] (53); 35% of Russian refugees[b,c,e,h] (52); 70% of non-Russian refugees[b,e,h] (52); 72% of Cambodian refugees[a,d,e] (50·51)

[a] Rate for those with a mental health diagnosis or established need

[b] Lifetime service use

[c] Used services from mental health specialists

[d] Past-year service use

[e] Used any mental health services

[f] Currently being treated

[g] Followed through on referral

[h] Rate for full sample with no diagnostic criteria

Table 2

Cultural and structural barriers to mental health service use among immigrants to the United States reported in the reviewed studies

Barrier	Studies in which barrier was endorsed
Cultural	
Stigma	45,64,67,71,76,77
Beliefs or norms about mental illness	60,69,71,79
Preference for alternative services	70,71
Distrust of formal providers	69,70
Self or family reliance	64,76
Acculturation difficulties	67
Structural	
Language	38,56,58,60,64,70,71,77,79
High cost	56,57,60,64,70,71,77,79
Lack of knowledge of resources	56,57,60,70,71,75,77,78
Transportation problems inaccessibility	60,64,67,70,77,79
Lack of insurance	33,56,57,60
Undocumented immigrant, fear of deportation	57,60,64,79
Long wait	56,57,77
Provider cultural incompetence	77,79
Fear of missing work	57
Lack of collaboration between services and churches	77
General structural barriers	76
Competing health demands	76
Gender of provider	64
Discrimination	70

Table 3

Barriers to mental health service use reported by immigrants to the United States in the reviewed studies

Group	Barrier (citation)
General immigrants	Lack of insurance most influential barrier (33)
Cambodian refugees	High cost, 80%; language, 66%; lack of knowledge, 25%; transportation, 24%; discrimination, 15%; prefer alternative care, 5%; distrust of formal services, 4% (70)
Cambodian immigrants	Stigma, norms, prefer alternative care, lack of knowledge, language, cost (71)
Korean immigrant women	Cultural incompetence of providers, language, wait time, cost, transportation, lack of knowledge, stigma, lack of collaboration between services and churches (77)
Chinese immigrants	Service inaccessibility, stigma, acculturation stress (67)
Asian immigrants	Embarrassment and discomfort (74)
Vietnamese immigrants	Norms, lack of knowledge, language, cost (71)
Latino immigrants	Lack of insurance, cost, language, knowledge, wait time (56); <25% knew where to access mental health care (78); cost, 59%; insurance, 35%; language, 31%; belief that services are unhelpful, 6%; lack of knowledge, 4%; fear of deportation, 6%; transportation problems, 5% (60); self-reliance, language, stigma, competing health demands, general structural barriers (76); a third unaware that they had a diagnosable problem; a third unaware of how to get help (75); language (38)
Latino immigrant men	Cost, lack of insurance, being undocumented, fear of missing work, wait time, lack of knowledge of services (57)
Latina immigrant women	Cost most important barrier, followed by language, inconvenient service hours, gender of provider, confidentiality concerns about being undocumented, stigma, desire to stay inside the family (64)
Latina immigrant (and nonimmigrant) women	Stigma, 30% (45)
Latina women service providers	Language, being undocumented, cost, beliefs about mental illness, transportation problems, cultural incompetency of providers (79)
Latina immigrants with limited English proficiency	Embarrassment and discomfort not related to service use (74)
African immigrants (and nonimmigrants)	Stigma, 30% (45)
African immigrants	Stigma most common barrier (72); prefer alternative care, lack of knowledge, language, cost (71)
Iranian immigrant elders	Cultural differences in mental health conceptualization, lack of trust in medication (69)
Iranian immigrants	Stigma, lack of knowledge, cost (71)
Iraqi immigrants	Stigma, prefer alternative care, lack of knowledge, cost (71)
Eastern European immigrants	Stigma, norms, lack of knowledge, language (71)