

Understanding the Healthcare Experiences of Deferred Action for Childhood Arrivals (DACA) Recipients

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UNDERSTANDING THE HEALTHCARE EXPERIENCES OF DEFERRED ACTION FOR
CHILDHOOD ARRIVALS (DACA) RECIPIENTS

by

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A thesis submitted in partial fulfilment of the requirements
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Abstract

Background: There is limited research on the healthcare experience of Deferred Action for Childhood Arrivals (DACA) recipients both before and after enrollment in the program. DACA is a program designed to defer deportation to children and young adults in the United States for up to 2 years. The goal of this qualitative study is to explore the lived experiences of DACA students with regards to access to healthcare and perceptions of treatment.

Method: This study is qualitative and uses a phenomenological approach. DACA Recipients (N = 5) were recruited from the UCF student population and 1:1 interviews were conducted. Interviews were transcribed and manually coded.

Results: Thematic analysis revealed the following three themes (1) Meeting Needs (2) It Takes a Village and (3) Documentation Over Insurance

Conclusion: The fundamental structure of the findings shows the struggles of receiving healthcare as an undocumented immigrant, and the limitations of DACA as a solution. Health insurance is a more prominent and impactful factor than documentation status in the quality and quantity of healthcare access. The healthcare experience ranges from volunteer clinics to local pharmacies. Although, if DACA recipients have insurance, their healthcare experience is more consistent, regardless of documentation. Their day to day lives is composed of meeting basic needs, receiving only necessary doctor's visits as a child, and being prepared for all circumstances in terms of future citizenship.

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Introduction

In 2012, the Deferred Action for Childhood Arrivals (DACA) was announced. This initiative established a way for children and young adults who immigrated to the United States of America to have their deportation deferred for upwards of 2 years; this initiative was renewable for as long as you are eligible. The following is the eligibility criteria:

1. Must be under the age of 31 as of June 15, 2012;
2. In the United States before reaching your 16th birthday;
3. Continuously residing in the United States since June 15, 2007, up to the present time;
4. Physically present in the United States on June 15, 2012, and at the time of making their request for consideration of deferred action with the United States Citizenship and Immigration Services (USCIS);
5. Have no lawful status on June 15, 2012;
6. Currently in school, have graduated or obtained a certificate of completion from high school, have obtained a general education development (GED) certificate, or are an honorably discharged veteran of the Coast Guard or Armed Forces of the United States; and
7. Never convicted of a felony, significant misdemeanor, or three or more other misdemeanors, and do not otherwise pose a threat to national security or public safety.

(United States Citizenship and Immigration Services, 2018)

By the first quarter of 2018, over 2.2 million cumulative DACA applications were received, and 87% of those applicants met the criteria as outlined above and were enrolled (United States Citizenship and Immigration Services, 2018). It should be noted that DACA does not grant citizenship. Furthermore, DACA recipients, also known as *Dreamers* are not eligible to enroll in the Affordable Care Act (ACA). As a result, many DACA recipients rely on employment, pay out of pocket, or go without healthcare.

Background

While there is limited research on DACA and access to healthcare, there is a significant amount of research on documentation status and healthcare. Urrutia-Rojas, Marshall, Trevino, Lurie, & Minguia-Bayona, (2006) surveyed the healthcare access and sociodemographic characteristics of 147 undocumented and 172 documented immigrants. The study found undocumented immigrants were 72% less likely to have health insurance and 51% less likely to have a healthcare provider than documented immigrants. Only 9% of undocumented immigrants reported having healthcare as opposed to the 60% of immigrants that do. Undocumented immigrants additionally reported overall poorer health and lower income than that of documented immigrants (Urrutia-Rojas et al., 2006).

Research by Siemons, Raymond-Flesh, Auerswald, & Brindis (2016) found that while DACA had smoothed immigrants' integration into US society, the lack of official legal status limited their full societal engagement. This lack of legal status limited their college prospects, preventing them from seeking employment and obtaining a driver's license. DACA recipients have reported feeling isolated, stressed and at times suicidal. Overall the research showed while DACA

provided a positive influence on the recipient's well-being, it shifted the focus from fear of deportation to fear of their parents being deported (Siemons et al., 2016).

DACA recipients cited cost as the most significant barrier to healthcare, reporting that they avoid going to the doctor due to expense (Raymon-Flesch, Siemons, Pourat, Jacobs, & Brindis, 2014). Participants voiced concerns that if they built up debt from medical bills it could diminish their opportunities for legal immigration. Additionally, participants reported an overall ignorance of the healthcare system as a result of their parents' lack of general understanding and access to healthcare because of their legal status. Likewise, participants were misinformed about the intricacies related to accessing healthcare and using their health insurance if they did receive it. This unfortunate circumstance was due in part to lack of knowledge regarding US healthcare, something that stems in part from ignorance on the part of their undocumented parents. DACA recipients reported that healthcare providers were either misinformed or indifferent to the effect of their immigration status, and recipients often felt discriminated by the providers. Participants reported depression, anxiety, trauma, substance abuse and stress. These symptoms often went unrecognized due to it being normalized in their community (Raymon-Flesch et al., 2014).

Mental health statistics from 2008-2015 were pulled from US National Health Interview Surveys (NHIS) using DACA criteria (N =3,972); The survey showed a significant decline in psychological distress for eligible participants after implementation. The decreased rates for psychological distress were as a result of no longer having fear and anxiety of deportation. It should be noted there was no decline in psychological distress for non-eligible individuals. This research demonstrates that DACA provides the benefit of mental wellbeing by decreasing stress related to

immigration status and deportation, but there is no direct benefit to the overall physical health of the participants (Venkataramani, Shah, Obrien, Kawachi, & Tsai, 2017).

In the studies previously mentioned, the majority population is Latino, but they are not the only immigrant group affected by DACA (Sudhinaraset, To, Ling, Melo, & Chavarin, 2017). Asian Pacific Islanders (API) are currently the fastest growing immigrant population in the US. Sudhinaraset et al., (2017) found while many aspects of their social life were similar, API's felt a specific kind of alienation due to the perception that documentation is exclusively a Latino issue, and also felt intraracial stigma against themselves and their family due to the belief of API's being considered the model minority. Many described their healthcare before DACA as filled with gaps in primary care, filled with alternative methods, or ignored altogether. Many reported that going to the hospital for healthcare was not an option for fear of being deported. There is a consistent theme of mental illness and the stress of living undocumented can be very difficult. Among API communities, many individuals "suffer in silence" only further perpetuating these mental health issues (Sudhinaraset et al., 2017).

The most prominent benefit that DACA offers is improved mental wellbeing and a greater sense of security (Venkataramani et al., 2017). Direct access to overall healthcare, however, has not been fully addressed by the legislation. For the people that are eligible for DACA, they either receive health insurance through their employer, which many do not fully understand, or pay for it out of pocket, which can be cost prohibitive. The most significant positive effect of DACA is minimizing the threat of deportation. While there is limited research on the impact of DACA on the health of its participants, there is even less research on the actual healthcare experiences of the

DACA population referred to as the *Dreamer* population, both before and after being a part of the program. This research intends to explore and better understand how DACA has impacted the healthcare experiences of *Dreamers*.

Methodology

A descriptive phenomenological approach was used. The research methodology entails an in depth, comprehensive, and systematic investigation of a phenomena. Using the Colaizzi interpretation, the process involved several steps (Edward & Welch, 2011). The first step is describing the phenomena of interest by the researchers themselves. The next step is to collect the subject's description of said phenomena. To do this, the investigator collected five, 1:1 interviews of local UCF students who were 18 years or older and who self-identified as being enrolled in the DACA program. This research received institutional review board (IRB) approval, #SBE-18-14239. Recruitment took place at local community events and classrooms on campus. An email address was provided to potential contacts. Snowball sampling occurred due to limited referrals during *Dreamer's* meetings. As participants responded and interest was gauged, interview locations and times were mutually agreed upon. Every effort to protect the participant privacy and ensure participant comfort was made. Verbal consent was obtained, with anonymity emphasized.

Interviews were 1:1 and lasted anywhere from 15-45 minutes. Incentives were provided in the form of \$10 gift cards to a local grocery store. This was given at the conclusion of the interview, regardless if the interviews concluded naturally, or if the participant became uncomfortable and requested to leave. The interviews were recorded, and then transcribed. The next step in the process is to code the transcripts, which was performed by the investigator. This was done by reviewing the transcripts repeatedly, extracting important concepts and forming themes out of them. Attempts were made to formulate more general statements from the participants narratives. The formulated meanings were grouped into theme clusters. One of the last steps is to identify the fundamental structure of the phenomenon. Finally, the themes were shared with the participants for the purpose

of validating the essence of the phenomenon (Edward & Welch, 2011). The investigator defined these themes and wrote descriptions for each theme individually, using the original transcripts to support the text (Streubert & Carpenter, 1995).

Findings

The participants all identified as Hispanic, there were two females and three males. This is not surprising given that of the 48% of UCF's population were minorities, 26% identifying as Hispanic (2018). Throughout the interview process, 3 themes had developed (1) Meeting Needs (2) Insurance over Documentation (3) It Takes a Village.

Meeting Needs

Meeting Needs explores the approach to health and health concepts that DACA recipients brought when they had become sick. When directly asked what would happen in their family when they got sick, the most common response involved home remedies of some form or another. Interviewee 5 stated when asked about how she handled sickness in her family,

"I didn't do doctor visits or anything like that, so my mom would just—because she had all these natural remedies and whatnot for her, then she's like, okay, well slap some—I'm pretty sure you've heard of vapor rub, right?"

When Interviewee 4 was asked a similar question, he responded, *"If you have a cold, you will put Vaporub on your chest, and then on your nose, and your lungs, or on your back."* In this instance healthcare is focused on prevention, taking special care to do everything they can before they resort to a doctor's visit. Interviewees were fortunate to report good overall health out of necessity to avoid doctor's visits.

Meeting Needs is situated at the lowest level of Maslow's hierarchy of needs. Maslow's hierarchy of needs establishes a framework to view priorities in healthcare, with self-actualization

at the top, and physiological needs at the bottom (1943). This highlights how receiving healthcare comes into conflict with financial comfort. Healthcare is a basic physiological need, but for *Dreamers*, it is expensive and that can put it directly at odds with other basic, but more immediate needs, like food and shelter. Interviewee 4 stated when discussing the extent of his healthcare, he described his decision making as, *"Save money or actually go to the doctor."* Doctor visits are scarce and only done as regular check-ups or when absolutely necessary. Interviewee 2 stated, *"I've only went for checkups and stuff like that...I know for the longest time, we didn't go to the doctor that much."* Interviewee 3 discussed infrequent doctor's appointments, and when questioned if they had regular check-ups, they stated, *"No, not really, except for when they make you get them for school and stuff."*

Documentation status influences the different types of care *Dreamers* can receive, and in turn forms a health paradigm of what is and is not healthy. *Meeting Needs* as a DACA recipient not only means only going to the necessary checkups, it also means nonessential aspects of healthcare are not considered unless they are at a discounted price. Interviewee 1 stated, *"I've probably been to the dentist maybe once in my life"* and interviewee 5 adds, *"I think I've only gone in that dental hygiene like four different—my entire life."* Their healthcare priorities are situated at the lowest level of Maslow's hierarchy of needs, only receiving healthcare that they deem physiologically necessary for basic health functioning. Things like mental healthcare and dental care are not seen as necessary, and treated like a luxury as a result, as interviewee 3 described,

"I have anxiety disorder. I have the beginnings of OCD...If you have an actual mental disorder, it doesn't help. I feel there's literally nowhere you could go. Because therapy is expensive. Even if you have insurance, it's expensive. Imagine not having insurance."

Cultural context also comes into play. Interviewee 2 described the experience as distinctly Hispanic, adding,

“It’s a very Hispanic cultural thing that health-wise, depending on how your parents are, they either try to—if the kids get sick or anything like that, they try to resolve it as much as possible... there’s a lot of mental health [problems] with minorities. It goes ignored. It’s ignored, or it’s never diagnosed or anything.”

A study on mental health care access for Hispanic women found that mental health stigmatization decreased with mental health literacy, and that low education and socioeconomic status was linked with mental health literacy (Lopez, Sanchez, Killian, & Eghaneyan, 2018).

Going beyond the hospital, *Meeting Needs* means maintaining a perspective that includes the threat of deportation. When asked about how they feel about their future, almost all participants discussed the threat and their acceptance of potential deportation. Interviewee 1 described his future as, *“my status will not determine what I try to do or not do...I guess, a personal agreement that if I have to leave the country, alright, what’s next...I’m only gonna focus on what I can control.”* Interviewee 5 describes her emotional readiness for a worst-case scenario *“I got my free education in the United States of America. If they deport me then I’ll take my free education, like thanks guys.”* Interviewee 4 described his plans for the future as uncertain but ready, stating,

“You just have to have backup plans. You have to have backup plans for the plans for the plans that you have already, and then further backups just in case everything else fails...I

could literally go to Canada in Toronto, or I could go to Italy, I could go to Spain...It's just trying to make a living right now, be happy in the moment.”

DACA recipients live a life of uncertainty. The uncertainty of how much time they have left, and what they'll be able to accomplish during it, so they are emotionally prepared for all contingencies. However, their perspective is not one without optimism. When interviewee 4 described the prospects of his film career and the threat of deportation, he stated, *“Have you watched that movie where [the credits] says, ‘So-and-so: DACA recipient?’”* A recurring theme is a separation of documentation status and identity. While their status may affect their future, it does not define their life.

Insurance over Documentation

Another theme that emerged was the concept of *Insurance over Documentation*. Insurance status, and the ways that DACA recipients paid for their healthcare, had a much greater effect on the routes and quality of healthcare than their documentation status. Participants did not feel that they were treated any different than other patients, which was influenced by several factors. *Dreamers* often live in communities with people of similar cultural heritage, and often of similar documentation status, which meant they rarely felt out of the ordinary at their healthcare setting. Interviewee 2 described his experience as

“It was natural to get there, and everybody’s speaking Spanish, or everybody’s brown. It’s common. Me going in there and the doctor just speaks straight up Spanish to me. I was like, okay... Yeah, there wasn’t—I’ve never felt discriminated against, in the hospitals.”

More than anything, the healthcare system is viewed as an indifferent business, as interviewee 3 described it, *“I feel like I'm treated well. Just their customer service is good”* or as interviewee 4 painted his experience,

“Yeah. That was one of the things growin' up. No one ever used that against me. No one ever said, "You're undocumented. You can't do that."... Every doctor you go to, it's a business, so if you can provide money for them, that's all they need.”

The *Dreamer* healthcare experience does not reside solely within the walls of the hospital. Undocumented immigrants are less likely to have insurance than documented immigrants do, and that plays a major role in how they view and approach healthcare (Urrutia-Rojas et al., 2006). This creates an aversion to going to the doctor, as this has a major financial impact. Interviewee 1 described it, *“I did understand that we did lack insurance and coverage...It was never feared going to the doctors. It was just avoiding it, if needed. If we could avoid it.”* As interviewee 2 describes his healthcare experiences, *“I just know that to a certain point my mom's like, alright. We have to go back home [in the US] and talk about how much we can afford, stuff like that.”* The lack of insurance had a greater impact on their healthcare than their lack of documentation.

Just as a lack of insurance is more impactful than a lack of documentation, gaining insurance has a greater impact on the quality of healthcare than becoming a recipient of DACA. Changes to quality of healthcare is more likely to come with changes to insurance, rather than that of documentation. Receiving insurance is more likely when documentation status is received. Interviewee 1 described his childhood as uninsured and undocumented, avoiding the doctor as much as possible, and becoming much more comfortable when he received insurance as opposed

to documentation, stating, *“it’s been better due to the fact that my mom got health insurance through her work. Every time I’ve gotten sick now—first year I got strep a couple times. I just go to the [college] health center.”* Interviewee 2 described his parents getting documentation and going to the doctors more often after they were also able to secure insurance, *“she had to pay a lot of money for her medication, her diabetes medication. Now that she became a resident, she has medical insurance.”* Some participants never received insurance and never experienced a change in the quality of healthcare, regardless of documentation status, as interviewee 3 describes *“I don’t have health insurance. I didn’t have health insurance back then, and I don’t have health insurance now. It’s like things are more expensive.”*

Additionally, interviewee 4 had insurance when he was undocumented, then lost his insurance and gained documentation, which presented a distinctly different healthcare experience than the others. As he described it,

“For me, it was easy. It was going to the doctor and getting everything taken care of and going home with medicine and going home with a prescription. I mean, after the DACA thing and then I became—when I turned 16, I’m no longer insured. I’m no longer insured even to this day. Everything we do, we pay out of pocket, everything.”

This creates an inverse effect to that of the other participants, as he then became more cautious of doctor visits than when he was as undocumented, stating *“My mom left the job that she was at, so she lost her insurance. At that point, we were careful not to get injured or hurt.”* Insurance status is ultimately the determining factor for quality and quantity of healthcare access, as opposed to documentation status.

It Takes A Village

The third and final theme to emerge is *It takes a Village*, and it serves to depict the *Dreamer* healthcare experience as a medley of different resources and avenues for healthcare. Routes of healthcare often consisted of community clinics, local pharmacies, and personal connections. Interviewee 1 received some prescription medications from his grandfather who still resided in Venezuela, and interviewee 2 received their dental hygiene from an undocumented dentist who would travel to their homes for a smaller fee and clean their teeth and do checkups. Social networks within a tightly knit community provide pivotal resources for undocumented immigrants.

Nonessential healthcare often involved accessing local community resources which did not interfere with finances. Interviewee 2 described receiving dental hygiene from a local community college to save money, describing,

“I know that for dentist, in Vegas—we also used to live in Vegas when we first got here. We went to a community college. Then we got our teeth cleaned from there ... It was pretty cheap. That’s why we went.”

Interviewee 5 received her dental care from the Ronald McDonald bus to save money, stating *“Ronald McDonald bus, the dental hygiene and stuff like that. They would come over summer, and I went to that four times, I think.”*

Essential healthcare is found in local clinics, pharmacies, and resources specifically for immigrants. Interviewee 1 described receiving his vaccines from a local pharmacy,

“From what I remember, just off the top of my head, we went to CVS [for vaccines]. I know we did a couple at CVS. I’d say from middle school up, I didn’t go to the doctor that much. I know that in elementary there was a doctor that we knew that I used to visit when needed. I’d say some local pharmacy such as CVS.”

Interviewee 2 went to a local Catholic Health Initiatives (CHI) clinic for healthcare and checkups, stating,

“Most of the time, when I was a kid we went to the little clinics that are funded by organizations and stuff like that. In Miami-Dade they had a CHI... I know I got my vaccines from there, and I went there and I had a checkup. We spoke to the doctor. They told me to do this, this, and this, to eat this, this, and this. If I had to get medication we’d get a prescription, but it wasn’t anything past beyond that.”

When asked if he received prescriptions or recommendations for over the counter meds at CHI, he confirmed that it was the latter. CHI offers financial assistance in multiple languages for patients uninsured or below the poverty line. Interviewee 3 also discusses having been to free clinics and receiving her vaccinations at a local pharmacy.

What this amounts to is a fragmented and informal healthcare experience; seeking care from multiple, different and disconnected resources to form a whole. Interviewee 2 painted a complete picture, describing

“I never had one single doctor. Whenever I went to the clinic, the same guy was attending me. That was a plus, I guess. At the clinic where I had my vaccines, we knew one lady who my mom was really friends with her... There wasn't anything formal, written down that—we had a particular doctor and stuff like that. It was more hey, I'll give you money if you do this for me, and stuff like that. Yeah, it was never—there was no regular relationship.”

A significant component of the theme *It takes a Village*, is that it is built on the average progression of a DACA recipient's healthcare experience beginning with uninsured and undocumented, and then gaining insurance as they register with DACA. While this is the majority of the healthcare experiences of undocumented immigrants, it is not the entirety of the population. Interviewee 4 was insured while he was a child and undocumented, and therefore had a formal and regular healthcare experience and did not seek several disparate sources. This ties in with the first theme, *Insurance over Documentation*, showing that insurance status overrides effects of documentation status.

Conclusion

The *Dreamer* healthcare experience study explores both the challenges of receiving healthcare as an undocumented immigrant and the effect that the pseudo-documentation DACA provides. Therefore, the fundamental structure as described by Colaizzi (Edward & Welch, 2011) entails the pitfalls of trying to afford healthcare as an undocumented immigrant, while also showing the limitations of DACA as a form of lawful status in the country. As participants grew up undocumented, they struggled to afford and experience a holistic healthcare experience, only going to the doctor as necessary and only seeking nonessential healthcare if it is was available at a discounted price. As they enrolled in DACA, it became clear that it only offered a neutralization of threat. While fear of deportation was no longer an issue, but it does not directly improve their healthcare experiences. Having a social security number makes access to healthcare more tangible, it did not guarantee an improved healthcare experience. Their healthcare encounters do not become normal until they receive health insurance. Money is the lynchpin to the American healthcare experience. If you can afford insurance or provider visits, then you get appropriate healthcare. Otherwise, you are left to fill in the gaps and receive whatever healthcare you can.

This study is one of few to cover the individual healthcare experiences of *Dreamers*, and while it does present many new findings, it aligns with many concepts tangentially developed. Siemons et al. (2016) explored how lack of documentation status limits societal engagement on things such as college applications and job interviews. Interviewee 1 discussed this dilemma with his parents trying to get a job

“The frustrating part I know is there’s job offers that they get and they literally can’t accept. They can’t even go on an interview. That was a big struggle. As of recent, because of getting documentation, I do think things have been going a little bit more uphill.”

Interviewee 2 also illustrated this conflict with college applications

“I’m like, oh, maybe I wanna go to California, maybe like that. My parents were like, eh. Eh, nope. Can’t do that. Eh, can’t get that scholarship. You have to be a U.S. citizen. Then I found out I couldn’t get bright futures or financial aid, and stuff like that, and federal aid. That’s how I found out.”

Raymon-Flesch et al. (2014) discussed barriers to healthcare among *Dreamers*, such as ignorance of insurance opportunities, ignorance or indifference of doctors, and normalization of mental diseases. These line up appropriately with the testimonies of the interviewees. Interviewee 5 discussed ignorance of the healthcare system, stating, *“I don’t even know if there are insurance plans for me, to be quite honest with you. I don’t know what the options are.”* Interviewee 2 discussed stigmatization of mental illnesses, *“[T]here’s a lot of mental health [problems] with minorities. It goes ignored. It’s ignored, or it’s never diagnosed or anything.”* Several participants also illustrated indifference or ignorance to the struggles of immigrants, simply describing their treatment as “customer service” or the system as “a business.”

Limitations and Future Works

This research had several limitations. The research was conducted by a novice researcher. The research only included participants who spoke English fluently which biases the interview towards recipients who are more culturally homogenized, reducing potential for discrimination. The research also targeted college-aged and college attending recipients. This causes the effect of reducing awareness of potential discrimination while undocumented due to being too young or protected by their parents. The targeting of college attending students additionally skews the research to more affluent participants, although many of them had stated that they received full scholarships and might not have been able to afford it otherwise. The research additionally consisted exclusively of Hispanic participants, which does not cover the total cultural range of DACA recipients. Further research could be done on lower income or rural young adult DACA recipients, or on the perspective of DACA recipients' parents and how the legislation affected them.

The problems presented are structural, so feasible solutions need to be targeted and far-reaching. Further, community clinics designed specifically for undocumented immigrants may be an option to allow for a more regular and formal healthcare experience. Participants found community outreach and nonprofits to be valuable sources of healthcare when a normal healthcare visit was not a financially viable option. Education can be provided regularly at community centers to educate the recipients on the dynamics of immigration and insurance and allow for one-on-one counseling to those who do receive health insurance on how they can use it appropriately. Education on mental illness and possible resources on mental healthcare are also essential for destigmatizing and providing opportunities for care and help. Using the tightly knit Hispanic

community to give opportunities for education and care are the most direct and essential avenues for solving these issues.

Significance to Nursing

By better understanding what motivates a population to seek healthcare, and their lived experience of receiving healthcare, nurses can better improve community outreach and provide holistic healthcare to all patients. Community nurses can adapt outreach programs for multiple languages and making accommodations for low income or uninsured patients to better facilitate *Dreamers* receiving healthcare. In the hospital setting, nurses can work with social workers to ensure patients have the support to receive follow-up appointments and ensure that families can afford necessary treatments.

Serendipitous Findings

It is impossible to separate this population from the political climate they are steeped in, and many reported feeling disfranchised and misunderstood as a result of it. Interviewee 1 felt that the media had *“no idea what they were talking about”* when the subject of DACA was discussed. Interviewee 2 felt boxed in by his identity as, *“It’s either rapist or drug dealers and stuff like that, or worse.”* This dynamic has a direct and negative effect on self-esteem and integration into the population. Without DACA recipients feeling safe and respected, it is incredibly challenging to make contact with and reach out to this community. Making contact with the population for the sake of this research proved to be difficult due to the population not feeling comfortable reaching out and discussing their issue.

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