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Immigration policy as health policy: Workforce shortages, shrinking resources and the future of U.S. mental health and substance use care

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Abstract

This investigation examines how U.S. immigration and health policies affect mental health and SUD treatment. Mental and drug use care in the U.S. is in crisis. Immigration rules that make it tougher for healthcare workers to immigrate to the country, especially in insufficiently staffed areas, make it harder to acquire care. Psychiatric, mental health, and SUD services depend on immigrant healthcare personnel. Given that 127 million people live in Mental Health HPSAs and thousands of mental health practitioners are needed now, immigration policy that expands and deploys behavioural health providers is, in practice, health policy. TPS termination, visa freezes, and ICE enforcement worsen things. This hurts mental health workers and immigrants' healthcare access. Without action, these care gaps will grow, especially in rural and urban regions where individuals are already at risk. Additional visa categories for mental health and substance use disorder professionals, TPS protections, and federal funding for culturally competent personnel are suggested. This will allow the U.S. to deliver full mental health and substance use care, reduce the number of staff needed, and improve care in underserved areas. According to the evaluation, immigration policy is health policy. Immigration rules need to be amended to foster a diverse and qualified healthcare staff to address the nation's mental health and substance use disorder crises and provide fair access to care.

Keywords: Immigration Policy; Mental Health; Substance Use Disorder (SUD); Healthcare Workforce; Disparities In Care; Culturally Competent Training

1. Introduction

The US is facing an unparalleled mental health and drug use treatment crisis due to systemic inequalities, restricted access to care, and growing opioid-related deaths. Around 50% of persons with mental health concerns go untreated, showing a major discrepancy in care (Volkow et al., 2019). Black youth had higher suicide rates, indicating mental health issues (Dunn et al., 2025). In addition, opioid and fentanyl overdoses have disproportionately harmed rural and minority populations, worsening healthcare inequities (Britz et al., 2023).

Rural locations, already lacking mental health and substance use treatment options, have more overdose deaths than urban areas. The rise in fentanyl and opioid misuse worsens the problem (Janis et al., 2019). Minority groups' access to treatment is hampered by a complex interaction of economic instability, stigma, and a lack of culturally appropriate

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care. Fentanyl's increased availability has exacerbated the opioid epidemic, which has disproportionately harmed minority people, especially in rural areas where care is scarce (Oladele, 2025). This crises and unresolved mental health concerns highlight the need for a comprehensive plan to address substance use and mental health issues. This study also examine how immigration rules affect immigrant patients' access and health-seeking behavior, including documented chilling effects on coverage and care (Bernstein et al., 2019; KFF, 2022). This analysis adopts a Health in All Policies (HiAP) perspective which treats immigration rules as upstream determinants of behavioral health, shaping who can deliver care, who can access it, and how equitably services are distributed (Makhlouf and Glen, 2021; Alegría et al., 2016).

1.1. Overview of the U.S. Mental Health and Substance Use Crisis

Millions of Americans struggle with mental health and addiction. Mental health and substance use disorders (SUDs) are major causes of disability and death in the US. Institutions meant to help people with these challenges are straining to fulfill demand, also, the National Institute of Mental Health (NIMH) estimates that over 50 million Americans have a mental illness (NIMH, 2023). However, many people cannot access mental health care, indicating that they are still not receiving help. About half of mental health patients do not receive treatment, revealing a major flaw in the system. A lack of mental health professionals, stigma, and access to care, especially for racial and ethnic minorities, rural residents, and low-income populations, contribute to this issue. High expenses and inadequate insurance also prevent many people from receiving treatment, counselling, or medicine (Volkow et al., 2019).

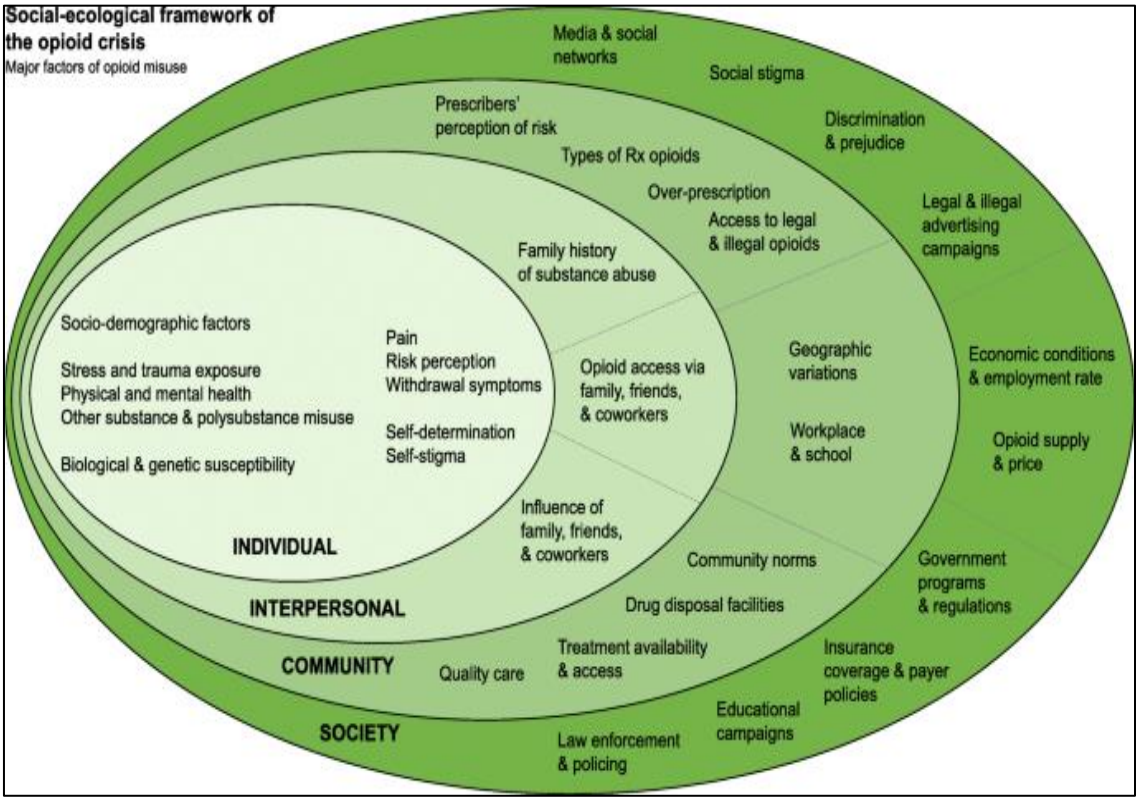

Figure 1 This diagram illustrates the social-ecological framework of the opioid crisis, highlighting the multi-level factors contributing to opioid misuse. It categorizes key influences on opioid abuse at the individual, interpersonal, community, and societal levels, from socio-demographic factors and family history to media exposure, policy, and healthcare access (Jalali et al., 2019)

The recent availability of strong synthetic opioids, such as fentanyl, has exacerbated the opioid crisis in the United States. Fentanyl and other synthetic opioids have made the opioid epidemic more deadly, which began with the excessive prescription of painkillers. According to the Centers for Disease Control and Prevention (CDC), over 70% of all opioid-related overdose deaths in 2021 involved synthetic opioids like fentanyl. In 2021 alone, more than 80,000 deaths were attributed to synthetic opioids, primarily fentanyl. This alarming surge in deaths represents a significant increase compared to previous years, with fentanyl being involved in nearly 75% of opioid-related overdose deaths in recent years. The crisis has led to an unprecedented number of overdose fatalities, far surpassing the toll of previous drug epidemics (Centers for Disease Control and Prevention, 2022). This has caused unprecedented overdose deaths.

The CDC reports that U.S. drug overdose deaths have exceeded 100,000 for several years. Many these deaths were from fentanyl overdoses (Kariisa et al., 2022). Depression and opioid use disorder often co-occur, and each condition can worsen the other. Untreated mental health disorders can lead to substance addiction because people use substances to cope. Due to a lack of facilities and treatment alternatives, many people with mental health and drug use issues go untreated, worsening their symptoms.

The scale of unmet behavioural health needs is mirrored by acute provider shortages. As of October 1, 2025, 127.35 million people live in Mental Health Health Professional Shortage Areas (HPSAs), and 6,405 additional mental health practitioners would be required to remove those shortage designations today (HRSA, 2025). Shortages are unevenly distributed, with large rural burdens that compound existing access barriers. These data underscore why workforce policy is central to any mental health or SUD strategy.

Psychiatry capacity is a particular pinch point. National projections have indicated a shortage of 14,280 to 31,081 psychiatrists by 2024, and 51 percent of U.S. counties have no practicing psychiatrist. Burnout and retirements raise concerns about further shrinkage of the psychiatric workforce by 2030, even as demand rises (AAMC, 2023).

1.2. 50% of Adults Untreated

50% of patients in the United States with mental health conditions go untreated. Many factors contribute to this issue, including economic constraints, a shortage of mental health experts, especially in rural areas, and mental health stigma. People with untreated mental illnesses suffer in silence, worsening their health and quality of life. Untreated mental health concerns can lower productivity, increase disability claims, and raise healthcare expenses (Volkow et al., 2019).

The epidemic intensified mental health issues, emphasizing the need for comprehensive mental health care. The COVID-19 epidemic increased isolation, job insecurity, and fear, causing anxiety, depression, and substance use problems. Due to overburdened healthcare institutions and a lack of online or in-person therapy, many people needed care but could not get it. This insufficiency is especially severe in marginalized populations, where poverty, prejudice, and poor healthcare infrastructure prevent treatment.

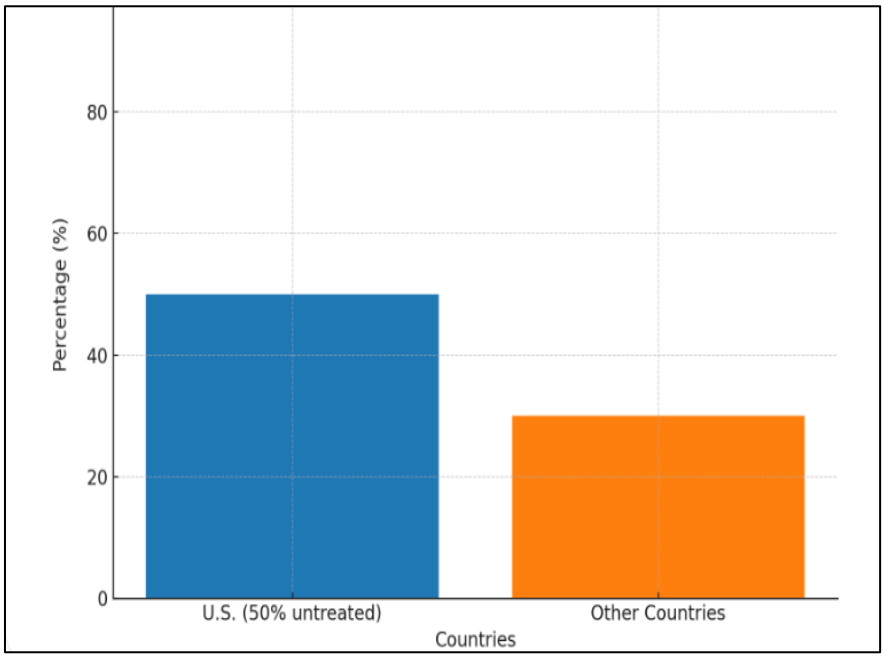

Figure 2 This bar chart compares the percentage of untreated mental health conditions between the U.S. (with 50% untreated) and other countries. It visually demonstrates the disparity in mental health treatment access, highlighting the substantial gap in care within the U.S. compared to other nations (European nations, Asian nations, South American or African nations)

1.3. Black Youth Suicide Rates Rising

Black children are hit most by the U.S. mental health epidemic. Suicide has become the second largest cause of death for Black kids aged 10–19 (Dunn et al., 2025). This worrying trend highlights the mental health issues young Black people face, worsened by institutional racism, financial challenges, and a lack of culturally competent care. Black youth also experience higher levels of discrimination and trauma, which harm their mental health. Black youth suffer more from discrimination and trauma, hurting their mental health.

Stigma, cultural misinterpretations, and a shortage of Black mental health professionals make it hard for Black youth to get mental health care. Due to a longstanding distrust of medical institutions, especially older generations, Black people may avoid mental health care. The suicide rate is rising due to these factors and a lack of mental health facilities in many Black communities.

1.4. Opioid/Fentanyl Overdoses Disproportionately Affecting Rural and Minority Populations

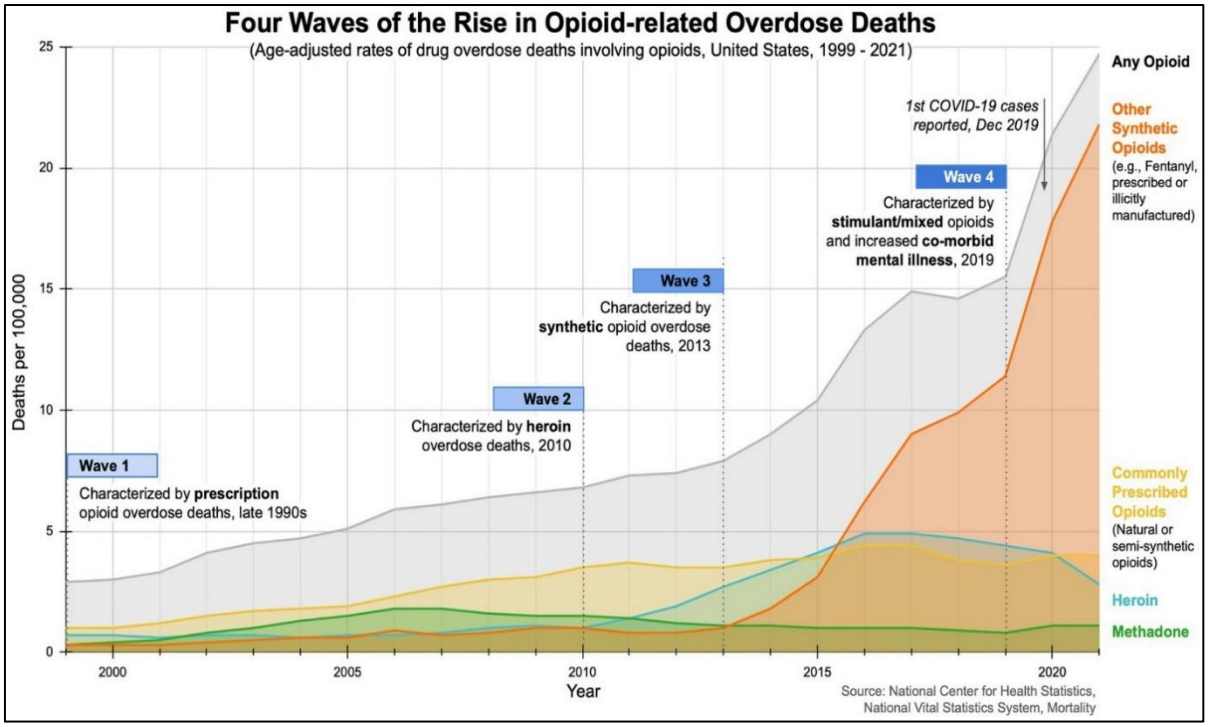

Figure 3 This graph illustrates the four waves of opioid-related overdose deaths in the U.S. from 1999 to 2021. It highlights the rise in deaths characterized by different types of opioids, from prescription drugs in Wave 1 to synthetic opioids like fentanyl in Wave 3, and the increasing impact of stimulants and co-morbid mental illness in Wave 4, marked by a sharp rise starting in 2019 (Choe et al., 2023)

Overdoses of opioids and fentanyl are central to the U.S. drug crisis. However, growing data shows that rural and racial minority groups are disproportionately affected by this disaster. In 2020, the age-adjusted rate of drug overdose deaths was 28.6 per 100,000 in urban communities and 26.2 in rural communities (CDC, 2022. CDC, 2025). However, this general trend masks significant disparities; for instance, non-Hispanic Black individuals had a higher rate of drug overdose deaths in urban counties (37.4 per 100,000) compared to rural counties (18.9 per 100,000) Rural overdose deaths have surpassed urban ones in recent years due to the increased availability of fentanyl, a synthetic opioid more deadly than heroin (Britz et al., 2023). Rural areas struggle to meet addiction treatment demand due to a lack of treatment facilities and mental health professionals. Transportation issues, poor public health resources, and social isolation further hinder care for isolated residents. Fentanyl and opioid overdoses are central to the U.S. drug issue. However, rising research suggests that rural and racial minority groups are disproportionately affected by this disaster. Due to the increased availability of fentanyl, a synthetic opioid more deadly than heroin, rural overdose deaths have surpassed metropolitan ones (Britz et al., 2023). Many rural areas lack treatment facilities and mental health professionals to handle the growing demand for addiction therapy. Remote patients face transportation issues, poor public health resources, and social isolation.

Economic disparity, inadequate healthcare infrastructure, and insufficient public health initiatives drive overdose rates and mental health care disparities. Mental health care is often lacking in rural and minority communities, making substance use treatment difficult. Additionally, stigmatization, especially among minorities, prevents many from receiving necessary care.

2. Immigrant workforce contributions

Immigration is crucial and rising to the U.S. economy, notably in healthcare and social services. Immigration has become vital to the caregiving industry as mental health and substance use therapies become more popular. Current labour gaps make immigrant providers' contributions even more consequential. With more than one in six U.S. health-care workers being foreign born and sizeable immigrant representation in physician and direct-care roles, recruiting and retaining immigrant practitioners can directly reduce access gaps in designated shortage areas (Migration Policy Institute, 2023). From psychiatric aides and technicians to substance use disorder counselors, immigrants help solve the mental health epidemic. Their efforts address staffing shortages and increase at-risk patients' quality and access to care, especially in marginalized and neglected areas. As the U.S. struggles with mental health and substance use, immigrants in direct care are increasingly important to providing effective and culturally competent care.

2.1. 28% of Direct Care Workforce Are Immigrants

Many U.S. patients engage with immigrants. Nursing aides, home health aides, and personal care attendants provide short-term and long-term care for mental health and substance use disorder patients. About 28% of US direct care workers are immigrants. These experts are crucial to the healthcare system, especially in behavioral health and substance use treatment settings (Gozdziak et al., 2009).

Immigrants play many vital roles in mental health and substance use treatment. In hospitals, outpatient clinics, residential treatment centers, and community settings, they help people with mental health emergencies or drug use issues. These individuals perform duties that might otherwise go unfulfilled because to a healthcare staff shortage, especially in underserved areas. Immigrants in direct care roles also help alleviate staff shortages, especially in mental health fields where psychiatrists and psychologists are scarce. They help more people get needed therapy despite the U.S. mental health and drug crises (Coffman et al., 2023). Without immigrants in direct care roles, the healthcare system would struggle to meet rising mental health and substance use treatment needs. Where immigrant direct-care staff provide language- and culture-concordant support, programmes report better engagement and clinical outcomes, not only higher throughput (Diamond et al., 2019; Griner and Smith, 2006).

2.2. In Psychiatric Care: Approximately 15% of Aides, approximately 12% of Technicians

Mental health workers, especially psychiatric aides and technicians, are mostly immigrants. These experts monitor patients and help psychiatrists, psychologists, and other mental health professionals with therapy and daily work. In the US, 15% of psychiatric aides and 12% of technicians are immigrants. This suggests they are essential to the mental treatment team (Zhu et al., 2022).

Psychiatric aides help with patient admissions, personal care, and safety at mental health facilities and activities. Psychiatric technologists focus on care technology. They observe and record patient behaviour, help implement treatment regimens, and lead therapy sessions. Patients need both positions to receive full treatment, from basic needs to mental health services.

Due to the rising number of mental health concerns and the shortage of skilled specialists, psychiatric aides and technicians are in high demand. Immigration workers in these jobs help mental health teams meet the needs of an increasing patient population. These professionals are vital in psychiatric hospitals, residential treatment programs, and community mental health clinics, where care and support are always needed.

2.3. Role of Immigrant Counsellors in Substance Use Disorder Treatment

Immigrant counselors help treat and rehabilitate US SUD patients. Cultural competency, linguistic proficiency, and understanding of immigration difficulties are crucial for immigrant counselors. Immigrant drug use disorder counselors often work with patients from similar cultures to build rapport and trust. In addiction rehabilitation, trust and rapport with counselors are essential for treatment success.

Counselors with personal experience and addiction treatment expertise can significantly improve substance use programs. Immigrant therapists often address language obstacles, cultural stigmas associated to addiction, and

healthcare system distrust to improve treatment strategies (Spetz et al., 2018). These hurdles may prevent people from starting or finishing therapy, but immigrant counselors provide culturally sensitive care. Immigration counsellors also advocate for clients, helping them navigate immigration status, access support resources, and receive comprehensive care. Their duties include providing counseling, emotional support, education, and assistance, especially for immigrant patients facing legal or social challenges related to their status in the U.S. Because underrepresented populations are often overlooked or underserved, advocacy is essential to ensure equitable access to treatment and recovery. Immigrants play a vital role in U.S. mental health and substance use treatment, working as psychiatric aides, technicians, and counselors. They help address staffing shortages, provide culturally competent care, and remove barriers to treatment, especially in vulnerable communities. With the ongoing mental health and addiction crises, immigrant workers remain essential for ensuring care is accessible to everyone. Counsellor–client concordance and peer support are associated with higher retention and lower relapse in SUD care, underscoring why immigrant counsellors are central to quality, not just capacity (Reif et al., 2014; Bassuk et al., 2016).

2.4. Quality and Outcomes: Why Who Delivers Care Matters

Beyond filling vacancies, immigrant clinicians often improve the effectiveness of behavioral health care. Outcomes are stronger when patients receive language-concordant care, including fewer adverse events and better clinical results in multiple settings (Diamond et al., 2019; Daggett et al., 2023; Reaume et al., 2024). In mental health specifically, culturally adapted interventions produce significantly better symptoms and engagement outcomes than non-adapted care in meta-analyses (Griner and Smith, 2006; Hall et al., 2016).

In addition, racial and cultural concordance increases uptake of recommended services and trust, which are critical for sustained treatment in SUD and psychiatric care (Alsan et al., 2019). Evidence on international medical graduates (IMGs) shows equal or better mortality outcomes for U.S. inpatients treated by IMGs compared with U.S. graduates, suggesting quality is at least maintained when immigrant physicians deliver care (Tsugawa et al., 2017). For SUD, peer and lived-experience providers improve retention, reduce relapses, and strengthen therapeutic alliance, illustrating how concordance and shared experience translate to measurable recovery gains (Reif et al., 2014; Bassuk et al., 2016).

Taken together, these findings show that immigrant health practitioners do more than expand headcount. They enable language and cultural alignment, which improves engagement, adherence, and outcomes in the very communities with the greatest unmet need.

3. Shrinking Resources and Federal Health Policy

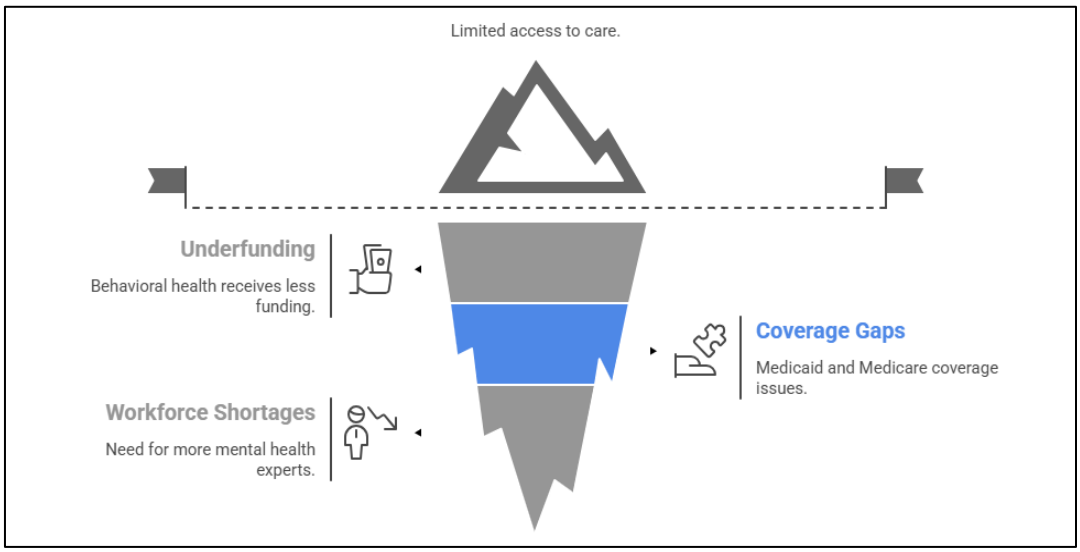

Figure 4 This infographic depicts the insufficient mental health services in the U.S., illustrating the key barriers to care. It highlights the issues of underfunding, workforce shortages, and coverage gaps (particularly with Medicaid and Medicare), which contribute to limited access to mental health services and create significant barriers for those in need of care

The state of mental health and substance use treatment in the U.S. is influenced by various factors, including insufficient funding for behavioural health services, deficiencies in Medicaid and Medicare coverage, and federal initiatives like as the Healthcare Workforce Resilience Act. The situation is exacerbated by a deficiency of skilled specialists, particularly in rural and underprivileged regions.

3.1. Underfunding of Behavioural Health

Insufficient funding for mental health and substance use services plagues the U.S. behavioral health system. Behavioral health receives less funding than other healthcare sectors, despite the high demand for mental health treatment, especially as depression, anxiety, and substance use disorders rise in the U.S. (Lipson et al., 2022).

Financial constraints affect behavioral health care quality and accessibility. Mental health clinics, community-based programs, and drug misuse treatment centers are underfunded, resulting in long wait times, restricted physician access, and inadequate accommodations for crucial patients. Due to funding constraints, many behavioral health programs cannot meet rising treatment needs. State and federal budget cuts often hurt mental health programs, worsening the situation.

The lack of financing is especially harmful in rural locations and communities with inadequate facilities, when mental health and substance use therapy is already limited. Thus, many people in these communities lack essential care, which worsens health outcomes, leads to more emergency department visits, and contributes to higher incarceration rates for mental health issues (Omiyefa, 2025). Staff training, patient support, and additional services are needed to provide high-quality mental health treatment; hence the budget imbalance must be addressed. A Health in All Policies approach would align financing and coverage reforms with immigration policy choices so that eligibility, status, and enforcement practices do not undermine equitable access to behavioural health services (Alegría et al., 2016; Makhlouf and Glen, 2021).

3.2. Medicaid/Medicare Gaps in Coverage

Medicaid and Medicare are vital programs that cover millions of Americans, including those with mental health or substance use difficulties. These programs have major coverage gaps, preventing many from receiving behavioral health care.

Medicaid is essential for low-income people, yet it often fails to fund mental health treatments like inpatient, residential, and long-term assistance. Many states limit Medicaid mental health care owing to fiscal restrictions. Inequitable Medicaid expansion under the Affordable Care Act (ACA) has left some low-income people uninsured (Esangbedo et al., 2025).

Medicare largely supports the elderly and disabled, yet it has its limitations. Medicare covers mental health therapy, but access is sometimes difficult. Medicare may pay short-term hospitalizations but not long-term mental health care. Mental health providers receive lower Medicare reimbursements than other medical services. Providing mental health care becomes difficult for many professionals.

Many people, especially in rural or low-income areas, face difficulties accessing care due to limitations in Medicaid and Medicare coverage. These gaps leave individuals with serious mental health and substance use disorders without adequate treatment options, placing additional strain on the healthcare system and increasing long-term costs (Last and Zhu, 2025). Expanding coverage and addressing these gaps are essential to ensure timely and sufficient care for all."

3.3. Federal Workforce Resilience Acts (e.g., Healthcare Workforce Resilience Act)

The federal Healthcare worker Resilience Act addresses healthcare worker shortages, notably in behavioural health. This legislation facilitates the hiring of foreign-trained healthcare professionals in the U.S. through expanded visa procedures. This measure addresses considerable service gaps, especially in impoverished areas with few mental health and substance use professionals.

Through relaxed immigration limits and incentives for international professionals to work in the U.S., the Healthcare Workforce Resilience Act addresses the need for more psychiatrists, psychologists, social workers, and other behavioural health experts. These strategies aim to reduce Labor shortages and guarantee behavioural health practitioners can meet rising demand, especially in rural and low-income settings (Patterson et al., 2022).

The Healthcare Workforce Resilience Act is progress, but more focused policies are needed to strengthen the behavioural health workforce. Expanding loan forgiveness programs, training funding, and financial incentives for behavioural health professionals in underserved areas would prepare a workforce for mental health and substance use care (Amba et al., 2024). These efforts improve staff resilience and reduce burnout, a major issue in behavioural health due to its emotional toll.

Mental health care system improvements at the local and state levels can boost federal workforce resilience initiatives. Expanding mental health services in schools, communities, and workplaces can help build a resilient healthcare workforce that can meet the U.S.'s diverse behavioural health requirements.

The U.S. mental health system has continuous challenges due to low funding, Medicaid and Medicare coverage issues, and the need for stronger healthcare regulations like the Healthcare Workforce Resilience Act. Federal measures help, but more is needed to ensure workforce support and access to mental health and substance use services. Resolving these difficulties will help the U.S. build a more equitable, accessible, and sustainable behavioral health system for disadvantaged groups..

4. Immigration Policy as Health Policy

This linkage is not abstract. In a system where over 127 million people live in Mental Health HPSAs and thousands of practitioners are needed now, immigration rules that influence who can enter, train, and practice in the U.S. function as de facto health policy (HRSA, 2025; AAMC, 2023). US immigration policy affects mental health and substance abuse treatment access. Visa limitations, TPS termination, and ICE activities affect healthcare professional demand. This applies especially to foreigners providing critical services in this industry. The intricate relationship between immigration policy and healthcare shows that immigration policy changes can affect care quality and accessibility.

4.1. Visa Freezes (EB-3 Nurses)

Since nurses and other healthcare professionals use the EB-3 visa category, it helps fix U.S. healthcare system issues. Nurses have been vital to U.S. healthcare. In oversupplied countries like the Philippines and India, this is especially true for nurses. Visa freezes, especially during immigration reform or global pandemics like COVID-19, have hurt the healthcare industry.

Recent visa suspensions and application delays have made it difficult for foreign-trained nurses to work in the U.S., worsening shortages in areas already lacking sufficient healthcare staff. Immigrant healthcare professionals often help build and staff hospitals, nursing homes, and other facilities, but nurses seeking to provide critical care can become bogged down in bureaucracy. These challenges suggest that hospitals struggle to meet the growing demand for healthcare, particularly in mental health and substance use treatment programs. Due to nursing shortages, the healthcare system suffers from longer wait times, higher staff tension, and increased employee burnout. Visa delays cause financial instability for those awaiting clearance, reducing healthcare worker stability and causing gaps in care. Insufficient staffing can negatively affect patient outcomes in behavioral health (Makhlouf and Glen, 2021).

4.2. TPS Expiration and Worker Precarity

Temporary Protected Status (TPS) allows people from countries facing emergencies like war or natural disasters to work and avoid deportation. Under recent U.S. administrations, TPS for certain nations has been increasingly terminated. Behavioral health services have been greatly aided by immigrants, who are losing their legal status and work permits.

After TPS expires, mental health professionals are vulnerable. In mental health and substance use programs, immigrants with TPS can work as psychiatric aides, counselors, and other support workers. These workers risk deportation and unable to work in the U.S. without TPS. This indicates a healthcare staffing shortage, especially in immigrant-heavy communities. Precarious legal situations make professionals less likely to advocate for better working conditions or professional growth, which lowers mental health and substance use disorder care.

In same vein, undocumented workers or those with temporary status may be exploited by employers, making this vulnerability crucial in healthcare delivery. Deportation and legal uncertainty increase anxiety and stress among mental health providers, leading to burnout and turnover. This affects staff and their capacity to give high-quality, consistent care (Makhlouf and Glen, 2021).

4.3. ICE Enforcement Chilling Effect

ICE's enforcement actions affect US immigrant labour, notably healthcare professionals. Many immigrants, especially those without permanent legal status or temporary work permits, fear deportation or incarceration for seeking medical care or reporting workplace difficulties. Low-wage healthcare workers, especially in mental health and drug treatment centres, are worried about job security owing to immigrant status. Patients who are immigrants or descend from immigrants also chill. Many people are afraid to use mental health treatments owing to ICE's increased enforcement. For mental health and drug use treatment, immigrants may need help for trauma, addiction, or mental health difficulties from their experiences as migrants or from U.S. prejudice and marginalization.

Deportation fears prevent people from obtaining help, worsening their mental health and substance use concerns and hurting vulnerable groups. The chilling effect hampers mental health provider-immigrant connections. Legal status verification may deter workers from participating in professional development or continuing education programs. This makes the behavioral health workforce unpredictable and less effective, especially in places with minimal staff and where immigrant workers are essential (Makhlouf and Glen, 2021). Immigration policy affects the U.S. healthcare workforce and access; especially mental health and substance use therapy. Visa limitations, TPS termination, and ICE enforcement make it harder for immigrant workers to contribute to the healthcare system and get needed care. These rules hurt workers and patients, many of whom are immigrants and minorities. The US faces major mental health and substance abuse difficulties. A more liberal immigration policy is needed to ensure the healthcare system fulfills the requirements of all Americans, especially the most vulnerable.

4.4. Immigrant Patients: Access Barriers and Health Effects

Immigration policy also shapes the health of immigrant patients and mixed-status families. Evidence shows a persistent chilling effect in which eligible families avoid Medicaid, CHIP, SNAP, or housing supports due to fear that benefit use could jeopardize immigration status. In 2019, more than one in seven adults in immigrant families reported avoiding noncash programs for this reason, with higher rates among low-income families and families with children (Bernstein et al., 2019; Haley et al., 2020). These dynamics have been widely documented and were a key rationale for revising the federal public charge regulation to reduce deterrent effects on health coverage and care (KFF, 2022).

Coverage exclusions magnify risk. Undocumented adults are ineligible for Medicaid, CHIP, Medicare, and ACA Marketplace coverage, and many lawfully present immigrants face waiting periods or other limits, which contributes to much higher uninsured rates among noncitizens compared with citizens (KFF, 2025). Recent litigation has also restricted Marketplace access for some DACA recipients in multiple states, further constraining coverage pathways (AP, 2024). Reduced coverage leads to delayed care, lower primary care use, and heavier reliance on emergency settings. Studies have observed declines in primary care visits among undocumented patients during heightened anti-immigrant rhetoric, with compensatory increases in acute care utilization (Nwadiuko et al., 2021).

Immigration enforcement environments influence health-seeking behavior and outcomes. Enforcement activity has been associated with reduced utilization among immigrants in several settings, although inclusive local coverage can buffer these effects (Yasenov et al., 2020). At the population level, criminalizing state policies have been linked to higher preterm birth risk among some immigrant groups, while inclusive policies are associated with lower risk, underscoring how policy climate translates into measurable health outcomes (Sudhinaraset et al., 2021). Changes to “protected areas” guidance around hospitals and clinics also affect perceived safety when accessing care and may deter visits if protections are narrowed or rescinded (ICE, 2021; DHS, 2025).

Taken together, immigration rules influence who seeks care, when they seek it, and what coverage or services they can access. Reducing legal precarity, clarifying public charge policy, restoring robust protected-area practices for health facilities, and expanding state-funded coverage where federal options are unavailable are public health strategies that improve access and outcomes for immigrant communities.

5. Equity Levers in Mental Health

Comprehensive and equitable policies are needed to provide effective mental health and substance abuse care to all Americans. Equity levers reduce mental health access, treatment, and outcomes gaps. These levers address stigma, insurance accessibility, rural-urban disparities, racism, and SDOH in behavioural health. Eliminating these barriers will make the mental health system more accessible and diverse.

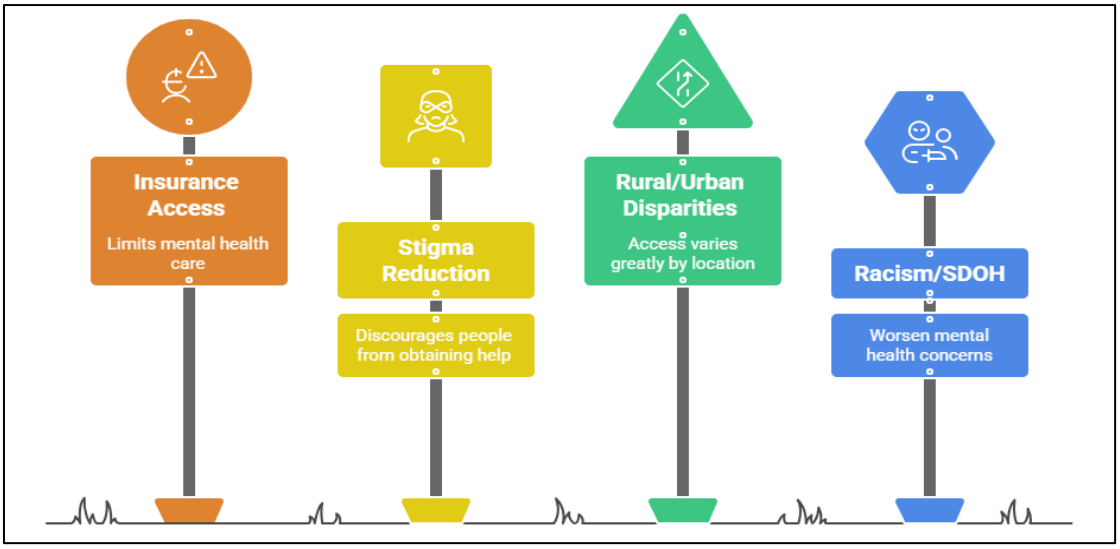

Figure 5 This infographic highlights key equity levers in mental health care. It focuses on insurance access, stigma reduction, rural/urban disparities, and the impact of racism and social determinants of health (SDOH), which influence access to and the quality of mental health services. These barriers exacerbate mental health issues, especially in underserved populations

5.1. Insurance Access, Stigma Reduction

Lack of insurance limits mental health care in the US, especially for low-income and minority communities. Commercial, Medicaid, and Medicare health insurance helps individuals access mental health treatment, including therapy, drugs, and psychiatric services. Without insurance, many individuals struggle to afford mental health care, leading to unresolved concerns and worsening outcomes (Alegría et al., 2016).

To help people get help, mental health care stigma must be reduced. Mental health disorders have been stigmatized, especially in racial and ethnic minority groups, where cultural norms sometimes prevent help. Stigma may discourage people from obtaining mental health help. Community education, public awareness initiatives, and mental health inclusion into regular treatment help normalize mental health services. Stigma reduction and health insurance expansion are essential for therapy access (Baffour, 2017). The Affordable Care Act (ACA) extended Medicaid and required insurance companies to provide mental health services, improving mental health care access. Providing mental health and substance use therapy to uninsured people, especially in vulnerable areas, requires significant efforts. Reducing stigma is most effective when care is delivered in patients' language and cultural context, which improves measurable outcomes across conditions (Diamond et al., 2019; Griner and Smith, 2006). Chilling effects and eligibility restrictions contribute to higher uninsured rates among noncitizens, reinforcing the need to pair stigma-reduction with coverage solutions tailored to immigrant families (KFF, 2025; Bernstein et al., 2019).

5.2. Rural/Urban Disparities

Mental health care quality and accessibility vary greatly across rural and urban areas. Healthcare access may be difficult in rural places. Mental health professionals like psychiatrists, psychologists, and social workers are few in rural areas, limiting care. Remote residents must travel far to obtain mental health services. Transportation, financial, or rural embarrassment for seeking help may make this impossible.

Rural areas have a workforce shortage and are more likely to have poverty, unemployment, or substance abuse, making mental health services harder to access. These characteristics are commonly linked to socioeconomic determinants of health (SDOH) such housing instability, inadequate education, and food insecurity, which worsen mental health and perpetuate disadvantage. The opioid crisis has hit rural areas harder than cities, causing more drug usage and overdose deaths. This worsens mental health concerns in these groups (Morales et al., 2020).

Despite discrepancies, metropolitan areas offer better mental health care access. More people live in cities, making mental health facilities and professionals easier to find. Immigrants, racial minorities, and those without permanent housing or employment have equity challenges in accessing care in these places (Baffour, 2017). Race, income, and insurance affect mental health care, not just location. Policies that improve telehealth, fund rural mental health

programs, and integrate mental health services into primary care can help rural and urban residents get the care they need. Mobile mental health units and community-based initiatives for distant residents can bridge the gap and provide important mental health care.

5.3. Addressing Racism/SDOH in Behavioural Health

Remote and urban areas have different mental health care access and quality. Rural healthcare may be difficult to access. Rural areas lack psychiatrists, psychologists, and social workers, limiting service. People in distant areas must travel far to get mental health care. This may be impossible owing to transportation, budgetary, or moral issues with rural help.

Due to labor shortages, rural residents are more likely to be poor, unemployed, or addicted, making mental health services harder to access. They are linked to socioeconomic determinants of health (SDOH) such housing instability, poor education, and food insecurity, which worsen mental health and perpetuate disadvantage. Addiction and overdose deaths are higher in rural areas than in cities due to the opioid crisis. These groups' mental health concerns worsen (Morales et al., 2020).

Despite differences, metropolitan areas offer better mental health care selection. Mental health institutions and professionals are easier to build and attract in cities. In these places, immigrants, racial minorities, and those without permanent housing or employment have equity challenges in receiving care (Baffour, 2017). Mental health care is affected by race, income, and insurance. Telehealth, rural mental health funding, and primary care mental health integration can help rural and urban residents get the care they need. To fill the gap, mobile mental health units and community-based programs for distant residents can provide vital mental health care.

6. Policy recommendations

Faced with rising mental health and substance use disorders, the U.S. must enact strong legislative reforms to improve, diversify, and increase accessibility in the behavioural health system. Key policy proposals include adding visa categories for mental health and substance use problem experts, maintaining TPS, and increasing federal financing for culturally competent staff training. These steps are necessary to solve personnel shortages, improve service delivery, and close care gaps.

6.1. Expand Visa Categories for Mental Health and SUD Workforce

Targeting visa pathways to HPSA needs would align immigration and health goals. Given the 6,405 mental health practitioners required to eliminate current mental health shortages, prioritising psychiatrists, psychologists, psychiatric NPs and PAs, licensed counsellors, and social workers for placement in high-need areas can yield immediate access gains (HRSA, 2025; AAMC, 2023). A significant issue in the fields of mental health and substance use disorders is the insufficient number of qualified professionals, particularly in rural and underserved regions. A crucial solution to this issue is to facilitate the visa acquisition process for healthcare professionals, particularly those specializing in mental health and substance use therapy. Numerous healthcare institutions rely on immigrant workers, particularly those holding EB-3 and other employment-based visas, to fulfill critical positions in behavioral health environments at present.

However, stringent immigration regulations, visa limitations, and protracted processing durations exacerbate the difficulty for talented professionals from outside to secure employment in the U.S. Broadening visa classifications for nurses, psychiatrists, psychologists, drug use counselors, and social workers would address staffing shortages and ensure access to mental health treatment for individuals, particularly in rural or underserved urban regions (O'Connor et al., 2019).

The United States may cultivate a more robust, diversified, and culturally proficient workforce by facilitating the employment of overseas specialists in the mental health and substance use disorder sectors. Moreover, the augmentation of these visa categories may help address the rising demand for care stemming from the opioid crisis and the ongoing mental health epidemic (Nagel, 2025).

6.2. Extend TPS Protections

TPS allows immigrants fleeing conflict, natural catastrophe, or other difficult countries to live and work in the U.S. while their deportation is pending. Many immigrants working in healthcare, especially those working with mental health or substance use issues, need TPS. Due to legal uncertainties, these people often operate under precarious situations.

TPS has been terminated for some nations due to U.S. immigration policy changes, leaving many people uncertain and vulnerable to deportation. This uncertainty makes employment less secure and may worsen TPS holders' mental health difficulties. Extending TPS protections allows vital healthcare workers, especially in underserved areas, to work in mental health without fear of deportation. Extending TPS protections will protect key behavioral health workers and guarantee immigrants receive culturally competent care. This legislation would affect immigrant-heavy areas because many healthcare workers have Temporary Protected Status (Rosenfeld, 2021).

6.3. Increase Federal Funding for Culturally Competent Workforce Training

Training that yields language-concordant and culturally adapted care improves symptom reduction and service uptake, strengthening the case for federal investment (Hall et al., 2016; Reaume et al., 2024). Additional federal financing for culturally appropriate workforce training is crucial to addressing the U.S. mental health and substance use disorder issue. Cultural competence in mental health care improves engagement, treatment adherence, and results, especially for minority populations (Choi et al., 2023). Many mental health professionals are unprepared to work with immigrants, refugees, and minorities. Culturally competent training programs for mental health and drug use disorder practitioners can be funded by the federal government to provide effective and culturally sensitive care. These programs should teach cultural norms, communication styles, linguistic barriers, and trauma care. SDOH, such as poverty, housing instability, prejudice, and inadequate access to quality education, disproportionately affect minority communities and must be addressed in training (Mancini, 2021). Training investments should be paired with distribution strategies that move graduates into shortage counties. Evidence on broad behavioural health shortfalls across disciplines supports expanding supervised task-sharing models and collaborative care to stretch scarce psychiatric capacity while the pipeline grows (Commonwealth Fund, 2023; AAMC, 2023).

Funding for this training could also improve educational possibilities for minority populations, who are underrepresented in behavioral health. By making mental health and substance use disorder careers more accessible to diverse groups, the US may create a more representative workforce. All patients, regardless of culture, will receive better care (Flanagan and Wakeman, 2024). To address rising mental health and substance abuse in the U.S., authorities must improve the workforce, promote equal access to care, and close treatment gaps. Increased visa categories for mental health and substance use disorder professionals, longer Temporary Protected Status, and federal funding for culturally competent workforce training can help the behavioral health system serve more people and meet their needs. The US mental health and substance use care system can be strengthened, equitable, and effective by implementing these policy proposals. All will benefit, especially marginalized and vulnerable people. Without reforms that expand and place the workforce where need is greatest, the current 127 million residents of Mental Health HPSAs will continue to face long waits and fragmented care (HRSA, 2025).

7. Conclusion

Immigration policy and health policy are increasingly intertwined in the US, notably for mental health and substance use disorder treatment. The US must address the growing mental health crisis caused by the COVID-19 pandemic, opioid epidemic, and systemic inequalities, considering workforce, access to care, and the social and political context of mental health and substance use services. Immigration policy affects health, notably the ability to care all populations, especially the most vulnerable, beyond border control and citizenship.

- Without Immigration Reform, Mental Health and SUD Treatment Gaps Will Widen

Inequalities in mental health and substance use disorder care may worsen in impoverished and rural regions without immigration law changes. They are vital to the U.S. healthcare system since many immigrant doctors address mental health and substance use diseases. Immigration works in psychiatry, social work, and addiction therapy. Behaviour health service recruiting is limited by immigration laws that bar foreign-trained professionals or complicate legal residency. Immigration restrictions, visa freezes, and TPS expirations hamper excellent treatment in rural and low-income metropolitan regions with high service demand. Due to the expanding mental health and drug use crises and a shortage of skilled practitioners, improving care accessibility will be challenging, especially in underfunded and scarce mental health services.

Immigration enforcement chills and undocumented worker insecurity worsens the problem. Healthcare professionals, especially those with questionable legal status, may be reluctant to participate in professional development, report workplace difficulties, or advocate for reforms, which can lower mental health and drug use facility quality. Immigration reform must address these challenges or treatment, and care gaps will grow. Millions of Americans, especially underprivileged ones, would lose access to vital mental health and substance use care.

- Immigration Policy = Health Policy

A Health in All Policies perspective clarifies why immigration decisions must be treated as health policy choices. Evaluating these choices for their behavioural health impacts will advance equity while strengthening access and quality for high-need populations (Makhlouf and Glen, 2021; Primm et al., 2009). Immigration and health policies are linked. Immigration policies affect healthcare staff, services, and quality for marginalized groups like immigrants and people of color. Immigration politics and health policy are increasingly linked due to the U.S. healthcare worker shortfall, notably in mental health. Public health has rarely been included in immigration policies. However, as the nation faces an unprecedented need for mental health and substance use treatment, these policies must adapt to a varied population. In underserved communities, immigrant healthcare workers provide vital services. Due to restrictions on hiring foreign-trained healthcare professionals, the U.S. is denying mental health and substance use disorder patients vital care.

Immigration status, economic inequality, and health insurance access all affect mental health and drug use therapy. Immigration status causes language obstacles, cultural stigmas, and limited access to comprehensive healthcare, which affect immigrants more than other populations. Policies that restrict immigrants' mental health treatment or fail to understand immigration's influence on healthcare will worsen health inequities. Immigration and health policy can create a more egalitarian, inclusive, and population-focused healthcare workforce. To solve the workforce shortfall and ensure fair access to care for all, immigration reform must allow competent healthcare workers, particularly in mental health and substance use treatment, to enter. Because language and cultural alignment improve outcomes, immigration pathways that sustain a diverse workforce advance population mental health, not only staffing ratios (Tsugawa et al., 2017; Alsan et al., 2019).

- Final Thoughts

In the midst of a public health crisis, immigration policy must be linked to national health. Immigration reform that improves the behavioral health workforce, protects key healthcare staff, and improves access to care can help the U.S. address mental health and substance use disorder treatment inequities. Health policy must be comprehensive, inclusive, and customized to all groups, especially marginalized and underserved ones. The US can only then fully address mental health and substance use issues that threaten millions of lives.

Compliance with ethical standards

Disclosure of conflict of interest

The authors declare that there is no conflict of interest regarding the publication of this manuscript. All authors have contributed to the conception, writing, and final approval of the manuscript and agree to be accountable for all aspects of the work.

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