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Unaccompanied children seeking safe haven: Providing care and supporting well-being of a vulnerable population☆

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ABSTRACT

As violence, inequity and poverty pervade El Salvador, Guatemala and Honduras, the number of children, family units and adults seeking refuge in the United States (US) continues to increase. Upon apprehension by Department of Homeland Security (DHS) Customs and Border Protection (CBP) or Immigration and Customs Enforcement agents (ICE), children enter a labyrinthine immigration system that can be further traumatizing and threatening to their health and well-being. The purpose of this article is to describe the impact of current and evolving immigration policy on the health of unaccompanied children, to delineate barriers to care and challenges they face prior to gaining legal relief, and to suggest policy recommendations that support health and safety for them from the point of apprehension to and through achieving legal status. By understanding the four unique phases of the immigration journey: pre-migration, migration, detention, and post-release, social service providers caring for newly arrived unaccompanied children can offer a trauma-informed approach that considers children's complex medical, psychosocial, educational, and legal needs. Case-based examples elucidate the role of social service providers at each phase of the journey. One community-based model is described in depth as an illustration of how cross-sector partnerships can be incorporated in an effort to mitigate stress and build resilience among this vulnerable population.

1. Background

Increasing numbers of unaccompanied immigrant children are fleeing their homelands and seeking safe haven in the United States. The principal countries of origin are Mexico, El Salvador, Guatemala and Honduras, which consistently rank amongst the deadliest countries in the world (American Immigration Council, 2015; Office of Refugee Resettlement, 2017b; Rosenblum, 2015; Rosenblum & Ball, 2016). DHS defines an "unaccompanied alien child" (UAC) as a child who does not have legal immigration status in the US; has not attained 18 years of age; and has either no parent or legal guardian in the US, or no parent or legal guardian in the US is available to provide care and physical custody ("6 U.S. Code § 279(g) - Children's affairs,", 2012). For the purposes of this manuscript, the term "unaccompanied child" will be used instead of UAC.[1]

Immigrant children seeking safe haven face traumatic experiences in their countries of origin, during their journeys, upon arrival onto US soil, and within US communities (E Kennedy, 2013; Linton, Griffin, & Shapiro, 2017; UNHCR, 2014; Women's Refugee Commission, 2012; Women's Refugee Commission, Lutheran Immigration and Refugee Service, & Kids in Need of Defense, 2017). Understanding the four phases of the migration journey is critical to the provision of trauma-informed care; the management of complex medical, educational, and legal needs; and the development of cross-sector partnership to address these complex needs. Additionally, understanding the migration process facilitates informed advocacy that offers a health lens to policy considerations at each phase.

In 2017, the American Academy of Pediatrics (AAP) published a policy statement outlining the current state of affairs for accompanied and unaccompanied immigrant children's migration-related detention

☆ The names and identifying details from all clinical cases described in this manuscript have been changed to protect the confidentiality and safety of the children and families for whom we care.

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[1] The authors believe that the term "alien" denies dignity and respect to human beings and thus choose not to use it.

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(Linton et al., 2017). Under the current US Administration, policy changes have exacerbated circumstances for children and their families. At the border, separation of children and families intensified, with the DHS threatening to systematically separate children from accompanying parents (Al Otro Lado et al., 2017; Allen, 2018; Harris et al., 2018). Furthermore, although federal law dictates that unaccompanied children from non-contiguous countries be treated differently than children from Mexico and Canada (American Immigration Council, 2015; Byrne & Miller, 2012; Linton et al., 2017), since they are perceived to be at greater risk for trafficking, the Trump administration suggested that this policy may change (The White House, 2017). In the wake of President Trump's executive orders relating to refugees, more U.S. agents on the southern border began informing people seeking protection that the United States is no longer accepting asylum seekers and illegally turned some away in violation of U.S. law and treaties (Acer & Shaw Drake, 2017). Additionally, in November 2017, the US Administration stopped processing applications for the Central American Minors (CAM) Program, which allowed parents lawfully residing in the US to apply for refugee resettlement for a child in El Salvador, Guatemala, or Honduras (US Department of State, 2017). Finally, parents who serve as sponsors for unaccompanied children are now at risk of criminal charges or deportation (Cervantes & Walker, 2017).

The subsequent sections incorporate the pre-migration, migration, detention, and post-release experiences of unaccompanied children at each stage of their journeys and identify opportunities to support their health and ensure the protections to which they are entitled. The authors integrate existing and emerging data regarding unaccompanied children with cases that offer context for social service providers. Cases are derived from the authors' clinical and community-based experiences with unaccompanied children at the four phases of the migration journey. The case-based approach elucidates the dire need for social service providers in offering trauma-informed services. A community-based model describes a possible example to mitigate stress and build resilience among this vulnerable population.

2. The pre-migration experience

> In 2016, the parents of 16-year-old Nelson assured us their Salvadoran neighborhood of fewer than 120 families was “tranquil.” They added that it was especially “healthy,” following several gang members' executions in 2015. Otherwise, they knew of no crimes (Kennedy & Castillo, 2014).
>
> In 2017, Lorena, a 12-year-old girl, also used the word “tranquil” to describe her Honduran neighborhood of approximately 3000 families. “No,” she is not afraid to be out at day or night. “No,” it's not a violent place. She repeated: her neighborhood, her home, is, “tranquil.” We asked Lorena what crimes she knew about in her neighborhood. She said there were murders around the football field. We asked: “how many last year?” She replied: “10 or so.” We followed: “how many must occur for you to consider your neighborhood violent?” She responded: “50” (Kennedy & Shorack, 2017).

Including war zones, El Salvador has the second highest national homicide rate in the world. Honduras ranks fourth or fifth. Rather than indiscriminate bombing or random crossfire, 69 to 85% of killings in El Salvador and Honduras are targeted and particular (IUDPAS, 2012, 2013, 2014, 2015, 2016). Neighborhoods like Nelson's and Lorena's are substantially more deadly. Still, Nelson and Lorena consider this armed conflict to be normal, even “tranquil.”

Salvadoran news reported eight homicides in Nelson's rural neighborhood in 2014, the year he first migrated.[2] This converts to a homicide rate of 1600 per 100,000. In 2016 and 2017, press reported death squads composed partially of off-duty police and soldiers who operate in the area. Several victims were teenage boys working in agriculture, like Nelson had. They too may have quit school in an attempt to evade the gang that patrolled it and co-opted its teachers.

In Lorena's neighborhood on the outskirts of an industrial hub, Honduran news reported six homicides in the first five months of 2017, on pace with the 15 to 20 a year from 2013 to 2016.[3] This translates to a homicide rate between 150 and 200 per 100,000. In several of the homicides, armed men in uniform arrived to the victims' homes, shooting them dead in front of loved ones or leaving their bodies in public spaces. Three years earlier, residents found the body of an 11-year-old girl abandoned in the same area; she was raped before her murder. A policeman shot and killed his partner. A father regularly abused his two daughters and son, selling the eldest – at eight years old – to at least seven men for U$8.00. Rather than help the siblings, the community mocked them.

Violence pervades rural and urban areas of El Salvador, Honduras, and Guatemala (Cara Labrador & Renwick, 2018; Eguizábal et al., 2014; Gagne, 2017; International Crisis Group, 2017). Authorities in all three countries rarely take reports, conduct investigations, or win convictions (IUDPAS, 2012, 2013, 2014, 2015, 2016; Segura, 2017). Tens of those brave individuals who did make reports were later murdered to send a message (Kennedy, 2014–17). Equally notable, the State is least effective for both genders at the crimes that impact each gender the most – rape for females and homicide for males – and falls especially short documenting rape (Arce, 2014; Kennedy, 2014). This is one of the strongest indicators that the State is either unable through lack of resources or unwilling through corruption to protect its citizens (Kennedy, 2013).

In these Northern Triangle countries, gangs or *maras*, “both victims of extreme social inequity and the perpetrators of brutal acts of violence” (International Crisis Group, 2017), have become the most present and powerful actors in most children's lives. Each country's departments are divided into municipalities, with each municipality unevenly divided into neighborhoods called *aldeas*, *barrios*, *cantones*, *colonias*, *caserios*, *lotificaciones*, or *urbanizaciones*. Gangs control territory at neighborhood levels (Dudley, Pachico, & Martinez, 2015; Muggah, 2015), strategically picking home bases in neighborhoods, like squatter settlements and those on the outskirts, with no or little authority presence (Szabo de Carvalho, Garzon, & Muggah, 2013). At the same time, gangs highly desire particular neighborhoods, like municipal centers, where many businesses, hospitals and people are present (Dudley et al., 2015), and near borders, where free movement is most critical (Szabo de Carvalho et al., 2013), even if authority presence is significant. Regardless, gangs mark their territories with graffiti and levy “taxes” against residents who live within and travel through their domains (International Crisis Group, 2017).

In communities like those of Nelson and Lorena, children and families are not merely exposed to direct and secondary trauma. They have lived their entire lives under constant surveillance and fear, knowing they are being constantly monitored but unable to fully determine by whom. Through threat and coercion, gangs acquire detailed information from residents and authorities about activities in public spaces, such as medical centers, schools, governmental offices, markets, and public transport, and in targeted homes. In so doing, gangs determine who violates their rules, including that of “see, hear, and shut up.” The punishment for violating these rules include beatings, rape, torture, and not uncommonly, death or disappearance. For this reason, mandated reporters like healthcare workers, teachers, and principals

[2] The Salvadoran news articles are on file with Elizabeth G. Kennedy, and you may contact her via email to obtain them. They cannot be included here, because doing so would reveal the name of the neighborhood the boy fled, putting his family who remains there at possible risk for having shared their story with us.

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often fear repercussions from gangs (Valencia, 2011).

Unaccompanied children from the Northern Triangle describe reasons for leaving home that include "family or opportunity," "violence in society," "abuse in the home," and "deprivation" (UNHCR, 2014). Children also highlighted the intersection between threats to security, poverty, and restricted education (Schmidt, 2017). Their governments did not invest in their communities or in their protection, and authorities may have persecuted them. Governmental offices, courtrooms, detention facilities, and even hospitals were subject to intense monitoring and at times became settings for homicide. Some neighbors in their communities cooperated with gangs. Gangs, neighbors, and relatives told them to keep quiet. Ongoing violations of core elements of childhood – attending school, playing safely, trusting the safety of one's family – create cumulative trauma that leaves children with no choice but to flee.

3. The migration experience

> Sebastian is a twelve-year-old boy from San Pedro Sula, Honduras. Five years ago, his mother placed him in his older brothers' care while fleeing Honduras after her husband was shot to death on their home's front steps. She was shot in her legs. She came to Texas without documentation. Working as a maid, she managed to save enough money to send for her three sons.
>
> Sebastian and his two older brothers traveled through Guatemala and Mexico. They ran out of money by the time they got to Reynosa, MX (a city across the border from McAllen, TX). Kidnapped by a local gang, the boys were taken to a shed where they were bound and left on the floor. Later that same day, after getting the phone number of the boys' mom, the gang took Sebastian's sixteen-year-old brother to an adjacent shed and beat him to death with baseball bats. The kidnappers took the corpse to a local clinic and forced technicians to take x-rays of the damage done to the body.
>
> The kidnappers returned to the shed, showed the photos to the two surviving brothers and told them that "this might convince your mother to send us money." When the kidnappers began drinking and passed out during the night, the boys escaped, made it to the river and swam across. The two then became separated.
>
> Sebastian surrendered to a Border Patrol agent shortly after crossing and was eventually placed in Office of Refugee Resettlement (ORR) care. He never discovered what happened to his brother (Griffin, 2018).

The United Nations High Commission for Refugees estimates that nearly 500,000 people cross Mexico, the world's largest migration corridor, every year (United Nations High Commissioner for Refugees (UNHCR), 2017b). Most of these irregular migrants originate in one of the three NTCA countries described previously. Unfortunately, the children and/or families who make the difficult decision to flee these countries face continued risk of abuse and violence by authorities and drug cartels in Mexico.

Since 2012, the international medical humanitarian organization, Doctors Without Borders/Médecins Sans Frontières (MSF), has been providing medical and mental health care in Mexico and Honduras to thousands of migrants fleeing neighborhoods like Lorena's and Nelson's. In 2017, MSF documented the additional violence and resulting emotional and physical distress they encounter in its report, "Forced to Flee Central America's Northern Triangle: A Neglected Humanitarian Crisis" (2017). More than 68% of the immigrants they surveyed reported being victims of violence during their transit at the hands of members of gangs, other criminal organizations, and Mexican security forces responsible for their protection (Medicins San Frontieres (MSF), 2017). Over 38% reported more than one violent incident, and more than 11% reported greater than three such incidents. Nearly one-third of the women and 17% of the men who were surveyed disclosed sexual abuse. This deeply personal violence was often compounded further by witnessing or experiencing abduction, theft, extortion, torture and death during the journey (Medicins San Frontieres (MSF), 2017), compounding the trauma experienced in home communities.

Although data on the abuses inflicted on immigrant children during their journey can be difficult and even dangerous to obtain, immigrant advocate groups have traveled to Mexico to gather firsthand information. They report that many immigrants are targeted for kidnapping and killing by drug cartels in Mexico. Others are trafficked into forced labor. Immigrant women and girls are trafficked to Mexico's southern border and forced to work in bars and nightclubs that cater to the police, military, and other security forces in the area (Acer & Shaw Drake, 2017). Immigrant children are exposed to sexual and physical violence and sex and labor trafficking and have little access to protection, justice, or services during their journeys through Mexico (Kids in Need of Defense (KIND) & Human Rights Center Fray Matías de Córdova, 2017).

For unaccompanied children, this level of trauma during the journey occurs without the physical presence and protection of a supportive adult. Toxic stress, or prolonged, serious stress in the absence of buffering support, can have immediate devastating mental health effects, but it also threatens normal brain development and is associated with negative impact on short- and long-term health (Garner et al., 2012). Those unaccompanied children who survive the journey must still cope with ongoing effects of this toxic stress.

Besides Doctors without Borders, there are other non-governmental organizations (NGO) providing services in shelters in Mexico, and efforts are underway to collect data and stories from these shelters (Suárez, Díaz, Knippen, & Meyer, 2017). This would be of great benefit in advocating for policy and services for this vulnerable population. Important U.S. policy addressing the root causes of migration and assisting Mexico and NGO's in providing protection and services for these children is deeply needed.

4. United States detention of children: the treatment of children at the border

It is not illegal to seek protection at the US border. The *1951 Refugee Convention* and its *1967 Protocol*, incorporated into the United States' *1980 Refugee Act*, defines the term "refugee" and outlines the rights of the displaced, as well as the legal obligations of States to protect them. A core principle is "*non-refoulement*," which asserts that a person should not be returned to a country where s/he faces serious threat to her/his life or freedom. This is accepted customary international law (United Nations High Commissioner for Refugees (UNHCR), 2017a). Yet, US officials increasingly violate it and individuals' right to seek asylum in the US.

After surviving the perilous journey to the US southern border, many unaccompanied children and families present themselves to immigration officials at "authorized Ports of Entry," which include the bridges crossing the Rio Grande River, to express their fears of harm, if returned to home country. DHS practice toward these asylum seeking children and families has long been problematic (Koh, Srikantiah, & Tumlin, 2011;Long, 2014; Mehta, 2014). CBP agents have purposefully ignored immigrants' expressions of fear, even harassing and threatening some; intimidated immigrants to abandon their asylum claims; and coerced immigrants into signing removal orders in a language they did not understand without explaining the availability of protection, their rights, or the consequences of signing (Long, 2014; Mehta, 2014). Furthermore, they have provided inaccurate, misleading and confusing information by overemphasizing the length of time they would spend in detention and failing to tell immigrants they could get bond or win the right to stay legally (Koh et al., 2011). Still, over this past year, DHS officials are increasingly turning children and families away, thereby violating international law and forcing desperate people to find other ways to cross, including on rafts, in inner-tubes, or by swimming. When they survive the crossing, most attempt again to seek safe haven by turning themselves into CBP agents patrolling the river.

Once in US custody, all immigrants, including single adults, families with children, and unaccompanied children, are transported to CBP Processing Centers. Almost 70% of all immigrants are processed through the Rio Grande Valley Sector Processing Center, located in McAllen, Texas. Temperatures in this facility are chilly (universally referred to as "*hieleras*" [ice boxes]), and children are initially in the same space with adults who may include the person who brought them through Mexico. "Processing" is the first step in US reception and takes place in chain-link, locked enclosures (called "*perreras*" [dog cages]), where children and their accompanying caregivers (parents, grandparents, older siblings, or other family members) are subsequently separated into short-term holding cells by gender and age. This can leave toddlers separated from their caregivers, siblings separated from each other, or fathers separated from their wives (Women's Refugee Commission et al., 2017).

It is here in the Processing Centers that an asylum seeker is first asked to tell her/his story. As a result of cumulative, complex trauma, children and families from the Northern Triangle are often afraid to tell their stories and unable to trust those who offer to hear their stories, particularly if in uniform. Many are further fearful that information they disclose will get back to their communities and endanger the lives of family left behind (Shapiro, 2016; Shapiro, Muniz, & Stark, 2014–15). When individuals seeking asylum recount personal narratives, discrepancies are common, particularly in the setting of post-traumatic stress (Herlihy, Scragg, & Turner, 2002). Although these discrepancies do not connote lack of credibility (Herlihy et al., 2002), this can impact legal outcomes beginning with determinations by CBP. CBP agents currently conduct a critical interview and stringent background check to determine whether to place single adults and family units in "expedited removal" (deportation) proceedings, detain the immigrants in adult or family detention centers, or release them to join their families who reside in the US to await their pending immigration hearing. However, the accuracy of this determination is of great concern, given the science on trauma.

Unaccompanied children from non-contiguous countries are all sent to ORR shelters. However, for unaccompanied children from Mexico or Canada, the 2008 Trafficking Victims Protection Reauthorization Act (TVPRA) requires that CBP determine whether they are possible victims of trafficking, have a possible claim to asylum, or cannot/does not voluntarily accept return (Linton et al., 2017). Given the trauma that most unaccompanied children face in countries of origin and during their journeys, there is grave concern that they will not be able to provide consistent histories and/or effectively answer the questions that they are being asked to determine admissibility.

4.1. Conditions in US processing centers

The US has determined that all immigrant children, whether unaccompanied or accompanied by a parent or guardian, are to be treated differently than adults. Prior to 1997, unaccompanied children were placed in detention facilities with unrelated adults of both sexes. Children were subjected to strip searches, body cavity searches and other abuses (López, 2012). A class action lawsuit ensued. After nine years of litigation, the *Flores Settlement Agreement* was negotiated. Under it, unaccompanied children must be transferred from DHS within 72 h to the "least restrictive setting appropriate" in facilities meeting state standards for children in foster care. Facilities for unaccompanied children must have at minimum: safe and sanitary conditions, toilets and sinks, drinking water and food, medical assistance in cases of emergency, adequate temperature control and ventilation, adequate supervision to protect minors from others, contact with family members, and separation from unrelated adults. Paramount to their care is "dignity, respect and special concern for their particular vulnerability as minors" (United States District Court, 1997).

In June of 2017, citing unsafe and unsanitary conditions with cold temperatures and inadequate access to clean drinking water, food, hygiene, and sleeping conditions (American Immigration Lawyers Association (AILA), 2017), Judge Dolly Gee with the Ninth Circuit Court determined that the *Flores Settlement Agreement* applied to initial DHS reception as well, and the CBP Rio Grande Valley Sector Processing Center was in violation. Below are some of the accounts she took into consideration:

Yessenia E. Decl. ¶ 6 "For three days [at McAllen station] we were given no soap to wash, no toothbrushes to brush our teeth, no paper towels to dry our hands when we washed our hands, nothing to brush our hair, no change of underwear or clothes, no pillows or blankets and no beds to sleep in" (United States District Court, 2017).

Julissa H. Decl. ¶ 4 I asked the officers if they could turn down the air conditioning because the kids were getting very chilly, but after I asked they actually made it colder… Sometimes the officers yelled to the kids to shut up because the children were crying so loud because of the cold" (United States District Court, 2017).

Declaration of Silvia V. ¶ 4 ("[W]e are held in a cell with about thirty to forty other mothers and children. The bright lights on the ceiling stay on all nights… It is very hard to get any sleep because the floor is hard and cold, the cell is very crowded, the lights are on and very bright, and children are crying and coughing all night long") (United States District Court, 2017).

As outlined in the 2017 American Academy of Pediatrics' (AAP) Policy Statement on the Detention of Immigrant Children, children should not be subjected to the CBP processing centers. Instead, processing of all children should occur in a child-friendly manner outside of CBP processing centers and conducted by child welfare professionals (Linton et al., 2017).

To date, these recommendations have not been adopted by the Department of Homeland Security. The AAP continues to push for its adoption into operating protocols for all immigrant children. Until the children are processed outside of CBP processing centers, pediatricians[4] who have toured these facilities, strongly recommend having a certified child life specialist or other child welfare professional present within the processing centers to help the immigrant children cope with their fears, loss of control and isolation and to mitigate any re-traumatization.

4.2. "I can't find my child"

In the spring 2017, the report "Betraying Family Values: How Immigration Policy at the United States Border is Separating Families" was published (Women's Refugee Commission et al., 2017). The report outlines the current processing of families by CBP (Fig. 1).

> Francisco was a tall, dignified man from Honduras, who CBP released that same day with his 6-year-old son, Jasiel. They had bus tickets to reunite with family in Nebraska and were being seen in the medical unit of a humanitarian shelter on the border for Jasiel's congestion and coughs. Francisco thought the cold temperatures in the Processing Center were to blame and worried that Jasiel was developing pneumonia. When I asked where his son's mother was, in Honduras or the States, tears began streaming down his face. He seemed surprised but incapable of stopping the steady flow with his palms pressed tightly on his eyes. In a shaky voice, he confided that CBP had taken his wife and 10-year-old daughter from him and placed them in a different cell. He could only catch glimpses of them from his cell. Then, they were gone. The CBP agents refused to tell him where his wife and daughter were taken (Griffin, 2017).

Not all children designated as "unaccompanied" actually make the journey alone. Instead, CBP separates families at the border as "punishment" or "consequence" (Women's Refugee Commission et al., 2017). Since 2005, DHS has systematically implemented a

[4] The authors have toured the CBP processing center.

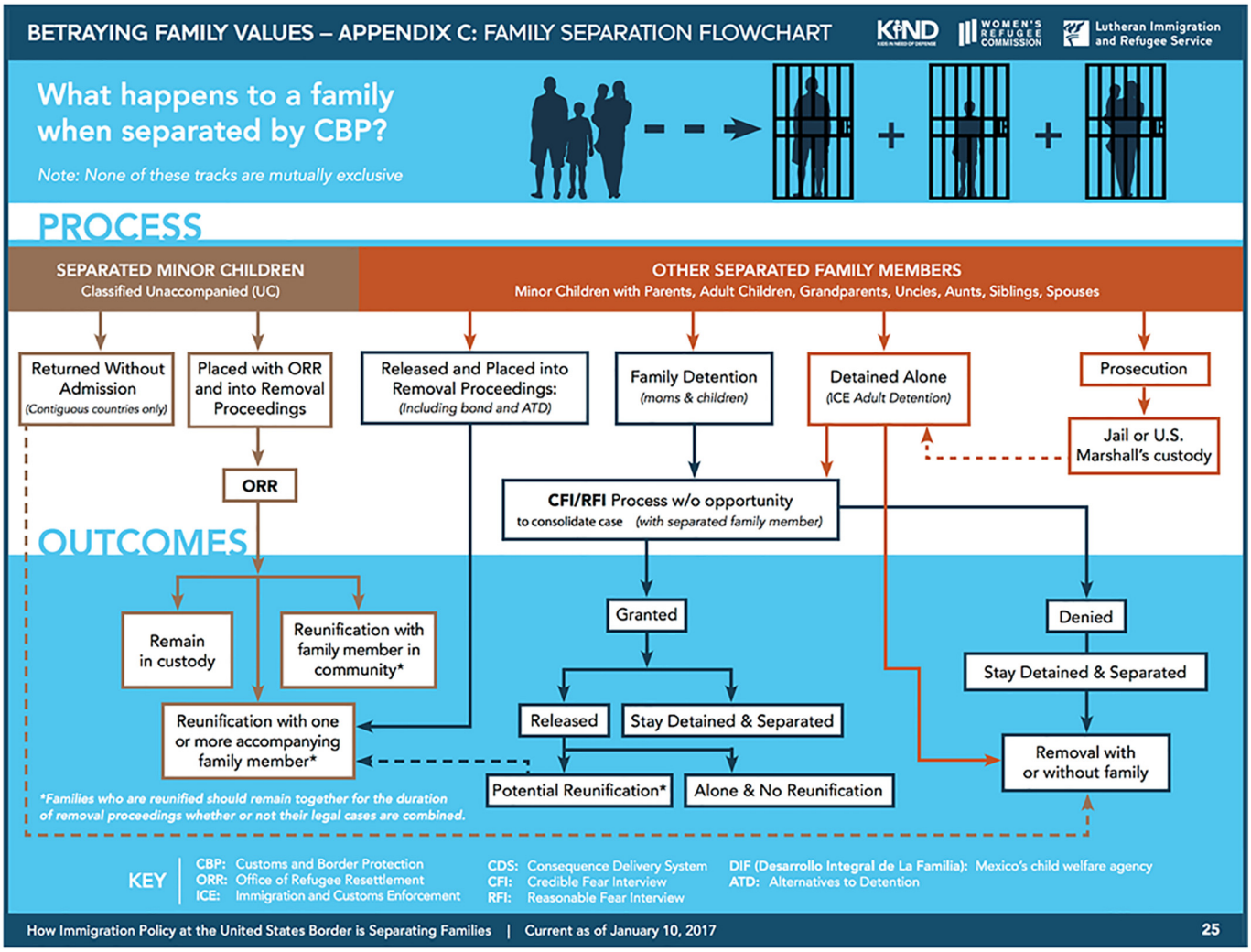

Fig. 1. Family separation flowchart (reprinted with permission) (Women's Refugee Commission et al., 2017).

"Consequence Delivery System (CDS)," developed to deter future immigrants from coming to the US. These "consequences" include intentionally separating parents from their children, coercing a parent to accept expedited removal, and repatriating children without their parents. Such actions ignore international protection guidelines and other humanitarian concerns and further distress parents, such as Francisco, who fled communities similar to those of Lorena and Nelson.

4.3. Further detention of an unaccompanied immigrant child

Since the Homeland Security Act of 2002 transferred the care and placement of unaccompanied alien children to ORR, ORR has sheltered over 175,000 children (Office of Refugee Resettlement, 2017a) in a variety of publically- and privately-contracted facility types that range in size and level of security, including foster care. Children are provided with dormitory-style rooms, shared bathrooms, showers, clothes, hot meals, year-round educational services, recreational activities, and limited legal services. ORR is also responsible for providing the children with ongoing medical and mental health care while in custody.

Although the care of unaccompanied children in ORR facilities is markedly improved over CBP processing facilities, it is still detention. Children are not allowed to leave independently, are only allowed two phone calls to designated individuals per week, and have no control over their schedules. The facilities are often surrounded by high fences and locked gates. Unlike CBP Processing Centers, which provide only cursory medical assessments, ORR-contracted shelters provide more comprehensive pediatric medical care (e.g. immunizations, TB screening, physical examinations, sexually transmitted disease screening) (Linton et al., 2017). In the setting of compound trauma described above, unaccompanied children are in great need of mental health services. However, the US does not provide adequate mental health assessment to determine which type of ORR facility is appropriate and individual services or group counseling once at the facility (E Kennedy, 2013), and the location of many of these facilities are often in communities with limited mental health resources. Counselors and social workers caring for unaccompanied children in ORR shelters report that these children can become stressed and anxious over the conditions and regulations, enforced for their safety, but often substantially different from the norms of their home communities; the uncertain future, particularly related to immigration hearings and deportation; the inability to work and provide for their families; and the separation from their families (Perez & Bryan, 2017). Although efforts are made to prioritize the safety of unaccompanied children, concerns have been raised regarding ORR's planning process and monitoring (United States Government Accountability Office (GAO), 2016), including some reports of abuse occurring within ORR shelters (Gruberg & Hussey, 2014). After further processing of the child's case, ORR releases most unaccompanied children to a sponsor or family member. This reunification, however, presents new challenges.

5. Release into communities: challenges and opportunities

> Oscar is a 15-year-old boy who goes to the local free clinic in need of a signed physical form to enter the public school system. He shares with the staff that he moved from Honduras two months ago to live with his grandmother, who he had never met before moving to the US. Oscar does not report any current medical problems but mentions difficulty with sleep. His grandmother also describes that he seems withdrawn and does not want to leave the house. Oscar brings some paperwork with him from his "medical exam" from the shelter, where he stayed prior to placement with his grandmother.
>
> Upon further history, Oscar reveals that his father left when he was an infant, and his mother recently died in a motor vehicle crash. Oscar has not attended school for nearly a year, because gang members threatened to murder him if he did not join. After his mother's death, his grandmother hired a family friend to transport Oscar to the US. Oscar does not want to discuss the journey and will not make eye contact when asked about it. He presented to authorities in El Paso asking for asylum. After processing, he spent four weeks in an ORR shelter before joining his grandmother. He does not have a lawyer for his approaching court hearing (Linton, 2017).

After detention in ORR shelters, most unaccompanied children are placed with sponsors within communities to await their immigration proceedings (Crea, Lopez, Taylor, & Underwood, 2017). While they wait, they must shift from flight or survival mode to integration and acculturation to a new family, environment, language, and culture. This acculturation also encompasses reconstructing one's identity – incorporating one's past identity and adapting to a new world. The presence of stable support is critical for successful integration. Clinical experience indicates that living with family or friends can offer a child new healthy relationships with caring, loving adults.

Immigrant youth, when relocating to new communities, face daunting tasks of adaptation and acculturation (Berry, Phinney, Sam, & Vedder, 2006). Ideally, the youth are able to retain a sense of their own cultural identity (Berry et al., 2006). However, in the case of unaccompanied children, caregivers may underestimate challenges relating to acculturation, previous traumatic exposures, and other issues, frequently related to battles they themselves are fighting or have not yet addressed. The success of reunification may either facilitate or hinder healthy adaptation and acculturation.

5.1. Access to health care

Access to health care is not guaranteed, and case management services that are sensitive to their physical and mental health needs can be lacking. Only six states (NY, CA, WA, MA, IL, OR) and the District of Columbia offer children eligibility to public coverage regardless of their immigration status (National Immigration Law Center (NILC), 2017). Many unaccompanied children are essentially "primary care naïve," having lacked access to preventive medical care during the various stages of childhood. Critically needed services include primary care (i.e. a medical home), family planning, mental health, and dental services. In states that do and do not provide health insurance, unaccompanied children may access care in federally qualified health centers, school-based health clinics, charity care hospitals' ambulatory, specialty care clinics, and private offices, as well as emergency departments and urgent care centers. Access to trauma-informed mental health screening and care is insufficient in many areas (Akin, Strolin-Goltzman, & Collins-Camargo, 2017; Donisch, Bray, & Gewirtz, 2016; Reeves, 2015; Rikard, Hall, & Bullock, 2015), a particular problem for children with limited English proficiency. Access to dental services, often needed urgently and/or chronically, is also inadequate. Addressing these healthcare barriers necessitates creative strategies that strengthen integration of health systems and services. Examples of these strategies are described below in the case-based discussion.

5.2. Public education

Unaccompanied children from the Northern Triangle countries often arrive with gaps in their formal schooling. Like Nelson and Oscar, many withdraw to avoid forcible recruitment into gangs. More broadly, education is often not free in their communities, and even when their families can afford the associated costs, the quality suffers, because of aforementioned dynamics. Still, educational attainment is a fundamental social determinant of health and, along with other socioeconomic factors such as income, is intimately intertwined with a wide range of health outcomes (Braveman & Gottlieb, 2014).

The United States Supreme Court ruled in the 1982*Plyler v. Doe* case that all children, regardless of immigration status, have a right to free, public education (United States Supreme Court, 1982). This right includes access to special education services as well as language assistance programs (Meneses et al., 2015). However, some schools illegally deny unaccompanied children enrollment, and many children face a number of external pressures, including repayment of family debts incurred during transit to the United States, which can make it difficult to both stay and succeed in school. Immigrant children, particularly those who lack legal status, may also face vulnerabilities in school, including unmet educational, social, and emotional needs (Adelman & Taylor, 2015; Garcia-Joslin et al., 2016; Sibley & Brabeck, 2017). For these reasons, allowing children to attend school but not guaranteeing them access to healthcare has adverse implications from a public health perspective. Much remains to be learned regarding effective strategies to promote integration into school for unaccompanied children (Crea et al., 2017). School- and community-based enrichment opportunities may also support their academic and personal adaptation (Dearing et al., 2016; Hall, Porche, Grossman, & Smashnaya, 2015). However, the unique needs of unaccompanied children must be considered in implementation of interventions.

5.3. The medical-legal Nexus

In addition to the challenges of normalizing their lives and acculturating into their new American communities, unaccompanied immigrant children live under the backdrop of pending removal hearings. The anxiety this generates for children can be exacerbated by anti-immigrant discourse and can contribute to the development of negative mental health symptoms The AAP affirms that in no case should a child be without legal representation in an immigration proceeding (Chilton, Handal, Paz-Soldan, & AAP Council on Community Pediatrics, 2013; Linton et al., 2017). However, in the United States, neither children nor adults are entitled to legal representation in their immigration cases ("Immigration and Nationality Act,"). Indeed, only 40% of unaccompanied children have attorneys to represent them (TRAC Immigration, 2017b). Most children appearing in immigration court do not speak English, have no understanding of the legal system, and may fear courtrooms because of their past experiences (First Focus & LIRS, 2016). These children face tremendous risk of "*notario* fraud," which occurs when individuals capitalize on immigrants' vulnerability and ignorance of the US legal system to offer substandard, false, or nonexistent immigration services (The Community Justice Project, 2013); high fees for private attorneys; lawyers provide substandard, false, or nonexistent immigration services (The Community Justice Project, 2013), or lack of legal representation.

Children without counsel are five times more likely to be deported, regardless of the merits of their cases or the dangers to which they would return (Kids in Need of Defense & Women's Refugee Commission 2015; Kids in Need of Defense (KIND), 2017a). Options for legal representation, at no cost to the child, vary by region and can be extremely limited in many regions of the country (Immigration Advocates Network, 2017; US Department of Justice Executive Office for Immigration Review, 2017). Accordingly, the likelihood of legal representation is highly dependent on geography (TRAC Immigration,

2017a), and the outcomes of immigration cases, in any case, depends upon geography and the individual judge, even within the same jurisdiction. In New York, 31% are deported (NY), while in Georgia and North Carolina, more than 80% are ordered deported (TRAC Immigration, 2017c).

Legal proceedings and health care are intimately intertwined, and the complexity of immigration law makes it all the more imperative for social services providers to have a referral network of legal experts with whom they work closely (preferably at no cost to the child/family). Achieving legal status confers access to public benefits, including work permits and health care (National Immigration Law Center (NILC), 2015). Conversely, access to healthcare can confer better legal outcomes (Lustig, Kureshi, Delucchi, Iacopino, & Morse, 2008; Scruggs, Guetterman, Meyer, VanArtsdalen, & Heisler, 2016). Social service providers can often elicit supportive information with trauma-informed history taking and careful physical examinations. Social service providers can take a sensitive social history that may uncover information not disclosed to lawyers, such as abuse, parent abandonment, torture, persecution, or being a victim of crime during their journey to this country or while in this country. Clinical evidence may be found (e.g. a bullet lodged in the spine) and/or medical conditions diagnosed (e.g. intellectual disability, which may make a child a target for further persecution, placing him/her in a "particular social group," one of the criteria for asylum) that can support legal relief.

Social service providers and immigrant advocates have a unique opportunity to create programs that respond to the complex needs of unaccompanied children. Key areas of focus should include: creating "safer" spaces; facilitating access to trauma-informed health care that is place-based, coordinated, and integrated with other key services; connecting newly arrived immigrants with *pro- or low-bono* legal services; identifying services that assist the processes of adaptation and acculturation; and underscoring advocacy. To illustrate how medical-legal collaboration can be developed and implemented for unaccompanied children, a model of care built around a *medical-legal partnership* within a community health center in the South Bronx, New York, is described in the subsequent section.

6. Opportunities for collaborative advocacy: the case of Terra firma

In the spring of 2013, Drs. Alan Shapiro and Cristina Muñiz, pediatrician and psychologist, respectively, were providing healthcare to homeless street youth on a mobile medical clinic at a drop-in center in Harlem. An adolescent from Guatemala, Jorge, was brought to the mobile clinic for care. Jorge had a history of severe mental health problems and had lost his medications. He did not know which medications he was prescribed or where he was receiving psychiatric care. Fortunately, he carried the business card of Catholic Charities, where he was receiving pro bono legal services and case management. The agency was immediately contacted, and important information regarding his mental health care was obtained. After speaking to his lawyer, Brett Stark, Esq., the clinical team also learned that Jorge had the "UAC" designation. The team wondered how many other children like Jorge they had seen yet never asked whether they met the criteria for this designation or had legal representation. Drs. Shapiro and Muñiz also learned that this pro bono legal agency was seeing an increasing number of unaccompanied immigrant children and was looking for sites to send their clients for medical and mental health services. A series of strategic discussions led to the founding of Terra Firma (TF), just before the media's intense coverage of arriving unaccompanied children in 2014 (Shapiro, 2017).

6.1. The program

The goals of TF are to provide a medical home for children, provide legal representation with medical documentation in relevant cases, and facilitate the process of adaptation and acculturation. Integrated, co-located services are a core feature. The program is embedded in a federally qualified community health center in the South Bronx, a community rich with new immigrant families from Latin America, the Caribbean, and West Africa. The health center provides patient- and family-centered primary care with integrated behavioral health and social services. Once weekly, a legal team made up of pro bono immigration attorneys, a case manager, paralegal and legal interns, comes to the health center, where they provide legal screenings and counsel to their clients.

The program works primarily on a referral basis, in which approximately 50% of referrals come from TF's legal partners, Catholic Charities and other pro bono legal agencies, and attorneys in the NYC area. In essence, this is a reversal of the medical-legal partnership, in which healthcare providers typically refer their patients for legal services. Other sources of referrals are public schools, school-based health clinics, community based organizations, and importantly, word of mouth (about 25% of referrals).

6.2. Strengths of the TF model

1. Creating a welcoming, "safer" space: In the setting of growing concerns regarding decreased utilization of healthcare facilities due to fears of deportation and ongoing discrimination (Artiga & Ubri, 2017; Page & Polk, 2017), healthcare facilities can build a welcoming environment for immigrants (Huerta, 2017; Joachin, 2017; Saadi, Ahmed, & Katz, 2017).
2. Trauma-informed approach: The TF model is grounded in trauma-informed care (Forkey, Gillespie, Pettersen, Spector, & Stirling, 2014). In order to meet obvious mental health, adaptation, and acculturation needs, TF developed separate Youth Support Groups for adolescent boys and girls. Enhanced support is often needed for their sponsors, especially parents.
3. Place-based services: Public health advocates increasingly acknowledge the value of place-based interventions in mitigating health disparities (Dankwa-Mullan & Pérez-Stable, 2016). Many pro bono legal services are not located in communities where their clients live. At TF, co-located legal services in the community health center subjectively enhances adherence to legal, medical, and mental health care.
4. Integrated, co-located services: Integrated mental health and legal services within the medical home can facilitate access to services and communication between social service providers (Foy & AAP Task Force on Mental Health, 2010; Hyatt Thorpe, Cartwright-Smith, Gray, & Mongeon, 2017). Children frequently disclose to social service providers painful experiences and traumatic events which may become critical evidence that can change the most likely outcome of a case. While upholding privacy is of utmost importance from a therapeutic standpoint and written into the law (Health Insurance Portability and Accountability Act of 1996, HIPAA (US Department of Health and Human Services Office of Civil Rights, 2003), an empathic and sensitive healthcare provider can assist the child in disclosing painful histories to the legal team. TF asks its participants to sign consent for release of information between professionals to permit discussion of their histories, making explicitly clear that sharing information is done for the purpose of strengthening their immigration case. No information (e.g. sexual abuse, torture, etc.) is shared without express consent.
5. Care coordination: Due to the large number of unaccompanied immigrant children who have arrived and continue to be reunited with family in NYC, the model had allowed for the healthcare team to care for children whose legal team is not on site. The TF Coordinator

facilitates communication with outside agencies through a modified model, through with attorneys from other agencies can schedule meetings with their clients at the health center. This modified model may be more replicable in cities with fewer legal resources.

6. Enrichment opportunities: TF developed its Youth Summer Enrichment Program, a pilot project that evolved into year-round enrichment activities. Examples of programming offered include tutoring, English as a Second Language (ESL), soccer, photography and field trips.
7. Focus on child advocacy: Since its inception, TF has focused multi-faceted child advocacy at the individual patient, professional, community and government levels. At the patient level, every eligible child is enrolled in health insurance, and educational equity is a priority (e.g. enrolling in public high school over GED programs). TF has engaged in interdisciplinary professional education regarding the complex needs of unaccompanied children at local, regional, and national levels. TF has also worked on numerous cases where a child lost her/his first immigration hearing only to win on appeal with professional affidavits as supporting evidence. Lastly, given the vast experience working with children and their sponsors, TF leadership have been vocal advocates for the needs of immigrant children at the local and national government levels through written and oral testimony (Shapiro, 2016; Shapiro et al., 2014–15; Shapiro & Linton, 2017; Stark, 2017).

6.3. Summative case study: Teofilo and his foot

A pro bono attorney referred Teofilo, an adolescent male from Guatemala, to Terra Firma for medical care. Teofilo had not seen a doctor since arriving in NYC and suffered from insomnia and constant tooth pain. He also struggled to attend legal appointments far from home, while he worked two jobs and continued with ESL classes. Importantly, the lawyer sensed that Teofilo was not fully disclosing why he left Guatemala.

Teofilo had a number of intake visits with his new pediatrician. During these visits, Teofilo was vague about why he came to the US, stating that he felt gangs had infiltrated his community and made it too dangerous. His pediatrician also noted that Teofilo refused to take off his shoes. The pediatrician eventually cajoled Teofilo to remove them, which revealed a large swollen toe (which embarrassed him) due to a common problem of ingrown toenails. His pediatrician made a podiatry appointment for him and then escorted him to it. After a short procedure and a week of convalescence, the infection resolved, and his toe returned to normal size. In a follow-up visit, with newfound trust in his pediatrician, Teofilo fully divulged why he came to the US.

Teofilo revealed that upon walking home from school one day, three masked men who had tried to recruit him into their gang grabbed him and his best friend. Teofilo remained calm, but his friend fought back and was brutally murdered. Teofilo explained that he was paralyzed with fear and ridden with guilt, refusing to tell anyone, including his parents, about what he saw. Nonetheless, Teofilo began receiving death threats at home. He and his parents agreed that it was best for Teofilo to leave.

During his medical visits, Teofilo revealed that he suffered from intrusive memories and nightmares so terrifying that he feared going to sleep. For this reason, he worked two jobs, went to English classes and spent hours in the gym – all to avoid going to sleep. He was referred to the mental health team and began both group and individual therapy. After about nine months of treatment, he agreed to disclose this history to his lawyer. Once he did, this new information became the key evidence for a winning case. Both his pediatrician and psychologist wrote professional affidavits that became part of the evidence. Furthermore, his psychologist testified in his immigration proceedings. Although the judge had initially not found sufficient evidence to grant him asylum, he won the case on appeal based on the new evidence presented.

On a recent visit, Teofilo appeared like a new person. He reported that he has had a significant improvement in his mental health symptoms and that he almost never has nightmares or suffers from insomnia. He has one full-time job, is fluent in English, and continues to study part-time (Shapiro, 2017).

A series of cases, such as that of Teofilo, embody the capacity of the TF model to break down the silos of healthcare, legal services, trauma-informed approaches, and youth enrichment. Community-based efforts are critical to support unaccompanied children but require time and effort to build and maintain. Social services providers may wish to begin by incorporating components of the TF model, engaging in a process of qualitative improvement using Plan-Do-Study-Act (PDSA) cycles (Institute for Healthcare Improvement (IHI), 2018). Elements from the TF model can be adapted to other communities to support the complex medical, mental health, and legal needs of unaccompanied children and their families.

6.4. Limitations and practical challenges

1. Building an evidence base: Ongoing data collection is essential to build an evidence base around medical-legal partnerships that prioritize the needs of immigrant children. However, it takes time to build programs, and the protracted time for each child's case requires longitudinal evaluation that can be cumbersome in resource-limited settings.
2. Barriers to providing and funding legal representation: Medical-legal partnerships receiving federal funding operating under Legal Services Corporation guidelines do not accept cases relating to immigration (Houseman, 2013). Furthermore, immigration cases require extensive training, and counsel has been deemed to be ineffective for given immigration cases in many instances (American Immigration Council, 2016). Several large-scale local and national efforts have enhanced access to legal representation for children in removal proceedings (Kids in Need of Defense (KIND), 2017b; New York City Council, 2016). However, creating and sustaining funding mechanisms, particularly in regions with more divisive dialogue regarding immigration, remains a profound barrier to establishing medical-legal partnerships focused on immigration.
3. Barriers to provision of medical and mental health care and documentation needed for legal cases: In addition to state-based disparities in access to public coverage for unaccompanied children (National Immigration Law Center (NILC), 2017), trauma-informed services are often limited in accessibility (Crea, Lopez, Hasson, et al., 2017). For legal cases, medical and mental health documentation can be highly specialized and time-consuming (Physicians for Human Rights, 2012). In an increasingly challenging health care landscape, committing to provide medical documentation for legal cases can be intimidating for busy social services providers.
4. Current climate of fear and uncertainty: Amidst increasingly hostile immigration policy and associated divisive rhetoric, immigrant children and families are experiencing fear and uncertainty (Artiga & Ubri, 2017). Furthermore, some individuals may be particularly fearful of interdisciplinary information sharing (Hyatt Thorpe et al., 2017). For social service providers without previously established relationships with legal organizations or advocacy organizations that serve unaccompanied children, building trust through relationships will be an essential foundational step.

7. Conclusions

The trauma that unaccompanied children experience pre-migration, during migration, upon arrival to the US, and within communities can threaten their short- and long-term health and well-being. In order to assist the children in establishing different ways of relating and living,

social service providers must first understand the difficult experiences they have survived and commit to building trust with families and within communities.

Policy-level strategies and community-based strategies must not only mitigate re-traumatization but must facilitate access to health care, educational support, and legal services. Above all, children and their families should be treated with dignity, respect, and compassion throughout their journeys. As a result, the Administration has a responsibility to develop child- and family-friendly policies. This includes but is not limited to: eradication of any and all separation of children from parents or other family members, unless the safety of the child is at-risk at the hand of that person; immediate establishment of monitoring of all processing and detention facilities by a team of trauma-informed social service providers; and elimination of conditions that traumatize or re-traumatize children, including processing centers as they currently exist. Within communities, the health, educational, and legal needs of children should be prioritized in all settings, and require collaborative efforts among interdisciplinary teams. We aspire towards access to integrated, comprehensive medical, mental health, and legal services for all immigrant children and their families. Ultimately, the short- and long-term health and well-being of unaccompanied children – and our communities – is contingent upon a fair system that fosters empathy, opportunity, and hope for an equitable future.

Conflicts of interest

The authors have no conflicts of interest to disclose.

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