



A Path to Meeting the Medical and Mental Health Needs of Unaccompanied Children in U.S. Communities

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American Academy
of Pediatrics



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Executive Summary

The number of migrant children entering the United States without a parent or legal guardian has increased significantly over the past decade, reaching a record high in 2022. Most of these unaccompanied children temporarily enter the care of the U.S. government before joining parents or other sponsors in U.S. communities to await the outcome of their immigration proceedings. Once they have made this transition, the services and supports they need to thrive can be difficult to access. Among the most essential are medical and mental health care, which are critical in order for children to reach their full potential. Given that unaccompanied children will be in the United States for several years, and many will ultimately remain in the country permanently, ensuring they are healthy, protected, and able to contribute to their communities benefits society more broadly.

Although most unaccompanied children are physically healthy, some have special health care needs, and all have likely experienced trauma. They have health insurance while the Office of Refugee Resettlement (ORR) finds and vets their sponsor, but this coverage ends when they leave federal custody. Most are not able to access public health insurance, such as Medicaid or the Children's Health Insurance Program (CHIP), or afford private insurance upon release and subsequently become uninsured.

Federally qualified health centers (FQHCs), other low-cost clinics, and hospital charity care programs may be options for obtaining medical and mental health services, but arranging care through these sources can be difficult and may only provide limited support. In addition, unaccompanied children often encounter numerous other barriers to receiving culturally appropriate, trauma-informed, high-quality services in their language of preference.

In 2022, the American Academy of Pediatrics and Migration Policy Institute came together to study unaccompanied children's access to medical and mental health services in U.S. communities. The researchers conducted field visits to three U.S. cities (Houston, TX; Los Angeles, CA; and New Orleans, LA) and held interviews and focus groups with more than 100 professionals working with this population, as well as unaccompanied children themselves. In these visits and discussions, a number of themes emerged that informed the findings and recommendations in this report.

A. *Barriers to Care and Promising Practices*

Barriers to unaccompanied children's care are related to various factors, including ORR policies and practices, the structure of the U.S. health care system, the individual and immigration-related circumstances of unaccompanied children and their sponsors, and the overall lack of sufficient community-based supports.

- ▶ **ORR's processes for transitioning children from federal care to a sponsor's household contribute to their challenges accessing medical and mental health care, especially for children with special**

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health care needs. Of particular concern are deficiencies in the discharge health paperwork ORR gives to children and sponsors, lack of communication between clinicians caring for children in ORR custody and community clinicians who do so after release, provision of a limited supply of medications for chronic conditions, and inadequate federally funded, post-release medical and mental health case management.

- ▶ **The U.S. health care system presents major obstacles, the largest being cost and unaccompanied children's inability to enroll in public health insurance in most states.** Even in cases where financial assistance is available, obtaining the documents necessary to apply can be challenging, with further difficulties caused by lengthy intervals between application and approval in addition to the fees that remain after sliding scale adjustments are applied. Lack of interpretation services and problems finding timely appointments—due to limited hours and availability at health facilities as well as clinician shortages, especially for mental health care—can also impede access to care.
- ▶ **As an immigrant household, unaccompanied children and sponsors may be unfamiliar with the complexities of the U.S. health care system.** In addition to limited systems knowledge and health literacy, they may also fear that accessing services could negatively impact their immigration case. Obtaining mental health care may be further complicated by cultural norms, family dynamics, and stigma.
- ▶ **Schools and other community organizations in frequent contact with unaccompanied children may miss opportunities to identify and help meet their health-related needs.** Funding limitations, staff shortages, and a lack of understanding of this population's unique experiences and circumstances may prevent them from serving children more fully.

Despite these and other barriers, promising practices exist in various U.S. communities that make it easier for unaccompanied children to access medical and mental health services. Examples include: 1) multidisciplinary clinics for newcomer children that provide comprehensive, tailored services to meet their unique medical, mental health, legal, and social needs; 2) school districts that offer enrollment centers to not only register children but also assist with health insurance applications, screen and refer for social determinants of health needs, and provide medical and mental health care on site; 3) community-based, in-person case management to connect children with health care; and 4) multidisciplinary, community coalitions that establish processes for smoother referrals between organizations, host events to connect children with further resources, and advocate for needed policy changes.

B. Recommendations

These findings inform steps that governments, health systems, schools, and communities can take to improve unaccompanied children's access to medical and mental health care.

The Office of Refugee Resettlement should:

- ▶ Provide complete and accessible information upon release to sponsors regarding the unaccompanied child's health and diagnoses, written in their language of preference and reviewed with both the child

(if age appropriate) and sponsor. Sponsors should also receive paperwork stating that they have the ability to provide medical consent for the child.

- ▶ Provide medical and mental health case management for all children following release. Initial contact between a sponsor and post-release case manager should, when possible, begin while the child is still in federal custody. Services should be offered locally, in person, and last for at least one year. Priority should be placed on utilizing case managers housed in multidisciplinary organizations in order to better facilitate referrals.
- ▶ Establish and fund medical and mental health orientations for unaccompanied children and sponsors in U.S. communities to help them better understand and utilize the U.S. health care system. These should be offered after release and, when possible, in conjunction with the Executive Office for Immigration Review's Legal Orientation Program for Custodians of Unaccompanied Children.
- ▶ Continue payment for medical and mental health services for at least three months after release and provide at least a three-month supply of medication for chronic conditions to help prevent gaps in care.
- ▶ Simplify and expedite the process for community-based clinicians to obtain a child's medical and mental health records (including vaccinations) from their time in ORR custody.

Federal, state, and local governments should:

- ▶ Extend eligibility for public health insurance to all low-income unaccompanied children, beginning as soon as they leave ORR custody. This should be accomplished at the federal level but, if not, states that have not yet done so should create state-funded public health insurance programs that include coverage of unaccompanied children. All public insurance expansions should be complemented with robust outreach campaigns and funding for program navigators.
- ▶ Expand funding to train more trauma-informed mental health clinicians with language and cultural backgrounds that match those of unaccompanied children. These clinicians should be positioned where they are needed most, particularly at schools and in rural areas where existing capacity is limited.
- ▶ Ensure that offices at all levels of government have staff who have the knowledge and ability to address the needs of immigrants, with a particular focus on children, health care, and language access.

Health care systems should:

- ▶ Create welcoming, accessible environments through inclusive messaging and signage, interpretation services, culturally sensitive and trauma-informed care, and policies that reduce logistical barriers, such as offering evening, weekend, and walk-in appointments.
- ▶ Bring appropriate medical and mental health services into the community through school-based clinics, telehealth services, mobile units, and community health workers.

- ▶ Create or expand financial assistance programs at all health facilities and make it easier for unaccompanied children to enroll. The application should be standardized as much as possible, especially across FQHCs (at least regionally, if not nationally).
- ▶ Co-locate medical and mental health services with other supports (such as social work, benefits enrollment, legal services, and supplemental food programs) to holistically address children's needs.

School districts should:

- ▶ Screen all new students for social determinants of health around the time of enrollment and provide resources and referrals to address any identified issues.
- ▶ Help ensure all students and their families have access to affordable health care by collaborating with community organizations to either bring medical and mental health services to schools or partner with nearby health facilities.
- ▶ Consider establishing programs designed to help address the unique needs of newcomer students, taking care to avoid creating any disadvantage or stigma for students who participate in them.

Communities should:

- ▶ Build or strengthen multidisciplinary coalitions of organizations and individuals serving unaccompanied children to improve referrals and expand the supports available locally. Coalitions should develop community-based initiatives, such as improving service providers' trauma-informed interactions with unaccompanied children and sponsors and helping to bridge the digital divide.

Unaccompanied children have experiences and circumstances that require a thoughtful approach to ensure their medical and mental health needs are met. These recommendations offer a path to improved physical, mental, and emotional well-being for unaccompanied children, to their benefit as well as that of their communities.

Unaccompanied children have experiences and circumstances that require a thoughtful approach to ensure their medical and mental health needs are met.

1 Introduction

The number of immigrant children traveling to the United States without a parent or legal guardian has risen tremendously over the last decade. Most enter the temporary care of the U.S. government, which in turn places them with an approved family member or other sponsor in a local community while they await the outcome of their immigration proceedings. During and after the transition from federal custody into their new communities, it can be very difficult for these children to access medical and mental health services. Not only do they face challenges arising from their unique circumstances as unaccompanied children, but they also encounter barriers stemming from government policies and the structure of the U.S. health care system. For children with special health care needs, the situation is even more complicated.

Having limited access to medical and mental health care harms both unaccompanied children and the communities in which they live. Children may miss preventive services such as vaccinations and recommended screenings, which can respectively prevent disease and identify conditions in their early stages to halt their progression. They may also experience delays in receiving needed treatments for chronic or acute conditions, further worsening their health and well-being in both the present and the future. Unaccompanied children who do not receive timely and appropriate care may be unable to participate fully in school and society. Communities miss out on both their immediate contributions and—as many unaccompanied children remain in the United States for the long term—the future benefits of having more members who are educated and employed in more skilled positions.

During and after the transition from federal custody into their new communities, it can be very difficult for these children to access medical and mental health services.

This report is the culmination of a joint initiative by the American Academy of Pediatrics (AAP) and the Migration Policy Institute (MPI) to study unaccompanied children's access to medical and mental health services in U.S. communities. It describes the barriers they face and the promising practices that some regions have adopted to facilitate their care. The report concludes with a set of evidence-informed recommendations for governments, health systems, schools, and communities that—if implemented—would substantially strengthen medical and mental health services for unaccompanied children in the United States.

The findings and recommendations presented here reflect themes that emerged during discussions with more than 100 individuals who shared their experiences and expertise with AAP and MPI researchers in 2022. The AAP-MPI team visited three U.S. cities that have either consistently received among the highest numbers of unaccompanied children (Houston, TX, and Los Angeles, CA) or have seen a noteworthy increase in arrivals in recent years (New Orleans, LA). In each location, the team convened roundtable discussions to learn about children's experiences seeking health care and what would help them access care more easily. Roundtable participants were a diverse array of professionals—including medical and mental health clinicians, social workers, post-release services caseworkers, education professionals, legal service providers, and representatives of community organizations and local governments—as well as young

adults who came to the United States as unaccompanied children. The team also conducted interviews with key informants across the United States, including leaders of organizations with a particular focus on unaccompanied children, state Medicaid officials, and other experts.

Across these conversations, there was a clear consensus that the barriers unaccompanied children face to accessing needed medical and mental health services are significant and stem from multiple causes, but also that there are implementable changes that can and are being made across the United States to address these barriers. The policy and practice changes this report recommends would have a direct, positive impact on the health of unaccompanied children and society as a whole.

2 Unaccompanied Children and the U.S. Health Care System

An unaccompanied immigrant child is an individual who has no lawful immigration status in the United States, is under 18 years of age, and does not have a parent or legal guardian immediately present and able to care for them when they enter the United States.¹ However, most have a parent, legal guardian, or close adult family member in the United States.

Since fiscal year 2012, more than 600,000 unaccompanied, newly arrived children have entered the care of the Office of Refugee Resettlement (ORR), a division of the U.S. Department of Health and Human Services (HHS).² These are typically adolescents, although some younger children arrive unaccompanied as well; nearly three-quarters of those who arrived in fiscal years 2012–22 were between 15 and 17 years of age and slightly more than 15 percent were ages 12 and under. The vast majority come from Guatemala, Honduras, and El Salvador and arrive in the United States after crossing its southern border. Unaccompanied children undertake the treacherous journey to the United States due to a variety of factors, such as gang violence and recruitment, child abuse and/or neglect, extreme poverty, persecution due to sexual orientation or gender identity, and domestic violence, among others.³ Other motivations may include a desire to reunify with a parent or parents already living in the United States and/or to seek educational opportunities, economic potential, and safety.

When unaccompanied children first enter the United States, they are usually taken into custody by Customs and Border Protection (CBP), under the Department of Homeland Security (DHS).⁴ Within 72 hours of placement in a CBP processing facility, unaccompanied children should be transferred to ORR,⁵ which is responsible for their care while in government custody.⁶ As of early 2023, ORR operated a network of

1 *Homeland Security Act of 2002*, 6 U.S. Code §279(g).

2 U.S. Department of Health and Human Services (HHS), Administration for Children and Families (ACF), Office of Refugee Resettlement (ORR), “[Fact Sheets and Data](#),” updated February 24, 2023.

3 United Nations High Commissioner for Refugees (UNHCR), Regional Office for the United States and the Caribbean, *Children on the Run: Unaccompanied Children Leaving Central America and Mexico and the Need for International Protections* (Washington, DC: UNHCR, 2016).

4 William A. Kandel, *Unaccompanied Alien Children: An Overview* (Washington, DC: Congressional Research Service, 2021).

5 *Trafficking Victims Protection Reauthorization Act* (TVPRA) of 2008, 8 U.S. Code §1232(b). But note that unaccompanied children from Mexico or Canada may be returned to their countries of origin if they meet criteria specified in TVPRA, 8 U.S. Code §1232(a)(2).

6 *Homeland Security Act of 2002*, 6 U.S. Code §279(g).

approximately 300 programs in 27 states that provide housing, food, clothing, health care, education, recreation, case management, and access to legal services.⁷ Most unaccompanied children are placed in congregate care environments (also termed shelters, in certain contexts); however, some are placed in specialized facilities due to significant medical and/or mental health needs, and others enter a limited number of federal foster care placements. ORR also operates temporary facilities, such as influx care facilities or emergency intake sites, when the number of unaccompanied children arriving exceeds the capacity of the programs described above.

The average length of stay in ORR's care was around one month in 2022.⁸ During this time, ORR works to find and vet a sponsor for the unaccompanied child, typically a parent, other relative, or family friend with whom the child will live while pursuing immigration relief.⁹ Sponsors must undergo background checks to help ensure the unaccompanied child's safety upon release from ORR to the sponsor.¹⁰

A. *The Health Needs of Unaccompanied Children*

Most unaccompanied children are physically healthy, requiring only routine preventive health care recommended for all children their age as well as intermittent acute care for the occasional common childhood illness or injury. However, a small percentage of children require more specialized health care, either for a known condition diagnosed prior to their arrival or for a condition newly diagnosed in the United States. Since nearly all unaccompanied children arrive from countries with limited health infrastructure (with the exception being that most have strong early childhood vaccination programs¹¹), few have received the recommended newborn screening, regular well child check-ups, or routine dental care that are standard in the United States. This can lead to a greater likelihood that asymptomatic conditions were not tested for or discovered while in their country of origin and may first be diagnosed in the United States.

In terms of mental health, it should be expected that all unaccompanied children have experienced trauma to some degree—whether in their home country, along the journey, at the border, in the United States (in federal custody and/or in communities), or a combination of the above—and their higher rates of anxiety, depression, and post-traumatic stress disorder (PTSD) compared to U.S.-born children reflect that.¹² Furthermore, establishing a new life in the United States can be difficult, in complex and unexpected ways. Learning a language, living with a sponsor the child may not have seen for a long time (or ever), attending an unfamiliar school, and other aspects of being an immigrant and newcomer to a community can all be significant stressors with the potential to create or exacerbate existing needs for mental health care.

7 ORR, "ORR Influx Care Facilities for Unaccompanied Children" (fact sheet, April 7, 2023).

8 ORR, "Fact Sheets and Data." But note that the average length of stay is significantly longer for children who receive certain placements, such as long-term foster care.

9 ORR, "2.4 Sponsorship Assessment Criteria and Home Studies," *ORR Unaccompanied Children Program Policy Guide*, updated March 15, 2016.

10 ORR, "2.5 Sponsorship Assessment Background Check Investigations," *ORR Unaccompanied Children Program Policy Guide*, updated January 18, 2019. See also Rob Portman, *Federal Care of Unaccompanied Children: Minors Remain Vulnerable to Trafficking and Abuse* (Washington, DC: U.S. Senate, Committee on Homeland Security and Governmental Affairs, 2022).

11 United Nations Children's Fund (UNICEF), "Immunization," updated July 2022.

12 Manuel Paris et al., *Vulnerable but Not Broken: Psychosocial Challenges and Resilience Pathways among Unaccompanied Children from Central America* (New Haven, CT: Immigration Psychology Working Group, 2018); Jodi Berger Cardoso, "Running to Stand Still: Trauma Symptoms, Coping Strategies, and Substance Use Behaviors in Unaccompanied Migrant Youth," *Children and Youth Services Review* 92 (September 1, 2018): 143–52.

B. *Medical and Mental Health Services While in Federal Custody*

When unaccompanied children are in CBP custody, they receive a rudimentary health intake interview to determine if they have any urgent medical, mental health, or dental needs or contagious illnesses such as lice, scabies, or varicella (also known as chickenpox), followed by a medical assessment.¹³ The screening should identify children with ongoing medication or special custodial needs. Any child with an urgent condition is transported to a local emergency room for evaluation and treatment, while children considered to have nonurgent infestations, infections, or injuries are treated at the CBP facility.

In contrast to CBP, ORR provides more comprehensive health services for unaccompanied children (in all facilities except the emergency intake sites operated in 2021 and 2022, where services were more limited). Upon transfer to ORR, children receive an initial medical examination (IME) within two business days.¹⁴ The IME consists of a medical history and physical examination—similar to a standard annual physical for children and adolescents in the United States—as well as a psychological assessment.¹⁵ Any necessary medications are prescribed at that time, including new treatments as well as replacements for chronic medications that were finished, lost, or confiscated by CBP.¹⁶ Furthermore, the full complement of vaccinations recommended by the Centers for Disease Control and Prevention are given and a routine laboratory screening is performed (in addition to laboratory testing needed to evaluate any issues arising during the medical history and physical examination). All unaccompanied children are tested for tuberculosis, and those 13 years of age or older are also tested for HIV. All females ages 10 and older receive urinary pregnancy testing as well. Any medical or mental health concerns identified during the IME are addressed by the shelter’s primary care provider (which may be on site or in the community) or referred out to the appropriate pediatric specialist, as needed. In addition, routine group counseling and limited individual counseling are provided while the child is in ORR custody.¹⁷

During their time in federal custody, medical and mental health services are paid for via ORR’s third-party contractor.¹⁸ ORR is also the medical decision-making authority (as are, by extension, the shelter providers or foster parents), although they recommend, when appropriate and feasible, the involvement of potential sponsors, other family members (including those still in the child’s country of origin), and unaccompanied children in making medical decisions.¹⁹ To ensure children with complex health care needs receive proper care while in ORR custody, facilities are supported by pediatric medical and mental health clinicians employed by ORR at its headquarters office.²⁰

13 *Flores v. Meese*, No. CV 85-4544-DMG (U.S. District Court for the Central District of California, Juvenile Care Monitor Report, January 2023), 26–28.

14 ORR, “3.4.2 Initial Medical Examination,” *ORR Unaccompanied Children Program Policy Guide*, updated January 24, 2016.

15 ORR, “Section 3.4.2 Initial Medical and Dental Examinations,” in *The UAC Manual of Procedures (UAC MAP)*, Version 2.0 (Washington, DC: ORR, 2021).

16 *Flores v. Meese*, No. CV 85-4544-DMG (U.S. District Court for the Central District of California, Juvenile Care Monitor Report, January 2023), 26–28.

17 For limitations on therapy provided to children in ORR facilities, see HHS Office of Inspector General, *Care Provider Facilities Described Challenges Addressing Mental Health Needs of Children in HHS Custody* (Washington, DC: HHS Office of Inspector General, 2019).

18 ORR, “Section 3.4.9 Provider Reimbursement,” in *UAC MAP*, Version 2.0 (Washington, DC: ORR, 2021).

19 ORR, “Medical Services Requiring Heightened ORR Involvement” (policy memorandum, September 29, 2020).

20 This team is called the Division of Health for Unaccompanied Children. See ORR, “Health and Safety,” updated March 11, 2021.

During an unaccompanied child’s release to a sponsor, the transition of their care to community-based providers and continuity thereafter are critical, especially if the child has medical or mental health needs beyond routine care. For children with special health care needs, case managers may require sponsors to schedule follow-up health care appointments before the child can be released from ORR custody.²¹ Sponsors are generally responsible for this activity, although case managers or ORR’s pediatric clinicians may become involved as well. However, when unaccompanied children have no specific health needs beyond routine care and vaccination follow-up, sponsors may not be given any information related to the child’s health and need for ongoing care, or they may receive only a list of community health centers in their area. This list—along with a copy of the IME, list of vaccinations given, laboratory results, and (if applicable) radiology reports, hospital admission notes, and discharge summaries—is included in the large packet of English-language documents given to the sponsor when they assume responsibility for the child.

When unaccompanied children have no specific health needs beyond routine care and vaccination follow-up, sponsors may not be given any information related to the child’s health and need for ongoing care.

Although many children receive no further support from ORR after they leave federal custody, medical or otherwise, some are offered federally funded post-release services (PRS), which can include in-person visits, needs assessments, and referrals to community providers.²² While these services have typically lasted for only 90 days, children with certain vulnerabilities or those facing particular risks—including those with a disability—receive them until their immigration proceedings conclude or they turn 18 years old.²³ This additional case management can be helpful for children with complex health conditions, though there are often long waitlists to receive PRS. As of early 2023, ORR was piloting revisions to its PRS program.

C. *Health Care Coverage and Financial Assistance*

Most unaccompanied children do not have health insurance when they are released from ORR’s care. Their coverage through ORR’s third-party contractor ends when they leave HHS custody, and they generally do not qualify for federally funded programs such as Medicaid and the Children’s Health Insurance Program (CHIP)—the two principal health benefit programs for children living in low-income households.²⁴

Some states have taken up an option that makes certain unaccompanied children eligible for federally funded health care coverage. Section 214 of the 2009 *Children’s Health Insurance Program Reauthorization Act* (CHIPRA) included a provision allowing states to extend Medicaid/CHIP coverage to income-eligible children considered to be lawfully residing in the country.²⁵ This includes children under 14 years old whose asylum applications have been pending for at least 180 days, child asylum applicants ages 14 years and

21 Migration Policy Institute (MPI) and American Academy of Pediatrics (AAP) researcher email correspondence with ORR, April 8, 2022.

22 For a more detailed description of ORR’s post-release services program, see Mark Greenberg et al., *Strengthening Services for Unaccompanied Children in U.S. Communities* (Washington, DC: MPI, 2021).

23 ORR, “6.2.3 Timeframe for Post Release Services,” *ORR Unaccompanied Children Program Policy Guide*, updated September 5, 2018. In the post-release service model being piloted at the time of writing, the service window was extended from 90 to 180 days.

24 Valerie Lacarte, *Immigrant Children’s Medicaid and CHIP Access and Participation: A Data Profile* (Washington, DC: MPI, 2022).

25 Letter from HHS, Center for Medicare and Medicaid Services (CMS), to state health officials, “Medicaid and CHIP Coverage of ‘Lawfully Residing’ Children and Pregnant Women,” July 1, 2010.

older who have a work permit, and children who have a pending application for Special Immigrant Juvenile Status. As of early 2023, 34 states and the District of Columbia had adopted the CHIPRA §214 provision.²⁶ However, even in states that have done so, the option may be underutilized because not all children who are eligible apply.

Meanwhile, a smaller number of states have elected to provide health care coverage to children regardless of immigration status. These programs use exclusively state funding and are not subject to federal restrictions. Unaccompanied children who meet the programs' income and residency criteria are eligible for coverage in California, Colorado (by 2025), Connecticut (for children enrolled before turning 13 years old), the District of Columbia, Illinois, Maine, Massachusetts, New Jersey, New York, Oregon, Rhode Island, Vermont, and Washington.²⁷

Unaccompanied children who are not eligible for federal or state health insurance programs and do not have private insurance may be able to obtain free or lower-cost medical and mental health services through community-based providers. Community health clinics—including federally qualified health centers (FQHCs)—generally aim to provide comprehensive, culturally appropriate health care regardless of a patient's income, insurance status, or immigration status, and their pricing is based on one's ability to pay.²⁸ In addition to primary medical care, health centers may offer onsite mental health and/or dental services,²⁹ but these services often remain difficult to access because the need for them is significantly greater than the available capacity. Additionally, some hospitals and local provider networks may offer financial assistance programs to low-income patients regardless of immigration status. Finally, some sponsors with private insurance may be able to add the child to their existing coverage.

D. The Importance of Medical and Mental Health Services

The gold standard for all children living in the United States is to have a “medical home,” which includes a primary care provider or team that cares for and coordinates all of their health needs and services. The same applies to unaccompanied children, who would all benefit from having a medical home upon their entry into a U.S. community.

Completing a comprehensive medical history and physical in the new medical home is a necessary foundation from which to build, especially since most of the information obtained during the IME while in ORR custody is not readily available to clinicians in the community. Additional vaccines are also likely needed (e.g., second or third doses) to complete all recommended vaccination series and satisfy school entry requirements. Furthermore, screening for mental health concerns, at-risk behaviors (such as substance abuse and sexual activity, as appropriate), and social determinants of health is important. Lastly, AAP recommends testing all foreign-born children for other asymptomatic conditions (beyond the tuberculosis

26 CMS, “Medicaid and CHIP Coverage of Lawfully Residing Children & Pregnant Women,” updated July 9, 2021. No additional states adopted the CHIPRA option through the end of 2022.

27 Kaiser Family Foundation, “Health Coverage of Immigrants,” updated December 20, 2022; Connecticut Department of Social Services, “New State HUSKY A and HUSKY B for Children Health Coverage,” accessed February 3, 2023.

28 Health Resources and Services Administration (HRSA), “What Is a Health Center?,” updated December 2021.

29 National Association of Community Health Centers, *Community Health Center Chartbook 2022* (Bethesda, MD: National Association of Community Health Centers, 2022).

and HIV screening routinely done by ORR), including but not limited to anemia, lead, syphilis, hepatitis B, and parasitic infections. Screening tests based on age and risk factors should also be done, in addition to any laboratory testing needed based on signs and symptoms.³⁰

In addition to an initial well child visit (or, at minimum, establishment of care), unaccompanied children need routine follow-up (and care as needed) within six months to repeat mental health, at-risk behavior, and social determinants of health screenings.³¹ The challenges associated with transitioning to life in a new society and household as well as exposure to trauma often do not manifest immediately, so a return visit is critical to identify new concerns (e.g., substance use, sexual activity, symptoms of mental health conditions) and to continue to address any issues identified at the first encounter. Not only is this care important to achieving and maintaining good health during this cultural transition and in the longer term, but good health can in turn affect the unaccompanied child's ability to participate in their immigration case, with implications for their future.

The challenges associated with transitioning to life in a new society and household as well as exposure to trauma often do not manifest immediately, so a return visit is critical to identify new concerns.

For unaccompanied children with special health care needs (including pregnancy), establishing follow-up with specialty providers (as well as a medical home) prior to release from ORR custody is essential to avoid potentially harmful delays in care. Although it rarely happens, clinicians for unaccompanied children in federal custody would ideally communicate with those assuming care for the child in the community, allowing for continuity of services including medications, laboratory testing, and other treatments.

3 Barriers to Medical and Mental Health Services

Unaccompanied children encounter numerous challenges when seeking medical and mental health services in U.S. communities. These roadblocks are related to ORR policies, problems inherent to the U.S. health care system, difficulties arising from the personal situations of children and their sponsors, and chronic gaps between the supports that unaccompanied children need and the community resources available to them. Because ORR may require children with special health care needs to have their community-based health care arranged before the agency will release them to a sponsor, these barriers not only make it difficult for these children to access necessary care in their new homes—they can also prolong a child's time spent in federal custody. This section discusses these different barriers in turn, drawing on insights shared during the AAP-MPI site visits, roundtables, and key informant interviews conducted as part of this study.

30 Cristina Meneses et al., "Immigrant Child Health Toolkit" (toolkit, AAP, June 2013), e2028–34.

31 Karla Fredricks and Fernando Stein, "Care of the Immigrant Child," *Pediatrics in Review* 43, no. 1 (January 1, 2022): 16–27.

A. *ORR Policies and Procedures*

Limited Pre-Release Health Coordination between ORR, Sponsors, and Community

When unaccompanied children leave ORR care, it is critical that those who will take up responsibility for their well-being are informed about the children's medical and mental health histories and needs. Yet case managers at ORR shelters do not always speak directly with sponsors to discuss post-release medical plans, and ORR does not typically notify its in-custody clinicians that a child will soon be released. Furthermore, ORR does not routinely facilitate a connection between the clinicians caring for unaccompanied children while in custody and those who will assume their care in the community. These communication breakdowns are missed opportunities for sharing vital information with those who need to hear it, thus limiting the continuity of care that children receive.

Overwhelming yet Insufficient Paperwork Provided to Sponsors

In the absence of close coordination between shelter case managers and sponsors, discharge paperwork is the primary way for sponsors to learn about a child's known medical or mental health needs at the time of release from federal custody. However, this material can be overwhelming and difficult to understand. Most of it is in English, which may not be the sponsor's primary language, and is not written in a way that makes it accessible to sponsors of varied literacy levels. The documents may also share only limited medical or mental health information and omit some diagnoses, particularly if they do not require immediate follow-up. This is problematic, as sponsors are left unaware of the child's full range of needs.

The discharge packet also lacks key documentation that could make it easier to access medical and mental health care and other services in the community. The Verification of Release form is the only proof of identity that ORR provides to unaccompanied children—a nonstandard type of identification that may not be recognized as valid, especially if the child's residential address changes. Furthermore, although ORR intends for the Verification of Release to certify the sponsor's custodial responsibilities, it is not always accepted as such. For example, the Verification of Release does not specifically state that sponsors can consent for the child's health care—despite the fact that ORR expects sponsors to have full responsibility for the health and well-being of the child—which can lead some health care facilities to not accept this document as proof of that ability. Additionally, insurance companies may deem the Verification of Release insufficient for establishing guardianship of a child, thereby preventing sponsors from adding the child to their private insurance.

Inadequate Post-Release Supports

Recognizing the significant challenges that can arise after unaccompanied children leave federal custody and the importance of continuity of care, ORR offers some support to forestall the potential harms of disrupted medical and mental health care—but these are frequently insufficient. For instance, children requiring prescription drugs are given a 30-day supply upon release. However, this is often not enough to last until a new appointment can be obtained, especially for mental health conditions.

More generally, although the federally funded PRS that some children receive can help with accessing medical and mental health care, ORR's PRS program faces significant challenges in this regard. Under current

policies, between 20 percent and 40 percent of children have typically received PRS³²—though nearly all children would benefit from it—and waitlists are often six months or more. Moreover, case managers often have caseloads too large to provide the responsive, individualized attention that many children require, and services are often provided remotely in lieu of meeting in person. And although ORR is now piloting a new PRS program, with a goal for all children to receive PRS by 2025, it is unclear how many or which children will qualify for local, in-person case management services, which are not included in the base-level activities of the pilot program.³³ Even if children were to receive this type of case management, it is uncertain whether those efforts (or other changes planned for ORR’s PRS program) will result in more children accessing health services.

Poor Access to Medical Records after Release

Once children establish a medical home in their new community, clinicians typically rely on the discharge packet to learn about their medical and mental health history and experiences in ORR care. If children or sponsors lose the packet or otherwise fail to bring it to appointments, these clinicians have to either proceed without the information or attempt to request it from ORR. This may lead to considerable delays in beginning appropriate treatments or services, since requests for the release of medical information are not processed while the child is in the clinician’s office; ORR reports that medical records requests are generally fulfilled within 40 days.³⁴

For vaccinations, it might be possible to obtain the records through state immunization registries, but the medical teams serving children in ORR custody do not always update these databases. Moreover, even if the state registry is properly updated, if a child is released to a sponsor in a different state than the one in which the vaccinations were received, clinicians in the new state cannot access vaccine records in another state’s registry.

B. The U.S. Health Care Infrastructure

The High Cost of Health Care

Medical and mental health services for individuals without adequate insurance generally exceed their ability to pay out of pocket. Even with sliding scale discounts offered at FQHCs or other financial assistance programs at health care facilities, the fees may be too high for individuals and families.

In non-emergency settings, an inability to pay can result in being turned away, making the emergency department the default source of care for some uninsured or underinsured children. Utilization of the emergency room for primary care is fraught with challenges, including a lack of continuity of care, preventive services, and screening, as well as much higher health care costs.³⁵ Inability to obtain medical and mental health services due to cost may mean that unaccompanied children avoid seeking any services at all until the situation becomes dire.

32 Greenberg et al., *Strengthening Services for Unaccompanied Children in U.S. Communities*.

33 HHS, *Fiscal Year 2024 Justification of Estimates for Appropriations Committees* (Washington, DC: HHS, 2023), 75–76.

34 MPI and AAP researcher email correspondence with ORR, December 14, 2022.

35 Lori Uscher-Pines et al., “Deciding to Visit the Emergency Department for Non-Urgent Conditions: A Systematic Review of the Literature,” *The American Journal of Managed Care* 19, no. 1 (January 2013): 47–59.

Restrictive Requirements for Health Insurance Coverage or Financial Assistance

Pathways for unaccompanied children to obtain health insurance are limited. Most are not released to sponsors in the 11 states (plus the District of Columbia) in which, as of early 2023, children can be eligible for public insurance programs regardless of immigration status (see Section 2.C.).³⁶ Some may become eligible for Medicaid or CHIP if they live in a state that has adopted CHIPRA §214. However, children who qualify under CHIPRA §214 on the basis of asylum or Special Immigrant Juvenile Status applications will usually not be eligible immediately after release from ORR. And attorneys, social workers, benefits specialists, and other professionals who advise sponsors and unaccompanied children may not even know that this option exists.

Beyond immigration-status-based restrictions on eligibility, other requirements can also serve as barriers to enrollment of unaccompanied children in health insurance or patient assistance programs. This may include a need for technology access if applications are only available online and the need to provide proof of income and place of residence. Sponsors may not be able to produce pay stubs—the most accepted form of proof of income—and a note from their employer may not be acceptable or possible to obtain. Proof of residence (or length of residence) in a particular state may also be a challenge, especially if bills or a mortgage/lease are not in the sponsor’s name. Even proper identification can be a barrier, since some assistance programs require specific forms of ID such as a driver’s license; other types, such as a voter ID card from one’s country of origin, may not be accepted. As of March 2023, only nineteen states and the District of Columbia have enacted legislation allowing individuals without immigration status to obtain a driver’s license or state ID.³⁷ Finally, even when unaccompanied children and their sponsors are able to apply for these programs, the time it takes for a submitted application to be reviewed and approved can delay these children’s access to care.

Clinician Workforce Shortages

When unaccompanied children seek medical and mental health services, they often discover that they cannot find an appropriate clinician or make a timely appointment. This problem is particularly acute for mental health, dental, and other forms of specialty care. Although clinician shortages exist in many cities that have relatively large health care infrastructures overall, they are even worse in rural areas.³⁸ Furthermore, smaller cities and rural areas may not have FQHCs

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³⁶ In fiscal year 2022, only 24 percent of the 127,447 unaccompanied children released by ORR joined sponsors in the nine states plus DC with state-funded insurance programs that did not consider immigration status. Note: State-funded plans in Maine and Vermont began accepting children regardless of immigration status on July 1, 2022, but releases to these states for the full fiscal year are included in the calculation above. Connecticut’s and New Jersey’s state-funded programs began in January 2023 and are not included. Author calculations based on data from ORR, “Unaccompanied Children Released to Sponsors by State,” updated March 9, 2023, and Kaiser Family Foundation, “Health Coverage of Immigrants.”

³⁷ National Conference of State Legislatures, “States Offering Driver’s Licenses to Immigrants,” updated March 13, 2023.

³⁸ Robert J. Vinci, “The Pediatric Workforce: Recent Data Trends, Questions, and Challenges for the Future,” *Pediatrics* 147, no. 6 (June 2021): e2020013292; Committee on Pediatric Workforce, “Pediatrician Workforce Policy Statement,” *Pediatrics* 132, no. 2 (August 2013): 390–397; American Academy of Child and Adolescent Psychiatry, “Severe Shortage of Child and Adolescent Psychiatrists Illustrated in AACAP Workforce Maps” (news release, May 4, 2022); Ashley Abramson, “Children’s Mental Health Is in Crisis,” American Psychological Association, January 1, 2022.

or other low-cost, primary care facilities, and any region may have a limited number of health care options that accept Medicaid or CHIP. As a result, there are often long waiting lists to access care, especially for those offering linguistically accessible, trauma-informed, and/or low-cost services. Apart from waiting lists, appointments may not be available when needed, such as in the evenings and on weekends, and there may be no option to obtain a walk-in appointment the same day. Moreover, appointments may not be available in the frequency needed—for example, weekly or biweekly—which is a major barrier for services involving regular follow-up, such as counseling or physical therapy.

Additionally, payment structures may not facilitate family-based therapy, even where that is the recommended approach. Although sponsors may require help to navigate the experience of reunification, funding for mental health services may be tied to therapy for the child alone.

Language and Cultural Barriers

There are numerous laws and regulations intended to ensure that language and cultural barriers do not prevent patients from accessing health care services, at both the federal and state/local levels.³⁹ Nevertheless, such barriers persist.⁴⁰

Language and cultural barriers can directly affect the accessibility and quality of care. When unaccompanied children and sponsors encounter language barriers when speaking with a clinic’s frontline staff and/or medical team, this limits their ability to convey their health concerns and understand the explanations and instructions they receive. Likewise, clinicians need to be able to communicate with sponsors and unaccompanied children effectively, not only with appropriate linguistic skills but also an appreciation for any cultural factors affecting what children and sponsors disclose. This is particularly critical during mental health care. Clinicians who cannot read medical records in the language of a child’s home country will lack a more comprehensive understanding of the medical services the child received prior to arrival in the United States, and certified medical translations of the documents may be difficult to obtain.

For clinicians who do not speak the same language as their patient, the required standard of care is to use a medically certified interpreter. While this service can be provided in person, telephonically, or by video, it may be unavailable for a variety of reasons. First of all, due to a lack of insurance payment for this service, it may be difficult to make interpretation a financially sustainable part of a facility. And even when interpretation services are available in general, there may be no interpreters available who speak the preferred language of the child and sponsor (a particular problem for Indigenous languages and others

39 As established by Title VI of the *Civil Rights Act*, and clarified through President Clinton’s Executive Order 13166, all providers of federally funded services should offer meaningful language access to individuals with limited English proficiency. Furthermore, Section 1557 of the *Affordable Care Act* (ACA) prohibits discrimination on the basis of national origin—which includes discrimination on the basis of languages spoken—in certain health programs and activities. Though regulations interpreting Section 1557 have changed over successive promulgations, this generally means that health care facilities receiving federal financial assistance—including Medicaid, Children’s Health Insurance Program (CHIP), and most Medicare payments—must take steps to ensure language is not a barrier for any patient. See Katie Keith, “HHS Proposes Revised ACA Anti-Discrimination Rule,” *Health Affairs Forefront*, July 27, 2022; Jacob Hofstetter, Margie McHugh, and Anna O’Toole, *A Framework for Language Access: Key Features of U.S. State and Local Language Access Laws and Policies* (Washington, DC: MPI, 2021).

40 Jessica Himmelstein et al., “Health Care Spending and Use among Hispanic Adults with and without Limited English Proficiency, 1999–2018,” *Health Affairs* 40, no. 7 (July 2021): 1126–34.

not commonly spoken in the United States). Furthermore, interpretation may only be offered during the appointment itself, and not during interactions with administrative staff or other service lines such as laboratories. In terms of telemedicine visits, the technical platform used may simply not have an option to include a remote interpreter.

Lack of Awareness of Best Practices for Working with Unaccompanied Children

Clinicians who frequently work with unaccompanied children become familiar with their medical and mental health care needs and how best to meet them. However, others may be unaware of best practices for working with this population. For instance, they may not conduct interviews about the child's medical history or physical examinations in a trauma-informed manner, or they may not realize that certain screenings or laboratory tests need to be done. The care plans they craft may also be suboptimal; for example, they may omit follow-ups to assess how things are going during the transition into the sponsor's home. Lastly, they may not know how to help these children acquire insurance or financial assistance, or where to refer them for additional services offered for free or at reduced costs.

Unwelcoming Environments

The perception an unaccompanied child and sponsor have of how welcoming a health facility is plays a large role in whether or not they will return for future care. Facilities that do not display signage in the language(s) their patients prefer, make little to no attempt to communicate in a patient's language of preference, do not explain policies and protocols well, or fail to offer a clear, affordable pathway to care for the uninsured or underinsured are often perceived as unwelcoming. In addition, interpersonal interactions throughout the visit—including those with front desk staff, clinicians, medical assistants, nurses, social workers, referral coordinators, benefits specialists, laboratory technicians, and others—shape the experiences of unaccompanied children and their sponsors as well. Negative verbal or nonverbal cues from those working in a health facility can also lead unaccompanied children and sponsors to seek care elsewhere (thus disrupting continuity of care) or cause them to avoid future care entirely.

C. Individual and Immigration-Related Circumstances

Limited Health Literacy and Logistical Barriers

Unaccompanied children are often unfamiliar with the health care system and recommended health guidelines in the United States. The same may be true of their sponsors, especially if they are young adults or newcomers themselves. Due to this limited health literacy, children and sponsors may be unaware of available health resources for noncitizen children, may not appreciate the importance of preventive or health supervision visits, or may not recognize that not receiving certain care, such as vaccines and physicals, can affect school enrollment or activities such as sports participation. Some may be more accustomed to seeing traditional healers than clinicians, particularly if they are Indigenous.

Children and sponsors may also be unsure how to obtain health care when the child needs it. The complexity of the U.S. health care system is daunting, and language and literacy barriers make it difficult to learn how to navigate it. When medical or mental health problems arise, families may be uncertain where to go—to the local clinic, to urgent care, to the emergency room, or elsewhere—or what to say when they get there. Cultural differences can also be a barrier; for instance, families may never have had to make appointments in their countries of origin, having only visited health care facilities that operated on a walk-in basis. Unaccompanied children may not know how to use an insurance card, that they must bring their ORR discharge packet to appointments, or that sponsors are required to attend most of a minor child’s health visits, including for vaccinations.

The complexity of the U.S. health care system is daunting, and language and literacy barriers make it difficult to learn how to navigate it.

Logistical barriers may also get in the way. Due to their school or work schedules, unaccompanied children and sponsors may be unable to visit health care facilities during typical working hours. Furthermore, travel to and from the clinic can be both expensive and time-consuming. Transportation is especially challenging if unaccompanied children and sponsors do not have a driver’s license or access to a car and the health facility is not located on a public transportation route or within walking distance of their home.

Common Fears and Hesitation to Seek Care

Fear may cause unaccompanied children and sponsors to hesitate to seek medical or mental health care, even when they know it is important. This hesitation is often grounded in worries about cost, language access, and/or immigration-related issues.

Families may have specific fears that accessing public health benefits or other subsidized care could lead to them being labeled a “public charge”—that is, likely to become dependent on the government for their subsistence—which could make it difficult to obtain a green card in the future.⁴¹ However, Medicaid and CHIP benefits for children have always been excluded from public-charge calculations (except for long-term institutional care). Moreover, other forms of support to reduce medical costs, such as provider-network financial assistance programs and FQHCs’ sliding scale fees, have never been included in public-charge determinations. Nevertheless, some unaccompanied children and sponsors still choose not to utilize benefits and services for which they are eligible, due to fear that it might negatively impact the child’s or sponsor’s immigration case.

Additionally, unaccompanied children and sponsors may generally avoid engaging with public health or other government-connected systems due to concerns about immigration enforcement. Although unaccompanied children have temporary permission to remain in the United States while their immigration case is being adjudicated, members of their household may not have immigration status. Thus, some sponsors may encourage unaccompanied children to avoid drawing attention to the household by not

41 For more on impacts of public-charge policies and additional observations regarding the 2022 final rule on public charge, drawn from the same AAP-MPI research as this report, see Jonathan Beier and Essey Workie, “[The Public-Charge Final Rule Is Far from the Last Word](#)” (commentary, MPI, September 8, 2022). For a concise summary of current public-charge policies, see Protecting Immigrant Families, “[Does Public Charge Apply to Me?](#)” (fact sheet, January 2023).

applying for health care or other benefits for which they are eligible, or to leave out necessary information from applications, such as a home address. Even if children do apply and are approved for a program, some sponsors may discourage them from using it.

Stigma and Other Complexities Related to Mental Health

Although many unaccompanied children experience anxiety, depression, and PTSD (see Section 2.A.), these conditions often go untreated. This partly arises from structural issues such as a lack of insurance and availability of appropriate services. However, mental health literacy, stigma, and other cultural factors also prevent some unaccompanied children from seeking services. Children's untreated trauma and other mental health challenges not only reduce their quality of life but can also affect other aspects of their lives, including their ability to attend school, maintain friendships, or participate in activities of daily life. Untreated mental health conditions can also make it difficult for unaccompanied children to make appointments and obtain health care more broadly.

Unaccompanied children may choose not to disclose mental health issues for a number of reasons. Doing so could be met with stigma by friends and family. Family members may also downplay any mental health challenges, insisting that such problems do not happen in their family. Furthermore, sponsors may have untreated trauma themselves, which can affect how they respond to issues the child raises. If children and sponsors do not report mental health concerns to their clinician, they may be unaware of treatment options and the possibility of improvement. Additionally, unaccompanied children may not speak about their mental health struggles to avoid bringing shame or other social repercussions upon their family, or because they do not want to add stress to their sponsors. Finally, religious beliefs may lead people in some communities to view mental health problems as resulting from a lack of faith or even punishment for perceived wrongdoing, which creates additional stigma and feelings of blame.

Challenges of the Unaccompanied Child–Sponsor Relationship

Like all minors, unaccompanied children require adult caregivers who will support them when medical and mental health issues arise, both on a personal level and in the practical steps involved in seeking health care. This dependency is not always easy to accept, particularly for older children who may be accustomed to having greater agency in their countries of origin. Some sponsors may also not embrace their responsibility to the child, especially if they do not have a close relationship or the sponsors are young adults themselves. These dynamics are further complicated by the fact that joining a sponsor's household—even if the sponsor is one's own parent—can itself be a challenging process. Children may feel resentful of parents who left them in their home country, particularly if they subsequently experienced trauma, while parents may feel angry if they do not believe their children appreciate the sacrifices they have made for them.

Strains in the relationship between unaccompanied child and sponsor can become barriers to the child's medical and mental health care access when they prevent essential communication from happening.

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Unaccompanied children may be particularly uncomfortable talking to their sponsors about stigmatized or personal issues such as mental health, reproductive health care, being a member of the LGBTQ+ community, or a history of sexual assault. When children and sponsors must build or rebuild their relationships while simultaneously dealing with these additional challenges, it makes it more difficult to overcome them.

Even more complications occur when sponsor placements fail, prompting the unaccompanied child to leave the sponsor's household to live elsewhere, become homeless, or enter the domestic child welfare system, which may not be equipped to address the unique circumstances of this population. Even if unaccompanied children move in with a responsible, caring adult, these new, unofficial sponsors will typically not have access to the guidance and documentation that ORR provided to the original sponsor. Additionally, the new caregiver may not be legally able to provide consent for medical or mental health care.

D. Community Factors

Limited Number of Nonmedical Providers with the Necessary Knowledge and Skills

Nonmedical service providers, including attorneys, teachers, social workers, and others, can play a critical role in supporting children's well-being, including ensuring they have access to medical and mental health services. However, like clinicians, there are too few individuals within the wider network of organizations involved in unaccompanied children's lives that have appropriate linguistic and cultural skills, training in trauma-informed practices, or a detailed understanding of their situation. This is especially common in regions that do not frequently receive unaccompanied children.

Due to both workforce limitations and a general lack of resources, organizations doing vital work may depend on the contributions of a small number of extraordinary individuals. For example, a school social worker may use their off-hours to meet families in their homes or escort children to a clinic. In other instances, a single employee's success in making referrals and helping children obtain appointments may depend on personal relationships cultivated to compensate for the lack of a formal, efficient system. These arrangements are tenuous, however, and risk the loss of practical knowledge and professional networks if key individuals were to leave their positions.

Schools Not Sufficiently Resourced to Support Unaccompanied Children's Health and Well-Being

Schools hold great potential for increasing unaccompanied children's access to medical and mental health services (see Section 4.A., "School Programming and Resources"). School registration may be the first opportunity to help these children enter the community's health care system after leaving ORR facilities, since additional vaccines may be required before enrollment can be completed. However, if the school does not have a partnership with a community health organization to provide free or low-cost medical services (either on site or near the school), children may go elsewhere to obtain vaccines only and the opportunity is lost to connect them to more comprehensive health services. In addition, although registration or soon after enrollment is an excellent time to screen for needs related to the social determinants of health and initiate appropriate referrals to resources, this does not routinely occur in all school districts. Lastly, schools may not have the ability to conduct school- and community-wide events throughout the year, thus missing the

chance to provide vital information and resources to children who enroll outside of the traditional back-to-school time frame (as unaccompanied children often do).

Attending school as a newcomer can also be stressful in and of itself, in ways that may lead to a worsening of a child’s mental health. If the school is not able to conduct a detailed evaluation of the student’s education level, initial grade-level placements may be inappropriate if based solely on age, particularly for older children whose education has been disrupted for multiple years. Additionally, insufficient staffing or resources may lead to delays in receiving necessary services or supports, thus prolonging situations that prevent children from thriving. For instance, schools may not be able to evaluate students for learning challenges in a timely fashion if the schools lack the appropriate language services to conduct the assessment in a language other than English and cannot communicate with sponsors and children in their language of preference.

4 Promising Practices

In some U.S. communities, local governments, schools, and community-based organizations have developed ways to help unaccompanied children overcome some of the barriers they face when seeking care. These practices, described by local stakeholders during the AAP-MPI roundtables and in expert interviews, include supports to smooth the transition out of ORR custody and specific changes that health care systems are implementing to make their services more accessible. Building trust and facilitating communication with children and their sponsors are essential ingredients of this work.

A. *Communities, Schools, and Local Governments Helping to Smooth Children’s Transition from ORR to a Sponsor*

Multidisciplinary Coalitions

When organizations serving unaccompanied children and sponsors in a particular region or locality form multidisciplinary coalitions, they can dramatically improve the efficiency and impact of their work. Community-based coalitions may include social workers, education professionals, legal service providers, federally funded PRS providers, clinicians, representatives from local government, and others working with unaccompanied children.⁴²

By increasing communication and coordination between organizations and across disciplines, coalitions can facilitate referrals and increase service utilization. When coalitions meet regularly, organizations can share updates on their current capacity and consult on the best way to help individual children access their services—a more streamlined process than if a social worker or case manager has to seek this information through more formal channels, not even knowing which organization might have appointments available. Additionally, tighter connections between organizations build a familiarity that can increase children’s and

⁴² For examples of community-based coalitions of organizations serving unaccompanied children, see Table A-1 in Jonathan Beier, Lauren Farwell, Rhonda Fleischer, and Essey Workie, *Four Strategies to Improve Community Services for Unaccompanied Children in the United States* (Washington, DC and New York: MPI and UNICEF, 2022).

sponsors' comfort with a referral, as one trusted provider can reassure families that they know the staff at the referred organization and guarantee they will have the child's best interests in mind.

Communities benefit when coalition members combine resources and expertise to host events for unaccompanied children and sponsors, such as educational forums to deliver important health and well-being messages and services in a trusted manner. Even events not explicitly focused on medical or mental health issues can bring unaccompanied children into community with others, thereby contributing to a smoother transition and better mental health. Furthermore, coalitions have strength in numbers to advocate at the regional, state, and national levels for policies that protect the rights of unaccompanied children and improve their access to medical and mental health care. Box 1 offers an example of one such community-based coalition's initiative to establish and build recognition for an alternative form of identity documentation available to nearly all community members.

BOX 1

The Enhanced+ Library Card in Harris County, Texas

In Houston, TX, a coalition consisting of county public libraries, community organizers, legal service providers, and other immigrant-serving organizations and individuals came together to develop a new form of identification available to nearly all members of the community, including children and adolescents. The Harris County Enhanced+ Library Card is not only a full-service library card, it is also a verified photo ID. The Enhanced+ Library Card is free, takes only 15–20 minutes to obtain at one of the Harris County full-service library locations, and is good for five years (with an option to renew). The card includes an individual's name, address, photograph (taken at the time of application), and other personal information. When applying, there is a long list of types of documents that are considered acceptable proof of identity and residence in Harris County, which should allow nearly everyone who lives there and desires an Enhanced+ Library Card to obtain one.

The coalition continues its advocacy to ensure that the Enhanced+ Library Card is accepted everywhere a photo ID is needed, including within health care systems and by the police department. This is particularly important for unaccompanied children and sponsors in a state such as Texas, where they may be unable to obtain a driver's license or other state ID. In those situations, a lack of accepted identification could preclude them from obtaining the child's necessary medical and mental health services.

Source: Harris County Public Library, "Enhanced+ Library Card FAQs," accessed March 13, 2023.

School Programming and Resources

All school-age children in the United States have the right to a public K-12 education, regardless of their immigration status.⁴³ This means that schools are in a unique position to provide supports and services to unaccompanied children that go beyond their traditional educational mission, either directly or through connections to other resources in the community.

Schools have opportunities to support unaccompanied children's medical and mental health starting from their first interaction: enrollment. Since children and sponsors are informed that a child must register for

⁴³ *Plyler v. Doe*, No. 80-1538, 457 U.S. 202 (U.S. Supreme Court, June 15, 1982).

school as soon as possible after leaving ORR custody, schools are often one of the first institutions with which almost all come into contact. This is an opportunity for school staff to also assess their broader needs, inform them of resources, and provide referrals, including for medical and mental health services. This may be done concurrently with enrollment or soon afterward, as the child meets with wraparound specialists or others designated by schools to identify and address their holistic needs.

Additional services are sometimes provided within the school or at centralized locations—though care should be taken to ensure that services offered off school grounds remain close by and accessible via public transportation. For example, the Los Angeles Unified School District’s School Enrollment Placement and Assessment Centers provide a broad array of services in a single location (see Box 2).

BOX 2

The Los Angeles Unified School District’s School Enrollment Placement and Assessment Centers

The Los Angeles Unified School District operates two School Enrollment Placement and Assessment (SEPA) Centers in the Los Angeles, CA region. SEPA Centers are physical locations that provide initial services for newcomer children and youth, such as individualized assistance to enroll in school and access additional supports. SEPA Center staff help students and families with limited English or literacy skills understand and complete school enrollment forms and benefits applications; conduct school physicals, including the administration of immunizations; assess students and families for trauma and provide mental health interventions and referrals; and facilitate connections with social and legal service resources, as needed. Furthermore, the district’s Children’s Health Access and Medi-Cal Program (CHAMP) is offered at SEPA Centers to help children, families, and community members obtain health insurance coverage through programs such as Medi-Cal (California’s Medicaid). These services are enhanced by the fact that SEPA Center staff frequently work with unaccompanied children and are familiar with ORR policies and facilities.

Importantly, SEPA Center programming also capitalizes on the opportunity to improve families’ health literacy, such as through workshops explaining the difference between preventive, primary, urgent, and emergency care. They are staffed by a multidisciplinary team including a pupil services and attendance counselor, psychiatric social worker, school nurse/nurse practitioner, health care advocate, school and family resource navigator, and interpreter aides. For those who have to travel far to reach one of the two SEPA Centers, staff members help to connect them with community-based navigator programs in their neighborhoods.

Sources: Los Angeles Unified School District (LAUSD), Office of the Chief Medical Director, Student Medical Services and Medi-Cal Programs, “[School Enrollment Placement and Assessment \(S.E.P.A.\) Center](#),” accessed March 31, 2023; LAUSD, Student Health and Human Services, Wellness Programs, “[Children’s Health Access and Medi-Cal Program \(CHAMP\)](#),” accessed March 31, 2023; author correspondence with Dr. Ron Tanimura, LAUSD Director of Student Medical Services and Medi-Cal Programs, February 2023.

Based on children’s needs and a school district’s resources, alternative education structures can sometimes help unaccompanied children adjust to the U.S. public education system. Newcomer programs are one approach that has proven effective in areas receiving significant numbers of newly arrived children. The newcomer program model is defined by the U.S. Department of Education as “separate, relatively self-contained educational interventions designed to meet the academic and transitional needs of newly arrived immigrants.”⁴⁴ These can be operated as separate schools or as schools-within-schools. In addition to grade-

44 U.S. Department of Education, Office for Civil Rights, “[Developing Programs for English Language Learners: Glossary](#),” updated January 16, 2020; National Clearinghouse for English Language Acquisition, “[Programs for Newcomer Students](#)” (issue brief, accessed July 2022).

level learning, newcomer programs offer specialized supports to help students acquire English language skills and address the specific challenges of acculturation, such as counseling and other activities to improve students' mental health. These programs can provide critical assistance to prepare unaccompanied children (and other newly arrived students) to integrate into a mainstream educational setting after a period of transition. However, care should be taken to ensure that immigrant youth who participate in these programs are not put at a disadvantage compared to their peers, stigmatized, or denied services or the opportunity to fully integrate into traditional school settings.⁴⁵

Community-Based Case Management Initiatives

Case management can make an enormous difference in the lives of unaccompanied children and their sponsors. Having an attentive, knowledgeable professional walk them through the process of scheduling and attending health-related appointments as well as address the social determinants of health can go a long way toward ensuring that children receive needed services and know how to continue accessing them in the future.

Because the majority of unaccompanied children do not receive this type of case management through ORR-funded PRS, many community-based organizations have developed their own versions of this type of support. When health facilities, legal service providers, and other unaccompanied-children-serving entities embed case managers within their services, they provide a valuable resource that many families desperately need. Moreover, embedding case management within the broader activities of an organization makes it easier to refer between services, as in-house referrals build on rapport that organizations have already established with children and sponsors.

Having an attentive, knowledgeable professional walk them through the process of scheduling and attending health-related appointments as well as address the social determinants of health can go a long way toward ensuring that children receive needed services.

Government offices at the city, county, and state levels that focus on immigrant youth can be instrumental in providing sustainable funding for these community initiatives. It is particularly helpful when they allow flexibility within their grants so communities can tailor the interventions they provide to the populations they serve. Box 3 describes California's Opportunities for Youth, an innovative pilot project that both provides essential funding and encourages flexibility in how organizations deliver their services.

⁴⁵ Ilana M. Umansky, Megan Hopkins, and Dafney Blanca Dabach, "Ideals and Realities: An Examination of the Factors Shaping Newcomer Programming in Six U.S. School Districts," *Leadership and Policy in Schools* 19, no. 1 (January 2, 2020): 36–59; Julie Sugarman, *Beyond Teaching English: Supporting High School Completion by Immigrant and Refugee Students* (Washington, DC: MPI, 2017).

BOX 3**Tailored Case Management through California's Opportunities for Youth Project**

California's Opportunities for Youth (OFY) pilot project offers trauma-informed and culturally responsive supports to unaccompanied children and their sponsors. OFY is funded and administered by California's Department of Social Services (CDSS), with Kids in Need of Defense (KIND), a nongovernmental organization focused on the protection of unaccompanied and separated children, offering technical assistance to providers. Community-based organizations provide case management, navigation, mentorship, wellness support, and other services. Enrollment continues until children reach 21 years of age—an extended period that allows them to receive support after ORR-funded post-release services end, or even if they never received such services at all.

There are two integral aspects of the project's design that aid its success. First, it is able to adjust its programmatic offerings based on feedback from participating community organizations. KIND, CDSS, and an external evaluator organize forums for providers to share feedback, receive advice and support, and discuss promising practices. For example, feedback from these forums led to the expansion of resources for children's mental health, such as counseling and nonclinical therapeutic activities, as well as staff wellness to build sustainable services for unaccompanied children. Second, the program offers organizations the flexibility to provide services in a manner that is best suited to their strengths and local environment. To illustrate, one provider, Esperanza Immigrant Rights Project in Los Angeles, conducts legal orientations for children and sponsors referred by ORR. Referred families are screened to identify and enroll those who would benefit from the support of Esperanza's three-person OFY team. A case manager, program navigator, and mentor work together with the child and sponsor to support their well-being, including meeting the child's medical and mental health needs. At other OFY providers, staffing arrangements may be different and programming customized based on the community served (e.g., a greater focus on Indigenous children or older adolescents needing assistance with independent living skills).

Sources: California Department of Social Services, "[Opportunities for Youth](#)," accessed April 2, 2023; author correspondence with representatives of KIND and the Esperanza Immigrant Rights Project, February 2023.

B. Health Care Systems Working to Mitigate Barriers to Access

Welcoming, Accessible Medical Homes

There are straightforward ways to work within the current health care system to make services more welcoming for unaccompanied children and sponsors. These begin with how initial appointments are scheduled, which can be facilitated by having a simple scheduling system that does not require the use of advanced technology, as well as ensuring that interpretation services are available. Flexibility is also helpful. Accepting walk-in patients who have not made a prior appointment and offering extended hours on evenings and weekends can make it easier for children and sponsors with busy or unpredictable school or work schedules to be seen. And telehealth options, especially for mental health care, can allow patients to attend appointments without the logistical challenges of getting to the clinic itself. Primary care facilities can also participate in tele-consultation programs where mental health clinicians offer real-time guidance for primary care clinicians on behavioral health such as medication management as well as referrals during a medical visit so that mental health concerns can be addressed in the primary care setting instead of in a separate appointment.⁴⁶

⁴⁶ HRSA, "[Pediatric Mental Health Care Access](#)," updated December 2022.

Upon entry into the health facility, unaccompanied children and sponsors are much more likely to feel welcome if they see themselves reflected in the setting—similar patients in the waiting area, staff from similar ethnic and cultural backgrounds who may be immigrants themselves, signage with text in their language and images of people who look like them, a certified interpreter who speaks their preferred language available in person (ideally) or by phone/video, and child-friendly areas. In addition, it is helpful to have the same clinician (or possibly two clinicians) see the child over repeated visits; this continuity builds rapport and trust. Primary care providers who are part of larger health systems with the same financial assistance program—which may include subspecialty, emergency, and hospital-based care, as well as pharmacy, laboratory, and radiology services—are well suited to care for this population and contribute strongly to continuity of care.

Co-locating health care and other types of providers is another excellent way to make services more accessible and effective. Convenient “one-stop shop” models reduce many of the logistical barriers that unaccompanied children face, as children no longer have to travel to different offices or repeat certain paperwork for different providers. Moreover, having social workers, referral coordinators, benefits specialists, financial counselors, legal service providers, food pantries, medical and mental health clinicians, and other ancillary services together under one roof improves communication among them. This integrated approach can go a long way toward addressing the social determinants of health that can negatively affect children’s well-being. The New Orleans Children’s Health Project, described in Box 4, is one such multidisciplinary provider.

BOX 4

Multidisciplinary Care through the New Orleans Children’s Health Project

The New Orleans Children’s Health Project (NOCHP) embodies the type of multidisciplinary, welcoming medical home that is best suited to meeting the medical, mental health, and social needs of newly arrived immigrant children. At NOCHP, a pediatrician, case manager, immigration attorney, program manager, and behavioral health specialist form the core bilingual team with particular expertise in working with this population. Through the project—a partnership between an academic medical center and a children’s hospital—and its collaboration with a local federally qualified health center (FQHC), patients have affordable access to medical and mental health care as well as any subspecialty services they may require. In addition, they are able to receive free legal services from NOCHP’s dedicated attorney. The case manager screens patients for any needs related to the social determinants of health and, if positive, works with them to ensure they obtain the resources to which they were referred. This could include (but is not limited to) health insurance, food (through the on-site food pantry and other community organizations), financial assistance for subspecialty care, and school enrollment. The program manager coordinates all logistics to keep NOCHP running smoothly, in addition to participating in community outreach and procuring in-kind and monetary donations as needed to continue to serve patients comprehensively.

In a state such as Louisiana that does not extend Medicaid or CHIP eligibility to all low-income children regardless of immigration status, NOCHP models that (with the necessary support, funding, and personnel) newcomer children can still receive appropriate, comprehensive, and well-coordinated care.

Source: AAP-MPI focus group in New Orleans, LA, August 1, 2022.

Bringing Services into the Community

In addition to traditional brick-and-mortar clinics, there are numerous other ways to bring medical and mental health services into the community. For many newly arrived children, health services offered at schools are their first entry into care. School-based clinics that are free of charge, accessible to all students as well as their families, and include a variety of health services (including mental health, reproductive health care, and general medical care) are valuable resources for unaccompanied children and sponsors, who may not have easy access to services elsewhere in their community. Having multiple types of services in the same location not only provides convenience, as discussed above, it can decrease the fear of stigma and discrimination. Because patients could have any number of reasons for seeking care at the clinic, they may find it easier to access more sensitive forms of care (such as mental health services). To ensure the success of this model, a strong partnership between the school and health clinic is essential—especially regarding the importance of obtaining parental or sponsor consent at the time of school registration, so that students can be seen without delay throughout the school year.

In addition to school-based clinics, other easy-to-access service models can further broaden unaccompanied children’s care options. For example, mobile clinics can serve children in a wide range of convenient locations. In some communities, they partner with schools to provide medical, mental health, and/or dental services on their campuses, while others collaborate with community organizations to offer care in additional areas frequented by under-resourced children.

C. *Effective Communication and Trust between Unaccompanied Children, Sponsors, and Communities*

Trust is rooted in human-to-human, in-person connection. For unaccompanied children, trust is deepened when the professionals they encounter understand their cultural background as well as the challenges they are experiencing during their transition to life in the United States.

The most effective way to work with unaccompanied children and sponsors in the community is to meet them where they are—both literally and figuratively. Routine contact, through remote communication (using their preferred method, such as WhatsApp) as well as physical presence, is necessary to overcome the mistrust that unaccompanied children and sponsors may feel, due to a history of trauma and legitimate concerns about their safety. Specific examples of ways community-based professionals working with this population can establish trust include: 1) visiting unaccompanied children and sponsors in their homes, if they are comfortable with that; 2) convening meetings with groups of unaccompanied children and sponsors in convenient locations, such as apartment complexes, schools, community centers, and houses of worship; and 3) speaking a shared language and having a similar background.

The most effective way to work with unaccompanied children and sponsors in the community is to meet them where they are—both literally and figuratively.

Clear communication and a foundation of trust translate into better access to medical and mental health services when individuals working with unaccompanied children and sponsors are knowledgeable about community resources and able to either schedule appointments for unaccompanied children or provide a direct number for the sponsor or child to call and schedule. Of note, the first priority for unaccompanied children and their sponsors may not be health care, especially if the child does not have any known diagnoses. They may be more open to help accessing these services once their other concerns have been addressed, such as housing instability, food insecurity, legal issues, lack of school enrollment, and unemployment.

5 Recommendations

The barriers to medical and mental health services and promising practices that emerged from this study point to a range of steps the federal government (in particular, the Office of Refugee Resettlement), state and local governments, health systems, schools, and communities could take to strengthen unaccompanied children's access to much needed medical and mental health services. In some cases, this would entail the expansion of current models that serve unaccompanied children well, while in others it would require the development of new processes and protocols. The implementation of these recommendations would not only increase access to medical and mental health services for unaccompanied children, but it could also improve access to necessary care for many other under-resourced children in the United States.

For the Office of Refugee Resettlement:

Strengthening the continuity of care between unaccompanied children's time in ORR facilities and after release, and reimagining the supports provided to children and their sponsors, would represent critical steps towards improving children's medical and mental health. These recommendations are focused on steps that ORR already has the authority to take, though some would require additional funding to implement.

1. Provide complete and accessible health-related information to unaccompanied children and sponsors through improved documentation and overview sessions, both before and after a child's release from ORR facilities

In preparation for an unaccompanied child's release, ORR should review with sponsors and children all of the health-related information in the discharge packet, confirming the sponsor's understanding of their responsibility for the child's health and well-being. This discussion should be conducted in the preferred language of the child and sponsor.

The discharge packet given to children and sponsors should clearly describe the child's health status and plans for their continuing care. In addition to what is currently included, there should be a "key information" summary sheet written in the language of the child's and sponsor's preference that includes a complete statement of all of the child's diagnoses, a list of the medications the child needs to take (with clear instructions for how to take them and why they are necessary), direct contact information for any medical or mental health clinicians the child has seen while in ORR facilities, and a list of all scheduled or necessary

post-release appointments. The packet should also contain a document that formally states that the sponsor can provide consent for medical and mental health care for the child (when needed, per state policies for all minors). If no appointments were scheduled prior to release, the packet should contain contact information for community health centers near the sponsor's home that could serve as the child's medical home.

ORR should support workshops for sponsors and unaccompanied children in communities to further orient them on how to transition the child's medical and mental health care after release. This programming could work similarly to the Executive Office for Immigration Review's Legal Orientation Program for Custodians of Unaccompanied Children.⁴⁷ Where possible, medical and legal orientations should be offered in conjunction with one another to reduce logistical barriers and encourage attendance. Topics could include practical tips on how to navigate local clinicians and resources (including discussion of possible eligibility for public health insurance coverage and ways to obtain financial assistance if uninsured), different types of care within the U.S. health system and when to access each one, the importance of preventive care (e.g., routine check-ups, vaccines, and completion of the recommended laboratory screening tests for immigrant children), public-charge policies, understanding ORR medical forms, and destigmatizing mental health care. These workshops should give sponsors and children the information they need to obtain necessary health care and reiterate how these services are essential to the child's overall well-being. The community organization hosting the orientation could also include information about local resources related to the social determinants of health, such as housing, food, and employment.

ORR should support workshops for sponsors and unaccompanied children in communities to further orient them on how to transition the child's medical and mental health care after release.

2. Continue support of medical and mental health care for at least the first three months of children's transition to U.S. communities

The current policy of abruptly ending nearly all support immediately after unaccompanied children leave ORR custody frequently leads to disruptions and delays in children's health care. ORR should assume greater responsibility for ensuring that children's medical and mental health services are smoothly transitioned to the community upon release.

ORR should explore extending payment for medical and mental health services through its third-party contractor (which provides payment for services for children while in ORR care) so that it continues until the child has obtained health care coverage through Medicaid, CHIP, private insurance, or regional programs, or for at least three months following a child's release, whichever is sooner. A phased-in approach whereby ORR provides this payment for children with special health care needs initially before expanding it to all unaccompanied children could allow ORR to optimize implementation.

⁴⁷ U.S. Department of Justice, Executive Office for Immigration Review, "Legal Orientation Program for Custodians of Unaccompanied Children," updated January 6, 2023.

Beginning as soon as feasible, ORR should provide at least a three-month supply for long-term medications upon release, along with clear instructions for why the medication is necessary and how to administer it. ORR should also explain that an appointment is needed with a clinician in the community as soon as possible to assess the child's ongoing need for the medication and, if so, to provide refills.

ORR case managers should schedule children's post-release follow-up appointments with community-based providers for all children with special health care needs, working with the sponsor as soon as possible to avoid delays in release from ORR care due to an unmet need for appointments. The extension of coverage through ORR's third-party contractor for at least three months after discharge from ORR custody would mitigate delays in release related to difficulties obtaining appointments for children who would otherwise be uninsured. Post-release follow-up appointments should also be scheduled for children with routine medical needs; if this is not possible, children and sponsors should be provided with information on health facilities near the sponsor's home that would accept the child. For any scheduled appointments, case managers should facilitate direct communication between the clinicians caring for a child in ORR facilities and those a child will see after release.

3. Improve communication with community medical and mental health clinicians and related systems

Despite steps taken in recent years to improve the post-release accessibility of unaccompanied children's medical records from their time in ORR custody, significant barriers prevent critical documents from reaching the hands of community-based clinicians and other organizations that require them.

Prior to a child's release, ORR should seek to obtain consent from sponsors to release health information to any community clinicians with whom appointments have been scheduled or whom a case manager has identified as a child's medical home. If community clinicians have not been identified, ORR should provide sponsors with a release of information form and explain how community-based clinicians can use it to make medical records requests.

ORR should designate sufficient staff to respond to community- and school-based clinicians' requests for immunization and other medical records within 30 minutes, during typical working hours. This is important for ensuring that clinicians can obtain necessary information while seeing a child, rather than requiring the child to schedule a new appointment. ORR should also consider creating a secure and confidential online system for children, sponsors, and approved clinicians to access the full contents of an individual child's discharge packet, which would ensure this material is available even if the physical packet is lost or forgotten.

ORR should ensure that all clinicians within its facility network enter vaccinations given into their respective state's immunization registry. However, because children are often released to sponsors in other states, the U.S. Department of Health and Human Services should also establish a nationwide vaccine registry (with secure access for schools and clinicians) to ensure that immunization records for all children on the move within the United States are available when and where they are needed.

4. Create and facilitate medical and mental health case management in the community

ORR should ensure that all unaccompanied children who leave its care are offered post-release medical and mental health case management. Given the limitations of ORR's current PRS system (see Section 3.A.), this should be implemented differently than the present model. ORR should conduct an evaluation of whether comprehensive medical and mental health case management can be delivered through modifications of the current PRS program or whether a separate program focusing on post-release medical and mental health case management is necessary.

Comprehensive post-release medical and mental health case management should last for at least one year following a child's release, and at least two years for children with special health needs (if they do not qualify to receive services until they turn 18 years of age). Services should begin prior to the child's release from ORR facilities, with the post-release case manager meeting with the sponsor and other household members, so long as that does not significantly delay the child's release from ORR. Services should continue from there, without interruption. Prior to the first meeting, case managers should provide clear information to the sponsor about the voluntary nature of the program and the guidelines to which the program adheres to ensure privacy protection for children and sponsors.

The comprehensive case management should also include several key components; some of these are intended to be part of ORR's current PRS program but are not always carried out in practice, while others would require reconceptualization of the PRS model. Among other activities, case managers should meet with sponsors to prepare them to welcome the child into their home; conduct an initial needs assessment and regular check-ins thereafter; orient both child and sponsor to educational, health care, and other systems; provide personal accompaniment as needed to ensure the child successfully enrolls in school and accesses medical and mental health services; and assist the child and sponsor in connecting to other community resources. Case managers should conduct regular check-ins with children and sponsors for ongoing reassessment of needs and progress. This approach to PRS should move beyond a system in which case managers mainly facilitate children's initial referrals; case managers should ensure that appointments are not just made but also attended, continuing to offer support until the child's connections with new service providers are firmly established.

ORR should prioritize contracts for post-release case management services housed within multidisciplinary organizations ... as intra-agency referrals can facilitate faster and better coordinated care.

ORR should prioritize contracts for post-release case management services housed within multidisciplinary organizations—such as those that also provide medical and mental health services—as intra-agency referrals can facilitate faster and better coordinated care. In addition, ORR should require that case managers receive implicit bias and cultural sensitivity training and encourage organizations providing post-release services to hire case managers who speak languages and have cultural backgrounds similar to those of the sponsors and children they serve, to the greatest extent possible. To ensure that case managers can provide the full support that many children and sponsors require, their caseloads should be small enough to allow for at least monthly in-person visits with children and sponsors, with additional phone calls as needed.

Caseloads should similarly be modified to allow for more intensive services for children with special health care needs.

For Federal, State, and Local Governments:

1. Extend eligibility for Medicaid and CHIP to unaccompanied children in low-income households

At the federal level, Congress should allow unaccompanied children to participate in public health insurance programs. Extending Medicaid and CHIP eligibility to unaccompanied children is a simple, direct way to increase their access to essential care, given that the high cost of medical and mental health services can often be a barrier to care.

If Congress does not take this step, the federal government should state that unaccompanied children released into U.S. communities immediately meet the CHIPRA §214 definition of lawfully residing persons, such that they can be deemed eligible as soon as they leave ORR's care. However, this latter approach would only lead to increased coverage of unaccompanied children in states that have adopted the CHIPRA option. In addition to this action at the federal level, states should pursue policies that expand unaccompanied children's eligibility for public insurance. If possible, states should extend eligibility to all income-eligible children, regardless of immigration status, following the lead of the 11 states plus Washington, DC, that have done so to date. At a minimum, states that have not already expanded eligibility by adopting the CHIPRA §214 option should do so. This would benefit both unaccompanied children as well as the state; the children directly benefit from having insurance, while the state benefits from increased federal matching funds and lower uncompensated or charity care costs.

Importantly, when states expand eligibility to allow more children to participate in public insurance programs, they should also fund outreach campaigns and navigators in communities to ensure that children, sponsors, clinicians, attorneys, and others are aware of newly created pathways to obtain coverage. The program developed by California during the expansion of eligibility for its Medi-Cal Program offers a good model: The state identified a set of hard-to-reach, priority populations and then provided grants to counties and community-based organizations for targeted outreach and enrollment.⁴⁸

States that provide health care coverage regardless of immigration status should also develop policies to speed unaccompanied children's enrollment as much as possible. Sponsors should be allowed to apply on the child's behalf (based on their future residency with the sponsor) prior to the child's release from ORR custody. A state-level version of presumptive eligibility could be used to ensure that unaccompanied children's coverage begins at the time of their release.⁴⁹

2. Improve access to mental health clinicians with suitable linguistic skills and training

Government at all levels should seek ways to address the critical shortage of trauma-informed mental health services in the United States, particularly for children. Governments should pay particular attention

⁴⁸ California Department of Health Care Services, "Medi-Cal Health Enrollment Navigators Project," updated January 23, 2023.

⁴⁹ Presumptive eligibility is a federal policy allowing states to authorize qualified entities such as health care providers, community-based organizations, and schools to make initial Medicaid and CHIP eligibility determinations and enroll people temporarily until a final determination is made. See CMS, "Presumptive Eligibility," updated August 31, 2021.

to regions where services are currently lacking, including rural areas and those with a large percentage of residents from minoritized populations or children for whom English is not their preferred language. They should also facilitate funding for services that may not be easily covered within current payment mechanisms, such as family-based therapy for unaccompanied children and their sponsors.

Federal and state governments should provide financial incentives for academic institutions to expand their capacity to train mental health clinicians (especially in trauma-informed techniques) and to recruit students from a wider array of linguistic and cultural backgrounds into this career field, particularly immigrants and other under-represented populations. Federal and state governments, in setting and monitoring payment rates for medical and mental health services (e.g., via Medicaid), should also ensure that these clinicians are adequately paid for their services.

Federal programs that support access to mental health services, such as the Health Resources and Services Administration's Pediatric Mental Health Care Access Program and the Screening and Treatment for Maternal Depression and Related Behavioral Disorders program,⁵⁰ federally qualified health centers (FQHCs), and Certified Community Behavioral Health Clinics should be enhanced to ensure they provide trauma-informed care of unaccompanied children and, where appropriate, their sponsors. In addition, because school-based services are such an effective way to reach unaccompanied children, federal funding for school-based mental health programming should be significantly increased.

3. Ensure all levels of government include positions dedicated to addressing immigrant integration, with a specific focus on health, youth, and language access

Governments at all levels should consider creating offices of immigrant affairs, if they have not done so already. These should aim to provide comprehensive support to assist new immigrants with all aspects of settling in to life in the United States. The offices should have multidisciplinary staff, including individuals with specific expertise in the medical and mental health care of immigrant youth.

Alternatively, teams or individual positions focusing on immigrant integration could be established within existing government agencies, particularly departments of public health, human services, and education as well as state child welfare agencies. These teams or individuals should communicate and coordinate directly with appropriate staff across other agencies and offices, with collaboration between state and local levels. They should also help ensure appropriate training for all staff to understand what services and resources are available to unaccompanied children, given their unique circumstances and needs.

Governments should also partner with knowledgeable community-based organizations to offer trainings to health facilities around language access, including nondiscrimination requirements such as those established by Title VI of the *Civil Rights Act* and Section 1557 of the *Affordable Care Act*.⁵¹

50 HRSA, "Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program (MDRBD)," updated October 2021.

51 See Section 3.B's subsection on language and cultural barriers, and its notes, for a description of the legal basis of language access policies.

For Health Systems:

1. Create a welcoming environment for newly arrived children and families

Health care facilities should strive to welcome patients in a way that immediately dispels any fears or hesitations they may have about seeking care. Extra attention should be paid to language access, health literacy, and a patient's possible lack of familiarity with the U.S. health care system. Facilities should offer interpretation services via medically certified phone, video, or in-person interpreters.

Facilities should train frontline staff to work flexibly with newcomer patients, offering explanations of policies and troubleshooting if needed. To ensure this, facilities should prioritize interpersonal skills when hiring and establish zero-tolerance policies for staff who express prejudice toward patients. Facilities should further reduce the challenges newly arrived immigrant patients face by implementing cultural humility and implicit bias training for all staff,⁵² utilizing signage written in languages representative of the patient population, adopting "safe spaces" practices,⁵³ and employing staff from the community served.

Extra attention should be paid to language access, health literacy, and a patient's possible lack of familiarity with the U.S. health care system.

Clinicians caring for unaccompanied children should be trained in trauma-informed care. Furthermore, they should understand the circumstances common in this population and screen accordingly, including assessing for adverse childhood experiences and inappropriate or harmful work situations.⁵⁴ Screening should also be used to identify children's personal strengths and protective factors.

2. Increase physical accessibility and community outreach

Health facilities should implement initiatives to bring their services into the community. There are several approaches that could be considered. Clinics could be established within community-facing organizations or at sites where unaccompanied children already are, such as public schools. Mobile clinics could also be used to provide services in multiple locations across a community. To expand accessibility further, facilities of all types should offer evening and weekend hours, as well as walk-in appointments. Furthermore, facilities should explore ways to use telehealth appointments where possible.

Health facilities should also utilize community health workers as an extension of facility staff. Among other activities, community health workers could follow up with patients in person (e.g., in their homes) and speak at local events to inform community members that health services are available and important to access.

52 William Okoniewski et al., "Culturally Sensitive Interventions in Pediatric Primary Care Settings: A Systematic Review," *Pediatrics* 149, no. 2 (January 31, 2022); Sunila J. Prasad et al., "Cultural Humility: Treating the Patient, Not the Illness," *Medical Education Online* 21 (February 3, 2016).

53 American Civil Liberties Union (ACLU), National Immigration Law Center (NILC), and Physicians for Human Rights (PHR), *Health Care Providers: Preserve Access to Care and Protect Your Patients from Border Patrol and ICE Interference* (New York and Los Angeles: ACLU, NILC, and PHR, 2020).

54 Hannah Dreier, "Alone and Exploited, Migrant Children Work Brutal Jobs across the U.S.," *The New York Times*, February 25, 2023.

3. Expand financial assistance programs and streamline their applications

Health care systems that do not currently offer affordable services to uninsured patients should establish charity care or other financial assistance programs. Since even reduced fees can be prohibitive for unaccompanied children and their sponsors, sliding scale payment programs should be reconfigured to allow for more services to be delivered at no cost.

Health care systems that do offer financial assistance programs should ensure that they do not unduly burden applicants. Information should only be required if it is necessary for applicants to obtain services. If an applicant is unable to provide the typical forms of evidence for obligatory portions of the application (such as proof of income or residence), acceptable alternatives should be listed. Ideally, all FQHCs should utilize the same standard application. This would facilitate transferring approval for financial assistance programs between FQHCs, benefiting populations such as unaccompanied children and sponsors that are more likely to change residences.

4. Establish in-house interdisciplinary service models and/or co-location of organizations

Medical and mental health clinicians should offer services as part of interdisciplinary teams that also include social work and legal service providers. If it is not possible to work as in-house teams within the same organization, co-locating different types of service-providing organizations within the same building or area can achieve many of the same benefits, including smoother coordination between providers, better provision of services, and reduced logistical demands on patients seen by multiple providers. When planning or redesigning a multidisciplinary health facility, additional resources such as food pantries and benefits enrollment specialists should also be included.

For Schools:

1. Create programs and partnerships to maximize unaccompanied children's health and well-being

Recognizing that most unaccompanied children will enroll in public education soon after release from ORR custody, schools are in a unique position to support the health of unaccompanied children initially and throughout their transition into U.S. communities.

Schools can play an important role in screening all newly arrived children for needs related to the social determinants of health. There should be knowledgeable staff who can refer children and families to resources to meet their identified needs, such as social workers or wraparound specialists. If schools do not have the capacity to fill all enrollment, screening, and referral needs themselves, partnering with community-based organizations can help them meet these goals.

Schools are in a unique position to support the health of unaccompanied children initially and throughout their transition into U.S. communities.

Schools should partner with health care entities in their vicinity to offer medical, mental health, dental, and vision services for students and their families who would benefit from access in these locations. There are

several possible arrangements that may be appropriate, based on the physical space, funding, and other resources available.⁵⁵ Ideally, this would be implemented as a school-based clinic, housed on the academic campus and free of charge. Another option would be to have a mobile clinic program regularly visit the school, although the daily, consistent presence of services from a permanent school-based clinic is better suited for the purposes of continuity, availability, and rapport. Funding for school-based health services should not come from school districts' existing, already-tight budgets. Instead, school districts should seek out collaborations with community-based clinics and/or consider applying for grants. For instance, potential funding sources for culturally relevant and linguistically appropriate mental health clinicians include the U.S. Department of Education's School-Based Mental Health Services Grant Program and Mental Health Service Professional Demonstration Grant Program.⁵⁶

School districts should also develop programs to better recognize and address the experiences and circumstances of this population, without stigmatizing them for the extra support they receive. In areas with a large number of newly arrived immigrant students, one way to do this is by creating (or expanding, if already in existence) newcomer schools or other dedicated programs within schools.

For Communities:

1. Build or strengthen local, multidisciplinary coalitions focused on assisting unaccompanied children and their sponsors

Community organizations should form and participate in multidisciplinary coalitions, composed of professionals working with unaccompanied children and their sponsors, trusted community leaders, and community members that are unaccompanied children and sponsors themselves. These coalitions can provide services to directly assist children and sponsors. This may include creating relevant and effective health messaging, establishing infrastructure to improve service delivery to this population, conducting referrals between organizations, and advocating for improved access to benefits and health care.

Community-based coalitions can also participate in working groups established jointly with relevant government offices and agencies, to provide close consultation and even collaboration in the development and operation of government initiatives.⁵⁷

2. Develop community initiatives to better prepare communities to receive and support unaccompanied children

Community coalitions should consider what steps they can take to reduce barriers to medical and mental health services for unaccompanied children in their region. For example, as experts in best practices for working with children, coalitions of community-based organizations could create initiatives to educate all who would interact with them in professional settings. These trainings could be offered to help school staff, health professionals, employers, community leaders, and others better appreciate the experience of being an unaccompanied child.

55 Hayley E. Love et al., "Twenty Years of School-Based Health Care Growth and Expansion," *Health Affairs* 38, no. 5 (May 2019): 755–64.

56 U.S. Department of Education, Office of Elementary and Secondary Education, "Safe & Supportive Schools," updated January 19, 2023.

57 Beier, Farwell, Fleischer, and Workie, *Four Strategies to Improve Community Services*.

Coalitions could also consider developing initiatives to help newly arrived children access the computers, broadband internet, and digital skills training necessary to engage in educational, vocational, and telemedicine services. Schools and libraries are valuable partners in these efforts.⁵⁸

Additionally, community coalitions could cultivate a cadre of “mental health extenders”—individuals who work more extensively with unaccompanied children, such as teachers, faith-based leaders, and coaches or leaders of extracurricular activity groups—who are trauma-informed and able to support an unaccompanied child’s mental health if a licensed mental health professional is not available.

Lastly, communities receiving significant numbers of unaccompanied children could create or expand welcome centers for newly arrived children, in conjunction with local government and/or schools. These should be conveniently located (or mobile) and offer in-person services such as school enrollment, vaccinations, medical and mental health assessments, laboratory testing, screening of social determinants of health, and resource provision or referral. Welcome centers should also consider partnering with legal service providers and offering workshops for parents and sponsors, particularly on topics pertinent to acculturation and the integration of unaccompanied children into new households.

6 Conclusion

Unaccompanied children face a wide range of barriers to medical and mental health care in the United States. Some arise from their unique experiences and circumstances, while others are rooted in longstanding challenges posed by the U.S. health care system. Thus, ensuring that unaccompanied children’s medical and mental health care needs are met requires a thoughtful, deliberative approach. Many communities are successfully undertaking that work, developing promising practices to break down these barriers and make it easier for children to utilize health care services.

The recommendations presented here offer concrete, actionable steps that governments, health systems, schools, and communities can take to further improve unaccompanied children’s access to care. Achieving the societal goal of ensuring that all children in the United States reach their full potential necessitates policies and practices that are designed specifically for unaccompanied children. Implementing these recommendations would go far toward maximizing their physical, mental, and emotional health, as all children deserve. By helping unaccompanied children reach their full potential, such policies would also be of great benefit to the families, schools, and communities they join.

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⁵⁸ Essey Workie, Lillie Hinkle, Anna deDufour, and Valerie Lacarte, *Advancing Digital Equity among Immigrant-Origin Youth* (Washington, DC: MPI, 2022).

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Jonathan Beier was a Policy Analyst at the Migration Policy Institute (MPI) National Center on Immigrant Integration Policy, where he led MPI's work on unaccompanied children in the United States. He conducts research and policy analysis on issues affecting immigrant children and families, including child migration pathways and access to public benefits and services. Previously, Dr. Beier served as an American Psychological Association Congressional Policy Fellow on the U.S. Senate Finance Committee, managing immigration and human services portfolios for legislation and oversight. He was also an Assistant Professor of Psychology at the University of Maryland, College Park, where he directed a research lab studying social and cognitive development in early and middle childhood.

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The authors are responsible for all analyses, recommendations, and policy ideas in this report. AAP is a nonprofit professional organization of 67,000 primary care pediatricians and medical and surgical pediatric subspecialists dedicated to the health and well-being of all children. MPI is an independent, nonpartisan policy research organization. Both adhere to the highest standard of rigor and integrity in their work.

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