Title

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Journal

American Journal of Public Health, 114(3)

ISSN

0090-0036

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Publication Date

2024-02-08

DOI

10.2105/ajph.2023.307570

Peer reviewed

Health Risks of Unaccompanied Immigrant Children in Federal Custody and in US Communities

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Unaccompanied immigrant children continue to arrive at the US–Mexico border and are at high risk for ongoing abuse, neglect, and poor mental and physical health.

We are medical and legal experts in the fields of immigrant and refugee health, child abuse, and the legal rights of international refugee and migrant children. We provide an overview of US federal agencies with custody of unaccompanied immigrant children, a summary of medical care provided while in custody, and recent findings from the independent *Juvenile Care Monitor Report* mandating new custodial conditions for immigrant children while in federal custody.

We provide recommendations to improve the health and well-being of unaccompanied immigrant children while in custody and once released to US sponsors. (*Am J Public Health*. 2024;114(3):340–346. https://doi.org/10.2105/AJPH.2023.307570)

AJPH March 2024, Vol. 114, No. 3

Since 2012, more than 600 000 unaccompanied immigrant children[1] of all ages have immigrated to the United States, with almost 130 000 arriving in fiscal year 2022.[2] A large number of unaccompanied children arrive from the Northern Triangle countries of Central America: Guatemala, El Salvador, and Honduras. Many unaccompanied immigrant children are fleeing poverty, gang violence, abuse, neglect, sexual violence, and natural disasters and experience additional trauma during and after their immigration journey.[3] They are at high risk for physical and mental health issues, including acute injury, malnutrition, dehydration, pregnancy, sexual and physical assault, sexually transmitted infections, posttraumatic stress disorder, and depression.[4] Their unaccompanied immigrant status, young age, social marginalization, and other factors render them at high risk for trafficking and other forms of exploitation both outside and inside the United States.[5–7]

There are 2 federal agencies, the US Department of Homeland Security (DHS) and the US Department of Health and Human Services (HHS), that are the initial legal custodians for unaccompanied immigrant children. We provide a summary of their movement through these 2 federal agencies and medical care provided while in custody, which is based on our extensive experience working with unaccompanied immigrant children as well as findings from the independent *Juvenile Care Monitor Report* issued in January 2023 as a result of a 2022 legal settlement mandating new custodial conditions for immigrant children in federal custody.[8] To our knowledge, this is the only detailed description of the process published by an external source. We provide recommendations to address identified gaps in the care of unaccompanied immigrant children.

CUSTOMS AND BORDER PROTECTION

At the time of apprehension, DHS's Customs and Border Protection (CBP) ordinarily takes custody of unaccompanied immigrant children and should transfer them to HHS's Office of Refugee Resettlement (ORR) custody within 72 hours.[9,10] CBP agents are responsible for initially identifying children who are in acute medical distress after grueling overland travel that may last weeks to months and includes risks of severe dehydration, acute to chronic malnutrition, heat exposure, sexual and physical assault, trauma from border wall falls,[11] and respiratory infections. These conditions may be life threating in and of themselves, but the

risk is exacerbated when children have unidentified comorbid conditions, such as undiagnosed congenital heart malformations, asthma, and severe anemia from chronic poor nutrition. Such diagnoses are easily missed by CBP staff, who have neither training in pediatric medicine nor general medical care, and place children's health at risk.

Once brought to CBP sites—which may take hours or up to several days, during which time these children have no access to any formal medical evaluation, shelter, food, or latrines[12]—initial health interviews are completed by emergency medical technicians, who also lack advanced training in pediatric medicine and can easily miss that infants or children are in medical distress.[8] Within 24 hours of being put in custody, the children receive a limited health screening performed by either a nurse practitioner or a physician assistant (with on-call pediatrician consultation available if medical issues are identified).[8] Medications for acute and chronic issues are provided, and children with identified urgent health needs are referred to local health systems for further evaluation, work-up, and management.[8] Several pediatricians provide on-call support, clinical protocols, and chart reviews to ensure that standards of care are met.[8] Of note, only children in visible distress are provided further mental health services; unaccompanied immigrant children are not formally screened for mental health issues while in CBP custody.[8]

Per the *Juvenile Care Monitor Report*, noted deficiencies in the current model include wide variation in how medical protocols are implemented at CBP sites, including inadequate medical evaluations for older children with chronic medical issues, lack of continuation of chronic medications, absence of repeat health evaluations for children held for longer than 72 hours, and lack of provision of medical information to caregivers or medical providers once children are relinquished to ORR shelters as well as inadequate medical supervision when there are surges in the number of detained children.[8] Also of note are reports of acute medical issues directly related to a chronic condition not being diagnosed and addressed.[8] In such cases, accurate recognition and response may require more extensive clinical pediatric training than nurse practitioners and physician assistants receive.

After the initial medical evaluation, unaccompanied immigrant children are placed in holding areas, often with more than 100 children in each area; at this stage, they do not receive further medical attention unless they themselves alert CBP personnel, a nonmedical CBP staff member identifies a child in distress, or an adult caregiver reports an issue (in settings where they are allowed to stay with the child). Similarly, the *Juvenile Care Monitor Report* noted that when children have a contagious disease (e.g., COVID-19) requiring isolation, at some sites children were alone and in an area lacking appropriate staff supervision, and at others younger children were inappropriately housed with adolescents. Also, these isolation cells have been noted to become overcrowded, with only 1 advanced practice medical provider managing up to 125 children.[8]

Federal law requires screening to identify potential cases of trafficking. In an overzealous application of this mandate, when immigrant children are accompanied by a relative who is not a parent (e.g., adult sibling, cousin, or grandparent) and CBP apprehends them at the border, common practice is to separate the children from their family member, thus rendering them unaccompanied[13]; CBP may then deport the family member or send them to an adult immigrant detention facility.[8]

OFFICE OF REFUGEE RESETTLEMENT

Often within 72 hours, CBP transfers unaccompanied immigrant children to the custody of the ORR, where they are housed in 1 of more than 290 shelters across the country.[14] Within 48 hours of arrival to the shelter, they receive a physical examination, which is most often performed by a nurse practitioner or physician assistant (with the same limitations in extensive acute and chronic pediatric clinical training as noted); pediatricians may be onsite or available for consultation. Children receive limited medical, mental health, and maltreatment screenings, including for being trafficked. (A copy of the ORR medical and mental health screening form is on file with the authors and is available upon request.) Vaccinations are also initiated.[15]

Medical screening includes universal testing for tuberculosis and COVID-19 and urine pregnancy testing in postmenarchal females. Identified conditions requiring immediate medical care are addressed, which may involve transfer to a local hospital emergency department.[16] At the time of writing, unaccompanied immigrant children do not have the extensive medical and validated mental health screening evaluations recommended for newly arriving refugees, including children, per Centers for Disease Control and Prevention (CDC) refugee domestic screening guidance, even though they often have the same risk factors for infectious diseases, mental health concerns, and other diagnoses of significance.[14,17]

Children who arrive through formal US refugee resettlement pathways arrive legally, have formal medical screening initiated approximately 6 months before US arrival while in their refugee camp or in another site of displacement, and receive extensive medical and mental health screenings, most often within 30 days of US arrival.[17] Gaps in screening for unaccompanied immigrant children, compared with refugee children, include lack of testing for anemia, lead, eosinophilia, Strongyloides, other soil-transmitted helminth infections, vertical transmission of HIV, hepatitis B and C, and syphilis.

Unaccompanied immigrant children are only tested for sexually transmitted infections if they disclose sexual activity or abuse at arrival. Similarly, the children are only tested for blood-borne infections if they disclose injection drug use. Acute mental health interventions, treatments, referrals, and hospitalizations are only provided to unaccompanied immigrant children who have signs or disclose symptoms of severe depression, anxiety, or suicidal ideation. It is unlikely that detained children will disclose sensitive information, including sexual activity or abuse, intravenous drug use, trafficking, depression, anxiety, or suicidal ideation within 48 hours of arrival in an ORR shelter to clinicians who do not have a long-standing, trusting relationship; thus, underdiagnosing HIV, hepatitis B and C, syphilis, gonorrhea, and chlamydia and underidentifying children in need of more acute mental health services are likely.

If an unaccompanied immigrant child has a preexisting or newly diagnosed complex medical or mental health condition, before release from ORR custody ORR medical services staff ensure that linkage to a pediatrician and specialty follow-up care is established in or near the sponsor's community and arrange for medical or mental health records to be transferred to the accepting physician (per unpublished standards of ORR's Washington, DC, office and author experience). Thereafter, most children will be released to a parent or other "sponsor."[2] As of October 4, 2023, there were 10 818 unaccompanied immigrant children in HHS's care, and the average length of time an unaccompanied immigrant child remained in ORR's care was 24 days.[14]

RELEASE FROM FEDERAL CUSTODY

In calendar years 2021 and 2022, unaccompanied immigrant children were released to vetted sponsors, usually family members, with 11.8% and 14.0%, respectively, released to "distant relatives or nonfamily sponsors."[7,18] Sponsors are responsible for ensuring the child's ongoing safety and well-being and are advised to enroll the child in school, connect the child with a primary care medical home, and seek services from an immigration lawyer. Although sponsors are provided a copy of the child's ORR medical records at the time of discharge, the majority receive no federal or state oversight.[6,7] Unless the child is released in a state with Medicaid coverage for uninsured children—including those who are undocumented[19] or are identified as eligible for certain types of temporary legal status (e.g., victims of trafficking,[20] "special immigrant juveniles"[21])—they have limited access to health insurance once released from ORR custody.[19]

In fiscal year 2022, approximately 43% (55 900) of the nearly 130 000 unaccompanied immigrant children in ORR custody were deemed eligible for 4 months of postrelease services with a federally funded social worker to assist sponsors in linking the children to school, counseling, and legal, health, and mental health care.[14] There are no published criteria available that define which unaccompanied immigrant children are eligible for 4 months of social work support.

Also in fiscal year 2022, approximately 7% (9100) of the nearly 130 000 unaccompanied immigrant children in ORR custody had home studies to assess the home environment before release to a sponsor. However, recently updated ORR guidelines[14] require home studies for children identified as a victim of a severe form of trafficking (e.g., sex or labor trafficking), children with a diagnosed disability, children who have been identified as a victim of physical or sexual abuse "where the child's health or welfare has been significantly harmed or threatened," and children for whom there are concerns identified that the sponsor may pose a risk of abuse, maltreatment, exploitation, or trafficking.[14]

Home studies are also now newly required for any child who will be sent to live with a nonrelative sponsor who also will be hosting multiple children and when the child is aged 12 years or younger,[14] presumably in response to recent reports of unaccompanied immigrant children being labor trafficked by sponsors housing multiple unaccompanied immigrant children in nearly 50% of states.[6,7] These updated home study criteria require either that the traumatized child newly in the custody of CBP and ORR disclose they were sex or labor trafficked or physically or sexually abused or that a specific medical or mental health disability be diagnosed. These conditions may be easily missed if an extensively trained medical professional does not perform

an appropriate medical-screening examination.

Released children are at high risk for trafficking and other abuse because of debt, familial poverty, lack of knowledge of US culture and labor laws, social isolation, marginalization, and other factors.[5] Based on their recent interviews of 60 caseworkers across the country, investigative journalists estimate that two thirds of unaccompanied immigrant children are working full-time and not in school; they found that the children were trafficked to work in meat plants, food packaging, contracting, and food delivery with no ongoing oversight of their health and well-being after release from ORR custody.[6,7]

Unaccompanied immigrant children and their sponsors face significant barriers to accessing ongoing health and mental health care.[22] Most children are released to states with no Medicaid coverage for undocumented immigrants,[19] and sponsors may not know where or how to receive discounted services.[22] Undocumented sponsors may avoid seeking care for fear of being identified and deported, and they may fear stigma associated with receipt of mental health services.[22] A national shortage of mental health providers further limits access for unaccompanied immigrant children and sponsors.[23] Most health care professionals have had no systematic training in evidence-based medical and trauma screening of immigrant populations,[24,25] including unaccompanied immigrant children, and are not aware of options to link unaccompanied immigrant children and their families to pro bono immigration assistance and resources for suspected trafficking. Barriers to legal services are exacerbated by a nationwide shortage of trained immigration lawyers who accept pro bono cases.[26]

Many of the existing legal protections unaccompanied immigrant children receive are the outcome of the 1997 *Flores Settlement Agreement* (*Flores*) and subsequent judicial enforcement orders in a 1985 class action lawsuit (*Flores v. Meese*). The Trump administration unsuccessfully sought to reduce DHS's obligations under *Flores* and sought to end the agreement. The Biden administration announced in December 2021 that it would not seek termination of the agreement.[8,27,28] Consistent with that approach, the Biden administration introduced proposed regulations in December 2023 that would largely codify the terms of *Flores* as they relate to ORR and HHS while explicitly noting that the settlement would remain in force for other federal agencies.[29]

The United States will continue to see arrivals of unaccompanied immigrant children, particularly from countries affected by instability, wars, famine, climate change, and poverty and those whose governments are unwilling or unable to adequately protect children. To address the needs of these children in a way that protects fundamental child rights, the US federal and state governments, along with input from experts in public health, law, and medicine, should take the following steps, among others.[30,31]

Federal funding should be allocated to do the following:

- Allow the development of systematic protocols for onboarding and frequent recertification of all medical providers staffing CBP and ORR facilities. This initiative should be led by pediatric physicians with expertise in immigrant health in the settings of primary care, emergency medicine, psychiatry, gynecology, behavior and development, child abuse, and infectious disease.
- Require CBP to have pediatric-trained medical providers deployed with them at all times to assist with immediate identification and medical triage of unaccompanied immigrant children at the border; they should also allow timely identification of acute and chronic medical issues.
- Allow daily around-the-clock on-call coverage by pediatric physicians (including pediatric psychiatrists) and trauma-trained pediatric psychologists to oversee and provide consultation for all pediatric-trained nurse practitioners, physician assistants, and masters-level counselors onsite at both CBP and ORR facilities, with provisions to address expected overcrowding. Pediatric physicians, psychiatrists, and psychologists should also provide weekly chart reviews.
- Require that all unaccompanied immigrant children have validated mental health screenings verbally administered at both CBP and ORR facilities and that children with positive screens be formally evaluated by a child psychologist or psychiatrist. Screens should be culturally adapted, suitable for unaccompanied immigrant children with limited literacy and available in Spanish and other commonly spoken languages.[32–34]
- Ensure that trauma-trained professional interpreters are available for children who do not speak English. As much as possible, bilingual medical providers should be recruited. Interpreters should be screened to ensure that they are not from a child's community and, where possible, are of a gender preferred by the child.
- Ensure that ORR medical screening includes all aspects of the CDC's refugee domestic screening guidance

used for refugee arrivals, including universal screening for HIV, hepatitis B, hepatitis C, syphilis, gonorrhea, chlamydia, Strongyloides, anemia, eosinophilia, and stool ova and parasites.[17]

- Support the design and implementation of a unified electronic medical record to facilitate appropriate interagency communication for all unaccompanied immigrant children similar to the interagency US Electronic Disease Notification system used for refugees accepted into the United States.[35]
- Expand the Unaccompanied Refugee Minor program to include all unaccompanied immigrant children who will not be released to a sponsor who is a known, trusted relative.[36] The Unaccompanied Refugee Minor program provides foster care, full CDC domestic refugee medical screening, ongoing site visits, assurance of school enrollment and attendance, and ongoing medical care.
- Ensure that all unaccompanied immigrant children are assigned a trained social worker for a minimum of 12 months of postrelease services who will link the child to full-time school, a medical home, mental health support, and local immigration nonprofits that support legal status applications. The service provider should work to ensure the child's safety and well-being, connecting them with local migrant and refugee organizations for support and facilitating successful integration into school.
- Address the national shortage of immigration lawyers by supporting the hiring of immigration lawyers by legal nonprofits to prioritize legal case representation of unaccompanied immigrant children.[37]
- Provide systematic training of community health care providers who serve immigrant children, particularly in federally qualified health centers[38,39] and systematic training of health care providers in pediatric emergency departments and hospitals, particularly at the border.
- Include information on the following:
  - CDC refugee domestic screening guidance[17];
  - trauma-informed, rights-based care[40];
  - specialized needs of immigrant children and families (e.g., health, mental health, legal, housing);
  - risk factors and potential indicators of child abuse and trafficking involving both labor and sex;
  - child abuse and trafficking screening strategies and appropriate responses, including reporting and referrals[5]; and
  - available community and national resources to address the specific needs of unaccompanied immigrant children and assist families as they adjust to their new conditions.
- Train, recruit, and retain mental health providers to systematically manage unaccompanied immigrant children during and after release.

In addition, the federal government should do the following:

- Provide the CDC Division of Global Migration Health with the authority to oversee all stages of health management of children arriving in the United States. Staff of this division write the CDC refugee domestic screening guidance[17] and are experts in the management of the health and welfare of refugee populations as well as the management of large surges of populations in crisis.
- Pass legislation that prohibits the separation of accompanied children from a trusted relative unless it is necessary for the safety of the child. This prevents children with families from being rendered unaccompanied.[30]
- Review the current sponsor vetting process and provide recommendations for improvement, with a specific focus on preventing child abuse, exploitation, and trafficking.
- Provide unaccompanied immigrant children with a card identifying them as unaccompanied, which should be presented to health professionals in any health setting. The card should include information for clinicians on how to obtain medical records from ORR[15] and summarize the special needs of this patient population.
- Ensure that all unaccompanied immigrant children being discharged from ORR care have a copy of all medical records and are verbally signed out by the ORR medical provider to a local federally qualified health center provider.[39] This involves ORR staff scheduling an appointment with a local federally qualified health center for an initial primary care visit before the child's discharge from ORR custody and ongoing oversite by the postrelease social worker.
- Ensure that sponsors and children of appropriate developmental age are provided standard written and recorded information in their preferred language. Topics should include the following:
  - state laws requiring children to attend school[41];

- laws regarding child labor and worker rights[42];
- labor and sex trafficking definitions, common recruitment strategies, and guidance on contacting the National Human Trafficking Resource Center for assistance (i.e., 1-888-373-7888; text: 233733)[43];
- how to apply for legal status and links to pro bono legal services[44];
- information to identify and link to federally qualified health centers with sliding scale programs for medical care[37]; and
- information for local medical providers on how to access children's medical records, including vaccine records,[15] and links to the CDC refugee domestic screening guidance[17] to ensure that patients receive all appropriate medical-screening evaluations and follow-up of abnormal results.

- Authorize courts to prioritize applications by unaccompanied immigrant children relating to their cases for special immigrant juvenile status, asylum, and other immigration status.

Implementing these changes is not without major challenges, particularly because immigration has become a polarizing political issue. Efforts will need to be made at public health, medical, and governmental levels to convey the value immigrants have for the US economy and society and the needs of unaccompanied immigrant children for ongoing public health support to foster successful integration; this will require strong national and state leadership, political and social will, and sufficient funding. Without these changes, unaccompanied immigrant children will remain at high risk for poor mental and physical health and dubious social outcomes, including being trafficked. Early and comprehensive attention to the needs of unaccompanied immigrant children maximizes the likelihood that they will reach their full potential and positively contribute to society. AJPH

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PUBLICATION INFORMATION

Full Citation: Young J, Binford W, Bochenek MG, Greenbaum J. Health risks of unaccompanied immigrant children in federal custody and in US communities. *Am J Public Health*. 2024;114(3):340–346.

Acceptance Date: December 21, 2023.

DOI: https://doi.org/10.2105/AJPH.2023.307570

CONTRIBUTORS

The author contributed equally to this essay.

ACKNOWLEDGMENTS

J. Young is supported by the Minnesota Center of Excellence in Newcomer Health (grant NU50CK000563 of the Centers for Disease Control and Prevention).

We dedicate this essay to our patients, clients, and their families.

CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare.

REFERENCES

1. United Nations. Convention on the Rights of the Child. Available at: https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child. Accessed October 26, 2023.
2. US Department of Health and Human Services. Unaccompanied children released to sponsors by state. September 28, 2023. Available at: https://www.acf.hhs.gov/orr/grant-funding/unaccompanied-children-released-sponsors-state. Accessed October 26, 2023.
3. United Nations. Children on the run—full report. Available at: https://www.unhcr.org/us/media/children-run-full-report. Accessed October 26, 2023.
4. Leyva-Flores R, Infante C, Gutierrez JP, Quintino-Perez F, Gómez-Saldivar M, Torres-Robles C. Migrants in transit through Mexico to the US: experiences with violence and related factors, 2009–2015. *PLoS One*. 2019;14(8):e0220775. https://doi.org/10.1371/journal.pone.0220775
5. Greenbaum J, Kaplan D, Young J, et al. Exploitation, labor and sex trafficking of children and adolescents: health care needs of patients. *Pediatrics*. 2023;151(1):e2022060416. https://doi.org/10.1542/peds.2022-060416
6. Dreier H, Luce K. Alone and exploited, migrant children work brutal jobs across the US. *New York Times*. February 25, 2023. Available at: https://www.nytimes.com/2023/02/25/us/unaccompanied-migrant-child-workers-exploitation.html. Accessed October 26, 2023.
7. Dreier H. As migrant children were put to work, US ignored warnings. *New York Times*. April 17, 2023. Available at: https://www.nytimes.com/2023/04/17/us/politics/migrant-child-labor-biden.html. Accessed October 26, 2023.
8. *Jenny Lisette Flores, et al., v. Merrick B. Garland.* Case no. CV 85-4544-DMG (2021). 2023. Available at: https://youthlaw.org/sites/default/files/2023-07/2023.01.30%20-%20Flores%20Juvenile%20Care%20Monitor%20Report.pdf. Accessed January 22, 2024.
9. Center For Human Rights & Constitutional Law. Mission statement. June 22, 2022. Available at: https://www.centerforhumanrights.org/who-we-are. Accessed January 22, 2024.
10. 8 CFR § 236.3 (2012). Available at: https://www.law.cornell.edu/cfr/text/8/236.3. Accessed October 26, 2023.
11. Liepert AE, Berndtson AE, Hill LL, et al. Association of 30-ft US–Mexico border wall in San Diego with increased migrant deaths, trauma center admissions, and injury severity. *JAMA Surg*. 2022;157(7):633–635. https://doi.org/10.1001/jamasurg.2022.1885
12. Velasco P. More than 14,000 asylum seekers were sent to San Diego. Local support systems were overwhelmed. *The Guardian*. October 19, 2023. Available at: https://www.theguardian.com/us-news/2023/oct/19/california-asylum-seekers-san-diego-budget-cuts. Accessed October 26, 2023.
13. Women's Refugee Commission. Protecting unaccompanied children: the Office of Refugee Resettlement (ORR) and the Trafficking Victims Protection Reauthorization Act (TVPRA). December 9, 2019. Available at: https://www.womensrefugeecommission.org/research-resources/protecting-unaccompanied-children-the-office-of-refugee-resettlement-orr-and-the-trafficking-victims-protection-reauthorization-act-tvpra. Accessed January 19, 2024.
14. US Department of Health and Human Services. Fact sheets and data. October 13, 2023. Available at: https://www.acf.hhs.gov/orr/about/ucs/facts-and-data. Accessed October 26, 2023.
15. US Department of Health and Human Services. ORR Unaccompanied Children Program policy

guide. Section 3. October 23, 2023. Available at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide-section-3. Accessed October 26, 2023.

16. Administration for Children & Families. Medical services requiring heightened ORR involvement. September 29, 2020. Available at: https://www.acf.hhs.gov/sites/default/files/documents/orr/garza_policy_memorandum.pdf. Accessed October 31, 2023.
17. Centers for Disease Control and Prevention. Guidance for the US domestic medical examination for newly arriving refugees. March 30, 2023. Available at: https://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic-guidelines.html. Accessed October 26, 2023.
18. US Department of Health and Human Services. More than 340 migrant kids sent to live with nonrelatives who sponsored other kids. June 2, 2023. Available at: https://www.nbcnews.com/politics/immigration/advocates-hhs-questions-unaccompanied-migrants-child-labor-rcna87326. Accessed October 26, 2023.
19. KFF. State-funded health coverage for immigrants as of July 2023. July 26, 2023. Available at: https://www.kff.org/racial-equity-and-health-policy/fact-sheet/state-funded-health-coverage-for-immigrants-as-of-july-2023. Accessed October 26, 2023.
20. US Citizenship and Immigration Services. Victims of human trafficking and other crimes. August 21, 2023. Available at: https://www.uscis.gov/humanitarian/victims-of-human-trafficking-and-other-crimes. Accessed October 26, 2023.
21. US Citizenship and Immigration Services. Special immigrant juveniles. March 31, 2023. Available at: https://www.uscis.gov/working-in-US/eb4/SIJ. Accessed October 26, 2023.
22. Hacker K, Anies M, Folb BL, Zallman L. Barriers to health care for undocumented immigrants: a literature review. *Risk Manag Healthc Policy.* 2015;8:175–183. https://doi.org/10.2147/RMHP.S70173
23. Commonwealth Fund. Understanding the US behavioral health workforce shortage. May 8, 2024. Available at: https://www.commonwealthfund.org/publications/explainer/2023/may/understanding-us-behavioral-health-workforce-shortage. Accessed January 22, 2024. https://doi.org/10.26099/5km6-8193
24. Alpern JD, Davey CS, Song J. Perceived barriers to success for resident physicians interested in immigrant and refugee health. *BMC Med Educ.* 2016;16:178. https://doi.org/10.1186/s12909-016-0696-z
25. Bjorklund AB, Cook BA, Hendel-Paterson BR, Walker PF, Stauffer WM, Boulware DR. Impact of global health residency training on medical knowledge of immigrant health. *Am J Trop Med Hyg.* 2011;85(3):405–408. https://doi.org/10.4269/ajtmh.2011.10-0732
26. National Immigrant Justice Center. Access to counsel. Available at: https://immigrantjustice.org/issues/access-counsel. Accessed October 31, 2023.
27. Montoya-Galvez C. Biden administration discards Trump-era plan to end legal agreement protecting migrant children. December 11, 2021. Available at: https://www.cbsnews.com/news/biden-administration-discards-trump-era-plan-to-end-legal-agreement-protecting-migrant-children. Accessed January 19, 2024.
28. NPR. The history of the Flores Settlement and its effects on immigration. Available at: https://www.npr.org/2018/06/22/622678753/the-history-of-the-flores-settlement-and-its-effects-on-immigration. Accessed January 19, 2024.
29. US Department of Health and Human Services. Unaccompanied children program foundational rule. *Fed Regist.* 2023;88(191):68908–69002.
30. Linton JM, Griffin M, Shapiro AJ, et al. Detention of immigrant children. *Pediatrics.* 2017;139(5):e20170483. https://doi.org/10.1542/peds.2017-0483
31. Migration Policy Institute. Rising child migration to the United States. July 21, 2014. Available at: https://www.migrationpolicy.org/programs/us-immigration-policy-program/rising-child-migration-united-states. Accessed January 7, 2024.
32. Pathways to Wellness. Integrating refugee health and well-being. Available at: https://www.refugeehealthta.org/wp-content/uploads/2012/09/RHS15_Packet_PathwaysToWellness-1.pdf. Accessed October 26, 2023.
33. Minnesota Department of Health. WE-Check: Minnesota well-being and emotions check. December 30, 2021. Available at: https://www.health.state.mn.us/communities/rih/guide/wecheck.pdf. Accessed January 22, 2024.
34. Centers for Disease Control and Prevention. Guidance for mental health screening during the domestic medical examination for newly arrived refugees. August 30, 2022. Available at: https://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/mental-health-screening-guidelines.html. Accessed October 26, 2023.
35. Centers for Disease Control and Prevention. Electronic Disease Notification system. September 30, 2022. Available at: https://www.cdc.gov/immigrantrefugeehealth/Electronic-Disease-Notification-System.html. Accessed October 26, 2023.
36. US Department of Health and Human Services. Unaccompanied Refugee Minors Program. March 17, 2023. Available at: https://www.acf.hhs.gov/orr/programs/refugees/urm. Accessed October 26, 2023.
37. American Immigration Lawyers Association. Featured issue: ensuring legal representation for people facing removal. Available at: https://www.aila.org/advo-media/issues/featured-issue-ensuring-legal-representation. Accessed October 26, 2023.
38. Bureau of Primary Health Care. What is a health center? Available at: https://bphc.hrsa.gov/about-health-centers/what-health-center. Accessed October 26, 2023.
39. Health Resources and Services Administration. FQHCs and LALs by state. Available at: https://data.hrsa.gov/data/reports/datagrid?gridName=FQHCs. Accessed October 26, 2023.
40. Forkey H, Szilagyi M, Kelly ET, et al. Trauma-informed care. *Pediatrics.* 2021;148(2):e2021052580. https://doi.org/10.1542/peds.2021-052580
41. National Center for Education Statistics. State education practices. Available at: https://nces.ed.gov/programs/statereform/tab1_2-2020.asp. Accessed October 26, 2023.
42. US Department of Labor. State labor laws. Available at: http://www.dol.gov/agencies/whd/state. Accessed October 26, 2023.
43. National human trafficking hotline. Available at: https://humantraffickinghotline.org/en. Accessed October 26, 2023.
44. US Department of Justice. List of pro bono legal service providers. February 23, 2023. Available at: https://www.justice.gov/eoir/list-pro-bono-legal-service-providers. Accessed October 26, 2023.