Unaccompanied Immigrant Minors: Where to Begin

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ABSTRACT

The number of unaccompanied immigrant minors (UIMs) from Central America significantly increased in 2014. Nearly 50,000 children from El Salvador, Guatemala, and Honduras crossed the United States–Mexico border in 2014, compared with 3,933 in 2011. Few resources exist to guide pediatric nurse practitioners (PNPs) in their care of UIM. The multifactorial reasons behind migration and the state of children's health in Central America provide insight into the needs of UIMs. Guidelines for similar groups such as foreign-born children and refugees offer direction for the health care considerations of UIMs. This article provides demographic information on UIMs, highlights the unique and challenging medical and mental health issues facing UIMs, and discusses the role of the PNP. A UIM's initial visit with a PNP serves as an opportunity to build trust through culturally competent, trauma-informed care, provide preventive care, assess for unmet health needs, and screen for mental health conditions. J Pediatr Health Care. (2016) *30*, 231-240.

KEY WORDS

Unaccompanied immigrant minors, unaccompanied alien children, child migrants

The number of unaccompanied immigrant minors (UIMs) in the United States nearly tripled in 2014, with many children migrating to escape violence in Central America. Pediatric nurse practitioners (PNPs) face unique challenges and opportunities in providing care to this patient population. UIMs require sensitive, compassionate, and comprehensive medical and mental health services to promote a healthy and safe transition to their new lives in the United States. Caring for UIMs requires an understanding of their experiences before, during, and after migration, which will inform acute medical and mental health evaluations and influence long-term care and management. This article will discuss the recent surge in UIMs and the role of the PNP in working with these patients.

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BACKGROUND

Reasons for Migration

Many children from the "northern triangle," which refers to El Salvador, Guatemala, and Honduras, view migration to the United States as necessary for their survival (Terrio, 2015; Women's Refugee Commission [WRC], 2012). Central America has one of the highest homicide rates in the world, and males between the ages of 15 to 29 years have a homicide rate four times greater than the global average (United Nations Office on Drugs and Crime [UNODC], 2013). Violence perpetrated by gangs, including sexual violence and violent forced membership, plagues neighborhoods and communities (Perez, 2013; United Nations High Commissioner for Refugees [UNHCR], 2014). Of the 151 UIMs from Central America interviewed by the WRC (2012), 77% cited violence in their home country as the primary reason for migration, and most reported that they would repeat the journey to the United States.

Forty-eight percent of the 404 UIMs ages 12 to 17 years who were interviewed by UNHCR (2014) reported being personally affected by violence carried out by gangs, drug cartels, and others in their home countries. Other reasons for migration include educational and work opportunities, and, in some cases, for either sexual or commercial exploitation (Aldarondo

& Becker, 2011). Less than a third of UIMs with one or both parents living in the United States cited family reunification as a reason for their attempted migration (Kennedy, 2014). Table 1 summarizes the push and pull factors involved in migration.

Changing Patterns of Migration

In 2014, 75% of the 65,800 UIMs apprehended in the United States originated from El Salvador, Guatemala, and Honduras (Meyer, Seelke, Taft-Morales, & Margesson, 2015). This differs dramatically from 2009, when 82% of the 19,668 UIMs apprehended originated from Mexico (Seghetti, Siskin, & Wasem, 2014). Figure 1 shows statistics on the rise in UIMs. Hispanic males between the ages of 15 to 17 years represent the majority of UIMs (Byrne & Miller, 2012); however, the number of girls and children younger than 13 years increased in 2014 (Seghetti et al., 2014). These statistics do not capture the number of UIM who escaped arrest when crossing the border.

Apprehension and Processing

Prior to arrival in the United States, UIMs may have taken dangerous train rides; been arrested and detained in Mexico; and encountered intimidation, violence, and abuse by drug cartels involved in human smuggling across the United States–Mexico border (McEwen, Boyle, & Messias, 2015). The U.S. Government refers to UIMs as "unaccompanied alien children" (Seghetti et al., 2014). Table 2 defines important terms. After they are apprehended, UIMs are detained at a shelter managed by the Health and Human Services' Office of Refugee Resettlement (ORR; 2014) during immigration proceedings and, if granted, the ORR sponsors placement (Seghetti et al., 2014). Figure 2 shows the states receiving the highest numbers of UIMs. Federal requirements mandate a mental health screening and physical examination within 24 hours of transfer to the ORR. Many UIMs do not receive appropriate care at the shelter, and postrelease services for medical and mental health care are often not arranged, leading to lapses in care (Kennedy, 2013; WRC, 2012). Although providers can request records from the ORR, no formal system for communication between the ORR and future health care providers exists, further exacerbating delays in care and the identification of needs.

GENERAL HEALTH CARE PRACTICE CONSIDERATIONS

Barriers to Care

Once released to a shelter, a foster parent, a friend, or a family member, a number of barriers prevent UIMs from receiving timely and quality care in the primary care setting. Many UIMs and their guardians avoid accessing health care because of a fear of being discovered by immigration officials (Portes, Fernandez-Kelly, & Light, 2011). Federal immigration policies such as Section 287, which created a partnership among local and state law enforcement and the U.S. Immigration and Customs Enforcement, negatively impact utilization of health services by undocumented immigrants (Rhodes et al., 2015). Researchers reported that undocumented immigrants feared deportation if they sought medical care without documentation of legal status and feared being discovered at a checkpoint in route to a health center (Rhodes et al., 2015).

Because of these fears, discrimination, and racial profiling, some caregivers elected to abstain from taking their child to a health care provider and instead diagnosed and treated conditions at home (Rhodes et al., 2015). In lieu of medical care, undocumented young adults report using home remedies, medications from family members, traditional healers such as *curanderos* (general-purpose healers), and online sources such as WebMD for health problems (Raymond-Flesch, Siemons, Pourat, Jacobs, & Brindis, 2014). In a pilot study in a rural area of the Southeastern United States, two researchers trained as buyers requested treatment for sexually transmitted infections from nonmedical sources (Rhodes et al., 2011). Owners of *tiendas* or bodegas and community leaders sold these buyers nonsteroidal anti-inflammatory drugs, vitamin B complexes, and a penicillin derivative rather than approved treatment for sexually transmitted infections (Rhodes et al., 2011).

In terms of health insurance, UIMs who do not gain permanent residency in the United States after

TABLE 1. Reasons for migration based on ethnographic studies

Push factors	Pull factors
Violence (Kennedy, 2014; United Nations High Commissioner for Refugees [UNHCR], 2014; Women's Refugee Commission [WRC], 2012)*	Family reunification (Kennedy, 2014; UNHCR, 2014)
Gangs* (Kennedy, 2014; WRC, 2012)*	Educational opportunities
Drug cartels (Kennedy, 2014; WRC, 2012)	Work (UNHCR, 2014)
Abuse in the home (UNHCR, 2014)	
Deprivation (UNHCR, 2014)	
Extreme poverty (Kennedy, 2014; WRC, 2012)	

**The push factors most cited most frequently by unaccompanied immigrant minors in the ethnographic studies.*