CLINICAL SCHOLARS

A Robert Wood Johnson Foundation program

Toolkit to Support Providers Caring for Former Unaccompanied Immigrant Minors

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Clinical Scholars is a national leadership program of the Robert Wood Johnson Foundation led by the University of North Carolina at Chapel Hill. Learn more about RWJF's Leadership for Better Health programs by visiting: rwjf.org/leadershipforbetterhealth

ABOUT THE TOOLKIT

This toolkit is designed to:

- Raise awareness about Unaccompanied Immigrant Minors (UMs) among medical and mental healthcare providers
- Help address needs of UMs and their families
- Help provide adequate healthcare to UMs in the US

For more information visit:

bbhouston.org

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TOOLKIT
October 2021

Toolkit to Support Providers Caring for Former Unaccompanied Immigrant Minors

Unaccompanied Immigrant Minors (UMs) are children under 18 years of age without lawful immigration status who do not have a parent/legal guardian available to offer care (Byrne & Miller, 2012). UMs are among the most vulnerable immigrants in the United States, with many experiencing high levels of stress as they integrate into the country (Antony & Thomas, 2017; Jani, 2017; Roth & Grace, 2015). UMs are at high risk for human trafficking, exploitation, and abuse. In recent years, large numbers of UMs are arriving from Guatemala, El Salvador, and Honduras seeking safety from alarmingly increased rates of violence, criminal coercion, and/or extreme deprivation (Deckert, 2016). In 2021, the Department of Homeland Security referred over 75,000 UMs to the Office of Refugee Resettlement (ORR) for temporary shelter. Texas has the second largest number of UMs released from ORR custody to sponsors (usually family members) in the US while awaiting their legal process, with the Houston area receiving the highest influx.

Trauma-informed culturally-sensitive care for UMs

This wicked problem is of vital importance because there are high levels of trauma exposure within the UM population, including trauma in their home country, during their journey, during apprehension, and in the process of dealing with separation and loss, in addition to post-migration stressors such as acculturation, language difficulties, and racial discrimination (United Nations High Commissioner for Refugees, 2014; Carlson, Cacciatore, & Klimek, 2012). It is clear that UMs need mental health support as they navigate the many different stressors during reunification in the United States (Jani, 2017). Currently, the long-term mental health outcomes of UMs are not known, but one of the most remarkable characteristics of this group is their resilience and drive to move forward in life (Aldarondo & Becker, 2011). Furthermore, evidence suggests that comprehensive, integrated, and culturally responsive services can lead to a more positive integration of immigrant youth and families into United States communities (Murphey, 2016). There is a clear need for trauma-informed and culturally responsive mental health care services for UMs as they begin to heal here in the United States. Specifically, in Houston, we are in desperate need of an organizing group to gather community resources, create awareness, and educate local service providers so that they may join us in providing mental health education and services to our UMs and help their families. The BridgeUM team's project included three main aspects:

- Creation of Advisory Group – Collaborated with Houston-based Central American Minors (CAM) group and other area professionals involved with UMs
- Research – Comprehensive needs assessment and systematic review of literature
- Creation of Toolkit – The first ever toolkit for culturally sensitive, trauma-informed care of UMs

Planning

Tens of thousands of immigrant children come to the U.S. annually (US Customs and Border Protection, 2020), but the majority arrive with their parents or close family members. Although UMs are similar to non-UM immigrant children in many ways, UMs have inherently unique needs. UMs are specifically vulnerable because of their age, their separation from parents and relatives in their home countries, the hazardous journeys they undergo by fleeing their countries and crossing into the U.S. alone, and their adjustment to living in a new culture with parents or guardians who did not raise them (Office of Refugee Resettlement, 2020c). Due to their complicated histories and living situations, many UMs struggle with their past histories of trauma, new U.S. families, and new culture. The provision of trauma-informed and culturally responsive mental health care services for UMs is a social justice and human rights issue that must be tackled.

Team members, Adriana Gutierrez and Johanna Creswell Báez have worked with UMs for more than a decade either in UM shelters providing care or UM shelter policy creation for one of the largest shelter providers in the United States. Team members, Mitra M. Misra and Nohemi Garcia through Texas Children's Hospital, specifically the Mobile Clinic Program (TCH-MCP), have provided medical and mental health care to children who may not have access to adequate healthcare in the Houston community. The TCH-MCP, established in 2000, provides comprehensive medical care to under-resourced children all over the greater Houston area with immigrants and refugees comprising up to 70-80% of their patients. Working in collaboration with expertise in the area, we hope that our toolkit will (1) raise awareness about UMs among medical and mental healthcare providers, (2) help address needs of UMs and their families, and (3) help provide adequate healthcare to UMs living in the U.S.

KEY SKILL SETS

To create an interdisciplinary comprehensive approach, we needed experts in UM care from different fields of practice such as pediatrics, mental health, and social work. Johanna Creswell Báez and Adriana Gutierrez had incredible experience with UMs working at Southwest Key Programs. They approached Mitra Misra and Padma Swamy because of their pediatric practice in the community. Nohemi Garcia was included because of her unique perspective working in the Texas Children's Hospital Trauma and Grief Center which provided care to UMs in the community. Several team members, along with Cassandra Harper who supported the qualitative data analysis, brought skills in research, including needs assessments, qualitative research, systematic reviews, and toolkit development based on research findings.

We knew that we needed support from social workers in schools who interface with immigrant children, so we included Sarah Howell. To help with website technical support, we included a tech-savvy MPH student Natalie Holdstock. Additionally, we included Arlene Bjugstad who had experience working with UMs through her social work doctoral degree projects.

OUR TEAM

- Johanna Creswell Báez, PhD, LCSW, Social Worker and Assistant Professor at the University of Colorado at Colorado Springs
- Nohemi Garcia, LMFT, LPC, Licensed Professional Counselor at Garcia Roberts Counseling and Consulting
- Adriana Gutierrez, MA, LPC-S, Licensed Professional Counselor and Supervisor at Yes to Youth in Montgomery County
- Mitra M. Misra, MD, Pediatrician/Medical Director of Texas Children's Mobile Clinic Program and Associate Professor of Pediatrics at Baylor College of Medicine
- Padma Swamy, MD, MPH, Pediatrician of Texas Children's Mobile Clinic Program and Assistant Professor of Pediatrics at Baylor College of Medicine
- Sarah Howell, MSW, LCSW Houston ISD Las Americas Newcomer School
- Natalie Holdstock MPH student, University of North Carolina at Chapel Hill
- Arlene Bjugstad, MSW, Social work doctoral student, University of Houston
- Cassandra Harper, MPH, Research Assistant

COMMUNITY PARTNERSHIPS

- **Schools:** We have created a collaboration with Houston area school social worker Sarah Howell, who has been an asset in our work, as she has relationships with families in the immigrant community and has helped us make connections to complete focus groups.
- **Churches:** To help us conduct our needs assessment, we leaned on community leaders at Cathedral of St. Matthew and Epiphany Community Health Outreach Services (ECHOS). They have been instrumental in helping us find UMs, and we have served as a resource for the organizations when they need help finding resources for their community members.
- **Clinics:** The providers and community health worker from the Texas Children's Mobile Clinic Program and psychology department at Texas Children's Hospital have become a resource for us.
- **Universities:** We have collaborated on outreach with social work immigrant heath specialists and researchers at the University of Houston to help support our work. One doctoral student has been instrumental in coordinating our activities and helping with our literature systematic review. We have also collaborated with an MPH student at UNC Chapel Hill. She helped us create our website and conduct our literature systematic review.
- **Legal Services:** We are in discussions with immigration attorneys on best practices for reaching UMs who have been united with guardians in the community.

FUNDING

This project was funded by the Robert Wood Johnson Foundation with the support of the Clinical Scholars program. The UNC Consultant Support was vital to provide funds for important key aspects of the project such as toolkit review, project management, and UM expertise consultation. In-kind funds were provided by Jorge Martinez of Catedral de San Mateo and Epiphany Church Health Outreach Services ECHOS. In-kind support from the Harris County Youth Protective Services to allow use of the building for CAM meetings (the community advisory group).

Project work

The project pairs medical and mental health staff to develop training modules for community providers to identify unaccompanied minors in need and deliver trauma informed, and culturally responsive, mental health services.

- **Creating a local network:** We are supporting a local organization called the Central American Minors (CAM) group. The group includes professionals who care for immigrant children through work in clinics, mental health organizations, post-release services and schools. By supporting the group (taking minutes and helping with communication), we are able to reach leaders who will hopefully benefit from our work.

ELENA'S STORY

Elena came to the United States by herself at age 15 from Guatemala after suffering sexual harassment from neighbors. She was able to reunify with her mother in the United States, however, the process to obtain legal status was a nightmare.

Elena shared how scared she was when her mother would attend Court hearings because she thought she would never see her again. While in the process of legalization, she not only experienced fear of deportation but was also sexually harassed on her way to school.

Elena was able to attend therapy sessions and successfully graduated from treatment. She is very happy to be with her mother despite having many financial stressors and continuing to fight for her legalization. Elena is grateful for how hardworking her mother is, and would like to go to college to help her mom financially.

- **Creating the first clinical guide for UMs:** We analyzed data from the focus groups and using the results to develop a guide for medical and mental health providers. The completed toolkit is available at bbhouston.org/toolkit. We are now disseminating the toolkit guide to medical and mental health providers, including providing trainings featuring a documentary on this work and our key recommendations from the toolkit.
- **Continued community collaboration:** We continue to build relationships with community partners that are already working with immigrant populations. Further, we held a half-day conference (bbhouston.org/conference) with the key note by award-winning journalist Sonia Nazario. It included a panel of community leaders expert in supporting UMs and our team provided training on the toolkit to support community providers working with UMs. Lastly, using the results from the systematic review we have a platform to advocate for a better coordination of care for UMs in the community.

TIMELINE

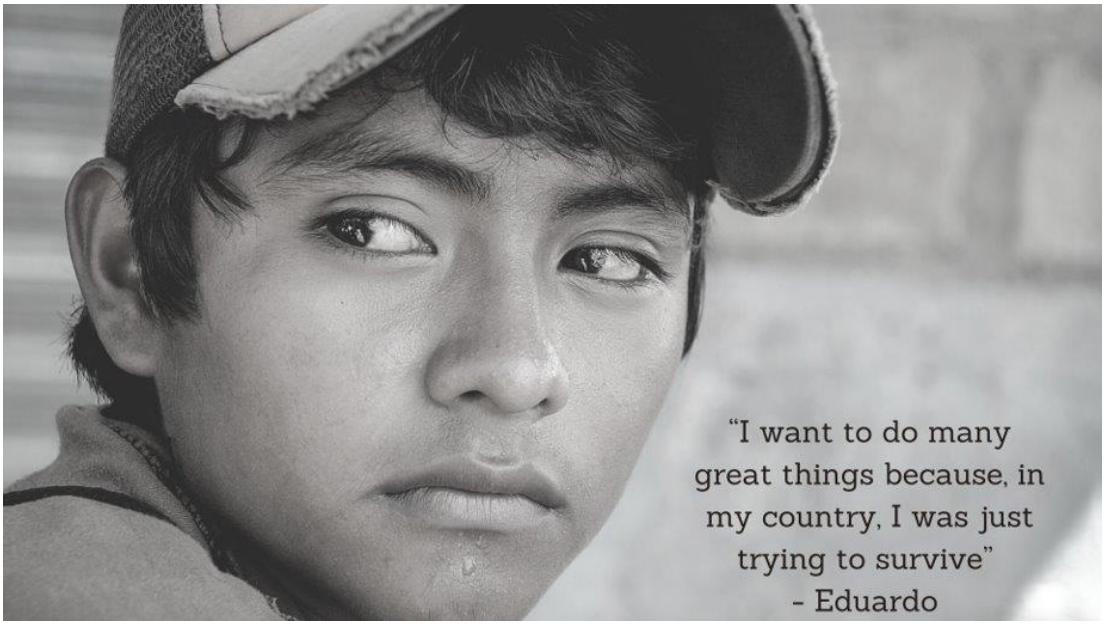
- **Year 1 Network Building:** Create network of partners and stakeholders and start in-depth needs assessment in Houston area of UMs mental health access, provision and use of services.
- **Year 2 Needs Assessment and Toolkit:** Finish in-depth needs assessment. Examine qualitative data to create a toolkit of best practices to support the mental health needs of vulnerable immigrant children.
- **Year 3 Implementation:** Finalize and publish toolkit, Deliver resources and trainings to providers dedicated to serving unaccompanied immigrant children in Houston by creating a unified standard of trauma-informed and culturally responsive mental health care.

EDUARDO'S STORY

Eduardo came here by himself from Honduras after his mother had died and he was threatened with violent death from a local gang who had targeted him for being gay.

At 13, he was living by himself and saw no hope in his small village town. Then a friend asked if he wanted to make the months-long journey to salvation in the United States He had godparents in the U.S. and saw this as his only hope.

We found him struggling to help pay for the family expenses with his godparents, trying to decide if he should go back to school and worrying about his untreated asthma.



Evaluation and dissemination

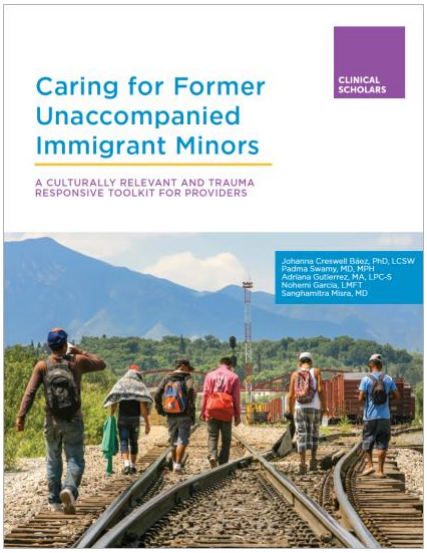
We evaluated qualitative data collected from UMs, their caregivers, clinical providers (healthcare and mental healthcare providers such as social workers and counselors), and community leaders. We examined the primary themes identified from six focus groups and two interviews to better understand the lived experiences of UMs in the context of their complex mental health, medical, and social needs. We used a qualitative case study approach with an action research design. Action research focuses on solutions to issues that require immediate attention, explores ways of improving practice, and emphasizes empowerment with a focus on social change in conjunction with community members (Ivankova, 2015). Action research includes a plan of action with cycles of development and implementation (Stringer, 2014). We began by conducting a community needs assessment to understand the needs of UMs. We then developed a list of Best Practices for Providers based on their words. Lastly, we are using our Best Practices for Providers and a Toolkit to provide training and support to providers working with UMs.

RESEARCH AND EVALUATION STEPS

- Interview questions were developed with feedback provided by community members.
- Approval was obtained from the Baylor College of Medicine Institutional Review Board (IRB) Protocol # H-44160.
- Data were collected in Houston, TX from April 2019 through November 2019.
- Six focus groups and two interviews were conducted with UMs, their caregivers, clinical providers (healthcare and mental healthcare providers such as social workers and counselors), and community leaders. Interviewers were in pairs, with one native Spanish speaker in each pair.
- Data were collected from six former UMs (ages 12-17), 8 Caregivers of UMs, and 22 community providers who care for UMs.
- Participants were asked about the needs and challenges of UMs, how UMs have felt about living in the U.S., how UMs are managing stress, and which services UMs are using in the community.
- Audio-recorded qualitative data were transcribed verbatim, translated to English when necessary, and analyzed using the qualitative data analysis software, MAXQDA.
- The data were analyzed and grouped into categories of information (codes) and then grouped into broader perspectives (themes).
- Accuracy of themes was checked with community members from a coalition group supporting UMs.
- Best Practices for Providers was developed from the themes to support UMs.

WEBSITE: BBHOUSTON.ORG

TOOLKIT / CLINICAL GUIDE



ESCÚCHAME: VOICES OF UNACCOMPANIED IMMIGRANT CHILDREN

Reflections

CHALLENGES

- **Recruiting:** UM participation was challenging due to possible fear of deportation with the political climate. We teamed up with a social worker in a school to bridge the gap between not having rapport with clients. We also provided incentives such as gift cards and snacks for their participation.
- **Allocating Funds:** We pivoted and hired Baylor's contractors and team member had conversations with Baylor's grant specialists.
- **Grant Allocation:** We shifted our grant from one organization to another.
- **Assistance:** We needed a project manager which we were not able to get. Instead, we had so much help from working very closely with Dr. Padma Swamy, who was even better than a project manager!

SUCCESSES

- **Toolkit:** We have disseminated the toolkit and has had very positive reviews as evidence by asking us to speak about our work in various organizations.
- **Short Documentary:** We were approved for creating a short documentary to share a story of a UM and promote our toolkit. There are two UMs who have been contacted and one seems very promising.
- **Conference:** We held a half-day conference (bbhouston.org/conference) with leading experts and community leaders working with UMs. We shared our toolkit and documentary during this conference with a wide audience.

RECOMMENDATIONS

- Recognize that each UM is an individual and has their own unique life experiences which shape how they interact with the world.
- Build trust at both the individual, organizational and community level.
    - Create trusting individual relationships so that UMs and their families will be willing to share what their needs are.
    - Promote, at the organizational level, these trusting relationships by having policies that are friendly to UMs also with the inclusion of education for staff on the care of the UM.
    - Build trusting bi-directional relationships with community organizations so you can help to be part of a referral network for the UMs. Organizations can also trust you to provide quality care for UMs.
- Having a community forum with representation from diverse fields that interface with UMs is key to understanding UMs' needs and how those needs may evolve.
- Advocate for policies that promote the well-being of UMs at different levels including organizational, community, and state/federal level.

KEY MESSAGES

- Useful and practical toolkit for providers with best practices for supporting UMs in the community
- Share a unified standard of trauma-informed, culturally responsive health care services for UMs
- Support efforts in creating community-based supports for UMs

"Gracias por querer escucharnos."

- UM Caregiver

CLINICAL SCHOLARS

Caring for Former Unaccompanied Immigrant Minors

A CULTURALLY RELEVANT AND TRAUMA RESPONSIVE TOOLKIT FOR PROVIDERS

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Who Are Unaccompanied Minors (UMs)?

Asylum-seeking unaccompanied minors (UMs) are immigrant youth who crossed the United States (U.S.) border without a legal guardian. A UM can be defined as "a child who has no lawful immigration status in the U.S.; has not attained 18 years of age; and, with respect to whom, there is no parent or legal guardian in the U.S., or no parent or legal guardian in the U.S. available to provide care and physical custody" (U.S. Department of Health and Human Services, 2020a).

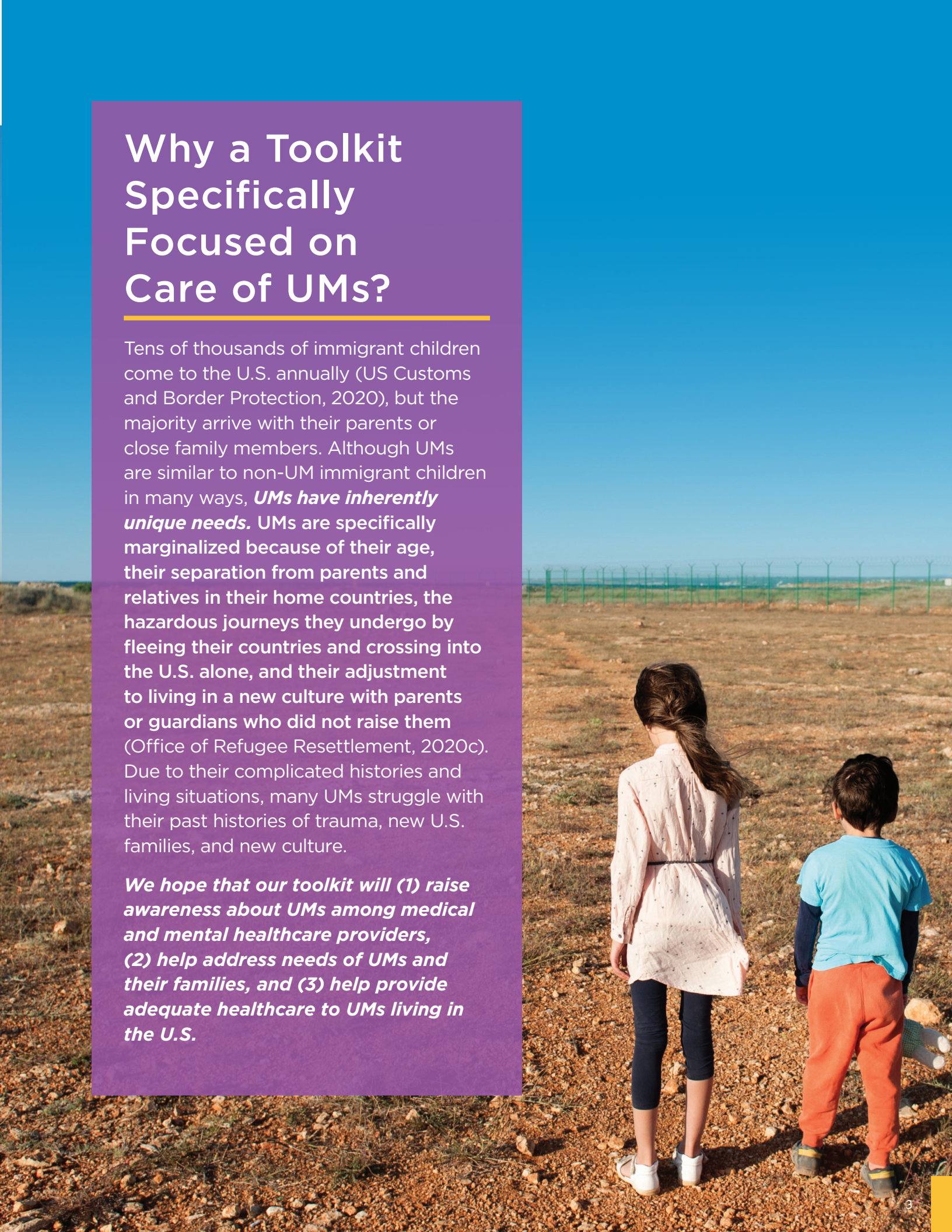
Over 400,000 UMs have crossed the U.S. border since 2003 (Office of Refugee Resettlement, 2020a), predominately coming from an area known as the "Northern Triangle" comprised of Guatemala, Honduras, and El Salvador (Office of Refugee Resettlement, 2020b). Since 2012, the number of UMs seeking asylum has grown dramatically. In 2019, a record number of UMs (69,488) were referred to the Office of Refugee Resettlement, the office responsible for the care of UMs under the U.S. Department of Health and Human Services with the Administration for Children & Families (U.S. Department of Health and Human Services, 2020b).

For the purposes of this toolkit, we use the abbreviation "UM" to describe asylum-seeking former unaccompanied immigrant children. We believe that UM is a non-dehumanizing and non-othering term. We use the term "minor" because the children are under the age of 18. In FY 2019, 84% of UMs who crossed the border were 13 years or older, while only 16% of UMs were under the age of 13 (Office of Refugee Resettlement, 2020c). Although there is overlap in care, this Toolkit does not specifically address needs of unaccompanied refugee children who entered the U.S. with legal immigration status. The term caregiver is used throughout this toolkit to describe the caregiver living now in the U.S. with the UM, this caregiver can be a biological parent or a family member that is sponsoring the UM.

Why a Toolkit Specifically Focused on Care of UMs?

Tens of thousands of immigrant children come to the U.S. annually (US Customs and Border Protection, 2020), but the majority arrive with their parents or close family members. Although UMs are similar to non-UM immigrant children in many ways, ***UMs have inherently unique needs.*** **UMs are specifically marginalized because of their age, their separation from parents and relatives in their home countries, the hazardous journeys they undergo by fleeing their countries and crossing into the U.S. alone, and their adjustment to living in a new culture with parents or guardians who did not raise them** (Office of Refugee Resettlement, 2020c). Due to their complicated histories and living situations, many UMs struggle with their past histories of trauma, new U.S. families, and new culture.

We hope that our toolkit will (1) raise awareness about UMs among medical and mental healthcare providers, (2) help address needs of UMs and their families, and (3) help provide adequate healthcare to UMs living in the U.S.



What is the Journey for UMs?

Leaving their country: UMs make the difficult decision to leave their families in their home countries, predominately from the "Northern Triangle", to travel primarily by foot over thousands of miles to the southwestern border of the U.S. As shown in Figure 1, there are several predominate routes from the Northern Triangle through Mexico that UMs and other Central American immigrants take to the U.S. UMs in 2019 and 2020 arrived in larger numbers to El Paso and Rio Grande in Texas, as compared to other U.S. Border processing centers (see Table 1). With around 76,000 UMs having encounters with U.S. Customs and Border Protection in 2019 and around 30,000 in 2020, due to political laws on reducing immigration to the U.S. **UMs come to the U.S. because a successful journey is often their last hope to reunite with family, avoid death by violence (especially gang violence), to escape extreme poverty or abuse, to flee political oppression, to find work to support their families, or to access education** (Jani, 2017).

FIGURE 1

Predominate routes from the Northern Triangle through Mexico to the U.S.

Common Migrant Routes from Northern Triangle through Mexico

Common migrant routes

Proportional size of apprehensions of Unaccompanied Minors by sector

Note: Adapted from Rodolfo Casillas R., Invisible Victims: Migrants on the Move in Mexico, by Amnesty International, 2011, https://www.amnesty.org/download/Documents/36000/amr410242010eng.pdf. With updated data from U.S. Customs and Border Protection for unaccompanied children, FY 2019 and FY 2020, https://www.cbp.gov/newsroom/stats/sw-border-migration/usbp-sw-border-apprehensions-fy2020. In the public domain.

TABLE 1

Unaccompanied minors, Encounters by Sector

Region	FY 2019	FY 2020
Big Bend	779	526
Del Rio	3,621	2,199
El Centro	2,688	1,607
El Paso	16,159	4,835
Laredo	2,521	2,641
Rio Grande	34,523	10,258
San Diego	3,335	1,855
Tucson	5,105	5,949
Yuma	7,289	687
BORDER TOTAL	76,020	30,557

Note. From U.S. Customs and Border Protection, 2020, U.S. Border Patrol Southwest Border Apprehensions by Sector Fiscal Year 2019 & 2020, Southwest Border Unaccompanied Children (0-17 yrs. old) Encounters, https://www.cbp.gov/newsroom/stats/sw-border-migration/usbp-sw-border-apprehensions-fy2020

Arriving in the U.S.: After UMs cross the border, they are predominately apprehended, **detained by U.S. Customs and Border Patrol for up to 72 hours, and subsequently transferred to shelters throughout the U.S.** (Congressional Research Service, 2019). Under the *Flores* Settlement, a 1997 court settlement agreement, shelters are required to provide food, clothing, education, medical services, and case managers for UMs who are working towards unification or reunification with a vetted guardian who can act as a sponsor during the UM's immigration legal proceedings (Byrne & Miller, 2012; Human Rights First, 2018). Sponsors are often biological parents that are here in the U.S., legal guardians, or other adult family members who go through a vetting process to sponsor and care for the UM (Office of Refugee Resettlement, 2020d). The average stay for UMs in a shelter during 2020 has been 152 days, mostly dependent on the time needed for the UM to find a vetted guardianas many sponsors don't often have legal and are at risk of being detained (Administration for Children & Families, 2020). The length of these stays has been steadily increasing, with the average length of stay just 66 days in 2019 (Office of Refugee Resettlement, 2020b). **Once released from the shelter, UMs move into temporary placement with a vetted guardian for the duration of their immigration hearings.**

Unfortunately, many UMs suffer significant culture shock after coming to the United States: Many UMs (1) have not had access to consistent schooling, (2) have been living on their own without parents or structure, (3) have left their social support structure of friends and family back home, and (4) have significant physical and/or mental health issues, while some (5) only speak a native language, making communication in English or even Spanish very difficult (Terrio, 2015).

Who Are We?

We are the **Bridge UM** team funded by the Robert Wood Johnson Foundation as part of the Clinical Scholars program. Our team is dedicated to solving the wicked problem of inadequate access, provision, and use of mental health services for UMs in the greater Houston community. The Bridge UM team consists of:

- **Johanna Creswell Báez, PhD, LCSW**, Social Worker at Columbia University School of Social Work
- **Nohemi Garcia, LMFT, LPC**, Licensed Marriage and Family Therapist and Licensed Professional Counselor at Baylor College of Medicine
- **Adriana Gutierrez, MA, LPC-S**, Licensed Professional Counselor and Supervisor at Yes to Youth
- **Sanghamitra M. Misra, MD**, Pediatrician and Medical Director of Texas Children's Mobile Clinic Program and Associate Professor of Pediatrics at Baylor College of Medicine
- **Padma Swamy, MD, MPH**, Pediatrician at Texas Children's Mobile Clinic Program and Assistant Professor of Pediatrics at Baylor College of Medicine

Pictured from left to right:
Johanna Creswell Báez, PhD, LCSW;
Nohemi Garcia, LMFT, LPC;
Adriana Gutierrez, MA, LPC-S; and
Sanghamitra M. Misra, MD.
Not pictured: Padma Swamy, MD, MPH.

Funding

Clinical Scholars, a national leadership program for experienced health care providers supported by the **Robert Wood Johnson Foundation**, provided funding for this research and toolkit. Working in teams of members from diverse disciplines, Clinical Scholars receive funding for projects addressing complex health problems while extending their influence and impact as professionals and trusted members of communities. The views expressed here do not necessarily reflect the views of the Foundation.

How Can I Provide the Best Care Possible to UMs?

The vast majority of healthcare providers work in busy settings, bear many responsibilities, and have limited time in the workday. This Toolkit offers simple recommendations that providers can use to optimally care for and insure the well-being of UMs.

Our recommendations are informed by interviews and focus groups with UMs, their caregivers, healthcare providers, mental health providers, and community leaders.

Identifying and Connecting with UMs

Healthcare providers who work in settings with predominately immigrant populations likely care for UMs. **However, many providers may not know which of their patients are former UMs.** A provider needs to first work on building trust and understanding with the UM and their family. After creating a framework of trust and understanding, providers can ask about their immigration history and/or legal stressors. Providers should be thoughtful and considerate in asking questions involving immigration history by considering their own intent and the impact on the UM and their family, as care must be taken not to re-traumatize. Providers can support trust by asking strengths based questions, such as asking them about their country and culture. Further, providers need to consider what information is important to document so that the UM's legal status and well-being can be protected.

Framing Interview Questions in a Culturally Relevant and Trauma Responsive Manner is Imperative

1. Conduct the interview in the family's preferred language. Translation services should be used if a clinic team member is not fluent in the family's preferred language.
2. Use simple language and closed ended questions requiring yes/no answers to help families with limited literacy and awareness of health issues.
3. Use normalizing statements (e.g., "We ask all our patients/clients and their families these questions") to help alleviate UM or caregiver fear
4. Be transparent about reasons for asking questions (e.g., using statements such as "We want to understand the patient/client so we can address all of his or her physical and mental health needs") as a way to create a framework of trust. And, be transparent about the process (e.g., we will talk about x, y, z. If you are not comfortable about y, we can take a break and come back to it.)
5. Explain that the UM and family members have the choice to not answer a question and can decline to participate, which emphasizes their individual voices and ability to choose.

Once a UM is identified, it is imperative that **trust** be established early between the UM, the caregiver, and the provider. Techniques for building trust and promoting best care for UMs are discussed in detail in the **Best Practices for Providers.**

Research Overview: Data Gathering

This Toolkit reports qualitative data collected from UMs, their caregivers, clinical providers (healthcare and mental healthcare providers such as social workers and counselors), and community leaders. **We examined the primary themes identified from six focus groups and two interviews to better understand the lived experiences of UMs in the context of their complex mental health, medical, and social needs.**

Our research priority is to promote social justice by raising awareness and understanding of this marginalized population of UMs living in the U.S.

Our team interviewed 6 former UMs (ages 12-17), 8 Caregivers of UMs, and 22 community providers who care for UMs in Houston, Texas.

We used a qualitative case study approach with an action research design. Action research focuses on solutions to issues that require immediate attention, explores ways of improving practice, and emphasizes empowerment with a focus on social change in conjunction with community members (Ivankova, 2015).

Action research includes a plan of action with cycles of development and implementation (Stringer, 2014). We began by conducting a community needs assessment to understand the needs of UMs. We then developed a list of **Best Practices for Providers** based on their words. Lastly, we will use our **Best Practices for Providers** and this Toolkit to provide training and support to providers working with UMs.

Research Steps:

- Interview questions were developed with feedback provided by community members.
- Approval was obtained from the Baylor College of Medicine Institutional Review Board (IRB) Protocol # H-44160.
- Data were collected in Houston, TX from **April 2019 through November 2019.**
- **Six focus groups and two interviews were conducted** with UMs, their caregivers, clinical providers (healthcare and mental healthcare providers such as social workers and counselors), and community leaders. Interviewers were in pairs, with one native Spanish speaker in each pair.
- Data were collected from six former UMs (ages 12-17), 8 Caregivers of UMs, and 22 community providers who care for UMs.
- Participants were asked about the needs and challenges of UMs, how UMs have felt about living in the U.S., how UMs are managing stress, and which services UMs are using in the community.
- Audio-recorded qualitative data were transcribed verbatim, translated to English when necessary, and analyzed using the qualitative data analysis software, MAXQDA.
- The data were analyzed and grouped into categories of information (codes) and then grouped into broader perspectives (themes).
- Accuracy of themes was checked with community members from a coalition group supporting UMs.
- **Best Practices for Providers** was developed from the themes to support UMs.

Joys and Challenges of Working with UMs

In our interviews and focus groups, the **22 providers** were vocal about the joys and challenges they experience working with this marginalized population. The providers were employees of federally funded health centers, schools, agencies, shelters, and medical clinics with between 1-10 years of experience working with UMs. Many identified with these youth personally, with one participant stating, "**My parents were immigrants and I saw them struggle...that is why I am interested in working with UMs**." Providers consistently noted the UMs' great resilience and how meaningful their work was to support these youths while emphasizing the following joys and challenges in working with UMs:

JOYS
OF WORKING WITH UMS

- Being able to provide care to kids who otherwise don't have good access to care
- Youth are very grateful, even for small things
- Youth are tough, resilient
- Seeing small accomplishments feels rewarding

> *At the end of the day, we're sitting in a room with kids who traveled 1,600 miles on their own. I mean talk about scrappy and resourceful and resilient, right?*
>
> – Provider

> *Despite the fact they have been through a lot, they are very charismatic. They are very respectful. They have very good values. That has been my experience, and I love talking to them because I always learn something from them.*
>
> – Provider

CHALLENGES
OF WORKING WITH UMS

- UMs are children having to navigate systems with little to no support for everything, including basic needs, schools, etc.
- UMs have culture shock and difficulty adapting to new culture
- Lack of accessibility to health and mental health services
- Lack of admin support in providing for the many needs of UMs

> *It's just always, always crisis.*
>
> – Provider

> *It's just the sense that immigrants aren't welcome...It's just a pervasive anxiety. It just feels like you're being slowly smothered by the uncertainty of the future. Then, yeah, a lot of living in the moment 'cause you don't know what the next moment will be.*
>
> – Provider

Overview

The following are seven key themes for better understanding the lived experiences of UMs in the context of their complex mental health, medical, and social needs.

These themes come directly from the voices of UMs, their caregivers, clinical providers (mental health clinicians, social workers, doctors, etc.), and community leaders. Each theme will be described in further detail alongside quotes in hope that their words will help community providers better support UMs.

Key Themes

1 The "Growing Phase" of Normal Teen Behavior

While navigating their immigration journey, UMs are also facing the normal developmental changes that occur with adolescence.

2 UMs Experience Discrimination and Are Labeled a "Bad One"

UMs experience discrimination and racism that adversely affects them, especially at school, where some caregivers noted their child had been labeled the "bad one."

3 UMs Need "Everything"

As one provider put it, the biggest need for UMs in the community is "everything" and safety is the "umbrella" under which all of these other needs fall.

4 Legal Support Comes Before Health

Legal issues were a significant source of stress for UMs and need to be attended to before mental and physical health needs can be addressed.

5 Caregivers Carry Guilt: "We Want to Give Them a Better Life"

Caregivers expressed guilt about not always being able to give everything to their UM. The caregivers were also worried about their UMs' safety and adjustment in a new country.

6 Financial Worries and Sacrifices for a Better Future

Both UMs and caregivers expressed worry about not having enough money. Caregivers discussed going to great lengths to make a better future possible for their UMs.

7 UMs' Needs are Unique

Each UM is unique and it is important to explore the complex intersection of factors impacting UM well-being. Caregivers and UMs noted the influences of acculturation and feelings of being trapped.

The "Growing Phase" of Normal Teen Behavior

KEY THEME 1

Adolescence, a transitional period between childhood and adulthood, is characterized by "development of health, competence and capacity" (Shlafer et al., 2014). **In addition to dealing with all the changes of adolescence from autonomy to purpose, UMs have the additional stress of adapting to life in a new culture and developing new relationships with caregivers.**

UMs undergo the typical adolescent development relationship stages starting from **early** (11-14 years) where changes occur in relationships with parents and friends, **middle** (15-17 years) where more focus is placed on peer groups and beginning romantic relationships, and **late** (18-22 years) where more intimate relationships develop. Along with these social changes in relationships and cognitive development, youth and **UMs typically experience a range of distance and interest in their own culture and traditions as they begin to understand their own identity separate from their caregivers, friends, and the intersection of their multiple identities** (Hutchinson, 2019).

A majority of UMs are adolescents, with Office of Refugee Resettlement data from FY 2019 showing that 72% of UMs were above the age of 14 (Administration for Children & Families, 2020). For many UMs, their adolescent development is on hold as they navigate the immigration process (Sleijpen et al., 2017). As community providers, you can support resiliency during this vital time by understanding the UM's stage of adolescent development and providing support. As one caregiver said, **"But they don't think like us, they are teenagers, right?"**

EARLY ADOLESCENCE

Early adolescence is characterized by physical growth and development (Hutchinson, 2019). At this stage, minors tend to have concrete thought processes that are often black or white, such as by describing situations as good or bad. One youth shared that their experience in the shelter was "**horrible**":

Interviewer:	*What was your experience in the shelters?*
Youth:	*Horrible*
Interviewer:	*Why?*
Youth:	*Because they gave us food without salt*

MIDDLE ADOLESCENCE

Middle adolescence is characterized by the want for independence (Hutchinson, 2019). This independence can often lead to increased arguments between the caregiver and teens. The caregivers shared how their UMs had **wants** that they could not always meet and that sometimes their UMs would get "**rebellious**." As providers, you can share with caregivers what to expect during middle adolescence and guide them on how to balance supervision and autonomy.

> ***They are in the growing phase, which is also a problem.***
>
> **– Caregiver**

> ***They want everything. The children want everything.***
>
> **– Caregiver**

Also at this stage, UMs may start to spend less time with family and more time with friends, becoming more susceptible to peer pressure and more concerned with appearance (Hutchinson, 2019). Middle adolescence is a period of autonomy where some adolescents might be reluctant to share how they feel or when they have a problem, especially when living with a new caregiver as demonstrated by the youth below.

Interviewer:	*When you have a problem, who do you talk to?*
Youth:	*No one*

As middle adolescence is characterized by a desire for independence, teens often experience the need for privacy. Newly arrived UMs who are adjusting to living with new caregivers may desire privacy not only from their adult caregivers, but from other children and adolescents living in the house as well.

> ***My sister is always annoying me. That's why I lock myself in the closet.***
>
> **– Youth**

LATE ADOLESCENCE

Late adolescence is characterized by a period where the youth has a greater sense of individuality and focus on the future (Hutchinson, 2019). For example, one UM teen recognized the contribution of their caregiver and wanted to contribute as an individual:

> ***They pay a lot of bills, and I would like to contribute too, but I can't, I can't afford it. And that's what I think about, because they aren't able to help me a lot, because they work too. That's what I think about if I were to get sick or something.***
>
> **– Youth**

These older teenagers also tend to be capable of thinking abstractly and gauging risk. This UM teen recognized the need to learn the rules before learning to drive:

> ***I said to my mom, 'Before you teach me to drive, explain to me the rules so that I can know a little bit.'***
>
> **– Youth**

UMs Experience Discrimination and Are Labeled a "Bad One"

KEY THEME 2

Caregivers shared their concerns regarding discrimination and its impact on UMs. **Discrimination is a significant barrier to accessing care for many immigrants (Hacker et al., 2015).** UMs and Caregivers noted that they faced discrimination in schools, and caregivers encouraged their UMs to address this discrimination. **Self-advocacy was promoted, with one caregiver telling her UM to "grab your phone and record them" when faced with an instance of discrimination.** With many immigrants fearing deportation and the effects of stigmatization, self-advocacy is a way to navigate ongoing bias and discrimination (Olukotun et al., 2020).

Even though UMs experience discrimination from non-UMs, several UMs and caregivers noted that they engage in discrimination. The historical impact of colonialism has resulted in colorism, or discrimination against darker skin, anti-Blackness and anti-Indigeneity, which especially impacts Afro-Latino populations and is still perpetuated today (Haywood, 2016). Recognizing and addressing both anti-Black racism, anti-Indigeneity, and colorism is needed to create a just and equitable society. Providers need to take an active stand against all forms of discrimination, specifically anti-Black racism, in their work with UMs and their families.

Providers can hold this deep injustice and talk with children and providers about anti-racist actions to create equity between racialized ethnic groups. Discussions can include topics of power, anti-Black racism, white supremacy, colonialism, and colorism to raise awareness and to [bold this] take action to overturn unjust discrimination.

DISCRIMINATION AND UMS

All participants noted that UMs experience discrimination and racism that adversely affects them, especially in schools, where some caregivers noted that their child has been discriminated against:

> *In my case, I work at a school in Las Americas. I can see how there are children from other countries who behave rudely, and bad towards Hispanics, such as us. I think the children know this and they say, "No, [but] that is why I don't want to go.[school]*
>
> **– Caregiver**

When asked about living in the United States, one UM said that she experienced other people as racist:

> *I don't like people…Because they are very racist.*
>
> **– Youth**

With regard to this discrimination, many caregivers said that their UMs don't want to attend school because of negative experiences with both school staff/administrators and other students. Many caregivers discussed ways they were teaching their children to take action when experiencing discrimination, or were taking action themselves:

> *She [a UM) said that they called her a b****, and a Latina and I don't know what else. I told her, 'Don't talk back to them,' I said, 'Grab your phone and record them so you can show the school what they are doing.' That is what she did. She found out about all this [discrimination].*
>
> **– Caregiver**

> *I tell her [the principal], 'The truth is you only notice what you want,' that is what I told the principal, and since then, they have not called me again.*
>
> **– Caregiver**

Even though UMs and caregivers themselves are a marginalized and targeted population, they also expressed mistrust toward racial groups and racism toward Black people.. It is clear that this is rooted in colonialism and anti-Black racism that has long unfortunate roots in countries that were colonized with unjust standards of white supremacy.

> ***I also see that my children like school, but sometimes there is so much discrimination in those schools, from other cultures, other races, and all that. Especially from those—from Blacks, there are children who are bad, and it is incredible what they are capable of.***
>
> **– Caregiver**

Some youth also noted similar fears towards Black people:

Interviewer:	*When you left the shelter and first went to your house, what were you feeling? What were you thinking?*
Youth:	*I wanted to go to Honduras too.*
Interviewer:	*Yes. I imagine that it felt strange. For many of you, it felt a little strange.*
Youth:	*I was scared because there were a lot of Black people.*
Interviewer:	*—and why did "Black people" worry you?*
Youth:	*Because they like to fight.*

LABELED AS A "BAD ONE"

Caregivers noted that at school their children are often labeled as the **"bad one."** Many caregivers were worried about their children being labeled as bad in the school. The caregivers were worried about how their children were being treated in school and noted that UMs were often blamed for misbehavior. Caregivers talked about their UMs being bullied and how the UMs were worried about repercussions due to their ongoing legal proceedings.

> ***There was a time when he was accused of misbehaving and it wasn't him, it was that they kept harassing him.***
>
> **– Caregiver**

> ***'Why do you always blame her and only her about things?' I said. 'Other kids do it as well, and you only blame her. Only her...just because she is not from here'***
>
> **– Caregiver**

Two caregivers talked about their pain and frustration at feeling that their children are singled out and viewed as a **"bad child"** at school:

Caregiver 1:	*But this is why we are saying, that if they already did something wrong, then they are going to single them out, even if they speak up—*
Caregiver 2:	*Yes, from then on, they focus on them.*
Caregiver 1:	*—they don't pay attention to what they say because they say, "No, you are a bad child."*
Caregiver 2:	*It's you.*
Caregiver 1:	*You are the bad one, and you are the one who causes the most problem.*

KEY THEME
3

UMs Need "Everything"

In the United States there are clear concerns about the adequacy of care and resettlement resources such as education, health, and social services that are provided to UMs released to family or legal guardians while their asylum and immigration cases are considered in court (Menjívar & Perreira, 2019). Further, the needs of UMs differ from other Latinx and immigrant populations because of their unique mental health, education, social, and legal needs (Evans, Diebold, and Calvo, 2018). UMs, caregivers, and providers all stated that the biggest need for unaccompanied minors in the community is "**everything**" and that safety is the "**umbrella**" under which all other needs fall.

Many UMs show great resilience in the face of substantial past and present adversities (Hodes & Vostanis, 2019). Data have shown that children being held in immigration detention experience high levels of mental health distress and have often experienced stress and trauma before migration, during migration, and after immigration (MacLean et al., 2019). Providers and caregivers noted that "**mental health is very important**," but also acknowledged that many UMs are not getting this support for many reasons, including services not being "**culturally appropriate or in a real-world setting where people can receive services in a more normalized way."**

BASIC NEEDS

UMs talked about needing money, legal support, medical care, food, transportation, and assistance learning English. One youth said,

> *I worry about certain things sometimes, about my health, food. All of that, the rent. The money I earn isn't enough, so I worry.*
>
> – Youth

Similarly, caregivers said that the biggest needs for unaccompanied minors living with them were medical, dental, mental health, safety, and access to food. One aunt put it clearly:

> *My niece needs medical attention, also dental work. In that regard, yes, I need help with her, because I don't have a job. The only one who has a job is my husband. We always need help because it's not easy here. Here it's really expensive. Dental work is very expensive. Medical attention is really expensive, everything...so we always need help.*
>
> – Caregiver

> *It takes too long to get an appointment and because of the cost.*
>
> – Caregiver

Providers also noted the overwhelming number of needs faced by UMs:

> *Basic needs I see as unmet needs a lot; food, clothing, baby items, and transportation. Any need you can think of, I come upon; housing.*
>
> – Provider

Providers were also concerned about UMs and their families having access to healthcare, including medical, dental, and mental health services:

> *I feel like medical needs are higher, as well as mental health.*
>
> – Provider

SAFETY IS IMPORTANT

Providers emphasized that safety is the number-one priority for UMs and that safety is the **"umbrella"** under which all other needs fall:

> ***Safety is number one, so I find—most UMs don't need help with shelter until safety becomes an issue, until they're no longer welcome in the home, something has happened in the home, and then it's a really urgent basic need...they're released with a plan in place, but then it breaks down.***
>
> **– Provider**

Caregivers also talked about safety and how many unaccompanied minors lacked adequate safety in their countries of origin, with the desire for safety being their reason for immigrating:

> ***That is the reason why we bring our children here: we are afraid for them.***
>
> **– Caregiver**

Further, it is important that providers are alert to any concerns for the UMs safety in their household or with their caregivers. It is important to note that UMs have greater risks for exploitation and human trafficking through the process of migration (Fong & Cardoso, 2010). Providers can ask UMs if they feel safe and complete ongoing safety assessments to protect UMs.

ACCESS TO MENTAL HEALTH

Providers and caregivers noted how hard it is to access mental health services and that many youths are not using them as much as is needed. However, parents and caregivers agree there is a need for mental health support. As one parent said:

> ***It [mental health] is important. It's very important. I think so. For me, it's very important. Imagine the conditions that he arrived in, although nothing happened on the way here, one suffers. He was very skinny and very depressed those first days.***
>
> **– Caregiver**

Both caregivers and providers talked about how mental health services were difficult to access even though they are available:

> ***I also think there are services available, but they're not necessarily culturally appropriate or in a real-world setting where people can receive services in a more normalized way***
>
> **– Provider**

Legal Support Comes Before Health

KEY THEME 4

In the United States, immigration courts are characterized as civil courts (not criminal courts). Due to this distinction, the U.S. government is not required to provide attorneys for UMs to aid them through immigration proceedings. **To support UMs through this process, nonprofit and governmental organizations provide pro bono legal services to UMs. Although there are available resources, up to 90% of UMs face deportation proceedings without an attorney** (NCSL, 2020).

Data traced back to 2004 demonstrate that **UMs are more successful in proceedings if they have the help of an attorney**. For example, in 2014, 12% of UMs who had an attorney were deported, while more than 80% of UMs who did not have an attorney were deported (TRAC, 2020).

Because of the incredible stress surrounding immigration proceedings and the UMs' vital hope that they have a successful outcome, **UMs and their caregivers experience significant anxiety and worry regarding these proceedings and accessing pro bono legal services**. For youth, this concern can result in stress, anxiety, and depression.

To support mental health and address mental health concerns, legal needs must be addressed. A physician stated that:

> ***The one that stands out to me the most is legal aid, because for many of these children, they come out of the shelters and there is uncertainty...and this affects how they function day-to-day because they are living with that uncertainty of not knowing if they are going to stay here legally.***
>
> **– Provider**

Youth require responsive legal support for themselves and their parents/caregivers. One youth mentioned:

> ***The lawyer that we have...when my mom calls her, she almost never answers, so my mom is worried because I am going to turn 18, and she doesn't answer.***
>
> **– Youth**

Youth need trusted legal support for themselves and their parents/caregivers. As one community leader clearly stated:

> ***We've seen that in legal services where we've had to really do a lot of trust building for people to seek services, like 'Kids In Need of Defense.' Even though these are free services...there's fear that those services aren't legitimate.***
>
> **– Provider/Community Leader**

Caregivers Carry Guilt and Worry: "We Want to Give Them a Better Life"

KEY THEME 5

Even though caregivers feel grateful that their children are now living with them in the U.S., they experience guilt about not being able to give their children or relatives everything they want. Caregivers continue to feel guilt for having left their children in their country of origin years ago. They want their children to learn from their struggles to have a better life than they did, with one caregiver noting their sacrifice and current situation with the phrase, "**I don't want you to end up like me."**

PARENT'S RELATIONSHIP WITH YOUTH: "ONE NEVER WANTS TO LEAVE THEIR CHILDREN."

Some parents come to the U.S. and leave their children with a family member in their country of origin with the hope of bringing their child to the U.S. Many parents are optimistic that this reunion will be soon, however the separation is often much longer and can be up to 10 years. Many parents remain in constant contact while separated from their children, and are relieved when UMs arrive to live with them. The adjustment period can be challenging for both the child and the caregiver, as it can take time to rebuild relationships.. Some children experienced a sense of abandonment from their caregivers, which caregivers found hurtful. One parent cried for weeks whenever their child would approach them about their relative who raised them remaining behind in their home country. The parent said:

> ***Yes, they do suffer a lot, and I agree with the part he mentioned about them confronting us because that happened to me with him. In the beginning, I felt hurt. I cried all night for a month or a month and a half because he would say to me, "You are not my mother. My mother is the one who is back in Honduras because she raised me.***
>
> **– Parent**

Several caregivers agreed that leaving their children was a very difficult decision:

> ***They are a part of us, so it does hurt a lot, but I talk to him. I tell him, "I am your mother. I am your friend." I explain, "Yes, I left you behind, but not because I wanted to. As a mother, one never wants to leave their children.***
>
> **– Caregiver**

CAREGIVERS WORRY ABOUT SAFETY

Caregivers worry about the dangers in their U.S. neighborhoods as many UMs arrive to low-income neighborhoods where safety continues to be a concern. The caregivers noted that they wished that there were less dangers for their UMs, as compared to their home countries:

> ***They want some chips, or a juice or something, they go and get it themselves, because there is no danger from a car or from someone, and here, it's different.***
>
> **– Caregiver**

When describing their perceived fears of the dangers in their community and with strangers, one caregiver said,

> ***I don't let my children cross the street by themselves, or anything. I am an overprotective parent. I say— 'Mommy, but we can go by ourselves. No, you can't go.' There are a lot of crazy people out in the street. I get scared. I don't let them.***
>
> **– Caregiver**

Financial Worries and Sacrifices for a Better Future

KEY THEME 6

Most studies on unaccompanied minors (UMs) have focused on their legal struggles, health, and mental health, and fail to include the hardships faced by caregivers living in the US with their UMs (Roth & Grace, 2015). UM caregivers, like any other parent, desire a safe environment in which their youths can pursue happiness and life fulfillment. These caregivers make the immense sacrifice of coming to the United States first and often bring their children afterwards.

Immigrants often love their home countries, but leave due to violence and/or financial issues (Berte, 2015). There is a wide range of feelings associated with their home country from pride, joy, nostalgia to sadness and anger. However, when their children arrive in the US, familial and financial struggles surge. One caregiver said, "**We want to give them a better life, but when we get here, it is not what we wanted.**"

FINANCIAL WORRIES

The UMs and their caregivers talked about their financial stressors, declaring that **"We need help."** Caregivers want to be able to give children what they need and want, and even when they try the best as they can, it is often still not enough. These financial struggles exist because individuals are not being paid living wages. Many sponsors are undocumented and many work under the table getting paid only in cash and well below what they should be getting paid.

One caregiver talked about their struggles to provide:

> ***Sometimes they want everything, and we cannot give it to them, because there is not enough.***
>
> **– Caregiver**

One caregiver contemplated going back to their home country and said,

> ***Life in the United States is not easy for me. Sometimes I tell myself, 'What am I doing here? I am going back,' but there is nothing over there for me yet, so how am I supposed to go back?***
>
> **– Caregiver**

The realization of not having enough money was evident with one caregiver, who said:

> ***It is not easy here. You may be making 400 a week, but you have to pay your bus fare, and this, and that, and when you realize you don't have enough to buy a hamburger or something for them…That is what you have to chew and swallow.***
>
> **– Caregiver**

Some caregivers become even more stressed when a major health issue arises in the family. One caregiver said,

> ***Here it's really expensive. Dental work is very expensive. Medical attention is really expensive, everything. In addition, I don't have a job, so we always need help. We need help.***
>
> **– Caregiver**

WORKING TO SACRIFICE FOR A BETTER LIFE: "I DON'T WANT YOU TO END UP LIKE ME."

Caregivers struggle in the workplace can include balancing childcare, low-paying jobs, long hours, and/or discrimination. Parents want their sacrifices to have been worthwhile and meaningful to their families. However, some children resent their parents for working so much and still not having enough money to buy them what they want or to spend time with them. One caregiver talked about her struggles with finding a job:

> ***I have to work, and I don't work, how do I do it? What do I do? I explain this to her…Who is going to buy your socks and shoes?***
>
> **– Caregiver**

Caregivers talked about their sacrifices and encouraged their children to go to school so they wouldn't end up doing physical work, with one caregiver saying:

> ***My daughter asks why I work and work and work so much, and what I am doing here, just working…Only to get by.***
>
> **– Caregiver**

Sometimes caregivers push their children because they want UMs to be more financially successful than them. There may be pressure on UMs to succeed because of the expectation that they take care of elders:

> ***On Saturday and Sunday, when the bosses don't go in, I take my girls so they can see what kind of work I do. I tell them, "Do you want to do what Mom does? Go to school, and pay attention and don't listen to what others say. Go to school, because I don't want you to end up like me, working out in the sun.***
>
> **– Caregiver**

> ***I say to my child, 'Come with me so you can see how Mommy works, so you can get an idea and decide you want to go to school, instead.' That's what I tell her.***
>
> **– Caregiver**

KEY THEME
7

UMs' Needs Are Unique

Caregivers, providers, and youth all identified different levels of adjustment and acculturation to their new environments. The youth's ability to adapt is shaped "by their own changing competencies in areas such as biological sensitivity to the environment (e.g., propensity for risk-taking at school), social–emotional self-regulation (e.g., curbing impulsive behavior when faced with discrimination), and temperamental tendencies" (Suárez-Orozco et al., 2018). **Providers should recognize that each UM is unique and explore the complex interplay of acculturation, trauma, adolescent development, and other factors in their work with UMs.**

ACCULTURATION IS A CONCERN

Youth identified needing to know the language as well as understanding social rules in their new culture as key factors in adjusting to the United States:

> ***There are differences in how we communicate. Maybe for you, it could be a bad word but for us, it isn't, because sometimes at school they take the words we say as bad words and they aren't.***
>
> **– Youth**

> ***Learn the basics, study English…learn the rules here***
>
> **– Youth**

In thinking about giving advice to a friend who had just arrived to the U.S., the youth continued to stress the importance of learning English and making the most of opportunities:

Youth 1:	*Learn how to socialize.*
Youth 2:	*Learn English.*
Interviewer:	*Learn English, socialize.*
Youth 3:	*To make the most of the opportunities.*
Interviewer:	*For example? What opportunities?*
Interviewee 4:	*Like study, because if you don't graduate, you won't get a good job.*

CAREGIVERS AND UMS NOTED THAT THEY FELT "ENCERRADO" OR TRAPPED AT HOME

Caregivers also noted the significant differences in living style between Central American countries and the United States as one of many adjustments facing youths. Several caregivers and UMs noted that they felt *encerrados*, or trapped at home, in the US compared to their home countries. Several caregivers mentioned their worries about their children's isolation: As compared to their home countries, UMs in the United States might be living in a city for the first time and experiencing a loss of green space, open spaces, or rural areas. Many UMs might also be experiencing a loss of community and knowing their neighbors.

> ***There is more freedom over there. For example, say, on the weekend, they go out, they play outdoors, or they hang out on the street.***
>
> **– Caregiver**

Youth also identified the differences in lifestyle compared to Central America as an adjustment of moving to the United States. The youth noted that they were bored and often had to stay inside, which did not support them in exploring their new culture:

> ***It's so boring being in the United States***
>
> **– Youth**

> ***We are always inside***
>
> **– Youth**

UMS ARE RESILIENT

Caregivers identified the emotional support provided in their homes, as primary factor in youth adapting to their new environment. Caregivers noted that with love and time that the youth began to feel comfortable:

> ***When she arrived, she felt something like, different—like everything was new...But from there, she adapted to how we live...now she feels comfortable here.***
>
> **– Caregiver**

Providers identified children's previous history of trauma, the stressors of their current home lives, and the children's motives for coming to the United States as factors in their ability to adapt to their new environment:

> ***I think it has a lot to do with their circumstance like their home life, whether they had some trauma, there, here, en route.***
>
> **– Provider**

> ***I think their success here has a lot to do with that family support and developing that relationship, and the time that the parent that's already here—the family that's already here—puts into developing that relationship with the kids.***
>
> **– Provider**

Best Practices for Providers: Supporting Unaccompanied Minors

The **Best Practices for Providers** are recommendations for how to best support UMs. Building trust and understanding each UM's unique situation is an essential framework to build on as you consider action steps that meet the needs of UMs and their families. This guide is intended as a dynamic and flexible tool that recognizes the need to meet UMs and their families where they are.

These practices are based on what UMs, caregivers, providers, and community leaders find important and useful when caring for former UMs. The first section is a framework for developing a relationship with UMs and their families, and the second section contains action steps to take with UMs and their families.

FRAMEWORK TO DEVELOP A RELATIONSHIP WITH UMS AND THEIR FAMILIES

Building trust with UMs

- Make a connection and take a genuine interest in UM/family
- Personalize the approach to the dynamic needs of the UM and family
- Ask about the family's culture to guide work/interventions

Understanding UMs:

- Each UM's situation is unique
- UMs feel uncertainty about the future and are living moment to moment
- UMs are worried about deportation
- Everything is a challenge
- UMs need support in general (food, housing, medical, legal, language, mental health)
- UMs are experiencing racism and xenophobia

ACTION STEPS TO TAKE

ASKING ABOUT IMMIGRATION HISTORY:

- Start where the UM/family is and go slow when needed
- Be cautious about asking too many questions, without first developing a relationship and understanding of trust
- Use strengths-based questions and ask questions within your scope of practice (e.g., mental health workers who have trauma training asking about trauma)
- Ask basic questions to understand pre, during, and post migration strengths and areas of concern
- Note areas of trauma, acculturation, and social support
- Listen for resilience

EMPOWERING UMS AND THEIR FAMILIES BY ADDRESSING THEIR SOCIAL NEEDS:

- Get training and understand resources and services for UMs
- Provide information on community services (specifically legal services)
- Inform families about how to advocate for their rights
- Support students and families in navigating schools
- Note that families can feel overwhelmed by too much information

ADDRESSING PHYSICAL AND MENTAL HEALTH NEEDS OF UMS:

- Ask about access to physical and mental health services
- Inquire about family readiness to use physical and mental health services
- Provide resources for physical and mental health services
- Facilitate the UM/family's connection to services
- Provide psycho-education on trauma and trauma responses, to normalize mental health services

ADDRESSING SYSTEMATIC ISSUES THAT AFFECT UMS:

- Take a stance against racism and injustice
- Support policy/systemic change to address racism and xenophobia

ENSURING WELLNESS OF THOSE WORKING WITH UMS AND THEIR FAMILIES:

- Practice self-care
- Get involved in networks for support and knowledge

Conclusion and Hope

We hope this toolkit will

1. **Raise awareness about UMs among medical and mental healthcare providers**
2. **Help address the needs of UMs and their families**
3. **Help provide adequate healthcare to UMs living in the US**

Providers are key to helping UMs navigate healthcare in the US, providing culturally relevant and trauma responsive care. Supporting these marginalized children in our communities is a humanitarian issue. The majority of these children stay here in the US, with those who have legal representation in court proceedings staying here in greater numbers (Roth & Grace, 2015). These children are part of our community and deserve high-quality healthcare. As one UM said, "I want to do many great things because, in my country, I was just trying to survive."

Please pass along this resource to others who are helping UMs and their families so that the issues faced by this vital group can be better addressed.

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CLINICAL SCHOLARS

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