Curbside Consultation

Caring for Unaccompanied Minors from Central America

Commentary by DOUGLAS S. BISHOP, MD, *Zufall Health Center, Morristown, New Jersey*
RINA RAMIREZ, MD, *Zufall Health Center, Dover, New Jersey*

Case scenarios are written to express typical situations that family physicians may encounter; authors remain anonymous. Send scenarios to afpjournal@aafp.org. Materials are edited to retain confidentiality.

This series is coordinated by Caroline Wellbery, MD, Associate Deputy Editor.

A collection of Curbside Consultation published in *AFP* is available at http://www.aafp.org/afp/curbside.

Case Scenario

A 16-year-old boy from Honduras came to our office at a federally qualified health center for a physical examination and vaccinations for school. He recently crossed the United States–Mexico border as an unaccompanied minor and was detained by U.S. immigration authorities before subsequently being sent to live with his older brother in the state where I practice. What initial primary care workup do I perform in this patient?

Commentary

The surge of unaccompanied minors from Central America crossing the United States–Mexico border in recent months has made national headlines, creating an "urgent humanitarian situation."[1] The reasons for this migration are multifactorial, and the resultant politics are deeply complex. As these issues sort out on the national stage, physicians will continue to be confronted with the practical challenges of caring for this underserved and highly vulnerable population.

From October 2013 through June 2014, approximately 54,000 unaccompanied minors (mostly from Honduras, El Salvador, and Guatemala) were detained attempting to enter the country at the United States–Mexico border.[2] After processing by the Department of Homeland Security, these children are placed into government shelters run by the Office of Refugee Resettlement (ORR), and, if appropriate, released to family members already in the United States to follow up for ongoing immigration processing.[3]

Beyond general guidance from the Centers for Disease Control and Prevention and others, there is little clarity on how to approach the care of these unaccompanied minors. Guidelines for domestic refugee care emphasize screening for and treatment of infectious diseases, as well as appropriate vaccination, health maintenance, dental care, and mental health screening (some of which is performed at the shelters).[4,5] Lead testing is recommended in refugees up to 16 years of age at arrival and six months postarrival.[6] Interferon-gamma release assay testing has replaced purified protein derivative testing as the preferred tuberculosis screen for patients older than five years who have received bacillus Calmette-Guérin vaccination.[7] Outbreaks of severe respiratory infections have been found in this population, including influenza and a cluster of rare pneumococcal bacteremia detected in a cohort of migrant children residing at an ORR shelter in California in June 2014.[8]

Physicians need to be alert for signs and symptoms of tropical diseases not typically seen domestically, including Chagas disease, dengue fever, and malaria. When possible, routine testing for human immunodeficiency virus, hepatitis, and parasitic infections is reasonable. Additionally, routine urine pregnancy testing and sexually transmitted infection screening in girls and women of reproductive age is recommended. This population has a considerable risk of sexual violence before, during, and after migration.

Unfortunately, medical care, particularly laboratory testing and follow-up, is complicated by uncertain legal status, lack of medical insurance, limited access to resources, and fear of discovery by authorities.[9] In New Jersey, for instance, undocumented children are not eligible for state Medicaid programs, making access to medical care and routine testing even more difficult.

These challenges underline the essential role of family physicians in creating systematic plans for evaluation, follow-up, and ▶

Table 1. Resources for the Care of Unaccompanied Immigrant and Refugee Minors

Topic	*Websites*
Emancipation laws by state	http://topics.law.cornell.edu/wex/emancipation_of_minors
General overview	http://emergency.cdc.gov/children/unaccompanied/ http://www.nytimes.com/interactive/2014/07/15/us/questions-about-the-border-kids.html
Medical care of refugees and immigrants	http://www.aap.org/en-us/advocacy-and-policy/federal-advocacy/Pages/ImmigrationReform.aspx http://www.cdc.gov/immigrantrefugeehealth/
Parents/guardians, advocates, and attorneys	http://www.acf.hhs.gov/programs/orr/programs/ucs/about http://www2.ed.gov/policy/rights/guid/unaccompanied-children.html

referral of these patients, as primary care visits may be one of their only contact points with the larger community. Initial primary care after community placement should focus on health screening and stabilization of any diagnosed medical conditions. Working to integrate these young patients into school and local communities, as well as catching up on preventive services (particularly immunizations and dental care) and addressing chronic conditions, is essential. Often, patients and family members know little of their medical histories, and physicians need to be on high alert for previously undiagnosed disease.

Particular attention should be paid to mental health issues in this population. Posttraumatic stress disorder; adjustment disorder; feelings of isolation because of language, physical, and cultural differences; and physical and sexual abuse are common. These topics need to be addressed comprehensively and in culturally appropriate manners. By law, mental health screening must be performed at ORR shelters, although the adequacy of this practice has been questioned,[10] and as processing times shorten, even less time is available for psychological screening and treatment. After ruling out severe mental illness and need for immediate treatment, physicians can build mental health screening into follow-up care. Validated screening tests, including the PCL-C for posttraumatic stress disorder and the Patient Health Questionnaire-9 for depression, have Spanish language versions and may be considered if appropriate mental health follow-up exists. Family reunification itself may pose psychological challenges, because strong family structures often are not intact, with many children having lived apart from their parents for years. Addressing these issues is no easy task, and extrapolating from the existing refugee mental health literature may be a starting point.

Knowledge of state laws as they pertain to emancipation of minors is essential to helping bring these children into care, and ultimately connect them with community resources. Who gives consent for treatment when a child presents to the clinic without a legal guardian? Is the undocumented 16-year-old boy who has been living on his own in a rented room since he was 14 years of age and working at a hotel kitchen considered an emancipated minor? Can an emancipated 17-year-old mother serve as a guardian for her 15-year-old cousin? ORR assigns the care of these children to a "responsible adult," but when the assignment is unknown or unclear, the treating physician and office staff face uncharted territory. Partnering with local school districts, as well as mental health physicians and local child and adolescent advocacy groups, is necessary for addressing questions of emancipation. *Table 1* provides information on finding emancipation laws by state, as well as resources on caring for unaccompanied immigrant and refugee minors.

Those of us on the front lines of community medicine continue to struggle daily with the challenges that this vastly complex and heterogeneous population brings, and we look forward to others sharing best practices to care for and foster resiliency in these children. For now, physicians caring for unaccompanied minors need to begin developing office protocols and medical evaluations that ▶

fit with state laws and financial realities while working to engage these children and keep them out of the shadows.

We as physicians must never forget that it is our job to do our best for the patients in front of us, no matter how they got there. These children, after all, are children, and deserve the best that we can offer them.

Address correspondence to Douglas S. Bishop, MD, at dbishop@zufallhealth.org. Reprints are not available from the authors.

Author disclosure: No relevant financial affiliations.

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