Unaccompanied Latino Minors, Immigration, and Mental Health: An Opportunity for Advocacy

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Child and adolescent psychiatrists (CAPs) have a duty to be patient advocates in multiple ways. Indeed, the Child and Adolescent Psychiatry Milestone Project's inclusion of advocacy within the systems-based practice competency recognizes this role as a core element of practice. However, while training programs focus on teaching advocacy for individual patients' needs, such as securing insurance coverage for medical treatment or obtaining school accommodations, preparedness in public policy and social justice domains is often limited. Accordingly, the current president of the American Academy of Child and Adolescent Psychiatry (AACAP), Dr. Gregory Fritz, has highlighted advocacy as one of four areas that his presidential initiative on integrated care will tackle.[1] The main goals of this article are to discuss the role of CAPs in advocacy efforts as they apply to the vulnerable population of unaccompanied children from Central America, to discuss ways in which CAP training programs can promote the special interests and advocacy efforts of their trainees, and to encourage all CAPs to consider ways to amplify their voices and roles as children's advocates.

Child Migration: History of the Problem

Between 1850 and 1930, more than 100,000 children were sent from the northeast of the US to rural areas; while some families were looking to adopt a child, many families saw these children as aid for manual labor.[2] These children, placed on "orphan trains" by their parents or by welfare agencies due to homelessness, were victims of poverty, culminating in their being sold or offered to farmers. Meanwhile, in the early 1960s, fearful parents wishing for a better future for their children outside of an antidemocratic government sent more than 10,000 children from Cuba.[3]

The current child migrant crisis in the US involves unaccompanied minors fleeing violence in Honduras, El Salvador, Guatemala, and Mexico. While unaccompanied children from Latin America have been crossing the border in smaller numbers for decades, largely unnoticed by the media, the issue has been publicized due to the increased volume of child migrants apprehended at the US–Mexico border.[4] The humanitarian crisis prompting this exodus is unique in that it is a chronic and gradual forced displacement, in contrast to the high-acuity mass migrations associated with natural disasters or violent conflicts.

Mental Health Implications

Though limited systematic research has focused on the psychological experience of immigrant children, these minors are at high risk of trauma and harm. Many would meet legal criteria for asylum if they had an opportunity to tell their stories. The report by the United Nations High Commissioner for Refugees in 2014 notes that almost 50% of displaced children shared experiences of violence associated with organized crime, including drug cartels, gangs, or governmental corruption. In a Mexican sample, 38% of children reported having been recruited into and exploited for human smuggling.[5] These stressors, coupled with those experienced during the immigration process, predispose them to substance use, anxiety, and adjustment disorders. Upon reunification, stressful living conditions can hinder the capacities of parents to nurture their children's socioemotional development.

How the children experience separation from family members, the social conditions in their home countries, their immigration experiences, and the new environments and opportunities upon arrival in the US will influence their development and adaptation.[6] Even

after arrival in the US, where they are seeking refuge, they continue to experience stressors added by the uncompassionate nature of our systemic immigration procedures. Additionally, given their language barrier, frequent lack of insurance, and high rates of placement in the foster care system, most of these children will not have the opportunity to seek and obtain needed mental health care. Depending on the clinical system and location in which they practice, CAPs may rarely interface with immigrant Latino children and other vulnerable populations, who are at the highest risk of psychiatric illness; the vulnerability of this population is therefore greatly worsened as their needs are under-recognized and often ignored by the health care system.

Opportunity for Advocacy

Children have rights, and it is our duty as health providers to foster policies and interventions in their best interest. Children coming from Central America or elsewhere should be protected in America. The high barriers they face to receiving mental health care and to maintaining mental health, as we have illustrated, require our advocacy to lower. Reform and progress do not happen by themselves. Whenever we stand up for an individual child or for a family, an extra step is needed to extend our actions into the larger community. CAPs have unique expertise in child development that should be brought to bear in educating policymakers dealing with the vulnerable population of unaccompanied Latino minors.

Our colleagues from the American Academy of Pediatrics (AAP) have set forth outstanding examples of promoting advocacy activities among members.[7] We are grateful that, in these times of political discord, AACAP's political action committee has encouraged members to engage in social policy activities. Dr. Fritz's address to AACAP in January 2017 regarding the proposed immigration ban demonstrates AACAP's commitment to the humane treatment of all individuals "without regard to their race, religion, ethnicity, or immigration status."[8] We are grateful that his message expanded past the effect of the immigration ban on the medical workforce into the greater needs of immigrant communities as a whole.

High-level advocacy is also illustrated by AACAP members Dr. Andres Pumariega and Dr. William Arroyo through their participation in an advisory committee created by the US Immigration and Customs Enforcement agency (ICE), which provided recommendations to improve detention practices of undocumented immigrant children and families. Their report notes that the detention of migrant children and families by the US government has been "controversial since its inception," and lists evidence-based recommendations for a more humane approach to detention practices for children and families. Most noteworthy was their primary recommendation that family detention be discontinued, stating that it should be presumed that "detention or the separation of families for purposes of immigration enforcement or management is never in the best interest of children."[9]

A Path Forward

Following the examples of these AACAP leaders, CAP trainees and training programs must also focus on advocacy. The process begins by engaging in self-reflection about one's biases, lack of experience in navigating complex systems, interest or disinterest in advocacy, and knowledge about how one's own skills and abilities are best utilized. Training programs can promote advocacy by creating opportunities for trainees. For example, training programs may develop clinical rotations tailored to the trainee's interest. Partnerships with other professionals such as lawyers, politicians, and organizational leaders can promote the development of leadership skills in public health efforts. Additionally, exposure to CAPs involved in advocacy or those working in the public sector is important, thus creating mentorship opportunities. We have found such mentors by engaging with AACAP and APA committees and attending committee meetings, conference calls, or other events, such as the AACAP Legislative Conference, creating opportunities to develop requisite leadership and advocacy skills.

Colleagues previously published in *JAACAP* verbatim accounts from refugee children to beautifully describe why it is imperative that CAPs continue their advocacy

and compassionate care to immigrant populations. They state that "one of the most pernicious effects of the politicization of immigration has been to obscure the humanity of those children traveling to this country."[10] These children's integral well-being and their human rights are at stake. Silence and neutrality are not options for those working with developing human beings. Social justice and policy issues are well within the scope of practice for those who care for and promote the well-being, development, and mental health of children. These issues are important to public health and clinical practice as well as to global child psychiatry, imperatives to which we are all held accountable.

Take Home Summary

Child and adolescent psychiatrists have an ethical responsibility to promote access to quality mental health care for vulnerable populations, such as unaccompanied Latino immigrants. Dr. Fritz has focused on advocacy during his presidency. We urge CAP training programs to promote advocacy efforts and for trainees to join AACAP committees so that CAPs can have a larger impact at the population level.

References

1. Ambler H. Five questions with: Dr. Gregory Fritz. Providence Business News. www.pbn.com. November 30, 2015. Accessed March 31, 2017.
2. Schene P. Past, present, and future roles of Child Protective Services. *Future Child.* 1998;8:23-38.
3. History: The Cuban children's exodus. http://www.pedropan.org/category/history. Accessed January 5, 2017.
4. Childhood and Migration in Central and North America: Causes, Policies, Practices and Challenges. San Francisco: Center for Gender and Refugee Studies, University of California Hastings College of Law, Universidad Central de Lanus; 2015.
5. Children on the Run: Unaccompanied Children Leaving Central America and Mexico and the Need for International Protection. A Study Conducted by the United Nations High Commissioner for Refugees Regional Office for the United States and the Caribbean. Washington, DC: UNHCR, the UN Refugee Agency; 2014.
6. Fortuna L, Porche M. Clinical issues and challenges in treating undocumented immigrants. Psychiatric Times. www.psychiatrictimes.com. August 15, 2013. Accessed March 31, 2017.
7. Protecting Immigrant Children. American Academy of Pediatrics. https://www.aap.org/en-us/advocacy-and-policy/federal-advocacy/Pages/Immigration Reform.aspx. Accessed December 5, 2016.
8. AACAP Releases Statement on Immigration Executive Orders. American Academy of Child and Adolescent Psychiatry. <https://www.aacap.org/AACAP/Press/Press_Releases/2017/Immigration_Executive_Orders.aspx> Accessed February 28, 2017.
9. Report of the DHS Advisory Committee on Family Residential Centers. US Immigration and Customs Enforcement. https://www.ice.gov/sites/default/files/documents/Report/2016/ACFRC-sc-16093.pdf September 30, 2016. Accessed April 3, 2017.
10. Henderson S, Baily C. In their Own Words: Immigration and Pediatric Mental Health in 2016. *J Am Acad Child Adolesc Psychiatry.* 2016;55:833-834.

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