



Toolkit Background

Children of immigrants are the fastest growing population of children in the United States and have contributed to the entire growth in the nation's child population over the past decade. Immigrant families are racially and ethnically diverse, and immigrate for variety of reasons that may include seeking economic opportunity, reuniting with family, fleeing war or violence.

Pediatricians can play a special role in supporting the health and well-being of immigrant children in the United States. By recognizing the unique challenges and strengths that many immigrants experience; pediatricians can identify effective practice strategies and relevant resources that support health within the community.

This toolkit was designed to provide practical information and resources for pediatricians to use to address some common matters related to immigrant child health. To develop the toolkit, the AAP gathered and developed content that addresses issues that AAP members have raised regarding providing optimal care to immigrant children and families. Those issues are addressed as "Frequently Asked Questions." As the AAP continues its work on immigrant child health issues, this content will be expanded.

A state by state directory of legal resources is also provided to help pediatricians determine local services and potential partners to help immigrant families with a variety of issues related to child health and well-being.

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Key Facts About Immigrant Children



From the **AAP Policy Statement: *Providing care for immigrant, migrant, and border Children.***
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Definitions and Demographics

- “Immigrant children” are defined as children who are foreign-born or children born in the United States who live with at least 1 parent who is foreign-born.
- One in every 4 children in the United States, approximately 18.4 million children, live in an immigrant family. Eighty-nine percent of these children are born in the United States and are US citizens.
- Although 64% of all children of immigrants live in 6 states (California, Texas, New York, Florida, Illinois, and New Jersey), immigrant children are dispersed throughout the country. Since 1990, the largest growth in percentage of immigrant children has occurred in North Carolina, Nevada, Georgia, and Arkansas.

Access to Health Care and Health Status

- Children of immigrants are nearly twice as likely to be uninsured as are children in nonimmigrant families.
- Immigrant children are less likely to have a usual source of medical care and to obtain specialty care when needed.
- Immigrant children who are foreign-born may not have received adequate screenings or immunizations in their home country.

Socioeconomic Factors

- Immigrant children are more likely to live below the federal poverty level than nonimmigrant children, despite the fact that immigrant children are more likely to live with two parents and have parents who work.
- Immigrant children can face barriers to accessing programs and benefits that support low income children
- Many immigrant children have less access to quality early education programs and are less likely to be enrolled in preschool programs, such as Head Start.
- Children in immigrant families are less likely to graduate from high school than are their nonimmigrant peers.

Unique Stressors/Family Separation

- Many immigrant children live in a family with a parent who faces the threat of deportation without notice or preparation.
- Children whose parents have been taken into custody/deported may demonstrate a number of health problems including anxiety, depression, poor school performance, sleeping and eating disruptions.
- Forced separations due to immigration enforcement can also result in the loss of family income and have been shown to result in family housing and food instability.
- Children who have crossed the border to enter the United States as well as children who are refugees may have experienced abuse, exploitation, and/ serious trauma.



Clinical Care

What screening resources are recommended for immigrant children?

Are some diseases or conditions more prevalent among immigrant children?

How do I communicate with families that are not English proficient?



WHAT SCREENING RESOURCES ARE AVAILABLE FOR IMMIGRANT/NEWLY ARRIVED CHILDREN?



According to the [2013 AAP Policy, Providing Care for Immigrant, Migrant, and Border Children](#) (May 2013)⁴, pediatricians should use available screening and diagnostic protocols for evaluating foreign-born children for infectious diseases and other medical conditions. Additional screenings commonly required for school entry, including lead testing, vision, and hearing screenings, should be provided for all age appropriate children. The Centers for Disease Control and Prevention (CDC)^{8,27} and the American Academy of Pediatrics (AAP) Red Book¹ offer resources with detailed discussions and/or checklists regarding screening of refugees and international adoptees. However, there has been little detailed guidance about post-arrival medical screening for other new immigrants; this generally has been extrapolated from published experience of screening of refugee and international adoptees. All immigrant children would benefit from comprehensive medical evaluation after arrival in the United States²⁷ and integration into a medical home. Please refer to the AAP [toolkit screening checklist](#) for general screening recommendations for all newly arrived immigrant children that incorporate recommendations from both the CDC and the AAP.

Many new immigrant children may have never had medical screenings or a visit with a health care provider in their country of origin. If children have had prior medical visits, families should be asked to bring all medical records, screening or health histories to the initial visit. Pediatricians should be aware that these records may need to be translated and should be carefully reviewed for accuracy. Immigrant families may be unfamiliar with navigating the health care system as well as standards of practice in the United States. Pediatricians should recognize that US screening and preventive health practices may be an unfamiliar practice in many countries and may need additional explanation. A comprehensive medical evaluation includes asking sensitive questions about issues such as migration experiences, trauma, and family separation. Setting aside adequate time for visits, providing professional interpretation services, and engaging in thoughtful and sensitive inquiry will

facilitate a trusting environment that will lead to optimal care for immigrant children⁸. In screening for trauma, it is essential to incorporate trauma-informed approaches (please see the mental health section of the toolkit for details). If follow-up can be ensured, the comprehensive evaluation does not need to be completed in the first 1-2 visits and some elements can be deferred until a trusting relationship with the family has been established.

Finally, throughout this document, a case study will demonstrate how this process was successfully used in a general pediatric practice setting.

Considerations for the Initial Screening of Immigrant Children

- *Birth country/ethnicity, country/countries of transit and length of time living in these countries, time in the United States*
- *Medical records, if available, including vaccine records*
- *Past medical history, including prenatal serology results of mother/health of mother, birth setting (home/medical facility), gestational age at birth, history of female genital cutting (FGC), other traditional cutting, transfusions, surgeries, tattoos*
- *Sexual history, including whether history of sexual abuse*
- *Nutrition history, including foods available, to determine risk for specific micronutrient deficiencies*
- *Use of complementary and alternative medications*
- *Environmental hazard exposure history, including possible lead exposure risks*
- *Tobacco, alcohol, opium/heroin, betel nut²⁴, khat²⁶, other drug use*
- *Allergies*
- *Dental history*
- *Education: last year of school completed and literacy level of patient/parents as applicable, potential learning difficulty and/or need for special education*
- *Social history—including family structure, support in US, school environment, individuals who live in the same home as the child, primary care taker*

- *Mental health evaluation (see Mental health section for further [details](#)), including use of validated screening instrument (such as the Patient Health Questionnaire [PHQ-9](#)²⁰, the Pediatric Symptom Checklist [PSC](#)²¹, or the Refugee Health Screener [RHS-15](#)²² for those over age 14) and specific screening for trauma*
- *Developmental screening (including use of age-appropriate screening instrument)*

ARE SOME DISEASES OR CONDITIONS MORE PREVALENT AMONG IMMIGRANT CHILDREN?



The specific health risks of immigrant children depend on the child's country/region of origin and experiences prior to arrival in the United States. Each child should be evaluated within the context of unique predisposing factors and experiences.

Infectious Disease

Infectious diseases are among the most common health issues encountered in immigrant children¹. Testing for tuberculosis by tuberculin skin testing or interferon gamma release assay (regardless of history of BCG vaccine) should be universally applied in all immigrant children^{1,8,9}. If there is no documentation of prenatal or parents' lab results, children should also be screened for hepatitis B (regardless of vaccine history), HIV, and syphilis^{8,11,12,13}. Other infectious diseases may be evident with a review of systems (hematuria suggesting schistosomiasis in a child from sub-Saharan Africa), or performance of physical examination (characteristic rash of scabies, or splenomegaly in hyperreactive malaria syndrome) however, some will need specific screening to identify.

Inadequate immunization status (insufficient number, inadequate serologic response due to improper storage of vaccinations, or severe malnutrition) places immigrant children at risk for vaccine-preventable illness^{1,2,4,8,23}. Immunizations should be initiated immediately according to recommended schedules for infants, children, and adolescents.

Specific infectious diseases that should be considered in immigrant children are included in Table 1.

(Please refer to the immigrant checklist for an approach to screening).

Certain parasitic infections, with which clinicians may be less familiar, are particularly prevalent among immigrant populations and warrant more detailed discussion, below. For more detail about specific infections, refer to the AAP Redbook¹ and the CDC Refugee Health Guidelines⁸.

Soil-transmitted helminths

The most common soil-transmitted helminth infections are *Ascaris lumbricoides*, whipworm (*Trichuris trichiura*), and hookworm (*Necator americanus*, *Ancylostoma duodenale*). Transmission of *Ascaris* and whipworm occurs via ingestion of soil contaminated with these helminths in human feces, and infection with hookworm occurs primarily through direct contact between skin (such as bare feet) and contaminated soil. Infections may be asymptomatic or may cause abdominal pain, diarrhea, nausea/vomiting, or anemia due to malabsorption or blood loss. Infections with soil-transmitted helminths may be diagnosed by stool ova and parasite examination, for which, ideally, three samples should be obtained at least 24 hours apart to increase sensitivity. Treatment of choice is albendazole; however clinicians should confirm that patients do not have a history of seizures or other neurologic deficits (which may be indicative of neurocysticercosis*) prior to treatment.

Giardia intestinalis

Giardia, a protozoan, may be asymptomatic, cause bouts of acute symptoms such as watery diarrhea and abdominal pain, or cause prolonged symptoms including foul-smelling stools, abdominal distention, anorexia, malabsorption, or failure to thrive. Neither stool ova and parasite examination nor eosinophilia are sensitive for *Giardia intestinalis*, and clinicians should send giardia specific stool antigen using enzyme immunoassay (EIA) to test for this infection. Treatments of choice are metronidazole, tinidazole, or nitazoxanide.

Strongyloidiasis (Strongyloides stercoralis)

Infections with the nematode roundworm *Strongyloides stercoralis* primarily occur when larvae penetrate skin after contact with infected soil. Thus, infection usually occurs after children are old enough to crawl or walk. Because *Strongyloides* can replicate in human hosts, the infection may persist for decades due to autoinfection and once acquired is considered a life-long infection unless treated. The infection is often asymptomatic, but some patients experience skin manifestations (transient pruritic papules at the site of penetration or erythematous tracks, known as larva currens, transient pneumonitis or gastrointestinal manifestations [abdominal pain, vomiting, diarrhea, malabsorption, or failure to thrive]). In the setting of immunosuppression (most commonly associated with corticosteroid use) *strongyloides* parasites may infiltrate internal organs and unexpectedly manifest as hyperinfection syndrome with associated high rates of morbidity and mortality. Eosinophilia may be present with strongyloides infections, however, its absence does not rule out infection. Ova and parasite testing is very insensitive for detecting strongyloides, given that shedding may occur intermittently and at

low levels¹⁴. Serology for IgG antibodies against strongyloides is the testing of choice for diagnosis. Ivermectin is the treatment of choice but should not be used in patients from **Loa loa-endemic regions unless co-infection has been ruled out**²⁸ (see CDC domestic refugee screening guidelines⁸ for further info).

Schistosomiasis

Schistosoma organisms, the trematode flatworm, are spread via parasites in contaminated fresh water. *Schistosoma* species are **endemic** in many areas of Africa¹⁶; distribution requires snail vectors, infected human reservoirs, and fresh water sources. Infection, also known as bilharzia, is contingent upon environmental exposure with organisms penetrating skin, therefore, children tend to be at risk of infection only once they are crawling or walking. Acute infection may present with fever, abdominal pain, hepatosplenomegaly, rash, or lymphadenopathy. Skin penetration may cause a pruritic, papular dermatitis similar to “swimmer’s itch.” Infection with *Schistosoma haematobium* may lead to bladder inflammation (with associated dysuria, hematuria, secondary urinary tract infections, and pelvic pain), fibrosis, and ultimately, increased risk of bladder cancer or renal failure. Chronic infection with intestinal forms of schistosoma (*S. mansoni*) may ultimately lead to portal hypertension. Eosinophilia may be present with schistosoma infections, however, its absence does not rule out infection. Ova and parasite testing is also insensitive for diagnosis. Blood schistosoma IgG antibody testing is the diagnostic method of choice. Treatment of choice is praziquantel. If seizures or neurologic deficits of unknown etiology are present, neurocysticercosis* must be ruled out with neuroimaging prior to treatment with praziquantel.

Malaria

Malaria classically presents with high fevers, chills, rigors, sweats, and headache. Although five species of malaria infect humans, *Plasmodium falciparum* causes the most significant morbidity and mortality and is hyper- and holo-endemic in some areas of sub-Saharan Africa. For newly arrived immigrants from areas in sub-Saharan Africa where *P. falciparum* is **endemic**¹⁵, CDC currently recommends presumptive treatment, particularly for specific refugee populations from areas that have greater than 40% endemicity (dark red on the **endemicity map**) for malaria infection¹⁵. For immigrants from regions outside of sub-Saharan Africa as well as immigrants from sub-Saharan Africa who are not presumptively treated, evaluation for malaria should be based on symptoms. Screening with thin and thick blood smears in asymptomatic patients has low sensitivity. Performing daily smears over three days increases sensitivity. PCR testing is available through CDC, particularly in cases of symptomatic infants or pregnant teens and women. A Rapid Diagnostic Test (RDT) is now available in the U.S and offers an alternate way of quickly establishing the diagnosis of malaria infection by detecting specific malaria antigens in blood. Although the use of the RDT does not eliminate the need for malaria microscopy, it can reduce diagnostic delay that may occur in some clinical settings due to challenges in accessing timely microscopic evaluation¹⁸. Presumptive treatment for *P. falciparum* is with atovoquone-proguanil or artemether-lumafantrine.

Table 1: Infectious diseases to consider in immigrant children

(Please refer to Medical Screening and Treatment Checklist for tiered approach to appropriate work-up)

<i>M tuberculosis</i>	Typhoid fever (<i>Salmonella Typhi</i>) among recently arrived febrile patients
<i>M Bovis</i>	Geographically specific infections:
HIV 1, 2	<ul style="list-style-type: none"> • Schistosoma spp. (trematode) • Histoplasmosis • <i>Opisthorchis</i> species • Lymphatic filariasis • Chagas Disease— (<i>Trypanosoma cruzi</i>) • <i>Loa loa</i> • Coccidioidomycosis • Leishmaniasis • Chikungunya virus
Viral hepatitis	Sexually Transmitted Infections
<ul style="list-style-type: none"> • Hepatitis A • Hepatitis B • Hepatitis C (overseas surgery, transfusion, female genital mutilation, traditional cutting, tattoos, sexual abuse)¹² • Hepatitis D (chronic carriers of Hepatitis B) 	<ul style="list-style-type: none"> • <i>Gonococcus</i> • <i>Chlamydia</i> • Syphilis
Parasitic infections	Skin infections
<ul style="list-style-type: none"> • Soil-transmitted helminths <ul style="list-style-type: none"> – Roundworm (<i>Ascaris lumbricoides</i>) – Whipworm (<i>Trichuris trichura</i>) – Hookworm (<i>Necator americanus, Ancylostoma duodenale</i>) • <i>Strongyloides stercoralis</i> (nematode) • <i>Entamoeba histolytica</i> • <i>Giardia intestinalis</i> • Cryptosporidium • <i>Taenia solium</i> (cysticercosis, pork tapeworm) • <i>Toxocara canis and visceral larva migrans</i> 	<ul style="list-style-type: none"> • Scabies • Lice • Impetigo • cutaneous larva migrans
Malaria	<i>Helicobacter pylori</i>

Nutritional Issues

Immigrant children may present with under-nutrition and malnutrition, including wasting and stunting⁸. Overweight and obesity are increasingly prevalent concerns among immigrant children⁸. A detailed dietary history, complete physical examination, and thoughtful laboratory evaluation can help clinicians to detect particular nutritional issues.

Throughout the world, iron deficiency is the most common nutritional issue. Among immigrant children with anemia, it is important to also consider undiagnosed hemoglobinopathies, particularly for children of African, Southeast Asian, East Asian, Hispanic or Mediterranean ethnicities^{1,2,4}. Vitamin D deficiency is also common among immigrant children, particularly in those with growth delay, poor vitamin D intake or limited sun exposure due to geography, veiling, or institutionalization^{2,8}. Other micronutrients that may be deficient among immigrant children in resource-limited settings include vitamin A, zinc, vitamin B12, iodine, vitamin B3 (niacin), tryptophan, vitamin B1 (thiamine) or vitamin C⁸. Refer to AAP Pediatric Nutrition handbook³ or CDC domestic refugee screening guidelines⁸ with further details regarding signs, symptoms and regional risks for specific micronutrient deficiencies.

Toxic and Environmental Exposures

As a result of living conditions in home countries and/or impoverished living conditions in the United States, toxin exposure is common among immigrant children. Lead exposure is the most widespread toxin exposure among immigrant children. Exposures prior to arrival in the U.S. may include leaded gasoline, contaminated home remedies or traditional cosmetics, leaded ceramic glazes, the use of car batteries as a domestic power source, leaded cookware, or air pollution^{4,8,27}. After arrival in the U.S., exposures may include many of the same items, in addition to lead paint in older homes in the US^{8,27}. A number of culture-specific exposures have been associated with elevated blood lead levels in children; see [Table 1](#) in the CDC refugee guidelines⁸ for further detail regarding lead exposure. The [CDC offers comprehensive guidelines](#)⁶ and a [Toolkit](#)¹⁰ regarding prevention of lead poisoning among refugee children.

A comprehensive medical history may reveal other potential hazardous environmental exposures. Prenatal exposure to alcohol may be associated with fetal alcohol syndrome that was not previously diagnosed^{1,2}. It is important to inquire about the use of non-prescribed medications as well as traditional treatments or herbal remedies obtained overseas or locally. Migrant children are also at particular risk for health problems related to workplace injuries⁴.

Other General Health Issues

Many immigrant children may have lacked access to pediatric medical care and their mothers may have had home births without prenatal medical screenings, including testing for hepatitis B, HIV, and syphilis. Dental problems, including dental caries or more serious dental diseases, are pervasive in immigrant children, given scant, if any access to dental preventive care and treatment in their countries of origin^{2,4,8}. Undiagnosed vision and hearing problems may be present^{1,2}. Other medical issues, such as thyroid disease, congenital defects, or genetic conditions, may be present and require subspecialty care^{1,8}. Overweight/obese immigrant children may be increasingly at risk for chronic conditions such as hypertension, diabetes, and cardiovascular disease⁸.

It is important to inquire about history of female genital cutting (also known as female genital mutilation, female circumcision) and parents' beliefs regarding this practice¹⁹, particularly if a child is from Africa (where female genital cutting is practiced in over 27 countries) or parts of the Middle East^{19,25}. Using a culturally sensitive and non-judgmental approach, pediatricians should discuss the illegality of female genital cutting in the US with families, including the illegality of sending children back to country of origin for the procedure (sometimes referred to as "vacation cutting") educate families about significant morbidity and mortality associated with this practice^{8,19}.

Developmental delays may be undetected or detected at a later age among immigrant children¹⁷. Pediatricians who care for immigrant children should conduct careful developmental surveillance and screening at regular intervals as recommended by the AAP. Developmental screening requires consideration of important issues by families, medical providers, interpreters, and school/child care personnel. Questionnaires and screening tools should be administered using validated translations or with the help of trained interpreter staff when possible. Appropriate referral for early intervention services and/or psychoeducational evaluation should be initiated as soon as a concern is identified.

Mental Health

Mental health merits particular attention in immigrant populations. Stressful experiences may take place prior to departing from one's country of origin, during transit or upon arrival to the United States. Sensitive and trauma-informed approaches to care are essential. In addition, immigrant children and families may experience discrimination and fear within the United States⁸, and acculturation may place stress upon children, adolescents, and families. Immigrant children may also have mental health conditions that are prevalent among the general U.S. population, such as depression, anxiety, posttraumatic stress disorder, somatization, sleep disturbance, and substance abuse^{2,8}. Mental health services should be sought for the entire family when appropriate. [See Immigrant Health Toolkit Mental Health Section for further details.](#)

*Cysticercosis is a parasitic tissue infection caused by larval cysts of *Taenia solium*, also known as the pork tapeworm. These cysts can infect the brain (neurocysticercosis), which may present as seizures or neurologic deficits in children. It may also manifest as cysts in the muscles and other tissues. Presumptive treatment with praziquantel or albendazole in the setting of neurocysticercosis is contraindicated without concomitant anti-epileptic and steroid pre-treatment because these drugs may provoke significant brain inflammation and seizures. If child has history of seizures or neurologic deficits of unknown cause, do not treat with praziquantel or albendazole until the presence of neurocysticercosis has been eliminated through neuroimaging.

HOW DO I COMMUNICATE WITH FAMILIES THAT ARE NOT ENGLISH PROFICIENT?

Language access is critical for ensuring that immigrant children and families are able to access and use health care services. 82 percent of immigrant children are fluent English speakers, however 40% of immigrant children live with at least one parent that does not speak English fluently. Approximately 24 percent of immigrant children live in a linguistically isolated household where no one over age 13 speaks English fluently in the home.²⁹

Families that are not fluent in English and cannot access language supports may be deterred from even making appointments for health care services. In health care settings, language barriers can lead to inadequate communication that may cause confusion, dissatisfaction, and/medical errors.³⁰ Language barriers have been linked to less routine and timely care for children whose parent's primary language at home is not English.³¹

Language barriers can occur in clinical settings from the outpatient clinic to the intensive care unit, or in non-clinical settings, like administrative, billing, and legal departments.

Trained medical interpreters can help pediatricians communicate with families that do not speak English or have limited English proficiency.

Trained medical interpreters are valuable assets to the health care team and are essential bridges to navigating language barriers. Trained medical interpreters may include trained bi-lingual staff, on-staff interpreters, contract interpreters, or telephone interpreters.

Trained bi-lingual staff are employed by the practice for a different primary role and also have interpreter duties as a secondary role

On-staff interpreters are employed by the practice solely for interpreter services.

Contract interpreters are not employed by the practice, and provide services on an on-call basis

Telephone interpreters provide interpreter services through telephone language lines, often providing interpretation for less commonly requested languages.

Although less common than telephone services, interpretation services can also be provided through Video Medical Interpretation.

Best practices for working with medical interpreters:

- *Treat interpreters as an important member of the health care team.*
- *Provide the interpreter with a brief summary of the patient and briefly share what is anticipated and will be covered during the visit.*
- *Establish and maintain eye contact with the parent or patient.*
- *Speak slowly, clearly, and concisely, with appropriate for interpretation. Try to avoid jargon.*
- *Avoid interrupting the interpreter once the session has started.*
- *Pay attention to the parent and patient's body language and other non-verbal cues.*
- *De-brief with the interpreter after the patient visit.*

Best practices for working with families with limited English proficiency

Determine a family's preferred language. To determine the patient's or family's language of preference, provide a brief to read a brief [language identification document](#) with a simple sentence in many different languages.

Unless you are fluent in the patient's preferred language, do not attempt to speak that language with a patient.

Avoid using family members, particularly children, as interpreters. Untrained interpreters may not accurately interpret information which may lead to misunderstandings, misdiagnoses, and medical errors. The most common interpretation errors involve omissions and editing of information.³² Children should not be used for interpretation for a variety of reasons including the potential for errors, omissions, and the potential for burdening the child or creating role reversal within the family.

Take caution when asking patients to read English-language information or to complete forms in English, when English is not their primary language.

Resources

AAP Culturally Effective Care Toolkit: Interpretive Services
<http://www.aap.org/en-us/professional-resources/practice-support/Patient-Management/pages/Culturally-Effective-Care-Toolkit-Interpretive-Services.aspx?nfstatus=402&nftoken=00000000-0000-0000-0000-000000000000&nfstatusdescription=ERROR%3a+Local+token+is+not+valid>

Language Access Assessment and Planning Tool for Federally Conducted and Federally Assisted Programs
http://www.spanadvocacy.org/sites/startingpointstemplate.drupalgardens.com/files/files/2011_Language_Access_Assessment_and_Planning_Tool_0.pdf

Health education materials for family members about common conditions affecting pediatric patient populations in multiple languages
<https://ethnomed.org/patient-education/pediatric-health-topics>

National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care
<http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>

References

- 1 AAP Academy of Pediatrics. Committee on Infectious Diseases. Kimberlin DW, Brady MT, Jackson MA, Long SS, eds. *Red Book: 2015 Report of the Committee on Infectious Diseases. 30th Ed.* Elk Grove Village, IL: American Academy of Pediatrics; 2015.
- 2 American Academy of Pediatrics Committee on Early Childhood, Adoption, and Dependent Care. Comprehensive health evaluation of the newly adopted child. *Pediatrics.* 2012;129(1):e214-e223
- 3 American Academy of Pediatrics Committee on Nutrition; Pediatric Nutrition Handbook, 7th Edition. Kleinman RE, Greer FR, eds. Elk Grove Village, IL. American Academy of Pediatrics 2014.
- 4 American Academy of Pediatrics Council on Community Pediatrics. Providing care for immigrant, migrant, and border children. *Pediatrics.* 2013;131(6):e2028-e2034.
- 5 Cappellini MD, Fiorelli G. Glucose-6-phosphate dehydrogenase deficiency. *Lancet* 2008; 371: 64-74.
- 6 CDC. CDC Recommendations for Lead Poisoning Prevention in Newly Arrived Refugee Children. Available at: <http://www.cdc.gov/nceh/lead/publications/#primary> Accessed June 5, 2015.
- 7 CDC. Elevated blood lead levels in refugee children – New Hampshire, 2003–2004. *MMWR.* 2005;54(02):42-46. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5402a4.htm>. Accessed June 5, 2015.
- 8 CDC. Guidelines for the U.S. Domestic Medical Examination for Newly Arriving Refugees. Available at: <http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/domestic-guidelines.html>. Accessed June 5, 2015.
- 9 CDC. Implementation of new TB screening requirements for U.S.-bound immigrants and refugees – 2007-2014. *MMWR*, March 21, 2014, 63(11): 234-236.
- 10 CDC. Lead poisoning prevention in newly arrived refugee children: tool kit. Available at: http://www.cdc.gov/NCEH/lead/Publications/RefugeeToolKit/Refugee_Tool_Kit.htm. Accessed June 5, 2015.
- 11 CDC. Recommendations for Identification and Public Health Management of Persons with Chronic Hepatitis B Virus Infection. *MMWR.* September 19, 2008 / 57(RR08);1-20. Available at: <http://www.cdc.gov/mmwr/pdf/rr/rr5708.pdf>. Accessed June 5, 2015.
- 12 CDC. Screening for hepatitis during the domestic medical examination for newly arrived refugees. 2014. Available at: <http://www.cdc.gov/immigrantrefugeehealth/pdf/domestic-hepatitis-screening-guidelines.pdf>. Accessed June 5, 2015.
- 13 CDC. Sexually transmitted diseases treatment guidelines, 2010. *MMWR.* December 17, 2010 / 59(RR12);1-110. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5912a1.htm>. Accessed June 5, 2015.
- 14 Dreyer G, Fernandes-Silva E, Alves S, Rocha A, Albuquerque R, Addiss D. Patterns of detection of *Strongyloides stercoralis* in stool specimens: implications for diagnosis and clinical trials. *Journal of clinical microbiology.* 1996;34(10): 2569-71.
- 15 Gething PW, Patil AP, Smith DL, Guerra CA, Elyazar IRF, Johnston GL, Tatem AJ, Hay SI. A new world malaria map: *Plasmodium falciparum* endemicity in 2010. *Malaria Journal* 2011, 10:378 doi:10.1186/1475-2875-10-378. Map available at: http://www.map.ox.ac.uk/browse-resources/endemicity/Pf_class/africa-plus/. Accessed June 5, 2015.

- ¹⁶ Hürlimann E, Schur N, Boutsika K, Stensgaard AS, Laserna de Himpl M, Ziegelbauer K, Laizer N, Camenzind L, Di Pasquale A, Ekpo UF, Simoonga C, Mushingi G, Saarnak CF, Utzinger J, Kristensen TK, Vounatsou P. Toward an Open-Access Global Database for Mapping, Control, and Surveillance of Neglected Tropical Diseases. *PLoS Negl Trop Dis*. 2011; 5(12): e1404. Available at: http://openi.nlm.nih.gov/detailedresult.php?img=3236728_pntd.0001404.g002&req=4. Accessed June 5, 2015.
- ¹⁷ Martin-Herz SP, Kemper T, Brownstein M, McLaughlin JF. Developmental Screening with Recent Immigrant and Refugee Children: A Preliminary Report (November 2012). Available at: <http://ethnomed.org/clinical/pediatrics/developmental-screening-with-recent-immigrant-and-refugee-children>. Accessed June 5, 2015.
- ¹⁸ Mouatcho JC & Dean Goldring, JP. Malaria rapid diagnostic tests: challenges and prospects. *J Med Microbiol* October 2013; 62 (10): 1491-1505. Available at: http://jmm.sgmjournals.org/content/62/Pt_10/1491.full. Accessed June 5, 2015.
- ¹⁹ Nour NM. Female genital cutting: clinical and cultural guidelines. *Obstetrical and Gynecological Survey* 2004;59(4): 272-279.
- ²⁰ Patient health questionnaire (PHQ) screeners. Available at: http://www.phqscreeners.com/overview.aspx?Screener=02_PHQ-9. Accessed June 5, 2015.
- ²¹ Pediatric symptom checklist (PSC). Available at: http://www.massgeneral.org/psychiatry/services/psc_forms.aspx. Accessed June 5, 2015.
- ²² Refugee Health Screener (RHS-15). http://www.refugeehealthta.org/files/2012/09/RHS15_Packet_PathwaysToWellness.pdf. Accessed June 5, 2015.
- ²³ Rytter MJH, Kolte L, Briend A, Friis H, Christensen VB. The immune system in children with malnutrition – A systematic review. *PLOS ONE*. 2014;9(8):e105017.
- ²⁴ Sharan RN, Mehrotra R, Choudhury Y, & Asotra K. Association of betel nut with carcinogenesis: Revisit with a clinical perspective. *PLOS ONE* 2012;7(8):e42759-. Available at: <http://www.plosone.org/article/fetchObject.action?uri=info:doi/10.1371/journal.pone.0042759&representation=PDF>. Accessed June 5, 2015.
- ²⁵ UNICEF. Female Genital Mutilation and Cutting: Status and Progress. Available at: <http://www.data.unicef.org/child-protection/fgmc>. Accessed June 5, 2015.
- ²⁶ Valente MJ, Guedes de Pinho P, de Lourdes Bastos M, Carvalho F, Carvalho M. Khat and synthetic cathinones: a review. *Arch Toxicol* 2014;88(1):15-45.
- ²⁷ Walker PF, Stauffer WM, Barnett ED. Arrival in the United States: Health Status, & Screening of Refugees & Immigrants. CDC Yellowbook. Chapter 9. Available at: <http://www.wnc.cdc.gov/travel/yellowbook/2012/chapter-9-health-considerations-newly-arrived/arrival-in-the-united-states-process-health-status-and-screening-of-refugees-and-immigrants.htm>. Accessed June 5, 2015.
- ²⁸ WHO. Map of the estimated prevalence of eye worm history in Africa. Available at: <http://www.who.int/apoc/raploa/en/>. Accessed June 5, 2015.
- ²⁹ Children in Immigrant Families: Ensuring Opportunity for Every Child in America: <http://www.firstfocus.net/library/reports/children-in-immigrant-families-ensuring-opportunity-for-every-child-in-america> March 2011
- ³⁰ Divi C, Koss RG, Schmaltz SP, Loeb JM. Language proficiency and adverse events in US hospitals: a pilot study. *Int J Qual Health Care*. 2007;19(2):60–67.
- Flores G, Laws MB, Mayo SJ, et al. Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics*. 2003;111(1):6–14.
- ³¹ Galbraith AA, et al Language disparities and timely care for children in managed care Medicaid. *Am J Manag Care*. 2008 Jul;14(7):417-26.
- ³² Flores G, Laws MB, Mayo SJ, Zuckerman B, Abreau M, Medina L, et al. Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics*. 2003;111:6–14.



Medical Screening and Treatment Recommendations for Newly Arrived Immigrant Children

The following section provides general medical screening recommendations for diverse immigrant children including unaccompanied minors, undocumented immigrants, asylees, refugees, and others.



A comprehensive medical evaluation should be available to all immigrant children, either within the medical home or coupled with referral to a medical home. Many aspects of this evaluation are routinely recommended per *Bright Futures*¹³ guidelines for evaluation of all children but have nuances specific to immigrant children. The Centers for Disease Control and Prevention (CDC)⁷ and the American Academy of Pediatrics (AAP) Red Book¹ offer resources with detailed discussions and/or checklists regarding screening of refugees and international adoptees. However, there has been little detailed guidance about post-arrival medical screening for other new immigrants; this generally has been extrapolated from published experience of screening of refugee and international adoptees.

The following checklist provides general medical screening recommendations for unaccompanied minor, undocumented immigrant, asylee, refugee, and other immigrant children from low resourced countries, especially if from low socioeconomic circumstances. These recommendations are consistent with current **CDC domestic refugee screening guidelines**⁷, and this document will be updated periodically in effort to maintain consistency with existing guidelines. Although the AAP defines “immigrant children” as children who are foreign-born or children born in the United States who live with at least 1 parent who is foreign-born², these recommendations are specific to foreign-born immigrant children. For all patients without legal access to health insurance (such as unaccompanied minors and other undocumented children), providers must balance the medical needs of individual patients with the reality of patient/institutional costs for laboratory evaluations and prescribed **medications**.

Comprehensive history and physical examination	
History (Initial/Interval)	<ul style="list-style-type: none"> • Immigration information (e.g. country of origin, country of transit, refugee camp history, time residing in the United States) • Birth history (e.g. home birth, prenatal lab records) • History of overseas blood transfusions, surgeries, female genital cutting, other traditional cutting, tattoos* • Nutritional history: Foods available overseas/while in-transit, risks for micronutrient deficiencies • Environmental exposure risks (e.g. lead, second-hand smoke) • Treatment prior to arrival (e.g. pre-departure therapy for parasitic infections for refugees, overseas medications/home remedies, treatment while in ORR** custody for unaccompanied minors) • Prior medical records including labs and immunizations <ul style="list-style-type: none"> • Menarche/LMP for females; pubertal onset for males and females • Family medical history (e.g. maternal/paternal HIV, Hep B, C, TB) • Social history (e.g. family structure, status of parents if not in the home, legal guardian/primary care taker, other individuals living in the household, social support) • Educational assessment (e.g. last year of school completed, literacy level of patient/parents as applicable, potential learning difficulty and/or need for special education) • Substance use—prior and current*** • Sexual history—consensual/non-consensual • History of trauma or abuse
Developmental Assessment	<ul style="list-style-type: none"> • Developmental screening tools+ with multiple available languages, such as the ASQ³, M-CHAT R¹⁶, PEDS¹⁹, and/or SWYC²⁵
Psychosocial Assessment	<ul style="list-style-type: none"> • Signs/symptoms of PTSD, depression, anxiety • Psychosocial screening tools+ such as the PHQ-9²⁰, PSC²¹, or RHS-15²³ (>14 years)

CONTINUES >

Comprehensive history and physical examination (continued)

Complete Physical Examination/Measurements	<ul style="list-style-type: none"> • Growth evaluation[#] • Screening for female genital cutting (FGC) in at-risk populations: routine external genital examination for all females^{##} • Complete skin evaluation (e.g. scarification, tattoos) • Pubertal development for males/females 	<ul style="list-style-type: none"> • Dental evaluation • Blood pressure evaluation (> 3 years or risk factors) • Vision screen (> 3 years) • Hearing screen (Newborn, > 4 years)
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* Possible risk factors for Hepatitis C¹¹

** ORR—Office of Refugee Resettlement (<http://www.acf.hhs.gov/programs/orr/programs/ucs>)¹⁷

*** Tobacco, marijuana, alcohol, opium/heroin, betel nut²⁴, khat²⁸, other

+ Validation of these tools for use in languages other than the English language varies by tool. Be sure that translated materials have been translated using internationally accepted translation methodology.

Use WHO growth charts for infants 0-2 years.

Children and adolescents who have not had a genital exam may find this experience less upsetting if deferred until a future encounter if follow-up is ensured.

Tiered^a laboratory screening/parasite treatment options for most immigrant children originating from resource-limited settings or from low socioeconomic circumstances

1. Tuberculosis testing: IGRA (TST if <5 years old)^{b,1,9}

2. Cbc/Diff

3. Lead^{d,6}:— Children 6mo–16 years

4. Hep B sAg^{e,10,11}

5. Intestinal Parasite Evaluation (NB: for refugees, may omit if received pre-departure treatment per CDC guidelines)

- **Stool O & P** >24 hours apart x 3^f **OR** presumptive treatment with **Albendazole**

AND

- **Strongyloides IgG** **OR** presumptive treatment with **Ivermectin**⁹

6. HIVⁱ

7. Syphilis EIA, reflex RPR if positive^{i,5}

- a. Consider laboratory tiering in this order when patients or health care facilities have no access to discounted financial coverage programs
- b. Interferon gamma release assay (IGRA), tuberculin skin test (TST). Screen regardless of history of BCG vaccine^{1,9}. If IGRA unavailable, may use TST at any age. Repeat TB screening in 6 months. NB: Repeat if chronic disease, malnutrition once medical issues managed, given that anergy may give a false negative result.
- c. Screen for anemia, eosinophilia (NB: absolute eosinophilia >400 warrants further work-up).
- d. Repeat in 3-6 months in children 6 mo-6 years⁶.
- e. If never screened for infection, screen even if documentation of complete hepatitis B vaccine series. Vertical and horizontal transmission possible^{10,11}.
- f. Greater number increases sensitivity of test—most experts recommend 2 or 3 samples.
- g. Consider presumptive treatment with ivermectin without serology if >15 kg, unless from **Loa loa endemic countries**³⁰.
- h. If > 1 year old and no history of seizures or other signs/symptoms of neurocysticercosis*.
- i. If prenatal lab results or recent maternal results available with negative screens and no risk for horizontal transmission, may omit.

Optional laboratory screening/presumptive treatment for children of specific ages, with specific exposures or risk factors

- | | | |
|---|--|--|
| <ul style="list-style-type: none"> • Urine B HCG^j • Urine GC/Chlamydia^k • Hep C Ab^l • Newborn screen, per state guidelines^m • TSHⁿ • Giardia stool antigen | <ul style="list-style-type: none"> • Hemoglobin electrophoresis^p • G6PD activity^q • Vitamin deficiency screening based on clinical presentation^r • Schistosoma IgG^s OR Presumptive treatment for schistosomiasis • Praziquantel | <ul style="list-style-type: none"> • Malaria thin and thick blood smears x 3^t OR Malaria Rapid Diagnostic Test¹⁸ OR Presumptive treatment for <i>P falciparum</i>^t • Atovaquone-proguanil^t OR • Artemether-lumafantrine^t |
|---|--|--|

- j. All pubertal girls (prior to vaccines or medication administration)
- k. All pubertal boys and girls or pre-pubertal boys and girls with history of sexual abuse
- l. If history of HCV-positive mother, overseas surgery, transfusion, major dental work, IVDU, tattoos, sexual activity/abuse, FGC, other traditional cutting¹¹
- m. If no state specific guidelines, infants <6 month old
- n. All children 6mo-3 years (screening for congenital hypothyroidism)
- o. If clinical suspicion based upon failure to thrive or gastrointestinal symptoms given low sensitivity of stool O&P and eosinophilia
- p. To evaluate for **SS, SC, S trait**²², and **thalassemias**²⁹ in high-risk populations
- q. For males from **high-risk areas**^{4,14}
- r. See **CDC review of micronutrient deficiencies**⁸
- s. For immigrants from **endemic regions of Africa**¹⁵ with no pre-departure treatment; May consider empiric treatment with praziquantel if > 4years and if no history of known neurocysticercosis*)
- t. New immigrants from areas of sub-Saharan Africa (SSA) **where *P falciparum* is endemic**¹² or with signs or symptoms of infection. For immigrants from SSA **where *P falciparum* is endemic**¹², if not pre-treated per CDC guidelines prior to departure and history of living **in area with high malaria risk**¹² consider treatment with atovaquone-proguanil or artemether-lumafantrine (if > 5kg), given that sub-clinical malaria infection is common and blood testing lacks sensitivity, particularly for specific refugee populations from areas that have greater than 40% endemicity (dark red on the **endemicity map**¹²) for malaria infection. For infants and pregnant teens with symptoms consistent with malaria, CDC recommends blood PCR testing.

*Cysticercosis is a parasitic tissue infection caused by larval cysts of *Taenia solium*, also known as the pork tapeworm. These cysts can infect the brain (neurocysticercosis), which may present as seizures or neurologic deficits in children. It may also manifest as cysts in the muscles and other tissues. Presumptive treatment with praziquantel or albendazole in the setting of neurocysticercosis is contraindicated without concomitant anti-epileptic and steroid pre-treatment because these drugs may provoke significant brain inflammation and seizures. If child has history of seizures or neurologic deficits of unknown cause, do not treat with praziquantel or albendazole until the presence of neurocysticercosis has been eliminated through neuroimaging.

Treatments and referrals

- | | |
|---|--|
| <ul style="list-style-type: none"> • Multi-vitamin with iron^u • Fluoride varnish^v • Vaccines, with catch-up plan as needed • Contraception for all sexually active males and females • Confirmation of medical home/assignment of specific PCP | <ul style="list-style-type: none"> • Dental Referral • WIC Referral (infants & children < 5 years, pregnant adolescents) • Mental health referral as needed • Care coordination, including orientation to US health care system • Set up follow-up appointment |
|---|--|

- u. All children 6 months-59 months and children 5 years and older with clinical evidence of poor nutrition
- v. All children up to 5 years of age

References

- American Academy of Pediatrics. Committee on Infectious Diseases. In: Kimberlin DW, Brady MT, Jackson MA, Long SS, eds. *Red Book: 2015 Report of the Committee on Infectious Diseases. 30th Ed.* Elk Grove Village, IL: American Academy of Pediatrics; 2015.
- American Academy of Pediatrics Council on Community Pediatrics. Providing care for immigrant, migrant, and border children. *Pediatrics*. 2013;131(6):e2028-e2034.
- Ages and Stages Questionnaire (ASQ). Brooks Publishing Company. Available at: <http://agesandstages.com/>. Accessed June 5, 2015.
- Cappellini MD, Fiorelli G. Glucose-6-phosphate dehydrogenase deficiency. *Lancet* 2008; 371: 64-74.
- CDC. Discordant Results from Reverse Sequence Syphilis Screening — Five Laboratories, United States, 2006–2010. *MMWR* 2011;60(05): 133-137.
- CDC. Elevated blood lead levels in refugee children — New Hampshire, 2003–2004. *MMWR*. 2005;54(02);42-46. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5402a4.htm>. Accessed June 5, 2015.

- ⁷ CDC. General Refugee Health Guidelines. 2012. Available at: <http://www.cdc.gov/immigrantrefugeehealth/guidelines/general-guidelines.html>. Accessed June 5, 2015.
- ⁸ CDC. Guidelines for evaluation of the nutritional status and growth in refugee children during the domestic medical screening examination. 2013. Available at: <http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/nutrition-growth.html>. Accessed June 5, 2015.
- ⁹ CDC. Implementation of new TB screening requirements for U.S.-bound immigrants and refugees – 2007-2014. *MMWR*, March 21, 2014, 63(11): 234-236.
- ¹⁰ CDC. Recommendations for Identification and Public Health Management of Persons with Chronic Hepatitis B Virus Infection. *MMWR*. September 19, 2008 / 57(RR08);1-20. Available at: <http://www.cdc.gov/mmwr/pdf/rr/rr5708.pdf>. Accessed June 5, 2015.
- ¹¹ CDC. Screening for hepatitis during the domestic medical examination for newly arrived refugees. 2014. Available at: <http://www.cdc.gov/immigrantrefugeehealth/pdf/domestic-hepatitis-screening-guidelines.pdf>. Accessed June 5, 2015.
- ¹² Gething PW, Patil AP, Smith DL, Guerra CA, Elyazar IRF, Johnston GL, Tatem AJ, Hay SI. A new world malaria map: *Plasmodium falciparum* endemicity in 2010. *Malaria Journal* 2011, 10:378 doi:10.1186/1475-2875-10-378. Map available at: http://www.map.ox.ac.uk/browse-resources/endemicity/Pf_class/africa-plus/. Accessed June 5, 2015.
- ¹³ Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics;2008.
- ¹⁴ Howes RE, Piel FB, Patil AP, Nyangiri OA, Gething PW, Dewi M, Hogg MM, Battle KE, Padilla CD, Baird JK, Hay SI. G6PD Deficiency prevalence and estimates of affected populations in malaria endemic countries: A geostatistical model-based map. *PLoS Med* 9(11): e1001339. doi:10.1371/journal.pmed.1001339
- ¹⁵ Hürlimann E, Schur N, Boutsika K, Stensgaard AS, Laserna de Himpel M, Ziegelbauer K, Laizer N, Camenzind L, Di Pasquale A, Ekpo UF, Simoonga C, Mushinge G, Saarnak CF, Utzinger J, Kristensen TK, Vounatsou P. Toward an Open-Access Global Database for Mapping, Control, and Surveillance of Neglected Tropical Diseases. *PLoS Negl Trop Dis*. 2011; 5(12): e1404. Available at: http://openi.nlm.nih.gov/detailedresult.php?img=3236728_pntd.0001404.g002&req=4. Accessed June 5, 2015.
- ¹⁶ Modified Checklist for Autism in Toddlers (M-CHAT). Diana Robins, Deborah Fein, & Marianne Barton. Available at: <https://www.m-chat.org/index.php>
- ¹⁷ ORR (Office of Refugee Resettlement). Medical Screening Protocol for Newly Arriving Refugees. Available at: <http://www.acf.hhs.gov/programs/orr/resource/medical-screening-protocol-for-newly-arriving-refugees>. Accessed June 5, 2015.
- ¹⁸ Mouatcho JC & Dean Goldring, JP. Malaria rapid diagnostic tests: challenges and prospects. *J Med Microbiol* October 2013; 62 (10): 1491-1505. Available at: http://jmm.sgmjournals.org/content/62/Pt_10/1491.full. Accessed June 5, 2015.
- ¹⁹ Parents' Evaluation of Developmental Status (PEDS). Frances Page Glascoe. Available at: <http://www.pedstest.com/default.aspx>. Accessed June 5, 2015.
- ²⁰ Patient health questionnaire (PHQ) screeners. Pfizer. Available at: http://www.phqscreener.com/overview.aspx?Screener=02_PHQ-9. Accessed June 5, 2015.
- ²¹ Pediatric symptom checklist (PSC). Massachusetts General Hospital. Available at: http://www.massgeneral.org/psychiatry/services/psc_forms.aspx. Accessed June 5, 2015.
- ²² Piel FB, Patil AP, Howes RE, Nyangiri OA, Gething PW, Williams TN, Weatherall DJ, Hay SI. Global epidemiology of sickle haemoglobin in neonates: a contemporary geostatistical model-based map and population estimates. *Lancet* 2013; 381: 142–51. Available at: [http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(12\)61229-X.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(12)61229-X.pdf). Accessed June 5, 2015.
- ²³ Refugee Health Screener (RHS-15). Available at: http://www.refugeehealthta.org/files/2012/09/RHS15_Packet_PathwaysToWellness.pdf. Accessed June 5, 2015.
- ²⁴ Sharan RN, Mehrotra R, Choudhury Y, & Asotra K. Association of betel nut with carcinogenesis: Revisit with a clinical perspective. *PLOS ONE* 2012;7(8):e42759-. Available at: <http://www.plosone.org/article/fetchObject.action?uri=info:doi/10.1371/journal.pone.0042759&representation=PDF>. Accessed June 5, 2015.
- ²⁵ Survey of Wellbeing of Young Children (SWYC). Floating Hospital for Children at Tufts Medical Center. Available at: <http://www.theswyc.org>. Accessed June 5, 2015.
- ²⁶ Trehan I, Meinen-Derr JK, Jamison L, Staat MA. Tuberculosis screening in internationally adopted children: The need for initial and repeat testing. *Pediatrics* 2008;122(1):e7-e14.
- ²⁷ UNICEF. Female Genital Mutilation and Cutting: Status and Progress. Available at: <http://www.data.unicef.org/child-protection/fgmc>. Accessed June 5, 2015.
- ²⁸ Valente MJ, Guedes de Pinho P, de Lourdes Bastos M, Carvalho F, Carvalho M. Khat and synthetic cathinones: a review. *Arch Toxicol* 2014;88(1):15-45.
- ²⁹ Weatherall, DJ. Phenotype-genotype relationships in monogenic disease: Lessons from the thalassaemias. *Nature Reviews Genetics* 2001;2(4):245-55. – Image available at <http://www.kidsnewtocanada.ca/conditions/thalassaemia#sthash.GyCial4W.dpuf>. Accessed June 5, 2015.
- ³⁰ WHO. Map of the estimated prevalence of eye worm history in Africa. <http://www.who.int/apoc/raploa/en/>. Accessed June 5, 2015.



Access to Health Care and Public Benefits

What health insurance options are available to immigrant children and families?

What rights do immigrant children have in schools? Can they obtain English language assistance or any other special services?

How can I help immigrant children access the benefits that they are eligible to receive?



WHAT HEALTH INSURANCE OPTIONS ARE AVAILABLE TO IMMIGRANT CHILDREN AND FAMILIES?



Children of immigrants are nearly twice as likely to be uninsured as are children in nonimmigrant **families**.¹ Access to health care insurance is dependent upon the child’s immigration status as well as federal and state level policies. Eligibility requirements and waiting periods can present barriers for immigrant families to access health insurance. However, many uninsured immigrant children are eligible for Medicaid or CHIP but are not enrolled. The following provides a quick guide to health insurance options for immigrant children and their families:

Overview of health care benefits options for immigrant children and families

Immigrant Status	Medicaid ¹	CHIP ²	ACA Subsidies
Pregnant Women	In some states, may be eligible for prenatal care regardless of immigration status ⁴	In some states, may be eligible for prenatal care regardless of immigration status ⁵	Not applicable
U.S. Citizen Children with undocumented parent(s)	Eligible	Eligible	Eligible
Lawful Permanent Resident (under age 18)	Eligible after 5 years of legal residency in the U.S.; states have the option to waive the 5 year ban	Eligible after 5 years of legal residency in the U.S.; states have the option to waive the 5 year ban	Eligible
Lawful Permanent Resident (age 18 and over)	Eligible after 5 years of legal residency in the U.S.; states have the option to waive the 5 year ban	Eligible after 5 years of legal residency in the U.S.; states have the option to waive the 5 year ban	Eligible
Refugees, Asylees, Victims of Trafficking and other humanitarian grounds	Eligible	Eligible	Eligible
Members of the military and veterans (and their spouses and children)	Eligible	Eligible	Eligible
Unauthorized Immigrants (including children and pregnant women)	Eligible for Emergency Medicaid Only. Some states may cover children	Not Eligible	Not Eligible (barred from purchasing coverage on their own in the Health Insurance Exchange)
Temporary Protected Status (TPS)	Not Eligible	Not Eligible	Eligible

- Depending on their state of residence, applicants who are lawfully present immigrant children may be subject to a five-year waiting period before they are legally able to access Medicaid or CHIP.⁶
- Children born in the United States are U.S. citizens regardless of their parents’ immigration status, and are therefore eligible for Medicaid or CHIP at birth with no waiting period.
- Refugees, asylees, victims of trafficking, members of the military and veterans (and their spouses and children) are eligible for Medicaid, CHIP, and health insurance subsidies without being subjected to the five-year waiting period.
- Undocumented immigrant children are not eligible for Medicaid, CHIP or health insurance subsidies provided through the ACA. However, the Emergency Medical Treatment and Active Labor Act (EMTALA)⁷ requires hospitals to provide care to anyone needing **emergency healthcare** treatment regardless of citizenship, legal status or ability to pay. While EMTALA requires that hospitals offer emergency treatment to stabilize the individual, it does not mandate preventative or out-patient care. If an undocumented parent and child presents with a medical emergency, pediatricians should not hesitate to encourage treatment at a hospital’s emergency room.

Resources

Coverage of Lawfully–Residing Immigrant Children and Pregnant Women without a 5 Year Waiting Period (January 2013) Georgetown University Health Policy Institute Center for Children and Families
<http://ccf.georgetown.edu/wp-content/uploads/2012/04/Coverage-of-Lawfully-Residing-Immigrant-Children-and-Pregnant-Women-without-a-5-Year-Waiting-Period-ICHIA-Option.pdf>

Key Facts on Health Coverage for Low-Income Immigrants Today and Under the Affordable Care Act (March 2013)
<http://www.kff.org/uninsured/upload/8279.pdf>

ARE IMMIGRANT CHILDREN AND FAMILIES ELIGIBLE TO RECEIVE PUBLIC BENEFITS SUCH AS SNAP, TANF, PUBLIC/SUBSIDIZED HOUSING?



30 percent of children in immigrant families live below the federal poverty level;⁸ however these families may face barriers to accessing public assistance programs that help with basic needs such as food and housing. Eligibility requirements, lack of knowledge about programs, or fear can prevent families from securing benefits for their children. The eligibility standards for immigrant children and families to access key public benefit programs are outlined below:

Overview of public benefits options for immigrant children and families⁹

Immigrant Status	SNAP ¹⁰	TANF	Non-cash benefits under TANF such as subsidized child care or transit subsidies ¹¹	Public Housing ¹²
Lawful Permanent Resident (under age 18)	Eligible with no waiting period	Eligible after 5 years of legal residency in the U.S.; states have the option to waive the 5 year ban	Eligible after 5 years of legal residency in the U.S.; states have the option to waive the 5 year ban	Eligible
Lawful Permanent Resident (age 18 and over)	Eligible after 5 years of legal residency in the U.S.; states have the option to waive the 5 year ban	Eligible after 5 years of legal residency in the U.S.; states have the option to waive the 5 year ban	Eligible after 5 years of legal residency in the U.S.; states have the option to waive the 5 year ban	Eligible
Refugees, Asylees, Victims of Trafficking, other humanitarian grounds	Eligible with no waiting period	Eligible with no waiting period	Eligible with no waiting period	Eligible
Members of the military and veterans (and their spouses and children)	Eligible with no waiting period	Eligible with no waiting period	Eligible with no waiting period	Eligible with no waiting period
Unauthorized Immigrants (including children and pregnant women)	Not Eligible	Not Eligible	Not Eligible	May live in residence with eligible family member
Temporary Protected Status (TPS)	Not Eligible	Not Eligible	Not Eligible	Not Eligible

- **Supplement Nutrition Assistance Program (SNAP) (formally “Food Stamps”):** SNAP is available to almost all low income households. The program is meant to help low income individuals purchase food and improve their nutrition. Nearly 72 percent of SNAP participants are in families with children. The average SNAP benefit is about \$133.41 a month (or about \$4.45 a day).¹³ Undocumented parent(s) may apply for SNAP benefits on behalf for their U.S. citizen children. The SNAP benefit amount will be calculated based on the parents’ income, but the parent (and any undocumented children) will be excluded from the household size.
- **Temporary Assistance for Needy Families (TANF):** TANF is a federal block grant that provides states, territories, and Tribes federal funds each year. The funds are used to provide beneficiaries with cash and/or benefits and services, such as subsidized child care or transit subsidies. In general, undocumented immigrants are not eligible for TANF. However, ineligible parents can receive TANF benefits for their U.S. citizen children.
- **Public Housing/Subsidized Housing:** Public and subsidized housing programs were created to provide safe and affordable rental housing for low-income individuals, people with disabilities and the elderly.¹⁴ U.S. citizens and qualified immigrants¹⁵ are eligible for assistance regardless of the immigration status of other family members. For mixed-status families living in the same household, benefits are prorated: the benefit is reduced by the proportion of nonqualified immigrants in the household.

- *Make inquiries of students or parents that may expose their immigration status.*
- *Require students or parents to provide social security numbers.*
- *Treat a student differently to determine residency.*
- *Engage in any practices to “chill” or “hinder” the right of access to education.*

Like other children, undocumented students are obligated under state law to attend school until they reach a mandated age. Even if an undocumented student is not living with a parent or legal guardian, school districts must enroll the student if the child resides in the district and the district cannot establish parents/guardians residence in a different district.

Immigrant children with unstable housing are also protected by the McKinney-Vento Homeless Education Assistance Act.¹⁷ The McKinney-Vento Act requires that school districts allow homeless children¹⁸ to enroll in public schools, even if they are unable to prove residency or guardianship.

The Right to Secondary Services in School

All secondary services, such as transportation, school based nursing services, free or reduced-meals, special education,¹⁹ and counseling are available and should be accessible to immigrant children regardless of their legal status because they are central to the student’s educational experience.

Immigrant parents and students who have limited English proficiency (LEP) are also entitled to language-assistance programs.²⁰ Under Title VI of the Civil Rights Act of 1964, private entities and state agencies that receive federal funding for programs are required to provide equal access to aid for eligible persons, regardless of their race, color, or national origin.²¹ Title VI prohibits conduct that has a disproportionate effect on LEP individuals because such conduct constitutes national-origin discrimination.²² Because refusing to provide services in other languages might be discriminatory in some localities,²³ special efforts should be made to ensure that there is access to translated materials and interpreters.²⁴

WHAT RIGHTS DO IMMIGRANT CHILDREN HAVE IN SCHOOLS? Can they obtain English language assistance or any other special services?



Immigrant children, regardless of immigration status, have the right to free public K-12 education.¹⁶ Public schools may not:

- *Require proof of citizenship or legal residence to enroll or provide services to immigrant students.*

HOW CAN I HELP IMMIGRANT CHILDREN ACCESS THE BENEFITS THAT THEY ARE ELIGIBLE TO RECEIVE?



1. *Screen for basic needs*

Screening for basic needs as a standard part of practice is essential for detecting and addressing issues such as hunger and housing insecurity. Practices can use a brief written screener or verbally ask family members questions if the family is having difficulty with issues such as food, housing, and heat. Screening for basic needs can help uncover new and “hidden” economic difficulties that impact child health. Practices should take a universal approach to screening, and never target specific families.

2. *Work with community partners to provide public benefits information*

When unmet basic needs are identified, immigrant families will need up to date, understandable information about public benefits programs. In order to provide families with the most accurate information and referral resources, practices should build relationships with trusted local and state organizations that have expertise with public benefits. Key partners will likely include local and state departments of public health, **legal services organizations**, and community development organizations that have ties to immigrant communities. These partners can help provide pediatricians with accurate benefits information to provide for families in the practice.

3. *Work with the care team and community partners to help encourage families to access public benefits*

Immigrant families may be reluctant to sign up for public benefits for a variety of reasons. Pediatricians can work with organizations and individuals that are trusted in the community to conduct education and outreach activities about public benefits. Within the practice, social workers, case managers, legal advocates, or peer educators can be effective messengers about public benefits. Working with local community institutions, faith based institutions, and community development organizations can also help pediatricians promote public benefits to immigrant families.

4. *Reassure families that the information they provide in the health care setting is confidential and that the practice is not involved in immigration enforcement.*

Inform them that undocumented parents of US citizen children can apply for benefits on behalf of their eligible citizen children.

Resources

Helping Immigrant Patients (page 10) in “Clinical Partners in Advocacy: How Can I-HELP?” Medical Legal-Partnership Boston October 2009 http://api.ning.com/files/sHxuGddmuirJjxyAENqoX48kxDVf0JoMj07pcfYiKQ2pQ*HLGqti5n8RS9eIjY0Od1xXhzKXwUaSZ1AVy9mJlFwwMuEx9KhI/IHELPGuide.pdf

Reaching, Supporting, and Empowering Immigrant Families: Experiences of the Statewide Parent Advocacy Network (SPAN) <http://www.cpe.rutgers.edu/njdcf/docs/Reaching-and-Serving-Immigrant-Families.pdf>

Strategies for Engaging Refugee and Immigrant Families http://www.promoteprevent.org/sites/www.promoteprevent.org/files/resources/strategies_for_engaging_immigrant_and_refugee_families_2.pdf

References

- 1 Foundation for Child Development. Children in immigrant families: essential to America’s future. Available at: <http://fcd-us.org/node/1232>. Accessed July 19, 2012
- 2 Benefits not subject to “public charge” consideration.
- 3 Id.
- 4 Unborn Child Option is state specific. It only covers services related to pregnancy or conditions that could complicate pregnancy can be covered under this option. Check individual state regulations.
- 5 Id.
- 6 Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), 42 U.S.C., §§ 601 et seq. Before 1996, lawfully present immigrants were generally eligible for public benefits. Under PRWORA, lawfully present immigrants are banned from receiving benefits for the first five years they live in the United States. Some states have chosen to waive that ban. To see a list of states that have waived the five-year ban, see KARINA FORTUNY AND AJAY CHAUDRY, URBAN INSTITUTE, A COMPREHENSIVE REVIEW OF IMMIGRANT ACCESS TO HEALTH AND HUMAN SERVICES, 12-20 (June 2011), <http://aspe.hhs.gov/hsp/11/ImmigrantAccess/Review/index.pdf>.
- 7 42 U.S.C. § 1395DD.
- 8 Foundation for Child Development. Children in immigrant families: essential to America’s future. Available at: <http://fcd-us.org/node/1232>. Accessed July 19, 2012
- 9 Fortuny & Chaudry, supra note 10.
- 10 Benefits not subject to “public charge” consideration
- 11 Id.
- 12 Id.

- ¹³ CENTER ON BUDGET AND POLICY PRIORITIES, POLICY BASICS: INTRODUCTION TO SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) (2012).
- ¹⁴ U.S. Dep't of Housing and Urban Dev., HUD's Public Housing Program, http://portal.hud.gov/hudportal/HUD?src=/topics/rental_assistance/phprog
- ¹⁵ Qualified aliens are defined as: legal permanent residents; refugees; asylees; an alien who is paroled into the U.S. (under INA §212(d)(5)) for a period of at least one year; an alien whose deportation is being withheld on the basis of prospective persecution; an alien granted conditional entry pursuant to INA §203(a)(7) as in effect prior to April 1, 1980; and Cuban/Haitian entrants. For further explanation and legal citations, see CONGRESSIONAL RESEARCH SERVICES, IMMIGRATION: NONCITIZEN ELIGIBILITY FOR NEEDS-BASED HOUSING PROGRAMS 1-2 (Jan. 23, 2012), <http://www.fas.org/sgp/crs/homesec/RL31753.pdf>.
- ¹⁶ *Plyer v. Doe*, 457 U.S. 202 (1982). The Supreme Court of the United States found that states must educate children of undocumented immigrants, interpreting the equal protection clause of the 14th Amendment to apply to anyone who lives in the U.S., regardless of citizenship.
- ¹⁷ 42 U.S.C. §1143a(2)(B)(i).
- ¹⁸ *Id.* The McKinney-Vento Act defines homeless children as "individuals who lack a fixed, regular, and adequate nighttime residence." The act provides examples of children who would fall under this definition: children and youth sharing housing due to loss of housing, economic hardship or a similar reason; children and youth living in motels, hotels, trailer parks, or camp grounds due to lack of alternative accommodations; children and youth living in emergency or transitional shelters; children and youth abandoned in hospitals; children and youth awaiting foster care placement; children and youth whose primary nighttime residence is not ordinarily used as a regular sleeping accommodation (e.g. park benches, etc); children and youth living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations; migratory children and youth living in any of the above situations.
- ¹⁹ Undocumented children with disabilities have a statutory right to services under the Individuals with Disabilities Education Act (IDEA) or Section 504 of the Rehabilitation Act of 1973 (Section 504). For a state to be eligible for federal assistance under IDEA Part B, it must provide assurance that a free appropriate public education is available to all children with disabilities residing in the state.
- ²⁰ *Lau v. Nichols*, 414 U.S. 563 (1974). The Supreme Court of The United States found that school districts not providing their limited English proficient students with language-assistance programs were violating Title VI of the Civil Rights Act.
- ²¹ 42 U.S.C. § 2000d (2004).
- ²² *Lau*, 414 U.S. at 568.
- ²³ The U.S. Department of Justice considers four factors to determine the obligations of state welfare agencies receiving federal funding in providing services to LEP individuals. The factors are: (1) the number or proportion of persons with LEP who would not have access without removing the language barriers; (2) the frequency with which persons with LEP contact the agency; (3) the nature and importance of the benefits to its beneficiaries; and (4) the resources available within the agencies and programs. This balancing of these four factors is meant to provide critical services to those in need, but not impose undue burdens on small business, small local governments, or small non-profits. Bilingual services are required when the number and frequency of contact by LEP persons are high, where the total costs for LEP services are reasonable, and when the lack of access to services may have dire consequences for the recipients. 67 Fed. Reg. 41459 (Jun. 18, 2002).
- ²⁴ 65 Fed. Reg. 50121 (Aug. 16, 2000).



Immigration Status and Related Concerns

What is the impact of parental separation or deportation on child health?

How do I assist families that face the deportation or removal of a child's parent or primary care giver?

What should I do if a family asks me to write a letter of support to prevent deportation or removal of a child's primary care giver?

Can immigration enforcement request information about my patient families?

What do I do if this happens?



The following content is for informational purposes only and not for the purpose of providing legal advice.

WHAT IS THE IMPACT OF PARENTAL SEPARATION OR DEPORTATION ON CHILD HEALTH?



Immigrant children may live in a “mixed status” family with an undocumented parent/primary care giver who lacks the proper documentation to live legally in the United States. Immigration enforcement actions can lead to the sudden removal of an undocumented parent without giving the family notice or time to prepare for the parent’s removal.

Children whose parents are taken into custody and/or deported have been shown to experience mental and emotional health problems including sleeping and eating disturbances, anxiety, depression, poor school performance, and other types of distress. Forced separations due to immigration enforcement can also result in a child’s household losing a working parent, which has been shown to threaten in family housing and food **stability**.¹

The mere possibility of deportation can negatively impact the well-being of some immigrant children, whether or not they themselves or family members are undocumented. Mexican immigrant children specifically have shown emotional distress, fear, confusion and anxiety.²

As part of the social history, pediatricians may consider asking families if a parent/other key family member has left or is potentially going to leave the family for any reason. This information may help provide insight into the child’s health. Reassure families that the information they provide in the health care setting is confidential and that the practice is not involved in immigration enforcement.

It is extremely important for parents or primary caregivers who may face separation from their children to develop a plan for their children’s health and safety, in the event of separation.

HOW DO I ASSIST FAMILIES THAT FACE THE DEPORTATION OR REMOVAL OF A CHILD’S PARENT OR PRIMARY CARE GIVER?



Pediatricians should advise parents or primary caregivers who may be at risk for separation from children to take the following basic steps:³

- *Appoint power of attorney to a trusted adult to care for children in the event of removal or deportation. Because the requirements for legally executed Powers of Attorney vary considerably by state, seeking the assistance of attorney is recommended.*
- *Maintain copies of medical records, including immunization history, medications and other health information. Give a copy to a trusted adult.*
- *Maintain copies of your child’s birth certificate, social security card and passport(s). Give a copy to a trusted adult.*
- *Maintain documentation about any public benefits your child may be receiving from local, state, or federal programs. Eligibility for these programs may be affected by parental deportation. Give a copy to a trusted adult who can help maintain the child’s benefits if possible.*
- *Maintain documentation of children’s school records. Give a copy to the adult that you have designated as Power of Attorney.*

Pediatricians should refer families to legal partners for assistance with legal and immigration related issues, such as **local legal aid organizations and non-profit advocacy groups**. When addressing deportation issues with families, pediatricians should reassure families that the information they provide in the health care setting is confidential and that the practice is not involved in immigration enforcement.

Resources

Suarez-Orozco et. al. Growing Up in the Shadows: The Developmental Implications of Unauthorized Status, Harvard Educational Review Vol. 81 No. 3 Fall 2011 <http://hepg.org/document/163/>

Detailed checklists are available for families to prepare for deportation/separation: Phil Storey, *Immigrant Family Preparedness Checklist* (2011), http://cj-network.org/cj/wp-content/uploads/2011/12/CJ_DeportationChecklist2011_Eng.pdf

WHAT SHOULD I DO IF A FAMILY ASKS ME TO WRITE A LETTER OF SUPPORT TO PREVENT DEPORTATION OR REMOVAL OF A CHILD'S PRIMARY CARE GIVER?

If I write the letter, what is most helpful to include or address?



Pediatricians may be asked to write a letter of support for immigrant families who face parental deportation or separation from a child. Support letters may also be requested for visa applications and other immigration administrative hearings. The pediatrician may be asked to attest that the parent(s) appear to be providing good care for a child and/or that the child seems to emotionally and physically well. Alternatively, the pediatrician might be requested to attest that the child has medical and/or psychological conditions for which he/she is currently being treated, and it is the pediatrician's professional opinion that it is not in the child's best interest to disrupt this care or send him/her to a location where adequate care may not be available.

If a pediatrician chooses or is required to attest to the state of the child's physical health, psychological health, and/or the need for treatment, he/she should: (1) reference medical notes when appropriate, (2) clearly identify as opinion any opinions offered, (3) release or disclose HIPAA-protected information only after obtaining proper consent or authorization, and (4) restrict his/her comments to fact with which he or she is personally familiar; care should be taken not to include false statements or to mislead officials. The pediatrician may incur significant liability risks if the statements are knowingly false or markedly exaggerated.

Support letters must be individualized and tailored to address any legitimate hardship that a child would face if the child's parent is detained or deported. If the child's parent(s) is working with an immigration attorney, the pediatrician should contact the attorney to address what to include in the letter. However, generally, a pediatrician should consider the following when writing a letter of support or affidavit:

- *Write the letter specifically for your patient. Honestly address your patient's issues and situation without exaggeration or falsehood.*⁴
- *Provide an overview of the physician's education, training, expertise, and the number of years in practice. This may persuade the immigration judge to accept the physician as an expert witness.*⁵
- *Provide an objective and individualized description of the child's medical diagnosis, treatment, and prognosis. The letter must be factual, unbiased and authoritative.*⁶
- *Discuss the instrumental role the parent plays in seeking, supporting and maintaining treatment, e.g. taking child to treatment, administering medication or otherwise providing care.*
- *Discuss how the child will be harmed physically, emotionally, and psychologically if the parent is detained or deported.⁷ Provide examples of the health consequences the child would face without their parent participating in their health care. If possible, discuss how the child would not get the care they need in their parent's country. Overall, your written testimony should support the parent's assertion that the child will suffer extreme hardship if the parent is detained or deported.*⁸
- *Always provide facts and rationale for your medical opinion.*⁹
- *Provide supporting medical documents or reports.*

CAN IMMIGRATION ENFORCEMENT REQUEST INFORMATION ABOUT MY PATIENT FAMILIES?

What do I do if this happens?



It is imperative that anytime immigration enforcement contacts a pediatrician for patient information that the pediatrician forwards the request to their health care facility's legal department, or in the case of a sole practitioner, their legal counsel. There are many complex and multi-faceted legal issues associated with producing medical records to Immigration and Customs Enforcement. The request for documents may be impacted by the following laws:

- *U.S. Constitution, Fourth Amendment*;¹⁰
- *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*;¹¹
- *Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act of 2001 (USA PATRIOT Act)*;¹²
- *Individual State Privacy Laws*;¹³ and
- *Legal Process such as court-ordered or administrative warrants, subpoenas, or summons.*

It is helpful to develop written policies and procedures on handling document requests and to train health care providers on how to interact with immigration authorities.¹⁴ Because there may be legal obligations on the health care provider if the request is a valid court order, a physician should never simply ignore a request. Pediatricians should document any experiences of intimidation or involvement with immigration enforcement officials. This information should be shared with the health care facility's legal department.

Practices may choose to designate a specific individual or individuals to assume primary responsibility for handling contacts with law enforcement officials. If this occurs, inform all other staff about the role of the designated individuals and any other established procedures for the practice in the event of an immigration enforcement action.

References

- ¹ Facing Our Future: Children in the Aftermath of Immigration Enforcement Chaudry, Ajay; Capps, Randy; Pedroza, Juan Manuel; Casteneda, Rosa Maria; Santos, Robert; Scott, Molly M. The Urban Institute 2010 http://www.urban.org/uploadedpdf/412020_FacingOurFuture_final.pdf Accessed March 7 2013
- ² The Burden of Deportation on Children in Mexican Joanna Dreby Immigrant Families Journal of Marriage and Family 74 (August 2012): 829–845)
- ³ Phil Storey, *Immigrant Family Preparedness Checklist*, http://cj-network.org/cj/wp-content/uploads/2011/12/CJ_DeportationChecklist2011_Eng.pdf
- ⁴ Expert affidavits that are general in nature and not specifically prepared for the patient are given less weight by immigration judges. See *Wang v. BIA*, 437 F.3d 270, 274 (2d Cir. 2006).

⁵ Katherine J. Eder, *The Importance of Medical Testimony in Removal Hearings for Torture Victims*, 7 DEPAUL J. HEALTH CARE L. 281, 306 (Spring 2004) ("Expert evidence, which includes both documentary and testimonial evidence, can be very significant and potentially determinative in whether a party meets his or her burden of proof."); see also Garry Malphrus, *Expert Witnesses in Immigration Proceedings*, 4 IMMIGRATION LAW ADVISOR 1, 13 (May 2012), available at <http://www.justice.gov/eoir/vll/ILA-Newsletter/ILA%202010/vol4no5.pdf>.

⁶ Id.

⁷ Id.

⁸ Eder, *supra* note 8 at 305.

⁹ Expert testimony and affidavits that are highly conclusory in its opinion without facts and rationale for the opinion are not persuasive. See Malphrus, *supra* note 8 at 13.

¹⁰ Generally bars the government from engaging in unreasonable searches and seizures. U.S. CONST., amend. IV.

¹¹ 45 C.F.R. § 164.512(f)(2002); For a general summary of HIPAA Privacy Rules, see <http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html>

¹² 50 U.S.C. § 1861.

¹³ State laws may offer stronger consumer protection than HIPAA.

¹⁴ CA. PRIMARY CARE ASS'N, INFORMATION FOR CLINICS IN THE EVENT OF AN IMMIGRATION (ICE) RAID: THE RIGHTS OF CLINIC, CLINIC STAFF AND THEIR PATIENTS (Oct. 2012), <http://www.cpcpa.org/cpcpa/assets/File/Policy-and-Advocacy/Active-Policy-Issues/MSFW/2012-10-17-ICE-Raid-Summary-Updated.pdf>; see also, NAT'L IMMIGRATION LAW CTR., IMMIGRATION ENFORCEMENT: KNOW YOUR PATIENTS' AND YOUR RIGHTS (Jan. 2011), [http://www.cpcpa.org/cpcpa/assets/File/Policy-and-Advocacy/Active-Policy-Issues/MSFW/2011-01-11-NILC-Know-Your-Rights-Clinics\(1\).pdf](http://www.cpcpa.org/cpcpa/assets/File/Policy-and-Advocacy/Active-Policy-Issues/MSFW/2011-01-11-NILC-Know-Your-Rights-Clinics(1).pdf).



Mental, Emotional and Behavioral Care

- What considerations should be included in a mental health assessment of immigrant children?
- What risk and protective factors should be included in the mental health assessment?
- What mental health screening instruments are available for use with children of immigrants?
- How can I help children link to mental health treatment?
- What are some proven intervention and treatment strategies for children with PTSD and other mental, emotional and behavioral health problems?
- What are some high-risk circumstances that may require special attention?



WHAT CONSIDERATIONS SHOULD BE INCLUDED IN A MENTAL HEALTH ASSESSMENT OF IMMIGRANT CHILDREN? ???

Overall, immigrant children are well adjusted and should be treated as all children in the pediatric medical home. However, the experiences of immigrant children may interfere with critical stages of intellectual, social, emotional and physical development.

This section of the toolkit addresses mental health considerations for immigrant children and pediatric assessments for children who may need mental health services. Disruption to families, education, and witnessed traumatic events compound developmental concerns. Assessment of mental health among children in immigrant and refugee families involves several key elements:

- Screening for trauma
- The influence of acculturation
- Consideration of changing social support structure
- Resilience

Screening for trauma:

Immigrants and refugees to the United States may come from regions characterized by violence and extreme poverty, such as Central America, the Caribbean and some Asian and African countries, placing them at high risk for emotional and behavioral health problems. Immigrant children may experience trauma in their country of origin, en route to the United States, upon arrival, or while living the community. Unaccompanied minors and refugees are at particular risk for traumatic exposure.

The influence of acculturation:

The influence of acculturation should be evaluated over three generations:

- *First generation immigrants (parents and children born in the country of origin) may experience more recent trauma but may be reluctant to seek mental health of services because of cultural expectations or, in the case of mixed status or undocumented families, because of the perceived risk of deportation.*

- *Second generation children (Americans born of immigrant parents), especially those in families with mixed legal status, often have more emotional and behavioral problems associated with persistent poverty, perceived lack of opportunity, intergenerational conflicts and explicit societal prejudice. These immigrants have been shown to use mental health services at a higher rate than those who immigrate as children.*
- *Third generation immigrants (both parents and children born in the US) experience the cumulative risk and chronic stressors common to life in poor, violent neighborhoods and, by many researchers, are considered native. Evidence strongly associates cumulative childhood adverse experiences with adult chronic illness and a shorter lifespan.*

Consideration of changing social support structure:

At the time of departure from the country of origin, children often lose the direct support of extended family networks, familiar cultural expectations and important intimate relationships such as with extended family members. During the migration, they may experience separation from caregivers.

Resilience:

As with all children, family functioning mediates the effects of poverty on emotional and behavioral health. If families are healthy, characterized by resilient parents and good interpersonal connectedness, children are better adjusted and have fewer difficulties with anxiety, depression and aggression. Biculturalism (and bilingualism) appears to be the most adaptive response retaining important elements for the culture of origin but adopting many values from the new culture.

Learn more:

Abe-Kim, J., Takeuchi, D., Hong, S., et al. Use of Mental Health-Related Services among Immigrant and US-Born Asian Americans: Results from the National Latino and Asian American Study. *Am J Public Health*. 2007;97:91-98.

Beiser et al. Poverty, Family Process, and the Mental Health of Immigrant Children in Canada. *Am J Public Health*. 2002;92:220-227

Fazel, M. and Stein, A. The mental health of refugee children. *Arch Dis Child* 2002;87:366-370

Lustig et al. Review of Child and Adolescent Refugee Mental Health. *J. Am. Acad. Child Adolesc. Psychiatry*, 2004;43(1):24-36.

Perreira, K. and Ornelas, I. 2011. The Physical and Psychological Well-being of Immigrant Children. *The Future of Children*. 2011: 21(1) pp.195-218 http://www.princeton.edu/futureofchildren/publications/docs/21_01_09.pdf Pumariega A, Rothe, E and Pumariega J. Mental Health of Immigrants and Refugees. *Community Mental Health Journal*. 2005;41(5): 581-597

Refugee Resettlement: Chapter 3.3 Investing the Future: Refugee Children and Young People. www.unhcr.org.

Child Trends Data Bank <http://www.childtrends.org/?indicators=immigrant-children#sthash.2MRsiehi.dpuf>

WHAT RISK AND PROTECTIVE FACTORS SHOULD BE INCLUDED IN A MENTAL HEALTH ASSESSMENT?



A variety of risk factors place immigrant children at risk for emotion, behavioral or relational problems:

- *Children of isolated, linguistically-challenged and depressed families are at high risk for emotional and behavioral problems.*
- *Pre-existing cognitive, emotional or physical disorder increases the likelihood of maladaptation.*
- *High intelligence and education level does not protect children from post-traumatic disorders.*
- *Unaccompanied children and young immigrant adolescents are at high risk for emotional distress and enduring relational difficulties.*
- *Disrupted family composition by death or other loss increases risk as do single parent families and parental mental illness.*
- *Persistent poverty, particularly associated with housing and food insecurity, are significant cumulative risk factors and many migrant families settle in poor neighborhoods with limited support services.*
- *Living in ethnic enclaves isolated from mainstream society may be detrimental for the second and third generation immigrants by slowing acculturation and by provoking intergenerational conflict.*

- *Perceived cultural prejudice and either overt or implicit prejudice are all associated with increased risk of poor acculturation and individual symptoms of stress.*

Protective factors should be encouraged and discussed by pediatricians with immigrant families:

- *High family cohesion, two-parent families, interpersonal support and communication, in addition to strong work ethics and aspirations are all strongly protective.*
- *Being part of an engaging community of fellow immigrants from the same country of origin on arrival also leads to better mental health outcomes.*
- *For foster children, a same ethnic origin foster parent may be protective.*
- *Perceived acceptance in receiving communities, safety in schools and strong neighborhood connections are protective, buffering many of these children from the negative influences of mainstream society.*

Resources for practices:

National Child Traumatic Stress Network: Addressing the Mental Health Problems of Border and Immigrant Youth: http://www.nctsn.org/sites/default/files/assets/pdfs/BorderlandersSpecialReport_Final_0.pdf

American Psychological Association: <http://www.apa.org/topics/immigration/index.aspx>

Chadwick Center: Adaptation Guidelines for Serving Latino Children and Families Affected by Trauma: <http://www.chadwickcenter.org/Documents/WALS/Adaptation%20Guidelines%20for%20Serving%20Latino%20Children%20and%20Families%20Affected%20by%20Trauma.pdf>

Learn more:

Fazel et al. Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors. *Lancet* 2012; 379: 266–82

Griffin, M., Son, M. and Shapleigh, E. Children's Lives on the Border. *Pediatrics* 2014;133:e1118

Shields, Margie K. Shields, Richard E. Behrman (2002) "Children of Immigrant Families: Analysis and Recommendations", *The Future of Children*, Vol. 14, No. 2, Children of Immigrant Families (Summer, 2004), pp. 4-15.

ARE SOCIO-EMOTIONAL SCREENING INSTRUMENTS AVAILABLE FOR USE WITH IMMIGRANT CHILDREN?



Many mental health and developmental screening instruments that are normed to the general culture are useful for children in immigrant families with some caveats. Although some instruments have been translated into Spanish, others are only available in English. It is important that the historian has the literacy level to answer the questions (if the instrument is written) and that a skilled medical interpreter is provided when needed. For a list of instruments, please refer to Table 1.

Table 1: Mental Health and Developmental Screening Instruments and Resources

Anxiety/ PTSD	Trauma Symptom Checklist for Children and Trauma Symptom Checklist for Young Children (TSCC and TSCYC) http://www4.parinc.com Child PTSD Symptom Scale (CPSS) foa@mail.med.upenn.edu Univ. of California at Los Angeles Posttraumatic Stress Disorder Reaction Index (UCLA-PTSDRI) http://www.istss.org/UCLAPosttraumaticStressDisorderReactionIndex.htm
Depression	Patient health questionnaire (PHQ-9) http://www.phqscreeners.com/overview.aspx?Screener=02_PHQ-9
ADHD	Vanderbilt ADHD forms http://www.brownfamilymedicine.org/pdf/vanderbilt%20-%20parent%20-%20spanish.pdf
Relational, emotional and behavioral development in pre-school children	Strengths and Difficulties Questionnaire (SDQ) in many languages http://www.sdqinfo.org/a0.html Ages & Stages Questionnaires®: Social Emotional (ASQ:SE) in Spanish http://products.brookespublishing.com/Ages-Stages-Questionnaires-Social-Emotional-ASQSE-in-Spanish-P580.aspx
Relational, emotional and behavioral development in school-aged children	Pediatric Symptom Checklist in many languages http://www.massgeneral.org/psychiatry/services/psc_forms.aspx http://www.brightfutures.org/mentalhealth/pdf/professionals/ped_sympton_chklst.pdf
Autistic Spectrum Disorders	M-Chat available in many languages http://www.firstsigns.org/screening/tools/rec.htm
Maternal Depression	The Patient Health Questionnaire-2 (PHQ-2) http://www.cqaimh.org/pdf/tool_phq2.pdf Maternal depression screening implementation guide http://www.commonwealthfund.org/publications/resources/2007/jan/section-four--guide-for-organizations-to-assist-practices-implementing--depression-screening
Intimate partner/ family violence	https://www.acog.org/About_ACOG/ACOG_Departments/Violence_Against_Women/Es_Usted_Victima_de_Maltratos HITS screen in English, Spanish and Creole http://www.orchd.com/violence/
Social determinants of health	WE CARE Project http://healthbegins.ning.com/page/social-screening-tools
Refugee health	Refugee Health Screener http://www.refugeehealthta.org/files/2012/09/RHS15_Packet_PathwaysToWellness.pdf

HOW CAN I HELP LINK IMMIGRANT CHILDREN TO TREATMENT?



Linking immigrant children to treatment and facilitating retention in quality mental health care are fraught with obstacles.

- *Families with mixed legal status are fearful of referrals because of the risk of detection or deportation.*
- *The referral to a mental health therapist often carries a stigma and may conflict with cultural values that disparage or deny the possibility that children may have emotional or mental problems.*
- *In many regions of the US, there may be a shortage of therapists with language and cultural concordance or cross-cultural experience.*
- *Few interpreters are trained in mental health care that include subtleties in communication and ethics.*
- *Funding for mental health care in most communities is limited and uninsured families find the payments prohibitive.*

Developing a multi-disciplinary medical home that provides community-based care coordination can help immigrant families engage in treatment. Nurses or social workers may perform the full spectrum of activities related to care coordination including maintenance of a centralized medical record. Often lay members of the immigrant community who are trained as community health workers (e.g. promotores de salud) are able to identify children in need, link them to services and improve engagement in treatment. Enhanced medical homes that include co-located mental health providers can be extremely helpful in reducing barriers to access such as transportation, limited hours of operation and stigma. If co-location or an integrated model is not practical, primary care pediatricians may develop agreements for facilitated referrals to therapists and psychiatrists in the community who they know will be receptive to immigrant families.

Resources for practices:

American Academy of Child and Adolescent Psychiatry. Facts for Families: Finding Mental Healthcare for Children of Immigrants. http://www.aacap.org/aacap/Families_and_Youth/Facts_for_Families/Facts_for_Families_Pages/Finding_Mental_Healthcare_for_Children_of_Immigrants_112.aspx

Introduction to Community Health Workers/Promotores de Salud <http://minorityhealth.hhs.gov/templates/content.aspx?vl=2&vlid=207&ID=8930>

Outreach-direct, one-to-one assistance from persons with similar experiences <http://kff.org/disparities-policy/issue-brief/connecting-eligible-immigrant-families-to-health-coverage/>

Rural Assistance Center Community Health Worker toolkit <http://www.raconline.org/communityhealth/chw/files/community-health-workers-toolkit.pdf>

WHAT ARE SOME PROVEN INTERVENTION AND TREATMENT STRATEGIES FOR CHILDREN WITH PTSD AND OTHER MENTAL, EMOTIONAL AND BEHAVIORAL HEALTH PROBLEMS?



Community pediatricians may be called upon to evaluate and recommend treatment strategies that have proven outcomes. Many evidence-based treatments are effective for children from various cultural backgrounds without significant adaption except for language. These include:

- *Cognitive-behavioral therapy (CBT) for anxiety and child focused play therapy are examples of therapies that are effective without modification.*
- *Functional Family Therapy (FFT) and Multi-Systemic Therapy (MST) for families with adolescents with substance abuse or conduct disturbance have been effect across cultures.*
- *Incredible Years and Parent-Child Interaction Therapy have similar outcomes in culturally modified and unmodified forms.*

Some treatment strategies have been developed or modified specifically for particular immigrant populations. These adaptations are often school based in order to increase identification and retention of children who otherwise would be difficult to reach because of lack of health coverage, parental perceptions and unrecognized need for care.

- *Cognitive Behavioral Intervention for Trauma in Schools (CBITS) utilizes bilingual therapy sessions, trauma narratives that use music settings familiar to the children and group treatment that may include faith tradition activities such as forgiveness rituals to improve social problem solving.*
- *Group TF-CBT (trauma focused cognitive behavioral therapy) and Functional Family Therapy have both been modified with reliably successful outcomes with Hispanic children.*

Learn more:

Kataoka et al. A School-Based Mental Health Program for Traumatized Latino Immigrant Children. *J. Am. Acad. Child Adolesc. Psychiatry.* 2003, 42(3):311–31

Malgady, R. Treating Hispanic Children and Adolescents Using Narrative Therapy. In: Evidence-Based Psychotherapies for Children and Adolescents. 2012 The Guilford Press. New York

McCabe, Kristen and Yeh, May(2009) 'Parent-Child Interaction Therapy for Mexican Americans: A Randomized Clinical Trial', *Journal of Clinical Child & Adolescent Psychology.* 38: 5, 753 — 759

McLaughlin et al. Trauma Exposure and Posttraumatic Stress Disorder in a National Sample of Adolescents. *J. Am. Acad. Child Adolesc. Psychiatry.* 2013;52(8):815–830.

National Child Trauma Stress Network: www.nctsn.org

Ngo et al. Providing Evidence-Based Practice to Ethnically Diverse Youths: Examples From the Cognitive Behavioral Intervention for Trauma in Schools (CBITS) Program. *J. Am. Acad. Child Adolesc. Psychiatry.* 2008,47(8):858–862

Practice Parameter for the Assessment and Treatment of Children and Adolescents with Posttraumatic Stress Disorder. *J. Am. Acad. Child Adolesc. Psychiatry.* 2010;49(4):414–430.

Robbins, M., Horigan, V., Szapocznik, J. and Ucha, J. Treating Hispanic Youths Using Brief Strategic Family Therapy. In: Evidence-Based Psychotherapies for Children and Adolescents. 2012 The Guilford Press. New York

WHAT ARE SOME HIGH-RISK CIRCUMSTANCES THAT MAY REQUIRE SPECIAL ATTENTION?



Children living in mixed legal status (at least one undocumented parent), in families affected by deportation and in foster care require special attention during the assessment.

Children living in mixed status families

An analysis by The Pew Research Center based on 2009 data estimates that there are 4.5 million children who are US citizens and who are living with one or more parents or guardians who are undocumented. Another million children who live in mixed status families are themselves undocumented. These families often live in constant anxiety of detection and fear of deportation so consequently use medical and mental health services at a low rate. In one survey, 40% of children in mixed status families had not seen a doctor in the previous year. Living with constant anxiety about their parents' future as well as their own is associated with poor school performance and a rate of school drop-out higher than children in a more secure family status.

Learn more:

Enchautegui, Maria. Broken Immigration Policy: Broken Families. The Urban Institute 2013 available from: <http://www.urban.org/UploadedPDF/412806-Broken-Immigration-Policy-Broken-Families.pdf>

Henderson S and Baily C. Parental Deportation, Families, and Mental Health. *J. Am. Acad. Child Adolesc. Psychiatry.* 2013;52(5):451-453

Human Impact Partners. June 2013. Family Unity, Family Health: How Family-Focused Immigration Reform Will Mean Better Health for Children and Families. Oakland, CA. www.familyunityfamilyhealth.org

Pew Research Hispanic Trends Project: <http://www.pewhispanic.org/>

Immigrant children in foster care

One particularly toxic effect of deportation is an increase in US citizen children in long-term foster care. It is estimated that 5,100 children are living in foster care (2011) due to deportation of a parent. The current immigration enforcement systems are significant barriers to reunification. The children left by deported parents are often denied placement with extended family members because of issues related to documentation. The effects of abrupt and total separation from parents and family may have profound effects on the child's emotional development which may be expressed by withdrawal, anxiety, depression or oppositional defiance.

Resource for practices:

Helping Foster and Adoptive Families Cope with Trauma <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/Guide.pdf>

Learn more:

Applied Research Center. (2011) Shattered Families: The Perilous Intersection of Immigration Enforcement and the Child Welfare System. Available from: <https://www.raceforward.org/research/reports/shattered-families>

Unaccompanied Minors and Asylum Seekers

In 2014, a humanitarian crisis involving children occurred at the southern border of the United States. The Customs and Border Protection (CBP) apprehended over 50,000 children and youth from three Central American countries (Guatemala, Honduras and El Salvador) who arrived without a guardian. A study by the United Nations High Commissioner on Refugees (UNHCR) found that over half of the unaccompanied minors “were forcibly displaced because they suffered or faced harms that indicated a potential or actual need for international protection.” The displaced children were often exposed to or threatened by gang violence, abuse in the home or drug cartel related activities. An additional 15,000 children and youth were Mexican nationals, one-third of whom, according to the UNHCR, had been recruited into human trafficking. Many children suffered assault, theft and rape as they made their way to the US border. In addition to the tremendous need for trauma informed mental health care, some children and youth may qualify for asylum status. Being able to remain in the US, as a refugee would make available appropriate treatment. The website for Physicians for Human Rights (PHR) contains much important information helpful for pediatricians to understand the legal process of applying for asylum.

Resources for practices:

Physicians for Human Rights training resources
<http://physiciansforhumanrights.org/training/asylum/>

American Bar Association Immigrant Children Assistance Project
http://www.americanbar.org/groups/public_services/immigration/projects_initiatives/south_texas_pro_bono_asylum_representation_project_probar/immigrant_childreassistanceprojecticap.html

Learn more:

Byrne, O. and Miller, E. 2012. *The Flow of Unaccompanied Children through the Immigration System: A Resource for Practitioners, Policy Makers and Researchers*. New York: Vera Institute of Justice.
<http://www.vera.org/sites/default/files/resources/downloads/the-flow-of-unaccompanied-children-through-the-immigration-system.pdf>

Southwest Border Unaccompanied Alien Children. U.S. Customs and Border Protection. Department of Homeland Security. <http://www.cbp.gov/newsroom/stats/southwest-border-unaccompanied-children>

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, D.C. (2014) http://www.unhcrwashington.org/sites/default/files/1_UAC_Children%20on%20the%20Run_Full%20Report.pdf

Immigrant youth who identify as Lesbian, Gay, Bisexual or Transgender

Immigrant youth may face additional cultural challenges and discrimination because of sexual orientation or gender identity. The need for socio-emotional support or mental health treatment may be especially acute if the young person left their country of origin after persecution because of sexual orientation and, upon arrival, experiences isolation, alienation and exploitation at the margins of society in the United States.

Resources for practices:

American Academy of Pediatrics. Committee on Adolescence Policy Statement. *Office-Based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth*. Pediatrics. 2013 Jul;132(1):198-203.
<http://pediatrics.aappublications.org/content/132/1/e297.full.pdf+html>

Immigrant Legal Resource Center
<http://www.ilrc.org/info-on-immigration-law/lgbt-immigrant-rights>