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INJURY PREVENTION (T RAYBOULD, SECTION EDITOR)

Unaccompanied Children Migrating from Central America: Public Health Implications for Violence Prevention and Intervention

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Abstract
Purpose of Review Unaccompanied children (UC) migrating to the USA from the Central American countries of El Salvador, Guatemala, and Honduras are an underserved population at high risk for health, academic, and social problems. These children experience trauma, violence, and other risk factors that are shared among several types of interpersonal violence.
Recent Findings The trauma and violence experienced by many unaccompanied children, and the subsequent implications for their healthy development into adulthood, indicate the critical need for a public health approach to prevention and intervention.
Summary This paper provides an overview of the violence experienced by unaccompanied children along their migration journey, the implications of violence and trauma for the health and well-being of the children across their lifespan, prevention and intervention approaches for UC resettled in the USA, and suggestions for adapted interventions to best address the unique needs of this vulnerable population.

Keywords Unaccompanied minors · Central America · Violence · Trauma · Public health · Intervention

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Introduction

The number of unaccompanied children arriving in the USA has increased substantially in the past several years. US Customs and Border Patrol reports that the number of children apprehended at the southwest border of the USA increased by 49% from 2015 to 2016 [1]. According to the Administration for Children and Families (ACF) Office of Refugee Resettlement (ORR), an unaccompanied child (UC) is a child under 18 years old who has no lawful immigration status in the USA and who has either no parent or legal guardian or no parent or legal guardian in the USA available to provide care and physical custody [2]. Research on unaccompanied children in the USA is an emerging area of study, the available data sources are limited, and many existing studies are qualitative in nature. Thus, systematic research is limited and the majority of what is known about these children comes from information collected by nonprofit organizations, and through small studies and convenience samples. There is a clear need for additional research in this area.

UC come to the USA primarily from the Central American countries of El Salvador, Guatemala, and Honduras. Children report migrating to the USA for a variety of reasons, including economic opportunity due to issues related to poverty in their home countries, lack of meaningful opportunities for education, and the possibility of reunifying with family members who have already migrated to the USA [3–5]. Reuniting with relatives in the USA does not mean that those relatives are legal guardians of the UC; however, the goal may be for those family members to eventually become the child's legal guardian. In addition, the primary drivers for this migration include substantial community violence, gang violence—including homicide and rape—and organized crime in the children's natal communities [4–8]. Because of this widespread violence, it is likely that these children have been exposed to at

least one form of violence. Their migration trajectory could also increase the risk for further exposure to trauma, including mistreatment by smugglers and becoming trapped by human traffickers [9].

Exposure to violence and trauma in childhood is a risk factor for future violent experiences and other negative outcomes throughout the life course for all children; thus, resettled UC are at high risk for health, academic, and social problems and need public health interventions and prevention programs [10]. This paper provides an overview of the violence and trauma experienced by UC along their migration journey, the implications of that violence and trauma for the health and well-being of UC, possible prevention and intervention approaches, and suggestions for adaptations to interventions.

When UC from the Central American triangle countries (i.e., El Salvador, Guatemala, and Honduras) cross into the USA, they may be apprehended by US Customs and Border Patrol (CBP). UC who are apprehended are transferred to the care and custody of ORR until they are able to be released to safe settings with sponsors, such as a relative or family friend already residing in the USA. ORR reports that children come from all three triangle countries in Central America as well as Mexico; the majority (68%) are 15 years or older and are male (68%). In addition, 17% of these children are aged 0–12 years, an age range for which trauma has distinct developmental consequences for physical and mental health [11]. Demographic data collected by ORR is presented in Table 1.

Once UC are resettled, they are no longer systematically tracked by any federal system outside of the legal system. The majority of children come under the care and supervision of other systems, such as social services, child welfare, or juvenile justice [12], but follow-up support services are often limited [13]. Some examples of coordinated local efforts, such as that of the Oakland Unified School District, may result in improved service delivery for these children at the local level [14]. However, the absence of linked data systems at the federal level makes it difficult to know the extent to which children interact with other systems and to track outcomes for these children. Thus, as the children are placed with sponsors and living in communities across the USA, it is critical to better understand the trauma and violence UC experienced in their country of origin, on their migration journey, and as they enter the USA. This enhanced understanding may help to inform interventions to mitigate any associated consequences related to their trauma exposure and to prevent the emergence of new problems that may be unassociated with past trauma exposure.

Table 1 Demographics of unaccompanied children who entered the USA in Fiscal Year 2015

Country of origin
Honduras 17%
Guatemala 45%
El Salvador 29%
Mexico 6%
All other countries 3%
Age
0–12 years old 17%
13–14 years old 14%
15–16 years old 38%
17 years old 30%
Gender
Male 68%
Female 32%

Administration for Children and Families, Office of Refugee Resettlement. Facts and data: General Statistics. 2016

Overview of Exposure to Violence and Trauma

During their migration journey, UC migrating to the USA from Central America face trauma in the form of exposure to a variety of stressors, which may include experiencing multiple forms of violence. This section provides an overview of the violence UC experience in their home country, on the migration journey, and once they arrive in the USA. While there are limited data sources from which to draw this information, it is possible to construct a general picture of the violence and trauma to which they may be exposed.

While the reasons for migration are complex, one of the most common reasons that UC leave their home country is fear of community and interpersonal violence [3–5, 8, 13]. This is illustrated by findings from a study conducted by the United Nations High Commission for Refugees (UNHCR), in which a representative sample of 404 children ages 12–17 were interviewed about their experiences migrating to the USA. The study found that two overarching patterns emerged, including exposure to community violence—particularly organized crime—and child maltreatment or other interpersonal violence in the home. Many children reported multiple exposures [4] (see Table 2).

Each of the three triangle countries experience extremely high rates of violence. According to UNICEF, as of 2014, El Salvador and Guatemala had the highest and second highest rates of homicide among children aged 0–19 in the world, respectively [15]. Globally, Honduras is one of the most violent countries due to gang violence and had the highest homicide rate in the world as of 2012 [16]. El Salvador has the fourth highest overall homicide rate in the world [16], and additionally experiences extremely high rates of extortion by gangs [5].

Table 2 Reasons for migration

Reason for migration	Percentage of children
Suffered harms or faced direct threats of violence	58
Affected personally by organized violence (e.g., drug cartels, gangs)	48
Victims of child maltreatment	21
Experienced or feared violence both at home and in society	11

United Nations High Commission on Refugees. Children on the run: unaccompanied children leaving Central America and Mexico and the need for international protection. Vienna: United Nations, 2016

Some reports have indicated that boys fear recruitment into gangs [5], girls fear sexual violence by gangs [5, 13], and families may send their children to the USA specifically to protect them from these risks [6]. In interviews, children from Honduras and El Salvador describe worsening conditions of crime and gang violence in their home countries [5, 13]. UNHCR found that for all of the children in their study, violence was reported as a primary driver of migration: 34% of Honduran children reported fleeing to escape violence perpetrated by gangs or other criminal groups, 72% of Salvadoran children left after experiencing severe harm and 66% left specifically to avoid violence by gangs or criminal groups, and 20% of Guatemalan children reported leaving because of violence, while 29% reported extreme poverty as their primary reason—a risk factor for gang recruitment [4].

Risk of violence and other traumatic experiences continue on the migration journey. For example, due to their own vulnerability, Mexican children are recruited into and exploited by the human smuggling industry, where they are forced to help facilitate the migration of children from Central American countries into the USA unlawfully [4, 6]. Mexican children may also be forced to perpetrate violence against the children they are smuggling [4, 6]. In their study, the UNCHR found that 38% of Mexican children that were interviewed were exploited through smuggling [4]. While there is limited research, several studies have indicated that UC from Central America may be exposed to violence by both criminals and authorities along the migration journey [17]. Bandits have been reported to kidnap and hold children for ransom [18, 19] and interviewed UC report that girls and women are sometimes raped at "crossing points" that occur along the journey [19]. In a qualitative study, UC living in the USA described that criminals also hijack the *Bestia*, a train that many children take to cross Mexico, and threaten to or commit kidnapping and murder of the children on board [19]. Children are in further danger of being maimed or killed by the train itself as they ride on the roof or sides of the train [13, 18]. Reports from some organizations, including the Women's Refugee Committee and the Center for Latin American Studies at Georgetown University, have cited interviews with UC who report violence and exploitation by immigration officials at multiple borders [13, 17, 19]. Finally, there are risks of child trafficking along the migration journey, where UC may become trapped in forms of labor to repay the smuggling fee. The Department of State 2015 Trafficking in Persons Report noted that Central American migrants, including both children and adults, are at risk of sex trafficking, forced labor, or forced criminal activity along the migration route [20]. Trafficking may be a particular risk for girls, who are being trafficked for domestic servitude or sex work [13, 18, 21].

Once UC arrive in the USA, there are multiple steps that must occur before they can be resettled into communities. These steps can have their own challenges and limitations. Upon arrival and apprehension by CBP, children are transferred to the care of ORR, usually within 48 h, and placed in temporary shelters [2]. These shelters are secure facilities [6]. Several studies of detained child migrants and asylum seekers have documented extensive mental health issues, including depression, anxiety, and post-traumatic stress disorder [22, 23] and developmental delays for very young children [23]. After release from the shelters, children are placed with sponsors in communities around the country, and unless children have been trafficked or are otherwise at risk, there is limited follow up [24]. This may reduce awareness of youth being in at-risk environments or new needs that emerge once children are placed with sponsors [8, 20]. Follow-up efforts with UC who contact ORR for assistance have been enhanced [24]. Additional research on possible risks and the needs of communities and families to adequately support youth is needed to understand how best to buffer children from negative health outcomes that could result from these experiences. Children can face arduous immigration proceedings, and only approximately half of children are assigned an attorney [25]. It may take up to 2 years for their cases to move through immigration courts determining their eligibility to remain in the USA [26]. Taken together, the experiences that occur after UC arrive in the USA can be daunting and may unintentionally expose UC to additional trauma and stress.

Consequences of Exposure to Violence: Adverse Childhood Experiences

As detailed in the previous section, many UC are exposed to violence and other traumatic events prior to and during their migration journey, and these experiences can increase the risk for harmful sequelae of outcomes across the lifespan. Much of what we know about associations between exposure to early adversity and adult health outcomes comes from research about Adverse Childhood Experiences (ACEs) with domestic samples, which have typically measured exposure to abuse, neglect, and household challenges [27, 28] but may also include items such as loss of a parent and community violence [29, 30]. The link between ACEs and later health and well-being is consistent regardless of the type of early adversity examined—as exposure to adversity increases so does the likelihood of poorer outcomes. ACEs have been associated with health risk behaviors (e.g., risky sexual behaviors and substance abuse [27]), chronic health conditions (e.g., obesity and heart disease [27, 28]), future exposure to violence and injury (e.g., sexual victimization, intimate partner violence, and suicide [31–33]), mental health concerns (e.g., depression and anxiety [27, 34], brain development and physiological responses (e.g., under developed executive functioning and dysregulated stress response [35], and premature death [36]. Early adversity also impacts one's life opportunities including educational attainment, income, and employment that can be protective for health and well-being [37–39]. Of additional concern is the documented intergenerational continuity of child abuse, neglect, and other early adversities [40], whereby children of parents exposed to violence are also at increased risk of victimization in childhood. The impact of ACEs on health and well-being can also reverberate across generations. For example, ACEs are associated with lower adult socioeconomic outcomes (SES) [39], and children of parents who are undereducated, unemployed, and/or living in poverty are also at risk for low SES outcomes [41].

While the majority of ACE research has occurred in domestic samples or other high income countries, several studies have documented similar patterns between ACEs and later health and well-being in South American countries [42, 43]. For example, early adversity has been associated with substance abuse and mental health issues in Brazilian samples [42, 43]. In addition, a review of childhood adversity in low-income countries found that varying types of adversity were linked to a number of mental health outcomes, including post-traumatic stress disorder, anxiety, and depression [44]. However, there is an overall lack of research that has investigated ACEs in the context of low and middle-income countries, and there is virtually no research that examines adverse experiences specifically for unaccompanied minors. Thus, additional research is needed to uncover the unique experiences of the UC population, as well as what may be protective for their health and well-being.

Taken together, preventing exposure to violence and other adversity in the children's natal communities, as well as mitigating the impact of ACEs on future outcomes once they have been exposed to violence, could produce long-lasting benefits on both health and productivity for individual children and communities across generations.

Implications for Prevention and Intervention

The trauma and violence faced by many UC, and the subsequent implications for their healthy development into adulthood, indicate the critical need for a public health approach to prevention and intervention. The legal issues pertaining to the structure of services that UC are eligible to receive in the USA are complex and critical; however, a full discussion is beyond the scope of this paper. This section will focus on the types of evidence-based interventions that are available for communities to help address the sequelae of violence experienced by these children, and some considerations for how those types of interventions may be adapted for the population of UC from Central American countries.

There are no current US-based violence prevention programs or interventions that have been specifically designed for this population of children. Therefore, the selected strategies below are primarily drawn from violence prevention technical packages [45–47], which represent the best available evidence on approaches to reduce or prevent violence against children in a broad context and include suggestions for both domestic [45] and international, low- and middle-income [47] countries. Other evidence-based approaches are also included below. The strategies fall into prevention and intervention activities that target all levels of the social ecology: individual, relationship, community, and societal.

UC are embedded into the communities in which they live, and communities and relationships that are safe, stable, and nurturing may be protective against previous violent exposure as well as future exposures [48]. These relationships and environments begin even prior to placement in the community. Although information is limited, some secondary or tertiary prevention work may already be occurring within ORR-directed shelters. For example, youth identified as victims of trafficking are provided education on healthy relationships, traffickers' coercive tactics, and safety planning [49]. Practitioners could assess the opportunity to expand such safety programming to all youth in ORR custody, given this populations' vulnerability to such issues once resettled within the community. Currently, the Trafficking Victims Protection Reauthorization Act (TVPRA) requires that a home study be

conducted for children who are at risk or who have special needs (e.g., victims of trafficking) prior to their placement with a sponsor in the community [50]. These children receive up to 6 months of case management services, referred to as post-release services [51]. However, these extensive services are not provided to all UC. After release, expanded post-release services could begin to create safe, stable, nurturing relationships in the community for all unaccompanied children, even while their immigration cases are moving through the legal system. Such services could include a case plan with individualized attention to the child's needs and a child advocate to assist with legal issues [13].

Second, there may be a need to address the trauma and violence histories of the children. While studies are limited, reviews of refugee children's mental health suggest that UC experience poor mental health outcomes that include depression, anxiety, post-traumatic stress disorder, and general psychological distress [52, 53]. Thus, UC may need response and trauma-informed support services to lessen harms and prevent future risk. Such interventions may mitigate the health consequences of exposure to violence while decreasing the risk for being victimized by or perpetrating other types of violence [45]. For example, for UC with regular access to health care, both enhanced primary care and the medical home model of care can support provider efforts to identify and address risk factors and, when needed, refer children for follow-up with a social worker for wrap-around services [45, 47]. In the community, supportive relationships with a screened mentor or a positive adult have been helpful [54]. Services may also include access to good-quality social support services, such as access to therapy [47]. For UC who are integrated into the school system, school-based mental health programs, such as the Mental Health for Immigrants Program, may be effective [55].

Given the trauma faced by UC, their US-based sponsors may need assistance in knowing how to care for the children's needs and may benefit from programs geared toward building and strengthening parenting and related skills and creating safe, stable, and nurturing relationships and environments [46]. Interventions designed to work with parents differ based on the developmental age of the child. These include evidence-based home visitation programs for caregivers of very young children, such as Nurse Family Partnership [45, 56], and other home visiting programs that may work for communities, as identified by the *Home Visiting Evidence of Effectiveness Review* [56]. Community-based small group interventions may be effective for caregivers of youth and adolescents [45]. Sponsors may also be stressed with the financial and emotional cost of caring for another child. Thus, policies and interventions, such as family friendly workplace policies (e.g., livable wages, paid leave, and flexible and consistent schedules [45] may help to alleviate familial stress. Other upstream prevention strategies may include policies that promote economic supports to families, such as offering tax credits for sponsors of UC [45]. Taken together, there is a need for prevention and intervention strategies that address the unique needs of UC and their caregivers at all levels of the social ecology. Programs that assure that UC have access to safe, stable, nurturing relationships and environments can provide opportunities for UC to thrive and realize their full health and life potential.

Need for Adaptation

As evidence-based programs have yet to be developed specifically for UC, practitioners may choose to adapt extant programs based on approaches used to modify programs for other diverse populations, populations from low-income communities, and populations with histories of trauma. Those charged with this task will need to attend to the unique contexts from which UC migrate, ensuring that programming is culturally relevant [57] and that measures used to assess UCs experiences are culturally equivalent [58]. Fortunately, numerous toolkits for increasing the accessibility of information and services (as well as increasing the cultural competence of staff and agencies) already exist [59, 60], as does the Immigrant Child Health Toolkit, developed by the American Academy of Pediatrics specifically for physicians working with child immigrant populations [61]. This toolkit contains information on clinical care and mental health and also provides guidance for physicians on how to access resources related to immigration status and legal concerns [61].

The needs and experiences of UC may vary by country of origin; clustering migrants into broader categories under umbrella terms (e.g., Latinas) may obscure these important differences, limiting the ability to understand and respond to the needs of migrant communities [62, 63]. Therefore, prevention programs originally developed for a US population may need to be tailored to ensure that the unique needs of migrant youth and the families that care for them are addressed. In addition, prevention programs and the practitioners who implement them may find that the diversity of natal contexts influence programming needs. Lastly, a culturally centered approach to prevention programming extends beyond risk reduction to the issue of promoting resilience, and this strength-based approach to prevention of violence among migrant populations also hinges on attention to rich cultural variation [64].

Conclusion

Resettled UC from conflict-affected regions of the world represent an underserved minority population at high risk for many health problems. Hillis and colleagues state that "violence can be prevented if governments, their citizens,

and the global community start now, act wisely, and work together" [46]. Utilizing a public health approach to prevention and intervention, one that includes strengthening the research base on their violence and trauma experiences, implementing prevention programs and interventions, and making cultural adaptations to existing evidence-based interventions where needed, is critical to ensuring that all children are given the opportunity and support to thrive and realize their full health and life potential. In addition, a true prevention-focused public health approach must also consider reducing and ending violence against children in their natal communities.

Compliance with Ethical Standards

Conflict of Interest Drs. Estefan, Ports, and Hipp declare no conflicts of interest relevant to this manuscript.

Human and Animal Rights and Informed Consent This article does not contain any studies with human or animal subjects performed by any of the author.

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