Correspondence

Immigrating Unaccompanied Minors—A Neglected Minority?

TO THE EDITOR: We write to convey our concerns for the health and well-being of children younger than 18 entering the United States without immigration documents and without family. The Children's Working Group of Physicians for Human Rights conducted a preliminary exploration of the health care of unaccompanied minors through interviews with them, Immigration and Naturalization Service (INS) officers, immigration lawyers, and health care and social workers and by reviewing legal documents, epidemiologic studies, and human rights documents. The quality of medical and mental health care for unaccompanied minors in the custody of the INS appeared to be inconsistent or neglectful in many locations.

The abuse and neglect unaccompanied minors experience in the United States stem in part from high influx. During 1994, the INS detained about 10,000 children, mostly from Cuba, El Salvador, Guatemala, Haiti, Honduras, Nicaragua, and China, 70% of whom were unaccompanied when they entered this country. These minors are held in about 110 detention centers that range from a nonsecure foster care facility to an adult correctional facility. At any given time, about 1,200 unaccompanied minors are in INS custody (Barbara Hall, INS Statistics Division, written communication, February 1995). Federal laws mandate that detention be limited to 30 days, legal assistance be provided to each child, and medical care, psychological care, and educational services be offered. Nonetheless, unaccompanied minors can be detained more than a year in facilities that are not monitored systematically.

We randomly selected 21 children (5 girls and 16 boys, ages 10 to 18) for personal interviews at a detention center in Los Fresnos, Texas, and at a foster care agency in Grand Rapids, Michigan. The review and interview procedures were not designed to gather information on a representative sample of INS detainees but were convenience samples. Among other problems in INS custody, there were 15 reports of physical or sexual assault, 18 reports of verbal abuse, and 10 reports of only one meal per day (one child may have reported more than one event). Only three children were granted medical care when requested (interviews by K. N.; L. Leutbecker, INS, November 1994; Tina White, Projecto Libertad, Harlingen, Texas, June 1995; and others available on request).

In addition, studies published between 1990 and 1991 by Stanford University, the University of Houston (Texas) Sociology Department, and the Immigration Law Center of San Francisco, California, found evidence of harassment, physical abuse, and neglect of unaccompanied minors in INS custody.[1-3] Many unaccompanied minors were traumatized before and after entering the United States. Few receive adequate mental health care in detention. Poor medical record keeping plus a lack of adequate immunizations and physical examinations are correctable problems.

The health and other needs of unaccompanied minors in INS custody demand serious investigation. The medical community and the INS could consider options to better protect the health of these children. Expanded linkages between the INS and the US Public Health Service and children's agencies could ensure consistent implementation of health care policies already in place. Health professionals can provide medical documentation of abuses and advocate for the early release of children from detention and the placement in appropriate care. Unaccompanied minors detained in the United States will continue to be at risk for abuse and neglect unless health professionals work to ensure that the fundamental medical and developmental needs of the children are met.

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The contents of this letter are the sole responsibility of the authors and not of the identified institutions.

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Immigration and Naturalization Service Responds

TO THE EDITOR: In response to the letter from Elena Nightingale MD, PhD, and co-workers concerning the health care minors receive when in the custody of the Immigration and Naturalization Service (INS), minors are detained only briefly, usually a few hours, at service processing centers (SPCs). The minors are interviewed, processed by INS personnel, and then screened by medical personnel. Afterwards, they are transferred to a state licensed shelter care program, attend school, and contin-

ue to get their medical care from the SPCs or local hospitals for emergency care. Medical care given at the SPCs is provided by the INS Health Service Division (INS HSD), which is staffed by the US Public Health Service. Health professionals are available 24 hours per day for medical consultation.

The initial medical screening process for minors at SPCs staffed by the INS HSD includes the following:

- Mental health screening forms given to minors 14 years of age and older. Forms are available in different languages. Furthermore, many medical staff members are multilingual and can read the forms to minors who cannot read. If a mental health problem is identified, the minor is referred to the contract psychologist or psychiatrist as soon as possible. If it is an emergency, the child is transferred to a local psychiatric facility;
- History and physical examination;
- Pregnancy test on female minors 15 years of age or older and younger if sexually active;
- Purified protein-derivative test. The minor returns to the clinic in two days to have the test read. If positive, a chest x-ray film is taken, a regimen of prophylactic medications (isoniazid, pyridoxine hydrochloride) is started, and baseline liver function tests are done. The minor is scheduled for follow-up appointments to complete prophylactic therapy, per guidelines of the Centers for Disease Control and Prevention (CDC);
- VDRL tests are done on minors 15 years of age or older and younger if sexually active;
- Age-appropriate immunizations are given following CDC guidelines;
- Additional laboratory tests are done if deemed necessary; for example, a hematocrit or hemoglobin level is done if anemia is suspected;
- A medical record is created; and
- Copies of immunization forms and a medical transfer summary are sent with the minor to the designated shelter care program.

During the child's stay at a licensed shelter, if an employee of the shelter thinks the minor may need medical or psychiatric care, the SPC's medical personnel are notified. The medical personnel then decide if the child needs to be brought to the facility immediately, the following day, or can be treated by the shelter personnel (such as for a headache).

Children in some facilities not served by INS HSD medical personnel are served by community health care professionals. These providers follow INS HSD medical guidelines and standards. The INS HSD is occasionally consulted with. For example, if a medical procedure is being recommended on a child in custody, the INS HSD is sometimes consulted for another medical opinion.

Minors in INS custody but placed in foster care receive their medical care from the local community where they reside. This care is comparable to that received by US minors because they must meet the same medical criteria for admission to local schools. Foster homes are licensed under state laws.

In addition, it should be noted that the SPCs staffed by INS HSD personnel are accredited by the National Commission on Correctional Health Care. This accreditation requires that certain standards of health care be met, including care to minors. One facility has also been accredited by the Joint Commission on the Accreditation of Healthcare Organizations, and other facilities are working toward this.

Therefore, it should be recognized that INS HSD personnel have guidelines set forth for them to provide all minors fundamental medical and psychiatric care.

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CORRECTION

In the January 1997 issue, Ira Jeffry Strumpf, MD, was listed as the Section Editor of the Chest Diseases series of epitomes.[1] Robert S. Fishman, MD, was the Section Editor, which entailed soliciting the papers and reviewing the manuscripts for this series. We apologize to both Drs Fishman and Strumpf for this error.

The Editors

REFERENCE

1. Fishman RS, editor. Important advances in chest diseases. West J Med 1997 Jan; 166:56–60