Terra Firma Anniversary Report: Creating Medical-Legal Partnerships for Unaccompanied Immigrant Children

March 2019

CATHOLIC CHARITIES
COMMUNITY SERVICES

Providing Help. Creating Hope.

In partnership with:

Montefiore | Children's Health Fund

Terra Firma graduate

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Funded by a private foundation that prefers to work anonymously.

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Terra Firma: Our Mission

We believe that all children deserve healthcare and justice. As a nationally-recognized medical-legal partnership, we work to facilitate access to medical care and enhance the role of medicine and mental health in legal services. By promoting the well-being of immigrant children through direct services and advocacy, we seek to strengthen local communities and inform public policy. Terra Firma aspires to empower immigrant children to develop resilience, attain stability, and reach their full potential.

Dear Friends,

On September 25, 2013 a small group of about twelve unaccompanied immigrant children gathered in a conference room at a pediatric clinic in the South Bronx. They had arrived with their lawyers and legal advocates to a room filled with balloons, welcome signs, snacks and seating. It was the first-ever meeting of the "Immigrant Youth Clinic," a new initiative designed to address the unmet medical, legal, and mental health needs of unaccompanied immigrant children, who had begun to arrive to the United States in historic numbers. These youth faced enormous challenges: at risk of deportation, acculturating to new environs, and processing traumatic histories as targets of persecution, torture, and abuse. Together, we created Terra Firma (latin for "solid ground").

Today, Terra Firma continues to serve recently arrived unaccompanied immigrant children in the South Bronx. From that first group of twelve has sprung a vibrant cohort of more than 500 children, adult caretakers, and family members that receive co-located medical, legal, and mental health services in an integrated, holistic setting.

Terra Firma is the first medical-legal partnership specifically designed for unaccompanied immigrant children in the community. As a programmatic partnership among Catholic Charities, Montefiore Medical Center, and the Children's Health Fund, Terra Firma operates out of a federally qualified health center that serves all patients regardless of their ability to pay. "TF" is a patient-centered medical home located within one of the poorest Congressional districts in the United States and a community center and enclave for recently-arrived children with aspirations of fulfilling the American dream.

As we celebrate the resilience, courage, and persevearance of the patients and clients who comprise Terra Firma, we are obligated to acknowledge the daunting political moment in which we find ourselves. 2014 saw the highest ever number of unaccompanied immigrant children arrive to the United States, and yet it pales in comparison to the developments that followed. The past few years have seen an onslaught of new attacks on our immigrant communities, including the tragic phenomena of family separation, the "Muslim ban," and the attack on America's "Dreamers." It is in this era when the mettle of our immigrant communities is truly tested, along with our collective, national commitment to justice.

As a guiding principle, we at Terra Firma believe that lawyers, doctors, therapists, and advocates of all stripes must unite in our efforts to deliver life-saving and life-changing interventions to our new neighbors. For this generation of future-Americans, we want to be part of the movement that lights the way.

This report humbly shares some of what we at Terra Firma have learned from five years of medical, legal, and mental health advocacy for unaccompanied children. Our original inspiration to break down silos in service delivery now extends to a wider-array of community activities, including photography workshops, English classes, and soccer games. Our work has taken us beyond the South Bronx, from detention centers in Texas to migrant shelters in Mexico. As always, our commitment to our patients and clients remains steadfast. On behalf of the children and families we serve, we thank you for your support.

— Brett Stark, Esq., Alan Shapiro, MD, and Cristina Muñiz de la Peña, PhD
Terra Firma co-founders

Tables and Figures

Abbreviations

Abbreviation	Description
AWC	Adults with children
CBP	Customs and Border Protection
CCHR	Center for Child Health and Resiliency
CCNY	Catholic Charities of New York
CHF	Children's Health Fund
CHIP	Children's Health Insurance Program
CHM	Children's Hospital at Montefiore
CoAWC	Children of Adults with Children
CPP	Community Pediatric Program
DHS	Department of Homeland Security
DOJ	Department of Justice
DUCS	Department of Unaccompanied Children's Services
EOIR	Executive Office of Immigration Review
FGD	Focus group discussion
FQHC	Federally Qualified Health Center
FTE	Full time equivalent
GED	General Education Development
HIPAA	Health Insurance Portability and Accountability Act
ICE	Immigration and Customs Enforcement
ICH	Immigration Court Helpdesk
KII	Key informant interview
KYR	Know your rights
LOPC	Legal Orientation Program for Custodians
LPR	Legal Permanent Resident
MLP	Medical Legal Partnership
MSF	Médecins Sans Frontières
NYCHP	New York Children's Health Program
ORR	Office of Refugee Resettlement
PCMH	Patient-centered medical home
PTSD	Post-Traumatic Stress Disorder
RFE	Requests for evidence
SHW	Self-help workshops
SIJS	Special Immigrant Juvenile Status
SPARCS	Structured Psychotherapy for Adolescents Responding to Chronic Stress
STIs	Sexually-transmitted infections
TF	Terra Firma
U.S.	United States
UIC	Unaccompanied immigrant child
UMP	Unaccompanied Minors Program
USCIS	United States Citizenship and Immigration Services

Executive summary

This report provides an overview of the work of Terra Firma ("TF") and a framework for replication of a medical-legal partnership in service of unaccompanied immigrant children.

Section I describes the TF model of care and defines key terms that are useful for understanding that model and replicating its successes. It proceeds to describe strengths of the TF model, highlighting the sense of community and safety created by the combined provision of pro bono immigration legal services, trauma-focused mental health care, and social services in a co-located space. It ends with a description of the daily and weekly time expenditures of TF in providing core medical, mental health, and legal services.

Section II breaks down specific activities provided by TF staff in the legal, mental health, medical, and social spheres. For each subcategory, it describes the needs of unaccompanied immigrant children and specific activities and interventions that address those needs. Those looking to replicate the TF model should turn to this section for detailed information on how to do so.

Section III identifies considerations for replication of the TF model. It describes municipal and state political contexts that support TF's success. It also issues specific recommendations to organizations looking to create a medical-legal partnership for unaccompanied immigrant children.

The conclusion summarizes key findings of the report. Lastly, it identifies areas in need of further research, including studies on the feasibility of replication of the TF model in other regions, patient adherence to the TF model, and effectiveness of the TF model in meeting stated objectives.

Introduction

This report provides an overview of Terra Firma's work with unaccompanied immigrant children. In this Anniversary Version, the full report has been condensed for brevity. In its current form, it examines TF's model of care, program inputs (structure, funding, staffing, space and resources) and activity implementation. The report subsequently highlights considerations and recommendations for organizations considering replication, before concluding with study limitations and recommendations for future areas of research.

This report sought to answer the following research questions:

1. What are the problems that TF seeks to address? What are the causes and consequences of these problems?
2. What activities does TF provide to address these problems?
3. What short, medium, and long-term outcomes does TF intend to produce through these activities?
4. What assumptions underlie the anticipated change process?

Needs in Greater New York

TF was founded in September 2013 to address the specific identified needs of UICs living in the Greater New York area. TF's founders identified seven primary challenges preventing Unaccompanied Immigrant Children ("UICs") (and subsequently Adults With Children, or "AWCs") from developing resilience, attaining stability, and reaching their full potential:

1. **Challenges prioritizing primary health, mental health care, and legal obligations over basic needs** UICs frequently missed legal, medical, and mental health

appointments because of challenges related to meeting their basic needs (e.g. losing housing). For the legal team, this impeded the development of an effective attorney-client relationship, adversely impacting the legal case.

2. **Challenges meeting basic needs without immigration status** UICs were (and continue to be) barred from accessing public resources (e.g. health insurance, employment, higher education, public benefits) due to their undocumented status.
3. **Challenge securing legal representation** due to cost, distrust, or lack of bilingual or culturally sensitive staff[1].
4. **Exacerbation of treatable medical and mental health conditions and difficulty adhering to legal appointments due to policy, health-system, and individual-level access barriers to care:**
   - **Policy-level:** undocumented immigrants lack health insurance[2];
   - **Health-system level:** undocumented immigrants struggle to navigate bureaucratic processes; face systemic discrimination; tend to reside in medically underserved areas; and experience external resource constraints (e.g. work conflicts, lack of transportation, lack of translation services or cultural competency within the clinic setting)[3];
   - **Individual-level:** undocumented immigrants fear being reported to authorities if they use health care services. This has worsened since the 2016 presidential election, with anti-immigrant rhetoric having a "chilling effect" on health care seeking and utilization by immigrant communities[4]. Additionally, undocumented immigrants lack the financial means to pay for services; experience communication challenges with clinic staff; lack knowledge and experience navigating health care systems[5]; and tend to be primary care naïve (meaning that they have not received ongoing preventative or primary care in their home countries).
5. **UICs lacked knowledge** about legal eligibility, obligations, and processes; the importance of primary health and mental health care; and resources to meet basic needs, which resulted in non-compliance with legal obligations and exacerbation of treatable medical and mental health problems.
6. Stakeholders (policy makers, immigration officials, external service providers, referral partners, and direct service providers) lacked knowledge about UICs and AWCs, resulting in sub-standard provision of care.
7. **Fragmented service provision** affected access to care for UICs and impacted the quality, coordination, comprehensiveness, and continuity of care.

Findings

I. Model of care

TF is a Medical-Legal Partnership ("MLP") incorporated into a Patient-Centered Medical Home ("PCMH"), providing integrated, interdisciplinary, wraparound services in one location to reduce fragmented service provision. An MLP is defined as a partnership between a legal and health entity that provides co-located services to address social determinants of health[6]. A PCMH is a centralized source of care and medical record for children with unique health needs to reduce fragmented service provision[7]. TF is currently the only MLP incorporated into a PCMH created to specifically serve UICs in the community. The incorporation of an MLP into a PCMH is expected to increase access to care and improve health outcomes, while potentially reducing costs for patients and health care systems[9]. TF adds elements of two additional models of care to their program: integrated primary care models and wraparound models.

The TF model was based on a mutual benefit for UICs and AWCs resulting from multidisciplinary providers working together: medical and mental health providers facilitated UICs' immigration cases by treating the medical and mental health issues that impeded their ability to follow through with their legal obligations, while legal providers supported mental health (by alleviating one of the primary mental health stressors for UICs) and medical outcomes (by providing a pathway to citizenship and consistent health insurance).

Strengths of TF model

The TF model expands beyond standard MLPs by providing pro bono immigration legal services, trauma-focused mental health care, and social services (in the form of case management and enrichment services), creating a sense of community and safety for UICs.

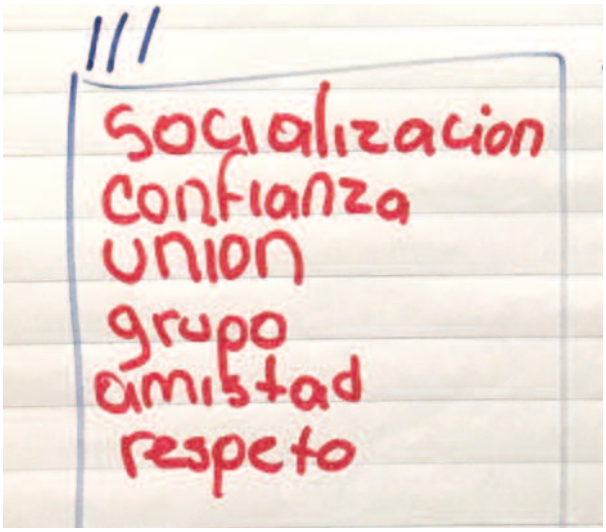
"Children can either seek [community] in the streets or they can find it within a safe and structured environment."

— TF partner

Provision of comprehensive, wraparound, and holistic programming Both providers and referral partners cited the comprehensive nature of TF programming as one of the program's greatest strengths. Respondents indicated that the wraparound nature of programming reduced isolation for participants and supported UICs' adjustment and integration into the U.S. Furthermore, the interdisciplinary nature of the program reportedly allowed providers to focus on their technical specialties, reducing re-traumatization.

Community-building aspect of the program Both providers and partners emphasized that TF did not simply provide clinical and legal services but provided a community safe space for UICs and provided a source of stability and consistency for a vulnerable population. This sentiment was reflected through FGDs with UICs, who reported "socialization" and "friendship" as words they associated with TF (Figure 1).

Figure 1: Results of mind mapping exercise with UICs



Co-location of medical, mental health, legal, and social services reportedly provided multiple entry points into the program for participants; ongoing points of contact between clients and providers to support relationship development and client engagement; faster identification of problems; smoother provider-to-provider referrals and case conferencing; and reduction of access barriers to medical and mental health care.

Client tracking for a population that is difficult to monitor Providers and partners cited that TF's coordinated care model helped them to keep track of clients by allowing providers to "keep multiple eyes" on clients.

"[TF provides a] supportive system that helps reduce client loss."

— TF referral partner

Focus on the family unit Multiple respondents highlighted TF's focus on the family unit (through support services for sponsors and adults) as one of the greatest assets of the program.

"After so many years apart, the adjustment [when my son reunified with me] was difficult. [Family] therapy helped us a lot."

— TF sponsor

Increased advocacy for the UIC population Respondents emphasized TF's capacity building efforts through education and advocacy as a strength of the program. For example, one referral partner shared that TF provided informal mental health guidance by phone for complex cases and another shared that TF's presentations to their team helped spread knowledge about the population.

PCMHs are considered to be the "gold standard" of primary care for children.

Child-centered approach TF's provision of services through a child-friendly, non-sterile clinic reportedly increased service utilization by UICs. One provider noted that TF was responsive to children's needs, as evidenced by their creation of group therapy for girls.

Location near TF's target population TF's geographic location in the South Bronx facilitates access and utilization of the clinic by their target population.

Therapeutic alliance between medical and mental health providers support disclosure of trauma in a way that a lawyer may not be able to identify alone.

Treatment of medical and mental health conditions facilitates adherence to legal obligations.

Support UICs to testify in court Medical, mental health, and legal providers within the MLP can work together to assist children testify in court or prevent them from having to testify altogether (through the provision of affidavits and letters of support from medical and mental health professionals), reducing re-traumatization.

Terra Firma Scheduling

Medical and mental health services for UICs TF's core program is delivered through a weekly Immigrant Youth Clinic on Wednesdays from 4:00-7:30pm at CCHR (Table 1), which only overlaps with standard CCHR services for one hour weekly. Operation during CCHR's evening hours provides three advantages: (1) increased access for the target population who are in school or work during standard CCHR operational hours; (2) allows the legal team to conduct screenings and follow-up appointments in exam rooms or office space not used during those hours; and (3) allows for lengthier medical intakes for UICs, and thus does not interrupt patient flow during normal hours of operation. Due to increased demand for services, both medical and mental health providers see UICs during other days of the week and during normal hours of operation.

Table 1: Immigrant Youth Clinic schedule

Time	Activity
4:00-7:30pm	New client intakes, legal screenings, medical screenings, individual psychotherapy, family therapy, primary health care, insurance enrollment
4:30-5:30pm	Nutrition class for UICs
5:30-7:30pm	Adult English Language Learning (ELL) classes
6:00-7:30pm	UIC group therapy (biweekly alternation for boys and girls ages 14+; weekly for preteens)

- UIC ELL game night on Thursdays from 4:30-6:00pm
- Adult group therapy on the last Thursday of every month from 5:00-6:30pm
- Adult nutrition group on the last Thursday of every month from 6:30-7:30pm

Medical and mental health services for AWCs, CoAWCs, and sponsors TF was initially intended to serve only UICs with support to their sponsors. As the influx of AWCs and CoAWCs increased in 2014, TF expanded services to meet the need. AWCs, CoAWCs, and sponsors receive comprehensive primary care primarily from NYCHP (with some exceptions) because: (1) NYCHP has the clinical capacity to accept more clients and (2) many AWCs and CoAWCs reside in New York City family homeless shelters and are thus part of NYCHP's target population. TF's expansion to NYCHP formally began in February 2017 with a TF presentation to NYCHP staff, although TF served this population prior to the formal partnership. Adults and CoAWCs who receive services from NYCHP benefit from select mental health (i.e. group therapy) and social services (i.e. case management and enrichment) through CCHR.

Legal services for all TF clients While initial legal screenings and follow up legal case meetings occur during the Immigrant Youth Clinic, the TF legal team is based out of CCNY's Immigration and Legal Services department in Manhattan, and clients sometimes travel there for follow up appointments. The TF legal team does not have designated space within CPP outside of the Immigrant Youth Clinic.

II. Program inputs

To address the multisector needs of UICs (and subsequently AWCs) in New York, TF delivers two primary groups of services: (1) direct services (i.e. legal, medical, mental health, and social services) and (2) advocacy and education activities (i.e. technical assistance, strategic partnerships, advocacy and education, and research)[9]. TF's target population for these services are described below (Table 2).

Target population

Table 2: Strengths of TF structure

Incorporation into legal organization (CCNY)	Incorporation into health organization (CHM)
Institutional support at project onset TF benefitted from CCNY's infrastructure and organizational history, immigration expertise, and reputation upon founding in September 2013. **Strong internal referral network** TF continues to benefit from CCNY's extensive immigration programming network for clients and screened individuals that TF cannot represent, including the Immigration Legal Services Department, UMP, Immigration Court Helpdesk (ICH), Office of Refugee Resettlement, International Center, and Safe Passages Project. Through these legal providers, TF clients are more likely to secure legal representation even if TF cannot represent the client directly.	**Ongoing institutional support** TF benefits from CHM's infrastructure (e.g. clinic, medical equipment, medications, specialty and sub-specialty services), and human (e.g. medical staff) resources.

TF initiated in September 2013 with a total of 22 proposed activities across four direct service sectors (legal, mental health, medical, and social)[10]. The program was purposefully flexible, allowing for program adaptation to meet needs as they arose. The program adapted over time to exclude certain activities and add additional components to meet shifting client needs. As of April 2018, TF implements a total of 35 direct service activities and five advocacy activities.

III. Program activities

Legal need and activities

Table 3: Legal activities

Incorporation into legal organization (CCNY)	Start date	UIC	AWC	CoAWC	Sponsor
Legal screenings for immigration eligibility are conducted at the Immigrant Youth Clinic by the case manager, legal director, or staff attorney. The number of screenings has increased over time (varying from an average of two to ten weekly screenings).	09/2013	●	●	●	●
Legal representation by TF attorney during removal proceedings and immigration relief application processes, which includes application and case preparation, writing declarations, appearance in immigration and family court, responding to Requests for Evidence (RFE), and referring asylees to CCNY's Office of Refugee Resettlement. Eligibility for TF legal representation is prioritized depending on CCNY's current grant requirements and UICs' and AWCs' detection status (e.g. in removal proceedings or not), eligibility for relief, strength of case, and appropriateness for TF (e.g. high trauma, willingness to receive medical care at CPP). Although the original TF model was based on a co-located MLP model between CCNY and CHM, TF also provides medical and mental health services to clients represented by external legal providers.	09/2013	●	●	●	
Legal referrals from TF to CCNY have remained a standard part of programming for clients that TF cannot represent. As of September 2016, eligible immigrants are referred to CCNY's ICH for assistance filing pro se applications. UICs that TF cannot represent are referred to CCNY's UMP program. AWCs and CoAWCs that TF cannot represent, and sponsors are referred to CCNY's Immigration Legal Services department.	09/2013	●	●	●	●
Legal Orientation Program for Custodians (LOPC) provides presentations about immigration court processes and basic information on relief by attorneys, paralegals, or case counselors.	09/2013	●			●
Legal rights education through presentations by the TF legal team and external agencies (e.g. New York County Defender Services, Qualitas of Life Foundation) on various issues including financial planning and interactions with law enforcement. TF initially proposed providing "Know your Rights" (KYR) presentations similar to those that UMP provides. This changed over time to general legal rights education, including a Question and Answer session with TF attorneys following the 2016 presidential election.	09/2013	●	●	●	●

Mental health need and activities

Needs

UICs are a vulnerable group with greater psychiatric morbidity than the general population[11] and greater exposure to trauma than other migrant groups[12]. Multiple exposures to trauma are associated with increased risk for psychopathology[13]. Detained UICs experience high levels of Post-Traumatic Stress Disorder (PTSD), anxiety, depression, aggression, psychosomatic symptoms, and suicidal ideation[14]. Among adult Central American migrants, a 2016 survey conducted by Médecins Sans Frontières (MSF) found that 90% showed signs of anxiety or depression related to violence suffered along the journey[15].

In addition to trauma at home and during migration, UICs and AWCs also experience poor mental health outcomes as a result of chronic stressors upon resettlement. Among UICs, the combination of pre-migration traumas with acculturative stress can lead to attachment problems, physical and cognitive deficits, poor self-esteem, dissociation, and emotional and behavioral regulation challenges[16]. Despite these risk factors, mental health service access and treatment among immigrants has shown to be worse than for the general population[17].

Response

TF implements 10 free, bilingual, culturally-sensitive, trauma-sensitive, and co-located mental health activities to address the challenges of exacerbation of treatable mental health conditions and difficulty meeting legal obligations due to policy, system, and individual-level access barriers to care and limited knowledge about the importance of mental health care among UICs and AWCs (Table 4).

Table 4: Mental health activities

Activity	Start date	UIC	AWC	CoAWC	Sponsor
Mental health assessments are applied during the medical intake process. UICs are screened for depression, anxiety, and PTSD with the Refugee Health Screener (RHS-15); high-risk behaviors with the Guidelines for Adolescent Preventative Services survey (GAPS); and the Child PTSD Symptom Scale (CPSS) during the first medical visit. Additional screeners are applied based on the presenting problem. Physicians review the results with the client and refer cases to mental health through the CHM online portal. Adults and CoAWCs referred to NYCHP receive the Generalized Anxiety Disorder 7-item (GAD-7) and Patient Health Questionnaire (PHQ-9) for depression screeners, upon the first medical visit.	09/2013	●			
	02/2017		●	●	●
Individual psychotherapy involves weekly or biweekly 45 to 60-minute sessions with a clinician for six months or until the resolution of symptomology. TF initially provided individual psychotherapy exclusively to UICs, expanding psychotherapy services for adults (AWCs, sponsors) and CoAWCs in February 2017. Each CPP practitioner utilizes a unique therapeutic approach, which may include Trauma-Focused Cognitive Behavioral Therapy, family systems therapy, dialectical behavioral therapy, emotion-focused therapy, and interpersonal therapy.	09/2013	●			
	02/2017		●	●	●
Family therapy is not a standalone activity but is used instead to support individual therapy for UICs and consists of bringing sponsors or caretakers to UICs' individual psychotherapy sessions. Although not explicitly outlined upon project onset, family therapy is considered a supplement to individual psychotherapy and was incorporated into treatment immediately.	09/2013	●			●
Individual psychiatry consists of medical treatment for psychiatric conditions of TF patients. TF has one English-speaking psychiatrist for medical treatment of psychiatric conditions.	09/2013	●	●	●	●

Incorporation into legal organization (CCNY)	Start date	UIC	AWC	CoAWC	Sponsor
Group therapy for UIC boys age 14+ addresses traumatic events experienced in the home country, in transit, in detention, and upon resettlement in the U.S. When TF initiated in September 2013, most UICs were boys from the Northern Triangle. As such, the support group consisted of only boys meeting biweekly with open and rolling enrollment (cohort one). The boys group became more structured in October 2015, involving bi-weekly counseling for six months (cohorts two through five). TF has expanded this group to include CoAWCs ages 14+. Entry into the group involves an invitation to the upcoming cohort, an initial introduction session, and individual screenings to assess suitability for group therapy.	09/2013	●			
Group therapy for UIC girls age 14+ initiated in October 2014 to meet the needs of a growing number of UIC girls. The initial cohort piloted the Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) model of group therapy but was discontinued because it was not well-received by participants. TF has expanded this group to include CoAWCs ages 14+. Entry into the group involves an invitation to the upcoming cohort, an initial introduction session, and individual screenings to assess suitability for group therapy.	10/2014	●			
Group therapy for adults consists of monthly group therapy sessions for sponsors experiencing challenges with reunified UICs and AWCs and sponsors seeking resources to meet basic needs. The adult group initiated following a needs assessment. The group is unstructured, allowing for open and ongoing enrollment.	03/2016		●		●
Group therapy for preteens ages 9-13 consists of weekly group therapy sessions with a clinician for an indeterminate amount of time and includes semi-structured play, mindfulness exercises, psycho-education, icebreakers, movement activities, and social skills building exercises. The group was created following the identification of a common need among this age group to learn basic social skills and to understand their experiences and adjust to life in the U.S.	10/2016	●		●	
External referrals are primarily provided to patients who do not live close to CCHR. In rare situations, TF refers children with acute sexual or physical abuse to CHM's Child Advocacy Center and children with developmental disabilities or autism to the YAI Center for Specialty Therapy or The Kennedy Center, Inc.	09/2013	●	●	●	●
Forensic psychological exams occur over three to four sessions with a therapist to assess psychosocial history, psychological status, provide a clinical interview, and apply mental health screeners. The results of the exam are compiled into a legal affidavit. Both affidavits and letters of support are provided primarily to UICs and AWCs enrolled as patients of TF, although TF has provided these for emergencies (e.g. sudden asylum hearings or children in detention who are close to aging out of the ORR system into adult detention).	09/2013	●	●		

Medical needs and activities

Needs

UICs and AWCs have multiple increased risks for poor health outcomes, including persistent poverty, environmental exposures en route to the U.S., and access barriers upon arrival to the U.S.

Poverty is a strong indicator for poor health outcomes globally, as low-income individuals are unable to access the items needed to ensure good health, including quality food, education, and health care[18]. Most UICs and AWCs are low-income. Upon arrival to the U.S., poverty persists, with immigrant children more likely to live below the federal poverty level than non-immigrant children[19]. Prolonged childhood poverty is associated with poor health outcomes including chronic illness, poor nutrition[20], and toxic stress, increasing the risk for inattention, impulsivity, and poor peer relationships[21]. Additionally, poverty experienced in youth has implications for the life course, with certain life events during adolescence (e.g. unemployment, displacement) increasing vulnerability to poverty[22].

Regular medical care Immigrant women and children are less likely than their non-immigrant peers to have a regular source of medical care, receive preventative services, and obtain specialty care[23]. Without consistent medical care, immigrants are not screened and treated for pre-existing or newly acquired conditions. For children, lack of preventative care can lead to delayed identification of developmental, hearing, and vision impairments[24].

Insurance Immigrants in the U.S. are barred from eligibility for federally-funded health insurance and are only eligible for emergency care under Medicaid if they meet certain requirements[25]. Undocumented immigrants are also prohibited from purchasing private health insurance[26]. New York, along with California, Illinois, Massachusetts, Oregon, Washington, and The District of Columbia are the only states that provide health insurance coverage for children under 18 regardless of immigration status[27]. Children with insurance coverage are more likely to access preventative care and have minor illnesses treated before they develop into more complex conditions[28].

Response

TF implements four free, bilingual, culturally-sensitive, trauma-sensitive, and co-located medical activities within the PCMH to address challenges meeting legal obligations and exacerbation of treatable medical conditions due to policy, system, and individual-level access barriers to care; lack of knowledge about primary health care; and increased risk for undetected illness (Table 5).

Table 5: Medical activities

Activity	Start date	UIC	AWC	CoAWC	Sponsor
Health insurance enrollment TF tries to enroll UICs and CoAWCs in health insurance on their first visit to the Immigrant Youth Clinic. In New York state, all children under age 18 qualify for Child Health Plus under the state CHIP program. UICs released from ORR custody can use their Alien Registration Number ("A number") to receive Medicaid for a short time. Adult immigrants can qualify for Emergency Medicaid through their children.	09/2013	●	●	●	●
Comprehensive primary care Comprehensive primary care involves medical intakes, routine healthcare maintenance (e.g. physical exams, vaccinations, laboratory tests, screenings), acute care, chronic illness management, and medication provision regardless of ability to pay. TF medical intakes are more time consuming than standard patient intakes, often leading to multiple appointments to complete the medical history review, psychosocial history, screenings, physical exams, vaccinations, and lab testing. At NYCHP, providers try to schedule AWCs and CoAWCs on the same day to minimize commuting for caregivers. TF is currently in the process of developing a standardized medical intake form.	09/2013 02/2017	●	 ●	 ●	●
Referrals to specialty, sub-specialty, and dental care within the CHM system. Although dental care was initially proposed as a co-located service for TF patients, this activity never materialized, and dental referrals are instead externally referred.	09/2013	●			●
Forensic medical exams involve a physical assessment of a patient to corroborate reports of physical/sexual abuse or medical findings relevant to an immigration case (e.g. deafness, blindness, cognitive impairment). Findings are consolidated into an affidavit.	09/2013	●	●	●	●

Social needs and activities

Needs

When TF initiated, access to basic survival needs such as housing, food, and clothing frequently prevented UICs from meeting medical, mental health, and legal obligations (Table 6). The need for income frequently competed with instructions from an immigration judge to enroll in and attend school. This closely reflects Maslow's hierarchy of need, which posits that humans have five hierarchical needs – biological (e.g. food, water, shelter), safety (e.g. protection, security, law, order), social (e.g. love, belonging), esteem (e.g. achievement, independence), and self-actualization needs (e.g. realizing personal potential). Lower levels of need (biological and safety needs) must be satisfied before moving upward[29].

Table 6: Social needs of UICs and AWCs

Need	Description
Basic living needs	AWCs and UICs experience challenges accessing basic needs such as housing, food, and clothing. For UICs living with sponsors, their addition to the home often causes financial stress.
Acculturation	Acculturation is the process of interacting and adjusting to a new culture, language, and environment[30], and is frequently a source of stress for UICs and AWCs.
Education	UICs have often experienced interrupted education, placing them academically behind their peers. UICs also struggle with the language barrier and often face pressure to work rather than attend school[31].
Social vulnerability	Youth aged 15 to 19 have elevated risk for early pregnancy, sexually-transmitted infections (STIs), violence, and substance abuse[32]. Adolescent exposure to trauma has been associated with increased risk for pregnancy[33] and substance abuse[34].
Family reunification	Conflicts often arise between adolescents and their sponsors upon reunification. UICs struggle to live again with a primary caretaker and typically have negative feelings related to the separation[35], causing emotional stress for both the sponsor and child.

Response

TF provides case management and enrichment services to help clients meet biological, safety, and social needs.

Case management is a collaborative process of assessment, planning, facilitation, care coordination, and advocacy to support holistic client needs[36]. From 2013 to 2015, TF clients benefitted from UMP's case management services as legal clients of UMP. In November 2015, CPP hired a Clinical Case Manager to support CCHR medical staff, including the TF clinical team and TF clients. In March 2017, UMP hired the first FTE Legal Case Manager to support TF legal clients. TF's case management service provision is channeled through each partner: the Legal Case Manager provides support to the TF Legal Director and staff attorney and the Clinical Case Manager provides support to the TF clinical team. TF implements six free, bilingual, culturally-sensitive, trauma-sensitive, and co-located case management activities to address social stressors that prevent TF clients from prioritizing medical, mental health, and legal services (Table 7).

Table 7: Case management activities

Activity	Start date	UIC	AWC	CoAWC	Sponsor
Homelessness prevention and housing advocacy For UICs living with a sponsor, homelessness prevention includes mediation of familial challenges. For homeless UICs, AWCs, sponsors, and CoAWCs, prevention and advocacy involve assistance entering the youth, adult, or family homeless shelter system.	09/2013	●	●	●	●
Assistance with basic living support such as food from pantries and soup kitchens and clothing from non-profit organizations.	09/2013	●	●	●	●
Public benefits assistance involves applying for public housing, cash assistance, and food stamps.	09/2013	Asylees, LPRs, and sponsors with U.S. citizen children			
Job placement assistance involves identifying employment opportunities, resume editing, and referrals to job assistance programs (primarily provided to AWCs and sponsors).	09/2013	●	●	●	●
School enrollment and educational advocacy involves identifying and enrolling in high school and General Education Development (GED) programs, retrieving required enrollment documents, and advocating for clients when the Department of Education blocks enrollment.	09/2013	●	●	●	●
Referrals to wraparound programs involves connecting UICs and CoAWCs to wraparound youth service programs (e.g. The Door).	09/2013	●		●	

Enrichment services are intended to help support acculturation and normalization for UICs through the development of a sense of community within a safe space. Enrichment services also represent an additional contact point for TF clients to engage in medical, mental health, and legal services. While TF directly facilitates nutrition classes and academic support, most enrichment activities are provided through partnerships with external organizations. TF provides 10 enrichment activities to help TF clients develop a sense of community (Table 8).

Table 8: Enrichment activities

Activity	Start date	UIC	AWC	CoAWC	Sponsor
Intramural soccer (spring, summer, fall) Partnership with South Bronx United (SBU) providing weekly 90-minute intramural soccer in the South Bronx for children ages 15+ with the objective of creating a community safe space for immigrant children.	09/2013	●		●	
Youth nutrition classes Weekly meal preparation class and nutrition lecture during the Immigrant Youth Clinic for UICs and CoAWCs over age 14. The CCHR nutritionist develops recipes based on request and teaches participants how to make healthy versions of the meals requested. Community gardening is included during the summer.	03/2014	●		●	
Intramural soccer (winter) Partnership with UMP's La Union providing weekly 90-minute intramural soccer in Harlem for children ages 6-17 with the objective of creating a community safe space for immigrant children.	11/2014	●		●	

Activity	Start date	UIC	AWC	CoAWC	Sponsor
Summer enrichment program Eight-week enrichment program combining partner programming in soccer with SBU, photography with the International Center for Photography (ICP), and ELL classes with CCNY's International Center: ▪ Two weekly two-hour soccer practices/games at SBU prior to ELL for eight weeks; ▪ Three weekly two-hour ELL sessions taught by a volunteer at CCHR in the afternoon for eight weeks; and ▪ One weekly photography workshop for five weeks (two classes at CCHR, two studio and editing sessions at ICP, and final presentation at CCHR). TF expanded on the success of the summer program by implementing components during the academic year.	07/2015	●		●	
Adult nutrition classes Monthly meal preparation workshop for adults involving a cooking demonstration and abbreviated nutrition lecture of traditional Central American dishes by a CCHR nutritionist following adult group therapy.	03/2016		●		●
Adult ELL Expansion of the summer program partnership with CCNY's International Center providing weekly two-hour sessions teaching basic English communication skills.	07/2017		●		●
Photography workshops Expansion of the summer program partnership with ICP providing five-session workshop from February to March 2018 to teach digital photography as a story-telling method for UICs and CoAWCs over age 14 (Figure 2).	02/2018	●		●	
Youth ELL Expansion of the summer program partnership with CCNY's International Center providing weekly 90-minute ELL through games.	03/2018	●		●	
Academic support Informal, limited drop-in tutoring and assistance with college applications by TF volunteers.	Not specified	●		●	
Acculturation workshops and field trips Monthly workshops on various topics including street safety, reproductive health, college application processes, and creative writing.	Not specified	●		●	
Zumba TF offered 30-minute Zumba classes for two years in different buildings of CPP. The class was ultimately discontinued due to low attendance.	2014 to 2016	●	●	●	●

Figure 2: TF participants involved in ICP's photography workshop

Photo credit: Terra Firma

III. Considerations for replication

Lessons learned

After five years providing integrated medical, mental health, legal, and social services to UICs and more recently to AWCs, TF is in a position to assess the success of its programs and to reflect on lessons learned, with the hopes that knowledge sharing will improve TF's own service provision and provide guidance for organizations interested in replicating the TF model.

Strengths of operational environment

Strengths of the operational environment refer to the macro-level policies and operational environment that facilitate TF program implementation in New York City.

Operation in a sanctuary city Sanctuary cities are jurisdictions that institute policies limiting cooperation with federal immigration enforcement[37]. New York City is considered a sanctuary city, and as such offers protections for undocumented immigrants, including the first statewide immigrant-defense fund[38], that facilitate their access to TF services.

Operation within a progressive state in terms of insurance and availability of social support services. New York is one of six (California, Illinois, Massachusetts, Oregon, Washington) states and Washington D.C. that insures undocumented children under state CHIP programs. Insurance coverage increases the quantity of UICs that TF can treat and increases institutional buy-in as most TF patients are revenue generating for CHM. Additionally, New York has the country's largest nonprofit sector, resulting in an expansive social support system for TF clients.

Operation within a city with a strong public transportation system Given the financial and logistical access barriers for TF's target population, the availability of a strong public transportation system facilitating TF's client base to access services cannot be underestimated.

"We're lucky in New York that most of our patients [UICs] are insurable, which is a key consideration for replication." — *TF provider*

Considerations and recommendations

System-level considerations and recommendations System-level considerations refer to the macro-level policies and operational environment that hinder TF program implementation in New York City (Table 9).

"I'm still in limbo. I'm neither here nor there. I don't know what will be of my future." — *TF participant*

Table 9: System-level considerations and recommendations

Considerations	Recommendations
The 2016 U.S. policy environment raised fears of deportation among undocumented immigrants[39] and raised fears regarding insurance coverage among low-income and underinsured populations[40].	Organizations should consider providing general legal education to reduce clients' fears.
Immigration policy changes have resulted in longer processing times for successful immigration petitions. The backlog of pending cases in June 2017 stood at a record high of roughly 600,000, with an average national wait time of 675 days, increasing the number of "active" TF clients over time[41]. As the wait time for processing has increased, TF clients have expressed frustration and confusion about the legal process.	Organizations should consider providing general legal education about the immigration court backlog to clients during legal appointments.

Considerations	Recommendations
High level of need among target population in terms of both numbers and vulnerability TF is currently serving a small proportion of the 4,977 UICs released to sponsors in New York since October 2017[42]. Respondents reported concerns about TF's capacity to meet increasing demand, with mental health and legal representation highlighted as particularly constrained.	Further replication of the model is both needed and warranted. In addition to standard medical and legal programming, organizations should consider the provision of case management and enrichment services, including strong academic support services within the model.
High demand for mental health services TF's target population has both a high number of clients seeking mental health care (reflected by the long waitlist for individual psychotherapy) and a high level of need among those seeking care (reflected in reports that therapy sessions frequently focus on current stressors rather than the history of trauma).	Organizations should consider investing more heavily in mental health staff, as this is identified as one of the greatest needs, and strengths, of the TF model.
Increased number of cases with histories of sexual and gender-based violence as influx of UIC girls began to increase in 2014[43].	Organizations should consider incorporating female clinicians onto various teams. TF is currently structured such that all mental health and two medical providers are female.
Health care system challenges While TF removes barriers to primary care for their target population, one provider noted that referrals to specialty care can involve long waitlists.	Organizations may consider strengthening internal partnerships with specialty care providers.

V. Conclusion

This process evaluation set out to identify the problems TF addresses, the activities TF implements to address these problems, the outcomes TF expects from these activities, and the assumptions underlying why the program is expected to work. The process evaluation examined inputs TF has invested; program delivery mechanisms; and provider, partner, and participant perceptions of program strengths and weaknesses.

The findings indicate that TF's model as an MLP within a PCMH responds to the needs identified at project onset from the perspective of providers, program partners, and participants. In particular, respondents emphasized:

- TF's structure as a partnership housed within an existing hospital system is viewed as one of the factors contributing to program success, as TF benefits from hospital resources including funding streams.
- TF's provision of comprehensive, wraparound programming which fosters a sense of community for UICs and AWCs as one of the model's greatest strengths. This underscores the value of TF as more than a standard MLP or PCMH - TF's enrichment services are a substantial pull factor for participants, strengthening the model more than medical, mental health, and legal services alone.
- TF's founders and staff commitment, responsiveness, and competence as one of the greatest strengths of program implementation. This has implications for replication, as perceptions of program success rely heavily on a specific people.

As the only MLP within a PCMH specifically intended for UICs, TF provides an important and necessary service for the growing population of UICs in New York. This theory-based process evaluation provides a foundation identifying and outlining

the various components of the program and the causal mechanisms underlying how the program is expected to work, providing a baseline for future research efforts within TF. The report also provides insights into replication by providing lessons learned and best practices shared by TF providers, referral partners, and participants. Replication of the model is needed and warranted, and it is the hope of the author that this report provides insights into the continued need for funding and programming for this vulnerable population.

Future areas of research

The program theory analysis was useful to build clarity about program activities and outcomes; understand program performance; identify areas for improvement; and set a foundation for outcome measurement. The process evaluation expanded on the program theory analysis, helping to better understand program successes and challenges and external factors affecting replication. TF may consider using the current evaluation data to develop the following research approaches in the future:

- **Applicability (feasibility) assessment** at local and/or national level to better identify the infrastructure needed for implementation (e.g. political leverage, social acceptability, availability of essential resources, and organizational expertise).
- **Quantitative process evaluation** defining and measuring fidelity to the model, patient adherence, and utilization.
- **Outcome or effectiveness research** to identify if TF is meeting stated objectives. The theory of change established a framework outlining program components, including time-sensitive outcome measures with potential indicators.

Annex 1: Interdisciplinary Models Adapted by TF

MLP model

Definition: partnership between legal and health entity to provide co-located services[44]. Legal providers give direct legal assistance[45], legal training to medical providers[46], and advocacy at the policy-level[47]. Medical providers give direct care, medical evidence for the legal case[48], and medical training to legal providers.

Problem the model addresses: social determinants of health (e.g. education, employment, immigration status)[49] impact health outcomes[50]. The model is based on the assumptions that (1) medical providers have limited resources to address social determinants of health[51], (2) social determinants of health are often regulated by policy, (3) there are gaps in policy implementation that result in social determinants impacting health outcomes[52], and (4) legal providers are well-suited to address violations in policy implementation[53].

Anticipated outcomes: lawyers alleviate legal issues affecting health outcomes and clinicians address medical problems affecting legal outcomes[54], resulting in (1) reduced access barriers for patients and (2) increased case consultation and information sharing among providers.

TF adaptation: TF is unique in that legal providers sought assistance from medical providers to treat patients with medical and mental health issues affecting their ability to follow through with their legal obligations.

PCMH model

Definition: centralized source of care and medical record for children with unique health needs, with an emphasis on team-based care, orientation toward the whole person, coordinated care across the health system and community, and improved access to care[55].

Problem the model addresses: children with unique health needs receive fragmented care across providers.

Anticipated outcomes: patients receive care when needed, in a suitable location, and in a culturally and linguistically appropriate manner[56].

TF adaptation: one of TF's long-term goals is to create a patient centered medical home for UICs that serves as a consistent source of safety, information, and care.

Integrated primary care model

Definition: provision of coordinated care across different medical providers to improve patient health outcomes[57].

Problem the model addresses: fragmented service provision contributing to (1) lack of ownership over treatment by providers, (2) poor communication across providers, (3) simultaneous duplication of care and gaps in services, and (4) lack of patient involvement in care[58].

Anticipated outcomes: improved access to and coordination, comprehensiveness, and continuity of care[59].

TF adaptation: TF reduces fragmentation through coordinated, wraparound programming for UICs.

Wraparound model

Definition: holistic and individualized method of planning and managing care for children with complex needs through multidisciplinary team-based planning[60].

Problem the model addresses: children with complex health needs receive fragmented care across providers.

Outcomes: wraparound models promote community-based care, reducing residential placement and juvenile justice recidivism and improving mental health outcomes and school success[61].

TF adaptation: TF provides formal services together with community and support structures, closely mirroring wraparound programs.

Annex 2: Acknowledgements

The consultant is grateful for funding from an anonymous private foundation, which supported this theory-based process evaluation and report, and which has allowed Terra Firma to provide legal and case management services to this highly vulnerable population for three years.

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Key providers

The insights and inputs of key providers and partners helped to inform this report and recommendations. The recommendations do not always reflect the views of the individual providers, nor have they endorsed the recommendations or conclusions of this report. The consultant is grateful for the 53 partners, providers, and participant who took the time to provide their insights about TF. A special thank you to TF founders (Dr. Cristina Muñiz, Dr. Alan Shapiro, Brett Stark) and Program Coordinator (Mia Stange) for the generous time they provided in informing this evaluation.

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