

The Mental Health Needs of Unaccompanied Immigrant Children: Lawyers' Role as a Conduit to Services

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Unaccompanied immigrant children are a highly vulnerable population, but research into their mental health and psychosocial context remains limited. This study elicited lawyers' perceptions of the mental health needs of unaccompanied children in U.S. deportation proceedings and their mental health referral practices with this population. A convenience sample of 26 lawyers who work with unaccompanied children completed a semi-structured, online survey. Lawyers surveyed frequently had mental health concerns about their unaccompanied child clients, used clinical and lay terminology to describe symptoms, referred for both expert testimony and treatment purposes, frequently encountered barriers to accessing appropriate services, and expressed interest in mental health training. The results of this study suggest a complex intersection between the legal and mental health needs of unaccompanied children, and the need for further research and improved service provision in support of their wellbeing.

The Mental Health Needs of Unaccompanied Immigrant Children: Lawyers' Role as a Con- duit to Services

Under the terms of 6 U.S.C. § 279(g)(2), federal law defines an unaccompanied alien child as any child or adolescent under the age of 18 who is in the United States without lawful immigration status and does not have a parent or other legal guardian present to provide custody. Of the 14,299 unaccompanied children detained by the Department of Homeland Security between October 2008 and September 2010, 91% were from Latin America (mostly Central America), 70% were between the ages of 15 and 17, and 73% were male (Byrne & Miller, 2012). Due largely to increasing

violence and insecurity in Central America, in recent years there has been a dramatic rise in the number of apprehensions. In 2013, U.S. immigration authorities detained 21,537 unaccompanied children from Guatemala, Honduras, and El Salvador alone (United Nations High Commissioner for Refugees, 2014).

Psychosocial Stressors

The available literature suggests that unaccompanied youth are at high risk for repeated exposure to psychosocial stressors before, during, and after their migration to the United States (Baily, Henderson, Taub, Ricks, & Verdeli, 2011). Children may be fleeing gangs, evading forced recruitment by military and paramilitary organizations, escaping war or civil unrest, avoiding coercion into child labor or prostitution, or facing displacement following natural disasters (Chavez & Menjivar, 2010). They can spend months traveling alone to the United States in treacherous conditions, and during the journey they are vul-

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nerable to abuse and physical and sexual exploitation by bandits, smugglers, and local officials (Bhaba & Schmidt, 2008; Casillas, 2006; Fazel & Stein, 2002; Seugling, 2004). Although government guidelines have been created to protect unaccompanied children apprehended by U.S. immigration, they may be detained in prison-like conditions for extended periods of time prior to release to family members or other less restrictive settings (Women's Refugee Committee, 2009). Once released to less restrictive settings, they still face a long period of instability and insecurity while they await immigration proceedings to determine whether they will be deported, during which they may also experience acculturation issues and discrimination within the local culture (Perez Foster, 2001).

Mental Health Needs

Despite the well-documented psychosocial stressors faced by unaccompanied children migrating to the United States, there has been limited research on their mental health needs. Research to date has largely taken the form of reports and papers by legal and human rights researchers and advocacy groups, has focused predominantly on children living in detention (as opposed to children reunified with family members in the community), has relied predominantly on qualitative interviews with key informants, and has discussed children's experiences broadly rather than focusing on mental health specifically. Nevertheless, several papers have documented high rates of Post-traumatic Stress Disorder (PTSD), other anxiety conditions, depression, aggression, psychosomatic complaints, and suicidal ideation among unaccompanied children (Bhaba & Schmidt, 2008; Chavez & Menjivar, 2010; Women's Refugee Commission, 2009).

To the authors' knowledge, only two empirical studies have used standardized instruments to assess the mental health status of unaccompanied children in the United States, both of which looked at very specific populations of unaccompanied children, and had very targeted research questions. Porte and Torney-Purta (1987) examined the relationship between different types of foster care and depression and academic achievement in unaccompanied Indochinese children. Geltman and colleagues (2005) looked at PTSD and its relationship to overall functioning

among unaccompanied Sudanese youth. The majority of empirical research on the mental health of unaccompanied children has been conducted in Northern Europe, and has found that these children are at high risk for exposure to traumatic events (Bean, Derluyn, Eurelings-Bontekoe, Broekaert, & Spinhoven, 2007b), have elevated rates of psychopathology (e.g., Derluyn, Broekaert, & Schuyten, 2008; Hodes, Jagdev, Chandra, & Cunniff, 2008; Lustig, Kia-Keating, & Knight, 2004), and have limited access to psychological care (Bean, Eurelings-Bontekoe, Mooijaart, & Spinhoven, 2006). However, the generalizability of these findings to unaccompanied children in the United States is likely limited, given differences in the countries of origin, migration experiences, legal systems, and resettlement conditions of unaccompanied youth in these European countries compared to America.

Legal Context

In contrast with unaccompanied children's mental health needs, the legal challenges they face have been widely documented (e.g., Byrne, 2008; Georgopoulos, 2005; Nafziger, 2006). These include lack of access to counsel, difficulty meeting the high evidentiary standards required to obtain legal relief, and the legal system's failure to consistently apply a "best interests of the child" standard when making decisions in their cases. However, a sustained legal advocacy campaign over the last 30 years has led to an expansion in the types of immigration relief for which unaccompanied children may be eligible, and increased access to legal services to help them prepare their cases (Byrne, 2008). Unaccompanied children may be eligible for a variety of forms of immigration relief, including Special Immigrant Juvenile Status, asylum, and petitions under the Victims of Trafficking and Violence Protection Act (Byrne & Miller, 2012). These cases can take years to resolve, during which children are placed in the temporary custody of family members residing legally in the United States or, when such an option is not available, in government-sponsored foster care or residential facilities (Women's Refugee Commission, 2009). Lawyers' advocacy role during this period often includes connecting children to a variety of services (e.g., academic, social, health) in support of their cases and overall wellbeing (Baily et al., 2011). In

particular, legal and mental health advocacy frequently overlap: each of the major forms of immigration relief available to unaccompanied children requires evidence of psychosocial stress, and lawyers frequently refer clients for assessment and documentation of mental health difficulties to be provided to the court as expert testimony in support of their cases (Baily et al., 2011). However, there has been little formal study of the intersection of mental health and legal needs in unaccompanied children in the United States.

Conceptual Rationale

In this exploratory study, lawyers completed a survey about their perceptions of the mental health needs of their unaccompanied child clients and referral practices with this population. The goal was to provide qualitative, descriptive information about the experiences of the lawyers surveyed, as opposed to quantitative data from which to draw inferences about the overall experiences of lawyers working with unaccompanied children or the mental health needs of these youth. The study was intended to provide a first step towards more extensive research to address the gap in the literature on the mental health needs of unaccompanied children in the U.S. immigration system.

This line of research was initiated following requests from several New York City lawyers to help them find mental health referrals for their unaccompanied child clients. Discussions with these lawyers suggested that they have concerns about the mental health of many of these clients, and often seek psychological referrals, but have difficulty finding services appropriate to their clients' needs. The lawyers mentioned a variety of reasons for mental health referrals: for psychological evaluations and expert testimony that lend weight to children's immigration petitions; for treatment to support children through a stressful legal process that frequently requires recounting of traumatic experiences; and because they are concerned more generally for children's psychological welfare (Baily et al., 2011). These rationales mirror those reported in the wider legal literature (e.g., Galowitz, 1999; Price & McCreary, 1976) as reasons lawyers request psychological services for clients. The current survey explored whether the concerns raised by lawyers during

these preliminary discussions were shared by other New York City lawyers who represent these youth.

Given the emotionally and legally vulnerable status of unaccompanied children, it seemed that an anonymous survey with an informed third party (as opposed to a study with unaccompanied children and their families directly) would be the least intrusive and most ethically appropriate point of departure for our research. This is consistent with the ethical principles of beneficence and nonmaleficence in conducting research with vulnerable populations (American Psychological Association [APA], 2010). The study was also intended to generate initial information about the feasibility of conducting research on this topic, and to gain information about questions such as recruitment, protection of subjects, and data issues (e.g., reliability, generalizability, qualitative versus quantitative methodology) in research on unaccompanied children. Thus, this research sought both to generate hypotheses for future study and inform subsequent research methodology.

The use of key informants in research with immigrant children is complicated by these children's diverse histories and experiences, as well as inconsistent reporting due to varying cultural and experiential perspectives (Suárez-Orozco & Suárez-Orozco, 2001). The decision to use lawyers as informants in this study was based on multiple rationales. From an information-gathering point of view, lawyers are often the professionals who know these children best: lawyers see their unaccompanied child clients at multiple time points during their often protracted immigration processes; in the course of developing immigration petitions, lawyers take detailed histories of these children's backgrounds (including their exposure and reactions to psychosocial stressors); and their unique role as children's advocates may help establish a relationship of trust within an otherwise confusing and intimidating system. From a service-provision perspective, lawyers are frequently charged with helping children access other services and resources, and the study sought to understand lawyers' role as a conduit to mental health services, to provide data on how mental health professionals can support them in this role, and to generate initial information about the possibility of developing a more

systematic mental health referral pathway for unaccompanied children via their legal processes in the future. From a research standpoint, this study with lawyers sought to contribute to the growing literature on the inter-relationship between unaccompanied children's mental health and legal needs (e.g., Derluyn & Broekaert, 2008; Nugent, 2006). Of note, the survey was not intended to provide epidemiological data about psychopathology in unaccompanied children. Accurately identifying psychological difficulties in their clients is outside attorneys' professional expertise and role, and was beyond the scope of this study.

The specific aims of this study were to investigate whether participating lawyers were observing mental health problems in their unaccompanied child clients, how lawyers characterized these problems, their referral practices with this population, barriers they encountered to service access, and their interest in further mental health training.

Method

Measure

A 71-question survey titled "Mental Health Referral Practices of Lawyers Representing Unaccompanied Immigrant Minors" was developed to assess lawyers' perceptions of their unaccompanied child clients' mental health needs, their mental health referral practices, and their mental health training and experience. The survey content was informed by a review of the available literature on the psychological needs of unaccompanied children and lawyers' mental health referral practices, and then refined through consultation with a lawyer member of the research team with experience representing unaccompanied children. The format and structure of the survey was revised through consultation with researchers from the New York State Psychiatric Institute with expertise in public health research and the assessment of child mental health.

The survey combined selected-response, Likert-style, and open-ended questions. Lawyers were asked to give some basic demographic information (e.g., number of years in legal practice, primary area of legal practice etc.), to provide information on their attitudes towards mental health diagnosis and referrals

(e.g., "In what ways does a diagnosis of a mental health problem in unaccompanied minors typically influence immigration proceedings?"), to rate their mental health knowledge (e.g., "Do you feel confident in your ability to identify mental health problems in your unaccompanied minor clients?"), and to describe areas of interest for further mental health training. For their three most recent clients, whether or not they were referred for mental health services, lawyers were asked to describe any behavior, emotions, or thoughts that made them concerned for the client's mental health. For their three most recent clients referred for mental health services, lawyers were asked about the reasons for referral and any barriers to obtaining services. Participants were given the opportunity to write optional additional comments pertaining to each of the above topic areas. The survey was hosted at SurveyMonkey, a service for web-based questionnaires that employs Secure Sockets Layer (SSL) encryption to secure the data provided by participants. It took approximately 30-40 minutes to complete.

Participants

Study participants were lawyers practicing in New York City who had represented at least one unaccompanied child client in immigration proceedings within the last five years (N=26). The data concerning the types of legal organizations for which respondents worked, their primary areas of legal practice, and the number of unaccompanied children they had represented are presented in Table 1. Broadly speaking, the participants fell into one of two categories: a majority of lawyers worked for private law firms and other organizations specializing in corporate law, and had represented a small number (<5) of unaccompanied children as a minor portion of their practice; a smaller group of lawyers worked for nonprofit legal services organizations, specialized in immigration law, and had represented a large number (>50) of unaccompanied children.

Procedure

A pool of potential participants was recruited via outreach to legal advocacy programs that work with unaccompanied children. These included Catholic Charities and the Legal Aid Society, nonprofit orga-

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Table 1

Participant Demographics (N=26)

	<i>n</i> ^a
<i>Legal Organization Type</i> (/26)	
Private law firm	18
Nonprofit legal services organization	5
Solo practitioner	2
In-house counsel	1
Government attorney	0
<i>Primary Area of Legal Practice</i> (/24)	
Corporate law	16
Immigration law	7
Family law	1
<i>Number of Cases Completed</i> (/26)	
< 5	17
6-10	1
11-20	3
21-50	0
50+	5

^a differences in *n* reflect variations in response rate between different demographic questions

nizations that provide free legal services to unaccompanied children, as well as Kids in Need of Defense (KIND), a national organization that arranges legal representation for unaccompanied children by pro bono lawyers. Representatives from these organizations sent an email describing the study and providing a link to the survey to their listservs of New York City lawyers representing unaccompanied children. Neither the contact details of lawyers on these listservs nor any other identifying information about them was provided to the research team. Approximately 150-200 attorneys were contacted via this method. In addition, participants were invited to forward the survey link to other lawyers who work with unaccompanied children. This methodology, known as snowball sampling, is common to many survey studies. In particular, it has been used in studies concerning vulnerable populations with heightened confidentiality and anonymity concerns (e.g., Kendall et al., 2008). These procedures were intended to recruit a convenience sample of lawyers who could describe their experi-

ence of the mental health issues involved in representing unaccompanied children. The sample and data collected were not intended to be representative of or generalizable to the wider population of lawyers representing unaccompanied children in New York City.

The e-link to the survey contained a consent form completed by all participants prior to completing the study. Participation was anonymous and voluntary, and neither the recruitment process nor the survey itself required lawyers to provide identifying information about themselves, their clients, or their places of work. The study was approved by the Internal Review Boards of the New York State Psychiatric Institute and Teachers College, Columbia University. *Data Analysis:* Due to the descriptive nature of this study, the nature of the sample, and the types of questions asked, the data were primarily analyzed qualitatively. For questions with a selected-response format, frequency data were collected. These data were intended to be used descriptively, rather than for the purposes of quantitative analysis. They are summarized in Tables 1-5. Variations in the *n* reported in the tables relate to differences in response rate for different survey questions. In some cases lawyers provided reasons for omitting questions, including privacy concerns (e.g., “I can’t comment (case in progress)”) and lack of knowledge in a particular area (e.g., “no experience”). In other cases, the reasons for omissions were unclear. The frequency data collected were used to supplement the qualitative data provided by lawyers’ open-ended responses.

Results

Mental Health Difficulties Observed by Lawyers

The lawyers in this study were asked whether they had observed any behaviors, emotions, or thoughts in their last three unaccompanied child clients which had made them concerned about their mental health and, if so, to describe them. Respondents were asked to comment separately on each of these clients, regardless of whether they were referred for mental health services. Overall, lawyers reported concerning behaviors, thoughts, or emotions in about half of these youth.

Lawyers used a mixture of lay terminology (e.g., “frustration and sense of rejection,” “just hyper

anxiety,” difficulty sleeping,” “tearfulness,” “reports of stress”) and clinical terminology (e.g., “flat affect,” “depression,” “separation anxiety,” “delusional behaviors,” “schizophrenia”) to describe areas of concern. They noted a wide range of difficulties, including what appeared to be internalizing symptoms (e.g., “poor self-esteem,” “nightmares,” “seemingly despondent”) and externalizing symptoms (e.g., “behavioral problems,” “self-mutilation,” “suicide attempts”). In addition to apparent psychological symptoms, they also reported potentially psychosomatic symptoms (e.g., “sleepiness”) and contextual signs of distress (e.g., “poor school performance,” “difficulties with personal relationships”). In some cases, they identified specific psychological stressors, including traumatic stressors (e.g., “Client expressed trouble sleeping, nightmares, [and] memory problems that appear to be related to trauma suffered in his home country”), family stressors (e.g., “not fully dealt with suicide of mother,” “severe depression related to rape by a family member,” “resentment against father for physical and emotional abuse”), detention-related stressors (“frustration at having spent nine months in federal custody,” “anger at family members for not stepping up to get minor released from custody,” “sense of rejection due to family not coming through for reunification”), and court-related stressors (“unwillingness to discuss journey to the U.S.” and “startle reaction to question by immigration judge”).

In addition to the mental health concerns noted, several lawyers described resilience processes that appeared to protect children from developing psychological symptoms despite the psychosocial stressors they may have endured. Some lawyers described protective individual characteristics in clients (e.g., “this kid was... very grounded”). Others emphasized systemic factors contributing to resilience (e.g., “most of my [unaccompanied child clients] have family support in the U.S., though not the mother and father”).

Reasons for Referral

A little under half of the lawyers surveyed had referred unaccompanied child clients for mental health services. These lawyers were asked about the primary and other reasons for referral for the three most recent unaccompanied child clients they had referred to

mental health services (these are combined in Table 2).

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Table 2

Reasons for Mental Health Referral in Three Most Recent Unaccompanied Child Clients

Referred (N=25)	n ^a (/25)
<i>Reason</i>	
Behavior observed by lawyer	17
Expert testimony	16
Child self-reported difficulties	15
Interference with legal process	11
Behavior reported by third party	7
Child's request for help	3
Caretaker's request for help	1

^a n reflects total number of clients in whom this was a reason for referral (some lawyers reported multiple reasons for referring a single client)

In almost half of the referred cases lawyers described, their primary reason for referral was to obtain expert psychological testimony in support of their clients' legal cases. Commenting more generally on their attitudes towards diagnostic evaluations, half of the lawyers surveyed agreed that having a mental health diagnosis typically assists in acquiring immigration relief. Most of the lawyers in this study who had made mental health referrals indicated that the potential legal implications of having a mental health diagnosis had been a factor causing them to refer unaccompanied child clients. Several lawyers' comments suggested a complex and nuanced relationship between mental health diagnoses and immigration petitions. For example, one respondent mentioned that the influence of a mental health diagnosis on immigration proceedings “depends on the diagnosis; generally [it] helps more than [it] hurts,” while another suggested that a diagnosis's utility “depends on its relation to the claim being asserted.” However, none of the lawyers surveyed agreed that the potential legal implications of having a mental health diagnosis had caused them not to refer a client for mental health services. Among the lawyers surveyed who work for nonprofit legal service organizations that specialize in working

with unaccompanied children, all reported that they had referred clients to mental health services. Within this highly experienced subset of respondents, all agreed that having a mental health diagnosis generally assists in acquiring immigration relief and that this had influenced their decision to make referrals.

In many cases, lawyers referred for both expert testimony and ongoing psychological services. In almost half of the referral cases lawyers described, one reason for doing so was to assist with psychological difficulties affecting legal representation. One lawyer described a client's "unwillingness to discuss the journey to the U.S." Another lawyer described a client from whom, "we needed the expert testimony for the case; also, I was concerned that I (as a lay-person) was not getting the full story from my client; that she was glossing over events that a professional would have been better placed to uncover." The possible legal benefits of mental health assessment and treatment aside, lawyers also frequently referred children out of a more general concern for their wellbeing. One lawyer described being "deeply concerned about the [client's] self-mutilation." Commenting more generally, another lawyer suggested "I find that youth will self-medicate and this is extremely disconcerting for the long term health and stability of the child." Lawyers frequently described making referrals for a combination of legal and mental health reasons. For example, one lawyer described referring a client, "to help the kid's mental health and to help the case and document the abuse."

In the majority of cases where participating lawyers had referred one of their last three clients, they did so on the basis of concerning thoughts, feelings, or behaviors that they observed directly or that children reported to them. By contrast, a child or guardian's direct request for help was a factor in less than a quarter of the cases lawyers described. One lawyer described a case in which the "child seemed like they wanted to speak to someone and I thought that they should speak to a qualified person," alluding to the multiple needs lawyers may feel pulled to address. Some lawyers appeared to refer clients routinely as a form of mental health screening. One reported, "I would assume they need an evaluation," and another noted "I err on the side of referral... [there's]

no real downside to a single visit consultation."

Barriers in Obtaining Mental Health Services

Lawyers were also asked about barriers to accessing mental health services for the last three clients they had referred (see Table 3). In the great majority of these cases they encountered obstacles, and in almost half of the referral cases described, the clients ultimately did not receive services. The most commonly endorsed difficulties were cost of services, difficulty in finding services in the client's/caretaker's primary language, and distance/transportation issues. One lawyer described systemic issues in helping children to access affordable resources: "We need social workers to help children sign up for medical and education programs and get Medicaid so they can pay for mental health treatment; for depressed clients (many) or those who are not motivated or savvy with adult bureaucracies in the US (most all), getting to a therapist is difficult." Other lawyers indicated a more fundamental lack of appropriate resources. As one lawyer suggested, "there are virtually no Spanish speaking counselors." Another indicated, "I wish there were more free therapy sources that take Medicaid and where therapists speak Spanish." Several lawyers contrasted the availability of services when children are in detention versus out in the community. As one explained, "All of the detained children receive mental health services in the ORR [Office of Refugee Resettlement] custodial centers. Very few of the released children have access to these services."

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Table 3
Barriers to Mental Health Services Encountered in Three Most Recent Unaccompanied Child Clients Referred (N=25)

	<i>n</i> ^a (/25)
<i>Reason</i>	
Cost	18
Language	14
Distance/transport	11
Confidentiality concerns	1
No barriers	3

^a *n* reflects total number of clients for whom this was a barrier (some lawyers reported multiple barriers encountered by a single client)

Lawyers appeared to have particular difficulty finding ongoing treatment services as compared to expert testimony evaluations. One lawyer stated, "I only refer for expert testimony because I can only find therapists able to provide that type of service. There are no programs for on-going therapy/care." Another indicated, "If there was a program/clinic providing service, I would refer independent of the legal case need...Sadly, these programs do not exist." Faced with a lack of resources, some lawyers appeared to operate an informal triage system. One lawyer suggested, "I tend to only be able to get access to mental health services for the most high risk cases." Another commented, "I wish I could get counseling for all of the children I work with because many who do not openly express depression/anxiety are actually experiencing it." Almost half of the lawyers surveyed indicated that they would have referred more unaccompanied child clients if they had been aware of available mental health services. One lawyer stated, "If mental health services were more readily available, I would refer ever single client to services."

Several lawyers mentioned stigma attached to mental health difficulties and treatment as a barrier to accessing services. One lawyer described a client who was "currently resisting assistance." Another reported, "One of the greatest challenges in working with youth is their reluctance to engage in treatment because of socio-cultural factors." Caregivers' attitudes towards mental health issues may also pose a barrier to service access. One lawyer "did not press for follow up treatment because I believed the [caregivers] were not engaged and would not take follow up steps." Mental health stigma was not the only source of reluctance to engage in treatment. For example, one lawyer cited a client's "mistrust of systemic actors" as a barrier to obtaining services.

Mental Health Services Received

Lawyers were asked about the types of mental health services to which they had referred unaccompanied children (see Table 4). Private practice and community service/nonprofit organizations were the most common types of referrals. None of the lawyers surveyed had ever referred clients to the emergency room. Lawyers had mixed feelings regarding

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Table 4
Types of Mental Health Services to which Lawyers Have Referred Unaccompanied Child Clients (N=14)

Service Type	n ^a (/14)
Private practice	10
Community service/NPO organization	7
Primary care provider	2
Student mental health clinic	2
Faith-based organization	1
Support group	1
Emergency room	0

^a n reflects total number of lawyers who referred to this type of service (some lawyers reported making multiple types of referral)

the effectiveness of the services to which they had referred their clients. Approximately half of the participating lawyers agreed that when they had referred unaccompanied child clients for mental health services it had been beneficial to them. Concerns were raised about the mandated mental health services provided to children detained in government-sponsored facilities, however. One lawyer explained, "Although detained minors ostensibly have access to mental health services in the shelters, there are real concerns about [the] confidentiality of those services, as well as whether the services are sufficiently rigorous to meet the needs of unaccompanied children."

Lawyers' Mental Health Knowledge/Training

Lawyers were asked to comment on their mental health knowledge and training. Approximately half did not feel confident in their ability to identify mental health problems in their clients or confident knowing when to refer clients. One lawyer stated succinctly, "I am not a mental health professional, so [it's] difficult to know when to refer." Most of the lawyers surveyed did not know where to refer clients. Among the lawyers surveyed who worked in programs in nonprofit organizations specializing in representation of unaccompanied children, all but one had received training in mental health issues related to working with unaccompanied children (and

in this subset of respondents, all but one felt confident in their ability to identify mental health problems in their clients and in knowing when to refer). By contrast, among the larger subset of corporate lawyers representing unaccompanied children pro bono, only one had received such training. Describing a previous case, one such lawyer commented, "As a new practitioner in removal defense, at the time I wasn't aware of the possibility or need of referring; and only one such behavior was exhibited, so I felt it was not a major issue. I might act differently now." Another lawyer implied that lack of awareness about psychological issues is a systemic problem: "Probably the immigration bar generally needs to be better informed about health issues concerning unaccompanied minor clients and relevant resources."

The great majority of the lawyers surveyed agreed that it was within the scope of their role as lawyers to recommend mental health services for clients. All but two indicated that they would be interested in receiving further training. The most popular suggestions for future training were methods for interviewing unaccompanied children with a traumatic history, recognizing common mental disorder symptoms, and means of accessing mental health resources (see Table 5).

mental health, and suggest that the overall standpoint for understanding these children should be primarily psychological rather than legal (i.e., seeing them first and foremost as youth with specific developmental needs, not as "unaccompanied alien children"). The lawyers in this study find themselves in precisely this predicament, moving between legal and psychological responsibilities, addressing children's mental health in both a legal context (e.g., requesting expert testimony to support clients' immigration claims) and a psychological one (e.g., requesting treatment for clients' emotional and behavioral concerns).

Given the legal context, one might imagine that lawyers would be primed to identify mental health difficulties such as anxiety, depression, and traumatic stress that could be seen as evidence of prior abuse and so might lend support to legal claims and bolster a case that a child needs further protections in the United States. Similarly, one might anticipate that lawyers would less readily identify problematic behaviors that could present a negative impression of their clients in court. However, lawyers in this survey reported a wide range of symptoms in their clients, including some that might potentially be viewed less favorably, such as "anger and resentment," "self-medication by drinking," and "out of control teenage behavioral problems." The range of mental health and behavioral problems noted by the lawyers in the survey mirrored symptoms found in previous studies with unaccompanied and other vulnerable immigrant children, including anxiety symptoms (Derluyn & Broekaert, 2007; Fazel & Stein, 2002; Silove & Steel, 1998; Sourander, 1998), depression (Derluyn & Broekaert, 2007; Fazel & Stein, 2002; Hodes et al., 2008; Silove & Steel, 1998), sadness (Fazel & Stein, 2002; Silove & Steel, 1998; Sourander, 1998), withdrawal (Ajdukovic & Ajdukovic, 1998; Fazel & Stein, 2002; Silove & Steel, 1998), tearfulness (Ajdukovic & Ajdukovic, 1998), loss of interest (Fazel & Stein, 2002; Silove & Steel, 1998), sleep disturbances (Fazel & Stein, 2002; Silove & Steel, 1998), nightmares (Ajdukovic & Ajdukovic, 1998; Fazel & Stein, 2002; Silove & Steel, 1998), concentration problems (Ajdukovic & Ajdukovic, 1998; Fazel & Stein, 2002; Silove & Steel, 1998; Sourander, 1998), hyperarousal (Fazel & Stein, 2002; Silove & Steel, 1998), psychosis

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Table 5

Areas for Future Mental Health Training with Lawyers (N=19)

Topic	n ^a (/19)
Interviewing unaccompanied children with trauma histories	16
Recognizing symptoms of common mental disorders	14
Means of accessing mental health resources	13
Encouraging unaccompanied child clients to follow-up on referrals	10
Presenting mental health concerns to children and their families	7

^a n reflects total number of lawyers who expressed interest in this type of training (some lawyers reported interest in multiple topics)

Discussion

Derluyn and Broekaert (2008) describe how differing legal and psychological perspectives on unaccompanied children may lead to neglect of their

(Hodes & Tolmac, 2005), suicidality (Silove & Steel, 1998), and behavioral problems (Ajdukovic & Ajdukovic, 1998; Fazel & Stein, 2002; Sourander, 1998).

The overlap between legal and mental health concerns was most apparent in the context of referrals. Among the referral cases lawyers described expert testimony was the most commonly cited primary reason for referral, and most of the lawyers who had made referrals suggested that the possible legal benefits of a mental health diagnosis had factored into their decision to do so. However, the potential for clients' psychological difficulties to have an impact on legal proceedings extends beyond giving expert testimony and providing mental health diagnoses. For example, posttraumatic stress can affect refugee petitioners' ability to testify and the content of their testimonies (Rousseau, Crépeau, Foxen, & Houle, 2002). In this study, lawyers described enlisting mental health professionals to support children in disclosing traumatic histories that were important to their cases but that they might otherwise have been unable to report. Similarly, some lawyers referred children to help them combat posttraumatic symptoms associated with appearing in court. The contrast between legal and psychological perspectives on unaccompanied children can create the impression that it is impossible to balance the two. However, lawyers in this survey frequently expressed great concern for their clients' well-being, over and above any potential relevance of the child's psychological presentation to their immigration cases. Likewise, in their great majority, the lawyers surveyed suggested that advocating for their clients' mental health needs was part of their role.

The surveyed lawyers' difficulty in accessing appropriate services for their clients was one of the most salient findings of the survey. The main barriers to care that lawyers described were similar to those commonly described in previous studies assessing access to mental health services for unaccompanied refugee children and adolescents in Europe (Derluyn & Broekaert, 2008). Although, for reasons of confidentiality, the survey did not include any questions about clients' ethnicity, most unaccompanied children are from Latin America (Byrne & Miller, 2012) and barriers to care lawyers reported were similar to those described elsewhere in the literature on Latino mental

health care access (e.g., Aguilar-Gaxiola, Loera, Méndez, & Sala, 2012): lack of affordable options, lack of local resources, and language difficulties. These same factors of course hinder service access for immigrants from many parts of the world (APA, 2012).

Some lawyers surveyed also cited stigma towards mental health issues and clients' wariness of treatment seeking as barriers to care, again mirroring the wider literature on immigrant mental health service utilization (e.g., Ishikawa, Caedemil, & Falmagne, 2010; Sue, Fujino, Hu, Li-Tze, & Takeuchi, 1991). In Latino immigrants, reluctance to seek mental health assistance has been linked to cultural values such as *marianismo*, which encourages females to be self-sacrificing and not to talk about personal problems, and *machismo*, which encourages males to show strength and not to demonstrate vulnerability (Workgroup on Adapting Latino Services [WALS], 2008). In addition, unaccompanied children often live in communities in which many people are undocumented and there is a culture of mistrust towards professional institutions, and this may dissuade them from seeking mental health services (Aguilar-Gaxiola et al., 2012; ter Kuile, Rousseau, Munoz, Nadeau, & Ouimet, 2007; WALS, 2008). However, further research is required to understand how these and other factors influence treatment-seeking in this socio-culturally diverse population of youth.

Future Directions

Although this is small study with a convenience sample, the responses of the lawyers surveyed are suggestive of a need for more systematic identification of unaccompanied children in need of mental health services, more comprehensive and cohesive referral pathways, and greater availability of services appropriate to their needs.

With few exceptions, the lawyers surveyed were the only source of referral for their unaccompanied child clients. Lawyers may represent one potential pathway into services, and training should be provided to support them in this role. However, in order to provide a more comprehensive approach to meeting unaccompanied children's needs, other mental health care pathways for unaccompanied children should be developed, such as schools (Hodes et al.,

2008; Kataoka et al., 2003) and primary health care clinics (Rousseau, Measham, & Nadeau, 2013). As several of the lawyers surveyed noted, the only unaccompanied children who routinely receive mental health services are those mandated to do so because they are detained in government-sponsored detention facilities (Women's Refugee Commission, 2009). The fact that provision of services is determined more by children's custodial status than their particular mental health needs is, as Derluyn and Broekaert (2008) note, a clear example of the favoring of a legal over a psychological framework for their care.

The lawyers surveyed consistently voiced the need to increase the availability of appropriate and feasible mental health services for their unaccompanied child clients. The fact that more respondents had referred clients to private practitioners than to other types of mental health care that more typically serve immigrant communities, such as community-based service organizations (WALS, 2008), speaks to the lack of programming currently available to unaccompanied children and, presumably, other undocumented immigrant youth. In the absence of such services, lawyers may look to private practitioners to provide services on an occasional, pro bono basis. However, this type of provider is unlikely to be able to respond to a high service demand, or to lead to the development of specialized mental health programming for unaccompanied children. When surveyed lawyers were successful in finding care for their clients, they had mixed opinions regarding the effectiveness of the services they accessed. In particular, several respondents' comments echoed concerns raised in previous studies about the consistency (United States Department of Health and Human Services, 2008) and confidentiality (Byrne, 2008) of the services provided to detained unaccompanied children.

Taken together, the surveyed lawyers' comments suggest a need for an improved mental health infrastructure for unaccompanied children. Such an approach might include aspects of the child advocacy center (CAC) model for victims of abuse, which emphasizes the coordination of investigation and intervention services (e.g., law enforcement, child protective services, prosecution, victim advocacy, medical care, and mental health services) to care for

children and minimize the number of times they have to retell their stories. The CAC model has been shown to improve the effectiveness and efficiency of responding to child abuse cases while reducing harm and discomfort to children and their families (e.g., Smith, Witte, & Fricker-Elhair, 2006; Jones, Cross, Walsh, & Simone, 2007). Community collaborative care models, whereby mental health providers with specialized cultural expertise in the patient population work with other providers (e.g., primary care and social service professionals) to offer sensitive care to vulnerable children and families, have also been proposed as a way of addressing the challenges faced in delivering psychological services to immigrant and refugee children (Rousseau et al., 2013).

Expanding mental health training for lawyers should be prioritized as an important part of any integrated program of services for unaccompanied children. Almost all of the lawyers surveyed indicated that they would be interested in further training in mental health considerations when working with unaccompanied children. The large percentage of lawyers who represent unaccompanied youth on an occasional pro bono basis (as opposed to working for a nonprofit organization specializing in work with this population) may benefit particularly from mental health education: this subset of respondents was less likely to have received mental health training, had represented fewer unaccompanied clients, expressed less confidence in identifying these clients' mental health needs and knowing when to refer, and appeared less aware of the possible benefits of mental health assessment and treatment for their clients' legal cases. Future training should, as respondents suggested, include areas such as identifying common psychiatric symptoms in children, interviewing traumatized children, and facilitating mental health referrals. Regardless of the topic area, training should be framed within a child-centered perspective, that takes into account children's needs, experiences, and developmental (i.e., physical, cognitive, social) processes (Nugent, 2006; Steinberg, Woodhouse, & Cowan, 2002).

Developments in programming for unaccompanied children and the professionals who serve them should go hand in hand with research examining the mental health needs of these youth. The meth-

odology used in this study (combining outreach via legal organizations and snowball sampling) provided an anonymous and confidential format through which respondents could ethically disclose sensitive and informative details about their cases. The detailed qualitative data provided by respondents suggest that unaccompanied children are a population with complex and frequently unmet psychological needs. Further study should investigate children's psychological needs directly (i.e., through interviews with children and their caregivers). This research should seek to examine risk and resilience processes in this population, and differences in experiences and need between different subsets of unaccompanied children (e.g., youth living in detention versus in the community). Research should also investigate the feasibility of different pathways into care (e.g., via primary care, schools, and child welfare services) and different models of service provision. Wherever possible, research and programming should seek to enhance a psychological perspective and to identify unaccompanied children's individual differences, as opposed to their common legal status and predicament (Henderson, Baily, & Weine, 2010). Finally, future research and programming should place a strong emphasis on children's strengths and protective factors, in addition to the challenges they face.

Limitations

This study had a small number of respondents. Due to the recruitment procedure, it was not possible to ascertain the survey response rate or how representative the participants were of the general population of lawyers serving this population. Of particular relevance for this study, lawyers who chose to participate may have been more invested in mental health referrals and may have been more likely to have observed mental health problems in their unaccompanied child clients than lawyers who chose not to. Differential response rates for different survey questions may have created additional bias. Furthermore, a survey may not provide the best format in which to inquire about certain sensitive questions, such as the potential legal benefits of a mental health diagnosis. All of these factors limit the generalizability of the findings.

New Contribution to the Literature

This is, to the authors' knowledge, the first study to investigate the mental health needs of immigrant youth from lawyers' perspectives. It is intended as a first step in research to help address the gap in the literature on the psychological needs of unaccompanied children in the United States. It is also intended to inform psychoeducational interventions for lawyers working with unaccompanied children. The long-term goal of this research is to contribute to the development of feasible, appropriate, effective, and sustainable mental health assessment and treatment services for this underserved population.

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