

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

March 2019



In partnership with:



Author: Chanel M. Marin, MPH and Brett Stark, Esq.
Funded by a private foundation that prefers to work anonymously.

Table of Contents

OUR MISSION	2	CONCLUSION	37
LETTER FROM THE CO-FOUNDERS	3	Study limitations	37
TABLES AND FIGURES	4	Future areas of research	37
ABBREVIATIONS	5	ANNEXES	38
EXECUTIVE SUMMARY	6	Annex 1: Methodology	38
INTRODUCTION	8	Annex 2: TF Direct Program Partners ..	38
CONTEXT — BACKGROUND AND NEEDS OF TARGET POPULATION	10	Annex 3: TF Indirect Referral Partners ..	39
Migration	10	Annex 4: TF Full Program Theory of Change	41
Needs in Greater New York	11	Annex 5: Legal Theory of Change	43
FINDINGS	12	Annex 6: Mental Health Theory of Change	44
I. Theory of change	12	Annex 7: Medical Theory of Change ...	45
II. Model of care	12	Annex 8: Social Theory of Change	46
III. Program inputs	14	Annex 9: Advocacy Theory of Change ..	47
IV. Program activities	17	Annex 10: Interdisciplinary Models Adapted by TF	48
V. Implementation	28	Annex 11: Acknowledgements	49
VI. Assumptions of the model	31	Annex 13: Works cited	50
VII. Anticipated outcomes	32		
LESSONS LEARNED — CONSIDERATIONS FOR REPLICATION	33		
Strengths of operational environment ...	34		
Considerations and recommendations ..	34		

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 perseverance 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 Muñoz de la Peña, PhD
Terra Firma co-founders

Tables and Figures

Table 1: Immigrant Youth Clinic schedule.....	15	Figure 1: FGD mind mapping exercise with UICs	8
Table 2: Strengths of TF structure	16	Figure 2: Map of the Northern Triangle ..	10
Table 3: TF target population	17	Figure 3: Results of mind mapping exercise with UICs	13
Table 4: Available forms of legal relief... ..	18	Figure 4: CBP-reported border apprehensions by fiscal year ..	18
Table 5: Legal activities.....	19	Figure 5: Proportion of UICs and AWCs without legal representation ordered removed in 2014	19
Table 6: Mental health activities	20	Figure 6: Terra Firma graduate	23
Table 7: Medical activities	22	Figure 7: TF participants involved in ICP's photography workshop	26
Table 8: Social needs of UICs and AWCs.....	24	Photo — Final Presentation of TF-ICP Photography Workshop, New York, New York © Terra Firma	
Table 9: Case management activities... ..	25		
Table 10: Enrichment activities.....	25		
Table 11: Advocacy activities	27		
Table 12: Causal assumptions underlying TF theory of change	31		
Table 13: System-level considerations and recommendations	33		
Table 14: Structural-level considerations and recommendations	34		
Table 15: Model-level considerations and recommendations	35		
Table 16: Implementation-level considerations and recommendations	35		

Abbreviations

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

Executive summary

Introduction

Terra Firma (TF) was co-founded by Catholic Charities of New York (CCNY), the Children's Hospital at Montefiore (CHM), and the Children's Health Fund (CHF) in September 2013. TF is a medical-legal partnership (MLP) within a patient-centered medical home (PCMH) that provides free, bilingual, culturally-sensitive, trauma-sensitive, and co-located medical, mental health, legal, and social services to unaccompanied immigrant children (UICs), immigrant adults with children (AWCs), children of AWCs (CoAWCs), and sponsors of UICs ("sponsors") in the South Bronx, New York, U.S.

An external consultant to conduct the first evaluation of TF in early 2018. This is the first published evaluation of a joint MLP and PCMH for UICs and is based on findings from secondary data review; 44 key informant interviews (KIIs) with TF administrators, referral partners, and providers; and focus group discussions (FGDs) and KIIs with 18 TF participants. The report details key findings of a program theory assessment to understand how TF facilitates service provision for UICs and AWCs, and a process evaluation examining details of program implementation and direct stakeholder perspectives.

Contextual background

TF was developed as a direct response to seven identified challenges for UICs in the Greater New York area: (1) difficulty prioritizing primary health, mental health care, or legal obligations over basic needs; (2) challenges meeting basic needs without immigration status; (3) difficulty securing legal representation; (4) challenges meeting legal obligations due to policy, health-system, and individual-level access barriers to medical and mental health care; (5) lack of knowledge among UICs about legal, medical, and mental health care; (6) lack of knowledge among stakeholders about UICs; and (7) provision of fragmented services across providers for UICs.

Evaluation findings

Theory of change – response to identified need

TF's theory of change examines TF's response to identified needs by outlining the assumptions underlying how program inputs, activities, and outputs contribute to desired program outcomes.

Model of care

TF is an MLP incorporated into a PCMH, providing interdisciplinary services in one location to reduce fragmented service provision.

- **Model-level strengths** The provision of holistic, wraparound programming; community-building for UICs and AWCs; co-location of medical, mental health, legal, and social services; client tracking for a population that is difficult to monitor; focus on the family unit; increased advocacy for the UIC population; provision of a PCMH; child-centered approach to care; location near TF's target population; therapeutic alliance between medical and mental health providers supporting disclosure of trauma; treatment of medical and mental health conditions to facilitate adherence to legal obligations; and support for UICs to testify in court.

Inputs and structure

TF is structured as a partnership between medical partner, CHM, and legal partner, CCNY and receives funding through a combination of medical insurance and grants. TF's core program is delivered through a weekly Immigrant Youth Clinic on Wednesdays with follow up services streamlined into regular service hours.

- **Structural-level strengths** Incorporation into CCNY provides institutional support, a strong internal referral network, and benefits for CCNY. Incorporation into CHM provides ongoing institutional support and benefits for CHM.

Activities

TF implements a total of 35 direct service and five education and advocacy activities. TF's target population for direct services are UICs, AWCs, CoAWCs, and sponsors and for education and advocacy are TF staff, referral partners, policy makers, and immigration officials.

Implementation

- **Implementation-level strengths** Staff commitment, responsiveness, and knowledge about the population; strong staff-client relationships, language and cultural proficiency of staff, and participant buy-in; provision of dignified support; flexible but clear boundaries; and an ability to engage youth in mental health services and address trauma.

Anticipated outcomes

Direct service provision TF's direct service activities are expected to increase access to care, increase knowledge about services, and increase service utilization among UICs and AWCs in the short-term (0-6 months). In the mid-term (7 months – 1 year), increased service utilization is expected to improve medical and mental health outcomes; improve UICs and AWCs relationships with others; help UICs and AWCs develop a sense of community; and improve behaviors among UICs and AWCs.

Advocacy and education TF's advocacy and education activities are expected to increase knowledge about UICs; increase the likelihood of service provision; increase interdisciplinary coordination of care; and increase trust of UICs among stakeholders in the short-term (0 – 6 months). In the mid-term (7 months – 1 year), this is expected to increase the likelihood that stakeholders advocate for UICs and AWCs; improve the quality, coordination, comprehensiveness, and continuity of care; and increase the likelihood of approved immigration petitions.

The long-term (13 months – 5 years) objective of all TF activities are legal status acquisition and the development of a PCMH for UICs and AWCs, which is expected to contribute to improved stability, resilience, and ability for UICs and AWCs to reach their full potential.

Lessons learned

System-level strengths Operation in a progressive state within a sanctuary city with a strong public transportation system.

Considerations for replication

System-level Immigration policy changes and current U.S. administration; high quantity and level of need among target population; high demand for mental health services; increase in cases with histories of sexual violence; and health care system challenges.

Structural-level Location of legal team and administrative challenges related to incorporation into a hospital system.

Model-level Increased administrative work; challenges related to adolescent population; secondary trauma among staff; information-sharing practices across sectors.

Implementation-level Facetime within and across providers; time allocation for non-clinical services; confidentiality; time constraints related to needs of target population; and coordination with external providers.

Recommendations for replication

System-level (1) provide legal education to the target population; (2) provide strong enrichment (including academic support) services; (3) invest in a high quantity of mental health staff; and (4) ensure incorporation of female staff onto teams.

Structural-level (1) co-locate legal services on a part or full-time basis and (2) strengthen partnerships within the hospital system.

Model-level (1) hire two program coordinators; (2) manage adolescent populations with stronger disciplinary structures, more support staff, or an ancillary adolescent safe space; and (3) establish self-care processes to reduce vicarious trauma among staff.

Implementation-level (1) standardize intake processes, internal referral mechanisms, and information-sharing processes within and across sectors (including external legal providers); (2) formalize opportunities for collaboration within and across sectors; (3) provide protected administrative and advocacy time for staff; (4) strengthen enrichment partnerships at project onset; and (5) develop formal confidentiality practices.

Introduction

UICs are children who enter the U.S. under the age of 18, lack immigration status, and have no parent or legal guardian to care for them in the U.S.¹ The vast majority of UICs in the U.S. travel from El Salvador, Guatemala, and Honduras (collectively referred to as the “Northern Triangle”). UICs are among the most vulnerable populations in the country, having faced violence in their home countries, risked a dangerous migratory route, and facing numerous challenges upon resettlement².

Recognizing the unique needs and vulnerabilities of this population, TF was co-founded by CCNY, CHM, and CHF in September 2013 as an MLP incorporated into a PCMH. TF provides free, bilingual, culturally-sensitive, trauma-sensitive, and co-located medical, mental health, legal, and social services to UICs released from the Office of Refugee Resettlement (ORR) and to a limited extent, sponsors. The development of TF was timely, as 2014 saw a large influx of UICs and AWCs from the Northern Triangle seeking refuge from endemic gang violence³. TF expanded services to include AWCs and their children in February 2016.

As the only MLP incorporated into a PCMH specifically for UICs, TF is in a position to assess the success of its programming, reflect on lessons learned, and share best practices for replication efforts. In early 2018, a private donor funding TF’s legal and case management services for the past three years funded an external consultant to conduct the first process evaluation of TF. The evaluation is based on secondary data review; 44 KIIs with TF administrators, referral partners, and providers; and FGDs and KIIs with 18 TF participants (Figure 1) (for more information on methodology, please see Annex 1). The following evaluation report details the findings of a program theory assessment to understand how TF facilitates integrated service provision for UICs and AWCs, and a process evaluation focused on examining program implementation and direct stakeholder perspectives of the program.

Figure 1: FGD mind mapping exercise with UICs



Program theory assessment The objective of the program theory assessment was to develop a theory of change examining how overall program inputs, activities, and outputs contributed to desired program outcomes. Understanding causal assumptions between program activities and desired outcomes will allow TF to develop outcome evaluation indicators and to adjust programming to meet stated objectives. The assessment sought to answer the following research questions:

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

Process evaluation The objective of the process evaluation was to examine program delivery processes such as program inputs, staff training, client flow, and activity implementation; explore program process measures such as service coordination, efficiency, strengths, and challenges; and understand quality and effectiveness from the perception of individuals with the greatest level of involvement with the program⁴ (i.e. TF providers, referral partners, and participants). The process evaluation sought to answer the following research questions:

- What resources have CHM and CCNY invested into TF?
- How were program activities intended to be delivered? How are activities actually delivered? How do clients flow through the program?
- What are providers' and referral partners' opinions of the program in terms of service coordination, strengths, challenges, and effectiveness?
- What are participants' opinions of the program in terms of relevance, satisfaction, quality, strengths, and challenges?

Stakeholders The core audiences requesting this evaluation are CCNY, the primary on-site legal provider within TF, and an anonymous private foundation. Additional interested parties include CHM (the medical and mental health providers within TF), additional supporters (CHF), clients (UICs, AWCs, sponsors,

and CoAWCs), direct program partners (Annex 2), indirect service providers interacting with the TF client base (Annex 3), and organizations interested in implementing similar models across the country and internationally.

The following report provides a brief contextual background on migration of UICs to the U.S. and their multisector needs in New York. This is followed by a breakdown of the program theory of change, which examines TF's model of care, program inputs (structure, funding, staffing, space and resources) and activity implementation. Following this, the report provides the rationale behind how the program is expected to work (assumptions and anticipated outcomes). The report subsequently highlights considerations and recommendations for organizations considering replication, before concluding with study limitations and recommendations for future areas of research.

Context — background and needs of target population

Migration

The migration process for UICs and AWCs can be viewed as a series of phases involving premigration, transit, temporary resettlement, and permanent resettlement, each with a unique set of risk factors⁵.

Premigration The countries composing the Northern Triangle (Figure 1) have consistently ranked among the most violent countries in the world due to the growth of criminal gangs, drug trafficking, weak rule of law, and political corruption⁶. As a result of this violence, UICs and AWCs are likely to have experienced trauma including threats, persecution, and gang violence. In addition to increased exposure to violence, UICs and AWCs are exposed to infectious diseases related to poverty in their home countries.

Transit UICs and AWCs who flee the Northern Triangle brave dangerous conditions to travel to the U.S., risking exposure to gang violence, physical and sexual abuse, and physical injury⁷. The transit route also exposes migrants to infectious diseases including scabies, lice, rashes, respiratory infections, and diarrhea⁸.

Temporary resettlement UICs either enter the U.S. “undetected” by immigration authorities and live as undocumented immigrants or are apprehended (“detected”) by immigration authorities on suspicion of violating immigration law. These apprehensions typically occur at the southern border of the U.S. and are carried out by U.S. Customs and Border Protection (CBP). Other apprehensions occur internally throughout the U.S. and are carried out by U.S. Immigration and Customs Enforcement (ICE). Following apprehension, UICs are transferred to the Department of Homeland Security

Figure 2: Map of the Northern Triangle



(DHS), and are placed under the care and custody of ORR, within the Department of Unaccompanied Children’s Services (DUCS). From ORR, UICs are often reunified with a sponsor. Both during ORR custody and after release to a sponsor, UICs must attend immigration court hearings during which DHS seeks the children’s removal (“deportation”)⁹. Detention can cause a variety of psychosocial stressors for UICs¹⁰.

Permanent resettlement UICs and AWCs who resettle in the U.S. struggle to meet basic survival needs (e.g. food, shelter, healthcare, education) and acculturate to life in a new country. Reunification with family members can cause interpersonal tension because relatives may not know the children or anticipate their arrival and may not be able to emotionally or financially provide for them¹¹. Youth are often resettled in low-income communities where they face continued exposure to risks associated with poverty, including community violence¹².

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 UICs (and subsequently 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 staff¹³.
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 insurance¹⁴;
 - 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)¹⁵;
- 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 communities¹⁶. Additionally, undocumented immigrants lack the financial means to pay for services; experience communication challenges with clinic staff; lack knowledge and experience navigating health care systems¹⁷; 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. Theory of change

TF's theory of change (Annex 4) explains how overall program inputs, activities, and outputs contribute to desired short, medium, and long-term outcomes, and delineates the assumptions underlying why the program is expected to

work. For more detailed information about the theories of change within each sector, please see the legal (Annex 5), mental health (Annex 6), medical (Annex 7), social service (Annex 8), and advocacy (Annex 9) theories of change.

II. Model of care

TF is an MLP incorporated into a 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 health¹⁸. A PCMH is a centralized source of care and medical record for children with unique health needs to reduce fragmented service provision¹⁹. TF is currently the only MLP incorporated into a PCMH focused on serving UICs. 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 systems²⁰. TF adds elements of two additional models of care to their program: integrated primary care models and wraparound models (for more information on these models of care, please see Annex 10).

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.

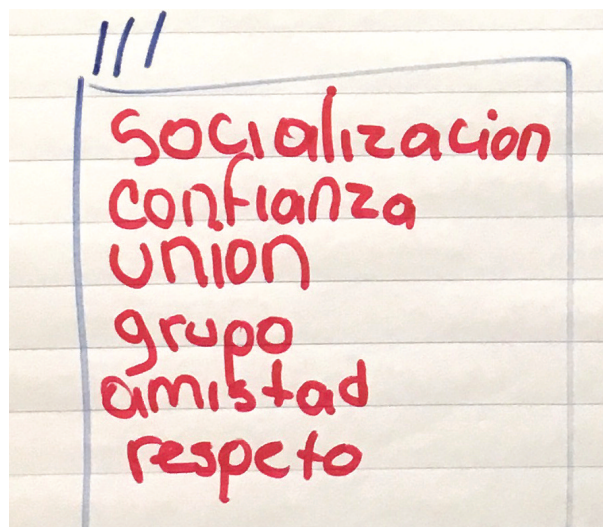
“Children can either seek [community] in the streets or they can find it within a safe and structured environment.”

— 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 3).

Figure 3: 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.

III. Program inputs

Structure

TF is structured as a partnership between medical partner, CHM, and legal partner, CCNY, rather than a standalone non-profit organization.

Medical partners The Community Pediatric Program (CPP) is a PCMH and a Federally Qualified Health Center (FQHC) cluster affiliated with CHM providing health care to homeless and underinsured families in New York City through three outpatient health centers: the New York Children's Health Project (NYCHP) serving homeless families, the South Bronx Health Center serving adults, and the Center for Child Health and Resiliency (CCHR) serving children under 21. TF is considered a program of CPP. As such, medical and mental health services for TF patients are absorbed into CPP's general medical care.

Legal partners The Unaccompanied Minors Program (UMP) is a program within CCNY's Immigration Legal Services department providing legal screenings, legal representation, and legal rights presentations to children released from New York shelters and in removal proceedings; soccer programming for UICs (through La Union); and legal support to TF. CCNY provides two full time equivalent (FTE) staff members to TF, an attorney and case manager, and provides additional legal representation. To better serve the expanding UIC population in the Greater New York area, TF has expanded the MLP model to include additional off-site legal providers who refer cases to TF for medical and mental health care.

Staffing

TF does not currently have dedicated full-time staff, utilizing instead an estimated five FTEs and a proportion of time from a total of 16 additional medical, mental health, legal, and social service providers and volunteers (Annex 11):

- Medical Director;
- Mental Health Director;
- Legal Director;
- Medical Program Coordinator; and
- Case Manager.

Space and resources

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.

Strengths of TF structure

TF’s structure as a program within two larger institutions rather than a standalone non-profit organization has provided mutual benefits to TF and both institutions (Table 2).

“TF could not operate without the health center infrastructure [provided by CHM].” — TF provider

Table 2: Strengths of TF structure

Incorporation into legal organization (CCNY)	Incorporation into health organization (CHM)
<p>Institutional support at project onset TF benefitted from CCNY’s infrastructure and organizational history, immigration expertise, and reputation upon founding in September 2013.</p> <p>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.</p>	<p>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.</p>

IV. Program activities

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)²¹. TF's target population for these services are described below (Table 3).

Target population

Table 3: TF target population

Type of service	Target population
Direct service provision (September 2013)	<p>UICs: immigrants who entered the U.S. under the age of 18 without a parent or legal guardian and resettled alone or with a sponsor in New York City.</p> <p>Sponsors (as a support structure for UICs): adults, typically family members, to whom UICs are released from federal immigration detention.</p> <p>Others: word-of-mouth referrals who arrive to the Immigrant Youth Clinic for legal screenings and referrals.</p>
Direct service provision (February 2016)	<p>AWCs: recently arrived women with children seeking asylum or other forms of relief in the U.S.</p> <p>CoAWCs: children of AWCs.</p>
Education/advocacy (September 2013)	<p>CCNY and CHM staff: as recipients of MLP training for the direct service target population.</p> <p>Referral partners: direct partners (organizations with whom TF has formal partnerships) (Annex 2) and indirect providers (organizations that serve UIC and immigrant populations with whom TF does not have formal partnerships) (Annex 3).</p> <p>Policy makers: advocacy organizations and United Nations bodies (e.g. UNICEF, UNHCR).</p> <p>Immigration officials: as the recipients of affidavits and letters of support and decision makers for legal relief.</p>

TF initiated in September 2013 with a total of 22 proposed activities across four direct service sectors (legal, mental health, medical, and social)²². 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.

Legal needs and activities

Needs

To obtain legal status in the U.S., UICs must apply for legal relief with United States Citizenship and Immigration Services (USCIS), DHS, or the Executive Office of Immigration Review

(EOIR) within the Department of Justice (DOJ). Below are some of the most common forms of immigration relief available to UICs and AWCs (Table 4).

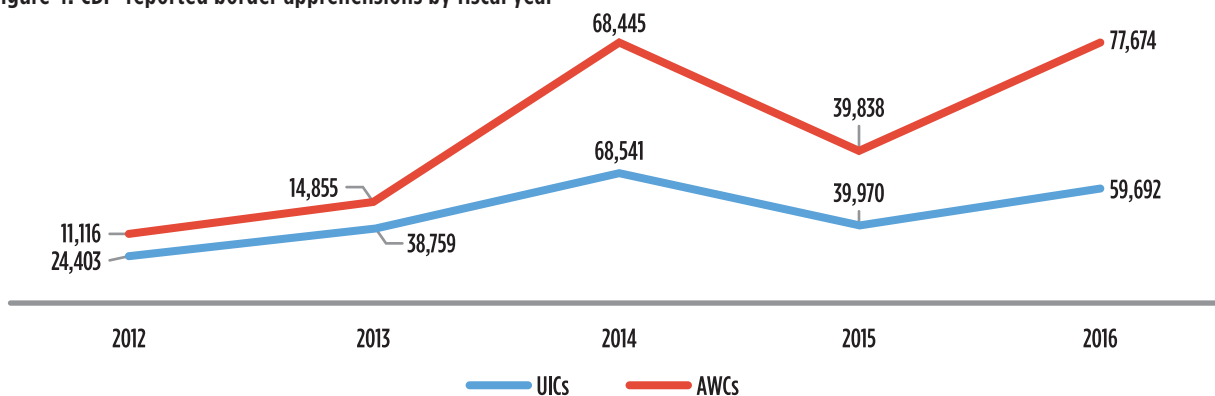
Table 4: Available forms of legal relief²³

Legal relief	Description
Asylum	Available for immigrants who are, inter alia, unable or unwilling to return to their home country for fear of persecution based on race, religion, nationality, political opinion, or social group ²⁴ .
Special immigrant juvenile status (SIJS)	Available for immigrant children who, inter alia, have been abused, abandoned, or neglected by one or both parents ²⁵ .
U-visa	Available for immigrants who have, inter alia, suffered “substantial physical or mental abuse” for being victim to a crime in the U.S. ²⁶ .
T-visa	Available for immigrants who, inter alia, can prove they have been victims of a “severe form of human trafficking” ²⁷ .
Family-based petitions	Available to immigrants who, inter alia, are the immediate relatives of a U.S. citizen or have specified relationships with a lawful permanent resident (LPR) ²⁸ .

Eligibility for relief Many UICs and AWCs have viable claims for legal status in the U.S. The Vera Institute of Justice found that 40% of UICs in custody were eligible for some kind of immigration relief in 2010²⁹. It is likely that a similarly large proportion of AWCs applying for asylum have viable claims for legal status, as 68% of credible fear interviews for asylum in 2015 were deemed positive³⁰.

Access to legal representation Adult immigrants are not entitled to court-appointed legal representation. Although two

federal provisions require that UICs in custody have legal counsel, this must be provided at no government cost³¹, leading most UICs to remain unrepresented. While the number of UICs and AWCs apprehended annually in the U.S. has increased since 2012 (Figure 4), the availability of immigration attorneys has not increased to meet this demand³². As a result, only 55% of UICs³³ and 63% of AWCs³⁴ in removal proceedings secured legal counsel from fiscal years 2014 to 2017.

Figure 4: CBP-reported border apprehensions by fiscal year

Source: US CBP. (2018). U.S. Border Patrol Southwest Border Apprehensions by Sector FY2018

Challenges without legal representation Access to legal representation impacts the likelihood of removal. In 2014, 74% of UICs without legal representation were ordered removed compared to 8% with legal representation³⁵ (Figure 5). Among AWCs, 86% without legal representation were ordered removed compared to 26% with legal representation³⁶ (Figure 5). Without a right to a court-appointed lawyer at government expense (i.e. a public defender), UICs and AWCs must defend

themselves alone against trained government lawyers in court. They are required to testify under oath, plead to government charges, inform the judge of the type of immigration relief they seek, file applications for relief, present evidence and call witnesses to prove their case³⁷. Additionally, because most UICs and AWCs do not speak English, this must often be completed through an interpreter.

Figure 5: Proportion of UICs and AWCs without legal representation ordered removed in 2014

Source: TRAC Immigration. (2018).

Response

To address the challenges of meeting basic needs without immigration status, securing legal representation, and limited knowledge about legal eligibility, obligations and processes,

TF offers five free, bilingual, culturally-sensitive, trauma-sensitive, and co-located legal activities (Table 5).

Table 5: 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 population³⁸ and greater exposure to trauma than other migrant groups³⁹. Multiple exposures to trauma are associated with increased risk for psychopathology⁴⁰. Detained UICs experience high levels of Post-Traumatic Stress Disorder (PTSD), anxiety, depression, aggression, psychosomatic symptoms, and suicidal ideation⁴¹. 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 journey⁴².

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 challenges⁴³. Despite these risk factors, mental health service access and treatment among immigrants has shown to be worse than for the general population⁴⁴.

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 6).

Table 6: 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 (Figure 9). 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
<p>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.</p>	09/2013	●			
<p>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.</p>	10/2014	●			
<p>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.</p>	03/2016		●		●
<p>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.</p>	10/2016	●		●	
<p>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.</p>	09/2013	●	●	●	●
<p>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).</p>	09/2013	●	●		

Mental health need 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 care⁴⁵. 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 children⁴⁶. Prolonged childhood poverty is associated with poor health outcomes including chronic illness, poor nutrition⁴⁷, and toxic stress, increasing the risk for inattention, impulsivity, and poor peer relationships⁴⁸. Additionally, poverty experienced in youth has implications for the life course, with certain life events during adolescence (e.g. unemployment, displacement) increasing vulnerability to poverty⁴⁹.

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 care⁵⁰. 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 impairments⁵¹.

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 requirements⁵². Undocumented immigrants are also prohibited from purchasing private health insurance⁵³. 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 status⁵⁴. Children with insurance coverage are more likely to access preventative care and have minor illnesses treated before they develop into more complex conditions⁵⁵.

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 7).

Table 7: 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 (Figure 6). 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		●	●	

Activity	Start date	UIC	AWC	CoAWC	Sponsor
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	●	●		

Figure 6: Terra Firma graduate



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 8). 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 upward⁵⁶.

Table 8: 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 ⁵⁷ , 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 ⁵⁸ .
Social vulnerability	Youth aged 15 to 19 have elevated risk for early pregnancy, sexually-transmitted infections (STIs), violence, and substance abuse ⁵⁹ . Adolescent exposure to trauma has been associated with increased risk for pregnancy ⁶⁰ and substance abuse ⁶¹ .
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 ⁶² , 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 needs⁶³. 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 9).

Table 9: 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 10).

Table 10: 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: <ul style="list-style-type: none"> 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). <p>TF expanded on the success of the summer program by implementing components during the academic year.</p>	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 7).	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 7: TF participants involved in ICP's photography workshop



Photo credit: Terra Firma

Advocacy and education needs and activities

Needs

To address a lack of knowledge about UICs and AWCs among stakeholders and the provision of fragmented services to UICs

and AWCs, TF implements five advocacy and education activities (Table 11).

Response

Table 11: Advocacy activities

Activity	Start date	Target population
Education and advocacy refers to publications, presentations, panels, trainings, and seminars provided by TF leadership to both internal and external stakeholders.	09/2013	CHM staff, direct and indirect referral partners, policy makers
Forensic medical and psychological exams An indirect result of forensic exams and letters of support for immigration officials is increased knowledge of and trust in UIC and AWC stories.	09/2013	Immigration officials
Referrals An indirect result of TF referrals across all sectors is increased education and advocacy about UICs, AWCs, CoAWCs, and sponsors to referral partners.	09/2013	Direct and indirect referral partners, policy maker
Technical support and strategic partnerships Strategic partnerships involve sharing of best practices, leveraging of shared resources, and collaboration for advocacy ⁶⁴ . For example, TF recently partnered with a medical resident to help TF establish a direct medical record release system from ORR to TF. TF also partners with Albert Einstein School of Medicine to offer a community-based health elective to medical students.	06/2016	Direct and indirect referral partners
Technical support refers to direct guidance in managing care for UICs (e.g. helping a referral partner provide psychological first aid) as well as guidance for program replication. Several providers have approached TF for assistance in establishing a similar model. Though these partnerships are not as programmatically robust as TF, several are actively providing care to immigrants and assistance to legal providers in through medical or mental health affidavits and letters of support.		
Research Conducting and disseminating research on the TF model is an objective of TF's founders. The Robin Hood Foundation supported a Scalability Assessment for TF in August 2017 and TF recently initiated the Institutional Review Board process for research on patient outcomes.	Ongoing	Direct and indirect referral partners, policy makers

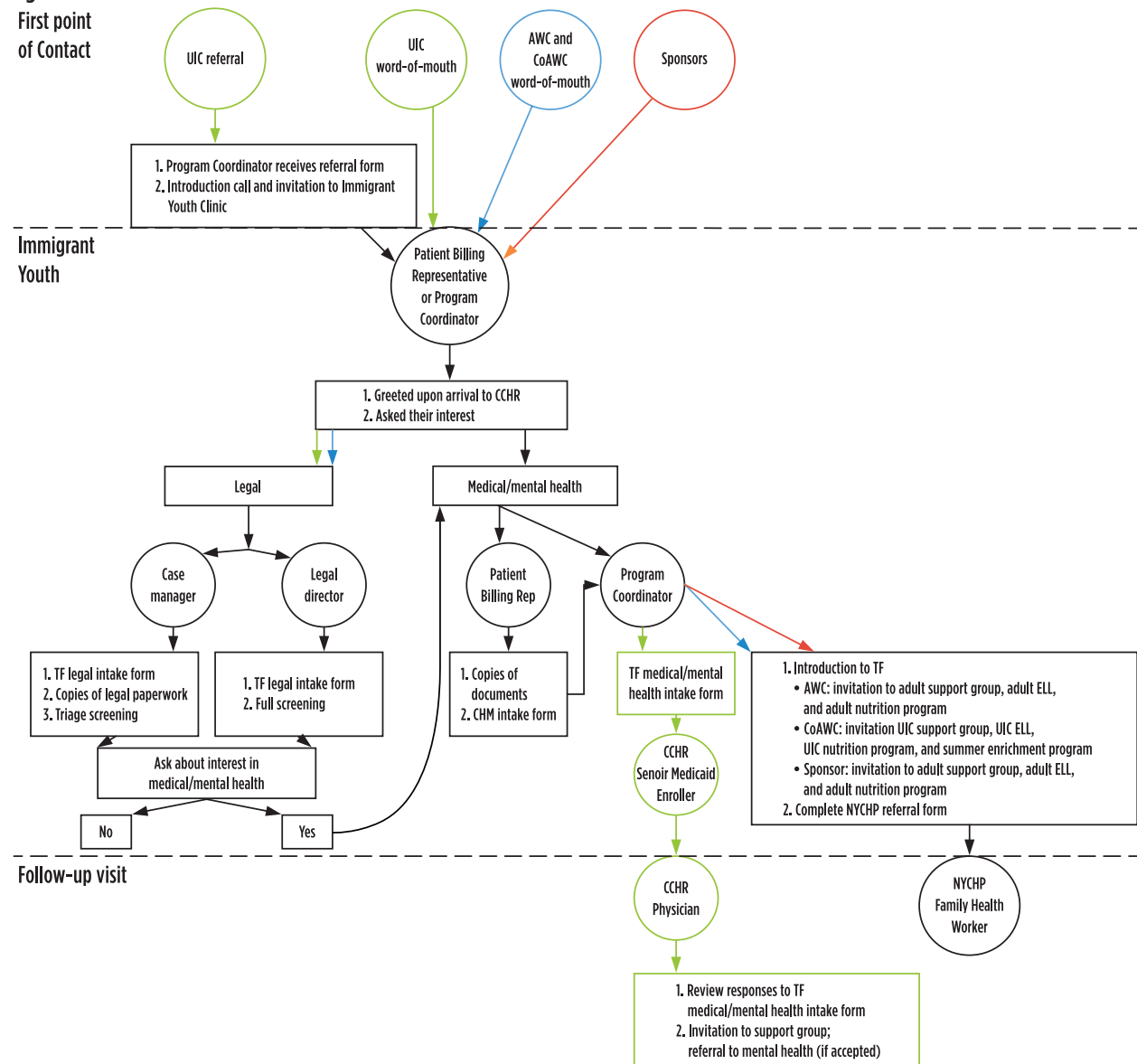
V. Implementation

Intake and client flow

New clients arrive to TF via referral from partner organizations or word-of-mouth (e.g. UMP, International Network for Public Schools, New York City public schools, faith-based organizations, community-based organizations, other health care sites, CCNY's Office of Refugee Resettlement, CCNY's Safe Passages program). TF has a total of four intake forms depending on the service sought: (1) TF legal intake form, (2) CHM intake form, (3) TF medical/mental health intake form (UICs), and (4) NYCHP referral form (AWCs, CoAWCs,

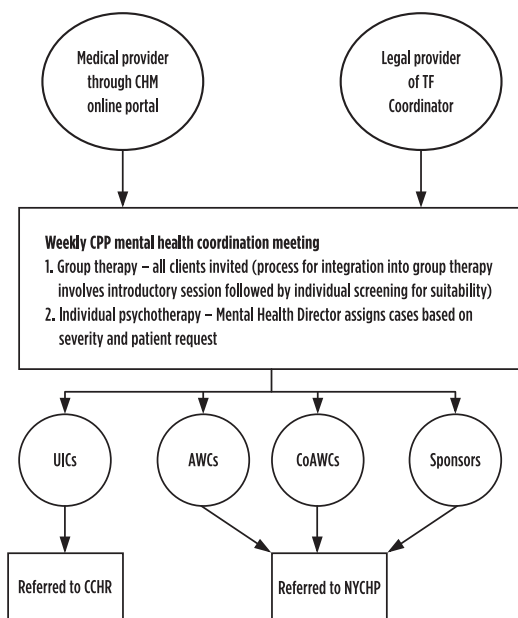
and sponsors). Once clients complete the intake process, those seeking medical or mental health services receive a CHM Patient Identification Number (Figure 8). Importantly, TF only accepts new clients who are willing to receive primary health care services from CCHR, in line with the PCMH model. Patients are not able to receive independent legal, mental health, or social services from TF without registering as CHM patients.

Figure 8: Client intake flow



Medical and mental health client flow Patients are typically able to meet with a medical provider during their first or second visit to CCHR. For mental health services, the referral process is slightly longer. While group therapy is offered to all new TF clients, referrals for individual treatment enter a pooled system that is reviewed by the CPP mental health team on a weekly basis. The Mental Health Director assigns cases for individual psychotherapy, family therapy, and psychiatry based on severity of need and willingness to engage in the therapeutic process (Figure 9).

Figure 9: Mental health client flow



Staff training

The National Center for MLPs defines MLP training as any formal session in which an MLP legal partner speaks to health care partner staff about MLP services, MLP processes, or health-related legal needs⁶⁵. Since project initiation, the TF Core Leadership Team has provided an annual TF program presentation describing the target population, a legal primer on types of immigration relief, and an overview of trauma to CPP staff. In October 2017, TF implemented the first clinical training for CPP staff on the clinical needs of TF's target population. Legal staff have not received specific training on the medical and mental health needs or trauma sensitivity of UICs, having been exposed to these needs through their work.

Coordination

Coordination of care is a core component of integrated primary care models and is an important part of TF's model. Case consultations across multisector providers within TF occur informally through e-mail, phone calls, or drop-ins. In addition to informal case-consultations, TF implements the following more structured coordination meetings:

- Weekly TF Core Leadership Team meeting (Medical, Mental Health, Legal directors and Program Coordinator)
- Weekly CPP mental health clinical meetings (all CPP mental health clinicians)
- Weekly legal team meeting (Legal Director and TF Legal Case Manager)
- Monthly CCHR operational meeting with TF's Clinical Leadership Team, administrative staff (Administrative Director, Office Manager, Patient Billing Representatives), clinical staff (mental health clinicians, pediatricians, nurse managers, nurses), and case manager.
- Monthly update phone calls between Program Coordinator and external referral partners

Strengths of implementation

While the TF model (as an MLP within a PCMH) has a number of strengths, execution of the model ensures program success. Implementation strengths explore TF's specific delivery mechanisms.

Staff commitment Various respondents underscored staff commitment as a strength of the program. Within the CHM system, TF reportedly had high institutional support and staff buy-in. Referral partners shared that TF staff went above and beyond their requirements to support clients. For example, although TF does not typically provide medical and mental health affidavits for clients who are not CPP patients, a referral partner shared that the Program Coordinator provided direct assistance in connecting UICs in need of this service to other clinics.

"[The TF] leadership team is entrepreneurial, creative, collaborative communicative, and inclusive of all staff."
— TF provider

Staff responsiveness Multiple partners and participants emphasized staff responsiveness as a strength of the program. The Program Coordinator reportedly responded to e-mail requests within 24 hours. TF was understood to have an “easy referral process and quick follow-up.” Additionally, the TF Program Coordinator instituted monthly case conference calls with legal referral organizations, facilitating coordination of care.

“I do not need to be after them to help me, [TF staff members] call me to let me know when I have a court date or need to submit something.” — TF participant

Staff-client relationships Referral partners reported that TF staff were “approachable, trustworthy, and invested in the client.” In terms of medical and mental health service provision, one partner highlighted that TF staff not only provided relief of conditions, but also provided education and advice for supportive processes (e.g. teaching clients how to problem solve). UICs listed “trust” and “respect” as words associated with TF. Additionally, UICs identified specific providers as friends with whom they “could be crazy,” which in this context referred to UICs’ ability to be themselves.

“[My favorite part about TF] is the way [the staff] treat us. They make us feel like family. For example, the way they receive us when we arrive. They ask about who we are and our story.” — TF participant

Strong foreign language (Spanish) and cultural proficiency of staff All TF frontline staff are bilingual in Spanish, reducing language barriers to service access. Additionally, services are provided in a culturally sensitive manner. For example, one provider reflected on the way that TF adapted a culturally and developmentally sensitive approach to client interactions which included hugging.

Staff knowledge about the population Multiple referral partners highlighted staff knowledge of the population as a strength of the program.

“I never need to warn my clients about potentially bad experiences with staff at TF. [The staff] speak Spanish. They will never be denied services or spoken to rudely.” — TF referral partner

Provision of dignified support Two referral partners underscored that TF stood out from other providers because they treated clients with dignity.

“Someone kept coming over to reassure the client that they would be seen by a provider.” — TF referral partner

Strong participant buy-in Nearly all referral partners reported that their clients enrolled and engaged with TF.

Simple referral process Nearly all referral partners recognized TF’s simple referral process as a strength of the program.

Flexible but clear boundaries One respondent highlighted that TF understood the needs of the population, accepting missed appointments or late arrivals, but also establishing clear guidelines for when a case would be closed.

Ability to engage youth in mental health services and address trauma TF was recognized by respondents as providing a safe space in which UICs could retell their trauma within a therapeutic setting. Group therapy was cited by respondents as one of TF’s greatest strengths. One provider noted that group therapy allowed mental health providers to treat more patients in less time, increasing program efficiency. Among participants, UICs associated words such as “friendship”, “union”, “trust”, “support”, and “tranquility” with group therapy and specific group therapy facilitators.

VI. Assumptions of the model

In a theory of change, an assumption is defined as an assertion that underlines the anticipated change process⁶⁶. Assumptions for the TF model are non-exhaustive and were developed through a combination of TF founder and staff responses, secondary data review of MLP theories of change, and a level-by-level analysis of each sector-specific theory of change⁶⁷. There are four categories of assumptions:

1. World-view assumptions about the pathways of change (e.g. traumatized youth are best engaged if they receive trauma-sensitive care);
2. Belief system assumptions (e.g. Latino youth will respond better to interventions in Spanish);
3. Operational assumptions about the external context (e.g. no policy change will affect immigration processes, insurance eligibility, or funding for medical or mental health services; referral partners will have the capacity to accept new clients)⁶⁸; and
4. Causal assumptions about the links between outcomes at different levels. For the purposes of this evaluation, the theories of change focus on causal assumptions (Table 12), which can be further sub-divided into three categories:
 - Implementation assumptions (e.g. assumption that participants will show up);
 - Full-pathway assumptions (e.g. education will change attitudes and behaviors); and
 - Purposive assumptions (e.g. acquisition of legal status will lead to long-term stability)⁶⁹.

Table 12: Causal assumptions underlying TF theory of change

Type of causal assumption	Assumption
Implementation	<ul style="list-style-type: none"> ■ Participation Participants will attend services if available. ■ Faith to model Providers will adhere to the provision of trauma-sensitive services and will educate clients (and referral partners) in their respective technical specialty.
Full-pathway	<ul style="list-style-type: none"> ■ Education will change behaviors This assumption is based on behavioral change models, which posit that behaviors are driven by the desire to avoid negative outcomes and that specific actions can prevent or resolve negative outcomes⁷⁰. ■ Co-location will reduce access barriers to medical, mental health, and legal services and increase clients' exposure to different service providers. Increased exposure to service providers will help to build trust and develop provider-client relationships. ■ Integrated services will address chronic stressors that contribute to poor mental health outcomes and behavioral manifestations of stress. ■ Interdisciplinary coordination reduces fragmented service provision and improves the quality, comprehensiveness, and continuity of care, ultimately contributing to improved outcomes for UICs. ■ Interdisciplinary advocacy to external stakeholders and immigration officials will contribute to policy change benefitting UICs.
Purposive	<ul style="list-style-type: none"> ■ Acquisition of legal status will support UICs in developing resilience, attaining stability, and reaching their full potential.

VII. Anticipated outcomes

TF is based on the belief that providing free, bilingual, culturally-sensitive, trauma-sensitive, and co-located medical, mental health, legal, and social services in the target

population's geographic location will lead to the following anticipated short-, mid-, and long-term outcomes (Figures 10 and 11).

Figure 10: Anticipated outcomes of direct service provision for TF participants

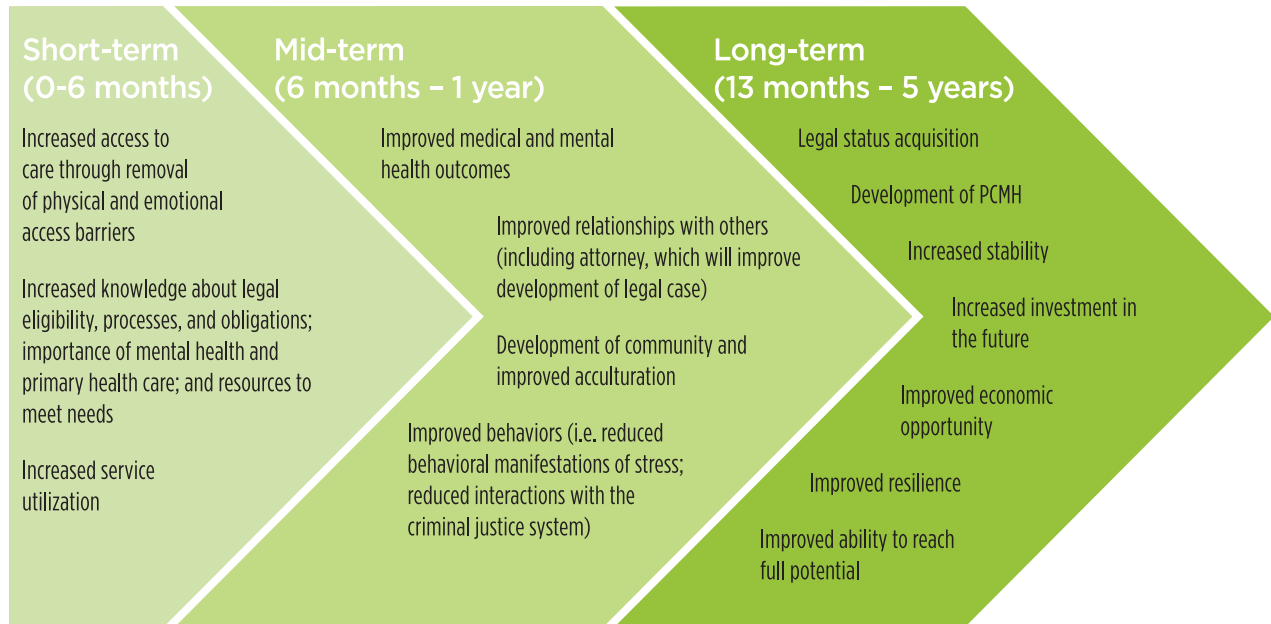
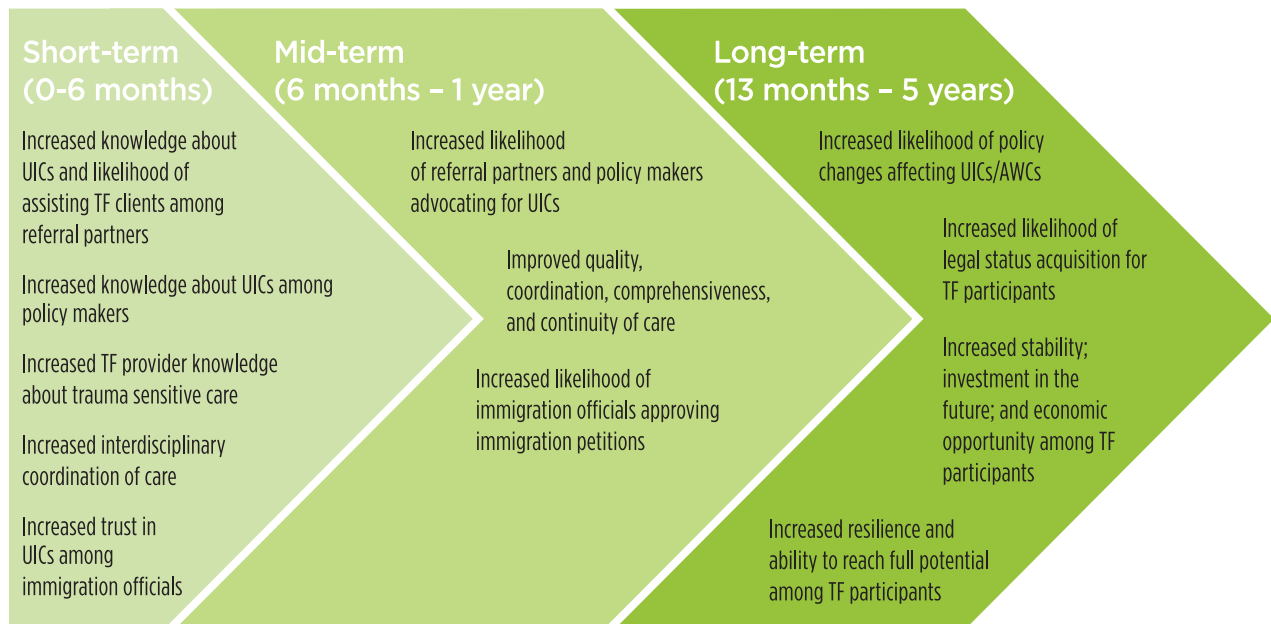


Figure 11: Anticipated outcomes of advocacy and education



Lessons learned – considerations for replication

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 enforcement⁷¹. New York City is considered a sanctuary city, and as such offers protections for undocumented immigrants, including the first statewide immigrant-defense fund⁷², 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 13).

“I’m still in limbo. I’m neither here nor there. I don’t know what will be of my future.” — TF participant

Table 13: System-level considerations and recommendations

Considerations	Recommendations
The 2016 U.S. policy environment raised fears of deportation among undocumented immigrants ⁷³ and raised fears regarding insurance coverage among low-income and underinsured populations ⁷⁴ .	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 ⁷⁵ . 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
<p>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 2017⁷⁶. Respondents reported concerns about TF's capacity to meet increasing demand, with mental health and legal representation highlighted as particularly constrained.</p>	<p>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.</p>
<p>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).</p>	<p>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.</p>
<p>Increased number of cases with histories of sexual and gender-based violence as influx of UIC girls began to increase in 2014⁷⁷.</p>	<p>Organizations should consider incorporating female clinicians onto various teams. TF is currently structured such that all mental health and two medical providers are female.</p>
<p>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.</p>	<p>Organizations may consider strengthening internal partnerships with specialty care providers.</p>

Structural-level considerations and recommendations

Structural-level challenges refer to difficulties related to TF's structure as a program within two larger institutions,

CCNY and CHM, rather than a standalone non-profit organization (Table 14).

Table 14: Structural-level considerations and recommendations

Considerations	Recommendations
<p>Location of TF legal team The TF legal team is based out of CCNY's office in lower Manhattan, limiting some of the benefits of co-location, as they are only co-located during the Immigrant Youth Clinic.</p>	<p>Organizations may consider co-locating medical and legal teams outside of Immigrant Youth Clinic on a full or part-time basis.</p>
<p>Minor administrative challenges Incorporation into a hospital system involves collaboration with large scale operations (e.g. procurement, finance). While this is easily managed, it requires bureaucratic navigation.</p>	<p>Organizations may consider increasing exposure of the program to the broader hospital community through presentations.</p>

Model-level considerations and recommendations

Challenges to the model primarily relate to TF's target population (i.e. high need, traumatized clientele) rather

than the program model itself (Table 15). The TF model has allowed for flexibility to respond to these needs.

Table 15: Model-level considerations and recommendations

Considerations	Recommendations
Increased administrative work as program expands to meet demand As MLP models expand, organizations should take into account an increase in administrative work.	Organizations with a partnership structure should consider hiring two program coordinators upon expansion, one for legal and another for medical and mental health services.
Challenges to working with adolescent populations It is difficult to merge TF's objective of creating a community safe space for UICs within a clinic setting. Youth require greater supervision and staff than standard populations.	Organizations should consider: formalizing disciplinary structures to create a community safe space for youth while teaching valuable emotional and behavioral regulation skills; increasing the number of support staff to supervise UICs (e.g. patient navigator, greeter, security) or hiring staff with youth development backgrounds; or opening an ancillary youth community center near the clinic or operating out of a community center with an incorporated medical clinic.
Secondary trauma of staff Lawyers, advocates, and service providers working with this population have increased risk of vicarious trauma ⁷⁸ .	Organizations may consider establishing self-care processes for MLP staff.
Information sharing practices across sectors Organizations should consider the challenges of information sharing across disciplines, including respective codes of ethics.	Organizations should consider developing standardized information sharing procedures for all new clients. For example, requesting a HIPAA release by a specified meeting with a patient (e.g. HIPAA signed by the third mental health consultation) and requesting a legal information release upon acceptance of legal representation.

Implementation-level considerations and recommendations

Implementation challenges explore difficulties with TF's specific delivery mechanisms (Table 16). Notably, one of TF's greatest reported strengths across respondents was the

commitment, responsiveness, and competence of its founders and staff, which presents a potential challenge for organizations interested in replication.

Table 16: Implementation-level considerations and recommendations

Considerations	Recommendations
Limited face-time within and across providers and staff members , including limited time for case consultations, due to high level of need for direct services. Although services are co-located, heavy caseloads can prevent medical and legal providers from interacting during clinic hours.	Organizations may consider formalizing collaborations across sectors (medical-legal, medical-mental health) and within sectors (medical-medical). Suggested approaches to this include scheduling formal case consultation time within and across providers, creating a care coordination schedule with deadlines, and increasing collaborative opportunities to share lessons learned, best practices, and provide formal training opportunities for support staff.
Limited time allocation for non-clinical services Given the high-level of need among the target population, clinical services may take precedence over non-clinical services such as administrative tasks, writing letters of support and affidavits, and advocacy.	Organizations should consider providing protected administrative, advocacy, and case consultation time.

Confidentiality concerns Given the vulnerability of TF's target population, confidentiality concerns should be considered.

Organizations may consider adjusting the type of information shared on the referral form or adjusting the transmission method (e.g. fax).

Organizations should consider discreet screening processes for arrivals to the clinic.

Organizations should consider providing a private space for case managers. Organizations should consider developing explicit photo sharing policies and practices.

Time constraints due to level of need of target population Medical, mental health, and legal services for TF's target population are more time consuming than for standard clients. This should be taken into consideration when developing Immigrant Youth Clinic hours.

Organizations may consider developing standardized legal intake processes (e.g. conducting UIC screenings before adult screenings to ensure insurance enrollment prior to staff member leaving).

Challenges identifying referred clients The provision of services across providers and clinics can create challenges during referral processes.

Organizations should consider developing structured referral mechanisms within the hospital and legal system.

Coordination with external legal providers As TF has expanded service provision to include clients represented by external legal agencies, coordination of care challenges have arisen.

Organizations should consider developing a standardized and consistent process for information sharing between medical and mental health providers and external legal providers (e.g. monthly case conference calls, monthly email). Alternately, organizations can consider the possibility of assigning a specific provider to manage cases for a specific legal provider or incorporate external legal providers into the Immigrant Youth Clinic to provide co-located services.

Partnership structures with enrichment service providers TF outsources most enrichment services to maintain technical expertise. The partnership structure varies by partner (i.e. volunteer, contracted).

At partnership initiation, organizations should formally meet with enrichment partners to determine project objectives, implementation structure, and scale of the program. For example, ELL programs require more consistency than art programs to achieve program objectives.

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.

Study limitations

A process evaluation was used to evaluate TF because to date TF had not been evaluated, and there was a need to identify and describe the multifaceted aspects of the program before measuring effectiveness. Qualitative data was a natural methodological approach to help develop ideas for potential quantitative research, uncover trends in opinions, and to more deeply explore program challenges.

This evaluation had three primary limitations. First, qualitative data is naturally subjective to researcher and respondent bias and is therefore not generalizable. The data collected during this evaluation should be used to provide a foundation from which TF can develop more robust, quantitative methods in the future. Second, the small sample size (n=53) of the study also limits the generalizability of results. Third, the primary participants in this evaluation were project staff members and referral partners with a vested interest in positively portraying program implementation. To limit the effects of this respondent bias, the researcher kept individual responses confidential.

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.

Annexes

Annex 1: Methodology

Sampling

Given the short timeframe and small scale of this evaluation, purposive sampling (e.g. sampling based on population characteristics and study purpose) was used to select participants.

Secondary data review

Data collection initiated with a review of TF program documents (e.g. initial concept paper, draft replication manual, grant proposals, donor reports, and existing research proposals) to develop a foundational understanding of the program, followed by an academic and grey literature review to identify the multisector needs of UICs and AWCs and the evidence base for effective medical, mental health, legal, and interdisciplinary interventions for UICs and AWCs. Given the limited published research on this population, the review included interventions focused on refugee children, children on the move, displaced populations, refugees, and asylum seekers across the globe.

KIIs with administrators, partners, and providers

The program theory assessment involved nine KIIs with TF founders (3) and select program staff (6) to understand the underlying assumptions linking program activities to anticipated outcomes. The process evaluation involved 35 KIIs with TF

founders (3), CCNY staff (3), CHM staff (15), referral partners (7), and enrichment partners (7) to understand program delivery structures and process and outcome measures.

KIIs with AWCs and sponsors

Initially planned as FGDs, low participant turnout resulted in a methodology shift to KIIs with adult TF participants (AWCs and sponsors). The evaluation involved three KIIs with adult TF participants to explore participant perceptions of service quality; program relevance, strengths, challenges, and satisfaction; and barriers to access and utilization.

Mind mapping FGDs with UICs

The first FGD with a group of three UICs failed to capture sufficiently robust data, resulting in a methodology shift to mind-mapping. Mind mapping is a technique that helps participants visualize concepts and understand connections between different ideas through brainstorming and categorization⁷⁹. The evaluation involved two mind mapping focus groups with 12 UICs.

Although the evaluation had a small sample size and was primarily qualitative, it provided important information on the perceptions of key providers and firsthand reports from the target population.

Annex 2: TF Direct Program Partners

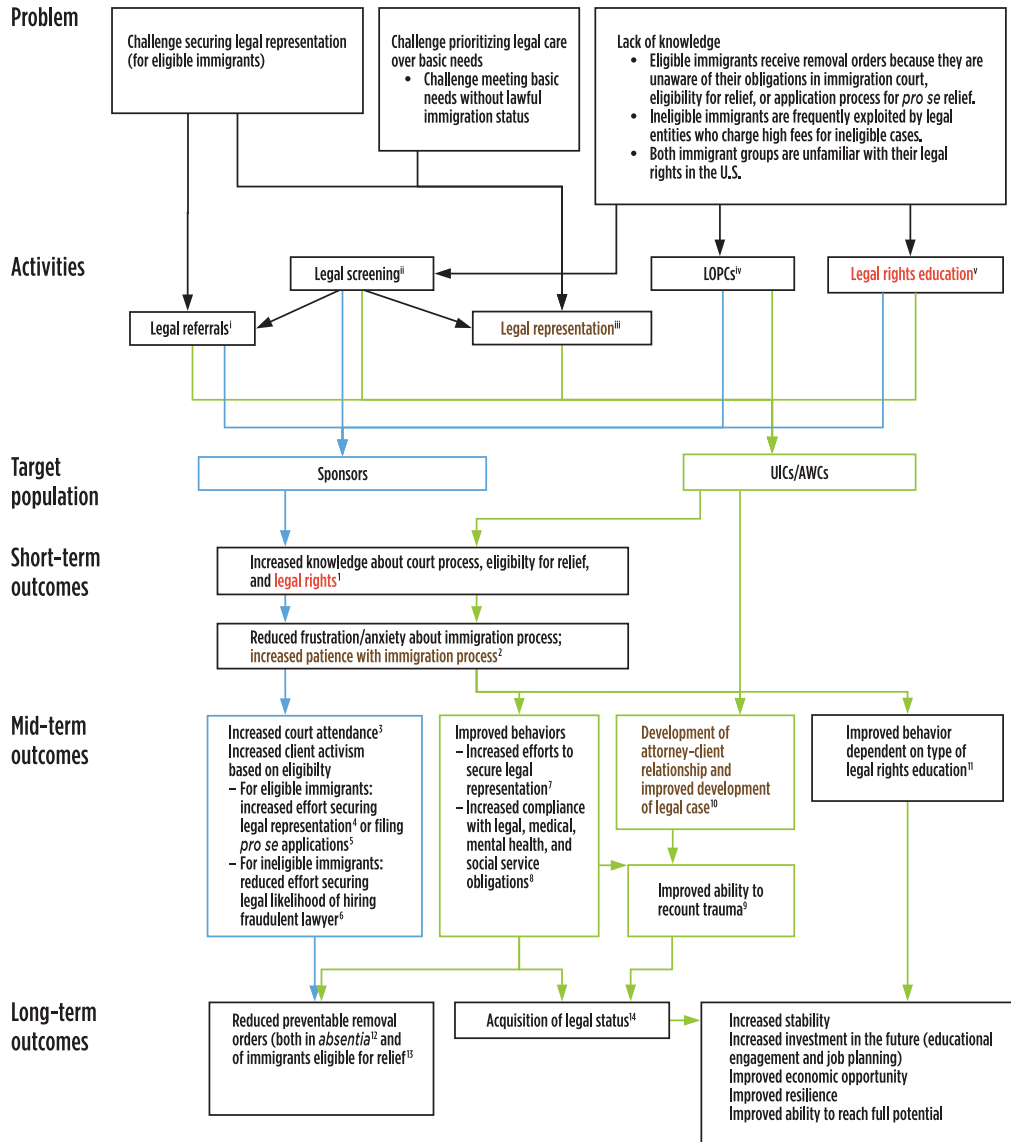
Sector	Agency	Sector	Agency
Donor	Children's Health Fund	Legal	CCNY Immigration Court Helpdesk
Donor	Anon. Private Foundation	Legal	CCNY Immigration Legal Services
Donor	Robin Hood Foundation	Legal	CCNY Immigration Legal Services – Unaccompanied Minors Program
Education	International Network of Public Schools	Legal	Legal Aid Society
Enrichment	International Center for Photography	Legal	Safe Passage Project (NY Law School)
Enrichment	South Bronx United	Legal	The Door
Enrichment	La Union	Resettlement	CCNY Safe Passages
Enrichment	CCNY International Center		
Health	CHM Community Pediatric Program		

Annex 3: TF Indirect Referral Partners

Sector	Agency	Sector	Agency
Advocacy	Child Protection Working Group	Housing	New York City Housing Authority
Advocacy	Congressional Research Service	Housing	Prevention Assistance and Temporary Housing Office (PATH)
Advocacy	Migration Policy Institute	Housing	Project Hospitality
Advocacy	Open Society Foundation	Housing	Rachels Place
Advocacy	The Center	Housing	Safe Space NYC
Advocacy	The Young Center	Housing	SCO Family of Services
Advocacy	Vera Institute of Justice	Housing	Seafarer's International House
Advocacy	Women's Refugee Commission	Housing	West End Residences (HDFC)
Education	Advocates for Children	Immigration	Department of Homeland Security
Education	Bronx Adult Learning Center	Immigration	Department of Unaccompanied Children's Services
Education	Department of Education	Immigration	Federal Immigration Court
Education	International Network of Public Schools	Immigration	Immigration and Customs Enforcement
Education	Office of Adult and Continuing Education	Immigration	New York Immigration Coalition
Education	Pathways to Graduation	Immigration	Office of Refugee Resettlement
Education	South Bronx Adult Learning Center	Immigration	United States Citizenship and Immigration Services
Education	The Advocacy Center (AHRC)	Immigration	US Customs and Border Patrol
Families	Diaspora Community Services	Immigration	Bronx Works
Families	Outreach	Immigration	New York Public Library
Health	American Pediatric Association	Job placement	Northern Manhattan Improvement Corporation
Health	Department of Health of New York	Job placement	Work Force 1
Housing	Ali Forney Center	Legal	African Services Committee
Housing	Cardinal McCloskey	Legal	Americans for Equality
Housing	Coalition for Homeless Youth	Legal	Asian Americans for Equality
Housing	Covenant House	Legal	CAMBA Legal Services
Housing	Department of Homeless Services		
Housing	Good Shepherd Services		
Housing	Green Chimneys		
Housing	Jericho Project		

Sector	Agency	Sector	Agency
Legal	Caribbean Women's Health Association	Legal	Medgar Evers College Immigration Center
Legal	Catholic Charities of New York	Legal	MinKwon Center for Community Action
Legal	Catholic Migration Office	Legal	New York Legal Assistance Group (NYLAG)
Legal	Catholic Migration Services	Legal	Queer Detainee Empowerment Project (QDEP)
Legal	Central American Legal Assistance	Legal	Safe Horizon Immigration Law Project
Legal	Church World Service	Legal	Sanctuary for Families
Legal	City Bar Justice Center	Legal	South Side Community Mission
Legal	City College Immigration Center	Legal	The Arab American Family Support Center
Legal	CUNY Citizenship Now!	Legal	United Jewish Council on the East Side
Legal	CUNY Express Immigration Services	Legal	United Methodist Committee on Relief
Legal	El Centro Inmigrante	Legal	York College Immigration Center
Legal	Emerald Isle Immigration Center	Legal	Youth Ministries for Peace and Justice
Legal	Episcopal Migration Ministries	LGBT	Henrick Martin Institute
Legal	Flushing Immigration Center	Policy	UNHCR
Legal	Haitian Americans United for Progress (HAUP)	Policy	UNICEF
Legal	Hebrew Immigrant Aid Society (HIAS)	Public benefits	Administration for Child Services
Legal	Her Justice	Public Benefits	CCNY Office of Refugee Resettlement
Legal	HIV Law Project	Public benefits	Human Resources Administration
Legal	Hostos Community College Immigration Center	Public benefits	IDNYC
Legal	Housing Conversation Coordinators	Youth	Children's Village
Legal	Human Rights First	Youth	Department of Youth and Community Development
Legal	Immigrant Justice Corps	Youth	Health and Education Alternatives for Teens (HEAT)
Legal	Immigration Equality	Youth	New Alternatives
Legal	International Rescue Committee	Youth	Safe Horizon Streetwork Project
Legal	Jacob A. Riis Neighborhood Settlement	Youth	Urban Justice Center
Legal	Justice for our Neighbors	Youth/Trafficking	Girls Education and Mentorship Services (GEMS)
Legal	Kids in Need of Defense (KIND)		
Legal	Lutheran Social Services of New York		

Annex 4: TF Full Program Theory of Change



Annex 4: TF Full Program Theory of Change

Process (Output) Indicator Key

Suggested indicator

- i # of clients screened by TF referred to ICH, CCNY UMP, CCNY Immigration Legal Services Department, and external legal partners (Legal Aid Society, The Door, South Bronx United)
- ii # UICs, # AWCs, # sponsors, # CoAWCs, # others receiving legal screenings
- iii # UICs from TF screenings represented by TF attorney, # AWCs from TF screenings represented by TF attorney
- iv # UICs attending LOPC presentations, # sponsors attending LOPC presentations, # LOPC presentations given
- v # legal rights education presentations, # attendees per presentation, # external providers brought in to provide presentations

Outcome Indicator Key

Short-term outcomes

Suggested indicator

- 1 Pre/post knowledge test
- 2 Qualitative survey of attitude change

Mid-term outcomes

Suggested indicator

- 3 % of screened immigrants, % of referred sponsors, % LOPC attendee UICs, and % LOPC attendee sponsors who attend court hearings
- 4 % UICs who sign contract with TF attorney following TF screening; % screened sponsors securing legal representation; % sponsors attending LOPC who secure legal representation
- 5 % screened sponsors, % sponsors referred to ICH, and % LOPC attendees who file *pro se* applications for relief
- 6 % screened sponsors who lose money on a fraudulent lawyer
- 7 % of UICs who sign contract with CCNY attorney through TF screening; % screened sponsors securing legal representation; % LOPC attendees who secure legal representation; % UICs who sign contract with CCNY attorney following LOPC
- 8 Comparison of no-shows for TF-CPP patients compared to non-TF CPP patients (medical/mental health); comparison of no-shows for TF-CCNY clients compared to non-TF-CCNY clients (legal/social); school attendance records; documentation of court attendance
- 9 Qualitative reports of client's disclosure of traumatic experiences to attorney, physician, psychologist/psychiatrist, asylum officer, etc.
- 10 Qualitative reports from attorney
- 11 Dependent on type of legal education provided Long-term outcomes Suggested indicator

Long-term outcomes

Suggested indicator

- 12 % screened sponsors in removal proceedings, % screened UICs, % sponsors in removal proceedings referred externally, % LOPC attendee UICs, % LOPC attendee sponsors who receive in absentia deportation orders
- 13 % screened eligible immigrants, % externally referred sponsors, % LOPC attendee sponsors, % LOPC attendee UICs, and TF represented UIC/AWC cases favorably resolved by type and venue (state family court, federal immigration court, USCIS); time to completion for TF cases (compared to non-TF cases)
- 14 Longitudinal follow-up of UICs (Kiddo KINDL)

Legal Theory of Change Narrative

Short and mid-term outcomes

Legal screenings For eligible immigrants, learning about immigration eligibility and requirements is expected to reduce anxiety about the immigration process and improve behaviors (e.g. increase court attendance). For ineligible immigrants, increased knowledge is expected to reduce the likelihood that they pay for fraudulent legal representation.

Legal representation Access to and utilization of legal representation is expected to reduce anxiety and increase clients' patience with the immigration court process, which as of December 2017 took an average of 1,224 days to resolve⁸⁰. Co-located representation is expected to increase provider-client interactions, improving the attorney-client relationship, and increasing compliance with obligations across all sectors and improving the development of the legal case. Increased compliance with mental health is anticipated to improve clients' ability to recount traumatic events supporting the legal case.

Legal referrals are expected to increase clients' knowledge of and access to legal resources, which is expected to reduce anxiety about the immigration case. Increased access to resources is expected to increase client activism, including efforts to apply for *pro se* immigration relief and secure representation.

LOPC presentations are expected to increase knowledge about the court process and eligibility for relief, reducing anxiety and increasing compliance with immigration court requirements (e.g. court and school attendance). For eligible immigrants, LOPC is expected to increase efforts to secure legal counsel or apply for *pro se* immigration relief. For ineligible immigrants, LOPCs are expected to reduce the likelihood of hiring fraudulent lawyers. The Vera Institute of Justice has found that LOPC participants move through the courts faster, receive fewer in absentia removal orders, and are better prepared to proceed *pro se*⁸¹.

Legal rights education presentations are expected to increase clients' knowledge about legal rights with the expectation that increased knowledge will improve behaviors depending on the type of legal education.

Long-term outcomes

All legal activities are intended to reduce preventable removal orders (both in *absentia* orders and orders for eligible immigrants). For UICs and AWCs, the long-term goal of legal service provision is the acquisition of legal status, with the ultimate goal of increasing stability, increasing investment in the future (through educational engagement and job planning), improving economic stability, improving resilience, and improving the ability for UICs and AWCs to reach their full potential.

Mental Health Theory of Change Narrative

Short-term outcomes

The primary objective of all mental health activities is to treat mental health conditions. All activities follow the health belief model that increased knowledge about mental health conditions, the importance of care, and resources for care will help destigmatize mental health and increase service utilization among patients.

Mid-term outcomes

Mental health assessments The primary objective of the mental health assessment is to assist providers in correctly diagnosing and treating patients. The assessments have the secondary effect of teaching patients about their mental health conditions to increase service utilization.

Individual psychotherapy is expected to increase clients' ability to manage the emotional impacts of specific traumas; improve positive mental health outcomes (e.g. self-awareness, self-efficacy, self-compassion, responsibility-taking); reduce negative mental health outcomes (e.g. feelings of isolation, guilt, shame, blame); and reduce behavioral manifestations of stress (e.g. dissociation, numbing, avoidance, withdrawal, risk-taking, involvement with the criminal justice system). The effectiveness of individual psychotherapy for refugee and asylum-seeking populations is varied, although the use of cognitive behavioral therapy models has been found to alleviate symptoms of PTSD among refugee children⁸².

Family therapy is expected to improve understanding and communication between UICs and family members and reduce household conflict. Family therapy has been found to be useful for children affected by trauma⁸³.

Individual psychiatry is expected to treat the physical causes of certain mental health conditions.

Group therapy

UICs age 14+ Group therapy for this population was initiated to address isolation and emotional difficulty related to the chronic stress of traveling alone to the U.S. Group therapy addresses sources of chronic stress (e.g. immigration process, reunification challenges, acculturation, trauma) and is expected to teach UICs to recognize trauma and learn skills to manage chronic stress, with the objective of reducing negative mental health outcomes (e.g. anxiety and isolation), improving

positive mental health outcomes (e.g. self-efficacy), improving relationships with others, and reducing behavioral manifestations of stress. For refugee children, group cognitive behavioral therapy has been found to modestly reduce PTSD severity, emotional symptoms, and behavioral difficulties⁸⁴.

Adults Group therapy for AWCs and sponsors is expected to improve the relationship between the sponsor and UIC, improve trauma literacy, and improve access to shared information about resources to meet basic survival needs.

Preteens Group therapy for preteens is expected to develop social skills and create a sense of group membership with peers, with a belief that this will lead to better relationships with adults (e.g. parents, teachers, providers).

External referrals are expected to assist clients in treating their mental health conditions by encouraging service utilization. The secondary expected outcome of these referrals is that increasing awareness about this population to referral partners will increase provision of services and lead to increased advocacy for this population.

Forensic psychological exams are expected to improve the likelihood that UICs' and AWCs' applications for legal relief are approved by immigration officials. Affidavits and letters of support are expected to increase trust in UICs' and AWCs' stories through professional testimony, resulting in an increased likelihood of approving petitions. Qualitative research with immigration attorneys has found that forensic psychological exams support migration petitions⁸⁵. A secondary anticipated outcome is that knowledge about mental health conditions will increase utilization of mental health services among UICs and AWCs.

Long-term outcomes

The long-term goal of all mental health activities is to assist in the acquisition of legal status, with the ultimate goal of increasing stability (by maintaining positive mental health outcomes), increasing investment in the future (through educational engagement and job planning), improving economic stability, improving resilience, and improving the ability for UICs and AWCs to reach their full potential.

Medical Theory of Change Narrative

Short-term outcomes

Health insurance assistance is expected to increase clients' knowledge of insurance eligibility and processes, increasing enrollment and subsequently increasing utilization of health care services by reducing financial barriers to health care.

Comprehensive primary care Through the provision of consistent primary care, medical providers teach patients about the importance of preventative care and managing their personal health conditions. Improved health literacy has been shown to improve health behaviors⁸⁶, and is expected to increase utilization of health care.

Referrals for specialty care teach patients about the importance of specialty care through their primary care providers, with whom they develop trust over time, increasing the likelihood of compliance with referrals.

Forensic medical exams

Forensic medical exams are expected to improve the likelihood that UICs' and AWCs' applications for legal relief are approved by immigration officials. Evaluations are expected to increase trust in UICs' and AWCs' stories through professional testimony resulting in an increased likelihood of approving petitions.

Mid-term outcomes

Increased health insurance enrollment and utilization of comprehensive primary and specialty care is expected to reduce the frequency and severity of illness, reducing the likelihood of clients missing appointments. The utilization of primary care within a co-located space increases the frequency of contact between patients and their multi-sector providers; improving relationships; establishing trust; and improving compliance with legal, mental health, medical, and social service obligations. Utilization of ongoing primary care is also expected to teach patients preventative health behaviors.

Long-term outcomes

The long-term goal of all medical activities is to assist in the acquisition of legal status and develop a PCMH for UICs and AWCs, with the ultimate goal of increasing stability (by maintaining positive medical outcomes), increasing investment in the future (through educational engagement and job planning), improving economic stability, improving resilience, and improving the ability for UICs and AWCs to reach their full potential.

Social Theory of Change Narrative

Case management

Homelessness prevention and basic living support

Short-term outcomes Case managers teach clients about the resources available to meet basic and housing needs, their rights to certain services (e.g. the right to shelter for families in New York), and how to navigate these resources. For UICs reunified with sponsors, mediation between the sponsor and UIC is expected to reduce household conflict.

Mid-term outcomes Increased knowledge and direct assistance is expected to increase access to and maintenance of basic needs, which is expected to reduce anxiety and chronic stress; improve clients' relationships with others; reduce behavioral manifestations of chronic stress; and improve compliance with obligations.

Job placement assistance

Short and mid-term outcomes Case managers teach clients about U.S. employment culture, resources to find employment, and how to apply to jobs, and support job searching and preparation, with the ultimate goal of assisting clients secure employment. In the mid-term, consistent employment is expected to improve financial stability.

School enrollment and educational advocacy

Short and mid-term outcomes Assistance with educational enrollment is expected to increase school attendance among clients. In the mid-term, school attendance is expected to help UICs develop friendships and a sense of community with peers; reduce feelings of isolation and depression and improve self-esteem; increase knowledge about U.S. culture; and increase high school graduation (which is expected to increase application to and enrollment in higher education).

Enrichment

Short-term outcomes

- **Summer program** is expected to provide recreational activities in a safe space and teach skills in English speaking and photography.
- **ELL classes** are expected to teach participants basic English speaking, listening, reading, and writing skills.
- **Intramural soccer** is expected to provide a safe space for youth to conduct recreational activities.

- **Photography** is expected to teach participants how to use digital photography as a story-telling method in a safe recreational space.
- **Academic support** UICs have frequently experienced interrupted education and struggle with both academic material and language while acculturating to U.S. schools. The provision of academic support at the weekly clinic is expected to improve participants' attitudes towards education by increasing confidence. Increased confidence is expected to support school attendance.

Mid-term outcomes

Enrichment activities are expected to help UICs and CoAWCs develop friendships and a sense of community; reduce feelings of isolation and depression and improve self-esteem; reduce behavioral manifestations of stress (including interactions with the criminal justice system); and improve compliance with medical, mental health, and legal obligations.

Nutrition classes

Short, mid, and long-term outcomes Nutrition classes are intended to teach participants basic nutrition concepts. Preparing and serving the food in a group setting is intended to improve the willingness of children to taste new foods and adults to adapt healthier visions of traditional recipes. In the mid-term, the objective of the nutrition classes is to increase diet variety and intake of healthy foods and reduce consumption of unhealthy foods. In the long-term, the program hopes that participants will maintain healthy eating habits, supporting long-term health outcomes.

Long-term outcomes

The long-term goal of all social activities is to assist in the acquisition of legal status, with the ultimate goal of increasing stability (by maintaining positive medical outcomes), increasing investment in the future (through educational engagement and job planning), improving economic stability, improving resilience, and improving the ability for UICs and AWCs to reach their full potential.

Annex 9: Advocacy Theory of change

Advocacy and education; referrals; technical support and strategic partnerships; research

Short-term outcomes These activities sensitize stakeholders about the unique needs and vulnerabilities of UIC and AWC populations.

Mid-term outcomes Increased knowledge and sensitization is expected to increase service provision and policy advocacy for this population in New York and across the U.S.

Long-term outcomes The long-term goal of advocacy activities for UICs and AWCs is to assist in the acquisition of legal status, with the ultimate goal of increasing stability (by maintaining positive medical outcomes), increasing investment in the future (through educational engagement and job planning), improving economic stability, improving

resilience, and improving the ability for UICs and AWCs to reach their full potential. At the policy-level, increased advocacy is expected to shift organizational and ultimately city, state, and federal policies in support of UICs (e.g. expansion of health insurance coverage).

Medical and psychological forensic exams

Short, mid, and long-term outcomes It is the role of immigration officials to vet applicants who apply for immigration relief. Given the high volume of applicants, immigration officials are skeptical of cases without evidence. Forensic evaluations and letters of support increase immigration officials' knowledge about UICs' experiences, vulnerabilities, and trauma with the mid-term goal of supporting the legal case by increasing trust in UICs' stories, and ultimately contributing to legal status acquisition for UICs.

Annex 10: Interdisciplinary Models Adapted by TF

MLP model

Definition: partnership between legal and health entity to provide co-located services⁸⁸. Legal providers give direct legal assistance, legal training to medical providers⁸⁹, and advocacy at the policy-level⁹⁰. Medical providers give direct care, medical evidence for the legal case⁹¹, and medical training to legal providers.

Problem the model addresses: social determinants of health (e.g. education, employment, immigration status)⁹² impact health outcomes⁹³. The model is based on the assumptions that (1) medical providers have limited resources to address social determinants of health⁹⁴, (2) social determinants of health are often regulated by policy, (3) there are gaps in policy implementation that result in social determinants impacting health outcomes⁹⁵, and (4) legal providers are well-suited to address violations in policy implementation⁹⁶.

Anticipated outcomes: lawyers alleviate legal issues affecting health outcomes and clinicians address medical problems affecting legal outcomes⁹⁷, 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.

Integrated primary care model

Definition: provision of coordinated care across different medical providers to improve patient health outcomes¹⁰⁰.

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 care¹⁰¹.

Anticipated outcomes: improved access to and coordination, comprehensiveness, and continuity of care¹⁰².

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

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 care⁹⁸.

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 manner⁹⁹.

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.

Wraparound model

Definition: holistic and individualized method of planning and managing care for children with complex needs through multidisciplinary team-based planning¹⁰³.

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 success¹⁰⁴.

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

Annex 11: TF Service Providers

Agency	Role	Name
CCNY	Legal Director	Brett Stark
CCNY	TF Case Manager	Laura Rodriguez
CCNY	Attorney	Jodi Zeisemer
Montefiore – CCHR	Medical Director	Alan Shapiro
Montefiore – CCHR	Mental Health Director	Cristina Muniz
Montefiore – CCHR	Program Coordinator	Mia Stange
Montefiore – CCHR	Pediatrician	Justin Kopa
Montefiore – CCHR	Pediatrician	Laura Marcus
Montefiore – CCHR	Social Worker	Brenda Punskey
Montefiore – CCHR	Social Worker	Lisa Pineda
Montefiore – CCHR	Montefiore Case Manager	Nancy Velez
Montefiore – CCHR	Nutritionist	Sandra Arevalo
Montefiore – CCHR	Enrichment Coordinator	Felin Martinez
Montefiore – CCHR	Volunteer	Jose Martinez
Montefiore – CCHR	Patient Service Representative	Isidra Rodriguez
Montefiore – CCHR	Senior Medicaid Interviewer	Carmen Rosario
Montefiore – NYCHP	Physician (Family Medicine)	Scott Ikeda
Montefiore – NYCHP	Nurse Practitioner	Wendy Quinones
Montefiore – NYCHP	Social Worker	Grace Padilla-Matthews
Montefiore – NYCHP	Nurse Practitioner	Robert Jackson
Montefiore – NYCHP	Physician (Family Medicine)	Rubayat Qadeer

Annex 12: 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.

Project team

- Chanel Marin, (Primary Author) Independent Consultant
- Brett Stark, Co-Founder and Legal Director, Terra Firma (sponsored by CCNY) – New York
- Mia Stange, Program Coordinator, Terra Firma (sponsored by CHM and CHF) – New York
- Alan Shapiro, Co-Founder Medical Director, Terra Firma (sponsored by CHM and CHF) – New York
- Cristina Muñoz, Co-Founder and Mental Health Director, Terra Firma (sponsored by CHM and CHF) – New York

- Kris Visich, Director of Operations, Unaccompanied Minors Program, Catholic Charities Community Services – New York

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 Muñoz, Dr. Alan Shapiro, Brett Stark) and Program Coordinator (Mia Stange) for the generous time they provided in informing this evaluation.

Annex 13: Works cited

- ¹ Candel, A. (2017). *Unaccompanied Alien Children: An Overview*. Washington, D.C.: Congressional Research Service.
- ² Children's Defense Fund of New York. (2018). *Unaccompanied Migrant Youth: Service Needs and Gaps in the New York Metropolitan Area*.
- ³ Council on Foreign Relations. (2014). *The U.S. Child Migrant Influx*. Retrieved from <https://www.cfr.org/backgrounder/us-child-migrant-influx>.
- ⁴ CDC. (2011). *A process evaluation of the Reproductive Health Assessment (RHA) Toolkit for conflict-affected women*.
- ⁵ Baily, C. D., Henderson, S. W., Ricks, A. S., Taub, A. R., & Verdeli, H. (2011). The psychosocial context and mental health needs of unaccompanied children in United States immigration proceedings. *Graduate Student J Psychology*, 13, 4-11.
- ⁶ Council on Foreign Relations. (2018). *Central America's Violent Northern Triangle*. Retrieved from <https://www.cfr.org/backgrounder/central-americas-violent-northern-triangle>.
- ⁷ Baily, C. D., Henderson, S. W., Ricks, A. S., Taub, A. R., & Verdeli, H. (2011). The psychosocial context and mental health needs of unaccompanied children in United States immigration proceedings. *Graduate Student J Psychology*, 13, 4-11.
- ⁸ Centers for Disease Control. (2015). *Unaccompanied Children: Health information for public health partners*. Retrieved from <http://www.cdc.gov/usmexicohealth/pdf/unaccompanied-children-factsheet.pdf>.
- ⁹ Burne, O., & Miller, E. (2014). *The Flow of Unaccompanied Children Through the Immigration System*. New York, NY: Vera Institute of Justice.
- ¹⁰ Baily, C. D., Henderson, S. W., Ricks, A. S., Taub, A. R., & Verdeli, H. (2011). The psychosocial context and mental health needs of unaccompanied children in United States immigration proceedings. *Graduate Student J Psychology*, 13, 4-11.
- ¹¹ Ibid.
- ¹² Alvarez, K., & Alegria, M. (2016). *Understanding and addressing the needs of unaccompanied immigrant minors*. Retrieved from <http://www.apa.org/pi/families/resources/newsletter/2016/06/immigrant-minors.aspx>.
- ¹³ Lieberman, H. (2011). *Overcoming Barriers that Prevent Low-Income Persons from Resolving Civil Legal Problems*. Hannah Lieberman Consulting.
- ¹⁴ Hacker, K., Anies, M., Folb, B. L., & Zallman, L. (2015). Barriers to health care for undocumented immigrants: a literature review. *Risk management and healthcare policy*, 8, 175.
- ¹⁵ Ibid.
- ¹⁶ Page, K. R., & Polk, S. (2017). Chilling Effect? Post-Election Health Care Use by Undocumented and Mixed-Status Families. *New England Journal of Medicine*, 376(12), e20.
- ¹⁷ Ibid.
- ¹⁸ McCabe, H. A., & Kinney, E. D. (2010). *Medical legal partnerships: a key strategy for addressing social determinants of health*.
- ¹⁹ Henderson, S., Princell, C. O., & Martin, S. D. (2012). The patient-centered medical home. *AJN The American Journal of Nursing*, 112(12), 54-59.
- ²⁰ Romney, M. (2011). *Medical-Legal Partnerships as a Value-Add to Patient-Centered Medical Homes*. Health Policy Newsletter, 24 (4).
- ²¹ Tong, W. (2017). *Terra Firma: The Path Forward – A Scalability Assessment*. Robin Hood Foundation.
- ²² Shapiro, A., Stark, B., and C. Muñoz. (2013). *Medical-legal partnership: immigrant youth clinic concept paper*.
- ²³ Manuel, K., & Garcia, M. (2016). *Unaccompanied Alien Children – Legal Issues: Answers to Frequently Asked Questions*. Washington, D.C.: Congressional Research Service.

- ²⁴ USCIS. (2018). Asylum. Retrieved from <https://www.uscis.gov/humanitarian/refugees-asylum/asylum>.
- ²⁵ USCIS. (2018). Eligibility status for SIJ. Retrieved from <https://www.uscis.gov/green-card/special-immigrant-juveniles/eligibility-sij-status/eligibility-status-sij>.
- ²⁶ Ibid.
- ²⁷ Ibid.
- ²⁸ U.S. State Department. (2018). Family-based immigrant visas. Retrieved from <https://travel.state.gov/content/travel/en/us-visas/immigrate/family-immigration/family-based-immigrant-visas.html#1>.
- ²⁹ Chen, A. (2014). *An Urgent Need: Unaccompanied Children and Access to Counsel in Immigration Proceedings*. New York, NY: American Bar Association.
- ³⁰ USCIS. (2015). *Credible Fear Workload Report Summary*. Retrieved from <https://www.uscis.gov/sites/default/files/USCIS/Outreach/PED-FY15CF-and-RF-stats-2015-03-31.pdf>.
- ³¹ Ibid.
- ³² Chen, A. (2014). *An Urgent Need: Unaccompanied Children and Access to Counsel in Immigration Proceedings*. New York, NY: American Bar Association.
- ³³ TRAC Immigration. (2018). *Juveniles – Immigration Court Deportation Proceedings*. Retrieved from <http://trac.syr.edu/phptools/immigration/juvenile/>.
- ³⁴ TRAC Immigration. (2018). *Priority Immigration Court Cases: Women with Children*. Retrieved from <http://trac.syr.edu/phptools/immigration/mwc/>.
- ³⁵ TRAC Immigration. (2018). *Juveniles – Immigration Court Deportation Proceedings*. Retrieved from <http://trac.syr.edu/phptools/immigration/juvenile/>.
- ³⁶ TRAC Immigration. (2018). *Priority Immigration Court Cases: Women with Children*. Retrieved from <http://trac.syr.edu/phptools/immigration/mwc/>.
- ³⁷ Chen, A. (2014). *An Urgent Need: Unaccompanied Children and Access to Counsel in Immigration Proceedings*. New York, NY: American Bar Association.
- ³⁸ Huemer, J., Karnik, N. S., Voelkl-Kernstock, S., Granditsch, E., Dervic, K., Friedrich, M. H., & Steiner, H. (2009). Mental health issues in unaccompanied refugee minors. *Child and adolescent psychiatry and mental health*, 3(1), 13.
- ³⁹ Bean, T., Derluyn, I., Eurelings-Bontekoe, E., Broekaert, E., & Spinhoven, P. (2007a). Comparing psychological distress, traumatic stress reactions, and experiences of unaccompanied refugee minors with experiences of adolescents accompanied by parents. *The Journal of Nervous and Mental Disease*, 195(4), 288–297. doi:10.1097/01.nmd.0000243751.49499.93.
- ⁴⁰ Terra Firma. (n.d.). *Unpublished replication manual*. New York, NY: Terra Firma.
- ⁴¹ Ibid.
- ⁴² Lakhani, N. (2016). Central American migrants showing record levels of mental health problems. *The Guardian*.
- ⁴³ Courtois, C. A. (2008). Complex trauma, complex reactions: Assessment and treatment. *Psychological Trauma: Theory, Research, Practice, and Policy*, 5(1), 86–100. doi:10.1037/1942-9681.5.1.86.
- ⁴⁴ Majumder, P., Vostanis, P., & O'Reilly, M. (2017). Barriers for unaccompanied refugee minors in accessing mental health care: Is it the therapy or the therapist? *European Psychiatry*, 41, S339. Derr, A. S. (2015). Mental health service use among immigrants in the United States: a systematic review. *Psychiatric Services*, 67(3), 265–274.

- ⁴⁵ World Bank Group. (2014). Poverty and health. Retrieved from <http://www.worldbank.org/en/topic/health/brief/poverty-health>.
- ⁴⁶ American Academy of Pediatrics. (2013). Key facts about immigrant children. doi: 10.1542/peds.2013-1099.
- ⁴⁷ Gitterman, B. A., Flanagan, P. J., Cotton, W. H., Dilley, K. J., Duffee, J. H., Green, A. E., ... & Nelson, J. L. (2016). Poverty and child health in the United States. *Pediatrics*, peds-2016.
- ⁴⁸ Ibid.
- ⁴⁹ Moore, K., (2005). Thinking about youth poverty through the lenses of chronic poverty, life- course poverty and intergenerational poverty (CPRC Working Paper No. 57). Manchester, England: Institute for Development Policy and Management.
- ⁵⁰ American Academy of Pediatrics. (2013). Key facts about immigrant children. doi: 10.1542/peds.2013-1099. Marshall, K. J., Urrutia-Rojas, X., Mas, F. S., & Coggin, C. (2005). Health status and access to health care of documented and undocumented immigrant Latino women. *Health care for women international*, 26(10), 916-936.
- ⁵¹ DeRosa, C., & Brazmeier, A. (2013). Closing the gap: why immigrant children must have access to health care and how to get there. New York, NY: CHF.
- ⁵² Nevarez, G. (2014). Undocumented immigrants face limits on health care options. *The Huffington Post*.
- ⁵³ Gusmano, M. (2012). Undocumented immigrants in the U.S.: Use of health care. Garrison, NY: Hastings Center.
- ⁵⁴ National Conference of State Legislature. (2017). Immigrant eligibility for health care programs in the United States. Retrieved from <http://www.ncsl.org/research/immigration/immigrant-eligibility-for-health-care-programs-in-the-united-states.aspx>.
- ⁵⁵ Halterman, J. S., Montes, G., Shone, L. P., & Szilagyi, P. G. (2008). The impact of health insurance gaps on access to care among children with asthma in the United States. *Ambulatory Pediatrics*, 8(1), 43-49.
- ⁵⁶ McLeod, S. (2007). Maslow's hierarchy of needs. *Simply Psychology*, 1.
- ⁵⁷ Berry, J. W. (1997). Immigration, acculturation, and adaptation. *Applied psychology*, 46(1), 5-34.
- ⁵⁸ Terra Firma. (2018). Presentation.
- ⁵⁹ World Health Organization (WHO). (2017). Adolescents: health risks and solutions. Retrieved from <http://www.who.int/mediacentre/factsheets/fs345/en/>.
- ⁶⁰ Garwood, S. K., Lara, G., Melissa, J. R., Katie, P., & Brett, D. (2015). More than Poverty—Teen Pregnancy Risk and Reports of Child Abuse Reports and Neglect. *The Journal of adolescent health: official publication of the Society for Adolescent Medicine*, 57(2), 164.
- ⁶¹ The National Child Traumatic Stress Network. N.D. Making the Connection: Trauma and Substance Abuse. Retrieved from http://www.nctsn.org/sites/default/files/assets/pdfs/SAToolkit_1.pdf.
- ⁶² Mitrani, V. B., Santisteban, D. A., & Muir, J. A. (2004). Addressing immigration-related separations in Hispanic families with a behavior-problem adolescent. *American journal of orthopsychiatry*, 74(3), 219.
- ⁶³ Case Management Society of America. (2018). What is a case manager? Retrieved from <http://www.cmsa.org/who-we-are/what-is-a-case-manager/>
- ⁶⁴ Tong, W. (2017). Terra Firma: The Path Forward – A Scalability Assessment. Robin Hood Foundation.
- ⁶⁵ NCMLP. (2016). NCMLP performance measures handbook. Washington D.C.: George Washington University.

- ⁶⁶ Guijt, I. (2013). TOC reflection notes 3: working with assumptions in a theory of change process. Wageningen University and Research: Knowledge co-creation portal theory of change. Retrieved from http://www.theoryofchange.nl/sites/default/files/resource/toc_notes_3_working_with_assumptions_in_a_toc_process.pdf.
- ⁶⁷ Ibid.
- ⁶⁸ Ibid.
- ⁶⁹ Ibid.
- ⁷⁰ Sharifirad, G. R., Hazavehei, S. M. M., Hasanzadeh, A., & Danesh, A. A. (2007). The effect of health education based on health belief model on preventive actions of smoking in grade one, middle school students.
- ⁷¹ Kopan, T. (2018). What are sanctuary cities, and can they be defunded? Retrieved from <https://www.cnn.com/2017/01/25/politics/sanctuary-cities-explained/index.html>.
- ⁷² Ewing, M. (2017). Should taxpayers sponsor attorneys for undocumented immigrations? Retrieved from <https://www.theatlantic.com/politics/archive/2017/05/should-taxpayers-sponsor-attorneys-for-undocumented-immigrants/525162/>.
- ⁷³ Human Rights Watch. (2017). US: Devastating Impact of Trump's Immigration Policy. New York, NY.
- ⁷⁴ Associated Press. (2017). Americans fear they'll lose coverage with Obamacare repeal: poll. Retrieved from <https://www.nbcnews.com/health/health-care/americans-fear-they-ll-lose-coverage-obamacare-repeal-poll-n713356>.
- ⁷⁵ Tong, W. (2017). Terra Firma: The Path Forward – A Scalability Assessment. Robin Hood Foundation.
- ⁷⁶ ORR. (2017). Unaccompanied Alien Children released to Sponsors by State. Retrieved from <https://www.acf.hhs.gov/orr/resource/unaccompanied-alien-children-released-to-sponsors-by-state>.
- ⁷⁷ Detention Watch Network. (n.d.). Family Detention. Retrieved from <https://www.detentionwatchnetwork.org/issues/family-detention>.
- ⁷⁸ Allysa J. Barrington & Jane Shakespeare-Finch, Working with Refugee Survivors of Torture and Trauma: An Opportunity for Vicarious Post-Traumatic Growth, 26 Counselling Psychol. Q. 89 (2013).
- ⁷⁹ BBC Active. (2010). Using mind mapping tools to promote independent learning and study skills. Retrieved from <http://www.bbcactive.com/BBCActiveIdeasandResources/UsingMindMappingTools.aspx>.
- ⁸⁰ TRAC Immigration. (2018). Immigration court processing time by outcome. Retrieved from http://trac.syr.edu/phptools/immigration/court_backlog/court_proctime_outcome.php
- ⁸¹ Siulc, N., Cheng, Z., Son, A., and Byrne, O. (2008). Improving Efficiency and Promoting Justice in the Immigration System: Lessons from the Legal Orientation Program for Custodians. Washington DC: Vera Institute of Justice.
- ⁸² Lustig, S. L., Kia-Keating, M., Knight, W. G., Geltman, P., Ellis, H., Kinzie, J. D., ... & Saxe, G. N. (2004). Review of child and adolescent refugee mental health. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43(1), 24-36.
- ⁸³ Cohen, J., Mannarino, A., and Deblinger, E. (2016). The Benefits of Parental Involvement in Treatment from "Treating trauma and traumatic grief in children and adolescents. Guilford Publications.
- ⁸⁴ Ehntholt, K. A., Smith, P. A., & Yule, W. (2005). School-based cognitive-behavioral therapy group intervention for refugee children who have experienced war-related trauma. *Clinical Child Psychology and Psychiatry*, 10(2), 235-250.

- ⁸⁵ Baily, C. D., Henderson, S. W., Taub, A. R., O'Shea, G., Einhorn, H., & Verdeli, H. (2014). The Mental Health Needs of Unaccompanied Immigrant Children: Lawyers' Role as a Conduit to Services. *Graduate Student Journal of Psychology*, 15, 3-17.
- ⁸⁶ University of Wisconsin. (2010). Health Literacy Interventions. Retrieved from <http://whatworksforhealth.wisc.edu/program.php?tl=22&t2=16&t3=120&id=95>.
- ⁸⁷ Health Outreach Partners. (2013). Medical-Legal Partnerships: Developing and Expanding Outreach Services to Address Legal Needs of Underserved Populations. Retrieved from <https://outreach-partners.org/2013/05/01/medical-legal-partnerships-developing-and-expanding-outreach-services-to-address-legal-needs-of-underserved-populations/>.
- ⁸⁸ McCabe, H. A., & Kinney, E. D. (2010). Medical legal partnerships: a key strategy for addressing social determinants of health.
- ⁸⁹ Zuckerman, B., Sandel, M., Smith, L., & Lawton, E. (2004). Why pediatricians need lawyers to keep children healthy. *Pediatrics*, 114(1), 224-228.
- ⁹⁰ Sylvia Caley, J. D., & Robert Pettignano, M. D. (2013). Bridging the quality gap with medical-legal partnerships. *Physician executive*, 39(3), 44.
- ⁹¹ Sylvia Caley, J. D., & Robert Pettignano, M. D. (2013). Bridging the quality gap with medical-legal partnerships. *Physician executive*, 39(3), 44.
- ⁹² Heiman, H., and Artiga, S. (2018). Beyond Health Care: The Role of Social Determinants in Promotion Health and Health Equity. Kaiser Family Foundation.
- ⁹³ McCabe, H. A., & Kinney, E. D. (2010). Medical legal partnerships: a key strategy for addressing social determinants of health.
- ⁹⁴ McCabe, H. A., & Kinney, E. D. (2010). Medical legal partnerships: a key strategy for addressing social determinants of health.
- ⁹⁵ Zuckerman, B., Sandel, M., Smith, L., & Lawton, E. (2004). Why pediatricians need lawyers to keep children healthy. *Pediatrics*, 114(1), 224-228.
- ⁹⁶ Ibid.
- ⁹⁷ Ibid.
- ⁹⁸ Henderson, S., Princell, C. O., & Martin, S. D. (2012). The patient-centered medical home. *AJN The American Journal of Nursing*, 112(12), 54-59.
- ⁹⁹ American College of Physicians. (2018). What is the patient-centered medical home? Retrieved from <https://www.acponline.org/practice-resources/business/payment/models/pcmh/understanding/what-pcmh>.
- ¹⁰⁰ Goodwin, N., Stein, V., and Amelung, V. (2017.) What is integrated care? In *Handbook Integrated Care* (pp. 3-23. Springer, Cham.
- ¹⁰¹ Ibid.
- ¹⁰² Starfield, B., & Shi, L. (2002). Policy relevant determinants of health: an international perspective. *Health policy*, 60(3), 201-218.
- ¹⁰³ National Wraparound Initiative. (2018). Wraparound Basics. Retrieved from <https://nwi.pdx.edu/wraparound-basics/#whatisWraparound>.
- ¹⁰⁴ Ibid.



Immigrant and Refugee Division

80 Maiden Lane — 13th Floor
New York, NY 10038