Newcomer Central American Youth

INFORMING OUR PRACTICE IN SCHOOL-BASED HEALTH CENTERS

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Executive Summary

This report is a collaboration between La Clínica de La Raza, Inc. (La Clínica) and the University of California, San Francisco, School of Nursing. It is based on joint research and clinical work with newcomer youth from El Salvador, Honduras, and Guatemala in school-based and other community settings. It contains findings from our research, with background and recommendations from other literature, and presents historical background that sheds light on reasons for the sudden increase in unaccompanied immigrant youth (UIY). It summarizes the response from La Clínica school-based health centers (SBHCs): outreach to youth in primary care centers; collaboration with school personnel, particularly in the Oakland Unified School District; and implementation of culturally appropriate school-based behavioral health services. Our hope is that this research will inform the clinicians and staff, in school-based and other settings, who serve newcomer youth from Central America. The report also evaluates a manualized group behavioral health treatment, Cognitive Behavioral Intervention for Trauma in Schools (CBITS) for this population. We found benefits and limitations to this intervention for newcomers; we also found that virtually all CBITS facilitators made significant modifications to the model.

Background

Since 2014, approximately 298,000 UIY have been detained by US Customs and Border Protection; and 246,700 have been released to sponsors in the US. Most of these UIY are from El Salvador, Guatemala, and Honduras. Alameda County is the second most popular destination for UIY within California, impacting health care and educational institutions. UIY arrive with significant experiences of trauma before, during, and after migration to the US.

La Clínica, with a 50-year history of serving Latinx and other immigrants, is well situated to provide innovative primary and behavioral health care to immigrant youth through its eight SBHCs. La Clínica's school-based model features holistic primary care, behavioral health crisis intervention and treatment, health education support services, and a medical-legal partnership. These SBHCs are located in high-stress neighborhoods, where youth experience high levels of arrest and assault, food insecurity, and other resource shortages, school suspensions, and chronic absences.

School-based settings are uniquely embedded in a community institution where school-aged children and youth spend most of their weekday time. School-based settings are also viewed as accessible and trusted health care sites for uninsured youth and families, including immigrant families. During the 2018-2019 school year, 99% of adolescents surveyed rated La Clínica's SBHCs as safe and easily accessible sites to go to for a problem.

Responding to the Needs of Immigrant Youth

Young immigrants often experience symptoms of trauma somatically. They complain of headaches, stomach aches, or difficulty sleeping. School personnel or primary medical providers in our SBHCs, often the first ones to identify these symptoms, refer the youth for clinic-based brief therapies to provide trauma treatment, stabilization, and coping skills. In addition to accepting referrals, La Clínica's SBHC providers also conduct outreach screening to newcomer classes. In a chart review of newcomer youth in a La Clínica high school health center in the 2015-2016 academic year, 70% of the newcomers overall and 82% of UIY screened at the clinic were detained at the US border. Over half of the newcomers had crossed the border without a parent. Of youth who participated in the screening visit, 44% were referred to behavioral health services. La Clínica tracks services to newcomer youth through electronic medical records by using particular case management codes (Z codes) to denote acculturation problems and family disruption.

Behavioral Health Services: CBITS for Newcomers

Integrated behavioral health clinicians (IBHCs) are embedded in SBHCs and available for cross-consultations, emergency referrals, and warm hand-offs to and from primary care clinicians. The National Child Traumatic Stress Network recommends Cognitive Behavioral Therapy, in general, and CBITS, in particular, for immigrant, refugee, and underserved children attending school. For these youth, there are barriers to accessing mental health services outside of school.

Although La Clínica's SBHCs provide trauma-informed treatment at all eight sites, demand for behavioral health services often exceeds capacity. In addition, youth who could greatly benefit from mental health treatment do not necessarily seek care. For those who are not accustomed to seeking help, CBITS in the classroom may be the only way for them to access treatment.

For these reasons, La Clínica has been providing CBITS groups since 2017.

During the 2017-2018 school year, La Clínica screened 469 students for trauma symptoms, and conducted 11 English language CBITS groups. With the help of the SAMHSA grant, La Clínica has expanded CBITS groups to newcomers, including UIY. In addition to English, CBITS groups were provided in Spanish; and a dedicated Mam interpreter supported individual therapy for monolingual Mam families at one community facing SBHC.

Collaboration to Improve Care of UIY

La Clínica's SBHCs collaborate with **schools** to help youth heal from the impacts of trauma, using an Integrated Behavioral Health model. These IBHCs partner with on-campus school supports to leverage services for all students, including participation in the school's Coordination of Services Team (COST). In 2015, SBHC IBHCs served 1,198 youth through individual and group behavioral health programs.

In 2016, Oakland Unified School District (OUSD) estimated that one out of seven youth in the District were newcomers. Many newcomers are at least two years behind their peers academically, due to disruptions in schooling and language barriers. Unaccompanied minors, in particular, enter with interrupted or little formal schooling and need more intensive academic supports. In 2016, OUSD had formal newcomer programs in 16 middle and high schools. Five of these programs are affiliated with La Clínica SBHCs.

La Clínica SBHCs also serve newcomers living in San Leandro and San Lorenzo. Partnering with these districts, newcomer students have access to an array of supports, including academic tutoring, linguistically appropriate counseling and social services, specialized classrooms for English language development, on-site appointments for legal services in partnership with a non-profit law center, and donated food and clothing.

La Clínica has established a **Medical-Legal Partnership** with East Bay Community Law Center (EBCLC) with the purpose of identifying and addressing harmful social determinants of health through collaboration with onsite legal services. EBCLC follows a "Social Determinants of Justice" framework that seeks to address the underlying causes of poverty and economic and racial inequality in order to increase justice and improve opportunities. EBCLC's immigration program provides a full-range of free legal services to low-income immigrants on a wide range of immigration issues with a focus on the most vulnerable populations – people with disabilities, members of the

> *Virtually all youth we interviewed named specific threats or general danger from gangs or local law enforcement as a primary reason for migrating.*

LGBTQ community, and youth. Since 2013, La Clínica has maintained a strong working relationship with EBCLC to implement Just Health, a Medical-Legal Partnership that co-locates attorneys and law students side-by-side with healthcare professionals at four SBHCs. The SAMHSA grants have supported the expansion of this partnership.

Research to Improve Behavioral Health Services to UIY

La Clínica and UCSF partnered to explore the cultural and immigration-related factors affecting the safety and acceptability of this promising group intervention to promote resilience with Central American UIY, with special emphasis on youth speaking indigenous languages. The study was led by Dr. Naomi Schapiro (Principal Investigator), Dr. Ellen Moore (Co-investigator), and Ericberto Garcia Barragan (Study Coordinator) as an expansion to a study already in progress by Schapiro and Garcia Barragan to explore factors supporting resilience in UIY and general safety issues of group interventions.

UCSF and UCSF Benioff Children's Oakland Institutional Review Boards and the Quality Assurance committee of La Clínica approved the studies. We conducted semi-structured interviews with 16 UIY and 10 adult key stakeholders drawn from schools, SBHCs, and community service providers in Alameda County.

Study Findings and Recommendations

Virtually all youth we interviewed named specific threats or general danger from gangs or local law enforcement as a primary reason for migrating. Many noted that local police were either unable to protect them from violence or were working in concert with local gangs or cartels. In addition, all endorsed dreams of completing high school or college and being able to get a better job to support families back home. Most youth were detained at the border and described a difficult process of adjusting to life in the US, including adjusting to relatives they had never met or had not seen in many years.

Our findings include:

- The importance of schools as a source of material and emotional support and the value of targeted education for newcomers.
- The reasons for silence and nondisclosure of trauma being multifaceted, partly rooted in the intersection of discrimination, inequities, and violence targeting indigenous communities.
- Newcomers' fear of gossip and discrimination, which may underlie refusal to use interpreters.
- CBITS group facilitators' need to make multiple adaptations to the intervention.
- Youth appreciation of the opportunities for group support and the opportunity to learn coping skills to calm somatic symptoms.

Future recommendations include:

- Encouraging transnational communication with families in home country.
- Deeper exploration of community and extended family support in US.
- Need for long-term youth-focused case management.
- Need for long-term legal follow-up.
- Strengthening interconnections among school, health, mental health, neighborhood, and legal resources, especially during COVID pandemic-related school closures.
- Working with interpreters as a team to bolster trust and ensure implementation of culturally appropriate interactions during clinical encounters.

DEFINITIONS

UIY, short for Unaccompanied Immigrant Youth, is defined as a child who has no lawful immigration status in the US; has not attained 18 years of age; and, with respect to whom, has no parent or legal guardian in the US, or no parent or legal guardian in the US available to provide care and physical custody (Office of Refugee Resettlement, 2020). UIY are sometimes referred to as Unaccompanied Refugee Minors (URM), to emphasize the dangers from which they have fled.

Children of Migrant Families are also designated as family units, children who cross the border accompanied by a parent or legal guardian (U.S. Customs and Border Protection, 2020).

Newcomers. OUSD generally defines newcomers as students who have been enrolled in a US school for 3 years or less and score between a 1-2 on the California English Language Development Test (CELDT). Newcomers exit from the newcomer designation once they receive a CELDT score of 3 or greater, have been enrolled in school at least 3-5 years, and demonstrate proficiency in grade appropriate reading level.

Introduction

This report is a collaboration between La Clínica de La Raza, Inc. (La Clínica) and the University of California, San Francisco, School of Nursing. It is based on joint research and clinical work with newcomer youth from El Salvador, Honduras, and Guatemala in school-based and other community settings. It contains findings from our research, with background and recommendations from other literature, and presents historical background that sheds light on reasons for the sudden increase in unaccompanied immigrant youth (UIY). It summarizes the response from La Clínica SBHCs: outreach to youth in primary care centers; collaboration with school personnel, particularly in the Oakland Unified School District (OUSD); and implementation of culturally appropriate school-based behavioral health services. Our hope is that this research will inform the clinicians and staff, in school-based and other settings, who serve newcomer youth from Central America. The report also evaluates a manualized group behavioral health treatment, Cognitive Behavioral Intervention for Trauma in Schools (CBITS) for this population. We found benefits and limitations to this intervention for newcomers; we also found that virtually all CBITS facilitators made significant modifications to the model.

The Influx of Immigrant Youth from Central America

Since 2014 there has been a dramatic increase of UIY migrating to the US from Central America to escape pervasive violence and extreme poverty (Restrepo & Garcia, 2014). Between 2014 and August 2020, approximately 298,000 UIY were detained by US Customs and Border Patrol (U.S. Customs and Border Protection, 2020) and 246,700 were released to sponsors in the US (Office of Refugee Resettlement, 2020). At the same time, approximately 312, 933 family units were detained by US Customs and Border Patrol (U.S. Customs and Border Protection, 2020). However, what happens to family units after their initial detention is much harder to track. Recent news reports of an ongoing policy of family separation (Shear et al., 2020) have sparked concerns within immigrant rights organizations that the children are being reclassified as unaccompanied minors after separation at the border. Kids in Need of Defense (KIND) has identified over 5,500 children who have been forcibly separated from their parents since July 2017; and this number is likely much higher (KIND: Kids in Need of Defense, 2020). The majority of detained minors are from El Salvador, Guatemala, and Honduras.

Behavioral Health Impacts/ Behavioral Health Needs of Immigrant Youth and Gaps in Care

UIY in the SF Bay Area who crossed the border before 2012 revealed significant exposure to trauma before, during, and after migration (Schapiro, 2012; Schapiro et al., 2015). Migration stressors have been associated with mental health symptoms. In a North Carolina study, 7% of first-generation immigrant youth reported symptoms of depression and 29% endorsed symptoms of anxiety (Potochnick & Perreira, 2010). Undocumented status alone has been shown to increase fear and isolation (Abrego, 2011). Interviews with young adults who had received Deferred Action for Childhood Arrivals (DACA) indicated that their largest unmet need was for mental health services (Raymond-Flesch et al., 2014). Yet, earlier cohorts of UIY in California have gone without health care, even when offered through low-cost safety net providers, for fear that they might incur debts that could trigger deportation (Raymond-Flesch et al., 2014).

BRIEF HISTORIC TIMELINE OF THE NORTHERN TRIANGLE OF CENTRAL AMERICA

- **1954:** Democratically elected Arbenz government in Guatemala, engaged in land reform and increasing rights of indigenous population, is overthrown in CIA-backed coup to protect United Fruit Company (Schlesinger & Kinzer, 2005).
- **1960-1996:** US-backed counterinsurgency campaigns result in 40-year genocidal war in Guatemala. Ladino-dominated (Westernized) military governments embark on systematic scorched earth campaigns to eliminate local indigenous communities, traditions, and languages, terminating local traditional governing structures and economies (Wilkinson, 2004).
- **1979 –1992:** Civil war in El Salvador kills hundreds of thousands (Chávez, 2015; Wilkinson, 2004).
- **1980s:** Salvadoran-identified Mara Salvatrucha or MS 13 and Calle 18 originate in Los Angeles area, with refugees of civil war fleeing conflict in Central America to Los Angeles (Lemoyne, 1987; Lineberger, 2011).
- **Early 1990s:** Social sequelae of decades-long counterinsurgency wars and displacement give rise to increased criminal activity.
- **1996:** Illegal Immigration Reform and Immigrant Responsibility Act changes US immigration laws increasing deportation of lawful permanent residents and barring many undocumented immigrants from applying for authorization to remain in the US (Lind, 2016; Lineberger, 2011). Gun shops on US border freely sell guns and ammunition within Mexico, facilitating spread to Central America (Viswanathan, 2018).
- **Late 1990s:** Deportees encounter poor economic conditions, limited educational opportunities, and weak police and judicial systems in their native countries and survive by increasing gang activity, recruiting disaffected teenagers desensitized to violence and former soldiers left jobless at the end of civil wars (InSight Crime, 2017; Lineberger, 2011). Social and economic conditions allow gangs to prosper in all three countries and increase ranks with ever-younger recruits using coercion and violence toward victims and their extended families.
- **Late 1990s-present:** Increasing activity of transnational criminal cartels, including Sinaloa and Zeta cartels based in Mexico, with involvement of high-level government officials, especially in Guatemala, as geopolitical conditions lead to Guatemala as a way station for drug transit from South to North America.
- **2009:** US supports right-wing coup in Honduras.
- **2014:** Violence increases in El Salvador, Honduras, and Guatemala. Mass flight of targeted youth from cities and rural indigenous communities of UIY to the US from Central America. UIY seek apprehension by the US Border Patrol to file an asylum claim and await adjudication at federal migrant centers in the US (Boulton, 2011; Guatemala Human Rights Commission, 2011).
- **2020:** Violence and forcible recruitment by gangs continue to escalate, with El Salvador having the highest murder rate in the world (Pariona, 2020).

Traumatic Experience and its Effects

More recent immigrant youth, especially those who cross the border unaccompanied, arrive to school and communities with significant trauma histories. These youth have often fled after experiencing violence themselves or witnessing or hearing about the death of friends and family members. On their journey to the US, they may experience extortion, physical or sexual assault, and/or accidental injury (Betancourt et al., 2017). Stressors continue after crossing into the US, with forcible separation from parents or other adult family members (KIND: Kids in Need of Defense, 2020; Young Center for Immigrant Children's Rights, 2020) and detention under conditions described below, under Research Findings.

La Clínica's History of Engagement with Immigrant Youth

La Clínica was opened in 1971 by activist Latinx students at the UC Berkeley School of Public Health with the driving principle: "Health Care is a human right." They began with a determination to provide low-cost, culturally responsive care to the Latinx community, including immigrant families. La Clínica added behavioral health care services in 1973, a separate clinic dedicated to adolescent services in 1978, and school-based services in 1992. The first school-based health center (SBHC) was the Hawthorne Clinic, which was followed by seven additional SBHCs. Today, these SBHCs serve Alameda County children and youth from ages 3 to 25. La Clínica is a Federally Qualified Health Center (FQHC), part of the Alameda County Health Consortium, and serves Latinx and other immigrant clients in Alameda, Contra Costa, and Solano Counties. La Clínica's SBHCs are part of a network of 26 SBHCs in Alameda County. La Clínica's SBHCs receive support and share innovations through Alameda County Health Care Services Agency's Center for Healthy Schools and Communities.

La Clínica's school-based model features holistic primary care, including routine physical assessments; reproductive and sensitive services care; behavioral health crisis intervention and treatment; and health education support services. Of the eight SBHCs, five are embedded on school campuses (elementary through high school) and provide full access to students, offering appointments throughout the school day and after-school hours. Three of the SBHCs are "community facing," meaning they are not embedded inside schools but near schools and are, therefore, open to community members as well. These community-facing SBHCs are currently operating on a hybrid telehealth and in-person model during the COVID 19 pandemic.

School-based settings are uniquely embedded in a community institution where school-aged children and youth spend most of their weekday time. School-based settings are also viewed as accessible and trusted health care sites for uninsured youth and families (Keeton et al., 2012). Spanish- and English-speaking parents have rated SBHCs as convenient, accessible, trustworthy and family-centered (Albright et al., 2016). Parents particularly endorse their children's access to primary care services without the need of caregivers to take time off work or have their children miss most of a school day. Adolescents have stated that SBHCs deliver the care and health counseling they need. Of the adolescents surveyed at La Clínica's SBHCs during the 2018-2019 school year, 99% rated the SBHC as a safe and easily accessible place to go for a problem and 98% stated that the health center helped them feel that they had an adult they could seek out if they needed help (Alameda County Center for Healthy Schools and Communities, 2019). However, immigrant youth in other SBHC settings are more likely to endorse unmet needs in anticipatory guidance around growth, development, and emotional health (Ramos et al., 2017).

Responding to the Needs of Immigrant Youth

Young immigrants often experience symptoms of trauma somatically. They complain of headaches, stomach aches, or difficulty sleeping. School personnel or primary medical providers in our SBHCs are often the first ones to identify these symptoms and can then refer the youth for clinic-based brief therapies, where we can provide trauma treatment, stabilization, and coping skills. Some youth are referred after exhibiting more external signs of trauma, including difficulty concentrating in class, exhibiting disruptive behavior, or engaging in conflicts with peers and school personnel. For students with internalized symptoms, those who do not exhibit symptoms or behaviors that would result in a referral to the clinic, classroom-based interventions are often the only avenue to identifying and treating their symptoms.

Integrated Behavioral Health Services in La Clínica's SBHCs

La Clínica uses an Integrated Behavioral Health model in its SBHCs, with integrated behavioral health clinicians (IBHCs) embedded in the clinic and available for cross-consultations, emergency referrals, and warm handoffs to and from primary care clinicians. IBHCs provide behavioral health assessments, one-on-one counseling, brief emergency services, family outreach, classroom screenings, and evidence-based group services to youth who otherwise may not have any access to care. In 2015, SBHC IBHCs served 1,198 youth through individual and group behavioral health programs. La Clínica's SBHCs are constantly adapting to meet the unique needs of their patients.

These behavioral health providers partner with on-campus school supports to leverage services for all students. They are constantly adapting to meet the unique needs of their clients. A key part of the IBHC's role is to assess what services within and outside the clinic are needed to support a given youth's health. This can include brief behavioral health treatment within the clinic, referral to on-campus supports, and/or classroom interventions or referral to external community providers. These clinicians also partner with the school and provide training and support to school staff and administration on trauma-informed approaches to support student learning in the classrooms and promote school community wellness. IBHCs participate in the Coordination of Services Team (COST) at their respective schools and share their behavioral health expertise as part of a school-wide support team. They provide behavioral health assessments, one-on-one counseling, brief emergency services, family outreach, classroom screenings, and evidence-based group services to youth who otherwise may not have any access to care. In 2015, SBHC IBHCs served 1,198 youth through individual and group behavioral health programs.

Why Reach Immigrant Youth through SBHCs?

One of the primary functions of SBHCs is to provide universal access to primary, preventive, confidential, and behavioral health care, with a particular focus on youth who are underserved in the traditional health care system. La Clínica's model of care is population-focused, consisting of routine screening for depression, substance use, and trauma among the general student population. In this way, services are provided to youth who are seeking this level of support; and outreach and assessment are also extended to youth who would not otherwise seek these services.

Newcomer Outreach and Service Provision 2014-20

La Clínica has addressed the needs of immigrant youth through targeted outreach screening visits to English Language Learners (ELL) and other newcomers in middle and high schools where their SBHCs are located, through a population-level screening model SBHC providers and staff developed (Schapiro et al., 2016). In a chart review of newcomer youth in a La Clínica High School health center in the 2015-2016 academic year, 70% of the newcomers overall and 82% of UIY screened at the clinic were detained at the US border. Over half of the newcomers had crossed the border without a parent. Of youth who participated in the screening visit, 44% were referred to behavioral health services (Schapiro et al., 2018). Although most youth did not have a trauma-related diagnosis, even brief screening forms revealed that some youth had disclosed histories of sexual assault or had witnessed murders or threats of being killed. Subsequent coding from behavioral health visits revealed past histories of abuse and lack of support in their current environment.

Most recently, the SBHCs have implemented specialized services to meet the needs of UIY at several sites. These services include individual counseling for youth, families, and guardians to address issues such as acculturation, trauma, living with unfamiliar family members or guardians, and navigating school, along with group support and education around grief, loss, trauma, acculturation, life skills, the migration experience, and self-care. Trainings have also been provided to teachers on the impact of trauma and how to support newcomer students.

Tracking Services to Newcomer Youth through Electronic Medical Records

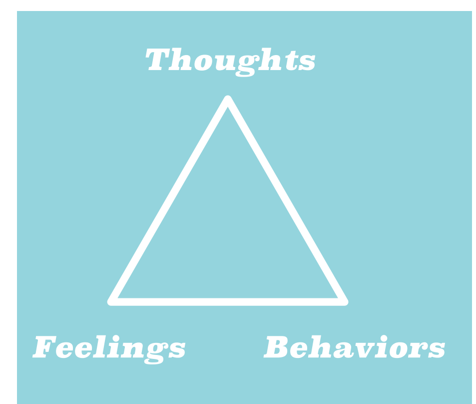
In order to track newcomer youth through electronic medical records (EMR), La Clínica asked SBHC primary care providers and IBHCs to use two case management diagnosis codes at least once on immigrant youth to identify newcomers and UIY: Z60.3 for acculturation problems and Z63.32 for "Family disruption due to other extended absence of family member" for UIY. IBHCs have extra training to reinforce the use of this coding. These Z-codes allow tracking of all UIY served by La Clínica in order to ensure that they are provided with all necessary mental health services from screening through full treatment services. A report running these combined codes, from January 2016 to April 28, 2020, indicated that La Clínica served 2,492 newcomer youth in their SBHCs, of whom 1,488 identified as Spanish-speaking and 447 as Mam-speaking. Using the Z63.32 code alone to run a report, from January 2019 to September 2019, La Clínica provided integrated behavioral health services to a total of 70 UIY. La Clínica continues to use this tracking mechanism.

Most recently, the SBHCs have implemented specialized services to meet the needs of UIYs at several sites. These services include individual counseling for youth, families, and guardians to address issues such as acculturation, trauma, living with unfamiliar family members or guardians, and navigating school, along with group support and education around grief, loss, trauma, acculturation, life skills, the migration experience, and self-care. Trainings have also been provided to teachers on the impact of trauma and how to support newcomer students.

La Clínica Provides Group Behavioral Trauma Treatment in Schools: CBITS

Cognitive behavioral therapy (CBT) is based on the belief that thoughts, feelings, and actions, often visually depicted as a triangle, are interrelated, and that changing thought patterns can affect and improve moods, feelings, and actions. CBT is recommended as an evidence-based treatment for post-traumatic stress symptoms by the American Psychological Association (Guideline Development Panel for the Treatment of Posttraumatic Stress Disorder in Adults, 2017). The American Academy of Child and Adolescent Psychiatry (AACAP) lists CBT as an effective method for treating depression, anxiety, and trauma in children (AACAP, 2019). The National Child Traumatic Stress Network recommends CBT, in general, and CBITS, in particular, for immigrant, refugee, and underserved children attending school, for whom there are barriers to accessing mental health services outside of school (National Child Traumatic Stress Network, 2012).

CBITS is an evidence-based promising practice group intervention, based on principles of CBT, for students in 5th through 12th grade who have been exposed to potentially traumatic events



> ***Although La Clínica's SBHCs provide trauma-informed treatment at all eight sites, demand for behavioral health services often exceeds capacity.***

including community violence, domestic violence, physical abuses, and/or other traumatic events (Kataoka et al., 2003; Marshall et al., 2019; Santiago et al., 2018). First piloted in the Los Angeles Unified School District and studied with Latinx immigrant youth, CBITS is aimed at relieving symptoms of Post-Traumatic Stress Disorder (PTSD), depression, and anxiety among trauma-exposed youth (McLaughlin et al., 2013). Parents give permission for youth to be screened for trauma in their classrooms. Youth who screen positive are seen by an IBHC for further screening and offered participation in a CBITS group. Group members attend a group in their school setting weekly for ten weeks, with two individual sessions. They receive psychoeducation about trauma, are taught coping skills, and are given the opportunity to talk to the group about the trauma that most bothers them.

SAMHSA Grant Supports Expansion of CBITS Groups

Although La Clínica's SBHCs provide trauma-informed treatment at all eight sites, demand for behavioral health services often exceeds capacity. In addition, youth who could greatly benefit from mental health treatment do not necessarily seek care. For those who are not accustomed to seeking help, CBITS in the classroom may be the only way for them to access treatment.

For these reasons, La Clínica has been providing CBITS groups since 2017. During the 2017-2018 school year, La Clínica screened 469 students for trauma symptoms, and conducted 11 English language CBITS groups. With the help of the SAMSHA grant, La Clínica has expanded CBITS groups to newcomers, including UIY. During the 2018-2019 grant year, La Clínica's IBHCs conducted eight CBITS groups in English at middle and high schools, and four groups in Spanish. La Clínica also hired a Mam speaking interpreter to provide support for individual behavioral health care at Hawthorne Clinic, a community-facing SBHC serving youth and families from ages 3 to 18.

School District Response (Oakland Unified School District)

In Alameda County, one of the most diverse in the nation, youth aged 10-24 years make up 19% of the population, comprised of 31% Latinx, 27% Asian and Pacific Islander, 11% African American, and 24% white youth (Alameda County Interagency Children's Policy Council, 2017). Six of La Clínica's SBHCS are located at schools in the Oakland Unified School District (OUSD). During the 2018-2019 school year, 42.3% of OUSD students were Latinx, 33% of students were English language learners, and over 50% spoke a language other than English at home. The top three languages spoken at home were Spanish (33.2%), Cantonese (4.2%), and Mam (2.8%). The District served 2,547 newcomers out of 50,077 students, including 267 refugee students, 241 asylees, and 648 UIY. (Oakland Unified School District, 2020).

In a nationwide survey of adolescents, 73.6% of youth were reported to have been victimized in at least one setting. Youth who had experienced victimization in multiple settings were the most likely to report elevated trauma screening scores, followed by youth who reported victimization at both home and school (Turner et al., 2015). Oakland's Measure Z funding supported development of a neighborhood stressor index, using data about food security and other resource shortages; arrest and assault records; and suspensions and chronic absence among OUSD students. Mapping these stressors over Oakland's 57 community policing beats show that SBHCs in Oakland are located within the 20 most stressed neighborhoods (Bright Research Group, 2015), which highlights the importance of school-based health to help youth heal from the impacts of trauma.

In 2016, OUSD estimated that one out of seven youth in the District were newcomers (English Language Learner & Multilingual Achievement Office, 2016). Many newcomers are classified as Students with Interrupted Formal Education (SIFE), defined as: entering US schools after second grade; having at least two fewer years of school than peers; functioning at least two years academically behind peers; and possibly being preliterate in their native language. Additionally, most newcomers fit at least two of these categories: SIFE, refugee or asylee, unaccompanied, or children of migrant families. Unaccompanied minors in particular enter with interrupted or little formal schooling and need more intensive academic supports.

In 2016, OUSD had formal newcomer programs in 16 middle and high schools (English Language Learner & Multilingual Achievement Office, 2016). Five of these programs are affiliated with La Clínica SBHCs. These programs include heterogeneous language skill groupings; small teacher-student ratios; and extended after-school, summer, and internship learning opportunities. Bilingual support staff and family engagement programs provide additional scaffolding for newcomers. An important part of the strategic plan for newcomers is to "ensure access to culturally sensitive health, mental health, legal services, and other social services" for newcomers and their families. OUSD case managers have partnered with La Clínica IBHCs to conduct group interventions, including CBITS.

La Clínica de La Raza, Inc. SBHCs also serve newcomers living in San Leandro and San Lorenzo. Partnering with these districts, newcomer students have access to an array of supports, including academic tutoring, linguistically appropriate counseling and social services, specialized classrooms for English language development, on-site appointments for legal services in partnership with non-profit law center, and donated food and clothing.

Medical-Legal Partnership

In response to identified community need, La Clínica has established a Medical-Legal Partnership with East Bay Community Law Center with the purpose of identifying and addressing harmful social determinants of health through collaboration with onsite legal services. The East Bay Community Law Center (EBCLC) has provided free legal services for the past 30 years to low-income Alameda County residents. EBCLC follows a "Social Determinants of Justice" framework that seeks to address the underlying causes of poverty and economic and racial inequality in order to increase justice and improve opportunities in five program areas – Housing, Health and Welfare, Immigration, Economic Security and Opportunity (ESO), and Education, Defense & Justice for Youth (EDJY) – by delivering legal services and policy advocacy that are responsive to the needs of low-income communities. EBCLC's immigration program provides a full-range of free legal services to low-income immigrants on a wide range of immigration issues with a focus on the most vulnerable populations – people with disabilities, members of the LGBTQ community, and youth. Since 2013, La Clínica has maintained a strong working relationship with EBCLC to implement Just Health, a Medical-Legal Partnership that co-locates attorneys and law students side-by-side with healthcare professionals at four SBHCs: Fremont Tiger Clinic, Havenscourt Health Center, Hawthorne Elementary School-Based Clinic, and Youth Heart Health Center. The SAMHSA grants have supported the expansion of this partnership.

Research

When primary care and IBHCs started interacting with larger numbers of Central American newcomers, we realized that not only had these young people endured significant trauma, but they were also facing numerous linguistic and cultural barriers to screening for and addressing these traumas. La Clínica had already found some success in treating English-speaking youth with CBITS (Marshall et al., 2019) including youth from immigrant backgrounds.

La Clínica and UCSF partnered to explore the cultural and immigration-related factors affecting the safety and acceptability of this promising group intervention to promote resilience with Central American UIY. The study focused on UIY from three Central American countries, Guatemala, El Salvador, and Honduras, with special emphasis on youth speaking indigenous languages. The study was led by Dr. Naomi Schapiro (Principal Investigator), Dr. Ellen Moore (Co-investigator), and Ericberto Garcia Barragan (Study Coordinator), as an expansion to a study already in progress by Schapiro and Garcia Barragan to explore factors supporting resilience in UIY and general safety issues of group interventions.

The studies were approved by the UCSF and UCSF Benioff Children's Oakland Institutional Review Boards and the Quality Assurance committee of La Clínica. We conducted semi-structured interviews with 16 UIY and 10 adult key stakeholders drawn from schools, SBHCs, and community service providers in Alameda County. Seven out of ten Key Stakeholders were first or second generation Latinx immigrants. Interviews were conducted in Spanish, English, or Mam (with interpreters), depending on participant preference.

An internal Resource Allocation Program grant from UCSF funded the work of Dr. Schapiro and Mr. Garcia. Additional funding was provided through the Substance Abuse Mental Health Resources Administration (SAMHSA), which funded Dr. Moore's release time to collaborate on the evaluation of the safety and acceptability of CBITS for youth who screen positive for trauma experiences and symptoms. This intervention was delivered by La Clínica therapists. Although researchers planned to add in observations and focus groups with youth who had participated in CBITS, logistical obstacles to these groups could not be overcome during the study period. However, 5 of the 10 Key Stakeholders were CBITS facilitators, and 6 of the 16 youth interviewed for the study were participants in CBITS groups. All interviews were conducted between December 2018 and September 2019. Qualitative analysis of interviews and observations have informed interim service recommendations and the next phase of research, detailed below.

Study Findings and Recommendations

Leaving Home and the Journey from the Voices of Youth

The following presents our findings and recommendations based on the voices of youth.

Reasons for Migrating

Virtually all youth interviewed named specific threats or general danger from gangs or local law enforcement as a primary reason for migrating. Many noted that local police were either unable to protect them from violence or were actually working in concert with local or regional gangs. In addition, all endorsed dreams of completing high school or college and being able to get a better job to support families back home. Some youth noted that gangs went into schools to recruit, or that their parents would have to pay protection from recruitment they couldn't afford in order to send them to school in their home country. Other youth talked about neighbors and relatives who had completed college in their home country and were still unable to find anything but menial jobs. One youth noted,

"I was studying in Guatemala, and the Maras wanted me to be a part of them, but I didn't want to. They went to my house looking for me, and my parents decided I should come here, so I did."

Most youth in the study came by land. However, as a group they were reluctant to describe their experiences leaving their home country or their journey through Mexico to the US border. This was in stark contrast to an earlier study of UIY in the same community, migrating from 2010-2012, in which participants described their experience in detail, without prompting by the interviewer (Schapiro, 2012; Schapiro et al., 2015). In the current cohort, youth stated that once they crossed the border, they looked for Border Patrol and asked for asylum.

Detention: Hieleras and Albergues

Youth detained at the border described two stages: "*hieleras*" (iceboxes) and "*casas hogar,*" or "*albergues*" (shelters). When first detained, they were stripped of most of their clothes, placed in *hieleras*, or cold white cells, brightly lit at all hours, with only thin blankets, and minimal food. This stage lasted a few hours to several days. They were then transferred to a sheltered environment, the *albergues*, which they described as "very nice," with showers, food, classes, sports, and some opportunities to call their families. Spanish-speaking youth stated they started learning English in the *albergue*; and youth who spoke primarily an indigenous language credited the *albergues* with giving them an opportunity to learn Spanish.

Adaptation to US Family, Sponsors, and Schools

Most youth in the study were released to relatives, including aunts, uncles, older siblings, and in a few cases, parents who had been in the US for a long time. Some youth in the study spoke positively about their US caretakers, although many still relied on their parents for advice. One young man felt very close to his aunt in the US, but still called his parents in El Salvador every day.

"I confide things to them, everything I feel or do, and they tell me what I'm doing wrong and what I'm doing right."

By contrast, a young woman, who had reunited with her father in the US after many years, said:

"Our first coming here with my sister by ourselves, it was really hard to ask him for money or for him to take us somewhere where we wanted to go. Even though by phone when we were in Guatemala, it was easy to ask him anything or for money, but then here, we didn't know how he was going to react."

The following table presents an overview of our findings and recommendations to help inform our response and better serve newcomer youth from Central America. Schools are important for immigrant youth adaptation, as education is a path to language and literacy acquisition, social mobility, and reaching life goals. Schools connect youth with resources, including health care, food, and legal help. At their best, they provide emotional warmth and a safe and stable location to connect with peers, as well as mentors and role models: from teachers, counselors, and case managers, to all levels of school staff.

UIY Study Findings and Recommendations

TOPICS	FINDINGS	QUOTES	RECOMMENDATIONS
Adjustment to sponsors and connections with distant family	Most youth remained connected to parents in home country, many called daily. Often reported caring relationships with US sponsors but did not rely on them in the same way.	*It's not like your aunt will support you exactly as your parents would support you.*	1. Encourage connections with distant parents: bring into behavioral health sessions. 2. Look for innovative ways to reach out to relatives in US to increase support.
School personnel and peers as crucial supports	Youth frequently named a staff or teacher in their school as the person they would most likely consult for practical help, including legal help, or emotional support. SBHCs were viewed as a seamless part of the school.	*Yes, I feel less depressed here because I come to school, we all greet each other. I go to work, and we all greet each other as well.* *I've gotten a lot of support here from the moment I arrived. If you don't have a lawyer, there's someone who calls you and asks you about how it went for you and all that.*	1. Provide unstructured opportunities for connections. 2. Strengthen interconnections among school, health, mental health, neighborhood, and legal resources.
Considerations for working with Guatemalan indigenous youth	Legacy of oppression; discrimination reproduced in US: • Teased for accents in Spanish, cultural clothes. Small divided communities: • Divided by village of origin, religion. • May decline interpretation – may feel that this will increase stigma, may not trust interpreter. Chisme (Gossip) – concerns about private affairs spreading within local or transnational communities. Body and mind seen as connected in traditional culture: • Emotional/mental health symptoms live in the body. • Cognitive behavioral therapeutic approaches do not necessarily make sense.	*Our culture is very reserved, and when someone is going to help, people think, say "They will know my history. When they see me in the street or I meet with these people, they will know who I am, what I said, and what happened to me.'"* *Here, if you tell something to somebody, it stays there. In my country, you tell something and they start gossiping. That's not all right. Sometimes, we have problems, and we can't count on anybody. It stays within the family, and sometimes, you can't even count on them. That's why sometimes the people that come here are afraid. They don't know if they can count on other people.*	1. Try to elicit reasons for declining interpretation. 2. Clinicians/interpreters work as a team to develop trust: use terms like "privacy" instead of confidentiality. 3. Consider pros and cons of matching of age, region of origin, if options for interpreter use. 4. Support programs for training youth/young adults as interpreters and encouraging Mam and K'iche speaking youth to enter health professions. 5. Explore preferences for group options for Mam or K'iche speaking youth, rather than mixing with native Spanish speakers.

TOPICS	FINDINGS	QUOTES	RECOMMENDATIONS
Screening for Trauma	Youth are reluctant to admit to trauma symptoms or experiences – "todo está bien:" • Silence about traumatic events and symptoms is safer than disclosure. • Terms and questions used in brief trauma screeners may not resonate. • Youth in study endorsed nightmares as primary symptom of trauma, saw decreasing nightmares as a sign of healing.	*So I would say the biggest challenge for me, for CBITS with them is that you're supposed to identify one singular trauma that happened and narrate it and talk about it extensively in front of people. And that's really challenging because many of the kids that we work with have multiple traumas, some that are still going on and many of them, it's really hard to verbalize even what the trauma is.*	1. Explore somatic symptoms: headaches, stomach aches, sleeping difficulties, nightmares. Encourage bidirectional referrals between primary care and behavioral health. 2. Consider screening tools developed for non-Western populations, including Refugee Health Screener (Bjärtå et al., 2018) and Maya Screener(Czerwinski et al., 2011). 3. Conduct more testing of culturally and developmentally appropriate trauma screens.
Group Interventions: CBITS	• **Coping skills** aimed at relaxation (deep breathing, eye pillows) were seen as helpful by youth and stakeholders. • **Group interaction:** youth liked hearing stories, appreciated support from group. • **Safety –** the concept of telling their traumas: "trauma narrative" did not seem safe. • **Written exercises** not seen as helpful – due to low literacy level of newcomers, lack of help at home. • **Parent involvement –** Challenging as parents in Central America or reunifying with parent in US after long separation; sponsors, even close relatives, not involved. • **Adaptations by group facilitators.** • **Groups co-facilitated by clinic and school staff –** successful model, as youth had greater familiarity and trust with school case managers.	*Sometimes, I have friends that—If you tell them you are afraid of your nightmares, they start making fun of you, and that's why I don't like to talk a lot with my friends.* *From my experience in the group, the more I would come, the more focused I would feel in my life.* *There's a bunch of curriculum out there that's just called acculturation groups… you're developing coping skills around the shared experience of being a new immigrant and transitioning to a new country. They're not necessarily each having to share your personal-personalized story about your exact trauma that you've pinpointed. You're more coming together as a group with a shared experience and developing coping skills to deal with symptoms like homesickness or anxiety or sadness or things like that.*	1. Consider group interventions more focused on support and developing coping skills, less on trauma narratives, as suggested by STRONG (Western Centre for School Mental Health) and FUERTE (ZSFG Child & Adolescent Services et al., 2018) curricula, currently in development. 2. Focus on developing trust and coping skills in individual therapy. 3. Consider innovative ways to involve distant parents via telehealth during therapy sessions, or ways to reach out to sponsors/ extended family to help them support youth. 4. Continue to strengthen school-clinic collaborations to provide support to youth.

TOPICS	FINDINGS	QUOTES	RECOMMENDATIONS
Need for long-term case management and support	• Continually changing and worsening legal protections for UIY. • May need to return to court within days of turning 18. • Existing case management programs often family (parent)-oriented, unless youth classified as homeless.	From school case manager: *There are several organizations, but now, they are taking no cases. A very delicate issue going on is that many of these cases were of minors. Now, what the court does is, say I am turning 18 today, and my court date is on Thursday or Friday, which is two or three days after my 18th birthday. In that case, those organizations can't take my case because I am already over 18.* *In spite of everything, we've acquired lawyers for many students. Last year, we supported around 25 students who were able to get free eyeglasses. Many of the students who come here aren't properly vaccinated to attend school, so we schedule the appointment for them and take them to the clinic. Then, they can enroll in school and pursue the studies they need to better themselves. We have gotten students a job. Maybe the jobs aren't the best, but at least they are enough to obtain a minimal income to pay for rent and food.*	1. There is a need for increased and long-term legal case management, including emergency assistance. 2. Re-configure case management programs to reach out to youth, including minors living with sponsors, as minors may still be largely responsible for own finances, health care, school.
Promoting resilience	• Seguir Adelante – youth count on hope in, and working for, the future, which means the ability to complete high school, attend college, work to support families – as a way to help them navigate and heal from current and past stresses and traumas. • "Dejarlo atras" – leaving bad feelings behind as a way to heal. • Sports and activity programs helpful for younger immigrants, most older teens need to work after school. • Strong recommendations from participants to new immigrants to avoid the "wrong path:" drugs/alcohol and crime.	*In my country, they don't give us many opportunities. Here, there are a lot of opportunities for underage boys and girls. They have more opportunities than the older ones because they can go to school and get their papers. That's the only thing I recommend to them, to focus on their studies, not to go down the wrong path because on the wrong paths, there are many bad things.*	1. There is a need for more youth development opportunities, including peer navigators for newcomers. 2. Conduct participatory action advocacy and research projects to incorporate youth voice. 3. Increase paid or stipend internship programs for youth regardless of legal status. 4. Explore alcohol and drug use, prevention and treatment in newcomer population – for youth who may not be accessing behavioral health and/or are not in school.

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