

# Unnecessary Suffering

## Potential Unmet Mental Health Needs of Unaccompanied Alien Children

**M**ENTAL ILLNESS IS one of the most prevalent health problems among children worldwide, with displaced children having a substantially greater burden of illness.<sup>1</sup> Yet, our health care system is not recognizing or addressing the needs of potentially the most vulnerable subset of displaced children in the United States: unaccompanied alien children (UAC).

### UAC'S SUFFERING

Unaccompanied alien children immigrate to the United States without a parent or legal guardian and without legal documents. Almost 70 000 have arrived since 2004, and their numbers are rapidly growing, with 14 500 arriving in fiscal year 2012.<sup>2</sup> That influx is even greater than the 13 000 unaccompanied refugee minors (URMs) brought to the United States since 1980. Like URMs, UAC flee persecution and widespread violence, leading some to call UAC the "lost boys and girls"<sup>2</sup> of the Americas.

Ninety-seven percent of UAC come from El Salvador, Guatemala, Honduras, and Mexico—countries with dramatically increasing crime, systemic state corruption, and poverty. For example, 920 Honduran children were murdered in the first 3 months of 2012, and girls as young as 9 years old have been reportedly gang raped.<sup>2</sup> Multiple UAC recount seeing more than one gruesome death, with gunshot wounds, mental and behavioral disorders (especially alcoholism), and violence against women among the leading causes of premature death in UAC's home countries.<sup>3</sup> No more than 18% of UAC have adequate access to health care,<sup>3</sup> indicating that the ef-

fects of trauma at home were probably undiagnosed or untreated.

Unaccompanied alien children's migration likely compounds significant levels of preflight trauma. The 2000-plus-mile journey to the United States traces routes controlled by drug cartels who beat, drown, drug, maim, murder, rob, molest, and starve undocumented migrants, with some UAC targeted for forced recruitment. Likewise, *coyotes* (guides) may offer UAC drugs or alcohol to stem their hunger or proposition them for hard labor or sex in return for survival. Combined, the high level of potential trauma before and during migration may lead to some of the highest levels of mental illness among children in the United States.

### UNNECESSARY SUFFERING

The sequelae for poor mental health are exacerbated by UAC's precarious legal position once in the United States.<sup>4</sup> Unlike refugees who the United States resettles from faraway camps, UAC self-initiate their northward voyages from Central America, Mexico, and even further away, and they are only in government care after being captured at the border. Unaccompanied alien children are subsequently transferred from traditional detention facilities to Office of Refugee Resettlement (ORR) care within 72 hours of arriving. The Office of Refugee Resettlement's Division of Unaccompanied Children's Services subcontracts 63 facilities across the United States to house UAC (146 per facility), as opposed to the 20 facilities subcontracted for URMs (20 per facility). In these, UAC principally work with staff during a brief 6 to 8 weeks (3-4 years for URMs) to find family or community members who will sponsor long-term stay for

the 88% released in the United States with pending immigration cases; the other 12% are transferred and placed in deportation proceedings.

Unfortunately, UAC are not entitled to the same benefits as URMs (who obtain immediate, ongoing access to numerous medical and social services). Still, some medical services, including mental health care, are mandated for UAC while in ORR custody. However, these provisions are not being systematically implemented, missing a cost-effective opportunity to diagnose and treat UAC's mental illness.

Based on existing federal guidelines and findings from a lone congressional study, the UAC program often fails to provide adequate mental health services. Mental health is not assessed before the transfer from traditional detention facilities to ORR, even though 4 of 7 facility types are better equipped to treat problems than the shelters where 80% are sent.<sup>4</sup> Consequently, UAC with symptoms of addiction, suicidality, or post-traumatic stress disorder may reside in shelters with extremely limited capacity to evaluate, let alone treat, mental illness. Unaccompanied alien children must receive a health screening within 24 hours of arriving at ORR facilities, but a single visit with a general practitioner may not achieve accurate mental health diagnoses and certainly does not imply proper management of chronic mental illness. Facilities do not have uniform educational requirements for staff, and health care providers do not report how often mental health care workers are present. Therefore, estimating how well mental health care is managed for the 50% of UAC taking psychiatric medicine (or those needing treatment but possibly not receiving it) is problematic.<sup>4</sup> According to a 2008 congressional study,

most youth do not receive therapy: 75% did not have evidence of group counseling, and 56% did not have evidence of individual counseling.<sup>5</sup> Of those who received counseling, whether it was evidence based, conducted routinely, or led by a licensed practitioner, is not described. Therefore, beyond large gaps in how treatment is theoretically delivered, large gaps exist in actual treatment delivery.

### ENDING UNNECESSARY SUFFERING

More must be done to diagnose and treat UAC's mental illness while in ORR care, especially given the limited treatment opportunities once released. Whereas URMs typically receive care until the age of 21 years, UAC's access to services ends abruptly on release. Unaccompanied alien children are then likely to encounter greater stigmatization of mental illness, inadequate insurance coverage, and linguistic or cultural barriers. Moreover, UAC may avoid treatment owing to fears of deportation. Short-term, poor mental health could negatively impact how they proceed in their immigration cases.<sup>6</sup> Longer-term, detrimental consequences of unmet mental health needs include higher co-occurring substance use disorders, lower educational attainment, unemployment, homelessness, and imprisonment. Thus, UAC could become individuals with high use and associated costs of both the US health care and criminal justice systems during their lifecourse. Moreover, UAC's untreated mental health could have collateral impacts, acting as vectors for mental health and substance abuse in their new US communities, with their problems spreading in their social networks. Equally important then, diagnosis and treatment in ORR care can defray substantially higher govern-

ment expenses for UAC, their communities, and the entire United States during their lifetime.

Fortunately, ORR's budget growth has outpaced caseload increases, meaning some structural barriers to care (such as rapid release or overcrowding) may be declining. A portion still could be allocated specifically for documenting and evaluating existing care and then implementing evidence-based, trauma-focused mental health care. An independent task force should systematically evaluate UAC's mental health needs and the pharmacologic and psychosocial interventions currently provided at ORR facilities. Evidence-based recommendations from this evaluation can transcend the general calls to action in this perspective. In the meantime, to ensure that UAC are sent to the ORR facility best suited to their needs, several brief self-report instruments, for example, the Child Posttraumatic Stress Disorder Symptom Scale, could be administered before transfer to ORR care.<sup>7</sup> A mental health practitioner could assess in greater detail those children who report symptoms or, after transfer, ORR-contracted medical staff could use the more extensive evaluators, such as the Juvenile Victimization Questionnaire, during intake. In addition to guiding care, evaluations could provide collaborative evidence during immigration proceedings and inform the provision of postrelease services.<sup>5</sup> While multiple therapies can be effective in reducing psychological harm in 6 to 8 weeks and should thus be implemented, we must also study whether UAC need access to postrelief services available to URMs.

The medical profession is specially situated to study, treat, and advocate on behalf of highly vulnerable UAC. Indeed, we must to stop UAC's unnecessary suffering.

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