

Guidance for Mental Health Professionals Serving Unaccompanied Children Released from Government Custody

**Stanford Early Life Stress and
Resilience Program**

National Center for Youth Law

**Center for Trauma Recovery
and Juvenile Justice**

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The National Center for Youth Law (NCYL) is a non-profit law-firm that has fought to protect the rights of children and youth for over four decades. Headquartered in Oakland, California, NCYL leads high impact campaigns that weave together litigation, research, policy development, and technical assistance. NCYL represents the class of thousands of immigrant children in federal custody and is responsible for monitoring the Government's compliance with the *Flores* Settlement Agreement. NCYL also collaborates with public agencies to develop policies and practices that will better help them support immigrant children and families.

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The Center for Trauma Recovery and Juvenile Justice (CTRJJ) brings together national leaders from CUNY John Jay College of Criminal Justice, Fordham University, New York University, the University of Utah, and the National Center for Youth Law who work with traumatized youth. CTRJJ works nationally with the National Child Traumatic Stress Network to enable systems, providers, and organizations to adopt, adapt, and deliver strengths-focused and evidence-based trauma specific interventions.

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How Immigrant Children Navigate U.S. Federal Immigration Custody

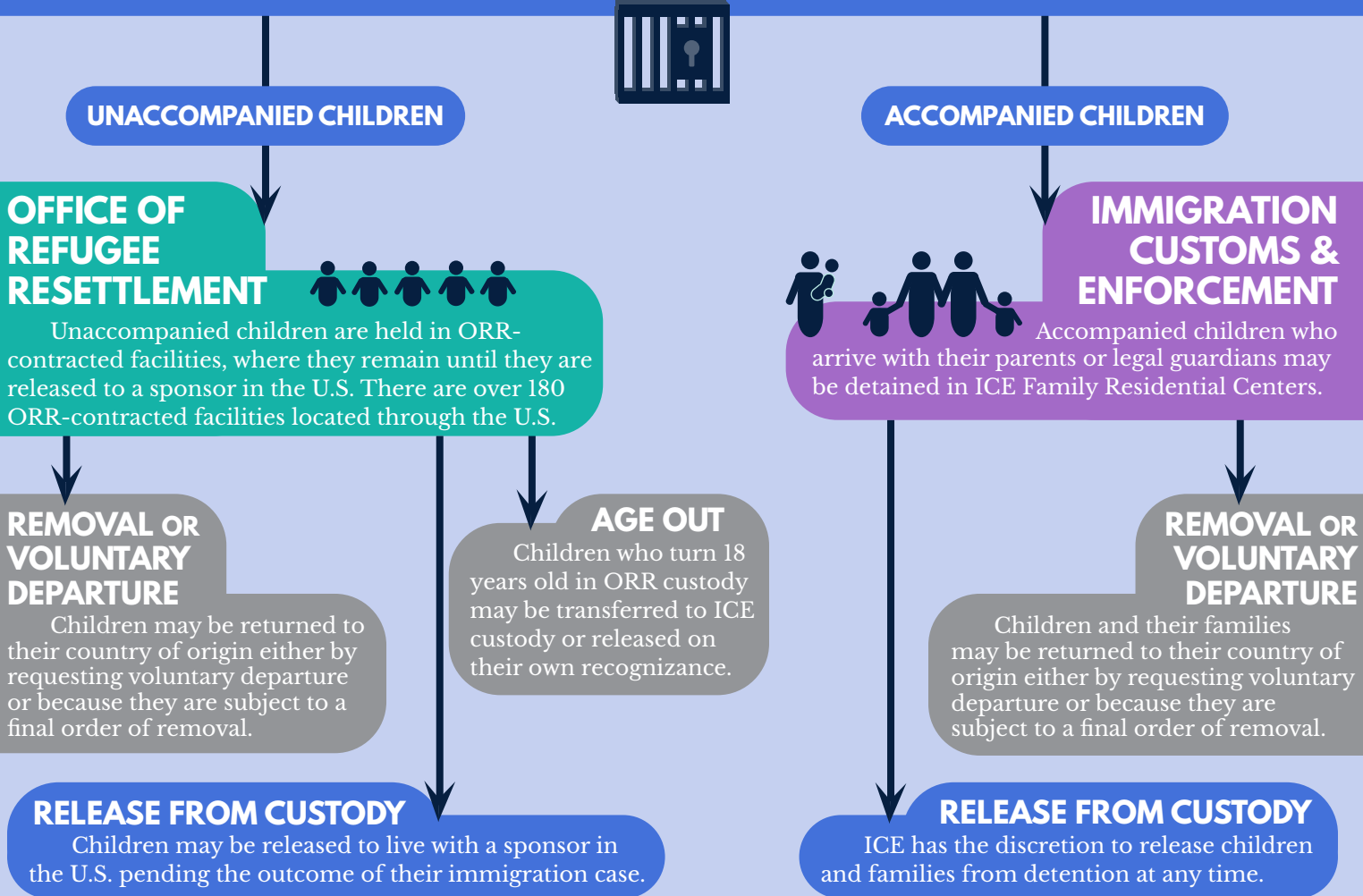
MIGRATION

Children make the journey to the United States for many reasons, sometimes accompanied by family members and sometimes unaccompanied. Oftentimes, this journey is dangerous, exposing children to violence and depriving them of basic necessities including food, water, shelter, and medical care.

U.S. BORDER AND CUSTOMS & BORDER PROTECTION

The majority of immigrant children cross into the U.S. through the Southwest border, where they are detained in CBP facilities. CBP agents then determine whether children are accompanied (arriving with parents or legal guardians) or unaccompanied (arriving alone). This determination subjects children to different processes and protections, or lack thereof.

TITLE 42



TITLE 42 BORDER CLOSURE

TITLE 42

In March 2020, the Trump Administration issued an order under Title 42 barring all “non-essential” travelers at the U.S. border - including asylum seekers and children. The Biden Administration officially exempted unaccompanied children from the Title 42 order in March 2021. As of August 2021, Border Patrol has carried out more than 1.13 million expulsions under Title 42.

1: EXECUTIVE SUMMARY

Providing effective mental health services to unaccompanied children released from federal immigration custody is both critically important and incredibly challenging. Developed by children's rights attorneys and mental health experts on trauma and immigration, this Guide is grounded in the voices and experiences of unaccompanied children. The Guide provides context on the distinctive experiences unaccompanied children carry with them and offers guidance on how to meet the therapeutic needs of these children. Featured quotes from detained unaccompanied children throughout the Guide come from interviews conducted by attorneys representing children in federal custody.

As a mental health provider, you may be the first adult who understands the multi-layered impact that trauma has had on your client. Although each child's experience is distinct, there are commonalities that can help you to provide trauma-sensitive and culturally responsive care for children who have faced the unique dangers, challenges, and losses involved in the journey to this country as an unaccompanied child. Without a deeper understanding of who unaccompanied children are, and what traumatic stressors their journey to and within the U.S. has entailed, even a seasoned clinician with expertise in child trauma may struggle to effectively provide mental health services to this population.

This Guide is intended to support mental health providers in effectively serving unaccompanied children released from immigration custody. To that end, the Guide includes the following, amongst other things:

- An overview of the layers of trauma unaccompanied children may experience throughout their journey – beginning in home country, through their time in federal immigration custody, and upon release into the community
- An overview of the distinctive traumatic stressors impacting unaccompanied children
- General and specific characteristics of the type of government custody where unaccompanied children are placed that increase the likelihood of traumatic stress
- Priorities for mental health professionals working with unaccompanied children

Children that arrive at the border without a parent or legal guardian are remarkably resilient, but many have experienced severe psychological and physical trauma which must be recognized and treated accordingly. When professionals who care for these children are prepared to help them recover from the impact of complex trauma, these children can thrive and regain the healthy development that trauma may have interrupted.

2: DEFINING THE POPULATION: UNACCOMPANIED CHILDREN

Children who come to the United States without a parent or legal guardian are classified as “unaccompanied”¹ and transferred to the custody of the Office of Refugee Resettlement (ORR), where they remain detained until they are released to sponsors. However, unaccompanied children are not without family. The majority (at least two-thirds) of unaccompanied children in ORR custody are seeking to join or reunite with family who are already present in the United States.²

Further, children arriving at the border with adult caregivers who are not their parent or guardian – for example, an aunt or cousin – may be separated from that adult caregiver and transferred to ORR custody, while the adult caregiver is transferred to Immigration and Customs Enforcement (ICE) custody. Therefore, while not officially tallied in the reported counts of migrant children who were literally physically separated from their parents at the border, many “unaccompanied” children have experienced disconnection from primary caregiver(s) and are trauma survivors. These children face the combined adversity of past traumatic experiences and separation from that caregiver, who may be a primary attachment figure or may represent an extension of the primary attachment relationship.

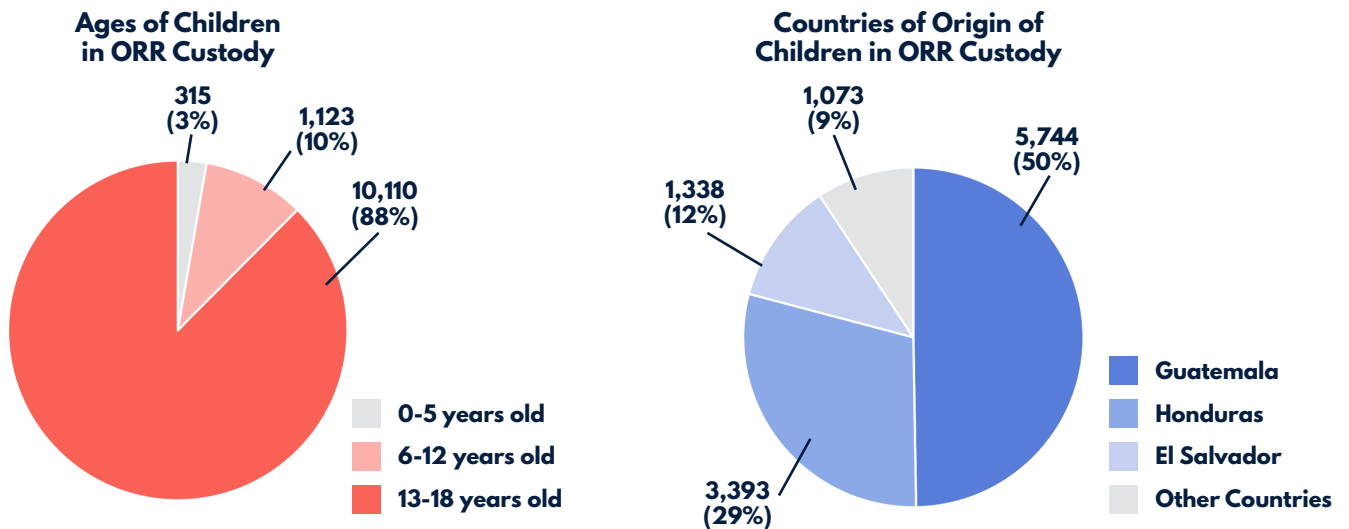
Unaccompanied Children Encountered by CBP at the Southwest Border (2013-2021)



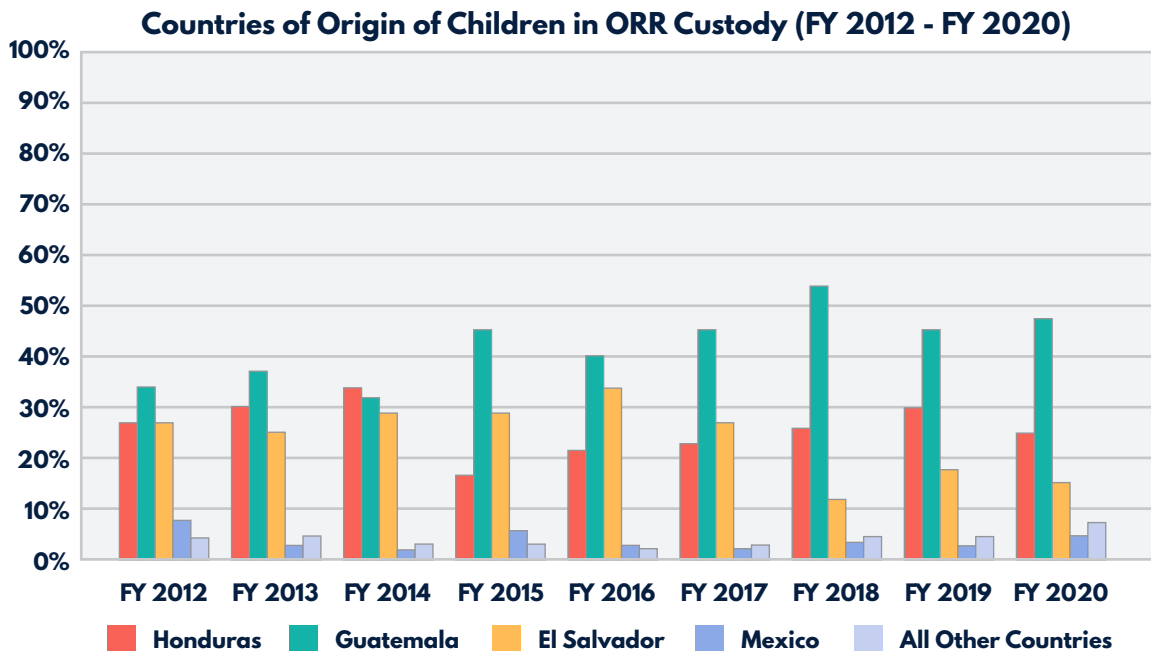
Over the past decade, unaccompanied children have continued to arrive at the southern border of the United States, despite changes in presidential administrations and increasingly punitive policies intended to deter migration.

The number of unaccompanied children in ORR custody has fluctuated dramatically in response to both federal policy changes and external factors. For example, there were approximately 20,320 children in ORR custody in May 2021 and 815 children in ORR custody in August 2020.

As of September 2021, approximately 86% of children in ORR custody were over the age of 12,³ and approximately 90% of children in ORR custody were from Honduras, Guatemala or El Salvador.⁴



The most common countries of origin have shifted over the years, reflecting the impact of complex political, social, economic, and climate factors on migration patterns.⁵ Once in the United States, unaccompanied children may seek asylum or may be eligible for other forms of legal relief including Special Immigrant Juvenile Status (SIJS)⁶, a T-Visa⁷, or a U-Visa.⁸



3: RECENT FACTORS IMPACTING MIGRATION

In addition to longstanding socio-political and economic forces driving migration, recent factors including the COVID-19 pandemic, natural disasters, and federal policies have substantially impacted migration patterns and experiences.

COVID-19 Pandemic

The COVID-19 pandemic has led to the loss of millions of lives and has caused extreme economic and social disruption to people around the world.

In Central America, the COVID-19 pandemic has exacerbated long-standing issues of extreme economic inequality, poverty, violence, and corruption. Already-fragile health care systems have been overwhelmed by COVID-19 cases and have left millions of people without access to basic healthcare, especially those living in rural and indigenous communities.⁹ Inadequate testing and tracing capabilities, insufficient hospital capacity, limited protective equipment, poor public health communication, and reduced access to public health prevention measures all contributed to high rates of cases throughout the region.¹⁰

The COVID-19 pandemic has also had a devastating economic impact, increasing unemployment, poverty, and the gender gap.¹¹ The Economic Commission for Latin America and the Caribbean projected that approximately 45.4 million people were expected to be forced into poverty due to COVID-19 in the region.¹²

Within Central America, many people have faced extreme food shortages, both as a result of the pandemic's impact on the global food system as well as national lockdowns.¹³ According to the United Nations, the number of households living with food insecurity increased by more than 50% in Honduras and 200% in Guatemala since the beginning of the pandemic.¹⁴

Organized criminal groups have also taken advantage of strict national lockdown measures, increasing the use of "extortion, drug trafficking and sexual and gender-based violence, and using forced disappearances, murders, and death threats against those that do not comply."¹⁵ People fleeing Central America have faced increasingly heightened obstacles to migration. In January 2021, Guatemala, Honduras, El Salvador and Mexico issued a joint declaration imposing coordinated health measures to deter migration, including requiring negative coronavirus tests at border checkpoints.¹⁶ As a result, many refugees and migrants have been stranded in increasingly dangerous conditions.

Natural Disasters

In 2020, multiple natural disasters significantly exacerbated the economic toll of the COVID-19 pandemic in Central America.¹⁷ In late spring 2020, tropical storms Amanda and Cristobal struck El Salvador, causing torrential rain, strong winds, and significant flooding.¹⁸ Tens of thousands of homes were damaged, and many people lost their source of income and access to food. Already facing the economic consequences of national lockdowns, people also faced the threat of contracting COVID-19 when sleeping in emergency shelters or receiving humanitarian aid deliveries.¹⁹

Within a two-week span in November 2020, two Category 4 hurricanes made landfall in Guatemala, Honduras, and Nicaragua. Hurricanes Eta and Iota caused flash flooding and landslides that took the lives of more than 200 people and caused thousands more to lose their homes, belongings, livelihoods, and access to food and water.²⁰ According to UNICEF's estimates, the combined impact of the hurricanes left 5.3 million people in need of assistance, including more than 1.8 million children.²¹

These storms overlapped with a period of drought in the “Dry Corridor,” a tropical dry forest region that extends from southern Mexico to Panama. Within this region, Guatemala, Honduras, and El Salvador are experiencing the most severe drought conditions, leaving more than 3.5 million people in need of humanitarian assistance.²²

The ongoing economic and structural challenges in countries affected by these natural disasters have led many families and children to seek safety in the United States.²³

Recent Federal Policies

In January 2019, the Trump Administration introduced the “Migrant Protection Protocols” (“MPP”) policy, also known as “Remain in Mexico.”²⁴ Under this policy, certain asylum seekers – including accompanied children and family members – are forced to return to Mexico to await their asylum hearings in U.S. immigration court.

In March 2020, the Centers for Disease Control and Prevention (“CDC”) issued an order under Title 42 barring all “non-essential” travelers from entering the United States – including asylum seekers and children.²⁵ Instead of children and families entering Customs and Border Protection (“CBP”) custody and then being transferred to Office of Refugee Resettlement (“ORR”) or Immigration and Customs Enforcement (“ICE”) custody, children and families are instead summarily returned or “expelled” without legally mandated protection screenings, immigration court hearings, or other due process safeguards. The Biden Administration exempted unaccompanied children from the Title 42 order in March 2021.

While neither MPP nor Title 42 directly apply to unaccompanied children, your clients may have been indirectly impacted by these policies. In some cases, families have been forced to take the drastic measure of sending their children into the US unaccompanied, rather than remain in Mexico in unstable circumstances where they are targeted for abuse, violence, extortion, and kidnapping. See Appendix B for more information.

4: STAGES OF TRAUMA THROUGHOUT THE IMMIGRATION JOURNEY

Unaccompanied children are vulnerable to many different types of trauma across their migration experience. The experience of compound, prolonged traumas throughout the migration experience – during the journey, crossing the border, and after entering the United States – is an example of sequential traumatization. Some traumatic experiences are unique to specific points of the migration process; others can occur at any point before, during, or after migration.

For unaccompanied children, the absence of their parents or adult caregiver means that they are more likely to experience toxic stress and its consequent short and long-term effects. A toxic stress response can occur when a child experiences strong, frequent, and/or prolonged adversity without adequate adult support.²⁶ By increasing the level of stress hormones and negatively impacting the development of the brain, toxic stress is associated with increased rates of mental health problems (including but not limited to posttraumatic stress disorder), cognitive deficits, risky health behaviors, and physical conditions such as diabetes, cancer, and heart disease.²⁷

The absence of parents or trusted adult caregivers is felt at every stage of a child’s migration. In general, while more than 85% of unaccompanied children are over the age of 12,²⁸ some children are younger, which places them at greater vulnerability to harms. Without the presence of the protective shield provided by caregivers or other trusted adults and without cultural and social supports, children lack the resources that help them to cope with the psychological effects of trauma, uncertainty, and distress.²⁹

Exposure to trauma places unaccompanied minors at increased risk of mental health and behavioral difficulties. For instance, unaccompanied children and adolescents are five times more likely than accompanied refugee minors to exhibit severe symptoms of anxiety, depression, and post-traumatic stress.³⁰ The absence of parents or other adult caregivers also impacts the child’s ability to “re-establish[] a sense of safety and ultimately recover[] from trauma.”³¹

The following sections provides examples of the traumatic experiences that are characteristic of the sequence of events and circumstances that occur at specific points in children’s journeys; however, this section is by no means exhaustive.

- In children’s countries of origin
- During children’s journeys to the United States
- While crossing the border
- After exiting government custody

Traumatic Experiences in Children's Countries of Origin

Before leaving their country of origin, children and their families often experience mass violence or other threats to survival, such as:

- War and large-scale violent conflict, such as genocide and massacres
- Direct and indirect exposure to physical and sexual violence
- Domestic violence and abuse in the home
- Lack of food, water, shelter, and medical care
- Forced internal displacement
- Community and gang violence and threats of violence, kidnapping, and murder
- Traumatic grief related to the death of a caregiver or other important person
- Cultural and religious persecution, ethnic and racial violence, systemic oppression

The majority of children fleeing to the United States have experienced significant and protracted violence in their home countries including: physical attacks, abuse, kidnappings, and extortion by drug cartels and armed gangs.³²

Traumatic Experiences During Children's Journeys to the U.S.

During their journey to the United States, unaccompanied children often experience additional traumas involving abuse, exploitation, and violence (both as a victim and as a witness), such as:

- Direct or indirect exposure to physical and sexual violence
- Lack of food, water, shelter, and medical care
- Human trafficking, sexual and financial exploitation and extortion
- Sudden and prolonged separation from family and other protective caregivers (in some instances, forced separation)
- Hazardous travel (often long distance by foot or unsafe transportation)
- Unsafe and harmful living conditions within refugee camps

Unaccompanied children attempting to flee to the United States face long and perilous trips without their parents or adult caregivers. Often crossing several international borders, children travel hundreds of miles by foot, by bus, or atop dangerous freight trains. They endure weeks or months without sufficient food or medical care, without safe sleeping spaces, with a constant fear of discovery, and a complete dependency on others for survival.

The lack of parents or other caregivers places unaccompanied children at higher risks of experiencing additional traumatic events, such as physical or sexual assault, during their trip to the United States.³³ The most recent estimates indicate that between 60% and 80% of women and girls crossing into the United States from Mexico are raped during their journey.³⁴ These traumatic events compound children's previous traumatic experiences in their home countries. The separation of children from parents and caregivers may occur during the migration journey. These separations often occur in a forceful or violent way that can cause children to feel confused and terrified.³⁵

Traumatic Experiences While Crossing the Border

While crossing the border, unaccompanied children often experience grave dangers, fear, and additional traumas, such as:

- Hazardous travel (harsh climate and terrain)
- Human trafficking
- Sexual and financial exploitation
- Apprehension by government officials
- Processing and physical detention in CBP custody
- Uncertainty about future while detained (concerned about siblings, family in country of origin and in the United States)

Children crossing the border face extremely dangerous conditions that may include harsh weather and temperatures, food and water deprivation, risk of personal injury, and witnessing others experience injury and even death. In some cases, children may be brought across the border by smugglers, upon whom they are completely dependent and therefore experience problematic vulnerability and power imbalance.

Once apprehended by Customs and Border Protection (CBP) agents, children may feel some relief – since they have finally arrived in the United States– but continue to feel uncertain and scared, fearing deportation. Children often experience traumatic interactions with CBP agents, who do not have child welfare training. There have been reports of widespread verbal, physical, and sexual abuse of children by CBP agents during the detention and screening process.³⁶

After being detained, some youth realize for the first time that their efforts to come to the United States to help their families and themselves might not come to fruition. Children face further uncertainty as they are not familiar with the U.S. legal system and often do not know what their rights are or who is in charge of making decisions that will directly impact them. Frequently, by the time children have crossed the border, they likely have not spoken to their families for a prolonged period of time. While waiting to be transferred to an Office of Refugee Resettlement (ORR) facility, children in CBP custody often worry about their loved ones and fear what will happen to them in the future.

Traumatic Experiences While in ORR Custody

See section 6 (“Unique Traumatic Stressors and Adversities for Unaccompanied Children”) on pg. 20 and section 7 (“General Characteristics of Immigration Custody that Increase the Likelihood of Children Experiencing Traumatic Stress”) on pg. 25.

Traumatic Experiences After Exiting Government Custody

Vulnerability to traumatic exposure does not end after children exit government custody. Rather, being in the United States brings with it a number of continuing challenges that can keep youth in a perpetual state of stress/survival. As unaccompanied children attempt to adjust to the language, norms, customs, and traditions of a new country, they often face stressors such as:

- Separation from and ongoing concern for family members in their country of origin
- Ambiguous loss (country, culture, family)
- Discrimination/bullying/hate crimes based on one's identity (e.g., race, ethnicity, sexuality, religion, disability, or native language)
- Release to parents or family members with whom they don't have a strong pre-existing relationship
- Extreme poverty
- Location in under-resourced neighborhoods (e.g., drug exposure, community and gang violence)
- Uncertainty regarding pending immigration case and potential deportation
- Feelings of rejection from a society that views them as inferior and a burden
- Fear that undocumented family members in the U.S. will be detained and deported

Acculturative stress may occur as children are thrust into an unfamiliar culture and society, different social structures, a foreign language, and new role patterns. If there is reunification with parents or primary caregivers, children may experience a lack of familiarity and connection with these caregivers due to prolonged separations. Children may also face a new set of challenges if they are released to sponsors who were not the primary caregivers that raised them. Sponsors or caregiving systems in turn may not be able to understand the child's behavior from a trauma perspective and may unintentionally respond to emotional and behavioral dysregulation in ways that may activate or intensify the youth's traumatic stress reactions.

At the same time that children are being forced to integrate into a new environment, they are also experiencing the disintegration and loss of the society that has been left behind.³⁷ This acculturation process can evoke acculturative stress, which may trigger depression, anxiety, feelings of marginalization and alienation, increased psychosomatic symptoms, and identity confusion.³⁸

5: TYPES OF IMMIGRATION CUSTODY EXPERIENCED BY UNACCOMPANIED CHILDREN

In order to have full context on your client’s experience in government custody, it is important to understand what type of facility or facilities your client has been placed in. When children first enter the United States, they are typically apprehended and detained by Customs and Border Protection (CBP). While detained at CBP facilities along the border, children are processed and determined to be either “accompanied” (if traveling with a parent or legal guardian) or “unaccompanied” (if not traveling with a parent or legal guardian). Unaccompanied children are transferred to the custody of the Office of Refugee Resettlement (ORR), where they are kept until their release to a suitable sponsor in the United States.

Customs & Border Protection (CBP) Custody

Children encountered at the border are typically apprehended, processed, and initially detained by U.S. Customs and Border Protection (CBP) at ports of entry or border stations. The vast majority of migrant children coming to the United States enter through the Southwest land border between the United States and Mexico.³⁹ CBP has two main components: the Office of Field Operations, which manages inspections at ports of entry along the border, and the U.S. Border Patrol, which is responsible for apprehending individuals who have crossed into the United States between ports of entry without valid entry documents.⁴⁰ CBP is also charged with providing short-term detention for individuals arriving to the United States and maintains over a dozen detention facilities located at or near the Southwest border.⁴¹

CBP facilities were initially designed to briefly detain single men migrating to the United States and are fundamentally inappropriate for children. Migrants detained in CBP custody consistently report that the drinking water is not clean, the food is sometimes spoiled or frozen, and there is extremely limited access to showers and soap.⁴² Although the infrastructure of CBP facilities varies, most facilities hold children and families in locked cinderblock cells that have a metal combined toilet and sink, while others separate groups of people with metal chain-link fences.⁴³ Detained migrants consistently report that the facilities are kept uncomfortably cold, leading to the common nickname of “*la hielera*” or “icebox.” Facilities generally do not have beds, so children and families either sleep on the concrete floor or on thin mats underneath silver mylar blankets. The lights are always on, and many facilities do not have windows that let in natural light.⁴⁴ There have also been reports of widespread verbal, physical, and sexual abuse of children by CBP agents during the detention and screening process.⁴⁵

“We sleep on the floor on a mat. I only get one thin aluminum blanket for myself and my son. It’s very cold all the time and I have trouble sleeping because of the cold. My son gets so cold he feels frozen to the touch. The lights are on all the time. There is lots of noise all the time because they are girls and children who can’t sleep and who cry a lot. We are all so sad to be held in a place like this.”

Child, 16 years old, CBP Facility, 2019

Once detained by CBP, children are generally required to be screened and interviewed within 48 hours.⁴⁶ Children’s interviews are conducted by CBP officers who do not have child welfare expertise and are not trained to detect or provide support for signs of abuse or trauma.⁴⁷ During these interviews, CBP officers determine whether children are “unaccompanied” or “accompanied,” which affects the next step in the detention process. Once a child is designated as “unaccompanied,” CBP must generally transfer custody of the child to the Department of Health and Human Services (“HHS”) Office of Refugee Resettlement (“ORR”) within 72 hours.⁴⁸

Some of your clients may have experienced family separation and/or severe overcrowding in CBP facilities – please see Appendix A for more information on these specific experiences.

Office of Refugee Resettlement (ORR) Custody

The Office of Refugee Resettlement (ORR) is responsible for the care and custody of unaccompanied children in federal immigration custody.⁴⁹ Once an unaccompanied child is transferred from CBP custody, ORR is required to “promptly place” the child “in the least restrictive setting that is in the best interests of the child.”⁵⁰ ORR contracts with over 180 state-licensed care provider facilities throughout the United States. These contracted care providers are required to provide basic educational, recreational, counseling, and medical services to the unaccompanied children in their custody.⁵¹

ORR is required to promptly release unaccompanied children to appropriate sponsors, and care provider facilities are required to provide case management services to facilitate each child’s safe and timely release.⁵² After a child is placed at an ORR facility, the child’s case manager works to identify a family member to whom the child can be released.⁵³ The majority of unaccompanied children coming to the United States have a parent, sibling, cousin, or other family member that can serve as their sponsor.⁵⁴ However, some children do not have any potential sponsors to whom they could be released. While some children may spend only a short time in ORR custody, others may be detained for months or even years while they wait to be released to a sponsor.⁵⁵

As there are multiple types of facilities in ORR’s network, it is important to understand what type of facility or facilities (for those that experienced transfers from one type of facility to another) your client experienced.

Licensed Facilities

With limited exceptions, ORR must place unaccompanied children in non-secure facilities that are licensed to care for dependent children.⁵⁶ These facilities must comply “with all applicable state child welfare laws and regulations.”⁵⁷

- Foster Care Placement
- Congregate Placement
- Restrictive Placement

Foster Care Placement

- Transitional Foster Care (TFC) is an initial community-based placement option for unaccompanied children “under 13 years of age, sibling groups with one sibling under 13 years of age, pregnant/parenting teens, or unaccompanied children with special needs.”⁵⁸ Children in TFC placements are placed with foster families, but may attend school and receive other services at the ORR TFC care provider facility site.
- As of March 2020, approximately one-third of all children in ORR custody did not have any viable sponsors to whom they could be released.⁵⁹ Without the option of a community-based foster care placement, these children remain in ORR facilities indefinitely. While ORR maintains contracts with some community-based foster care providers, there are often waitlists for children to obtain a foster care placement.
- Long-Term Foster Care (LTFC) is a community-based foster care placement for unaccompanied children who are determined likely to be in ORR custody for an extended period of time.⁶⁰ Children in LTFC placements are “typically placed in licensed foster homes, attend public school, and receive community-based services.”⁶¹

Congregate Placement

- Within ORR’s network of care providers, there are a significant number of large-scale facilities that house hundreds of children. For example, Southwest Key Casa Padre shelter, a converted Walmart Supercenter, can hold more than 1,400 children at a time.⁶² The network also includes a number of smaller-scale facilities, more similar to group homes, that house between 10-20 children at a time.
- Between January 2018 and September 2019, more than half of the unaccompanied children in ORR custody were detained in care provider facilities that held over two hundred children at a time.⁶³

Restrictive Placement

- Most children in ORR custody live in shelters licensed by the state to care for dependent children. However, some children in ORR custody are transferred – or “stepped-up” – to much more restrictive placements, such as secure facilities, staff-secure facilities, and residential treatment centers.
- Secure facilities are state or county juvenile detention centers that are physically secure structures and licensed to hold children that have been adjudicated delinquent.⁶⁴
- Staff-secure facilities and residential treatment centers have increased staff ratios, place varying degrees of restriction on children’s movement, and provide different levels of therapeutic services.⁶⁵ Children who are stepped-up to restrictive placements remain in ORR custody much longer on average than children in shelter settings.⁶⁶ In September 2019, the average length of detention for discharged children who were placed only in ORR licensed shelters was 52 days. In comparison, discharged children who had any placement in staff-secure or secure facilities were detained an average of 198 days, and discharged children who had any placement in residential treatment centers or therapeutic placements were detained an average of 243 days.⁶⁷
- Children in restrictive facilities experience a substantial loss of liberty. Children in secure facilities are placed in secure cell-block units where they live in single cells, have limited time outdoors, and may experience physical restraint.⁶⁸

Unlicensed Facilities

In past years, when the number of children in ORR custody exceeded its state-licensed bed capacity, ORR opened unlicensed facilities. The agency relied heavily on “influx care facilities” in 2018 and 2019 and on “emergency intake sites” in 2021. These facilities were not state licensed and were not regulated by state child welfare and foster care authorities.

Influx Facility Placement

- Between April 2018 and July 2019, ORR relied on large influx facilities to accommodate increasing numbers of children in custody.⁶⁹ During this time period, ORR detained children at three unlicensed influx facilities – Homestead Influx Facility (Homestead) in Florida, and Tornillo Influx Facility (Tornillo) and Carrizo Springs Influx Facility in Texas. There are minimal standards for health and educational services in influx facilities.
- Homestead could hold up to 2,350 children at one time.⁷⁰ The facility had 24-hour surveillance and monitoring by security guards and staff and was surrounded by a chain-link fence.⁷¹ In February 2019, HHS reported that the average length of stay for children held at Homestead was 67 days.⁷²
- Tornillo held nearly 3,000 children in canvas tents in the Texas desert.⁷³ Similar to Homestead, Tornillo housed children in a restrictive and regimented environment. Children slept in rows of hundreds of bunk beds in enormous canvas tents.⁷⁴

“I sleep in a huge room with 100 boys. It’s very noisy. I have no privacy. Even when we change our clothes there is no privacy. There are about 20 youth care workers in the room with us. They sit up in chairs all night while we’re sleeping, watching us.

When kids break the rules here, the staff write up a report and then the reports are taken to the government. I’ve been told that if I break the rules here then I won’t get to stay in the United States.”

Child, 17 years old, Homestead, 2019

Emergency Intake Sites

- In early 2021, decreased capacity within ORR’s licensed bed network, combined with increased numbers of children arriving at the border seeking protection led to a dangerous backup within CBP facilities. As explained in Appendix A, the severe overcrowding and prolonged lengths of stay in CBP compromised the health and safety of children. In response, ORR established 14 temporary “Emergency Intake Sites” (EIS) located at sites such as convention centers, military bases, and oilfield worker camps.⁷⁵ ORR awarded contracts to run these sites without competitive bidding and to companies with no prior expertise in serving unaccompanied children.⁷⁶
- The minimal standards that exist for EISs are largely aspirational and are lower than the standards ORR previously developed for unlicensed influx care facilities. Visits to EISs around the country revealed serious concerns regarding basic conditions such as inadequate food, limited access to showers and clean clothes,⁷⁷ limited or a complete lack of education or recreation,⁷⁸ and unmet medical and mental health needs.⁷⁹ Children at EISs have experienced panic attacks, self-harm, suicidal ideation, and other serious mental health concerns.⁸⁰ At the Fort Bliss EIS, located on a military base, thousands of children slept in long rows of bunk cots in tents. Children held at the Dallas Convention Center EIS were never allowed to go outside and had extremely limited recreation opportunities.
- Thousands of children spent prolonged periods of time in emergency intake sites before being released to family members or transferred to a licensed placement. As of mid-September 2021, approximately 4,000 children were being detained at one of four EIS facilities in the United States.

“Most of the day we spend on our beds in the sleeping room. We stay on our beds for hours, and sometimes we are allowed to play card games. It’s really boring. I’ve been in custody for 16 days, and I haven’t been able to see the sun or the sky. Sometimes I feel very sad because I have been here for so long. It’s hard to tell time because we can’t tell when it gets dark outside. We are only allowed outside for the short walk to the shower trailers.”

*Child, 17 years old,
Dallas Convention Center, 2021*

“Some of the girls have plastic identification cards on a lanyard around their neck, but I can’t have one of those because I was on the 1:1 suicide watch list. Some girls were using the plastic identification cards to cut themselves, and the staff was worried about the security risk from the lanyard, so I was given an identification bracelet instead.”

*Child, 13-year-old,
Fort Bliss EIS, 2021*

6: UNIQUE TRAUMATIC STRESSORS AND ADVERSITIES FOR UNACCOMPANIED CHILDREN

The experience of traumatic danger in the context of separation from primary sources of security permeates unaccompanied children's experience in immigration custody and beyond. Separation and disconnection from primary caregivers and family supports puts children at risk for additional exposure to traumatic stressors, adding to the cumulative burden of peri-migration trauma exposure. Because of children's disconnection and limited opportunities for contact with caregivers and family while in government custody, children lack protection from institutional or predatory violence, exploitation, and victimization. Without the protection and comfort provided by primary caregivers, children can experience pervasive anxiety about their own safety and about the whereabouts and well-being of their loved ones. This can include intrusive preoccupations that cue and exacerbate potentially pre-existing Posttraumatic Stress Disorder (PTSD) symptoms and intensify reactions to new or ongoing traumas.

Unaccompanied children in Office of Refugee Resettlement (ORR) custody often live in a chronic state of ambiguity and uncertainty about the safety and well-being of their primary attachment figures, and they are often rendered helpless to do anything for their family or even to gather more information that may offer psychological stability and security. This uncertainty, separation from protective caregivers, and vulnerability to violence and exploitation requires extreme psychological coping adaptations that profoundly undermine unaccompanied children's physical and mental health and adversely impacts their worldview (for example, resulting in beliefs and feelings that the world is unsafe, that protective supports are unavailable, and that there are individuals and governmental systems that are seeking to harm refuge-seeking children and families).

Specifically, children in ORR custody often have been or will be confronted with the following severe challenges to their safety, security, and development that adversely affect their mental health:

- Exposure to traumatic stressors (such as community, school, and family violence or maltreatment)
- Experiencing the deaths and loss, both actual and potential, of primary significant others
- Exposure to traumatic exploitation (such as sexual abuse, trafficking, kidnapping, torture, captivity, or gang-related coercion and violence)
- Racism-based threats, violence, deprivation, and devaluation
- Removal of protective caregiving supports that promote resilience in the face of adversity
- Disruption in primary caregiver-child attachment and core sense of trust and security

Exposure to Traumatic Stressors (such as community, school, and family violence and maltreatment, both as directly experienced and as a witness)

First, unaccompanied children often leave their home communities to escape violence or maltreatment. In the often dangerous journey to the United States, they are vulnerable to being directly victimized by or witnessing further or new forms of traumatic violence and maltreatment. Additional traumatic violence and maltreatment may occur to them while in ORR custody due to harsh conditions or acts by staff that are either formally or tacitly condoned, as well as covert actions by adults or other youth that are not monitored and prevented. Children subjected to these forms of traumatic harm and threats adapt in order to survive, but their coping adaptations can become symptoms of PTSD and complex traumatic stress disorders that include, but are not limited to, hypervigilance, anxiety, hopelessness, emotional numbing, self-protective aggression, self-harm and suicidality, sleep disturbances, and dissociation.

Experiencing Deaths and Loss, Both Actual and Potential, of Primary Significant Others

Second, unaccompanied children live with the almost constant threat of permanently losing primary caregivers, other important adult family members, siblings, teachers, mentors, friends, and other significant persons due to either those persons' deaths or an irreversible separation from them. Complicated and unresolved grief and bereavement resulting from such deaths or losses can impair all aspects of a child or youth's development and functioning, often in ways that are not obviously visible and mistakenly attributed to depression, motivational problems, oppositional defiance, or other psychiatric disorders. These children's grief reactions also may manifest as social isolation, school problems, recurrent unexplained medical symptoms, defiance and oppositionality toward adults, and self-harm and suicidality.

Exposure to Traumatic Exploitation (such as sexual abuse, trafficking, kidnapping, torture, captivity, or gang-related coercion and violence)

Third, unaccompanied children are vulnerable to exploitation due to the absence of protection and guidance from their caregivers, other family members, and community. This can take overt forms such as victimization by sexual trafficking, coercion by adult perpetrators or gangs, kidnapping and captivity, extortion, or torture, or covert forms such as sexual abuse or other types of sexual assault. Children may also have left their home and community in order to flee from these kinds of traumatic exploitation or threats associated with resisting exploitation.

Exposure to Racism-Based Threats, Violence, Deprivation, and Devaluation

Fourth, unaccompanied children are subjected to not only discrimination, disparities, and micro-aggressions based on being Black, Indigenous, or other Persons of Color (BIPOC) – but also to traumatic violence, exploitation, and losses specifically due to racism. Such race-related trauma has a compounded adverse impact that magnifies the harm and threat caused by exposure to life threats, irreversible losses, and exploitation by assaulting the child’s sense of identity and security as a member of a racial/ethnic community that is respected, valued, protected, and able to access vital resources equitably by the larger community and society. Children exposed to racial trauma may develop extreme and complex symptoms of PTSD (such as isolation, self-harm, hypervigilance, emotional numbing, interpersonal isolation, and dissociation) in order to cope with the threat of being targeted for extreme violence and dehumanized.

Over many prior generations of this type of racial trauma, historical patterns of oppression can intensify these survival-based reactions such that they are vicariously learned from earliest childhood as well as through direct experiences of racism-based traumatic violence, loss, and exploitation. In order to not be targeted for further victimization, unaccompanied children often develop remarkable grit and resilience, preserving good physical and mental health despite having experienced severe threats and harm. However, the psychological impact of multiple traumas, racism, and microaggressions is severe⁸¹ and their resilience often is only “skin deep”⁸² because the cost of survival coping is correspondingly severe on a biological level (e.g., advanced aging, changes in brain structures, alterations in physiological stress activity) even when appearances and self-reports may suggest that these children are unaffected and are “doing just fine.”

Removal of Protective Caregiving Supports that Provide Security During Adversity

Fifth, the presence of a stable and supportive caregiver is a crucial resource that helps to promote a sense of security and the capacity for resilience by children in the face of adversity. The availability of responsive caregivers provides children with a sense of hope, validation, understanding, emotional support, and co-regulation.⁸³ Caregivers also provide modeling that enables children to learn vital skills such as risk detection, assertiveness/self-protection, self-regulation, and executive control. Children in ORR custody not only are separated from primary caregivers, but also are severely restricted in even their remote contact with caregivers and family members. Current ORR policies allow each child 20 minutes of phone contact with family or caregivers per week.⁸⁴ Within the permitted family contact time, children are often attempting to check-in with loved ones, provide and receive updates on child and family well-being, discuss ongoing immigration and legal proceedings, arrange contact with sponsors, receive emotional support, and discuss future goals and plans. From the child’s perspective, twenty minutes per week of phone contact is wholly insufficient for achieving these aims, especially under the physically and psychologically harsh conditions of confinement and deprivation created by ORR detention.

The absence of contact with caregivers and the institutional denial of access to caregiver supports leave children without the sense of security and the role modeling that are essential in enabling children to thrive and to be protected against physical ailments and psychological distress. As a result, children in ORR custody – especially those held in congregate care settings – are vulnerable to debilitating medical illnesses and unexplained somatic complaints, to posttraumatic stress symptoms, and severe anxiety, depression, self-harm, and suicidality. The absence of caregiving and protection also often leads children to develop the belief that they must be constantly vigilant and ready to defend and protect themselves, which may lead to impulsive and risky behavior, problems with concentration, learning, and sleep,

and problems in relationships including extreme distrust, isolation, emotional detachment or over-involvement, defensive aggression, and vulnerability to re-victimization due to not recognizing or not sufficiently protecting themselves with people and situations that are dangerous or exploitive.

Disruption in Primary Caregiver-Child Attachment

Finally, separation from caregivers and family in a context of vulnerability to violence and victimization causes a significant disruption in attachment security. This combination of traumatic threats and attachment insecurity has been described as developmental trauma, which is associated with not only anxiety and depression but also with difficulties in managing intense emotional distress, reactive behavior, and related relationship dynamics.⁸⁵ Though many refuge-seeking children come from environments fraught with instability, insecurity, and trauma, they are nonetheless often able to find a supportive connection with at least one caring adult from their family or community; access to these protective supports are substantially limited or removed while in ORR custody. The expected norms of a stable, caregiving relationship are violated, and children can begin to internalize a world without protective relational supports. This can result in a pervasive mistrust of others (including individuals and institutions), feelings of anger or blame towards self or family, difficulty with emotion and behavior regulation, and general interpersonal conflict (often marked by presentations that test the limits of family member or caregiver commitment and capacity to support the child). Consequently, the process of family (re-)unification following release from ORR custody is often more challenging than anticipated, with frequent experiences of conflict, rejection, sadness, anxiety, and anger in the caregiver-child dyad, as children and families work to build attachment security anew.

“...the process of family (re-)unification following release from ORR custody is often more challenging than anticipated, with frequent experiences of conflict, rejection, sadness, anxiety, and anger in the caregiver-child dyad, as children and families work to build attachment security anew.”

Related to ambiguous loss (as defined on pg. 39), children may experience difficulty in transitioning back into a typical child-adult relationship after having been accustomed to independently adapting and surviving in life-threatening circumstances. Research shows that the longer the separation they experienced, the less likely adolescents reported being able “to identify with their parents or being willing to conform to their rules at the time of reunification.”⁸⁶ Unaccompanied children who are subsequently reunited with their parents may feel competitive with siblings born in the United States for their parents’ affection and attention.⁸⁷ Children may also feel disappointed in how their reunions with their caregivers turn out, as compared to their fantasies and dreams about life in the United States.⁸⁸

Throughout this transition period, children are also subject to constant uncertainty over their immigration cases and potential deportation back to their home countries. Thus, they face the potential

additional adversity of further separation and loss, which makes it difficult to risk the emotional vulnerability of re-attaching to their parents or guardians. When placed with caregivers and families whom they do not know (e.g., relatives residing in the United States, residential or foster family placements), unaccompanied children face the additional challenge of determining whether their new adult caregivers are safe and can be trusted.

Child-parent relationships can be repaired and restored after migration-related separations depending on a number of factors like the quality of responsiveness of other caregivers (e.g. grandparents), the quality of the previous relationship between caregivers and children, the ability to maintain social and emotional ties with immigrant parents, and the overall support of the community. When reunification happens, the ability to repair the emotional connection is influenced by the parent's functioning (psychological availability of the parent to help the child adjust to the new environment, make meaning of experiences, provide co-regulation, predictability and protection), the child-parent emotional attunement, the child's strengths and vulnerabilities (temperament, developmental, medical and socio-emotional, self-regulatory abilities, how the child experiences the separation from substitute caregivers and prior traumas), and adequate external circumstances and resources (natural and community resources).

While these attachment disruptions may also result from migration patterns and experiences that are independent of ORR practice, the experience of extended separation and disconnection while in ORR custody exacerbates, prolongs, and intensifies this stressor.



7: GENERAL CHARACTERISTICS OF IMMIGRATION CUSTODY THAT INCREASE THE LIKELIHOOD OF CHILDREN EXPERIENCING TRAUMATIC STRESS

Institutionalized Care and Detention Impose Immediate and Long-Lasting Harm to Children

The experience of being detained in government custody has clear, demonstrated negative consequences for the psychological health and general functioning of children. These consequences are due both to the inherent harms of detention as well as of institutionalized care. For many children, detention constitutes a form of traumatic stress and toxic stress exposure that puts them at increased risk of suffering the various health and psychological harms described above. The harm to children only increases when detention is prolonged or occurs in a restrictive environment.

Harm of Institutionalized Care

Research on the impact of child-care and child-rearing in institutionalized settings and congregate care settings demonstrates profound short- and long-term harm. Institutionalized care refers to child-rearing in government or other institutionally-sponsored facilities, as opposed to adoption, kinship care, or placement in another family-like setting.⁸⁹ In many cases, ORR custody constitutes institutionalized care as defined here because most children in ORR custody live in congregate facilities that are not family-like settings. While specific institutionalized care conditions are highly variable and diverse, there are common features of institutionalized care, including: generally high child to staff ratios; rotating staff who lack formal education and training in child development and generally receive low wages; regimented and non-individualized care; and a lack of psychological investment in children.⁹⁰ Institutionalized care has been deemed a form of child neglect because of the failure to provide appropriate levels of individualized attention, caregiving support, and secure relationships that are typical and required for healthy child development.⁹¹ Experts conclude that providing for children's basic needs (e.g., food, sleep, health) is insufficient for promoting typical development in the absence of individualized and reliable caregiver-child relationships.⁹²

The conditions of child-rearing in institutional settings have demonstrated negative consequences on child health and well-being, including attachment and relationship disruption, atypical social behavior, impaired physical development, impaired intellectual and cognitive development, and abnormalities in functioning of the stress response system.⁹³ These developmental impairments are associated with short- and long-term difficulties in psychological functioning, including symptoms of depression, anxiety, PTSD, and general behavioral difficulty.⁹⁴

Placement in congregate care settings (i.e., residential care facilities with more than 12 children) within the U.S. child welfare system is associated with a three-fold increase in prevalence of psychiatric diagnosis.⁹⁵ While the nature of causality in this association is unconfirmed, there is general consensus among child mental health and child welfare experts that institutionalized care and congregate care is inappropriate for children with psychiatric disabilities, and there has been a reduction in the rates of placement in congregate care for children in foster care in the U.S. since 2004.⁹⁶

Harm of Immigration Detention

Immigration detention has been associated with elevated rates and severity of anxiety, depression, and PTSD in adults, adolescents, and children.⁹⁷ For some children and adolescents, the psychological symptoms associated with detention have manifested in thoughts of suicide and self-harming behaviors.⁹⁸ Children’s distress related to immigration detention has also manifested in significant behavioral difficulties, including disruptive conduct, behavioral regression, mutism, and social and behavioral withdrawal.⁹⁹ These findings are consistent with predictions from the science of toxic stress and developmental trauma¹⁰⁰ as well as observations of psychologists interviewing children in ORR custody.

A systematic review of prior research on immigration detention demonstrates that children in particular experience somatic symptoms and health complaints in detention (i.e., headache, stomachache), as well as difficulties with sleeping and eating.¹⁰¹ Researchers attribute these psychological and health problems specifically to the experience of detention, as multiple studies in the review demonstrated that such problems onset or intensified following placement in detention.¹⁰² Furthermore, comparison studies indicated that children who are separated from family members due to detention or deportation have worse mental health outcomes than children who stay with caregivers or family members.¹⁰³ However, being detained even with family members still has a negative impact on child health and functioning. A 2019 study of Central American immigrant children detained in an ICE facility with a caregiver showed that these children demonstrated two times the rates of abnormal emotional and behavioral difficulties, and three to four times the rates of PTSD prevalence compared with children in the general U.S. population.¹⁰⁴

Children in immigration detention are also at risk of exposure to additional trauma including abuse and threat from facility staff, physical and sexual violence from other detainees, social isolation, and family separation and loss.¹⁰⁵

Restrictive Placement is Particularly Harmful

Some children in ORR custody are detained in restrictive placements, i.e. placements that maintain heightened security measures, increased supervision, secure or locked structures, and/or 24-hour surveillance and monitoring.¹⁰⁶ Detaining children in restrictive environments is exceedingly harmful to their physical and mental health.¹⁰⁷ A well-established body of research has demonstrated that detaining children in restrictive environments interferes with healthy development, exacerbates pre-existing trauma, puts children at greater risk of self-harm, and exposes children to abuse.¹⁰⁸

Prolonged Detention is Particularly Harmful

Furthermore, research has demonstrated that increased time in immigration detention is associated with greater psychological distress and increased impairment in mental health functioning for children.¹⁰⁹ While this research has not been specifically conducted in ORR facilities, the broad consensus around the harms of detaining immigrant children against their will in locked and restricted facilities justifies extrapolation of findings to the ORR context. The data indicates that things do not “get better with time” for children in immigration detention; rather than experiencing positive or healthy adjustment to detention, children’s adaptations are associated with psychological deterioration and increased symptom severity.¹¹⁰

Findings from the U.S. Office of Inspector General report (2019) state that “some children [in ORR custody] who did not initially exhibit mental health or behavioral issues began reacting negatively as their stays grew longer . . .

longer stays resulted in higher levels of defiance, hopelessness, and frustration among children, along with more instances of self-harm and suicidal ideation.”¹¹¹ Mental health clinicians “described that a child’s mental health often deteriorates as the length of their stay in ORR custody increases.”¹¹²

With increased time in custody, children experience longer chronicity of symptoms of depression and anxiety, which increases the burden on their stress response systems and exacerbates symptom severity. Chronic and prolonged stress exposure alters hormonal and physiological systems, with long-term consequences for neurological development and immune functioning.¹¹³ Furthermore, with prolonged and repeated delays in release or family reunification, children become increasingly desperate and despondent.

Long-Lasting Harm of Institutionalization and Detention

While release from detention has been shown to correspond with some relative alleviation in psychological distress, the psychological consequences of detention are clearly demonstrated to endure post-release, and may result in long-term impact.¹¹⁴ Multiple research studies have shown that symptoms of depression, anxiety, and PTSD endure for years beyond release from detention, with many enduring symptoms being directly related to the detention experience (e.g., avoidance of detention reminders, nightmares and flashbacks from detention).¹¹⁵ Similarly, institutionalized child-rearing has been shown to have long-term negative effects on children’s development and functioning in multiple domains.¹¹⁶

Once again, the severity of symptoms post-release has been associated with length of time in detention.¹¹⁷ The psychological consequences of the trauma of child detention are expected to have a lasting impact in the form of ongoing/unresolved symptoms, impaired sense of personal agency, feelings of worthlessness and self-blame, impaired sense of trust and safety within interpersonal relationships, and alterations in worldview. Furthermore, the experience of chronic toxic stress in childhood due to detention is, in some cases, expected to alter a child’s developmental trajectory due to the psychological impact (described above), health impairment, neurobiological alterations, and general lost opportunities to practice and hone life skills during critical periods of development.¹¹⁸

Therefore, the detention of immigrant children is expected to have long-term (including potentially life-long) impacts on mental health, psychological functioning, and general health and achievement.¹¹⁹

8: SPECIFIC CHARACTERISTICS OF ORR CUSTODY THAT INCREASE THE LIKELIHOOD OF CHILDREN EXPERIENCING TRAUMATIC STRESS

Several aspects of ORR custody make it more likely that children will experience ORR detention as traumatic.¹²⁰ Children’s experiences of stress, threat, and adversity are likely to be traumatic when such experiences entail:

- A limited sense of control, autonomy, or personal agency over what is happening;
- Limited knowledge or information about current circumstances or expected outcomes;
- Perceived lack of predictability, consistency, or security in the environment;
- Limited access to social and family supports and/or protective resources;
- Perceived constant and pervasive threat of danger in the environment; and
- Experiences of fear or helplessness.

The accounts of children in ORR custody clearly demonstrate a preponderance of trauma exposure and resulting manifestations of traumatic stress and related disabilities, including psychiatric and learning disabilities.¹²¹ Many times, these stressors and difficulties are directly related to children’s current circumstances in ORR custody, including the conditions of the facility and the ways in which children are treated. While ORR custody settings range from shelters to “staff secure” to “secure” facilities, some children in less restrictive settings, such as shelters, still perceive their environment as highly restrictive and secured. Children are not allowed to leave the facility premises and are required to adhere to strict routines and schedules, with knowledge and fear that noncompliance can jeopardize their prospects for family reunification. Many children in ORR custody, regardless of the type of facility they were in, describe feeling involuntarily trapped and confined, express a strong desire to be released and to live with family or in the community, and feel helpless to improve their situation.

“Being detained for such a long time has made me feel really bad. I never used to have such problems with depression or anxiety, but since I have been detained I have become much more frustrated. Being detained at Yolo makes me feel like I am going crazy. I am always alone with my thoughts and bad memories of the things that have happened to me run through my head all day. I don’t know how I can improve my mental health if I am kept in a cage.”

*Child, 16 years old,
Yolo Juvenile Detention Center, 2018*

Limited Sense of Control or Personal Agency

Children in ORR facilities consistently express a limited sense of control or personal agency over what is happening to them. Additionally, children in ORR custody often report difficulty in accessing legal support for their cases and demonstrate a lack of understanding of the legal standards and requirements for their release, custody, and assurance of safety. This leaves these children feeling disempowered with regard to their status and placement. In addition, children report that placement transfers are often made abruptly and unexpectedly, without their knowledge or understanding of why they are being transferred. As a result of these significant and unanticipated changes, children commonly experience emotional and behavioral difficulties such as anxiety, anger, and sadness.

“Then, one morning around 5:00am, I was transferred to [new facility]. I didn’t know I was leaving the shelter until the day before the transfer. The staff told me that they were taking me somewhere else, but I didn’t know where. I was sad when they told me that I was leaving. I told the staff that I didn’t want to leave; I had friends at the shelter and had gotten used to being there. The staff just told me that I had no choice and had to leave.”

*Child, 14 years old,
Shiloh Residential Treatment Center, 2018*

“One night, around 2 A.M I was woken up and told it was time to leave. I thought I was finally being released to my parents, but instead I was taken to [a new facility] in California, far away from my family.”

*Child, 17 years old,
Yolo Juvenile Detention Center, 2019*

Another example of minimized child agency involves the administration of medication without a child’s (or legal representative’s) permission or understanding of what they are taking. There are numerous documented incidents of children being forced, pressured, or coerced to take medication. Interactions with staff also contribute to children’s sense of disempowerment, including experiences in which children are forced or coerced to sign documents and agreements that they don’t understand. Such experiences undermine children’s sense of personal autonomy and sense of agency, thereby rendering the entire detention and care experience potentially traumatic.

Limited Knowledge or Information About Current Circumstances or Expected Outcomes

Many children in ORR custody struggle with the psychological impact and uncertainty of having limited knowledge about their circumstances and expected outcomes. With minimized child agency in placement and custody determinations, they experience distress due to the uncertainty of their situation and general well-being. Children report and demonstrate particular difficulty related to the lack of clear and consistent information about the reunification or placement process and timeline. In the vast majority of cases, children report that their predominant goal is to be released from restrictive care and be reunified with family or placed in safe community settings where they can develop their lives. However, they often receive little information about placement plans, or experience numerous delays or setbacks in placements; children report not understanding delays in placement and having no information about what they (or their potential sponsors) need to do to pursue placement.

Children in ORR custody often experiences delays in being stepped down from secure care; in the meantime, children are left in a state of “unknowingness” and helplessness that corresponds with anxiety

and depression. In many cases, children report not having clear information or understanding about how placement decisions are made and what they can do to improve their level status or obtain privileges. This lack of information and understanding leaves children feeling helpless and disempowered, further contributing to the risk for psychological harm and traumatization. This may result in children mistakenly thinking that they are doing something wrong or that they have been abandoned by the people who were supposed to help them.

Perceived Lack of Predictability and Consistency in the Environment

Many children in ORR custody perceive a lack of predictability, consistency, or security in the caregiving environment due to lack of clear information, inconsistent application of policies, and/or abrupt and severe changes in placement. Children experience unanticipated and abrupt changes in placement, facility schedules and routines, which they find confusing, disorienting, and unpleasant, but they fear that they will be punished if they do not comply with changes. Children also report that consequences and reward systems are applied differently amongst children.

This lack of consistency in response or knowledge of what to expect creates uncertainty for children thereby potentially exacerbating psychological distress or any existing disability (e.g., by heightening anxiety, shame, or self-blame). Witnessing or directly experiencing sudden and unexpected placement transfers (often times in the middle of the night), further contributes to children's sense of unpredictability and insecurity while in ORR custody. Misinformation or dishonest communication about placement transitions is a source of distress and anger that impacts children's behavior and functioning in ORR care.

“One day the staff told me and four of my peers that we would be leaving . . . to be with our families. The staff all gathered around when we left and gave us a happy farewell. We were all so excited to see our families. Later once I was on the plane, one of the staff members told me I wasn't going to be with my family after all. I was so angry and confused . . . I tried to run away because I was so upset that the staff had lied to me about going to see my family.”

*Child, 17 years old,
Children's Village Staff Secure, 2019*

Limited Access to Family and Social Supports

Children report emotional distress due to missing their family and having limited access to social and family supports:

“I had a lot of intense emotions because I missed my family. Sometimes, I cut myself. Sometimes my feelings made me feel aggressive and led to fights.”

- Child, 16 years old, Yolo Juvenile Detention Center, 2018

“One of the reasons I cut myself is because I was angry that the staff at BCFS would not let me live with my family.”

- Child, 17 years old, MercyFirst Residential Treatment Center, 2019

“I feel like I am a prisoner here, but I have not done anything wrong. Every morning I wake up crying because I want to be with my family.”

- Child, 17 years old, Homestead Influx Facility, 2019

The distress and worry children feel impacts their ability to engage in typical tasks of development, such as learning:

“It is hard to study when I am worried about my mother who is ill in Honduras. . . I also feel very worried that I can’t leave this place and so I can’t study.”

- Child, 16 years old, Homestead Influx Facility, 2019

The mere prospect of long-term placement and restriction from being with family is a source of stress:

“The psychiatrist had initially predicted that I would need to be in the RTC program for three to six months; I felt like that was a really long amount of time, and that made me feel even more anxious. . . I am so desperate to leave this place. I want to leave and live [with] my family.”

- Child, 17 years old, MercyFirst Shelter, 2019

Furthermore, due to limited communication with family or other known caregivers, children experience chronic worry, anxiety, and PTSD symptoms about family members’ well-being, and they are denied access to the psychological relief that results from co-regulation and protective support from a trusted caregiver.¹²²

Perceived Constant and Pervasive Threat of Danger in the Environment

Children experience constant and pervasive threats of danger to their well-being and safety while in ORR custody. For example, children report experiencing physical threats and direct assault from peers and facility staff, demonstrate pervasive anxiety and nervousness due to fears of being attacked or assaulted, and sometimes fear that they will be deported or have their reunification delayed due to discipline for a behavioral infraction (with these fears often stemming from direct threats received from facility staff). These anxieties often amount to symptoms of PTSD intrusive thoughts or hypervigilance, as children cannot stop thinking about these pervasive fears or dangers and they are on constant alert for danger or threat around them. The lack of appropriate responses to child health problems is an additional source of perceived threat.

Experience of Fear or Helplessness

The combination of incidents and reactions described above result in experiences of fear, helplessness, and distress for many children in ORR custody. Some children become increasingly distressed, despondent, and unstable when they receive news that a release or transfer (e.g., to a sponsor or to a step-down facility) is denied or delayed. For example, one child stated:

“ . . . [M]y dad called me . . . to explain that he was no longer interested in serving as my sponsor. I was devastated by this news and became very depressed. Then I was transferred to the psychiatric hospital. . . the doctor there told me that my reunification process would stop moving while I was there. I’m not exactly sure why the reunification process stopped . . . ”

- Child, 17 years old, MercyFirst Shelter, 2019

Interviews with children reveal anxiety about potential dangers to their well-being while in detention, or anxiety about the well-being of loved ones with whom children receive limited contact or information. With limited information about reunification or release processes, as well as limited opportunities for autonomy and independence due to highly-structured detention environments and limited child or family agency in placement planning, children experience a sense of helplessness while in custody. Children also report a sense of helplessness and fear after being stepped-up to more restrictive facilities such as residential treatment centers, staff-secure, and secure facilities.

Some children report being assaulted by facility staff, or fearing physical confrontation with staff. Children’s perceived experiences of being confined and mistreated by facility staff are sources of distress contributing to psychological difficulties – for example:

“I would probably feel a little better . . . if the staff stopped yelling at me all [the] time. If the staff didn’t make the rules so strict, and if I didn’t have to keep taking the medicine, I would feel a little bit healthier and happier. This place makes me so angry . . . I have never been incarcerated like this in my life . . . I want my freedom so badly.”

- Child, 16 years old, Shenandoah Valley Juvenile Detention Center, 2020

“I can’t stand being locked up any more. I feel so helpless and desperate. I don’t know what to do. I want to be released so badly. I want to live with my family. I know I will be so happy when I am finally free.”

- Child, 17 years old, St. Michael’s Home for Children Shelter, 2018

In sum, the experience of ORR detention is a form of traumatic stress for many children in custody. Many children arrive to the U.S. with pre-existing trauma exposure and the additional traumas and adversities experienced while in ORR custody further compound existing vulnerabilities. In this way, experiences in ORR custody can exacerbate children’s prior psychological and health risk, resulting in increased prevalence and severity of health problems, psychiatric disorder, and disability in this population.

9: PRIORITIES FOR MENTAL HEALTH PROFESSIONALS PROVIDING CARE FOR UNACCOMPANIED CHILDREN

Helping unaccompanied immigrant children successfully make the difficult transition to living in a new family, community, and country after experiencing multiple layers of psychological and physical trauma requires a trauma-informed and culturally responsive approach.

The coping adaptations that children must make in order to survive trauma and adversity can directly cause, or greatly exacerbate, emotional and behavioral symptoms. It is critical for mental health providers to understand each child's unique experience and consider the therapeutic implications of the types of harms children released from government custody may have experienced. For example—

Children who have experienced...	may...
life-threatening events and prolonged circumstances of actual/potential life threat for the child and/or their caregivers, family, friends, and community members	➔ experience anxiety and hypervigilance until they have been helped to therapeutically remember and make meaning of those experiences and know that they now are safe.
deaths and losses, actual and potential, of primary significant others	➔ need help in grieving those losses and knowing that they can hold the lost loved ones or significant others in their heart while finding security and happiness in continuing and new relationships.
exploitation (such as sexual abuse, trafficking, kidnapping, torture, captivity, or gang violence)	➔ need help in overcoming shame and in regaining a sense of control in their life.
moral injury (i.e., when the child feels a sense of guilt or shame for things s/he did, or failed to do)	➔ need help in determining what they were and were not actually responsible for and what they can do in their life currently to uphold their (and their family and community's) values.
loss or destruction of home or community	➔ be fearful of losing their new home, community, and family, and reluctant to become vulnerable by being emotionally involved in those relationships and that new home, community, and school.
historical trauma including ethnic-motivated crimes and violence, racism-based threats, violence, deprivation, or devaluation	➔ not trust mental health providers who do not recognize or fully appreciate the psychological burden and danger involved in surviving the modern expressions of historical trauma and racism, and would only be reassured if the provider explicitly validated those concerns.

Given the extraordinary complexity in serving this population, mental health professionals should prioritize the following:

- Ensuring that services are meaningfully trauma-focused
- Addressing basic needs and providing stabilization (pre- and post-release)
- Assessing trauma-related developmental impacts and adaptations
- Restoring self-worth by overcoming guilt, shame, and self-blame
- Restoring hope, security, and emotional connections in relationships by overcoming unresolved and invisible grief
- Understanding and supporting connection to the child’s culture and heritage
- Addressing challenges with family integration/re-unification
- Ensuring multi-systemic, cross-disciplinary integration
- Managing secondary traumatic stress reactions

Mental health professionals reading this Guide will have different levels of expertise in providing trauma-focused mental health services and working with recently detained unaccompanied children. This section is meant to provide in-depth information on priorities in clinical practice that is accessible to mental health professionals with varying experience.

Ensuring that Services are Meaningfully Trauma-Focused

Trauma-focused assessment and therapy can enable an unaccompanied child to safely recall, no longer feel fearful, and find meaning in memories of past traumatic experiences. However, it is important for a child to have assured stability in their primary family relationships before beginning trauma-focused processing of memories, and for primary caregivers to be willing and able to participate in the therapy so that the child can safely share their trauma memories with caregiver(s) (after first sharing them with the therapist). Caregiver involvement in trauma-focused therapy is important so that the caregiver(s) understand any reactions that the child may have while working through difficult memories (e.g., increases in anxiety, irritability, or challenging behavior) and support rather than criticize the child should those reactions occur. It is important to help the child and caregivers to not only feel a sense of safety in their current lives, but because they often still are in precarious and stressful circumstances (e.g., due to fluctuating immigration policies and vulnerability to discrimination and hate-based threats), also to emphasize that their safety is the result of their competence and their bond with one another.

Trauma-focused services begin with having a therapist who is experienced in helping children recover from trauma, and who is knowledgeable about the types of trauma and adversity that unaccompanied children may have experienced and the trauma-related emotional and behavioral problems that can result. The therapy begins with the therapist developing a therapeutic alliance with the unaccompanied child and caregiver(s) based on showing genuine interest in getting to know them and their background—not inquiring about traumatic experiences specifically but instead talking about their life and experiences. Therapy also initially involves the therapist explaining clearly what therapy entails, how it can help the child or youth to achieve goals important to them, how long it will continue, and how the therapist will continue to care about the child or youth even when they no longer meet together.

The first practical focus of therapy with unaccompanied children and youth should be to address any immediate problems that are placing the child or youth at risk or causing major distress or impairment.

Any external safety risks or adversities should be ameliorated with the help of trustworthy persons or services. Behaviors by the child or youth that place them at risk should be identified and nonjudgmentally understood and accepted as trauma-related coping adaptations, so that discussion with the child or youth of potential safer alternative behaviors can be done as a collaborative exploration of how the child/youth can experiment with alternative behaviors that were not available or would not have been effective under past traumatic circumstances.

Having begun trauma processing by making a link between current risky or maladaptive behavior and past trauma-related coping, therapy proceeds by helping the child (through play or storytelling or other creative activities that are developmentally appropriate for the child) and caregiver to develop a narrative describing the experiences that preceded, occurred during, and have occurred since immigrating and being in ORR custody. Helping the child and caregiver develop a personal narrative (or the very young child to enact their memories in play with their caregiver) of what has happened and how they have reacted and coped—including protective resources or relationships as well as traumas—can enable the child and caregiver to not avoid (and involuntarily re-experience) troubling memories and to make sense of their reactions to current stressors as ways of coping with reminders of traumas that they can choose to continue or change (i.e., affirming self-determination and self-worth). The goal is to restore the child's and caregivers' sense of safety, security, and competence by helping the young child to express through interaction with their caregiver, or the older child or youth to express through age- and culturally-appropriate activities, their understanding of and emotional reactions to what has happened to them in traumatic events.

Addressing Basic Needs and Providing Stabilization (Pre- and Post-Release)

It is important for mental health, healthcare, and social services providers to recognize that the basic physical, socio-emotional, and learning needs of unaccompanied children typically are at best only partially met in even a transient manner—let alone on a sustained basis—when they are released from ORR custody. Assessing each child's basic needs in each of those domains is essential on an ongoing basis when providing mental health services to unaccompanied children not only during ORR custody but for years afterward when they have been permanently re-located. The key to meeting the full range of a child or youth's basic needs is the safety, stability and security provided by trustworthy and responsive relationships with primary caregivers (including relatives, mentors, teachers, and other adults to whom the youth can look for protection, guidance, affection, and role modeling). Supportive relationships that are temporary and time-limited (including crisis or short-term mental health support or treatment) can contribute to a child's safety and security but are not alone sufficient.

Although mental health, healthcare, and social services providers are limited in the time or amount of services they can provide for a formerly detained unaccompanied child, it is essential to ensure that the provider serves as a bridge to connect the child to long-term or permanent sources of caregiving and support—and also helps the child to experience the temporary relationship as a connection that will be carried on by the caregivers who are more permanently a part of the child's life. In that manner, transitional mental health services can help these children to develop internal schemas of themselves as worthy of being cared for and of transitional caregivers (such as short-term mental health services providers) as continuing to be supportive despite not being able to be directly involved in the child's life after their limited time together.

Assessing Trauma-Related Developmental Impacts and Adaptations

Children experience traumatic threats, victimization, and losses in distinctive ways at different ages and developmental stages, and the adverse impact of trauma also differs based on the child's stage of biopsychosocial development both at the time of trauma and currently. With unaccompanied children and youths of all ages, trauma-informed assessment should include a sensitive exploration of how the child's feelings (often unacknowledged) of sadness, loneliness, anger, anxiety, guilt, shame, or confusion are related to separation from or loss of:

- Primary caregivers
- Other persons who are or have been sources of security or are perceived as integral members of the child's psychological family
- Role models and mentors
- The community, culture and language that the child identifies as their psychological home
- Their original physical home and community environment

This is especially complicated when the child does not understand why or how the separation or loss occurred, leaving the child with unanswered questions as well as grief. Enabling unaccompanied children to successfully grieve losses involves helping them develop ways of understanding the loss that are meaningful to them and ways of keeping or regaining a sense of connection to the lost person(s) and relationships.

Infants & Toddlers

Infants and toddlers react to stressors primarily based on immediate physical and emotional adaptations related to fear, frustration, sadness, and pain or deprivation. Their knowledge and memory of traumatic experiences tend to be nonverbal and both felt and expressed through dysregulated bodily states such as heightened or diminished arousal, attention, interest, activity, and distress, and disabilities that may be misdiagnosed as severe emotional disturbance, autism spectrum disorders, or disruptive behavior disorders. Trauma-focused services for unaccompanied infants, toddlers, and preschoolers should involve dyadic-relational approaches (e.g. Child-Parent Psychotherapy) involving the caregiving figures in the child's life who can serve as protective shields and assist the child with co-regulation and making-meaning of their experiences.¹²³ With older children who were exposed to trauma in infancy or toddlerhood, therapy focuses on helping the child to independently self-regulate when experiencing trauma-related reactions as well as assisting the child's caregivers in supporting the child's sense of secure attachment. When the caregiver has a history of trauma that interferes with his or her response to the child, the therapist also helps the caregiver understand how this history can affect perceptions of and interactions with their child.

Preschool & Early School-Age Children

Preschool and early school-age children rely upon dependable daily routines and the consistent and responsive availability of caregivers as needed for help and security. Traumatic experiences disrupt or eliminate the child's routines and access to caregivers, causing confusion, frustration, anxiety, loneliness and a sense of helplessness or determination to be self-reliant that can appear to be depression,

oppositonality, impulsivity, aggression, withdrawal, or a combination of some or all of these reactions. Therapy for unaccompanied young children involves helping them and their adult caregivers to recognize and regulate their bodily and emotional reactions and behavioral impulses¹²⁴ and to develop a life story that enables them to understand trauma experiences without feeling confused, helpless, or unsafe.¹²⁵ This enables the child to rely and build on their personal abilities, strengths, and positive relationships and to initiate or resume healthy routines that affirm their autonomy and develop a sense of security and trust in healthy relationships. For the very young child, their caregiver's sense of safety, competence, and love for the child are the crucial sources of security to affirm in therapy.

Older School-Age Children & Pre-Adolescents

Older school-age children and pre-adolescents rely on a combination of practical rules for living and adventurous exploration of the world in order to feel confident in themselves and engaged in activities and relationships. Traumatic experiences in this developmental period lead children to become rigidly reliant on fixed beliefs (e.g., the world is never safe, no one can be trusted, things will never get better) and ways of coping (e.g., defiant, reckless, careless, or avoidant behavior). When unaccompanied children present with these cognitive and behavioral challenges, they can be misdiagnosed with depression, generalized anxiety, attention deficits, oppositional-defiance, or, in extreme cases, psychoses or mania. If the trauma involved sexual abuse or assault—which becomes more prevalent at this age—problems with sexualized behavior can lead to the mis-diagnosis as a sexual predator or to risky sexual behavior that places the child or youth at risk for rerevictimization. Therapy with unaccompanied older/pre-adolescent children involves helping them develop or strengthen a realistic positive view of themselves, their relationships, and the world, helping them to independently manage their emotions and behavior, and helping them to develop an understanding of what happened to them in traumatic experiences so that they feel safe in their current life and do not feel confused or blame themselves and feel guilty or ashamed about traumatic experiences.

Adolescents & Transition-Age Youths

Adolescent and transition-age youths are seeking to define their identity as autonomous individuals while experimenting with roles, relationships, moral and ethical principles, and activities that are novel and exciting (i.e., sensation seeking) while also affirming of their worth and independence. Traumatic experiences that occur in this developmental epoch often activate posttraumatic reactions that developed earlier in childhood, greatly complicating the impact of the more recent traumas. Unaccompanied youth who have layers of trauma exposure over their lifetime often reject the moral/ethical values of their original and current families, communities, and cultures, and adopt cynical, pragmatic, and egocentric beliefs and behaviors that can lead to conflict in relationships and with social institutions, (e.g., school drop-out, delinquency) as well as compromising their safety (e.g., substance abuse, gang involvement, self-harm or suicidality). Assessment with unaccompanied youth who present with these socioemotional problems and risks should identify how traumas that have occurred over the youth's lifespan have led the youth to feel unsafe and alienated and to cope with defensive trauma-related tactics that may have originated earlier in life and have become more complex and ingrained with repeated use for many years. Assessment and therapy also should address the conflict between the core values and beliefs that the youth derived from positive experiences with family, community, and culture, versus the trauma-based sense of anger, helplessness, hopelessness, and distrust that they have developed to cope with traumas that have occurred in their life.

Restoring Self-Worth by Overcoming Guilt, Shame, and Self-Blame

Experiences of guilt, shame, and self-blame are common outcomes of trauma exposure generally, as survivors seek to make sense of their trauma experience(s).¹²⁶ In trying to integrate and understand why traumatic events occurred, survivors can experience intense remorse and guilt around the events transpiring before, during, and after the trauma experience, and often attribute culpability to themselves when they don't perceive an alternate explanation, or when others (especially authority figures) assign responsibility (i.e. blame) to the trauma survivor. Familial and cultural attitudes – including stigma about trauma experiences and related mental health challenges – can also correspond with guilt, shame, and self-blame. Due to the experiences and characteristics of being taken into ORR custody as an unaccompanied minor, these youth are at particular risk for struggling with guilt, shame, and self-blame.

As children experience the lack of age-appropriate activities and interactions in ORR custody, they may come to internalize the discrepancies between the custody environment and normative child-rearing environments as a result of their own personal faults. While in ORR custody, children may be redirected, punished, criticized, or discouraged from engaging in age- and developmentally-appropriate behaviors, and thus receive implicit and explicit messages that such behaviors are inappropriate or “bad.” Once again, the result is that children may feel guilty about their behaviors and impulses, and they may blame themselves or feel ashamed for behaviors and interactions that are entirely age-appropriate. The lack of a trauma-sensitive caregiving environment in ORR systems further exacerbates and intensifies the experience of guilt, shame, and self-blame for children struggling with posttraumatic stress symptoms and related behavioral challenges.

Difficulties with unresolved and invisible grief may also correspond with experiences of guilt, shame, and self-blame. For unaccompanied youth, there may be pointed experiences of regret and remorse due to the loss of home and community. Experiences of being homesick or feeling hopeless may transition to feelings of guilt as youth reflect on the various events, actions, and trajectories that led them to arrive in ORR custody. Youth may come to blame themselves for past events that transpired in their journey. Despite the fact that migrant youth (and families) are attempting to navigate severe threats to their safety and well-being, and are generally responding appropriately to abnormal and extreme life circumstances, they may come to attribute responsibility to themselves for the disconnection and distancing from home and community they experience while in ORR custody.

Following encounters with overt and covert forms of racism and discrimination that are experienced by youth in ORR custody, many may begin to internalize the messages they receive regarding their personal and cultural identities. Experiences of cultural aggression and oppression can lead youth to feel inferior and “unworthy” due to their cultural and ethnic backgrounds, resulting in feelings of guilt, shame, and self-blame. This is particularly true for youth from indigenous communities, who have often already experienced a lifetime of discrimination and oppression prior to arrival at the US-Mexico border.

Restoring Hope, Security, and Emotional Connections in Relationships by Overcoming Unresolved and Invisible Grief

Many children in ORR custody experience grief due to the disconnection from family, home, community, and culture. Grief reactions for all types of loss can include intense and alternating experiences of anger, sadness, anxiety, guilt, and confusion.¹²⁷ These reactions are particularly complicated when the loss is ambiguous and/or invisible. Such is the case of children in ORR custody, whose losses often go unrecognized and unappreciated by those around them.

“Ambiguous loss” can refer to the uncertainty involved when a family member is psychologically or physically absent for an indefinite period of time.¹²⁸ Without clear information about when a family member will return, children and caregivers are forced to live in a paradox of absence and presence. It may be unclear to children if their caregiver is still part of the family, if they will return, if things will be the same when reunited. This ambiguity about the family boundary (who is in and out of the family) and the impossibility of closure, even if reunification happens, can give place to high levels of stress and lead to psychological and emotional conditions in children and caregivers: depression, detachment, anxiety, guilt, and immobilizing feelings of powerlessness.

Due to the wide range of possible losses and separations experienced by unaccompanied youth at various stages, it may be helpful to organize therapeutic response in terms of specific dimensions of loss experienced by the youth. A guide for this is provided by Multi-Dimensional Grief Theory (MGT).¹²⁹ See Appendix C for more information.

Understanding and Supporting Connection to the Child’s Culture and Heritage

Each unaccompanied child has unique experiences that providers must understand through the lens of the child’s cultural background and heritage. An important starting point in learning from a child about their culture is to ask the child what would happen in an ordinary day in the place they lived, and what they and their family, friends, other children and adults in their neighborhood (and school, if they were able to go to school; or work, if they had to work for money for themselves or their family) would do during that day. For many children who were living in violence and poverty, there were few, if any, ordinary days, but they may have had routines or rituals, informal or formal, that they or their families attempted to carry out to achieve as much normalcy as possible. This question may also lead to disclosure of traumas or adversity in the child’s home community that you otherwise would have been unaware of.

Another way to learn about culture is to talk with the child about the people with whom they felt safe and supported, or who they or their family saw as mentors and role models. This includes members of their family, which can provide insight into how family roles, responsibilities, rules, and values were learned by the child. It may include adults outside the family, such as religious officials, teachers, community leaders, or neighbors from whom the child learned core beliefs, values, and skills. It could include peers who served as role models or surrogate caregivers. And it might include public figures to whom the child (and family) looked as authorities, role models, or sources of inspiration. Holidays or times of the week or year that have special meaning, and how they are celebrated or observed in shared rituals, are another key source of shared culture.

In these discussions, mental health professionals should listen carefully to understand the child’s core beliefs about right and wrong, how people should treat each other, and practices that were taught as the way to be a responsible member of their family, community, and society and to cope with distressing experiences and feelings of fear, anger, guilt, shame, and sadness.

With older children and adolescents, discussion about their family, community, and culture can best be done through informal conversation, inviting the youth to tell their story when they feel sufficiently safe and comfortable in their current life and in their relationship with you as a professional. This also can be done in conversations with the youth and their placement family, which is informative for the family/caregivers and can help them understand and be supportive if conflicts emerge between the youth and them as a result of different cultural expectations. Family discussion also provides caregivers and other family members with opportunities to share their informal and formal cultural beliefs and practices, and the rationale for them, so that the youth can understand the nature and purpose of the family's routines, rituals, and practices.

With younger children, and with older children and adolescents who are more reticent about personal disclosures or have difficulty with this due to intrusive trauma memories or emotional numbing, nonverbal creative modalities such as drawing, collage, crafts, or music can be a source of insight into the child's cultural heritage, beliefs, and practices.

The ultimate benefit of learning about an unaccompanied child's culture and heritage is for professionals to be able to weave aspects of that culture and history into ongoing interactions with the child and caregivers in therapeutic, healthcare, or social services. Acknowledging the child's and caregivers' beliefs and formative memories and relationships can communicate to the child and caregiver that their experience (and family and culture) is not lost or taken for granted, but instead is valued and respected. This enables the child and caregiver to see how her/his past and current beliefs and experiences, and the values and sense of self and security they provide are supported by the current professional and the care and services that are being provided.

“Acknowledging the child’s and caregivers’ beliefs and formative memories and relationships can communicate to the child and caregiver that their experience (and family and culture) is not lost or taken for granted, but instead is valued and respected.”

It also is important to find ways to connect the child and family to sources of support (e.g., relatives or peers who also are immigrants from the same or similar places of origin) and therapy (e.g., culturally-specific healers, mentors, or faith guides) that are specific to their cultural, racial/ethnic, faith, and linguistic background and community. Many communities have informal and formal groups, associations, and programs that provide connections to people who are immigrants and who have traditions and practices from their places of origin that can serve as a connection to their former home and community and a source of support and healing for unaccompanied children and their families.

Addressing Challenges with Family Integration/Re-unification

A pre-condition for successful family integration or reunification is achievement of some degree of stability and safety with continuity of care routines provided by responsive primary caregivers in a long-term or permanent arrangement (see pg. 34). Services designed to assist integration or re-unification are best guided by a thorough understanding of the child's chronology of trauma experiences and adversities through a developmental lens (see pgs. 35-36). For purposes of reintegration it can be helpful to organize these impacts in terms of stress-points "within" the child and stress-points "between" the child and the caregivers. The former includes the constellation of post-traumatic reactivity, co-morbid depression and anxiety or other mental health issues, and/or problematic beliefs about self or others. The latter can include prior histories of estrangement, neglect or abuse, traumatic circumstances of separation, time elapsed since separation, and factors that undermine a caregiver's ability to extend a stable and supportive relationship such as health or psychological impairments or substance abuse.

The process of re-building attachment bonds and caregiver-child attunement and communication is a gradual one, made more lengthy by the degree of stress or injury within the child and between the child and caregiver(s). A first important step is to meet with the caregivers to temper their expectations and make sure all parties share a common understanding of the child's history, traumatic impacts and losses, and likely hurdles to adaptation. Caregivers may expect a seamless resumption of prior levels of trust and closeness and may become impatient or angry when this takes time due to bureaucratic hurdles. Caregivers also may feel hurt or angry if their child has difficulty emotionally feeling secure in their re-unified relationship (which is a common trauma-related reaction) or in shifting back to relying on them for security instead of the temporary caregivers who have functioned as interim attachment figures during their separation (e.g., service providers, foster parents, or older siblings or peers).

“The process of re-building attachment bonds and caregiver-child attunement and communication is a gradual one, made more lengthy by the degree of stress or injury within the child and between the child and caregiver(s).”

The essential scaffolding for family integration or reunification is a consistent and secure daily living routine that presents ongoing small opportunities for caregiver and child to interact and increasingly become reacquainted and learn that they can trust and depend on each other. Specific pieces of work can also be accomplished in this context. Early on it can be helpful to provide a safe and structured way for the caregivers to engage in developmentally-appropriate activities that facilitate attunement and conversations with the child in which they can use different modalities (play, drawing, storytelling) to talk about what they have all been through. Family meetings in which family members share aspects of their story or narrative can be coordinated and even facilitated by mental health providers. If possible, these are conducted with concurrent individual therapeutic contacts with the child and caregivers. During these meetings it is important that the child has a safe space to share painful and even angry thoughts, feelings and experiences through different avenues (e.g., words, art, play). For example, children may feel that the caregivers did not protect them or may even feel betrayed by them. This can be very painful for the caregivers to hear so they need to be prepared and supported in understanding that children's feelings that a caregiver let them down are an expression of the importance that the child places on their relationship with the caregiver and not a devaluation of the caregiver.

The intention of family meetings to support re-unification of unaccompanied children with their primary caregivers-of-origin is to provide a safe and developmentally appropriate format for family members to have essential conversations that address the most painful aspects of the child and family experience and provide an ongoing venue and skillset for emotional co-regulation, shared meaning making, and collaborative problem solving. By sharing individual narratives a new shared family narrative can be formed by the child, caregivers, and other family members that incorporates trauma and loss along with a renewed sense of security, trust, and hope.

Ensuring Multi-Systemic, Cross-Disciplinary Integration

As unaccompanied children settle into their families and communities following release from ORR custody, they are frequently in need of specialized services and supports that span multiple systems and disciplines beyond mental health care, including (but not limited to) law, primary care, and education. Immigrant youth and families in general benefit from multi-systemic interventions that promote coordination across service systems and reduce common barriers to care and resource access. For mental health professionals, this means that therapeutic intervention can be enhanced through cross-disciplinary consultation and care coordination, mental health integration within other care systems, and/or advocacy. In particular, mental health integration within legal, primary care, and educational systems reduces common access barriers related to lack of familiarity and trust with mental health service resources, stigma related to mental health support-seeking, and limited mental health literacy.

Health-legal integration has been important and effective for addressing primary concerns and needs of immigrant youth, and can take the form of medical-legal partnership programs.¹³⁰ From a mental health perspective, uncertainty and concern regarding short- and long-term legal status (both for children and their caregivers) is a significant driver of anxiety and psychological distress; therefore, achieving protected legal status can serve as a primary remedy for mental health challenges. Mental health professionals can facilitate this process through referral and consultation with legal providers, providing psychological evaluations (e.g., for asylum cases), or submitting general letters of support and advocacy for immigration attorneys and judges.¹³¹

“...mental health integration within legal, primary care, and educational systems reduces common access barriers related to lack of familiarity and trust with mental health service resources, stigma related to mental health support-seeking, and limited mental health literacy.”

Integration between legal and health professionals has been shown to improve both health and legal outcomes for immigrant populations,¹³² with promising results including more than two-fold improvement in asylum grant rates for cases that included a medical evaluation.¹³³ Mental health integration within primary care settings is also effective, as immigrant youth and families often present their primary concerns to pediatric or general health professionals. In some cases, health care needs are paramount as youth with medical concerns settle in new communities; in other cases, symptoms of psychological distress or somatic manifestations of trauma exposure are often initially reported or observed in primary care. In the context of primary care, mental health professionals can assist with the identification and treatment of traumatic stress (or other mental health difficulty), provide support around safety concerns or risk, deliver short-term behavioral health intervention, facilitate referral or “warm handoff” to longer-term mental health and trauma treatment, and provide support and consultation with primary care providers.

Finally, mental health integration in educational and community settings is essential.¹³⁴ Involvement and integration of mental health professionals and services in early care and education settings (Early Head Start, Head Start, Early Intervention), schools and other community programs are particularly effective in addressing barriers related to mental health literacy and stigma, which are common for unaccompanied children. Early Care and Education Mental Health Consultation and activities and school-based mental health activities for unaccompanied youth may include implementation of mental health screening to identify needs, general/universal mental health education and socioemotional learning programs, and specialized programs for immigrant children, youth and their caregivers/families. In particular, there is much promise and initial success in delivering school-based psychosocial support groups specifically for immigrant youth that focus on supporting adjustment, fostering social support networks, skill-building, and processing immigration stress.¹³⁵

Managing Secondary Traumatic Stress Reactions

Professionals helping and wanting to help youth who have experienced psychological and physical trauma often themselves experience personal reactions in response to learning of the harm and suffering experienced by the child. These reactions, known as vicarious trauma or secondary traumatic stress, are an occupational hazard that is linked to feelings of empathy and compassion, characteristics that are the cornerstone of being effective and caring service providers. Secondary traumatic stress (STS) largely presents with symptoms that are similar to those described by people who are directly exposed to psychological and physical traumas. Professionals might find that they are repeatedly thinking about the events described by the child or family (reexperiencing) or conversely are avoiding thoughts of or conversations about the traumatic events (avoidance). They may even avoid going to work or meeting with the family, or develop symptoms of hyperarousal, such as sleep difficulties and irritability.

Similar to posttraumatic stress symptoms experienced by youth and family members, STS should be addressed directly through preventative strategies, as well as through intervention strategies if symptoms emerge. Although STS interventions largely focus on self-care, there are no known rigorous scientific studies that demonstrate a reduction in symptoms with increased self-care,¹³⁶ therefore professional intervention is recommended if symptoms are distressing or impair functioning. Given the occupational hazards associated with helping youth and families exposed to traumas, particularly long-term, chronic traumas and injustices, it is imperative that secondary trauma be managed from an organizational level with preventative strategies infused into the work climate. STS training, trauma-informed supervision, suitable leave time, working in mutual support teams with adequate time and space for processing team-trauma exposures, and encouragement of balanced non-work activities are a few activities for consideration.

For a more complete example of an STS prevention curricular, see the Resilience for Trauma-Informed Professionals (R-TIP) program¹³⁷ and products developed by the National Child Stress Traumatic Network (NCTSN).

APPENDIX A: CHILDREN'S EXPERIENCES IN CBP CUSTODY

Over the past few years, children may have experienced the following during their time in Customs and Border Protection (CBP) custody:

Severe Overcrowding in CBP Facilities

In the spring of 2019, hundreds of children and families, including infants, were held for extended periods of time in severely overcrowded and unsanitary CBP border stations. In some instances, cells were so crowded that not everyone could sit or lie down at the same time.¹⁴² As CBP facilities exceeded their maximum capacity, emergency tents for holding hundreds of people were constructed in high-volume border areas.¹⁴³ Children and families were held for weeks in dangerous conditions, without access to soap, clean water, showers, clean clothing, toilets, toothbrushes, adequate nutrition, or adequate sleep.¹⁴⁴ The influenza virus quickly spread and endangered the health and safety of people detained in CBP custody.¹⁴⁵

In the spring of 2021, thousands of unaccompanied children were held for extended periods of time in severely overcrowded and unsanitary CBP border facilities. At one point, the Donna Processing Center, designed for 250 people, held more than 1,800 people.¹⁴⁶ Children were held for days and weeks without access to adequate sleeping conditions, food, showers, outside recreation, or phone calls to family members. In an effort to decrease overcrowding and prolonged stays in CBP custody, the government opened 14 emergency intake sites, as described on pg. 19.

“I am kept in a cage. There are many, many cages. There are about 100 people in the cage with me and it’s very crowded. Everyone can not lie down at the same time. People sleep sitting up with aluminum blankets. There is a toilet but it is not private. There is a sink but no soap, towels or toothbrushes. We have to drink water from the sink faucet but there are no cups. The lights are very bright and stay on all night.”

Child, 15 years old, CBP Facility, 2019

“There are toilets near the cage but not inside. Sometimes the guards get angry and will close them. Sometimes there is water and soap to wash your hands, but not now. We have only been allowed to shower and brush our teeth one time since we arrived nine days ago. A woman in my cell was here for twenty days and not allowed to shower.”

Child, 16 years old, CBP Facility, 2019

Separation from Parents/Legal Guardians at the Border

Between 2017 and 2020, more than 5,400 children, some under 5 years old, were separated from their parents or legal guardians at the U.S. border.¹³⁸ While some children were separated due to the Trump Administration’s “zero tolerance” policy to prosecute all apprehended adults for unlawful entry, other children were separated due to a CBP agent’s unilateral determination that their caregiver presented fraudulent information, posed a danger to the welfare of the child, or had a past criminal history.¹³⁹ The Trump Administration separated families without any effective system for tracking children and parents, enabling communication, or facilitating their reunification.¹⁴⁰ More than 660 separated children have still not been reunified with their parents.¹⁴¹

APPENDIX B: RECENT FEDERAL POLICIES IMPACTING MIGRATION

If your client arrived to the United States in the past few years, their journey may have been impacted by the following federal immigration policies:

“Migrant Protection Protocols” (“MPP”) or “Remain in Mexico”

In January 2019, DHS introduced the “Migrant Protection Protocols” (MPP) policy.¹⁴⁷ Under MPP, certain asylum seekers – including accompanied children and family members – are forced to return to Mexico to await their asylum hearing in U.S. immigration court. As of November 2020, more than 67,000 asylum-seekers had been returned to Mexico under this policy.¹⁴⁸

While there are a few nonprofit shelters available for people waiting for MPP court dates, there are not nearly enough available beds. As a result, thousands of people have been forced to live in impromptu refugee camps or on the streets near the border, unprotected from the elements and without access to food, clean water, or medical care.¹⁴⁹ Migrant children and families are often the targets of harassment and criminal activity due to their lack of Mexican citizenship and vulnerable status. As of December 2020, there were more than 1,314 publicly documented cases of rape, kidnapping, assault, and other crimes committed against individuals sent back under MPP.¹⁵⁰

Unaccompanied children are exempt from MPP. However, as families have grown desperate waiting in Mexico for court dates that are months away, there are reports of some children going to the border alone so that they can enter the United States and be transferred to ORR custody.¹⁵¹

“MPP has fostered the creation of conditions which pose direct threats to the life, survival and development of migrant children.”

Submitted Input to the Special Rapporteur for the Human Rights of Migrants to the Office of the United Nations High Commissioner for Human Rights¹⁵²

Title 42 Expulsion & Detention

In March 2020, the Centers for Disease Control and Prevention (CDC) issued an order under Title 42 barring all “non-essential” travelers from entering the United States – including asylum seekers and children.¹⁵³ Instead of children and families entering CBP custody and then being transferred to ORR or ICE custody, children and families are instead summarily returned or “expelled” without legally mandated protection screenings, immigration court hearings, or other due process safeguards. That order was extended indefinitely in May 2020, and the government has maintained that the order and associated expulsions are a necessary public health response to the COVID-19 pandemic. However, recent media reports reveal that CDC scientists themselves objected to the March 20 Title 42 order, finding no “valid public health reason to issue it.”¹⁵⁴

As of mid-September 2020, approximately 8,800 unaccompanied children and 7,600 accompanied children and family members had been returned under the Title 42 order. While most of these children were rapidly expelled at the border, at least 660 were detained for various lengths of time in unlicensed motels – some for up to 38 days.¹⁵⁵ Children detained at motels were supervised 24 hours a day by private contractors without any training or qualifications in childcare.¹⁵⁶ One unaccompanied 17-year-old girl, held for over 15 nights at a motel pursuant to the order, told her attorney that she was “rarely allowed outside of her room,” felt “isolated and anxious while she was detained in a hotel room” by unknown adults who “watched her at all times,” and was warned by DHS officials that if she informed her mother of her location, she would no longer be allowed to call her.¹⁵⁷

While the vast majority of children detained in motels were expelled from the United States, a small number were transferred to ORR custody.¹⁵⁸ Although the number of unaccompanied children in ORR custody decreased significantly after the Title 42 order was implemented, the ORR population started to increase after a federal judge ruled that the federal government may not detain children in motels for prolonged periods of time.¹⁵⁹ Some children and families have attempted to enter the United States multiple times since the order was implemented, experiencing repeated detention, transfers, and return.

In November 2020, the United States District Court for the District of Columbia issued a preliminary injunction, ordering a stop to Title 42 expulsions for unaccompanied children.¹⁶⁰ The Biden Administration officially exempted unaccompanied children from the Title 42 order in March 2021.¹⁶¹

“The [Title 42] order is based on specious justifications and fails to protect public health. . . The nation’s public health laws should not be used as a pretext for overriding humanitarian laws and treaties that provide life-saving protections to refugees seeking asylum and unaccompanied children.”

*Letter to HHS Secretary Azar and CDC Director Redfield
signed by Leaders of Public Health Schools, Medical Schools, Hospitals,
and Other U.S. Institutions¹⁶²*

APPENDIX C: MULTI-DIMENSIONAL GRIEF THEORY

Multi-Dimensional Grief Theory (MGT) proposes that grief reactions consist of responses to three central challenges posed by the death or prolonged separation from a loved one. Each of these three challenges forms the conceptual basis of a separate dimension of grief. The extent to which a given bereaved youth engages in specific grief responses—both adaptive and maladaptive—within each domain, and across domains, makes up their individual grief profile. This grief profile can provide specific guidance on how best to support and therapeutically intervene with a youth.

Separation Distress

Many youth, especially younger children, experience profound separation distress in which there is sadness and heartache over the absence of the loved one and a longing to be reunited. Problematic manifestations can include intrusive and unconstructive thoughts or images of the lost loved one or developmental slowing or regression to stay connected by remaining in the same developmental stage when parted.¹⁶³ Many youth in ORR suffer from separation distress regarding family members who remain in their communities of origin, or family in the U.S. who are applying for reunification.

Circumstance-Related Distress

Given that unaccompanied children may experience separations or deaths in a sudden, violent or extremely upsetting manner, they may be visited by circumstance-related distress in which their memories of their lost loved ones are dominated by painful thoughts and images of how the separation or death occurred. This can result in persisting feelings of rage, guilt, shame, retaliatory fantasies, and intense desires for (often violent) revenge with significant consequences for adaptation and normative development.¹⁶⁴ For youth in ORR, this distress may relate to experiences of forced separation (including physical restraint) by US/CBP authorities, experiences of loss in their communities of origin (which can often serve as the precipitant for emigration), or losses experienced during the journey.

Existential or Identity-Related Distress

Youth of all ages, especially pre-teens and teens, may experience existential or identity-related distress in which the individual may struggle with a loss of identity, grounding, and meaning as a result of death or separation from a caregiver or pivotal relation. Reactions can range from a perceived loss of personal identity (e.g., “I feel like a big part of me is gone”); feeling ashamed or embarrassed (e.g., “I feel weird or different from other kids now that I don’t have a dad”); nihilism (e.g., “I’ve lost what I cared about most, so nothing else really matters); or hopelessness, despair, or resignation in anticipation of a grim future without the lost loved one (e.g., “Without mom, I’ll always be alone with no one to help me” “My life is ruined”). Loss-related identity or existential crises may also manifest as risky behaviors, recklessness, or indifference to one’s safety, well-being, or social standing (e.g., “I don’t care what happens to me), neglect of self-care, or failure to develop positive future aspirations appropriate to one’s life circumstances and developmental stage (e.g., “Even if I keep on existing, I don’t have a future”).¹⁶⁵

Endnotes

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7. T Nonimmigrant Status (“T-Visa”) is a temporary form of immigration relief that allows victims of human trafficking to remain in the United States for up to four years if they have assisted law enforcement in an investigation or prosecution of human trafficking. Certain T-Visa recipients may be able to adjust their status and become lawful permanent residents. Certain family members, such as children under 18, may be eligible to become derivative U-Visa recipients if the primary petitioner’s application is approved. *See* INA, 8 U.S.C. § 1101 (a)(15)(T) (2012); 8 C.F.R § 214.11(p) (2012).
8. U Nonimmigrant Status (“U-Visa”) is a form of immigration relief for victims of certain crimes who have suffered mental or physical abuse and are helpful to law enforcement or government officials in the investigation or prosecution of criminal activity. Certain U-Visa recipients may be able to adjust their status and become lawful permanent residents. Certain family members, such as children under 18, may be eligible to become derivative U-Visa recipients if the primary petitioner’s application is approved. *See* INA, 8 U.S.C. § 1101(a)(15)(U) (2012); 8 C.F.R § 245.24(b)(2)(i), (ii) (2012).
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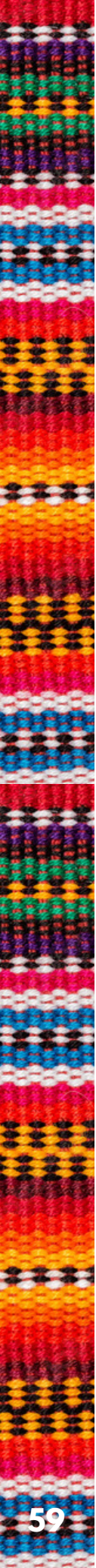
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