Expert Recommendations Regarding Custody and Care of Children at the Border

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I. Introduction

Recent events at the U.S.-Mexico border[1] suggest that it is time for members of Congress to establish clear legal standards for the care of children apprehended by Customs and Border Patrol and to codify the processing of arriving children and the terms of their release. The following information is intended to ensure that any legislation drafted is informed by established knowledge regarding child health. This document is intended to provide the reader with general overviews of (1) the current and recent legal landscape regarding children's legal rights in immigration detention, (2) the children's placement in various immigration-related facilities, and (3) rigorous scientific research highlighting the significant risk of harm from certain government policies and practices on arriving children.

II. Legal Background

For the past 34 years, tremendous time and energy has focused on the standards of care and terms of release for children who enter the United States without documentation. That concern led to the filing of *Flores v. Meese*[2] in 1985 on behalf of the children detained. That case was actively litigated for twelve years before the U.S. government and the children (through their attorneys) entered a settlement agreement in 1997, the Flores Settlement Agreement (FSA), which provides the U.S. government will do several basic things for children in its care, including:

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[1] Although the U.S. is nowhere near the highest number of apprehensions at the border in recent decades, since 2014, a higher percentage of apprehensions include families and unaccompanied children seeking humanitarian relief, which require government systems to adapt and respond accordingly.

[2] Currently *sub nom* Flores v. Barr, No. 17-56297, 2019 WL 3820265 (9th Cir. Aug. 15, 2019).

1. Expeditiously process the children[3];
2. Provide the children with a notice of their rights, including their right to request a bond redetermination hearing[4];
3. Hold the children in facilities that are "safe and sanitary" and are "consistent with…concern for the particular vulnerability of minors";[5]
4. Ensure "access to toilets and sinks, drinking water and food as appropriate, medical assistance if the minor is in need of emergency services, adequate temperature control and ventilation, adequate supervision to protect the minor from others"[6];
5. Provide the children contact with family members arrested with the child[7]; and
6. Segregate the children from unrelated adults.[8]

The U.S. government also agreed to a "general policy" favoring the release of children.[9] Examples of the limited exceptions allowing the government not to release a particular child include to ensure the child's safety or to secure the child's timely appearance at court.[10] Instead, almost all children are to be released from government custody "without unnecessary delay" to, in order of preference: (1) a parent; (2) a legal guardian; (3) an adult relative or entity designated by the parent or legal guardian; (4) a licensed program willing to accept custody; or (5) an adult or entity seeking custody of the child when there is no other likely alternative to long-term detention and family reunification is unlikely.[11] According to Commander Jonathan White in his testimony to Congress in February 2019, of the children released from ORR custody in FY19, 89 percent were released to individual sponsors, and of those, 91 percent went to parents or other close relatives.[12]

The FSA provides that the U.S. government would collect statistical information on all children taken into custody and provide that information to the children's class counsel until "two years after the court determines…that the INS has achieved substantial compliance with the terms of this Agreement."[13] A determination of substantial compliance was never made. Instead, the children's attorneys repeatedly documented, starting in the first few years after the settlement was reached, that the terms of the FSA were not being met and so litigated to enforce the agreement. Generally, the court in *Flores* has ruled with the children,[14] relying on evidence collected by attorneys conducting attorney-client interviews or facility visits authorized under

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[3] Stipulated Settlement Agreement, Flores v. Reno, No. CV 85-4544- RJK(Px) (C.D. Cal. Jan. 17, 1997), at Sec. V.12A (attached as Exhibit 1; hereinafter FSA).
[4] *Id*.
[5] *Id*.
[6] FSA at V.12A.
[7] *Id*.
[8] *Id*.
[9] FSA at VI.
[10] *Id*. at VI.14.
[11] *Id*.
[12] *Examining the Failures of the Trump Administration's Inhumane Family Separation Policy, Hearing before the H. Comm. on Energy & Commerce*, 119th Cong., 1st Sess. (statement of Jonathan White, U.S. Dept. Health & Hum. Servs.).
[13] FSA at IX.28A-29.
[14] See, e.g., Order re Plaintiffs' Motion to Enforce Settlement of Class Action, Flores v. Johnson, No. CV 85-4544, (C.D. Cal. July 14, 2015).

Sections XI and XII of the settlement agreement.[15] In recent years, the children's attorneys have repeatedly documented children being detained for long periods of time and in conditions that are neither safe nor sanitary, and give no regard for the unique vulnerability of children.[16] Indeed, Commander White reported in his testimony that the average length of detention for children in the custody of the Office of Refugee Resettlement has been 89 days in FY19,[17] while a government attorney argued before the 9th Circuit Court of Appeals in June 2019 that the "safe and sanitary" provision under the FSA did not necessarily require the U.S. to provide children with soap or bedding[18]—an argument that was roundly dismissed by the court.[19]

The parties to the FSA agreed that it would terminate the earlier of five years after the court approved the agreement, which was January 17, 1997, or, as mentioned above, three years after the court determined that the US government was in substantial compliance with the agreement. However, one term was to survive the termination: the U.S. is obligated to continue to house the general population of children in custody in licensed facilities.[20] The FSA also included (1) minimum standards for licensed programs,[21] (2) "Instructions to Service Officers re: Processing, Treatment, and Placement of Minors,"[22] (3) a contingency plan in case of an emergency or influx;[23] (4) an agreement concerning facility visits;[24] and (5) a notice of the right to judicial review that explains:

> The INS usually houses persons under the age of 18 in an open setting, such as a foster or group home, and not in detention facilities. If you believe that you have not been properly placed or that you have been treated improperly, you may ask a federal judge to review your case. You may call a lawyer to help you do this. If you cannot afford a lawyer, you may call one from the list of free legal services given to you with this form.[25]

In December 2001, the children's attorneys and the U.S. government agreed to extend the FSA until "45 days following defendants' publication of final regulations implementing [the] Agreement."[26] The extension expressly reiterated that, "*Notwithstanding the foregoing*, the INS shall continue to house the general population of minors in INS custody in facilities that are state-licensed for the care of dependent minors" [emphasis in original].[27]

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[15] FSA at XI and XII.
[16] Notice of Motion and Motion to Enforce Settlement Agreement, Flores v. Barr, No. CV 85-4544 (May 31, 2019).
[17] Examining the Failures of the Trump Administration's Inhumane Family Separation Policy, Hearing before the H. Comm. on Energy & Commerce, 119th Cong., 1st Sess. (statement of Jonathan White, U.S. Dept. Health & Hum. Servs.).
[18] Oral Argument, Flores v. Barr, 26:25 (bedding); 29:33 (soap), No. 17-56297 (9th Cir. Aug. 15, 2019), https://www.ca9.uscourts.gov/media/view_video.php?pk_vid=0000015907.
[19] Flores v. Barr, No. 17-56297, 2019 WL 3820265, at 5 (9th Cir. Aug. 15, 2019).
[20] FSA at XIX.40.
[21] FSA at Exhibit 1.
[22] FSA at Exhibit 2.
[23] FSA at Exhibit 3.
[24] FSA at Exhibit 4.
[25] FSA at Exhibit. 6.
[26] Stipulation Extending the Settlement Agreement and for Other Purposes, and Order Thereon, Flores v. Reno, No. CV 85-4544-RJK (Px) (C.D. Cal. December 7, 2001).
[27] *Id*. at ¶ 1.

The final regulations ("Final Rule on Apprehension, Processing, Care, and Custody of Alien Minors and Unaccompanied Alien Children") were not published until August 23, 2019, and would (1) allow for the long-term detention of children in unlicensed facilities and (2) eliminate all external oversight of the children and (3) eviscerate the standards for their care. The final regulations are currently under review by the judge who oversees the *Flores* litigation to determine whether they sufficiently satisfy the terms of the FSA settlement to end the litigation.

The children's attorneys immediately filed a response in opposition to the regulations on August 30, 2019, arguing that the regulations expressly breach the terms of the FSA in multiple ways. For example, the final regulations allow for the long-term detention of children in unlicensed facilities and eliminate all external oversight of the children and their standards of care. Many of the nation's top children's organizations filed an amicus brief opposing the regulations including the American Academy of Pediatrics, the American Medical Association, the American Academy of Child and Adolescent Psychiatry, the American Professional Society on the Abuse of Children, the American Psychiatric Association, the National Association of Social Workers, among others. The amici rely on some of the same research summarized below that shows the significant potential harm to children from some of the government's policies and practices, including the detention of children and separation from family.

The proposed regulations appear to try to respond to the widespread public outcry that resulted when the "Zero Tolerance" policy was announced in spring 2018. That policy effected the routine separation of children from their parents when a family entered the U.S. without documentation, even if asylum claims were presented. The American Civil Liberties Union filed a lawsuit on behalf of the class of separated parents and the U.S. District for the Southern District of California issued a class certification and preliminary injunction requiring the U.S. government to keep children with their parents and to promptly reunify those children who had been separated from their parents.[28] Priority was given to children under the age of 5 years. The court ordered that those children had to be reunified with their parents within 15 days. The U.S. government was ordered to reunify children between the ages of 5 and 17 years within 30 days. The government was unable to comply.[29] Moreover, there are other children who have been separated at the border by their parents and are unaccounted for to this day.[30]

[28] Ms. L. v. U.S Immigration & Customs Enf't, No. 18CV0428 DMS (MDD), 2018 WL 8665001 (S.D. Cal. June 26, 2018) (certifying class); Ms. L. v. U.S Immigration & Customs Enf't ("ICE"), 310 F. Supp. 3d 1133 (S.D. Cal. 2018), modified, 330 F.R.D. 284 (S.D. Cal. 2019) (granting preliminary injunction).
[29] *Examining the Failures of the Trump Administration's Inhumane Family Separation Policy, Hearing before the H. Comm. on Energy & Commerce*, 119th Cong., 1st Sess. (statement of Jonathan White, U.S. Dept. Health & Hum. Servs.).
[30] *Id*.

These practices violate both domestic and international law.[31] For example, the U.S. is a party to the International Covenant on Civil and Political Rights (ICCPR)[32] and Article 9(3) of the ICCPR provides that detention "shall not be the general rule." The enforcement body of the ICCPR, the United Nations Human Rights Committee (HRC), has already considered family detention in the case of Australia and held that the detention of a father and son for several months violated Article 9 of the treaty because parties are obligated to identify the least invasive means of accomplishing the country's immigration policy objectives, such as reporting obligations or sureties. Moreover, the prolonged detention created a hardship for the child.

The United Nations Commissioner for Human Rights has stated: "Children should never be detained for reasons related to their own or their parents' migration status. Detention is never in the best interests of the child and always constitutes a child rights violation."[33] Similarly, the Inter-American Commission on Human Rights, which has jurisdiction to make observations on U.S. compliance with international human rights law,[34] has also found that:

> the deprivation of liberty of a child for migratory motives would not be understood as a measure that responds to the child's best interests. Multiple stud[ies] have documented that detention has negative and lasting effects on children's physical and mental development, and lead to the development and worsening of conditions such as anxiety, depression, and psychological and emotional damage.[35]

These negative health effects on children are describe in more detail in Section IV below.

In short, current and proposed policies and practices with regard to children being held in immigration detention facilities violate the terms of FSA and domestic and international law and it is time for Congress to pass research-informed legislation to address this issue.

III. Overview of an Arriving Child's Processing through U.S. Facilities

On arrival to the U.S. border, children and families usually present themselves to Customs and Border Patrol (CBP) agents. They are then processed into the U.S. immigration system. While

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[31] Examples of treaty provisions violated include Articles 31 and 33 of the Convention relating to the Status of Refugees, July 28, 1951, 189 U.N.T.S. 150; which was codified in the 1980 Refugee Act, 8 U.S.C. §§ 1101 et seq. (2018); Articles 3 and 16 of the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Dec. 10, 1984, 1465 U.N.T.S. 85, 113; Articles 7, 9, 17, 23, and 24 of the International Covenant on Civil and Political Rights, Dec. 16, 1966, 999 U.N.T.S. 171; as well as customary international law. Under the U.S. Constitution's Supremacy Clause, "treaties…under the authority of the United States shall be the supreme law of the land, and judges of every state shall be bound thereby." U.S. Const. art. IV, cl. 2. The President is also obligated to comply with international law under his constitutional duty to faithfully execute the law. U.S. Const. art. II, sec. 3. It was the intent of the framers that the constitution obligate the President to comply with both treaty obligations and customary international law. See, e.g., ALEXANDER HAMILTON, PACIFICUS NO. 1 (June 29, 1793), reprinted in 15 THE PAPERS OF ALEXANDER HAMILTON 33, 33-43 (Harold C. Syrett ed. 1969).

[32] International Covenant on Civil and Political Rights art. 2(2); 138 CONG. REC. S4781-01 (daily ed., Apr. 2, 1992).

[33] U.N. High Commissioner for Human Rights, Press Briefing Note on Egypt, the United States, and Ethiopia (June 5, 2018), https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=23174&LangID=E.

[35] INTER-AMERICAN COMM'N ON HUMAN RTS., HUMAN RIGHTS SITUATION OF REFUGEE AND MIGRANT FAMILIES AND UNACCOMPANIED CHILDREN IN THE UNITED STATES OF AMERICA, OAS Doc. OAS/Ser.L/V/II.155, para. 80 (July 24, 2015), *available at* https://www.oas.org/en/iachr/reports/pdfs/refugees-migrants-us.docx.

some adolescents travel alone, younger children are highly dependent on the adults who have brought them to provide stability and protection. It is while in CBP custody that children are most likely to be separated from parents, either temporarily or long-term. Children are often separated from adult family members who are not parents, even though CBP regulations allow children to be kept with adult caregivers who are not parents if the family relationship is vetted and a CBP supervisor determines that keeping the child and the caregiver is appropriate under "the totality of the circumstances."[36]

CBP processing facilities were designed for single migrant men–not children–and are staffed by law enforcement. These facilities are not equipped to provide for the unique needs of children. Hundreds of sworn declarations from both children and parents collected by the children's attorneys document severe, widespread problems with lack of sanitation, nutrition, medical care, childcare and supervision, temperature controls, a lack of bedding, and more.

CBP stations are typically referred to as "la hielera" (the icebox) because of their cold temperatures; and "la perrera" (the dog kennel) because of the cages in which the children are kept. Children are not supposed to spend more than 72 hours in CBP facilities,[37] although during site visits by both the U.S. Inspector General and *Flores* attorneys in the spring 2019, numerous facilities were documented as overcrowded with some people, including children being held in CBP facilities, for weeks. Numerous fatalities of children in CBP care or immediately after transfer were reported by the media between late 2018 and mid-2019.
After processing in CBP custody, families normally are detained in ICE facilities and "unaccompanied"[38] children are transferred to Office of Refugee Resettlement (ORR)-contracted facilities. These facilities must follow child welfare standards and regulations set by the state in which they are found. Children receive medical and mental health evaluations upon entry and there are generally programs for education and recreation, although the administration recently ordered the discontinuation of those programs.[39]

ORR has created influx shelters such as the tent city in Tornillo, Texas, and the influx facility run at the abandoned military facility in Homestead, Florida, during times of high volume. Located on federal land, the administration has taken the position that these facilities are not required to follow state regulations regarding child residential facilities. The Homestead facility is run by a for-profit corporation, and according to Congresswoman DeLauro at a hearing on

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[36] U.S. CUSTOMS AND BORDER PROTECTION, DEPT. OF HOMELAND SECURITY, NATIONAL STANDARDS ON TRANSPORT, ESCORT, DETENTION, AND SEARCH, 5.6 Detention (Oct. 2015), https://www.cbp.gov/sites/default/files/assets/documents/2017-Sep/CBP%20TEDS%20Policy%20Oct2015.pdf.
[37] 8 U.S. Code § 1232 (2018) and U.S. CUSTOMS AND BORDER PROTECTION NATIONAL STANDARDS ON TRANSPORT, ESCORT, DETENTION, AND SEARCH (Oct. 2015), https://www.cbp.gov/sites/default/files/assets/documents/2017-Sep/CBP%20TEDS%20Policy%20Oct2015.pdf.
[38] Although some children arrive without familiar adult caregivers, such as parents, many arrive with their caregivers, such as their parents, but then are forcibly separated and classified as "unaccompanied."
[39] Maria Sacchetti, *Trump Administration Cancels English Classes, Soccer, Legal Aid for Unaccompanied Child Migrants in U.S. Shelters*, WASH. POST, June 5, 2019, https://www.washingtonpost.com/immigration/trump-administration-cancels-english-classes-soccer-legal-aid-for-unaccompanied-child-migrants-in-us-shelters/2019/06/05/df2a0008-8712-11e9-a491-25df61c78dc4_story.html.

February 27, 2019, the cost to the U.S. taxpayer is $775 per day.[40] The facilities have been criticized for their extremely large size and a lack of supervision and oversight.

All ORR shelters are supposed to provide the "least restrictive setting" for children.[41] In reality the children are detained; they are locked into these facilities and cannot leave. It is within the ORR shelters where the process to reunify the child with their family in the U.S. or another sponsor takes place. Interviews with children in ORR facilities indicate that they do not know their legal rights, have limited access to speak with their family or other sponsors, and that they are not provided reliable information about the process for placement with their family or other sponsor, which leads to unnecessary anxiety and fear.

The Family Residential Detention Centers overseen by ICE are supposed to follow certain guidelines regarding the care and custody of children. In general, however, these facilities are often run by prison corporations and are just too big and unwieldy to provide care that is adequate for children. While these facilities are supposed to follow state child welfare regulations for housing of children, they have been challenged in court both in Texas and Pennsylvania. The ICE facilities lack pediatric expertise and child mental health professionals, and parents often complain that their concerns about the health of their children are not taken seriously. Both the size, lack of expertise and off-handed treatment of detainees has resulted in delays in care, which has led to deadly consequences in some cases.

IV. Physical and Mental Health-Related Effects of Detention and Separation on Children

Child detention and separation can cause profound and lasting physical and mental harm in many ways. We offer scientific evidence of the potentially harmful effects of these practices on child health to better inform policy.

A. The Biology of Adversity and the Health Consequences of Child Detention and Separation

Extensive neurobiological research demonstrates that significant trauma (including both neglect and abuse) can disrupt the architecture and function of the developing brain as well as other biological systems (e.g., immune, metabolic, cardiovascular) beginning in infancy and extending through adolescence.[42] When separated abruptly from their parents, children experience a massive biological stress response. This includes elevated heart rate, activation of stress hormones, increased blood pressure, and mobilized inflammatory responses. These reactions are related to the fight or flight response, which is protective in an acute situation, but can have serious negative impacts if not resolved.[43] While research on the neurobiology of detention affecting arriving children explicitly is limited, there is extensive evidence that circumstances

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[40] *Reviewing the Administration's Unaccompanied Children Program*, Hearing before the H. Comm. on Appropriations at 9:47, 116th Cong., 1st Sess. (Feb. 27, 2019) (statement of Rep. DeLauro).
[41] FSA, at ¶ 11.
[42] Michael D. De Bellis & Abigail Zisk, *The Biological Effects of Childhood Trauma*, 23 CHILD & ADOLESCENT PSYCH. CLINICS OF NORTH AMERICA 185 (2014).
[43] Jack P. Shonkoff, Andrew S. Garner & Am. Acad. Pediatrics, *The Lifelong Effects of Early Childhood Adversity and Toxic Stress*, 129 PEDIATRICS e232 (2012).

that trigger persistent fear and anxiety can produce "toxic stress" responses with negative impacts on child development and learning. [44] In this context, it is important to underscore both the mitigating effects of responsive caregiving for children facing adversity and the "psychological unavailability" of a physically present parent or other familiar caregiver whose ability to provide nurturing care is severely compromised by her own traumatized condition. Stated simply, the psychological trauma of detention affects both adults and children—and a depressed or highly anxious caregiver may be too impaired to protect the child from a toxic stress response.[45]

A wide range of adverse childhood experiences (ACEs) have been shown to affect multiple biological systems with lifelong consequences. [46] Persistent inflammation can lead to greater likelihood of heart disease, obesity, diabetes, later dementia, and other chronic impairments later in life.[47] Persistent elevation of stress hormones disrupts developing brain architecture that affects memory, attention, and behavior regulation, leading to problems in learning and long-term emotional well-being.[48] Brain circuits especially susceptible to stress during early childhood are involved in detecting and responding to threats as well as later regulation of the stress response. Brain regions affected by adversity during the pre-pubertal and teenage years are involved in emotional regulation, impulse control, and other executive functions. These kinds of disruptions in brain development have lifelong impacts on the ability to respond to and recover from stress, and often lead to a host of stress-related diseases in adulthood.[49]

B. Psychological and Mental Health Consequences of Child Detention and Separation

Clinical experience and research on child traumatic stress support the conclusion that children who are subjected to detention and family separations are vulnerable to posttraumatic stress disorders, long-term negative health consequences,[50] and have poorer outcomes as compared to immigrant refugee children living in the community with caregivers.[51] Children in immigration detention experience negative mental health outcomes similar to those that result from other forms of severe trauma. This includes significantly elevated rates of emotional and behavioral problems as well as symptoms of depression, anxiety, PTSD, and suicidal ideation.[52]

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[44] National Scientific Council on the Developing Child, *Persistent Fear and Anxiety Can Affect Young Children's Learning and Development: (*Working Paper No. 9, 2010), https://developingchild.harvard.edu/resources/persistent-fear-and-anxiety-can-affect-young-childrens-learning-and-development/.

[45] National Scientific Council on the Developing Child (2012). *The Science of Neglect: The Persistent Absence of Responsive Care Disrupts the Developing Brain: Working Paper No.12*. http://www.developingchild.harvard.edu.

[46] Karen Hughes et al., *The Effect of Multiple Adverse Childhood Experiences on Health: A Systematic Review And Meta-Analysis*, 2 LANCET PUB. HEALTH E356–66 (2017), https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(17)30118-4/fulltext.

[47] Hughes et al., *supra* note 46.

[48] Charles B. Nemeroff, *Paradise Lost: The Neurobiological and Clinical Consequences of Child Abuse and Neglect*, 89 NEURON 892 (2016).

[49] Jack P. Shonkoff et al., *Neuroscience, Molecular Biology, and the Childhood Roots of Health Disparities: Building a New Framework for Health Promotion and Disease Prevention*, 301 JAMA 2252 (2009).

[50] *Id*.

[51] *Id*.; Karen Zwi et al., *The Impact of Detention on the Social-Emotional Wellbeing of Children Seeking Asylum: A Comparison with Community-Based Children*, 27 EUR. CHILD ADOLESC. PSYCH. 411 (2018).

[52] Ann Lorek et al., *The Mental and Physical Health Difficulties of Children Held within a British Immigration Detention Center: A Pilot Study*, 33 CHILD ABUSE & NEGLECT 573 (2009); Louise Newman & Z. Steel, *The Child*

The environment of immigration detention has a detrimental effect on the psychological well-being of children. While in U.S. government custody, arriving children commonly experience denial of access to basic needs including adequate medical and mental health care, educational services and recreation and are often separated from caregivers and family members.[53] Each of these experiences constitutes a form of traumatization, maltreatment, and neglect. At its core, trauma results from a lack of control or personal agency while experiencing adversity or threat to an individual's (or a loved one's) well-being. Children are particularly vulnerable for developing Posttraumatic Stress Disorder (PTSD), as compared to adults, when exposed to such experiences and conditions. Furthermore, when trauma occurs during a time of critical brain development, there is a significant risk of disrupting normal neurological and cognitive development permanently.[54]

A recent review of the research on immigration detainees, including adults, adolescents, and children concludes that all three age groups demonstrated higher levels of mental health problems during and following detention as compared to individuals who had not been detained. Those who were detained for longer periods demonstrate more severe symptoms, as did those who had greater exposure to trauma prior to detention.[55] The duration of detention is positively correlated with deterioration of mental health and overall functioning and this is attributable to the ongoing uncertainty and associated distress of immigration detention.[56] Being detained for prolonged and uncertain periods can induce profound hopelessness, despair, depression, and even suicidal urges.[57] Other studies have similarly found that both adults and children held in immigration detention demonstrate poor mental health outcomes, including depression, anxiety, and PTSD.[58] Children detained in immigration facilities may experience higher rates of social, emotional, and behavioral difficulties as well as developmental delays and regression.

Research has consistently found that that early separation from parents is associated with psychiatric symptoms that can continue into adulthood.[59] In a study of 425 children detained with their mothers at an immigration center in the U.S. in mid-2018, the researchers found that almost half of the children still experience psychological distress, and that those who had been forcibly separated from their mothers, experience the most significant psychological distress.[60] Depressed individuals who in childhood have experienced parental loss have poor coping skills and functional outcomes compared to age-matched controls and this, in turn, is a risk factor for

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Asylum Seeker: Psychological and Development Impact of Immigration Detention, 17 CHILD & ADOLESCENT PSYCH. CLIN. NORTH AM. 665 (2008); Sarah Mares, *Fifteen Years of Detaining Children Who Seek Asylum in Australia: Evidence and Consequences*, 24 AUSTRALASIAN PSYCH. 11 (2016).

[53] Gillian Calvert, Childhood in Detention, 25 AUSTRALIAN & NEW ZEALAND J. FAM. THERAPY 113 (2004).

[54] *Id*.; Ryan Herringa, *Trauma, PTSD, and the Developing Brain*, 19 CURRENT PSYCH. REP. 69 (2017).

[55] Martha von Werthern et al., *The Impact of Immigration Detention on Mental Health: A Systematic Review*, 18 BMC PSYCH. no. 382 (2018).

[56] Calvert, *supra* note 53; Mares, *supra* note 52; Zwi et al., *supra* note 51.

[57] Mina Fazel & Derrick Silove, *Detention of Refugees*, 332 BMJ 251 (2006).

[58] von Werthern et al., *supra* note 55.

[59] A.K. Pesonen et al., *Childhood Separation Experience Predicts HPA Axis Hormonal Responses in Late Adulthood*, 35 PSYCHONEUROENDOCRINOLOGY 758 (2009); A.K. Pesonen et al., *Depressive Symptoms in Adults Separated from Their Parents as Childr*en, 166 AM. J. EPIDEMIOLOGY 1126 (2007).

[60] Sarah A. MacLean et al., *Mental Health of Children Held at a United States Immigration Detention Center*, 230 SOC. SCI. MED. 303 (2019).

long-term health problems.[61] Even temporary separation from parents in childhood has been found to be associated with an increased risk for mental health and substance use disorders severe enough to contribute to psychiatric hospitalizations and increased risk of early death later in life.[62]

Current government responses to children arriving in the U.S. create the conditions for trauma, as children in government custody experience: (1) chronic fear, anxiety, worry, and sadness; (2) a lack of information regarding what is happening to them or their loved ones; (3) a lack of agency, autonomy, or personal or family control over their situation and well-being; (4) denial of access to caregiving support and protective buffers typical of child development; and (5) denial of access to standard resources and protections available elsewhere in society. The resulting experiences of trauma in government custody (which include risk for exposure to physical, sexual, and/or psychological abuse) are compounded with prior traumas experienced before or during the migration process, thereby increasing the burden on children and increasing the prevalence and severity of both immediate and long-lasting negative psychological outcomes, maladaptive behaviors, poorer cognitive functioning and impaired social attachments.[63] Parental presence and comfort is the most important buffer against distress and mental health problems developing in children who have been exposed to severe adversity and trauma. The environment and circumstances of immigration detention, especially indefinite prolonged detention, is detrimental for children and families and poses a significant risk to overwhelm the ability of both parental caregivers and children to cope with and overcome the cumulative effects of the trauma they have experienced.

C. Health and Medical Systems in Detention.

If the government is going to take arriving children its care, the government is obligated to provide a functioning public health and medical system. In September 2019, the Office of the Inspector General for the Department of Health and Human Services released a report documenting the numerous failings of the current ORR facilities to provide for the mental health needs of children in its care and recommended that "all reasonable steps" should be taken "to minimize the time that children remain in ORR custody.64 Public health conditions include severe crowding and lack of access to soap and water, which increase transmission of infectious disease. Ursula was closed due to flu outbreak. Young children not cared for (including diapering and feeding) constitutes neglect, the most common reportable form of child maltreatment.[65]

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[61] Hideyuki Takeuchi et al., *Childhood Parental Separation Experiences and Depressive Symptomatology in Acute Major Depression*, 53 PSYCH. & CLIN. NEUROSCIENCE 215 (2002).
[62] Marius Lahti et al., *Temporary Separation from Parents in Early Childhood and Serious Personality Disorders in Adult Life*, 26 J. PERSONALITY DISORDERS 751 (2012).
[63] Martin H. Teicher, *Childhood Trauma and the Enduring Consequences of Forcibly Separating Children from Parents at the United States Border*, 16 BMC MEDICINE No. 146 (2018).
[64] U.S. DEPT. OF HEALTH & HUMAN SERV., OFF. INSPECTOR GEN., CARE PROVIDER FACILITIES DESCRIBED CHALLENGES ADDRESSING MENTAL HEALTH NEEDS OF CHILDREN IN HHS CUSTODY 20 (2019), https://oig.hhs.gov/oei/reports/oei-09-18-00431.pdf.
[65] Other conditions documented in the June 2019 FSA site visits included inadequate nutrition, bedding, extreme temperatures, overcrowding, lack of physical movement, no educational or recreational activities, lack of care and supervision, infrequent washing, lack of diapering of a diaper-age child, forcible diapering of a school-aged child due to denial of access to toilets at night, assaults by government personnel, toileting inadequacies, lights being left

The media have reported seven known child deaths within or shortly following CBP or ORR detention with none recorded in the decade prior. While there are many factors that may have led to the death of these children, they stand out as sentinel cases exposing profound deficiencies in the medical care in these facilities such as lack of appropriate medical staff with pediatric training, overcrowded conditions that increase exposure and transmission of communicable diseases, and the inability to respond swiftly to a child showing rapid decline. These factors all contribute to poor outcomes including death. Additionally, there are anecdotal cases of children being moved back and forth from emergency departments and then to different detention facilities. The multiple moves place children at risk and also increases the risk of transmission of infectious diseases to multiple children. Other anecdotal reports include children being released from CBP and requiring direct admission to the hospital or at times the pediatric ICU. While these children would be important to track in order to understand the epidemiology of severe illness in arriving children, so far, given recent governmental policies, it is hard to keep track.

D. Health and Medical Conclusions.

Thus, it is not surprising that the American Academy of Pediatrics has issued a policy statement that "[C]hildren in the custody of their parents should never be detained, nor should they be separated from a parent, unless a competent family court makes that determination."[66] The AAP recommends that children have "limited exposure" to immigration detention facilities and that follow-up monitoring and care be provided to those children who experienced detention. "From the moment children are in custody of the United States, they deserve health care that meets guideline-based standards, treatment that mitigates harm or traumatization, and services that support their health and well-being."[67] In September 2019, the Office of Inspector General of the U.S. Department of Human Services issued two reports documenting the failures of the care provider facilities to ensure adequate health care for the children and appropriate staffing.[68] In response, the American Psychological Association issued a statement offering its help:

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on 24 hours a day, seven days a week in some locations and lack of windows (leading to disorientation between day and night. Notice of Motion and Motion to Enforce Settlement Agreement, Flores v. Barr, No. CV 85-4544 (May 31, 2019).

[66] Am. Acad. Pediatrics, AAP Statement Opposing the Border Security and Immigration Reform Act, https://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/AAPStatementOpposingBorderSecurityandImmigrationReformAct.aspx (2018).

[67] Julie M. Linton, Marsha Griffin, Alan J. Shapiro, Council on Community Pediatrics, *Detention of Immigrant Children*, 139 PEDIATRICS 483 (2017).

[68] U.S. DEPT. OF HEALTH & HUMAN SERV., OFF. INSPECTOR GEN., CARE PROVIDER FACILITIES DESCRIBED CHALLENGES ADDRESSING MENTAL HEALTH NEEDS OF CHILDREN IN HHS CUSTODY (2019), https://oig.hhs.gov/oei/reports/oei-09-18-00431.pdf and U.S. DEPT. OF HEALTH & HUMAN SERV., OFF. INSPECTOR GEN., UNACCOMPANIED ALIEN CHILDREN CARE PROVIDER FACILITIES GENERALLY CONDUCTED REQUIRED BACKGROUND CHECKS BUT FACED CHALLENGES IN HIRING, SCREENING, AND RETAINING EMPLOYEES (2019), https://oig.hhs.gov/oas/reports/region12/121920001.asp. In May and June 2019, the Office of the Inspector General of the U.S. Department of Homeland Security issued a management alert regarding overcrowding in a facility for adults and report documenting "Concerns about ICE Detainee Treatment and Care at Four Detention Facilities. U.S. Dept. of Health & Human Serv., Off. Inspector Gen., Management Alert – DHS Needs to Address Dangerous Overcrowding and Prolonged Detention of Children and Adults in the Rio Grande Valley (2019), https://www.oig.dhs.gov/sites/default/files/assets/2019-07/OIG-19-51-Jul19_.pdf. U.S. Dept. of Health & Human Serv., Off. Inspector Gen., Concerns about ICE Detainee Treatment and Care at Four Detention Facilities (2019), https://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1000&context=dhspapers. Similar

> The health, mental health and well-being of these children must be paramount. The American Psychological Association agrees with the HHS' Office of Inspector General that these facilities need evidence-based approaches to treating traumatized children, and that they must hire enough qualified caregivers to handle the increasing caseloads. APA and our more than 118,000 members stand ready to assist in any way possible.[69]

Another 220 organizations committed to the prevention of child abuse and neglect, including 45 national organizations and another 175 organizations from 38 states and Puerto Rico, sent a letter to Speaker Pelosi, Leader McCarthy, Leader McConnell, and Leader Schumer on August 21, 2019, calling on the administration and Congress to "take swift action" to ensure that immigration facilities "provide safe conditions that do not expose children to an unreasonable risk of physical or mental harm" and stated that the members of the coalition "are ready and eager to join with the Administration and U.S. Congress to consider how to best achieve this goal."[70] In short, there are hundreds of thousands of pediatric professionals across the country who stand ready to assist you as you work to establish clear legal standards for the care and custody of arriving children. Based on established knowledge, our initial recommendations are below.

V. Recommendations

In light of the children's rights, domestic and international legal standards, and the established knowledge regarding child detention and family separation, we recommend that any legislation adhere to the following principles.

1. First and foremost, children should not be separated from their parents (or other familiar caregivers) or detained in institutionalized settings. Detention should not be used as a deterrent for immigration nor a punishment, especially not for children. If children must be placed in detention, it should be for the shortest amount of time possible. Children should not be held anywhere for more than 72 hours before transfer to a state-licensed and minimally-restrictive facility. While we advocate for appropriate conditions if they are detained, we should be mindful to avoid creating a culture and business of child detention. If resources are put into child detention, they should be used for creative, child-friendly, interagency interventions to help children reunite with sponsors in the most expeditious and safe manner possible. Alternative placements should be explored only if a child cannot be reunited with family or loved ones in the U.S. expeditiously.

2. During the limited period that children are in government custody for processing, transfer, reunification efforts, etc., their basic needs must be met including the provision

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conditions were reported by *Flores* site visitors in facilities where children were being kept around the same period. Notice of Motion and Motion to Enforce Settlement Agreement, Flores v. Barr, No. CV 85-4544 (May 31, 2019).

[69] Rosie Phillips Davis, Press Release, *Statement of APA [American Psychological Association] President Regarding HHS Inspector General Reports on Care, Treatment of Migrant Children* (Sept. 4, 2019), https://www.apa.org/news/press/releases/2019/09/treatment-migrant-children.

[70] Letter from the Alliance for Strong Families & Communities et al., to the Hon. Nancy Pelosi et al. (Aug. 21, 2019).

of adequate and nutritious food, clean drinking water, proper sleeping arrangements (clean beds and linens), hygiene products, toileting, exercise and recreation, education, adequate care and supervision by licensed professionals, access to physical and mental healthcare, proper temperatures and ventilation, appropriate privacy, etc.

3. Where detention cannot be avoided, children must be placed in a state-licensed and minimally-restrictive facilities. "Self-licensing" or overflow facilities must be affirmatively prohibited. Minimally restrictive facilities should be staffed by child welfare specialists and healthcare personnel with pediatric and child mental health expertise. For profit facilities should be avoided to ensure that children are not commodified and that there is no profit incentive to detaining children or cutting corners in the provision of their basic needs.

4. Families should be kept apprised, to the greatest extent possible, of the child's location and state of physical and mental health, and be given frequent opportunities to communicate with the child. Both the child and the family should be advised of the timeline and steps necessary for reunification. Children especially should be informed of their case progress, and any changes in their status such as transfers between facilities—and the inability of young children to understand such information underscores their vulnerability and the need for rapid reunification.

5. Policies and procedures should ensure that family members living in the United States can come forward to sponsor a child without fear of immigration consequences (for example, information-sharing regarding sponsor applicants between ORR and ICE should not take place normally).

6. Health and medical systems must be set up in any facility where children are in government care for any length of time. These systems must contain protocols for care-seeking, evaluation, and transfer to a higher level of care as needed.

7. There must be an ability for independent child welfare specialists to monitor and report deficiencies.

8. Children normally should be with family and care-giver adults. If they arrive together, they should be kept together until the child is unified with their sponsor. If they become separated for any reason, all efforts should be made to reunify them. Limited exceptions should apply. Those exceptions should be made in accordance with the best interests of the child and should be made only by a court of law or licensed child welfare professional. If they cannot be with their own family, they should be placed with a parent-appointed guardian; and if not a guardian, then another family-oriented situation.

9. During any time spent separated from family, children should have access to cost-effective, developmentally appropriate, and personally empowering services (including case management, legal assistance, and trauma-sensitive mental health evaluation and treatment). There must be appropriate case management work towards expedient family reunification.

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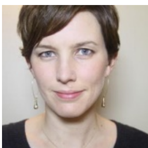

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For more than 10 years, Mukherjee has been working on issues related to the Flores settlement, an agreement that outlines how the U.S. government must care for unaccompanied migrant children and promptly release them from custody. Mukherjee regularly collaborates with immigrants' rights advocates on strategic litigation, legislative reform, grassroots advocacy, public education, and coalition building.

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Having spent 2 decades studying the effects of early adversity on children's brain and behavioral development, including the effects of early, prolonged parent-child separation and the effects of institutional care, Dr. Nelson offers expertise relevant to the current situation many children and families find themselves in at the US-Mexican border.

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Jennifer Podkul is an international human rights lawyer and expert on child migration in the United States. She has published articles, handbooks and reports on U.S. immigration law and presents regularly as an expert at national conferences, briefings, and professional trainings. She co-authored "Forced From Home: The Lost Boys and Girls from Central America" and was a contributing author to "Childhood, Migration, and Human Rights in Central and North America: Causes, Policies, Practices, and Challenges." Jennifer has taught child migration at Georgetown Law Center's Human Rights Institute. Jennifer began her legal career as an attorney at Ayuda in Washington, D.C. first as an Equal Justice Works Fellow and later as a KIND Fellow. Prior to joining KIND, Jennifer Podkul was a senior program officer at the Women's Refugee Commission where she researched issues facing vulnerable migrants seeking protection in the United States and advocated for improved treatment. She served as a Peace Corps volunteer in Honduras, holds a B.A. in American Studies and Spanish from Franklin and Marshall College and a J.D. with honors from the Washington College of Law, American University, where she was a Public Interest/Public Service Scholar.

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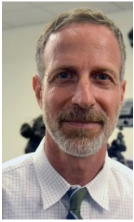
Mary Kelly Persyn is an attorney, author, and children’s advocate in San Francisco, California. She is the owner of Persyn Law & Policy and serves as Senior Director, Legal & Strategy at New Teacher Center; Chair of the Board of Directors of the Center for Youth Wellness; member of the Amicus and Policy Committee of the American Professional Society on the Abuse of Children (2018 Special Recognition Award); member of the California Campaign to Counter Childhood Adversity; and member of the Leadership Council of Children Now. She has published articles on childhood adversity in Poverty & Race, the journal of the Poverty & Race Research Action Council (PRRAC), and has represented the American Professional Society on the Abuse of Children as amicus curiae in cases involving childhood adversity and maltreatment in the Second, Fourth, and Ninth Circuit Courts of Appeal and the United States Supreme Court. Prior to her current roles, Persyn was a government enforcement and appellate associate at law firms in Boston and San Francisco and served as a judicial law clerk in the U.S. Court of Appeals for the Ninth Circuit. Driven by compassion, integrity, justice, and a fierce love of children, Persyn’s work raises public awareness of childhood adversity and advocates for the interventions that strengthen resilience and improve lifetime outcomes for children who have experienced trauma. Persyn earned a Ph.D. in English Literature from the University of Washington and a J.D. from Columbia Law School.



Alan Shapiro, MD, FAAP
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Alan Shapiro, MD, FAAP is the Senior Medical Director of Community Pediatric Programs and a Clinical Assistant Professor of at the Albert Einstein College of Medicine and Department of Pediatrics, Montefiore Health Systems. He is the co-founder and Medical Director or Terra Firma, a medical-legal partnership focused on the complex needs of newly arrived immigrant children and a member of the Executive Committee of the American Academy of Pediatrics'(AAP) Council on Immigrant Child and Family Health. He has co-authored articles in peer-reviewed journals including Terra Firma: Medical-Legal Care for Unaccompanied Immigrant Garifuna Children, in the Harvard Journal of African American Public Policy (2015), the AAP's policy statement, Detention of Immigrant Children, published in Pediatrics (2017) and Unaccompanied children seeking safe haven: Providing care and supporting well-being of a vulnerable population in the Children and Youth Services Review (2018). Dedicated to providing care to vulnerable children throughout his career he was the 2015 recipient of the AAP's Local Hero award. He received his BS in psychology from Emory University and is a graduate of State University of NY Health Sciences Center at Brooklyn, and completed his residency in Pediatrics from Montefiore Medical Center's Residency Program in Social Medicine .

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Jack P. Shonkoff, M.D. is Professor of Child Health and Development and Director of the Center on the Developing Child at Harvard University. He chairs both the National Scientific Council on the Developing Child, whose mission is to bring credible science to bear on public policy affecting young children, and the JPB Research Network on Toxic Stress, which is developing new measures to assess the biological, behavioral, and health consequences of significant stress activation in children. In 2011, he launched Frontiers of Innovation, a science-based, R&D platform to develop more effective strategies to catalyze breakthrough impacts on the health and development of young children and families experiencing adversity. He has authored more than 150 publications and received multiple honors, including elected membership to the National Academy of Medicine, the Aldrich Award in Child Development from the American Academy of Pediatrics, and the Award for Distinguished Contributions to Public Policy for Children from the Society for Research in Child Development.

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Dr. N. Ewen Wang is a Professor of Emergency Medicine and Pediatrics, Associate Director of Pediatric Emergency Medicine, Director of the Social Emergency Medicine Program, and a Faculty Member in the Human Rights in Trauma Mental Health Program at Stanford University School of Medicine. Her scholarly expertise is in health services research with a focus on Social Emergency Medicine, or the intersection of vulnerable populations with the health care system. Dr. Wang created a team of child experts to collaborate with the Center for Human Rights and Constitutional Law. The group provides pediatric medical, psychological and psychiatric expertise to the Center and other advocates working to improve conditions of separated and unaccompanied children in detention. Dr. Wang's analytic team has over 10 years of experience using national and statewide datasets to analyze population-wide access to specialty care and health outcomes. In this capacity, Dr. Wang's team provided the Center with a population wide analysis of trends of detention for class members.