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Physicians for Human Rights (PHR) welcomes the opportunity to provide its perspective regarding the Notice of Proposed Rulemaking on the Apprehension, Processing, Care and Custody of Alien Minors and Unaccompanied Alien Children, DHS Docket Number ICEB-2018-0002.

In this Public Comment, PHR expresses grave concern regarding the U.S. government's proposal to replace the migrant child protections mandated in the *Flores* Settlement Agreement with the proposed rule, 83 FR 45486.

From a medical and mental health perspective, the changes to the *Flores* Settlement Agreement proposed by the Department of Homeland Security (DHS) and the Department of Health and Human Services (DHHS) undermine critical child protections and are neither safe nor humane. The proposed rule would legalize prolonged and indefinite detention of families, eliminate the state licensing requirement for facilities, institutionalize a permanent state of emergency to justify the government's failure to meet standards of care, and increase resort to inaccurate and unethical age determination procedures. This will further compromise the treatment of migrant families already subjected to unjustifiable detention. Under these proposed changes, inadequate conditions of confinement in family detention facilities are inevitable, heightening the risk of preventable health harms to those detained.

PHR objects to the proposed rule itself. *Flores* protections should be codified into law, not undermined by the agencies tasked to implement them. As a human rights organization, PHR opposes indefinite detention, and detention of children specifically, as violations of U.S. obligations under domestic and international law. This public comment first addresses the violations inherent in the proposed rule and then outlines concerns regarding specific provisions.

The proposed rule violates the health and human rights of children and migrants:

1. **Indefinite detention of children is unlawful and deeply harmful.**

The purpose of the proposed rule, legalizing indefinite detention of children with their families, is directly prohibited under the *Flores* settlement precisely because it is harmful and inhumane. [1]

[1] Julie M. Linton, Marsha Griffin, and Alan J. Shapiro, "Detention of Immigrant Children," Pediatrics 139, no. 4 (April 2017): doi:10.1542/peds.2017-0483.

As a preliminary matter, detention poses a serious health risk to children and is never in the child's best interest, violating a mandatory principle of children's human rights.[2] In a retrospective analysis, detained children had a tenfold increase in developing psychiatric disorders.[3] Studies of detained children found that most children since being detained reported symptoms of depression, sleep problems, loss of appetite, and somatic complaints such as headaches and abdominal pains. Additional medical concerns include inadequate nutritional provisions, restricted meal times, and child weight loss.[4] DHS' own medical experts have documented gross neglect of children and severe harm in detention, including the case of a 16-month-old baby who lost a third of his body weight over 10 days from untreated diarrheal disease, yet was never given IV fluids.[5] Detention of children is not a reasonable policy and cannot be considered a reasonable alternative to separating children from their parents, which is also cruel, unnecessary, and harmful.[6] Numerous clinical studies have demonstrated that the mitigating factor of parental presence does not negate the damaging impact of detention on the physical and mental health of children.[7]

2. **Indefinite detention of asylum seekers and migrants breaches U.S. obligations under international law.**

The United States has a legal obligation to provide protections to refugees and asylum seekers, in accordance with well-established international law.[8] Medical evaluations conducted by PHR over the past 25 years have documented valid claims of persecution by migrants arriving at the U.S. border. Many migrants are fleeing epidemic levels of violence, including homicide and physical and sexual assault, and are in need of international protection and services that address

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[2] UN Committee on the Rights of the Child, General Comment No. 6 (2005) on the Treatment of Unaccompanied and Separated Children Outside their Country of Origin, CRC/GC/2005/6, para. 86.
[3] Zachary Steel, Shakeh Momartin, Catherine Bateman, Atena Hafshejani, Derrick M. Silove, Naleya Everson, Konya Roy, Michael Dudley, Louise Newman, Bijou Blick, and Sarah Mares, "Psychiatric Status of Asylum Seeker Families Held for a Protracted Period in a Remote Detention Centre in Australia," *Australian and New Zealand Journal of Public Health* 28, no. 6 (September 25, 2004): 527-36. doi:10.1111/j.1467-842x.2004.tb00042.x.
[4] Ann Lorek, Kimberly Ehntholt, Anne Nesbitt, Emmanuel Wey, Chipo Githinji, Eve Rossor, and Rush Wickramasinghe. "The Mental and Physical Health Difficulties of Children Held within a British Immigration Detention Center: A Pilot Study," *Child Abuse & Neglect* 33, no. 9 (September 2009): 573-85. doi:10.1016/j.chiabu.2008.10.005.
[5] Dr. Scott Allen and Dr. Pamela McPherson, Letter to the Senate Whistleblowing Caucus, July 17, 2018, accessed at: https://www.whistleblower.org/sites/default/files/Original%20Docs%20Letter.pdf.
[6] Miller, Alexander, Hess, Julia Meredith, Bybee, Deborah, Goodkind, Jessica R, (2018), "Understanding the mental health consequences of family separation for refugees: Implications for policy and practice," American Journal of Orthopsychiatry, Vol 88(1), 2018, 26-37, http://psycnet.apa.org/doiLanding?doi=10.1037%2Fort0000272
[7] Michael Dudley, Zachary Steel, Sarah Mares, and Louise Newman, "Children and Young People in Immigration Detention," *Current Opinion Psychiatry* 25, no. 4 (July 2012): 285-92, doi:10.1097/YCO.0b013e3283548676; K. Ehntholt, D. Trickey, J. Harris Hendriks, H. Chambers, M. Scott, W. Yule, and P. Tibbles, (2018), "Mental health of unaccompanied asylum-seeking adolescents previously held in British detention centres," *Clinical Child Psychology and Psychiatry*, 23(2), 238–257; R. Kronick, C. Rousseau, and J. Cleveland (2015), "Asylum-seeking children's experiences of detention in Canada: A qualitative study," *American Journal of Orthopsychiatry*, 85(3), 287,
[8] American Immigration Council, Factsheet: Asylum in the United States (May 14, 2018), accessed at: https://www.americanimmigrationcouncil.org/research/asylum-united-states

their medical and mental health needs.[9] Article 31(1) of the UN Refugee Convention prohibits States parties, which includes the United States, from penalizing irregular entry of refugees fleeing persecution, as long as they present themselves to the authorities.[10] Asylum seekers are properly exercising their rights and should not be detained, but rather released on bond or parole. Alternatives to detention, such as case management programming, have a high rate of compliance (over 95 percent) with immigration proceedings.[11] Federal data suggests that the demographic profile of those apprehended for unauthorized entry into the United States has shifted towards children (both unaccompanied and with families) and asylum seekers (a higher rate of defensive asylum applications). Both are vulnerable populations that warrant heightened protections rather than criminalization. From a public health perspective, these demographic trends indicate that family detention centers will have inadequate capacity to accommodate families and that the government will be unable to provide adequate services to the increased number of detained families.

3. **Family detention facilities cannot ensure humane conditions of confinement for children.**

Family detention facilities, all located in remote areas far from urban centers, have consistently failed to recruit an adequate number of qualified health staff, including pediatricians, child and adolescent psychiatrists, and pediatric nurses, leaving the facilities both understaffed and lacking necessary medical expertise.[12] If these same families were released through non-custodial measures, they would have access to providers based in the community; however, in detention, their access to qualified medical and mental health professionals is limited to whomever the facility is able to recruit, as access to off-site clinicians is at the discretion of the detention facility. For example, a 27-day-old infant who was born during his mother's journey was not examined by a physician until he had a seizure due to undiagnosed bleeding of the brain.[13] In another facility, numerous children were vaccinated with adult doses of vaccine as the providers were not familiar with labels on pediatric vaccines.[14] Family detention facilities have also consistently failed to provide interpretation services to ensure access to health information and services, either through ensuring adequate bilingual staff or telephonic translation of indigenous languages, described as "a pervasive concern across facilities."[15] This constitutes a critical barrier to health care access, as requests for medical care, information about available care, access to care, and informed consent are conditioned on communication in an understandable language. In any emergency situation, there is no reliable mechanism to allow staff to communicate effectively with all detainees. **In contrast, alternatives to detention not only eliminate the health risk of detention itself, but also enable access to supportive familial, social, co-ethnic and host community networks and resources.** Access to health care and other rights, including education, is best facilitated through placement

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[9] A. Keller, A. Joscelyne, N. Granski, and B. Rosenfeld, "Pre-Migration Trauma Exposure and Mental Health Functioning among Central American Migrants Arriving at the US Border," *PloS ONE*, 2017; 12(1):e0168692.
[10] UN General Assembly, Convention Relating to the Status of Refugees (28 July 1951) UNTS 189(137).
[11] Megan Golden, Oren Root, David Mizner, "The Appearance Assistance Program: Attaining Compliance with Immigration Laws through Community Supervision," Vera Institute of Justice, 1998, accessed October 12, 2018, https://storage.googleapis.com/vera-web-assets/downloads/Publications/appearance-assistance-program-attaining-compliance/legacy_downloads/aap.pdf.
[12] Allen and McPherson, op cit.
[13] Allen and McPherson, op cit.
[14] Allen and McPherson, op cit.
[15] Allen and McPherson, op cit.

in the community. Clinical studies have repeatedly demonstrated that a sense of belonging and connectedness in schools and neighborhoods is a strong supportive factor for positive health outcomes for immigrant and refugee families.[16]

4. **Indefinite detention of children for the purpose of migration deterrence is discriminatory and amounts to inhumane treatment.**

Indefinite detention violates the prohibition against torture and cruel, inhuman, and degrading treatment under U.S. and international law, and has severe medical and mental health consequences.[17] The UN Special Rapporteur on Torture confirms that detention policies or practices that expose migrants to grossly inadequate conditions of confinement constitute ill-treatment; this can amount to torture if intentionally imposed "for the purpose of deterring, intimidating, or punishing migrants or their families, or coercing them into withdrawing their requests for asylum."[18] The indefinite nature of such detention raises additional health and human rights concerns. The profound uncertainty and lack of control can cause severe physical and psychological harm, which can amount to ill-treatment and, in some cases, torture. Given the extensive medical literature on this practice and recent reports by DHS' own medical experts on the harms to health and safety posed by child detention, DHS and DHHS are on notice that detained children and families will face a serious risk of substantial harm. The provisions of the proposed rule disregard that known risk. The government's actions in seeking to detain children and families indefinitely in unlicensed facilities, despite the known risks, amounts to deliberate indifference.

Feedback on specific provisions of the proposed rule, 83 FR 45486:

- **The proposed self-licensing scheme is unlikely to ensure a minimum level of protection.** DHS states that challenges to state licensing of family residential facilities justify eliminating the *Flores* state licensing requirement.[19] However, challenges to licensing these facilities have come about as state oversight mechanisms exercised their authority to enforce accountability for unacceptable conditions of confinement for children and families. It is not difficult to detain families due to state licensing requirements – it is difficult to detain families because detention centers facilities are inappropriate for housing families for any length of time. State-level oversight has confirmed that, in practice, family detention has failed to fulfill standards for adequate conditions of confinement.[20] Family detention, by definition, cannot comply with

[16] Mina Fazel, Ruth Reed, Catherine Panter-Brick, and Alan Stein (2012), "Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors," the *Lancet*, 379(9812) 266-282; K. Zwi, S. Mares, D. Nathanson, A.K. Tay, and D. Silove (2018), "The impact of detention on the social–emotional wellbeing of children seeking asylum: a comparison with community-based children," *European Child & Adolescent Psychiatry*, 27(4), 411-422.
[17] Physicians for Human Rights, "Punishment Before Justice: Indefinite Detention in the US," June 1, 2011, accessed at: https://phr.org/resources/punishment-before-justice-indefinite-detention-in-the-us/.
[18] Rapport of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Nils Melzer, Migration-related Torture and Ill treatment, A/HRC/37/50 (February 2018).
[19] NPRM, pg. 47
[20] As cited in the NPRM: Grassroots Leadership, Inc. v. Tex. Dep't of Family and Protective Servs., No. D-1-GN-15-004336 (Tex. Dist. Ct. amended final judgment Dec. 2, 2016); Commonwealth of Pa., Dep't of Human Servs., Adjudication and Order, Pa. Dep't of Human Servs., Bureau of Hearings and Appeals, BHA Docket No. 061-16-0003 (Apr. 20, 2017).

requirements that protect the safety, health, and well-being of children, as it is characterized by inadequate medical and mental health staff, lack of provision for adequate language interpretation, inappropriate physical facilities which are not child-proofed, and inadequate preparation for emergency situations. The government's stated intent to increase the number of detained families and the duration for which they are detained is an intentional decision to greatly increase the foreseeable risk of harm to families. The proposed self-licensing scheme is patently unrealistic and unfeasible, given the recent OIG report which stated that recent audits of existing facilities "do not ensure adequate oversight or systemic improvements in detention conditions."[21]

- **Family detention facilities are not suitable for housing children.** The architectural layout and design of family residential centers themselves increase the likelihood of injury as they are not adapted to the needs of children. Troubling revisions in the proposed rule to the Pennsylvania code definition of secure facilities in the proposed changes (from "voluntary egress" to "egress," from "a building" to "a portion of a building"[22]) indicate that DHS will continue to inappropriately house families in minimally adapted maximum security facilities with heavy duty locks and doors which are not adapted to child care. DHS' own medical experts have documented numerous severe finger injuries (including lacerations and fractures) due to spring-loaded closure of heavy doors in a converted medium-security prison used as a family detention center.[23] Many facilities lack medical space, in addition to constrained residential space; in one center, the gymnasium was used as an ad hoc medical overflow space.[24] The proposed self-licensing scheme is likely to exempt facilities from architectural standards of traditional child care licensing, such as those considered by Texas Pediatric Society in opposition to a rule creating a "family residential center" licensing category in Texas in 2015.[25] These missing standards can include limiting the number of room occupants and preventing children from sharing a room with unrelated adults and with adults of the opposite gender, which puts children at an increased risk of child abuse.[26] In current family detention facilities, families are typically placed in rooms that accommodate six people at a time and where children share rooms with unrelated adults, including sleeping, dressing, and using the restroom with no door or privacy from adults.[27]
- **Emergency situations cannot excuse inhumane treatment through denial of food or medical care.** Through the proposed rule, DHS seeks to expand the definition of "emergencies" as events that delay the placement of minors within the required time frame[28] to include delaying or excusing noncompliance.[29] Children will be at greater risk of exposure to dangerous conditions if DHS operates under an influx standard that states

[21] Department of Homeland Security Office of Inspector General, ICE's Inspections and Monitoring of Detention Facilities Do Not Lead to Sustained Compliance or Systemic Improvements, OIG-18-67 (June 26, 2018).
[22] NPRM p. 158.
[23] Allen and McPherson, op cit.
[24] Allen and McPherson, op cit.
[25] Texas Pediatric society, Letter to Judge John J. Specia Jr., December 13, 2015, accessed at: https://txpeds.org/sites/txpeds.org/files/documents/newsletters/tps-comments-on-dfps-detention-center-licensing.pdf.
[26] Allen and McPherson, op cit.
[27] Human Rights First, "Health Concerns at the Berks Family Detention Center" (February 19, 2016), accessed at: https://www.humanrightsfirst.org/resource/health-concerns-berks-family-detention-center
[28] Flores Settlement Agreement at para. 12B.
[29] NPRM at 44.

that minors must be transferred "as expeditiously as possible," which can be broadly interpreted, instead of a defined period of three to five days.[30] Critical medical care for acute and infectious conditions which require immediate attention may be ignored or delayed if "emergency" conditions are defined as broadly as proposed in the rule. Recent cases have demonstrated the current deficiencies in emergency care for detained families, including the death of a 19-month-old toddler due a respiratory infection that went untreated[31] and the near death of a five-year-old due to an untreated ruptured appendix,[32] both shortly after being released from Dilley family detention center. From a public health perspective, designation of an emergency should trigger additional resources, prepared in advance through contingency planning and made available through standing mechanisms. It is unacceptable that an emergency situation should legitimize violation of minimum standards and remove the mandatory requirement that deviations from minimum standards must be recorded. DHS offers as an example delaying access to meals during transfer from a facility in the path of a natural disaster;[33] the hypothetical example should instead ensure that nonperishable, nutritious food and bottled water in packs will be kept on site at all times in case of an emergency evacuation in order to ensure that nutritional needs of children are met.

- **Proposed age determination procedures are both unreliable and unethical.** From a medical perspective, the proposed age determination procedures are known to be inaccurate, raising protection concerns. Clinical evaluation of radiographs, proposed in the change, have concluded that hand and wrist radiographs cannot provide accurate estimates of the age of living individuals.[34] Furthermore, the Royal College of Pediatrics and Child Health, among others, has indicated that taking radiographs for non-medical purposes is unethical as it exposes children to radiation unnecessarily with no anticipated health benefit.[35] A recent systematic review of age determination on the basis of dental maturation found that ages of individuals under consideration were consistently overestimated.[36] Skeletal maturity data is unreliable because skeletal tissue development is impacted by nutritional and environmental influences, not solely chronological age.[37] In conclusion, there is no scientific or medical consensus on a

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[30] *Id.* at 45, 87.
[31] Jamiel Lynch, Dave Alsup, and Madison Park, "Law firm alleges neglectful medical care after child dies weeks after ICE custody," *CNN*, August 28, 2018, accessed at: https://www.cnn.com/2018/08/28/us/texas-ice-child-death/index.html.
[32] Debbie Nathan, "A 5-year-old Girl in Immigrant Detention Nearly Died of an Untreated Ruptured Appendix
September 2 2018," the *Intercept*, accessed at: https://theintercept.com/2018/09/02/border-patrol-immigrant-detention-medical-neglect-texas/.
[33] NPRM at 44.
[34] S. Serinelli, V. Panetta, P. Pasqualetti et al, "Accuracy of three age determination X-ray methods on the left
hand-wrist: A systematic review and meta-analysis," *Leg Med* (Tokyo) 2011, 13: 120–133.
[35] Royal College of Paediatrics and Child Health UK, X-Rays and Asylum Seeking Children: Policy Statement, 19th November 2007.
[36] J. Jayaraman, H.M. Wong, N.M. King et al, "The French Canadian dataset of Demirjian for dental age estimation:
A systematic and meta-analysis," *J Forensic Legal Med* 2013, 20: 373–381.
[37] J. Jayakumar, G.J. Roberts, H.M. Wong et al, "Ages of legal importance: Implications in relation to birth registration and age assessment practices," *Medicine, Science and the Law* 2016, 56(1): 77–82 pg. 81.

reliable medical method of age assessment. No procedure can verify age with certainty, therefore individuals should be given the benefit of the doubt. Improper age determination carries the risk of excluding vulnerable children from age-appropriate preventative health screening and services. Most concerning is that improper age determination may cause a child to unnecessarily lose legal status as an Unaccompanied Alien Child (UAC) and associated legal protections, such as a non-adversarial asylum interview and release to an eligible sponsor. Age assessment procedures should be regarded as a measure of last resort, when documentation and interviews failed to establish the child's age and when there are serious grounds for doubting the child's self-declared age.[38] Children should be offered a range of options through which to prove their age and should have the right to refuse to undergo a procedure which subjects them to medical risks. International child protection standards emphasize the importance of the best interests of the child during age determination procedures, in accordance with medical ethical principles of patient autonomy and informed consent, and with human rights law provisions that the views of children must be given due weight in relation to their age and maturity and that children have the right to protection from arbitrary interference with their privacy.[39] Informed consent of children to age assessment procedures must take into account their understanding of the procedure and its possible medical and legal consequences. The findings should be shared with the child in writing in a language that they understand and a mechanism should be provided to appeal the outcome.[40] Best practices indicate that the procedures should be undertaken by an independent, multidisciplinary team, including medical and mental health professionals and social workers, as well as legal counsel, including those with expertise in relevant cultural factors.[41]

PHR experts have conducted forensic evaluations of asylum seekers for more than 25 years, including recent evaluations of children and families in immigration detention. The medical and mental health evidence is clear that detention is harmful for children; international human rights law is clear that detention is never in a child's best interest and violates minimum child protection standards. Alternatives to detention, including case management programming, are a rights-respecting alternative which prevent health harms and ensure compliance with immigration proceedings, and should be relied upon as the preferred policy option.

Respectfully,

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[38] T. Smith and L. Brownlees, "Age assessment practices: A literature review & annotated bibliography," accessed at: http://www.unicef.org/protection/Age_Assessment_Practices_2010.pdf.
[39] UN General Assembly, Convention on the Rights of the Child, 20 November 1989, UNTS 1577(3).
[40] Smith and Brownlees, op cit.
[41] Smith and Brownlees, op cit.