Dr. Julie M. Linton, MD, FFAP
Co-Chair, Immigrant Health Special Interest Group
American Academy of Pediatrics
Submitted March 13, 2019 QUESTIONS

FROM SENATOR BOOKER

1. **You have studied and written about the detention of immigrant children. According to your research, "Reports by advocacy organizations, including interviews with detainees and the DHS Office of Inspector General have cataloged egregious conditions in many of the centers, including lack of bedding (eg, sleeping on cement floors), open toilets, no bathing facilities, constant light exposure, confiscation of belongings, insufficient food and water, . . . and a history of extremely cold temperatures." What dangers do these facilities present for Central American children who are fleeing extraordinary violence and poverty and what impact can these conditions have on a child's development?**

Children, who have often experienced terror in their home countries and then additional trauma during the journey to the U.S.,[1] are often re-traumatized through processing and detention in Customs and Border Protection (CBP) facilities not designed for children. This re-traumatization may invoke emotional and behavioral responses, such as feelings of terror, fear, anxiety, depression, as well as physical reactions such as difficulty sleeping, loss of appetite, headaches, stomach pains, and bedwetting. Sick children, children who have been hospitalized, or children with special health care needs should never be returned to a CBP processing facility. When a child is diagnosed with an illness in a pediatrician's office or is discharged from an emergency room or a hospital, he or she is sent home to recover with plenty of rest and a parent to care for them. Parents of children being detained in CBP processing centers do not have that luxury; rather, the conditions in the centers themselves exacerbate children's suffering, and without medical professionals who understand the signs and symptoms to look for to assess a child's condition, these children are at further risk. A sick child should recover in the comfort of a home or child-friendly setting under the care of a parent or caregiver, not on a cold, concrete floor in federal custody.

The trauma of processing in CBP facilities is profoundly worsened by forced separation from their parents. This toxic stress, defined as serious stress in the absence of buffering support from a parent or known caregiver, can lead to long-term mental health effects such as developmental delays, learning problems and chronic conditions such as hypertension, asthma, cancer and depression. Children who have been separated may also be mistrusting, questioning why their parents were not able to prevent their separation and care for them. A child may show different behaviors in response to exposure to traumatic events like separation from parents depending on their age and stage of development. Some of these signs of distress are listed in the chart below:[2]

---

[1] Kadir A, Shenoda S, Goldhagen J, Pitterman S. The Effects of Armed Conflict on Children. *Pediatrics*. 2018;142(6).

[2] The National Child Traumatic Stress Network. Effects. https://www.nctsn.org/what-is-child-trauma/trauma-types/refugee-trauma/effects. Published September 4, 2018. Accessed February 1, 2019.

Preschool children	Elementary school children	Middle and high school-aged youth
• Bed wetting • Thumb sucking • Acting younger than their age • Trouble separating from their parents • Temper tantrums • Aggressive behavior like hitting, kicking, throwing things, or biting • Not playing with other kids their age • Repetitive playing out of events related to trauma exposure	• Changes in their behavior such as aggression, anger, irritability, withdrawal from others, and sadness • Trouble at school • Trouble with peers • Fear of separation from parents • Fear of something bad happening	• A sense of responsibility or guilt for the bad things that have happened • Feelings of shame or embarrassment • Feelings of helplessness • Changes in how they think about the world • Loss of faith • Problems in relationships including peers, family, and teachers • Conduct problems

Detention is also not a solution to forced separation. There is not evidence that any amount of time in detention is safe for children. The AAP policy statement entitled *Detention of Immigrant Children* outlines the evidence regarding the harms of detention on short- and long-term children health and wellbeing.

2. **In a paper you wrote on the detention of immigrant children, you recommended that "[c]children, especially those who have been exposed to trauma and violence, should not be placed in settings that do not meet basic standards for children's physical and mental health and that expose children to additional risk, fear, and trauma." Do any of CBP's current facilities meet the basic standards for children's physical and mental health?**

   I am not aware that any of CBP's facilities meet evidence-based standards for the care and treatment of children. The AAP policy statement entitled *Detention of Immigrant Children* states, "Because conditions at CBP processing centers are inconsistent with AAP recommendations for appropriate care and treatment of children, children should not be subjected to these facilities."

3. **Do you think the policy changes CBP adopted in December in response to two migrant children dying in its custody are sufficient? If not, why?**

   I believe you are referring to the CBP Interim Enhanced Medical Efforts Directive that was signed on January 28th. The success of the Interim Directive will depend on how it is implemented. In order to determine whether the policies specified in the Interim Directive are

being followed by CBP agents and officers, there needs to be independent oversight. I have a number of questions about the Interim Directive such as what exactly constitutes a medical assessment? What type of equipment are providers being given to, for example, check temperatures and is that equipment reliable? Can providers conduct any lab tests such as a rapid strep test on site and can they order and quickly fill needed prescription medications? Are there private medical exam rooms? Given the number of children in family units cited by CBP that are seeking asylum in the U.S., there needs to be greater numbers of pediatric medical providers. How is that need being filled? What proportion of the $128 million in the FY2019 Conference Appropriations bill provided to CBP for contracting with medical professionals will be for pediatric medical providers?

4. **How would you prioritize the policy changes CBP needs to make with respect to the detention of immigrant children?**

First and foremost, processing of children and family units should occur in a child-friendly manner, taking place outside current CBP processing centers and conducted by child welfare professionals, to provide conditions that emphasize the health and well-being of children and families at this critical stage of immigration proceedings.

CBP agents, including those who are not trained as EMTs or paramedics and including those who work in remote areas along the border, should be trained to know how to identify the signs of a child who is in medical distress and needs immediate medical attention. We must also ensure that CBP provides its agents with necessary basic supplies such as oral rehydration, food, first-aid kits, and other supplies that could be life-saving should those agents encounter a sick child. The AAP is pleased to support S. 412, the Remote, Emergency, Medical, Online Training, Telehealth, and EMT (REMOTE) Act, which would provide for this training and supplies, among other provisions.

The Academy is urging CBP to ensure that all children under 18 years of age receive evidenced-based medical screening and care from professionals trained in pediatric care. We must have medical professionals who are trained in the care of children screening and treating vulnerable children who are in the custody of our government.

Children who are identified as needing additional medical care should be immediately referred for evaluation and treatment. Procedures should be in place to ensure that when children need treatment, they are quickly able to receive appropriate care and have access to professionals trained in the care of critically ill children during transport. If a children's hospital is available in the area, that should be the preferred site of care.

Screening and treatment should occur in the child or parent's preferred language so as to ensure the family is able to understand what is happening and accurately answer questions. This means that trained medical interpreters should be used in all clinical encounters with children and their families.

Children should never be separated from their parents unless there are concerns for the safety of the child at the hand of the parent and a competent family court makes that determination.

Nowhere is that more important than in the case of a child needing medical screening and treatment. Parents know their child's medical history and are often better able to share that history than the child him or herself. Separation from a parent is traumatic to children, causes stress, and has the potential to negatively impact the child's short- and long-term health.