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**Testimony of Julie M. Linton, MD, FAAP, Co-Chair, American Academy of Pediatrics Immigrant Health Special Interest Group**

On Behalf of the American Academy of Pediatrics

**Before the U.S. House of Representatives**

Committee on Homeland Security Subcommittee on Border Security, Facilitation, and Operations

**“The Department of Homeland Security’s Family Separation Policy: Perspectives from the Border”**

**March 26, 2019**

Chairwoman Rice and Ranking Member Higgins, thank you for the opportunity to speak here today. I am Dr. Julie M. Linton, a practicing pediatrician in Greenville, South Carolina, and my clinical work is focused on the care of children in immigrant families. I am testifying today on behalf of the American Academy of Pediatrics (AAP) where I serve as co-chair of its Immigrant Health Special Interest Group (SIG) and as a member of the Executive Committee for the AAP Council on Community Pediatrics. I am also a co-author of the AAP's 2017 policy statement entitled *Detention of Immigrant Children*. The AAP is a non-profit professional membership organization of 67,000 primary care pediatricians and medical and surgical pediatric subspecialists dedicated to the health and well-being of all infants, children, adolescents, and young adults.

The AAP is non-partisan and pro-children. Pediatricians care about the health and well-being of **all** children—no matter where they or their parents were born. The AAP supports comprehensive health care in a medical home for all children in the U.S. As pediatricians, we know that children do best when they are together with their families. When we read media reports in March of 2017 that the Department of Homeland Security (DHS) was considering a policy that would separate immigrant mothers from their children when they arrived at the U.S. border, we were compelled to immediately speak out against this proposed policy. We urged federal authorities to exercise caution to ensure that the emotional and physical stress children experience as they seek refuge in the U.S. is not exacerbated by the additional trauma of being separated from their siblings, parents, or other relatives and caregivers.

We subsequently wrote to DHS six times to urge the agency to reject a policy that would separate immigrant children from their parents at the border. In addition to these letters, the AAP issued roughly half a dozen statements, and pediatricians across the country, myself included, penned countless op-eds about why family separation devastates the most basic human relationship we know — that of child and parent.

The AAP has said repeatedly that separating children from their parents contradicts everything we stand for as pediatricians—protecting and promoting children's health. In fact, highly stressful experiences, like family separation, can cause irreparable harm, disrupting a child's brain architecture and affecting his or her short- and long-term health. This type of prolonged exposure to serious stress—known as toxic stress—can carry lifelong consequences for children. Today I would like to speak more about the health effects of separation, both what we know from the scientific literature and what I know from caring for my patients. I will also emphasize the harmful impact of detention on the health and wellbeing of immigrant children and underscore the critical need to avoid retraumatizing children and families with detention or separation.

## Observations of Pediatricians

Writing about her experience visiting a “tender age” shelter run by the Department of Health and Human Services’ Office of Refugee Resettlement (ORR) in April 2018, then-president of the AAP Dr. Colleen Kraft described a little girl:

A toddler, her face splotted red from crying, her fists balled up in frustration, pounding on a play mat in the shelter for unaccompanied children run by the Department of Health and Human Services (HHS)' Office of Refugee Resettlement. No parent was there to scoop her up, no known and trusted adult to rub her back and soothe her sobs. The staff members at the center tried their best, and shared my heartbreak while watching this child writhe on the floor, alone.

We knew what was wrong, but we were powerless to help. She wanted her mother. And the only reason she could not be with her mother was because immigration authorities had forcibly separated them when they crossed the border into the United States. The mother was detained, and the little girl was handed over to the shelter as an "unaccompanied" child.<sup>1</sup>

The co-chair of AAP’s Immigrant Health, SIG Dr. Marsha Griffin, and SIG member Dr. Rita Agarwal, told the story of a child they encountered during a visit to an ORR shelter for unaccompanied children in the spring of 2018. This child had been separated from her mother. They wrote:

In a walled-in courtyard, we saw a 5-year-old girl chasing iridescent bubbles blown by two adults. Staff said she tried to run away any time she played outside, so she was limited to the courtyard. She would bite anyone who approached her, so she was kept away from other children and distracted with bubbles. Biting and seeking to run are signs of acute distress in a child of this age — a normal reaction to extreme fear. This girl did not need bubbles and a walled courtyard but rather her mother or her father to calm her — someone who could hold her and make her world right again.<sup>2</sup>

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<sup>1</sup> Kraft C. Separating parents from their kids at the border contradicts everything we know about children’s welfare. LA Times. <https://www.latimes.com/opinion/op-ed/la-oe-kraft-border-separation-suit-20180503-story.html>. Published May 3, 2018. Accessed February 1, 2019.

<sup>2</sup> Agarwal R, Griffin M. Taking immigrant kids from parents shows contempt for families. Houston Chronicle. <https://www.houstonchronicle.com/opinion/outlook/article/Taking-immigrant-kids-from-parents-shows-contempt-12963039.php>. Published June 3, 2018. Accessed February 1, 2019.

## Evidence of the Harms of Family Separation

Studies overwhelmingly demonstrate the irreparable harm caused by breaking up families.<sup>3</sup> We know that children who have been separated can have a host of health challenges, including developmental delays like those in gross and fine motor skills, regression in behaviors like toileting and speech, as well as constant stomach and headaches. Prolonged exposure to highly stressful situations — known as toxic stress — can disrupt a child's brain architecture and affect his or her short- and long-term health. A parent or a known caregiver's role is to mitigate these dangers. When robbed of that buffer, children are susceptible to a variety of adverse health impacts including learning deficits and chronic conditions such as depression, post-traumatic stress disorder and even heart disease.

The government's practice of separating children from their parents at the border counteracts every science-based recommendation I have ever made to families who seek to nurture and protect their children's physical, intellectual, and emotional development. Children, who have often experienced terror in their home countries and then additional trauma during the journey to the US,<sup>4</sup> are often re-traumatized through processing and detention in Customs and Border Protection (CBP) facilities not designed for children. This trauma is profoundly worsened by forced separation from their parents. It 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:<sup>5</sup>

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<sup>3</sup> Shonkoff JP, Garner AS. The Lifelong Effects of Early Childhood Adversity and Toxic Stress. *Pediatrics*. 2012;129(1):e232-46.

Masten AS. Global perspectives on resilience in children and youth. *Child Dev*. 2014;85(1):6-20.

Bouza A, Camacho-Thompson DE, Carlo G, et al. Society for Research in Child Development. The Science Is Clear: Separating Families Has Long-Term Damaging Psychological and Health Consequences for Children, Families, and Communities. <https://www.srcd.org/policy-media/statements-evidence/separating-families>. Published June 20, 2018. Accessed February 1, 2019.

<sup>4</sup> Kadir A, Shenoda S, Goldhagen J, Pitterman S. The Effects of Armed Conflict on Children. *Pediatrics*. 2018;142(6).

<sup>5</sup> 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   |
|--|---|---|
| <ul style="list-style-type: none"> <li>• Bed wetting</li> <li>• Thumb sucking</li> <li>• Acting younger than their age</li> <li>• Trouble separating from their parents</li> <li>• Temper tantrums</li> <li>• Aggressive behavior like hitting, kicking, throwing things, or biting</li> <li>• Not playing with other kids their age</li> <li>• Repetitive playing out of events related to trauma exposure</li> </ul> | <ul style="list-style-type: none"> <li>• Changes in their behavior such as aggression, anger, irritability, withdrawal from others, and sadness</li> <li>• Trouble at school</li> <li>• Trouble with peers</li> <li>• Fear of separation from parents</li> <li>• Fear of something bad happening</li> </ul> | <ul style="list-style-type: none"> <li>• A sense of responsibility or guilt for the bad things that have happened</li> <li>• Feelings of shame or embarrassment</li> <li>• Feelings of helplessness</li> <li>• Changes in how they think about the world</li> <li>• Loss of faith</li> <li>• Problems in relationships including peers, family, and teachers</li> <li>• Conduct problems</li> </ul> |

**Detention of Children is Not a Solution to Separation**

Some have suggested that an alternative to separating families is to increase the use of Immigration and Customs Enforcement (ICE) family detention. However, family detention is neither a safe nor effective solution to address the forced separation of children and parents at the border. I co-authored the AAP Policy Statement entitled *Detention of Immigrant Children*, which recommends that immigrant children seeking safe haven in the United States should never be placed in ICE detention facilities. There is no evidence that any amount of time in detention is safe for children.<sup>6</sup> In fact, even short periods of detention can cause psychological trauma and long-term mental health risks for children.<sup>7</sup> Studies of detained immigrants have shown that children and parents may suffer negative physical and emotional symptoms from detention, including anxiety, depression and posttraumatic stress disorder.<sup>8</sup> Detention itself undermines parental authority and the capacity to respond to their children’s needs; this difficulty is complicated by parental mental health problems.<sup>9</sup> Parents in detention centers have described regressive behavioral changes in their children, including decreased eating, sleep disturbances, clinginess, withdrawal, self-injurious behavior, and aggression.<sup>10</sup>

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<sup>6</sup> Linton JM, Griffin M, Shapiro AJ. Detention of Immigrant Children. *Pediatrics*. 2017;139(5).  
<sup>7</sup> Ibid.  
<sup>8</sup> Ibid.  
<sup>9</sup> Ibid.  
<sup>10</sup> Ibid.

Specifically, detention of youth is associated with physical and mental health symptoms that appear to be caused and/or worsened by detention. A study of children ages 3 months to 17 years in a British immigration detention center revealed physical symptoms that included somatic complaints (*e.g.*, headaches, abdominal pain), weight loss, inability to manage chronic medical problems, and missed follow-up health appointments including those for vaccinations, developmental and educational problems, and mental health symptoms including anxiety, depression, and reemergence of post-traumatic stress disorder.<sup>11</sup> In a systematic review that explored risk and protective factors for the psychological wellbeing of children and youth who were resettled in high-income countries, the authors indicate that adverse events during and after migration may be more consequential than pre-migration events. Specifically, the authors conclude that detention of immigrant children and youth is particularly detrimental to mental health and an example of trauma for which impact is cumulative.<sup>12</sup>

### **Firsthand Observations at CBP Processing Centers and from Children in the Community**

In November of 2016, I toured the CBP's Ursula Central Processing Center in McAllen, Texas as part of a team of pediatricians from the AAP and the Texas Pediatric Society. The building, hidden behind a fence, was a warehouse-like facility identifiable only with a white placard stating that this was property of the U.S. government. Our CBP tour guide demonstrated empathy toward the detainees and recognized that the setting was not designed for children.

Upon entering the holding area, we saw rows of children lying on mats on the floor, wrapped in silvery Mylar blankets. We saw clusters of children huddled in cages created by chain-link fences that extended towards the ceiling. Within this 55,000-square-foot space, there were four giant cages holding boys, girls, and mothers with young children. There was one small area that held adult men. The children ranged from infants to older adolescents. Most of the detainees appeared to be exhausted and frightened. Extremely bright lights shone from the high ceilings, the smell of porta-potties infiltrated the air, and the chilling sound of crinkling Mylar blankets echoed through the warehouse. The windowless environment was particularly disorienting because the lights were kept on 24 hours a day, seven days a week, which we were told was for "safety reasons."

In the Ursula facility (as it is known), there are private toilets, showers, and a clean, dry change of clothes if detainees arrive before 7 p.m.; the detainees who arrive late sit in wet clothes until the morning. Old clothes, shoes and other belongings, like backpacks and stuffed animals, are sealed away in individual plastic bags. Our guide told us three meals were provided each day.

The medical care we saw provided at Ursula was cursory at best and took place in the open, behind curtained screens. Detainees were checked for scabies, lice and obvious signs of

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<sup>11</sup> Lorek A, Ehntholt K, Nesbitt A, et al. The Mental and Physical Health Difficulties of Children Held within A British Immigration Detention Center: A Pilot Study. *Child Abuse Negl.* 2009;33(9):573-85.

<sup>12</sup> Fazel M, Reed RV, Panter-Brick C, Stein A, Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors, *Lancet*, 379(9812):266-282 (2012).

infectious disease, such as active chicken pox lesions. Vital signs (temperature, blood pressure, respiratory rate, heart rate) and height and weight were not routinely taken. Those who needed more detailed exams were taken to a small, cold "medical room." There was a small cabinet with over-the-counter medications, and pictures of infectious diseases adorned the walls. We were told that emergency responders were called for those who appeared ill or injured after presenting to CBP officials in the field.

We were not permitted to speak with children during our tour of the Ursula facility. However, I can speak to my patients' experiences who were processed at Ursula and other CBP facilities. As a pediatrician in both North and South Carolina, I have learned through taking medical histories from dozens of children who have been processed at Ursula, that children and families have been held there for up to eight days. Although they are offered food, the sandwiches have at times been kept so cold that they were frozen. Several families have shared that their belongings have been "lost" during processing, including vaccination records and medical documents that they have brought from their countries of origin. Families have also shared with me their gratitude when treated kindly by CBP officials, and this gratitude is particularly striking given the conditions to which they are exposed.

Separation of children from siblings, parents, and caregivers are routine during processing. One set of siblings fled Central America with their mother after experiencing persecution in their community. When they presented to CBP officials to seek refuge and face processing, the younger child was held in one cage with her mother, and the older child, a teenager, was kept separately from her mother and sister for three days. After thousands of miles of travel with the proximity and support of her family, this child no longer had the buffering support of her family. When she recounted her story, she became tearful and withdrawn. She shared with me that she was incredibly frightened during the time in the processing center, unable to eat or sleep. Even this brief period of time in a CBP processing center was re-traumatizing for this child, placing her at risk for short- and long-term health effects.

### **Children are Not Little Adults**

As pediatricians, we know that children are not little adults. Children's vital signs (breathing rate, heart rate, blood pressure) have different normal parameters than adults, and these parameters vary by age. When children begin to get sick, they present with subtle findings, and they tend to get sick more quickly. For example, children can become dehydrated more quickly than adults. They require greater amounts of fluid per pound of body weight than adults, and high fevers and fast breathing can cause children to lose fluid quickly. Children also need encouragement to drink when they are ill, and this encouragement is exceedingly difficult to provide to frightened children.

The flu can be particularly serious for children and can escalate quickly. Signs differentiating a child with mild illness from a child with severe illness are quite subtle. A child can be happily playing, even running around, while her body systems begin to shut down. When a child is having difficulty breathing, she may breathe more quickly or her ribs may pull in with each

breath; these signs would often not be easily visible, especially not to an untrained eye. Additionally, children are more prone to muscle fatigue, including the breathing muscles, and are thus at greater risk for respiratory failure.<sup>13</sup> Even the dosing of common medications is different in children than it is in adults; rather than standard dosing, children are dosed based on their weight.<sup>14</sup>

Sepsis, for example, must be treated early in children. According to the Society of Critical Care Medicine (SCCM), sepsis is a complicated disease causing the body to be compromised by serious systemic infection leading to multiple organ failure.<sup>15</sup> The importance of recognizing and treating sepsis early in children cannot be underestimated; each hour of delay in treatment dramatically increases mortality. Because sepsis can be so serious and so difficult to recognize in children, the SCCM has a separate set of guidelines for recognizing and treating sepsis in children that are different than for adults.<sup>16</sup> For these reasons, it is essential that the individuals who interact with children apprehended at the border are trained to recognize signs and symptoms of distress and know when to urgently refer children to additional care.

### **AAP Recommendations**

We urge federal agencies to apply a child-focused lens when considering policies that could have an impact on child health and well-being. The deaths of 7-year-old Jakelin Caal Maquin and 8-year-old Felipe Gómez Alonzo while in the custody of CBP are tragedies that demand systematic improvements. AAP remains committed to working with federal agencies to offer its expertise as medical providers for children, in an effort to protect and promote child well-being. In that vein, we offer the following recommendations:

1. 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.

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<sup>13</sup> Woollard M, Jewkes F. 5 Assessment and identification of paediatric primary survey positive patients. *Emergency Medicine Journal*. 2004;21:511-517.

<sup>14</sup> Palchuk MB, Seger DL, Recklet EG, Hanson C, Alexeyev A, Li Q. Weight-based pediatric prescribing in ambulatory setting. *AMIA Annu Symp Proc*. 2006;2006:1055.

<sup>15</sup> Weiss SL. Five Important Things to Know about Pediatric Sepsis. Society of Critical Care Medicine. <https://www.sccm.org/Communications/Critical-Connections/Archives/2018/Five-Important-Things-to-Know-About-Pediatric-Seps>. Accessed March 4, 2019.

<sup>16</sup> Dellinger RP, Levy MM, Rhodes A, et al: Surviving Sepsis Campaign: International guidelines for management of severe sepsis and septic shock: 2012. *Crit Care Med*. 2013; 41:580-637.



2. Family detention threatens the health of children and their parents and is not a safe or effective solution to address the forced separation of children and parents at the border. The AAP has said that no amount of time in detention is safe for children.<sup>17</sup>
3. Instead of detention, AAP recommends the use of community-based alternatives for children in family units. Community-based case management should be implemented for children and families, thus ending both detention and the placement of electronic tracking devices on parents. Community release with case management has been shown to be cost-effective and can increase the likelihood of compliance with government requirements.<sup>18,19,20</sup> We urge Congress to provide funding to support case management programs. AAP also advocates for expanded funding for post-release services to promote the safety and well-being of all previously detained immigrant children and to facilitate connection and access to comprehensive services, including medical homes, in the community.
4. All immigrant children seeking safe haven in the U.S. should have comprehensive health care and insurance coverage, which includes access to qualified medical interpretation covered by medical benefits, pending immigration proceedings. Children and families should have access to legal counsel throughout the immigration pathway. Unaccompanied children should have free or pro bono legal counsel with them for all appearances before an immigration judge. As such, the AAP strongly supports the “Fair Day in Court for Kids Act”.
5. 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.<sup>21</sup> The 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.<sup>22</sup>
6. CBP agents, including those who are not trained as EMTs or paramedics and 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. Ideally, such training would be both online and in-person. While it may not be possible to provide

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<sup>17</sup> Ibid.

<sup>18</sup> Edwards, A. Measures of first resort: alternatives to immigration detention in comparative perspective. *The Equal Rights Review*. 2011;7:117-142.

<sup>19</sup> U.S. Immigration Customs and Enforcement. Report of the DHS Advisory Committee on Family Residential Centers. <https://www.ice.gov/sites/default/files/documents/Report/2016/ACFRC-sc-16093.pdf>. Published September 30, 2016. Accessed February 1, 2019.

<sup>20</sup> Lutheran Immigration & Refugee Service, Women's Refugee Commission. Locking Up Family Values, Again. <https://www.womensrefugeecommission.org/resources/document/1085-locking-up-family-values-again>. Published October 28, 2014. Accessed February 1, 2019.

<sup>21</sup> Linton JM, Griffin M, Shapiro AJ. Detention of Immigrant Children. *Pediatrics*. 2017;139(5).

<sup>22</sup> Ibid.

pediatric medical training to all CBP agents, we can work to ensure that they are better prepared to identify a sick child and to get that child into appropriate care. We must also ensure that CBP provides its agents with necessary basic supplies such as oral hydration, 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 addresses many of these recommendations.

7. 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. CBP recently released an Interim Enhanced Medical Efforts Directive which states that all children under 18 years of age will receive a health interview and medical assessment. The success of the Interim Directive will be in how it is implemented.

Children who are identified as needing additional medical care should be immediately referred for evaluation and treatment, at a children's hospital if there is one available. 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.

8. 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.
9. 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.
10. Independent oversight of locations in which children are temporarily housed, detained, or sheltered is critical. Licensure of those locations is important to ensure appropriate care and oversight. As these locations are selected, we encourage DHS and HHS to consider their remoteness as that can impact proximity and access to trained pediatric providers. The AAP has called for a thorough, independent investigation of the government's detention practices, including the appointment of an independent team comprised of

pediatricians, pediatric mental health providers, child welfare experts, and others to conduct unannounced visits to federal facilities including CBP processing centers, ICE family detention centers, and ORR shelters to assess their conditions for children, capacity to respond to medical emergencies involving a child, and to ensure that immigrant children receive optimal medical and mental health care. These experts need unfettered access to sites where children are held in federal custody to ensure that they receive suitable care while there.

11. We must remember that immigrant children are, first and foremost, children. Protections for children in law or by the courts exist because children are uniquely vulnerable and are at high risk for trauma, trafficking, and violence. The Flores Settlement Agreement (FSA) and the *William Wilberforce Trafficking Victims Protection Reauthorization Act* (TVPRA) provide critically important and necessary protections for children in the custody of the federal government. They are not “loopholes”. They are legal protections that account for the fact that children are uniquely vulnerable and need to be protected. The FSA set strict national standards for the detention, treatment, and release of all minors detained in the legal custody of the federal government. It requires that children be held in the least restrictive setting appropriate for a child’s needs and that they be released without unnecessary delay to a parent, designate of the parent, or responsible adult as deemed appropriate.

Pending regulations proposed by DHS and Health and Human Services (HHS) are inconsistent with the FSA by allowing DHS to expand family detention centers, increase the length of time children spend in detention, and create an alternative licensure process that undermines state child welfare laws and basic protections for children. Proposals, such as the pending regulations that would pave the way for the longer-term detention of children with their parents or to weaken federal child trafficking laws like TVPRA, serve to strip children of protections designed for their unique circumstances. We urge Congress to reject these proposals.

## **Conclusion**

As a pediatrician, my professional responsibility is to apply science to advocate for and support children’s health. Evidence affirms that parental separation and family detention are dangerous for the short- and long-term health of children.

It is critical that all children who have been reunited with their parents receive appropriate medical care to help them recover from the traumatic experience of separation from their families. As a pediatrician, I also know that children and families who have faced trauma, with trauma-informed approaches and community support, can begin to heal. As such, immigrant children seeking safety should have access to health care, education, legal representation, and other essential services that support their growth, development, and capacity to reach their full potential. We must continue to support all immigrant children and families seeking safe haven in the U.S. and treat them with dignity and respect.