

November 6, 2018

Debbie Seguin
Assistant Director
Office of Policy
U.S. Immigration and Customs Enforcement
Department of Homeland Security
500 12th Street SW
Washington, DC 20536

Re: DHS Docket No. ICEB-2018-0002, RIN 0970-AC42 1653-AA75, Comments in Response to Proposed Rulemaking: Apprehension, Processing, Care, and Custody of Alien Minors and Unaccompanied Alien Children

Dear Ms. Seguin:

I am writing on behalf of the National Association of County and City Health Officials (NACCHO) and nearly 3,000 local health departments in response to the Department of Homeland Security's (DHS) Notice of Proposed Rulemaking (proposed rule) to express strong opposition to amending regulations relating to the apprehension, processing, care, custody, and release of alien juveniles published in the Federal Register on September 7, 2018.

Local public health departments are the governmental agencies that work every day in their communities to prevent disease, promote wellness, and protect health. NACCHO and local health departments are partners with HHS and agencies like the Centers for Disease Control and Prevention "to enhance the health and well-being of Americans." Local health departments are responsible for safeguarding the health of everyone in their communities, regardless of race, ethnicity, economic level, or immigration status.

From a public health and mental health perspective, the changes proposed by DHS and the Department of Health and Human Services (HHS) to replace the standards of the Flores settlement agreement are neither safe nor humane. Legalizing prolonged and indefinite detention of families, eliminating the state licensing requirement, and institutionalizing a permanent state of "emergency" to justify failure to meet standards of care will further compromise the treatment of migrant families. Under these proposed changes, inadequate



conditions of confinement are inevitable, heightening the risk of foreseeable health harms to the detained population.

Indefinite detention of children is deeply harmful

The main purpose of the proposed change, that of legalizing indefinite detention of children with their families which is prohibited under the Flores settlement, is harmful in and of itself. Although separation of children from their parents is inherently harmful, so is child detention. 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.¹ In a retrospective analysis, detained children were reported to have tenfold increase in developing psychiatric disorders.² Studies of health difficulties of detained children found that since being detained most children reported symptoms of depression, sleep problems, loss of appetite, and somatic complaints such as headaches and abdominal pains; specific concerns include inadequate nutritional provisions, restricted meal times, and child weight loss.³

Unlimited detention also violates the prohibition against torture and ill-treatment under U.S. and international law. The UN Special Rapporteur on torture has unequivocally stated that ill-treatment can amount to torture if it is intentionally imposed “for the purpose of deterring, intimidating, or punishing migrants or their families, or coercing them into withdrawing their

¹ Dudley, Michael, 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; Ehntholt, K., Trickey, D., Harris Hendriks, J., Chambers, H., Scott, M., Yule, W., & Tibbles, P. (2018). Mental health of unaccompanied asylum-seeking adolescents previously held in British detention centres. *Clinical Child Psychology and Psychiatry*, 23(2), 238–257; Kronick, R., Rousseau, C., & Cleveland, J. (2015). Asylum-seeking children’s experiences of detention in Canada: A qualitative study. *American Journal of Orthopsychiatry*, 85(3), 287.

² Steel, Zachary, Shakeh Momartin, Catherine Bateman, Atena Hafshejani, Derrick M. Silove, Naleyva 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.

³ Lorek, Ann, 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.



requests for asylum”.⁴ Indefinite detention has severe medical and mental health consequences.⁵

Family detention centers are unable to provide adequate services

The role of structural determinants of health in health outcomes sheds light on the reasons that family detention is so dangerous to physical and mental health. Family residential centers located in remote areas far from urban centers have consistently failed to recruit adequate health staff, including pediatricians, child and adolescent psychiatrists, and pediatric nurses.⁶ Families released through non-custodial measures have access to providers based in the community, but in detention their access to qualified medical and mental health professionals has been demonstrated to be dangerously inadequate. 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.⁷ In another facility, numerous children were incorrectly vaccinated with adult doses of vaccine as the providers were not familiar with labels on pediatric vaccines.⁸

Another crucial factor in health care access is language: requests for medical care, information about available care, and access to care are all conditioned on being able to communicate with health professionals in an understandable language. Family residential centers consistently faced difficulties in providing interpretation services to ensure access to health information and services, either through recruitment of an adequate number of bilingual staff or telephonic translation of indigenous languages. This deficiency has been described as “a pervasive concern across facilities.”⁹ Moreover, in an emergency situation, there is no reliable mechanism to allow staff to communicate effectively with all detainees.

Policymakers should heed public health studies which have found that 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 their specific medical and mental

⁴ 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).

⁵ Physicians for Human Rights, Punishment before Justice: Indefinite Detention in the US (June 1, 2011), <https://phr.org/resources/punishment-before-justice-indefinite-detention-in-the-us/>.

⁶ Dr. Scott Allen and Dr. Pamela McPherson, Letter to the Senate Whistleblowing Caucus, July 17, 2018, <https://www.whistleblower.org/sites/default/files/Original%20Docs%20Letter.pdf>.

⁷ Allen and McPherson, *id.*

⁸ Allen and McPherson, *id.*

⁹ Allen and McPherson, *id.*



health needs.¹⁰ It is clear that these facilities do not have the trained personal or resources to do so consistently.

Facilities of detention centers are not suitable for housing children

The architectural layout and design of the facilities themselves increase the likelihood of injury as they are not adapted to the needs of children. Troubling revisions 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”) indicate that DHS will continue to inappropriately house families in minimally adapted maximum security facilities with heavy duty locks and doors that 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.¹¹ Detention facilities and processing centers under the authority of U.S. Customs and Border Protection and HHS in recent months have exposed children to constant illumination. This caused sleep, deprivation and affected circadian rhythms that are crucial for development.¹² Research shows that constant exposure to light can contribute to loss of muscle strength and inflammation. For example, newborns in neonatal intensive care units who are exposed to constant light spend an average of 15 days longer in intensive care than those whose eyes are shielded.¹³

In addition to constrained and unsafe residential conditions, many facilities also lacked adequate medical space; in one case the gymnasium was used as ad hoc overflow medical space.¹⁴

The proposed rule’s self-licensing scheme is likely to exacerbate the dangers of these facilities by exempting them from the standards of traditional child care licensing.¹⁵ These safety

¹⁰ Keller A, Joscelyne A, Granski M, Rosenfeld B. Pre-Migration Trauma Exposure and Mental Health Functioning among Central American Migrants Arriving at the US Border. PloS ONE. 2017;12(1):e0168692.

¹¹ Allen and McPherson, *id.*

¹² Czeisler, C., Housing Immigrant Children — The Inhumanity of Constant Illumination (July 12, 2018) New England Journal of Medicine 379:e3, <https://www.nejm.org/doi/full/10.1056/NEJMp1808450?query=TOC>.

¹³ Vásquez-Ruiz S, Maya-Barrios JA, Torres-Narváez P, et al. A light/dark cycle in the NICU accelerates body weight gain and shortens time to discharge in preterm infants. Early Hum Dev 2014;90:535-540.

¹⁴ Allen and McPherson, *id.*

¹⁵ Texas Pediatric Society, Letter to Judge John J. Specia Jr., Dec. 13, 2015, <https://txpeds.org/sites/txpeds.org/files/documents/newsletters/tps-comments-on-dfps-detention-center-licensing.pdf>.



standards include protections for children that limit the number of room occupants and prevent children from sharing a room with unrelated adults and with adults of the opposite gender, factors that put children at an increased risk of child abuse.¹⁶ 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.¹⁷

In contrast, least restrictive alternatives address these concerns and provide access to supportive familial, social, co-ethnic and host community networks and resources. Access to health care and holistic services, including education, is best facilitated through placement 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.¹⁸

In light of the recent DHS Office of the Inspector General report stating that current audits “do not ensure adequate oversight or systemic improvements in detention conditions,”¹⁹ the self-licensing scheme is unrealistic and unfeasible.

State licensing is essential to ensure a minimum level of protection

DHS states that challenges to state licensing of family residential facilities are a justification for eliminating the Flores requirement of state licensing.²⁰ 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 children due to state licensing requirements—it is difficult to detain families because detention center facilities are inappropriate for housing families for any length of time.

¹⁶ Dr. Scott Allen and Dr. Pamela McPherson, Letter to the Senate Whistleblowing Caucus, July 17, 2018, <https://www.whistleblower.org/sites/default/files/Original%20Docs%20Letter.pdf>.

¹⁷ Human Rights First, “Health Concerns at the Berks Family Detention Center,” Feb. 19, 2016, <https://www.humanrightsfirst.org/resource/health-concerns-berks-family-detention-center>.

¹⁸ Fazel, Mina and Ruth Reed, Catherine Panter-Brick, 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; Zwi, K., Mares, S., Nathanson, D., Tay, A. K., & Silove, D. (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.

¹⁹ Dept. 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), <https://www.oig.dhs.gov/sites/default/files/assets/2018-06/OIG-18-67-Jun18.pdf>.

²⁰ NPRM p. 47.



Family detention by definition cannot comply with requirements that protect the safety, health, and well-being of children. State-level oversight has confirmed that in practice family detention has failed to fulfill standards for adequate conditions of confinement. Inadequate medical and mental health staff, lack of provision for adequate language interpretation, inappropriate physical facilities that are not child-proofed, and inadequate preparation for emergency situations, combined with the stated intent to greatly 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 children and families.

Emergencies do not 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 frame²¹ to include delaying or excusing noncompliance.²² Children will have a greater risk of exposure to dangerous conditions if DHS operates under an influx standard that states that minors must be transferred “as expeditiously as possible,” which can be broadly interpreted, instead of a defined period of 3-5 days.²³ This is already happening, as DHS is currently operating under the unchanged influx definition of more than 130 minors eligible for placement²⁴ 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, not be used to allow children to be exposed to more dangerous conditions.

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 a meal during transfer from a facility in the path of a natural disaster; the hypothetical example should instead ensure that non-perishable, nutritious food and bottled water in packs be kept on site at all times in case of an emergency evacuation in order to ensure that nutritional needs of children are met. 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 untreated²⁵

²¹ Flores Settlement Agreement at para. 12B.

²² NPRM p. 44.

²³ *Id.* at 45, 87.

²⁴ *Id.* at 45, 87.

²⁵ Jamiel Lynch, Dave Alsup and Madison Park, *CNN*, “Law firm alleges neglectful medical care after child dies weeks after ICE custody,” Aug. 28, 2018, <https://www.cnn.com/2018/08/28/us/texas-ice-child-death/index.html>.



and the near death of a 5-year-old due to an untreated ruptured appendix,²⁶ both shortly after being released from Dilley family detention center.

NACCHO calls on DHS and HHS to immediately withdraw the current proposal and dedicate their efforts to advancing policies that safeguard the health, safety, and best interests of children and their families, not least through robust, good-faith compliance with the Flores Settlement Agreement.

Thank you for the opportunity to submit comments on the NPRM. Please do not hesitate to contact Eli Briggs, Senior Government Affairs Director at ebriggs@naccho.org or 202-507-4194 for further information.

Sincerely,



Lori Tremmel Freeman, MBA
Chief Executive Officer

²⁶ Debbie Nathan, *The Intercept*, "A 5-year-old Girl in Immigrant Detention Nearly Died of an Untreated Ruptured Appendix," Sept. 2, 2018, <https://theintercept.com/2018/09/02/border-patrol-immigrant-detention-medical-neglect-texas/>.

