American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Testimony of Julie M. Linton, MD, FAAP
On Behalf of the American Academy of Pediatrics

Before the United States Senate
Committee on the Judiciary

"Oversight of the Customs and Border Protection's Response to the Smuggling of Persons at the Southern Border"

March 6, 2019

Chairman Graham, Ranking Member Feinstein, and members of the Senate Judiciary Committee, thank you for the opportunity to testify here today. I am Dr. Julie M. Linton, a practicing pediatrician in Greenville, South Carolina, where 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.

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. We have maintained enduring concern for the health and safety of immigrant children in the custody of our government, and we published our medical recommendations as an AAP policy statement, *Detention of Immigrant Children*, in March 2017, which I co-authored.[1] Given our professional responsibility and engagement with this issue, we were outraged to learn in December of the death of 7-year-old Jakelin Caal Maquin while in Customs and Border Protection (CBP) custody, and then, just a few weeks later, to learn of the death of 8-year-old Felipe Gómez Alonzo also in the custody of CBP. During the hours, days, and weeks following the tragic deaths of Jakelin and Felipe, the Academy spoke out, urging for improved conditions and adequate medical care that could have saved the lives of these children and seeking answers from federal government officials.

Deaths of Jakelin Caal Maquin and Felipe Gomez Alonzo

On December 18, the AAP, and thirteen medical and mental health organizations, wrote to Department of Homeland Security (DHS) Secretary Kirstjen Nielsen and CBP Commissioner Kevin McAleenan expressing outrage over the death of Jakelin.[2] The letter stated that conditions in CBP custody are inconsistent with evidence-based recommendations for appropriate care and treatment of children and pregnant women, and as such, are not appropriate for children or pregnant women. The signers urged that specific meaningful steps be implemented to ensure all children and pregnant women in CBP custody receive appropriate medical and mental health screening and necessary follow-up care by trained providers. The letter stated that the signs and symptoms of dehydration and shock in a child, which can be fatal, are recognizable and treatable by a trained professional.

As experts in medical and mental health care for pregnant women and children, we urged DHS and CBP to work with us to develop policies that ensure the health of children and families is protected throughout the immigration process. We asked Secretary Nielsen and Commissioner McAleenan to investigate the circumstances that led to Jakelin's death in a transparent and thorough manner, that they take actions to ease the suffering of her family, and that they implement specific meaningful changes to ensure children and pregnant women in their custody receive necessary medical and mental health screening and follow-up care by trained professionals.

[1] Linton JM, Griffin M, Shapiro AJ. Detention of Immigrant Children. *Pediatrics*. 2017;139(5).
[2] https://downloads.aap.org/DOFA/CBP%20Provider%20Group%20Letter%20Final.pdf

In an editorial that same month in the Las Cruces *Sun News*, then-AAP president Dr. Colleen Kraft wrote:

> Jakelin's tragic death could have been prevented. It is long past time to re-evaluate immigration agencies' policies and procedures for the care and treatment of children. As experts in the care of children, pediatricians' phones are open. Please call us. We renew our offers, which have so far been ignored, to aid the Department of Homeland Security, Customs and Border Protection, and Immigration and Customs Enforcement in improving the conditions for children in their custody.
>
> Jakelin joins many other children who come here with their parents fleeing circumstances that endanger them. Their families seek asylum and safety in the United States. Instead, they are detained in facilities that utterly fail to meet their needs. Children are kept in cages and sleep on cement floors. They are exposed to frigid temperatures, open toilets and lights on all the time. And they aren't receiving adequate medical and mental health screening and care.

Evidence-Based Policy on Children in DHS Custody

As aforementioned, December of 2018 was not the first time AAP spoke out about the conditions in CBP custody and their appropriateness for children. The AAP policy statement, which I co-authored, entitled *Detention of Immigrant Children,* reviews the evidence on conditions in which immigrant children are processed and detained. The AAP ultimately recommended that because conditions in CBP processing centers are inconsistent with AAP recommendations for appropriate care and treatment of children, children should not be subjected to these facilities.[3] The statement says that processing of children and family units should occur in a child-friendly manner, taking place outside current CBP processing centers or 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.[4]

The policy statement details egregious conditions in many of the CBP processing centers, including lack of bedding (e.g., sleeping on cement floors), open toilets, no bathing facilities, constant light exposure, confiscation of belongings, insufficient food and water, lack of access to legal counsel, and a history of extremely cold temperatures. At times, children and families are kept longer than 72 hours, denied access to medical care and medications, separated from one another, or physically and emotionally maltreated. No child should ever have to endure these conditions.

CBP processing centers are where we see children being separated from their parents, sometimes for short periods of time (hours or days) but in other cases the separations have been much longer. Who can forget the images of crying children in metal cage-like structures from last spring and summer at a CBP processing center as the Administration's Zero Tolerance Policy was being carried out?

---

[3] Linton JM, Griffin M, Shapiro AJ. Detention of Immigrant Children. *Pediatrics*. 2017;139(5).
[4] Ibid.

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 U.S.,[5] are often re-traumatized through processing and detention in CBP facilities not designed for children. This trauma is profoundly worsened by forced separation from their parents.

The AAP has said repeatedly that separating children from their parents contradicts everything we stand for as pediatricians—protecting and promoting children's health. Studies overwhelmingly demonstrate the irreparable harm caused by breaking up families.[6,7,8] 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.[9] A parent or a known caregiver's role is to mitigate these dangers. When robbed of that buffer, children exposed to extreme stress, such as separation from a loving parent or caregiver, are susceptible to a variety of adverse health impacts, including physical symptoms (e.g. headaches, abdominal pain) changes in bodily functions (e.g. loss of appetite, difficulty sleeping, toileting problems), and developmental and behavioral problems (e.g. regression in developmental milestones, problems with memory, emotional outbursts, startling easily).[10,11]

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. Over time, children exposed to serious adversity are at risk for chronic conditions, such as obesity, asthma, and depression. The impact of toxic stress can be lifelong, manifesting as depression, post-traumatic stress disorder, heart disease, and diabetes in adulthood.[12]

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 not

---

[5] Kadir A, Shenoda S, Goldhagen J, Pitterman S. The Effects of Armed Conflict on Children. *Pediatrics*. 2018;142(6).
[6] Shonkoff JP, Garner AS. The Lifelong Effects of Early Childhood Adversity and Toxic Stress. *Pediatrics*. 2012;129(1):e232-46.
[7] Masten AS. Global perspectives on resilience in children and youth. *Child Dev*. 2014;85(1):6-20.
[8] 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.
[9] Shonkoff JP, Garner AS. The Lifelong Effects of Early Childhood Adversity and Toxic Stress. *Pediatrics*. 2012;129(1):e232-46.
[10] Dowd MD, et al. AAP Trauma Toolbox for Primary Care. https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Trauma-Guide.aspx#trauma. Accessed March 4, 2019.
[11] 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.
[12] Shonkoff JP, Garner AS. The Lifelong Effects of Early Childhood Adversity and Toxic Stress. *Pediatrics*. 2012;129(1):e232-46.

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.[13] When children are detained, studies show that they experience physical and emotional stress, and this causes both short- and long-term health problems, which can be severe.[14] Young detainees may experience developmental delay and poor psychological adjustment, potentially affecting functioning in school.[15] Expert consensus has concluded that even brief detention can cause psychological trauma and induce long-term mental health risks for children.[16]

Visits to family detention centers by pediatricians revealed discrepancies between the standards outlined by ICE and the actual services provided, including inadequate or inappropriate immunizations, delayed medical care, inadequate education services, and limited mental health services. Just last week, AAP Immediate-Past President Colleen Kraft, MD, MBA, FAAP, visited the Dilley family detention center where she met ten very ill children who were unable to obtain needed medical care. One child had boils and impetigo, and another had clear signs of dehydration. Both were in grave need of medical attention. Other parents reported that when they attempted to obtain medical care for their children upon arrival to the facility they were told to come back. These are not appropriate places for children.

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.

[13] Linton JM, Griffin M, Shapiro AJ. Detention of Immigrant Children. *Pediatrics*. 2017;139(5).
[14] Ibid.
[15] Ibid.
[16] Ibid.

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 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. However, I know a lot more about what children experienced there because some of them became my patients. 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 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 visible underneath clothing or 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.[17] 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.[18]

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.[19] 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.[20] 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.

It is our understanding that CBP agents do not receive medical training related to children. While CBP does employ some EMTs and paramedics, pediatrics is a very small proportion of their training. As AAP Immediate Past President Colleen Kraft said in the days following Jakelin and Felipe's deaths, "when it comes to the medical care of children, if you're not trained in pediatric care, you don't know what you don't know."

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. 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. 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.[21] The processing of children and family units should occur in a child-friendly manner, taking place outside current CBP processing centers or 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.[22]

[17] Woollard M, Jewkes F. 5 Assessment and identification of paediatric primary survey positive patients. *Emergency Medicine Journal.* 2004;21**:**511-517.
[18] 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.
[19] 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.
[20] 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.
[21] Linton JM, Griffin M, Shapiro AJ. Detention of Immigrant Children. *Pediatrics*. 2017;139(5).
[22] Ibid.

2. 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. The AAP has discussed with CBP what such a training could look like. Ideally, such training would be both online and in-person. While it may not be possible to provide 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 would provide for this training and supplies, among other provisions.

3. 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 testified before the House Judiciary Committee that they are providing 100 percent medical screening of all juveniles. Yet, a number of questions remain. Will those screenings be done by medical providers who are trained in pediatrics? Do the medical providers feel prepared to care for children who may present with serious, life-threatening illness? How is follow-up care handled, and how does CBP work with community-based providers to ensure children receive optimal care? These are some of the important questions that deserve answers.

   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. We recognize that it may not be possible to have a pediatrician available at all points along the border, but there are opportunities to utilize telehealth and other technology to ensure that appropriate care is being delivered to children in a timely manner. As we saw in the tragic case of Jakelin, well-timed care can be a matter of life or death.

4. 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.

5. 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.

6. 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.

7. Independent oversight of locations in which children are temporarily housed, detained, or sheltered is critical. 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 Office of Refugee Resettlement 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.

8. Family detention 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.[23]

9. 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.[24,25,26] 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. 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.

---

[23] Ibid.

[24] Edwards, A. Measures of first resort: alternatives to immigration detention in comparative perspective. The Equal Rights Review. 2011;7:117-142.

[25] 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.

[26] 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.

10. 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), authored by Ranking Member Senator Dianne Feinstein, 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.

Children, both unaccompanied and in family units, seeking safe haven in the United States often experience traumatic events in their countries of origin and during their journeys to the U.S. Children fleeing armed conflict should be allowed to petition for asylum and should be screened for evidence of human trafficking.[27] Children and their families who flee their homes to seek refuge deserve access to quality healthcare and should be treated with dignity and respect. We must remember that first and foremost, children are children, and they deserve our compassion.

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