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How Should Unaccompanied Minors in Immigration Detention Be Protected From Coercive Medical Practices?

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Abstract

Current policies and ongoing border crossings have increased the number of unaccompanied minors and the length of time they spend in detention. The US Department of Health and Human Services Office of Refugee Resettlement and its detention facilities currently determine what constitutes appropriate medical care for unaccompanied minors in immigration detention. This care might not be in a child's best interest. In contrast, juvenile detention and human subject research regulations rely on child advocates and court orders to protect children from coercion and safeguard a child's best interest. It is urgent that the medical community advocate for these same safeguards to be put in place for the unaccompanied minors in immigration detention.

Immigrant Detention

From October 2017 through September 2018, more than 50 000 unaccompanied minors were detained while attempting to enter the United States at the border with Mexico,[1] and more are arriving every day. Most are fleeing violence in their home countries of Honduras, El Salvador, and Guatemala in the hopes of reuniting with family members and applying for asylum in the United States. Once in detention, these children are held for an average of 61 days before being released to local sponsors as they wait for their chance to claim legal status in immigration court.[2-5] With ongoing border crossings, stringent policies (recently eased) for the vetting of potential child sponsors, as well as the growing backlog in the immigration court system, the number of children and length of time they are held in detention is only likely to increase over the coming months and years. If the Flores Settlement Agreement[6]—the result of a class action lawsuit that outlined standards for the detention and release of unaccompanied minors in US custody—is replaced with new regulations proposed by the current administration,[7] it would, as Matlow and Reicherter note, "permit the detention of noncitizen children and

their families for indefinite periods in facilities without appropriate and independent monitoring,"[8] thus exacerbating the problem.

Health Care for Detained Children

In addition to having the medical needs normal to children, unaccompanied minors in immigration detention often have immediate medical needs related to malnutrition and vaccinations.[9] High rates of exposure to violence and trauma, as well as continued and prolonged detention, have also led to an increased need for medical and mental health care for anxiety, depression, and posttraumatic stress disorder.[10,11]

It appears there is no set process for ensuring that minors in immigration detention—who are noncitizens held in mostly private institutions—receive care that is in their best interest. And though the United States is the only country in the world that has not yet ratified the Convention on the Rights of the Child,[12-14] care of these minors should still be held to the best interest standard guaranteed by multiple state laws and upheld by courts across the country as well as the medical community at large.[15,16] Parents typically provide consent for medical treatment and serve as their child's advocate, and children who are wards of the state have court-appointed guardians. However, immigrant children lack these protections; there are multiple reports of shelters pressuring detained minors into consenting to medical treatments and medicating as many as 70% of their charges using psychotropic medication[17]—sometimes via forced injections—as a means of behavioral control.[17-19] Lack of appropriate informed consent in a shelter in Texas was so egregious that a federal judge ordered the government to obtain written informed consent by a surrogate authorized by court order before administering psychotropic medications, unless it was an emergency as defined by state law.[18] With no clear mechanism for unaccompanied minors to receive appropriate health care with the safeguard of informed consent, we must ask: What should informed consent look like for detained children, and which processes should be put in place to ensure that decisions are made in the best interests of each child?

Medical Decision Making

Private immigration detention centers have various contracts and regulations; there is apparently no standard policy for determining who is responsible for making medical decisions on behalf of detained children. The US Department of Health and Human Services Office of Refugee Resettlement (ORR) policy states that ORR-funded facilities housing children are responsible for initiating and implementing health care services, but there is no mention of who provides consent for children.[20-23] Few states have set more stringent standards for health care delivered in immigration detention facilities than the ORR. Thus, it is left to individual centers to decide what constitutes consent for those in their care, and it is unclear whether, or to what extent, children have any say in who

might make decisions for them or what happens when children disagree with those decisions.[20-22] But the interests of the ORR and detention facilities are not always aligned with the best interest of the child, as the reports of overmedication with psychotropic medications clearly demonstrate.

One model for obtaining informed consent for treating detainees is that used in juvenile penitentiaries. Traditionally, most states require parental consent for nonemergent procedures or treatment of minors in juvenile detention or court orders when those are not available.[24,25] Many unaccompanied minors currently in immigration detention are waiting to be released to local sponsors who must first be vetted and approved by the government.[26] These sponsors are often parents or close family members and thus the first persons from whom detention facilities should seek informed consent. However, sponsors might themselves be undocumented, and government policies that took effect in May 2018 required fingerprinting of a sponsor's entire household and allowed for information sharing with the US Department of Homeland Security Immigration and Customs Enforcement (ICE).[27,28] Subsequently, reports of detention of 170 would-be sponsors by ICE[29] led to a steep drop in sponsorship claims and an increase in the number of unaccompanied children with no clear point of contact for consent.[5,29,30] Although the policy has been scaled back, it still allows for ORR information collection and sharing with ICE.[28,31] As a result, the time a child spends in detention has lengthened considerably, with government data showing that the average time spent in detention has been as high as 89 days in the first 4 months of fiscal year 2019.[32]

When parents are not available to make decisions, and when the court system is bloated with long wait times that may significantly delay critical medical and mental health care,[33,34] how should consent be obtained? In most jurisdictions, teenagers are allowed by law to provide consent for some health procedures. Specifically, "Adolescents can consent to receive treatment for sexually-transmitted diseases, substance abuse, mental health disorders, or to obtain contraceptives or pregnancy tests."[35] At least 33 states and the District of Colombia have statutes allowing minors to consent for some outpatient mental health services, and in many of those jurisdictions, such as Virginia, this right has been interpreted to include consent for psychotropic medications.[17,24,36]

However, circumstances faced by unaccompanied minors make consent—and their rights to be free from undue influence—difficult to ensure. Facilities use a variety of pressures to get minors to "consent," such as in some facilities in which, as reported by *ProPublica*, the "Department of Homeland Security instructed staff to file a 'significant incident report' every time a teen refused to take medication.... That report could then be used to justify delaying reunification with family."[17] Pressures such as these can prompt teenagers to assent to medications and procedures to which they might not otherwise agree, and can be coercive enough to undermine typical standards of consent.[37]

The ideal of consent free from coercion has been a focus of many rules guiding human subject research among vulnerable populations, including incarcerated subjects. In scientific research involving minors in detention, it has become common practice to use child advocates to ensure proper consent is obtained.[38] Child advocates are defined as persons who act in a child's best interests, confirm the child's comprehension of implications of participating, and ensure that a child provides consent voluntarily, free from coercion.[38] Establishing a third party independent of the ORR and facilities detaining the children, whose sole responsibility is child welfare, seems a reasonable course of action. In fact, this is already being done. The Child Advocate Program was created under the Trafficking Victims Protection Reauthorization Act of 2008, which authorized the Department of Health and Human Services to "appoint independent child advocates for child trafficking victims and other vulnerable unaccompanied alien children."[39,40] However, this program was only able to serve 321 children in 2015.[40] In addition, the program advocates for children's "family reunification, release from detention, legal representation and the ultimate question as to whether the child will remain in the US or return to [his or her] home country."[41] In order to serve children's best interest as patients, the government and the medical community should advocate for expansion of this program—or other programs like it—to cover all children in immigration detention and to train advocates to defend children's best interests.

Advocacy

Medical community members should advocate for the application of juvenile detention and human subject research ethical standards to child detainees, especially when the number of unaccompanied minors and the amount of time they spend in immigration detention continues to increase. It is important that medical professionals voice support for child advocacy programs and decision-making processes free from coercion and undue influence. It's also worthwhile to remember that health care professionals treating unaccompanied minors in immigration detention centers are doing important work and that overhauling policies and adding needed resources could take years. In the meantime, the American Medical Association, other health professional societies, and the medical community at large must (1) urge policy changes that allow clinicians to refuse to provide nonemergent care to detained minors unless they can obtain consent free from coercion, (2) push for independent health professionals to be given access to audit care currently given in ORR facilities, and (3) ensure that health care of minors in detention receives the attention it deserves in the media and in current legal and policy discussions. Finally, it is important to remember that even though detained children are not US citizens, they are entitled to dignity, health, and decisions made in their best interest rather than that of the governmental agency detaining them.

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