OUR RESPONSIBILITY TO UNACCOMPANIED AND SEPARATED CHILDREN IN THE UNITED STATES: A HELPING HAND

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I. INTRODUCTION

Children throughout the world are placed in harm's way through the circumstances of their lives, often far from the childhoods available for many in societies that are politically stable and economically prosperous. Our own society is at a crossroads. How do we want to treat the unaccompanied youth who come to our borders – as the children they are, or as objects of interest to homeland security, border patrols, and immigration discourse? Although one might easily respond, that we should treat the youth as children first, our immigration policy continues to objectify children as a group. Furthermore, our immigration policy does not take into account the vulnerability of each individual child, their histories, potential victimization and resultant distrust, their human rights and personal dignity, resilience, cognitive development, or susceptibility to persuasion. There is very little written about the mental health impact of immigration detention on children in the United States. This paper will attempt to draw on what has been written about both adults and children detained abroad to underscore the necessity of incorporating child development and mental health considerations into the immigration debate. In addition, I will advocate against the use of immigration detention of children in favor of foster care and group homes, as well as for the use of guardians *ad litem*.

Here is story of a young man, now 25, from Guatemala who fled his country. Had he been picked up by border control, he would have likely been deported.

> His mother left him when he was five. He thinks it was because she was pregnant with another child, and was very poor. Guatemalan soldiers threatened his father as they wanted him to serve in the army. He then disappeared. His uncle was brutally murdered and was drowned in front of him. His grandfather was burned in his house alive. He was alone on his own at age ten . . . at the whim of the adults he met along the way who sometimes fed him, and often abused him. For so many years of his young life, he had to fend for him-

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> self. He met a young woman, only later to be found by the rebels who wanted his grandfather's deed to the land. They raped her, and killed one daughter, but did not see their other infant. She fled. Over some years, he made his way to Mexico, and crossed over into the United States. . . sometimes hidden in a truck with others, afraid. They could hardly breathe, he thought he would die. Undocumented, he arrived in the Northeast. By serendipity, he found his significant other. He suffered from Posttraumatic Stress Disorder and Major Depression. He applied for asylum and demonstrated well- founded fear of persecution. He was granted, and now prays that he can one day be reunited with his other daughter who he left with a family in Guatemala for safe keeping. Now he is learning English, and wants desperately to provide for his family. He prays for people back home, because "they do not have what he has at this time.

With a resilient spirit, he wants very much to contribute to American society, his new country. As the immigration system currently operates, if he had been picked up by border control, it is likely that he would have been sent back. He did not have documents when he crossed into the United States. He was told by the smugglers not to say anything if asked questions. He was also afraid to tell his story as he had never told anyone what he had experienced, not even to his significant other. He could not have afforded a lawyer. It is possible he would have been offered detention or voluntary removal, both of which would have been frightening to him. There would have been no family to sponsor him, as he did not know where they were at the time he entered the United States, or even if they were alive. Speaking a dialect, he may not have had access to an interpreter. Many youth like him never get to the point of asking for asylum or other legal remedies to allow them to stay, although they may be eligible to do so.

If an unaccompanied minor arrives in the U.S. without documentation, he or she is put into removal proceedings. An unaccompanied refugee minor is "any person under the age of 18 who is separated from both parents and is not being cared for by an adult who, by law or custom, has a responsibility to do so, and who is an asylum seeker, recognized refugee or other externally displaced person." [1] As defined by United Nations High Commissioner for Refugees, UNHCR, there is an increasing preference to call children "separated" who though accompanied by an adult, are not with a parent, legal or customary caretaker, but perhaps with a trafficker, sibling, or acquaintance. [2] Children may raise a defense for why they should not be deported. These defenses can include: applying for asylum, being a victim of torture, abuse or abandonment, neglect, domestic violence, trafficking, and other crimes against them.[3]

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[1] Andre Sourander, *Behavior Problems and Traumatic Events of Unaccompanied Refugee Minors*, 22 CHILD ABUSE & NEGLECT 719 (1998).

[2] Jacqueline Bhabha, *Seeking Asylum Alone: Treatment of Separated and Trafficked Children in Need of Refugee Protection*, 42 INT'L MIGRATION 141 (2004).

[3] Emily A. Benfer, *In the Best Interests of the Child?: An International Human Rights Analysis of the Treatment of Unaccompanied Minors in Australia and the United States*, 14 IND. INT'L & COMP. L. REV. 729 (2004).

In the United States, *Reno v. Flores* set out standards, which the immigration service must uphold, namely, that minors be detained in the least restrictive setting appropriate for the minor's age and special needs.[4] International guidelines by UNHCR dealing with unaccompanied children seeking asylum, emphasize that care and protection should be delivered in "the best interests of the child."[5] About 4-5% of those who apply for asylum in the industrialized world are unaccompanied and separated children according to extrapolations from UNHCR data.[6]

As a prosperous society, what is our moral responsibility to traumatized children under the age of 18 who cross our country's borders and arrive in the U.S. alone, or escorted by adults?

II. EPIDEMIOLOGY

These children flee from war and its effects, persecution, natural disasters, and from places in the world where there is civil, political, and economic upheaval.[7] Sometimes as victims of trafficking, they are lured by the promise of being united with family or attending school or perhaps that they will get a good job in the new country.[8] Others can be kidnapped by traffickers or sold by parents.[9] Some of the children try to cross back into the U.S. after being voluntarily returned because they are often homeless.[10] UNICEF has characterized children as: at risk (children of the urban poor from where street children emerge), children on the street (who return to their families at night, but work during the day to contribute to the family income), and children of the street (who have remote or no connections to family, and live on the street). Children of the latter group are often the children who are abandoned, orphaned, runaways, refugees and others without any significant caretaker.[11]

Some are eligible for asylum due to a well-founded fear of persecution on the basis of race, nationality, gender, religion, and membership in a social group. Others

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[4] *Reno v. Flores*, 507 U.S. 292 (1993).

[5] Office of the United Nations High Commissioner for Refugees, *Guidelines on Policies and Procedures in Dealing with Unaccompanied Children Seeking Asylum*, (1997), *available at* http://www.unhcr.org/cgi-bin/texis/vtx/home.

[6] JACQUELINE BHABHA ET AL., SEEKING ASYLUM ALONE: UNACCOMPANIED AND SEPARATED CHILDREN AND REFUGEE PROTECTION IN THE U.S. (forthcoming 2006).

[7] Jacqueline Bhabha, American Immigration Law Foundation, Immigration Policy Ctr., Crossing Borders Alone: The Treatment of Unaccompanied Children in the United States (2004), *available at* http://www.ailf.org/ipc/crossingBordersPrint.asp.

[8] THE CAMPAIGN TO RESCUE AND RESTORE VICTIMS OF HUMAN TRAFFICKING, FACT SHEET: CHILD VICTIMS OF HUMAN TRAFFICKING, *available at* http://www.acf.hhs.gov/trafficking/about children_victims.html.

[9] THE CAMPAIGN TO RESCUE AND RESTORE VICTIMS OF HUMAN TRAFFICKING, FACT SHEET: SEX TRAFFICKING, http://www.acf.hhs.gov/trafficking/about/fact_sex.html (last accessed 11/30/05).

[10] Interview by Jacqueline Babhha, Susan Schmidt, and Lisa Frydman with Alice Linsmeier 63 (Sept. 28, 2004).

[11] Kevin J. Lalor, *Street Children: A Comparative Perspective*, 23 CHILD ABUSE & NEGLECT 759 (1999).

do not fulfill the traditional refugee criteria,[12] but may be victims of child specific persecution like sale of a child, domestic violence, or social cleansing of street children, fleeing gang membership, sexual orientation, forced labor in the family, have severe disability (autism), or family position in violation of population control[13] Some flee abuse as other homeless and runaway youth do in the United States. One such study of American children interviewed in Seattle, showed that 47% (n= 372) were survivors of childhood physical abuse mostly by parents and 29% were survivors of sexual abuse mostly by non-family members like strangers or acquaintances.[14]

The numbers of unaccompanied youth are increasing around the world. Factors contributing to future complex emergencies include: urbanization of global populations, urban dominance of the world's poor, failing public health infrastructures, lack of moral integrity of governments, availability of weapons and access to weapons of mass destruction, economic iniquities and corruption, undisciplined military, paramilitary, and police, suspension of the rule of law, wanton violations of protective treaties, failures in environmental and ecological security, food and water insecurity and transmigration of populations' political, economic, and environmental issues.[15] Generally, children do not have the independent resources for travel, and are often sent by parents or family members to improve their lot, and may be shepherded by relatives, acquaintances, or professional smugglers. Children who are homeless or street children may decide on their own to travel. Trends suggest that receiving countries are targeted by specific groups. For example, children from Mexico and Central America make up the largest group of separated/unaccompanied children who come to the United States. Although challenged by some, many concur that serving as an anchor for other family is not the primary reason for traveling, as often the circumstances from which they are fleeing are dangerous, some report wishing to improve their own circumstances without regard to other family, and many disincentives exist in countries of reception for easy reunification.[16] The reality is that no one really knows how many children there are, or their demographics, or their stories or the true circumstances.

March 1, 2003 ushered in a new period for detained children in the United States with the transfer of care of minors from the Department of Justice to the Department of Health and Human Services, Office of Refugee Resettlement (ORR).[17] ORR was

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[12] BHABHA ET AL., SEEKING ASYLUM ALONE: U.S., *supra* note 6, at 19.

[13] Bhabha, Crossing Borders Alone (2004), *supra* note 7, at 5.

[14] Kimberly A. Tyler & Anna Mari Cauce, *Perpetrators of early physical and sexual abuse among homeless and runaway adolescents*, 26 CHILD ABUSE & NEGLECT 1261, 1264-1265 (2002).

[15] Frederick M. Burkle, Jr., *Lessons learnt and future expectations of complex emergencies*, 319 BRITISH MEDICAL JOURNAL 422 (1999).

[16] Sarah Maloney, *TransAtlantic Workshop on 'Unaccompanied/Separated Children: Comparative Policies and Practices in North America and Europe' held at Georgetown University, 18-19 June 2001*, 15 J. REFUGEE STUD. 102 (2002).

[17] Jessica G. Taverna, *Did the Government Finally Get It Right? An Analysis of the Former INS, The Office of Refugee Resettlement and Unaccompanied Minor Aliens'*

assigned the responsibility for the housing and care of unaccompanied juvenile aliens who were detained pending resolution of their immigration cases. ORR was asked to facilitate and make decisions about placement, have oversight and monitor facilities, to run immigration and criminal checks on potential sponsors and to transport juveniles for medical care, court appearances, and facility transfer.[18] Of the 122,122 juveniles apprehended by the Bureau of Customs and Border Protection (CBP) in 2004, 101,731 (83.7%) were Mexican nationals, and approximately 85% were apprehended along the SW border of the US. [19] At the Border Control Center youth can either be voluntarily returned, placed in detention, or released on bond into custody of a sponsor pending removal decision.[20] Border Patrol in FY2004 subjected over 3/4 of apprehended juveniles (77.5%) to voluntary return.[21] Most Mexican children are turned around at the border and do not get to shelters. Most children who are retained are between the ages of fifteen and seventeen, and if they come with their families they are separated.[22]

When the Amnesty Report [23] about children in U.S. detention came out in 2003, various problematic circumstances were highlighted including detention of children for administrative reasons, prolonged periods in holding cells or juvenile jails, comingling with juvenile offenders, excessive discipline. In some cases, there was physical and emotional abuse, extended periods of isolation, the use of strip searches, the use of restraints in detention facilities, during transport, and in the courtroom. Additionally, these juveniles were subjected to chemical restraints, limited or lack of access to education, exercise, and recreation, lack of legal representation, and cross-state boundary transfers without lawyer notification.[23] Since that time, a series of studies have come out that address the negative psychological impact of detention which raises concerns about its usage for children.

III. THE MENTAL HEALTH IMPACT OF IMMIGRATION DETENTION ON ADULTS

There is limited systematic U.S. data available on the specific mental health impact of immigration detention on children. We will draw from the implications of work that has come out of other communities, as well as the limited U.S. experience with adults. It should be kept in mind that detention settings vary from country to country, and also within the country itself. In a study done by Physicians for

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Due Process Rights, 12 WM. & MARY BILL RTS. J. 939, 942 (2004).

[18] Department of Homeland Security, Office of Inspections and Special Reviews, Office of Inspector General, OIG-05-45, *A Review of DHS' Responsibilities For Juvenile Aliens* 20 (Sept. 2005), at 7.

[19] *Id.* at 3.

[20] *Id.* at 8.

[21] *Id.* at 4.

[22] The Florence Project, http://www.firrp.org/children.asp (last visited Nov. 19, 2005).

[23] Amnesty International USA, *Why Am I Here? United States of America, Unaccompanied Children in Immigration Detention* (2003), http://www.amnestyusa.org/refugee/children_detention.html.

Human Rights and the Bellevue/NYU Program for Survivors of Torture of adult asylum seekers in immigration detention, the mental health of the asylum seekers interviewed for their study was poor, and worsened the longer they were in detention. When interviewed, the mean length of their detention in two INS detention centers and three county jails in New York, New Jersey, and Pennsylvania of the individuals interviewed (n=70), was 5 months (range of one month to four years). Whereas 58% said they had poor psychological health when they fled their country, 70% reported their mental health worsened substantially while in detention. Of this sample, 86% had clinically significant depression, 77% anxiety, and 1/2 PTSD. Approximately one quarter (26%) had suicidal thoughts while detained, but only 3/18 told the detention officers. Two reported suicide attempts while in detention. Of note, in their study, 74% were torture survivors, 67% were imprisoned in their native country, 59% had a family member or friend murdered, 26% experienced sexual assault, and almost all (97%) thought that their lives would be in danger if they were forced to return to their own countries.[24] Detention facilities can have similar effects as traditional correction facilities as noted in a recent report on expedited removal. Those with psychological vulnerability before incarceration are more likely to suffer later on.[25]

Children flee similar forms of persecution. In a European study, the longer the duration of stay in the Netherlands (often in reception facilities), the more anxiety, depressive, and somatoform disorders experienced by Iraqi asylum seekers.[26] Australia is another destination of refugees and asylum seekers. When comparing asylum seekers living in the community with those who were detained, the latter had significantly higher levels of depression, posttraumatic stress disorder, anxiety, panic, and physical symptoms.[27]

A psychologist who worked at the Woomera Detention Centre in Australia from September 2000 to January 2002 observed that its detainees went through several stages. During their first three months in detention, they had euphoria, hope, and

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[24] Physicians for Human Rights and the Bellevue/NYU Program for Survivors of Torture, *From Persecution to Prison: The Health Consequences of Detention for Asylum Seekers* (2003), http://www.phrusa.org/campaigns/asylum_network/detention_execSummary/dr1-toc.html.

[25] Craig Haney, *Study on Asylum Seekers in Expedited Removal, Conditions of Confinement for Detained Asylum Seekers Subject to Expedited Removal* (2005), *available at* http://www.uscirf.gov/countries/global/asylum_refugees/2005/ february/conditionConfin.pdf.

[26] Cornelius J. Laban, Hajo B.P.E Gernaat, Ivan H. Komproe, Bettine A. Schreuders & Joop T. DeJong, *Impact of a Long Asylum Procedure on the Prevalence of Psychiatric Disorders in Iraqi Asylum Seekers in The Netherlands*, 192 J. NERVOUS AND MENTAL DISEASE 843 (2004).

[27] DERRICK SILOVE & ZACHARY STEEL EDS., *THE MENTAL HEALTH AND WELL-BEING OF ONSHORE ASYLUM SEEKERS IN AUSTRALIA* (PP. 27-31) SYDNEY, AUSTRALIA: UNIVERSITY OF SOUTH WALES. PSYCHIATRY RESEARCH AND TEACHING UNIT (1998), *available at* http://safecom.org.au/zachary-steel-report.pdf.

dreams for a new life. During the following three months, they were interviewed by authorities, and became progressively anxious. After six months, there was clear deterioration in their emotional health as demonstrated by: increased self harm, hunger strikes, emotional anxiety, psychological disturbances, sleep problems, and need for antidepressant medication.[28] These studies suggest that immigration detention can have negative effects in and of itself on adults when one's hopes and aspirations begin to feel unattainable and one faces possible deportation.

A review of factors noted in the United Kingdom that impacted the mental health of immigration detainees was compiled. They include the following:

- The impact of indeterminate detention including why they were detained and what will happen to them;
- The experience of detention, particularly if someone had been previously imprisoned and tortured;
- Isolation cause by language difficulties, separation form family and friends, and cultural isolation;
- Fear and uncertainty about the future and possible deportation;
- Bereavement including loss of country, cultural values, family, and close friends;
- Previous experiences of torture and other trauma;
- Shame at being detained;
- Loss of status particularly if they were previously successful;
- Survivor guilt;
- Shock and anger at their treatment upon arrival in the U.K.[29]

It is not difficult to imagine how the mental health of child detainees would be similarly compromised as a result of comparable experiences.

IV. MENTAL HEALTH IMPACT OF DETENTION ON CHILDREN

What can we learn from the experiences of children in detention abroad as we reflect on our own? Unlike the previous groups who were non-clinical samples, assessments were done of Cuban adolescent refugees held at camps in Guantanamo Bay who sought treatment (n=74). Those at risk for psychiatric pathology were those who had experienced traumatic migratory experiences and those with prolonged confinement.[30] Yet another study, which involved unaccompanied adolescents 15 or greater in age, was done with arrivals in the Netherlands during two five-month periods in 2002 and 2003. They were placed in two very different programs. One program was highly restricted and tended to emphasize the likelihood of repatriation, no possibility of learning Dutch, limited possibilities to leave the premises, and some adult monitoring (1 adult: 15 minors) (n=74). The other pro-

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[28] HREOC. A LAST RESORT? (2004), http://www.humanrights.gov.au/human_rights/children_detention_report/index.html.

[29] http://www.nelmh.org/page_view.asp?c=17&did=292&fc=010001.

[30] Eugenio M Rothe and Hector Castillo-Matos, *Posttraumatic Stress Disorder Among Cuban Children and Adolescent Refugees After Release From a Refugee Camp*, 53 ADOLESCENT PSYCHIATRY: DEVELOPMENTAL AND CLINICAL STUD. 970 (2002).

gram was less restrictive, and similar to that of adult asylum seekers, namely routine reception. Here, youth were allowed to leave during the day, become acquainted with Dutch society, receive guests and education (n=56). Those in the restricted setting endorsed more emotional problems – particularly an increase in anxiety. Girls in the more restricted setting had statistically higher scores for emotional problems, anxiety, and depression than other girls. The difference between the boys in the two settings was small, and not statistically significant. Gender differences and sensibilities need to be taken into account when planning.[31] It raises the issue that we need to better understand how boys and girls differ, and what kind of accommodations need to be made.

In Finland, unaccompanied minors (n=46) awaiting placement at an asylum center were evaluated by staff using Achenbach's Child Behavior Checklist (CBCL). Staff that knew the child well filled out evaluations. About one half were noted to function within the clinical or borderline range. Those who were less than fifteen years old had more psychiatric symptoms. Almost all of the children were persecuted before their flight. Youth between ages 6-14 had significantly more problems than children between 15-17 in terms of aggression, social problems, and attention difficulties. More than half of the children (n=46) were noted to be argumentative, exhibit sadness, impulsive, stubborn, had worries, mood changes, feelings of loneliness, trouble sitting still, concentrating, got into fights, or lied.[32]

The detention of youth is a problematic practice in many countries in addition to our own. Fifty consecutive adolescents who were admitted to a youth detention centre in Tasmania, Australia were evaluated. Almost half of the children (46%) had a mood disorder: 30% with major depression and 16% with dysthymia. Almost one third of the children (36%) had posttraumatic stress disorder and 32% had anxiety disorders other than PTSD. What was striking was that almost one half (48%) had intellectual levels that were borderline or below: 22% significant intellectual impairment and 26% borderline intellectual functioning reflective of major deficits in both educational attainment and basic literacy.[33] The rates of psychiatric morbidity among this group were five times the rates noted in the community, and equivalent to rates of children referred to mental health services.[34] Although our population is different, it does raise the need to incorporate cognitive screening with our youth, for example, who may have had poor or scanty educational opportunities, head trauma, torture, psychiatric problems, possible effects of substance use, and malnutrition. Also, sometimes children may appear socially advanced in part due to highly developed survival skills, but still have cognitive impairments. Re-

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[31] Sijmen A. Reijneveld, Josien B. de Boer, Tammy Bean & Korfker G. Dineke, *Unaccompanied Adolescents Seeking Asylum: Poorer Mental Health Under a Restrictive Reception*, 193 THE J. NERVOUS AND MENTAL DISEASE 759 (2005).

[32] Sourander, *supra* note 1.

[33] Rosie Bickel & Alistair Campbell, *Mental health of adolescents in custody: the use of the 'Adolescent Psychopathology Scale' in a Tasmanian context*, 36 AUSTRALIAN AND NEW ZEALAND J. PSYCHIATRY 603 (2002).

[34] *Id.*

gardless of the etiology, there are obvious implications for the capacity of some children to exercise judgment and make decisions.

Further effort was made in Australia to understand the impact of detention on children by making visits to immigration facilities, interviewing current detainees and former detained children, reviewing medical records, consulting external health consultants, reviewing incident reports, having discussions with child welfare authorities and mental health experts and agencies.[35] Some children in the study showed anxiety, distress, bed-wetting, suicidal ideation, and in some cases self-destructive behavior.[36] A smaller number had diagnoses such as PTSD and Depression.[37] Various factors were identified as contributing to psychological problems of children in detention:

- Torture and trauma prior to arrival in Australia;
- Length of detention;
- Negative immigration decisions;
- Uncertainty about the visa process;
- Family breakdown within detention;
- Living in a close environment;
- Child's perception that they are not safe within detention;
- Treatment of children by detention staff.[38]

If we look at these factors closely, we can see that many of these same factors are present for children who come to the United States as well. It would behoove us to be sensitive to these same issues as once again, they are comparable to what our children sometimes face. The Australians noted that although pre-arrival experiences were significant, they could not exclusively account for the mental health problems experienced by children in detention.[39] On the same token, the report showed that if children were there for shorter periods, many did not suffer significant problems.[40] Other work in Australia revealed that after two years in detention, all children had at least one psychiatric disorder, and most (80%) had multiple diagnoses showing a ten percent increase.[41] It appears that prolonged detention, independent of prior trauma history, can impact on the mental health of children as well as adults.

Similar experiences have come out of the U.K., where approximately 2000 children are detained each year for the purpose of immigration control.[42] A 2005 study,

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[35] HREOC, A LAST RESORT?, *supra* note 28, at 359.

[36] *Id.* at 359.

[37] *Id.* at 360.

[38] *Id.* at 368.

[39] *Id.* at 369.

[40] *Id.* at 360.

[41] *Id.* at 369 (referencing also: Steel, Z., Silove, Derrick M, *The mental health implications of* detaining asylum seekers, 175 MEDICAL JOURNAL OF AUSTRALIA 596 (2001); Steel et al, *Psychiatric status of asylum seeker families held for a protracted period in a remote detention center in Australia*, 28 AUSTRALIAN AND NEW ZEALAND J. PUB. HEALTH 527 (2004)).

[42] Elli Free, *Executive Summary* for Heaven Crawley and Trine Lester, *No Place for a*

for instance, found detention to have a negative impact on the mental health, physical health, and educational of thirty-two child detainees.[43] The report was based on case studies of the children; observational visits to two detention centers; interviews with government officials, policy makers, practitioners, and stakeholders; and on an extensive literature review.[44] Detention created the largest impact on the mental health of the children, causing depression, changes in behavior, and confusion.[45] Physical effects included the failure to thrive, an unwillingness to eat (which led to weight loss), sleeping problems, respiratory difficulties, and skin complaints.[46] Government officials and policymakers, accordingly, must be attuned to the effects of detention on both the physical and mental health of children and must also be able to evaluate and address the children's specific needs.[47] It is necessary to look at children holistically and view this time in their lives as an opportunity to evaluate and address their needs on many levels: emotionally, physically, cognitively, socially, and spiritually as well in view of the potential existential issues that they face.

V. SHOULD THERE BE A DILEMMA?

Currently, a tension exists between the duty to care for detained children and immigration policies, which seem to neglect these same youth. Governments could alleviate this tension by establishing the protection of children's mental health and well being as their primary objective. If the U.S. ratifies the Convention on the Rights of the Child ("the Convention"), this nation would be obligated to respond to the vulnerability of children and simultaneously to recognize their human rights.[48] Children are already protected by international humanitarian, human rights, and refugee law.[49] Certain rights described in the Convention, however, are of particular import to children separated from their parents, including:

- the right to a name, legal identity, and birth registration;
- the right to physical and legal protection;

Child. Children in U.K. Immigration Detention: Impacts, alternatives and safeguards (The Save the Children Fund (2005), *available at http://www.savethechildren.org.uk/scuk/jsp/resources/details.jsp?id=2560&group=resources&section=publication&subsection=details.*

[43] *Id.* at viii.

[44] *Id.*

[45] *Id.* at ix.

[46] *Id.*

[47] *Id.*

[48] International Committee of the Red Cross; International Rescue Committee; Save the Children/UK; United Nations Children's Fund; United Nations High Commissioner for Refugees; World Vision International, *Inter-Agency Guiding Principles on Unaccompanied and Separated Children* (Jan. 2004), *available at* http://www.unhcr.org/cgi-bin/texis/vtx/protect/opendoc.pdf?tbl=PROTECTION&id=4098b3172.

[49] *Inter-Agency Guiding Principles, supra* note 48, at 49.

- the right to remain united with their parents;
- the right to provisions for their basic subsistence;
- the right to care and assistance appropriate to their age and developmental needs;
- the right to participate in decisions about their future; and
- the right to services aimed at reuniting them with their parents or primary legal or customary caregivers as quickly as possible.[50]

The Convention also states, "No child shall be deprived of his or her liberty unlawfully or arbitrarily."[51] As a result, governments should only use detention or imprisonment "as a measure of last resort," and the period of detention should end as quickly as possible.[52]

When adjudicating non-immigration offenses by juvenile offenders, the US judicial system carefully balances public safety with the identifiable needs of children. It has increasingly recognized, for instance, that "detaining youth in facilities prior to adjudication should be an option of last resort only for serious, violent, and chronic offenders and for those who repeatedly fail to appear for scheduled court dates."[53] Regarding legal resident juveniles, the judicial system has thus come to appreciate the community-based support model, as opposed to detention and confinement programs. The community alternative reduces crowding, costs less than operating juvenile detention centers, reduces the stigma of institutionalization, separates youths with serious delinquent histories from the remaining offenders, and maintains positive ties between the youths and their families and communities.[54]

Because a child's first incarceration will greatly impact his or her self-concept, states have developed alternatives to incarceration.[55] Many states have replaced traditional secure detention programs with release programs, including: home detention, electric monitoring, intensive supervision, day and evening reporting centers, and skills and training programs.[56] Children who cannot return safely to their homes but do not warrant secure detention are offered residential alternatives such as foster home programs, detention homes, and programs for runaways.[57] Why, then, should the government deny unaccompanied minors both alternatives to detention and legal representation?

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[50] *Id.* at 16.

[51] Convention on the Rights of the Child, Nov. 20, 1989, 1577 U.N.T.S. 3, I.L.M. 1456 (1989).

[52] *Id.*

[53] James Austin, Kelly D. Johnson & Ronald Weitzer, *Alternatives to the Secure Detention and Confinement of Juvenile Offenders*, U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention 1 (Sept. 2005), http://www.ncjrs.gov/pdffiles1/ojjdp/208804.pdf.

[54] *Id.*

[55] *See* Robert G. Culberson, *The Effect of Institutionalization on the Delinquent Inmates' Self Concept*, 66 J. CRIM. L. AND CRIMINOLOGY 88, 88-93 (1975).

[56] Austin et al., *supra* note 53, at 13.

[57] *Id.* at 16.

Juvenile immigrants to the United States are generally vulnerable youths seeking safety, reunification, or opportunity. When considering the well-being of these immigrants, equal protection of the law should require the United States to make available the minimum protections offered to juvenile offenders who commit non-immigration offenses in view of what has been learned by the penal system. As a democratic society which welcomes newcomers, this country has a duty to respond to the needs of the most vulnerable from a compassionate, as opposed to draconian, perspective. This nation must acknowledge the tremendous number of individuals who have risked their futures and their lives in order to call this country their home.

In the absence of ratification of the Convention, some have suggested that Congress create a non-immigrant visa for immigrant children "based on their status as unaccompanied minors."[58] A second suggestion is to expand the definition of refugee to include displaced unaccompanied minors.[59] The expansion would protect the interests of the children and align U.S. immigration law with international norms, thereby encouraging more humane treatment for this vulnerable population.[60]

ORR has significantly improved treatment of immigrant children since assuming responsibility for their care and custody. For example, between 2003 and 2005, the number of juvenile detention centers in use decreased from 32 to 4. and the number of children in secure detention also decreased from over 30% to 3%.[61] The majority of the children now live in foster care.[62] Despite these positive changes, the following concerns remain:

- detention of children for more than 24 hrs[63]
- persistent cross state transfers[64]
- family separations[65]
- insufficient bed space near areas of greater apprehension[66]
- use of shackles and restraints during transport[67]
- failure to appoint a guardian or responsible figure to the juvenile alien[68]

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[58] Carolyn J. Seugling, *Toward a Comprehensive Response to the Transnational Migration of Unaccompanied Minors in the United States,* 37 VAND. J. TRANSNAT'L L. 861, 889 (2004).

[59] *Id.*

[60] *Id.* at 895.

[61] Interview with Maureen Dunn, Director of Division of Unaccompanied Children, Office of Refugee Resettlement; Shereen Faraj, Jed Haven, and Tsegay Wolde, staff at the Division of Unaccompanied Children, Office of Refugee Resettlement (Oct. 6, 2005).

[62] *Id.*

[63] Office of Inspections and Special Reviews, *supra* note 18.

[64] *Id.* at 27.

[65] The Florence Project, *supra* note 22.

[66] Office of Inspections and Special Reviews, *supra* note 18, at 23.

[67] Interview with Ivonne Velasquez (May 3, 2004) and Chief Luis Barker (April 20, 2004), Bhabha, Schmidt, Frydman, *supra* note 10.

[68] The Florence Project, *supra* note 22.

- use of semi-secure facilities[69]
- absence of legal advice regarding detention options[70]
- expedited removal[71]
- mistreatment of children in border control custody[72]
- use of confidential information against the juveniles during court proceedings[73]
- undocumented family members' failure to claim a child due to fear of removal based on their own illegal immigrant status [74]
- placement in overcrowded cells without food for up to twenty hours, physical abuse, and knowing placement with adult strangers who "falsely claim that they're [the] child's father, brother, or guardian" because agents "don't want to do the paperwork"[75]
- unknown numbers of children held at Border Control[76]
- detention of minors who have not been charged with a crime in jail-like facilities for non-immigrant juvenile offenders.[77]

When establishing policies and programs, governments and policymakers must consider their children's developmental and psychological characteristics to accommodate their interests and special needs.

Sending children back to the countries from which they fled is a high stakes decision. These decisions may often have terrible results, as illustrated by the death of a 16 year-old deportee who officials denied asylum, after discovering he was an illegal immigrant.[78] U.S. authorities forced the teenager to return to Guatemala, where shortly after his arrival, the gang he had tried to escape killed him.[79] The boy predicted this fatal result, but the authorities ignored both his pleas and his aunt's offer to take custody of him and ensure that he attended his court hearings.[80] By sending him home, the authorities ultimately sent him to his death. The media alerted the public to the tragic outcome of this troubled Guatemalan boy, yet the U.S. returns thousands of minors to countries where the consequences remain

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[69] *Id.*

[70] *Id.*

[71] *Id.*

[72] *Id.*

[73] *Id.*

[74] *Id.*

[75] Tim Vanderpool, *Alone on the Border; Border Patrol Neglect May Place Kids at Risk,* TUCSON WEEKLY, Dec. 8, 2005, *available at* http://www.tusconweekly.com/gbase/currents/Content?oid=oid:76257.

[76] The Florence Project, *supra* note 22.

[77] Areti Georgopoulos, *Beyond the Reach of Juvenile Justice: The Crisis of Unaccompanied Immigrant Children Detained by the United States*, 23 LAW & INEQUALITY 117, 133 (2005).

[78] Bruce Finley, *Death of a Deportee Back in Guatemala, Teen Slain by Gang He Tried to Escape*, DENVER POST, Apr. 5, 2004, at A-01.

[79] *Id.*

[80] *Id.*

unknown. The development of an efficient monitoring system, therefore, is imperative to the survival of these children.

The U.S. must create a continuum of care for juvenile aliens in order to ensure their well-being. The government, however, must recognize that children are not merely small adults[81] and should adjust its plan to conform to minors' specific needs and abilities. We must consider a child's capacity to project and analyze circumstances. The plan must also attempt to understand how the effects of prior traumatic experiences and from being alone, such as the exposure to violence and the pressure to survive, might create trust and disclosure issues. This country has a responsibility to create a safe and trusting environment for these children. In order to succeed in this endeavor, it is necessary to consider certain factors particular to children.

A. Developmental Considerations

The stages of intellectual development in children correspond to the development of the brain.[82] Due to their undeveloped or underdeveloped thinking skills, children and adolescents, accordingly, may not have the cognitive capacity to understand the legal system and the implications of their decisions. They may, for instance, impulsively respond to circumstances without weighing the severity of the situation. They do this because it is often difficult for them to conceive of any future implications of the choice.

Children also perceive time differently than adults.[83] A study of thirty Latin American children between the ages of eight and twelve indicates that armed conflict negatively impact children's view of the future, personal outlook, and ability to cognitively integrate time.[84] Such perceptions are all necessary for informed decision-making.[85] In addition, another study of the mental health effects of the Salvadoran Civil War on fifty-four twelve-year-olds found that those children with the highest levels of exposure to violence had a "foreshortened vision of the future."[86] These studies, therefore, indicate that young children may have difficulty analyzing their legal options due to an inability to effectively think about their future.

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[81] *Prison Guard or Parent? INS Treatment of Unaccompanied Refugee Children,* Women's Commission for Refugee Women and Children, 11-12 (2002), *available at* http://www.womenscommission.org/pdf/ins_det.pdf.

[82] Stages of Intellectual Development In Children and Teenagers, *available at* www.childdevelopmentinfo.com (last visited Nov. 28, 2005).

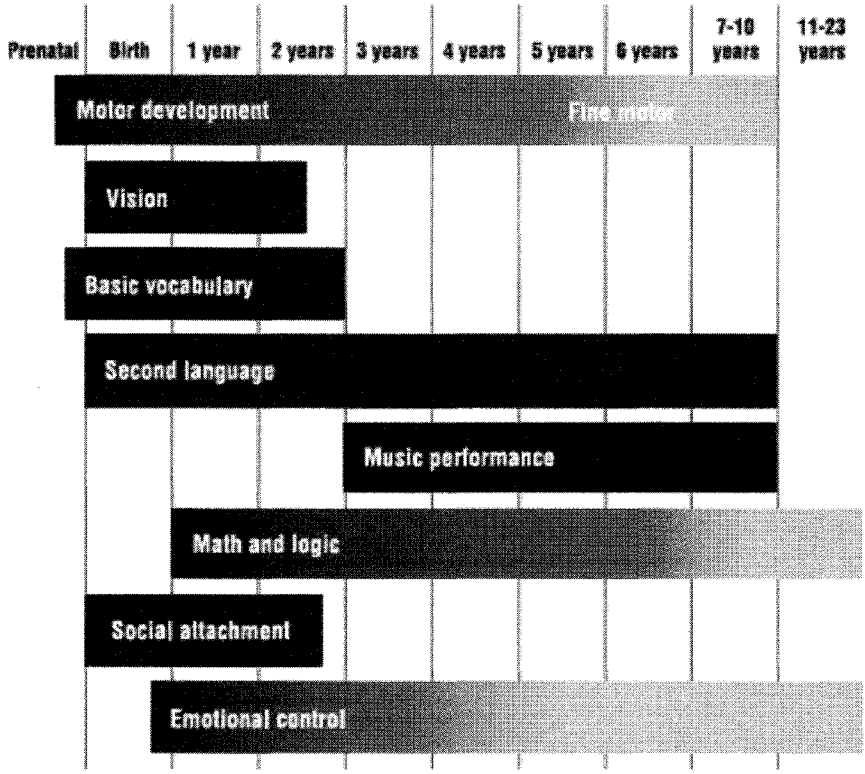
[83] Cecile Rousseau & Ellen Corin, *Time perspective in children living in a situation of armed conflict, Immigrant and refugee children and their families: Clinical, research, and training issues* 113-132, (Fern J. Cramer Azima & Natalie Grizenko eds., 2002).

[84] *Id.*

[85] *Id.*

[86] Joan Riley Walton, Ronald L.Nuttall, Ena Vazquez Nuttall, *The Impact of War on the Mental Health of Children: A Salvadoran Study,* 21 CHILD ABUSE & NEGLECT 737, 747 (1997).

Figure1. Stages of Optimal Development of Youth [87]



The brain continues to develop through adolescence – particularly in regions involved with response inhibition, the assessment of risk and reward, and the regulation of emotion.[88] There can be disjunctions between a developing brain's behavioral and cognitive systems which mature along different time lines.[89] From early to middle adolescence, youth experience growth and improvements in reasoning, information processing, and expertise.[90] Information processing improves through adolescence as a result of myelination and pruning of neural synapses in the prefrontal cortex of the brain.[91] This processing improvement leads to improved executive functioning, including long-term planning,

[87] DCCEL BrainNet Main Page, *available at* http://www1.dshs.wa.gov/esa/dccel/bnmain.shtml (last visited Dec. 20, 2005).

[88] Laurence Steinberg, *Cognitive and affective development in adolescence,* 9 TRENDS IN COGNITIVE SCIENCES 69, 69-74 (2005).

[89] *Id.*

[90] D.P. Keating, *Cognitive and Brain Development*, in HANDBOOK OF ADOLESCENT PSYCHOLOGY 45-84 (Richard M. Lerner & Laurence Steinberg eds., 2d ed. 2004); Steinberg, *supra* note 88, at 70.

[91] Steinberg, *supra* note 88, at 70.

metacognition, self- evaluation, self-regulation and coordination of affect and cognition.[92] Enhancement of the ventromedial prefrontal cortex also facilitates the calibration of risk and reward. During adolescence, more connections are made between the prefrontal cortex and several areas of the limbic system.[93] It is hypothesized that "adults and adolescents sixteen and older share the same logical competencies, but that age differences in social and emotional factors, such as susceptibility to peer influence or impulse control, lead to age differences in actual decision making."[94] In real-life situations, adolescents may not rationally weigh the risks and consequences of their behavior. Instead, they are greatly influenced by their own developing feelings and by social influences.[95] It is thought that as the frontal lobes mature, regulatory competence develops integrating cognition and emotion.[96] In the case of juvenile aliens, adolescents can be swayed emotionally by their surroundings, even though many have the ability to logically weigh their legal options. The prospect of detention could terrify unaccompanied minors. This terror may trump other reasonable options and result in unaccompanied minors "choosing" to return voluntarily to their country.

B. Trauma Exposure

Trauma can also lead to concentration and memory problems. Some children have had limited or no formal education. They may have difficulty trusting or interacting with peers or authority figures.[97] Traumatized children rarely talk spontaneously about their fears or traumatic experiences and may have limited insight into "what they do, what they feel, and what has happened to them."[98] Children can be dysregulated when exposed to real threats or perceived threats (which may be misinterpretations of the environment) and demonstrate "extreme responses to seemingly innocuous stimuli."[99] Such disoriented or disordered processing might trigger immediate responses to threatening signals which may not be appropriate to the social environment. When children were in threatening situations this difficulty in self-regulation may have had survival value. The problem becomes apparent when the children are out of harm's way because the difficulty in self-regulation is now neurologically embedded.[100]

Children around the world are being exposed to more violence then ever before. In some parts of the world, they are even intentionally targeted especially if they are

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[92] Keating, *supra* note 90; Steinberg, *supra* note 88, at 70.

[93] Steinberg, *supra* note 88, at 71.

[94] Laurence Steinberg, ADOLESCENCE (7th ed. 2005); Steinberg, *supra* note 88, at 71.

[95] Laurence Steinberg, *Risk-taking in adolescence: What changes, and why?*, 1021 ANN. N. Y. ACAD. SCI., 51, 51-58 (2004); Steinberg, *supra* note 88, at 72.

[96] Steinberg, *supra* note 88, at 73.

[97] Videotape: Children of War, A Video for Educators (The National Child Traumatic Stress Network 2005, Refugee Trauma Group, Children of War Production Committee, *available at* www.nctsnet.org.

[98] Bessel van der Kolk, *Developmental Trauma Disorder,* 35(5) PSYCHIATRIC ANNALS 408, 408-410 (2005).

[99] Glenn N. Saxe, et al., *Comprehensive Care for Traumatized Children*, 35(5) PSYCHIATRIC ANNALS, 443, 443-448 (2005).

[100] *Id.* at 444.

"invisible."[101] Armed conflict in many of these countries often leaves children at risk for exploitation and denies them essential services, such as State protection for those children without parental care.[102] In the past decade, armed conflict has caused the deaths of more than two million children.[103] At least six million children have been disabled or seriously injured, and more than one million have been orphaned or separated from their families.[104] In addition, "an estimated twenty million children have been forced to flee their homes because of conflict and human rights violations and are living as refugees in neighboring countries or are internally displaced within their own national borders."[105] Approximately 300,000 youth under the age of eighteen are child soldiers—forcibly recruited to join or forced to join conflicts because of "poverty, abuse and discrimination," or to avenge those who may have caused them or their family members harm.[106] In 2004, forty-seven percent of refugees, asylum-seekers, stateless and others of concern to UNHCR were under the age of eighteen, and thirteen percent were under the age of five.[107] There are also tens of millions of "street children . . . vulnerable to all forms of exploitation and abuse."[108] According to the International Labor Organization, 246 million children between the ages of five and seventeen are engaged in child labor, and almost seventy percent of these children are working in hazardous situations or conditions.[109] The amount of child smuggling and trafficking has also increased, specifically in "the number of girls trafficked for sexual exploitation."[110]

> The increase in children who are trafficked for sexual exploitation and other forms of bonded labour is typically explained by a combination of factors: (a) socio-economic problems in the country of origin and/or breakdown of the family. . .; (b) demand in the sex-trade industry or for low-skilled work force in the informal sector; and (c) growth in criminal enterprises that recognize the high profitability and low risk involved in [human] trafficking.[111]

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[101] UNICEF, THE STATE OF THE WORLD'S CHILDREN 2006: EXCLUDED AND INVISIBLE, 45 (2005), *available at* http://www.unicef.org/sowc06/index.php.

[102] *Id.*

[103] UNICEF, Child Protection, Armed conflict, http://www.unicef.org/protection/index_armedfonflict.html?q=printme, (last visited Jan. 13, 2006).

[104] *Id.*

[105] *Id.*

[106] *Id.*

[107] UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES, 2004 GLOBAL REFUGEE TRENDS, 2, 5 (June 17, 2005), *available at* http://www.unhcr.org/statistics. In Africa, Central Asia, South West Asia, North Africa and the Middle East, more than half of the refugees were under eighteen. In other parts of Asia and the Pacific region, children under eighteen comprise thirty-seven percent of refugees, Europe twenty-three percent, and the Americas (twenty-five percent). *Id.* at 5.

[108] UNICEF, THE STATE OF THE WORLD'S CHILDREN, *supra* note 101, at 50-51.

[109] *Id.* at 56.

[110] Maloney, *supra* note 16, at 114.

[111] *Id.*

Displaced children are generally more depressed and experience a greater sense of hopelessness than those non-displaced children.[112]

The types of children listed above often experience severe trauma due to the hardships they must endure in order to survive. Children fleeing persecution, for example, are often faced with many distressing hurdles, especially if they are unaccompanied by an adult. "Adverse psychiatric outcomes from traumatic exposure" are generally related to the level of exposure to the traumatic event(s), the quality of social support, and characteristics of the individual.[113] A number of risk factors are associated with the mental health of refugee children. First, parental factors include PTSD in either parent, maternal depression, torture (especially in the mother), death of or separation from parents, direct observation of helplessness of parents, parental underestimation of stress levels in children, and unemployment of parents.[114] Child factors, on the other hand, take account of the number of traumatic events either experienced or witnessed, expressive language difficulties, PTSD leading to long term vulnerability in stressful situations, older age, and physical health problems caused by trauma or malnutrition.[115] Finally, environmental factors include the number of transitions, degree of poverty, time taken for immigration status to be determined, cultural isolation, time in a refugee camp, and time in host country.[116]

Danger presents itself in different forms over the course of childhood, adolescence, and adulthood.[117] Dangers are also included by where children live and the circumstances of their families. Moreover history and culture also determine threats. Please remove your additions.[118] In the face of danger, an individual normally assesses the threat, responds emotionally and physically, and then attempts to prevent the harm from occurring or to protect himself and others from the danger and avoid any further danger.[119] Danger, unfortunately, can become "traumatic" when it threatens serious injury or death.[120]

When young children experience trauma, they may feel helpless and turn to the protection provided by the adults and siblings in their lives.[121] These same individuals also help them assess the "seriousness of dangerous."[122] Young children may also witness violent situations and are the most challenged by their own in-

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[112] M. Grgic, et al., *Differences in Depression and Children, Hopelessness Between Displaced Children and Non-Displaced Children*, 30(3) SOCIJALNA PSIHIJATRIJA 154, 154-159 (2002).

[113] Daniel S. Pine & Judith A Cohen, *Trauma in Children and Adolescents: Risk and Treatment of Psychiatric Sequelae*, 51 BIOLOGICAL PSYCHIATRY 519, 523 (2002).

[114] M. Fazel & A. Stein, *The Mental Health of Refugee Children*, 87 ARCH. DIS. CHILD. 366, 366-370 (2002).

[115] *Id.*

[116] *Id.*

[117] National Child Traumatic Stress Network, Understanding Child Traumatic Stress, *available at* http://www.nctsnet.org/nccts/nav.do?pid=ctr_aud_prnt_under (last visited Jan. 9, 2006).

[118] *Id.*

[119] *Id.*

[120] *Id.*

[121] *Id.*

[122] National Child Traumatic Stress Network, *supra* note 117.

tense physical and emotional reactions, specifically caused by cries of distress from their caretakers.[123] School age children, on the other hand, have an increased ability to assess the seriousness of threats and may respond by imagining extraordinary, often superhero-like actions to address them.[124] As a result, they can feel guilty when unable to correct the situation.[125] Adolescents have a greater capacity to assess danger on their own, but they are still in the process of learning how to handle their intense physical and emotional reactions to such dangers.[126] Moreover, they are also grappling with issues related to accountability, malevolence, and irresponsibility.[127]

Geography, culture, and religion are significant factors in determining the normative beliefs of different societies.[128] Accordingly, the concerns of one culture may not be as important to another. For instance, many recognize that the medicalization of psychological processes is a Western notion.[129] Mental suffering, consequently, may be viewed as a disorder in some cultures but not in others.[130] Therefore, when considering developmental descriptions and issues, their potential cultural relevance is significant.[131] Cultural acceptability may also result in expression or repression of certain problems. In addition, parents may tolerate different behaviors across different cultures.[132] Trauma can also impact attachment, self-regulation, and competency.[133] The experiences of physical and sexual abuse in childhood have been associated with both health and mental health problems in adulthood which include: substance abuse, personality disorders, eating, dissociative, affective, somatoform, cardiovascular, metabolic, immunologic, and sexual disorders.[134]

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[123] *Id.*

[124] *Id.*

[125] *Id.*

[126] *Id.*

[127] *Id.*

[128] V.F. DiNicola, *Children and Families in Cultural Transition*, *in* CLINICAL METHODS IN TRANSCULTURAL PSYCHIATRY 365-390 (S.O. Okpaku ed. 1998).

[129] Vincent Iacopino, *et al,. Manual on the Effective Investigation and Documentation of Torture and Other, Cruel, Inhuman, or Degrading Treatment or Punishment*, The Istanbul Protocol, *available at* http://www.phrusa.org/past_news/istanbul.html (last visited Feb. 13, 2006).

[130] *Id.*

[131] Stuart Lustig, *et al., Review of Child and Adolescent Refugee Mental Health*, 43(1) J. AM. ACAD. CHILD AND ADOLESCENT PSYCHIATRY 24, 25 (2004).

[132] Cecile Rousseau & Aline Drapeau, *Parent-Child Agreement on Refugee Children's Psychiatric Symptoms: A Transcultural Perspective*, 37(6) J. AM. ACAD. CHILD AND ADOLESCENT PSYCHIATRY 629, 634 (1998) (citing J.R. Weisz et al. *Over and Undercontrolled Referral Problems Among Children and Adolescents from Thailand and the United States: the Wat and Wai of Cultural Differences* 55 J. CONSULT CLINICAL PSYCHOLOGY 719 (1987))

[133] Kristine Kinniburgh, *et al, Attachment, Self-Regulation, and Competency*, 35(5) PSYCHIATRIC ANNALS 424, 424-425 (2005).

[134] Bessel Van der Kolk, *The Neurobiology of Childhood Trauma and Abuse*, 12(2) CHILD ADOLESCENT PSYCHIATRIC CLINICS OF N. AM. 291 (2003), *cited in* Bessel Van der Kolk, *Developmental Trauma Disorder*, 35(5) PSYCHIATRIC ANNALS 405 (2005).

Taking cultural caveats into account, development also influences posttraumatic reactions. Young children have a difficult time coping with the failure of protection experienced during a traumatic event.[135] They may respond by becoming passive and quiet, easily alarmed, and insecure about future protection.[136] They can also become increasingly fearful, particularly in response to separations and new situations, and may also experience difficulty in learning.[137] In addition, if a parent or caretaker is responsible for the trauma, a child can become confused as to where to find protection and where there is a threat."[138] Reminders of the trauma can easily trigger additional regression, such as bedwetting or baby-talk.[139] Finally, very young children can be easily startled, have night terrors, or become aggressive following a traumatic experience.[140]

School age children tend to think more about the frightening moments and often engage in "traumatic play"—thoughts of what might have been done to prevent them the traumatic experience or to produce a different outcome.[141] In addition, "concrete reminders," of the experience may easily trigger intense responses and often further the development of new fears related to the original danger in addition to fears of reoccurrence.[142] Emotionally, school age children may vacillate between withdrawn and aggressive behavior.[143] Finally, they may have irresolvable thoughts of revenge as well as sleep problems which may potentially interfere with daytime concentration, attention, and school performance.[144]

Adolescents may be particularly challenged by their reactions to traumatic events and fear that their responses indicate that they are "going crazy" or feel that they are different from others.[145] They may feel embarrassed by their fears or their emotional reactions and as a result, may not share their feelings with others, which may lead to a sense of isolation.[146] It may be easier to understand these feelings of grief rather than their reactions to trauma.[147] They may become preoccupied with their lives before the trauma or sensitive to the failure of their family, school, or community to prevent injustices from occurring.[148] As a result, adolescents may turn increasingly more to their peers to evaluate risks.[149] For some, reminders of the trauma may cause "extreme avoidant" or, on the contrary, reckless behavior.[150] They may also

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[135] National Child Traumatic Stress Network, *supra* note 117.
[136] *Id.*
[137] *Id.*
[138] *Id.*
[139] *Id.*
[140] *Id.*
[141] *Id.*
[142] *Id.*
[143] *Id.*
[144] *Id.*
[145] *Id.*
[146] *Id.*
[147] *Id.*
[148] *Id.*
[149] *Id.*
[150] *Id.*

experience sleep disturbances and may use alcohol or drugs to cope with their emotional or physical reactions.[151]

Some children go on to develop posttraumatic stress disorder, but also depression as well as and separation anxiety disorder.[152] Trauma can also affect the normal development of the brain, including the size of brain components which help control responses to danger later in life.[153] In earlier years, traumatized children may experience a delayed ability to manage automatic reactions to danger, such as the startle reflex, and may consequently be more responsive to noise and have trouble concentrating.[154] In addition, children exposed to significant traumatic stress may also experience changes in the levels of stress hormones in their body, which may impact their responses to future stress and their long-term health.[155]

Traumatic stress can also disrupt the development a child's emotional maturity.[156] In the absence of trauma, children ordinarily learn to manage their emotions and learn to identify the varying intensities of emotions they experience.[157] When a child experiences trauma, however, their fear can overwhelm their attempts to manage their emotions.[158] As a result, some traumatized children may "clamp down on their emotional life" and internalize their feelings due to a fear that everyday emotions will overwhelm them.[159] During adolescence, youths become more emotionally aware and begin to learn how to regulate their emotions as they prepare to deal with a wider world and develop intimate relationships.[160] This emotional sensitivity can have far-reaching effects.[161] Children are actively learning about the world through their experiences. Those who are traumatized, consequently, may conclude that the world is an unsafe place, fraught with dangers and lacking proper protection. Their world view will also influence how they act, and a negative world view might lead to adolescents indifferent about the future and reluctant to get close to others.[162]

According to the Surgeon General, several factors predispose children to developing mental disorders: poverty; low birth rate; exposure to environmental toxins; child abuse and neglect; exposure to traumatic events or violence; the presence of a mental disorder in a parent; and prenatal exposure to alcohol, illegal drugs, and tobacco.[163] It is imperative that the United States recognize that unaccompanied and separated children satisfy many of these factors and accordingly, are at great risk. Without treatment, childhood disorders will persist and lead to failure in school,

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[151] *Id.*
[152] *Id.*
[153] *Id.*
[154] *Id.*
[155] *Id.*
[156] *Id.*
[157] *Id.*
[158] *Id.*
[159] *Id.*
[160] *Id.*
[161] *Id.*
[162] *Id.*
[163] U.S. Dep't of Health & Human Services, Substance Abuse and Mental Health Services Administration, *Mental Health: A Report of the Surgeon General* 129 (1999).

poor unemployment opportunities, and poverty in adulthood.[164] Children with untreated mental illnesses are also at risk for substance abuse, suicide, criminal behavior, and incarceration.[165]

While many traumatized children often embody the negative results brought on by their experience,[166] there are some exceptional children who have flourished despite the trauma and exhibit extraordinary resilience and survivor skills.[167] There are others, unfortunately, who present significant behavioral problems and have difficulty self-regulating.[168] Our immigration system needs to have the capacity to provide the requisite services to each individual child. To merely detain individuals is problematic, as it does not take into account their vulnerabilities, individual needs, and the kind of environment each needs to feel comfortable and share their traumatic story. Without knowledge of a child's traumatic story, the child's advocate may be unaware of legal options that may allow the child to remain in the United States. In addition, without full disclosure, children may be returned to dangerous situations. Wendy Young explains unaccompanied minors "are often too young or uninformed to appreciate the nature of the immigration proceedings in which they are involved and are vulnerable to agreeing to deportation as their only recourse to getting out of the correctional facility."[169]

C. Children Should Not Be Separated From Parents During Immigration Detention

History has acknowledged the enormous impact that separation from parents has on young children during war.[170] As shown in the seminal work of Freud and Burlingham at the Hamstead Nursery in London [171] which aimed to provide foster care for children of single-parent families during the war."[172] Children's ability to self-regulate, therefore, depends to a large extent on the emotional state of their caretakers. Refugee youth without caretakers may, consequently, have a greater risk of displaying psychiatric symptoms in the wake of traumatic exposure.[173] Children need parental responses to address appropriate reactions to reminders of trauma and potential behavioral regression.[174] Parental absence, both physically and emotion-

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[164] BAZELON CTR. FOR MENTAL HEALTH LAW, *Facts on Children's Mental Health* (2004), *available at* http://www.bazelon.org/issues/children/factsheets/children.htm.

[165] *Id.*

[166] National Child Traumatic Stress Network, *supra* note 117.

[167] *Mental Health: A Report of the Surgeon General, supra* note 163.

[168] BAZELON CTR. FOR MENTAL HEALTH LAW, *supra* note 164.

[169] Wendy A. Young, *Refugee Children at Risk*, 28 A.B.A. HUM. RTS. MAGAZINE 10, 11 (2001).

[170] *See* Anna Freud & Dorothy T. Burlingham, *War and Children*, 93-103, MEDICAL WAR BOOKS (1943).

[171] *Id.*

[172] *Id.*

[173] Lustig, *supra* note 131.

[174] Rober S. Pynoos, *et al.*, *A Developmental Psychopathology Model of Childhood Traumatic Stress and Intersection with Anxiety Disorders*, 44 BIOLOGICAL PSYCHIATRY 1542, 1546 (1999).

ally, can also cause sleep disturbances.[175] For example, a study of 311 Middle Eastern refugee children between the ages of three and fifteen who arrived in Denmark revealed a number of risk factors for sleep disturbance.[176] These risk factors included family history of violence, such as a grandparent's death or parental exposure to torture, as well as stressful family situations.[177] The presence of both parents rather than one upon arrival in Denmark, however, modified the amount of sleep children received.[178]

Evacuations can also cause long-term effects. An English study, for instance, utilized a retrospective non-randomized design to compare 169 people who were evacuated as children during World War II with forty-three individuals who were children during the war but remained in the country.[179] The two groups were systematically the same regarding demographics and childhood exposure to war-related events.[180] Former evacuees, however, exhibited "a greater likelihood of insecure attachment, which was . . . associated with lower levels of [present] psychological well-being."[181] While limited by its retrospective design, the study suggests that evacuation coupled with insecure attachment, or separation from parents, may lead to long-term psychological vulnerabilities.[182] Children exposed to violence, therefore, must perceive their parents as a "secure base."[183] Disturbances in attachment that can make it hard for youth to trust others.[184] At the same time, children from families in which boundaries are problematic may also affect emotional security.[185]

While keeping families together provides children with the benefits of protection by their parents, family unity is also better for other reasons.[186] The U.K., for example, has demonstrated that governments can ensure asylum seekers' compliance

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[175] Edith Montgomery & Anders Foldspang, *Traumatic Experience and Sleep Disturbance in Refugee Children from the Middle East*, 11(1) EUR. J. PUB. HEALTH 18, 21 (2001).

[176] *Id.* at 20.

[177] *Id.*

[178] *Id.*

[179] D. Foster *et al.*, *The Evacuation of British Children During WWII: A Preliminary Investigation into the Long-term Psychological Effects*, 7(5) AGING AND MENTAL HEALTH 398, 400 (2003).

[180] *Id.* at 404.

[181] *Id.* at 405.

[182] *Id.* at 406.

[183] Kjerstin Almqvist & Anders G. Broberg, *Silence and Survival: Working with Strategies of Denial in Families of Traumatized Pre-school Children.* 23(3) J. OF CLINICAL PSYCHOTHERAPY. 417 (1997).

[184] HI Yoo, BN Kim, MS Shin, SC Cho, KE Hong, *Parental Attachment and Its Impact on the Development of Psychiatric Manifestation in School-Aged Children Psychopathology*, 39 PSYCHOPATHOLOGY 165-174 (2006).

[185] PT Davies, EM Cummings, MA Winter, *Pathways between profiles of family functioning, child security in the inter-parental system, and child psychological problems.* 16 DEVELOPMENT AND PSYCHOPATHOLOGY 525-550 (2004).

[186] Heaven Crawley & Trine Lester, *Save the Children, No Place for a Child, Children in U.K. Immigration Detention: Impacts, Alternatives, and Safeguards* (2005), http://www.savethechildren.org.uk/scuk_cache/scuk/cache/cmsattach/2414_no_place_for_a_child.pdf.

by providing support and information to individuals and families rather than emphasizing mandatory retention.[187] In addition, Bruegel and Natamba traced ninety-eight former U.K. detainees "who were bailed between July 2000 and October 2001 through to the winters of 2001/2002."[188] Over ninety percent of those released adhered to their bail conditions, including compliance with removal directions.[189] This fact illustrates that it is unnecessary to detain these individuals and that retention problems are further compounded by the great cost to the individual and country.[190]

D. Children Should Be Evaluated Medically and Psychiatrically

Interviewing young traumatized children, particularly those traumatized by physical and sexual abuse, is challenging, not only because it can be difficult for children to remember, but because standard interviewing formats can be ineffective with economically disadvantaged and culturally different children. Family interaction patterns and childrearing styles can affect their ability to respond to both verbal and non-verbal interviewing techniques. In addition, interview outcomes can be also be influenced by children's familiarity with the material to be remembered, their motivation to remember, their cognitive style and their communication skill.[191]

The United Nations recommends that authorities inquire about the following information when dealing with unaccompanied children seeking asylum:[192]

- Family information;
- Information on non-family members important to the child;
- Circumstances when the child was found;
- Information concerning the child' separation from the family;
- Information about the child's life before and since the separation;
- Child's physical condition health and past medical history;
- Educational background;
- Present care arrangements;
- Child's wishes and plans for the future;
- Preliminary assessment of the child's mental and emotional development and maturity.[193]

Several studies have emphasized the importance of screening children for trauma in pediatric settings.[194] Children, however, must trust in order to feel comfortable

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[187] *Id.*

[188] Irene Bruegel & Eva Natamba, *Maintaining Contact: What Happens After Detained Asylum Seekers Get Bail?* SOUTH BANK UNIVERSITY LONDON SOCIAL SCIENCE RESEARCH PAPERS, 6 (2002), *available at* http://www.lsbu.ac.uk/php-cgiwrap/fhss/docsys/getpapers.phtml?papersid=96.

[189] *Id.*

[190] *Id.*

[191] John Mordock, *Interviewing Abused and Traumatized Children*, 6(2) CLINICAL CHILD PSYCHOLOGY AND PSYCHIATRY 271, 271 (2001).

[192] *Guidelines on Policies and Procedures in Dealing with Unaccompanied Children Seeking Asylum, supra* note 5; Mordock, *supra* note 191.

[193] *Id.*

enough to disclose both their symptoms and their stories. A child is more likely to become trusting in a nurturing environment. Officials, correspondingly, are more likely to understand a child brought before them in a nurturing environment rather than in a punitive one. In addition, survival in traumatic circumstances requires hiding one's vulnerability. Since expedited removal of children and adults does not consider the issue of trauma and its impact on disclosure, such expedited removal may paradoxically place at risk those who need the greatest amount of protection.

Children also come to the Unites States from foreign countries with many physical maladies.[195] A general health screening for children, as a result, should include many physical and cognitive components. Testing and screening recommended by the American Academy of Pediatrics screening for internationally adopted children includes: "a detailed history and physical exam, hepatitis B surface antigen, surface antibody and core antibody, HIV testing, Mantoux test, stool examination for ova and parasites, rapid plasma regain for syphilis, complete blood count with erythrocyte indices, and hepatitis C virus testing."[196] When determining which tests to administer, physicians must consider which illnesses are endemic in the children's countries of origin.[197] For example, in a study of 1,825 young refugees from nineteen countries who resettled in Massachusetts, twenty-one percent had pathogenic parasites, sixty-two percent had caries, and twenty-five percent tested positive for PPD.[198] In addition, twelve percent of the children were anemic, and twenty-eight percent of those children were younger than two years of age.[199] Finally, the refugees also displayed significant growth abnormalities.[200] The Massachusetts study demonstrates the importance of prompt screening, medical follow-up, and assurance of necessary food support.[201] In Miami-Dade County, Florida, another study examined the health status of 241 newly arrived Cuban refugee children.[202] Tuberculosis, hepatitis B, and anemia were relatively rare, but parasitic infections and lead poisoning were common.[203] In addition, refugee children can also exhibit cognitive and mental status changes, which can result from head trauma or torture,[204] persis-

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[194] Betsy McAlister Groves & Marilyn Augustyn, *Identification, Assessment, and Intervention For Young Traumatized Children within a Pediatric Setting*, *in* YOUNG CHILDREN AND TRAUMA: INTERVENTION AND TREATMENT 173, 174 (Joy D. Osofsky ed. 2004).

[195] *See* Lin H. Chen *et al.*, *Preventing Infectious Diseases during and after International Adoption*, 139(5(1)) ANNALS OF INTERNAL MED. 371 (2003).

[196] *Id.*

[197] *Id.*

[198] Paul Geltman *et al.*, *Growth Status and Related Medical Conditions Among Refugee Children in Massachusetts, 1995-1998*, 91(11) AM. J. PUB. HEALTH 1800, 1801-1802 (2001).

[199] *Id.* at 1802.

[200] *Id.* at 1800.

[201] *Id.* at 1804.

[202] Pamela P. Entzel *et al.*, *The Health Status of Newly Arrived Refugee children in Miami-Dade County, Florida*, 93(2) AM. J. PUB. HEALTH 286 (2003).

[203] *Id.*

[204] Linda Piwowarczyk *et al.*, *Health Care of Torture Survivors*, 284(5) J. AM. MED. ASS'N 539 (2000).

tent musculoskeletal injuries that were previously untreated, or and injuries to the skin, which can leave evidence of scarring.[205] Other chronic problems include malnutrition,[206] ear problems, fungal and parasitic infestations of the skin, latent tuberculosis, carriage of intestinal parasites, hepatitis B, anemia, lead poisoning, dental caries, and other abnormalities.[207]

E. Children Should Be Offered the Care Provided Traditionally For Unaccompanied Refugees

The Unaccompanied Refugee Minors (URM) Program provides support to children under the age of eighteen who are refugees (URM status granted overseas), entrants (reclassified as URMs after arrival), asylees (reclassified to URMs status when they are granted asylum), and victims of trafficking.[208] Refugee children who enter the country with a parent who is unable to care for them may also be eligible.[209] The children become the State's legal responsibility and are subsequently eligible for the assistance, care, and services that meet minimum state guidelines for standard of care.[210] In order to enable youths to develop the skills necessary for independent adulthood, the state provides English language training, career planning, physical and mental health needs, socialization skills/adjustment training, family reunification, residential care, education/training, and ethnic/religious preservation.[211] In the period between unaccompanied alien children's transfer to the care of are Office of Refugee Resettlement (ORR) of the Department of Health and Human Services and their release from custody or deportation, ORR strives to place them in "the least restrictive setting appropriate to their age and special needs."[212] During this period, ORR houses the children in a network of shelter care facilities, secure settings, group homes, and foster care.[213] The facilities provide the children with education, health care, socialization/recreation, mental health services, family reunification, access to legal services, and case management.[214]

1. Foster Care and Group Homes

Unaccompanied children arriving independent of resettlement programs should be provided with the same description of care and services that are provided to selected refugee foster children. The resettlement program aims for an improvement of the quality of life for traumatized children irrespective of their mental health.[215]

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[205] *Id.*

[206] Peter R. Dallman, *Iron Deficiency and the Immune Response,* 46 AM. J. CLINICAL NUTRITION 329 (1987).

[207] Lustig, *Review of Child and Adolescent Refugee Mental Health, supra* note 131.

[208] Office of Refugee Resettlement, Unaccompanied Refugee Minors Program, http://www.acf.hhs.gov/programs/orr/programs/urm.htm (last visited 1/13/2006).

[209] *Id.*

[210] *Id.*

[211] *Id.*

[212] *Id.*

[213] *Id.*

[214] *Id.*

[215] Maloney, *supra* note 16.

As a result, resettled children are assigned a social worker upon arrival and are introduced to services which will assist them with adjustment, education, and eventual independence (including English classes, family tracing, and therapeutic treatment for refugee children). Authorities are sensitive to the developmental needs, ethnic, linguistic, and religious backgrounds, personality, and opinions of each child when considering placement in foster care group homes or supervised independent living.[216]

Foster family care was initially offered only to unaccompanied refugee minors but is now offered to youth awaiting immigration decisions. This model of care provides a more intimate environment for children. Nevertheless, officials must consider various factors when determining foster placements, such as the role of family and community (keeping in mind kinship options); meeting children's cultural needs with the use of refugee foster homes; family dispersal and possibilities of reunification; secondary migration; possibilities for independent living; and the need for specialized services.[217]

A study addressing foster placements of primarily Southeast Asian minors (Vietnamese, Khmer, and Haitian refugee/entrants) suggests that it is "preferable to place unaccompanied refugee minors in ethnically similar homes whenever possible."[218] Another study looked at the successful resettlement of unaccompanied Indochinese refugees between the ages of twelve and nineteen.[219] This study found that unaccompanied refugees living with ethnic foster families had higher grade point averages and were significantly less depressed than their counterparts living with Caucasian families or in group homes.[220] Thus, the ongoing presence of an adult of similar ethnicity helped reduce the stressors of adaptation to a new country.[221]

L.C. Miller suggests that several factors hinder identity development among unaccompanied refugee minors in the US, including the following: exposure to overwhelming tension-producing situations, failure in values, withdrawal from societal channels that facilitate identify formation, and inadequate coping mechanisms.[222] Prior trauma is also related to attachment problems with new families.[223] Major predictors of positive adjustment in Amerasians beginning in the U.S. as unaccompanied refugee minors were the pre-migration length of time the child had spent

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[216] *Id.* at 117.

[217] Lutheran Immigration and Refugee Service and United States Conference of Catholic Bishops/Migration and Refugee Services, *Serving Foreign-Born Foster Children: A Resource for Meeting the Special Needs of Refugee Youth and Children,* A6-A7 (2004), *available at* http://www.brycs.org/documents/fostercare.pdf.

[218] Patricia Adler, *Ethnic Placement of Refugee/Entrant Unaccompanied Minors,* 64(5) CHILD WELFARE 491 (1985).

[219] *See* Zelda Porte & Judith Torney-Purta, *Depression and Academic Achievement Among Indochinese Refugee Unaccompanied Minors in Ethnic and Non-ethnic Placements,* 57(4) AM. J. ORTHOPSYCHIATRY 536 (1987).

[220] *Id.*

[221] *Id.*

[222] Mary Bromley, *Identity as a Central Adjustment Issue for the Southeast Asian Unaccompanied Refugee Minor,* 17(2) CHILD & YOUTH CARE Q. 104 (1988).

[223] Karen N. Olness, *Refugee Health, in* HANDBOOK OF IMMIGRANT HEALTH, 227-241 (Sana Loue ed. 1998).

with parents or parental substitutes and post-migration amount of stable foster care.[224] Other notable factors that aided in adjustment were the child's relationship to institutions and caseworkers as adjunct caretakers.[225] It is important, therefore, to generate a sense of belonging and independence for children.[226] Generally, bicultural and culturally competent foster homes do the following:

- Understand what the refugee child has experienced during war and flight;
- Have an interest in the culture and background of the refuge child;
- Can enable better communication and less misinterpretation due to language or cultural barriers;
- Provide familiar food, language, and customs;
- Provide religious continuity and support, when the family is of the same faith. This trait can be especially important for religious minorities and religiously observant children.[227]

BRYCS has summarized factors which appear to influence a refugee child's adjustment to foster care, and which also have implications for a broader range of children:

a. Before Arrival

- Mental health of the child;
- Level of trauma from war and flight;
- Physical health conditions following war and flight;
- Type of care received during flight and refugee camp – e.g. care by a relative, institutional care, or no adult supervision;
- Location and safety of the child's immediate relatives;
- Developmental stage at time of trauma, flight, and resettlement (e.g. circumstances of child during onset of puberty or the age of the child at the death of a parent or sibling);
- Strength of child's family systems in home country – etc. A child from a strong and loving family may be able to adjust better to a home environment in the United States; a child who lived on the street may have more difficulty adjusting to a family system here;
- Child's birth order – e.g. the oldest child may struggle with more guilt or a sense of responsibility about the care and condition of younger siblings.[228]

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[224] Mary Eileen English, *Resettling Vietnamese Amerasians: What have we learned?* (2001) (unpublished Ed. D. dissertation, Univ. Mass. Amherst), *abstracted in* 62(9-B) DISSERTATION ABSTRACTS INTERNATIONAL: SECTION B, THE SCIENCES AND ENGINEERING 4251 (April 2002).

[225] *Id.*

[226] Ravi Kohli and Rosie Mather, *Promoting psychosocial well-being in unaccompanied asylum seeking young people in the United Kingdom*, 8 CHILD AND FAMILY SOCIAL WORK 201 (2003).

[227] Lutheran Immigration and Refugee Service, *supra* note 217.

[228] *Id.*

b. After arrival

- Foster family's knowledge of child's past experience;
- Foster family's cultural sensitivity and level of acceptances of the child;
- Child's ability to maintain contact with family, friends, and peers from refugee camp or home country (residing in either the Untied States or overseas);
- Amount of contact between caseworker and the child and foster family;
- Cultural competence of foster care staff;
- Reception from and influence of American-born peers.[229]

BRYCS notes that there can also be specific challenges in using refugee foster families.[230] For example, they can find it strange to talk with strangers, may be unable to meet physical space and needs, be unable to follow though with paper work due to language, have language barriers which make it difficult during training, or have certain licensing requirements which may be culturally different. Moreover, legal status of family members may vary in the family. They may have busy work schedules, authority issues with adolescents, impatience with certain problem behaviors, lacking of follow-through with training, rigid expectations of male and female roles, expectations that the child will follow the foster parent's path to success, and reluctance to take advantage of mental health services for refugee children.[231] Foster families are also there to support the children through the immigration/asylum process until allowed to remain in the United States or safely repatriated.[232]

Small group homes allow for the possibility for more intimate relationships with the children due to the staff:child ratio. They are more likely to have more freedom of movement and opportunity for exercise. The educational challenges are less challenging to the sheer number of children and levels. When the meals are not delivered in large groups and highly scheduled, the environment is more of a home. At times of peak movement, it is difficult to keep up with the numbers in large shelters.[233] Building children's strengths in a residential setting can enhance functioning independent from improving potential psychiatric problems.[234]

2. Programming considerations

In its work with refugee children, UNHCR guidelines remind us of the importance of considering cultural issues in programming in part because it provides children with identity and continuity while at the same time acknowledging that culture is a dynamic phenomenon, and not static.[235] Programming needs to take

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[229] *Id.*

[230] BRYCS, *available at* http://www.brycs.org/documents/fostercare._app1.pdf, at A-4.

[231] *Id.*

[232] Maloney, *supra* note 16, at 108-09.

[233] Anonymous personal communication (Dec. 9, 2005).

[234] John S. Lyons *et al.*, *Strengths of Children and Adolescents in Residential Settings: Prevalence and Associations With Psychopathology and Discharge Placement*, 39 J. AM. ACAD. CHILD AND ADOLESCENT PSYCHIATRY 176 (2000).

[235] UNHCR, REFUGEE CHILDREN: GUIDELINES ON PROTECTION AND CARE 9 (1994).

into account not only cultural, but also developmental needs. For refugee children, they recommend in refugee settings that children ages of 5- 10 should be involved in games, dance, music, drawing, painting, story telling and singing with small groups of children.[236] These can be incorporated with primary school programs or carried out as extracurricular activities, organized and run by refugee adults. Older children can help younger ones. Moreover, for youth ages 11-17 years, UNHCR suggests group activities emphasizing peer leadership like sports, group discussions and community projects are examples.[237] It also recommends supporting adolescents in making the transition to adulthood by discussions on issues such as sexuality and adjusting to the host country culture and help with finding employment when legally able to do so.[238]

For those youth who do join with family, specific issues can arise particularly when they have not seen family members for a long time. They can struggle to make an attachment. Sometimes children feel anger and betrayal toward their parents who "left them behind." They may have feelings of guilt over the separation, or be confused why it occurred. It is not uncommon for both parents and their children to have high expectations about being reunited. Parents on the other hand may feel guilty for having left their children behind, and on some level feel like a stranger to their own child as someone else has needed to be the caretaker in the interim.[239]

3. The need for an advocate

Some argue that some children do not have the capacity to make decisions concerning their legal options. This should not be surprising due to the developmental considerations stated above. Within the medical field, much emphasis is placed on whether a child has the capacity to give informed consent or assent to medical procedures, as well as the explicit role of parents. It is problematic then that when this same child is facing "legal procedures" that there is an automatic assumption, regardless of their age, that they can give informed consent as evidenced by the fact that children are not generally provided with someone to act as a guardian *ad litem* advising their best interests or a lawyer. In medicine, the American Academy of Pediatrics Committee on Bioethics argues that the "doctrine of 'informed consent' has only limited direct application in pediatrics.[240] "Only patients who have appropriate decisional capacity and legal empowerment can give their informed consent to medical care.[241] In all other situations, parents or other surrogates provide informed permission for diagnosis and treatment of children with the assent of the child whenever appropriate."[242] As noted by Appelbaum, Lidz, and Meisel, in-

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[236] *Id.* at 10, 17.

[237] *Id.* at 18.

[238] Kohli, *supra* note 226.

[239] Susan Schmidt, *Separated Refugee Children in the United States: Challenges and Opportunities Bridging Refugee Youth and Children's Services* (BRYCS) (2004), *available at* http:www.brycs.org/documents/separated_children.pdf.

[240] American Academy of Pediatrics Committee on Bioethics, *Informed Consent, Parental Permission and Assent in Pediatric Practice*, 95 PEDIATRICS 314 (1995).

[241] *Id.* at 314.

[242] *Id.*

formed consent generally encompasses information about the condition, proposed diagnostic steps and/or treatments, the probability of success, potential risks benefits of recommended alternatives including no treatment, an assessment of the patient's understanding of the information and the capacity of the patient or surrogate to make decisions, and that the decision is made voluntarily without coercion.[243] Having said this, it appears that we are using a double standard that needs to be addressed. We place in question the capacity of children to make health decisions, but then without requisite adult supervision, those same children are being asked to make legal decisions in the immigration process. As has been pointed out by Bhabha, Schmidt, and Frydman, only one third of children seeking asylum had attorneys to help them with their interviews, which does have implications, as those with lawyers are more apt to obtain asylum than those without.[244] One way in which this issue can be addressed is through the use of advocates on a universal scale.

The Immigrant Children's Advocacy Project is a pilot project commissioned by ORR (1) to provide children with guardians *ad litem* (Advocates) as set forth in the Unaccompanied Alien Child Protection Act (S.1129 and H.R. 3361).[245] Located in Chicago, the project assigns Advocates to individual children. The Advocate's objective is to identify and give voice to the child's best interests while he or she is subject to immigration proceedings. Children are automatically assigned an Advocate if they are less than fourteen years old, have physical or mental disabilities, have asylum cases or are filing petitions for SIJ, T, or U visas, or who are likely to be in custody for more than ninety days, as well as individual cases which do not fall into these categories.

The Advocate meets with the child as least once per week and (1) helps the child process information; (2) explains the consequences of decisions and assists the child in making decisions in situations in which the child requests help; and (3) for children who are not able to make decisions (due to cognitive or other reasons), the Advocate identifies the options that are in the child's best interests, within the parameters of the law. As a liaison to the legal system, the Advocate ensures that the child has an attorney who is diligently representing the child, ensures that the child understands the legal process and communicates with the attorney regarding any lack of understanding, accompanies the child to court, and is available to the child after court hearings to help the child process the information. Other activities include monitoring that no one like traffickers, smugglers or others are exploiting the child, as well as advocating on behalf of the child while she is in custody in the areas of:

- Alternative placement (foster care).
- Supplemental or alternative educational services.
- Legal services.
- Therapeutic services
- Medical care.

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[243] P.S. Appelbaum, C.W. Lidz & A. Meisel, *Informed Consent: Legal Theory and Clinical Practice* (1987), *quoted in* American Academy of Pediatrics Committee on Bioethics statement, *supra* note 240.

[244] BHABHA ET AL., SEEKING ASYLUM ALONE: U.S., *supra* note 6, at 118.

[245] Interview with Maria Woltjen, Director, Immigrant Children's Advocacy Project (Dec. 20, 2005).

- Social support.
- Spiritual and religious needs.
- Dietary needs.
- Access to telephones.
- Access to interpreters.
- Recreational programs.
- Visitation with relatives and other adults (nature and frequency).

The responsibility concludes when the child is placed in custody of his or her parent or legal guardian, the child is granted permanent resident status in the United States, the child departs the United States, the child attains the age of 18 and no longer requires the services of an Advocate, or the Advocate's duties are assumed by another qualified entity.[246]

VI. DISCUSSION

The Passage of the Unaccompanied Alien Protection Act by the Senate[247] established criteria for the care and protection of children, including the prohibition of placement of children in adult detention facilities or facility housing for delinquent children. It also speaks against the unreasonable use of handcuffs, shackling, solitary confinement and strip searches. By making way for child advocates and legal representation, the provisions are there to recognize the developmental needs of children. At the same time, it still allows for the detention of children and activity by border patrol.

So as to provide for the maximum degree of protection of children while in our care, we should consider a mandated reporting system when children are found whose human rights, as guaranteed by the Unaccompanied Alien Protection Act, have been violated.

Our focus should be the care and protection of children during the time that they are with us. Each child will come with his or her own history and experiences. In the best-case scenario, it is our opportunity to nurture these youth for as long as we have them. Inevitably there will be those who return to their country of origin. For those children, our task is to not only assess the safety concerns of that decision, but also to use the time, however limited, to validate what they have gone through, identify their strengths, and support their resilience. By doing so, we can incorporate therapeutic elements into each step in the immigration process.

The effort is to create a continuum of care sensitive to the legal issues but also the psychosocial issues of each child. The more that we can work with ethnic community organizations and communities of faith, we will add further recognition of the cultural identity of each child. These immigration issues are superimposed upon ongoing child development. It is important for us to be aware of those challenges. According to Eriksonian theory, stage four is the latency stage or school age children from 6-12.[248] Their social sphere broadens and their task is to develop *industry* while avoiding excessive *inferiority*. Children need encouraging and ac-

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[246] *Id.*

[247] Unaccompanied Alien Protection Act, S. 119 (passed by the Senate Dec. 21 2005).

[248] Dr. C. George Boeree, *Personality Theories, Erik Erikson 1902-1994* (2006), *available at* http://www.ship.edu/~cgboeree/erikson.html.

ceptance as their social horizon expands beyond the immediate family. It is important for children this age to feel successful in order to develop a sense of competence. Stage five is adolescence (from about puberty to age 18 or 20), which Erikson refers to the task as being achieving *ego identity* and avoiding *role confusion.* As the grounding for future development, this is about "knowing who you are and how you fit into the rest of society." This is the basis of a unified self-image. Rites of passage allow for the identification of the onset of adulthood with all its responsibilities. When this stage is successfully negotiated, some have found a place in the community where they can contribute.[249] By being cognizant of the age-related challenges, as we further develop programs for unaccompanied youth we help to facilitate them becoming adults who can contribute to society.

We can take it yet a step further. Traumatized children's treatment needs include: establishing safety and competence, dealing with traumatic reenactments, and integration and master of the body and mind.[250] Increasing evidence is mounting as to mental health interventions that can be helpful to traumatized children.[251] While in our care, we can develop a system which directly incorporates evidenced-interventions that have been found to be helpful for traumatized children in other settings and create a milieu whose emphasis is therapeutic, emphasizing skill development, mobilization of resources, and enhancing resilience. Regardless of the legal outcome, these could be personal resources that children could take with them.

VI. IN SUMMARY

Creating an environment for children where trust can be established through foster care or group homes whose approach is holistic is advantageous on a number of levels. The refugee foster care system has taught us that it takes time to create an environment where traumatized youth feel safe and are able to share. It is at that point, and perhaps not until then, that one can properly make recommendations as to which legal options as well as voluntary return are appropriate for a particular child. Premature adjudication and prompt return can result in children attempting to return or actual persecution upon return. For our society to welcome newcomers, and particularly children we need to have the political will to more holistically work with these children, and to provide environments which are safe, intimate, and nurturing. Our immigration policy toward children must not look at children as a group, which inevitability results in polarization as good or bad as this is particularly problematic for children with trauma histories.

In the wake of 9/11, there has been much anti-immigrant sentiment in the United States. We cannot allow those attitudes to interfere with what is the "right thing to do" for unaccompanied or separated youth who must flee their homes. We can-

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[249] *Id.*

[250] Van der Kolk, *supra* note 98, at 407.

[251] National Child Traumatic Stress Network, *Mental Health Interventions for Refugee Children in Resettlement: White Paper II* (2005), http://www.nctsnet.org/nctsn_assets/pdfs/promising_practices/MH_Interventions_for_Refugee_Children.pdf; National Child Traumatic Stress Network Empirically Supported Treatments and Promising Practices, http://www.nctsnet.org/nccts/nav.do?pid=ctr_top_tmnt_prom.

not confuse what we can't do from what we won't do . . . . The fact that the Unaccompanied Alien Protection Act would pass also recognizes the statement that "minor aliens do not pose a significant threat to national security in the context that the PATRIOT ACT was designed to address."[252]

The issues of the detention of children and their care while under our supervision goes beyond a moral imperative. There is sufficient evidence from around the world as to the deleterious effects of the detention of both adults and children. The Convention on the Rights of the Child needs to shape how we define the care and protection of children. It clearly dictates to us, as signatory, the importance of treating children in the way that they can be safe, protecting their human rights, while at the same time encouraging their well-being. Significant steps have been made toward providing an environment for children, which is more child friendly. The protections afforded children in international law speak to their protection, right not to be separated from parents, basic support, the rights to participate in decisions concerning them, family reunification, and care and assistance appropriate to their age and development needs.[253] Having said this, there is medical evidence also to support the questionable reasoning and executive judgment of youth, particularly under emotionally charged circumstances. If, as a society, we question the capacity of youth to make decisions about their health, we need to provide them with the proper adult supervision in the form of legal representation or adult assistance to make decisions that may result in life or death.

The real challenges going ahead speak to whether or not family reunification is a more important goal than the potential legal status of their parents. If we were to look at the impact of family separation, we would say yes. Are we willing to allow the time necessary to understand what individual children have experienced so that their legal options are informed by personal information? If we were to look at the impact that trauma and difficult life experiences can have on one's ability to trust, we would not have a system based on disclosure on demand. If we made a decision that we wanted to invest and support unaccompanied and separated children whose birthright, life circumstances, or political events dealt them a difficult beginning, we would provide the funding necessary to ORR to approach children holistically enabling our impact to not only be responsible, but also therapeutic facilitating their healing.

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[252] Taverna, *supra* note 17.

[253] Convention on the Rights of the Child, *supra* note 51.