IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF VIRGINIA
Harrisonburg Division

JOHN DOE 1, *et al.* by and through their next friend, NELSON LOPEZ, on behalf of themselves and all persons similarly situated, *Plaintiffs,* v. SHENANDOAH VALLEY JUVENILE CENTER COMMISSION, *Defendant.*	Civil No. 5:17-cv-00097-EKD Judge Elizabeth K. Dillon

PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

Plaintiffs John Doe 1, *et al.*, by and through their next friend, Nelson Lopez. by their undersigned attorneys, hereby move this Court pursuant to Fed. R. Civ. P. 65(a), for the entry of an Order preliminarily enjoining the Defendant, Shenandoah Valley Juvenile Detention Commission ("Shenandoah" or "the Commission") from continuing to allow the imposition of improper, excessive and inherently injurious forms of physical discipline and punishment upon traumatized, mentally ill Plaintiffs detained at the Defendant's juvenile facility and denying said Plaintiffs appropriate mental health care, as described in the Plaintiffs' First Amended Complaint, pending the ultimate resolution of this action on its merits.

For the reasons fully set forth in the Memorandum of Law filed concurrently in support hereof. this Motion should be granted.

DATED: February 28, 2018

Respectfully submitted,

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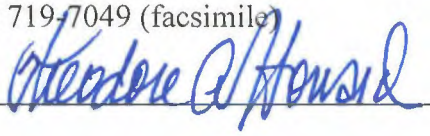
By: 

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CERTIFICATE OF SERVICE

I hereby certify that on this 28th day of February 2018, a true and correct copy of the foregoing Plaintiffs' Motion for Preliminary Injunction was served via this Court's electronic case filing system upon the following:

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IN THE UNITED STATES DISTRICT COURT
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JOHN DOE 1, *et al.*, by and through their next friend, NELSON LOPEZ, on behalf of themselves and all persons similarly situated, Plaintiffs, v. SHENANDOAH VALLEY JUVENILE CENTER COMMISSION, Defendant.	Civil No. 5:17-cv-0097 Judge Elizabeth K. Dillon

ORDER

This matter comes before the Court for decision on the Plaintiffs' Motion for Preliminary Injunction. The Court having considered the Plaintiffs' Motion and supporting Memorandum of Law; the Defendant's Memorandum in Opposition; the Plaintiffs' Reply Memorandum; the evidence submitted; and the arguments of counsel; and the Court having determined on the basis of all of the foregoing that: (i) the Plaintiffs have demonstrated a substantial likelihood of success on the merits of their substantive due process claims; (ii) irreparable harm to the Plaintiffs and the similarly-situated immigrant children detained at SVJC will result in the absence of preliminary injunctive relief, (iii) that the balance of the equities weighs in the Plaintiffs' favor; and (iv) that the public interest will be served by the granting of a preliminary injunction, and that good cause has therefore been shown to exist for the granting of the relief requested;

The Court hereby finds that Plaintiffs' Motion should be and the same is hereby GRANTED. Accordingly, the Court hereby ORDERS as follows:

1. Shenandoah Valley Juvenile Center ("SVJC"), by and through its agents, employees, contractors, and any individual acting or purporting to act on its behalf, is immediately prohibited from engaging in any of the following practices with respect to Plaintiffs and other unaccompanied alien children ("UACs") who are, or will be, detained at SVJC until further Order of this Court:

   a. The use of an "emergency restraint chair" or "spit mask" as a form of punishment;

   b. The use of an "emergency restraint chair" or "spit mask" in response to, or as a deterrent for, an act of self-harm, suicidality or self-mutilation;

   c. The use of an "emergency restraint chair" or "spit mask" under any circumstances for a detainee who has mental illnesses unless it has been approved by a licensed psychologist or psychiatrist;

   d. The use of physical force, restraints or isolation as punishment or in retaliation for verbal disobedience;

   e. The use of isolation, solitary confinement, or room restriction, as a form of punishment;

   f. The use of solitary confinement, or room restriction, for a period of more than one (1) hour for youth who are known to have a mental illness unless a longer time has been approved by a licensed psychologist or psychiatrist;

2. SVJC, by and through its agents, employees, contractors, and any individual acting or purporting to act on its behalf, shall also observe the following

conditions with respect to its application of force against Plaintiffs and other unaccompanied alien children ("UACs") who are, or will be, detained at SVJC:

a. Ensure that staff use the least amount of force appropriate to the risk posed by the youth to stabilize the situation and protect the safety of the involved youth and others. As soon as the youth regains self-control, staff shall discontinue their use of physical force with respect to the youth involved;

b. Limit the use of physical force or restraints to exceptional situations where the youth is currently physically violent, poses an immediate danger to self or others, and where SVJC has attempted and exhausted a graduated set of interventions that avoid or minimize the use of force or restraints and permit only the least restrictive measures to prevent physical harm to the youth or others;

c. Establish a clear protocol for when particular forms of restraint or isolation may be used;

d. Require the prompt documentation and reporting of all uses of force and restraint, including non-physical alternatives attempted prior to the use of force or restraint;

e. Ensure that youth who have been subjected to force or restraint are evaluated by qualified medical personnel following the incident if the youth claims an injury or requests medical attention, or if a reasonable person would believe the youth has been injured;

3. Within __ days of this Order, SVJC, by and through its agents, employees, contractors, and any individual acting or purporting to act on its behalf, shall submit to Plaintiffs' counsel and to the Court a plan to adopt and implement a fully trauma-informed environment that is consistent with national standards.

It is so ORDERED.

ENTERED this _____day of _____, 2018.

_____
The Hon. Elizabeth K. Dillon
United States District Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF VIRGINIA
Harrisonburg Division

JOHN DOE 1, *et al.*, by and through their next friend, NELSON LOPEZ, on behalf of themselves and all persons similarly situated, *Plaintiffs,* v. SHENANDOAH VALLEY JUVENILE CENTER COMMISSION, *Defendant.*	Civil No. 5:17-cv-00097-EKD Judge Elizabeth K. Dillon

MEMORANDUM OF LAW IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

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RULES AND REGULATIONS

Plaintiffs John Doe 1, *et al.*, by and through their next friend, Nelson Lopez, by their undersigned attorneys, submit this Memorandum of Law in support of their Motion for Preliminary Injunction. For the reasons set forth below, Plaintiffs seek preliminary relief to suspend implementation of Defendant's excessive, abusive, and irreparably punitive and disciplinary practices and denial of adequate mental health care that continue to subject Plaintiffs to physical, emotional and psychological damage, in violation of fundamental constitutional norms.

INTRODUCTION AND STATEMENT OF THE CASE

On October 4, 2017, John Doe 1, the original named Plaintiff,[1] filed a Class Action Complaint, alleging that he and a class of similarly-situated unaccompanied immigrant children who are in the custody of the Office of Refugee Resettlement of the U.S. Department of Health and Human Services ("ORR") and detained by ORR at the Shenandoah Valley Juvenile Center ("SVJC"), an ORR contract facility owned and operated by the Defendant, have been subjected to conditions of confinement at SVJC that violate the Plaintiffs' constitutional rights. *See* ECF Dkt. No. 1.

Specifically, the Complaint asserted, on the basis of detailed allegations reflecting John Doe 1's experiences while in detention at SVJC beginning in April 2016, that he and the other immigrant detainees in custody at the facility were routinely subjected to: (i) race and national origin-related discriminatory practices by the facility's predominately white, non Spanish-speaking correctional staff; (ii) physical and verbal abuse, excessive physical force and excessive

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[1] The original Complaint was accompanied by a Motion seeking leave of the Court to permit John Doe to proceed in the litigation on an anonymous basis in order to shield his identity from public disclosure in light of his age and the nature of the matters alleged. The Court, without objection by the Defendant, granted the Motion on or about November 9, 2017. *See* ECF Docket No. 12.

solitary confinement and restraints, all as punishment for purported misconduct of any kind allegedly engaged in by the children; and (iii) a pervasive failure to provide even minimally adequate treatment with respect to an entire class of children traumatized by their past experiences, many of whom suffered from clearly manifesting mental illness in various levels of severity including, in some instances, very serious self-harm. *See generally*, ECF Dkt. No. 1, ¶¶ 39-98. These allegations served as the foundation for multiple claims seeking declaratory and injunctive relief on behalf of the class under the Fifth and Fourteenth Amendments to the U.S. Constitution and 42 U.S.C. § 1983. *See id.*, ¶¶ 105-147.

The Defendant, Shenandoah Valley Juvenile Center Commission ("Shenandoah" or "the Commission"), by counsel, filed its Answer to the original Complaint on November 3, 2017. *See* ECF Dkt. No. 8. The Answer did not include any Affirmative Defenses, *id.*, but generally denied the allegations of the Complaint. Notably, however, the Answer admitted:

- That the majority of SVJC staff members are Caucasian and do not speak Spanish;
- That the majority of the local juvenile offenders detained at SVJC are Caucasian and were born in the U.S.;
- That confinement and restraints are used when immigrant detainees fight with one another or fight with staff, and that "restraints are used when youth . . . engage in self-harm. . . .";
- That approximately two weeks after his arrival at SVJC, Plaintiff John Doe 1 "was evaluated by a psychologist . . . and diagnosed with conduct disorder, disruptive mood dysregulation. and depressive disorder";
- That "[s]ince his initial psychological evaluation, attention to Doe 1's mental health has been primarily provided by Evenor Aleman, a licensed professional counselor";
- That "Plaintiff [Doe 1] has engaged in self-harm by cutting his wrists and banging his head against the wall or floor while at SVJC";
- That, on or about August 21, 2017, "Plaintiff [Doe 1] wrapped a curtain around his neck . . . and that Plaintiff has repeatedly expressed a desire to kill himself";

- That "[o]ther immigrant youth have also engaged in cutting and other self-harming behaviors, including ingesting shampoo and attempting to choke themselves";

- That "SVJC staff are aware that Doe 1 and other immigrant youth engage in cutting and other self-harming behaviors . . . [and] have seen visible scarring on [Doe 1's] wrists, a distinct marker of self-mutilation, and [that] Doe 1 has reported these behaviors to Mr. Aleman on multiple occasions";

- That "[i]solating children who are suicidal is extremely damaging, and violates well-established professional standards"; and

- That "there is no legitimate penological interest or rational basis for subjecting Plaintiff and other immigrant youth to unequal treatment on the basis of their race . . . or national original."

See ECF Dkt. No. 8, ¶¶ 39, 69, 81-82, 86, 88-89, 91, 97, 138 and 145. The Defendant denied that any of these admitted facts would support a class action, ostensibly because "the factual allegations of the Complaint are particular to Plaintiff [Doe 1]." *Id.*, ¶ 101.

Following the filing of the Defendant's Answer, an Initial Rule 16 Conference was held on December 4, 2017, and counsel for the parties jointly submitted a proposed Scheduling Order on December 13, 2017. At the time of that submission, the parties advised the Court that Plaintiff John Doe 1 had been transferred to another ORR secure facility and requested a Status Conference at which the possible legal significance of that development could be addressed. During the January 9, 2018 Status Conference, Plaintiffs, without objection, were granted leave to amend their pleadings. *See* Minute Order (ECF Dkt. No. 16).

Plaintiffs filed their First Amended Complaint, incorporating the allegations of two additional named Plaintiffs, John Doe 2 and John Doe 3, on January 31, 2018. *See* ECF Dkt. No. 22. The Defendant answered the First Amended Complaint on February 14, 2018. ECF Dkt. No. 26.

As before, the Defendant did not raise any Affirmative Defenses. And, without altering any of its prior admissions with respect to the allegations of the original Complaint, Defendant acknowledged the following with respect to the allegations of John Doe 2 and John Doe 3:

- While he was detained at a prior facility, "Doe 2 saw a doctor and was diagnosed with attention deficit/hyperactivity disorder (ADHD), depression and anger management issues;"
- That Doe 2 engaged in self harm involving the creation of "superficial scratches on this [*sic*] arm due to feeling frustrated while housed at [the prior detention facility];"
- That Doe 3 "reported" being threatened with death by a gang in Honduras;
- That Doe 3 "has been restrained by SVJC staff members" when deemed by them to be "necessary to protect him from hurting himself and others;"
- That "[c]onfinement and restraints are used" at SVJC "when youth fight with one another or fight with staff" and that "restraints are used" at SVJC "when youth continue to engage in self-harm and less restrictive measures have been exhausted[.]";
- That "[Doe 3] has been confined in his room" purportedly "for a limited time while wearing boxers after he has [allegedly] destroyed his other clothes.";
- That "[Doe 2 and Doe 3] have been temporarily confined to their rooms without a mattress, [allegedly] for time periods of less than half a day," purportedly when they "have either destroyed their mattresses or are acting aggressively" in light of an alleged history of mattress destruction;
- That "an emergency restraint chair is utilized," purportedly "as the last step of a progressive response to aggressive behavior by residents," and that "[w]hen the emergency chair is utilized, residents are restrained by their arms, legs, and torso, and a spit mask is placed on the resident to prevent staff from being spit [*sic*] upon or bitten[.]";
- That Doe 2 "has been diagnosed with ADHD, major depressive disorder, conduct disorder, intermittent explosive disorder, and general anxiety disorder.";
- That, as with Doe 1, attention to Doe 2's mental health at SVJC has primarily been provided by Evenor Aleman, a licensed professional counselor; and
- That Doe 2 has engaged in self-harm at SVJC."

ECF Dkt. No. 26, ¶¶ 21, 22, 27, 75, 92(a), 92(b), 100(a), 100(b), 101(a), (b), 107(b), 109 and 114.

STATEMENT OF RELEVANT FACTS

A. Conditions Of Confinement at SVJC

Immigrant youth detained at SVJC uniformly describe a facility in which they are regularly, routinely subjected to verbal and physical abuse, harassing and taunting by staff and experience harsh, disproportionate discipline and punishment for behavioral issues that, in many instances, are either directly provoked by the abusive treatment they receive or are manifestations of mental health problems for which little, if any, treatment is provided. These conditions violate settled constitutional norms and deprive the Plaintiffs and all other immigrant detainees at SVJC of their entitlement to a reasonably safe environment free from harm and an excessive risk of harm.

1. Plaintiff John Doe 1

Plaintiff Doe 1, 17 years of age, was detained at SVJC from April 2016 to December 2017. *See* Plaintiffs' First Amended Class Action Complaint ("Am. Comp."), ¶¶ 6-12; Declaration of Doe 1, dated Jan. 17, 2018, ¶¶ 1, 5.[2] Doe 1 remains in the custody of ORR and is currently detained at the Northern Virginia Juvenile Detention Center ("NOVA"), from which he is subject to being retransferred to SVJC at any time. Am Comp., ¶ 12.

Soon after his arrival at SVJC in April 2016, Doe 1 was evaluated by a psychologist, Dr. Gustavo Rife, and was diagnosed with conduct disorder, disruptive mood dysregulation, and

[2] A redacted copy of Doe 1's sworn Declaration is attached to the publicly-filed version of this Memorandum as Exhibit 1 thereto. The unredacted version of Doe 1's Declaration will be filed under seal pursuant to W.D.Va. Gen. Local Rule 9 and this Court's Order entered February 26, 2018 (ECF Dkt. No. 30).

depressive disorder. Am Comp., ¶ 107; *compare* Defendant's Answer to Plaintiffs' First Amended Class Action Complaint ("Answer"), ¶ 107; *see also* Declaration of Doe 1, ¶ 6. Following his initial evaluation session with Dr. Rife, Doe 1 was not examined or treated by any psychologist during the remainder of his detention at SVJC. Am. Comp., ¶ 108; Answer, ¶ 108. Attention to Doe 1's mental health problems was provided solely by a staff member, Evenor Aleman, a counselor with whom Doe 1 generally met on a weekly basis. Am Comp., ¶ 109; Answer, ¶ 109.

Although Doe 1 never engaged in self-harm before he came to the United States, he learned this behavior by observing other children while in ORR custody and began to harm himself shortly after his arrival at SVJC. Am. Comp., ¶¶ 111-113; Answer, ¶¶ 111-113; Declaration of Doe 1, ¶¶ 23-29. Doe 1 cut his wrists with pieces of glass or plastic, and would sometimes bang his head against the wall or the floor when he was angry or sad. *Id.* Doe 1 told his counselor, Mr. Aleman, that he was harming himself and other staff were aware of this because they could see the scarring on Doe 1's wrists resulting from his self-mutilation. Am. Comp. ¶ 111; Answer, ¶ 111; *see also* Am. Comp., ¶¶ 119-121; Declaration of Doe 1, ¶ 24. Staff members advised Doe 1 on multiple occasions that they did not care that he was engaging in self-harm. *Id.*

On or about August 21, 2017, Doe 1 unsuccessfully attempted to commit suicide by hanging himself with a curtain. Am. Comp., ¶ 116; Answer, ¶ 116; Declaration of Doe 1, ¶ 27. SVJC responded not by providing Doe 1 with treatment or therapy, but rather by removing all of his clothes and placing him on restriction for several days. Am. Comp., ¶ 116; Declaration of Doe 1, ¶ 27.

Apart from its lack of appropriate responsiveness to Doe 1's repeated, glaring manifestations of mental illness, SVJC subjected Doe 1 to a variety of other forms of mistreatment. He was subject to verbal or physical abuse, or both, by staff on a regular basis. Declaration of Doe 1, ¶ 10. Adverse reactions by Doe 1 to such provocation were met with brutal beatings, placement in restraints – including, on multiple occasions, being strapped to a chair, sometimes for hours on end – and solitary confinement. ¶¶ 11, 14-17, 19-22. Doe 1 frequently saw other immigrant detainees at SVJC subjected to similar punitive measures. *Id.*, ¶ 18.

2. Plaintiff John Doe 2

Plaintiff Doe 2, a 16-year old, while detained in a facility in Texas prior to being transferred to SVJC in September 2017, was evaluated by a psychologist who told him he had ADHD, depression and anger management issues. Declaration of Doe 2, dated Jan. 5, 2018, ¶ 7.[3] Defendant admits that Doe 2 suffers from attention deficit hyperactivity disorder (ADHD), major depressive disorder, conduct disorder, intermittent explosive disorder, and general anxiety. Answer, ¶ 21. While in detention in Texas, feelings of extreme anger and/or sadness caused Doe 2 to begin engaging in self-harm. Declaration of Doe 2, ¶ 9; Answer, ¶ 22. After arrival at SVJC, Doe 2 was told he had been transferred there because of behavioral issues, and he was assigned to live in Alpha Pod, where the "bad" kids were sent. Declaration of Doe 2, ¶¶ 13-14.

Doe 2 experiences feelings of great anger and sadness resulting from his detention at SVJC. *Id.*, ¶ 24. When he has expressed his frustration with his circumstances, those

[3] A redacted copy of Doe 2's sworn Declaration is attached to the publicly-filed version of this Memorandum as Exhibit 2 thereto. The unredacted version of Doe 2's Declaration will be filed under seal pursuant to W.D.Va. Gen. Local Rule 9 and this Court's Order entered February 26, 2018 (ECF Dkt. No. 30).

expressions have been routinely met by staff with physical assaults, application of restraints, deprivation of possessions and isolation. *Id.*, ¶¶ 25, 29, 32-33. On at least one occasion, Doe 2 was punished by having his arms and legs strapped to a chair and some form of hood pulled down over his head and face over an extended period of time. *Id.*, ¶¶ 30-31, s*ee generally* Answer, ¶¶101(a),(b). He has suffered painful bruises on his wrists, his ribs and his shoulder as a result of physical force inflicted upon him by staff. *Id.*, ¶ 33.

3. Plaintiff John Doe 3

Plaintiff Doe 3, who is 15 years old, was transferred to SVJC in early August of 2017, only a few weeks after having been apprehended by ICE while crossing the border from Mexico into the U.S. after fleeing gang violence in his native Honduras. Am. Comp., ¶¶ 27-29; Declaration of Doe 3, dated Jan. 5, 2018, ¶¶ 1, 5.[4] *See also* Answer, ¶ 27. Since arriving at SVJC, Doe 3 has been place "on restriction" – *i.e.*, subjected to solitary confinement – more than 10 times "for any little thing." Declaration of Doe 3, ¶ 9. For holding the door and letting others enter the classroom before him, Doe 3 was subjected to verbal abuse and a physical assault by staff members, and then placed on restriction in his room, with his mattress, blanket and all clothing but his boxer shorts removed. *Id.*, ¶¶ 10-11; *see also* Answer, ¶¶ 75, 100(a) (admitting that Doe 3 was confined to room while only wearing boxers); 100(b)(admitting that Does 2 and 3 have been confined to their rooms without mattresses). Sometimes Doe 3 has been confined to his room in handcuffs and leg restraints, and he has been subjected to beatings by staff while restrained. Declaration of Doe 3, ¶¶ 13-15. He was restrained by being strapped to a chair on at

[4] A redacted copy of Doe 3's sworn Declaration is attached to the publicly-filed version of this Memorandum as Exhibit 3 thereto. The unredacted version of Doe 3's Declaration will be filed under seal pursuant to W.D.Va. Gen. Local Rule 9 and this Court's Order entered February 26, 2018 (ECF Dkt. No. 30).

least one occasion. *Id.*, ¶ 14; *see generally* Answer, ¶¶ 101(a), (b) (admitting use of "emergency restraint chair").

4. Former SVJC Detainees

The verbal and physical abuse, instances of excessive restraint and imposition of solitary confinement and failure to address mental health concerns recounted by Plaintiffs Doe 1, Doe 2 and Doe 3 are also reflected in the sworn factual accounts of other immigrant youth who previously spent time in detention at SVJC.

An especially harrowing account of some of the practices employed against immigrant detainees at SVJC is provided by J.A., a 15-year old who was detained at SVJC for several months. He relates:

> 6. At Shenandoah, they punished us by putting us in solitary confinement for long periods of time. If we got in a fight, refused to go to our rooms or to follow the program, or broke the rules in another minor way, they would put us in our rooms for weeks at a time. Three times, they put me into my room in solitary confinement for two weeks, and one time, they put me in my room for three and a half weeks. When we were in solitary confinement, they did not let us out for any reason, including to eat, take showers or use the bathroom. Each room had a bathroom which we used to do our necessities so we would not go out. We had to do all of that in our rooms. I didn't know of any way to appeal or challenge the staff's decision to put me into solitary confinement; no one seemed to pay attention to how they were treating us.
>
> 7. They also tied us to restraint chairs as punishment. One time, when I was at Shenandoah, I didn't want to go into my room. The staff members reacted by pushing me to the floor, and one of the staff members grabbed my head and forced my head down to the ground. Then they handcuffed me and put a white bag of some kind onto my head. They took off all my clothes and put me into a restraint chair, where they attached my hands and feet to the chair. They also put a strap across my chest. They left me naked attached to that chair for two and a half days, including at night. They took the bag off my head when they sat me down on the restraint chair. There were staff members in the room at times but they would leave me alone for a few hours. I do not remember very well. I never saw a doctor while I was in the chair or after they took me out.
>
> 8. I saw three other children tied to the restraint chair at different times. Each time, they were left there for about a day.

Declaration of J.A., dated Jan. 16, 2018, ¶¶ 6-8.[5]

Declarant D.M., now 20 years of age and free from ORR custody, reported a similar experience during a period of eight months of secure detention at SVJC commencing in 2014. By the time he was transferred to SVJC, D.M. was already diagnosed with "post-traumatic stress disorder, major depressive disorder, and bipolar disorder" as a result of psychological evaluation at a prior ORR detention facility. Declaration of D.M., dated Jan. 2, 2018, ¶ 14.[6] Notwithstanding this prior assessment, D.M. was not seen by a psychologist at SVJC until six weeks after his transfer there. *Id.* The mental health medications he had previously been determined to need were not provided by SVJC. *Id.* Moreover, outward manifestations of his mental illness at SVJC were met not with therapeutic treatment, but rather with punitive measures:

> 15. I had a lot of issues [at SVJC] because of my mental disorder. Whenever I was in crisis – if I was trying to hurt myself inside my cell, or saying things to someone no one else could see – they would drag me out of my cell and put me in the restraint chair. All I could see was them running for the chair.
>
> 16. Whenever they used to restrain me and put me in the chair, they would handcuff me. Strapped me down all the way; from your feet all the way to your chest, you couldn't really move. Handcuffs would have been enough. Once you're strapped down, they have total control over you.
>
> 17. They also put a bag over my head. It has little holes; you can see through it. But you feel suffocated with the bag on.
>
> * * *

[5] Redacted copies of the sworn Declarations referred to in this subsection are attached to the publicly-filed versions of this Memorandum as Exhibits 4-6 thereto. The unredacted versions of these Declarations will be filed under seal pursuant to W.D.Va. Gen. Local Rule 9 and this Court's Order entered February 26, 2018 (ECF Dkt. No. 30).

[6] *See* n.5, *supra*.

> 20. I saw two other cases, besides me where kids had to be put in the chair. It was when the guards had to break up a fight. I never had a fight in that place. I was placed in the chair when I was having a mental crisis.
>
> 21. *Every time I was in a crisis, they put me in the chair. The guards never did anything less extreme than that. . . .*

Id., ¶¶ 15-17, 20-21 (emphasis added).

A disturbingly consistent story is recounted by former SVJC detainee R.B., 18 years old, who also is no longer in ORR custody. R.B., who also had a preexisting diagnosis of mental illness before being transferred to SVJC, was determined to have additional mental health problems while there for which he was treated with serious psychotropic drugs. Declaration of R.B., dated Jan. 8, 2018, ¶ 19 ("They keep you drugged there.").[7] R.B. was at SVJC, to which he was transferred based on "behavioral problems," for a little over three months. During that time, R.B. says he had a fight at least once a week, "with a guard, another kid, or anybody who wanted to fight me – because I was so angry." *Id.*, ¶ 9. Whenever he fought, R.B. was physically restrained by SVJC staff and then subjected by them to the restraint chair, solitary confinement, or both. *See id.*, ¶¶ 12-17. On at least one occasion, when strapped into the restraint chair, R.B. had to urinate on himself because SVJC staff would not free him in order to use the bathroom. *Id.*, ¶ 15.

Although R.B. himself was not subject to provocation by staff during his time at SVJC, he "saw it happen with other kids. [The staff] would say things to them and challenge them until the kids got really mad and fought back. Then the kids would push the guard, and then the guard would grab both of the kid's arms and try to force them into a restraint. The guards were twice

[7] *See* n.5, *supra*.

the size of the kids, who were 13 or 14 years old, but [the guards] would use their full weight to push [the kids] to the ground. Sometimes it was two guards doing this to a little kid." *Id.*, ¶ 18.

B. Plaintiffs' Experts' Opinions

Gregory N. Lewis, Psy.D., is a licensed clinical psychologist with well in excess of twenty years of experience. *See* Report of Gregory N. Lewis, Psy.D., dated February 27, 2018, ("Lewis Rept."), ¶ 1 (copy attached hereto as Exhibit 7). Dr. Lewis has had extensive first-hand involvement in the assessment and evaluation of children who emigrated to the United States from Central American countries, many of whom were detained by U.S. Customs and Border Patrol, handed over the U.S. Immigration and Customs Enforcement ("ICE"), and eventually entrusted to the custody of ORR. In addition to his direct encounters with such children in connection with asylum and Special Immigrant Juvenile Status ("SIJS") proceedings, Dr. Lewis has served as a trainer in programs for Physicians for Human Rights, the Vera Institute of Florida, the Young Center for Immigrant Children's Rights and the Loyola Center for the Human Rights of Children with respect to the subject of forensic psychological evaluation of trauma in the context of asylum and immigration. Lewis Rept., ¶¶ 7-9. Dr. Lewis has also performed psychological evaluations of numerous unaccompanied minor immigrant children ("UACs") in his capacity as a consulting expert for the plaintiffs in two prior class action lawsuits against governmental detention facilities charged with mistreatment of the immigrant minors detained in those facilities. *Id.*, ¶¶ 11-16.

Apart from his work specific to immigrant children, Dr. Lewis has also, through his education, training and employment experiences, developed in-depth familiarity with the U.S. juvenile justice system and the standards governing the proper care and treatment of children affected by trauma and/or mental health problems within the context of that system, and he has both written and spoken on this subject matter. *Id.*, ¶¶ 1-3, 5.

Dr. Lewis first became familiar with the facts and circumstances of detention involving immigrant children at SVJC as a result of conducting a psychological evaluation of John Doe 1 in August 2017 for purposes of an unrelated Immigration Court proceeding. The evaluation was conducted for 10 hours over the course of two days and included an extensive interview as well as the administration of a battery of psychological tests and questionnaires. Dr. Lewis was also provided access to Doe 1's entire set of medical and mental health records as maintained by ORR. At the time of the evaluation, Doe 1 was a detainee at SVJC. *Id.*, ¶ 24 & Appendix A thereto.

As a result of his in-depth examination of Doe 1, Dr. Lewis learned that

> Doe 1 experienced many forms of repeated and prolonged abuse and punishment while in SVJC detention including teasing and physical abuse from staff, humiliation when being observed using the toilet, being confined to his room or restrained to a chair (sometimes with a mask put over his head) for long periods of time, and being forced to wear handcuffs and shackles. These actions on the part of staff replicated and exacerbated the abuse and teasing he experienced as a child from his father and his peers, and further traumatized Doe 1.
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> [I]t is my opinion that Doe 1's traumatic childhood history of abuse, neglect and teasing has been replicated while in detention. Individuals with this kind of history are extremely vulnerable to becoming emotionally and behaviorally dysregulated in situations where others are saying or doing things that are abusive and demeaning. Even such subtle interpersonal signals as a harsh look, a critical tone of voice, or a humiliating comment could be enough to trigger a traumatic reaction of "fight" of "flight" in someone like Doe 1.

Id., ¶¶ 36, 48. On the basis of these findings, Dr. Lewis concluded that the punitive treatment of John Doe 1 and SVJC's failure to respond appropriately to Doe 1's mental health needs were "abusive" and "exacerbated his prior trauma and caused additional long-term harm." *Id.*, ¶ 50.

As a supplement to his knowledge of the policies and practices in effect at SVJC obtained through his extended interaction with Doe 1, Dr. Lewis reviewed the sworn Declarations prepared by Plaintiffs John Doe 2 and John Doe 3, as well as three former SVJC detainees, J.A.,

R.B. and D.M. The accounts of those Declarants reprise the same sorts of experiences described by Doe 1 with respect to verbal abuse by staff, excessive physical assaults, application of restraints -- including subjection to time in the restraint chair -- and imposition of solitary confinement, resulting in feelings of anger, frustration, sadness, humiliation and manifestations of self-inflicted harm. *See generally id.*, ¶¶ 51-72.

Based on his education, training and substantial experiences in working with traumatized youth in general and immigrant children in particular, and his familiarity with contemporary professional standards of care governing practices in the juvenile justice system, Dr. Lewis has concluded that the Plaintiffs and the former-detainee Declarants all suffered grave mistreatment as a result of the punitive disciplinary measures to which each of them was subjected, and that each of them may have suffered harm of an unquantifiable nature. *Id.*, ¶ 91-99. Summarizing his findings in this regard, he made it clear that these were not merely isolated failures, but the consequence of deficient facility-wide practices:

> The predominant approach utilized at SVJC is that of punishment and behavioral control through such methods as solitary confinement, physical restraint, strapping to a restraint chair, and loss of behavioral levels. These approaches are not only unsuccessful, but are extremely detrimental to detained, traumatized youth -- especially to UACs. At times the use of solitary confinement and restraint chairs reached the level of what could be considered torture and other cruel, inhuman or degrading treatment or punishment. The use of these methods leads to a vicious cycle in which youth, who are already distrustful and traumatized, become further distrustful and traumatized when staff punish them. This leads them to act out even more and then justifies to the staff the need for further efforts to control and punish the youth.
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> . . . It is my opinion that the mental health care and overall care provided at SVJC are deficient and fall far short of the standards of care expected in the juvenile justice system, and that this represents deliberate indifference to the health and mental health needs of the Plaintiffs as well as other detainees at SVJC.

Id., ¶¶ 100, 104.

Importantly, Dr. Lewis noted that a readily achievable, well-established alternative to the harmful practices in effect at SVJC would be a "trauma-informed" model, which would bring the facility into compliance with baseline professional standards. *Id.*, ¶¶ 83-87.

Andrea Weisman, Ph.D., is a licensed clinical psychologist whose experience spans nearly 30 years. *See* Report of Andrea Weisman, Ph.D., dated February 27, 2018 ("Weisman Rept."), ¶ 1 (copy attached hereto as Exhibit 8). Dr. Weisman has worked with juveniles in corrections settings for over 25 years, including five years serving as the Chief of Health Services for the Department of Youth Rehabilitation Services of Washington, D.C. from 2007 to 2011. *Id.*, ¶ 2. She has been appointed to serve as the mental health expert for Court-appointed monitors overseeing the implementation of consent decrees addressing the reform of the juvenile justice systems of Pennsylvania, Illinois, Kentucky, California, Ohio and Maine. In Georgia, she assisted the U.S. Department of Justice in monitoring the implementation of a memorandum of understanding reached between the DOJ and the State, in connection with which her focus was on conditions of confinement to which juveniles were subject and the adequacy of the mental health services they were provided. *Id.*, ¶ 6. Dr. Weisman has written and spoken extensively on the issues of isolation and mental health services for juveniles involved in the justice system, including testimony before the U.S. Congress in 2007 on mental health issues in the juvenile justice system. *Id.*, ¶ 7; *see generally* Weisman Rept., Exhibit A (curriculum vitae).

Based upon her review of the Declarations of the Plaintiffs and the former-detainee Declarants, Dr. Lewis' Report, and her own substantial education and training, her significant level of familiarity with applicable professional standards and her professional experiences directly pertinent to the subject matter, Dr. Weisman has formed opinions concerning the disciplinary and punitive practices employed by the staff at SVJC in their interactions with the

immigrant children detained there. She is especially concerned with the widespread imposition of solitary confinement at SVJC, due to the particular risk of harm that this pernicious practice poses to youth due to their psychological and physiological immaturity:

> It is my opinion, within a reasonable degree of certainty in the field of clinical psychology that all juveniles subjected to the SVJC policy and practice of solitary confinement . . . are at a substantial risk of serious harm to their social, psychological, and emotional development.
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> Due to their developmental vulnerability, solitary confinement causes juveniles much greater harm than does such confinement of adults, and the risks of solitary confinement to juveniles are alarming.

Weisman Rept. at 5-6. *See also id.* at 9 ("Medical professionals, including organizations like the American Medical Association, agree that juveniles with mental illnesses should not be placed in solitary confinement for longer than one hour without a comprehensive evaluation from a physician. *Solitary confinement should never be used to punish people with mental illness*." Emphasis added.)).

Beyond the concern with use of solitary confinement, Dr. Weisman also criticized SVJC staff's routine engagement in excessive verbal and physical abuse of immigrant detainees at the facility and its use of restraints, concluding that "[t]hese overly punitive and degrading practices at SVJC lead to a culture within which youth cannot possibly be rehabilitated[,] which is the mandate of juvenile correctional facilities." *Id.* at 10. In summary, she opines that "[t]he practices employed by the SVJC create a hostile and punitive environment that runs counter to all national standards. While implementation of an adequate mental health program may take time, these practices must cease immediately." *Id.* at 14. Like Dr. Lewis, Dr. Weisman outlined the essential components needed to bring SVJC into compliance with applicable national standards, also drawing on the framework for a trauma-informed approach, including those

necessary for proper screening, assessment, basic mental health treatment, staff training and grievance procedures for minor detainees. *Id.* at 11-13.

GOVERNING LEGAL STANDARD

Courts in the Fourth Circuit have expressly adopted and follow the four-part test for preliminary injunctive relief articulated by the Supreme Court of the United States in *Winter v. Natural Resources Defense Council, Inc.*, 555 U.S. 7 (2008). *See Metro Reg'l Info. Sys., Inc. v. Am. Home Realty Network, Inc.*, 722 F.3d 591, 595 (4th Cir. 2013); *Real Truth About Obama, Inc., v. FEC*, 575 F.3d 342, 346 (4th Cir. 2009), *vacated on other grounds*, 559 U.S. 1089 (2010). As set forth in *Winter*, in order to obtain a preliminary injunction, the moving party must establish:

(i) that it has a likelihood of success on the merits;

(ii) that it has suffered and will continue to suffer irreparable harm absent the granting of preliminary relief;

(iii) that a balancing of the relevant equities weighs in its favor; and

(iv) that the issuance of a preliminary injunction is consistent with the public interest.

555 U.S. at 20; *Metro Reg'l Info. Sys.*, 722 F.3d at 595; *Real Truth About Obama*, 575 F.3d at 346; *Draego v. City of Charlottesville, VA*, No. 3:16-cv-00057 NKM, 2016 WL 6834025, at *23 (W.D. Va. Nov. 18, 2016); *Handsome Brook Farm. LLC v. Humane Farm Animal Care, Inc.*, 193 F.Supp.3d 556, 565-66 (E.D. Va. 2016), *aff'd*, 700 F. App'x 251 (4th Cir. 2017). All four factors must be satisfied for the movant to be awarded preliminary injunctive relief. *Id.*

As an initial matter under the *Winter* analysis, a plaintiff seeking a preliminary injunction must make a "clear showing" that he or she is likely to succeed at trial on the merits of his or her claim(s). *Di Biase v. SPX Corp.*, 872 F.3d 224, 230 (4th Cir. 2017); *Pashby v. Delia*, 709 F.3d 307, 321 (4th Cir. 2013). The courts are careful to note, however, that this "clear showing"

standard does *not* amount to a requirement that the plaintiff show that he/she is *certain* to succeed. *Pashby*, 709 F.3d at 321 ("plaintiffs need not show a certainty of success").

Next, *Winter* requires plaintiffs to show that "irreparable injury is likely in the absence of an injunction." 522 U.S. at 22. Absent the requisite showing of irreparable harm, equitable relief in the form of a preliminary injunction may not be granted. *SAS Inst., Inc., v. World Programming Ltd.*, 874 F.3d 370, 386 (4th Cir. 2017), *citing City of Los Angeles v. Lyons*, 461 U.S. 95, 111 (1983). A clear showing of existing or imminent harm, neither specifically quantifiable nor readily compensable by monetary relief alone, must be made in order to satisfy the second *Winter* element; the mere possibility of irreparable harm will not suffice. *Handsome Brook Farm*, 700 F. App'x at 263 ("[Plaintiff] must show that the likelihood of irreparable harm rises above the threshold of mere possibility and is likely to occur if the request is denied."); *see also Signature Flight Support Corp. v. Landow Aviation Ltd P'ship*, 442 F. App'x 776, 785 (4th Cir. 2011) (noting that *Winter* standard for irreparable harm is satisfied by plaintiff's demonstration of "harm in fact"); *Potomac Conf. Corp. of Seventh-Day Adventists v. Takoma Acad. Alumni Ass'n. Inc.*, No. Civ. A. DKC 13-1128, 2014 WL 857947, at *19 (D. Md. March 4, 2014) (irreparable harm cannot be "remote nor speculative" but rather must be "actual and imminent").

Finally, the moving plaintiffs must show that the balance of the equities (or the "balance of hardships" as expressed by some courts) weighs in their favor, and that a preliminary injunction is favored by or consistent with the public interest. These last two elements of the *Winter* test are frequently considered together by the courts. *See, e.g., Centro Tepeyac v. Montgomery Cty.*, 722 F.3d 184, 191 (4th Cir. 2013). Where, as here, the underlying premise for the request for preliminary injunctive relief is alleged conduct violative of constitutional rights,

courts in the Fourth Circuit have repeatedly acknowledged that the equities favor the granting of relief. *See, e.g., Giovani Carandola, Ltd. v. Bason*, 303 F.3d 507, 521 (4th Cir. 2002) ("[A] state is no way harmed by issuance of a preliminary injunction which prevents [it] from enforcing restrictions likely to be found unconstitutional." (Citations and internal quotations omitted.)); *Draego*, 2016 WL 6834024, at *23 (concluding that "the balance of harms . . . weighs exclusively in Plaintiff's favor" because there was no chance that the city government could be harmed by a preliminary injunction "which prevents it from enforcing a regulation . . . likely to be found unconstitutional."). Accordingly, to the extent the Plaintiffs here satisfy the "likelihood of success" and "irreparable harm" elements of the *Winter* analysis, it follows that the balance of equities and public interest will strongly favor the granting of the preliminary injunction they seek. *See generally Newsom ex rel. Newsom v. Albermarle Cty. Sch. Bd.*, 354 F.3d 249, 261 (4th Cir. 2003) ("upholding constitutional rights serves the public interest"); *accord Centro Tepeyac*, 722 F.3d at 191.

A threshold matter to be considered in the Court's determination as to the rigor with which the four *Winter* factors are to be applied concerns the particular nature of the preliminary injunction sought. Whether a preliminary injunction is "mandatory" or "prohibitory" in nature affects the strictness with which courts will conduct their inquiry and dictates the standard of appellate review. *See Pashby*, 709 F.3d at 320; *Handsome Brook Farm*, 193 F.Supp.3d at 566; *Draego*, 2016 WL 6834025, at *24. Here, Plaintiffs submit that the preliminary injunction they seek is primarily prohibitory in nature; such injunctions "aim to maintain the status quo and prevent irreparable harm while [the] lawsuit remains pending." *Pashby*, 709 F.3d at 319. The Fourth Circuit has defined the "status quo" for these purposes as "the last uncontested status between the parties which preceded the controversy." *Id.* at 320, *quoting Aggarao v. MOL Ship*

Mgmt. Co., 675 F.3d 355, 378 (4th Cir. 2012). Here, such "last uncontested status" with respect to the Plaintiffs was when they and those they seek to represent were transferred to SVJC, and prior to the onset of application of the practices and procedures challenged as unconstitutional herein against those individuals. The preliminary injunction sought by the Plaintiffs would foreclose SVJC's continuing employment of those inherently injurious practices and procedures against the Plaintiffs during the pendency of this action. *See generally Wetzel v. Edwards*, 635 F.2d 283, 286 (4th Cir. 1988) (mandatory preliminary injunctions compel rather than prohibit action).

Lastly, under Fed. R. Civ. P. 65(c), a preliminary injunction can be granted only if the movant provides some form of security in order to protect the defendant from costs incurred in the event it is subsequently determined that the injunction was improperly granted. In the Fourth Circuit, "the district court retains the discretion to set the bond in the amount it sees fit or waive the security requirement." *Pashby*, 709 F.3d at 332. That discretion may, upon due consideration, be exercised to excuse a bond requirement under appropriate circumstances, such as those presented in this case, wherein the Plaintiffs plainly lack financial resources. *See, e.g., Draego*, 2016 WL 6834025, at *24 (bond waived where plaintiff was "an ordinary citizen unable to post anything more than a nominal bond," but had a strong case on the merits "and the injunction will result in little to no harm to the government" (*citing Doe v. Pittsylvania Cty., VA*, 842 F.Supp.2d 927, 937 (W.D.Va. 2012) (setting bond at $0 where municipality had little likelihood of success and would suffer no harm for injunction)).

ARGUMENT

THE INFLICTION OF IMPROPER, EXCESSIVE AND INHERENTLY INJURIOUS FORMS OF DISCIPLINE AND PUNISHMENT UPON TRAUMATIZED, OFTEN MENTALLY ILL PLAINTIFFS AT THE DEFENDANT'S FACILITY SHOULD BE ENJOINED PENDING RESOLUTION OF THIS ACTION

1. The Plaintiffs Are Substantially Likely to Succeed On the Merits Of Their Constitutional Claims That The Defendant Used Excessive, Inappropriate Forms Of Discipline And Punishment, And Improperly Denied Them Adequate Medical Care

As addressed above, Plaintiffs must first demonstrate a "clear showing" that they are likely to succeed on the merits of their claims. *Winter*, 555 U.S. at 22; *Di Biase*, 872 F.3d at 230. Accordingly, Plaintiffs must demonstrate that they are likely to prevail on their contentions that, in subjecting them and other putative class members at SVJC to (1) the excessive forms of discipline and punishment routinely imposed by the staff at the facility, and (2) withholding from the Plaintiffs and similarly-situated immigrant youth at the facility adequate mental health care, the Defendant has violated and continues to violate Plaintiffs' substantive rights under the Fifth Amendment, as made applicable to the States by the Fourteenth Amendment.

> The Due Process Clause of the Fourteenth Amendment bars States from "depriv[ing] any person of life, liberty or property, without due process of law." U.S. Const. amend. XIV, § 1. The Clause "guarantees more than fair process." *Troxel v. Granville*, 530 U.S. 57, 65 (2000) (plurality opinion) (internal quotation marks omitted). It "also includes a substantive component that provides heightened protection against government interference with certain fundamental rights and liberty interests." *Id.* (internal quotation marks omitted); *see County of Sacramento v. Lewis*, 523 U.S. 833, 840 (1998) (The Due Process Clause "cover[s] a substantive sphere as well, barring certain government actions regardless of the fairness of the procedures used to implement them." (internal quotation marks omitted); *Love v. Pepersack*, 47 F.3d 120, 122 (4th Cir. 1995) ("Substantive due process . . . is an absolute check on certain governmental actions notwithstanding the fairness of the procedures used to implement them." (internal quotation marks omitted)).

Doe ex rel. Johnson v. S.C. Dep't of Soc. Servs., 597 F.3d 163, 170 (4th Cir. 2010); *accord D.B. v. Cardall*, 826 F.3d 721, 740 (4th Cir. 2016). Notwithstanding their status as currently

undocumented immigrants, there is no question that the Plaintiffs are entitled to the protections afforded by the Due Process Clause. *See generally Zavydas v. Davis*, 533 U.S. 678, 693 (2001) ("[T]he Due Process Clause applies to all 'persons' within the United States, including aliens, whether their presence here is lawful, unlawful, temporary or permanent. *See Plyler v. Doe*, 457 U.S. 202, 210 (1982); *Matthews v. Diaz*, 426 U.S. 67, 77 (1976); *Kwong Hai Chew v. Colding*, 344 U.S. 590, 596-98 & n.5 (1953); *Yick Wo v. Hopkins*, 118 U.S. 356 (1886)."); *accord Santos v. Smith*, 260 F. Supp. 3d 598, 609 (W.D. Va. June 1, 2017) (*citing Zavydas*).

A. Excessive Physical Force

The Plaintiffs' "liberty interests" subject to protection under substantive due process principles include the right to be free from excessive physical abuse and punishment at the hands of State actors such as staff members at SVJC. *See Gisbert v. U.S. Att'y Gen.*, 988 F.2d 1437, 1442 (5th Cir. 1993) ("[W]hatever due process rights excludable aliens may be denied by virtue of their status, they are entitled under the due process clauses of the fifth and fourteenth amendments to be free from gross physical abuse at the hands of state or federal officials." (*citing Lynch v. Cannatella*, 810 F.2d 1363, 1374 (5th Cir. 1987)). The same protections apply to detained juveniles generally. *Alexander S. ex rel. Bowers v. Boyd*, 876 F. Supp. 773, 797-98 (D.S.C. 1995) ("[T]he Due Process Clause guarantees to juveniles who are incarcerated the right to reasonably safe conditions of confinement [and] freedom from unreasonable bodily restraint[.] . . . Safety, in [this] context . . . encompasses the Plaintiffs' right to reasonable protection from the aggression of others, whether 'others' be juveniles or staff." (Citations omitted.)); *see generally Schall v. Martin*, 467 U.S. 253, 269 (1984) (it is "axiomatic" that "particular restrictions and conditions of confinement amounting to punishment" are unconstitutional if imposed upon juveniles in pretrial detention).

While the foregoing authorities clearly establish that the rights the Plaintiffs seek to vindicate pursuant to the claims asserted in their First Amended Complaint are cognizable and subject to protection under the Due Process Clause, Plaintiffs must also show that the nature of the Defendant's conduct, in alleged abrogation of those rights, meets the heightened standard pursuant to which liability may be imposed for a constitutional violation. In this regard, "there are 'two strands of the substantive due process doctrine.' The first strand protects rights that are 'fundamental,' whereas the second 'protects against the exercise of governmental power that shocks the conscience.'" *Cardall*, 826 F.3d at 740, *quoting Seegmiller v. LaVerkin City*, 528 F.3d 762, 767 (10th Cir. 2008). Elaborating on the latter "strand" of substantive due process analysis, which the Plaintiffs have invoked here,[8] the Court of Appeals, in *Patten v. Nichols*, 274 F.3d 829 (4th Cir. 2001), stated as follows:

> The substantive component of the due process clause protects against only the most egregious, arbitrary governmental conduct -- that is, conduct that can be said to "shock[] the conscience." *County of Sacramento v. Lewis*, 523 U.S. 833, 846 (199); *see also Young v. City of Mount Ranier*, 238 F.3d 567, 574 (4th Cir. 2001). Depending on the circumstances of each case, however, "different degrees of fault may rise to the level of conscience-shocking." *Young*, 238 F.3d at 574; *see Lewis*, 523 U.S. at 850 ("Rules of due process are not, however, subject to mechanical application in unfamiliar territory. Deliberate indifference that shocks in one environment may not be so patently egregious in another. . . ."): *Miller v. City of Philadelphia*, 174 F.3d 368, 375 (3d Cir. 1999) ("The exact degree of wrongfulness necessary to reach the 'conscience-shocking' level depends upon the circumstances of a particular case."). *While it is clear that intentionally harmful conduct may constitute a violation of the Fourteenth Amendment,* it is equally clear that negligence alone does not amount to a constitutional violation. *See Lewis*, 523 U.S. at 849 ("[L]iability for negligently inflicted harm is categorically beneath the threshold of constitutional due process. . . . *[C]onduct intended to injure in some way unjustifiable by any governmental interest is the sort of official action most likely to rise to the 'conscience-shocking' level.*").

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[8] *See* First Amended Complaint (ECF Dkt. No. 22), ¶ 1 ("Plaintiffs and other similarly situated young people at SVJC are subjected to unconstitutional conditions that shock the conscience, including violence by staff, abusive and excessive use of seclusion and restraints, and denial of necessary mental health care.").

Id. at 834 (emphasis added).

In determining whether the Plaintiffs' claims premised upon the Defendant's use of excessive physical force and the imposition of restraints upon them and other similarly-situated immigrant youth detained at SVJC implicate unconstitutional "conscience-shocking" conduct on the Defendant's part, trial courts are to apply the standard of "objective reasonableness" endorsed by the Supreme Court in *Kingsley v. Hendrickson*, 135 S. Ct. 2466 (2015). In *Kingsley*, presented with the question of whether a physical altercation between jail officers and a suspected drug offender under pretrial detention involved the use of excessive force in violation of the detainee's substantive due process rights under the Fourteenth Amendment, the Court had to decide whether the applicable standard by which the officers' conduct should be judged was "objective reasonableness" under the circumstances alleged, or whether a subjective standard should apply under which the plaintiff would have to plead and prove "that the use of force was not 'applied in a good faith effort to maintain or restore discipline' but, rather, was applied 'maliciously and sadistically to cause harm.'" 135 S. Ct. at 2469, 2475 (citations omitted).

Noting that the intentional nature of the officers' acts constituting force was not in dispute, but only whether or not the acts were *excessive*, the Court embraced the proposition "that a pretrial detainee must show only that the force purposely or knowingly used against him was objectively unreasonable." *Id.* at 2473. In so holding the Court acknowledged that "objective reasonableness turns on the 'facts and circumstances of each particular case,'" and noted that the Court's determination must be made "from the perspective of a reasonable officer on the scene, including what the officer knew at the time, not with the 20/20 vision of hindsight." *Id.*; *see generally Dilworth v. Adams*, 841 F.3d 246, 255-56 (4th Cir. 2016); *Oliver v. Baity*, 208 F. Supp. 3d 681, 695 (M.D.N.C. 2016).

Observing that some degree of deference is due the relevant governmental entity's interest in maintaining internal order, discipline and security, the Court stated:

> Considerations such as the following may bear on the reasonableness or unreasonableness of the force used: the relationship between the need for the use of force and the amount of force used; the extent of the plaintiff's injury; any effort made by the officer to temper or limit the amount of force; the severity of the security problem at issue; the threat reasonably perceived by the officer; and whether the plaintiff was actively resisting. We do not consider this list to be exclusive. We mention these factors only to illustrate the types of objective circumstances potentially relevant to a determination of excessive force.

Kingsley, 135 S. Ct. at 2473 (citation omitted).

Assessing Plaintiffs' evidence, as set forth in sworn Declarations, regarding the physical assaults and exposure to restraints to which they have been and continue to be subjected at SVJC in light of the considerations outlined in *Kingsley*, the conclusion is inescapable that the degree of force in use against minor immigrant detainees at the facility is excessive and objectively *unreasonable*. Even assuming, for the sake of argument, that the use of some level of force on the part of SVJC's adult staff is occasionally necessary to break up a fight between detainees or to control a child manifesting temperamental behavior, nothing in the nature of the brutal physical abuse related by the Plaintiffs and supporting Declarants is warranted as a response to the circumstances to which they attest.

Indeed, applying the factors set forth in *Kingsley*, it is clear that the amount of force used by SVJC staff on detainees is consistently grossly disproportionate to the "need" for such force. Each of the Plantiffs and several of the Declarants describe incidents in which they were shoved to the ground (or headfirst into a concrete wall) by one or several adult staff members, who were much larger than them in size, for any perceived slight. Doe 1, while at SVJC, was subject to verbal and physical abuse by staff on a regular basis. Any adverse reaction on his part was met with brutal beatings, including being shoved to the floor by several staff members at one time

and hit in the abdomen after having "pushed" a staff member who had repeatedly taunted him. Declaration of Doe 1, ¶¶10-11; *see also* ¶¶ 14-17, 19-22. Doe 2 reports that when he has expressed his frustration with being detained at SVJC, those expressions have been routinely met by staff with physical assaults, including having his face pushed into the wall while he was handcuffed and being poked in the ribs and grabbed by the jaw by three or four staff members at a time. Declaration of Doe 2, ¶¶ 25, 29, 32. For merely holding a door open for others entering a classroom, Doe 3 was physically assaulted by staff and then solitarily confined to his room with his mattress, blanket and all clothing but his boxer shorts removed. Declaration of Doe 3, ¶¶ 10-11.

The Declarations of former SVJC detainees attest to virtually the same adverse experiences. For resisting going to his room, Declarant J.A. was physically assaulted, handcuffed, stripped naked and bound to a restraint chair for multiple days. Declaration of J.A., ¶¶ 6-8. He noted that he and other immigrant children at SVJC were frequently placed in solitary confinement in their rooms for *weeks at a time* for breaking the rules in any "minor way." *Id.* Declarant D.M. similarly described how youths were placed in solitary confinement in their rooms for such trivial offenses as not reading a book. Declaration of D.M., ¶ 8. Such brutal applications of force scarcely could have been deemed necessary to respond to the threats allegedly posed by frustrated adolescents who failed to follow staff directives.

Defendant's regular and prolonged use of a restraint chair for behavioral incidents that are similarly minor, and often manifestations of serious mental health problems, is especially harrowing. Declarant D.M. was dragged bodily out of his room and placed in a restraint chair with a suffocating bag over his head in response to behavior reflecting his mental health problems. Declaration of D.M., ¶¶ 15-17, 20-21. Declarant R.B., who admits frequent

behavioral problems attributed to his mental illness and anger issues, was physically restrained and subjected to the restraint chair, solitary confinement, or both, by staff. Declaration of R.B., ¶¶ 12-17. Moreover, it is evident that youths remain restrained long after any perceived threat posed by their behaviors has dissipated, as youths describe having been placed in the restraint chair for hours at a time – sometimes after having been stripped of their clothing. Declaration of Doe 1, ¶¶14-15; Declaration of Doe 3, ¶ 14; Declaration of J.A., ¶¶ 7-8; Declaration of D.M, ¶ 19.

Both of Plaintiffs' expert witnesses found SVJC's use of restraints and brutal force contrary to all known professional standards and clearly repugnant. Dr. Weisman stated unequivocally that the practices violate national standards. Weisman Rept. at 9 ("National standards do not allow staff members to 'slam' youth against the wall, excessively shackle and restrain youth and use derogatory language in describing immigrant youth."), 14; *see also* Lewis Rept., ¶ 54 (confinement, restraint and brutalizing of Doe 3 "fall below all professional standards of which I am aware); ¶ 62 (use of chair restraint for Declarant J.A. "highly unusual" and "borders on a form of torture"); ¶ 67 (R.B.'s experience with solitary and chair restraint "a form of torture and cruel, degrading punishment); ¶ 71 (same comment with respect to Declarant D.M.); *see also* ¶¶ 95-103.

Notwithstanding the emotional and psychological harms that such practices impose on traumatized youths, which is discussed more fully below, the assaults and excessive and inappropriate use of restraints have left Plaintiffs with physical injuries, including bruising (Declaration of Doe 1, ¶¶ 19, 21; Declaration of Doe 2, ¶ 33 ("The force used by staff has left bruises on my wrists, on my ribs, and on my shoulder. The doctor here gave my ibuprofen for the pain."); Declaration of Doe 2, ¶ 13) and sleeplessness due to pain from restraints (Declaration of

Doe 3, ¶ 13), which further underscores the unreasonableness of the force used. These recitations do not present a close question in terms of describing situations in which a "reasonable officer" would conclude that it was "objectively reasonable" to engage in the forms and types of brutal force to which the Plaintiffs -- *children*, and neither criminals nor the subject of criminal charges -- have been subjected.

Indeed, the conduct engaged in by SVJC staff constitutes the kind of force applied "maliciously and sadistically to cause harm" that would meet the *subjective* standard rejected by the Court in *Kingsley*. Plaintiffs and the Declarants repeatedly describe how staff goad children into acting out, to which predictable behavior staff members respond with disproportionately harsh physical restraint and beatings. *See, e.g.,* Declaration of Doe 1, ¶¶ 10, 11 (describes mocking by staff, noting that "[t]hey were always trying to provoke me"); Declaration of Doe 3, ¶ 16 ("I think they do things to make me angry so that I will hit them and then charges will be pressed and I will get a longer sentence"); Declaration of J.A., ¶ 5 (staff would say ugly things "to try to make me mad and to act out. I saw them do similar things to the other kids who were there."); Declaration of R.B. ¶ 18 (saw guards pick fights with other kids: "They would say things to them and challenge them until the kids got really mad and fought back"). For these reasons, the Plaintiffs have made a "clear showing" of likelihood of success on the merits of their claims that the physical discipline and punishment in which Defendant's staff at SVJC regularly engage "shock the conscience" and violate the Plaintiffs' substantive due process protections.

B. Denial Of Adequate Mental Health Treatment

A similar conclusion is warranted, albeit under a different analytical standard, regarding the way SVJC staff inadequately – indeed, harmfully -- addresses the serious mental health needs of the Plaintiffs and other immigrant youth detained there. A common characteristic of the unaccompanied minor immigrants detained at SVJC is the extent to which they experience

psychological (if not physical) trauma in their home countries or en route from those countries to the U.S. border, long before their entered detention at SVJC. *See* Lewis Rept., ¶¶ 18-19. In fact, Plaintiffs Doe 1 and Doe 2, and Declarants D.M. and R.B., were all diagnosed with serious mental illnesses before they were transferred to SVJC. *See* Declaration of Doe 1, ¶ 3; Declaration of Doe 2, ¶ 7; Declaration of D.M., ¶ 14; Declaration of R.B., ¶ 19. Accordingly, it is clearly known to the Defendant that children entrusted to its care and custody often struggle with serious mental health problems and are in need of appropriate attention and treatment.

Defendant's obligation to provide mental health care constitutionally adequate to meet the needs of Plaintiffs and other similarly situated immigrant detainees, all of whom are civil detainees, is governed by the "professional judgment" standard established by *Youngberg v. Romeo*, 457 U.S. 307 (1982), and its progeny. In *Youngberg*, the Supreme Court addressed "the substantive rights of involuntarily committed mentally retarded persons under the Fourteenth Amendment[.]" 457 U.S. at 314-15. The respondent did not challenge his commitment, but "argue[d] that he has a constitutionally protected liberty interest in safety, freedom of movement, and training within the institution, and that petitioners infringed these rights by failing to provide constitutionally required conditions of confinement." *Id.* at 315.

Noting that "whether respondent's constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests," and that "if there is to be any uniformity in protecting these interests, this balancing cannot be left to the unguided discretion of a judge or jury," (*id.* at 321), the Court set about determining the proper standard to apply. *Id.* It found guidance in the concurring opinion of then-Chief Judge Seitz of the Third Circuit in the *en banc* appellate proceedings that had taken place below. *Id.* In this regard, the Court stated as follows:

> We think the standard articulated by Chief Judge Seitz affords the necessary guidance and reflects the proper balance between the legitimate interests of the State and the rights of the involuntarily committed to reasonable conditions of safety and freedom from unreasonable restraints. He would have held that "the Constitution only requires that the courts make certain that professional judgment in fact was exercised. It is not appropriate for the courts to specify which of several professionally acceptable choices should have been made." 644 F.2d [147], 178 [3d Cir. 1980) (*en banc*)].
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> By so limiting judicial review of challenges to conditions in state institutions, interference by the federal judiciary with the internal operations of these institutions should be minimized. Moreover, there certainly is no reason to think judges or juries are better qualified than appropriate professionals in making such decisions. For these reasons, the decision, if made by a professional, is presumptively valid; *liability may be imposed only when the decision by the professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a [professional] judgment.*

Id. at 321-23 (emphasis added; citations omitted). The Fourth Circuit and district courts therein have embraced and applied the *Youngberg* "professional judgment" standard in subsequent cases involving involuntary civil commitments that can be analogized to the plight of the Plaintiffs and members of the putative class they seek to represent in the case at bar. *See, e.g., Patten*, 274 F.3d at 845-46 (holding that involuntarily committed psychiatric plaintiff's Section 1983 denial of medical care claim should be determined on the basis of the *Youngberg* "professional judgment" standard, not the Eighth Amendment "deliberate indifference" standard applicable to the unconstitutional medical care claims of prisoners); *Alexander S.*, 875 F. Supp. at 798 (holding that claims of class of juvenile offenders concerning unconstitutional conditions of confinement in violation of substantive due process rights should be resolved by application of the *Youngberg* "professional judgment" standard); *cf. Heyer v. U.S. Bureau of Prisons* 849 F.3d 202, 209 n.6 (4th Cir. 2017) (holding, in case involving civil detainee sexual offender's claim that the Bureau of Prison's failure to provide sign language interpreters for deaf persons'

interactions with medical personnel constituted deliberate indifference to his serious medical needs, that the Court need not decide whether the *Youngberg* "professional judgment" standard should have been applied since the claimant's "evidence is sufficient to support a finding of deliberate indifference").[9]

Here, SVJC's clear failure to afford a trauma-informed treatment environment to detained immigrant children known to be affected by mental health problems, and its routine response to the children's outward manifestation of those problems with vicious physical abuse and knee-jerk punitive imposition of restraints and solitary confinement, undoubtedly constitute the "substantial departure from accepted professional judgment, practice [and] standards" held constitutionally actionable and violative of substantive due process rights in *Youngberg*. Plaintiffs' experts, Dr. Lewis and Dr. Weisman, have both explained that established professional standards in the field of clinical psychology governing the treatment of traumatized, mentally ill minors, particularly detainees such as the Plaintiffs, dictate the application of a trauma-informed approach. *See* Lewis Rept., ¶¶ 83-97 & nn.25-33; Weisman Rept. at 9-13. Both experts emphasize the extent to which punitive responses to behavioral manifestations of traumatized children's mental illness in general, and the use of solitary confinement in particular, depart from the accepted standard of care in the profession.

Dr. Lewis and Dr. Weisman found that SVJC's punitively-focused responses have severely exacerbated known mental illness, and pose a continuing, significant risk of permanent emotional and psychological harm to minors subjected to such practices. Both opined that Plaintiffs and Declarants have been denied adequate mental health treatment. Lewis Rept., ¶ 92

[9] In their First Amended Complaint, Plaintiffs have pled this claim under both the "deliberate indifference" standard (Am. Comp., ¶¶ 144-152) and the "professional judgment" standard (*id.*, ¶¶ 153-161). For purposes of this Motion, Plaintiffs seek relief under the *Youngberg* standard.

(mental health care provided to Doe 1 at SVJC was deficient), ¶ 99 (D.M. "did not receive appropriate mental health care for his conditions"); ¶ 104 ("[T]he mental health care and the overall care provided at SVJC are deficient and fall far short of the standards of care expected in the juvenile justice system, and . . . this represents deliberate indifference to the health and mental health needs of the Plaintiffs, as well as the other detainees at SVJC."); Weisman Rept. at 5 (solitary confinement practices place children at SVJC at substantial risk for serious harm to their social, psychological and emotional development). These deficiencies are not limited to individual detainees' circumstances, but are pervasive and systemic. Lewis Rept., ¶ 100; *see also* Weisman Rept. at 14 ("The practices employed at SVJC create a hostile and punitive environment that runs counter to all national standards.").

In sum, there is nothing to suggest that the exercise of professional judgment plays *any role whatsoever* in the reactive manner in which SVJC staff responds to serious, known mental health needs through punitive measures, including inflicting physical force, restraints and isolation. Indeed, there is overwhelming evidence to the contrary. In light of the evidence supporting these conclusions, the Plaintiffs have clearly shown that they have a substantial likelihood of success on the merits of their claim that the Defendant's failure to provide an adequate, appropriate level of care to address their serious mental health needs violates their substantive due process rights.

2. The Plaintiffs Are Suffering Irreparable Harm As A Result Of The Defendant's Practices As To Which An Injunction Is Sought

An integral element of a movant's showing that preliminary injunctive relief is warranted is its demonstration that "irreparable injury is likely in the absence of an injunction." *Winter*, 522 U.S. at 22; *see SAS Inst.*, 874 F.3d at 386; *Handsome Brook Farm*, 700 F. App'x at 263; *Signature Flight Support*, 442 F. App'x at 785. As reflected by the analysis in the cited

authorities, more than a "possibility" of irreparable harm in the absence of injunctive relief is required; irreparable harm must be shown to be "likely" and "imminent." *See also Potomac Conf. Corp. of Seventh-Day Adventists*, 2014 WL 857947, at *19 (irreparable harm cannot be "remote nor speculative" but rather must be "actual and imminent"). Plaintiffs satisfy this standard here. The reports provided by Plaintiffs' experts leave no room for doubt that the punitive disciplinary measures to which the Plaintiffs and similarly-situated minor immigrant detainees at SVJC have been and continue to be subjected are causing them harm of a character that cannot be quantified or compensated by monetary relief. *See generally Multi-Channel TV Cable Co. v. Charlottesville Quality Cable Operating Co.*, 22 F.3d 546, 551 (4th Cir. 1994) (an element of irreparable harm is that "monetary damages are difficult to ascertain or are inadequate").

As detailed by Dr. Lewis,

> Punitive approaches such as prolonged isolation, restraints. and physical abuse are harmful and ineffective. For example, 50% of all suicides in juvenile facilities occur while youth are in isolation. Facilities, including SVJC, continue to harm youth by using force as a means of behavioral control (e.g., aggressively restraining youth) and isolation as means of behavioral control rather than using de-escalation and conflict resolution, and trauma-informed strategies that are more effective and not harmful.
>
> * * *
>
> Solitary confinement can lead to severe psychological and physical effects including difficulties with thinking, overt paranoia, panic attacks, illusions and hallucinations, self-injurious behavior, hopelessness, sleep disturbances, headaches, heart palpitations and dizziness.
>
> . . . Youth held in solitary confinement, especially when it is frequent and prolonged, needlessly suffer a great deal and can become depressed and suicidal, self injurious, acutely anxious or psychotic, and aggressive. They are at increased risk of having psychological problems if they have a history of trauma and abuse. Youth are also at increased risk simply because their bodies and brains are still developing physically and psychologically.
>
> * * *

> . . . Approaches . . . that are punitive are detrimental to [children] and have no place in the juvenile justice system. Irreparable harm can result from punitive, physically abusive approaches because of the residual psychological scars brought about by youth no longer feeling safe in the world and no longer being able to trust others to treat them with dignity and respect. *While the extent of the damage caused by these approaches cannot always be determined in the moment, it is likely that many of these detained youth will never recover from their traumatic experiences prior to and during detention[.]*

Lewis Rept., ¶¶ 75, 77, 101 (emphasis added; footnotes omitted).

These consequences are likely to follow the children detained at SVJC, who will continue to struggle with enduring damage caused by their exposure to inhumane treatment at SVJC. *See* Lewis Rept., ¶ 95 (forms of punishment in use at SVJC "likely to result in compounding prior trauma and causing longstanding harm); ¶ 98 (noting "enduring impact" of harm suffered at SVJC by Declarant R.B.); ¶ 102 ("It is likely that many of these detained youth will never fully recover from their traumatic experiences prior to and during detention[.]").

Dr. Weisman, focusing in particular on the use of solitary confinement at SVJC, is no less emphatic, stating:

> It is my opinion, within a reasonable degree of certainty in the field of clinical psychology, that all juveniles subjected to the SVJC policy and practice of solitary confinement . . . are at a substantial risk of serious harm to their social, psychological and emotional development.
>
> * * *
>
> Due to their developmental vulnerability, solitary confinement causes juveniles much greater harm than does such confinement of adults, and the risks of solitary confinement to juveniles are alarming.
>
> Because juvenile are still developing socially and emotionally, they are especially susceptible to psychological, and neurological harms when they are deprived of environmental and social stimulation. For a juvenile, simply being placed in isolation -- the utter helplessness of it -- is enormously stressful. This surge of cortisol -- of fear, anxiety, and agitation -- will be especially severe in juveniles. The consequences, including actual changes in brain structure, have been demonstrated to persist into adulthood.
>
> * * *

> Exposure to chronic, prolonged traumatic or stressful experiences, such as solitary confinement, has the potential to permanently alter an adolescent's brain which may cause longer-term problems.

Weisman Rept. at 5-7 (citations omitted).

Simply stated, the serious and grave physiological and psychological risks to which the Plaintiffs and other immigrant youth residing at SVJC, attributable to the punitive practices the facility employs, have been and continue to be exposed constitute unquantifiable harms remediable only by the granting of injunctive relief. That the treatment to which these children are subject likely violates their substantive due process rights, as shown in Argument Section 1 above, only confirms the necessity of a preliminary injunction in the circumstances presented. *See, e.g., Marietta Mem'l Hosp. v. W. Va. Health Care Auth.*, No. 2:16-cv-08603, 2016 WL 7363052, at *8 (S.D. W.Va. Dec. 19, 2016) ("Where a person's constitutional right will be denied if an action is allowed to continue, an irreparable harm will be established.") (*citing Bd. of Supervisors of La. State Univ. & Agric. & Mech. Coll. v. Wilson*, 92 F. Supp. 986, 988-89 (E.D. La 1950), *aff'd*, 340 U.S. 909 (1951)); *see R.I.L.R. v. Johnson*, 80 F. Supp. 3d 164, 191 (D.D.C. 2015) (in action seeking preliminary injunction with respect to federal governmental policy of detaining immigrant families as a means of discouraging further mass migration of refugees form Central America, the Court, observing the "detention harms putative class members in myriad ways, and as various mental health experts have testified, it is particularly harmful to minor children," held: "Members of the proposed class . . . seek injunctive and declaratory relief invalidating and setting aside the improper deterrence policy. Unlike economic harm, the harm from detention pursuant to an unlawful policy cannot be remediated after the fact.").

Based on the definitive opinions of Plaintiffs' experts and the relevant case authorities, the irreparable harm element of the test for injunctive relief is clearly satisfied.

3. The Balance Of The Equities And The Public Interest Weigh Heavily In Favor Of A Preliminary Injunction

Finally, under *Winter* and its progeny, a party seeking the entry of a preliminary injunction must show: (i) that the balance of the equities (or "hardships") weighs in favor of the relief sought; and (ii) that the public interest likewise favors the granting of an injunction. 522 U.S. at 20; *Di Biase*, 872 F.3d at 235; *Pashby* 709 F.3d at 329

Plaintiffs submit that the hardships to them and other immigrant youth detained at SVJC of a continuation of the punitive, abusive practices reflected in this submission during the pendency of this action are obvious and egregious, whereas the hardship to SVJC of suspending those practices while this case is fully adjudicated are essentially nonexistent. Alternative means by which SVJC staff can respond to the Plaintiffs' "bad behavior" -- if any -- while this case proceeds to final resolution are readily reflected in Plaintiffs' experts' opinions and the professional standards for the juvenile justice system upon which those stated opinions rest. Any "hardship" to SVJC of conforming its treatment of immigrant detainees to the professional standards in accordance with which all juveniles are to be treated is no burden with which this Court should be concerned.

Likewise, it is difficult to identify any interest that the public would have in the perpetuation of the use of excessive physical force, undue use of restraints, and imposition of solitary confinement against detained immigrant children while this case continues.

The "balance of equities" and "public interest" elements of the *Winter* test have frequently been assessed together by the Courts in this Circuit, especially where constitutional rights are implicated and the movant has already satisfied the "likelihood of success" and "irreparable harm" criteria. So, Plaintiffs suggest, should it be here. *See Centro Tepeyac*, 722 F.3d at 191 ("[A] state is in no way harmed by issuance of a preliminary injunction which

prevents the state from enforcing restrictions likely to be found unconstitutional. If anything, the system is improved by such an injunction. . . . Upholding constitutional rights surely serves the public interest." (*citing Giovani Carandola, Ltd. v. Bason*, 303 F.3d 507, 520 (4th Cir. 2002)); *accord Newsom ex rel. Newsom*, 354 F.3d at 261 ("Surely, upholding constitutional rights serves the public interest.").

In light of these considerations, a preliminary injunction is supported by the balancing of the equities and the public interest.

CONCLUSION

For all of the foregoing reasons, Plaintiffs' Motion for Preliminary Injunction should be granted.

DATED: February 28, 2018

Respectfully submitted,

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By: 
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CERTIFICATE OF SERVICE

I hereby certify that on this 28th day of February 2018, a true and correct copy of the foregoing Memorandum of Law In Support of Plaintiffs' Motion for Preliminary Injunction, supporting Exhibits and proposed Order was served via this Court's electronic case filing system upon the following:

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EXHIBIT 1

DECLARATION OF JOHN DOE 1

I, John Doe 1, declare and state the following:

1. I am 17 years old. I was born in Tamaulipas, Mexico.
2. I came to the United States right after I turned 15. I believe it was in August.
3. I was taken into custody by immigration authorities as soon as I crossed the border. I was sent to BCFS in San Antonio, Texas, and I stayed there for a few months until I was transferred to Mercy First, a treatment center in New York, for psychological issues.
4. After a short time in New York, I was transferred to NOVA, a staff secure facility in Virginia. Then I was sent to Shenandoah.
5. I was detained at Shenandoah for over a year and a half, from April 2016 to December 2017.
6. I have been diagnosed with depression and other disorders, and I take medications for them. I think they increased the dosage of my depression medication when I came to Shenandoah. At first it made my symptoms worse, and I didn't feel like getting out of bed or doing anything, but then I got used to it.
7. For most of my time at Shenandoah, I was placed in Alpha Pod. It is for kids who have misbehaved.
8. We would get points awarded for good behavior and points taken away for bad behavior. If you had all of your points at the end of the week, you could buy things like toothpaste and soap. I regularly got points taken away for things like not wanting to work on the mural in art class, complaining about a headache, or throwing a ball that hit the ceiling in the gym.
9. At Shenandoah, my room had a mattress, a sink, and a toilet. There is no wall or divider

in the room, and the staff could see into the rooms through a window in the door. The kids would sometimes put a piece of paper over this window so people couldn't see them using the toilet, but the staff would remove it. One time a staff member stood at my doorway and watched me use the bathroom.

10. While I was at Shenandoah, staff members would make fun of me on a daily basis. They would call me names such as "pendejo" and "onion head," and do things like drop my clean towel on the dirty floor in front of me. They were always trying to provoke me.

11. I once became so frustrated by a staff member's repeated mocking that I pushed the staff member. In response, four staff members shoved me to the floor and piled on top of me, and they began hitting me in my abdomen with their elbows. I had a lot bruises from this.

12. There are American and Latino kids at Shenandoah. The Latino kids are treated differently than the American kids.

13. Staff frequently refused to allow us to watch Spanish shows on the TV in our pods. They would tell us they didn't care what we wanted and didn't care that we were Latino.

14. On one occasion, I got into a fight with one of the American kids after he had taunted me and told me that he "hates Latinos". When staff broke up the fight, I was grabbed and thrown forcefully to the ground, but the other kid was just held by the arms and pulled away. I was then restrained, tied to a chair, and hit several times by staff members while I was tied to the chair. I was left tied to the chair in my room for four hours.

15. They tied me to a chair about five times while I was at Shenandoah. My hands, legs and chest were tied to the chair. On some occasions they put something over my head. It had small holes that I could see out of, but only a little.

16. I was assaulted by Shenandoah staff on many occasions while I was detained there, and

several times while I was tied to a chair. On one occasion, I was hit in the face and scratched by a staff member while I was restrained. I developed a black eye and bruising from this.

17. On another occasion, I asked to come inside during gym because I had a headache. Staff suspected, for no apparent reason, that I may have found a piece of glass outside. I was thrown to the ground and searched, and my clothes were shredded. Though they found nothing, staff transferred me to Alpha Pod after this incident.

18. I saw other kids being hit by staff too. I once tried to defend another kid when a staff member was hitting him. As a result, the other kid and I were both stabbed by the staff member with a pen.

19. Another time, a staff member entered my room when I didn't want him to and provoked a fight. The staff member hit me, and I bit the staff member. Thereafter, the staff member beat me, leaving me with bruises on my neck and arms. A supervisor took photographs of my injuries. I have asked for these photos repeatedly, but staff members have never given them to me.

20. After this incident, I was placed in cha-chas (handcuffs). I was forced to wear handcuffs on my wrists and shackles on my feet for approximately 10 days in a row. During this time, the handcuffs were only removed when I was sleeping or eating alone in my room.

21. The handcuffs are very tight, and they often left bruises and cuts on my wrists after they were taken off. I complained about this and showed my injuries to the staff, but they took no action.

22. At Shenandoah, I was also placed on restriction a lot. This happened whenever kids would act out or hit the staff, or if they hurt themselves. When you are restricted, you are largely

in your room and you can't leave. When you are outside your room, staff place you in handcuffs. I have been restricted in my room for several days at a time. I was only allowed to leave my room for classes.

23. Soon after I arrived at Shenandoah, I began to hurt myself. I would cut my wrists with a piece of glass or plastic, whatever I could find. I would sometimes bang my head against the wall or the floor because I was angry and sad.

24. Staff members saw the scars on my wrists and knew I was hurting myself. They told me they didn't care. Sometimes I would lose points or be placed on restriction for hurting myself.

25. One time I cut myself after I had gotten into a fight with staff. I filled the room with blood. This happened on a Friday, but it wasn't until Monday that they gave me a bandage or medicine for the pain.

26. I had never cut myself before I came to the United States. I learned this from other kids while I was detained.

27. On August 21, 2017, I tried to kill myself. I tied part of a curtain around my throat. Staff found me, and they responded by taking away all of my clothes and placing me on restriction for several days.

28. I was angry that I was at Shenandoah for so long, and I didn't want to be there anymore. I would throw food down the toilet because I couldn't eat it. I would feel sick and dizzy.

29. I had the urge to cut myself frequently, and expressed a desire to kill myself.

30. In December 2017, I was transferred back to NOVA. It's better here. I don't know how long I will be here or whether I will be transferred back to Shenandoah.

31. This statement has been prepared in English but it has been read to me in Spanish by a bilingual interpreter.

32. I declare, under penalty of perjury, that all the information I have provided here is true and correct to the best of my knowledge, and I am aware of the legal consequences of making a false declaration.

Executed this 17th day of January, 2018, in Alexandria, Virginia

_____

John Doe 1

EXHIBIT 2

DECLARATION OF JOHN DOE 2

I, John Doe 2 :, declare and state the following:

1. I am 16 years old. I was born in Reynosa, Mexico.
2. I came to the United States when I was ten months old. I lived with my mom in Macallen, Texas until I was sixteen. While living in Macallen, I attended school. I was about to finish ninth grade when I was taken into custody by immigration authorities.
3. One day in 2017, I was driving with some friends. The driver of the car was pulled over, and the police searched our car. They asked for identification, and no one had any, so they called immigration.
4. I was then arrested, and taken to a shelter in Harlingen, Texas. I stayed at the shelter in Harlingen for approximately two months.
5. While I was staying at Harlingen, I tried to escape, but I did not succeed. I was then transferred to BCFS, a staff secure facility in San Antonio, Texas.
6. I felt safe at BCFS. I played soccer, was treated well by staff, and enjoyed visits from my family.
7. While I was staying at BCFS, I saw a doctor who told me I had ADHD, depression, and anger management issues. The doctor gave me Prozac, Trazodone, and two other medications, which I was told are used for my mood and concentration.
8. Sometimes I would get in trouble with the staff at BCFS because other kids would pick on me and I would defend myself. I got in verbal fights with other kids a few times, and once I tried to hit a kid. The staff restrained me, and took me to the floor.
9. I was feeling very angry and very sad during this time. I started to harm myself. I cut my wrists.

10. Because of my anger, I was taken to see a doctor at a hospital or a rehab place. I stayed there for about twenty days, before I was taken back to BCFS.

11. Shortly after I returned to BCFS, I was transferred to Shenandoah. I had been at BCFS for about three months. I was told I was "going to a better place," but I knew I was being transferred to juvenile.

12. I arrived at Shenandoah on September 30, 2017. I did not see a doctor when I arrived, but my medications came with me. I am still taking them.

13. Soon after I arrived at Shenandoah, I met my case manager, Emily. She told me I had been transferred to Shenandoah because of behavioral issues. She also told me that if I'm good for 30 days, they'll send a request for a transfer.

14. I was assigned to live in Alpha Pod. I was told by staff and other kids that people who behave badly go to Alpha Pod.

15. I feel very sad at Shenandoah. I do not have many privileges. A few months ago I cut myself again, but I haven't done it in a while.

16. I am not allowed outside of the building at all. I have not been outside since I've been here. We have gym class, but it is always indoors.

17. In addition to gym, I take math, science, and art. My favorite class is art. I don't like my other classes. They aren't interesting because they are too easy. The teachers teach things I learned in elementary and middle school. I never took a test here to measure my grade level.

18. Generally, they teach class in Spanish. Sometimes they teach in English. Spanish is my native language, but I understand English very well because I lived most of my life in Texas.

19. Some of the staff here are nice, they'll joke around with you. Some are all mean. They tell you do this, do that. Some of them are bilingual, but a lot of them are not.

20. I often overhear staff members insult me and other kids in English, thinking we cannot understand them. If you don't know Spanish, they will talk shit. They will say, "Hispanics, they don't know nothing, they just come to our country," and tell the kids they're stupid, make fun of them for not understanding English. I was the only one who understood what they were saying because I am the only federal kid who speaks English.

21. The staff will say things behind the kids' backs, but in a way that the kids can hear them. I became very frustrated, so I started to tell the other kids what the staff was saying about them in English. The staff got very mad at me for this and took away my points.

22. I have complained about the staff being racist. I submitted a report and Mr. K, the director, came to talk to me about it.

23. There are local kids and federals (immigrant kids) at Shenandoah. We don't interact with the local kids at all but we see them in the hallways and pass by the pods where they live. They have different privileges and they are treated differently. They can go outside more, staff is friendlier to them. They get Xboxes in their pods and they have computers in their classrooms. I have said things to the staff about it, but no changes have been made. We want to be treated equally, like the locals. They shouldn't look down on us for not having papers.

24. It feels bad to be here. I get really angry. I'm frustrated about being locked up, and I miss my family.

25. One time, about one or two months ago, I was mad and I said, "Fuck school and fuck this place" during class, and the staff removed me from the program. They took me to my

room. I told them I didn't want to go, and I was resisting it – I wasn't letting them grab me. They put the handcuffs on me. When I kept resisting, they drew me to the wall and put my face in the wall. Once I was inside my room, they took the handcuffs off. They kept me in my room for four hours and overnight.

26. After that I started to behave bad a lot. I got removed from the program a lot. I was placed on restriction for dumb things, like trying not to go to class, joking around with other kids, or for saying bad words to a teacher.

27. If you lose two points in a day, you don't go outside your room. During the night shift, you don't leave your room. So if you are placed on restriction you're in your room from the time when you are removed from the program, and through the night until the next day.

28. If you are behaving bad, resisting the staff when they try to remove you from the program, they will take everything in your room away – your mattress, blanket, everything. They will also take your clothes. Then they will leave you locked in there for a while. This has happened to me, ad I know it has happened to other kids too.

29. One time I was kept in my room for a day and a half. I had tried to swing at a staff member. I was pushing back, so they called a 1033 for backup. When the other staff came, they put me to the floor. They used force to push me inside my room, and then they put the handcuffs on me.

30. There's this chair, and they brought it outside my room. It has wheels on it so it can be moved. They put me in the chair, strapped my arms and legs down, and put something over my face. It's a white thing with small holes in it. You can see and breathe out of it. They told me they were putting it on so I couldn't spit, but I hadn't tried to spit.

31. When I was strapped to the chair, they took the handcuffs off and they brought the chair to another room. I don't know how long I stayed there, but it was maybe 30 or 40 minutes. After that I was brought back to my room. This was during the evening, and I was kept in my room for the next day and a half, until the morning of the day after. They took away my mattress, blanket, and shirt for the first few hours, and then they brought them back.

32. When I get frustrated sometimes I talk back to staff and insult them, and I get removed from the program. When this happens, the staff will sometimes use force to restrain me. They will grab my hands and put them behind my back so I can't move. Sometimes they will use pens to poke me in the ribs, sometimes they grab my jaw with their hands. They are bigger than me. Sometimes there will be three or four of them using force against me at the same time.

33. The force used by staff has left bruises on my wrists, on my ribs, and on my shoulder. The doctor here gave me ibuprofen for the pain.

34. I have been good for the past 44 days, and I haven't been removed from the program. They told me they sent a request for a transfer, and that it generally takes 60-90 days, but they didn't tell me why.

I declare, under penalty of perjury, that all of the information I have provided here is correct and complete to the best of my knowledge, and I am aware of the legal consequences of making a false declaration.

Executed this 5th day of January, 2018, in Staunton, Virginia

John Doe Z

EXHIBIT 3

DECLARATION OF JOHN DOE 3

I, John Doe 3, declare and state the following:

1. I am 15 years old. I was born in Honduras.
2. I left Honduras because I was being persecuted by the "18 gang" who threatened to kill me.
3. My girlfriend and I fled to Guatemala and then travelled to Mexico. My girlfriend wanted to go back to Honduras, but I told her that I couldn't, because the gang was going to kill me.
4. With a friend, I took buses and jumped on trains through Mexico to get to the United States. It took us something like 25 days to get to the US border from Mexico.
5. I was picked up by immigration right after I crossed the border. I was placed at a house in Texas and then moved to a house in San Antonio, where I stayed for about a month. I was then moved to a center called BCFS where I stayed for about two weeks. After that, I was moved to Shenandoah.
6. To get to Shenandoah, they put me on three planes. I kept asking where I was going but they never told me. It took a long time and put me in a bad mood.
7. They said the reason for the moves from place to place was because I was a member of MS-13. I told them I was not part of anything.
8. When we landed at the airport, a grey van was waiting to transport me to Shenandoah. They put cuffs on my hands that were connected to a belt around my waist and put cuffs on my feet. When I asked them why they put us in handcuffs, they said that everyone

who is transported here gets handcuffs. I threw a fit. I asked what was going on and kicked a chair. They put handcuffs on my hands and legs.

9. At Shenandoah, I was put in restriction for any little thing. I was put in restriction many times; more than 10. They restrict me when I get angry and send me back to the pod. I get angry because of the things they do.

10. On one occasion, going to art class, I held the door open so everyone could enter. A staff member yelled at me for doing this, and I asked him why he was yelling at me and bringing his anger here. In response, the staff member lunged towards me, and I crouched down to avoid him. He fell and then restrained me, putting my hands behind my back and slamming my face into the wall. I maneuvered my way out of the hold and asked, "what is happening"? Then two staff members slammed my body to the ground and, when they picked me back up, shoved me against the wall again.

11. After this, they put me in restriction in my room. They took away my mattress and my blanket and left me only in my boxers. I was left in my room all day without clothes and it was very cold. I did not get the mattress and blanket back until 9:00 that night. I did not get my clothes back until the next morning.

12. On another occasion, I moved the TV in the pod so that the light wouldn't hit it and we could see better. A staff member came over and took a point away from me for that and put me in restriction. Whenever I was put in restriction, they took away my mattress and blanket. They took my clothes away about 8 times.

13. About four times when they put me in restriction, staff put cuffs on my hands and my feet inside my room. The cuffs were very tight and left marks on my wrists. One night in

particular I couldn't sleep well because of the pain in my wrists. When I was cuffed, staff also hit me. They came into my room and started hitting me.

14. One time I got angry when staff sent me to my room. I hit the door with my fist and my hand started bleeding. Staff then they put cuffs on me and I was strapped to a chair with a belt. I was just in my boxers. I was there for definitely more than half an hour. I was crying. Staff said that they did it to calm me down. No one did anything for my bleeding hand.

15. Another time I put paper over the window in the door to my room for privacy. A lot of staff came into the room with plastic shields and swarmed over me. A large staff member put all his weight on me. I had scratches and bruises all over my arms.

16. Staff members take away points without telling me. When I ask how many points I have, they tell me 4 to 5 points less than I have. That makes me mad. I ask the supervisor why they do this and say that they are messing up. They don't give me an answer. I think they do things to make me angry so that I will hit them and then charges will be pressed and I will get a longer sentence.

17. Staff take away points for little things. They take away points when I don't want my food and give it to a friend. Some staff take away points when you don't raise your hand.

18. I feel like people here are racist. The American kids are treated differently. For example, an American kid asked for chapstick and got it immediately. I asked for Vaseline for my lips which were chapped and hurting. I got it eventually but not immediately.

19. The pods for the American kids are very different than the pods for the Hispanic youth. Bravo and Echo, the pods for the American youth, have soft chairs, X-boxes all week

and I-pods. The immigrant youth have steel chairs, no I-pods and have X-boxes one to three times a week.

20. We get special food, like Burger King and pizza, on Tuesdays. My Honduran friends who arrived this past Saturday did not get the special food on the following Tuesday, but the American kids who also arrived on that Saturday got the special food.

21. Staff is disrespectful to us. When I asked a friend to ask a staff member why the staff member was taking away so many points, the staff member said to my friend, "tell that Hispanic guy to tell me in English".

22. If something hurts, I can see a doctor. But I don't get medicine until much later than I ask for it. I get very strong headaches, that are so bad that they make me cry. Many times when I ask for medicine I have to wait a long time. When I had a stomach ache, I did not get medicine until a week after I asked for it. Then it was pointless.

23. We got six vaccinations at a clinic. I do not know what the shots were for. They had us in hand and leg cuffs the entire time we were in public. People stared at us.

24. I am taking medications for anger and to help me sleep. I would like calcium and iron supplements but they refused to give them to me.

25. I have been on good behavior for three months. I should have been stepped down after 30 days of good behavior. I am upset that I haven't been stepped down. I will talk to my case manager about that.

26. I want us to be treated as human beings.

This statement has been prepared in English but has been read to me in Spanish by a bilingual interpreter. I declare, under penalty of perjury, that all the information I have provided here is correct and complete to the best of my knowledge. I am aware of the legal consequences of making a false declaration.

Executed this 5 day of January, 2018, in Staunton, Virginia

JOHN DOE 3

EXHIBIT 4

I, J. A. declare as follows:

1. This declaration is based on my personal knowledge. If called to testify in this case, I would testify competently about these facts.

2. I am 15 years old. I am from Mexico. I speak Spanish and some English. I have been in the United States for about one year and nine months. I am currently in immigration detention in the custody of ORR at Mercy First Residential Treatment Center.

3. When I came to the United States, I was taken into immigration custody and then transferred to BCFS in San Antonio. I was just there for four days. One morning, they woke me up at 4 am and put me on a plane. They did not tell me where I was going; they just said that I was being taken to a better place, which turned out to be a lie. When I arrived in Virginia, they finally told me where I was and that they were taking me to Shenandoah Juvenile Detention Center.

4. I don't remember ORR telling me why they were moving me to Shenandoah. I don't remember ever getting anything in writing that told me the reason that they moved me to Shenandoah. I don't remember being told that I could challenge or appeal the decision to put me in Shenandoah.

5. I was in Shenandoah for seven months. I did not like being in Shenandoah or the way that the staff treated us there. The staff members would say ugly things about my mother and my family members. I think they did that to try to make me mad and to act out. I saw them do similar things to the other kids who were there. I think the worst ~~thing about being in Shenandoah was the fights and seeing the staff members hit other~~ kids in the facility.

6. At Shenandoah, they punished us by putting us in solitary confinement for long periods of time. If we got into a fight, refused to go into our rooms or to follow the program, or broke the rules in another minor way, they would put us into our rooms for weeks at a time. Three times, they put me into my room in solitary confinement for two

weeks, and one time, they put me in my room for three and a half weeks. When we were on solitary confinement, they did not let us out for any reason, including to eat, take showers or use the bathroom. Each room had a bathroom which we used to do our necessities so we would not go out. We had to do all of that in our rooms. I didn't know of any way to try to appeal or challenge the staff's decision to put me into solitary confinement; no one seemed to pay attention to how they were treating us.

7. They also tied us to restraint chairs as punishment. One time, when I was at Shenandoah, I didn't want to go into my room. The staff members reacted by pushing me to the floor, and one of the staff members grabbed my head and forced my head down to the ground. Then they handcuffed me and put a white bag of some kind onto my head. They took off all of my clothes and put me into a restraint chair, where they attached my hands and feet to the chair. They also put a strap across my chest. They left me naked attached to that chair for two and a half days, including at night. They took the bag off my head when they sat me down on the restraint chair. There were staff members in the room at times but they would leave me alone for a few hours. I do not remember very well. I never saw a doctor while I was in the chair or after they took me out.

8. I saw three other children tied to the restraint chair at different times. Each time, they were left there for about a day.

9. Early one morning at about 3 am when I was at Shenandoah, the staff woke me up and told me that I was leaving. I was moved to Yolo Juvenile Detention Center that day. I don't remember ever getting anything in writing about the transfer telling me why I was being moved or that I could appeal or challenge the decision to put me in Yolo.

10. Yolo was also a horrible place. They used pepper spray on the kids there, and I was sprayed seven times in my eyes. It burned and hurt a lot.

11. After I was at Yolo for five months, they moved me to Mercy First in the RTC program. I have been here for nine months now.

12. I receive a number of medications here, to help me sleep and for my emotions, including depression and anxiety. They told me here that I have to take the medications,

and that it is mandatory. When I have refused to take my medications, they put me on the red level of our program, which means that I cannot leave the unit.

13. During the time that I have been in immigration detention, I do not remember being told that I could have a bond hearing if I requested one.

14. I considered taking voluntary departure because of the way that I have been treated at the different centers that I have been held at. Because of the things that have happened to me, I do not have any trust in them that they will treat me properly or that the government will try to release me to a sponsor or to be held in a less restrictive environment. I have been in immigration detention for a long time, and I have never had any good news in the time that I have been here. I just want to have freedom and to not have to live in these types of places.

I declare under penalty of perjury that the foregoing is true and correct. Executed on this 16 day of January, 2018, at New York, New York.

J. A.

CERTIFICATE OF TRANSLATION

I, Denise Guerrero, hereby certify that I am proficient in both Spanish and English, and that I accurately translated the foregoing statement and read it back to J. A. in its entirety in Spanish on [DATE] 1/8/18.

[NAME]

EXHIBIT 5

DECLARATION OF D.M.

I, D.M., declare and state the following:

1. I am 20 years old. I currently live in San Antonio, Texas.
2. I was born in Honduras, and I came to the United States when I was 15. I was taken in by immigration authorities when I crossed the border, and then I was in ORR custody for about three years.
3. I arrived at Shenandoah in 2014, around the last week of May. I was at Shiloh Treatment Center before that.
4. At first the people transferring you don't tell you they're going to take you to jail – all they do is tell you you're going to another placement. But then they handcuff you, and put a big heavy bag on your right or left leg. Once you have the handcuffs and the big bag, you know you're going to jail.
5. I was told I was sent to Shenandoah because I was too aggressive, supposedly because I had had physical issues with staff more than three times in one week. But I never had a chance to dispute this, and I was only told the reason for the transfer after I arrived there.
6. When I was at Shenandoah, there was a lock-in (secure) part and a staff secure part of the facility. I was in the lock-in part for 8 months, and then I was stepped down to the staff secure part for about 3 months.
7. The rules at Shenandoah were really strict. There was one hour when you had to read a book. The guards had to see your eyes moving back and forth on the page, and if they didn't, they would put you on restriction in your cell.
8. One day, it was reading time, and there was this kid who was quiet but wasn't looking at his book like he was supposed to. This guard – I forgot his name, but he was a big guy,

he used to be an NFL player – he was really strict and he used to be mean to everyone. He asked the kid why he wasn't looking at his book. The kid responded and said he wasn't causing any trouble or anything. The guard told him to shut up. The kid got up and said, "I'm sorry, sir." And the guard grabbed him by the shirt and pushed him away. Then the kid felt disrespected, so he got mad and he punched the guard. In response, the guard grabbed the kid and tackled him, and slammed him to the floor. The guard put his whole weight on top of him. He had his elbow on the kid's chest and had his other arm pinning the kid down. He took his time calling a 1033 on his radio (for backup). There was a group of us watching this, and we didn't think it was necessary for the guard to treat the situation as he did.

9. It's easy for the guards to write incident reports – you did this, you did that, you disrespected me – but they never hear the kid's side of the story. My voice was never heard. They never came and talked to us about what was going on inside of us. A kid starts suffering as soon as Border Patrol gets them. They're all scared of being sent back home or being sent to jail.

10. I didn't feel like I belonged there. I never threatened staff members. I wasn't affiliated with a gang in my home country or anywhere else. I was terrified there.

11. There were both federals (immigrant kids) and local American kids at Shenandoah, and there were differences in the way they were treated. The locals were able to have a roommate, while federals have to have cells by themselves. The guards would joke with the local kids about the federals, telling them that the federals were in their cells alone because they raped someone or because they had sexual problems (HIV, stuff like that). I

overheard them talking like this in the gym, and I understood because I was the only one who spoke English. The guards are adults, and they were supposed to be there for us.

12. The guards at Shenandoah also put down the federals, calling them wetbacks. They used that word because they know it's insulting. Most of the kids don't even understand what's being said about them because the staff doesn't speak Spanish.

13. The guards would also mock us by trying to speak Spanish. They would say "Vamonos! Vamanos!" with a smirk on their faces.

14. Before I came to Shenandoah, I had been diagnosed with post-traumatic stress disorder, major depressive disorder, and bipolar disorder. I didn't meet with a psychologist until about a month and half after I had arrived there. I went in with medication from Shiloh, but I didn't receive any meds until a month and a half in, when I met with the psychologist. What did they do with my meds? What did they think, they I didn't need them in secure?

15. I had a lot of issues there because of my mental disorder. Whenever I was in crisis – if I was trying to hurt myself inside my cell, or saying things to someone no one could see – they would drag me out of my cell and put me in the restraint chair. All I could see was them running for the chair.

16. Whenever they used to restrain me and put me in the chair, they would handcuff me. Strapped me down all the way; from your feet all the way to your chest, you couldn't really move. Handcuffs would have been enough. Once you're strapped down, they have total control over you.

17. They also put a bag over your head. It has little holes; you can see through it. But you feel suffocated with the bag on.

18. When you're in a crisis, the bag is the least helpful thing – it's scary, you know. And they don't do it in a nice way. They don't explain what they are doing; they just grab the left side of your head and they force it over you. You can't move to resist. The first thing that came to my head when they put it on me was, "They are going to suffocate me. They are going to kill me."
19. They had me in that chair for a good hour, but they don't check the time. They don't check if blood is flowing through your veins. I feel like they should have to do a 20-minute check to make sure it's not too tight, it's not hurting you, or whatever. There is a guard there with you, but they never checked on me.
20. I saw two other cases, besides me, where kids had to be put in the chair. It was when the guards had break up a fight. I never had a fight in that place. I was placed in the chair when I was having a mental crisis.
21. Every time I was in crisis, they put me in the chair. The guards never did anything less extreme than that. They would call for help from a psychologist only after I was strapped down. They would wait for like 45 minutes or an hour to call though.

I declare, under penalty of perjury, that all the information I have provided here is correct and complete to the best of my knowledge, and I am aware of the legal consequences of making a false declaration.

Executed this 2nd day of January, 2018, in San Antonio, Texas

_____

D.M.

EXHIBIT 6

DECLARATION OF R.B.

I, R.B., declare and state the following:

1. I am 18 years old. I am currently living in Corpus Christi, Texas, with my mom.
2. I am originally from Guatemala, but I came to the United States with my mom when I was young.
3. When I was 13, I got picked up by immigration authorities. I had run away from home and I was living in Rio Grande City at the time.
4. I stayed in a sorting facility for one night, and then I was sent to Nueva Esperanza, a staff secure facility in Brownsville, Texas. From there I was moved to a juvenile facility in Newark, New Jersey. I stayed there for about two months, but I started losing it. I was sad because I hadn't seen my mom in a long time. I had a lot of anger problems, and it was really hard.
5. I told the guards I wanted to hurt myself, and they sent me to Sandy Pines, a hospital in West Palm Beach, Florida. The guards at Newark told me they were sending me away because I needed help, and they didn't have the right resources there.
6. A few months later, I was sent to Shenandoah because of behavioral problems. I lit a piece of toilet paper on fire using lead from a pencil. I burned it in the sink, right under the faucet, and I put it out in a matter of seconds. I wasn't trying to start something, I was just showing off. I also got into a fight with my roommate that night. Two or three days later, they told me I was being transferred. They didn't tell me where I was going. I was 14 at the time.
7. I was at Shenandoah for a little over three months. After being there for two months, I escaped while I was being transported to a doctor's office. I was so sad, I felt worthless

and I didn't feel like I had anything to live for. In Shenandoah, they locked me in a room that was 8x10, or maybe 8x16, for 23 hours a day, all by myself. It's not good for a person to be isolated that long. I started talking to myself.

8. I wasn't myself after that. When I left home I was just a little boy, but being there changed me. I'm not optimistic any more. Even now, my mom tells me that I changed a lot, that I'm not the same person. I rarely go out with friends. I just spend time with my family now.

9. When I was at Shenandoah, at least once a week, I had to fight – with a guard, another kid, or anybody who wanted to fight me – because I was so angry. They didn't tell me anything about what was going on with my case or when I was going to leave. Not knowing anything month after month drove me crazy.

10. When I got in fights, the guards at Shenandoah would grab my arms and put them behind my back. They would cross my elbows and put pressure on them. Then they would fold my knees and push me down. It hurt, so I fought back to relieve the pressure. I told them, "If you just let me go a little bit, I'll calm down," but they wouldn't do it.

11. When they couldn't get one of the kids to calm down, the guards would put us in a chair – a safety chair, I don't know what they call it – but they would just put us in there all day. This happened to me, and I saw it happen to others too. It was excessive.

12. At other detention facilities where I had been, the staff would treat us differently when we were angry. They would tell me to calm down and then slowly let me go, and then they would take me to my room so I could punch a wall or something. The guards at Shenandoah would say, "calm down, calm down" and I would say "I just got punched in the face, why you want me to calm down?" And then they would put me in the chair.

13. I was put in this chair 4-6 times I guess. The longest time I was in it was probably half a day, or two shifts. I was really mad that time. I was young, I had a lot of problems.

14. The chair is painful. Imagine a little rocking chair with straps for your head, elbows, legs, feet; you could turn your head a little from side to side, but you can barely move it in. It's a metal chair that has two little wheels in the back, so they can lean it back and transfer it, like a dolly.

15. This is embarrassing, but on one occasion, I had to pee, and they wouldn't let me, so I just went on myself. I know one or two other kids this happened to as well; they peed on themselves while they were in the chair.

16. One time they put a mask on my face because I spit on the guard when I was strapped down. I know now that was bad, but you have to understand there was nothing you could do, except move your head back and forth, while you were in the chair. The mask is like a white veil I guess, or a net for your hair – it has a million little holes in it. You can see through it and breathe through it.

17. I also got placed on room restriction a lot. If me and another minor got into a fight, they'd put us on room restriction for 3, 4, 5 days at a time. When you were on room restriction, when they woke you up at 6 or 7 am, they'd take your mattress away, and wouldn't give it back until room checks at the end of the day. They would leave you in your room with nothing but a book and a Bible, but no mattress – so you can't sleep, because you would just be laying on the concrete. I started talking to myself and banging my head against the wall. I felt like I was going crazy, and I would do anything to get the guard's attention.

18. The guards never picked fights with me, but I saw it happen with other kids. They would say things to them and challenge them until the kids got really mad and fought back. Then the kids would push the guard, and then the guard would grab both of the kid's arms and try to force them into a restraint. The guards were twice the size of the kids, who were 13 or 14 years old, but they would use their full weight to push them to the ground. Sometimes it was two guards doing this to a little kid.

19. Before I was at Shenandoah, I had been diagnosed with ADHD and prescribed medications for it, but that was it. When I came to Shenandoah, they told me I had bipolar disorder and PTSD. At first I didn't even take medicine, but they made me think I needed it – sleeping pills, Seroquel, and a bunch of others. They keep you drugged there.

20. Now I just take melatonin to help me sleep, nothing else. I don't need any anti-psychotic drugs.

21. I declare, under penalty of perjury, that all the information I have provided here is true and correct to the best of my knowledge, and I am aware of the legal consequences of making a false declaration.

Executed this 8th day of January, 2018, in Corpus Christi, Texas

_____

R.B.

EXHIBIT 7

Gregory N. Lewis, Psy.D.
Licensed Clinical Psychologist
5636 N. Virginia Avenue
Chicago, IL 60659

February 27, 2018

Theodore A. Howard, Esq.
Wiley Rein LLP
1776 K Street, NW
Washington, DC 20006

Re: John Doe, et al. v. Shenandoah Valley Juvenile Center Commission

Dear Mr. Howard:

On November 10, 2017 we discussed my willingness to serve as an expert witness on the case referenced above and agreed that I would serve in that capacity. The following is a report addressing: 1) my psychological evaluation of Plaintiff John Doe 1 (who was a detainee at the Shenandoah Valley Juvenile Detention Center for an extended period of time), the conditions under which he was detained, and the appropriateness of the treatment he received; 2) my review of the declarations of the two other plaintiffs and three other individuals who were formerly detained at Shenandoah; 3) my prior clinical experiences in evaluating unaccompanied alien children who are in detention in the United States; 4) standards of care for treating UACs and other youth who are in detention; and 5) my opinions regarding the appropriateness of care offered to the plaintiffs at Shenandoah and how their experiences there impacted them.

Executive Summary:

Shenandoah Valley Juvenile Center (SVJC) staff do not understand the manifestations of trauma and stress in youth and are not well trained in utilizing trauma-informed approaches that are the standard of care in all stages of the juvenile justice system. The predominant approach utilized to manage youth at SVJC is punishment and behavioral control through methods such as solitary confinement, physical restraint, strapping to a chair, and loss of behavioral levels. These approaches are not only ineffective, but have a profound negative impact on youth, can seriously impair their development and psychological well-being, and can cause or exacerbate mental health problems including panic attacks, suicidal and self-injurious behavior, psychotic symptoms, paranoia, and hopelessness. Because of their special vulnerabilities and needs as adolescents, the use of these approaches is a cruel and harmful practice when utilized and can have long-term deleterious consequences that are difficult to remediate. The mental health care and the overall care provided at SVJC are deficient and fall well below the standards of care in the juvenile justice system.

Qualifications/Background:

1. I am a licensed clinical psychologist. I received my doctorate in clinical psychology from the Illinois School of Professional Psychology in 1989. I became licensed in Illinois in 1990. As part of my professional training, I completed a one-year internship in clinical psychology and a one-year fellowship in adolescent health psychology at Cook County Hospital (now John H. Stroger, Jr. Hospital of Cook County).

2. I was a Clinical Psychologist in the Department of Psychiatry at Stroger Hospital from September 1987 – July 2013. I worked with children, adolescents, and adults including those who had chronic medical illnesses and/or were traumatized or abused. I was Co-Director of the Adolescent & Young Adult Clinic and Coordinator of the Child & Adolescent Inpatient Consultation-Liaison Service that provided assessment and consultation to the pediatric, trauma, and ob-gyn units, as well as to the Child Protective Services team and the pediatric emergency room. During my time at Stroger, I evaluated many detainees from the Cook County Juvenile Temporary Detention Center and worked at the center for a period of four months when they were understaffed.

3. In addition to working at Stroger Hospital, I was a Lecturer in the Department of Behavioral Sciences at Rush University Medical Center in Chicago from January 1998 - July 2013. I have had a private practice in Wheaton, Illinois since 1987, working primarily with adults providing individual, couples, and family therapy. Since 2013 I have also been the Clinical Director of The Counseling Center at the First Presbyterian Church of Evanston. In addition, I provide psychological services in a school-based health center in a Chicago area high school that is predominantly Latino.

4. I have served on two medical missions with the Syrian American Medical Society providing psychological trauma services to Syrian refugees living in Jordan, primarily to those living at the Zaatari Refugee Camp.

5. I was guest co-editor for a special issue of the *Journal of Child and Adolescent Trauma*: Resilience-Based Approaches to Trauma Intervention for Children and Adolescents (Volume 9, Issue 1, March 2016).

6. I am a member in good standing of both the American Psychological Association and the Illinois Psychological Association.

7. I have done numerous forensic psychological assessments in Special Immigrant Juvenile Status and asylum cases in the United States and have also done several forensic psychological assessments of immigrants involved in civil cases. I have completed the training by the Physicians for Human Rights Asylum Program on "Aiding Survivors of Torture & Other Human Rights Abuses: Physical and Psychological Documentation of Individuals Seeking Humanitarian

Protection in the U.S." I am familiar with the Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. I have received training in forensic psychological assessment and testimony from the American Psychological Association and in forensic report writing, comprehensive assessment of feigning in forensic contexts, and forensic assessments in immigration proceedings from the American Academy of Forensic Psychology. I have done trainings for Physicians for Human Rights, the Vera Institute of Justice, the Young Center for Immigrant Children's Rights, and the Loyola Center for the Human Rights of Children on the topic of forensic psychological evaluation of trauma in the context of asylum and immigration.

8. I have personally evaluated about 25 UACs since 2004 for reasons of asylum and Special Immigrant Juvenile Status. Most have been referred to me from the Young Center for Immigrant Children's Rights, but others have been referred from the National Immigrant Justice Center, the DePaul Asylum & Immigration Law Clinic, the Loyola Civitas ChildLaw Center, as well as various law firms. I have also done numerous evaluations on adults seeking asylum.

9. I was involved in a civil class action lawsuit brought by several women from Central America against the federal government and the Corrections Corporation of America after these women were sexually assaulted by a guard during transport. I did not testify, but did provide deposition testimony. This case was eventually settled (see Appendix B No. 1).

10. I, along with several others, submitted a brief to the United States Court of Appeals for the Fourth Circuit in support of an alien child who was detained by the Office of Refugee Resettlement (ORR) despite the availability of his mother to care for him in the United States (see Appendix B No. 2).

11. I am familiar with conditions of detention and mental health treatment for unaccompanied minors who reside in facilities similar to the Shenandoah Valley Juvenile Justice Center as a result of my work in doing Special Immigrant Juvenile Status and asylum evaluations, as well as my involvement in civil cases brought against other juvenile facilities.

12. I have evaluated UACs as part of two civil class action lawsuits against detention centers in the U.S. that did not provide appropriate care to UACs. I evaluated five youth as part of a civil case in 2009 brought against the Abraxas Hector Garza Center ("Abraxas"), Cornell Companies, the Office of Refugee Resettlement, U.S. Immigration and Customs Enforcement, the Texas Department of Family and Protective Services, and the city of San Antonio alleging that these youth were physically and emotionally abused while residing at Abraxas. I did not testify and did not provide deposition testimony. This case was eventually settled (see Appendix B No. 3). The Division of Unaccompanied Children's Services (DUCS) terminated its contract with Abraxas for many

reasons including inadequate services.[1] I evaluated six youth as part of a civil class action lawsuit brought against the federal government alleging that these youth were sexually, physically, and emotionally abused while residing at the Texas Sheltered Care Facility in Nixon, TX. I did not testify, but did provide deposition testimony. A settlement agreement was reached with the facility and its employees, but the case against the United States and its employees was lost. The case has been filed with the Inter-American Commission on Human Rights (see Appendix B No. 4). DUCS had been previously alerted to problems at Nixon by child advocates, but no action had been taken.[2]

13. The boys that I evaluated for both of these lawsuits were all UACs from Central America. Most of them had experienced various forms of abuse, neglect, abandonment, and violence from their families and communities, and many had also been traumatized during their journey to the U.S. They came to the U.S. to get away from their abusive environments in the hopes of obtaining a better life.

14. The youth who were at Abraxas reported physical and verbal abuse; inadequate medical care; confinement; denied access to attorneys; and abrupt transfers to other facilities with no explanation. The youth I evaluated for the Nixon litigation also reported significant abuse.

15. It was my opinion that all but one of the youth I evaluated at both facilities had suffered substantial physical, mental, and emotional harm as a result of the abuse they experienced while in detention. Most had experienced prior traumas that were exacerbated due to the traumas they experienced in detention. Most were diagnosed with PTSD, depression, and/or anxiety.

16. It was also my opinion that these youth had not been provided with a safe and humane environment in which to live and that they had not received adequate mental health care.

Materials Reviewed:

17. See Appendix A.

Unaccompanied Alien Children and Complex Trauma:

18. Children who come to the United States unaccompanied from other countries (unaccompanied alien child – "UAC") come for a variety of reasons including: fleeing parental abuse and neglect; fleeing violence and unsafe conditions in

[1] *Halfway home: Unaccompanied children in immigration custody.* (2009). Women's Refugee Commission. https://www.womensrefugeecommission.org/resources/document/196-halfway-home-unaccompanied-children-in-immigration-custody

[2] Ibid.

their home country; fleeing persecution; to join parents or other relatives already living in the U.S.; and a desire for a better life in which they will have opportunities to work and go to school. Some children are also involuntarily trafficked into the U.S. as part of the worldwide labor and sex trafficking industry.[3] UAC's are vulnerable before, during, and after their journey to the U.S. because they do not have adult protection and are unable to properly care for themselves.[4]

19. Most UACs have experienced abuse, neglect, and trauma within their home countries, but are then faced with the additional stresses of migrating to the U.S. often traveling through unsafe and dangerous countries over a period of weeks and months. During their journey - which may take them through multiple countries - UACs may undergo highly traumatic experiences including: going days without food, water, or shelter; being exposed to unsanitary conditions; getting sick or injured; being robbed or kidnapped; being beaten; being raped; watching others being tortured or murdered; having to survive in the jungle; and having to survive crossing through deserts and rivers. Once they arrive in the U.S., UACs may be further traumatized if apprehended by Immigration and Customs Enforcement and detained. In addition, they have to adjust to living in a country in which they often do not speak the language and are unfamiliar with the customs. All of these experiences contribute to UACs who are likely to have suffered extensive and multiple instances of abuse and trauma, often referred to as complex trauma, prior to any trauma they may experience if detained.

20. Complex trauma occurs when a child has been exposed to multiple, chronic, and prolonged traumatic experiences that are often of an interpersonal nature (e.g., abuse from a caretaker).[5] When untreated, these lead to changes in the brain (i.e., prolonged activation of the body's stress response system) and result in a loss of core capacities for self-regulation and interpersonal relatedness.[6] Trauma-exposed children develop psychological symptoms including hypervigilance, over reactivity to perceived threats of danger, difficulties in calming themselves, and avoidance or dissociation – i.e., they try not to think about their traumatic experiences so as not to be overwhelmed by them and can

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[3] Levinson, A. (2011). Unaccompanied immigrant children: A growing phenomenon with few easy solutions. Migration Policy Institute. https://www.migrationpolicy.org/print/4328

[4] Young, W., & McKenna, M. (2010). The measure of a society: The treatment of unaccompanied refugee and immigrant children in the United States. *Harvard Civil Rights-Civil Liberties Law Review*, 45, 247-260. http://harvardcrcl.org/wp-content/uploads/2009/06/247-260.pdf

[5] Van der Kolk, B. (2005). Developmental trauma disorder. *Psychiatric Annals*, 35, 401-408.

[6] Cook, A. et al. (2005). Complex trauma in children and adolescents. *Psychiatric Annals*, 35, 390-398.

become very distressed when these experiences come to mind.[7] Children who have been abused develop strategies and mechanisms to manage their anxiety and to cope with their abuse (e.g., fleeing the abuse, fighting back, or emotionally detaching from the abuse). This is what is typically referred to as the "fight" or "flight" response and gets activated when the child is in a situation or interacting with someone that triggers past memories of the abuse. The child is essentially doing his or her best to "survive-in-the-moment" in response to a threat or perceived threat that is overwhelming and for which they have limited abilities to soothe and regulate themselves.

21. The responses of children who have experienced complex trauma are rooted in their past traumatic experiences (which may include parental abuse and neglect) that can be easily triggered in an environment - such as a detention center - where staff are not trained to see how their own actions and words can precipitate traumatic memories and, therefore, survival-in-the-moment responses on the part of detainees as a way of managing these traumatic memories. Once a child knows what it is like to feel danger and terror, it takes very little new threat to reignite it.[8] Children who have been abused develop strategies and mechanisms to manage their anxiety and to cope with their abuse (e.g., fleeing the abuse, fighting back, or emotionally detaching from the abuse), and these strategies become activated by the parts of the brain that control basic emotionality and survival-motivated behavior and prepare the body for emergency responses. Sensory information from the environment is transmitted very quickly and unconsciously so that the child has a chance to respond immediately to the danger or perceived danger. Analysis of details and the context of the situation are sacrificed for speed of transmission so that the child can survive.[9]

22. Youth who experience complex trauma often do not meet criteria for Posttraumatic Stress Disorder (PTSD), but instead are given several diagnoses that reflect their various symptoms and behaviors (e.g., depression, conduct disorder, anxiety). This often leads to attempts to treat each of these particular diagnoses rather than seeing that all of these are part of a complex trauma presentation. It is not that these youth are not depressed or anxious or have behavioral problems, it is that these need to be viewed as manifestations of, and coping methods for dealing with, their past abuse and trauma.

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[7] Dudley, R. (2015). Childhood trauma and its effects: Implications for police. *New Perspectives in Policing Bulletin*. Washington, D.C.: U.S. Department of Justice, National Institute of Justice. NCJ 248686.

[8] Garbarino, J. (2008). *Children and the dark side of human experience*. New York: Springer.

[9] Saxe, G., Ellis, B., & Kaplow, J. (2007). *Collaborative treatment of traumatized children and teens: The trauma systems therapy approach*. New York: The Guilford Press.

23. Youth who have been abused will often unconsciously get drawn into, or draw others into, situations in which they can try to master their past abuse. For example, a youth who felt powerless and helpless when physically abused as a child might be drawn to, or draw others into, situations in which he/she could feel powerful and in control and, in this way, undo or master their previous victimization and abuse.

Evaluation of Plaintiff John Doe 1:

24. On August 10 and August 11, 2017 I evaluated Plaintiff John Doe 1 at the request of the Young Center for Immigrant Children's Rights. The evaluation was requested to provide an understanding of Doe 1's past trauma and detention history, the impact this had on him, and recommendations for future placement and treatment. The evaluation was conducted at the Legal Aid Justice Center in Charlottesville, VA over a period of 10 hours with the assistance of Mr. Jeff Divers, who served as my Spanish-English interpreter. Doe 1 was also administered several psychological tests and questionnaires (as adjuncts to the clinical interview) that assess for anxiety, depression, traumatic life events, behavioral problems, self-esteem, and cognitive functioning. At the time of the evaluation, Doe 1 was a UAC at the Shenandoah Valley Juvenile Center (SVJC).

25. Doe 1 is a 17-year-old Mexican youth. His childhood history in Mexico indicates that he had experienced abuse and neglect from his parents and struggled with depression. Doe 1's father drank a lot and would become violent. He physically abused Doe 1 (this was confirmed by the Young Center after conversations with Doe 1's mother) with objects such as shoes, belts, and cables and psychologically abused him by saying Doe 1 was not his child and by making other disparaging remarks. His mother was unable to adequately protect him from the father's abuse and appears to have been unable to provide Doe 1 with the nurturance and support he needed to process, understand, and cope effectively with his father's abuse. Doe 1 has no positive memories of his father.

26. Doe 1 would cry and feel scared and angry when his father abused him and would frequently run away from the house to escape the abuse. He would run and hang out on the streets or hide near the river and either his mother would come and get him or he would return home on his own after about half a day.

27. Doe 1 was frequently teased about his physical appearance when he was a child. He dropped out of school when he was 14 years old because he lost interest and was getting into fights.

28. Doe 1 came to the U.S. right after his 15th birthday because he felt unsafe and unhappy in Mexico due to the violence there and because he wanted the opportunity for a better life. He would eventually like to have a family and work in a car factory.

29. Doe 1 expressed fears of being killed by the drug cartels if returned to Mexico.

30. I diagnosed Doe 1 with: 1) Child Physical Abuse, Confirmed; 2) Child Psychological Abuse, Suspected; 3) Major Depressive Disorder (MDD), Recurrent Episode, Moderate; 4) Persistent Depressive Disorder (Dysthymia); and 5) Conduct Disorder, Unspecified onset, Moderate.

31. Results of the evaluation indicate that Doe 1 is a very depressed young man with serious doubts about his self-worth who has limited abilities to regulate his mood and behavior when upset. He desires to better control his temper and admits to feeling bad when he hurts someone. He experiences a high degree of behavioral and emotional maladjustment and does not easily trust others because he fears being taken advantage of. Doe 1 vacillates between feeling depressed and sad about where his life is at and that others do not like him vs. liking that others are afraid of him because it gives him a sense of feeling powerful and in control over them. He believes it is a sign of weakness to show that he is depressed. Results of the evaluation also suggested that Doe 1 has below average intellectual functioning.

32. Doe 1 became highly distressed during the evaluation when asked to talk about his father. He had trouble discussing the abuse that he experienced with any detail and at times completely shut down emotionally. He reported forgetting and not wanting to remember things from his past – especially memories regarding his father. While detaching from these painful memories allows Doe 1 to not have to feel the emotional pain associated with these memories, it also serves to keep these hurtful memories buried inside him like an old wound that can be all too easily opened up in situations in which he is reminded of the abuse.

33. Although Doe 1 did not meet criteria for Posttraumatic Stress Disorder (PTSD), it is my opinion that, from a complex trauma framework, his behavioral and emotional difficulties have most likely resulted from and been shaped by his early childhood abuse and neglect and have been exacerbated while he has been in detention. Complex trauma is not a diagnosis listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DMS-5), but is likely to be included in the next edition of the DSM. Viewing Doe 1's problems from a complex trauma perspective is critical in that it not only helps to explain his behaviors and moods, but also helps to understand both the type of treatment and environment that he will best respond to and how his experience at SVJC has exacerbated his pre-existing trauma. In other words, understanding that youth such as Doe 1 are traumatized can avoid creating additional harm and improve the diagnoses and facilitate matching them to trauma-informed services.

34. It was my opinion that it would be detrimental for Doe 1 to be returned to Mexico and I recommended that he receive services in a trauma-focused residential treatment facility. It was my belief that his depression and aggressive

behaviors originated in his adversity and trauma and would likely not improve without proper trauma-focused treatment in a safe environment over an extended period of time. It was also my opinion that Doe 1 would probably never fully recover from the traumatic events that he experienced as a child (and while detained at SVJC) without proper trauma-informed treatment.

Doe 1's Experiences in Detention at SVJC:

35. Doe 1 reported feeling very depressed while in detention at SVJC. He felt "stuck" and "trapped" because he was not allowed to go outdoors much. At times he felt so depressed that he struggled to get out of bed in the morning and had thoughts that he would be better off dead.

36. Doe 1 experienced many forms of repeated and prolonged abuse and punishment while in SVJC detention including teasing and physical assault from staff, humiliation when being observed using the toilet, being confined to his room or restrained to a chair (sometimes with a mask put over his head) for long periods of time, and being forced to wear handcuffs and shackles. These actions on the part of staff replicated and exacerbated the abuse and teasing that he experienced as a child from his father and his peers, and further traumatized Doe 1. Several examples will be provided below.

37. Doe 1 tended to respond to his traumatic experiences in both internalizing and externalizing ways. At times he would internalize by withdrawing from others and engaging in self-injurious acts such as cutting himself with an object or hitting his head against the wall when upset. On several occasions, he talked about or made suicide attempts. He felt he was frequently blamed for things that were not his fault.

> *"I feel all torn up inside, but I don't show this to people because it is a sign of weakness. I feel like there is something broken with me. When I feel bad, it comes up on me suddenly and I just want to be left alone and sit in the sun."*

38. For example, on 07/10/16, Doe 1 refused to leave his room and engaged in self-injurious behavior (carving initials on his chest and banging his head against the wall). Subsequent discussion with his counselor on 07/11/16 suggested that Doe 1's self-destructive behavior was in response to being chronically bullied by one of his peers. The counselor seemed more concerned with why Doe 1 self-harmed and what the meaning was of the initials he carved on his chest than on understanding his experience of being bullied, the feelings that this triggered in him (e.g., fear, anger, shame, self-loathing), and more appropriate ways to manage these feelings.

39. At other times Doe 1 would get "really angry" and act out aggressively. He thought that others did not like him and would get upset and feel "bad" when others insulted or pushed him, and would want to retaliate. He stated that his

"adrenalin would kick in" when he felt insulted or abused and this would sometimes cause him to respond aggressively.

> *"I feel depressed and rejected and take it out on whoever is around. There is nothing I can do about my bad feelings, so I attack people because I can't tolerate my bad feelings."*

40. For example, Doe 1 was involved in an incident during recreation time on 04/20/16 in which he was verbally redirected several times to not forcefully throw the ball. Doe 1 failed to obey and continued to throw the ball. He cursed at staff and a physical altercation ensued. This resulted in Doe 1 being physically restrained, confined to his room, and losing all of his behavioral levels or "points".[10] This altercation occurred only five days after Doe 1 had been transferred to SVJC and appears to have set the tone for further aggression from both Doe 1 and staff throughout his detainment. The progress note dated 04/20/16 said, "UC stated that this staff member spoke to him 'like my father' which caused him to react with physical aggression." This statement and the above incident are significant for several reasons. First, Doe 1 himself is providing his mental health counselor the link between his prior abuse and his current reaction, yet there was no attempt by the counselor to process this with Doe 1 despite their meeting for 60 minutes. Had this been recognized as a traumatic trigger for Doe 1, a different treatment approach could have been utilized which would have included working with Doe 1 to calm himself and express his anger in other ways and to work with the staff member to be aware of how his words triggered Doe 1 so as to be more aware of this in their future interactions. Second, things appear to have escalated after Doe 1 cursed at the staff member. A staff member asked Doe 1 if he had directed the curse words towards staff and a fight ensued. While it is understandable that the staff member likely felt disrespected, it appears that this staff member may have unnecessarily provoked Doe 1 through his words and actions. This would have been an opportunity to utilize de-escalation strategies to defuse the situation. However, there is no indication that this was done. Instead, "with no time left for less intrusive intervention, Doe 1 was placed in a physical restraint." Third, this incident exemplifies that the predominant approach utilized at SVJC is one of behavioral control and punishment. This incident very likely set the stage for Doe 1 to not feel safe at or understood by the staff at SVJC and to feel angry for being unjustly treated. Fourth, for many youth times of transition are often difficult to manage because of the ensuing anxiety. Doe 1 had recently transitioned from NOVA, a staff secure facility in Virginia, and may have been

[10] Points are given to reinforce behaviors such as turning in schoolwork and taken away to punish behaviors such as fighting or cursing. The total number of points is used to determine the behavioral level of a detainee. The lower the behavioral level, the less privileges the detainee has. Unfortunately, staff may arbitrarily give or not give points based on their own attitude and mood at a particular time rather than relying on objective criteria and administering the point system consistently.

confused about the expectations at SVJC. He may have also been experiencing shame as a result of being sent to a more secure facility. However, there was no attempt on the part of his counselor to discuss Doe 1's feelings about the recent transition and the adjustments he was having to make.

41. Four days later, on 04/24/16, Doe 1 again lost all of his behavioral levels and was restricted to his room for disruptive behavior and assault on staff. When meeting with his mental health counselor the following day, the "clinician emphasized to UC the significant consequences that can occur if he were to continue assaulting staff/peers while at the facility." Again, there was no effort to process with Doe 1 what his feelings and thoughts were during this incident and to help him learn more adaptive ways to cope; instead, the main intervention was to punish him and to emphasize his need to behave better.

42. On 05/03/16, Doe 1 lost all of his behavioral levels and was confined to his room for stealing a pencil. On 05/04/16, he was put in restraints and confined to his room for assaulting a peer. In his therapy session on 05/05/16, his counselor "emphasized both the immediate and long-term consequences of his aggressive behavior at the facility/outside in the community." The only effort made to help Doe 1 process his behaviors was when the counselor tried to get him to discuss his "motives," which Doe 1 had difficulty doing. This is not an effective approach with impulsive youth, as they often do not know why they are behaving in certain ways. An effective approach would have been to ask him what he was thinking and feeling before he took the pencil and before he assaulted the peer, to link these thoughts and feelings to his subsequent behaviors, and to help Doe 1 understand how his behaviors were likely efforts to survive in the moment and to self-regulate emotions (such as depression, loneliness, fear, or anger) that were distressing him.

43. In his session with his counselor on 08/01/16, Doe 1 attributed much of his acting out at the facility to "bad dreams" that upset him during the day. "UC stated that his dreams often include staff members and previous cartel members involved in violent acts." This was a clear indication that Doe 1 was carrying around a great deal of traumatic anxiety with him during the day and was an opening for the counselor to further process Doe 1's experiences of trauma, as well as to provide education for Doe 1 as to what trauma is, how it is carried in our bodies, and how to manage it. Instead, the counselor seemed to mostly focus on whether the content of the dreams was true and to reiterate the consequences that would occur if Doe 1 were to continue assaulting others.

44. A psychological evaluation was completed by Gustavo Rife, Psy.D on 05/04/16 at the request of Mr. Evenor Aleman, Doe 1's mental health counselor at SVJC. The results of this evaluation and the recommendations appear to have contributed to the behavior control and punishment approach utilized at SVJC rather than a more trauma-focused approach. For example, Dr. Rife states, "Testing also indicated that [Doe1] consistently approves of antisocial behavior

and has a generalized predisposition to resolve problems of social and personal adjustment in ways that disregard social customs and rules." This statement sets up Doe 1 to be viewed as being predisposed to antisocial behavior vs. considering that his "antisocial behavior" may, instead, be behavior that has been learned in response to his past abuse and distrust of others and which can be easily triggered in situations in which he is treated (or perceives that he is being treated) unfairly and harshly.

45. Dr. Rife also states, "There was also a history of physical abuse and possible exposure to other trauma, but there are no evident symptoms for PTSD at this time." While I agree with this statement, it does not go far enough in recognizing that youth with complex trauma often do not meet criteria for PTSD and often have several diagnoses (e.g., depression, conduct disorder, etc.) that become the focus of treatment rather than the underlying trauma and abuse that drives these moods and behaviors. Dr. Rife goes on to state, "...testing indicates that his interpersonal difficulties may be due more to social anxiety than a complete lack of regard for other people....he also had a very low score on his sense of relatedness suggesting great difficulties being in relationships." It is my opinion that this more accurately captures the trauma and anxiety that gets easily triggered in reactively aggressive ways when Doe 1 is around others. However, rather than focusing on ways to address his underlying anxiety and trauma, the approach taken at SVJC was largely to just control his aggression and self-injurious behavior. This was further reinforced by Dr. Rife's recommendation that "[Doe 1's] persistent anger, self-centeredness, lack of respect for authority and lack of concern about others put him at high risk for antisocial acting out which needs to be directly confronted and contained." Again, the emphasis here is on controlling antisocial behavior rather than considering that his acting out behaviors may be defensive reactions to protect himself from further victimization by those in his environment.

46. In his summary of Doe 1, Dr. Rife states, "He does not appear to suffer from active symptoms of serious mental illness that significantly impairs his cognitive competence to make informed decisions although his cognitive abilities may be temporarily impaired when he is highly angered or upset. " It is my opinion that this statement minimizes the impact of Doe 1's depression and past abuse/trauma on his ability to function in the moment when his reaction to past trauma gets triggered. This would have been an opportunity to explain in the report that Doe 1's behaviors are often in reaction to his environment and to those around him and are an attempt to "survive" in the moment when there are reminders of his past abuse and traumas, rather than simply manifestations of disregard for others and delinquency.

47. During the course of my evaluation of Doe 1, he was noticeably agitated and restless when discussing his experiences in detention. His legs were constantly shaking, he pulled apart the paper cup he was drinking from, and kept looking down at his feet. He said that talking about these experiences reminded him of

when he was growing up and would feel bad about himself because kids would tease and make fun of him. He also said that witnessing other boys being mistreated was upsetting to him because it reminded him of his father's abuse. He would sometimes try to defend the other boys and would then be punished for this by being put in restraints or confinement.

48. Based on the information provided above, it is my opinion that Doe 1's traumatic childhood history of abuse, neglect, and teasing has been replicated while in detention. Individuals with this kind of history are extremely vulnerable to becoming emotionally and behaviorally dysregulated in situations where others are saying or doing things that are abusive or demeaning. Even such subtle interpersonal signals as a harsh look, a critical tone of voice, or a humiliating comment could be enough to trigger a traumatic reaction of "fight" or "flight" in someone like Doe 1. As described above, his usual responses vacillate between those that are internalized (i.e., fleeing or detaching) and those that are externalized (i.e., fighting). "Fleeing" is a survival behavior that he learned as a child to get away from his father's abuse and may partly explain his threats to run away from the detention center and being labeled a "flight risk." However, Doe 1 also reported numerous situations in which he felt insulted or humiliated by things staff said or did to him and would go into fight mode and become reactive and aggressive. Later, when staff would ask him why he responded the way he did, he would often not know why. He was simply surviving in the moment.

49. Doe 1 has difficulties self-regulating his emotions (e.g., humiliation, fear, anger, self-loathing) and behaviors (e.g., aggressiveness), especially when faced with situations in which he does not feel safe. It is my opinion that it is highly likely that many of Doe 1's aggressive behaviors (both self and other directed) in detention were survival responses to situations in which he felt in danger (or felt another detainee was in danger), much as he felt with his dad. An environment in which people intentionally or unintentionally provoke an abused child and then focus on limiting, shaming, and punishing the child can lead to further acting out (because the child does not feel understood and feels angry and helpless) and to the child's being labeled as antisocial or delinquent rather than as a previously abused and traumatized child who is trying to survive in an environment that is triggering him and not understanding or supporting **him in ap**propriate ways.

50. In my professional opinion, the abusive punishment Doe 1 experienced at SVJC exacerbated his prior trauma and caused additional, long-term harm.

Declaration of John Doe 2:

51. Plaintiff John Doe 2 is a16-year-old Mexican youth. He has been living in the U.S. since the age of 10 months and was taken into custody at the age of 16 by immigration simply for not having identification. Doe 2 was detained at two

other facilities prior to being transferred to SVJC for behavioral problems. He has not been allowed outside of the facility for recreation. He attends school, but finds the academic work well below what he is capable of doing. He is likely bored as a result of this and this, in turn, may be contributing to his frustration in the classroom.

52. Doe 2 was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), depression, and anger management issues while residing at a staff secure facility in Texas. He was prescribed four medications for these problems including Prozac and Trazodone. While it is possible that Doe 2 is in need of and benefits from some, or all, of these medications, it is also possible that these medications are used primarily to try to control his behavior in lieu of other therapeutic strategies (e.g., trauma-focused therapy) and environmental modifications (e.g., more recreational and social opportunities, more appropriate educational opportunities) that would improve his attitude, increase his ability to cope, and decrease his acting out.

53. Doe 2 witnessed many of the SVJC staff insulting and making derogatory remarks about many of the Hispanic youth. He was retaliated against (i.e., he lost points) for informing the other kids as to what the staff was saying about them. Doe 2 experienced racism and discrimination at SVJC and submitted a report to the facility director. He complained that the immigrant kids did not receive the same privileges as the local kids (e.g., they were not allowed to go outside as much and did not have X-boxes in their pods or computers in their classrooms).

54. Doe 2 reports several instances of harsh and abusive treatment while at SVJC. On one occasion, he cursed in the classroom and was taken to his room. He became resistive and was handcuffed and had his face pushed into the wall. He was confined to his room until the next day. On another occasion, after being confined to his room for a day and a half, he had an altercation with staff which led to his being strapped to a chair with a bag (with holes in it) put over his head. He was kept tied to the chair for 30 - 40 minutes, after which he was again confined to his room for one and a half days. Doe 2 was confined to his room on several occasions for resisting staff's attempts to remove him from the program. His mattress, blanket, personal items, and clothes were taken from him during his confinements. These above experiences of confinement for long periods of time, being handcuffed, having his head physically pushed into a wall, being strapped to a chair with a bag over his head, and having his mattress and other belongings removed from him are, in my opinion, highly detrimental, unreasonable and abusive. They fall below all professional standards of which I am aware.

55. Doe 2 reports several instances of being restrained by staff and taken to the floor, often by three or four men using force against him. He was often left with bruises as a result of this. While there are times that some youth may need to be

physically restrained for their own safety or that of others (much as an inconsolable baby sometimes needs to be swaddled or a small child who is out of control needs to be put in "time out"), these types of interventions should only come after other efforts have been made to de-escalate the situation, and should only be used for the period of time it takes for the youth to regain control. Once control has been established, the restraints should be removed. In my opinion, there are very few, if any, situations in which it is justified to have three or four large men jump on a smaller youth (much less push his head into a wall) or for a youth to have to be strapped to a chair with a bag over his head.

56. Doe 2 reports feeling sadness, anger, and frustration at being locked up at SVJC. This is likely compounded by the fact that he has lived in the U.S. for over 15 years and was only arrested for failure to have identification on him. On one occasion he cut himself and on several occasions got into verbal and/or physical fights with the other kids. This suggests that he does not know how to emotionally self-regulate and self-soothe. He does not report any efforts by staff to talk to him about his feelings and thoughts, so it is not clear whether he was provided with any type of therapy that might have helped him.

Declaration of John Doe 3:

57. Plaintiff John Doe 3 is a 15-year-old Honduran youth who fled Honduras due to gang violence and death threats. He took busses and trains through Guatemala and Mexico to get to the U.S. border. He was assumed to be a gang member and was told that, for this reason, he was transferred from a facility in Texas to SVJC. Doe 3 reports several situations in which punishment resulted for no reason or from minor infractions of the rules. In one situation, Doe 3 was yelled at by staff for holding the door to the art room open. This escalated and led to staff restraining Doe 3, pushing his face into the wall, and then two staff members slamming him to the ground. Subsequent to this, he was put on room confinement for the remainder of the day with no mattress or blanket, and only allowed to wear his boxers. The room was cold and he did not get his clothes back until the next day (although he did get his mattress and blanket back that evening). He reports numerous times in which his clothes were taken away. On at least one occasion, he was strapped to a chair with only his boxers on.

58. Doe 3 reports being handcuffed several times and that staff would hit him while he was handcuffed. He felt the staff would intentionally try to get him to hit them so they could punish him further. He tried to cover the window in the door to his room for privacy, but this led to several staff entering his room with plastic shields and becoming physical with him. Doe 3 felt the staff was racist and discriminatory in their treatment of the Hispanic kids compared to the American kids. He also felt the staff was intentionally disrespectful and provocative and that they administered the point system in an arbitrary and inconsistent manner which led to his earning fewer points than he should have earned.

Declaration of J.A.:

59. J.A. is a 15-year-old Mexican youth. He does not recall being given any explanation as to why he was being transferred from BCFS in San Antonio to SVJC and does not remember getting anything in writing explaining this. This lack of transparency can create confusion, anxiety, suspicion, and misunderstandings for the detainee. Transitions can be difficult in the best of circumstances, but can be particularly stressful for youth such as UACs who have not come from stable family situations.

60. The Division of Unaccompanied Children's Services (DUCS) Manual states that all children placed in secure and staff-secure facilities will be given a *Notice of Placement in Secure and Staff-Secure* form[11], which will explain the reasons for the placement in that kind of facility and written in language the child understands.[12]

61. J.A. reports considerable mistreatment during his time at SVJC. He reports receiving demeaning remarks from staff, being provoked by staff, seeing staff hit other detainees, and being put in solitary confinement – often for long periods of time. During some of these confinements he was not allowed to leave for any reason.

62. J.A. was restrained in a chair as punishment on at least one occasion. He was stripped of his clothes, handcuffed, strapped across his chest, had his feet and hands strapped to the chair, and had a white bag put over his head. He was left naked and attached to the chair for more than two days. This is highly unusual punishment and was likely highly traumatizing for J.A. In my opinion, this borders on a form of torture. Torture, as defined by the Istanbul Protocol, is "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person, has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such or pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions."[13]

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[11] DUCS Manual, Section 5.02 cited in *Halfway home: Unaccompanied children in immigration custody*. (2009). Women's Refugee Commission.
[12] DUCS Manual, Section 2.05 and 3.02 cited in *Halfway home: Unaccompanied children in immigration custody*. (2009). Women's Refugee Commission.
[13] *Istanbul protocol: Manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment.* (2004). Office of the United Nations High Commissioner for Human Rights.

Review of Declaration of R.B.:

63. R.B. is an 18-year-old male from Guatemala. He came to the U.S. with his mom when he was young, but ran away from home at the age of 13 and was picked up by immigration authorities. Due to his behavioral problems, he was eventually sent to SVJC.

64. While at SVJC, R.B. was frequently placed on room confinement for 3-5 days at a time for up to 23 hours a day. His mattress would be removed early in the morning and he would only be left with a book and a Bible. This isolation was difficult for him and led him to start talking to himself and banging his head against the wall. He felt like he was going crazy.

65. When he got into fights, he felt the guards used excessive force to subdue him. He was frequently put into a restraint chair and left in it for long periods of time, sometimes for up to half a day, or "two shifts." He described his feet, legs, arms, and head being strapped to a metal chair. On one occasion, he had a mask put over his face after he spit at a guard. He described the chair as a physically painful and humiliating experience. One time he peed on himself when he was not allowed to go to the bathroom.

66. R.B. witnessed the guards provoking some of the other detainees into fights and then pushing them to the ground and forcing them into restraints.

67. R.B. was undoubtedly traumatized by his confinement and restraint chair experiences at SVJC and experienced what I believe to be a form of torture and cruel, degrading punishment. He describes not being himself since being detained at SVJC.

> *"When I left home I was just a little boy, but being there changed me. I'm not optimistic anymore. Even now, my mom tells me that I changed a lot, that I'm not the same person. I rarely go out with friends. I just spend time with my family now."*

Review of Declaration of D.M.:

68. D.M. is a 20-year-old Honduran male who resided at SVJC for 11 months. He witnessed another boy being slammed to the floor after hitting a guard who had physically provoked the boy by grabbing his shirt and then pushing him. D.M. says this incident started because the guard was upset that the boy was not reading a book like he was supposed to. D.M. felt this whole incident was unnecessary.

69. D.M. believes the guards wrote up biased incident reports on the detainees and did not allow the "kid's side of the story to be heard. They never came and talked to us about what was going on inside of us."

70. D.M. reported that the guards were prejudicial and discriminatory in how they dealt with UACs vs. local American youth. The UACs were not allowed to have a roommate and lies were told to the local youth that the UACs had raped someone or had HIV. The guards called the youths derogatory names and insulted them.

71. D.M. had been previously diagnosed with PTSD, major depressive disorder, and bipolar disorder. He had taken medications when at the previous facility (Shiloh Treatment Center), but then did not receive medications for six weeks after transferring to SVJC. D.M. experienced periods of crisis in which he would want to hurt himself and, instead of receiving counseling, would be taken out of his cell and put in a restraint chair for about one hour. He would be handcuffed and strapped in the chair from his feet to his chest. A bag with little holes was put over his head, which made him feel like he was being suffocated. "They are going to suffocate me. They are going to kill me." This was undoubtedly a very traumatizing and humiliating experience for D.M. and, in my opinion, borders on a form of torture and cruel, inhumane punishment. This type of controlling and degrading response suggests that the facility staff were not trained in dealing with mental illness and were simply trying to control D.M. because of their own fears. It is situations like this that breed fear, distrust, and resentment amongst detainees and lead to further acting out as a way to protect themselves.

72. D.M. witnessed two other boys being put in the restraint chair as a punishment for fighting. However, he never had any fights and was only put in the restraint chair when he was in crisis.

Youth in the Juvenile Justice System/Detention:

73. Immigration detention has a significant detrimental effect on the mental health of all children and youth no matter whether they have suffered previous trauma or whether they are UACs. Psychological harm has consistently been associated with detention.[14] Children held in detention are at risk for many psychological problems such as depression, anxiety, PTSD, suicidal ideation, and self-destructive behavior. The longer children and youth are detained, the greater the chance of mental health problems developing.[15] Immigrant children

[14] Kronick, R., Rousseau, C., & Cleveland, J. (2015). Asylum-seeking children's experiences of detention in Canada: A qualitative study. *American Journal of Orthopsychiatry*, 85, 287-294.

[15] Australia Human Rights and Equal Opportunity Commission. (2004). A last resort? National inquiry into children in immigration detention, 357-454, https://www.humanrights.gov.au/sites/default/files/document/publication/alr_complete.pdf

and youth who are detained even for very short periods of time show signs of psychological deterioration.[16]

74. Research indicates that a high percentage of youth involved in the juvenile justice system have been exposed to multiple types of traumatic events including violence, family abuse, and traumatic losses.[17] These youth often become distrustful, hypervigilant, impulsive, reactively aggressive, and display lack of empathy for others.[18]

75. Punitive approaches such as prolonged isolation, restraints, and physical abuse are harmful and ineffective. For example, 50% of all suicides in juvenile facilities occur while youth are held in isolation.[19] Facilities, including SVJC, continue to harm youth by using force (e.g., aggressively restraining youth) and isolation as means of behavioral control rather than using de-escalation, conflict resolution, and trauma-informed strategies that are more effective and not harmful.[20]

76. UACs, asylum seekers, and other displaced persons experience mental health problems at higher rates than the general population.[21] Their mental illnesses get worse when they are detained, especially when interventions such as solitary confinement and force are utilized.[22]These types of practices serve to re-traumatize already vulnerable youth and can retrigger painful feelings of fear,

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[16] Lorek, A., Ehntholt, K., Nesbit, A., Wey, E., Githinji, C., Rossor, E., & Wickramasinghe, R. (2009). The mental and physical health difficulties of children held within a British immigration detention center: A pilot study. *Child Abuse & Neglect: The International Journal*, 33, 573-585. http://dx.doi.org/10.1016/j.chiabu.2008.10.005

[17] Ford, J., Grasso, D., Hawke, J., & Chapman, J. (2013). Poly-victimization among juvenile justice-involved youths. *Child Abuse and Neglect*, 37, 788-800, http://dx.doi.org/10.1016/j.chiabu.2013.01.005

[18] Report of the Attorney General's National Task Force on Children Exposed to Violence (2012).

[19] Puzzancherra, C., & Hockenberry, S. (2016). *Data reflect changing nature of facility populations, characteristics, and practices.* Pittsburgh, PA: National Center for Juvenile Justice. https://www.ojjdp.gov/ojstatbb/snapshots/DataSnapshot_JRFC2014.pdf

[20] Bilchik, S., Umpierre, M., & Lenhoff, C. (2017). A roadmap for change: How juvenile justice facilities can better serve youth with mental health issues. *Focal Point*, 31, 13-16, www.pathwaysrtc.pdx.edu/publications

[21] Fujio, C. (2011). *Dual loyalties: The challenges of providing professional health care to immigration detainees.* Physicians for Human Rights, www.physiciansforhumanrights.org

[22] Holman, B., & Ziedenberg, J. (2006). *The dangers of detention: The impact of incarcerating youth in detention and other secure facilities.* Justice Policy Institute, www.justicepolicy.org

helplessness, powerlessness, and loneliness.[23]Furthermore, the harm caused by these practices can often be long-term and difficult to remediate. Their use falls well below professional standards for treating detained youth.

Use of Solitary Confinement and Seclusion in Youth:

77. Solitary confinement can lead to severe psychological and physical effects including difficulties with thinking, overt paranoia, panic attacks, illusions and hallucinations, self-injurious behavior, hopelessness, sleep disturbances, headaches, heart palpitations, and dizziness.[24]

78. Youth are frequently subjected to solitary confinement for one of three reasons: to punish them (disciplinary segregation); to manage them because they are considered dangerous (administrative segregation) or vulnerable to abuse (protective custody); or as a form of treatment (e.g., seclusion after a suicide attempt). Youth held in solitary confinement, especially when it is frequent or prolonged, needlessly suffer a great deal and can become depressed and suicidal, self-injurious, acutely anxious or psychotic, and aggressive. They are at increased risk of having psychological problems if they have a history of trauma and abuse. Youth are also at increased risk simply because their bodies and brains are still developing physically and psychologically. When youth are placed in solitary confinement they are often restricted from getting adequate exercise and recreation, socialization, nutrition, and education.[25]

Interpersonal dynamics in working with youth in facilities such as hospitals, schools, and detention centers:

79. Youth who are hospitalized for psychiatric reasons (e.g., being a danger to themselves or others) will sometimes "act out" towards themselves or others while hospitalized. While these episodes may be a manifestation of their mental illness (e.g., their depression or psychosis), they may also occur in response to either inappropriate actions or inappropriate monitoring on the part of the staff. For example, staff that react in verbally or physically aggressive and punitive ways to youth who are getting out of control will often trigger further acting out because the youth feel angry and unsafe. Milieu meetings (when staff and adolescents meet together) and team meetings (when the entire treatment team

[23] Burrell, S. (2013). *Trauma and the environment of care in juvenile institutions.* Los Angeles, CA & Durham, NC: The National Center for Child Traumatic Stress, www.NCTSN.org

[24] Fujio, C., & Corradini , M. (2013). *Buried alive: Solitary confinement in the US detention system.* Physicians for Human Rights, http://physiciansforhumanrights.org/solitary

[25] Human Rights Watch/American Civil Liberties Union. (2012). Growing up locked down: Youth in solitary confinement in jails and prisons across the United States, https://www.aclu.org/files/assets/us1012webwcover.pdf

meets) are held regularly to address these issues. Periodic staff trainings address the kinds of psychological problems youth experience and appropriate ways of treating them while hospitalized.

80. Youth who are hospitalized for medical reasons (e.g., complications of a chronic illness or surgery) often display behavioral and emotional difficulties due to such things as the degree of pain they are experiencing, the enforced dependency brought about by being hospitalized, anxieties about their illness and the treatment they will need to undergo, and being separated from their parents. However, hospitalized youth will also exhibit behavioral and emotional difficulties (e.g., refusing to comply with recommended treatments) when they feel misunderstood or mistreated by medical and nursing staff. For this reason, multidisciplinary team meetings, case conferences, and regular staff trainings are held to enable staff to discuss their frustrations and concerns regarding particular adolescent patients, to coordinate patient care, to educate staff on the problems the youth are experiencing and more effective approaches in dealing with these problems, and to help the staff become aware of how their communication and behavior at times triggers their adolescent patients' noncompliance and acting out.

81. All teachers, but especially those working with youth with various developmental and psychological difficulties, need help in understanding the emotional and learning needs of their students, to develop appropriate ways of behavior management, and to understand how their own verbalizations and behaviors may at times unintentionally provoke their students to act out. In-service training and consultation are provided to assist teachers with these issues.

82. The interpersonal dynamics that exist in hospitals and schools that treat and work with youth are also manifested in juvenile detention centers. Just as medical personnel and teachers need education, training, and consultation to understand how their own reactions can provoke negative reactions in youth, so too do detention center staff that work with youth. Training juvenile detention center staff in conflict de-escalation strategies and trauma-informed care would help them to better understand youth who are traumatized, to better understand interpersonal situations and dynamics that can trigger traumatic reactions in youth, and to learn more effective ways to manage these situations. This, in turn, would enable staff to meet basic professional standards of care in ways that are not harmful to detainees.

Trauma-Informed Treatment of Juveniles:

83. Trauma-informed approaches are the standard of care in all stages of the juvenile justice system.[26] UACs, because of their substantial histories of trauma and loss, are members of a particularly at-risk population that is in need of specialized mental health services including comprehensive clinical assessments that consider both their early traumas as well as their current hardships and stressors.[27]

84. Recent research suggests child abuse and neglect targets certain brain regions and pathways and can lead to brain abnormalities. Essentially, once a child has experienced maltreatment, the world is experienced with a different nervous system. [28] Psychological treatment must address the chronic emotional dysregulation, ruptured attachments with caregivers, and deficiencies in personal identity and competence caused by the trauma of the abuse and neglect. Treatments and approaches that simply try to control behavior rather than working to restore the underlying brain abnormalities and treating the "trauma" will be ineffective and likely harmful.[29]

85. Treatment of detained youth is served when the social ecology in which these youth are embedded is addressed – i.e., when it is understood that the social environment and the interpersonal dynamics to which the youth is exposed can also contribute to the youth's problems and re-victimize them. More specifically, there needs to be an assessment of the extent to which a detention facility is capable of helping traumatized, emotionally-dysregulated youth to regulate their emotions and behaviors.[30] Often, there is a disconnect between these two leading to a punitive, coercive approach that just treats the particular youth as the problem and easily leads to punishment, seclusion, aggressive force, and over reliance on medication to control the youth's "bad behavior." This approach essentially ignores the fact that many, if not most, detained youth have been

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[26] The National Child Traumatic Stress Network. (2016). Essential elements of a trauma-informed juvenile justice system, www.NCTSN.org

[27] Betancourt, T., Newnham, E., Birman, D., Lee, R., Ellis, H., & Layne, C. (2017). Comparing trauma exposure, mental health needs, and service utilization across clinical samples of refugee, immigrant, and U.S.-origin children. *Journal of Traumatic Stress*, 30, 209-218.

[28] Teicher, M. and Samson, J. (2016). Annual research review: Enduring neurobiological effects of childhood abuse and neglect. *Journal of Child Psychology and Psychiatry*, 57, 241-266.

[29] Van der Kolk, B. (2016). Commentary: The devastating effects of ignoring maltreatment in psychiatry – a commentary on Teicher and Samson 2016. *Journal of Child Psychology and Psychiatry*, 57, 267-270.

[30] Saxe, G., Ellis, B., & Kaplow, J. (2007). *Collaborative treatment of traumatized children and teens: The trauma systems therapy approach*. New York: The Guilford Press.

previously traumatized and/or will be traumatized while in detention and that their "bad behaviors" are often trauma based. That is, the "bad behaviors" are often traumatic reactions to being detained or to provocative peer and staff behavior.

86. The primary purpose of a trauma-informed juvenile detention system is to provide an environment in which youth feel safe, are assisted in coping when past traumatic experiences are triggered, and in which exposure to potentially traumatizing reminders or events is reduced.[31] This would necessitate: appropriate trauma-informed policies and procedures; appropriate methods of screening, assessing, and treating traumatized youth; culturally sensitive, trauma-informed programs that strengthen the resilience of youth; and culturally sensitive, trauma-informed staff education and training.[32]

87. There are three major implications of utilizing a trauma-informed approach. The first is that understanding behaviors as symptoms of trauma will lead to appropriate interventions that can reduce these symptoms and improve overall functioning. The second is that this type of approach will encourage a more global or systems perspective on traumatized youth such that other alternatives to detention can be considered which are less restrictive and allow for more comprehensive trauma treatment.[33]The third is that staff trained in trauma-informed care rely less on the use of restraint and seclusion, are better able to manage their own emotions and behaviors, and find their work more rewarding.[34]

Failure to Utilize a Trauma-Informed Approach at SVJC:

88. My evaluation of Doe 1 and the records provided me, along with my review of the declarations of the other plaintiffs, suggests that the approach utilized with the detainees at SVJC was primarily based on behavioral control and punishment that was often of a humiliating and abusive nature. Although there is documentation that Doe 1 received some mental health treatment, there is no documentation or other indication of efforts to utilize a trauma-informed treatment approach, or to address staff behaviors that were abusive and

[31] Buffington, K., Dierkhising, C., & Marsh, S. (2010). *Ten things every juvenile court judge should know about trauma and delinquency.* Reno, NV: National Council of Juvenile and Family Court Judges.

[32] The National Child Traumatic Stress Network. (2016). Essential elements of a trauma-informed juvenile justice system, www.NCTSN.org

[33] Kretschmar, J., Capizzi, A., & Shafer, E. (2017). A decade of diversion: Ohio's behavioral health juvenile justice initiative. *Focal Point*, 31, 22-24, www.pathwaysrtc.pdx.edu/publications

[34] Marrow, M., Knudsen, K., Olafson, E., & Bucher, S. (2012). The value of implementing TARGET within a trauma-informed juvenile justice setting, *Journal of Child & Adolescent Trauma*, 5(3), 257-270.

provocative in contributing to the detainees' behavior. In other words, the approach utilized at SVJC is based on the notion of needing to control and punish "bad behavior" on the part of youth vs. understanding that many, if not most, of these youth are demonstrating traumatic "fight or flight" reactions in response to being detained, as well as in response to being secluded, confined, mistreated, and misunderstood by staff.

89. When the behavior of youth in juvenile facilities is simply seen as "bad" behavior and not seen from a trauma-informed lens (in which the behaviors are viewed as originating in trauma and adversity) then the behavioral problems worsen, the chances for rehabilitation are reduced, and the likelihood of youth becoming further involved in the juvenile justice system is increased.[35]

90. Simply put, it is not sufficient to offer general mental services to youth who are UACs and/or are involved in the juvenile justice system; given the high likelihood they have been previously traumatized. When youth have been exposed to violence, abuse, and neglect growing up they may respond by becoming defiant, appearing indifferent, or becoming aggressive as a means of protecting themselves. Their attempts to protect themselves from further victimization and helplessness when in detention are often motivated by a desire to feel safe and in control rather than by the callous indifference and antisocial qualities often attributed to them as "delinquents."[36] When this difference is not understood and the role played by traumatic stress is overlooked (as is often the case in detention facilities), then harsh, punitive, and harmful approaches such as seclusion, restraint, and staff aggression become the default methods utilized.

Opinions:

91. Plaintiff John Doe 1 experienced abuse and neglect from his parents, as well as teasing from his peers, when growing up in Mexico. These traumatic experiences were replicated when he was detained at SVJC. He experienced teasing, humiliation, physical assault, confinement, chair restriction for long periods of time, and was handcuffed and shackled many times. Experiences like these have instilled a legacy of shame, resentment, fear, and distrust in Doe 1 that he will likely never fully recover from without proper trauma-informed treatment over a considerable period of time in a safe setting.

[35] Kinscherff, R., & Keator, K. (2017). Adversity, trauma, and behavioral health needs among justice involved youth. *Focal Point*, 31, 17-19, www.pathwaysrtc.pdx.edu/publications

[36] Ko, S., Ford, J., Kassam-Adams, N., Berkowitz, S., Wilson, C., & Wong, M. (2008). Creating trauma-informed systems: Child welfare, education, first responders, juvenile justice. *Professional Psychology: Research and Practice*, 39 (4), 396-404.

92. The mental health care provided to Doe 1 at SVJC was deficient. The main approach was to emphasize the consequences of his continuing to engage in aggressive behavior as a way to deter him. There was no attempt to understand the underlying traumas that were being triggered in Doe 1, and there was very little effort to help him learn more adaptive self-soothing and self-regulating strategies.

93. Although Doe 1 had a history of being depressed as a child in Mexico, nevertheless, his feelings of being abused and trapped at SVJC greatly exacerbated his depression and at times led to self-injurious and suicidal behavior. At other times this led to aggressive behavior. However, rather than viewing these behaviors as "survival-in-the-moment" behaviors in which Doe 1 was essentially coping the best that he could in a prison-like environment, these behaviors were viewed as "bad" behaviors in need of punishment through confinement and loss of behavioral levels.

94. The psychological evaluation conducted by Gustavo Rife, Psy.D appears to have been heavily relied upon to direct Doe 1's treatment. Dr. Rife largely viewed Doe 1 as a depressed, conduct-disordered adolescent in need of confrontation and containment for his antisocial and delinquent tendencies. There was no attempt to understand these behaviors from a complex trauma framework in which his aggression could be seen as reactive to his environment and those around him as a way to protect himself from being victimized. As a result, Dr. Rife's report served to further justify the behavioral control and confrontation approach utilized by both mental health and other staff, which exacerbated Doe 1's preexisting trauma.

95. A review of the Declaration of John Doe 2 suggests that he may have been overmedicated as a means of behavioral control and that he suffered from racist and discriminatory attitudes and behaviors of staff. When the environment in which youth reside does not treat them equally and justly, it is not unusual to expect that they would feel humiliated and would talk back and/or become aggressive as a way to survive and try to maintain their dignity. Doe 2's aggressive behaviors were punished with prolonged confinements, unnecessary physical force, and being strapped to a chair with a bag over his head - all of which represent cruel, traumatizing, and degrading forms of punishment. Such punishment, which falls below any professional standards of which I am aware, is likely to result in compounding prior trauma and causing longstanding harm.

96. A review of the Declaration of John Doe 3 suggests that he was a victim of excessive force on multiple occasions; suffered humiliation and degradation as a result of racial and derogatory staff remarks, lack of privacy in his room, and being stripped of all his clothes except for his underwear; and was unreasonably restrained, handcuffed and/or confined, for minor infractions. Doe 3's history of fleeing gang violence and death threats in Honduras, as well as his dangerous journey to the U.S. suggests a youth with considerable past trauma who was

likely retraumatized while in detention due to the excessive punishment and degrading experiences he suffered there. A youth such as Doe 3 is in need of an environment that is safe and responsive to his needs vs. a detention facility such as SVJC that appears to discriminate against immigrant youth, that enforces rules inconsistently and arbitrarily, and that utilizes harsh and cruel punishment as a means of controlling youth who act out. This form of control leads to shame and helpless rage on the part of the youth (who feel misunderstood and treated unfairly) and inadvertently leads these youth to continue to act out further through self-destructive and/or outwardly aggressive behavior.

97. A review of the Declaration of J.A. suggests that he was subject to extremely and unreasonably harsh punishment including: being put in solitary confinement for long periods of time; and left naked and strapped to a chair for more than two days. These experiences were likely highly traumatizing to him.

98. A review of the Declaration of R.B. suggests that he was highly traumatized while at SVJC and may have had a psychotic episode when in solitary confinement. He began talking to himself, hitting his head against the wall, and felt he was going crazy. His experiences at SVJC appear to have been highly disturbing to him and to have had an enduring impact – he said he had lost his optimism for life and that both he and his mom noticed that he had changed and was not the same person anymore.

99. A review of the Declaration of D.M. suggests that he did not receive appropriate mental health care for his psychiatric conditions. He not only was not given his medications for six weeks after being transferred to SVJC, but was put in a restraint chair on several occasions when he was in "crisis" and wanting to hurt himself. While in the restraint chair, a bag with holes was put over his head causing D.M. to fear that he would suffocate and die. This was undoubtedly highly frightening and traumatizing for D.M. It would not be surprising if he developed PTSD symptoms as a result of these experiences.

100. The predominant approach utilized at SVJC is that of punishment and behavioral control through such methods as solitary confinement, physical restraint, strapping to a restraint chair, and loss of behavioral levels. These approaches are not only unsuccessful, but are extremely detrimental to detained, traumatized youth – especially to UACs. At times the use of solitary confinement and restraint chairs reached the level of what could be considered torture and other cruel, inhuman or degrading treatment or punishment. The use of these kinds of methods leads to a vicious cycle in which youth, who are already distrustful and traumatized, become further distrustful and traumatized when staff punish them. This leads them to act out even more and then justifies to the staff the need for further efforts to control and punish the youth.

101. From my evaluation of Doe 1 and the materials I reviewed, it is my opinion that SVJC facility staff do not understand the manifestations of trauma and stress

in youth and are not well trained in dealing with highly traumatized children and youth. To avoid harming youth, SVJC needs to implement trauma-focused approaches that will help staff to understand how easily the past experiences of abuse and trauma in some youth, especially UACs, can be triggered, especially when staff are abusive or insensitive. Implementing these approaches will require appropriate trauma-informed policies and procedures, appropriate methods of screening, assessing, and treating traumatized youth, culturally sensitive and trauma-informed programs that strengthen the resilience of youth, and culturally sensitive, trauma-informed staff education and training.

102. While all detainees (adults as well as children) should be treated with dignity and respect, this is especially critical for children and youth because of their inherent vulnerabilities. Approaches that violate the rights of children and youth, that do not consider their "best interests", and that are punitive are detrimental to them and have no place in the juvenile justice system. Irreparable harm can result from punitive, physically abusive approaches because of the residual psychological scars brought about by youth no longer feeling safe in the world and no longer being able to trust others to treat them with dignity and respect. While the extent of damage caused by these approaches cannot always be determined in the moment, it is likely that many of these detained youth will never fully recover from their traumatic experiences prior to and during detention, particularly if effective trauma-informed treatment is not available to them.

103. SVJC staff frequently violated the rights of youth in their custody and became outright abusive as a way to maintain control. The punitive methods used by SVJC staff often reached the threshold of torture and cruel, inhuman, and degrading punishment and likely did substantial, if not irreparable, harm to these youth.

104. Detention, in and of itself, is traumatizing to youth, but even more so when their physical and emotional needs are not met, when they are subjected to abuse, and when their environment does not keep them safe. It is my opinion that the mental health care and the overall care provided at SVJC are deficient and fall far short of the standards of care expected in the juvenile justice system, and that this represents deliberate indifference to the health and mental health needs of the Plaintiffs, as well as the other detainees at SVJC.

Sincerely,

Gregory N. Lewis

Gregory N. Lewis, Psy.D.

Appendix A:

1. Declaration of Plaintiff John Doe 1, dated January 17, 2018
2. Declaration of Plaintiff John Doe 2, dated January 05, 2018
3. Declaration of Plaintiff John Doe 3, dated January 05, 2018
4. Declaration of J.A., dated January 08, 2018
5. Declaration of R.B., dated January 08, 2018
6. Declaration of D.M., dated January 02, 2018
7. Forensic Psychological Assessment of Plaintiff John Doe 1 by Gregory N. Lewis, Psy.D., dated October 10, 2017
8. John Doe v. Shenandoah Valley Juvenile Center Commission Class Action Complaint, filed October 4, 2017
9. John Doe v. Shenandoah Valley Juvenile Center Commission First Amended Class Action Complaint, filed January 31, 2018
10. Office of Refugee Resettlement Records for Plaintiff John Doe 1:
    - Case Management and Progress Notes
    - Clinical Addendum by Evenor Aleman, M.A., Ed.S., dated May 2, 2016
    - Medical Evaluations by Timothy J. Kane, M.D.
    - Psychological Evaluation by Angela Medellin, M.Ed., LPC and Anne M. Esquivel, Ph.D., not dated
    - Psychological Evaluation by Gustavo E. Rife, Psy.D., dated May 4, 2016

Appendix B:

1. *Kimberly Doe, et al. v. United States*, 1:11-cv-907-LY (WD. Tex. – Austin Division)

2. D.B., as next friend of R.M.B, a minor, v. Cardall et al., 1:15-cv-00745-JCC-JFA (ED. VA. – Alexandria Division): Brief of Amici Curiae Linda Brandmiller, Holly Cooper, Greg Lewis, Carter White and Lorilei Williams in support of appellant's petition for panel rehearing or rehearing en banc

3. Abraxas Litigation: *L.M.V.F., et al. v. United States*, 5:08-CA-124-XR (WD. Tex. – San Antonio Division)

4. Nixon Litigation: *Gaitan-Fabian, et al. v. Dunn, et al.*, 5:08-CV-269-XR (WD. Tex. – San Antonio Division)

EXHIBIT 8

ANDREA WEISMAN, Ph.D.
Juvenile and Correctional Mental Health Consultant
Phone: (202) 531-0488 Email: aweisman@aol.com

Date of Report: 2/27/18

To: Theodore A. Howard, Esq.
Wiley Rein, LLP
1776 K Street, NW
Washington, DC 20006

MY INVOLVEMENT IN THIS CASE

1. I was retained by Theodore A. Howard, Esq. with Wiley Rein, LLP to provide an overview of established national standards regarding the essential ingredients in an adequately functioning juvenile correctional facility and to comment on current practices at the Shenandoah Valley Juvenile Center as revealed by the evidence made available thus far. This declaration is submitted in support of the motion for a preliminary injunction submitted by the plaintiffs. If called upon to testify I would do so competently as follows.

MY QUALIFICATIONS

2. I am a licensed clinical psychologist in Washington, D.C. My experience as a clinical psychologist spans nearly 30 years. I have extensive experience evaluating juveniles who have been subjected to stringent conditions of confinement, a very large percentage of whom have experienced severe trauma or are diagnosed with mental or intellectual disabilities. I have evaluated several hundred juveniles during my career.

3. I have worked with juveniles in correctional settings for over 25 years. Most recently I served as the Chief of Health Services for the Department of Youth Rehabilitation Services (DYRS) in Washington. DC from 2007 - 2011. While there, I was responsible for the oversight of all medical and behavioral health programs and services for youth detained in or committed to DYRS facilities or in the community. DYRS had been under court order (*Jerry M.*) since 1987, in large part due to the inadequacy of medical and mental health services. During my tenure, both medical and behavioral health services came into substantial compliance with

the consent decree. In addition, I oversaw the development of specialized programs, including programs introducing trauma informed care.

4. From *December, 2004 – April, 2007,* I was Director of the Division of Behavioral Health Services for the Maryland Department of Juvenile Services in Baltimore, Maryland. I was responsible for the development, implementation and oversight of a continuum of behavioral health services (i.e., mental health and substance abuse) for youth in the 15 Department of Juvenile Services (DJS) facilities, encompassing both detention and commitment. DJS was operating under agreements with the U.S. Department of Justice under the Civil Rights of Institutionalized Persons Act (CRIPA) in three facilities (Baltimore City Juvenile Justice Center, Cheltenham Youth Facility and Charles H. Hickey School). During my tenure, we came into partial or substantial compliance on most CRIPA-related indicators.

5. From *December, 1995 – July, 2000,* I was the Director of Mental Health Services at the Central Detention Facility (DC Jail) during the time it was under federal receivership (*Campbell v. McGruder).* Under my leadership, the D.C. Jail developed protocols, procedures and policies that conformed with, and in many instances went beyond, the National Commission on Correctional Health Care standards.

6. I have been appointed to serve as the mental health expert for monitors of consent decrees involving reforms in the juvenile justice systems in Pennsylvania, Illinois, Kentucky, California, Ohio, Maine and Georgia. In my role in Ohio, I aided in the restructuring of the mental health system and revamping of the disciplinary process in the State's three secure juvenile facilities. Ohio's use of isolation and programmatic restraint was a central part of the litigation. *See S.H. v Reed* 2:04-cv-1206 (S.D. Ohio). In Georgia, I assisted the US Department of Justice (DOJ) in monitoring a memorandum of understanding DOJ reached with the State. My focus was on the conditions of confinement juveniles were subjected to and the adequacy of mental health services provided to the juveniles.

7. I have written and spoken extensively on the issues of isolation and mental health services for juveniles involved with the justice system. In 2007, I testified before Congress on mental health issues among youth in the juvenile justice system.

8. I obtained my Doctor of Philosophy (Ph.D.), in clinical psychology from Clark University in 1988. I am a licensed clinical psychologist in Washington D.C.

9. I have included a copy of my curriculum vita as Exhibit A.

MATERIALS REVIEWED

I reviewed the declarations of six immigrant youth who were or are at the Shenandoah Valley Juvenile Center Commission: John Doe 1, John Doe 2, John Doe 3, D.M., J.A. and R.B.

I reviewed Dr. Greg Lewis' declaration.

I also relied on my extensive knowledge of best practices in the field of juvenile justice. In addition, I relied on the national standards promulgated by the National Commission on Correctional Health Care, the Juvenile Detention Alternatives Initiative and the American Correctional Association. Finally, as will be evident throughout this declaration, I referenced professional literature on adolescent development/brain development, prevalence and presentation of youth in the juvenile justice system with complex trauma, consequences of solitary confinement and the effectiveness of incentivized behavior management programs.

THE BACKGROUNDS OF THE IMMIGRANT YOUTH

Immigrant youth at Shenandoah Valley Juvenile Center (SVJC) were picked up because they crossed the border while fleeing from trauma and abuse they were suffering at home and in their communities. As Dr. Lewis notes in his report:

> Children who come to the United States unaccompanied from other countries (unaccompanied alien child – "UAC") come for a variety of reasons including: fleeing

parental abuse and neglect; fleeing violence and unsafe conditions in their home country; fleeing persecution; to join parents or other relatives already living in the U.S.; and a desire for a better life in which they will have opportunities to work and go to school. Some children are also involuntarily trafficked into the U.S. as part of the worldwide labor and sex trafficking industry.[1] UAC's are vulnerable before, during, and after their journey to the U.S. because they do not have adult protection and are unable to properly care for themselves.[2]

Most UACs have experienced abuse, neglect, and trauma within their home countries, but are then faced with the additional stresses of migrating to the U.S. often traveling through unsafe and dangerous countries over a period of weeks and months. During their journey - which may take them through multiple countries - UACs may undergo highly traumatic experiences including: going days without food, water, or shelter; being exposed to unsanitary conditions; getting sick or injured; being robbed or kidnapped; being beaten; being raped; watching others being tortured or murdered; having to survive in the jungle; and having to survive crossing through deserts and rivers. Once they arrive in the U.S., UACs may be further traumatized if apprehended by Immigration and Customs Enforcement and detained. In addition, they have to adjust to living in a country in which they often do not speak the language and are unfamiliar with the customs. All of these experiences contribute to UACs who are likely to have suffered extensive and multiple instances of abuse and trauma, often referred to as complex trauma, prior to any trauma they may experience if detained.

These already significantly traumatized youth are then detained in the SVJC and subjected to additional traumatization as will be discussed in this report.

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[1] Levinson, A. (2011). Unaccompanied immigrant children: A growing phenomenon with few easy solutions. Migration Policy Institute, *available at* https://www.migrationpolicy.org/print/4328

[2] Young, W., & McKenna, M. (2010). The measure of a society: The treatment of unaccompanied refugee and immigrant children in the United States. *Harvard Civil Rights-Civil Liberties Law Review*, 45, 247-260, *available at* http://harvardcrcl.org/wp-content/uploads/2009/06/247-260.pdf

THE YOUTHS' DECLARATIONS

All six youth spoke of spending repeated, extended periods of time in solitary confinement, often for minor infractions. While in solitary, the youth's clothes, personal items, mattress and bedding are typically removed from the cell. They are left in the cell in only their boxer shorts. They are afforded one book and a bible.

All youth also spoke of having been excessively restrained by the use of a restraint chair to which they are physically attached for hours (shifts), sometimes days at a time. Several youths told of having been placed in the restraint chair as an intervention to address their suicidality.

The youth also detailed the physical and verbal abuse they experienced at the hands of the staff members. These experiences will be discussed in detail in this report.

MY OPINION

I. SOLITARY CONFINEMENT: PRACTICES AT THE SHENANDOAH VALLEY JUVENILE CENTER

1. It is my opinion, within a reasonable degree of certainty in the field of clinical psychology, that all juveniles subjected to the SVJC policy and practice of solitary confinement as described above are at a substantial risk of serious harm to their social, psychological, and emotional development.

2. Solitary confinement can be dangerous for anyone. Severely limiting an individual's environmental and social stimulation has a profoundly deleterious effect on mental functioning.

3. Research over the last half-century has demonstrated that solitary confinement can worsen mental illness and produce symptoms even in prisoners who start out

psychologically robust. Individuals who are deprived of meaningful external stimuli are soon unable to maintain an adequate state of alertness and attention to the environment. Even a short time in solitary confinement will predictably shift the encephalogram (EEG) pattern towards an abnormal pattern characteristic of stupor or delirium.[3]

4. Due to their developmental vulnerability, solitary confinement causes juveniles much greater harm than does such confinement of adults, and the risks of solitary confinement to juveniles are alarming.

5. Because juveniles are still developing socially and emotionally and psychologically, they are especially susceptible to psychological and neurological harms when they are deprived of environmental and social stimulation. For a juvenile, simply being placed in isolation – the utter helplessness of it – is enormously stressful. This surge of cortisol – of fear, anxiety, and agitation – will be especially severe in juveniles. The consequences, including actual changes in brain structure, have been demonstrated to persist into adulthood.[4]

6. Our knowledge of the harms caused to juveniles in solitary confinement is based on extrapolation from the clinical interviews of adults and the expanding knowledge of adolescent development. It is widely accepted that, in the adolescent brain, the connections between the frontal lobe and the mid-brain are still developing.[5] The frontal lobe sits just behind the forehead. As it develops, teenagers can reason better,

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[3] These harms are discussed in further detail in Psychiatric Effects of Solitary Confinement, 22 Wash. U. Journal of Law & Policy 325 (2006) an article written by Stuart Grassian, M.D. one of the leading experts on the harmful effects of solitary confinement.

[4] Tottenham, N, Galvan, A. (2016). Stress and the adolescent brain; Amygdala-prefrontal cortex circuitry and ventral striatum as developmental targets. Neuroscience and Behavioral Reviews, 70, 217-227.

[5] See, e.g.: Casey, B.J., Jones, R.M., and Hare, T.A., (2008) The Adolescent Brain, Ann. N.Y. Acad. Sci. 1124: 111-126; Ernst, M., Mueller, S.C. (2008) The adolescent brain: Insight from functional neuroimaging research. Dev. Neurobiol 68(6) 729-743.

develop more control over impulses and make better judgments.[6] This part of the brain continues to develop until an individual's mid-twenties.

7. Exposure to chronic, prolonged traumatic or stressful experiences, such as solitary confinement, has the potential to permanently alter an adolescent's brain which may cause longer-term problems in the following domains:

   a. **Attachment:** Trouble with relationships, boundaries, empathy, and social isolation;

   b. **Emotional (Dis)Regulation:** Difficulty identifying or labeling feelings and communicating needs;

   c. **Cognitive Ability:** Problems with focus, learning, processing new information, language development, planning and orientation to time and space;

   d. **Behavioral (Dis)Control:** Difficulty controlling impulses, oppositional behavior, aggression, disrupted sleep and eating patterns, trauma re-enactment.[7]

8. The American Academy of Child and Adolescent Psychiatry, the American Medical Association, the World Health Organization and the United Nations have all concluded that, due to their developmental vulnerability, adolescents are in particular danger of adverse reactions to prolonged stays in isolation.

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[6]Noted developmental psychologist Lawrence Steinberg, details adolescents' growing capacity for executive functioning as their brains mature. Age of Opportunity: Lessons from the New Science of Adolescents. Houghton, Miffin, Harcourt, 2014).

[7] How Trauma Affects Child Brain Development – N.C. Division of Social Services. Vol. 17, No.2, 2012; See, e.g.: Tottenham, N., Galvan, A. (2016) Stress and the adolescent brain. Amygdala prefrontal cortex circuitry and ventral striatum as developmental targets. Neuroscience and Bio-behavioral Reviews 70:217-227.

9. Juveniles with intellectual and mental health disabilities are especially vulnerable to a substantial risk of serious harm from solitary confinement because they are more likely than persons in the general population to have diagnosed mental illnesses, learning disabilities, and a high incidence of trauma. Research shows that over 60% of the youth in correctional settings have an underlying major mental illness. These include Posttraumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, and various forms of Bi-Polar mood disorders. Youth in solitary confinement have an even higher incidence of mental disorders than those in the general population.

10. Juveniles experience time differently - a day for a child feels longer than a day to an adult.[8] Whittmann et.al. conducted research investigating this perception difference, examining 499 subjects aged 14 to 94 years old. Their results generally support the widespread perception that the process of experiencing passage of time speeds up with age. In addition, juveniles have a greater need for social stimulation.

11. Across all developmental spheres, children are different from adults, making their time spent in isolation even more difficult and the developmental, psychological, and physical damage more comprehensive and lasting. [9]

12. The incidence of trauma among incarcerated youth is also significant, with some studies reporting the number to be as high as 50 – 90%.[10] There is a clear medical consensus that, for those juveniles with mental illness, the risk of harm posed by solitary confinement is especially great. People with mental illnesses already have cognitive defects in their brain structure or biochemistry. They already have weakened

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[8] Age effects in perception of time. Psychol Rep. 2005 Dec;97(3):921-35.Wittmann M, Lehnhoff S.

[9] See. e.g. Bremner,J. (2006) Traumatic Stress: effects on the brain. Dialogues in Clinical Neuroscience: Vol. 8, No. 4, 445-461.

[10] Ford, J., et.al, Trauma Among Youth in the Juvenile Justice System: Critical Issues and New Directions, National Center for Mental Health and Juvenile Justice, 2007.

defense mechanisms, are at a higher risk for mental health abnormality and are more susceptible to significant trauma from lack of environmental and social stimuli. Therefore, the trauma that can occur in juveniles with pre-existing mental illnesses will be more significant than the already significant and long-lasting effects on juveniles without a mental health condition when exposed to isolation.

13. Medical professionals, including organizations like the American Medical Association, agree that juveniles with mental illnesses should not be placed in solitary confinement for longer than one hour without a comprehensive evaluation from a physician. Solitary confinement should never be used to punish people with mental illnesses.

14. Youth exposed to traumatic or stressful events exhibit a wide range of symptoms. They present with not just internalizing problems, such as depression or anxiety, but also externalizing problems like aggression, conduct problems, and oppositional or defiant behavior. These are the very behaviors that result in institutional infractions that lead to placements in solitary confinement. This in turn causes more trauma, and can lead to more negative behavior, resulting in infractions, prolonging a youth's time spent in solitary.

I. SHENANDOAH VALLEY JUVENILE CENTER'S HOSTILE ENVIRONMENT

In addition to the trauma youth experience consequent to their placement in solitary confinement, the hostile environment created by the correctional officers is also traumatizing. National standards do not allow officers to "slam" youth against the wall, excessively shackle and restrain youth and use derogatory language in describing immigrant youth.

Physical Abuse

All youth reported that they had been beaten up by staff members. One youth spoke of having been placed naked in a restraint chair fully shackled and then beaten by staff members; the youth reports he was left naked in the restraint chair for two and a half days. All youth spoke of

being slammed against the wall or floor in staff members' attempts to "de-escalate" them and the situation. Clearly, these abusive actions further traumatized youth and were anything but calming interventions.

Verbal Abuse

The youth also spoke of the verbal harassment visited upon immigrant youth with remarks such as: "Hispanics, they don't know nothing, they just come to our country." The same youth said that staff "tell the kids they're stupid and make fun of them for not understanding English." The youth that reported this understood English enough to understand what the officers were saying.

Another youth spoke of being taunted by officers on a daily basis: "While I was at Shenandoah, staff members would make fun of me on a daily basis. They would call me names such as "pendejo" and "onion head," and do things like drop my clean towel on the dirty floor in front of me."

These overly punitive and degrading practices at SVJC lead to a culture within which youth cannot possibly be rehabilitated which is the mandate of juvenile correctional facilities. Shenandoah's strategies for managing youth's behaviors is entirely counter-productive. For over 70 years, behavioral psychological research has demonstrated that rewarding desired behavior is much more effective than punishing undesirable behavior. With a reward-centered paradigm, youth learn what *TO DO,* not just what *NOT TO DO.* As such, rewarded behaviors have a much greater likelihood of being repeated as opposed to behaviors which are not reinforced, which have a tendency to extinguish.

Research has shown that effective behavior management programs in juvenile justice systems are based on providing incentives for youths' production of desired behavior. Typically, the youth participates in identifying what rewards would be meaningful (e.g., extra phone call, later bed time, etc.). While the rewards jump-start the change process, as youths' behavior changes, so too does the reaction of others engaging with the youth. Over time, improved interactions

with others becomes its own reward. Through this process, youth come to incorporate the behavioral changes into their repertoire. Encouraging the development of more acceptable behaviors while detained has the greatest likelihood of their repetition in the community.

This is consistent with the Juvenile Detention Alternatives Initiative (JDAI) standard that requires "[t]he facility [to have] a system of positive behavior interventions and supports that provides a set of systemic and individualized strategies for achieving social and learning outcomes for youth while preventing problem behavior."[11]

II. ESSENTIAL COMPONENTS OF A MENTAL HEALTH PROGRAM IN JUVENILE FACILITIES

National standards promulgated by the National Commission on Correctional Health Care (NCCHC), the American Correctional Association (ACA) and the Juvenile Detention Alternative Initiative (JDAI) articulate the *essential* components of an adequately functioning mental health program in juvenile correctional facilities. As a general matter, there should be a sufficient number of mental health staff to perform the following functions:

1a. Intake Screening and Assessment – upon admission, all youth should receive a screening to determine if they are "eligible" for admission (e.g., they are not acutely psychotic or suffering a medical condition that cannot be treated at the facility).

1b. Admission screening should also determine if the youth is at risk of self-harm or has any other mental health condition requiring immediate intervention. When the screening detects possible mental health or substance use conditions, detainees should be referred for further evaluation, assessment and treatment by mental health professionals.[12]

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[11] JDAI standard at D1 – Positive Behavior intervention and Supports
[12] E.g., NCCHC standard Y-E-05 Mental Health Screening and Evaluation.

2a. Suicide Prevention – All juvenile justice facilities should have and follow well-articulated policies and procedures for the management of youth who express suicidality or intent to harm themselves or engage in self-harming behaviors following admission. Typically, these procedures include placement of the youth on a suicide watch with either close (every 15 minutes) or constant observation.

In most facilities, anyone can place a youth on a suicide watch but only a mental health professional can lower or remove a youth from watch status.[13]

Several youths reported being placed in a restraint chair when they expressed intent on harming or killing themselves. Placing a youth in a restraint chair because he/she expresses suicidality is not consistent with national standards.

3. Mental Health Services

Youth are entitled to adequate medical and mental health care, to protection from harm including staff abuse, and to a facility in which the vulnerable can be protected: a safe, sanitary and humane environment. In order to provide this environment, certain measures should be implemented:

a. All detainees should be screened upon admission by trained personnel for mental health and substance abuse problems.
b. Treatment should be provided in an atmosphere of empathy and respect for the dignity of the person. It should be strength-based and recovery-oriented. A reasonable array of mental health interventions should be available (e.g., individual and group therapies, psychoeducational programs).
c. Youth should have unimpeded access to care. This is accomplished by having a "kite" or sick call system where in every living unit has a sick call box into which youth can place their request to be seen by a mental health provider.
d. Mental health providers make daily rounds ensuring they check in with all youth.

[13] E.g., NCCHC standard Y-G-05 Suicide Prevention Program

e. Mental health providers meet regularly with each other and with correctional staff to ensure everyone involved has knowledge of youths' needs and to coordinate intervention strategies going forward.

f. Treatment plans are developed for each youth (with or without a mental health disorder) which articulate what the youth and staff will work on/toward during the youth's residency. This is essential as it serves as the contract between the youth and staff.

III. Staff Training (See JDAI Training Standards at C)

At a minimum correctional staff should receive pre-deployment training on:

- Adolescent development/brain development.
- Signs and symptoms of youth with mental health disorder and the prevalence of these among incarcerated youth.
- Suicide prevention policy and protocols and their attendant responsibilities.
- The incidence of trauma among incarcerated youth and what staff can do minimize further traumatization.
- De-escalation strategies. Programs such as Safe Crisis Management have been shown to have great efficacy in calming youth and reducing confrontations between staff and youth. Their literature states: "Safe Crisis Management® 'SCM' is a comprehensive training program focused on preventing and managing crisis events and improving safety in agencies. Safe Crisis Management has a trauma-sensitive approach with emphasis on building positive relationships with individuals. Our program is designed to assist staff with responding to the needs of all individuals and particularly with the needs of the most challenging."[14][15]

IV. Grievance System

[14] See: JKM Training, Inc. Safe Crisis Management

[15] E.g., NCCHC Y-C-04 Training for Child Care Workers

National standards require an accessible and meaningful grievance process. For example, JDAI standard (at Rf1) reads, "The facility provides more than one way to report abuse, neglect, harassment, and retaliation by other youth or staff within the facility." Further, the standard (at Rf4) requires that, "Staff provide all youth with access to a grievance procedure that provides an opportunity for a fair consideration and resolution of complaints about any aspect of the facility, including medical and mental health services."

A fair and equitable grievance system is essential in any correctional facility so that those incarcerated within them feel they have recourse in the event they feel they are being mistreated. The declarations of the youth made it clear they felt abused and demeaned but that they did not have any meaningful recourse to address their complaints. One youth said, "It's easy for the guards to write incident reports - you did this, you did that, you disrespected me - but they never hear the kid's side of the story. My voice was never heard."

FINAL CONCLUSIONS

The SVJC is riddled with problems. The concerns of the immigrant children must be taken seriously. These already traumatized youth report being abused both physically and verbally while at SVJC. The practices employed by the SVJC create a hostile and punitive environment that runs counter to all national standards. While implementation of an adequate mental health program may take time, these practices must cease immediately.

It is imperative that the leadership at Shenandoah Valley Juvenile Center familiarize themselves with national standards and develop a plan for their implementation to avoid continuing practices that create lasting harm for vulnerable youth.

I submit this report on 2/27/2018.

Andrea L. Weisman, Ph.D.

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ANDREA WEISMAN
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Forensic Consultation

June, 2017 – present
Corrections Information Council
Washington, DC

CIC provides oversite of DC inmates in the FBOP. I am their mental health consultant. I have been involved in their assessment of mental health services for inmates at the ADX Florence Facility.

August, 2016 – present
Equal Justice Initiative
Montgomery, AL

This is a Miller re-sentencing case. A JLWOP case concerning a woman sentenced when she was 14.

May, 2015 – June, 2016
Office of the State Public Defender
Kalispell, MT

I was the mental health expert evaluating a young man charged with mitigated deliberate homicide.

March, 2015 – present
Lee Hunt Law Office
Santa Fe, NM

I am the mental health expert in a wrongful death suit of a youth in the Santa Fe County Juvenile Detention Facility.

August, 2017 – September, 2017
Center for Children's Law and Policy
Washington, DC

I served on a team of experts assessing four juvenile detention centers in Kentucky.

August, 2017 – September, 2017
Center for Children's Law and Policy
Washington, Dc

I was the mental health expert on a team of experts assessing the Long Creek Juvenile Detention Center in Portland Maine.

September, 2015 – October, 2016
Law Offices of Victor Fleitis
Tupelo, MS

I was the mental health expert in a case involving the intrusive and unnecessary strip search of a 12 year old girl.

May, 2014 – June, 2016
U.S. Department of Justice v. Glen Mills School

I was the mental health expert for DOJ investigating services for youth with mental health disabilities.

July, 2014 – June, 2015
Center for Children's Law and Policy
Washington, DC

I served as the mental health expert for the Center for Children's Law and Policy as part of a team brought in to assess the Rhode Island Training School's compliance with Juvenile Detention Alternative Initiative I standards.

July, 2014
Georgetown Criminal Justice Law Clinic
Washington, DC

I conducted a competency assessment of a 54 year old man with schizophrenia and MR charged with crack distribution.

November, 2011 – December, 2015
S.H. v. Reed
Ohio Department of Youth Services
Columbus, Ohio

I served as the mental health expert for the federally appointed Monitor in the class action lawsuit regarding conditions of confinement in three secure juvenile justice facilities in Ohio. Their use of isolation and programmatic restraint had been a central component of the litigation.

February, 2012 – August, 2013
Troy. D. v. Mickens, et. al.
Juvenile Law Center
Philadelphia, PA

I served as the expert mental health consultant regarding the use of extensive isolation and the development of an adequate mental health program.

April, 2013
Center for Children's Law and Policy
Washington, DC

I was the mental health expert on a team brought in to review the Cook County Temporary Juvenile Detention Facility in Chicago, Illinois on behalf the Annie E. Casey Foundation's Juvenile Detention Alternatives Initiative.

May, 2013 – August, 2013
State Office of the Public Defender
Cheyenne, WY

I was the expert mental health consultant regarding the resentencing of a juvenile originally sentenced to life without parole.

December, 2003 – September, 2004
Receiver, Riverview Psychiatric Center/Augusta Mental Health Institute
Augusta, Maine

I served as an expert forensic consultant, working for the Receiver of Riverview Psychiatric Center (RPC), appointed by the federal court, regarding the structure and design of mental health services within the RPC (Maine's state mental hospital serving the forensic population) and the accessibility of acute care services for incarcerated populations in Maine jails and prisons. My consultation included the development of strategies for implementation of community-based services.

July, 2003 – January, 2004
Dickstein, Shapiro, Morin & Olinsky LLP
Washington, DC

I served as a mental health expert in a wrongful death lawsuit against the Virginia Department of Corrections. This case

involved the suicide of a 37-year-old man in one of the Sussex prisons in Virginia.

January, 1998 – June, 2001
Institute on Crime, Justice and Corrections
George Washington University
Washington, DC

I worked as a mental health expert for the Institute, which served as monitor of a Memorandum of Understanding between the US Department of Justice and the Georgia Department of Juvenile Justice regarding health care and conditions of confinement in the state's juvenile detention facilities and training schools for sentenced youth. Adequacy of mental health services in all the facilities was one of DOJ's principal concerns. I traveled throughout the state monitoring program capacity, speaking with youth and staff about practices and resources, and communicating back to the Institute, DOJ and the Georgia Commissioner on Juvenile Justice.

November 1999
Human Rights Watch
Baltimore City Jail
Baltimore, Md.

I was the mental health expert for HRW on a team brought in to investigate mental health services and conditions of confinement for juveniles in the Baltimore City Jail.

March, 1999 – June, 2001
Physicians for Human Rights
Washington, DC

As a mental health expert for PHR, I provided training for medical students and physicians on how to inspect juvenile facilities.

February 1999
Amnesty International
Norway

I served as a mental health expert for AI as part of a team that toured Norway to discuss the American Juvenile Justice system with public officials and other policymakers, attorneys, law students, and other advocates.

September, 1994 – December, 1994
National Coalition for Mental and Substance Abuse Health Care in the Criminal Justice System
Washington, DC

This was a national advocacy organization funded by SAMHSA promoting mental health services for juveniles/adults in the juvenile/criminal justice system. I served as Senior Policy Analyst and helped to coordinate state policy planning meetings.

Full-time Employment

May, 2007 – August, 2011
Chief, Health Services Administration
Department of Youth Rehabilitation Services
Washington, DC

I was responsible for the oversight of all medical and behavioral health programs and services for youth detained in or committed to DYRS facilities or in the community. The Agency has been under court order (*Jerry M.*) since 1987, in large part due to the inadequacy of medical and mental health services. Among my responsibilities was the development of a consent decree work plan with the court's Special Arbiter and plaintiffs' attorneys that would

allow DYRS to bring medical and behavioral health services up to national standards and move toward exiting *Jerry M.*

My responsibilities included oversight of the *Jerry M.* work plan, including the development of new policies, procedures, protocols, services, programs and staffing requirements and patterns of deployment for both medical and behavioral health programs. During my tenure, both medical and behavioral health services came into substantial compliance with the work plan. In addition, I oversaw the development of specialized programs, including programs introducing trauma informed care, the use of bio-feedback to address youths' trauma issues, a fatherhood program (Baby Elmo), gender specific programming, including family planning, implementation of an evidence-based substance abuse program, Lesbian-Gay-Bisexual-Transgender-Questioning programming and sensitivity training, the development of an extensive continuous quality improvement program for the Health Services Administration and access to an array of evidence-based programs and services, including Multisystemic Therapy, Functional Family Therapy, and Multidimensional Treatment Foster Care.

I have also been responsible for the development of significant interagency collaborative opportunities with the District's Departments of Education, Child and Family Services, Mental Health, Health, Health Care Financing, the Addiction Prevention and Recovery Administration, and Court Social Services. I have also had significant responsibility for working with the District's judges and court system.

December, 2004 – April, 2007
Director, Division of Behavioral Health Services
Maryland Department of Juvenile Services
Baltimore, MD.

I was responsible for the development, implementation and oversight of a continuum of behavioral health services (i.e., mental health and substance abuse) for youth in the 15 Department of Juvenile Services (DJS) facilities, both detention and commitment. DJS was under agreements with the U.S. Department of Justice under the Civil Rights of Institutionalized Persons Act (CRIPA) in three facilities (Baltimore City Juvenile Justice Center, Cheltenham Youth Facility and Charles H. Hickey School). During my tenure, we came into partial or substantial compliance on most CRIPA-related indicators.

I was responsible for the collaboration and coordination of behavioral health services with Maryland sister agencies, including the Department of Health and Mental Hygiene (DHMH), Maryland State Department of Education (MSDE), Department of Social Services (DSS), Department of Health and various community mental health and advocacy organizations.

I was a co-founder of the Community and Family Resource Center in the Baltimore City Juvenile Justice Center, which provided information, short-term mental health counseling and linkage to an array of community-based services for families of youth in the juvenile justice system.

September, 2002 – June, 2004
Director, Alternative Pathways
Department of Mental Health
Washington, DC

Alternative Pathways (AP) was a locally- and federally-funded initiative to divert youth with mental health and/or substance abuse disorders from the juvenile justice system. I became the director of this initiative after I secured the funding from the federal Office of

Juvenile Justice and Delinquency Prevention for $1,600,000 for the Department of Mental Health to take the lead for the District.

AP spearheaded interagency collaboration among all the District agencies that touch youth involved in the juvenile justice system, including the Family Court, the Metropolitan Police Department, Court Social Services, Public Defender Services, Department of Mental Health, Youth Services Administration, the Deputy Mayor for Children, Youth and Elders and various community stakeholders.

As chair of the mayorally appointed committee, known as the Front-End Assessment Team (FEAT), I was responsible for leading the effort and for bringing together those who could conceptualize the infrastructure and resources that would be needed. I developed the RFPs for vendors and was responsible for the development of all budgets and accounting to the District and federal agency. I was also responsible for all quarterly and annual reports.

In FY 2003, Alternative Pathways launched Youth Empowerment Services (YES), with the goal of screening chronic truants and all apprehended youth for co-occurring disorders so that linkage to necessary services and supports could be established.

Alternative Pathways was also asked to apportion a percentage of its funds for "deep-end" youth, defined as those residing on the Oak Hill Youth Center campus, or in out-of-District residential settings. I was responsible for developing the budget criteria, and protocol for identifying youth with mental health needs who required resources not available in their current placements. Dozens of youth were identified and, with Medicaid and AP funds, were transitioned into the community to receive the services they required. Th blending of funds from these source made it

possible to focus on community-based plans that were a mix of traditional and non-traditional services and supports.

In addition, AP provided the funds to support the validation of Court Social Services' Risk Assessment Instrument (RAI) used in screening youth for detention. As part of AP's strategic plan for addressing the front-end, it was essential that the District used an objective and validated RAI. I budgeted funds in the AP grant to accommodate this expenditure and developed a contract between AP and the National Council on Crime and Delinquency. Progress and monitoring was provided by the FEAT.

February, 2001 – September, 2002
Director, Mental Health Services, Oak Hill Youth Center
Department of Mental Health
Washington, DC

As noted previously, the Youth Services Administration (YSA), which was the predecessor of the Department of Youth Rehabilitation Services, had been under court order (*Jerry M.*) since 1987. During my tenure the daily census on the OHYC campus averaged 175, with up to 20 daily admissions. The population included a co-mingled mix of detained and committed youth. Working for the Department of Mental Health, I was responsible for the administrative and clinical oversight of mental health services and supports at the facility. I worked to develop interagency agreements between DMH and YSA, and other District agencies providing direct service to the population (e.g., Department of Education, Court Social Services and various group and shelter home providers). With supervisory responsibility for 15 mental health professionals, I developed a comprehensive mental health program that included: suicide screening, comprehensive psychiatric and psychological assessments, medication management crisis management, acute care services

and protocols for hospital transfers, and brief and on-going psychotherapy. I also established procedures for the linkage of youth to mental health services upon their release to the community.

In addition, I provided a number of trainings for OHYC juvenile corrections officers, including: "Mental Health 101," strategies for de-escalating youth, and suicide prevention.

December, 1995 – July, 2000
Director, Mental Health Services, Central Detention Facility (DC Jail)
Federal Receivership (*Campbell v. McGruder*) DC Jail
Washington, DC

In 1995, the DC Jail (Central Detention Facility, or CDF) was placed into receivership after nearly two decades of failing to come into compliance with consent decrees. The sentinel events leading to a receivership were the large number of completed suicides (9) that had occurred in the jail in the previous year. At that time, CDF provided services for all DC inmates, including sentenced inmates residing in the Virginia-based Lorton prison complex. Upon my appointment, I decentralized mental health services. This included training prison staff and developing protocols and procedures for delivery of mental health services throughout the DC Department of Corrections.

The CDF had a court-mandated ceiling of 1,767 (there were 1,700 on any given day and about 1,000 monthly admissions). I developed two residential treatment units, one serving those identified as acutely mentally ill, and a second, long-term stay unit that served as a step-down for those unable to be housed in the general population. All officers, detailed and relief, had to go through an 40-hour, full-week training in order to qualify to work on the "mental health units." In addition, I developed an outpatient

mental health program for inmates residing in the general population. I hired and supervised a professional staff of 13 licensed psychologists and social workers to accomplish this. Together we developed protocols, procedures and policies that conformed with, and in many instances, went beyond the National Commission on Correctional Health Care standards.

I developed, staffed and resourced numerous trainings for correctional officers
Including, the 40-hour mental health training, suicide prevention, stress management, and de-escalation strategies.

I also developed the funding necessary to launch two residential treatment units, (one for men, the other for women) for inmates with substance abuse histories or charges. Working with Pretrial Services, the Addiction, Prevention and Recovery Administration (APRA), and the Salvation Army, these jail-based units provided comprehensive mental health and substance abuse assessments and medical evaluations of detainees. I also began the process of establishing a recovery plan and effecting real linkages for detainees returning to the community.

My responsibilities included negotiating aftercare services and supports with the Department of Mental Health. In addition, I spearheaded an initiative to divert non-violent misdemeanants from the criminal justice system into mental health services and settings. As Chair of the DC Jail Diversion Task Force, I brought together the DC Superior Court, the Attorney General's Office, Public Detender Services, numerous community-based mental health advocacy groups and others to craft the District's diversion plan.

January, 1995 – August, 1996
Director, DC Women's Jail Project
Central Detention Facility (DC Jail)

Washington, DC

I developed the program and funds to establish the Women's Jail Project, which provided direct mental health services and advocacy for women in the DC Jail. I supervised four Howard University clinical psychology doctoral students who worked on site in the Jail. The project was supported by funds from the U.S. District Court for the District of Columbia, the Public Welfare Foundation, the Eugene and Agnes E. Meyer Foundation, and the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration/HHS.

Volunteer Work

April, 2010 – June, 2011
International Sports Federation (INAS)

I was part of an international eligibility committee of psychologists that reviewed applications from intellectually disabled athletes from around the world who were applying to compete in the International Olympics.

August, 1992 – September, 1994
Death Penalty Focus
San Francisco, CA.

I volunteered for the Death Penalty Focus Group in San Francisco offering technical assistance in their development of media campaigns.

September, 1993 – December, 1993

Pelican Bay Information Project
San Francisco, CA

I volunteered for this grass-roots project whose mission was to monitor the Pelican Bay Prison trial and stay in communication with inmates in Pelican Bay's Special Housing Unit (SHU).

Clinical Practice

- Director, Psychological Services Center, Clark University, Worcester, Ma. (1/91-6/91)
- Partner, Private Practice, Clinical Associates of Shrewsbury, Shrewsbury, Ma. (9/90-6/93)
- Treatment Team Coordinator, Westborough State Hospital, Westborough, Ma. (9/87-12/90)
- Sexual Abuse Specialist, Westborough State Hospital, Westborough, Ma. (9/88-12/90)
- Staff Psychologist, Psychiatry and the Law Program, Worcester Area Community Mental Health Center, Worcester, Ma. (9/83-6/87)

Education

1988Ph.D. Clinical Psychology Clark University, Worcester, MA
1977 M.A. Psychology Clark University, Worcester, MA
1972 B.A. Psychology Clark University, Worcester, MA

Honors and Awards

1987 Research Scholar Appointment, Clark University, Worcester, Ma.
1972 Phi Beta Kappa, Clark University, Worcester, Ma.
1972 B.A. Cum Laude and with High Honors in Psychology, Clark University, Worcester, Ma.

Select Publications, Reports and Presentations

(2014) Hartford Courant Op-Ed: State Must End Use of Restraints On Juveniles.

(2014) Workshop presentation: Solitary Confinement and Isolation of Youth: Successful Reforms and Next Steps. Coalition for Juvenile Justice. With Amy Fettig, Senior Staff Counsel for the ACLU and Mishi Faruque, National Juvenile Justice Policy Strategist, ACLU.

(2007) Testimony on "Mental Health Issues among Youth in the Juvenile Justice System" presented to the Congressional Subcommittee on Healthy Families and Communities of the Committee on Education and Labor.

(2003) "Remarks Mental Health in Prison Groups," UDC David A. Clarke School of Law Law Review, Vol. 7, Spring, Number 1, pgs. 224-232.

(2002) "Trends in Mental Health and Juvenile Justice in the U.S." XXVIIth International Congress on Law and Mental Health, Amsterdam, the Netherlands.

(2000) "Mental Illness Behind Bars." In J. May and K. Pitts (Eds.) *Building Violence: How America's Rush to Incarcerate Creates More Violence.* Sage Publications, Ca.

(1999) "Central Detention Facility Safety Net Program." An interactive journaling series for use in a jail-based substance abuse program. Developed with Corrective Action Publications, a subsidiary of Serenity Support Services.

(1999) "Manufacture of Mental Illness in U.S. Prisons: Can Psychologists Respond?" With Craig Haney. Panel presented at the American Psychological Association meeting in Boston, Ma. The panel was part of a session entitled *Crisis in U.S. Prisons: Implications for a Culture of Peace.*

(1998) "Mental Health Outpatient Services in Correctional Settings." In M. Puisis, R. Shansky, and J. May (eds.) *Clinical Practice in Correctional Settings.* Mosby, Chicago, Ill.

Licensed in DC: license # PSY 1752
Licensed in MD: license # 04384 (inactive)

References upon request.