WASHINGTON LAWYERS' COMMITTEE
FOR CIVIL RIGHTS AND URBAN AFFAIRS

Written Testimony to the U.S. Commission on Civil Rights
Regarding the Condition of Immigrant Detention Centers and
the Status of Treatment of Immigrant Children in Detention

May 13, 2019

INTRODUCTION

Detention in jail-like conditions is causing irreparable harm to vulnerable children fleeing oppression, violence and hopelessness. As lawyers[1] for a class of unaccompanied immigrant children confined at Shenandoah Valley Juvenile Detention Center ("SVJC") in Staunton, Virginia, one of the two most restrictive detention facilities for immigrant youth in the country, we learned much about the punishing conditions to which unaccompanied minors detained in a "secure"[2] facility in the United States are subjected. All children deserve care, protection, and safety, and no child should be placed in and further traumatized by prolonged detention. However, to the extent incarceration facilities for youth are permitted to stand, our experience informs and highlights the need for change: comprehensive reform to the detention of immigrant children is urgent, and among the most pressing problems is their serious, unmet need for mental health supports. Based on our experience and research, we recommend the following: detention

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[1] The Washington Lawyers' Committee is a civil rights, non-profit organization based in Washington, D.C. that works to create legal, economic and social equity through litigation, client and public education and public policy advocacy, focusing on issues of housing, employment, education, criminal legal reform, public accommodations, and immigration. In 2017, the Washington Lawyers' Committee, along with the law firm Wiley Rein LLP, filed a federal lawsuit against the Shenandoah Valley Juvenile Center ("SVJC"), a secure detention facility in Staunton, Virginia, on behalf of unaccompanied immigrant minors detained at the facility seeking an end to a pattern and practice of excessive force, unnecessary and punitive seclusion, and deprivation of adequate mental health care. In the course of our representation, we reviewed the records of hundreds of children and obtained the testimony of a number of current and former SVJC staff, which also inform these comments.

[2] The Office of Refugee Resettlement ("ORR") contracts with or funds detention facilities for immigrant youth, and there are various categories of detention settings provided by these facilities. "Secure" facilities are defined by ORR as facilities providing the most restrictive placement option for an immigrant child.

facilities must be trauma-informed environments; the federal Office of Refugee Resettlement ("ORR") must ensure treatment for immigrant children in its custody who have serious mental health needs; detention centers must be subject to rigorous, independent and meaningful oversight; and federal standards must be sufficiently stringent to ensure safe and humane conditions in states where regulations are lax.

WHO ARE THE CHILDREN?

Unaccompanied children – fleeing life-threatening violence and severe economic deprivation in their home countries and exposed to serious dangers, injury and exploitation on a treacherous journey – arrive at the U.S. border suffering the effects of serious trauma. These thirteen- to seventeen-year-olds, mostly from Honduras, Guatemala, El Salvador and Mexico, have seen and experienced horrors that no one, much less a child, should ever endure: they have witnessed brutal killings of friends and relatives (including parents); received threats of and been subjected to the violence of drug cartels; experienced torture, abandonment, and neglect; suffered physical and sexual harm; weathered days without food, water, or shelter; and are likely to have suffered other extensive and multiple instances of abuse and trauma. Fear and desperation drove them to travel through foreign countries, often by foot, hitchhiking or jumping onto moving trains, seeking work and shelter with strangers who were sometimes kind, but often brutal.[3] As

[3] Despite some public attempts to demonize the children and recast them as would-be or actual gang members, it is well recognized, including by senior SVJC management, that the majority of unaccompanied children who immigrate to the U.S. are not gang members but leave their home countries to find a better and safer life, to be reunited with their families or – most notably – to escape violence. *See* https://www.hsgac.senate.gov/imo/media/doc/Wong%20Testimony.pdf (Senate testimony of SVJC Deputy Director of Programs Kelsey Wong). Indeed, the results of a class action lawsuit by immigrant children demonstrate that many children are wrongfully classified as gang members and, once granted a hearing, are released. *See Twenty-two Immigrant Teens Freed After Wrongful Arrests by the Trump Administration*, ACLU OF NORTHERN CALIFORNIA, Dec. 20, 2017, *available at* https://www.aclunc.org/news/twenty-two-immigrant-teens-freed-after-wrongful-arrests-trump-administration.

one child detained at SVJC wrote, "no one knows, nor could they imagine, what has happened in our lives."[4] Another child wrote: "Although borders are hard / To traverse / I'll one day make it across and improve my life."[5]

Arriving at the border after long and generally harrowing journeys, these children are initially taken into ORR custody. They are transferred to a more secure facility, like SVJC, after they exhibit behavior that allegedly makes them a danger to themselves or others.[6] Such behavior generally involves fighting or self-harm, including cutting themselves or suicide attempts. The behavior that causes the transfer to SVJC is often the manifestation of serious mental health problems resulting from their trauma. This is not surprising: data shows that unaccompanied minors, asylum seekers and other displaced persons experience mental health problems at higher rates than the general population.[7]

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[4] A collection of poetry written by immigrant children detained at SVJC, titled "Dreaming America: Voices of Undocumented Youth in Maximum-Security Detention," was published in 2017. Ed. Michelson, Seth, *Dreaming America: Voices of Undocumented Youth in Maximum-Security Prison*, Settlement House Books, Inc., 2017. *See also* Pearson, Jake, *Hope, despair in poetry by immigrant children in US lockup*, AP NEWS, June 22, 2018, available at https://www.apnews.com/1796692d28294c31a3a4183aa4360f0c. The collection includes poems written in Spanish as well as their English translations; where the poetry is cited throughout this written testimony, only the English translations are quoted. This excerpt is from a poem titled "the Future." Dreaming America at 28.

[5] This excerpt is from a poem titled "Crossing Borders." Dreaming America at 90.

[6] Children are sent to SVJC in one of three ways: as border arrivals, as internal ORR "step up" transfers due to allegedly dangerous behavior (as referenced in the above sentence), or as transfers from the juvenile legal system in the U.S. state in which they were living. Almost all the immigrant children we spoke to at SVJC had been "stepped up" from a prior ORR facility. The facility also houses non-immigrant, local children who have been adjudicated delinquent. In 2017, when we filed our lawsuit, approximately 30 immigrant children were detained there. As of the end of April 2019, five immigrant children were detained at SVJC.

[7] Fujio, C. (2011), *Dual loyalties: The challenges of providing professional health care to immigration detainees,* Physicians for Human Rights, available at www.physiciansforhumanrights.org. *See also* Holman, B., & Zeidenberg, J. (2006), *The dangers of detention: The impact of incarcerating youth in detention and other secure facilities*, Justice Policy Institute, available at www.justicepolicy.org (detention exacerbates mental illnesses, especially when solitary confinement and force are used); Burrell, S., (2013), *Trauma and the environment of care in juvenile institutions,* The National Center for Child Traumatic Stress, www.NCTSN.org (force and solitary confinement retraumatize already vulnerable youth).

Senior staff at SVJC were, and continue to be, well aware of the fragility and the mental health needs of these children. They generally are told by the child's prior placement that the child has serious mental health issues and has experienced serious trauma.[8] Indeed, SVJC's Deputy Director for Programs, Kelsey Wong, testified before a Senate Committee that "[t]he majority of unaccompanied children in a secure setting have histories of repeated and various forms of abuse and neglect; life-threatening accidents or disasters; and interpersonal losses at an early age or for prolonged periods of time."[9] SVJC staff acknowledge that "[a] high percentage," if not all, of the children in SVJC's care suffered trauma prior to entering ORR custody.[10] They know that aggressive and acting-out behavior, as well as self-harm, are manifestations of mental health needs that are crying out for treatment. Despite this knowledge, they do not treat those mental health conditions. Instead, the evidence revealed that they focus on forcibly controlling behavior; prescribing medication for the symptoms of prior trauma, such as sleeplessness and anxiety;[11] and inflicting severe punishment when children question decisions, are defiant, act out or hurt themselves.

PUNISHMENT INSTEAD OF TREATMENT

When we first became involved with children at Shenandoah in 2017, we discovered that they were routinely punished – often severely – for behavior that ran the gamut, but often

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[8] Although they can decline to accept a child, staff testified that they hardly ever did so.
[9] *See* https://www.hsgac.senate.gov/imo/media/doc/Wong%20Testimony.pdf (Senate testimony of SVJC Deputy Director of Programs Kelsey Wong).
[10] *John Doe 4 v. Shenandoah Valley Juvenile Center Commission*, No. 5:17-cv-00097 (W.D. Va. filed Oct. 4, 2017), Dkt. No. 129, Plaintiffs' Memorandum of Law in Opposition to Defendant's Motion for Summary Judgment ("Pl.'s Opp. to Mot. Summ. J."), at 15 (citing clinician testimony).
[11] Medications were often psychotropic drugs, often prescribed in multiples. Even the doctor who saw the children for brief periods of time (sometimes for five-minute appointments) recognized that drugs, particularly psychotropics, should not be routinely administered nor the sole response to serious mental health needs. Another lawsuit, *Lucas R., et al. v. Alex Azar, et al.*, Case No. CV 18-5741 DMG (PLAx) (C.D. Cal.), challenges ORR's policies or practices of administrating psychotropic drugs to minors without obtaining informed consent or court authorization.

included minor issues, such as questioning decisions ("talking back"), pushing, yelling, throwing food on the floor, or approaching another child or adult staff person in an allegedly "threatening manner." Disciplinary write-ups commonly documented multiple staff members physically overpowering a child, throwing him against the wall or to the floor, often for a verbal altercation or a minor infraction. Children were shackled during many of these altercations. They were then thrown into their cells for periods of isolation, at times wearing only their underwear, that sometimes extended for days.[12] Instances of misbehavior were often treated with immediate and disproportionate force from staff, rather than with de-escalating techniques aimed at diffusing the situation. As written by a child detained at SVJC, "[I]t doesn't feel good to know that everyone is afraid of you. It turns you into a monster, which is what they think of people like me."[13]

One of the most appalling methods of punishment involved immobilizing the child in a "restraint chair" by strapping the child to the chair by their ankles, wrists and across the chest, often with a perforated "spit mask" pulled over the face. One former staff member compared sitting in the chair to being "in a horror movie."[14]

Although SVJC's own policies acknowledged that restraints should not be used as responses to self-harm or other manifestations of mental health problems,[15] its staff placed children engaging in self-harm, such as cutting themselves or attempting suicide, in shackles and in the restraint chair. Indeed, a floor staff member acknowledged that, on at least one occasion,

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[12] The facility also imposed on-going restrictive program "modifications" that allowed a child to come out of his cell for limited purposes but continued to substantially limit the child's ability to engage in activities with others. Those "modified programs" were an additional form of harmful isolation in addition to the straightforward solitary confinement that regularly occurred.
[13] An except from a poem titled "After I Fled." Dreaming America at 84.
[14] Dkt. No. 129, Pl.'s Opp. to Mot. Summ. J., at 19 (citing former floor staff testimony).
[15] SVJC policies directed that use of restraints "will be avoided if at all possible on residents with self-injurious behavior" and will be "only used until an emergency mental health screening can be accomplished." Dkt. No. 129, Pl.'s Opp. to Mot. Summ. J., at 5-6 (citing security manager testimony).

staff were directed to immediately place a child in the chair if they saw "any behavior ... that he's about to cut himself or do anything," without any attempt at engaging in less intrusive interventions.[16] Many times, no doctor, nurse or clinician was present. Our psychologist expert had no trouble concluding that subjecting a severely traumatized child to multiple sessions in the restraint chair constituted "torture."[17]

Despite their awareness that it was their responsibility to attempt to de-escalate potentially volatile situations through non-punitive measures, the floor staff (guards) routinely did exactly the opposite. The failure to de-escalate small disputes, such as whether a child had earned "points" leading to rewards for good behavior, caused many disagreements to escalate into confrontations, landing the child in shackles and, on occasion, to placement in the restraint chair. While some confrontations were undeniably started by the children, we learned that staff were often not just the contributors, but the instigators. Child after child reported goading by staff – often laced with racial epithets and slurs based on national origin – until the child was prompted to react in anger and then was restrained or "taken down" and locked alone in a cell.

Resorting to punishment was frequent and severe. John Doe 1, for example – a 17-year-old youth with severe mental health needs – was placed in isolation for approximately 2,400 hours (a cumulative 100 days) during the less than two years he was detained at SVJC. Between June 2015 and May 2018, SVJC documents reveal that physical restraints were used on immigrant children on well over 100 occasions; senior SVJC staff acknowledged that physical restraints are used on these children even when a child's behavior is not "immediate[ly] threaten[ing]."[18] Between November 2015 and November 2017, the restraint chair was used

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[16] Dkt. No. 129, Pl.'s Opp. to Mot. Summ. J., at 6 (citing floor staff testimony).
[17] *John Doe 4 v. Shenandoah Valley Juvenile Center Commission*, No. 5:17-cv-00097 (W.D. Va. filed Oct. 4, 2017), Dkt. No. 126-7, Dr. Gregory Lewis Report ("Lewis Report"), ¶ 186.
[18] Dkt. No. 129, Pl.'s Opp. to Mot. Summ. J., at 6 (citing security manager testimony).

over 40 times on immigrant children, often in excess of SVJC's two-hour limit policy; on one occasion, one youth suffering from serious mental health problems was placed in the restraint chair for over 6 hours in a day and for nearly 9 hours the very next day, while John Doe 1 was put in the chair 11 times over a 16 month period for between 25 minutes and 2 hours at a time.[19] Such use of force and/or isolation deviates from professionally accepted standards in the medical (AMA) and psychologist communities and has been rejected by governmental and private commissions that guide standards for juvenile facilities.[20]

What makes this record particularly offensive is that SVJC staff knew that a punitively focused approach was wrong. Indeed, in 2016, they modified their written policies purportedly to eliminate their overtly punitive approach to the children's behavior. However, we discovered that the changes were largely window-dressing and failed to change the culture of the institution: the data and the children's experiences confirmed that the punitive approaches continued until, and at times following, our filing of the lawsuit.

THE CONSEQUENCES OF PUNITIVE PRACTICES

The children's experiences highlight the essentially punitive approach that SVJC and, from reports of other advocates, other detention centers take to controlling the children in their care. The excesses that we documented would be reprehensible under any circumstances, but are particularly indefensible given the known mental health problems with which large numbers of unaccompanied minors are grappling. Failing to take steps to de-escalate, asserting physical control and confining children to their cells has profound and lasting harmful effects. Based on

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[19] Recent news stories indicate that even Virginia is abandoning this highly discredited and dangerous practice except in limited transport situations. *See* Oliver, Ned, *State officials say they no longer use 'restraint chairs' detailed in immigrant abuse allegations*, VIRGINIA MERCURY, Sept. 6, 2018, *available at* https://www.virginiamercury.com/2018/09/06/state-officials-say-they-no-longer-use-restraint-chairs-detailed-in-immigrant-abuse-allegations/

[20] *See infra* at fn. 34, 35.

his extensive experience with unaccompanied minors, and following intensive interviews of two of four named plaintiffs in our case and his review of thousands of pages of SVJC documentation, an expert psychologist concluded that SVJC's punitive approaches "are not only ineffective, but have a profound negative impact on youth, can seriously impair their development and psychological well-being," can trigger the children into acting out further, and "can cause or exacerbate mental health problems including panic attacks, suicidal and self-injurious behavior, psychotic symptoms, paranoia, and hopelessness."[21] He concluded that SVJC's use of excessive force, restraints, and solitary confinement "likely did substantial, if not irreparable, harm to these youth," and "it is likely that many of these detained youth will never fully recover."[22]

This is not simply his impression. Scientific studies have shown, time and again, that solitary confinement irreparably harms individuals,[23] and can be particularly harmful to juveniles. The consequences of psychological stressors such as solitary confinement, including actual changes in adolescent brain structure, have been demonstrated to persist into adulthood[24] and may cause longer-term problems such as difficulties with emotional attachment, cognitive ability, difficulties with behavioral control, and emotional dysregulation.[25] The harmful effects of isolation are also well known to SVJC staff,[26] yet do not seem to be a consideration when

[21] Dkt. No. 126-7, Lewis Report, at 1.
[22] *Id.*, at ¶ 193, 195, 196.
[23] Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, Wash. U. Journal of Law & Policy, Vol. 22 (Jan. 2006).
[24] Nim Tottenham, Adriana Galvan, *Stress and the adolescent brain: Amygdala-prefrontal cortex circuitry and ventral striatum as developmental targets*, Neuroscience and Behavioral Rev., 70:217-227 (Nov. 2016).
[25] How Trauma Affects Child Brain Development - N.C. Division of Social Services. Vol. 17, No.2, 2012; *see, e.g.*, Nim Tottenham, Adriana Galvan, *Stress and the adolescent brain: Amygdala-prefrontal cortex circuitry and ventral striatum as developmental targets*, Neuroscience and Behavioral Rev., 70:217-227 (Nov. 2016).
[26] Dkt. No. 129, Pl.'s Opp. to Mot. Summ. J., at 19 (citing clinician and Deputy Director of Programs Wong testimony).

floor staff confine children to their rooms for far longer than a calming-down period would require and far longer than the four-hour presumptive limit established in their own policy.

On top of SVJC's harmful and punitive approach to discipline, the mental health services provided at SVJC are deficient in staffing, frequency, substance and scope. Psychologists who sometimes evaluate the immigrant children detained at SVJC often recommend that the children be placed in therapeutic settings to receive better treatment for their mental health needs. Staff members admitted that children frequently need higher levels of care than SVJC provides.[27] Clinicians at SVJC, who are not psychologists, focus on behavioral control and do not attempt to treat the conditions that underlie behavior. In fact, the evidence showed that a child's serious mental health issues are generally not addressed in individual consultations between the child and his counselor. One SVJC clinician believed that "it would be unethical and inappropriate" for SVJC clinicians to "treat trauma."[28] In fact, even when clinicians receive diagnoses or treatment recommendations from a child's psychological evaluation, they do not provide counseling specific to individual diagnoses or are unqualified to provide the therapeutic services recommended by the psychologist. Finally, clinicians are generally unavailable at night or on weekends, times when there is an increase in behavioral incidents.

There are no other staff members at SVJC who provide or are qualified to provide the therapeutic treatment that these children need. The psychiatrist who visits the immigrant children at SVJC only manages their medications and does not provide any other therapeutic services to otherwise treat the underlying mental health problems of the children he meets every three to six weeks for a short period of time. The contracted psychologists, who are not on staff

[27] Dkt. No. 129, Pl.'s Opp. to Mot. Summ. J., at 16 (citing clinician and case manager testimony).
[28] Dkt. No. 129, Pl.'s Opp. to Mot. Summ. J., at 12 (citing clinician testimony).

at SVJC, provide no services beyond psychological evaluations.[29] Case managers are not required to, and in fact generally do not, have any clinical experience or education.

The problem is not just the lack of direct professional treatment for the children's mental health problems. The guards who most directly interact with the children are not made aware of which children have mental health issues, and do not communicate or work together with SVJC clinical staff to address the needs of the children. Furthermore, floor staff are not equipped to deal with the children because they are not adequately trained in responding to the manifestation of underlying trauma. Trauma-specific training is not provided to new hires at SVJC, and some staff only received minimal training in trauma-related issues after their first year at SVJC. Moreover, the techniques purportedly taught as an element of SVJC's limited trauma training, like active listening and empathy, are not implemented by staff in their interactions with the immigrant children, and the training has had little to no effect on the procedures or practices at SVJC. A floor staff member at SVJC candidly acknowledged that he "d[id]n't have the type of training" required to "calm . . . down" a child who "seem[ed], you know, reluctant or mad."[30]

Because the emphasis with floor staff is mastery of tools of punishment (like, for example, the best technique to "take down," or physically subdue, a child) rather than following a trauma-informed approach, floor staff routinely resorted to "punishment or control" to manage behavior. By failing to follow a trauma-informed approach, and by departing so drastically from SVJC's own written policies regarding isolation, restraints, and force, staff "triggered" and "retriggered" these children into acting out further, experiencing more mental health distress, or engaging in more self-injurious behavior. As one expert explained succinctly: "violence begets

[29] Children may be sent to DC to see a psychologist for a diagnosis (based on an approximately 2 hour session) if they are expected to remain at the facility for a relatively long time. The psychologist does not provide on-going treatment.
[30] Dkt. No. 129, Pl.'s Opp. to Mot. Summ. J., at 14 (citing floor staff testimony).

violence."[31] As a result, as described above, children in SVJC's care deteriorated over time and the damage from their prior trauma was magnified immeasurably.

These punitive measures are not isolated to SVJC and, in fact, reflect the types of systemic abuses suffered by immigrant children elsewhere in ORR's detention network. Findings made earlier this year regarding a secure youth detention center in California bear striking similarity to what our clients experienced in Shenandoah.[32] For example, the report observed that physical "take downs" and discipline were the "primary means of controlling youth" at the California facility, and that force was "frequent[ly]" used by staff against immigrant minors; trainings regarding de-escalation were entirely overshadowed by trainings on the use of physical and punitive force; and inadequate mental health services were provided to the children, including "rote" and "insufficient[]" levels of care by clinicians as well as "individual service plans" that existed in name only and were not tailored to any child, regardless of the child's particular mental health needs or trauma history.[33]

ACTION IS NEEDED TO PREVENT ABUSE AND PROVIDE ADEQUATE CARE

1. Detention Facilities Must be Trauma-Informed Environments Throughout

A trauma-informed approach to juvenile detention is hardly new. It was developed at least 20 years ago,[34] and since that time has been accepted by experts in the field, examined and

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[31] Dkt. No. 129, Pl.'s Opp. to Mot. Summ. J., at 22 (citing expert testimony).

[32] Becerra, Xavier, *The California Department of Justice's Review of Immigration Detention in California*, Feb. 2019, *available at* https://oag.ca.gov/sites/all/files/agweb/pdfs/publications/immigration-detention-2019.pdf.

[33] *Id*.

[34] The National Child Traumatic Street Network ("NCTSN") was established by Congress in 2000 to raise the standard of care and improve access to services for children who have experienced trauma, especially those in the juvenile justice system. Over the course of the ensuing 18 years, it has grown from 17 funded centers to over 250 combined currently funded centers and "affiliate" (formerly funded) centers, in hospitals, universities and community-based programs in 44 states and the District of Columbia. https://www.nctsn.org/about-us/who-we-are (last visited November 5, 2018). It is funded by the Center for Mental Health Services, the Substance Abuse & Mental Health Services Administration, the US Department of Health & Human Services and is jointly coordinated by UCLA and Duke University. *Id.*

refined by academics, and implemented in a growing number of states, including Missouri, New York, Ohio, North Carolina and Kentucky. Research has shown that trauma-informed approaches are effective, reducing the use of inherently harmful restraints and seclusion, as well as the prevalence of PTSD symptoms, depression, anxiety and hopelessness among detained juveniles. Trauma-informed care is the standard embraced by the US Department of Justice for all facilities serving children and families exposed to violence.[35]

Recently, the punishments the immigrant children at SVJC have encountered appear to be less severe in magnitude and frequency than in the past – although the few immigrant children that are still there continue to describe periods of isolation that last for a day, as well as physical restraints as a response to small infractions. They continue to lack treatment for known mental health conditions. We believe that the reduction in physical maltreatment is largely, if not entirely, due to the attention from both the public and government entities our lawsuit brought to

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NCTSN has developed standardized trauma-informed clinical interventions across a "continuum of evidence-based and evidence-supported interventions," and offers a curriculum to guide care providers. https://www.nctsn.treatments-and-practices/trauma-treatments (last visited November 5, 2018).

[35] Twelve years after the founding of the NCTSN, the Justice Department issued the Report of the Attorney General's National Task Force on Children Exposed to Violence ("Report"). The Report makes clear that trauma-informed care should be the standard in juvenile justice facilities, hospitals, and all other agencies serving children and families exposed to violence. (*See, e.g.*, recommendations 3.3, 3.5, 6.1) https://www.justice.gov/defendingchildhood/cev-rpt-full.pdf (last visited November 5, 2018). It concludes that all persons providing care to children exposed to violence should receive training in trauma-informed approaches. *Id*. at 3.6. Chapter 3 of the Report, focused on Treatment and Healing, "describes the essential features of successful treatments and services for children exposed to violence and psychological trauma, and it makes recommendations for how such treatments and services can be made more reliably accessible for these children." *Id*. at 81-82. The cornerstone for all such treatments and services is trauma-informed care -- "essential" for programs and providers who work with children who have been exposed to violence. *Id*. at 84. The AGs' Report thus makes manifestly clear that trauma-informed care is the state-of-the-art approach that has been proven effective in healing the effects of violence and capable of implementation. Physical restraints, isolation and shackling, which further traumatize youth and contribute to cycles of revenge, fly in the face of these established and tested approaches to care and treatment.

the facility. Still, there is no assurance that the horrors the immigrant children experienced for years cannot or will not happen again, particularly after our case concludes and media attention fades.

As detailed above, action is needed to protect immigrant children from the violence and harm that our current system of detention permits. Reform, at both an individual-facility and systemic level, is necessary to avoid re-traumatizing children who are already suffering from the consequences of deeply traumatic experiences. A child entering a detention center should be properly diagnosed by a qualified professional and provided an individualized treatment plan that addresses the child's unique mental health needs. Mental health clinicians should be onsite at all hours, but especially during the evening and weekend – the times when children lack other structured activities, may feel most alone and have a higher frequency of "misbehaving." The presence of trained mental health clinicians during these times would help avoid escalating violence. Comprehensive training and integration of trauma-informed approaches is absolutely critical at every level, particularly for floor staff who have the most intense and continuous contact with the children.

2. ORR Must Provide Appropriate Treatment for Children with Serious Mental Health Needs

Even fully trauma-informed facilities may not be adequately equipped to serve children suffering from serious mental health issues. As SVJC's own Deputy Director of Programs acknowledged, these children often require specialized expertise and environments that ORR detention centers are unable or unwilling to provide. ORR needs to maintain a network of resources that meet a continuum of mental health problems in the least restrictive environments possible, to ensure that any facilities purportedly providing treatment are licensed and well

monitored, and to ensure that children who need these resources promptly and consistently receive proper treatment.

3. Detention Centers Must Be Subject To Rigorous, Independent and Meaningful Oversight

Despite internal and external audits conducted by the facility, ORR and state agencies, immigrant children at SVJC suffered severe and persisting harms at the hands of those entrusted with their care. These multiple forms of monitoring were insufficient to ensure adequate protection. Indeed, the most recent audit conducted of the center – an investigation prompted by public outcry over our clients' experiences while detained – is a prime example of the type of superficial monitoring that makes a mockery of meaningful oversight.

In August 2018, the Virginia Department of Juvenile Justice ("DJJ") concluded there were "no life, heath, or safety concerns for the residents at SVJC."[36] However, the report's own description of the review process reveals the compromising flaws in DJJ's investigation. Although DJJ staff interviewed all the immigrant residents, a staff member from SVJC – an explicitly intimidating and coercive presence – was physically present in all the interviews. Moreover, although DJJ staff were allowed to review certain documentation related to the children's custody at the center, they were not allowed to copy records for subsequent review or to even keep written notes of information contained in the center's files. The reviewers never spoke with persons who might have additional knowledge of conditions, including the children's lawyers, families and advocates. It is not clear that interviewers were trained in effective communication or trust building with children. Meaningful review is critical to properly holding

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[36] *See Virginia Department of Juvenile Justice Report of Findings, Shenandoah Valley Juvenile Center*, Aug. 13, 2018, *available at* https://www.governor.virginia.gov/media/governorvirginiagov/secretary-of-public-safety-and-homeland-security/pdf/Virginia-DJJ-Report-of-Findings.pdf, at 4.

these facilities accountable, and central to this oversight is an independent, untainted process of ascertaining the children's experiences in detention.

4. The Commission Must Advocate for More Stringent Federal Standards

Finally, it is critical to note that current regulations or laws in the state of Virginia were insufficiently stringent to prevent many of the egregious violations experienced by the immigrant children at SVJC. Unlike many states and facilities that have outlawed its use, Virginia permits the use of the restraint chair.[37] It permits extended solitary confinement of children, including those suffering from trauma or mental health needs, for 72 hours at a stretch and up to 5 days with proper notification to facility administration[38] – far beyond the time period countenanced by any medical, psychological or juvenile detention best practice. Experts (even including the SVJC psychiatrist), advocates, and detention staff members all agree that these punitive measures result in lasting harm to youth. Stringent federal standards are needed to ensure safe and humane conditions in those states where the regulations are lax. We urge the Commission to study the extent to which immigrant children in ORR custody are in facilities which are adhering to weak state regulations, and, consistent with the Attorney General's Report and well-established professional standards, to advocate for alternatives to detention and, where that may not be possible, for federal policies and practices that require immigrant children to be placed in trauma-informed environments that strictly limit the use of restraints, solitary confinement or other essentially punitive and harmful approaches.

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[37] Recent news stories indicate, however, that even Virginia is abandoning this highly discredited and dangerous practice except in limited transport situations. *See supra* at fn. 19.

[38] *See* https://law.lis.virginia.gov/admincode/title6/agency35/chapter101/section1100/ (6 VAC 35-101 – 1100, Room Confinement and Isolation).

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