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Testimony of Altha J. Stewart, MD

On Behalf of the American Psychiatric Association

Before the U.S. House of Representatives

Labor, Health and Human Services, Education and Related Agencies Subcommittee of
House Appropriations Committee

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**"Reviewing the Administration's Unaccompanied Children Program: State-Sanctioned
Child Abuse"**

February 27, 2019

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Chairwoman DeLauro, Ranking Member Cole, and distinguished members of the Labor HHS Subcommittee, thank you for allowing me the opportunity to serve on today's panel. My name is Dr. Altha Stewart, and I am an associate professor of Psychiatry and Director of the Center for Health in Justice Involved Youth at the University of Tennessee Health Science Center. My testimony today is on behalf of the American Psychiatric Association, an organization representing 38,500 psychiatrists and for which I am the current President.

The American Psychiatric Association is an organization of psychiatrists working together to ensure *humane care* and effective treatment for all persons with mental illness, including substance use disorders. It is the voice and conscience of modern psychiatry. Its vision is a mentally healthy nation that provides accessible quality psychiatric diagnosis and treatment. These foundational principles include promoting the best standards of clinical practice, ensuring high ethical standards of professional conduct, delivering patient-focused treatment, and promoting the rights and best interests of patients that use psychiatric services. It is the intersection of the goals and values of our association and the needs of vulnerable populations that has compelled the APA's strong opposition to the practice of separating children and families at the United States border.

The APA was among the first organizations to speak out last spring when it became clear that the administration's "zero tolerance" policy of referring those crossing the border for federal criminal prosecution would result in the widespread separation of children and families. As physician experts in mental health, we have, and will continue to oppose any policy that separates children from their families. From my perspective as a psychiatrist, the reasons for the APA position on this are grounded in an understanding of the brain science that frames the 'toxic stress' caused by separation of children from their families. All children who were abruptly separated from familiar caregivers at the border

experienced overwhelming stress. Some will survive without significant problems, but many will be seriously impaired for the rest of their lives. According to the work of the Harvard University Center for the Developing Child, the direction that the biology of adversity takes in an individual child is based on three specific risk factors.

- 1. Age.** Young children are most vulnerable because the sole familiar and trusted adult in their lives as they made the hard journey is the person from whom they have been separated at a point when their undeveloped brain circuitry is compromised and unable to adequately adapt to their absence.
- 2. Impact of previous adversity.** The pile-up of stress on children who are already compromised shifts the odds against them even further. Intentionally withholding the most powerful healing intervention we could possibly offer—the care and comfort that parents provide when their children are in danger— goes against everything science tells us about healthy development in children.
- 3. Duration of the separation.** Toxic stress is like a ticking clock—and prolonged separation inflicts increasingly greater harm as each week goes by.

Children depend on their parents for comfort, safety and support. Any forced separation is highly stressful for children and can cause lifelong trauma, as well as an increased risk of other mental illnesses, such as depression, anxiety, substance use, and posttraumatic stress disorder (PTSD). The evidence¹ is clear that this level of trauma can also result in serious medical and health consequences for these children and their caregivers. Many families crossing the United States border are fleeing war

¹ <https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experience>

and violence in their home countries and are already coping with the psychological effects of stress and trauma. A recent study found that among Central American migrants arriving at the border, 83% reported violence as the primary reason for fleeing their country.² The exposure to violence included extortion, death threats, and being victims of domestic violence. Reports of serious violence are also common, with nearly one third of study participants (32.2%) reporting that a family member had been murdered. As a physician who has dedicated a career to promoting the importance of Trauma-Informed Care, my goal today is to ensure members of the Subcommittee, and your congressional colleagues, have a more comprehensive understanding of the inherent trauma associated with any forced separation of families, and the lasting impact associated with these sorts of experiences.

Most of us can recall, and articulate, at least one “defining” moment in our lives. And suffice it to say, most of these events tend to be characterized as positive. However, for many people, the incidence of traumatic events has extraordinary impact on the trajectory of their future life experience. For children, the impact is especially profound and is usually a result of events over which the child had no control. Our understanding that childhood experiences, both good and bad, can determine future health status relates to a longstanding body of research known as Adverse Childhood Experiences (ACEs).³ ACEs are stressful or traumatic events that occur in childhood that are major risk factors for certain illnesses and poor quality of life in adulthood. Common examples are: physical, sexual or emotional abuse; physical or emotional neglect; household exposure to mental illness, substance use disorder or domestic violence; divorce or separation; and incarceration of a parent or caregiver.⁴ The culminating impact of ACEs on an individual can then result in risky health behaviors, chronic health

² Keller A, Joscelyne A, Granski M, Rosenfeld B. Pre-Migration Trauma Exposure and Mental Health Functioning among Central American Migrants Arriving at the US Border. PLoS ONE. 2017;12(1):e0168692.

³ <https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/aboutace.html>

⁴ <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/EBCD/Documents/ebcdEdModules/powerpointModule3.pdf>

conditions, and early death.⁵ It is important to note that not all bad experiences will result in lasting trauma. However, we, as clinicians and lawmakers, must continue to recognize and when necessary, work to mitigate, instances where the creation or enforcement of ill-thought policies could potentially predispose a particular population—in this case immigrant children and their families—for higher risk of poor health outcomes. A substantial body of research links the trauma of childhood separation with lasting adverse outcomes, including an increased risk of mental illness, such as depression, anxiety, substance use, and post-traumatic stress disorder.⁶ While people who are displaced can demonstrate high levels of resiliency, they can also experience disabling post-traumatic stress disorder or other consequences that adversely impact their medical, psychological, social, and spiritual well-being. These consequences can range from demoralization to various sequelae, involving simple and complex trauma complicated by the migratory journey and resettlement process. These migration-related and postmigration stressors can produce demoralization, grief, loneliness, loss of dignity, and feelings of helplessness as normal syndromes of distress that impede refugees from living healthy and productive lives.^{7,8} It is critical that children remain with their parents, but this will not eliminate the risk of negative outcomes for them. Prolongation of these families' detention will compound the already significant mental health consequences they face. Research shows that despite the threat of punitive measures, families fleeing the Northern Triangle region of Central America will continue to flee violence to save

⁵ <https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/aboutace.html>

⁶ Felitti, Vincent J et al. Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. *American Journal of Preventive Medicine*, Volume 14, Issue 4, 245 – 258.

⁷ Al-Krenawi, A., Lev-Wiesel, R., & Sehwal, M. (2007). Psychological symptomatology among Palestinian children living with political violence. *Child and Adolescent Mental Health* 12:27–31.

⁸ Fernando, G.A., Miller, K.E., & Berger, D.E. (2010). Growing pains: the impact of disaster-related and daily stressors on the psychological and psychosocial functioning of youth in Sri Lanka. *Child Development* 81:1192-1210.

their lives and those of their children.⁹ It is therefore, critical that the family residential centers (FRCs) are better prepared to meet the trauma related mental health needs of detained families. We know that children are more susceptible to trauma because their brain is still developing. When a person is exposed to a traumatic event, the brain naturally enters a heightened state of stress and fear-related hormones are released (“fight or flight”). And, although stress is a common element of life, when a child is exposed to chronic trauma or extreme stress, their underdeveloped brain will remain in this elevated state. Ultimately, consistent exposure to this heightened stress or trauma can change the emotional, behavioral, and cognitive functioning of the child in order to promote survival.¹⁰ Psychiatrists are most qualified to help children and families recover from the trauma inflicted upon immigrants and refugees by displacement from and within their home countries and can provide direct psychotherapeutic and psychosocial interventions.¹¹ ***Each FRC should staff their leadership teams with psychiatrists to appropriately care for those persons suffering posttraumatic symptoms and other migration-related syndromes of distress.***

In a July 2018 letter to Senators Grassley and Wyden, Drs. Scott Allen and Pamela McPherson, internal medicine and psychiatric physicians, and medical experts for the Department of Homeland Security’s Office of Civil Rights and Civil Liberties (CRCL) wrote, “The problem with family detention is not the failure of the many good people who have labored tirelessly to make the existing centers better, with improvements in access to health and mental health services, educational and social programs. The fundamental flaw of family detention is not just the risk posed by the conditions of confinement—it’s

⁹ Medecins sans Frontieres, Forced to Flee Central America’s Northern Triangle: A Neglected Humanitarian Crisis (June 2017), https://www.msf.org/sites/msf.org/files/msf_forced-to-flee-central-americas-northern-triangle_e.pdf.

¹⁰ <https://dmh.mo.gov/healthykids/providers/trauma.html>

¹¹ American Psychiatric Association. Position Statement on the Role of Psychiatrists in Addressing Care for People Affected by Forced Displacement (2017). <https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2017-People-Affected-by-Forced-Displacement.pdf>

the incarceration of innocent children itself. In our professional opinion, there is no amount of programming that can ameliorate the harms created by the very act of confining children to detention centers. Detention of innocent children should never occur in a civilized society, especially if there are less restrictive options, because the risk of harm to children simply cannot be justified.” This statement from Drs. Allen and McPherson underscores the profound impact of the various detention or detainment scenarios and means it is imperative that we all work tirelessly to ensure that the programs and systems that ARE available are well-equipped to meet the short and long-term needs of these children and families.

As this Subcommittee and others continue to assess the conditions and services available at various facilities run by the federal government, I cannot stress enough the importance of Trauma-Informed Care, which is a holistic approach to establishing programs, organizations or systems designed to shift focus from “What’s wrong with you” to “What happened to you? This is done by:

1. **Realizing** the widespread impact of trauma and understand potential paths for recovery;
2. **Recognizing** the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
3. **Responding** by fully integrating knowledge about trauma into policies, procedures, and practices; and
4. Avoiding scenarios resulting in **re-traumatization**.¹²

Failure to incorporate programs that emphasize Trauma-Informed Care reinforces an outdated approach of addressing a patient’s symptoms instead of identifying the root cause. It is also short-sighted to not embrace the notion that childhood experiences are impactful in relation to future life experiences. For

¹² <https://www.samhsa.gov/ntic/trauma-interventions>

example, and to quote The National Child Traumatic Stress Network, “Complexly traumatized children are more likely to engage in high-risk behaviors, such as self-harm, unsafe sexual practices, and excessive risk-taking such as operating a vehicle at high speeds. They may also engage in illegal activities, such as alcohol and substance use, assaulting others, stealing, running away, and/or prostitution, thereby making it more likely that they will enter the juvenile justice system.”¹³ This characterization eloquently outlines the high-stakes associated with proactively mitigating the impacts of childhood trauma. And, I will take this opportunity to note that this fact is relevant beyond the specific focus point of today’s hearing. Ensuring quality healthcare, addressing increasing rates of substance use disorders, heightened mental health needs, and criminal justice reform are all critical topics for Congress, the Administration, the average American, and those who seek to build a life in this nation. Ensuring Trauma-Informed Care is a foundational principle in the healthcare and social support infrastructure in this nation will not only equate to providing better and more meaningful care for those who need it, but also provide an opportunity to mitigate several social determinants that result in higher costs across the breath of our government programs.

Thank you again for inviting me to discuss these very important topics, and I look forward to working with members of this Subcommittee to address these issues more broadly. I am also happy to answer any questions you may have.

¹³ <https://www.nctsn.org/what-is-child-trauma/trauma-types/complex-trauma/effects>