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Doe Not Worry: Expanding Protections for Unaccompanied Children

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A recent Fourth Circuit decision created a circuit split regarding the standard applied to constitutional violations in secure holding facilities. The more "liberal" professional judgment standard—as promulgated by Youngberg v. Romeo[1] and applied to unaccompanied immigrant minors in Doe 4 ex rel. Lopez[2]—is necessary but insufficient for the protection of unaccompanied children. This Note first examines the origins of the professional judgment standard in the Youngberg case. Then, cases are surveyed showing that the Supreme Court has recognized children as a vulnerable population, and current regulations, legislation, and court opinions recognize the vulnerabilities of unaccompanied children. With these ideas in the foreground, this Note shows that the standard, as applied to adults and to other children, is not sufficient protection. Based on these insufficiencies, this Note then assesses the system experienced by the petitioner. After an evaluation of the purpose of that system, it is clear there are not adequate structures in place to realize that purpose. The Youngberg standard enables those inadequacies; therefore, a more robust standard is needed for the adequate protection of unaccompanied minors like Doe 4. Future research should be done to develop new standards to apply in these cases and ensure vulnerable populations are protected by the systems designed to care for them.

INTRODUCTION

In a recent Fourth Circuit decision, the court applied the *Youngberg* "professional judgment" standard to allegations of constitutional infringement of a minor in a juvenile immigration detention center.[3] The departure from the previous standard used—the "deliberate indifference" standard of the Third Circuit[4]—created the circuit split, which is the topic of much scholarship in this area. While the new application of the *Youngberg* standard is necessary, this Note argues that it is not sufficient in protecting vulnerable populations, particularly unaccompanied children.[5] To determine that this standard is insufficient for the protection of

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1 457 U.S. 307 (1982).

2 Doe 4 *ex rel.* Lopez v. Shenandoah Valley Juv. Ctr. Comm'n, 985 F.3d 327 (4th Cir.), *cert. denied*, 142 S. Ct. 583 (2021).

3 *Id.*

4 The deliberate indifference standard was established in *Estelle v. Gamble*. 429 U.S. 97 (1976).

5 The U.S. government insists on calling this population "UACs" or "unaccompanied alien children"; this term is outdated and offensive, so I will be referring to this population as "unaccompanied children," per the

unaccompanied children, Part I explains how the standard came about, Part II discusses the background and holding of the *Doe 4* case, where it was applied to a new population. Part III outlines the Supreme Court's recognition of children as a vulnerable population.[6] Then, Part IV explains the particular vulnerability of unaccompanied children because of their life experiences and traumas. Part V shows how the standard is insufficient when applied to other children, and Part VI demonstrates how it is insufficient when applied to an arguably less vulnerable population, adults. The purpose of different child-based systems is examined in Part VII. Based on that discussion, Part VIII explains that the standard is not a sufficient means of promoting the mission of the immigration system as it applies to unaccompanied children. As such, the standard must be improved so it supports the mission of the system and protects unaccompanied children in a more fundamental manner; these developments and recommendations are the subject of Part IX.

I. How the "Professional Judgment" Standard was Created

In order to understand the insufficient nature of the standard as applied to *Doe 4*,[7] it is necessary to understand how the standard was first established in *Youngberg v. Romeo*.[8] Nicolas Romeo was committed to a state facility at the age of twenty-six, as his mother was unable to care for him alone after his father's death.[9] At age thirty-three, Romeo had the mental capacity of an eighteen-month-old; he was unable to talk or care for himself in any capacity.[10] The complaint alleged that during the first two years of his residence in the facility, he was injured more than sixty times.[11] His mother filed a § 1983 claim[12] on his behalf, alleging violations of her son's constitutional rights.[13] The jury found for the defendants, but the Third Circuit reversed and remanded.[14] The court held that the Eighth Amendment, as used by the lower court, was not appropriate for the rights of the involuntarily

Office of Refugee Resettlement. This population is also referred to as "unaccompanied minors" in other contexts. For the sake of clarity, I will refer to these individuals as "unaccompanied children" or in the singular, an "unaccompanied child" throughout.

6 *See, e.g.*, Bellotti v. Baird, 443 U.S. 622 (1979).

7 John Doe 4 is a pseudonym used to protect the identity of this unaccompanied child.

8 Youngberg v. Romeo, 457 U.S. 307 (1982).

9 *Id.* at 309.

10 *Id.*

11 *Id.* "Romeo was injured on numerous occasions, both by his own violence and by the reactions of other residents to him." *Id.* at 310. This is troubling on many levels, not the least of these being that he was supposed to be living in a state of highly supervised care. Such an extreme number of injuries indicates that the facility was, at minimum, negligent in their supervision of their residents.

12 42 U.S.C. § 1983 ("Every person who, under color of any statute, ordinance, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.").

13 *Youngberg*, 457 U.S. at 309.

14 *Id.* at 312.

committed; rather, the Fourteenth Amendment must be utilized as a constitutional basis.[15] Implicit in the Fourteenth Amendment, according to the court, are rights for the involuntarily committed, including freedom of movement and personal security that can only be restricted by an overriding state interest.[16] Despite this emphatic holding, the court, sitting *en banc*, could not agree on the proper standard to be used in these circumstances.[17] Because of this, the Supreme Court granted certiorari.[18]

The Supreme Court affirmed the Third Circuit holding—the district court erred in applying the Eighth Amendment to Romeo and that the Fourteenth Amendment applied instead. Furthermore, simply because Romeo was committed did not mean that he had no substantive rights under the Fourteenth Amendment.[19] The Court considered the purpose of Romeo's confinement—care for his well-being—and concluded that he had a "constitutionally protected interest" of personal safety and care, including nonrestrictive movement.[20] But, these rights are not absolute.[21] The Court noted that in order to find a professional liable for a violation of these interests, the decision made by the professional must be "a substantial departure from accepted professional judgment, practice, or standards."[22] They also afforded these decisions "a presumption of correctness," based on the need for "institutions of this type—often, unfortunately, overcrowded and understaffed—to continue to function."[23]

The scope of the standard, including its application to unaccompanied children, is not as clear as desired. In *Youngberg*, the Court distinguished the purpose of confinement for "involuntarily committed" individuals versus "criminals," stating that the former are "entitled to more considerate treatment and conditions of confinement" because they are held for their care, rather than to punish.[24] As discussed later, the court in *Doe 4* concluded that the purpose of holding Doe 4 was also to give him care. In this way, his situation is analogous to Romeo's. This is a step in the right direction, but regard for human dignity would require the court to declare that all individuals held in confinement are due at least a *Youngberg* level of care. Unfortunately, that is not the current standard, and the

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15 *Id.*

16 *Id.* at 313.

17 *Id.*

18 *Id.* at 314 ("We granted the petition for certiorari because of the importance of the question presented to the administration of state institutions for the mentally retarded.").

19 *Id.* at 315 ("The mere fact that Romeo has been committed under proper procedures does not deprive him of all substantive liberty interests under the Fourteenth Amendment.").

20 *Id.* at 324.

21 *Id.* at 320.

22 *Id.* at 323. The Court further noted that "there certainly is no reason to think judges or juries are better qualified than appropriate professionals in making such decisions." *Id.* For more information on how this idea is flawed, beyond the claims of this Note, see generally Susan Stefan, *Leaving Civil Rights to the "Experts": From Deference to Abdication Under the Professional Judgment Standard*, 102 YALE L.J. 639 (1992).

23 *Youngberg*, 457 U.S. at 324.

24 *Id.* at 321–22.

argument for making it so would be the subject of another note. Currently, there is a circuit split on how this slightly more deferential treatment should be applied and to whom. Therefore, it is not easy to say what the scope of this standard is in full; but regardless, this standard and its subsequent applications, while necessary, do not adequately protect vulnerable populations, such as unaccompanied children.

II. THE APPLICATION OF THE "PROFESSIONAL JUDGMENT" STANDARD IN *DOE 4* IS ONLY A STEP IN THE RIGHT DIRECTION

Many papers have been written on the circuit split between the Third and Fourth Circuits' standards for constitutional violations in secure holding facilities (i.e., deliberate indifference versus professional judgment).[25] This Note contends that, while a necessary stop-gap measure, even the more "liberal" standard—"substantial departure from accepted professional judgment"[26]—is not a sufficient standard when applied to particularly vulnerable populations like unaccompanied immigrant children.

This recent circuit split is due to the case *Doe 4 ex rel. Lopez*, in which the title plaintiff, a young boy dubbed "John Doe 4," fled his home in Honduras after witnessing the murder of several of his friends by gang members in addition to being seriously injured himself.[27] He was taken into custody after being apprehended by U.S. Customs and Border Patrol (CBP) and eventually placed in the Shenandoah Valley Juvenile Center (SVJC) in Virginia.[28] SVJC is a facility for unaccompanied children who "require a secure placement due to safety concerns" at the "discretion of [the Office of Refugee Resettlement (ORR)]."[29] SVJC's clinicians do an assessment of each child and are able to "reject the placement of the child at SVJC" if they decide "SVJC cannot provide the necessary services for a child's mental health needs."[30] Doe 4 was admitted to the facility and diagnosed by a doctor with post-traumatic stress disorder (PTSD) and attention deficit hyperactivity disorder (ADHD).[31] The doctor also recommended that Doe 4 be placed in a

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25 For a more complete overview of the circuit split with detailed explanations of the background of each standard, see Matthew Skolnick, *The Doctor Will See You Now: The Fourth Circuit Revives the Juvenile Detainee's Right to Treatment by Adopting the Professional Judgment Standard in* Doe 4, 67 VILL. L. REV. 377 (2022); Taylor C. Joseph, *Revitalizing the* Youngberg v. Romeo *Professional Judgment Standard to Require Trauma-Informed Care for Detained Children*, 81 MD. L. REV. 1329 (2022); Caitlin Fernandez Zamora, *Professional Indifference? How One Case Improves Protection for Immigrant Children in United States Detention Centers*, 20 NW. J. HUM. RTS. 239 (2022).

26 *Youngberg*, 457 U.S. at 323.

27 Doe 4 *ex rel.* Lopez v. Shenandoah Valley Juv. Ctr. Comm'n, 985 F.3d 327, 331 (4th Cir.), *cert. denied*, 142 S. Ct. 583 (2021). The report claims that he was "hacked with a machete . . . and cut with a switchblade on his arm." *Id.*

28 *Id.* at 331–32.

29 *Id.* at 330.

30 *Id.*

31 *Id.* at 332. The doctor at the facility rated Doe 4 at a "medium risk" of suicide and self-harm; this was after an event where Doe 4 punched a wall, breaking some bones in his hand. *Id.* He also had self-inflicted

residential treatment facility, but SVJC did not acquiesce, ostensibly due to the lack of open facilities willing to take Doe 4 with his history of violent misconduct.[32] The staff at SVJC responded to Doe 4's outbursts with vehemence and mockery, despite their knowledge of his past trauma and diagnoses.[33] Doe 4 was not alone in this treatment, nor in his subsequent self-harming responses.[34] According to the class action suit, forty-five unaccompanied children detained in SVJC self-harmed or attempted suicide between June 2015 and May 2018.[35] Testimony from a former SVJC employee stated that staff reacted indifferently when children exhibited self-harm behaviors, including making comments like "let them cut themselves."[36]

Following a class action lawsuit filed in October of 2017, in which Doe 4 was the class representative, the three prior "Doe" plaintiffs were transferred out of SVJC.[37] The class action was a § 1983 claim, alleging a failure to provide constitutionally adequate mental health care, among other allegations.[38] The district court, using the "deliberate indifference"[39] standard, granted summary judgment to the SVJC on the mental health issue, stating it provided "adequate care" by allowing access to counseling and medication to the children in the facility.[40] The plaintiffs appealed this ruling to the Fourth Circuit, arguing that the *Youngberg* standard should apply.[41]

The Fourth Circuit found that the district court applied the wrong standard and agreed with the petitioners that the *Youngberg* standard applied in Doe 4's case.[42] The *Youngberg* standard states that liability is found only when there is a

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scratches on his arm and was found in his room with a shirt tied around his neck after being forcibly removed to his room. *Id.* Other such events are chronicled in the case. *See id.* at 332–34.

32 *Id.* at 332.

33 He was restrained in a "full nelson" several times, punched, pinned to the wall such that he could not breathe, and was alone or restricted from contact with others for over 800 hours (more than a month) of his seven-month stay. *Id.* at 332–34. When he asked to see his clinician, the guard denied the request. *Id.* at 333. When Doe 4 protested by sitting in a chair, the guard ordered him to get out and subsequently confined him to his room for six hours. *Id.*

34 *Id.* at 334.

35 *Id.*

36 *Id.*

37 *Id.* at 334–335.

38 *Id.* at 334.

39 The "deliberate indifference" standard has both objective and subjective elements. Doe *ex rel.* Lopez v. Shenandoah Valley Juv. Ctr. Comm'n, 355 F. Supp. 3d 454, 468 (W.D. Va. 2018), *rev'd and remanded*, 985 F.3d 327 (4th Cir. 2021). There must be an objective "serious medical need" and the defendant must have 1) subjectively recognized "a substantial risk of harm" and 2) realized their actions were inappropriate given the risk. *Id.*

40 Doe 4 *ex rel.* Lopez v. Shenandoah Valley Juv. Ctr. Comm'n, 985 F.3d 327, 329 (4th Cir.), *cert. denied*, 142 S. Ct. 583 (2021).

41 *Id.* at 329. Petitioners argued that the use of the deliberate indifference standard rather than the *Youngberg* standard ignored the fact that Doe 4 and other plaintiffs were children and that SVJC is statutorily mandated to provide care, which is when the professional judgment standard must be used. Reply Brief of Plaintiff-Appellants, Doe 4 *ex rel.* Lopez, 985 F.3d 327 (4th Cir. 2021) (No. 19-1910), 2020 WL 967402, at *8–*12.

42 *Doe 4* ex rel. *Lopez*, 985 F.3d at 339.

"substantial departure from accepted professional judgment."[43] The Fourth Circuit said this standard was appropriate because of the purpose of the system (to "give [children] care") and noted the particularly lengthy confinement of these individuals, also recognizing their "particular vulnerability."[44] The court was not convinced by the respondent's argument that because children are placed at SVJC for security reasons they are not owed *Youngberg* level treatment.[45] On the contrary, Chief Judge Gregory noted that the respondent's argument created "a false binary."[46] The *Youngberg* Court, he said, made it clear that the facility must provide "care *and* safety," such that the two are "not mutually exclusive."[47] Because aggressive behavior is caused, in this case, by trauma, and SVJC is to hold the child until they are no longer behaving aggressively, "then it follows that SVJC's efforts to improve a child's behavior should also treat the child's underlying trauma that gives rise to their misbehavior."[48] The case was subsequently remanded to the lower court for a judgment in line with this new standard.[49]

III. THE COURT'S FREQUENT RECOGNITION OF CHILDREN AS A VULNERABLE POPULATION

Since Doe 4 is a child, it is relevant to consider what the Supreme Court has said about children and their rights. The psychological and developmental differences between children and adults are well documented by the Supreme Court.[50] In an oft-quoted line, the Court noted the "peculiar vulnerability" of children in *Bellotti v. Baird*.[51] Invoking *Roper* and *Graham* in the majority opinion in *Miller v. Alabama*, Justice Kagan stated that children are "constitutionally different."[52] The court in *Doe 4* refers to a famous 1982 decision, quoting, "[Y]outh is more than a chronological fact. It is a time and condition of life when a person may be most susceptible to influence and psychological damage."[53] This sentiment is parroted in other opinions, where the court claimed that "childhood is a particularly

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43 *Id.* at 339 (quoting Youngberg v. Romeo, 457 U.S. 307, 320–323 (1982)).

44 *Id.* at 339.

45 *Id.* at 340.

46 *Id.*

47 *Id.*

48 *Id.* at 341.

49 *Id.* at 347.

50 *See, e.g.*, *infra* notes 51–55 and accompanying text.

51 443 U.S. 622, 634 (1979). For a fascinating discussion of this phrase, and descriptions as to possible categories of vulnerability, see Lois A. Weithorn, *Children and the Law: Constitutional Decisionmaking and the "Peculiar Vulnerability of Children,"* 2 THE JUDGES' BOOK, Art. 4 (2018).

52 567 U.S. 460, 471 (2012). *See also* Graham v. Florida, 560 U.S. 48, 68 (2010) (pointing out the "fundamental differences between juvenile and adult minds"); Roper v. Simmons, 543 U.S. 551, 569–70 (2005) (stating that juveniles lack maturity, are more vulnerable to negative influences, and their character is less fixed).

53 Doe 4 *ex rel.* Lopez v. Shenandoah Valley Juv. Ctr. Comm'n, 985 F.3d 327, 342 (4th Cir.) (quoting Eddings v. Oklahoma, 455 U.S. 104, 115 (1982)), *cert. denied*, 142 S. Ct. 583 (2021).

vulnerable time of life."[54] These opinions, and others, point to juveniles as a particularly vulnerable population in the mind of the court. This conclusion is also in regulations such as those protecting unaccompanied children in government care, which notes the "particular vulnerability of minors,"[55] a further echoing of *Bellotti*.[56]

IV. Studies Recognize the Particular Vulnerability of Unaccompanied Children Due to High Exposure to Trauma

While the court recognizes children as a particularly vulnerable population, this vulnerability is only compounded for unaccompanied children as a result of their immigration process.[57] In a book for mental health clinicians working with refugee and immigrant families and children, the authors split possible trauma across migration into three main categories: premigration, migration, and resettlement.[58] Each of these can be broken down further into events in which families or children may have faced situations resulting in trauma, including exposure to war, natural disaster, food shortages or starvation, sexual assault, or familial separation.[59] In general, trauma, specifically during childhood, increases the risk of developing mental illnesses such as depression, anxiety, eating disorders, and suicidal ideation, as well as increasing the risk of chronic health conditions.[60] In one case, for example, researchers compiled studies and literature published between 2003 and 2013 in the United States.[61] Eight out of ten studies surveyed showed that children exposed to "chronic childhood trauma" exhibited a "significant

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[54] Parham v. J.R., 442 U.S. 584, 626 (1979) (Brennan, J., concurring), *quoted in* Reno v. Flores, 507 U.S. 292, 318 (1993) (O'Connor, J., concurring).

[55] 45 C.F.R. § 410.102(c) (2019).

[56] *See Bellotti*, 443 U.S. at 634 (noting the "peculiar vulnerability" of adolescents).

[57] *See, e.g.*, Sarah Mares, *Mental Health Consequences of Detaining Children and Families Who Seek Asylum: A Scoping Review*, 30 Eur. Child & Adolescent Psychiatry 1615, 1616 (2021) ("There is consensus that exposure to violence at any stage of the 'journey,' separation from or loss of a parent, and lack of support in resettlement all increase vulnerability to mental health problems.").

[58] Heidi B. Ellis, Saida M. Abdi & Jeffrey P. Winer, Mental Health Practice with Immigrant and Refugee Youth: A Socioecological Framework 67 (2019). Drs. Ellis and Winer are well-known refugee trauma specialists at Boston's Children's Hospital and Harvard Medical School. Dr. Saida Abdi is a University of Minnesota Social Work Professor. For a study on the disparate impact of parental deportation (or the fear of possible deportation) on children, see Joana Dreby, *The Burden of Deportation on Children in Mexican Immigrant Families*, 74 J. Marriage & Fam. 829 (2012).

[59] Ellis et al., *supra* note 58.

[60] *See* Satu Larson, Susan Chapman, Joanne Spetz & Claire D. Brinidis, *Chronic Childhood Trauma, Mental Health, Academic Achievement, and School-Based Health Center Mental Health* Services, 87 J. Sch. Health 675, 684 (2017). *See generally* Emily M. Zarse, Mallory R. Neff, Rachel Yoder, Leslie Hulvershorn, Joanna E. Chambers & R. Andrew Chambers, *The Adverse Childhood Experiences Questionnaire: Two Decades of Research on Childhood Trauma as a Primary Cause of Adult Mental Illness, Addiction, and Medical Diseases*, 6 Cogent Med. 1 (2019) (describing the risks of different diseases and mental illnesses based on childhood trauma).

[61] Larson et al., *supra* note 60, at 677.

risk of increasing mental health disorders with subsequent poor academic achievement."[62]

Other research through twenty years of data collected via the Adverse Childhood Experience (ACE) Questionnaire indicates that early childhood trauma, including abuse and neglect, "negatively impacts the long-term function and development" of the immune system and the neurohormonal system, which together "determine how brain and body systems interact with each other" and how they interact with external threats.[63] This study is discussed by renowned trauma psychiatrist Dr. Bessel van der Kolk in his book *The Body Keeps the Score*.[64] In describing trauma, he calls it an "imprint" left on the brain and body: "Trauma results in a fundamental reorganization of the way mind and brain manage perceptions. It changes not only how we think and what we think about, but also our very capacity to think."[65] These changes impact the brain's functions in general,[66] but can also lead to future physical issues including diabetes, heart disease, cancer, stroke, and suicide.[67]

These issues are only exacerbated for unaccompanied children who face trauma prior to, during, and after their immigration journey, and are either separated from or left home without their parents.[68] In 2008, a review of scholarship from the last ten years revealed higher PTSD rates for unaccompanied minors than for other children or accompanied minors.[69] In another study, unaccompanied children displayed high rates of depression and anxiety, with 25 percent or more reporting high depression and anxiety; more than 40 percent of the children were found to have "severe PTSD."[70]

These adverse effects are only compounded when a child is placed in detention, including juvenile holding facilities like those where John Doe 4 was

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62 *Id.*

63 Zarse et al., *supra* note 60, at 13. This study discusses certain types of trauma and the likelihood of developing different diseases or behaviors, including mental health disorders, addictions, and general health issues.

64 BESSEL VAN DER KOLK, THE BODY KEEPS THE SCORE: BRAIN, MIND, AND BODY IN THE HEALING OF TRAUMA 174 (2015).

65 *Id.* at 30.

66 *Id.* at 53–57.

67 *See* Zarse et al., *supra* note 60, at 11–12.

68 For a more complete idea of the experiences of an average unaccompanied child before, during, and after migration, see Amanda NeMoyer, Trinidad Rodriguez & Kiara Alvarez, *Psychological Practice with Unaccompanied Immigrant Minors: Clinical and Legal Considerations*, 5 TRANSLATIONAL ISSUES PSYCH. SCI. 4, 5–8 (2019).

69 Julia Huemer, Niranjan S. Karnik, Sabine Voelkl-Kernstock, Elisabeth Granditsch, Kanita Dervic, Max H. Friedrich & Hans Steiner, *Mental Health Issues in Unaccompanied Refugee Minors*, 3 CHILD & ADOLESCENT PSYCHIATRY & MENTAL HEALTH (2009). *See also* Suzan J. Song, *Mental Health of Unaccompanied Children: Effects of U.S. Immigration Policies*, 7 BJPSYCH OPEN e200 (2021) ("[T]he consensus is that psychological difficulties are higher in unaccompanied children than the general population.").

70 NeMoyer et al., *supra* note 68, at 9. Due to the lack of studies done on this population in the United States, studies done abroad can provide useful insights. This study was done in Belgium.

held.[71] Unaccompanied children who have spent time in detention have higher risks of mental health illness because they have high rates of deeply traumatic experiences.[72] "[R]eports have documented high rates of PTSD, anxiety, depression, aggression, psychosomatic complaints, and suicidal ideation among unaccompanied children in detention."[73] A study of comparative research papers found evidence that high rates of mental "disorder" and distress were found in *all* conducted studies of detained children.[74] Furthermore, "restrictive detention" compounds "pre-existing vulnerabilities" with higher mental illness rates than in children "with similar risks who were not detained."[75] Despite the array of studies that were surveyed, there is a consistent conclusion that detention is a "profoundly adverse reception experience for already vulnerable children," and has consistent high rates of mental distress.[76]

Recent United States regulations have recognized this extreme vulnerability, indicating a widespread understanding and redress of this phenomenon. For example, "Apprehension, Processing, Care, and Custody of Alien Minors," created by U.S. Immigration and Customs Enforcement (ICE), U.S. Department of Homeland Security (DHS), and U.S. Department of Health and Human Services (HHS), requires unaccompanied children to be treated with "special concern for their particular vulnerability."[77] This is echoed in mandates that the Office of Refugee Resettlement (ORR) place children in facilities that are in line with "the particular vulnerability of minors."[78]

V. THE STANDARD IS INSUFFICIENT WHEN APPLIED TO OTHER CHILDREN[79]

The standard has had obvious failings as applied to people in care facilities, like Mr. Rehbein,[80] but it has also failed children in schools. The case of nine-year-old Cherry Heidemann is one such example. Cherry was a young girl with profound

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71 Not all children are sent to detention facilities. As many as ninety percent are released from ORR's custody into that of a parent, relative, or family friend while their case pends. *See* TEX. EDUC. FOR HOMELESS CHILD. & YOUTH, *UAC Overview*, https://www.theotx.org/wp-content/uploads/2015/03/Undocumented_Alien_Children_UAC_Overview.pdf. However, children in ORR custody are still held in facilities that are often akin to detention, not to mention that generally children are held by CBP before they are released to ORR custody. NeMoyer et al., *supra* note 68, at 8.

72 Solange Paredes, *Health and Nutrition of Migrant Youth*, 24 HARV. PUB. HEALTH R. 1, 1 (2019).

73 Charles D. R. Baily, Schuyler W. Henderson, Amber S. Ricks & Amanda R. Taub, *The Psychosocial Context and Mental Health Needs of Unaccompanied Children in United States Immigration Proceedings*, 13 GRADUATE STUDENT J. PSYCH., Colum. U. 4, 7 (2011).

74 Mares, *supra* note 57, at 1630.

75 *Id.* at 1633.

76 *Id.* at 1634.

77 45 C.F.R. § 410.102(d) (2019).

78 45 C.F.R. § 410.102(c) (2019).

79 The difficulty in adequately showing this is the distinctive nature of many juvenile claims: they are often redacted or sealed to protect the interests of the child. For two *Youngberg* standards gone awry in institutional settings, see Jordan v. District of Columbia, 161 F. Supp. 3d 45 (D.C. Cir. 2016), and Clift ex rel. Clift v. Fincannon, 657 F. Supp. 1535, 1546–47 (E.D. Tex. 1987).

80 *See infra* Part VI.

cognitive impairment who went to a public elementary school in Nebraska.[81] On several documented occasions, Cherry's teachers used a mechanical restraint technique on her they called "blanket wrapping."[82] This practice "involved binding her body with a blanket such that she could not use her arms, legs, or hands."[83] This practice was recommended by Sharon Joy, a licensed physical therapist who worked with the school district.[84] Reports indicate that Cherry was confined in this manner against her will for "periods of one and a half hours or more."[85] Cherry's mother, June, was unaware Cherry was being confined like this until one day at school pickup, she found Cherry "blanket wrapped on the floor, with flies crawling in and around her mouth and nose," with the blanket wrapped so tightly that June was unable to remove it by herself.[86] A week later, again picking Cherry up from school, June found Cherry confined this way once more and was again, because of the severity of the bind, unable to remove the blanket without assistance.[87]

Cherry, through her mother, filed a § 1983 claim alleging violations of constitutional rights.[88] Because of Cherry's cognitive impairments, the court held that her constitutional claims had to be evaluated under the *Youngberg* standard.[89] Dismissing the claims against the school,[90] the court considered the testimony of Joy, in which she stated that blanket wrapping was "an accepted practice" and was the "most effective and least restrictive form of treatment" for Cherry.[91] Unlike other cases discussed below, where judges note regretfully that there simply was no other evidence on record to indicate there was a deviation from accepted practice, here the judge noted the affidavits of two other experts' testimony. Despite this expert testimony, the judge *still* decided the lower court improperly denied summary judgment.[92] The school and employees were granted summary judgment

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81 Heidemann v. Rother, 84 F.3d 1021, 1025 (8th Cir. 1996).

82 *Id.*

83 *Id.*

84 *Id.*

85 *Id.* at 1026.

86 *Id.*

87 *Id.*

88 *Id.*

89 *Id.* at 1029.

90 The court concluded that even if the treatment was a departure from professional norms (which it was not, the court insisted), "a reasonable official would not have known that to be true." *Id.* As such, the school and employees were entitled to qualified immunity. *Id.*

91 *Id.* at 1030.

92 *Id.* at 1030 & n.6. Expert Penny White-Romero, a licensed physical therapist, testified that the technique could be used "for a maximum of ten (10) minutes" as a relaxation technique prior to therapy, but it was not widely used. *Id.* Also, she noted that confining Cherry as she was (so tightly she could not move and for over an hour) "would constitute restraint, and would clearly fall outside the scope" of appropriate use." *Id.* The other expert, Kenneth D. Keith, Ph.D., claimed that this technique was an adverse behavior management tool and inappropriately used would be "detrimental" to the child. *Id.* See discussion *infra* regarding the *Rehbein* case.

on qualified immunity grounds.[93] The court also granted Joy qualified immunity, as a decision otherwise "would restrict unnecessarily the exercise of professional judgment."[94]

It is worth noting that some of the most important developments for children happen in schools, a fact which casts light on how the court did not adequately protect Cherry in this case.[95] Numerous studies have looked at the effects of different kinds of restraint and their consequences on individuals.[96] "Mechanical restraint" is the "use of any device or object (e.g., tape, tiedowns, calming blanket, body carrier) to limit an individual's body movement to prevent or manage out-of-control behavior."[97] This type of restraint is most akin to what was used on Cherry, although terminology is varied.[98] As early as 1793, psychiatrists were arguing against the use of restraints.[99] In 1839, Dr. John Conolly famously adopted a nonrestraint policy in the Hanwell Asylum in Middlesex based on the work of Dr. Robert Hill, who said, "[i]n a properly constructed building with [enough attendants], restraint is never necessary, justifiable, and always injurious."[100] This became the policy in English mental institutions but was not favored in America.[101] Institutions and schools continue to use restraints today.[102] However, regarding restraint in all environments, "[b]oth governmental and professional reviews have found no therapeutic value in the practices."[103]

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[93] *Heidemann*, 84 F.3d at 1029. *See supra* note 90 discussion and accompanying text. In deciding a qualified immunity claim "the court considers: (1) whether a federal violation had been asserted; (2) whether the allegedly violated right was clearly established; and (3) whether, given the facts most favorable to the plaintiffs, a reasonable official would have known that the alleged actions violated that right." *Heidemann*, 84 F.3d at 1027–28 (citing Foulkes v. Cole Cnty, 991 F.2d 454, 456 (8th Cir. 1993)).

[94] *Id.* at 1031 (quoting Youngberg v. Romeo, 457 U.S. 307, 322 (1982)).

[95] *See School-Age Children Development*, MOUNT SINAI, https://www.mountsinai.org/health-library/special-topic/school-age-children-development? (last visited Nov. 19, 2023). For a description of some of the children who died due to physical restraint in school, see David Ferleger, *Human Services Restraint: Its Past and Future*, 46 INTELL. & DEV. DISABILITIES 154, 155 (2008).

[96] *See, e.g.*, Patrick J. Schloss & Maureen A. Smith, *Guidelines for Ethical Use of Manual Restraint in Public School Settings for Behaviorally Disordered Students*, 12 BEHAV. DISORDERS 207 (1987).

[97] Joseph B. Ryan & Reece L. Peterson, *Physical Restraint in School*, 29 BEHAV. DISORDERS 154, 154 (2004).

[98] NCLEX-RN, the examination for nursing school, defines restraints in different categories including physical, chemical, and safety devices, as well as preventative measures that are done in order to deter the use of restraints. Registered Nursing, *Use of Restraints and Safety Devices: NCLEX-RN* (Aug. 11, 2023), https://www.registerednursing.org/nclex/use-restraints-safety-devices/.

[99] Lucy Ozarin, *The Question of Restraint: 200 Years of Debate*, PSYCHIATRIC NEWS (September 21, 2001) ("In 1793 Philippe Pinel struck the chains binding the lunatic women confined in the French Asylum of Bicêtre in Paris.").

[100] *Id.*

[101] Ferleger, *supra* note 95, at 154.

[102] *See, e.g.*, IND. CODE § 20-20-40-13 (2013).

[103] Ferleger, *supra* note 95, at 157.

Restraints have been used in schools for many years, but literature on their efficacy remains slim.[104] However, there were reports on the effectiveness of these types of techniques in schools in the 1970s and 1980s; professional organizations such as the American Psychological Association and the Association for the Advancement of Behavioral Therapy Task Force "established standards that reflect[ed] their concern for legal and ethical issues" surrounding these techniques.[105] Indeed, these ethical concerns were only expounded on in 1999 in a statement by the Autism National Committee who "condemn[ed] the widespread and excessive use of mechanical and physical restraints," noting that "[b]ehavioral restraints are neither treatment nor education."[106] A paper released in 1987 reviewed some of the advantages and disadvantages of restraint, specifically manual restraint in school, noting that states at the time "authorize[d] the use of mechanical and manual restraint only under well prescribed circumstances."[107] A study in 2004 found that the "preponderance" of decisions by State Education Agencies, the Office for Civil Rights, and the courts found that "the use of any type of mechanical restraint other than a time-out or tray chair" was a violation of the student's rights.[108]

Despite the evidence presented in the record to the contrary, and the plethora of studies in the psychiatric realm that indicated otherwise, the judge in Cherry's case was unmoved.[109] Perhaps the judge did not allow the argument to go forward because the evidence in the record came from only two experts. There is no indication the academic trepidations about restraints, as discussed above, were entered before the court as evidence.[110] Regardless, it is clear the standard applied did not adequately protect Cherry.

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104 *Id.* ("The efficacy of the use of seclusion and physical restraint as behavior change techniques has not been documented, and research on the use of these techniques in schools is sketchy." (quoting the Wisconsin Department of Public Instruction)).

105 Schloss & Smith, *supra* note 96, at 207.

106 Press Release, Autism Nat'l Comm., Position on Restraints (Sept. 3, 1999) http://www.autcom.org/restraints.html.

107 Schloss & Smith, *supra* note 96, at 209. The likelihood that leaving a child for over an hour in this kind of restraint qualifies under this kind of narrow allowed circumstances seems quite unlikely.

108 Ryan & Peterson, *supra* note 97, at 160. Notably, all the decisions surveyed by the paper are from the 1980s and '90s, exactly when *Heidemann* was decided.

109 Heidemann v. Rother, 84 F.3d 1021, 1030 (8th Cir. 1996). This situation is confused by the court awarding qualified immunity to the defendants, but the evaluation by the court is muddied greatly by the use of the professional judgment standard. *See supra* notes 90, 93 and accompanying discussion; *see also Heidemann*, 84 F.3d at 1027–29 (where the court held that even if the actions were a departure from professional norms "a reasonable official would not have known that to be true.").

110 *Heidemann*, 84 F.3d at 1030–31 ("Although plaintiffs have submitted affidavits showing that other professionals in the field would not have recommended the use of blanket wrapping in this particular case or in the manner applied in this case, we hold that plaintiffs' submission of evidence on summary judgment was insufficient to create a genuine dispute as to whether the blanket wrapping treatment represented a substantial departure from accepted professional judgment, practice, or standards in the care and treatment of Cherry.") (footnote omitted).

VI. THE STANDARD IS INSUFFICIENT WHEN APPLIED TO ADULTS

To prove that the professional judgment standard, while necessary, is insufficient in protecting the mental and physical health of unaccompanied children, it is important to show that the standard is insufficient even as applied to arguably less vulnerable populations like adults.[111] In *Rehbein v. Terry*, an adult man was confined by physical restraints for thirty-nine hours in a hospital while held there as a pretrial detainee.[112] The psychiatrist, Dr. Martin, who ordered the treatment appealed a judgment by the magistrate judge in favor of Rehbein.[113] Reviewing the record, Judge Urbom noted that Dr. Martin approved restraints for twenty-four hours, then, the next day, concluded Rehbein "[c]ontinue[d] [to require] restraints," and renewed the order approving restraints "if needed to control behavior."[114] The court noted that Dr. Martin utilized his professional judgment and went on to discuss Dr. Martin's personal beliefs on the benefits of physical restraints, quoting from his testimony: "The primary purpose in using restraints is to control the physical activity so as to make direct action impossible. There are secondary psychological intents."[115] Dr. Martin, in his testimony, went on to say that these secondary intents are "a clear set of limits" so that a "severely disturbed" patient may "identify a psychological need to be in restraints" prior to an outburst; essentially, the patient would associate the onset of an episode with the need to be physically held back.[116] Dr. Martin also testified that he believed the restraints were "medically necessary" for the time they were used and that it was not rare to keep someone in restraints for longer than twenty-four hours.[117] Upon application of the appropriate standard, Judge Urbom concluded "[n]othing in the record supports a finding that the decision was 'such a substantial departure from accepted professional judgment'" to find liability.[118]

Questions around the ethics of such extreme length of confinement (thirty-nine consecutive hours) likely come to the mind of modern readers. This sentiment was echoed by health professionals who saw this behavior rampant in facilities.[119] In 1988, federal regulations were promulgated by HHS that created a standard for physical restraints for Medicaid and Medicare care facilities for the mentally ill.[120]

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111 I do not mean to imply that there are not categories of adults who are as vulnerable as unaccompanied children; however, there exist myriad studies that note the *particular* vulnerability of unaccompanied children. *See supra* notes 57–78 discussion and accompanying text.

112 836 F. Supp. 677, 678 (D. Neb. 1992).

113 *Id.*

114 *Id.* at 680–81.

115 *Id.* at 681.

116 *Id.* at 681–82.

117 *Id.* at 682–83.

118 *Id.* at 684 (quoting Youngberg v. Romeo, 457 U.S. 307, 323 (1982)).

119 *See* 42 C.F.R. § 483.450 (1988) and surrounding regulations.

120 *See* 42 C.F.R. §§ 483.400 and 483.450. These regulations likely did not apply to Rehbein because the Douglas County Hospital where he was housed as a pretrial detainee was not considered an "Intermediate

These regulations included requirements for "opportunity for motion and exercise" for at least ten minutes every two hours, required check-ins every thirty minutes, and a stipulation that the restraints could not be issued under an "as needed" or "standing" basis.[121] If used for emergency purposes, restraints could be used "no longer than 12 consecutive hours."[122] In 2000, Congress passed the Children's Health Act, which established minimum guidelines for restraint and seclusion in federally funded facilities for youth.[123] In 2001, HHS created additional requirements that included time limits on restraints based on the age of the individual.[124] These requirements were later adapted to include similar protections for adults in federally funded hospitals as well.[125] Much of the discussion on restraints above in Part V is also relevant and of note here.[126]

The fact that public concern and private medical practice did not necessarily support Dr. Martin's decision was not of concern to the court.[127] Judge Urbom cared only about the application of the standard, and there was simply nothing in the record that indicated a substantial departure from accepted professional practice or standards.[128] Therein lies the key issue of the standard: even with fairly clear violations of rights and bodily autonomy as seen here, the judge (even if he wanted to) is unable to rule that an action violates certain constitutional rights unless it is a "substantial departure."[129] This gives an incredible amount of deference to the professional, allowing almost any practice to be green-lit as long as at least one other doctor would have permitted the prescribed treatment, or lack thereof.[130]

Care Facility for the Mentally Retarded." Intermediate Care Facilities (ICFs) require registration and licensing by the state. Connected Risk Solutions, *What is an Intermediate Care Facility*, Jan. 31, 2018, https://connectedrisksolutions.com/what-is-an-intermediate-care-facility/. Douglas County Hospital does not appear on a list of Nebraska's approved ICF placements, even in 2023. Dept. Health & Human Servs., *Intermediate Care Facilities for Persons with Developmental Disabilities*, https://dhhs.ne.gov/licensure/Documents/ICFDDRoster.pdf. *See also* 42 C.F.R. § 483(D) (1988).

121 42 C.F.R. § 483.450(d)(3), (4), (6).

122 *Id.* at (d)(2)(i).

123 Children's Health Act of 2000, 42 U.S.C. § 290ii. For additional information on how states handled these issues, see JUNE GIBBS BROWN, INSPECTOR GEN., DEP'T HEALTH & HUM. SERVS., RESTRAINTS AND SECLUSION: STATE POLICIES FOR PSYCHIATRIC HOSPITALS, OEI-04-99-00150 (Aug. 2000), https://oig.hhs.gov/oei/reports/oei-04-99-00150.pdf.

124 42 C.F.R. § 483.358(e)(2). The time frames then were not to exceed four hours for eighteen- to twenty-one-year-olds, two hours for nine- to seventeen-year-olds, and one hour for eight-year-olds and under. *Id.*

125 *See* 42 C.F.R. § 482.13. This was first written in 2006 and later amended in 2010. *Id.*

126 *See supra* notes 82–110 discussion and accompanying text.

127 *See* Rehbein v. Terry, 836 F. Supp. 677, 684 (D. Neb. 1992) ("Whether or not a judge considers that restraints have therapeutic value, the medical testimony in this case verifies that they do and none undercuts it.").

128 *Id.*

129 *See* Youngberg v. Romeo, 457 U.S. 307, 323 (1982).

130 *See* Joseph, *supra* note 25 ("The [Illinois Appellate Court] acknowledged that some courts have interpreted *Youngberg*'s professional judgment standard to mean that any decision by a professional, 'however outrageous it may be,' is valid. However, a 'careful reading of *Youngberg* . . . explodes this interpretation' to reveal that 'professional judgment' does not mean any decision made by a professional, 'but rather [any decision] synonymous with accepted standards and practices within the relevant

Furthermore, *Youngberg* says that these decisions, if made by a professional, are "presumptively valid" in terms of constitutional liability.[131] In bringing a claim before the court, plaintiffs are calling into question these very decisions. Furthermore, "it is perverse to insist that a court grant presumptive validity to the very decisions being challenged."[132] The standard does not adequately protect adults, so it cannot adequately protect a group the Supreme Court has deemed particularly vulnerable: children.

VII. THE PURPOSES OF DIFFERENT JUVENILE SYSTEMS

Seeing that the standard, as applied to both adults and children, is insufficient, it is worth considering the purpose of the system in which Doe 4 found himself. If the purpose of that system is merely to contain him, regardless of additional protection and support he required, then there could be no reason why the *Youngberg* standard would be insufficient. The *Youngberg* standard provides some level of constitutional protection—granted, a very low level;[133] thus, the standard is sufficient if there is no additional care required of the state in his circumstances.

There are several state and federal systems that deal directly with juveniles, specifically, the juvenile justice system, the foster care system, and the immigration system. The purpose of the juvenile justice system is fraught with conflicts on the importance of "rehabilitation" versus the more recent shift toward "getting tough" on crime.[134] Ultimately, courts have not drawn parallels between unaccompanied children and juvenile offenders in court opinions.[135]

Alternatively, the foster care system's mission is quite straightforward and applicable: it was "designed to meet the particular needs of all eligible neglected children."[136] The system recognizes the state's "*parens patriae* interest in preserving and promoting the welfare of the child."[137] Furthermore, courts have established

profession."") (quoting Lucas v. Peters, 741 N.E.2d 313, 324 (Ill. App. Dist. 2000)). Because another professional's affirmative opinion would be used to justify the practice was within "accepted standards," this enables the professional wide leeway in the course of prescribing treatment. For a discussion on the Supreme Court cases that have "transcended some professional's judgment" to "vindicate an individual's constitutional rights" and cases that are "shameful[ly] replete with language of deference to professional judgment," *see* Stefan, *supra* note 22.

131 *Youngberg*, 457 U.S. at 323.

132 Stefan, *supra* note 22, at 692.

133 *See Youngberg*, 457 U.S. 307 (using the standard to protect a mentally incapacitated adult); T.M. *ex rel.* R.T. v. Carson, 93 F. Supp. 2d 1179 (D. Wyo. 2000) (using the standard to overturn a summary judgment decision against abused foster care children).

134 *See generally* Katherine Twomey, *The Right to Education in Juvenile Detention Under State Constitutions*, 94 VA. L. REV. 765 (2008).

135 *Cf.* Doe 4 *ex rel.* Lopez v. Shenandoah Valley Juv. Ctr. Comm'n, 985 F.3d 327, 342 (4th Cir.), *cert. denied*, 142 S. Ct. 583 (2021) (calling unaccompanied children, individuals "whom the Government holds for the purpose of providing care," seemingly differentiating from juveniles held for punitive purposes).

136 Miller v. Youakim, 440 U.S. 125, 134 (1979).

137 Santosky v. Kramer, 455 U.S. 745, 766 (1982).

that when it comes to court proceedings, "[f]oster children are entitled to a high[er] standard."[138] In regard to juvenile immigration facilities, the *Reno v. Flores* Court equates this kind of custody to "legal custody rather than detention," similar to "foster care, group care, and related services to dependent children."[139] This is made even more obvious by the court in *Doe 4*: "The statutory and regulatory scheme governing unaccompanied children expressly states that these children are held to give them care."[140] The *Doe 4* court notes several U.S. Code provisions that uphold this premise,[141] including mandates such as those requiring that children be placed in the "least restrictive setting that is in the best interest of the child."[142] Furthermore, ORR is responsible for holding unaccompanied children in safe and sanitary facilities, as well as ensuring they are able to make court dates and are protected from individuals who would do them ill.[143] In Doe 4's case, these mandates were reflected in his facility's agreement with ORR.[144] Specifically, SVJC was a "care provider" that agreed to furnish appropriate living conditions for children, which included "routine medical care," emergency services, and "appropriate mental health interventions when necessary."[145]

If the purpose of the system is adequately represented by these opinions of various courts, regulations, and legislation, then the bottom line is clear: it is the duty of the state or the federal government to protect unaccompanied children and provide for them as if they were acting *in loco parentis* for youth in the foster system.

VIII. The Structures of Current Systems Are Insufficient

If the purpose of the system is to protect and provide for unaccompanied children, what structures are in place to ensure that this is being carried out? As discussed above, there are regulations and legislation aimed at ensuring unaccompanied children get the safety and care they deserve.[146] Also, once a month, ORR must review the placement of every child "to determine whether a new level of care is more appropriate" given the unique needs and age of each child.[147] Each facility also makes an agreement with ORR, ensuring it is a proper environment

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138 *E.g.*, Braam *ex rel.* Braam v. State, 81 P.3d 851, 859 (Wash. 2003) (holding that deliberate indifference is not the right standard as "[s]omething more than refraining from indifferent action is required to protect these innocents.").

139 Reno v. Flores, 507 U.S. 292, 298 (1993) (internal citations omitted).

140 *Doe 4*, 985 F.3d at 339.

141 *Id.* at 339–40.

142 *Id.* (citing 8 U.S.C. § 1232(c)(2)(A)).

143 *Id.* at 340. *See also* 6 U.S.C. § 279(b)(2)(A).

144 *Doe 4*, 985 F.3d at 340.

145 *Id.*

146 *See supra* section VII "The Purposes of Different Juvenile Systems."

147 45 C.F.R. § 410.203(c)–(d).

with adequate capacities to house unaccompanied children.[148] There is no evidence on SVJC's website that they have any internal reporting mechanism that unaccompanied children can use if they feel they are not being adequately protected.[149] Nor is there any evidence a child can lodge a complaint with ORR.[150]

If there is a serious issue, a child can, of course, sue. But, suing brings its own consequences, such as determining who will fund the suit and who will represent an indigent client in a difficult civil proceeding with unfavorable precedent.[151] It is particularly difficult for immigrants to find and fund legal representation for civil deportation cases, let alone a § 1983 claim.[152] There is a distinct lack of resources for immigrants in general, and the situation for unaccompanied children seems particularly bleak. From October 1, 2017 through March 31, 2021, in cases where an unaccompanied child was unrepresented, ninety percent resulted in removal.[153] Almost sixty-eight percent of total removal cases tried in that period were performed without legal representation.[154] Enabling a wronged child to sue the facility where they were held, under a standard that gives deference to the individuals that run said facility, cannot be the answer. The purpose of the system is to protect and provide for children, but there are few supports in place that allow them to speak when this purpose is not met. Even when they are able to file, it has been shown that the professional judgment standard works against them, practically ensuring that some of the worst cases are not fully heard.[155] Judicial review is meant to "ensure[] that [the] government acts in this sensitive area with the requisite care,"[156] but here, claims cannot even get to

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148 *See generally Doe 4*, 985 F.3d at 329.

149 *See Juvenile Center Main Page*, SVJC, https://www.svjc.org/ (last updated June 15, 2020). While there is information publicly available on how to lodge a complaint based on the Prison Rape Elimination Act (PREA), there is no information on how juveniles may lodge other kinds of complaints based on constitutional violations at SVJC. *See PREA Initiative*, SVJC, https://www.svjc.org/new-page (last visited Dec. 26, 2022).

150 According to the ORR website, there is a complaint mechanism for grievances about "any ORR-funded resettlement program service," but there is no evidence that this includes facilities for youth that are—technically speaking—*not* "resettlement" services, but rather, holding facilities. *See Concerns About ORR Services*, OFF. REFUGEE RESETTLEMENT (July 7, 2022), https://www.acf.hhs.gov/orr/programs/refugees/concerns-about-orr-services. Also, ORR is within HHS, and it is difficult to see how constitutional claims could be heard in HHS's extremely limited adjudicative capacity.

151 *See, e.g.*, Beth Fertig, *Why it's Harder to Win Asylum, Even in New York*, WNYC NEWS, https://www.wnyc.org/story/why-its-harder-win-asylum-even-new-york/ (describing a limited case decision as "a win" when considering "the case law that [they were] working with").

152 *See, e.g.*, Marco Poggio, *NY Seeks First-In-The-Nation Right to Counsel in Deportations*, LAW 360, (Oct. 14, 2022), https://www.law360.com/articles/1540216/ny-seeks-first-in-the-nation-right-to-counsel-in-deportations ("There are nearly 180,000 noncitizens in [New York] who have pending immigration proceedings. Over 52,000 of them are unrepresented . . . .").

153 WILLIAM A. KANDEL, CONG. RSCH. SERV., R43599, UNACCOMPANIED ALIEN CHILDREN: AN OVERVIEW 17 (2021), https://sgp.fas.org/crs/homesec/R43599.pdf.

154 *Id.*

155 *See, e.g.*, Heidemann v. Rother, 84 F.3d 1021, 1025, 1029 (8th Cir. 1996); Rehbein v. Terry, 836 F. Supp. 677, 680–81 (D. Neb. 1992).

156 Reno v. Flores, 507 U.S. 292, 318 (1993) (O'Connor, J. concurring).

the courthouse door. Even if the claim is successfully lodged, the current standard does not allow adequate protection for such a vulnerable population, just as it failed to protect Cherry and Mr. Rehbein.[157] Because this population has such a modest opportunity to have their voices heard at all, it is critical that they are met with a standard that encourages their claims, rather than discourages their attempts at justice from the beginning.

The court has been clear in the past: children are a vulnerable population.[158] The regulations and court opinions are clear now: unaccompanied children are particularly vulnerable.[159] As such, there should be a standard in place that respects the vulnerability of these children and holds the system responsible for their protection and care. When the government acts as a care provider, it must create strong protections to ensure the safety of the ones it is caring for. Here, it is critical to note that Doe 4 still has not received justice on his claims. More than five years after the case was originally filed, the case continues to progress slowly; litigation thus far has proved unfruitful.[160] It is imperative to change this standard before more John or Jane Does are subjected to the same treatment. The professional judgment standard does not adequately protect this population, and as such, the court must establish a new standard that ensures the care of those who have been entrusted to the government's protection.

IX. A BETTER STANDARD AND FUTURE RESEARCH

A. Gross Negligence

What may a better standard look like? The Second Circuit claimed that the professional judgment standard was "essentially a gross negligence standard."[161] Adopting a gross negligence standard explicitly could be a step in the right direction if one considers "willful, wanton, and reckless"[162] in a way deferential to the child. However, if it does not have bite behind it, petitioners will be no better off than they were with a "deliberate indifference" standard. Part of the argument for the "professional judgment" standard is that it eliminated the subjective element the

[157] *See supra* text accompanying notes 79–132.

[158] *See supra* text accompanying notes 50–56.

[159] *See supra* text accompanying notes 57–78.

[160] It is not clear if Doe 4 is still in ORR custody. Most recently the parties agreed to a voluntary dismissal due to lack of subject matter jurisdiction. Consent Motion to Dismiss, Doe 4 ex rel. Lopez v. Shenandoah Valley Juv. Ctr. Comm'n, No. 5:17-cv-00097 (W.D. Va. Apr. 26, 2023), ECF No. 6766. For another story about a child held in SVJC see Keegan Hamilton, *They Basically Disappeared Him*, VICE (June 26, 2018, 9:00am), https://www.vice.com/en/article/9k84wy/they-basically-disappeared-him.

[161] Doe v. New York City Dep't of Soc. Servs., 709 F.2d 782, 790 (2d Cir. 1983).

[162] *See* Legal Information Institute, *Gross Negligence*, CORNELL L. SCH. (Jan. 2022), https://www.law.cornell.edu/wex/gross_negligence#:~:text=Gross%20negligence%20is%20a%20heightened,life%20or%20property%20or%20another.

"deliberate indifference" standard required.[163] Thus, according to the court, the "professional judgment standard" requires "a lower standard of culpability."[164] Recklessness, willfulness, and wantonness are commonly litigated to include a subjective element, a "conscious disregard" for a substantial risk, according to the Model Penal Code.[165] This gross negligence standard would then leave individuals no better off than they were under the deliberate indifference standard, and as described in early sections, that standard is nowhere near sufficient.[166]

B. Softening the Language

Another alternative would be to take the existing standard and soften the language. For example, the standard currently calls for a "substantial departure" from accepted professional judgment.[167] If this were changed to an "unreasonable" departure from accepted professional judgment, this could allow for a larger consideration of what would have been reasonable in those circumstances, making the standard more flexible and case specific. But this is one of the weaker options, as it could sow confusion with courts, leaving them unsure which language to use. Furthermore, this creates room for ambiguity and therefore provides avenues for judge-made law. Justice Cardozo famously called judge-made law "one of the existing realities of life."[168] It does not mean this approach is poor, but it may cause inequitable administration of the law until it is standardized across courts, something courts have warned others of in the past.[169] Furthermore, there are legal language issues with the term and idea of "reasonable"—and by extension, "unreasonable"—that make this option less appealing.[170]

C. Medical Standard of Care

Perhaps the most persuasive choice is a test using the medical standard of care.[171] This standard could be more appropriate: here, the conduct of the

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[163] *See* Doe 4 *ex rel.* Lopez v. Shenandoah Valley Juv. Ctr. Comm'n, 985 F.3d 327, 343 (4th Cir.), *cert. denied*, 142 S. Ct. 583 (2021) ("[O]ne difference between the two standards is that *Youngberg* does not require proof of subjective intent.").

[164] *Id.*

[165] MODEL PENAL CODE § 2.02 (AM. L. INST. 2007).

[166] *See, e.g.*, *supra* note 25 for papers that discuss both standards and the progress made under the "professional judgment" standard.

[167] Youngberg v. Romeo, 457 U.S. 307, 323 (1982).

[168] BENJAMIN N. CARDOZO, THE NATURE OF THE JUDICIAL PROCESS 10 (1921).

[169] *Cf.* Hanna v. Plumer, 380 U.S. 460, 468 (1965) (saying the Erie Doctrine was created for "avoidance of inequitable administration of the laws.").

[170] For an interesting look into possible philosophical underpinnings of the "reasonable person" standard and its shortcomings overall, consider Gregory Jay Hall, *Demystifying the Enigma: The Reasonable Person Standard in Tort*, 90 UMKC L. REV. 801 (2022).

[171] *See* Jackson v. United States, 708 F.3d 23, 29 (1st Cir. 2013) (holding the standard is what an "average qualified physician would provide in similar circumstances."); Butts v. United States, 930 F.3d 234, 239

professional is compared to an ordinary member of the profession with comparable training and expertise.[172] Instead of requiring a substantial departure from professional judgment, this would require only that the treatment, or lack thereof, would have been a deviation from an ordinary professional in the same field.[173] This is perhaps one of the stronger alternatives as it is already an accepted application of medical wrongfulness in certain contexts, like in medical malpractice cases.[174] While it is possible this could cause more lawsuits against "good" doctors and professionals, the benefits outweigh the cons here, especially as applied to vulnerable populations.[175] Courts are also already familiar with this standard and therefore would be able to employ it more easily.[176] It is also a low-cost solution, eliminates confusion on interpretation, and has a plethora of precedent.[177] More cases may come as a result of this solution, but there is already a paved pathway for the courts to follow. Furthermore, it is in line with the objectives of the juvenile immigration system: to protect and provide for unaccompanied children. The medical standard of care would allow better enforcement on the ground, ensuring that unaccompanied children get the physical, mental, and emotional security they so desperately need and deserve.

D. Greater Access of Resources for Unaccompanied Children

Unaccompanied children should have access to internal and external reporting mechanisms to contest violations of their rights, and these reports should be taken seriously by both the facility in question and the ORR. For unaccompanied children, a more obvious solution to this issue is the expansion of a right to an attorney for immigration proceedings, especially in cases involving constitutional issues in immigration holding facilities. This is not a novel idea and several papers have espoused solutions to the issue, including right expansion approaches through

(4th Cir. 2019) (holding the doctor liable if they failed to exercise "that degree of care, skill and learning required or expected of a reasonable, prudent health care provider in the profession or class" that the doctor is a member of); Watkins v. United States, 589 F.2d 214, 217 (5th Cir. 1979) (holding the doctor liable if the care falls "below the standard of care in the medical community.").

172 *See* Greene v. United States, 540 F. Supp. 3d 467 (M.D. Pa. 2021); *see also* Chiarino v. United States, 189 F. Supp. 3d 1371 (S.D. Fla. 2016); Armacost v. Davis, 200 A.3d 859 (Md. 2019).

173 *See supra* note 171 discussion.

174 *See, e.g.*, notes 171–72 discussion and accompanying text.

175 It is also worth noting that this standard has not overrun the medical industry with malpractice claims. *See generally* Aaron E. Carroll, *A Missed Opportunity for the Malpractice System to Improve Health Care*, N.Y. TIMES, (May 27, 2019), https://www.nytimes.com/2019/05/27/upshot/malpractice-health-care-missed-opportunity.html ("A new study, confirming earlier research, found that about 2 percent of doctors accounted for about 39 percent of all claims in the United States.").

176 *See Medical Malpractice Lawsuits: 50-State Survey*, JUSTIA, https://www.justia.com/injury/medical-malpractice/medical-malpractice-lawsuits-50-state-survey/ (last visited Dec. 27, 2022).

177 *See generally supra* notes 171–72 discussion and accompanying text.

the Fifth Amendment[178] and the appointment doctrine.[179] Because of the vulnerability of this population, and the special accommodations they have already been granted,[180] it seems more likely that the government could read into the Immigration and Nationality Act the requirement that they be represented at government cost.[181] In *Franco-Gonzalez v. Holder*, the court held that under the Rehabilitation Act, a noncitizen with severe mental illness had a statutory right to a qualified representative at government expense as a reasonable accommodation.[182] It would not be such a stretch to say that this vulnerable population, in court without a guardian or adult representative, would be entitled to such a reasonable accommodation as well. Additional funding and resources could be allocated to public defender offices around the United States to provide this kind of legal assistance, utilizing a system already in place.

E. Substantial Research Needed

Future research should focus on these ideas for a new standard, taking special care to consider the vulnerability of the population that is being studied here. Immigration scholars could also introduce additional scholarship applying new schema to different immigrant populations,[183] as they too experience trauma untold. But this issue is especially critical for unaccompanied minors. As discussed above in Part IV, unaccompanied children have an increased risk of developing mental illness and subsequent chronic health issues due to the severe trauma they face while immigrating.[184] Because of this, it is imperative that facilities begin implementing trauma-informed care in their long-term treatment plans, but also in their everyday interactions with children.[185]

Trauma-informed care "realizes the widespread impact of trauma and understands potential paths for recovery; [and] recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system."[186] These

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178 *See* Andrew Leon Hanna, Note, *A Constitutional Right to Appointed Counsel for the Children of America's Refugee Crisis*, 54 HARV. C.R.–C.L. L. REV. 257 (2019).

179 *See* Benjamin Good, Note, *A Child's Right to Counsel in Removal Proceedings*, 10 STAN. J. C.R. & C.L. 109 (2014).

180 *See* Reno v. Flores, 507 U.S. 292, 297–98 (1993).

181 These could be "regular" public defenders or a special class of lawyers or public defenders with specific immigration knowledge.

182 Franco-Gonzalez v. Holder, No. CV 10-02211 DMG (DTBx), 2013 WL 3674492, at *3 (C.D. Cal. Apr. 23, 2013).

183 Such as women fleeing domestic violence, families fleeing violence, or young men escaping gang recruitment.

184 *See generally* Zarse et al., *supra* note 60.

185 For information on trauma-informed care and how to read it into the current *Youngberg* standard, see Joseph, *supra* note 25.

186 U.S. DEP'T OF HEALTH & HUM. SERV., SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., SAMSHA'S CONCEPT OF TRAUMA AND GUIDANCE FOR A TRAUMA-INFORMED APPROACH, 9 (2014), https://ncsacw.acf.hhs.gov/userfiles/files/SAMHSA_Trauma.pdf.

are important steps to ensuring that unaccompanied children are well cared for in the facilities they are placed. Introducing care with trauma treatment specifically in mind would likely decrease the need for children to make claims at all. Trauma-informed care includes an important last step: "[It] responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization."[187] By putting these practices into action, facilities can utilize this last step of trauma-informed care to ensure they are actively caring for children, fulfilling the purpose of the system laid out in *Doe 4*, and effectively ensuring that fewer constitutional violations occur. This in turn will decrease the need for lawsuits that are bound by insufficient standards discussed.[188]

F. Limiting Factors to Future Research

Furthermore, additional studies are needed to provide more empirical research on unaccompanied children in general. Because of their age, vulnerabilities, and population size, very few empirical studies have been done to understand more about their health, well-being, treatment in society, life outlook, or the discrimination unaccompanied children face. Further research should be done to understand how the legal system can best protect the children at the heart of this issue. This could include surveying and empirical studies done at SVJC or other facilities that allow unaccompanied children to speak to their own issues and give concrete data on mental health, stigma, resources available (legal and health related), and abuse within the system. Such data may be difficult to gain as children in situations where they feel threatened or unsafe may not be motivated to answer truthfully. Because of this, it is necessary to ensure that children feel safe and cared for in their facilities, specifically through trauma-informed care and therapeutic resources.

CONCLUSION

If SVJC would have employed a trauma-informed care approach to Doe 4's healthcare and if the standard for the constitutional violations in his case would have been a medical standard of care, it is far more likely that Doe 4 would have been cared for and given justice long ago. Utilization of some of these tactics and approaches will ensure that unaccompanied children are protected—something the professional judgment standard has not done.

The system is designed to "give [immigrant children] care."[189] It is imperative that this issue remain relevant by increasing studies, court cases, and lobbying to protect this vulnerable class. It is the duty of the strong to protect those who cannot

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[187] *Id.*

[188] Doe 4 *ex rel.* Lopez v. Shenandoah Valley Juv. Ctr. Comm'n, 985 F.3d 327, 339 (4th Cir.) ("[T]hese children are held to give them care."), *cert. denied*, 142 S. Ct. 583 (2021).

[189] *Id.*

protect themselves by cultivating a better standard of care and demanding that the legislature and courts adopt more protective laws.