Ill-Advised, Ill-Prescribed: A Remedy for the Alarming Usage of Psychotropic Drugs Among Migrant Children Held in U.S. Detention Facilities

ILANA GOMEZ*

In recent years, many U.S. detention facilities have faced intense scrutiny for failing to comply with the 1997 Flores Settlement Agreement — a binding agreement that outlines national standards for the detention and release of migrant minors. Among other Flores Settlement violations, a 2018 class-action lawsuit revealed that a detention facility in Texas was unlawfully administering psychotropic medications to migrant minors under its supervision. The class members in Flores v. Sessions *alleged receiving psychotropic drugs without parental or legally authorized consent, in addition to experiencing abusive medical practices. In response, the U.S. District Court in* Flores v. Sessions *ordered that the detention facility follow Texas child welfare laws and regulations when administering psychotropic medications to detained minors.*

After the Flores v. Sessions *order, detention facilities across the country have looked to their respective state child welfare laws and policies for instruction on how to authorize psychotropic medications to detained migrant minors. At present, state laws and policies governing consent and assent to psychotropic treatment vary across jurisdictions and are not tailored to the needs of migrant minors detained separately from their families. Of concern is the lack of guidance on who should consent for a migrant minor when their parent or legal guardian is not available; and the lack of procedure on how and when to obtain consent and assent from migrant youth. To address these outstanding issues, this Note proposes a national consent and assent*

---

* Notes Editor, Colum. J.L. & Soc. Probs., 2020–2021. J.D. Candidate 2021, Columbia Law School. The author would like to thank Professor Philip Genty and the staff of the *Columbia Journal of Law and Social Problems* for their helpful feedback throughout this project. She is also immensely grateful for the outpour of encouragement and support from her family.

framework for minors undergoing psychotropic treatments at U.S. detention facilities. By incorporating Loretta Kopelman's "Best Interests Standard," this framework will help facilitate the administration of psychotropic drugs in a manner that respects the health, safety, and rights of migrant youth.

I. Introduction

> *The staff threatened to throw me on the ground and force me to take the medication. I also saw staff throw another youth to the ground, pry his mouth open and force him to take the medicine. . . . They told me that if I did not take the medicine I could not leave, that the only way I could get out of Shiloh was if I took the pills.*
>
> — A minor held at a U.S. detention facility[1]

In 2018, several minors at Shiloh Treatment Center, a government-contracted detention facility, reported abusive medical practices by staff members.[2] A lawsuit against the U.S. government, principally, the Office of Refugee Resettlement (ORR), an operational division of the U.S. Department of Health and Human Services (HHS), revealed that detained migrant minors were being prescribed psychotropics without their parents' consent, were coerced into taking psychotropics, and were subject to assaultive restraining practices.[3] One child reported witnessing staff members forcefully pin down a child to give her injections.[4] Another child noted how he took nine pills in the morning, seven pills in the evening, and occasionally received injections as a tranquilizer.[5] He recalled that "[the guards] would come and give me a shot to tranquilize me. . . . [Then] they left me in the classroom near the wall to sleep."[6] Employed as a "tool of control," the staff reportedly

1. Memorandum in Support of Motion to Enforce Class Action Settlement at 13, Flores v. Sessions, No. CV-85-4544-DMG (AGRx), 2018 WL 10162328 (C.D. Cal. Apr. 16, 2018) (Declaration of Julio Z.) [hereinafter "Flores Memorandum"].
2. Andrew Hay, *U.S. Centers Force Migrant Children to Take Drugs: Lawsuit*, REUTERS (June 20, 2018, 11:01 PM), https://www.reuters.com/article/us-usa-immigration-medication/u-s-centers-force-migrant-children-to-take-drugs-lawsuit-idUSKBN1JH076 [https://perma.cc/8UXC-Z8TG].
3. Flores Memorandum, *supra* note 1, at 12–14.
4. *Id.* at 13 (Declaration of Maricela J.).
5. *Id.* at 12–13 n.11 (Declaration of Javier C.) (brackets in original).
6. *Id.* at 13 n.11 (Declaration of Javier C.).

administered psychotropics to sedate, rather than treat, unruly minors suffering from psychological and emotional trauma.[7]

These practices are a product of the Trump Administration's response to the rise in migrants apprehended at the Southwest border beginning in 2018.[8] Family units and unaccompanied children[9] constituted forty-seven percent of all apprehensions at the border in 2018,[10] which then surged to sixty-five percent in 2019[11] — both years marking a significant rise from years prior.[12] Frustrated by the uptick in migrant apprehensions, President Trump introduced the "Zero-Tolerance Policy" in May 2018, which effectively ordered the forced separation of adult migrants and their children when apprehended at the border.[13] As of June 2019, more than 5,500 children were separated from their families.[14]

Unprepared for the thousands of minors who would enter U.S. detention,[15] facilities faced many challenges in providing adequate

---

7. Amy Cohen, a physician who treated detained immigrant children in 2018 noted, "the purpose of [psychotropics] is not really to treat an illness, but to tranquilize them. It's not a tool of therapy, it's a tool of control." Scott J. Schweikart, *April 2018 Flores Settlement Suit Challenges Unlawful Administration of Psychotropic Medication to Immigrant Children*, 21 AMA J. ETHICS 67, 70 (2019) (internal quotation marks omitted).

8. Apprehensions declined to 303,916 at the Southwest border in 2017, a "45-year low." The number rose to 396,579 in 2018, and then to 851,508 in 2019, the highest level since 2007. AUDREY SINGER & WILLIAM A. KANDEL, CONG. RSCH. SERV., IMMIGRATION: RECENT APPREHENSION TRENDS AT THE U.S. SOUTHWEST BORDER 1 (2019), https://fas.org/sgp/crs/homesec/R46012.pdf [https://perma.cc/8XWS-AJY6].

9. "Unaccompanied Alien Children" or "UAC" is a U.S. government classification for minors that are "under age 18 who lack lawful immigration status in the United States, and who are either without a parent or legal guardian in the United States, or without a parent or legal guardian in the United States who is available to provide care and physical custody." WILLIAM A. KANDEL, CONG. RSCH. SERV., UNACCOMPANIED ALIEN CHILDREN: AN OVERVIEW (2019), https://fas.org/sgp/crs/homesec/R43599.pdf [https://perma.cc/68JS-K4AQ]. This Note refers to UACs as "unaccompanied migrant children," "unaccompanied children," or "unaccompanied minors."

10. Kristen Bialik, *Border apprehensions increased in 2018 — especially for migrant families*, FACTTANK (Jan. 16, 2019), https://www.pewresearch.org/fact-tank/2019/01/16/border-apprehensions-of-migrant-families-have-risen-substantially-so-far-in-2018/ [https://perma.cc/PRZ7-2ZN5].

11. *See* SINGER & KANDEL, *supra* note 8, at 9.

12. Families and unaccompanied children made up twenty-nine percent of total apprehensions in 2014, twenty-seven percent in 2015, thirty-seven percent in 2016, and thirty-three percent in 2017. *See* Bialik, *supra* note 10.

13. Ron Nixon, *'Zero Tolerance' Immigration Policy Surprised Agencies, Report Finds*, N.Y. TIMES (Oct. 21, 2020), https://www.nytimes.com/2018/10/24/us/politics/immigration-family-separation-zero-tolerance.html [https://perma.cc/WP4D-TNQR].

14. Caitlin Dickerson, *Parents of 545 Children Separated at the Border Cannot Be Found*, N.Y. TIMES (Oct. 21, 2020), https://www.nytimes.com/2020/10/21/us/migrant-children-separated.html?auth=login-google [https://perma.cc/NT3K-P6LS].

15. In June 2018, there were approximately 11,400 migrant minors in U.S. detention. Michael E. Miller et al., *Inside Casa Padre, the converted Wal Mart where the U.S. is holding*

pediatric mental health care. For one, the Zero-Tolerance Policy increased the number of separated children under age twelve, and as a result, "[ORR facility staff] reported feeling challenged" with caring for young children who presented different needs than the teenagers routinely detained.[16] In particular, ORR staff reported difficultly caring for the significant number of separated minors who were battling "more fear, feelings of abandonment, and post-traumatic stress" than non-separated minors.[17] Facilities also faced a lack of access to on-site mental health specialists as well as an inability to transfer minors with substantial mental health needs to appropriate treatment centers.[18] As a quick and easy fix, minors were sometimes given psychotropics to control any disorderly and unruly behaviors.[19] It is clear that poor policy, coupled with ill-equipped facilities, resulted in the gross neglect and abusive mental health care practices that occurred in 2018.[20]

This Note focuses on the issue of the unauthorized administrations of psychotropics to detained migrant minors and, more specifically, the implications of the 2018 U.S. District Court decision in *Flores v. Sessions*.[21] *Flores v. Sessions* involved a lawsuit filed on behalf of migrant minors who were medicated with psychotropic drugs without appropriate parental or legally authorized

---

nearly 1,500 immigrant children, WASH. POST (June 14, 2018, 1:15 AM), https://www.washingtonpost.com/local/inside-casa-padre-the-converted-walmart-where-the-us-is-holding-nearly-1500-immigrant-children/2018/06/14/0cd65ce4-6eba-11e8-bd50-b80389a4e569_story.html [https://perma.cc/647Y-N89G].

16. "The [detention facility] reports cite policy changes in immigration enforcement, including the zero-tolerance policy, and the unanticipated influx of unaccompanied children in 2018 as factors that exacerbated challenges faced by care provider facilities." In particular, "[t]he zero-tolerance policy in 2018 . . . presented additional challenges for facility staff in gaining the trust of separated children and providing age-appropriate services to a dramatically increased population of children under 12. Faced with a sudden increase in young children, staff reported feeling challenged to care for children who presented different needs than the teenagers they typically served." *See HHS OIG: ORR-Funded Facilities Experienced Challenges Addressing the Mental Health Needs of Children In HHS Custody and Obstacles Hiring, Screening Employees*, OFF. OF INSPECTOR GENERAL (Sept. 4, 2019), https://oig.hhs.gov/newsroom/news-releases/2019/uac-09042019.asp [https://perma.cc/3D23-R434] [hereinafter "*HHS OIG*"].

17. *Id.*

18. JOANNE M. CHIEDI, U.S. DEP'T OF HEALTH & HUM. SERVS., OFF. OF INSPECTOR GEN., CARE PROVIDER FACILITIES DESCRIBED CHALLENGES ADDRESSING MENTAL HEALTH NEEDS OF CHILDREN IN HHS CUSTODY 14 (2019). https://oig.hhs.gov/oei/reports/oei-09-18-00431.pdf [https://perma.cc/2E53-2Z3N].

19. *See* Schweikart, *supra* note 7, at 70.

20. *See infra* Parts III.B–C.

21. Flores v. Sessions, No. CV 85-4544 DMG (AGRx), 2018 WL 10162328 (C.D. Cal. July 9, 2018).

consent.[22] The District Court found that this practice was in violation of the Flores Settlement Agreement ("Flores Agreement") — a 1997 agreement that outlines national standards for all detention facilities[23] to follow in their detention and release of minors.[24] Among other offenses, the Texas facility violated the Flores Agreement's requirement that U.S. detention facilities "comply with all applicable state child welfare laws and regulations" and provide "appropriate mental health interventions when necessary."[25] The court ultimately ruled that Texas child welfare laws and regulations govern the administration of psychotropic treatment to migrant children held at the detention facility in question.[26] Although the court's order only addresses a single Texas detention facility, there is a lesson to be learned: detention facilities must authorize and administer psychotropics in a manner that is consistent with the Flores Settlement Agreement, or face consequences.[27]

Despite the court's best efforts to combat the inappropriate authorization of psychotropic drugs administered to detained migrant minors, questions remain regarding *who* should provide consent. Because there is no national framework that addresses the

---

22. Class members sought to enforce the Flores Settlement Agreement, which outlines specific standards that detention facilities must adhere to. Among the violations of the Flores Settlement Agreement, the class members allege that the ORR was accused of "routinely administer[ing] children psychotropic drugs without lawful authorization." *Id.* at 2; *see also* Flores Memorandum, *supra* note 1, at 2.

23. Immigration detention centers are managed by three agencies: the Customs and Border Protection (CBP), Immigration and Customs Enforcement (ICE), and the Office of Refugee Resettlement (ORR). Facilities run by these agencies are all bound by the Flores Settlement Agreement. *See Immigration Detention in the United States by Agency*, AM. IMMIGR. COUNCIL (Jan. 2, 2020), https://www.americanimmigrationcouncil.org/research/immigration-detention-united-states-agency [https://perma.cc/WJS6-BKHU].

24. Stipulated Settlement Agreement ¶ 9, Flores v. Reno, No. CV 85-4544-RJK(Px) (C.D. Cal. Jan. 17, 1997) [hereinafter "Flores Agreement"].

25. Judge Gee's order is based in part, on a finding that Shiloh Treatment Center breached "Paragraphs 6 and 9 and Exhibit 1 of the *Flores* Agreement in the course of administering psychotropic medications." *See Flores*, 2018 WL 10162328, at *17.

26. *See Flores*, 2018 WL 10162328, at *21–22.

27. *See Judge Orders Administration to Comply with Flores Settlement Agreement*, NAT'L CTR. FOR YOUTH L. (Aug. 1, 2018), https://youthlaw.org/publication/judge-orders-administration-to-comply-with-flores-agreement/ [https://perma.cc/VR85-2HG5] ("[Judge Gee] also indicated that this finding could apply to other facilities administering drugs with additional evidence.") [hereinafter "*Judge Orders Administration*"]; *see also* UC DAVIS IMMIGR. L. CLINIC, PRACTICE ALERT ON JULY 30, 2018 DECISION IN *FLORES V. SESSIONS III* (July 30, 2018), https://law.ucdavis.edu/faculty-activity/files/gee-july-30th-practice-advisory-flores-order.pdf [https://perma.cc/8CTV-HV9Y] ("As noted, the Court indicated that its ruling regarding Shiloh should be considered a bellwether for other ORR facilities in which children are medicated.").

administration and authorization of psychotropic treatment at U.S. detention facilities,[28] facilities have been following local child welfare laws or ORR policy.[29] Nevertheless, problems have persisted. In a 2018 HHS-led review of forty-five ORR-funded facilities, ORR staff reported confusion over proper authorization and consent — ORR staff "were not always sure who within ORR needed to approve psychotropic medications" or if "parents' consent was required."[30] The *Flores* ruling, combined with differing state child welfare laws, contributes to that confusion. Given the risks of administering psychotropic drugs to minors, and the inability of child welfare laws to meet the needs of detained migrant children, this Note proposes a national consent and assent framework for the authorization of psychotropic drugs administered to migrant minors held at U.S. detention facilities. As an initial clarification, informed consent is the patient's legal "authorization or agreement" to undergo medical care after receiving appropriate information.[31] By contrast, a patient providing informed assent cannot provide legal authorization, and instead can express a "willingness to accept the proposed care."[32] This Note will address these concepts in turn.

This Note proceeds in five parts. Part II briefly discusses the risks psychotropic drugs pose to minors, and how these risks compound the varying vulnerabilities of detained migrant minors. Part III examines how detention centers have violated the Flores Settlement Agreement by forcing psychotropic medication on minors without appropriate authorization. Further, it examines the *Flores v. Sessions* decision and discusses its impact. Part IV compares child welfare laws in Texas, Arizona, and California — states that are home to a number of detention facilities — and describes some of their concerning effects on minors held in state custody

---

28. Currently, there is no national framework in place. However, "[a]s of May 2019, ORR reported that it is working through the Department of Justice to try to negotiate a national framework for treatment authorization and consent for psychotropic medications with class counsel in Flores." CHIEDI, *supra* note 18, at 30.

29. *See id.*

30. *See id.*

31. *Informed Consent: Code of Medical Ethics Opinion 2.1.1*, AM. MED. ASS'N, https://www.ama-assn.org/delivering-care/ethics/informed-consent [https://perma.cc/BGL9-PFPU] (last visited Mar. 14, 2021); *see also* Aviva L. Katz et al., *Informed Consent in Decision-Making in Pediatric Practice*, 138 PEDIATRICS 1, 2 (2016) (describing informed consent as incorporating two duties: disclosing "information to patients and their surrogates" and "obtaining legal authorization before undertaking any interventions.").

32. *See* Katz et al., *supra* note 31, at 8.

and U.S. detention facilities. Part V provides a formulation of consent and assent procedures that detention centers should practice nationwide. In doing so, it defines and sets appropriate ages for the concepts of informed consent and informed assent, and describes the role of a parent, sponsor, and advocate when providing consent or co-consent[33] on behalf of a detained minor. It also discusses how to proceed when a minor refuses to undergo psychotropic treatment. Part VI proposes that Loretta Kopelman's Best Interests Standard (BIS) should guide the process of consenting or co-consenting to psychotropic treatment for minors. The BIS outlines a set of duties that decision-makers should follow when making decisions for those who lack the capacity to make them for themselves.[34] It is recommended that a consenting adult should practices these duties when acting on behalf of a migrant minor. In its totality, this Note proposes a framework that could supplement current policies and laws that regulate U.S. detention facilities. It provides guidance on how to address the substantial problem of improperly authorizing the psychotropic treatment of migrant minors detained on U.S. soil.

II. PSYCHOTROPICS: A HIGH-RISK TREATMENT FOR CHILDREN

Because of the many risks associated with psychotropic drugs, it is important to take special care in their use. This is particularly so for detained migrant children, a vulnerable group with an increased need for mental health care. The following Parts will dive into these issues, beginning with a general explanation of the nature of psychotropic drugs in Part II.A. Part II.B then explores some of the mental health challenges endured by minors before and after U.S. detention.

---

33. Petronella Grootens-Wiegers, Irma M. Hein, Jos M. van den Broek, and Martine C. de Vries, describe a "double-consent" procedure as achieving an "equitable consideration between the legal position of the child and that of the parents." Petronella Grootens-Wiegers et al., Abstract, *Medical Decision-Making in Children and Adolescents: Developmental and Neuroscientific Aspects*, 17 BMC PEDIATRICS 1, 7 (2017). Part V will further explain this procedure, in addition to the term "co-consent." As an initial clarification, "co-consent" refers to the roles a competent adult and a competent adolescent respectively have when consenting to psychotropic treatment under a double consent procedure. Therefore, in order for the medical professional to administer or prescribe psychotropic drugs to the adolescent, the adolescent and adult must co-consent to the treatment plan. Throughout this process, the adult and the adolescent have equal decision-making authority.

34. Loretta M. Kopelman, *Using the Best Interests Standard to Generate Actual Duties*, 4 AM. J. BIOETHICS 11, 12 (2013).

A. A BRIEF INTRODUCTION TO PSYCHOTROPIC DRUGS

Psychotropic drugs are substances that affect one's mental processes.[35] They "act directly on the brain to chemically alter mood, cognition, or behavior, their effect typically being achieved by altering the process of neurotransmission."[36] General uses include treating symptoms of mental disorders and disabilities, and preventing relapse of the mental health condition.[37] The main classes of psychotropics include stimulants, antidepressants, antipsychotics, mood stabilizers, and antianxiety agents.[38]

Although psychotropic drugs can be effective,[39] there are negative side effects and risks associated with their use. The side effects of these drugs generally fall into three categories: "minor (such as headaches), moderate (such as decreased appetite), or severe (such as obesity or seizures)."[40] Antipsychotics and antidepressants — some of the psychotropic drugs that were allegedly administered to migrant minors while in U.S. detention[41] — fall

35. *Management of Substance Abuse*, WORLD HEALTH ORG., https://www.who.int/substance_abuse/terminology/psychoactive_substances/en/ [https://perma.cc/Q75A-L2LL] (last visited Feb. 7, 2020).

36. Angela Olivia Burton, *"They Use It Like Candy": How the Prescription of Psychotropic Drugs to State-Involved Children Violates International Law*, 35 BROOK J. INT'L L. 453, 466 (2010) (internal quotation marks omitted). The brain is composed of interconnecting nerve cells called "neurons," which send and receive chemical messengers called "neurotransmitters." Neurotransmitters determine how one perceives, thinks, feels, and acts. Psychotropics disrupt or alter neurotransmitters. *See* Carl Sherman, *Impacts of Drugs on Neurotransmission*, NAT'L INST. ON DRUG ABUSE (Mar. 9, 2017), https://www.drugabuse.gov/news-events/nida-notes/2017/03/impacts-drugs-neurotransmission [https://perma.cc/2EPT-98YD].

37. *Psychotropic Medications*, REG'L OFF. FOR THE E. MEDITERRANEAN, WORLD HEALTH ORG., http://www.emro.who.int/health-topics/psychotropic-medications/introduction.html [https://perma.cc/4J7P-UQWP] (last visited Feb. 7, 2021).

38. DEP'T OF FAMILY AND PROTECTIVE SERVS., CLASSES OF PSYCHOTROPIC MEDICATIONS 4 (2012), https://www.dfps.state.tx.us/Training/Psychotropic_Medication/51-classes.html [https://perma.cc/DAM7-E8H8]; *see also Psychiatric Medication for Children and Adolescents: Part II — Types of Medications*, AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY (last updated July 2017), https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Psychiatric-Medication-For-Children-And-Adolescents-Part-II-Types-Of-Medications-029.aspx [https://perma.cc/XY3G-CVRS].

39. AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY, A GUIDE FOR COMMUNITY CHILD SERVING AGENCIES ON PSYCHOTROPIC MEDICATIONS FOR CHILDREN AND ADOLESCENTS 6 (2012), https://www.aacap.org/App_Themes/AACAP/docs/press/guide_for_community_child_serving_agencies_on_psychotropic_medications_for_children_and_adolescents_2012.pdf [https://perma.cc/K8B5-CL62] (noting that "[m]any youth benefit from psychotropic medications used as part of a comprehensive treatment plan").

40. *Id.* at 13.

41. Emily Birnbaum, *5 Migrant Children File Complaint Over Forced Medication in Detention Centers*, THE HILL (July 3, 2018, 8:32 AM) https://thehill.com/homenews/

within the class of psychotropics that contain severe side effects. Children that take antipsychotics, for example, are at a higher risk of obesity, Type II diabetes, cardiovascular conditions, and hypotension.[42] These risks become more likely when multiple antipsychotics are taken.[43] Antidepressants, even when taken in a regular dose, can increase the risk of suicidal ideation and behaviors among children.[44]

Many psychotropic medications that are administered to children are prescribed "off-label,"[45] that is, they are used in a manner that the Food and Drug Administration (FDA) did not approve.[46] The FDA has approved an estimated 31% of psychotropic medications for children and adolescents, yet around 75% of psychotropics administered to children are used off-label.[47] Although off-label prescribing is an accepted and common practice,[48] there are

---

administration/395312-5-migrant-children-file-complaint-over-forced-medication-in-detention [https://perma.cc/RE7M-ZHMV].

42. Jeanette M. Jerrell & Roger S. McIntyre, *Adverse Events in Children and Adolescents Treated with Antipsychotic Medications*, 23 HUM. PSYCHOPHARMACOL. CLIN. EXP. 283 (2008). The results of the research showed that the odds of developing adverse events associated with antipsychotic treatment were higher among female children, children of age twelve and under, and those prescribed multiple antipsychotics. "The odds of developing obesity/excessive weight gain, Type II diabetes and dyslipidemia, digestive/urogenital problems, and neurological/sensory symptoms were higher for females and those prescribed multiple antipsychotic medications. The odds of developing cardiovascular conditions were higher for those prescribed multiple antipsychotic medications and haloperidol. The odds of developing somatic conditions were higher for females, children 12 and under, and those prescribed multiple antipsychotics."

43. *Id.*

44. *See Suicidality in Children and Adolescents Being Treated with Antidepressant Medications*, U.S. FOOD & DRUG ADMIN. (Feb. 5, 2018), https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/suicidality-children-and-adolescents-being-treated-antidepressant-medications [https://perma.cc/W9TD-LPQW]; *see also* Mayo Clinic Staff, *Antidepressants for Children and Teens*, MAYO CLINIC (June 25, 2019), https://www.mayoclinic.org/diseases-conditions/teen-depression/in-depth/antidepressants/art-20047502 [https://perma.cc/Q4T3-NLUV].

45. JOANNE SOLCHANY, PSYCHOTROPIC MEDICATION AND CHILDREN IN FOSTER CARE: TIPS FOR ADVOCATES AND JUDGES 17 (2011), https://www.americanbar.org/content/dam/aba/administrative/child_law/PsychMed.pdf [https://perma.cc/EUW4-EEHF].

46. The term "off-label," can mean that the approved drug is being used for "a disease or medical condition that it is not approved to treat," given in a different way (e.g., "when a drug is approved as a capsule, but it is given instead in an oral solution"), and given in a different dose (e.g., "when a drug is approved at a dose of one tablet every day, but a patient is told by their healthcare provider to take two tablets every day"). *Understanding Unapproved Use of Approved Drugs "Off Label"*, U.S. FOOD & DRUG ADMIN. (2018), https://www.fda.gov/patients/learn-about-expanded-access-and-other-treatment-options/understanding-unapproved-use-approved-drugs-label [https://perma.cc/4ZSC-R9P4].

47. SOLCHANY, *supra* note 45, at 17.

48. AM. ACAD. OF ADOLESCENT & CHILD PSYCHIATRY, *supra* note 39, at 11.

concerns about the risk of widespread off-label use.[49] One concern is that because off-label psychotropic drugs have not been studied on children, there is little knowledge of the long- and short-term effects of such drugs.[50] Other safety concerns include the possibility of receiving ineffective medication, receiving inappropriate dosages, or experiencing certain side effects that are unique to children, including effects on growth and development.[51]

Because of the potential side effects and risks associated with psychotropic drugs, it is recommended that children and adolescents take psychotropic drugs as a last resort, as opposed to the sole treatment.[52] Therapeutic approaches like psychotherapy, for example, can effectively replace psychotropic treatment for nonpsychotic disorders.[53] When psychotropics are needed, the American Academy of Child and Adolescent Psychiatry (AACAP) recommends a "high-quality approach" to treating children.[54] Under this approach, health providers should develop a treatment plan for the child, inform the patient and family of the child's problem, treatment options, and treatment plan, and then monitor the patient's experience with the treatment.[55]

---

49. SOLCHANY, *supra* note 45, at 17.

50. Jack T. Brock II, *Strong Voices for a Vulnerable Group*, 20 WM. & MARY J. WOMEN & L. 197, 214 (2013).

51. SUSAN THAUL, CONG. RSCH. SERV., FDA'S AUTHORITY TO ENSURE THAT DRUGS PRESCRIBED TO CHILDREN ARE SAFE AND EFFECTIVE 3–4 (2012), https://fas.org/sgp/crs/misc/RL33986.pdf [https://perma.cc/9GRF-H3GQ].

52. Jacqueline A. Sparks & Barry L. Duncan, *The Ethics and Science of Medicating Children*, 6 ETHICAL HUM. PSYCHOL. & PSYCHIATRY 25, 36 (2004) ("[W]e consider the practice of prescribing drugs to youths as clearly the last resort, and in many cases, unethical, until other options have been discussed."); *see also* Joyce Nolan Harrison et al., *Antipsychotic Medication Prescribing Trends in Children and Adolescents*, 26 J. PEDIATRIC HEALTH CARE 139, 143 (2012) ("Increasing consensus exists that antipsychotic medication should be the treatment of last resort, after parenting skills training and other behavioral treatments have been tried and have failed.").

53. *Therapy or Medication?*, EFFECTIVE CHILD THERAPY (Dec. 5, 2020, 6:02 PM), https://effectivechildtherapy.org/therapies/therapy-or-medication/ [https://perma.cc/3SQR-BCBM] ("In general, findings suggest that cognitive behavioral therapy for children and adolescents can do anything that medications can do in the treatment of nonpsychotic disorders, and it can do so without causing problematic side-effects."); Ajit Ninan et al., *Adverse Effects of Psychotropic Medication in Children: Predictive Factors*, 23 J. CAN. ACAD. CHILD ADOLESCENT PSYCHIATRY 218, 219 (2014) ("Psychotherapy, such as cognitive behavioral therapy (CBT), is also considered a first-line treatment for conditions such as obsessive-compulsive disorder and generalized anxiety disorder." (citation omitted)).

54. John Walkup, *Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents*, 48 J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 961, 964 (2009).

55. *Id.*

B. MIGRANT CHILDREN AS A VULNERABLE GROUP

More often than not, detained migrant children are grappling with a number of emotionally damaging events that have occurred prior and upon arrival to the U.S. border.[56] The overall experience — from the migratory journey to the resettlement process — can produce "demoralization, grief, loneliness, loss of dignity, and feelings of helplessness" that ultimately "impede the children from living healthy and productive lives."[57] Many children continue to face "trauma after trauma" after entry in to the U.S.,[58] and their conditions only deteriorate from prolonged stays in detention.[59]

Between 2018 and 2019, most unaccompanied migrant minors came from Guatemala, Honduras, and El Salvador[60] — countries that have experienced a dramatic escalation in organized crime and violence.[61] These conditions, in addition to factors like economic insecurity and corrupt governance,[62] have left families with

---

56. "Facility managers and mental health clinicians reported that many children who entered facilities in 2018 had experienced intense trauma from a variety of events before and upon their arrival in the United States." CHIEDI, *supra* note 18, at 9; *See also* Rhitu Chatterjee, *Lengthy Detention Of Migrant Children May Create Lasting Trauma, Say Researchers*, NPR (Aug. 23, 2019, 1:48 PM) https://www.npr.org/sections/health-shots/2019/08/23/753757475/lengthy-detention-of-migrant-children-may-create-lasting-trauma-say-researchers [https://perma.cc/W78P-5X3A] ("[M]ost Central American children in U.S. immigration detention centers have already experienced layers of trauma by the time they arrive here . . . The trauma that happened in their home countries — the violence, the extortion, the police complicity, government inaction. . . .") (internal quotation marks omitted).

57. U.S. COMM'N ON C.R., TRAUMA AT THE BORDER: THE HUMAN COST OF INHUMANE IMMIGRATION POLICIES 3 (2019) https://www.usccr.gov/pubs/2019/10-24-Trauma-at-the-Border.pdf [https://perma.cc/97U3-NYC5].

58. *Detained Migrant Children Suffer 'Trauma After Trauma,' Say Pediatric Experts*, PBS NEWS HOUR (Sept. 17, 2019, 6:35 PM), https://www.pbs.org/newshour/show/detained-migrant-children-suffer-trauma-after-trauma-say-pediatric-experts [https://perma.cc/JFC4-AUZJ] [hereinafter "*Trauma After Trauma*"].

59. *HHS OIG*, *supra* note 16 ("[ORR] [f]acility staff also reported that longer lengths of stay resulted in deteriorating mental health for some children and increased demands on staff."); *see also* Rhitu Chatterjee, *Lengthy Detention of Migrant Children May Create Lasting Trauma, Say Researchers*, NPR (Aug. 23, 2019, 1:48 PM), https://www.npr.org/sections/health-shots/2019/08/23/753757475/lengthy-detention-of-migrant-children-may-create-lasting-trauma-say-researchers [https://perma.cc/4KJE-74QM] ("Research by the Australian Human Rights Commission found that children in detention facilities suffer from mental disorders and the level of mental health problems increases with time in detention[.]").

60. *Facts and Data*, OFF. OF REFUGEE RESETTLEMENT (Jan. 14, 2021), https://www.acf.hhs.gov/orr/about/ucs/facts-and-data [https://perma.cc/QP6T-ZB3J].

61. *Central America Refugee Crisis*, USA FOR UNHCR THE UN REFUGEE AGENCY, https://www.unrefugees.org/emergencies/central-america/ [https://perma.cc/UJE8-3UWG] (last visited Feb. 10, 2020).

62. Jonathan Pedneault, *The Long Journey to the US Border*, HUM. RIGHTS WATCH (Aug. 31, 2019, 9:00 AM) https://www.hrw.org/news/2019/08/31/long-journey-us-border [https://perma.cc/UPJ2-L5TY].

little choice but to flee and embark on treacherous journeys to the U.S.[63] Throughout their travels, many minors suffer assaults, robberies, and abductions by criminal gangs.[64] Minors also experience harsh weather conditions, food and water scarcity, and long, painful travel by foot to their destinations.[65] Many minors are shouldering severe emotional and physical pain that predates U.S. detention.

Children face additional stress when they are forced to separate from their families and enter government custody.[66] This policy is patently detrimental to a child's health. Parental attachment is natural to a child's upbringing and forced separation can induce anxiety and depression, in addition to academic difficulties and disruptions in development.[67] Likewise, childhood detention can cause posttraumatic stress disorder, anxiety, depression, suicidal ideation, and other behavioral problems.[68] These mental health conditions only exacerbate with time in detention,"[69] and even a brief stay at the facilities can cause "psychological trauma and induce long-term mental health risks for children."[70]

The unique circumstances of migrant children demand attention. In addition to having the typical, everyday needs of children, detained minors have a greater need for medical and mental health care.[71] At a minimum, migrant minors should receive care

---

63. *See id.*; *see also* Eitan Peled, *Help Migrant Children Fleeing Violence and Poverty*, UNICEF USA (Jan. 22, 2021), https://www.unicefusa.org/stories/help-migrant-children-fleeing-violence-and-poverty/35091 [https://perma.cc/PYW9-L97T].

64. Salil Shetty, *Most Dangerous Journey: What Central American Migrants Face When They Try to Cross the Border*, AMNESTY INT'L (Feb. 20, 2014), https://www.amnestyusa.org/most-dangerous-journey-what-central-american-migrants-face-when-they-try-to-cross-the-border/ [https://perma.cc/3W5M-G72G].

65. Angelica M. Tello et al., *Unaccompanied Refugee Minors From Central America: Understanding Their Journey and Implications for Counselors*, 7 PROF. COUNS. 360, 365–66 (2017).

66. "[T]hey're traumatized and they're stressed. And when you think about, where would you want to put a child like that, you don't want to put a child in a freezing cold cell, or in a warehouse that's filled with cages, and that doesn't have the right mix of staff to actually take care of them." *Trauma After Trauma*, *supra* note 58 (internal quotation marks omitted).

67. *Psychological Impact of Forced Separation of Families on Children*, ERIE COAL. FOR A TRAUMA INFORMED CMTY., https://www.traumainformederie.org/single-post/2018/06/20/psychological-impact-of-forced-separation-of-families-on-children [https://perma.cc/2QNB-EXAG] (last visited Feb. 10, 2021).

68. Julie M. Linton et al., *Detention of Immigrant Children*, 139 PEDIATRICS 1, 6 (2017); *see also* U.S. COMM'N ON C.R., *supra* note 57.

69. Chatterjee, *supra* note 59.

70. Linton et al., *supra* note 68.

71. Giselle Malina, *How Should Unaccompanied Minors in Immigration Detention Be Protected from Coercive Medical Practices?*, 21 AMA J. ETHICS 603, 604 (2019).

involving trauma-informed mental health screening and re-screening, recreational and social enrichment activities, and educational services.[72] Further, migrant minors should receive care that addresses past traumatization and receive protection from additional traumatization in the U.S.[73] Medical care involving high-risk treatment like psychotropics should involve careful oversight and monitoring, particularly when parents or legal guardians are unavailable to the migrant minor.[74] In stark contrast to these recommendations, the following Part describes how detention facilities have provided mental health care for migrant minors before and after *Flores v. Sessions*.[75]

III. UNAUTHORIZED PSYCHOTROPIC TREATMENT AS A VIOLATION OF THE FLORES SETTLEMENT AGREEMENT

In April 2018, civil rights groups filed a lawsuit, *Flores v. Sessions*, on behalf of a class of detained migrant children[76] from several ORR facilities in the Central District of California.[77] The lawsuit alleged that some of ORR's practices at the facilities violated the 1997 Flores Settlement Agreement.[78] The class members asserted three general violations of the Flores Settlement Agreement: (1) the ORR had a policy of placing detained minors in residential treatment centers, staff-secure facilities, and secure facilities; (2) the ORR had a practice of administering psychotropic drugs to detained minors without first obtaining a court order or the informed consent of a person authorized by state law; and (3)

72. Linton, *supra* note 68, at 8.

73. *Id.* at 9.

74. *See* Jonathan D. Moreno, *What are the rules for ethical medication of migrant kids?*, PSYCH. TODAY (June 29, 2018) https://www.psychologytoday.com/us/blog/impromptu-man/201806/what-are-the-rules-ethical-medication-migrant-kids [https://perma.cc/E66D-XHYE] ("The effects of these powerful psychotropic medications must be carefully monitored, especially in children whose reactions may be unpredictable and whose medical histories are unknown. The government has a special moral burden to take extreme care in these cases because the children have been forcibly separated from their parents, their natural protectors and surrogate decision-makers.").

75. *See infra* Parts III.B–C.

76. *See* Flores Memorandum, *supra* note 1, at 1.

77. The class members were from different facilities, including Yolo Juvenile Detention Center in Woodland, California, Shiloh Treatment Center in Manvel, Texas, and Shenandoah Valley Juvenile Center in Verona, Virginia, to name a few. *See* Flores v. Sessions, No. CV 85-4544 DMG (AGRx), 2018 WL 10162328, at *7 (C.D. Cal. July 9, 2018).

78. *See* Flores Memorandum, *supra* note 1, at 1–3; *see also Flores*, 2018 WL 10162328, at *1.

the detention of minors in ORR facilities was unnecessarily long.[79] At issue is the second violation, namely, that the ORR administered psychotropic drugs without lawful authorization at the Shiloh Treatment Center, a Texas ORR detention facility.[80] The class members argued that in doing so, the Texas center failed to "comply with all applicable state child welfare laws and regulations" as postulated by the Flores Agreement.[81]

In order to understand the District Court's decision on this precise issue, this Note offers an explanation of the 1997 Flores Settlement Agreement and the alleged violations described in the *Flores v. Sessions* lawsuit. Accordingly, Part III.A briefly describes the background of *Flores v. Reno*[82] and the subsequent Flores Agreement. Part III.A also introduces the William Wilberforce Trafficking Victims Protection Reauthorization Act of 2008 — legislation that creates additional protections for unaccompanied migrant children. Part III.B begins with a discussion of some of the violations found by the *Flores v. Sessions* court in 2018, with a particular focus on the unlawful administrations of psychotropics that occurred at Shiloh Treatment Center. Part III.B then sheds light on alarming mental health care practices that occurred at other detention facilities. Finally, Part III.C focuses on the *Flores v. Sessions* order and its aftermath.

A. THE FLORES SETTLEMENT AGREEMENT

The 1997 Flores Settlement Agreement emerged from the 1985 class-action lawsuit *Flores v. Reno* and spurred a nationwide conversation about the ethical standards of processing undocumented minors separated from their families. The initial lawsuit was brought by a class of unaccompanied migrant children who had been apprehended at the U.S. border and were awaiting removal proceedings.[83] At the time of the lawsuit, there was no national policy on how to care for unaccompanied migrant children.[84]

---

79. *See Flores*, 2018 WL 10162328, at *1.

80. *Id.* at *2.

81. *Flores*, 2018 WL 10162328, at *17 (citation and internal quotation marks omitted); *see also* Flores Agreement, *supra* note 24.

82. 507 U.S. 292 (1993). As a note of administrative convenience, the Flores Agreement stemmed from *Flores v. Reno*, a case which is distinct from *Flores v. Sessions*.

83. *Id.* at 294.

84. Jasmine Aguilera, *Body Cavity Searches, Indefinite Detention and No Visitations Allowed: What Conditions Were Like for Migrant Kids Before the Flores Agreement*, TIME (Aug. 21, 2019) https://time.com/5657538/flores-settlement-agreement-standards/

Without any guidelines to follow, one former Immigration and Naturalization Service (INS) facility in California adopted a policy where apprehended migrant children could only be released to "a parent or lawful guardian" or to another responsible guardian under "unusual and extraordinary cases."[85] The class-action lawsuit challenged this policy and the conditions at the detention facilities.[86] The litigation ultimately landed at the U.S. Supreme Court, and in 1993, the Court upheld the constitutional validity of INS's policy of releasing migrant minors to a "willing-and-able private custodian" when a parent, legal guardian, or close relative is unavailable.[87]

Years later, concerns regarding the poor conditions at the detention facilities and INS's non-compliance with the terms of the *Reno v. Flores* decision remained.[88] As a final halt to litigation involving these concerns, the parties in *Flores v. Reno* reached an agreement in 1997.[89] The Flores Settlement Agreement established a "nationwide policy for the detention, release, and treatment of minors" in immigration custody.[90] "Minors" include any person under the age of eighteen,[91] accompanied or unaccompanied.[92] Among other requirements, the Flores Agreement stipulates that minors must be detained in the "least restrictive" setting, and the facilities must be safe, sanitary, and "consistent with the INS's concern for the particular vulnerability of minors."[93] Facilities that hold minors with mental health needs must "meet those standards . . . set forth in Exhibit 1 [of the Flores Settlement Agreement]," which requires, in relevant part, that licensed programs "comply with all applicable state child welfare laws and regulations . . . and shall provide or arrange for the following services for each minor in its care:. . . . appropriate mental health

[https://perma.cc/ ("Prior to the Flores Agreement there were no regulations or standards of care for children in detention, including no oversight over whether the INS was complying with child welfare laws[.]").

85. *Reno*, 507 U.S. at 296 (citation and internal quotation marks omitted).

86. *Id.*

87. *Id.* at 302.

88. MATTHEW SUSSIS, THE HISTORY OF THE FLORES SETTLEMENT: HOW A 1997 AGREEMENT CRACKED OPEN OUR DETENTION LAWS 3 (2019), https://cis.org/Report/History-Flores-Settlement [https://perma.cc/JY4H-NNMG].

89. *Id.*

90. Flores Agreement, *supra* note 24, ¶ 11–12.

91. *Id.* ¶ 4.

92. Flores v. Lynch, 828 F.3d 898, 905–08, 910 (9th Cir. 2016).

93. Flores Agreement, *supra* note 24, ¶¶ 11–12.

interventions when necessary."[94] Detention facilities must also provide basic necessities and medical assistance during an emergency, allow "contact with family members who were arrested with the minor," and make certain that "every effort" is taken to "ensure that the safety and well-being of the minors detained in these facilities are satisfactorily provided for."[95] The Flores Agreement remains in force today.[96]

In the years that followed the Flores Settlement Agreement, other laws were passed to protect unaccompanied migrant children. Although the William Wilberforce Trafficking Victims Protection Reauthorization Act of 2008 (TVPRA) was enacted with the purpose of "prevent[ing] and protect[ing] against the illegal trafficking of human beings," it has nonetheless created additional safeguards for unaccompanied migrant children.[97] Generally speaking, it mandates the screening of unaccompanied minors for risks of illegal trafficking and a possible claim to asylum, in addition to ensuring unaccompanied minors are "safely repatriated to their country of nationality or last habitual residence."[98] The TVPRA also authorizes HHS, via the TVPRA-led "Child Advocate Program," to appoint "child advocates" for vulnerable

---

94. Flores Memorandum, *supra* note 1, at 16 n.13; *see also* Flores Agreement, *supra* note 24, ¶¶ 6–9, Ex. 1.

95. Flores Agreement, *supra* note 24, ¶ 12.

96. In 2019, the Department of Justice (DOJ) attempted to withdraw from the Flores Settlement Agreement. In response, a District Court issued a permanent injunction, blocking the DOJ's withdrawal. Flores v. Barr, 407 F. Supp. 3d 909, 931 (C.D. Cal. 2019). The court noted in its decision, "The blessing or the curse - depending on one's vantage point - of a binding contract is its certitude. The Flores Agreement is a binding contract and a consent decree. It is a final, binding judgment that was never appealed. . . . Defendants cannot simply ignore the dictates of the consent decree merely because they no longer agree with its approach as a matter of policy." *Documents Relating to Flores v. Reno Settlement Agreement on Minors in Immigration Custody*, AM. IMMIGR. LAWYERS ASS'N (Sep. 27, 2019), https://www.aila.org/infonet/flores-v-reno-settlement-agreement [https://perma.cc/67UN-V6PV] (citing Flores v. Barr, 407 F. Supp. 3d 909, 931 (C.D. Cal. 2019)).

97. "Congress passed the TVPRA in response to growing concerns about human trafficking and the purpose of the act is to "prevent and protect against the illegal trafficking of human beings." The thrust of TVPRA was not about [unaccompanied migrant children], but rather an overall recognition of the need for increased vigilance for human trafficking. However, the Act's implementation alters the procedural rights and standard of care for [unaccompanied migrant children]." Anne Harrison, *Like A Good Neighbor: Extending the Anti-Trafficking Protections to Mexican Unaccompanied Children*, 19 J. GENDER RACE & JUST. 195, 205–06 (2016); *see also* 8 U.S.C. § 1232.

98. WILLIAM A. KANDEL, CONG. RSCH. SERV., UNACCOMPANIED ALIEN CHILDREN: AN OVERVIEW 4–5 (2017), https://crsreports.congress.gov/product/pdf/R/R43599/25 [https://perma.cc/MGL6-VZAN]. The TVPRA contains a number of provisions — for both victims of human trafficking and unaccompanied migrant children — that are outside the scope of this Note. This Note focuses on the TVPRA's Child Advocate Program in Part V.B.

unaccompanied migrant children and "child trafficking victims."[99] During initial U.S. custody and immigration court proceedings, the advocate is expected, among other responsibilities, to assist unaccompanied migrant children with decision-making and provide "best-interest recommendations with respect to care, placement, and release options."[100] The role of an advocate under the TVPRA will be further discussed in Part V.B.

B. *FLORES V. SESSIONS* AND THE INAPPROPRIATE AND LEGALLY UNAUTHORIZED ADMINISTRATION OF PSYCHOTROPIC MEDICATIONS TO MINORS HELD AT U.S. DETENTION FACILITIES

The District Court in *Flores v. Sessions* found that "Paragraphs 6 and 9 and Exhibit 1 of the Flores Agreement" were violated in the course of administering psychotropic medications at the Shiloh Treatment Center.[101] That is, the Texas facility violated the requirement that a facility must "comply with all applicable state child welfare laws and regulations" and shall provide or arrange "appropriate mental health interventions [for a migrant minor in their care] when necessary."[102] The court's conclusion was based on a number of findings. For one, it was revealed that minors at the Texas facility were given psychotropic medications without the appropriate authorization from a parent or legally authorized individual.[103] Indeed, one parent reported that she was not notified of her child's psychotropic treatment, despite the facility having her contact information.[104] Other children undergoing psychotropic treatment at the same Texas facility also reported that consent was not obtained from their families.[105] In addition to failing to contact the appropriate consenting authority, the court found that the ORR facility staff would sign forms "consenting" to children's medications, despite the forms only allowing consent from a

---

99. U.S. GOV'T ACCOUNTABILITY OFF., UNACCOMPANIED CHILDREN: HHS CAN TAKE FURTHER ACTIONS TO MONITOR THEIR CARE 24 (2016), https://www.gao.gov/assets/680/675001.pdf [https://perma.cc/AYG8-2ZKY] (internal quotation marks omitted).

100. Policy Letter from James R. McHenry III, Director, U.S. Dep't of Just., to the Exec. Off. for Immigr. Rev. (Nov. 15, 2019), https://www.justice.gov/eoir/page/file/1217976/download [https://perma.cc/R7EN-HVY8].

101. *Flores*, 2018 WL 10162328, at *17.

102. Flores Memorandum, *supra* note 1, at 16 n.13; *see also* Flores Agreement, *supra* note 24, ¶ 6–9, Exhibit 1.

103. *Flores*, 2018 WL 10162328, at *16–17.

104. Flores Memorandum, *supra* note 1, at 14 (Declaration of "Mother of Isabella M.").

105. *Id.*

"Parent, Guardian or Conservator."[106] And, contrary to the defendant's contention that psychotropic drugs were administered on an "emergency basis,"[107] the court found that the ORR officials did not keep a record of the minors that were given emergency psychotropics and officials would "consistently" administer psychotropic drugs without proper authorization.[108]

In addition, class members in their *Flores v. Sessions* court filings recounted taking many psychotropics at once, sometimes against their will.[109] One minor described taking four pills in the morning and five pills at night and having no idea what the pills were supposed to treat.[110] Another minor reported taking a total of sixteen pills a day.[111] When minors objected to the medication, they were given no procedural recourse. One minor shared: "I tried to ask [the doctor] why I was being forced to take the medications but he would ignore my questions . . . I wasn't told of any way that I could challenge the decision to be on the medications."[112] Similarly, when one child asked to stop psychotropic treatment, ORR staff allegedly denied the request because it "calmed" the child.[113]

Unfortunately, abusive medical practices similar to those at Shiloh Treatment Center have occurred in other detention facilities. One minor at an Arizona facility reported how he was given psychotropics against his will.[114] The minor was administered painful psychotropic drugs to ostensibly control his "moderate depression."[115] At a Chicago facility, minors were forcibly given sedating injections when they misbehaved.[116] One child recalled

106. *Id.; see also Flores*, 2018 WL 10162328, at *16.

107. The court noted that Texas law does permit Shiloh Treatment Center to administer psychotropic medications "in an emergency during which it is immediately necessary to provide medical care" in order to "prevent the imminent probability of death or substantial bodily harm to the child or others." *Flores*, 2018 WL 10162328, at *17.

108. *Id.*

109. Flores Memorandum, *supra* note 1, at 12–13.

110. *Id.* (Declaration of Maricela J.).

111. *Id.* at 12 (Declaration of Javier C.).

112. *Id.* at 13 (Declaration of Julio Z.).

113. *Id.* at 13–14 (Declaration of Javier C.).

114. Aaron C. Davis, *12-year-old immigrant prescribed antidepressants in shelter due to distress over family separation, lawsuit alleges*, WASH. POST (June 29, 2018, 11:02 AM), https://www.washingtonpost.com/investigations/immigrant-minor-distraught-over-family-separation-is-prescribed-antidepressants-in-us-shelter-lawsuit-alleges/2018/06/29/4386420a-7ba7-11e8-93cc-6d3beccdd7a3_story.html [https://perma.cc/CK8K-DYP3].

115. *Id.*

116. Michael E. Miller, *'I want to die': Was a 5-year-old drugged after being separated from his dad at the border?*, WASH. POST (Aug. 9, 2018, 7:00 AM), https://www.washingtonpost.com/local/i-want-to-die-was-a-5-year-old-drugged-after-being-separated-from-his-

seeing a doctor come in the middle of class to inject an unruly peer "with a shot," which calmed the peer to sleep.[117]

In addition to abusive and inappropriate health care practices, ORR facilities have reported challenges with medical staffing, oversight, and meeting the children's mental health needs. The 2018 HHS-led review of ORR-funded facilities revealed that ORR facilities faced challenges with hiring and retaining medical health professionals and accessing external mental health specialists.[118] Further, single clinicians were left to care for over twenty-five children at a time, violating the ORR facility-wide staffing ratio requirement of one mental health clinician for every twelve children.[119] The high caseloads reportedly hurt the clinicians' ability to "build rapport with children and allowed less time for counseling."[120] In terms of oversight, there were challenges with maintaining medical case management and tracking. According to HHS, one out of thirty migrant children had been prescribed psychotropic medications in 2018,[121] and from this group, HHS did not have data on how many migrant children arrived to the U.S. already taking psychotropic medications.[122] This lack of oversight, coupled with the improper prescription of psychotropics, made it nearly impossible to provide accurate and consistent healthcare.[123]

Sedating migrant children's anxieties and fears at the facilities through legally unauthorized and high-risk psychotropic treatment is morally reprehensible and violates the Flores Agreement on several grounds. As the *Flores v. Sessions* court reports in its order, the Shiloh Treatment Center failed to seek appropriate consenting authorities for psychotropics given to minors, failed to notify parents of their child's psychotropic treatment, and consistently administered legally unauthorized psychotropics to

---

dad-at-the-border/2018/08/08/df4cc2aa-95e1-11e8-a679-b09212fb69c2_story.html [https://perma.cc/3QJ5-YK8Q].

117. *Id.*

118. CHIEDI, *supra* note 18, at 14.

119. *Id.*

120. *Id.*

121. *Id.* at 29 ("A relatively small number of children in ORR custody had been prescribed a psychotropic medication. Between May 1, 2018, and July 31, 2018, only about 300 children (roughly 1 in 30, overall, in the facilities that we visited) had been prescribed a psychotropic medication.").

122. Sandy Santana, *Migrant Children, Like Kids in Foster Care, Subject to Powerful Drugs*, CHILDREN'S RIGHTS (Sept. 27, 2019), https://www.childrensrights.org/migrant-children-foster-care-psychotropic-drugs/ [https://perma.cc/AEJ2-4UDV].

123. *Id.*

minors.[124] The next Part discusses the court's order on these issues, and how U.S. detention facilities have responded.

C. *FLORES V. SESSIONS* AND ITS AFTERMATH

In *Flores v. Sessions*, the class members argued that the Shiloh Treatment Center violated the Flores Settlement by failing to follow Texas child welfare laws in the course of administering psychotropic medications to detained minors.[125] The court agreed, and held that before psychotropic medication is administered to a minor held at a detention facility, (1) disclosure required by 26 Texas Admin. Code § 748.2253 to a "person legally authorized to give medical consent," as that term is defined under 26 Texas Admin. Code § 748.43(47), must be provided, and (2) informed written consent must be obtained from a person in accordance with 26 Texas Admin. Code § 748.2001 and § 748.2253.[126] If ORR staff is unable to obtain informed consent, then "they may not administer the psychotropic medication to the Class Member unless they obtain a court order authorizing them to do so under Texas law."[127]

Although the District Court's order on the second allegation only addresses Shiloh Treatment Center,[128] its decision is based on a finding that facilities must "comply with all applicable state child welfare laws and regulations" per the Flores Agreement.[129] Indeed, the Court indicated that its ruling should be considered a "bellwether for other ORR facilities in which children are medicated."[130] Detention facilities must authorize and administer psychotropics in a manner that is consistent with the Flores Settlement Agreement,[131] or face consequences.

---

124. *Flores*, 2018 WL 10162328, at *15–16.
125. *Id.* at *15–16.
126. *Id.* at *17.
127. *Id.*
128. *Id.* at *16–17.
129. Judge Gee's order is based off a finding that Shiloh Treatment Center breached "Paragraphs 6 and 9 and Exhibit 1 of the Flores Agreement in the course of administering psychotropic medications." *See id.* at *17.
130. UC DAVIS IMMIGR. L. CLINIC, *supra* note 27, at 3 ("Because Judge Gee found a violation of the Flores Agreement, the court's order has implications for practices outside the state of Texas and Shiloh RTC. As noted, the Court indicated that its ruling regarding Shiloh should be considered a bellwether for other ORR facilities in which children are medicated."); *see also Judge Orders Administration*, *supra* note 27 ("[Judge Gee] also indicated that this finding could apply to other facilities administering drugs with additional evidence").
131. *See id.*; *see also supra* Part III.A.

A year after the order, HHS published its review of a number of ORR-funded facilities[132] and indicated that facilities were following local law and ORR policy in its administration of psychotropic medications to detained minors.[133] Still, ORR facilities expressed a "lack of clarity about [the] authorization and consent for psychotropic medications to children" — this confusion being partly attributable to the *Flores v. Sessions* order and "varying state laws."[134] The HHS report further illuminates some of the challenges faced by ORR facilities in authorizing psychotropic treatment to detained minors. For example, in Texas, ORR informed facilities that they must obtain consent from a parent, close relative, or other legally-authorized persons in light of the *Flores v. Sessions* order.[135] Soon after, however, Texas licensing authorities also informed facilities that "ORR, as the Federal custodian, should continue to give informed consent."[136] By doing this, ORR has effectively returned to its previous practice of providing informed consent for psychotropic treatment.[137] Equally worrisome, ORR staff from other facilities reported that they "were not always sure who within ORR needed to approve psychotropic medications" or if "parents' consent was required."[138] And, if a parent's consent was required, it was sometimes impossible to "locate or establish communications with [the detained minor's] parents."[139]

---

132. CHIEDI, *supra* note 18, at 5.

133. Although HHS did not reveal how each surveyed facility was obtaining consent for psychotropic treatment, it did provide a general glimpse into which policies and laws facilities are following. The facilities are working under ORR policy: "an ORR federal field specialist described uncertainty about the process for obtaining authorization to treat children using psychotropic medications. ORR policy requires that an ORR staff member authorize children's use of prescription drugs to treat mental health conditions. However, facility staff reported that they were not always sure who within ORR needed to approve psychotropic medications." *Id.* at 30. The facilities are also following state laws: "ORR told [HHS] that if a facility notifies it that State law requires informed consent from parents before children use psychotropic medications, then ORR directs the facility to seek such consent, recognizing that this may not be possible or timely due to their inability to locate or establish communications with parents." *Id.*

134. "Confusion about authorization and consent may have been attributable, at least in part, to rulings by the *Flores* court regarding informed consent and varying State laws." *Id.*

135. *Id.* at 30 n.40.

136. *Id.*

137. "According to ORR, before the implementation of the July 30, 2018, order, ORR Federal staff provided informed consent as the Federal custodian of children in Texas facilities." *Id.*

138. *Id.* at 30.

139. *Id.*

While the ORR is reportedly working with the U.S. Department of Justice on a national framework that addresses the "authorization and consent" needed before providing psychotropic medications to detained children,[140] the aforementioned challenges currently remain.

IV. A CLOSE LOOK AT VARYING STATE CHILD WELFARE LAWS AND POLICIES

The District Court's order in *Flores v. Sessions* has raised the following question: how should U.S. detention facilities administer psychotropics when state laws are not adequate or clear enough to address the needs of migrant children?[141] Before answering this question in Part V, this Part will examine the child welfare laws and policies of three states, with a particular focus on how consent and assent to medical care are defined. Because the states under analysis do not have a specific law or policy that addresses medical treatment to migrant minors held at U.S. detention facilities, this Part will examine child welfare laws that govern consent and assent to medical treatment for minors that are under the care of the state, which often means the foster care system. At focus are three states with a number of shelters and foster care centers that house migrant minors — Texas, Arizona, and California.[142] Part IV.A will provide a brief summary of child welfare laws and policies in these three states. Part IV.B will highlight some of the troubling ramifications of these laws and policies.

A. TEXAS, ARIZONA, AND CALIFORNIA

In Texas, the Texas Family Code postulates that a "legally authorized" individual must consent to a minor's psychotropic treatment.[143] The Texas Family Code defines legally authorized

140. "As of May 2019, ORR reported that it is working through the Department of Justice to try to negotiate a national framework for treatment authorization and consent for psychotropic medications with class counsel in Flores." *Id.*

141. *See supra* Part III.C.

142. Decca Muldowney et al., *The Immigrant Children's Shelters Near You*, PROPUBLICA (June 27, 2018), https://projects.propublica.org/graphics/migrant-shelters-near-you [https://perma.cc/2VMS-DU2Z]; Aura Bogado, *Here's a Map of Shelters Where Immigrant Children Have Been Housed*, REVEAL (June 26, 2018), https://www.revealnews.org/article/heres-a-map-of-shelters-where-immigrant-children-have-been-housed/ [https://perma.cc/4PNS-22HK].

143. 26 TEX. ADMIN. CODE § 748.2001(b) (2018).

persons, in relevant part, to include a parent, a close family member (i.e., a grandparent, an adult sibling, or an adult aunt or uncle), the educational institution in which the child is enrolled, an adult who has received written authorization to consent, a court "having jurisdiction over a suit affecting the parent-child relationship" of the minor in question, an adult authorized by a juvenile court, or a peace officer "who has lawfully taken custody of a minor."[144] In an emergency situation,[145] however, the consent or court authorization mandated under the Texas Family Code is no longer required, and the physician providing medical care must notify "the person authorized to consent to medical care" no later than the second business day "after the date of the provision of medical care under this section."[146]

In Arizona, a "Health Care Decision Maker" may provide "informed consent" on behalf of a minor that is considering medical treatment.[147] "Informed consent" is an agreement for the minor to receive "health services following the presentation of facts necessary to form the basis of an intelligent consent."[148] The Health Care Decision Maker is authorized through a "Power of Attorney" to make this decision.[149] If a child is under the care of a "foster parent, group home staff, foster home staff, relative or other person or agency," then those individuals may consent to medical treatment per A.R.S. § 8-514.05(D)(1)(b).[150] The Health Care Decision Maker or persons designated under A.R.S. § 8-514.05(D)(1)(b) may consent on behalf of a minor to psychotropic treatment.[151]

---

144. TEX. FAM. CODE ANN. § 32.001(a) (West 2015).

145. The Texas Family Code defines an emergency as a situation where it is "immediately necessary to provide medical care to the foster child to prevent the imminent probability of death or substantial bodily harm to the child or others, including circumstances in which: (1) the child is overtly or continually threatening or attempting to commit suicide or cause serious bodily harm to the child or others; or (2) the child is exhibiting the sudden onset of a medical condition. . . ." *See id.* § 266.009(a).

146. *Id.* § 266.009(a)–(b).

147. *See* ARIZ. HEALTH CARE COST CONTAINMENT SYS., AHCCS MEDICAL POLICY MANUAL: CHAPTER 300, SECTION 320 — SERVICES WITH SPECIAL CIRCUMSTANCES 4 (2020), https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320Q.pdf [https://perma.cc/CPD3-QLRD].

148. *Id.* at 2.

149. The "Power of Attorney" is a "written document that designates an individual who is allowed to make health care decisions for someone." *See id.* at 2.

150. ARIZ. REV. STAT. ANN. § 8-514.05(D)(1)(b) (2017).

151. A Health Care Decision Maker has "the right to consent, refuse to consent, or withdraw consent to health care, treatment, service, or a procedure to maintain, diagnose, or treat an individual's physical or mental condition as specified in A.R.S. §12-2291." *See* ARIZ. HEALTH CARE COST CONTAINMENT SYS., AHCCCS MEDICAL POLICY MANUAL: CHAPTER 500 — CARE COORDINATION REQUIREMENTS (2020), https://www.azahcccs.gov/shared/

California's child consent laws are contained in the state's rules for the "Dependency System" under the Welfare and Institutions Code.[152] When a parent or legal guardian is not available to consent on behalf of a minor child, a "juvenile court judicial officer" may step in and consent to the psychotropic medication.[153] This is "most commonly a judge."[154] A judge makes this decision "based on a request from a physician, indicating the reasons for the request, a description of the child's diagnosis and behavior, the expected results of the medication, and a description of any side effects of the medication."[155]

Quite different from practices in Arizona and Texas, California requires the completion of a form called the "JV-220," which must be submitted to the court.[156] A prescribing physician must fill out the form, and a social worker or probation officer will then submit this form as an application for psychotropic treatment for youth in foster care.[157] This form requires proper notice to the minor's current caregiver, Court Appointed Special Advocate (CASA), Indian Tribe (if applicable), all parties' attorneys, and the minor's available parent or legal guardian.[158] The form requests that a prescribing physician write about the youth's diagnosis and symptoms, the last visit with the youth, the names of individuals from whom information about the youth was obtained, other treatments that the

---

Downloads/MedicalPolicyManual/500/541.pdf [https://perma.cc/Z3F2-AS4T]. Under A.R.S. § 8-514.05(D)(1)(b), the "foster parent, group home staff, foster home staff, relative or other person or agency in whose care the child is currently placed" may consent to "services by health care providers to relieve pain or treat symptoms of common childhood illnesses or conditions." ARIZ. REV. STAT. ANN. § 8-514.05(D)(1)(b) (2017). The Arizona Health Care Cost Containment System (AHCCCS) stated that treatment of "common childhood illnesses or conditions" in A.R.S. § 8-514.05(C-D) includes "behavioral health services and psychotropic medications." *See* ARIZ. HEALTH CARE COST CONTAINMENT SYS., *supra* note 147, at 5.

152. *See* Jessie Conradi, Comment, *A New War on Drugs: Fighting State-Sponsored Overmedication of California's Foster Youth*, 46 GOLDEN GATE U. L. REV. 87, 95 (2016); *see also* CAL. WELF. & INST. CODE § 369.5 (West 2020).

153. WELF. & INST. § 369(a)(1).

154. Conradi, *supra* note 152, at 95.

155. WELF. & INST. § 369.5(a)(1).

156. Form JV-220 Application for Psychotropic Medication, https://www.courts.ca.gov/documents/jv220.pdf [https://perma.cc/MBS6-45C6] (last visited Feb. 10, 2021) [hereinafter "Form JV-220"].

157. Informational Handout on JV-220 — Application for Psychotropic Medication, https://calswec.berkeley.edu/sites/default/files/jv220_forms_info_handouts.pdf [https://perma.cc/8V24-5746] (last visited Mar. 14, 2021).

158. *Id.*

youth is currently receiving, and a list of the medications sought to be administered and their side effects.[159]

In California, Arizona, and Texas, "assent" to psychotropic treatment is not required by or codified into law and is instead encouraged through state policies. The California Department of Social Services and the California Department of Health Care Services note in their guidelines that minors should be "included in the consent and assent process to the extent feasible and appropriate based on their developmental stage."[160] Prescribers are expected to inform the minor of "the risks and benefits of the proposed treatment and of alternative treatments," in addition to reporting on the minor's feelings regarding the medication in the JV-220 form.[161] By contrast, Arizona's general guidelines recommend that youth under the age of eighteen are to be educated on options in a "clear and age-appropriate manner," are allowed to provide input, and are encouraged to assent to prescribed medications.[162] In its guidelines on the use of psychotropic medication with youth, the Texas Department of Health and Human Services notes that "assent from the child or adolescent before beginning psychotropic medication" "should be obtained," but there is no mention of how procedurally a child can provide assent.[163] The Texas Department of Family Protective Services further recommends that youth in their custody should have a developmentally appropriate awareness of his or her condition and the recommended psychotropic

---

159. Conradi, *supra* note 152, at 96.

160. CAL. DEP'T OF SOC. SERVS. & CAL. DEP'T OF HEALTH CARE SERVS., CALIFORNIA GUIDELINES FOR THE USE OF PSYCHOTROPIC MEDICATION WITH CHILDREN AND YOUTH IN FOSTER CARE 11, https://www.courts.ca.gov/documents/BTB24-1G-12.pdf [https://perma.cc/AJ9X-ZDNH] (last visited Jan 28, 2021).

161. *See* PATIENT-CENTERED OUTCOMES RSCH. INST., CALIFORNIA POLICY: ENSURING THAT YOUTH IN OUT OF HOME CARE ARE ONLY PRESCRIBED PSYCHOTROPIC MEDICATION WHEN IT IS IN THEIR BEST INTERESTS, https://www.pcori.org/sites/default/files/Current-Policies-and-Practices-in-Target-States.pdf [https://perma.cc/T3SL-E9HX] (last visited Feb. 10, 2021); *see also* Form JV-220, *supra* note 156, at 2.

162. ARIZ. HEALTH CARE COST CONTAINMENT SYS., FEE-FOR-SERVICE PROVIDER BILLING MANUAL 293 (2020), https://www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/MasterFFSManual.pdf [https://perma.cc/Q5QK-BTHH].

163. *See* TEX. HEALTH AND HUM. SERVS., PSYCHOTROPIC MEDICATION UTILIZATION PARAMETERS FOR CHILDREN AND YOUTH IN TEXAS PUBLIC BEHAVIORAL HEALTH (2019), https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/facilities-regulation/psychiatric/psychotropic-medication-utilization-parameters.pdf [https://perma.cc/4FE6-H492].

treatment, and adults providing consent for the youth should consider the youth's wishes with regards to treatment.[164]

B. THE TROUBLING REALITY OF CURRENT CHILD WELFARE LAWS AND POLICIES

A crisis in the administration of psychotropics to children is occurring not only at detention facilities, but also in child welfare programs across the country. Programs in Texas, California, and Arizona are subject to the laws and policies discussed in Part IV.A and have their own set of challenges with psychotropic overuse in the foster care system. The following is a small glimpse into some of these issues. A 2011 U.S. Government Accountability Office (GAO) report revealed that approximately thirty-two percent of minors in Texas foster care were prescribed psychotropic drugs, which was the second-highest rate in the U.S. at the time.[165] In 2015, a U.S. District Court ruled that Texas's foster care system was unconstitutional and found a number of issues with its "broken" system — children are "shuttled throughout a system where rape, abuse, psychotropic medication, and instability are the norm."[166] In Arizona, foster care children were nine times more likely to be on at least five concomitant prescriptions than the general Medicaid population in 2013.[167] And, in California, almost one

164. *See* TEX. DEP'T OF FAM. & PROT. SERVS., RESPONSIBILITIES OF A MEDICAL CONSENTER, https://www.dfps.state.tx.us/Child_Protection/Medical_Services/Medical_Consenter.asp [https://perma.cc/EB4F-LER9] (last visited Feb. 21, 2021).

165. Though the rate of foster care children prescribed psychotropics drugs in Texas has decreased ("42 percent in 2004 to 32 percent in 2012"), Texas still had the second-highest rate in the country in 2011. Becca Aaronson, *Rate of Foster Kids on Psychotropic Drugs Falls*, TEX. TRIB. (Jan. 29, 2013), https://www.texastribune.org/2013/01/29/interactive-foster-children-prescribed-high-doses/?utm_source=articleshare&utm_medium=social [https://perma.cc/JZ24-SAYM]; *see also Foster Children: HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions: Hearing Before the Subcomm. on Fed. Fin. Mgmt., Gov't Info., Fed. Servs., & Int'l Sec. of the S. Comm. on Homeland Sec. & Governmental Affs.* 112th Cong. (2011) (statement of Gregory D. Kutz, Director, Forensic Audits and Investigative Service) [hereinafter "*Foster Children: HHS Guidance*"].

166. M.D. v. Abbott, 152 F. Supp. 3d 684, 828 (S.D. Tex. 2015) (noting that "Texas's foster care system is broken, and it has been that way for decades"). In 2011, minors in foster care brought a class action lawsuit against DFPS asserting that the Texas officials violated their Fourteenth Amendment right to due process, specifically, "the right to be reasonably safe from harm while in government custody and the right to receive the most appropriate care, treatment, and services by how the State and its officials manage [DFPS]." *Id.* at 688. The court ruled in favor of the plaintiffs and issued an injunction against the state of Texas. *Id.* at 823.

167. ARIZ. HEALTH CARE COST CONTAINMENT SYS., BEHAVIORAL HEALTH NEEDS OF CHILDREN INVOLVED WITH THE DEPARTMENT OF CHILD SAFETY: PSYCHOTROPIC

in four adolescents in foster care were prescribed psychotropics in 2014, and California foster adolescents were three-and-a-half times more likely to be on psychotropic drugs than all adolescents in the U.S.[168]

Even though children in foster care are more likely to experience "moderate to severe mental health problems" this alone does not explain high prescription rates.[169] The overuse of psychotropic drugs can be partly attributed to inadequate "monitoring programs" at state agencies. HHS recommends that state foster care agencies implement monitoring programs that cover the AACAP's guidelines on "consent, oversight, consultation, and [the sharing of] information" on psychotropic treatment to children under the care of the state.[170] The aforementioned 2011 GAO report revealed that foster care programs in five states had monitoring programs that fell short of these guidelines,[171] and as a result, had high rates of "concomitant prescriptions of five or more drugs, prescriptions exceeding dosage guidelines . . . and psychotropic prescriptions to children under 1 year old."[172] The report sheds light on lax oversight policies on the part of the states,[173] and other issues present in the foster care system, including the lack of a "consistent caretaker to plan treatment, offer consent, and provide oversight" of a

PRESCRIBING UPDATE 10 (2016), https://www.azahcccs.gov/Members/Downloads/Resources/BHNeedsofChildren.pdf [https://perma.cc/6WSR-G54X].

168. In an analysis of ten years of data, from 2004 to 2014, the Mercury News noted that "[o]ver the last decade, almost 15 percent of the state's foster children of all ages were prescribed the medications, known as psychotropics, part of a national treatment trend that is only beginning to receive broad scrutiny." *See* Karen de Sá, *Drugging Our Kids*, MERCURY NEWS (Aug. 24, 2014), https://extras.mercurynews.com/druggedkids/ [https://perma.cc/AQG6-SBZV].

169. *Overuse of Psychotropics in Foster Care*, FIRST FOCUS, https://firstfocus.org/overuse-psychotropics-foster-youth [https://perma.cc/TDA7-XM2X] (last visited Feb. 10, 2021).

170. *Foster Children: HHS Guidance*, *supra* note 165, at 18–19, 30.

171. The GAO examined the "rates of psychotropic prescriptions for foster and non-foster children in 2008" and the "state oversight of psychotropic prescriptions for foster children through October 2011." The following states were reviewed: Florida, Maryland, Massachusetts, Michigan, Oregon, and Texas. *Id.* at 1, 18.

172. *Id.* at 2.

173. Mark Abdelmalek et al., *New Study Shows U.S. Government Fails to Oversee Treatment of Foster Children with Mind-Altering Drugs*, ABC NEWS (Nov. 30, 2011, 2:39 PM), https://abcnews.go.com/US/study-shows-foster-children-high-rates-prescription-psychiatric/story?id=15058380 [https://perma.cc/4GFE-CYYT] (discussing how the states in the GAO report fell "short of providing comprehensive oversight" practices).

foster child's medical treatment,[174] and the challenges associated with treating foster children that frequently change placements.[175]

Without a national policy governing the authorization of psychotropic treatment administered to detained migrant children, U.S. detention facilities look to state child welfare laws and policies that govern the foster care system.[176] A problem, however, is that state child welfare laws and policies were not written with detained migrant children in mind. For example, Arizona law states that a "foster parent, group home staff, foster home staff, relative or other person or agency in whose care the child is currently placed," may consent to medical treatment for a child.[177] But when applied to the context of a U.S. detention facility, this language fails to specify who at the facility has consenting authority. Facilities following Arizona's law, or similarly-worded statutes, may find it unwieldy to authorize medication without specific policy naming the staff member that should provide consent. Unfortunately, this has already occurred. The 2018 HHS report revealed that ORR staff felt that it was not always clear who within the facility needed to approve psychotropic medications and if consent should be obtained from an "ORR federal field specialist or another ORR representative."[178]

An additional issue is whether the legally authorized individual providing medical consent is fully informed of the child's needs. The power of a court to consent on behalf of a child, or grant consenting authority, is a common mandate of child welfare laws.[179] A court will sometimes make this decision based off information provided by a physician or a social worker.[180] Many problems can

---

174. *Foster Children: HHS Guidance*, *supra* note 165, at 11.

175. *Id.* ("As we have previously reported, changes in placement pose significant challenges for agencies, foster parents, and providers with regard to providing continuity of health care services and maintaining uninterrupted information on children's medical needs and courses of treatment. Several studies of the utilization of psychotropic drugs have also noted that multiple foster care placements over short periods prevent an individual familiar with the child from coordinating and overseeing his or her long-term medical care." (citations omitted)).

176. The District Court's order in *Flores v. Sessions*, for example, directs Texas detention facilities to follow laws that govern the foster care system. *See, e.g.*, Flores v. Sessions, No. CV 85-4544-DMG (AGRx), 2018 WL 10162328, at *17 (C.D. Cal. July 30, 2018).

177. ARIZ. REV. STAT. ANN. § 8-514.05(D)(1)(b) (2020).

178. CHIEDI, *supra* note 18, at 30.

179. *See supra* Part IV.A.

180. In California, for example, a judge will sign off on psychotropic medications for foster care youth based off reports submitted by a social worker and physician. *See* Conradi, *supra* note 152, at 106–07.

arise from this transfer of information. In California, for example, prescribing physicians will sometimes provide a court with minimal information about the child's prescription — "generic printouts about the [psychotropic] medication that do not address the risks pertaining to the specific child."[181] This could potentially place a child's health in danger, where their medical decisions are founded upon incomplete information. Social workers, on the other hand, are overburdened with cases and have "neither the resources nor the sensitivity to respond to a growing child's ever-changing needs and demands."[182] Relying on these sources of information alone, a court's decision will end up being a "rubber-stamp" of the physician's request due to inaccurate or insufficient information.[183]

Issues involving a court's decision to grant consent to psychotropic treatment on behalf of a child can arise in U.S. detention facilities. High caseloads have overburdened the low number of health practitioners and staff at the detention facilities, which has resulted in limited health care to detained children.[184] According to an HHS report, mental health practitioners felt that "high caseloads limited their effectiveness in addressing children's needs,"[185] and other staff similarly reported challenges with meeting the mental health needs of the high number of detained children.[186] Where U.S. detention facilities may be unable to provide comprehensive medical reports to a court because they are unequipped or short-staffed is cause for major concern.

Moreover, the state policies discussed in Part IV.A do not sufficiently address the issue of obtaining a minor's assent to psychotropic treatment. In particular, the state policies do not address the minimum age for a minor to assent to treatment and how to proceed when a minor refuses to assent.[187] Setting an age of assent is important, as developmental levels of a single child can vary widely according to his or her age and experience, and can

---

181. *Id.* at 106.

182. Maggie Brandow, Note, *A Spoonful of Sugar Won't Help this Medicine Go Down: Psychotropic Drugs for Abused and Neglected Children*, 72 S. CAL. L. REV. 1151, 1162 (1999).

183. *See* Conradi, *supra* note 152, at 107.

184. CHIEDI, *supra* note 18, at 19.

185. *Id.* at 14.

186. "Faced with a sudden and dramatic increase in young children, staff reported feeling challenged to care for children who presented different needs from the teenagers they typically served. Facilities noted that elementary-school-aged children had shorter attention spans, lacked the ability to comprehend the role of the facility, and more commonly exhibited defiance and other negative behaviors." *Id.* at 12.

187. *See supra* Part IV.B.

ultimately affect his or her ability to understand and agree to treatment.[188] It is also important to have procedures in place regarding how to obtain assent, and how to proceed when a child refuses to undergo psychotropic treatment.[189] As a final point, it is equally worrisome that the surveyed states generally do not require assent under their respective policies.[190] Without a required mandate, courts, medical professionals, and legally authorized individuals may feel less compelled to retrieve assent, thus leaving a child with little opportunity to provide input on his or her treatment plan. As it already occurs in California, if the youth does not appear in court, then the court may grant consent solely on the information submitted by the prescribing physician and social worker.[191] As Part V explains, assent is "recognized as an essential part of health care practice,"[192] and should be included in the child's treatment plan. Part V will dive into this issue, in addition to the all-important task of obtaining appropriate consent for psychotropic treatment.

---

188. "There is a general growing tendency in favour of personalisation of the process of assessment of the age of assent, i.e. suggesting that it should be tailored to a particular child. Here commentators use different arguments. Firstly, large developmental differences between children of the same age and differences in experience influence a child's ability to understand essential information, such as the purpose, risk and benefit of research. In particular, children undergoing long-term medical treatment demonstrate surprising competences concerning their own medical situation." Marcin Waligora et. al., *Child's Assent in Research: Age Threshold or Personalization?*, 15 BMC Med. Ethics 2 (2014).

189. *See infra* Part V.C (discussing the American Academy of Pediatrics (AAP) recommendations on how to procedurally solicit assent from a child and how to proceed when a minor refuses to assent).

190. Few states require assent from children. The Congressional Research Service revealed in a 2015 report that in its review of thirty-four state policies on oversight of psychotropic medications, "few states described the involvement of young people in making decisions about their mental health treatment or taking psychotropic medications. Eleven states reported involving children in the consent process, and one state specifically mentioned that it had plans to provide information to foster children about the use of psychotropic medications." *See* CONG. RSCH. SERV., R43466, CHILD WELFARE: OVERSIGHT OF PSYCHOTROPIC MEDICATION FOR CHILDREN IN FOSTER CARE 27–32 (2015), https://www.everycrsreport.com/files/20150728_R43466_5c63888068e06e7bcd67d67ac0dfb94551ce81aa.pdf [https://perma.cc/6LS7-MAXB].

191. Editorial, *The Drugging of Foster Youth*, SFGATE (Jan. 12, 2012, 4:04 PM), http://www.sfgate.com/opinion/editorials/article/The-drugging-of-foster-youth-2494981.php [https://perma.cc/B7P4-2AR6].

192. COMM. ON BIOETHICS, AM. ACAD. OF PEDIATRICS, *Informed Consent in Decision-Making in Pediatric Practice,* 138 PEDIATRICS 1, 2 (2016); *see also infra* Part V.

V. Consent and Assent

Because the over-administration and unnecessary prescription of psychotropic treatment to detained migrant minors is partly due to insufficient state laws on pediatric consent and scant policy on pediatric assent,[193] a national framework defining informed consent and informed assent is necessary. These concepts will be further discussed in the following Parts. Part V.A will define "informed consent" and delineate procedures on how to obtain informed consent. Further, it will introduce the concept of a "double consent" procedure and discuss the appropriate age for a minor to co-consent to treatment. It will also discuss how to proceed in a situation where a minor refuses to co-consent to psychotropic treatment. Part V.B will describe the role of the adult that consents or co-consents with the minor in question. It will also provide a recommendation as to who this adult should be. Lastly, Part V.C will similarly outline procedures for obtaining informed assent, recommend a minimum age for assent, and discuss the issue of when a minor refuses to assent to treatment.

A. Informed Consent

The American Medical Association (AMA) defines informed consent as a "communication between a patient and physician [that] results in the patient's authorization or agreement to undergo a specific medical intervention."[194] Therefore, informed consent is understood to incorporate the following duties: disclosing "information to patients and their surrogates" and "obtaining legal authorization before undertaking any interventions."[195] The American Academy of Pediatrics (AAP) recommends several steps in securing informed consent[196] to medical treatment for a minor. First,

---

193. *See supra* Parts III.C, IV.B.

194. *Informed Consent: Code of Medical Ethics Opinion 2.1.1*, Am. Med. Ass'n, https://www.ama-assn.org/delivering-care/ethics/informed-consent [https://perma.cc/BGL9-PFPU] (last visited Mar. 14, 2021).

195. *See* Katz et al., *supra* note 31, at 2.

196. The Committee on Bioethics at the AAP refers to the process through which an adult consents to treatment for a minor as "informed permission." *See id.* ("[P]arents or other surrogates provide "informed permission" for diagnosis and treatment. . . ."). However, many state laws and policies use the terms "informed consent" or "consent" when referring to this process. In a study of various state policies on psychotropic oversight for children in foster care, the Congressional Research Service referred to the process through which an adult may agree to medical treatment for a minor as "informed consent" or

the patient and his or her surrogate[197] should receive explanations, in understandable and developmentally appropriate language, of the patient's condition, the nature of the proposed diagnostic steps and/or treatment, the potential risks and benefits of the treatment, and information of alternative treatments.[198] Second, the health care provider should determine whether the patient and/or surrogate understood the information provided in the first step.[199] Third, the health care provider should determine whether the patient and/or surrogate decision-maker has the capacity necessary to make a medical decision.[200] And fourth, the health care provider should determine that the consent is voluntary and that the patient and/or surrogate has the freedom to choose among medical alternatives without coercion or manipulation.[201]

An adult will provide informed consent when a child lacks "appropriate decisional capacity" or legal permission to provide informed consent.[202] To clarify, "capacity" is a health provider's clinical determination of the mental abilities of the patient.[203] "Competence," by contrast, is a "legal determination that addresses society's interest in restricting decision-making when capacity is in question."[204] States vary in their age requirements for consent to medical treatment, but the general age cutoff is eighteen.[205] The underlying belief is that minors under the age of eighteen "lack decisional capacity" and are presumed incompetent to make "cogent, mature, and binding decisions about their own well-being."[206]

"consent." The states that participated in the study used this terminology as well. *See* CONG. RSCH. SERV., *supra* note 190, at 39–40. This Note has referred and will continue to refer to informed permission as "informed consent" (or "consent" for short).

197. A "surrogate" or "proxy" is an individual that may make decisions on a patient's behalf. *See* Danielle Hahn Chaet, *The AMA Code of Medical Ethics' Opinions on Patient Decision-Making Capacity and Competence and Surrogate Decision Making*, 19 AMA J ETHICS 676, 675–77 (2017).

198. *See* Katz et al., *supra* note 31, at 4.

199. *See id.*

200. *See id.*

201. *See id.*

202. COMM. ON BIOETHICS, AM. ACAD. OF PEDIATRICS, *Informed Consent, Parental Permission, and Assent in Pediatric Practice*, 95 PEDIATRICS 314 (1995).

203. *See* Katz et al., *supra* note 31, at 3.

204. *Id.* For example, a court may determine whether an individual is "competent" to make personal decisions. *See* Paul S. Appelbaum & Thomas Grisso, *Assessing Patients' Capacities to Consent to Treatment*, NEW ENG. J. MED. 1635, 1635 (1998).

205. Kimberly M. Mutcherson, *Whose Body Is It Anyway? An Updated Model of Healthcare Decision-Making Rights for Adolescents*, 14 CORNELL J.L. & POL'Y 251, 259 (2005).

206. *Id.*

The many risks associated with psychotropics merits a second look at the age limit for consent to medical treatment. This idea — increasing a minor's involvement in the decision-making process of his or her medical care — has developed significantly over the last several decades and is largely corroborated by research. Research has shown that adolescent patients are much more capable than initially perceived and, contrary to current state laws on consent, can provide "voluntary consent comparable to that of young adults."[207] Indeed, the AAP noted from a review of empirical data that adolescents over the age of fourteen "may have as well developed decisional skills as adults for making informed health care decisions."[208]

While there is support behind the general idea of increasing a minor's involvement in decision-making regarding medical treatment, there are some concerns related to the "self-regulation"[209] of adolescents. The brain system of an adolescent between ages twelve and eighteen is in a stage of growth, and the ability to self-regulate (i.e., control impulses and urges) is still under development.[210] Adolescents are thus prone towards increased risk-taking, which affects decision-making competence.[211] This becomes heightened in an "emotionally loaded situation."[212] For example, an adolescent's judgment can be clouded by the presence of peers because "social cues" and "acceptation by peers becomes an important purpose in everyday life and guides decision-making."[213] In a situation involving medical treatment, there is a similar

---

207. In a study comparing the decision-making of a group of nine and ten year old children, a group of fourteen and fifteen year old adolescents, and a group of young adults aged twenty-one through twenty-five, the study noted that "the law can be notified that, at least in regard to medical decisions presented in this research, there is no conclusive evidence to presume that adolescents are incapable of a voluntary consent comparable to that of young adults." David G. Scherer, *The Capacities of Minors to Exercise Voluntariness in Medical Treatment Decisions*, 15 L. & HUM. BEHAV. 431, 436–46 (1991); *see also* Rhonda Gay Hartman, *Adolescent Decisional Autonomy for Medical Care: Healthcare Provider Perceptions and Practices*, 8 U. CHI. L. SCH. ROUNDTABLE 87, 103 (2001) (revealing in a study of healthcare provider practices that over half of the surveyed health care providers reported that adolescent patients "understand information about medical treatment and conditions, engage in rational deliberation during the decisional process, and communicate choices and concerns clearly[ ]").

208. *See* COMM. ON BIOETHICS, AM. ACAD. OF PEDIATRICS, *supra* note 202, at 317.

209. Grootens-Wiegers et al., *supra* note 33, at 5.

210. *Id.*

211. *Id.* at 6.

212. *Id.*

213. *Id.*

concern that adolescents will fail to make responsible decisions.[214] This is dependent on whether the treatment involves the aforementioned external social influences or other external emotional factors.[215]

Given the concerns associated with an adolescent's maturity, coupled with the lack of consensus[216] as to the exact age a minor is deemed competent to provide informed consent, it would be in the best interests of all parties for U.S. detention facilities to adopt a "double consent procedure"[217] standard. A double consent procedure involves "equable consideration" of "the legal position of the child and that of the parents."[218] In other words, the competent adolescent and adult are on equal footing in terms of decision-making authority. The minor considering psychotropic treatment, and operating under a double consent procedure, should be at least fourteen years of age — a review of literature confirms this minimum age.[219] Since the parents of a migrant minor that is detained may not always be readily available or accessible, the individual co-consenting alongside the adolescent may have to be a competent adult[220] other than the parent. In sum, a health care provider at a U.S. detention facility will have to obtain consent from the

214. *Id.*

215. *Id.*

216. *See, e.g.*, *Consenting to Medical Treatment Without Parental Consent*, EUR. UNION AGENCY FOR FUNDAMENTAL RIGHTS, https://fra.europa.eu/en/publication/2017/mapping-minimum-age-requirements/consent-medical-treatments [https://perma.cc/67KS-S4E5] (last visited Mar. 24, 2021) (listing various ages of consent to medical treatment across Europe); *see also* Mutcherson, *supra* note 205.

217. Grootens-Wiegers et al., *supra* note 33.

218. *Id.*

219. *See* Scherer, *supra* note 207; *see also* COMM. ON BIOETHICS, AM. ACAD. OF PEDIATRICS, *supra* note 202, at 317 (noting that adolescents over the age of fourteen "may have as well developed decisional skills as adults for making informed health care decisions"); *see also* Sanford L. Leikin, *Minors' Assent or Dissent to Medical Treatment*, 102 J. PEDIATRICS 169, 173 (1983) ("There is now good evidence that, by age 14 years, many minors attain the cognitive developmental stage associated with the psychological elements of rational consent."); Wallace J. Mlyniec, *A Judge's Ethical Dilemma: Assessing a Child's Capacity to Choose*, 64 FORDHAM L. REV. 1873, 1887–88 (1996) ("With respect to children below the age of six, most judges considered the child's wishes to be irrelevant. By contrast, ninety percent of the judges deemed children's wishes to be either dispositive or extremely important when they were fourteen years old and older."); Robert Schwartz, *Drawing the Line at Age 14: Why Adolescents Should Be Able to Consent to Participation in Research*, 45 J.L. MED. & ETHICS 295, 302 (2017) (finding that "the attributes that develop between age 14 and 18 do not make any potential subject better at making these decisions at the end of adolescence than they were at the beginning" and that a child at age fourteen should be allowed to consent to participation in research).

220. Part V.B will explain who this competent adult should be. *See supra* Part V.B.

competent migrant minor that is between the ages of fourteen and eighteen (hereinafter "adolescent") and from an adult.

Under a double consent procedure, both the co-consenting adult and the co-consenting adolescent would participate in the AAP-recommended informed consent process,[221] and would make an appropriate decision after careful deliberation with one another. Throughout this process, an adolescent would enjoy more autonomy over his or her medical condition and treatment, because consent from the adolescent would be a requirement. At the same time, the involvement of a co-consenting adult may help mitigate concerns of adolescent immaturity and risk-taking.[222] A co-consenting adult "offers extra protection by creating the context for the child's competent decision-making and by facilitating the child's long term autonomy."[223] A minor becomes "optimally competent" to consent when the involved adults acknowledge that the minor has his or her "own characteristics and perspectives" and that the minor is "informed and supported accordingly."[224] The co-consenting adult should foster an environment that empowers the minor to be optimally competent in his or her decision-making.

As an extension of the informed consent doctrine, informed refusal to medical treatment is a right of a competent decision-maker.[225] Under the double consent procedure, if an adolescent wants to refuse medical treatment, medical professionals should respect this decision unless non-medication would result in death or cause substantial harm. As previously noted, an adolescent would have a decision-making authority equal to the co-consenting adult and should therefore enjoy the legal protections of the right to informed consent to medical treatment. In the same way that medical professionals would respect an adult patient's decision to refuse medical treatment,[226] so too should they respect an

---

221. *See* COMM. ON BIOETHICS, AM. ACAD. OF PEDIATRICS, *supra* note 202, at 316–17.

222. *See* Schwartz, *supra* note 219, at 302 (discussing a study that found that nine- and fourteen-year-olds only diverged from twenty-one-year-olds in healthcare decision-making when confronted with emotional environments, but when there was a "trusted adult sounding board" available, the nine- and fourteen-year-olds made decisions "virtually indistinguishable from those of the [twenty-one-year-olds]").

223. Grootens-Wiegers et al., *supra* note 33.

224. *Id.*

225. *See* Kevin Klauer, *Informed Refusal: Just as Important as Informed Consent*, RELIAS MEDIA (Apr. 1, 2013), https://www.reliasmedia.com/articles/64232-informed-refusal-just-as-important-as-informed-consent [https://perma.cc/S2FZ-X4TF] ("Informed refusal is the antithesis of informed consent, a natural extension of the doctrine.").

226. *See* Stephanie Cooper, *Taking No for an Answer: Refusal of Life-Sustaining Treatment*, 12 AMA J. ETHICS 444, 446 (2010) ("In general, if a patient with decision-making

adolescent's final decision. In practice, this would mean that a treatment could not take place pending the adolescent and adult's mutual agreement to consent. However, a child wishing to refuse treatment does not imply that the health care provider or co-consenting adult should halt discussions about the treatment plan. In a context where the treatment's benefits outweigh the risks, a physician or co-consenting adult should make a concerted effort to determine the reasons underlying the adolescent's refusal to enter treatment.[227] This should be a part of an open, respectful conversation about the adolescent's view on the proposed medical treatment and any associated feelings and needs.

It is important to further note that the right to refuse is an important feature of the double consent procedure — by refusing treatment, an adolescent is able to assert their right to bodily integrity. The right to bodily integrity includes rights to autonomy and self-determination,[228] and in its simplest terms, means that a minor has the right to decide what happens to his or her body.[229] A physician and co-consenting adult should ensure, at all times, that an adolescent's right to refuse treatment is protected and his or her right to bodily integrity is preserved throughout a treatment plan.

B. WHO SHOULD PROVIDE INFORMED CONSENT OR CO-CONSENT WITH A MINOR?

While the appropriate age for consent is one important consideration, another key question is who should be the co-consenting adult for an adolescent between ages fourteen and eighteen. This question is also relevant when a minor is not of age to co-consent.[230] The following recommendations apply to both scenarios. Contacting and involving the parent(s) should always be a priority when psychotropic treatment is an option for a minor. Parents are best positioned to provide medical consent on behalf of their children

---

capacity refuses the recommended medical treatment, his or her refusal must be honored and accepted.").

227. *See generally* Leikin, *supra* note 219, at 174.

228. *Bodily Integrity*, CHILD RTS. INT'L NETWORK, https://home.crin.org/issues/bodily-integrity [https://perma.cc/8GRB-XNC2].

229. Mariana Buchner-Eveleigh, *Is It a Competent Child's Prerogative to Refuse Medical Treatment?,* 52 DE JURE L.J. 242, 242 (2019).

230. To clarify, a minor that is not of age to co-consent is under the age of fourteen. This includes minors that are of the age of assent and are below the age of assent. Part V.C will clarify this difference. *See supra* Part V.C.

because they understand their child's unique needs and interests,[231] and generally have an inherent instinct to act in the best interests of their child.[232] If a parent cannot be reached, then contacting a "sponsor" should be the next course of action. "Sponsors" are adults who live in the U.S. and are suitable to provide for the minor's physical and mental well-being as the minor awaits immigration proceedings.[233] A sponsor usually refers to qualified parents, guardians, relatives, or other adults.[234] Many migrant children held at U.S. detention facilities are awaiting release to these sponsors, who tend to be family members.[235] However, if the sponsor is undocumented, he or she may be less likely to apply for sponsorship, since fingerprinting of a sponsor's entire household is now required under a 2018 policy.[236] At times, Immigration and Customs Enforcement (ICE) may have access to this information, which has effectively caused "a steep drop in sponsorship claims" and an increase in the number of unaccompanied children without a point of contact.[237]

Where attempts to contact parents and sponsors are unsuccessful, co-consent or consent should be obtained from an advocate who is well-versed in medical training and has the ability to advocate for and make timely decisions on behalf of migrant minors. In addition to following the Best Interests Standard in Part VI, this advocate should act in the minor's best interests, confirm the minor's understanding of his or her condition and the proposed treatment

231. *Pediatric Decision Making, Code of Medical Ethics Opinion 2.1.1*, AM. MED. ASS'N, https://www.ama-assn.org/delivering-care/ethics/pediatric-decision-making [https://perma.cc/3Y6T-LSQW].

232. Mathew M. Cummings, *Sedating Forgotten Children: How Unnecessary Psychotropic Medication Endangers Foster Children's Rights and Health*, 32 B.C. J.L. & SOC. JUST. 357, 367 (2012).

233. Memorandum of Agreement among the Off. of Refugee Resettlement of the U.S. Dep't of Health and Hum. Servs. and U.S. Immigr. and Customs Enf't and U.S. Customs and Border Prot. of the U.S. Dep't of Homeland Sec. Regarding Consultation and Information Sharing in Unaccompanied Alien Children Matters 4 (2018), https://www.texasmonthly.com/wp-content/uploads/2018/06/Read-the-Memo-of-Agreement.pdf [https://perma.cc/K47M-AHJB].

234. *Sponsors and Placement: Release of Unaccompanied Alien Children to Sponsors in the U.S.*, OFF. OF REFUGEE RESETTLEMENT (May 15, 2019), https://www.acf.hhs.gov/orr/about/ucs/sponsors [https://perma.cc/V6Z8-7CKQ].

235. *See* Malina, *supra* note 71, at 605.

236. *See id.*; *see also Fact Sheet for Proposed Sponsors of Unaccompanied Children*, CATH. LEGAL IMMIGR. NETWORK (Mar. 6, 2020), https://cliniclegal.org/resources/childrens-issues/unaccompanied-children/fact-sheet-proposed-sponsors-unaccompanied [https://perma.cc/EA8Y-GGM9] (describing the information ORR collects from proposed sponsors, which includes the sponsor's immigration status).

237. *See* Malina, *supra* note 71, at 605.

plan, and ensure that the child is providing voluntary and informed consent or assent to the treatment.[238] The advocate should participate in the AAP's informed consent procedure discussed in Part V.A.

A detained minor should have an advocate appointed through the Child Advocate Program (CAP), a TVPRA program.[239] This program should be available to all migrant minors — unaccompanied or separated from their families or guardians — that enter U.S. detention.[240] At present, a CAP advocate meets regularly with the unaccompanied minor while in ORR custody, attends all immigration court proceedings, and can make recommendations on "custody, care, legal representation, and other issues to immigration judges."[241] With regards to decision-making, the CAP advocate may help the minor "understand legal and care-related issues, explain[ ] the consequences of decisions made in response to those issues, and assist[ ] the child in making decisions when the child requests such help."[242] These responsibilities should be expanded to include the co-consenting or consenting role to psychotropic treatment discussed in Parts V.A and V.C. Unfortunately, however, the program has been unable to serve all unaccompanied children referred.[243] But with enough funding and an expansion of the program to appoint advocates to all migrant minors who enter U.S. custody, detained minors will enjoy the safeguards of a watchful advocate providing appropriate guidance, or consent, as it pertains to psychotropic treatment.

C. INFORMED ASSENT

The final step is defining the decision-making role of minors under the age of fourteen. Informed assent is the minor's "willingness to undergo the proposed treatment" after appropriate information about the treatment is provided.[244] Assent is appropriate

---

238. *Id.* at 606 (describing the role an advocate should have for a minor detained at a U.S. detention facility).

239. *See supra* Part III.A.

240. Currently, HHS appoints "independent child advocates" to child trafficking victims and vulnerable unaccompanied migrant children. U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 99, at 24.

241. *Id.*

242. Policy Letter from James R. McHenry III, *supra* note 100, at 1.

243. *Id.*

244. Katz et al., *supra* note 31, at 8; *see also* Cristie M. Cole & Eric Kodish, *Minors' Right to Know and Therapeutic Privilege*, 15 AMA J. ETHICS 638, 639 (2013).

for child patients who lack decision-making capacity and are not capable of providing informed consent.[245] It provides an alternative opportunity for children to communicate their preferences and participate in the decision-making process regarding their health. According to the AAP, the process of soliciting assent from a minor should involve the following:

> 1. Helping the patient achieve a developmentally appropriate awareness of the nature of his or her condition.
> 2. Telling the patient what he or she can expect with tests and treatment(s).
> 3. Making a clinical assessment of the patient's understanding of the situation and the factors influencing how he or she is responding (including whether there is inappropriate pressure to accept testing or therapy).
> 4. Soliciting an expression of the patient's willingness to accept the proposed care.[246]

Children are able to appropriately assent when they have "sufficient competence to have some appreciation of a procedure, but not enough competence to give fully informed consent."[247] Therefore, under the AAP's requirements, once a child has an awareness of his or her condition, and an understanding of the consequences, benefits, and risks of the proposed treatment, then his or her assent should be heeded.

Currently, there is not a nationally established minimum age for assent to psychotropic treatment.[248] Nonetheless, a single age of assent must be established for all U.S. detention facilities to abide by. Research points to at least primary school age,[249] and in particular, the age of seven, as an appropriate time to assent to

---

245. *See* COMM. ON BIOETHICS, AM. ACAD. OF PEDIATRICS, *supra* note 202, at 314.

246. *Id.* at 315–16.

247. D. M. Foreman, *The Family Rule: A Framework for Obtaining Ethical Consent for Medical Interventions from Children*, 25 J. MED. ETHICS 491, 491 (1999).

248. The state of Missouri set the minimum age of assent to psychotropic treatment at age twelve. *See* Joint Settlement Agreement, M.B. v. Tidball, No. 2:17-cv-04102-NKL, at 19–20 (W.D. Mo. 2019); *see also supra* Part IV.A (discussing how Arizona, California, and Texas encourages assent from children under age eighteen); *see also* CONG. RSCH. SERV., *supra* note 190.

249. Christine Harrison, *Treatment Decisions Regarding Infants, Children and Adolescents*, 9 PEDIATRIC CHILDREN'S HEALTH 99, 101 (2004) ("Children of primary school age may participate in medical decisions but do not have full decision-making capacity.").

medical treatment.[250] The AAP also recommends that seven should be the age of assent because children at this age are in "the concrete operations stage of development, allowing for limited logical thought processes and the ability to develop a reasoned decision."[251] As such, minors at U.S. detention facilities should be permitted to provide assent to psychotropic treatment beginning at age seven. This minimum age requirement respects the child's limited capacity to participate in medical decisions,[252] while also promoting the child's medical care, moral growth, and autonomy.[253] A child will also be able to communicate his or her preferences and concerns with regards to health treatment. This involvement in the treatment process is vital to a child's confidence — a child that provides informed assent may feel empowered and more likely to comply with the psychotropic treatment plan because he or she trusts his or her physician.[254] This can improve long-term health outcomes for the minor.

It is important to note that unlike the right to consent, a minor with the right to assent does not have legal authorization to make a final decision on medical treatment.[255] This final decision is left to the adult that has legal authorization to consent on behalf of the minor.[256] Therefore, if a minor at a U.S. detention facility dissents (i.e., refuses to assent[257]), to psychotropic treatment, an adult could potentially override that dissent by providing his or her consent. The AAP recommends overriding the patient's dissent when the

250. One study, in defending the position that the minimum age of assent should be seven, referred to the "centuries old 'Rule of Sevens,' which . . . states, roughly, that children under age seven do not have the capacity necessary to make their own decisions; children from seven to fourteen years of age are presumed not to have this capacity until proven otherwise in individual cases, and children over age 14 are presumed to have capacity to make their own decisions and lead their own lives, unless proven otherwise." D. S. Wendler, *Assent in Paediatric Research: Theoretical and Practical Considerations*, 32 J. MED. ETHICS 229, 230 (2006); *see also* Philip J. Rettig, *Can a Minor Refuse Assent for Emergency Care?*, 14 AMA J. ETHICS 763, 764 (2012) ("Children and youth from 7 to 14 years of age should be asked to assent to care and receive basic information about the proposed care, its risks, and potential benefits.").

251. COMM. ON BIOETHICS, AM. ACAD. OF PEDIATRICS, *supra* note 192, at 2.

252. Harrison, *supra* note 249, at 101.

253. *See* COMM. ON BIOETHICS, AM. ACAD. OF PEDIATRICS, *supra* note 192, at 2.

254. *See id.* at 3–4.

255. Maria De Lourdes Levy et. al., Abstract, *Informed Consent/Assent in Children. Statement of the Ethics Working Group of the Confederation of European Specialists in Paediatrics (CESP)*, 162 EUR. J. PEDIATRICS 629 (2003).

256. *See id.*; *see also* Katz et al., *supra* note 31, at 8.

257. COMM. ON BIOETHICS, AM. MED. ASSOC., *supra* note 202, at 316.

benefits of the medical treatment outweigh the burdens.[258] If the proposed intervention is "not essential and/or can be deferred without substantial risk," considerable weight should be given to the child's dissent.[259] The participating health care provider should work with the minor and consenting adult on any emerging disagreements. When conflict persists, the AAP recommends retaining additional input from secondary consultants, other health care professionals, or chaplains.[260]

VI. The Best Interests Standard

The Best Interests Standard (BIS) is the leading ethical standard in pediatric ethics and provides guidance on how to make medical decisions for minors[261] and adults lacking decision-making capacity.[262] This standard, as Part VI will discuss, should guide the competent adult as he or she provides consent or co-consent to psychotropic treatment for a minor. It serves as the final piece to this Note's consent and assent framework.

The BIS takes many forms, including serving as a legal standard for tribunals and legislative bodies.[263] One well-known formulation is found in Article Three of the United Nations Convention on the Rights of the Child, which holds that "in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the *best interests of the child* shall be a primary

258. *See* Comm. on Bioethics, Am. Acad. of Pediatrics, *supra* note 192, at 4. An example of a risky, but beneficial, treatment is an appendectomy. An appendectomy is the surgical removal of the appendix. While it is a common treatment for appendicitis, certain complications like internal bleeding can arise. Here, the benefit of treating the appendix outweighs any risks associated with the procedure. *See* Rachel Nall, *What to Know About Appendectomy*, Med. News Today (Nov. 26, 2018), https://www.medicalnewstoday.com/articles/323805#appendectomy-procedure [https://perma.cc/KRY3-5J5L].

259. Comm. on Bioethics, Am. Acad. of Pediatrics, *supra* note 192, at 4.

260. *Id.*

261. Johan C. Bester, *The Best Interest Standard and Children: Clarifying a Concept and Responding to its Critics*, 45 J Med Ethics 117 (2019) ("The best interest standard (BIS) has been the prevailing ethical principle in paediatric ethics for many decades. It has served as ethical guide in making medical decisions for children, illuminating ethical obligations, values and ethically sound decisions.").

262. Loretta M. Kopelman, *The Best Interests Standard for Incompetent or Incapacitated Persons of All Ages*, 35 J.L. Med. & Ethics 187 (2007).

263. Lainie Friedman Ross and Alissa Hurwitz Swota, *The Best Interest Standard: Same Name but Different Roles in Pediatric Bioethics and Child Rights Frameworks*, 60 Perspect. Biol. Med. 186 (2017) (examining and comparing the best interests standard as it operates within the pediatric bioethics framework found in the U.S. and the child rights framework based on the U.N. 1989 Convention on the Rights of the Child.).

consideration."[264] Courts in the U.S. legal system have endorsed their own BIS standard for medical decision-making, with a focus on factors like the risks and benefits to a proposed course of action.[265]

Of particular interest is Loretta M. Kopelman's formulation of the BIS. Kopelman, an expert in the field of Bioethics, developed a BIS framework that determines one's actual duty in making decisions on behalf of individuals of all ages that lack the capacity to make decisions for themselves.[266] Her BIS framework for practical decision-making[267] is optimal for the critical task of making medical decisions on behalf of detained migrant minors. It creates a "safeguard against subjugation of childhood interests that are essential for childhood well-being."[268] Through three separate conditions, the parents, sponsors, and advocates defined in Part V.B will be able to consent or co-consent within a framework designed to protect the health, safety, and rights of migrant children.

When used as a practical guide for decision-makers, Kopelman's BIS should be analyzed in terms of three necessary and jointly sufficient features:

> 1. First, decision-makers should use the best available information to assess the incompetent or incapacitated person's immediate and long-term interests and set as their *prima facie* duty that option (or from among those options) that maximizes the person's overall or long term benefits and minimizes burdens.
> 2. Second, decision-makers should make choices for the incompetent or incapacitated person that must at least meet a minimum threshold of acceptable care; what is at least good

---

264. COMM. ON THE RIGHTS OF THE CHILD, U.N., General Comment No. 14, at 12 (2013) (internal quotation marks omitted).

265. As one court put it, "[t]he best interests standard . . . allows a guardian or court to objectively weigh the benefits and burdens of a proposed course of action to determine 'how a reasonable person in the patient's circumstances would promote her well-being.'" *In re* K.I., B.I., and D.M., 735 A.2d 448, 465 (D.C. 1999) (quoting Karen H. Rothenberg, *Foregoing Life-Sustaining Treatment: What Are the Legal Limits in an Aging Society?*, 33 St. Louis U. L.J. 575, 589 (1989)); *see also* Rasmussen v. Fleming, 741 P.2d 674, 689 (Ariz. 1987) ("Under the best interests standard, the surrogate decisionmaker assesses what medical treatment would be in the patient's best interests as determined by such objective criteria as relief from suffering, preservation or restoration of functioning, and quality and extent of sustained life.").

266. Kopelman, *supra* note 262.

267. *Id.*

268. Bester, *supra* note 261, at 120.

> enough is usually judged in relation to what reasonable and informed person[s] of good will regard to be acceptable were they in the person's circumstances.
> 3. Third, decision-makers should make choices compatible with moral and legal duties to incompetent or incapacitated individuals.[269]

The BIS standard contains both subjective and objective elements. On the one hand, decision-makers may consider their values, views, and perceptions in selecting the best option for another person. On the other hand, the BIS contains objective elements, where the choices made for others "must meet standards of care, evidence and good judgment."[270] The next sections will explain each of the three features and their application to a migrant minor's psychotropic treatment plan.

A. THE FIRST DUTY — AN ASSESSMENT OF THE BENEFITS AND RISKS

The first duty asks the decision-maker to assess the immediate and long-term interests of the incompetent or incapacitated person. The decision-makers should then set as their "*prima facie* duty"[271] the option that maximizes the person's overall benefits and minimizes any burdens. The immediate interests of a child suffering from a chronic illness, for example, could be minimizing pain, while long-term interests include living a long, healthy life. Knowing this, the decision-maker can assess the benefits and risks of the decision. This can be a relatively easy task if there are options that are widely available and supported and have already been ranked by their potential benefits and risks. For example, if a child has bacterial strep throat, it is common and widely accepted

---

269. Kopelman, *supra* note 262, at 188–89; *see also* Loretta M. Kopelman, *Using the Best Interests Standard to Decide Whether to Test Children for Untreatable, Late-Onset Genetic Diseases*, 32 J. MED. & PHIL. 375, 379–80 (2007).

270. Kopelman, *supra* note 269, at 390.

271. Kopelman defines a *prima facie* duty as an "all-things-considered obligation" that can be "overridden by higher duties." In other words, unless there are other overriding duties, there is a strong presumption in favor of doing the *prima facie* duty. *See* Loretta M. Kopelman, *Using the Best-Interests Standard in Treatment Decisions for Young Children*, *in* PEDIATRIC BIOETHICS 26 (Geoffrey Miller ed., 2009); *see also* Jan Garrett, *A Simple and Usable (Although Incomplete) Ethical Theory Based on the Ethics of W. D. Ross*, W. KY. U. (Aug. 10, 2004), https://people.wku.edu/jan.garrett/ethics/rossethc.htm [https://perma.cc/Q7N4-9F3Q] (describing a *prima facie* duty).

to prescribe antibiotic medicine.[272] This option, compared to risking a home remedy like warm tea with lime, may be best for a child, considering that rheumatic fever and kidney inflammation can occur if strep throat is left untreated.[273]

A decision-maker may rank the benefits and risks of a decision according to his or her personal values and goals.[274] For instance, a decision-maker who feels strongly against physician-assisted death may let this personal principle affect the question of whether the patient should seek euthanasia. Kopelman notes that subjectivity in the process of ranking is fine — as long as the decision-maker's values do not endanger, neglect, or abuse the person for whom the decision is being made.[275]

Under this duty, then, a parent, sponsor, or advocate should only consent to psychotropic medication for a migrant minor after considering a wide range of options. In doing so, a physician and the consenting adult should consider the overall interests of a minor suffering from mental health issues, and then weigh the benefits and risks of the proposed treatment options. As an example, a minor suffering from depression may possess long-term interests of leading a happy life, free of depression. Cognitive behavioral therapy (CBT) can improve symptoms of depression in an "enduring fashion" by "teaching youth valuable skills that may reduce symptoms" after the CBT has ended.[276] This low-risk option is preferable to psychotropic drugs, which has many risks and only works if the minor continues to take them.[277] If, for personal reasons, the parent, sponsor, or advocate were to select psychotropic treatment over CBT, then the physician may have to override this decision because it would endanger the minor's well-being.[278]

---

272. In her discussion of the first duty, Kopelman provides a similar example of antibiotics being a common and widely accepted remedy for bacterial pneumonia. *See* Kopelman, *supra* note 271.

273. *Strep Throat*, MAYO CLINIC, https://www.mayoclinic.org/diseases-conditions/strep-throat/symptoms-causes/syc-20350338 [https://perma.cc/D2H5-YC8Y].

274. Kopelman, *supra* note 271.

275. *See id.* at 25–26.

276. *Therapy or Medication?*, *supra* note 53.

277. *Id.*

278. Per Kopelman, "people's values or goals may shape decisions about what is best or worst so long as they do not abuse, neglect, or endanger their ward." Kopelman, *supra* note 271, at 25–26.

B. THE SECOND DUTY — ESTABLISHING A THRESHOLD

The second duty asks the decision-maker to select the option that meets a "minimum threshold of acceptable care."[279] This involves an objective and subjective inquiry. On objective grounds, the decision-maker should consider what is "ethically, legally, or socially acceptable care" to "reasonable and informed persons of goodwill."[280] Subjectively, the decision-maker may also consider his or her personal view about what is acceptable.[281] We can see this duty pan out in an example of a staunch anti-antibiotics parent deciding to treat his or her child's pneumonia with herbal tea rather than the appropriate medication. This parent may view herbal tea as an acceptable treatment, while a reasonable and informed person would find this decision as ethically or socially unacceptable because it endangers the child's life.[282] This decision would likely fail under the second duty.

Kopelman notes that in meeting the second condition, the parent can take the interests of others into account.[283] It is a "mistake to conclude that [the BIS] is excessively individualistic and excludes all other people's interests other than the needs of the patient."[284] This decision, therefore, need not be what is "best" for everyone, including the patient.[285] A parent, for example, need not select the best and costliest surgeon in the world for one child at the expense of other family members.[286]

As in any decision, personal biases will inevitably affect the decision of whether to authorize the administration of psychotropic medication to a minor. So, the second condition provides a necessary limit to that final choice by asking the decision-maker to consider what a reasonable and informed person would consider acceptable. This condition would prevent, for instance, an advocate from consenting to psychotropics for the purpose of controlling the child's behavior. As Part III.B described, facility staff would

279. Kopelman, *supra* note 262, at 188–89.
280. Kopelman, *supra* note 271, at 26–27.
281. *Id.* at 26.
282. While herbal teas may soothe symptoms of pneumonia, it cannot treat or cure it. Medication is often prescribed to treat it. *Are There Any Home Remedies for Pneumonia*, COMPLEMENTARY MED. ASS'N, https://www.the-cma.org.uk/Articles/Are-there-any-home-remedies-for-pneumonia-6326/ [https://perma.cc/G8SF-AQPN] (last visited Mar. 13, 2021).
283. Kopelman, *supra* note 271, at 27.
284. *Id.* at 27–28.
285. *Id.* at 28.
286. *Id.*

sometimes forcefully inject uncooperative minors with sedatives.[287] Sedating as a first response to a minor's debilitating mental health issues is not ethically acceptable.[288] While it may be convenient (and in the agency's interests) to quickly calm the anxiety a detained child might be feeling, a powerful tranquilizer is not the most reasonable option for a child's mental health.[289] An entire slate of treatment options should be assessed before automatically resorting to high-risk psychotropics.

C. THE THIRD DUTY — RESPECTING THE RIGHTS OF A CHILD

Finally, the third duty focuses on the moral and legal duties owed to and the rights[290] of those who are unable to make fully informed decisions.[291] Appealing to these duties and rights "may sometimes offer important additional guidance," and decision-makers are encouraged to consider "general" duties and rights when making a decision.[292] For instance, a parent's decision to enroll his or her young adolescent in a harmless low-risk study erodes that adolescent's right to bodily autonomy.[293] Although the study would pose few risks, one may argue that the parent should not consent to the study out of respect to the adolescent's right to have control over his or her body.[294] In the same vein, a parent may not consent to euthanasia on behalf of a child, because a child has a legal right to not receive euthanasia in the U.S.[295]

Like the role a decision-maker has in the previous examples, a parent, sponsor, or advocate should ensure all moral and legal rights of the minor are preserved in the ultimate decision to undergo or bypass psychotropic treatment. Rights to bodily

---

287. Miller, *supra* note 116; see also Flores Memorandum, *supra* note 1, at 13 n.11.

288. *See* Sparks & Duncan, *supra* note 52.

289. *Id.*

290. Kopelman writes about "duties" and "rights" in her explanation of the third feature of the BIS. Kopelman, *supra* note 262, at 189.

291. *Id.*

292. *Id.*

293. *See e.g.*, CHILD RTS. INT'L NETWORK, *supra* note 228 ("[C]hildren, . . . [have] the right to autonomy and self-determination over their own body, and the only person with the right to make a decision about one's body is oneself — no one else. This is the principle of bodily integrity, which upholds everyone's right to be free from acts against their body which they did not consent to.").

294. *Id.*

295. Marije Brouwer et al., *Should Pediatric Euthanasia be Legalized?*, 141 PEDIATRICS, Feb. 2018, at 1 (2018).

integrity,[296] confidentiality,[297] and to refuse care[298] (depending on his or her age), among other generally accepted patients' rights, may inform the final outcome. Like a "lighthouse guiding a ship,"[299] these rights create additional safeguards and signposts that will lead the decision-maker to elect a beneficial treatment with the best interests of the migrant minor in mind.

VII. CONCLUSION

Unaccompanied migrant minors and migrant minors that have been separated from their families upon arrival to the U.S. are deserving of comprehensive mental health care. Current state laws and policies insufficiently address this need, in part by failing to create procedures for the authorization and administration of psychotropic treatment at U.S. detention facilities. Given the high risks associated with psychotropic drugs, it is paramount that minors held at detention facilities have agency in their medical decisions. As such, there is an urgent need for a national framework that defines medical consent and assent, while also recognizing a minor's right to refuse or dissent to treatment. However, this alone is not enough. A parent, sponsor, or advocate providing consent or co-consent on behalf of a minor needs guidance on how to make a medical decision with that minor's best interests in mind. Loretta Kopelman's BIS framework should serve as an appropriate basis — the three duties guide decision-makers to 1) assess the potential benefits and risks to an option and act to maximize the minor's interests, 2) select the option that meets at least a minimum threshold of acceptable care, and 3) make a final choice compatible with any external rights of and duties owed to the minor.[300]

This framework should improve, though not entirely solve, the delicate issue of prescribing psychotropic medications to minors held at U.S. detention facilities. Ultimately, facilitating and encouraging the involvement of a minor in the decision-making process for psychotropic treatment — whether through co-consent or assent — will help protect the minor's safety and health.

---

296. *See* CHILD RTS. INT'L NETWORK, *supra* note 228.
297. Patient Rights: Code of Medical Ethics Opinion 1.1.3, AM. MED. ASS'N, https://www.ama-assn.org/delivering-care/ethics/patient-rights [https://perma.cc/8WMT-XPYH] (last visited Mar. 25, 2021).
298. *Id.*
299. Kopelman, *supra* note 269, at 388.
300. *Id.* at 389–90.