



THE UNIVERSITY OF TEXAS AT AUSTIN  
**SCHOOL OF SOCIAL WORK**

INSTITUTE ON DOMESTIC VIOLENCE AND SEXUAL ASSAULT  
CENTER FOR SOCIAL WORK RESEARCH

**DECLARATION OF LAURIE COOK HEFFRON**

I, Laurie Cook Heffron, declare as follows:

I make this declaration based on my own personal knowledge and if called to testify I could and would do so competently as follows:

**I. Qualifications**

1. I have a background as a social science researcher and licensed social worker on the topics of violence against women, human trafficking, and refugee and immigrant communities. My qualifications in education, research, teaching, social work practice, and serving as expert witness are summarized below.

*Research*

2. I am currently the Associate Director for Research at the University of Texas at Austin's Institute on Domestic Violence and Sexual Assault (IDVSA) and Principal Investigator of a study that explores the experiences of, and relationships between, violence against women and migration, with a focus on migration from Central America to the US. Since 2010, I have served as IDVSA's Associate Director for Research and have designed and contributed to multiple research projects related to intimate partner violence, sexual assault, and human trafficking. Prior to serving in this role, I managed and directed research projects at IDVSA for 8 years. I have published multiple journal articles, book chapters, technical reports related to my areas of research. I regularly present at regional, statewide, and national conferences on these

areas of research. A full list of publications and conference presentations is included in the attached curriculum vitae.

*Social Work Practice*

3. I am a Master's level social worker licensed by the Texas State Board of Social Work Examiners. The state board describes Master's level social work practice as involving the application of specialized knowledge and advanced practice skills in assessment, treatment, planning, implementation and evaluation, case management, mediation, counseling, supportive counseling, direct practice, information and referral, supervision, consultation, education, research, advocacy, community organization and developing, implementing and administering policies, programs and activities. My background includes direct social work practice with battered and exploited immigrant women. From 2003 to 2007, I was a social worker and Program Coordinator with Green Leaf Refugee Services in Austin, Texas.

*Expert Witness*

4. I have served as an expert witness, providing either written and/or oral testimony, in 14 cases since 2012. These include 1 criminal case in Bexar County (not immigration related), 3 T visa applications, 1 U visa application, 4 cancellation of removal cases, 2 bond hearing cases, 1 credible fear interview appeal, and 2 asylum cases. I am also currently involved in coordinating the mental health experts available to provide pro bono assessments and testimony in the cases of women and children detained in the Karnes City and Dilley detention centers.

*Teaching*

5. I have taught undergraduate courses in the School of Social Work at the University of Texas at Austin and am scheduled to teach a graduate course in forced migration at the University of Texas at Austin in spring 2015.

*Education*

6. I hold an undergraduate degree in Linguistics from Georgetown University (1996) and a Master's degree in Social Work from the University of Texas at Austin (2002). I am currently completing a PhD in Social Work at the University of Texas at Austin and expect to graduate in August 2015. I am a Harrington Fellow at the University of Texas at Austin.

**II. Basis for Conclusions**

7. I offer this declaration to provide my professional opinions about the impact of detention on immigrant women, children, and families from Central America who have migrated to the United States to seek asylum. I have thoroughly reviewed the Declaration of Stephen M. Antkowiak ("Antkowiak Declaration") and Declaration of Tae D. Johnson ("Johnson Declaration"), and offer my opinions as to both the accuracy of the conditions described therein as well as the sufficiency of those conditions to adequately mitigate the inherently harmful nature of detention on psychologically vulnerable women and children.

8. I base these conclusions on my background as a social worker and researcher, as listed above.

*Scientific Literature*

9. In particular, I draw my conclusions from the evidence base of social science research and literature related to immigrant survivors of violence and trauma and immigrant detention. I have reviewed the relevant scientific literature in forming my conclusions and have cited those below.

*Research*

10. I also base the following conclusions on the social science research I have personally conducted on these topics. This includes in-depth, in-person interviews with at least

79 immigrant women with experiences of violence or trauma (19 from current dissertation research and more than 60 from previous research).

*Interviews with and Assessments of Women*

11. In addition to the many immigrant women I have interviewed for the purposes of research, I have conducted another 13 in-depth interviews and assessments with the women on whose cases I have provided expert witness testimony. I have testified in both written and oral format as an expert witness in 2 immigration cases (cancellation of removal). I also provided a written affidavit as expert witness but did not testify in court in 11 cases (related to asylum, cancellation of removal, bond hearing, credible fear interview appeal, T visa, and U visa).

12. Specifically related to the Karnes City detention facility, I have been to Karnes in person on 4 occasions during the past 5 months. I have spoken directly with 5 families who are currently or were previously detained at Karnes, all of whom had already passed or eventually passed their credible fear interviews and were seeking asylum. These interviews were for the purposes of research (1) and as an expert witness (4). In connection with the 4 interviews I conducted as an expert witness, I provided written testimony for all 4 and oral testimony for 2.

13. In addition, I have received information from other mental health professionals regarding their interviews with women and children detained in the Karnes and Dilley family detention facilities. I am responsible for coordinating the efforts of a small network of mental health professionals to volunteer their time to conduct expert witness evaluations, and occasionally ongoing therapy, with women and children detained in Karnes and Dilley. I regularly speak with the volunteer mental health services providers regarding their experiences and interviews at Karnes and Dilley. The information that I have received from these other providers is consistent with the information I have obtained in my own interviews of women and

children detained at Karnes and Dilley, so I rely on that information as well to reach my conclusions.

### **III. Impact of Detention on Immigrant Women, Children, and Families**

14. Overall, the detention of survivors of violence and trauma and the detention of children is highly problematic. Both short-term and prolonged detention lead to the deterioration of mental health and well being. The isolating and controlled environment of detention exacerbates pre-existing mental health conditions and/or generates negative mental health outcomes for women and children. Furthermore, detention prevents trauma survivors from receiving much-needed services and supports from mental health professionals and from their family members in the United States.

15. The effects of detention on previously traumatized populations may include self-harm, suicidal ideation and suicide attempts, depression, traumatic stress, and anxiety. This negative emotional impact of detention has been well documented in the literature (Coffey, Kaplan, Sampson, & Tucci, 2010; Keller, Rosenfeld, Trinh-Shevrin, Meserve, Sachs, Levis, Singer, Smith, Wilkinson, Kim, Alden, & Ford, 2003; Robjant, Hassan, & Katona, 2009; Silove, Austin & Steel, 2007; Steel, Silove, Brooks, Momartin, Alzuhairi, & Suslijik, 2006). Numerous studies have shown that women who are detained are more likely to develop psychiatric symptoms including depression, post-traumatic stress and anxiety (Coffey, Kaplan, Sampson, & Tucci, 2010; Robjant, Hassan, and Katona, 2009; Steel, Silove, Brooks, Momartin, Alzuhairi, & Suslijik, 2006). Detention is related to increased vulnerability to additional traumatic events and even to suicide (Davis, 2014; Fazel & Stein, 2002). Furthermore, long-term detention is found to produce lasting psychological harm (Coffey et al, 2010). The amount of time in detention is linked to increased severity of mental health symptoms, and this impact is maintained after

release (Robjant, Hassan, & Katona, 2009). Detention may produce an overall increased need for mental health services (Davis, 2014). While much of the existing research has focused on the impact of long-term detention, my experience indicates that short-term detention has serious and negative impacts on the mental health and well-being of women and children as well.

16. The adult women I interviewed at Karnes described traumatic histories in their home countries or during their journey to the United States, often including intimate partner violence and sexual abuse. Individuals having suffered this type of trauma often suffer from mental health conditions such as PTSD. Other mental health professionals have informed me that their interviews with women detained in the Karnes facility revealed similar trauma backgrounds.

17. While I did not conduct testing designed to lead to diagnoses in my interviews at Karnes, the adult women I interviewed at Karnes reported a variety of symptoms that can accompany stress, anxiety, and PTSD consistent with the literature. These symptoms included but were not limited to flashbacks, nightmares, physical reactions to reminders of past trauma, hyper arousal (feeling jittery and alert), negative changes in beliefs and feelings related to other relationships, difficulty sleeping, and anhedonia. It remains difficult to separate past traumatic experiences and the detention setting itself, as sources or causes of these symptoms. Regardless, the detention setting may trigger and/or exacerbate symptoms, even where those symptoms may have originally developed in response to trauma that occurred before migration or before detention.

18. The concerns about the impact of detention on mental health are equally, if not more, relevant to detained children. Detention, whether it be brief or prolonged, is neither developmentally nor socially appropriate for children, particularly for children who are trauma

survivors and who have witnessed and/or experienced violence, which was the case with the children I interviewed at Karnes. Research on children in immigration detention centers shows evidence of a recent onset of mental and physical health difficulties, thought to be related to the detention experience itself (Fazel & Stein, 2002). Furthermore, children coming out of detention may be at increased risk of future stressors. In sum, children's developmental, nutritional, educational, and child protection needs are not adequately met in the detention setting, and detention is not in the best interest of children (Lorek, Ehntholt, Nesbitt, Wey, Githinji, Rossor, & Wickramasinghe, 2009; Silove, Austin & Steel, 2007).

19. Interviews with women and children detained at Karnes revealed the following behaviors and concerns about children's physical and emotional well-being: difficulty adjusting to the imposed routine, behavior issues, such as temper tantrums and getting into fights with other children, onset of urinary incontinence, lack of developmentally appropriate and adequate independent play and physical activity, subdued mood, frequent crying, self-isolation, difficulty falling asleep, disturbed sleep, nightmares, waking up in the night screaming, trembling, and crying, the sense that someone is following them, loss of appetite.

20. It is clear that children need therapeutic services related to the trauma they experienced and that detention impedes recovery for both mothers and their children. Trauma often ruptures a survivor's sense of safety and control over her life and also interferes with the survivor's ability to trust in relationships with others. Recovery requires re-establishment of a sense of autonomy and safety as well as connections with loved ones and community. Settings based on choice, empowerment, and community are necessary for recovery, as opposed to those based on control, coercion, and containment, which may traumatize or re-traumatize individuals and families who are already vulnerable. Furthermore, approaches and settings that make recovery possible include the reduction and elimination of practices of seclusion and isolation, as well as

attention to workforce orientation, training, and support in trauma, violence and coercion (Ferencik & Ramirez-Hammond, 2013); Jennings, 2004; NASMHPD, 2005; SAMHSA, 2014). These elements of recovery are not available in a detention setting, such as at the Karnes and Dilley facilities.

21. The scientific literature and my interviews with detained families also shed light on the negative impact of detention on parenting and mother-child relationships. Parents who are detained may become too depressed or anxious to provide adequate care for their children. Over time, if they are denied appropriate treatment, their symptoms may worsen, and this could impair their ability to care for their children. Family detention may generally cause disruptions to the family unit, create role reversal of parents and children, and undermine attachment relationships (Silove, Austin & Steel, 2007).

#### **IV. Conditions of Detention**

22. Both the Antkowiak and Johnson Declarations provide a brief sketch of the conditions of detention at the Karnes and Dilley facilities. As explained below, these descriptions do not adequately describe the limitations on freedom of movement and the limited services available to the women and children at the Karnes facility. However, regardless of conditions, the detention of mothers and children, particularly those with trauma in their past, exacerbates previous trauma and prevents appropriate care and treatment.

23. The scholarly literature and my experience reflect that mental health services may not be fully effective in the detention setting for this population. At best, they can act as a temporary band-aid. This is due to the setting of detention, with its restricted and controlled nature. Detention exacerbates the lack of stability women and children feel, along with the persistent state of alertness, heightened fear, and hyper-vigilance.



24. The description of family detention centers provided in the Antkowiak and Johnson Declarations do not provide a complete account of the restrictions of liberty experienced by the women and children held there. The Antkowiak Declaration states that the family facilities, including Karnes, permit “free movement” of adult residents and for minors 12 years and older, with the permission of a parent. Antkowiak Decl. ¶ 25; Johnson Decl. ¶ 17 (“[r]esidents . . . enjoy free movement during waking hours”). While there may be a general freedom of mobility in the facility, women and children report restrictions on their freedom of movement as it relates meal times and sleep schedules, in particular. These include rigid schedules for meals, for being in sleeping quarters, lights out, and waking times. I have received accounts of these restrictions from the women and children I personally interviewed at Karnes, and other mental health service providers have relayed similar accounts to me based on their interviews with additional women and children. I also received information, in my interviews with detained women and children and in my interactions with other mental health providers, indicating that women and children are sometimes awoken in the middle of the night by loud alarms or guards conducting room checks. These sleep disruptions have a negative impact on children, for whom sleep is necessary for development. Furthermore, these conditions exacerbate the sleep disturbances for children who are already experiencing disrupted sleep related to trauma, depression and general stress.

25. These restrictions on women and children’s freedom of movement and decision-making are particularly problematic when considering their impact on survivors of violence and trauma, particularly children. The lack of control over their movement and everyday activities and over their futures places women and children in positions of uncertainty and isolation, contributing to traumatic stress, depression and anxiety. These restrictions on liberty disempower

women and children and hinder their ability to recover from trauma. It also sends messages of wrongdoing to women and children, which can be re-traumatizing and further impede healing and development. The restrictive nature of detention facilities and the highly controlled movement and regimented schedule may also mirror and re-trigger negative mental health outcomes associated with past gender-based violence experienced by women.

26. Both the Antkowiak and Johnson Declarations state that medical and social services are available at family detention facilities. Antkowiak ¶ 13, Johnson ¶ 17. Not all of the women I interviewed at Karnes were able to access mental health services, although they all would have benefitted from the intervention of trained mental health workers. It would also be very important to know whether the mental health and social services providers at the family detention facilities have adequate Spanish language capabilities and training related to working with survivors of trauma, domestic violence, sexual violence, or child welfare. That information is not available in the Antkowiak and Johnson Declarations. Treatment by inadequately trained mental health care providers can lead to the development or aggravation of negative mental health symptoms or re-traumatization. It is also my understanding that the Karnes and Dilley facilities are not licensed explicitly for the care of children. Licensing requirements in the child welfare field are developed for the purpose of ensuring safety and well-being of children.

Without such requirements, there exists risk for greater harm to adults, children, and families.

27. The Antkowiak Declaration states that additional resources and amenities are provided, such as recreational areas for children. Antkowiak Decl. 10. These are no substitute for comprehensive mental healthcare. For example, women have described a crochet class offered in the past. While this activity might help distract them from the fear and stress of daily

lives while detained, it does not mitigate the negative effects of detention on mental health. It is also my understanding that this crochet class has been recently discontinued.

28. In sum, despite attention to the basic needs of detainees and regardless of the number and quality of amenities, resources, and trained staff available, detaining women and children in secure and controlled settings remains a harmful and highly problematic practice from a mental health perspective.

#### **V. Trauma Response and Migration Decision-Making**

29. The Johnson Declaration theorizes that individuals migrating to the United States are drawn by a perception that they will be granted “permisos” and that the possibility that they will instead face detention will therefore deter future migration. Johnson Decl. ¶ 7. The interviews I have conducted with multiple women from Central America indicate otherwise. As a researcher and expert witness, I have conducted 64 interviews since 2007 with women who are seeking asylum and related relief in the United States, mostly from Guatemala, El Salvador and Honduras. Based on these interviews, women who have survived traumatic experiences make the decision to migrate to the United States based on survival and on finding safety for themselves and their children, with those imperatives outweighing the expected risks they might experience during migration or after arriving in the United States. These decisions are made in the context of life-threatening experiences or experiences perceived to be life threatening and are often made in a state of urgency and desperation. For example, many Central American women report a general awareness that rape is expected during migration through Mexico and while crossing the Mexico-US border. However, women report that their understanding of the likelihood of rape did not impact their decisions to leave their home countries, because their decisions were driven by the urgency and desperation to escape violence in their home countries.

**VI. Compensation**

I have received no compensation for my participation in this case.

I reserve the right to amend or supplement this report as appropriate upon receipt of additional information or documents.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed this 13 day of April, 2015 in Austin, Texas.

A handwritten signature in black ink, appearing to read "Laurie Cook Heffron", is written over a horizontal line. The signature is cursive and somewhat stylized.

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Laurie Cook Heffron, LMSW

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