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For the Least of These Brothers and Sisters of Mine: Providing Mental Health Care to Undocumented Immigrant Children

Patrick D. Murphree*

“But I wasn’t sure I wanted to come. I decided for sure only when the gang threatened me.” —Maritza, age 15.¹

Imagine being 10 years old, leaving the only home you have ever known in the company of a stranger to be taken to reunite with a mother you barely know. Imagine being shuffled from bus to train, packed in with throngs of other immigrants making the perilous passage north through Mexico to the United States border. Imagine your cell phone, your only link to your family, being thrown away by the stranger to reduce the risk of being tracked. Then imagine being left a half mile from the border and told you were on your own. Imagine climbing a fence, running into Border Protection, and being so frightened that all you can do is repeat your mother’s phone number. Imagine doing all of this because criminal gangs target boys your age for recruitment.² Children may be resilient, but the

* I would like to thank Jennifer Coco and Sara Godchaux of the Southern Poverty Law Center in New Orleans for the initial suggestion from which this Article germinated and Professors Davida Finger and Hiroko Kusuda of Loyola University New Orleans for their advice on earlier versions.

¹ REGIONAL OFFICE FOR THE UNITED STATES & THE CARIBBEAN, UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES, CHILDREN ON THE RUN: UNACCOMPANIED CHILDREN LEAVING CENTRAL AMERICA AND MEXICO AND THE NEED FOR INTERNATIONAL PROTECTION 6 [hereinafter CHILDREN ON THE RUN], http://www.unhcrwashington.org/sites/default/files/1_UAC_Children%20on%20the%20Run_Full%20Report.pdf.

² This paragraph is based on the story of Alex, a 10-year-old El Salvadorian child. Eli Saslow, *A Ten-Year Old Immigrant Faces Risks, Doubts on the Journey to Reunite with His Mother*, WASH. POST (Sept. 7, 2014), <https://www.washingtonpost.com/national/a->

trauma of such a journey under these circumstances is likely to leave lasting psychic scars. Unfortunately, this little boy is not alone.

Without appropriate mental health care, the scars of the migration experience may permanently disfigure a child's life. Regardless of documented status, immigrant children have a right to mental healthcare. Further, the provision of this care benefits not only these children but also the society of which they are a part, since their ability to contribute to society as productive adults could be inhibited by the presence of unaddressed trauma.³ To address this potentially debilitating mental trauma, eligibility for Medicaid and the Children's Health Program (CHIP) should be expanded to include low-income undocumented youth.⁴

This article will first examine the recent "surge" of unaccompanied children migrating to the United States, exploring the causes of this "surge,"

10-year-old-immigrant-faces-risks-doubts-on-the-journey-to-reunite-with-his-mother/2014/09/07/169f16d6-3213-11e4-9e92-0899b306bbea_story.html.

³ See *infra* notes 73-77 and accompanying text.

⁴ While a number of student notes and comments have addressed providing health care to undocumented immigrants through Medicaid and other programs, these works have not addressed mental health needs specifically. See generally Jayne Bart-Plange, Comment, *Equal Protection Violations: An Asylum-Seeker's Right to Medicaid Benefits and Primary Health Care*, 83 UMKC L. REV. 207 (2014); Elizabeth R. Cesler, Note, *Denying Undocumented Immigrants Access to Medicaid: A Denial of their Equal Protection Rights?*, 17 B.U. PUB. INT. L.J. 255 (2008); Cindy Chang, Note, *Health Care for Undocumented Immigrant Children: Special Members of an Underclass*, 83 WASH U. L.Q. 1271 (2005); David J. Deterding, Note, *A Deference-Based Dilemma: The Implications of Lewis v. Thompson for Access to Non-Emergency Health Benefits for Undocumented Alien Children*, 52 ST. LOUIS U. L.J. 951 (2008); Akeisha R. Gilcrist, *Undocumented Immigrants: Lack of Equal Protection and Its Impact on Public Health*, 34 J. LEGAL MED. 403 (2013); Ryan Knutson, Note, *Deprivation of Care: Are Federal Laws Restricting the Provision of Medical Care to Immigrants Working as Planned?*, 28 B.C. THIRD WORLD L.J. 401 (2008); Jeffery A. Needelman, Note, *Attacking Federal Restrictions on Noncitizens' Access to Public Benefits on Constitutional Grounds: A Survey of Relevant Doctrines*, 11 GEO. IMMIGR. L.J. 349 (1997); Alexander Vivero Neill, Comment, *Human Rights Don't Stop at the Border: Why Texas Should Provide Preventative Health Care for Undocumented Immigrants*, 4 SCHOLAR 405 (2002); Hyejung Janet Shina, Note, *All Children Are Not Created Equal: PRWORA's Unconstitutional Restriction on Immigrant Children's Access to Federal Health Care Programs*, 44 FAM. CT. REV. 484 (2006).

children's experiences on their journeys, and what happens once they arrive in the United States. The article next addresses these children's mental health needs and the fiscal and human costs of failing to address them before advocating for expanding the eligibility criteria for Medicaid and CHIP. After briefly examining the history and structure of these programs, the remainder of the article presents constitutional and policy arguments for removing the ban on providing these program's benefits to children who are in the country without authorization.⁵

I. THE SURGE IN UNACCOMPANIED CHILDREN ARRIVING AT THE US-MEXICO BORDER

In fiscal year 2014, border patrol apprehended over 68,000 unaccompanied children, a 76 percent increase over the previous year⁶ and a 269 percent increase since fiscal year 2010.⁷ Apprehensions of families with

⁵ While there is significant literature on the need to expand access to health care for noncitizens in the United States, *see, e.g.*, Jennifer Y. Seo, *Justice Not for All: Challenges to Obtaining Equal Access to Health Care for Non-Citizen Immigrants in the United States*, 3 GEO. J.L. & MOD. CRITICAL RACE PERSP. 143 (2011) (analyzing the issue through the lens of the experience of the Asian-American community), the mental health needs of undocumented immigrants often become a side issue within that larger discussion, *see, e.g., id.* at 146-47, 153-54, 159, 161-63.

⁶ U.S. CUSTOMS & BORDER PROTECTION, DEP'T OF HOMELAND SEC., CBP BORDER SECURITY REPORT 1 (2014), https://www.cbp.gov/sites/default/files/documents/FINAL%20Draft%20CBP%20FY14%20Report_20141218.pdf.

⁷ U.S. Border Patrol, *Total Unaccompanied Alien Children (0-17) Apprehensions by Month*, U.S. CUSTOMS & BORDER PROTECTION 1, 5, <https://www.cbp.gov/sites/default/files/documents/BP%20Total%20Monthly%20UACs%20by%20Sector,%20FY10.-FY14.pdf> (last visited Nov. 23, 2015). The most recent data for fiscal year 2015 indicates that the "surge" may be slowing with a 42 percent decline in apprehensions of unaccompanied children and of individuals traveling with a family unit. *See* U.S. Border Patrol, *Southwest Border Sectors*, U.S. CUSTOMS & BORDER PROTECTION, <http://www.cbp.gov/sites/default/files/documents/BP%20Southwest%20Border%20Family%20Units%20and%20UAC%20Apps%20-%20FY14-FY15.pdf> (last visited Nov. 23, 2015). Additionally, although fiscal year 2015 suggested that the "surge" may have ended, *id.* at 6, the most recent data indicates that the apprehension rate may be rising again, *United States Border Patrol Southwest Family Unit Subject and Unaccompanied*

children have also increased, adding to the number of children potentially in need of care.⁸ Additionally, the demographics of this migrant population have changed. Until 2013, children from Mexico constituted the majority of the unaccompanied children entering the United States, but since that time the majority of these children have been fleeing Honduras, El Salvador, and Guatemala (the so-called Northern Triangle).⁹ Although the rate of unaccompanied children arriving in the United States has declined somewhat since peaking in 2014, it nevertheless remains higher than before the beginning of the surge.¹⁰

A. Factors Driving the Surge

The causes of any child's migration to the United States are as individual as the child herself, but observers and academics have isolated several common explanations.¹¹ One strand, emblemized by a recent study from the United Nations High Commissioner for Refugees, emphasizes social factors: "entrenched poverty, an escalating threat posed by drug trafficking, polarized political systems, weak law enforcement and social hardships—

Alien Children Apprehensions Fiscal Year 2016, U.S. Customs & Border Protection [hereinafter *Apprehensions*], <http://www.cbp.gov/newsroom/stats/southwest-border-unaccompanied-children/fy-2016/> (last visited Aug. 15, 2016) (showing 48,311 apprehensions for the first 10 months of fiscal year 2016 compared to 39,970 apprehensions for the whole of fiscal year 2015). Regardless of whether the rate is slowing or not, even the slower 2015 rate is still significantly higher than the rate in 2010, and the children already present in the United States as a result of migrations during the "surge" still require access to mental health care.

⁸ U.S. CUSTOMS & BORDER PROTECTION, *supra* note 6, at 1 (reporting a 356 percent increase in apprehensions of families since fiscal year 2013).

⁹ *Apprehensions*, *supra* note 7.

¹⁰ See WILLIAM A. KANDEL, CONG. RESEARCH SERV., R43599, UNACCOMPANIED ALIEN CHILDREN: AN OVERVIEW 2 tbl.1 (2016), <http://fas.org/sgp/crs/homsec/R43599.pdf> (reporting numbers of unaccompanied children apprehended at the Southwestern border through the first half of fiscal year 2016).

¹¹ See generally Scott Rempell, *Credible Fears, Unaccompanied Minors, and the Causes of the Southwestern Border Surge*, 18 CHAP. L. REV. 337 (2015).

such as poverty and unemployment.”¹² Additionally, the rise of powerful and brutal gangs has forced many children to either join a gang or become victims of violent recruitment pressure;¹³ these gangs have driven murder rates in Northern Triangle countries to astronomical heights.¹⁴ Children cannot even escape this violence at home, as evidence shows domestic violence is also rising.¹⁵ Thus, it should come as little surprise that in one study 48 percent of unaccompanied children cited gang violence as a motivation for their migration to the United States, and 21 percent mentioned domestic violence.¹⁶

For other children, more personal factors account for the choice to migrate. Some children have simply been abandoned by their parents or guardians and see no reason to stay in their country of origin.¹⁷ On the other hand, some make the journey to reunite with family members who have already migrated to the United States.¹⁸ In the latter case, there may be a

¹² CHILDREN ON THE RUN, *supra* note 1, at 24.

¹³ Rempell, *supra* note 11, at 361. In Mexico, children also face pressure to become part of smuggling gangs. See CHILDREN ON THE RUN, *supra* note 1, at 6 (reporting that 38 percent of unaccompanied children from Mexico who were interviewed for the study reported this pressure).

¹⁴ Dennis Stinchcomb & Eric Hershberg, *Unaccompanied Migrant Children from Central America: Context, Causes, and Responses* 17-18 (Ctr. for Latin Am. & Latino Stud., Working Paper No. 7, 2014), http://papers.ssrn.com/sol3/papers/cfm?abstract_id=2524001. The three Northern Triangle countries are Guatemala, El Salvador, and Honduras. For a brief introduction to the violence in the region, see Danielle Renwick, *Central America's Violent Northern Triangle*, Council on Foreign Relations (Jan. 19, 2016), <http://www.cfr.org/transnational-crime/central-americas-violent-northern-triangle/p37286>.

¹⁵ Stinchcomb & Hershberg, *supra* note 14, at 17-18.

¹⁶ See CHILDREN ON THE RUN, *supra* note 1, at 6.

¹⁷ Stinchcomb & Hershberg, *supra* note 14, at 22-23; CHILDREN ON THE RUN, *supra* note 1, at 33.

¹⁸ See CHILDREN ON THE RUN, *supra* note 1, at 31-37; see also Carola Suárez-Orozco et al., *Growing Up in the Shadows: The Developmental Implications of Unauthorized Status*, HARV. EDUC. REV. 438, 442 (2011) (noting that some parents' decision to bring their children to the United States without authorization may stem from frustration with slow-moving bureaucratic systems and “the realization that they are missing their children’s childhood”); Saslow, *supra* note 2 (describing the journey of a 10-year-old boy from El Salvador to join his mother in Los Angeles).

mix of motives: familial sentiment along with a desire to escape raging violence.

Finally, some commentators have suggested that increased awareness of changes in US immigration policy, spread through word-of-mouth, may account for the surge.¹⁹ In a nuanced version of this argument, Professor Scott Rempel acknowledges a contributing role for deteriorating circumstances within countries of origin but concludes that beliefs inspired by new US policies are the main driving force.²⁰ According to Professor Rempel, smugglers may be misrepresenting the Trafficking Victims Protection Reauthorization Act of 2008 in order to entice people to use their services to send their children to the United States.²¹ Additionally, the Deferred Action for Childhood Arrivals (DACA) program²² may play a role

¹⁹ See, e.g., Rempel, *supra* note 11, at 381-83.

²⁰ *Id.*

²¹ *Id.* For examples of recent legislation embodying changes in United States immigration policy, see Violence Against Women Reauthorization Act of 2013, Pub. L. No. 113-4, 127 Stat. 54; William Wilberforce Trafficking Victims Protection Reauthorization Act of 2008, Pub. L. No. 110-457, 122 Stat. 5044.

²² The DACA program grants employment authorization to immigrants under age 31, as of the effective date of the policy, who came to the United States when they were under 16 and who meet specified criteria, including continuous residence for five years, lack of serious or numerous convictions, and attaining a high school diploma or GED or receiving an honorable discharge from the armed forces. For more detailed breakdowns of DACA's requirements and benefits, see *Consideration of Deferred Action for Childhood Arrivals (DACA)*, U.S. CITIZENSHIP & IMMIGR. SERVS., <http://www.uscis.gov/humanitarian/consideration-deferred-action-childhood-arrivals-daca> (last updated Aug. 10, 2016); *DACA (Deferred Action for Childhood Arrivals)*, IMMIGR. EQUALITY, <http://www.immigrationequality.org/get-legal-help/our-legal-resources/path-to-status-in-the-u-s/daca-deferred-action-for-childhood-arrivals/> (last visited Nov. 3, 2015). The program has been controversial for, among other things, having been established by the executive branch rather than Congress. See Memorandum from Janet Napolitano, Sec. of Homeland Security, to David V. Aguilar, Acting Commissioner, U.S. Customs & Border Protection, Alejandro Mayorkas, Director, U.S. Citizenship & Immigration Services, & John Morton, Director, U.S. Immigration & Customs Enforcement (June 15, 2012), <http://dhs.gov/xlibrary/assets/s1-exercising-prosecutorial-discretion-individuals-who-came-to-us-as-children.pdf> (characterizing DACA as merely an exercise of prosecutorial discretion to not deport certain deportable persons).

through either an inaccurate belief that it will apply to unaccompanied children or a belief that it signals a new direction for US immigration policy.²³

B. The Traumas of the Migration Experience

After a child has decided to migrate (or had that decision made for him or her), the child must still cross hundreds or thousands of dangerous and potentially traumatic miles to reach the United States. Although the freight train route known as “La Bestia” is famous as a means for Central American migrants to move through Mexico,²⁴ 75 to 80 percent of children migrate with the aid of smugglers,²⁵ typically by van or bus.²⁶ This system avoids some of the physical dangers of the rail journey, but children still risk extortion, kidnapping, human trafficking, and forced disappearance²⁷ because their routes north are controlled by drug and trafficking gangs.²⁸ Girls travelling alone face additional dangers of sexual assault and forced prostitution.²⁹ Up to 80 percent of women and girls who make the migration endure a sexual assault along the way.³⁰ To overcome these risks and reduce

²³ Rempell, *supra* note 11, at 381-83.

²⁴ See Rodrigo Dominguez Villegas, *Central American Migrants and “La Bestia”: The Route, Dangers, and Government Responses*, MIGRATION INFO. SOURCE (Sept. 10, 2014), <http://www.migrationpolicy.org/article/central-american-migrants-and-la-bestia-route-dangers-and-government-responses>.

²⁵ Stinchcomb & Hershberg, *supra* note 14, at 12; see also Camilo Vargas, *Coyotes: The Smugglers that Bring Kids to the Border*, LATINO USA (Sept. 12, 2014), <http://latinousa.org/2014/09/12/smugglers/> (distinguishing between smugglers and traffickers and explaining that smugglers are successful due to their ties to communities in migrants’ countries of origin).

²⁶ Villegas, *supra* note 24.

²⁷ Stinchcomb & Hershberg, *supra* note 14, at 8-9.

²⁸ See Villegas, *supra* note 24.

²⁹ Salil Shetty, *Most Dangerous Journey: What Central American Migrants Face When They Try to Cross the Border*, AMNESTY INT’L: HUMAN RTS. NOW BLOG (Feb. 20, 2014, 12:58 PM), <http://blog.amnestyusa.org/americas/most-dangerous-journey-what-central-american-migrants-face-when-they-try-to-cross-the-border/>.

³⁰ Erin Siegal McIntyre & Deborah Bonello, *Is Rape the Price to Pay for Migrant Women Chasing the American Dream?*, FUSION (Sept. 10, 2014, 5:51 PM), <http://fusion.net/story/17321/is-rape-the-price-to-pay-for-migrant-women-chasing-the->

the chances of becoming victims, young migrants may make themselves appear older and affect a toughness and bravura, further heightening the psychological toll taken by the migration.³¹

Once apprehended in the United States by Customs and Border Protection, children identified as unaccompanied minors from noncontiguous countries are transferred to the custody of the Office of Refugee Resettlement (ORR) while their immigration cases proceed.³² Because the law requires unaccompanied children to be “promptly placed in the least restrictive setting that is in the best interests of the child,”³³ the vast majority of Central American children who have successfully migrated are placed with a sponsor—a parent, relative, or family friend in the United States.³⁴ Children for whom a sponsor cannot be located are placed in long-

american-dream/ (basing this percentage on interviews with directors of migrant shelters); *see also* AMNESTY INT’L, *INVISIBLE VICTIMS: MIGRANTS ON THE MOVE IN MEXICO* 15 (2010), <http://www.amnestyusa.org/sites/default/files/amr410142010eng.pdf> (“According to some experts, the prevalence of rape is such that people smugglers may require women to have a contraceptive injection prior to the journey as a precaution against pregnancy resulting from rape.”); Shetty, *supra* note 29 (“Health officials report that as many as six in ten migrant women and girls are raped on the journey.”).

³¹ *See, e.g.*, Saslow, *supra* note 2 (“If there was one skill he had acquired during his long journey, it was how to affect toughness—how to stiffen his shoulders and spike up his wavy black hair with gel to make himself look a few inches taller and a few years older.”).

³² Stinchcomb & Hershberg, *supra* note 14, at 29. Under federal law, an “unaccompanied alien child” is a child under 18 who “has no lawful immigration status in the United States” and whose parents or legal guardian is either outside the United States or inside the United States but not “available to provide care and physical custody.” 6 U.S.C. § 279(g)(2) (2012). Unless they request a hearing before an immigration judge or are eligible for refugee status, Mexican and Canadian children are voluntarily repatriated; if they are not, they are transferred to ORR custody. Stinchcomb & Hershberg, *supra* note 14, at 29.

³³ 8 U.S.C. § 1232(e)(2) (2012).

³⁴ Stinchcomb & Hershberg, *supra* note 14, at 29 (reporting that 85 percent of unaccompanied children are placed with a sponsor); Muzaffar Chishti & Faye Hipsman, *Dramatic Surge in the Arrival of Unaccompanied Children Has Deep Roots and No Simple Solutions*, MIGRATION POL’Y INST. (June 13, 2014), <http://migrationpolicy.org/article/dramatic-surge-arrival-unaccompanied-children-has-deep-roots-and-no-simple-solutions> (reporting 90 percent being placed with a sponsor).

term foster care or extended-care group homes.³⁵ While children who remain in some form of secure care with ORR (generally children who pose a threat to public health or safety) have access to mental health care,³⁶ children released to sponsors may not,³⁷ even though their need may be just as great, particularly as they face the further challenges of living as undocumented persons in the United States.

II. MENTAL HEALTH NEEDS AMONG UNDOCUMENTED CHILDREN

In addition to trauma from the migration experience, undocumented children have unaddressed mental health needs due to the stressors of undocumented status and racial discrimination.³⁸ If unmet, these needs leave children exposed to a higher risk of lifelong disabilities.³⁹ One in five children in the United States will develop a severe mental disorder at some point during his or her lifetime,⁴⁰ while half of all chronic mental illness begins by age 14.⁴¹ We should not assume that undocumented children are

³⁵ Olga Byrne & Elise Miller, *The Flow of Unaccompanied Children Through the Immigration System: A Resource for Practitioners, Policy Makers, and Researchers*, VERA INST. JUST. 16 (Mar. 2012), <http://www.vera.org/sites/default/files/resources/downloads/the-flow-of-unaccompanied-children-through-the-immigration-system.pdf>.

³⁶ *Id.* at 14; see also Lara Yoder Nafziger, *Protection or Persecution: The Detention of Unaccompanied Immigrant Children in the United States*, 28 HAMLIN J. PUB. L. & POL'Y 357, 370-73, 379-85 (2008) (describing the terms of the *Flores* settlement, which required safe facilities and medical care for children in ORR custody as well as encouraged release to sponsors whenever possible, but noting that in many ways the ORR continues to fall short of the requirements in the settlement agreement).

³⁷ Stinchcomb & Hershberg, *supra* note 14, at 30 (contrasting children who remain in ORR custody, and therefore “have immediate access to a range of services provided by a network of ORR-funded providers” with children released to sponsors, “only a fraction of [whom] are aware of or have access to similar services”).

³⁸ See *infra* notes 44-65 and accompanying text.

³⁹ See *infra* notes 73-77 and accompanying text.

⁴⁰ *Any Disorder Among Children*, NAT'L INST. MENTAL HEALTH, <http://www.nimh.nih.gov/health/statistics/prevalence/any-disorder-among-children.shtml> (last visited Sept. 23, 2015).

⁴¹ Ronald C. Kessler et al., *Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication*, 62 ARCHIVES GEN. PSYCHIATRY 593, 593 (2005).

somehow exempt from these larger trends. Among a sample of Latino adolescents—93 percent of whom were not US citizens—31 percent displayed clinical or subclinical levels of anxiety and 18 percent exhibited symptoms of depression.⁴² Indeed, as the American Academy of Pediatrics has recognized, “the urgency of [undocumented] children’s mental health needs is secondary only to their legal needs.”⁴³

Although there are some genetic risk factors for mental illness,⁴⁴ environmental stressors contribute significantly to its manifestation.⁴⁵ Such stressors frequently accompany the migration experience. For instance, one meta-study of forcibly displaced children identified the following risk factors for reduced mental health outcomes: being female, being exposed to violence either before or after migration, migrating without adult accompaniment, feeling discriminated against by citizens of the host country, changing addresses multiple times in the host country, having a parent with psychological problems, being raised in a single-parent household, and having a parent who has been exposed to violence.⁴⁶

⁴² KRISTA M. PERREIRA & CATINCA BUCSAN, CAROLINA POPULATION CTR., *LATINO IMMIGRANT PARENTS: ACCESSING MENTAL HEALTH SERVICES FOR THEIR ADOLESCENTS I* (2008). Although this study did not separate undocumented immigrants from immigrants more generally, *see id.* at 8, it is unlikely that the stress levels of undocumented adolescents would be lower.

⁴³ Peter Cooch & Fukuda Yasuko, *Resolution: Addressing the Legal and Mental Health Needs of Undocumented Immigrant Children*, AM. ACAD. PEDIATRICS – CAL. CHAPTER 1 (Nov. 24, 2014), https://www.aapca1.org/sites/aapca1/files/u34/final_resolution_-_addressing_the_legal_and_mental_health_needs_of_undocumented_immigrant_children.pdf. The American Academy of Pediatrics’ leadership selected this resolution as the organization’s top priority for 2015. *See* Melissa Jenco, *Needs of Undocumented Children Tops AAP Annual Leadership Forum Resolution List*, AM. ACAD. PEDIATRICS – D.C. CHAPTER, <http://www.aapdc.org/newsletter/2015.04.01.html#update8> (last visited Sept. 23, 2015).

⁴⁴ *See, e.g., Five Major Mental Disorders Share Genetic Roots*, NAT’L INST. MENTAL HEALTH (Mar. 1, 2013), <https://www.nimh.nih.gov/news/science-news/2013/five-major-mental-disorders-share-genetic-roots.shtml>.

⁴⁵ *See* Charles W. Schmidt, *Environmental Connections: A Deeper Look into Illness*, 115 ENVTL. HEALTH PERSPECTIVES A404 (2007).

⁴⁶ Mina Fazel et al., *Mental Health of Displaced and Refugee Children Resettled in High-Income Countries: Risk and Protective Factors*, 379 LANCET 250, 260 tbl.4 (2012).

While Central American children fleeing threats from murderous gangs can aptly be described as forced migrants, even those children whose migrations were somewhat voluntary still likely confront many of the risk factors identified in this study. Children who migrated without their families typically experienced high levels of poverty and violence in their countries of origin;⁴⁷ this experience is strongly correlated with poorer mental health outcomes.⁴⁸ Moreover, the migration itself is frequently a traumatic experience—something recognized by caseworkers who provide sponsors with information regarding post-traumatic stress before releasing unaccompanied children into sponsors’ custody.⁴⁹ Sources of trauma include sexual assault and the fear and experience of being victimized by smugglers, gangs, or government officials.⁵⁰ Children’s ambivalence about the decision to migrate can also lower their resilience to these shocks.⁵¹

Stressors do not cease once children arrive in the United States. Children may be “despondent about being apprehended by immigration officials.”⁵² Children who have been separated from their parents may have difficulty trusting parents from whom they are estranged or by whom they feel abandoned.⁵³ Although poverty may be less desperate than that in their

The article also identified some protective factors: “high parental support and family cohesion,” “self-reported support from friends,” “self-reported positive school experience,” and “same ethnic-origin foster care.” *Id.*

⁴⁷ See *supra* notes 12-16 and accompanying text.

⁴⁸ Laura Pacione et al., Int’l Ass’n for Child & Adolescent Mental Health, *The Mental Health of Children Facing Collective Adversity: Poverty, Homelessness, War, and Displacement*, in IACAPAP TEXTBOOK OF CHILD AND ADOLESCENT MENTAL HEALTH (Joseph M. Rey ed., 2015) (e-book), <http://iacapap.org/wp-content/uploads/J.4-POVERTY-072012.pdf>.

⁴⁹ See, e.g., Saslow, *supra* note 2 (describing a packet of information on post-traumatic stress given to a parent of an unaccompanied minor by a caseworker before the minor was released into her custody).

⁵⁰ See *supra* text accompanying notes 27-31.

⁵¹ See CHILDREN ON THE RUN, *supra* note 1, at 20 (noting that children may have conflicting emotions regarding their decision to migrate).

⁵² See *id.*

⁵³ See Suárez-Orozco et al., *supra* note 18, at 449; Saslow, *supra* note 2.

country of origin, unaccompanied children in the United States are generally placed with parents or other family members who, as immigrants themselves, typically have a lower income than comparably situated nonimmigrants.⁵⁴ Poor families often live in more violent, segregated, and under-resourced communities.⁵⁵ If the child's parents are also undocumented, then the fear of having his or her parents taken away can produce a debilitating insecurity that manifests as anxiety and depression.⁵⁶ If undocumented parents are detained by immigration authorities, their children experience trauma not only as a result of the separation but also from the financial burden inflicted by a breadwinner's incarceration.⁵⁷ If those parents are subsequently deported, "the impact . . . is devastating to both the physical and mental health of these children."⁵⁸ For children,

⁵⁴ See Judith Gans, HOUSEHOLD INCOME, POVERTY, AND FOOD-STAMP USE IN NATIVE-BORN AND IMMIGRANT HOUSEHOLDS: A CASE STUDY IN USE OF PUBLIC ASSISTANCE 4 (2013) (indicating that at all income levels, immigrant household income lags behind that of native households); see also Maria Pabón López, *Reflections on Educating Latino and Latina Undocumented Children: Beyond Plyler v. Doe*, 35 SETON HALL L. REV. 1373, 1380-81 (2005) (discussing the particular challenges faced by children of migrants, which include "severe poverty, inadequate housing, and 'the stigma of being a migrant'" (quoting Michael A. Olivas, *Storytelling Out of School: Undocumented College Residency, Race, and Reaction*, 22 HASTING CONST. L.Q. 1019, 1081 (1995))).

⁵⁵ Suárez-Orozco et al., *supra* note 18, at 448.

⁵⁶ See Kari Lydersen, *Fear and Trauma: Undocumented Immigrants and Mental Health*, INST. FOR JUST. & JOURNALISM (Apr. 24, 2013), <http://justicejournalism.org/whiteboard/fear-trauma-uncertainty-undocumented-immigrants-and-mental-health/>; see also López, *supra* note 54, at 1380-81 (describing how the fear of deportation can be exacerbated by state policies that encourage public school employees to report undocumented youth to federal authorities); Suárez-Orozco et al., *supra* note 18, at 443 (describing the "daily nightmare of knowing their parents may be swept away any time").

⁵⁷ See Kris Anne Bonifacio, *Undocumented Youth Struggle with Anxiety, Depression*, YOUTH PROJECT (Jan. 25, 2013), <http://www.chicago-bureau.org/undocumented-youth-struggle-with-anxiety-depression/>.

⁵⁸ Nikki Smith, *Children's Rights Nationally and Internationally During the Deportation of Their Parents or Themselves: Does the Right to Sovereignty Trump the Best Interests of the Child?*, 5 CRIT 1, 36 (describing negative psychological effects of this experience, including fear, frequent crying, withdrawal, and aggression, and how these worsen with increased separation).

keeping their undocumented status a secret and suppressing their native culture produces psychological stress, while the status itself isolates children from social rituals such as getting a driver's license.⁵⁹ If parents attempt to shield their children from this stress, the psychological damage caused when children suddenly discover that they themselves are undocumented mirrors "the displacement felt by persons who had to physically move."⁶⁰

Additionally, undocumented youth from Central America must face the daily stress of racial discrimination,⁶¹ compounded by the "barrage of derogatory portraits of immigrants, particularly of unauthorized immigrants, in the media, school, and community settings."⁶² Thus, for undocumented children, particularly those who arrived unaccompanied, "the slow-burn effects of being unauthorized in the [United States] are piled on top of the post-traumatic stress disorder and other mental health impacts sparked by traumatic experiences suffered in coming to the [United States]."⁶³ Because there is a positive correlation between the frequency of adverse experiences and the negative health effects associated with those experiences,⁶⁴ a child

⁵⁹ See Suárez-Orozco et al., *supra* note 18, at 443-44, 453-56.

⁶⁰ Ragini Shah, *Sharing the American Dream: Towards Formalizing the Status of Long-term Resident Undocumented Children in the United States*, 39 COLUM. HUM. RTS. L. REV. 637, 669-70 (2008) ("Psychiatrists, working closely with undocumented youth, indicate a disturbing pattern of emotional difficulties that directly results from a young person hearing the news that he lacked lawful status."). Such deception would be possible, for instance, if the child came to the United States when very young.

⁶¹ See, e.g., Shelly P. Harrell, *A Multidimensional Conceptualization of Racism-Related Stress: Implications for the Well-Being of People of Color*, 70 AM. J. ORTHOPSYCHIATRY 42 (2000) (collecting studies analyzing racism-related stress); see also Sarah L. Szanton et al., *Racial Discrimination Is Associated with a Measure of Red Blood Cell Oxidative Stress: A Potential Pathway for Racial Health Disparities*, 19 INT'L J. BEHAVIORAL HEALTH 489 (2012) (postulating a cellular pathway through which the stress of racial discrimination can produce observed health disparities between African-American and white populations).

⁶² Suárez-Orozco et al., *supra* note 18, at 450.

⁶³ Lydersen, *supra* note 56; see generally Suárez-Orozco et al., *supra* note 18 (characterizing this stress as the "duress of liminality" or in-between-ness).

⁶⁴ Fazel et al., *supra* note 46, at 279.

who arrives in the United States unaccompanied likely needs mental health support.⁶⁵

All too often, this need goes unmet.⁶⁶ Undocumented youth are ineligible for Medicaid and CHIP, even if they are income-qualified.⁶⁷ They typically lack health insurance⁶⁸—even children eligible for DACA are excluded from the federal Health Insurance Marketplace and from most state exchanges.⁶⁹ In the absence of insurance or government funding, the high cost of health care is a significant financial barrier.⁷⁰ Even when money is available, inadequate language services may prevent undocumented youth in need from accessing care.⁷¹ Finally, fear of having a family member’s immigration status reported by a health care provider, although a very rare

⁶⁵ Suárez-Orozco et al., *supra* note 18, at 461 (“[T]he effects of unauthorized status on development across the lifespan are uniformly negative, with millions of [US] children and youth at risk of lower educational performance, economic stagnation, blocked mobility, and ambiguous belonging. In all, the data suggest an alarming psychosocial formation.”).

⁶⁶ See Lindsay Pérez Huber, “*Como Una Jaula De Oro*” (*It’s Like a Golden Cage*): *The Impact of DACA and the California Dream Act on Undocumented Chicanas/Latinas*, 39 CHICANA/O-LATINA/O L. REV. 91, 122 (2015) (“Most participants identified access to healthcare as a concern for themselves and their communities.”). As one participant in the study noted, “a lot of our peers and colleagues were undocumented. We always knew we were dealing with a lot of health issues from physical to mental, to just overall well-being and we realized that we didn’t have access.” *Id.* at 123.

⁶⁷ See *infra* Section III(C).

⁶⁸ See Bonifacio, *supra* note 57.

⁶⁹ *Health Care and DACA Deferred Action*, NAT’L IMMIGR. L. CTR., <http://www.nilc.org/acadacafaq.html> (last visited Oct. 6, 2015).

⁷⁰ See Bonifacio, *supra* note 57 (noting as well the obstacle posed by waiting lists for mental health services at local clinics).

⁷¹ PERREIRA & BUCSAN, *supra* note 42, at 15 (reporting that 61 percent of Latino parents with limited English skills indicated “that it was very important that providers speak their language”). Although the federal government has interpreted Title VI of the Civil Rights Act as requiring a provision of services for patients with limited English proficiency, language access continues to be spotty, particularly at non-hospital sites. See generally Alice Hm Chen et al., *The Legal Framework for Language Access in Healthcare Settings: Title VI and Beyond*, 22 (Supp.) J. GEN. INTERNAL MED. S362 (2007).

occurrence, discourages some parents from seeking services for their children.⁷²

The consequences of leaving mental trauma unaddressed can be dire. Because children suffering from PTSD display reduced activity in brain areas associated with recall,⁷³ they have lower academic performance and an increased risk of dropping out of school.⁷⁴ If left unaddressed, trauma can develop into more serious forms of mental illness.⁷⁵ Consequences of serious mental illnesses include “high rates of chronic medical problems”⁷⁶ with their associated public health and finance implications. Finally, an undocumented child with a mental illness may make the ultimate decision to take his or her own life—“[o]ver 90 percent of children and adolescents who commit suicide have a mental disorder.”⁷⁷ Access to necessary mental health care reduces the risk that undocumented children will experience the adverse effects of untreated trauma and mental illness.

⁷² Bonifacio, *supra* note 57; Shannon Fruth, Comment, *Medical Repatriation: The Intersection of Mandated Emergency Care, Immigration Consequences, and International Obligations*, 36 J. LEGAL MED. 45, 54 (2015) (“[I]llegal immigrants may delay diagnosis and treatment of communicable diseases, due to fear of detection.” (quoting the Los Angeles County Department of Health Services)).

⁷³ Erin Digitale, *Brain Imaging Shows Kids’ PTSD Symptoms Link Poor Hippocampus Function in Stanford/Packard Study*, STANFORD MED. (Dec. 8, 2009), <https://med.stanford.edu/news/all-news/2009/12/brain-imaging-shows-kids-ptsd-symptoms-linked-to-poor-hippocampus-function-in-stanfordpackard-study.html>.

⁷⁴ See, e.g., OFF. OF SPECIAL EDUC. & REHABILITATIVE SERVICES, U.S. DEP’T EDUC., 35TH ANNUAL REPORT TO CONGRESS ON THE IMPLEMENTATION OF THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT, 2013, at 220 (2014), <http://www2.ed.gov/about/reports/annual/osep/2013/parts-b-c/35th-idea-arc.pdf> (“[A]n estimated one-third of students with ADHD ultimately drop[] out of high school.”).

⁷⁵ See, e.g., Patricia Kerig et al., *Posttraumatic Stress as a Mediator of the Relationship Between Trauma and Mental Health Problems Among Juvenile Delinquents*, 38 J. YOUTH & ADOLESCENCE 1214, 1214-16 (2009).

⁷⁶ Craig W. Colton & Ronald W. Manderscheid, *Congruencies in Increased Mortality Rates, Years of Potential Life Lost, and Causes of Death Among Public Mental Health Clients in Eight States*, PREVENTING CHRONIC DISEASE, Apr. 2006, at 1, 2, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1563985/pdf/PCD32A42.pdf>.

⁷⁷ U.S. PUB. HEALTH SERV., U.S. DEP’T OF HEALTH & HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 150 (1999), <http://profiles.nlm.nih.gov/ps/access/NNBBJC.pdf>.

III. TOOLS TO PROVIDE MENTAL HEALTH CARE TO UNDOCUMENTED IMMIGRANT CHILDREN

The tools already exist in the government's arsenal to address the significant risk posed by the poor mental health status of many undocumented children: Medicaid and the Children's Health Insurance Program. Together, these programs can provide the mental health coverage these children need.

A. Medicaid

Although the federal government had experimented with funding health care for poor people prior to Medicaid, these early attempts gave states extreme latitude to determine eligibility and benefits.⁷⁸ According to one scholar, the 1965 establishment of Medicaid as part of the War on Poverty signaled a shift that prioritized the health needs of the poor over federalist concerns.⁷⁹ Thus, Medicaid requires states accepting funding to provide a standard package of benefits.⁸⁰ However, Medicaid also continues to give states limited flexibility to set their own eligibility requirements.⁸¹ For instance, in Maryland, children from families earning less than 317 percent of the federal poverty line are income-eligible, while in Alabama, only children from families earning less than 141 percent of the poverty line are eligible.⁸²

⁷⁸ Laura D. Hermer, *Federal/State Tensions in Fulfilling Medicaid's Purpose*, 21 ANNALS HEALTH L. 615, 618 (2012) (describing the Kerr-Mills Act, the predecessor to Medicaid).

⁷⁹ *Id.* at 618-19.

⁸⁰ *Id.*

⁸¹ *Id.*

⁸² See *State Medicaid and CHIP Income Eligibility Standards*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/medicaid-and-chip-eligibility-levels-table.pdf> (last visited Nov. 15, 2015) [hereinafter *Medicaid Eligibility Standards*]. It is worth noting that in Alabama, children from families that earn between 141 percent of the poverty line and 312 percent of the poverty line are income-eligible for CHIP, so in part the distinction is whether a given state chooses to provide services to the near poor through Medicaid or through a separate program. *Id.*

Beyond the instrumental purpose of funneling federal money to “states that choose to reimburse certain costs of medical treatment for needy persons,”⁸³ the Medicaid program also shares an aspirational goal with other anti-poverty programs: “providing health care to the indigent in quantity and quality equivalent to the standard of care available to the general population.”⁸⁴ The mere fact a person is undocumented does not make them cease to be indigent and so worthy of participating in this aspirational goal.

Although states may provide additional services, minimum Medicaid benefits include visits to doctors and psychiatrists, laboratory services, short-term hospitalization, and, for children, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT).⁸⁵ EPSDT includes physical exams, immunizations, vision, dental, and hearing services, as well as treatment for conditions discovered during these screening and diagnostic procedures.⁸⁶ Medicaid is “the single largest payer for mental health services in the United States.”⁸⁷ Hence, Medicaid provides children from families with low incomes access to a range of services that would otherwise be unavailable to them.⁸⁸

B. Children’s Health Insurance Program (CHIP)

Complementing Medicaid, CHIP provides health insurance coverage to children from families whose income exceeds Medicaid’s eligibility

⁸³ *Harris v. McRae*, 448 U.S. 297, 301 (1980).

⁸⁴ *Guzman v. Shewry*, 552 F.3d 941, 951 (9th Cir. 2009).

⁸⁵ On the benefits of Medicaid for persons with mental illness, see NAT’L ALLIANCE ON MENTAL ILLNESS, *MEDICAID EXPANSION AND MENTAL HEALTH CARE 2-7* (2013).

⁸⁶ *Early and Period Screening, Diagnostic, and Treatment*, MEDICAID.GOV: KEEPING AM. HEALTHY, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html> (last visited Oct. 8, 2015).

⁸⁷ *Behavioral Health Services*, MEDICAID.GOV: KEEPING AM. HEALTHY, <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/mental-health-services.html> (last visited Sept. 29, 2015).

⁸⁸ See Diane Rowland & Rachel Garfield, *Health Care for the Poor: Medicaid at 35*, 22 HEALTH CARE FINANCING REV. 23, 27 (2000), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/Downloads/00Fallpg23.pdf>.

threshold, but is still insufficient to allow the purchase of insurance on the private market.⁸⁹ For instance, in Illinois, only children from families with incomes below 142 percent of the federal poverty line are eligible for Medicaid, while children from families with incomes between 142 percent and 313 percent of the federal poverty line are eligible for CHIP.⁹⁰ Though the State Children's Health Insurance Program (CHIP) was created in 1997 in response to a health insurance marketplace somewhat different from the one in place today under the Affordable Care Act,⁹¹ CHIP continues to be an important safety net for children of the near poor and working poor.⁹² Unlike Medicaid, which provides individual entitlements, CHIP allows each state to design its own program as either an entitlement or a discretionary benefit.⁹³ The greater flexibility allows states to elect to charge co-pays or to place additional restrictions on benefits.⁹⁴

C. Current Limitations on Immigrants' Access to Medicaid and CHIP

Although the act creating Medicaid did not address the eligibility of noncitizens, later statutes limited Medicaid's availability.⁹⁵ In 1986, Congress amended the Medicaid statutes to restrict noncitizens' eligibility;

⁸⁹ See Janet L. Dolgin, *Class Competition and American Health Care: Debating the State Children's Health Insurance Program*, 70 LA. L. REV. 683, 698-708 (2010) (providing a detailed explanation of how the program works).

⁹⁰ *Medicaid Eligibility Standards*, *supra* note 82.

⁹¹ See Dolgin, *supra* note 89, at 698-700.

⁹² See Robin Rudowitz et al., *Children's Health Coverage: Medicaid, CHIP, and the ACA*, HENRY J. KAISER FAMILY FOUND. (Mar. 26, 2014), <http://kff.org/health-reform/issue-brief/childrens-health-coverage-medicare-chip-and-the-aca/>.

⁹³ See *id.* at 700-02. An entitlement program creates a right to participate for eligible individuals, whereas a discretionary benefit program allows states to cap enrollments below the number of eligible participants. *Id.*

⁹⁴ Rudowitz et al., *supra* note 92.

⁹⁵ Sana Loue, *Access to Health Care and the Undocumented Immigrant*, 13 J. LEGAL MED. 271, 288 (1992) [hereinafter Loue, *Undocumented Immigrant*]; Seo, *supra* note 5, at 145-47; see also Sana Loue, *Immigrant Access to Health Care and Public Health: An International Perspective*, 17 ANNALS HEALTH L. 213, 224-26 (2008), <http://lawcommons.luc.edu/cgi/viewcontent.cgi?article=1125&context=annals> (criticizing statutory limitations on the provision of health care to international migrants).

only “lawfully admitted permanent resident aliens and aliens permanently residing in the states under the color of law” could participate.⁹⁶ The latter category included individuals whose presence in the United States was known to immigration officials, but who were unlikely to face deportation.⁹⁷ However, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 stripped these immigrants of eligibility,⁹⁸ declaring that it is a “compelling government interest to remove the incentive for illegal immigration provided by the availability of public benefits.”⁹⁹

Thus, under current law, to qualify for Medicaid or CHIP, a person must be a citizen or a “qualified alien.”¹⁰⁰ “Qualified aliens” include lawful permanent residents, asylees, refugees, domestic violence victims, humanitarian parolees, and immigrants who cannot be removed due to a threat to the immigrant’s life or liberty in his or her country of origin.¹⁰¹ Most immigrants, even those lawfully present, must wait five years after obtaining qualified status before becoming Medicaid-eligible.¹⁰² However, in some states, pregnant women can receive a form of CHIP for prenatal

⁹⁶ Loue, *Undocumented Immigrant*, *supra* note 95, at 288 (citing Act of Oct. 21, 1986, Pub. L. No. 99-509, § 9406, 100 Stat. 1874, 2057 (amending 42 U.S.C. § 1396b)).

⁹⁷ See Michael K. Gusmano, *Undocumented Immigrants in the United States: U.S. Health Policy and Access to Care*, UNDOCUMENTED PATIENTS: UNDOCUMENTED IMMIGRANTS & ACCESS TO HEALTH CARE (Oct. 3, 2012), <http://www.undocumentedpatients.org/issuebrief/health-policy-and-access-to-care/>.

⁹⁸ 8 U.S.C. § 1611(a) (2012).

⁹⁹ *Id.* § 1601(6).

¹⁰⁰ *See id.* §§ 1611(a), 1641.

¹⁰¹ *Id.* § 1641 (qualified alien definition and exceptions).

¹⁰² *Id.* § 1613(a) (imposing the five year residency requirement for means-tested benefits); 42 U.S.C. § 1396a(a)(10) (2012) (making Medicaid eligibility contingent on family income). In some circumstances, states can offer benefits to income-eligible “qualified aliens” before the five-year mark has arrived, provided that only state funds are used. See AJAY CHAUDRY & KARINA FORTUNY, OFFICE OF THE ASSISTANT SEC’Y FOR PLANNING & EVALUATION, U.S. DEP’T OF HEALTH & HUMAN SERVS., OVERVIEW OF IMMIGRANTS’ ELIGIBILITY FOR SNAP, TANF, MEDICAID, AND CHIP 3-6 (2012), <http://aspe.hhs.gov/sites/default/files/pdf/76426/ib.pdf>. Additionally, certain vulnerable immigrants such as refugees may receive Medicaid for seven years beginning upon receipt of legal status. 8 U.S.C. § 1612(b) (2012).

care.¹⁰³ Additionally, undocumented immigrants, as well as other immigrants who have yet to reach the five-year mark, are eligible for emergency Medicaid services.¹⁰⁴

This emergency Medicaid exception is quite narrow, applying only when withholding medical treatment is reasonably likely to “result in placing the patient’s health in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.”¹⁰⁵ At a practical level, this becomes a question of whether hospitals can be reimbursed for providing the services,¹⁰⁶ since the Emergency Medical Treatment and Labor Act requires any hospital with an emergency department to provide emergency treatment regardless of a patient’s ability to pay.¹⁰⁷

IV. ARGUMENTS FOR PROVIDING MENTAL HEALTH CARE TO UNDOCUMENTED CHILDREN THROUGH MEDICAID

Because Medicaid and CHIP are such useful tools for providing necessary mental health care to undocumented youth, I propose two arguments for making undocumented children eligible for these programs. First, applying the equal protection analysis appropriate for undocumented immigrant children found in *Plyler v. Doe*¹⁰⁸ reveals a constitutional imperative for extending the mental health care available to citizens and permanent residents to undocumented immigrant children. Second, extending eligibility for this benefit to undocumented children supports two key US policies: reinforcing the conditions necessary for advancement

¹⁰³ See, e.g., LA. ADMIN CODE tit. 50, pt. III, § 20301 (providing LaCHIP for pregnant noncitizens).

¹⁰⁴ 8 U.S.C. § 1611(b)(1)(A) (2012).

¹⁰⁵ 42 U.S.C. § 1396b(v)(2)-(3) (2012).

¹⁰⁶ *Id.* § 1396b; see Fruth, *supra* note 72, at 54-56 (discussing difficulties medical providers face in receiving reimbursement for emergency care provided to undocumented immigrants).

¹⁰⁷ Federal Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd (2012).

¹⁰⁸ See *Plyler v. Doe*, 457 U.S. 202 (1982); see *infra* Section IV(A)(1).

based on individual merit and protecting minors' legal entitlement to be cared for by adults and society at large.

A. The Constitutional Argument

1. The Promise of *Plyler v. Doe*

The Equal Protection Clause applies to undocumented immigrants, including children.¹⁰⁹ Though equal protection is explicitly guaranteed in the Fourteenth Amendment only, the Due Process Clause of the Fifth Amendment “contains within it the prohibition against denying to any person the equal protection of the laws.”¹¹⁰ The Due Process Clause protects all persons, even undocumented persons.¹¹¹ Thus, if a federal law distinguishing between youth with legal status and youth without such status violates equal protection, the law must fall. A law triggers application of the Equal Protection Clause when (1) it treats one group differently from another group or (2) when it is adopted for the purpose of discriminating against a certain group and impacts that group more than another group.¹¹² If this first test is satisfied, a court then applies the requisite standard of scrutiny to evaluate the law's constitutionality.¹¹³ Strict scrutiny—generally reserved for classifications based on race or national origin or for circumstances in which fundamental rights are affected—requires that the challenged law be necessary to achieve a compelling governmental

¹⁰⁹ See *Graham v. Richardson*, 403 U.S. 365, 375 (1971); see also *Plyler*, 457 U.S. at 214-16 (tracing the legislative history of the Fourteenth Amendment to show that it applies to undocumented persons as well as persons lawfully present in the state).

¹¹⁰ *United States v. Windsor*, 133 S. Ct. 2675, 2695 (2013) (citing *Bolling v. Sharpe*, 347 U.S. 497-500 (1954)).

¹¹¹ *Mathews v. Diaz*, 426 U.S. 67, 77 (1976).

¹¹² See *Palmore v. Sidoti*, 466 U.S. 429 (1984) (holding that a state court practice of denying a parent custody of a child because the parent had married a person of a different race was unconstitutional); *Washington v. Davis*, 426 U.S. 229, 239 (1976).

¹¹³ Compare *F.C.C. v. Beach Comm'ns*, 508 U.S. 307, 313 (1993) (applying rational basis review for questions of “social and economic policy”), with *Fisher v. Univ. of Tex. at Austin*, 136 S. Ct. 2198, 2210 (2016) (requiring an affirmative action program to satisfy strict scrutiny).

interest.¹¹⁴ Intermediate scrutiny—used for classifications based on gender and nonmarital birth—requires that a challenged law be substantially related to an important government purpose.¹¹⁵ Finally, the rational basis test—used when neither a suspect class requiring strict scrutiny or a quasi-suspect class requiring intermediate scrutiny is involved—requires only that the law be rationally related to a legitimate state interest.¹¹⁶

By denying income-qualified undocumented children access to mental health services that are made available to citizens or children who have entered the country with proper authorization, federal law clearly treats these two groups differently. Since undocumented immigrants are neither a suspect class nor a quasi-suspect class, strict scrutiny and intermediate scrutiny do not apply.¹¹⁷ Applying rational basis review, the Supreme Court held that requiring immigrants to have lawfully resided in the United States for five years before receiving Medicare was not an equal protection violation because it was reasonable to distinguish between different groups of immigrants on the basis of duration of residency.¹¹⁸ By analogy, it would seem likely that the Court would apply rational basis review to a statute that distinguishes between authorized and unauthorized immigrants for Medicaid eligibility purposes.

¹¹⁴ See, e.g., *Palmore*, 466 U.S. at 432-33.

¹¹⁵ See, e.g., *Craig v. Boren*, 429 U.S. 190, 197 (1976).

¹¹⁶ See, e.g., *Mass. Bd. of Retirement v. Murgia*, 427 U.S. 307, 313-315 (1976) (per curiam).

¹¹⁷ See *Plyler v. Doe*, 457 U.S. 202, 223 (1982) (“Undocumented aliens cannot be treated as a suspect class, because their presence in this country in violation of federal law is not a ‘constitutional irrelevancy.’”). While legally-present noncitizens generally are a suspect class, see *Graham v. Richardson*, 403 U.S. 365, 367 (1971), the Court applies only rational basis review when the law in question affects the democratic process, see, e.g., *Cabell v. Chavez-Salido*, 454 U.S. 432 (1982), or when Congress or the President has expressly approved the discrimination, see, e.g., *Matthews v. Diaz*, 426 U.S. 71, 81, 85 (1976). In addition, as discussed below, the Court appears to suggest that a standard somewhat above that of ordinary rational basis, though below intermediate scrutiny, applies when a law discriminates against undocumented children. See *Plyer*, 457 U.S. at 224; see *infra* text accompanying notes 126-28.

¹¹⁸ *Diaz*, 426 U.S. at 69, 82-83.

However, when reviewing statutes affecting children, the Supreme Court has regularly subjected them to a less deferential standard of scrutiny than it might employ when reviewing statutes regulating the conduct of adults.¹¹⁹ Thus, in a series of landmark cases in the 1960s and 1970s, the Court extended equal protection doctrine to shield children born out of wedlock from the vindictiveness of state legislatures.¹²⁰ As a result of these cases, laws distinguishing between children based on their parents' marital status are now subject to intermediate scrutiny.¹²¹ Although the logic justifying intermediate scrutiny for laws regarding so-called illegitimate children (i.e., that they are not responsible for their parents' "sins") should apply with equal force to the noncitizen children of undocumented immigrants, the Court, in its reluctance to increase the number of suspect and quasi-suspect classes,¹²² has not taken this approach. Rather, in *Plyler v. Doe*, the Court applied a somewhat heightened form of rational basis review to strike down a Texas law that discriminated against undocumented children.¹²³

¹¹⁹ See, e.g., *Clark v. Jeter*, 486 U.S. 456, 461 (1988) (“[W]e have invalidated classifications that burden illegitimate children for the sake of punishing the illicit relations of their parents, because ‘visiting the condemnation on the head of an infant is illogical and unjust.’” (quoting *Weber v. Aetna Cas. & Sur. Co.*, 406 U.S. 164, 175 (1972))).

¹²⁰ See *Jimenez v. Weinberger*, 417 U.S. 628 (1974); *N.J. Welfare Rights Org. v. Cahill*, 411 U.S. 619 (1973); *Gomez v. Perez*, 409 U.S. 535 (1972); *Weber*, 406 U.S. 164; *Levy v. Louisiana*, 391 U.S. 68 (1968). *But see Mathews v. Lucas*, 427 U.S. 495 (1976) (upholding under intermediate scrutiny a classification that only certain nonmarital children are presumed dependent).

¹²¹ See *Clark*, 486 U.S. at 461-63.

¹²² See, e.g., *Thomasson v. Perry*, 80 F.3d 915, 928 (4th Cir. 1996) (citing *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 441 (1985) (rejecting application of strict scrutiny to the intellectually disabled; *Lyng v. Castillo*, 477 U.S. 635, 638 (1986) (rejecting application of strict scrutiny to “[c]lose relatives”); *Murgia*, 427 U.S. at 313 (rejecting application of strict scrutiny to the elderly)) (“[B]ecause heightened scrutiny requires an exacting investigation of legislative choices, the Supreme Court has made clear that ‘respect for the separation of powers’ should make courts reluctant to establish new suspect classes.”).

¹²³ *Plyler*, 457 U.S. at 224. This heightened form is somewhat akin to the rational basis with bite standard used by the Court in cases in which animus motivated the statute at issue. See *Romer v. Evans*, 517 U.S. 620 (1996) (animus against gays, lesbians, and bisexuals); *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432 (1985) (animus

The Texas statute at issue in *Plyler* withheld state per capita funds from school districts for any students who had not been “legally admitted” into the United States.¹²⁴ To recover that lost funding, the Tyler Independent School District imposed a “full tuition fee” on undocumented children.¹²⁵ Disturbed by the implications of this law and its potentially devastating effects not only on the children affected but also on society as a whole, the Court altered the traditional rational basis analysis that would merely require that a law be rationally related to a legitimate state interest.¹²⁶ Instead, the Court concluded that when a statute denies services to undocumented children and those services are needed for children to become productive adults, that denial must further a *substantial* state interest.¹²⁷ To develop this heightened standard, the Court balanced the facts that undocumented youth are not a suspect class and education is not a fundamental right against four factors: (1) a lack of education imposes a “lifetime hardship” on undocumented children, (2) children are not responsible for their undocumented status, (3) children need education to be able to participate in civic life, and (4) children need education to be able to contribute economically.¹²⁸ The greater weight of these factors justified the Court’s heightened form of scrutiny.

To determine whether Texas had a substantial interest in denying a basic education to undocumented children, the *Plyler* Court weighed the interests the state asserted for not educating these children against the interests that

against the intellectually disabled); *U.S. Dep’t of Agric. v. Moreno*, 413 U.S. 528 (1973) (animus against “hippies”).

¹²⁴ *Plyler*, 457 U.S. at 205.

¹²⁵ *Id.* at 206 n.2.

¹²⁶ *See, e.g., City of New Orleans v. Dukes*, 427 U.S. 297, 303 (1976) (“Unless a classification trammels fundamental personal rights or is drawn upon inherently suspect distinctions such as race, religion, or alienage, our decisions presume the constitutionality of the statutory discriminations and require only that the classification challenged be rationally related to a legitimate state interest.”).

¹²⁷ *Plyler*, 457 U.S. at 224.

¹²⁸ *Id.* at 223-24.

would accrue to society by educating them.¹²⁹ Texas first argued that because undocumented children are present in the country in violation of a congressional scheme, it has a rational basis for denying them an education.¹³⁰ Texas further asserted interests in preserving its resources and in deterring illegal immigration out of a concern for the state economy and the availability of employment.¹³¹ Against these interests, the Court weighed the significant contributions of undocumented immigrants to the economy and their underutilization of public services.¹³² Because undocumented children are not responsible for their status and because “many of the undocumented children will remain in this country indefinitely, and . . . some will become lawful residents or citizens of the United States,” the Court further found that the state and the nation would incur greater costs if these children remained illiterate and less able to contribute to society.¹³³ As a result, the Court concluded that Texas’s denial of public education to undocumented children was unjustified by a substantial interest and so failed to withstand constitutional scrutiny.¹³⁴

2. Applying *Plyler* to Mental Health Coverage

The heightened standard applicable to the education of undocumented children should also apply to health care. Undocumented youth are still not a suspect class, and health care is not a fundamental right protected by the Due Process Clause.¹³⁵ However, as *Plyler* notes, undocumented youth are

¹²⁹ *See id.* at 224-30.

¹³⁰ *See id.* at 224-26.

¹³¹ *See id.* at 227-30.

¹³² *Id.* at 228.

¹³³ *Id.* at 227, 230.

¹³⁴ *Id.* at 230.

¹³⁵ *Cf. id.* at 223. Indeed, when the Supreme Court has treated health care, it has notably avoided analyzing health care as a freestanding right. *See King v. Burwell*, 135 S. Ct. 2480 (2015) (upholding the tax premium portion of the ACA on the basis of statutory analysis); *Nat’l Federation of Indep. Business v. Sebelius*, 132 S. Ct. 2566 (analyzing the Affordable Care Act under the taxing power, the Spending Clause, and the Commerce Clause); *Memorial Hosp. v. Maricopa Cty.*, 415 U.S. 250, 269-70 (applying *Shapiro v.*

not responsible for their status.¹³⁶ Moreover, poor mental health during childhood reduces overall life outcomes,¹³⁷ thereby inhibiting undocumented children's ability to become productive members of American society. To deprive undocumented youth of a service necessary for their growth and development, the government must show that this deprivation furthers a substantial government interest.¹³⁸ Interests in deterring unauthorized immigration and protecting scarce government resources are not substantial when balanced against the harms inflicted on children denied access to mental health care. Even if a court were to find these government interests substantial, denying Medicaid coverage that would provide mental health care to undocumented youth would not suitably further the government's interests.

a. Substantial Interests are Not Served by Denying Mental Health Coverage to Undocumented Youth

The two interests for denying mental health coverage to undocumented youth that the federal government would most likely assert are the same as those Texas asserted in *Plyler*: conserving resources and deterring illegal immigration.¹³⁹ There is precedent for each interest being a valid, and

Thompson, 394 U.S. 618 (1969), *overruled in part by* Edelman v. Jordan, 415 U.S. 651 (1974), to hold that a duration-of-residency requirement for free medical care provided by a county violated the right to interstate travel).

¹³⁶ *Plyler*, 457 U.S. at 223; *see also* Suárez-Orozco et al., *supra* note 18, at 440.

¹³⁷ Colton & Manderscheid, *supra* note 76, at 7 (reporting increased rates of chronic medical problems among persons with serious mental illness); JOE PARKS ET AL., NAT'L ASS'N ST. MED. MENTAL HEALTH DIRECTORS, MORBIDITY AND MORTALITY IN PEOPLE WITH SERIOUS MENTAL ILLNESS (2006), <http://nasmhpd.org/sites/default/files/Mortality%20and%20Morbidity%20Final%20Report%202008.18.08.pdf> ("People with serious mental illness . . . die, on average, 25 years earlier than the general population."); *see also* Sarah Miller & Laura Wherry, The Long-Term Health Effects of Early Life Medicaid Coverage 4 (July 15, 2014) (unpublished manuscript), http://www-personal.umich.edu/~mille/MillerWherry_Prenatal2014.pdf.

¹³⁸ *See Plyler*, 457 U.S. at 224.

¹³⁹ *See* LeClerc v. Webb, 419 F.3d 405, 420 (5th Cir. 2005); *see also Plyler*, 457 U.S. at 227-30.

possibly substantial, one.¹⁴⁰ A state's preservation of its financial stability is a "valid interest."¹⁴¹ When treating unauthorized immigration, one court recently suggested that states are validly concerned about "their own resources being drained by the constant influx of illegal immigrants into their respective territories."¹⁴² Additionally, the federal government has a legitimate interest in discouraging undocumented immigration.¹⁴³

However, as the Court did in *Plyler*, these interests must be balanced against those of the undocumented children to determine whether the government's interests are substantial.¹⁴⁴ Despite the costs to the federal government and the states in providing mental health care to undocumented children and the federal government's undeniable interest in disincentivizing unauthorized immigration, the balance weighs in favor of funding mental health care for low-income undocumented children. Providing mental health care to undocumented youth addresses the potential trauma of their experience and reduces the impact that trauma will have on

¹⁴⁰ See *Sure-Tan, Inc. v. NLRB*, 467 U.S. 883, 903 (1984) (finding that "detering unauthorized immigration" is as important a Congressional objective as ensuring fair labor practices); *Shapiro v. Thompson*, 394 U.S. 618, 633 (1969) ("We recognize that a State has a valid interest in preserving the fiscal integrity of its programs."), *overruled in part on other grounds by Edelman v. Jordan*, 415 U.S. 651 (1974).

¹⁴¹ *Shapiro*, 394 U.S. at 633.

¹⁴² *Texas v. United States*, 86 F. Supp. 3d 591, 672 (S.D. Tex.) (holding that Texas had demonstrated a substantial likelihood of success on the merits of whether the Deferred Action for Parents of Childhood Arrivals (DAPA) program and an expansion of the DACA program were subject to notice and comment under the APA), *stay denied by* 787 F.3d 733 (5th Cir. 2015) *and aff'd*, 809 F.3d 134 (5th Cir. 2015), *aff'd by an equally divided court*, 136 S. Ct. 2271 (2016). *But cf.* *Graham v. Richardson*, 403 U.S. 365, 376 (1971) (holding that, in the context of legal immigration, the "justification of limiting expenses is particularly inappropriate and unreasonable when the discriminated class consists of aliens" (quoting *Leger v. Sailer*, 321 F. Supp. 250, 253 (E.D. Pa. 1970))).

¹⁴³ *Cf. Sure-Tan*, 467 U.S. at 903 (finding that "detering unauthorized immigration" is as important a Congressional objective as ensuring fair labor practices); *see also LeClerc*, 419 F.3d at 420 (suggesting that states have a valid interest in deterring illegal immigration).

¹⁴⁴ *Plyler*, 457 U.S. at 224-30; *see supra* text accompanying notes 129-34.

their subsequent physical and mental health.¹⁴⁵ A healthy and mentally stable population is more prepared to engage with civil society.¹⁴⁶ Moreover, since unaddressed mental health needs all too frequently lead to extended (and therefore expensive) contacts with the criminal justice system in the form of pre-trial detentions and incarcerations,¹⁴⁷ society's interest in a smoothly functioning criminal justice system designed to isolate criminals is ill-served when many of those "criminals" are simply mentally ill individuals swept up in that system.¹⁴⁸ Finally, because individuals with unaddressed mental health needs often lead impoverished and unstable lives,¹⁴⁹ these individuals utilize emergency social services (e.g., crisis

¹⁴⁵ See, e.g., Stephanie J. Dallam, *The Long-Term Medical Consequences of Childhood Trauma*, in *THE COST OF CHILDHOOD MALTREATMENT: WHO PAYS? WE ALL DO* (K. Franey et al. eds., 2001), <http://www.leadershipcouncil.org/1/res/dallam/4.html> (describing the medical consequences of childhood trauma).

¹⁴⁶ M. David Low et al., *Can Education Policy be Health Policy? Implications of Research on the Social Determinants of Health*, 30 *J. HEALTH POL. POL'Y & L.* 1131, 1147 (2005).

¹⁴⁷ In 2006, the Bureau of Justice Statistics concluded that over half of all inmates in prisons and jails had some sort of mental health problem. DORIS J. JAMES & LAUREN E. GLAZE, *BUREAU JUST. STAT., MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES I* (2006). The percentage of inmates with mental health problems was higher in jails than in prisons, reflecting the role of jails as pre-trial detention facilities for those unable to make bail as well as temporary detention facilities for the mentally ill pending transfer to mental health facilities. See *id.* at 3. Given that only a third of state prisoners and only 17 percent of jail inmates received mental health treatment while incarcerated, see *id.* at 9, the criminal justice system is not providing the services needed by its population, see Christine M. Sarteschi, *Mentally Ill Offenders Involved with the Criminal Justice System: A Synthesis*, *SAGE OPEN*, July-Sept. 2003, at 1 (collecting the results of various studies).

¹⁴⁸ Robert Bernstein & Tammy Seltzer, *Criminalization of People with Mental Illnesses: The Role of Mental Health Courts in System Reform*, 7 *U.D.C. L. REV.* 143, 160 (2003) ("No rational purpose is served by the current system. Public safety is not protected when people who have mental illnesses are needlessly arrested for nuisance crimes or when the mental illness at the root of a criminal act is exacerbated by a system designed for punishment, not treatment."); see generally KIDEUK KIM ET AL., *URBAN INST., THE PROCESSING AND TREATMENT OF MENTALLY ILL PERSONS IN THE CRIMINAL JUSTICE SYSTEM* (2015), <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000173-The-Processing-and-Treatment-of-Mentally-Ill-Persons-in-the-Criminal-Justice-System.pdf>.

¹⁴⁹ See *supra* text accompanying notes 73-77.

services, soup kitchens, and homeless shelters) at a higher rate than do individuals without these unaddressed needs.¹⁵⁰ Because undocumented immigrants remain eligible for these emergency services,¹⁵¹ society will continue to pay a substantial cost for its failure to provide undocumented children with the mental health services necessary to enable them to lead stable and productive adult lives.

Hence, while the federal government can articulate some legitimate reasons for denying Medicaid to undocumented children, when balanced against the long-term benefits to our communities and our public health budgets that will proceed from providing mental health services through Medicaid to these children, these interests do not reach the threshold of “substantial.”

b. Even Assuming that the Government’s Interests are Substantial, Denying Medicaid to Undocumented Youth May Not Further Those Interests.

Under the *Plyler* standard, a law depriving undocumented youth of vital services cannot be “rational unless it furthers some substantial goal.”¹⁵² Because the government’s interest here is not substantial, it is unnecessary to ask whether the denial of Medicaid payments for mental health care furthers that interest. However, assuming that the government’s asserted interest is substantial, it remains uncertain whether such a law suitably furthers interests in deterring unauthorized immigration or conserving fiscal resources. Although denying mental health care to undocumented children will clearly save money in the short term, there is no guarantee that unaddressed mental health needs will not lead to greater utilization of

¹⁵⁰ See, e.g., *Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the United States*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. 2, 5-6, 8, http://homeless.samhsa.gov/ResourceFiles/hrc_factsheet.pdf (last updated July 2011).

¹⁵¹ 8 U.S.C. § 1613(c)(2)(G) (2012); see *infra* Section IV(A)(2)(b).

¹⁵² *Plyler v. Doe*, 457 U.S. 202, 224 (1982).

medical, psychiatric, and social services as mental health crises worsen. Furthermore, the denial of government-supported mental health care to undocumented children only deters unauthorized immigration if undocumented adults weigh the unavailability of these services for their children when deciding whether to immigrate. However, there is no evidence that undocumented adults are either leaving their children in their country of origin or electing not to immigrate as a result of the denial of mental health services to undocumented children in the United States.¹⁵³ Their children may not have access to mental health care in their country of origin, so immigrating would produce no net change in a family's access to mental health service. Moreover, the reduction in stress as a result of the potentially greater family income available in the United States may be more valuable from a mental health standpoint than access to mental health professionals.¹⁵⁴ Finally, because misinformation about the legal status of immigrant children in the United States is common,¹⁵⁵ parents in countries of origin may incorrectly assume that care will be available for their children.

3. Addressing Counterarguments

Applying the heightened *Plyler* standard is critical because under rational basis review, a court would likely find that denying Medicaid or CHIP to undocumented immigrant children is rationally related to the government's

¹⁵³ See Emily Ryo, *Deciding to Cross: Norms and Economics of Unauthorized Migration*, 78 AM. SOC. REV. 574, 592 (2013) (indicating as a result of a statistical study of individuals in Mexico that the main variables considered by prospective migrants are "perceived availability of jobs in Mexico, . . . perceived dangers of crossing the border, . . . belief that disobeying the law is sometimes justified, . . . belief that it is okay to migrate illegally in search of economic opportunities beyond basic survival, . . . belief that Mexicans have a right to be in the United States without the U.S. government's permission, and . . . perception that family and friends have tried to migrate illegally.").

¹⁵⁴ See Jitender Sareen et al., *Relationship Between Household Income and Mental Disorders*, 68 ARCHIVES GEN. PSYCHIATRY 419, 422-23 (2011) (finding a correlation between lower income levels and increased incidence of mental illness and suicide in a large-scale population study).

¹⁵⁵ See Rempell, *supra* note 11, at 381-83.

legitimate interests. For instance, the Fifth Circuit Court of Appeals emphasized that under rational basis review “Texas’s legitimate interests—conservation of budget resources and deterrence of illegal immigration—probably would have been sufficient to justify the state’s decision [in *Plyler*] to deny state benefits to illegal entrants and their children.”¹⁵⁶ This pronouncement strongly suggests that under ordinary rational basis review, the federal government’s decision to limit undocumented persons to emergency Medicaid only does not violate equal protection. Conserving resources and deterring unauthorized entry are both legitimate objectives; moreover, “undocumented status is not irrelevant to any proper legislative goal.”¹⁵⁷ Under rational basis review, “legislative choice . . . may be based on rational speculation unsupported by evidence or empirical data.”¹⁵⁸ Thus, a court might uphold the denial of Medicaid since it is conceivable that present savings may be more valuable or that immigrants might consider the availability of mental health care for their children. Hence, some heightened form of review is required if a court is to find denial of Medicaid to undocumented youth to be unconstitutional.

This section will address three potential counterarguments that could be raised in opposition to applying the *Plyler* standard to the denial of Medicaid services to undocumented youth. First, because the law at issue concerns immigration, an area of legislation for which the federal government has unique responsibility,¹⁵⁹ the Fourteenth Amendment analysis conducted by the Court in *Plyler* may not apply. Second, the most pressing needs of undocumented immigrant children may already be protected by the availability of emergency Medicaid and crisis services. Third, Congress has expressed a clear intention to deny certain benefits to

¹⁵⁶ *LeClerc v. Webb*, 419 F.3d 405, 420 (5th Cir. 2005) (discussing *Plyler*).

¹⁵⁷ *Plyler*, 457 U.S. at 220.

¹⁵⁸ *F.C.C. v. Beach Commc’ns, Inc.*, 508 U.S. 307, 315 (1993).

¹⁵⁹ See *Arizona v. United States*, 132 S. Ct. 2492 (2012) (“The National Government has significant power to regulate immigration. With power comes responsibility . . .”).

undocumented immigrants, a factor absent in the circumstances analyzed by the *Plyler* Court.

a. Does the Plyler Standard Constrain the Federal Government or only the States?

First, *Plyler* was decided under the Fourteenth Amendment.¹⁶⁰ On its face, the decision constrains only the states, not the federal government.¹⁶¹ So arguably, the federal government, due to its unique responsibility for immigration, should only have to satisfy ordinary rational basis review.¹⁶² However, Fourteenth Amendment jurisprudence applies to the federal government through the Due Process Clause of the Fifth Amendment.¹⁶³ Moreover, even if the *Plyler* holding itself applies only to state laws, the humanitarian justification behind the decision applies with equal force here and militates heavily in favor of extending *Plyler*'s heightened scrutiny to the ban on providing Medicaid to undocumented children. The *Plyler* Court found that undocumented youth are "special" and "not comparably situated" to undocumented adults.¹⁶⁴ Whether given legislation is state or federal does not affect the inability of children to choose to "remove themselves" from the United States.¹⁶⁵ Hence, the *Plyler* standard should also restrain the federal government when its laws exclude undocumented youth from receiving essential services.

¹⁶⁰ *Plyler*, 457 U.S. at 205.

¹⁶¹ Compare *Graham v. Richardson*, 403 U.S. 365, 376 (1971) (holding that an Arizona statute imposing a residency duration requirement on immigrants before they can receive welfare is unconstitutional) with *Mathews v. Diaz*, 426 U.S. 67, 84-85 (1976) (interpreting *Graham* narrowly and finding that the federal government can impose duration of residency requirements for welfare benefits).

¹⁶² See *Soskin v. Reinertson*, 353 F.3d 1242, 1255 (10th Cir. 2004); *Doe v. Comm'r of Transitional Assistance*, 773 N.E.2d 404, 409 (Mass. 2002) ("Courts apply the rational basis standard in these circumstances because of the scope and nature of congressional authority to regulate immigration.").

¹⁶³ See *United States v. Windsor*, 133 S. Ct. 2675, 2695 (2013) (citing *Bolling v. Sharpe*, 347 U.S. 497-500 (1954)).

¹⁶⁴ *Plyler*, 457 U.S. at 219-20.

¹⁶⁵ *Id.*

b. Is Emergency Mental Health Care Sufficient?

Second, because current Medicaid regulations allow undocumented immigrants to access emergency care, some provision has been made for immigrants' mental health needs.¹⁶⁶ This is thus distinguishable from the complete exclusion from education that motivated the court to craft the heightened scrutiny standard in *Plyler*.¹⁶⁷ Moreover, the Department of Justice has interpreted the prohibition on providing federal and state benefits to undocumented immigrants to exclude "crisis counseling and intervention" and "mental health . . . assistance necessary to protect life or safety."¹⁶⁸ One could argue that these provisions suffice to protect undocumented children.

At the outset, it is unclear whether the emergency provision covers mental health treatment. On its face, the emergency provision applies only to situations where a patient's health is in "serious jeopardy" or there is a reasonable expectation of "serious impairment to bodily functions" or "serious dysfunction of . . . bodily organ[s]."¹⁶⁹ Even if urgent mental health needs to cope with a crisis might be construed to fall under the "serious jeopardy" provision, treatment of an ongoing mental health problem, no matter how severe, seems unlikely to qualify as an emergency under these definitions.

In addition, the Department of Justice has interpreted the emergency services provision to allow undocumented immigrants to access community-based services when necessary to protect "life or safety."¹⁷⁰ Under this interpretation undocumented immigrants could access services

¹⁶⁶ 8 U.S.C. § 1611(b)(1)(A) (2012).

¹⁶⁷ See *Plyler*, 457 U.S. at 223-23.

¹⁶⁸ Final Specification of Community Programs Necessary for Protection of Life or Safety Under Welfare Reform Legislation, 66 Fed. Reg. 3613-02 (Jan. 16, 2001) [hereinafter Specification of Community Programs] (interpreting 8 U.S.C § 1613(c)(2)(G) (2012)).

¹⁶⁹ 42 U.S.C. § 1396b(v)(3) (2012) (defining "emergency medical condition").

¹⁷⁰ 8 U.S.C § 1613(c)(2)(G) (2012) (requiring as well that the services not be means-tested).

necessary to prevent a death from drug overdose or suicide, for instance. While this dispensation suggests some space for some mental health services for undocumented children, the “life or safety” rationale suggests that the services envisioned are crisis services, not the sort of sustained mental health treatment necessary to support quality of life. Moreover, even though this interpretation specifically allows “treatment of mental illness” to continue irrespective of immigration status, this can only occur in settings where no means testing is performed.¹⁷¹ Since this requirement eliminates the possibility of using a sliding-scale fee arrangement, the interpretation excludes many established clinics and other service providers,¹⁷² as well as most providers of psychiatric services (as opposed to counseling services more generally).¹⁷³ This requirement thus limits the scope of this potential exception to the blanket ban on government services to undocumented immigrants.

Finally, encouraging people to wait until their mental health deteriorates such that they require emergency care may be financially irresponsible given the high cost and lack of availability of emergency inpatient mental health care.¹⁷⁴ Undocumented children’s mental health needs are higher

¹⁷¹ Specification of Community Programs, *supra* note 168 (mentioning in the discussion of comments prior to the specification that sliding-scale arrangements would not fall under the exception provided by Congress); *see also* 8 U.S.C. § 1613(c)(2)(G) (2012) (requiring that the services “not condition the provision of assistance, the amount of assistance provided, or the cost of assistance provided on the individual recipient’s income or resources”).

¹⁷² Specification of Community Programs, *supra* note 168.

¹⁷³ The funding model of psychiatric services for low-income populations typically relies upon Medicaid (a means-tested program) or upon sliding-scale arrangements. *See, e.g.*, 42 U.S.C. § 254g(b)(1)(B) (2012) (requiring that community clinics using National Health Services Corps members operate on a sliding-scale fee arrangement unless a particular patient is covered by Medicaid, Medicare, or CHIP).

¹⁷⁴ *See, e.g.*, Ashley Stone et al., *Impact of the Mental Healthcare Delivery System on California Emergency Departments*, 12 W.J. EMERGENCY MED. 51 (2012), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3298229/pdf/wjem-13-01-51.pdf> (reporting a lack of inpatient psychiatric beds into which to transfer psychiatric patients who appear in emergency departments).

than those of other children.¹⁷⁵ Undocumented youth suffer significant trauma due to the hazards of crossing the border, the fear of deportation, and the disruption to family bonds occasioned by forced separation.¹⁷⁶ Allowing children to grow up with unaddressed trauma affects their neurological development, impairing their ability to learn and to adjust socially.¹⁷⁷ The consequences of failing to address children's mental health needs are as dire as the consequences of failing to address children's physical health needs. Just as the prevention of illiteracy, which imposes a lifetime handicap upon children denied an education, is an "interest [that], though not constitutionally guaranteed, must be accorded a special place in equal protection analysis,"¹⁷⁸ treatment of mental illness that can impair a child's life prospects is entitled to similar solicitude. Society does not benefit from having an underclass of the unwell. Because emergency and crisis services are insufficient to address the urgent mental health needs of undocumented children, their availability does not justify refusing to apply the *Plyler* standard.

c. Can Congressional Intent to Deny Benefits Justify Unequal Treatment of Undocumented Youth?

Third, the *Plyler* decision relied upon the Court not wishing to impute to Congress the intent to deny an education to undocumented youth.¹⁷⁹ However, the Personal Responsibility and Work Opportunity Act of 1996

¹⁷⁵ See *supra* Section II.

¹⁷⁶ *Undocumented Americans*, AM. PSYCHOLOGICAL ASS'N, <http://www.apa.org/topics/immigration/undocumented-video.aspx> (last visited July 24, 2015).

¹⁷⁷ Bruce Perry & Ronnie Pollard, *Homeostasis, Stress, Trauma and Adaptation: A Neurodevelopmental View of Childhood Trauma*, 7 *CHILD & ADOLESCENT PSYCHIATRIC CLINICS N. AM.* 33 (1998).

¹⁷⁸ *Plyler v. Doe*, 457 U.S. 202, 233 (1982) (Blackmun, J., concurring) (citing *San Antonio Indep. Sch. Dist. v. Rodriguez*, 411 U.S. 1, 34, n.74, 35, n.78 (1973)).

¹⁷⁹ *Id.* at 226 (majority opinion).

offers a clear expression of precisely such an intent.¹⁸⁰ The Act defines “qualified alien” so as to exclude undocumented immigrants¹⁸¹ and specifically forbids providing non-emergency health benefits to non-qualified aliens.¹⁸² Given this clear intent, it may be that *Plyler* does not apply and that ordinary rational basis review is appropriate. However, Congress cannot violate equal protection, even if it does so intentionally.¹⁸³ Even if Congress could do so, the undocumented children affected by its decision did not choose their current situation. The law imputes less culpability and capacity to juveniles.¹⁸⁴ Given minors’ special position, *Plyler*’s stricter “substantial interest” standard is still appropriate.¹⁸⁵ Because denying mental health care to undocumented children fails review under that standard, the government should immediately remove barriers to Medicaid and CHIP for these children.

B. Policy Arguments

In addition to constitutional arguments in favor of extending Medicaid and CHIP mental health coverage to undocumented youth, two policy arguments weigh heavily in favor of increased coverage. First, because mental health plays such a critical role in an individual’s ability to reach his or her full potential, access to mental health care is required in order to provide children with equality of opportunity. Second, minors—particularly undocumented children—are limited in their ability to provide themselves

¹⁸⁰ Personal Responsibility and Work Opportunity Act of 1996, §§ 401, 411, 431 (codified at 8 U.S.C. §§ 1611, 1621, 1641 (2012)).

¹⁸¹ 8 U.S.C. § 1641 (2012).

¹⁸² *Id.* § 1611 (federal benefits); *id.* § 1621 (state benefits).

¹⁸³ *United States v. Windsor*, 133 S. Ct. 2675, 2695 (2013) (“[T]hough Congress has great authority to design laws to fit its own conception of sound national policy, it cannot deny the liberty protected by the Due Process Clause of the Fifth Amendment.”).

¹⁸⁴ *See, e.g.*, LA. CIV. CODE ANN. art. 1918 (2008) (“All natural persons have capacity to contract, except unemancipated minors”); *Graham v. Florida*, 560 U.S. 48, 67-69 (2010) (citing *Roper v. Simmons*, 543 U.S. 551, 569-73 (2005)) (holding that minors have reduced criminal culpability).

¹⁸⁵ *See Plyler v. Doe*, 457 U.S. 202, 224 (1982).

with the necessities of life. Thus, the state must intervene to ensure that undocumented youth are provided with these necessities. These policy arguments may provide motivation for legislatures and the courts to expand mental health coverage for low-income undocumented children.¹⁸⁶

1. Equality of Opportunity

Equal opportunity is a foundational principle of American society.¹⁸⁷ The framers of the Fourteenth Amendment devised the Equal Protection Clause to abolish “governmental barriers presenting unreasonable obstacles to advancement on the basis of individual merit.”¹⁸⁸ Likewise, Congress has structured the meritocratic federal employment system to “assure[] that all receive equal opportunity.”¹⁸⁹ Where there is equal opportunity, every child

¹⁸⁶ Human rights law also positions health care as a fundamental right. *See, e.g.*, Convention on the Rights of the Child art. 24. Some scholars have suggested that human rights thus provide a powerful argument for extending health care benefits to undocumented persons generally, and undocumented children in particular. *See, e.g.*, Berta Hernández-Truyola & Justin Luna, *Children and Immigration: International, Local, and Social Responsibilities*, 15 B.U. PUB. INT. L.J. 297, 312 (2006) (“Human rights ideals are the foundation for establishing state health care as a fundamental right.”); Puneet K. Sandhu, Comment, *A Legal Right to Health Care: What Can the United States Learn from Foreign Models of Health Rights Jurisprudence*, 95 CAL. L. REV. 1151 (2007) (arguing that international examples demonstrate both the moral and social utility of a legal right to health care as well as the fact that “a right to health care need not raise troubling justiciability concerns”). However, given the reluctance of federal courts and legislatures to embrace principles of international law, for instance, by refusing to ratify the Convention on the Rights of the Child, this Article will not address such arguments in further detail.

¹⁸⁷ As a factual matter, it is also clear that the equal opportunity envisioned during the Republican period did not extend to all people. Women were routinely denied the right to civic participation, while black people were subjected to the inhumanity of slavery. Nevertheless, equal opportunity as an ideal provides a potential avenue to create support for the expansion of the welfare state among critics for whom that expansion cannot be justified by purely humanitarian concerns.

¹⁸⁸ *Plyler*, 457 U.S. 202 at 221-22 (“[D]enial of education to some isolated group of children poses an affront to one of the goals of the Equal Protection Clause: the abolition of governmental barriers presenting unreasonable obstacles to advancement on the basis of individual merit.”).

¹⁸⁹ 5 U.S.C. § 2301(b)(1) (2012).

ostensibly has an equal chance to advance based on his or her own merits.¹⁹⁰ As a result, equal opportunity prevents the creation of a “discrete and permanent underclass.”¹⁹¹ However, by solidifying the negative effects of untreated trauma and transforming those deleterious effects into potentially debilitating mental illnesses that lead to personal and social instability, the denial of mental health care to undocumented children creates precisely such an underclass.¹⁹²

Without major structural changes to American society, substantial economic and social inequality will continue. Equal opportunity provides a moral justification for unequal outcomes.¹⁹³ A political and social commitment to a meritocracy thus requires an equally strong commitment to ensuring that the circumstances into which one was born do not determine the outcome of one’s life.

A lack of health care generally, and a lack of mental health care specifically, render children unequal in their opportunities to advance on their merits. Research consistently demonstrates that children without access to health care have reduced life outcomes across a range of metrics.¹⁹⁴ Congress has implicitly recognized the equivalence of the suffering caused by mental and physical conditions by requiring that employer-provided health care treat mental health and physical health

¹⁹⁰ *Kadrmas v. Dickinson Pub. Schs.*, 487 U.S. 450, 470 (1988) (Marshall, J., dissenting).

¹⁹¹ *Id.*

¹⁹² See also Suárez-Orozco et al., *supra* note 18, at 465 (“Permanently encircling millions of children and youth behind a barbed wire of liminality is counter to fundamental democratic ideals, the values we share as Americans, and the core tenets of our civilization.”).

¹⁹³ See generally Sandhu, *supra* note 186.

¹⁹⁴ See Janet Currie & Nancy Reichman, *Policies to Promote Child Health: Introducing the Issue*, *FUTURE CHILD.*, Spring 2015, at 3, 3 (“A large volume of high-quality research shows that unhealthy children grow up to be unhealthy adults, that poor health and low income go hand in hand, and that the consequences of both poverty and poor health make large demands on public coffers.”).

comparably.¹⁹⁵ Recent Centers for Medicaid and Medicare Services regulations make similar parity provisions applicable to all state Medicaid and CHIP programs, regardless of the specific mechanism through which services are delivered.¹⁹⁶ As a result, poor children now have expanded access to mental health services.¹⁹⁷ If citizen children from low-income families have such access, it would seem a monumental denial of equal opportunity to exclude immigrant children.

The absence of mental health treatment leads to an increased risk of chronic mental health problems.¹⁹⁸ Children thus afflicted may need to devote time and resources throughout their lives to managing their illnesses—time and resources that could otherwise be spent on activities geared towards social and economic advancement. Moreover, children with serious mental illnesses are much less likely to graduate from high school,¹⁹⁹ let alone earn the college diploma or technical degree that is increasingly necessary for success in the American economy.²⁰⁰ Just like the constitutional imperative to provide equal education to undocumented

¹⁹⁵ 29 U.S.C. § 1185a (2012). Notably, however, this provision does not mandate that employer-provided health care include mental health coverage; it only mandates that if a plan did cover mental health, it must not impose greater restrictions than for physical health care. Nevertheless, since most health care plans offer some mental health coverage, these parity provisions are improving access to mental health treatment. *See infra* notes 196-97 and accompanying text.

¹⁹⁶ Medicaid and Children's Health Insurance Program; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18389 (Mar. 30, 2016).

¹⁹⁷ *See id.*

¹⁹⁸ *See, e.g.,* Kerig et al., *supra* note 75, at 1214-16.

¹⁹⁹ Nicholas Freudenberg & Jessica Ruglis, *Reframing School Dropout as a Public Health Issue*, PREVENTING CHRONIC DISEASE, Oct. 2007, at 1, https://www.cdc.gov/pcd/issues/2007/oct/pdf/07_0063.pdf.

²⁰⁰ ANTHONY P. CARNEVALE, GEORGETOWN PUB. POLICY INST., RECOVERY: JOB GROWTH AND EDUCATION REQUIREMENTS THROUGH 2020, at 15 fig.4 (2013), https://cew.georgetown.edu/wp-content/uploads/2014/11/Recovery2020.FR_Web_.pdf ("By 2020, 65 percent of all jobs will require postsecondary education and training, up from 28 percent in 1973.").

children,²⁰¹ a similar imperative exists to provide the mental health services that would enable those children to meaningfully access that education. The evidence suggests that providing mental health care to children can alter the trajectory of their lives, positioning them so that they, like their healthy peers, can achieve their goals.²⁰²

As the *Plyler* Court recognized more than 30 years ago, undocumented children are likely to remain in the United States.²⁰³ Unaccompanied children who arrived during the surge are ineligible for DACA and its pathway to authorized status.²⁰⁴ However, some children may be eligible for asylee status²⁰⁵ or for visas for victims of crime, abuse, or neglect.²⁰⁶ By impairing the future prospects of children who remain in the United States, this denial of equal opportunity produces negative consequences for American society. Having an underclass of the mentally ill not only increases health care costs generally,²⁰⁷ it also leads to increased criminal justice expenditures.²⁰⁸ More importantly, denying mental health care to

²⁰¹ *Plyler v. Doe*, 457 U.S. 202, 230 (1982) (holding that because a state offers free public education to other children, it must offer that education to undocumented children as well).

²⁰² OFFICE OF MENTAL HEALTH, INTEGRATED CMY. SERVS. FOR CHILDREN AND FAMILIES, SCHOOL AND MENTAL HEALTH PARTNERSHIPS (2015), <https://www.omh.ny.gov/omhweb/Childservice/docs/school-based-mhservices.pdf> (arguing for expanding access to mental health services through schools in order to promote school engagement and educational success).

²⁰³ *Plyler*, 457 U.S. at 230.

²⁰⁴ For a further discussion of the DACA program, see *supra* note 22.

²⁰⁵ See 8 U.S.C. § 1158(b) (offering asylum to individuals who can “establish that race, religion, nationality, membership in a particular social group, or political opinion was or will be at least one central reason for [their] persecut[ion]”).

²⁰⁶ See 8 U.S.C. § 1101(a)(15)(T) (stating requirements for visas for human trafficking victims); *id.* § 1101(a)(15)(U) (stating requirements for visas for certain crime victims); *id.* § 1101(a)(27)(J) (stating requirements for visas for abused, neglected, or abandoned children).

²⁰⁷ See Colton & Manderscheid, *supra* note 76, at 2.

²⁰⁸ *Spending Money in All the Wrong Places: Jails and Prisons*, NAT’L ALLIANCE FOR MENTAL ILLNESS (Mar. 2004), <http://static1.1.sqspcdn.com/static/f/1176392/18407948/1337955233993/2007071> (collecting statistics demonstrating that a substantial percentage of the incarcerated

undocumented children betrays the American value of equal opportunity constitutionalized by the Fourteenth Amendment.²⁰⁹ In light of this value, children must have a right to the resources necessary to ensure that accidents of birth do not create lifetime impediments. Some would argue that a right to health care, as a positive right, is inconsistent with the negative rights enshrined in the Constitution—the right to be free from government intrusion.²¹⁰ But the right to be left alone means little if one is left inside a personal hell.

2. Protection of Minors

As minors, undocumented youth are entitled to have someone provide them with healthcare. Current federal law deprives undocumented children of the right to any form of non-emergency and non-crisis mental health care.²¹¹ However, if an undocumented child is in ORR custody, which must provide mental health care to children in its custody, that child acquires a right to health care as a result of the custodial relationship.²¹²

The source of this obligation is the common-law principle that by confining a person, the government has taken away that person's ability to obtain the necessities of life for himself or herself; thus, the government

population is mentally ill and that a substantial percentage of mentally ill Americans will interact with the criminal justice system).

²⁰⁹ See *Plyler*, 457 U.S. at 221-22.

²¹⁰ See LOUIS HENKIN, *THE AGE OF RIGHTS* 2-4 (1990).

²¹¹ See *supra* Section III(C).

²¹² See Office of Refugee Resettlement, *Children Entering the United States Unaccompanied: Section 3 (Services)*, U.S. DEP'T HEALTH & HUM. SERVS. (Apr. 20, 2015), <http://www.acf.hhs.gov/programs/orr/resource/children-entering-the-united-states-unaccompanied-section-3> (requiring individual care providers to provide “appropriate mental health interventions” by “licensed mental health professional[s]”). State-run childcare institutions are “not constitutionally required to be funded at such a level as to provide . . . the *best* health care available.” *Reno v. Flores*, 507 U.S. 292, 304 (1992). The corollary is that they are required to provide an adequate level of health care to the child in custody.

must shoulder that obligation.²¹³ The Supreme Court has explicitly adopted this principle with regard to prisoners²¹⁴ and inmates of state mental institutions.²¹⁵ Thus, the Court has recognized that those subject to custodial relationships have a right to be provided with basic necessities.²¹⁶ Health care is a “basic necessity of life.”²¹⁷ When the government prevents a person from obtaining aid, it creates “total dependency on the state for treatment,” which the state must then provide.²¹⁸

Given that they are unable to provide for themselves due to legal and practical restrictions,²¹⁹ undocumented children have neither the opportunity nor the obligation to provide themselves with the necessities of life. As a result, that obligation must fall upon someone else. Parents are the initial obligors.²²⁰ If parents are unable to provide for their children, state governments, with federal encouragement, have created foster care systems that channel funding to foster parents who agree to raise those children.²²¹

²¹³ *Estelle v. Gamble*, 429 U.S. 97, 103-04 (1976) (“[I]t is but just that the public be required to care for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself.” (quoting *Spicer v. Williamson*, 132 S.E. 291, 293 (N.C. 1926))).

²¹⁴ *Id.*

²¹⁵ *Youngstown v. Romeo*, 457 U.S. 307, 315 (“[R]espondent has a right to adequate food, shelter, clothing, and medical care.”).

²¹⁶ *See id.*; *Estelle*, 429 U.S. at 103-04.

²¹⁷ *Mem'l Hosp. v. Maricopa Cty.*, 415 U.S. 250, 259 (1974) (quoting DEP'T OF HEALTH, EDUC., & WELFARE, MEDICAL RESOURCES AVAILABLE TO MEET THE NEEDS OF PUBLIC ASSISTANCE RECIPIENTS 74 (1961)).

²¹⁸ *Newman v. Alabama*, 503 F.2d 1320, 1329-30 (5th Cir. 1974) (“[T]here has been a proliferation of decisions in which the fact that incarceration disables an inmate from procuring aid has been and creates total dependency upon the state for treatment has been seized upon as a justification for judicial scrutiny of prison medical prisons.”).

²¹⁹ *See, e.g.*, 29 U.S.C. §§ 203(l), 212, 213(c) (2012) (restricting employment of minors); 8 U.S.C. § 1324(a)(3) (2012) (criminalizing the hiring of undocumented workers).

²²⁰ *See, e.g.*, LA. CHILD. CODE ANN. art. 101 (2014) (“[P]arents have the responsibility for providing the basic necessities of life.”).

²²¹ *See* 42 U.S.C. § 671 (2012) (requiring states to make “foster care maintenance payments” in order to be eligible for federal funding); *see, e.g.*, LA. STAT. ANN. § 36:477(B)(1) (Supp. 2015) (“The office shall provide for the public child welfare functions of the state, including . . . meeting [foster children’s] daily maintenance needs of food, shelter, clothing, necessary physical medical services, school supplies, and incidental personal needs . . .”).

Thus, the federal government has already recognized and embraced an obligation to provide children *qua* children with the basic necessities of life. Since this obligation emerges from a child's legal status as a minor, rather than from a child's immigration status, it follows that an undocumented child is entitled to mental health care through Medicaid or CHIP. While the federal government has already recognized this obligation for children in ORR custody,²²² since the obligation to provide mental health care for undocumented children does not proceed solely from the custodial arrangement, but rather exists by analogy with the custodial arrangement, the fact that most undocumented children are not in the government's custody does not lift this obligation.²²³ Rather, by preventing undocumented children from procuring the necessities of life,²²⁴ the government has obligated itself to ensure that those children are provided for. While one could argue that this obligation should fall upon undocumented children's parents, they may not be present in the country. Moreover, even if they are, they may be undocumented and thus limited in their ability to provide for their children due to work restrictions on undocumented immigrants.²²⁵ Given that the government has created the conditions in which undocumented children are unable to obtain the necessities of life, the government has imposed upon itself the obligation to provide these necessities, including mental health care.

²²² See Office of Refugee Resettlement, *supra* note 212.

²²³ Stinchcomb & Hershberg, *supra* note 14, at 29 (reporting that 85 percent of unaccompanied children are placed with a sponsor); Muzaffar Chishti & Faye Hipsman, *Dramatic Surge in the Arrival of Unaccompanied Children Has Deep Roots and No Simple Solutions*, MIGRATION POL'Y INST. (June 13, 2014), <http://migrationpolicy.org/article/dramatic-surge-arrival-unaccompanied-children-has-deep-roots-and-no-simple-solutions> (reporting a 90 percent placement rate).

²²⁴ See *supra* note 219.

²²⁵ 8 U.S.C. § 1324(a)(3) (2012).

V. CONCLUSION

Children who enter the United States without proper authorization, particularly those who make the perilous journey to the United States alone, are in the midst of a mental health crisis.²²⁶ If left unaddressed, the complex trauma that these children have experienced will manifest in severe mental illnesses that will strain already overtaxed mental health and criminal justice systems while robbing these children of their futures.²²⁷ The programs already exist to treat these illnesses, but federal law currently denies undocumented children access to them.²²⁸

Denying undocumented children access to Medicaid and CHIP not only violates equal protection under the *Plyler* standard, it also flies in the face of American ideals of equal opportunity and the sanctity of childhood. Providing adequate mental health care to undocumented children removes one obstacle to their ability to participate equally in the social, economic, and civic life of their adopted country. Moreover, all children, whether undocumented or not, have neither the legal right nor the legal responsibility to provide themselves with the necessities of life. When a government prevents children from providing themselves with the necessities of life, it obligates itself to ensure that children receive the necessary care. That care includes appropriate mental health treatment.

²²⁶ See *supra* Section II.

²²⁷ See *supra* notes 73-77 and accompanying text.

²²⁸ See *supra* Section III(C).