VIEWPOINT

Safeguarding the Health of Children in Carceral Custody

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Children deprived of their liberty in the US juvenile justice, criminal justice, and immigration detention systems face profound and evolving health risks that demand a creative, sustained, and urgent pediatric response. These risks unfold within distinct but overlapping systems that share structural gaps in oversight, inconsistent standards of care, and a legacy of harm to children's health and development. A promising opportunity lies in linking expertise across these systems to strengthen care, safeguard rights, and address the vulnerabilities of this often-overlooked population, which is disproportionately composed of racially and ethnically minoritized children.

Epidemiology and Health Vulnerabilities of Children in Custody

Children confined in immigration detention, juvenile justice, and criminal justice custody represent a sizable pediatric population and are among the most vulnerable, marginalized children in the United States. On any given day in early 2025, an estimated 27 600 youths younger than 18 years were held in the juvenile justice system and 2500 in the adult criminal justice system.[1] Although the number of migrant children entering detention is dynamic, 110 000 unaccompanied children (UC) and 996 000 individuals in families (the precise number of children in families is not publicly available) entered US Customs and Border Protection (CBP) custody in the 2024 fiscal year.[2] Some 2100 UC are, as of October 2025, in immigration detention. On an annual basis, hundreds of thousands of children cycle through custody settings. In 2020, US law enforcement made more than 424 000 arrests of children younger than 18 years who entered the juvenile justice system,[3] while in fiscal year 2024, approximately 98 000 children were referred to the Office of Refugee Resettlement (ORR) for placement with family or sponsors after apprehension at the US border.[4] However, recent restrictions on family releases into the US has resulted in a dramatic reduction of family apprehensions at the border. Similarly, UC apprehensions have also fallen substantially as the aggressive vetting of accepting households now includes a significant risk of deportation for any unauthorized individuals in the household. Nevertheless, as of October 2025, there are some 2100 UC in ORR custody.

Children in custody face heightened health, developmental, and social risks compared with their peers.[5] In the US juvenile justice system, many youths enter detention with an urgent health need. Approximately 70% have at least 1 mental health condition, and suicide remains the leading cause of death in confinement.[5] As socioeconomic disparities widen and jurisdictions adopt community-based responses to incarceration, the health needs of youths who remain in custody have grown more complex. Youths with the most intense behavioral health, developmental, and social needs tend to be the ones who remain incarcerated, and incarceration itself can worsen health. National surveys found that nearly 10% of youths in juvenile facilities reported experiencing sexual violence in the prior year, most often by staff.[6] For children confined for years, correctional health care serves as their only source of health services unless community referrals are made. However, most children in confinement transition out within days to months, making timely, developmentally appropriate care and reentry coordination essential and underscoring the critical role of community pediatrics in ensuring continuity across settings.[5]

Bridging Expertise: A Call for Cross-System Collaboration to Address Emerging Risks

Protecting the health of children in custody demands agile, creative approaches that leverage existing expertise and infrastructure to respond to emerging risks. In the US, oversight of pediatric health care in youth confinement facilities remains inadequate, with diverse requirements based on state law and local jurisdiction. At the federal level, the prevailing legal minimum standard for health care in custody settings, set by the US Supreme Court, requires only that care not be medically neglectful, a low bar that allows serious deficiencies to persist. The juvenile justice and adult criminal justice systems have largely stalled in advancing health care quality, although recent landmark federal Medicaid reforms have the potential to improve access to care for youths during community transitions after incarceration.

The immigration detention system presents parallel challenges, with significant emerging risks given rapidly shifting federal policies. Within the US immigration detention system, children are usually apprehended and detained by CBP.[7] Families are transferred to US Immigration and Customs Enforcement (ICE) and are deported, placed into ICE family detention facilities, or, currently rarely, released into the US. UC are generally apprehended by CBP and then transferred within 72 hours to the ORR of the US Department of Health and Human Services.[7] ICE has also intensified its interior enforcement actions, with UC transferred to ORR and families either deported or transferred to ICE family detention. Litigation resulted in the development of much improved medical and custodial standards for children in CBP custody as well as an independent, court-appointed monitor to ensure that these standards were actually being met.

The urgency for greater pediatric engagement has been heightened by several developments. The independent monitor role for CBP custodial care sunsetted in September 2025, with monitoring responsibilities transferred to oversight units within CBP. The expected intensification of interior enforcement efforts by ICE has underscored the need to fully assess the medical and custodial care of children in custody, including before transfer to ORR or for families, prior to arrival at a designated family detention facility. Also of concern is the quality of care in these recently reopened ICE family de-

tention facilities. Another concerning development is the unprecedented duration of detention of UC in ORR care, currently approaching an average of 200 days in custody.

Child imprisonment is a profound social determinant of health affecting some of the most vulnerable children in the United States. Although there are a variety of steps the pediatric community can take to address this challenge, we recommend 3 central priorities for child health professionals. First, strengthen clinical practice across all settings where children in custody or recently released from custody receive care, including at community clinics, emergency departments, inpatient services, and juvenile or adult correctional and immigration detention facilities. The National Commission on Correctional Health Care has long-established standards for youths in custody, and the American Academy of Pediatrics has issued an immigration health toolkit and policy statement on collaborative care for justice-involved youths. Second, ensure that the best science and clinical insight are used to develop and enforce pediatric health standards in youth custody settings, across immigration detention facilities, juvenile justice facilities, and adult prisons and jails. This will require technical review of the standards being used in justice and immigration detention facilities. Third, it is essential that the correctional health and migrant child communities speak with a unified, authoritative voice for all children deprived of liberty. These coordinated efforts can center pediatric-led advocacy for children who have long been socially marginalized and politically dehumanized, in a collective effort to ensure that no child—regardless of circumstance or custody status—is beyond the reach of evidence-based, safe, and humane custodial care.

ARTICLE INFORMATION

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