KIDS IN CARE:

Unaccompanied Children in Federal Government Custody

Lauren Heidbrink, MA/MS, PhD.
Sarah J. Diaz, J.D. LL.M.
Center for the Human Rights of Children at
Loyola University Chicago School of Law

TABLE OF CONTENTS

EXECUTIVE SUMMARY 3

CONTRIBUTORS 9

ACKNOWLEDGEMENTS 9

ACRONYMS AND ABBREVIATIONS 10

BACKGROUND 11

METHODOLOGY 15

LIMITATIONS 16

CHILDREN'S VOICES 17

SAFETY AND PROTECTION 22

FAMILY REUNIFICATION 30

MEDICAL CARE 43

MENTAL HEALTH 48

RECREATION AND LEISURE 57

ACCESS TO EDUCATION 60

ACCESS TO LEGAL COUNCEL 65

CULTURE, IDENTITY, LANGUAGE, RELIGION 72

SPECIALIZED POPULATIONS 80

PREGNANT AND PARENTING TEENS 81

CHILDREN WITH DISABILITIES 85

LGBTQIA+ CHILDREN 91

AGING OUT AND AGE REDETERMINATIONS 95

INFORMATION SHARING 102

STAFFING AND TRAINING 107

ABOUT THE AUTHORS 112

APPENDIX 113

ENDNOTES 114

EXECUTIVE SUMMARY

When established in 2003, the Office of Refugee Resettlement's (ORR) Division of Unaccompanied Children's Services cared for roughly 6,000 children in thirteen facilities. Twenty years later, ORR's program has grown to over 240 facilities and programs spread across 23 states. Global child migration is at an all-time high as more children flee extreme violence, corruption, forced gang conscription, social inequality, and the effects of climate change. As ORR's program for unaccompanied children is expected to grow, Loyola University Chicago's Center for the Human Rights of Children (CHRC) undertook an 18-month interdisciplinary study to examine the conditions of care for unaccompanied children in federal custody.

The study uniquely brings together socio-legal scholarship on children's rights, migration studies, and child welfare in a comprehensive examination of the care of unaccompanied children in ORR custody. Enlisting a national survey with 135 respondents and 55 in-depth interviews with current stakeholders—including facility staff, clinicians, attorneys, and advocates—we identify ORR's strengths and challenges in providing research-informed, culturally-, linguistically- and age- appropriate services to children in government custody.

To ensure a holistic evaluation of children's needs—those needs essential to ensuring the well-being and proper development the child—researchers employed a comprehensive, internationally-recognized interdisciplinary tool: the Convention on the Rights of the Child. Using this framework, researchers identified distinct areas for evaluation, including the recognition of a child's voice; measures for safety and protection; right to family unity; access to health care, legal services, education, recreation, and leisure; and the right to practice one's religion, culture, and language. Researchers also evaluated these core areas with respect to the intersectional identities of young people, including for specialized populations such as Indigenous children, pregnant and parenting teens, children with disabilities, LGBTQIA+ children, and children aging out of ORR care. Finally, the study sought to identify policies and practices that shape children's experience of ORR custody, including information sharing as well as staffing and training.

Each section of the report identifies key findings and extensive recommendations across multiple domains. While too numerous to distill in an executive summary, the following high-level findings and recommendations can be used as a roadmap for the report. A deeper dive into each area of the report will yield detailed findings and corresponding recommendations that identify immediate, concrete, achievable recommendations and strategies to improve the quality of care for children seeking safety in the United States.

FINDINGS

1. Unsuitability of congregate care for children: Approximately 85% of children in ORR custody are placed in congregate care facilities—facilities that most commonly hold 50 to 200 children with some facilities holding up to 1,400 children. While the findings and recommendations contained in this document are designed to ameliorate the conditions of such care, it cannot go unnoted that ORR's use of congregate care—a form of child detention—is contrary to the well-being, health, and development of migrant children.

2. Need to solicit and incorporate children's wishes: Children in ORR custody have little opportunity to provide input on the conditions of their care. When asked if there are formal feedback mechanisms available to children, 45% of survey respondents indicated that they were unaware of any mechanisms for child feedback. 35% of respondents were aware of a comment box as the only feedback mechanism for children. In addition to conditions of care, the voice of the child is not routinely reflected in the family reunification process. Survey respondents indicated that 1 in 4 children do not have meaningful input in their family reunification. This trend appears across other areas including, importantly, decision-making related to the child's medical and mental health care, preferred religious practices, and preferred cultural observances. Creating opportunities and processes that incorporate children's wishes are central to providing trauma-responsive care and creating a safe space for children.

3. Inconsistent quality of care and monitoring across facilities. There is considerable variation in the conditions of care, access to services, and training of staff across facility types, sizes and locations. For example, in the provision of medical care, our findings indicated that ORR struggles with "less visible" medical and mental health needs such that 90% of survey respondents opined that children do not receive the highest standard of mental health care. These inconsistencies persisted across other areas of a child's care, for example outdoor spaces for recreation and leisure vary considerably such that only 38% of survey respondents indicated that children regularly go outdoors to play. The variations also appear in education and the implementation of access to culture, language, and religion. For example, one participant shared, "we provide Muslim children time and space to pray, but transportation to a place of worship with an Imam is rare." In contrast, in another facility, a participant explained, "children get a prayer rug but not a special place to pray." These inconsistencies appear to result from limited or ambiguous policy guidance, variance in the interpretation of ORR policy, and limited supervision of facilities by ORR and state child-welfare licensing bodies. In fact, even in areas related to safety and protection, including reporting abuse, interviewees consistently shared that law enforcement and child welfare agencies may not respond to reports of abuse. The inconsistency of care is further exacerbated by high rates of staff turnover and burnout which create challenges in hiring and retaining a well-qualified and well-trained workforce.

4. Specialized populations of children are acutely impacted. Children's social and political identities are multifaceted and intersectional, uniquely shaping how they experience ORR custody. Specific populations—namely Indigenous children, pregnant and parenting teens, children with disabilities, LGBTQIA+ youth, and children aging-out or aged-out of care—consistently do not receive the services to which they are entitled. The clearest example of this related to Indigenous children and the underutilization of interpretation services; when asked why language lines are not used or underutilized, staff described the inconvenience of scheduling telephonic interpreters when they can "get by" in Spanish. Similarly, we found that facilities struggle to provide specialized services to children with disabilities with many respondents reporting that facilities will "screen out" children with specialized needs rather than accepting the child with heightened needs into the placement. Our findings indicate that ORR facilities were unable to either promptly identify or fully address the needs of those with intersecting vulnerabilities including pregnancy, LGBTQIA+ identity, and disability. The full findings for each of these specialized populations are laid out in the report.

5. Institutionalized procedures for family reunification and release presume immigrant parents are unable to provide proper care for the child. ORR's family reunification policies appear predicated on the presumption that parents and identified care givers for unaccompanied children are "unfit" until proven otherwise. To overcome this presumption, ORR enlists a series of institutional processes—family reunification packets, fingerprinting, proof of income, and home studies—that are arduous for families to complete, fail to effectively evaluate the fitness of caregivers, and tend to ignore the harm of protracted custody. For example, 54% of respondents identified documentation requirements as the primary reason for delays in family reunification (followed closely by biometric requirements). These components of family reunification delay are reported to be deeply impacted by sponsors' fear of ORR's perceived or actual association with law enforcement. Similarly, 42% of survey respondents indicated that home studies unnecessarily delay family reunification. These procedures are contrary to fundamental domestic child welfare principles that presume fitness of parents or family members in the absence of allegations or evidence of abuse, abandonment or neglect.

6. Need for greater transparency and accountability. Staff and stakeholders consistently shared a need for greater transparency and accountability in processes and decisions regarding the care and custody of unaccompanied children. This includes investigations into abuse and mistreatment within facilities, family reunification/release decisions, significant incident reports, transfers to more secure facilities, referrals for specialized evaluations and health services, age-determination and age-out procedures, and information sharing between ORR and law enforcement agencies.

RECOMMENDATIONS

1. Congregate care should be a measure of last resort. In ORR facilities, children experience a loss of liberty, control and autonomy. Rather than expand facility capacity and size, ORR should emphasize kinship care and develop community-based placements, concordant with the domestic child welfare system. To the extent practicable, these placements should be made immediately following apprehension.

2. The U.S. Government's approach to care and custody of children should be child-centered and research-informed. Instead, many current policies and practices are rooted in immigration law enforcement priorities. Drawing on a robust body of research, ORR should align its policies, procedures, and practices with research-informed, child welfare best practices. Throughout, ORR should implement mechanisms to enlist a child's voice and expressed desires to inform decision-making impacting their care and release.

3. ORR must develop more consistent mechanisms for monitoring children's experiences and quality of care across facilities, including in educational assessments and curriculum, recreation and leisure, religious and cultural practices, and access to interpreters.

4. Governmental agencies and contractors working with children require more robust interdisciplinary training and guidance, especially as it relates to specialized populations. Additionally, ORR staff and contractors need training on effectively working with children and with independent experts, including child development experts, physicians, country conditions and socio-cultural experts, and attorneys.

5. ORR should partner with external child welfare experts within and outside of the U.S. Department of Health and Human Services to review its family reunification processes to ensure its alignment with research-informed, child welfare best practices. Due to the dual nature of ORR's role of holding children in immigration custody while providing care, many ORR policies and practices remain embedded in law enforcement approach rather than in child welfare.

6. To remediate the harms associated with detention, there is a need for greater transparency and accountability in ORR decision-making. Further, to protect children and families from government policies that inadvertently cause harm to children, Congress should appropriate and ORR should allocate greater funding to appoint an attorney and, where appropriate, a child advocate to all children in federal custody at the government's expense.

LETTER FROM THE DIRECTOR

Global migration is at an all-time high, as is the number of children arriving at U.S. borders without an adult guardian. While the arrival of unaccompanied children is often characterized and politicized as a "crisis," children have been arriving to the United States since the concept of national borders. While the reasons for increasing numbers of arriving children are complex, the response should be simple–to provide the best care possible to support children's health and well-being.

The way migrant children are received and treated by the U.S., however, has been a contentious issue for decades. In 1987, a federal lawsuit was brought on behalf of Jenny Flores, a fifteen-year-old girl who fled the civil war in El Salvador arriving in the U.S. to live with her aunt. Jenny was apprehended, forced to endure a strip-search, denied release to her aunt, and detained indefinitely in a dilapidated hotel used as a federal detention facility without access to recreation, education, or medical services. Jenny's experience was not unique. The subsequent class action lawsuit resulted in a national settlement known as the Flores settlement agreement. In spite of continued efforts to nullify or circumvent the Flores settlement—including the Obama administration's expanded use of federal detention, the Trump administration's numerous policies that sought to undermine it, and the Biden administration's use of large-scale, unlicensed emergency intake facilities—the minimum standards of care remain in place. With the impending codification of the Flores standards into federal regulation on the horizon, this research study on federal detention for unaccompanied children is both critical and timely.

In 2009, the Women's Refugee Commission published the landmark study, Halfway Home: Unaccompanied Children in Immigration Custody. The study was the distillation of field research with migrant children and stakeholders and site visits to ORR facilities. The study showed that while there were many positive outcomes for children in transferring the custody and care of children from immigration enforcement to ORR, the policies and practices in place continued to blur lines between a law enforcement model and child welfare approach to the care, custody, and release of migrant children. Since the publication of Halfway Home, the landscape for care, custody and placement of unaccompanied migrant children has changed dramatically. ORR's national network of shelters has grown to over 240 facilities and programs spread across 23 states. While the program has benefited from some legislative and policy improvements, there has been little research addressing how the increasing arrivals of children has impacted the agency's ability to develop research-informed and child-appropriate policies and practices for custodial care.

To address this knowledge gap, the Center for the Human Rights of Children at Loyola University Chicago embarked on this 18-month interdisciplinary national study Kids in Care to learn more about contemporary experiences of children in ORR care. The interdisciplinary design

of the study is informed by law, medicine, social work, anthropology, and child welfare, along with the most universally adopted human rights instrument in the world–the UN Convention on the Rights of the Child. Learning about ways U.S. laws, policies, and practices impact children is a vital part of our obligations under both domestic and international human rights law and policy. It is also a moral obligation–to ensure that we protect the most precious members of our human family.

Those working with children in ORR custody frequently describe their commitment to children's well-being as the primary reason for seeking this work. Their efforts, however, are consistently impeded by a bureaucratic system and anti-immigrant voices—in the public, in Congress, and even within the Administration—challenging their every move. While this study is focused on the conditions and treatment of children in ORR custody, it is important to note that ORR's mandate and work is part of a larger ecosystem of branches of government, public agencies, civil society, and public will. For example, the resources allocated to ORR are determined by Congress, and its policies and practices are both informed and affect various agencies, organizations, and governmental, non-governmental and private-sector providers. In other words, the findings of this study have implications not only for ORR and the children it serves, but for all of us.

It is my hope that the findings and information presented in this study will advance efforts to create better laws, policies and practices for arriving children and will inspire a paradigm shift in how the U.S. responds to kids in our care.

Katherine Kaufka Walts
Director
Center for the Human Rights of Children
Loyola University Chicago, School of Law

CONTRIBUTORS

We are grateful to doctoral students Sarah Galvin, Juan Pantoja-Patino, Jiwon Lee, and Elizabeth Moran, graduate assistants of the Center for Human Rights of Children at Loyola University who contributed valuable research, transcription, coding, editing, and insights and who worked tirelessly on this initiative.

ACKNOWLEDGEMENTS

This study has been made possible by the generous support of Schreiber Philanthropy.

Our study began as a collaboration with Women's Refugee Commission; while the collaboration evolved into two separate studies with distinct research inquiries, we are thankful for their thoughtful partnership. The Center for the Human Rights of Children also thanks Leah Chavla, Michelle Brané, and Loyola University faculty Sacha Coupet, JD, PhD; Cate Santiago, PhD; and Loretta Stalans, PhD for their contributions to early stages of research plan conceptualization.

Special thanks to Loyola University Chicago students—Laila Alvarez, Sarah Galvin, Grant Everly, Josh Halliday, Jake Klaiman, Mashwa Nadeem, Nicole Provax, and Stephanie Salinas—and to California State University, Long Beach students—Britney Bancour, Maryna Marzeena, Lizebeth Mendez Martinez, Tatiana Tamayo, Alexandra Trementozzi, and Emily Vasquez for research, transcription, data analysis, and assistance in drafting initial findings.

We are indebted to several expert anonymous reviewers for their critical insights and feedback.

We are also grateful to Emily Ruehs-Navarro, PhD (Elmhurst University) who edited the final version of this report, Gabriela Afable for her compelling artwork and Andy Montgomery at Good Work Design for his graphic design assistance.

ACRONYMS AND ABBREVIATIONS

ACF	Administration for Children and Families (a division of the US Department of Health and Human Services)
ADA	Americans with Disabilities Act of 1990
CBP	US Customs and Border Protection
CDC	Center for Disease Control & Prevention
CHIP	Children's Health Insurance Program
DHS	US Department of Homeland Security
EIS	Emergency Intake Site
EOIR	Executive Office for Immigration Review
FFS	Federal Field Specialist
FOJC	Field Office Juvenile Coordinator
FRA	Family Reunification Application
HHS	US Department of Health and Human Services
ICE	US Immigration and Customs Enforcement
ICF	Influx Care Facility
KYR	Know Your Rights
LOPC	Legal Orientation Program for Custodians of Unaccompanied Children
LSP	Legal Services Provider
LTFC	Long-term Foster Care
ORR	Office of Refugee Resettlement
OTIP	Office of Trafficking in Persons
PREA	Prison Rape Elimination Act
PRS	Post Release Services
ROR	Release on Recognizance
SIJ	Special Immigrant Juvenile
SIR	Significant Incident Report
TVPRA	Trafficking Victims Protection Reauthorization Act of 2008
UNCRC	United Nations Convention on the Rights of the Child
URM	Unaccompanied Refugee Minors (Program)

BACKGROUND

Unaccompanied children arriving in the United States flee extreme violence, corruption, forced conscription into gangs and organized crime, social inequality, and the devastating effects of climate change. While the overall number of people arriving to the U.S. southern border is less than when the Office of Refugee Resettlement (ORR) began caring for unaccompanied children, the proportion of children has dramatically increased. According to U.S. Customs and Border Protection (CBP) statistics, in fiscal year 2023, DHS referred 118,938 children to ORR, roughly 87% of all apprehensions of unaccompanied minors. In contrast, that number of referrals was 7,383 children (or 40% of all apprehended unaccompanied minors) in fiscal year 2010.

Figure 1: Countries of origin of unaccompanied children in ORR custody (FY2012 to FY2023)

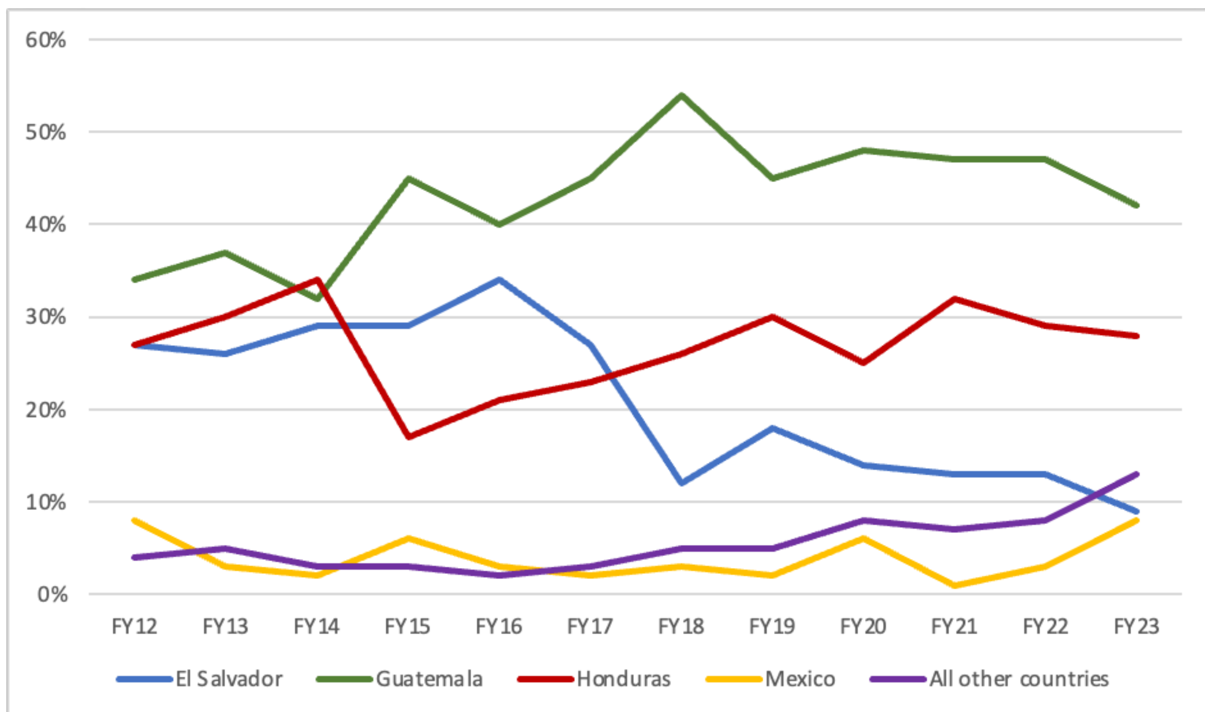
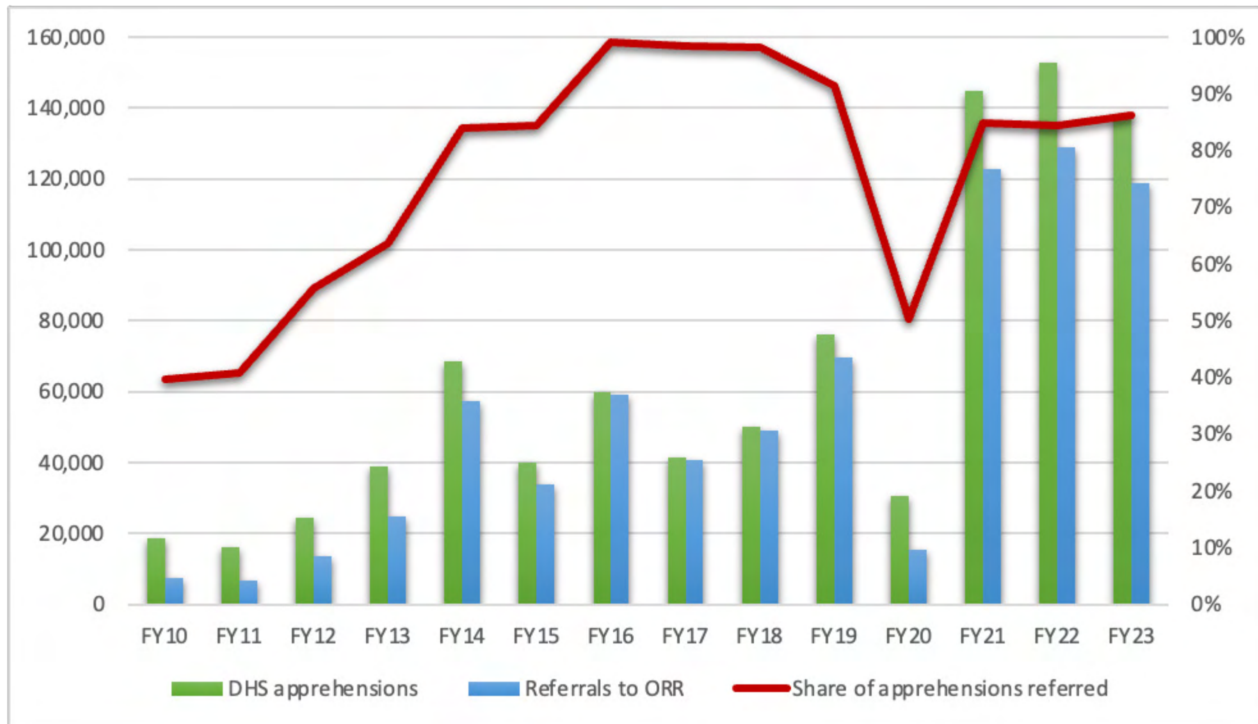


Figure 2: DHS apprehensions and referalsls of unaccompanied children to ORR (FY2010 to FY2023)



Within 72 hours of apprehension, Customs and Border Protection is required to transfer most unaccompanied children (excluding children from Mexico and Canada, unless they are identified as a victim of a severe form of trafficking and/or express a fear of returning to Mexico or Canada) to the care and custody of the ORR's Division of Unaccompanied Children's Services. Pursuant to the 1997 Flores Settlement Agreement [hereafter: Flores], ORR is responsible for caring for children in the least restrictive setting until they can be reunified with family, placed in foster care, age-out of custody, or deported.

In practice, ORR places children in one of its 240 subcontracted facilities across 23 states. Approximately 85% of children in ORR custody are placed in congregate care facilities. The U.S. Department of Health and Human Services (HHS) defines congregate care as an umbrella term for a child care facility that provides 24-hour care and/or treatment for 7 to 12 children "who require separation from their own homes or a group living experience." Yet, in the context of unaccompanied children, ORR defines congregate care as "a licensed or approved child care facility operated by a public or private agency and providing 24-hour care and/or treatment typically for 12 or more children who require separation from their own homes or a group living experience." Applying this standard, ORR operates congregate care facilities that are as small as

15 or 25 beds but which most commonly hold 50 to 200 children; some facilities hold 400 and up to 1400 children.

Facilities typically are run by non-governmental organizations but over the years have also been operated by for-profit companies, especially in the context of emergency sites. Facility types in the ORR system are defined by the level of care and/or security, namely shelters (less security), staff-secure (medium security), secure (high security), residential treatment centers (high security), group homes, and short and long-term foster care (least security). ORR places children in facilities according to their age, gender, and specialized needs but not necessarily in proximity to family already living within the US. In 2021 and 2022, ORR opened emergency intake sites (EISs) and influx care facilities (ICFs) to house tens of thousands of unaccompanied children in converted convention centers, stadiums, and military bases; notably, these facilities are not required to meet *Flores* protections. The majority of these facilities now stand vacant or have since closed, although the Pecos ICF in Texas continued to house children as of January of 2024. In addition, ORR also utilizes out-of-network placements for children with more complex needs identified on an ad-hoc basis which are less controlled by ORR and subject to less monitoring by ORR and Flores Counsel.

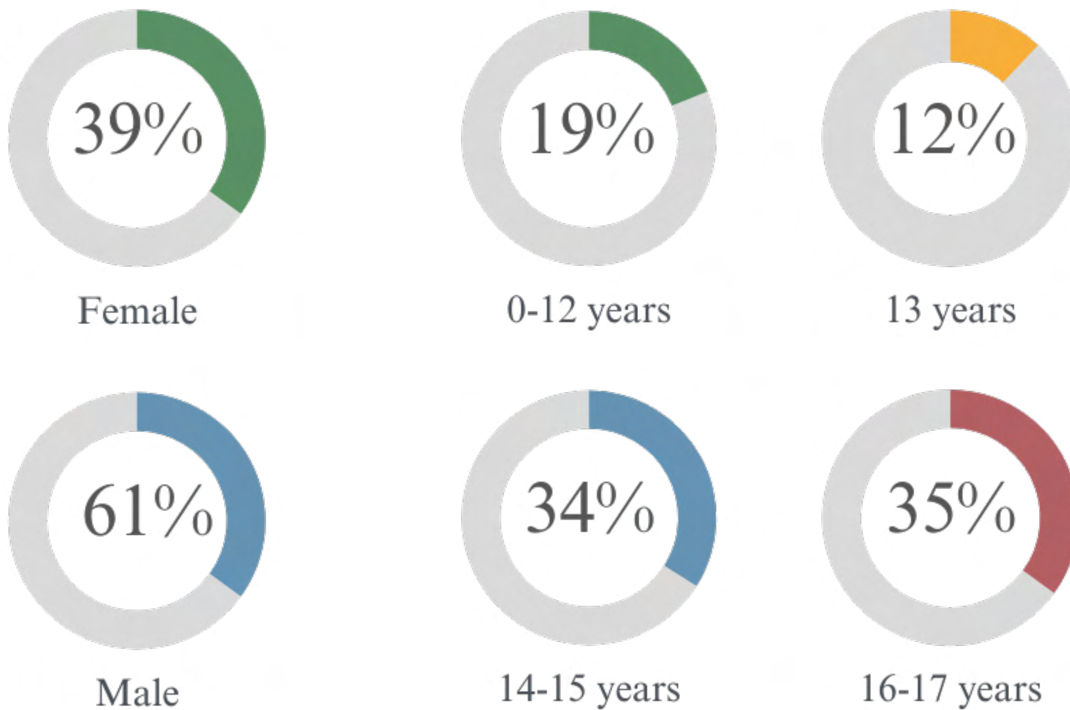


Figure 3: Gender of children in ORR custody (2023)

Figure 4: Age of children in ORR custody (2023)

Over the last decade, ORR has grown its reliance on large congregate care facilities. In fact, ORR' congregate care facilities are significantly larger than their counterparts in the domestic child-welfare systems. While publicly available data from ORR is limited, data reveal that 90% of unaccompanied children are held in facilities with more than 50 beds for, on average, 41 days in 2022, down to 27 days in 2023. Others remain held in ORR facilities for over one year and up to several years. These facilities function akin to detention, whereby children experience a loss of liberty, control and autonomy. Facilities restrict children's movement, personal expression and identity, communication with family and community, and access to school and recreation. Held in institutional spaces that can be disorienting and overwhelming, especially when apprehended upon arrival in a new country, children are left with few mechanisms to cope with considerable anxiety and uncertainty. It is important to note that ORR does not consider their system of care to be carceral nor refer to their placements as detention. That said, the majority of our research informants, including those who work within facilities, refer to ORR facilities as "detention" as do children who navigate these institutions.

In contrast to ORR's facilities, the domestic child welfare system has recognized that congregate care is anathema to the health and well-being of children. Even short periods of confinement can translate to "profound and negative impact[s] on child health and development." Not only does research show that institutional care negatively impacts cognitive development, it can adversely impact a child's overall wellbeing, physical and mental development, as well as future educational and employment opportunities. For children who suffer from poor physical or mental health, congregate care can further exacerbate these conditions and damage long-term development. As a result, nearly every child-serving system in the United States and Europe has reduced its reliance on congregate care, moving toward kinship care and family-like placements.

Throughout this report, in addition to sharing our research findings, we identify how ORR and facility staff might enlist long-standing research and established child welfare best practices to ensure the safety and well-being of unaccompanied children. In the absence of comprehensive reforms, we note our ameliorative approach does not address the reasons spurring children to migrate nor the harms of congregate care on children.

METHODOLOGY

This report is the culmination of an 18-month study on conditions of unaccompanied children in the custody of the Office of Refugee Resettlement. This mixed-methods study included secondary research, an anonymous survey, and 1-on-1 interviews.

Desk research included reviewing U.S. statutes, regulations, policies, and reports; ORR guidelines; international human rights law and guidelines; academic research; non-governmental reports; and child welfare best practices.

We conducted an anonymous survey via Qualtrics of 135 stakeholders (hereafter: respondents or participants) working within the ORR system across the country. Stakeholders include program directors and administrators, case managers, family reunification specialists, mental health clinicians, physicians, education specialists, and case coordinators. Special attention was paid to generate a representative sample that included staff from various sizes and diverse types of ORR facilities across 22 states. In addition, we surveyed others who routinely enter ORR's permanent facilities, including attorneys, child advocates, and *Flores* class counsel. This 30 to 45-minute survey included several topics, such as access to legal services, religious/ethnic/cultural services, medical and mental health services, educational services, leisure and play, and access to counsel. The U.S. Department of Health and Human Services (HHS) confirmed that ORR grantees were permitted to participate in this independent, confidential study. HHS declined our request to speak with ORR federal field specialists.

In addition, we conducted 55 one-on-one, open-ended interviews (60 to 90 minutes in length) using an interview guide with stakeholders within the ORR system (hereafter: interviewees or participants). As with the survey, we paid special attention to interviewing stakeholders who worked in various sizes and diverse types of ORR facilities, including shelters, staff-secure, secure, therapeutic, and foster care. The majority of interviewees had several years of experience working in multiple facilities and in various roles, allowing them to speak about issues across facility types and changes over time. Taken together, facility staff we interviewed worked in 15 states where ORR maintains permanent facilities. Interviewees were recruited via snowball sampling and through practitioner conferences, regional stakeholder meetings, and professional connections. Interviews were recorded, transcribed, coded and, when available, triangulated with publicly available data.

The study was approved by the Institutional Research Review Board of Loyola University Chicago (IRB #3435).

LIMITATIONS

The findings outlined in this report are the most salient themes that emerged in our research. There are some themes, however, that our research insufficiently addresses, such as the experiences of youth in a secure setting and children under 13 years old (termed "tender age" by ORR). In addition, HHS declined our request to interview children in ORR custody. Children's voices and insights are critical to ensuring that policies and practices meet their diverse needs. Where possible, we reference scholarly research and organizational reports that incorporate the experiences of children and youth themselves. In addition, this study focuses exclusively on the conditions of children while in ORR custody. Additional research is needed on children's experiences in CBP custody prior to transfer. Elsewhere, in partnership with the Women's Refugee Commission, the first author has conducted research on children's experiences following release.

CHILDREN'S VOICES

A growing body of literature documents the importance of children exercising their right to expression, even from very young ages. 'Having a voice' is a protective factor from harm and is critical to promoting their safety, wellbeing, and development, The United Nations Convention on the Rights of the Child (UNCRC) urges that children be permitted to express their views freely, and to have their views "given due weight according to the age and maturity of the child," particularly on issues that affect them. A child's expression or feedback on the conditions of their care while in ORR custody and their release is no exception.

With few exceptions, the ORR Program Policy Guide contains no *specific* guidance for soliciting or considering the wishes or expressions of a child. For example, when determining a child's placement, ORR guidelines state that the decision should be based on "child welfare best practices in order to provide a safe environment and place the child in the least restrictive setting appropriate for the child's needs." There is no specific instruction about or inclusion of children's

wishes; as a result, facility staff are not obligated to consider their wishes nor to explain when those wishes are not considered. Creating opportunities and processes that incorporate and are responsive to children's wishes is central to child welfare systems, as well as to provide trauma-responsive care. Conversely, ignoring children's voices can create situations in which children are unable to challenge or to report situations of harm or abuse.

Finding: Limited mechanisms for soliciting children's anonymous feedback on the conditions of their care

Stakeholders we surveyed and interviewed shared a desire for children to communicate openly about their wishes or concerns about the conditions of ORR care. When asked if they were aware of any formal feedback mechanisms available to children at the facilities where they work, 45% of survey respondents were unaware. Only 35% of survey respondents were aware of a comment box for anonymous feedback. The remaining 20% indicated having multiple methods of soliciting children's feedback on the conditions of care at the facilities where they work. Mechanisms included soliciting children's input on the conditions of their care in house meetings, exit interviews, or through post-release telephone calls to children; notably, each of these interactions are not anonymous.

One participant queried whether non-anonymous feedback mechanisms can yield fruitful responses from children, "How do you give a child a voice when they feel like they're in detention? How do you get honest and real input from them? I'm not sure. I feel like our program is well-run and comfortable, but kids' voices are not as actively involved as we might want them to be."

> ***Another respondent shared, "I don't think there is a systematic way to get feedback from kids other than comments or suggestion boxes at facilities which may or may not be reviewed and followed up on. I feel like we have to advocate for kids on a case-by-case basis when they share with us concerns or feedback they have."***

Finding: Facility staff struggle to incorporate children's wishes, particularly in family reunification and medical decisions.

Our findings indicate that care providers attempt to allow children to freely express their views yet struggle with limited written guidance and formal processes. Facility staff and ORR officials alike appear unclear how to incorporate a child's expressed wishes when at odds with preferred

administrative outcomes. These struggles manifest primarily within two institutional processes: 1) family reunification (sponsorship) and 2) children's medical needs.

Family reunification: 26% of survey respondents reported that children's desires and wishes were not reflected in the family reunification process. One respondent explained: "It depends on the child. For some children, their opinion is given weight in the decision to reunify with a sponsor; for others it's ignored." Another respondent indicated that a child's wishes are considered in the sponsorship process "only when safe and feasible." Indeed, several participants highlighted concerns about abuse or trafficking. One participant shared: "Cases of trafficking or abuse can be a bit easier because there is a real concern about their safety. It's the complex and really unclear cases with conflicting information that are much harder."

Amid an absence of clear guidance on when or how to weigh a child's expressed desires with respect to sponsorship, family reunification staff describe turning to existing ORR guidance indicating that reunification must "promote public safety and ensure that sponsors are able to provide for the physical and mental well-being of children" while emphasizing efficiency and timeliness. One stakeholder described, "We can sometimes strongly suggest that a child goes with a specific sponsor because we know it will get them out [of the facility] quicker but it may not be who they really want or will end up living with." The interviewee went on to give the example of a parent who would likely not be approved due to a prior deportation order. "Based on experience, we know that ORR would likely not approve bio[logical] mom so an uncle stepped forward, though we know full-well that the child will live with mom following release." Indeed, over 29% of survey respondents reported that ORR had reunified a child with a sponsor against their expressed wishes.

Another participant described, "There are these panicked narratives about ORR losing children or children gone missing, but I often wonder if it has more to do with ORR as a system not listening to what children want. Many end up living with parents or siblings that they asked for but who didn't meet institutional perceptions of fitness." (*See: Family Reunification*.)

***Children with medical needs*:** Research findings additionally reveal that facility staff and ORR officials struggle to solicit and incorporate children's wishes in decisions regarding medical care. ORR provides policy guidance on the administration and management of medication, for example, which prioritizes safety and confirms administration of medication. ORR policy does not provide guidance related to how best to weigh a child's objection or concerns about any given medication. Survey participants reported that children are given very little discretion regarding their medications. One participant shared, "Even melatonin. They just make them take it every day. But then kids have these horrible nightmares, and are just like, I don't want to take this pill, yet they're forced to." (*See: Medical Care.*)

One stakeholder summarized the concern, "ORR shelters are ORR policy-centered, not child centered."

Absent child-welfare procedures that systematically solicit and incorporate children's wishes—in terms of the care they receive in federal custody or decisions regarding their custodial placements or medical care—facility staff must discern whether to listen to or ignore children's expressed wishes.

To capture the child's voice around placement, release, conditions of detention, or medical care, we found that ORR often turns to child advocates from the Young Center as a mechanism through which to solicit children's wishes. This is problematic for a number of reasons. First, only 7% of children in federal custody are appointed a child advocate, leaving many children without opportunities to express their wishes or concerns. More critically, however, this approach conflates roles and priorities around the expressed wishes of the child and an assessment of the child's best interests. In theory, children's expressed desires should be represented by their attorney, whereas the best interests of children are the purview of the child advocate. This is not to say that child advocates do not also consider a child's expressed wishes, but the concepts should not be conflated as best interests and expressed interests do not always align. While a child's attorney is obligated to advance their child clients wishes, the government's funding of attorneys for children is *extremely* limited, and often those attorneys only have capacity to focus on the child's immigration case. Thus, they are not always able to give significant attention to the myriad issues that arise with respect to a child's placement, release, or conditions of care. In many cases, instead of listening directly to the child and following their expressed desire, a child advocate is appointed to make best interests recommendations that, in practice, become representative of the child's presumed desire.

Recommendations

1. ORR should implement robust feedback mechanisms to ensure solicitation, documentation, and consideration of children's wishes. This might include anonymous surveys, facility youth advisory councils, and Youth Advisory Councils for ORR's Division of Unaccompanied Children's Services.
2. ORR should incorporate explicit guidance and monitoring on incorporating opportunities for children to be heard on issues including but not limited to placement, services, family reunification, and medication and on how to obtain, weigh, and implement the children's expressed wishes.

3. Congress should appropriate and ORR should subsequently allocate additional funding to children's attorneys so that children's counsel can represent all children in ORR custody for 30+ days to ensure their *expressed wishes* are considered in all decisions including, but not limited to, placement, services, family reunification, and medication.

4. ORR should expand the child advocate program to appoint child advocates to all children who remain in custody beyond 30 days and for all children placed in restrictive settings, including residential treatment centers, staff secure, secure, therapeutic and out of network placements to ensure their *best interests* are considered in all decisions.

SAFETY AND PROTECTION

Safety and protection are essential for a child's development and form the foundation of a child's well-being. In response to documented cases of abuse within ORR facilities, ORR has adopted administrative measures designed to protect the safety of children from abuse, harassment, and violence while in federal custody. ORR additionally prioritizes safety as paramount in a placement determination. Consistent with child protection, ORR guidance addresses safety planning whereby case managers are responsible for safety planning for the facility and for individual children when deemed appropriate.

Safety planning within ORR facilities enlists a "zero-tolerance policy" requiring reporting of all "forms of sexual abuse, sexual harassment, and inappropriate sexual behavior." In practice, safety planning takes two forms: 1) regulations stemming from the Prison Rape Elimination Act (PREA) and 2) internal significant incident reporting (SIR). Our findings suggest that there is a gap between the administrative goals and tangible outcomes of safety and protection for children in ORR custody. Whether facility staff or other detained children commit abuse, children in federal custody have less access to reporting, monitoring and investigations from state child welfare authorities and local law enforcement than if abuse occurred in other contexts.

Finding: Facility staff have a limited understanding of safety and reporting obligations and when reported, law enforcement may not respond.

In 2014, in accordance with federal law, ORR adopted regulations implementing the Prison Rape Elimination Act (PREA) in all ORR facilities. Pursuant to these regulations, ORR facilities "must provide and inform the child of at least one way for children to report sexual abuse and sexual harassment to an entity or office that is not part of the care provider facility and is able to receive and immediately forward a child's reports of sexual abuse and sexual harassment to ORR officials, allowing children to remain anonymous upon request."

Yet, 62% of survey respondents indicated that they "did not know" or were "unsure" when asked to describe the location, setting, and privacy measures for PREA telephones (required reporting mechanisms) in the facilities where they work or visit regularly. Of the 44% of survey respondents that work or routinely visit a facility with a PREA telephone, 6% indicated that the telephone is located in a private room; 31% reported that the telephone is located in a common area where others might overhear. Only 28% of survey respondents reported recalling training around PREA reporting.

When asked whether children are informed of reporting mechanisms upon arrival, a survey respondent shared, "Usually children get a written notice of ways to report upon admission that they sign, but it is one of many forms they sign and receive when they arrive." Others indicated that a verbal advisal or signage were most common. Another stakeholder noted, "Kids don't know about posters, or they're like, 'What posters?' By and large, kids don't know where they can go or who they can call." In other words, information about how to report may not be properly elevated and sufficiently repeated in interactions with children.

> ***Another participant shared, "In my experience, I have not seen the emergency phone used. I think it's great to have it as a back-up, but the reality is that building a culture of reporting and strong trust and rapport with staff members is what will allow children to disclose abuse. 100% of our disclosures have come through staff members."***

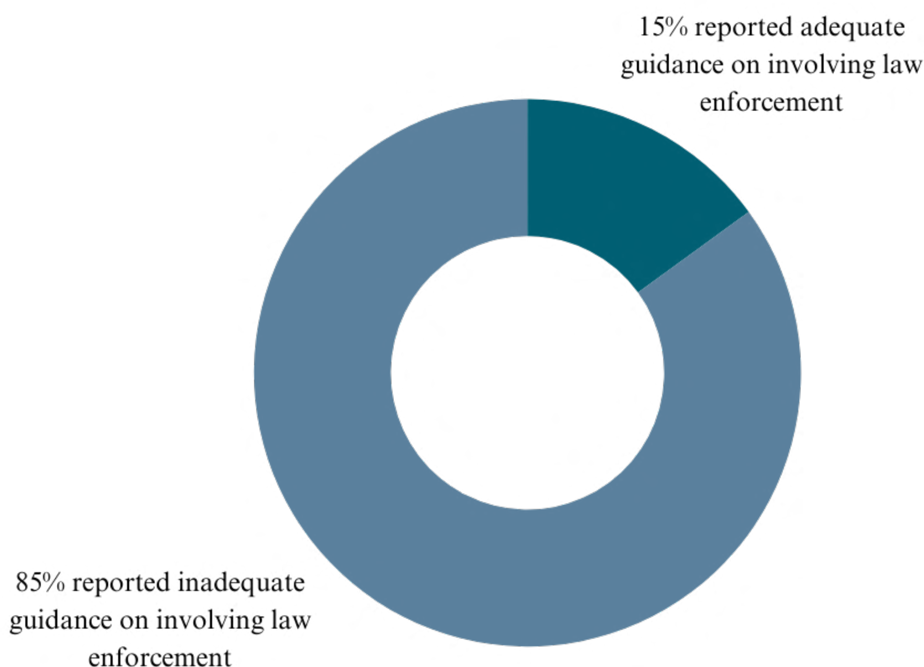
Even when reported, interviewees consistently shared that law enforcement and child welfare authorities may not respond. A participant described, "Even in cases where a child is being abused by facility staff, across states, state CPS [child protective services] typically declines to investigate stating that children are in ORR custody and it's ORR's responsibility." When state CPS investigates, interviewees lamented that children become ensnared in state child welfare systems that may lead to little to no benefit to the child. Interviewees recognized that state CPS is often "understaffed" and "does not work the way that it's supposed to."

An attorney summarized the lack of reporting information and procedures, “There’s nowhere for children to call if they’re harmed in a facility. Maybe they can call the PREA hot line if the facility has the PREA phone, but there’s no licensing entity ensuring the PREA safeguards exist and are accessible. Texas DCFS will refer anything that sounds criminal to law enforcement and *maybe* they will let ORR know, but ORR cannot and will not, out of fear of litigation, tell us what they do with that information. We know they send somebody to talk to the facility, but they’ve told us off the record that they can’t mete out any consequences.” In sum, children often do not know how to report if they are mistreated, and if they do report abuse while in ORR custody, there are limited investigations and few, if any, consequences.

Finding: Reporting structures via law enforcement can be counter-productive to a child’s safety and protection.

ORR requires facilities to develop safety plans, yet 85% of survey respondents indicated that they do not have adequate guidance on when to involve law enforcement. 79% of respondents indicated that first responders have been called to their respective facilities. Common reasons to involve first responders such as emergency medical services (EMS) or law enforcement included a risk of self-harm, physical fights, property damage, and threats and/or attempts to abscond.

Figure 5: Survey respondents were asked: "Have you received adequate guidance on involving law enforcement?"



Some survey respondents commented that ORR's zero tolerance policy requiring reporting for all forms of abuse, harassment, and inappropriate behavior left little wiggle room for reporting inappropriate behavior that might be perceived as sexual: "Per ORR policy, law enforcement must be contacted when there is a report of sexual abuse. For example, one boy touched another boy's butt while playing a game. The 'victim' said it was intentional and the alleged 'perpetrator' said it was an accident. Per ORR requirements, police were called, and they came to the facility."

A participant with over a decade of experience working in multiple facilities identified that most calls to law enforcement could be avoided, resulting from a lack of staff training, ORR policies, or too rigid or literal interpretations of ORR policy. Another participant shared,

> ***"Shelters often resort to calling law enforcement when they do not know how to de-escalate a situation with a child who may be at risk to harm themselves or others."***
>
> ***This concern was echoed by another stakeholder, "It seems like when a child is in crisis, staff call local law enforcement. It creates a bunch of problems. Especially for 17-year-olds in Texas, it likely includes charges as an adult."***

Pending charges have implications for a child's placement type while in ORR custody, their potential for release to sponsors, as well as adverse consequences for the immigration petitions.

Staff may also call law enforcement when a child is in a mental health crisis. 45% of respondents indicated that emergency responders had been called to their facility for "harm to self", and another 38% of reported calls to emergency responders for suicidality. Depending upon state and local policies, law enforcement may be required to accompany emergency medical services. In one example, "[A] girl was in a severe mental health crisis, and we called EMS so she could be transported to the hospital. EMS called the police and said they wouldn't arrive at the scene without the police being there as well. The girl was not being violent with anyone and was only causing harm to herself. It was traumatizing to have the police show up in a mental health crisis."

As researchers have documented, law enforcement agencies often respond with law enforcement tactics that are ill-suited for child welfare. One respondent reported a child suffering the traumatic effects of a three-day isolation who was met with an enforcement response: "He didn't want to submit to a doctor checking him out [for COVID-19], so he was in medical isolation. He was going crazy as anyone would after three days in isolation. The facility called 911 when he threatened to leave. When he opened the door, the cops were there and tackled him, and put him in a restrictive hold on the floor. His roommate runs to aid his friend and cops also put him in a re-

strictive hold. When he recounted the experience to me, it was through Zoom. He was crying. He said that he felt that cops were almost breaking his arm, that he was on the floor for a long time with handcuffs. He showed me the lacerations on his arms, on his legs, the bruises on his face."

In Fall 2023, ORR proposed regulations designed to acknowledge the tension between trauma-informed responses to the behavior of children in a detention setting and the response that can be triggered by involving law enforcement. We have found, however, that the regulations do not go far enough to provide meaningful guidance to care provider facilities on how to properly engage law enforcement.

Finding: Significant incident reports do not protect and may cause harm to children.

In 2023, ORR began implementing changes to the significant incident report (SIR) system to protect children from potential harm associated with the SIR process. While those efforts represent a step toward ameliorating harms, these efforts remain insufficient to properly protect children. Pursuant to ORR policy guidance, SIRs are designed to elevate incidents which "may immediately affect the safety and well-being of a child." Per ORR policy, SIRs do not distinguish between past abuse, current abuse, harm to self, or harm to others, yet the absence of distinction is consequential for children. In practice, SIRs impact a child's placement (e.g., stepped up to a higher security facility), the timeliness of their family reunification, and at times, their immigration status. Consistent with other reports, we similarly found that SIRs do not necessarily protect, and actually may harm, children.

SIRs for disclosures of past trauma: Clinicians in ORR facilities are often asked to report on experiences of violence or abuse that took place prior to a child entering federal custody and that does not pose a risk to the child's health and safety. Take, for example, a child that was assaulted by an unknown assailant in route to the United States. Past trauma is deeply relevant to a child's mental health and need for services but poses no imminent or future risk to the child's physical safety. One participant explained, "It was kind of a tight line to walk. We're required to report everything, but ethically and professionally, we have guidelines that dictate confidentiality and do no harm."

When asked whether ORR policy on SIRs conflicted with professional ethics or mandated reporting practices, 71% of survey respondents indicated, 'yes' or 'sometimes.' Clinicians have shared that, at times, they keep separate clinical notes or do not write down information a child discloses about past abuse that otherwise would result in an SIR because of potential harm to children related to their placement, release, and immigration cases, as ORR files can and have been shared with ICE. One survey respondent shared, "These past traumas are important to address in clinical

practice but are not information that needs to be shared in a child's institutional file." (*See: Information sharing.*)

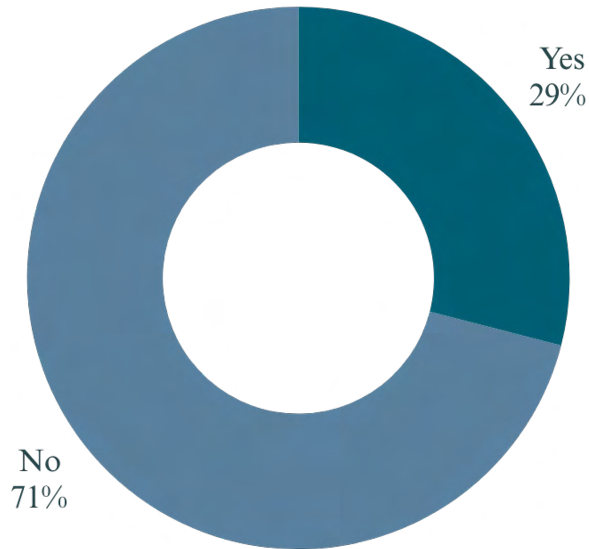


Figure 6: Survey respondents were asked: "Do SIR Policies conflict with your professional ethics and/or reporting practices?"

SIRs enlisted to manage a child's behavior: Interviewees indicated that SIRs are often enlisted to manage a child's behavior.

> ***One respondent shared, "We've seen children's behavior, including toddlers who throw a temper tantrum, documented in an SIR."***

Another participant shared, "ORR requires providers to report all instances of verbal aggression by a child, even though they themselves can see that in most cases, verbal aggression does not pose a safety risk to others."

One interviewee explained, "ORR parameters far exceed the reporting requirements under state licensing standards and mandatory reporting requirements, which typically focus much more on incidents that directly threaten the safety and health of a child. As a result of these broad parameters, a lot of developmentally appropriate behavior, like children testing boundaries and expressing frustration ends up being reported."

So too, multiple interviewees shared that SIRs can "be weaponized" and "used as retaliation" against children. One interviewee explained: "I have seen shelter staff retaliate against children after they reported abuse, including by writing a baseless SIR and telling other children that that child was bad, and they shouldn't speak to her."

Consequences of SIRs for children: SIRs are consequential for children's placements in ORR (e.g., stepped up to higher security or therapeutic placements) and the timeliness of their family reunification.

One respondent described how the SIR reporting structure produced significant bureaucratic hurdles that impede a child's family reunification and ultimately harm children by prolonging their time in detention. The interviewee illustrated, "We had a girl that was with us for six or seven months because of a sexual abuse report, which was a case manager making a note about how the girl said she'd seen pornography when she stole her aunt's phone. ORR then decided to interpret this as a sexual abuse report. The reporting held her up [in ORR custody] for over half a year."

> ***A stakeholder, reflecting on nearly a decade of experience working in ORR facilities, lamented that "It's becoming harder and harder for a child to function within detention. And then there's all of these SIRs that move them up to higher levels of care and delay release even when they are trying to share what happened to them in the past. SIRs just start feeding into more SIRs." In this view, SIRs beget protracted detention which, in turn, begets more SIRs.***

Recommendations

1. ORR should conduct an independent, external audit of safety and reporting policies and practices to ensure that ORR policies and practices are trauma-informed and consistent with child welfare principles.
2. ORR should conduct training of all stakeholders and monitor the consistent implementation of safety and reporting obligations in facilities, including PREA, significant incident reports, and guidance for engaging law enforcement.
3. ORR and state licensing bodies should develop a protocol for monitoring and investigating claims made from ORR facilities via PREA hotlines concordant with federal guidelines.
4. ORR should limit the use of significant incident reports to only serious incidents to prevent over-reporting. If issuing an SIR, ORR should require facility staff to describe how they enlisted a trauma-informed approach and to document the specific techniques used to de-escalate incidents.

5. ORR should implement mechanisms to prevent SIRs from being used as a form of discipline or punishment in placement or reunification decisions; instead, ORR should enlist a holistic, interdisciplinary review that formally includes the child, the attorney and the child advocate (if appointed).

6. ORR should prioritize new contracts in states that will partner with the federal government to provide independent licensing, investigations, and enforcement of child welfare standards.

FAMILY REUNIFICATION

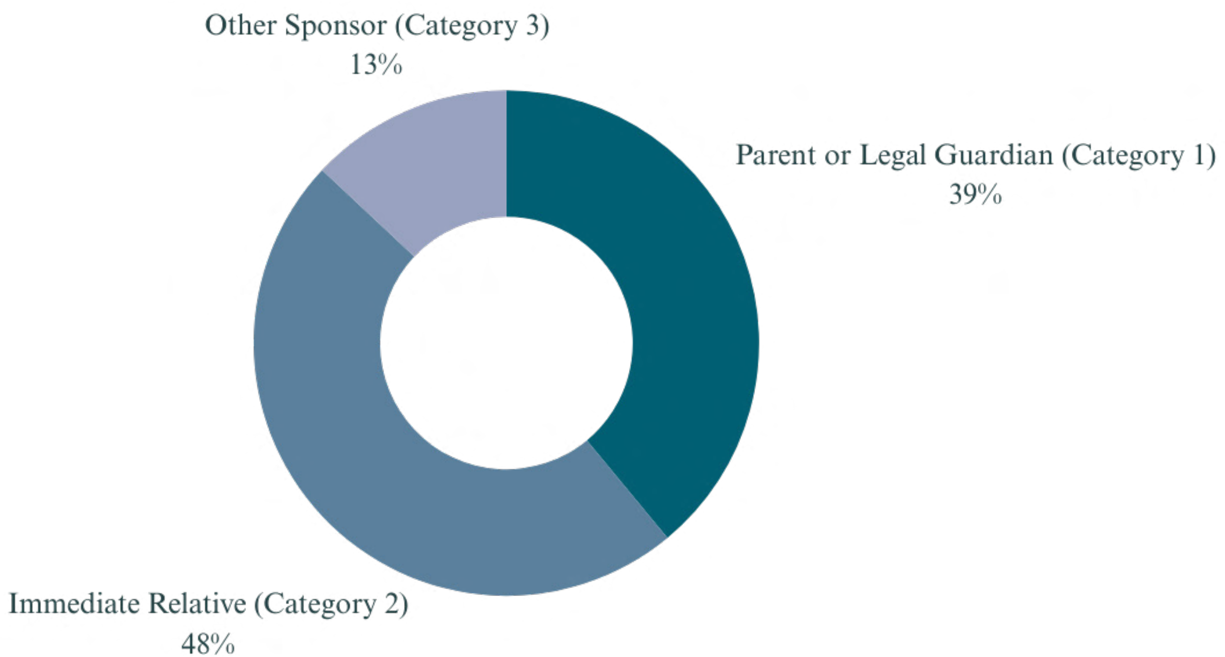
Family integrity is critical to children's development, well-being, and safety. Accordingly, there is broad consensus that child welfare policies should aim to preserve families. In contexts of migration and displacement, the United Nations Convention of the Rights of the Child (UNCRC) emphasizes the imperative of states to quickly locate and reunify families. Article 9 of the UNCRC urges states to "ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child."

Best practices in domestic child welfare prioritize family and family-based care, sometimes referred to as kinship care. HHS in other contexts, has already adopted and implemented research that has repeatedly demonstrated that children's experiences in congregate care placements, even when brief, have adverse consequences for young people's development of caring relationships needed to successfully transition to adulthood. For example, in 2023, relying on social scientific

and child development research, HHS' Administration for Children and Families (ACF), the federal domestic child welfare guidance providing agency, launched a historic child welfare package to expand and support kinship care placements for domestic children.

Per the *Flores* settlement agreement, ORR is required to make prompt and continuous efforts toward releasing children to a parent, legal guardian, adult relative, other responsible adult, or licensed program. The sponsorship process (also referred to as family reunification) entails contacting potential sponsors who can care for the child. In fiscal year 2023, of the 113,495 children released to a sponsor, 39% of children were released to a parent or legal guardian (category 1 sponsor), 48% to an adult sibling, grandparent, or other immediate relative (category 2 sponsor), 13% to a non-relative (category 3 sponsor). Under current ORR policies, children can be released to undocumented sponsors. Taken together, ORR releases 87% of children to family, consistent with best practices in child welfare. However, the length of time children spend in federal custody awaiting safe reunification remains a concern.

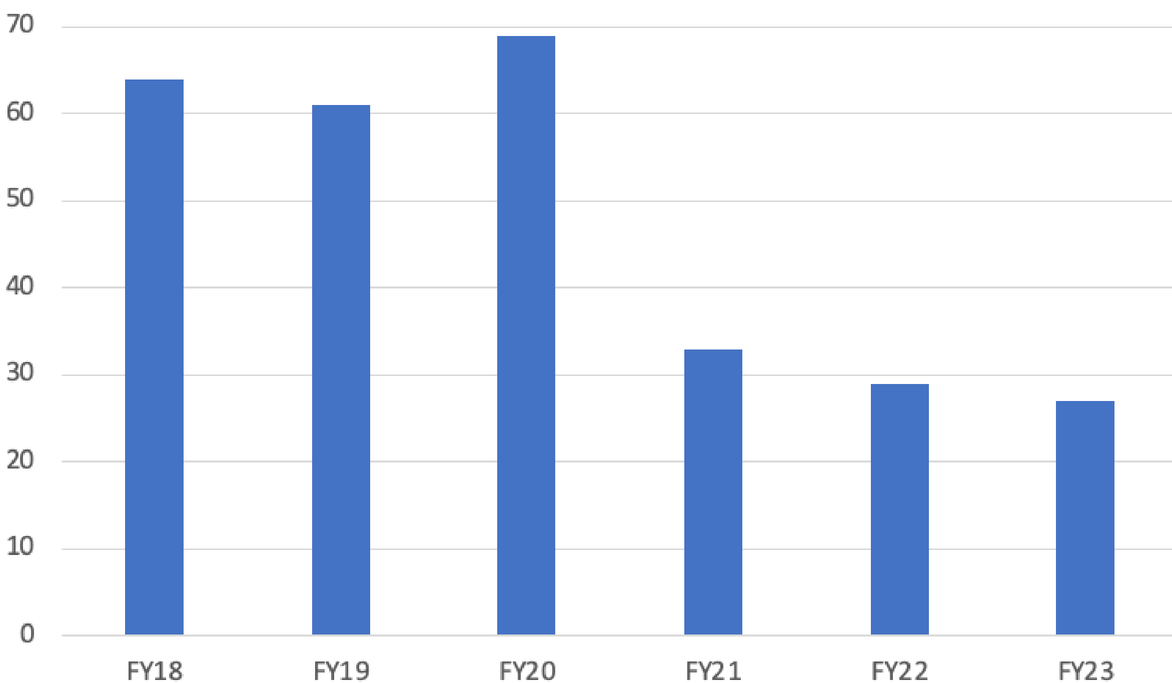
Figure 7: ORR discharge of unaccompanied children by sponsor type (FY2023)



The length of time children are held in ORR custody has fluctuated over time. It bears noting here that all interviewees expressed concern about the mechanism for calculating a child's "length of stay" and whether that was reflective of the length of time in actual custody. Participants all cited concerns that the statistics presented by ORR do not actually reflect the period for which any given child is maintained in government custody.

The recorded length of stay under available ORR data reached an all-time high of 102 days in 2023 and currently averages 27 days in FY2023. Some participants reported stays averaging 120 to 160 days during the Trump Administration. It is important to note that the official figures exclude any time held in CBP custody prior to entering ORR custody nor represent the total length of time a child spends in ORR custody (e.g., placement in foster care, transfers between facilities). Further, research finds that the length of stay is differentially experienced by children depending on the type of placement. For example, the average length of stay for children placed in secure (high security) and staff secure (medium security) facilities reached 183.8 days in 2018. For those without a viable sponsor, ORR may place children in a group home or federal foster care but some children without a viable sponsor remain stuck in congregate care.

Figure 8: Average number of days in ORR custody (FY18 to FY23)



Finding: ORR's family reunification process, in practice, appears to presume a lack of parental or sponsor fitness.

The administrative process to evaluate the safe and timely release of an unaccompanied child from ORR custody to sponsors involves several steps, including identification of sponsors, a sponsor application, interviews, an evaluation of sponsor suitability (including verification of the sponsor's identity and relationship to the child), background checks, home studies (for some children), and post-release planning. ORR enlists this "to evaluate potential sponsors' ability to provide for the child's physical and mental well-being." There is considerable urgency among

facility staff and ORR alike to complete the sponsorship process, as children remain detained until a placement is approved.

Outside of ORR, child welfare best principles and practices presume parental fitness in the absence of allegations or evidence of abuse, abandonment or neglect. The onus is on child protective services to investigate and document abuse, abandonment, or neglect prior to separating a child from their caregiver. Yet, as our research finds, ORR's sponsorship policies appear predicated on a presumption that parents and family members of unaccompanied children are "unfit." To overcome this presumptive deficit, ORR enlists assessments of parental fitness in a series of institutional processes that can be disorienting for children and parents. Our survey found that the administrative process not only is burdensome for families but also fails to effectively evaluate the fitness of caregivers and tends to ignore their rights as parents (if sponsors are parents). When asked to identify the primary reasons for delays in family reunification, respondents shared the following reasons:

Identification and contact with sponsors (61%): Many children enter ORR custody with names and phone numbers of family members or loved ones in the US who may serve as a sponsor. For those without contact information, case managers may contact parents in their home country to identify potential sponsors. Even with the contact information, respondents pointed to obstacles in connecting with potential sponsors. This includes case workers blocking their work phone number when calling potential sponsors (and thus limiting sponsors from returning calls directly to the case manager), contacting potential sponsors during the traditional workday (9:00am to 5:00pm) during which time sponsors may be working and unable to answer the phone, and large caseloads whereby case managers struggle to keep pace with the necessary follow-up. Several stakeholders disclosed that they attempt to circumnavigate these challenges by using their personal phone numbers, WhatsApp, and calling sponsors during their time off—activities that reportedly are prohibited by ORR and facilities. Another interviewee reflected, "It's a Catch-22. I either do the follow up on my personal time and get burnt out or kids are held longer."

Primary Reasons for Family Reunification Delays

- ***Identification of sponsors (61%)***
- ***Sponsors fear immigration enforcement (59%)***
- ***Document requirements (54%)***
- ***Language and cultural barriers (46%)***
- ***Home studies (42%)***
- ***Biometrics (40%)***

An attorney shared that much depends on the quality and training of the case manager when it comes to successfully contacting a potential sponsor. "Sometimes you hit the lottery with a

case manager that is wonderful, trained to stick to the policy, wanting to do everything correctly and appropriately, and very professional. And then you have others where they're just guessing or demanding requirements that are not required for the sponsorship category." (*See: Staffing and Training.*)

***Sponsors fear immigration enforcement (59%*)**: 59% of survey respondents identified that sponsors fear immigration enforcement and thus are fearful or reluctant to complete the necessary paperwork. Staff with a Legal Orientation Program for Custodians of unaccompanied children (LOPC) shared, "Sponsors are unsure who to trust. Just because ORR says that they will keep their information confidential, many don't distinguish between ORR and immigration enforcement because ORR is detaining their child." (*See: Information Sharing.*)

Several interviewees shared that the reasons for delays, including the sponsor's fear of immigration enforcement, often are not shared with children, leaving children to wonder why family members are not completing the requisite paperwork in a timely manner. One interviewee shared, "Many kids feel like their families have abandoned them. If they aren't explained the context, it can inflict a lot of harm on families over the long term." Stakeholders principally pointed to not having time to explain to each child and the confidentiality of sponsor information as the reasons for not sharing these updates with children.

***Document requirements* (54%):** Sponsors are required to complete a sponsorship packet which includes a series of forms and supplemental material depending on the type of sponsor in order for facility staff to vet a sponsor. Survey respondents identified four elements that routinely delay family reunification:

- ***Verification of family relationships*** typically relies on the provision of a series of birth certificates to demonstrate the relationship between a child and their parent (category 1) or family member (category 2). Case managers identify logistical challenges and considerable delays in securing these documents especially when families live in remote villages, confront limited access to public transportation, lengthy wait periods for birth certificates, children born at home without official state documentation, and children who are cared for by extended family or godparents rather than by biological parents. On a program-by-program basis, some facilities have entered Memoranda of Understanding (MoU) with consulates to expedite access to and verification of identity documents.

- ***Proof of identity of adult household members:*** Case managers report that it is often challenging to secure proof of identity of other adult household members as they may be undocumented and fear detection by immigration authorities.

- ***Proof of address:*** Some undocumented individuals do not have the means to live on their own and thus do not have bills or pay stubs in their names to document proof of address. In order to accommodate this, ORR has agreed to receive certified letters from employers or landlords, which may be difficult to secure for those who navigate the persistent fear of deportation.

- ***Sponsor care agreement:*** Case managers and LOPC providers share that generally sponsors fully understand and embrace the opportunity to care for their young family member. However, the sponsorship care agreement itself can prove overwhelming to potential sponsors. In particular, the agreement stipulates that sponsors must provide medical, dental, and mental health care and ensure school enrollment, which is often unrealistic due to income levels and/or tenuous or undocumented legal status.

Language and cultural barriers (46%)*:* Respondents identified that language and cultural barriers often prolong the sponsorship process. This includes the limited languages of ORR materials. Currently the forms provided are only in English, Spanish, Dari, Haitian Creole, Pashto, Ukrainian, and Russian. In addition, several survey respondents pointed to time-related challenges of scheduling telephonic interpreters. "Case managers are often overwhelmed and overworked, so adding in scheduling an interpreter at a set time to meet with a sponsor adds to the workload," an interviewee shared. (*See: Culture, Identity, Language, and Religion*.)

Still others identified unique challenges to children from Indigenous communities in Central America, including anti-Indigenous discrimination, "I've had multiple Indigenous children say that they feel discriminated against. It takes longer to speak through a translator, and they aren't always provided. Indigenous children feel as if they're an afterthought and are prevented from reunifying."

Biometrics (40%). ORR's policy on biometric and biographical information, including fingerprints, has shifted repeatedly. The Obama administration waived biometrics requirements for all closely related sponsors (category 1 and 2A). In contrast, the Trump administrations required biometric background checks for all sponsors and all adult household members. The current policy guidance requires that category 1 and 2A sponsors be fingerprinted, and an FBI criminal history checked "[w]here a public records check reveals possible disqualifying factors… or where there is a documented risk to the safety of the unaccompanied child, the child is especially vulnerable, and/or the case is being referred for a home study." A survey respondent shared, "The Trump administration added steps to the process to slow it down significantly, especially fingerprinting for all household members while not increasing fingerprinting capacity nationwide. So, wait times went from two days to two months for appointments." Indeed, the average length of

time in care increased to 195 days in 2020 amid this added restriction. The Biden administration initially repealed the biometric requirement for category 1 and 2 sponsors and even launched a very promising initiative with CBP conducting mobile fingerprinting upon apprehension. While children were briefly separated, mobile fingerprinting allowed children to reunite with a trusted family member at the border and, thus, forego protracted ORR custody.

Respondents shared that requests for biometrics continued to stoke fears of potential sponsors about how the federal government would collect, store and use biometric data. "No one's data was safe, and with Trump potentially taking office in the next election, it's already having a chilling effect on sponsors." In fact, sponsors must sign the Sponsorship Agreement packet which currently includes that their data can be shared with law enforcement.

Emergent finding: Redlining and the Need to Balance Equities

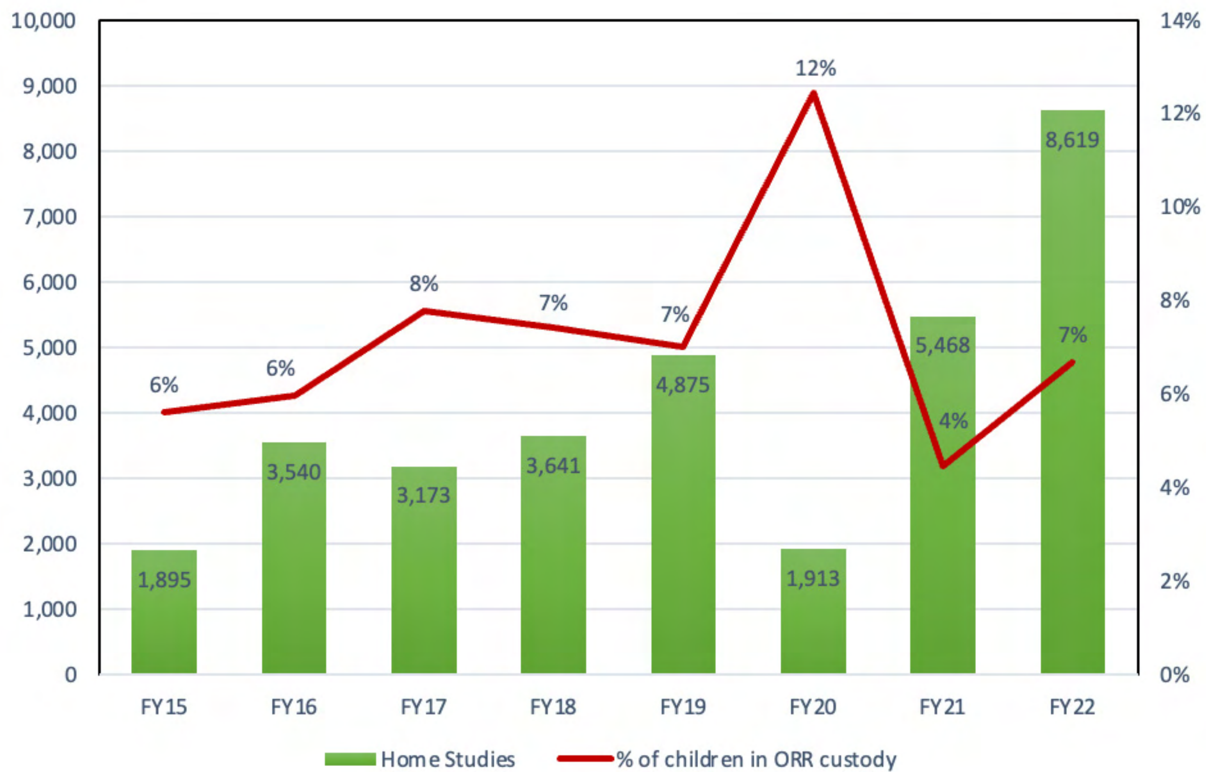
ORR currently tracks names and addresses for individuals who sponsor multiple children from ORR custody. In response to recent media reports on abusive labor conditions for some young people previously in ORR custody, ORR recently has added additional layers of review for sponsors in particular zip codes. Interviewees call this practice "redlining." The term "redlining" refers to the discriminatory practice of denying services (typically financial) to residents of certain areas based on their race or ethnicity. In practice, interviewees observed this informal or internal policy delays reunification of children to some communities even when the sponsor is a family member. They identified red lined zip codes to include communities such as Little Village in Chicago and specific areas in Houston, among other high density migrant neighborhoods. While we recognize the significant media attention to children released to situations of labor exploitation, we also express concern that the practice of redlining. If taking place as described, the practice is highly discriminatory; accordingly, ORR must balance equities, weighing the undue hardship on children who remain detained for protracted periods given the disproportionate scrutiny of their sponsors.

Finding: Home studies are highly problematic and can significantly delay reunification.

ORR defines home studies as "an in-depth investigation of the potential sponsor's ability to ensure the child's safety and well-being." Home studies are required by the Trafficking Victims Protection Reauthorization Act of 2008 (TVPRA) for "a child who is a victim of a severe form of trafficking in persons, a special needs child with a disability (as defined in section 12102 of Title 42), a child who has been a victim of physical or sexual abuse under circumstances that indicate the child's health or welfare has been significantly harmed or threatened, or a child whose proposed sponsor clearly presents a risk of abuse, maltreatment, exploitation, or trafficking to the child based on all available and objective evidence." ORR, facility staff, or a third-party reviewer

can also request a home study. Home studies entail a sub-contracted provider conducting a home visit(s) and interviews with the sponsor and other household members. In 2022, ORR conducted 8,619 home studies. While the largest annual number of home studies to date, the percentage of home studies has remained relatively constant at 6 to 7% of the total number of children in ORR custody.

Figure 9: Number of home studies conducted by ORR and percentage of total children in ORR custody (FY2015 to FY2022).



As mentioned above, domestic child welfare practices presume parental fitness in the absence of allegations of abuse. In contrast, survey respondents and interviewees contend that ORR home studies presume migrant parents are unfit. Rather than assessments that ensure a child's safety, participants shared that suitability assessments are often are often skewed against parents who are poor, male, and/or who come from backgrounds less represented in the overall system, including Indigenous and Black communities, leading to prolonged stays in ORR care even for children being reunified with parents and family members (category 1 and 2 sponsors).

Indeed, 42% of survey respondents indicated that home studies unnecessarily delay family reunification.

Participants identified the following features of home studies as areas of concern:

Few rural providers: Several interviewees identified significant delays in the availability and coverage of home study providers for sponsors in rural areas. One participant explained, "Home studies in rural or remote areas take much longer, months even, because ORR has to find someone to travel there because there are so few providers." Currently, ORR policy requires home studies be completed in 10 days, but respondents shared that the process often takes several months for those living rural areas. A participant shared, "Having an extensive number of home study providers who have capacity to travel, and availability is essential to ensuring cases get picked up and processed quickly. But those 10 or so days don't count all the time spent in deliberation and decision-making that happens if and when the study is actually complete."

In practice, homes studies cause discrimination based on socio-economic background and gender: ORR policy prohibits discrimination based on income, in theory, recognizing that income is irrelevant to parental fitness. However, in practice assessments often include income-related considerations and decisions that prevent family reunification, contrary to ORR policy. One participant shared, "In some of the reports I've seen, the red flags raised are the working hours. In one case, it was a mother who worked long hours and cited her inability to afford childcare for her 12-year-old child. In another, the sponsor's income was low, so how will he financially support his kids? The report said that he has to get a second job to raise his income."

Another participant shared her frustrations at assessments that often involved socio-economic and gendered expectations, "The sponsor in an impossible situation where ORR judges a dad because he doesn't have a separate bedroom for his daughter or, in another case, mom because she doesn't have the space that ORR believes is adequate to look after a child."

Others described home studies identifying concerns about a child sharing a bedroom with the sponsor or that there are too many people living in a small apartment, and as a result, did not recommend their placement with the sponsor. "This does not mean that the sponsor is not the best person to be taking care of the child. It's arbitrary and deeply problematic," an interviewee stated.

In practice, home studies discriminate against/harm children with disabilities: Survey respondents and interviewees voiced frustration at TVPRA-mandated home studies adversely impact children with disabilities or medical conditions. The TVPRA, requires home studies for children with a disability as defined by the Americans with Disabilities Act of 1990 (ADA). On individual explained, "TVPRA-mandated home studies cause the majority of delays in our shelter." Respondents pointed to examples of children with disabilities who have been in the care of their parents who then require a home study to evaluate the parent's capacity to care for their

child. A participant illustrated, "I worked with a child who was set to be reunified with her mom, but she had [a genetic condition] from birth. The FFS [federal field specialist] wanted me to refer for a home study, even though mom also has the same [genetic condition] and has been managing it her entire life as well. It was hard for me to understand the rationale to keep a youth away from her mother for months."

Others pointed to similar situations where children with disabilities lingered in care longer; some attributed these delays to poorly written legislation of the TVPRA that seem to require home studies of sponsors even while there is no specific child welfare concern beyond the presence of a disability or a child's experience of a past trauma. One stakeholder shared, "It's biased and discriminatory and violates the Americans with Disabilities Act (ADA), but because they are migrant kids, there are no consequences." (*See: Children with Disabilities.*) While the home study for some children with disabilities may be mandated by the TVPRA, the statutorily requirement appears to create disparate treatment for some children with disabilities in conflict with the spirit of the ADA.

Finding: Family reunification determinations lack transparency and engage a deeply flawed appeal mechanism.

Stakeholders shared concerns about the discretion of FFSs and the lack of transparency in ORR decision making when determining the release of a child to a family member (category 1 and 2 sponsors). One participant shared a sentiment echoed by several respondents, "I can't tell you the number of times an FFS refuses to release a child to a parent for some reason or other, and then [the FFS] goes on vacation or is transferred and the new FFS releases the kid because they don't see the same concern. There is so much unchecked and arbitrary discretion, and it cuts both ways."

In contrast to the state child welfare system whereby a juvenile or family court judge usually presides over custodial determinations, ORR is an administrative body with no judicial oversight. Therefore, determinations of release and transfer of custody are singularly the responsibility of ORR. It is important to note that if ORR declines to release a child to a parent, ORR is not legally terminating parental rights; in practice, however, the failure to release a child effectually makes a custodial determination. Further, unlike juvenile and family courts that have financial and judicial discretion to provide services to parents seeking to maintain or regain custody of their minor child, ORR is not obligated to provide nor pay for these services. "It's often arbitrary. There is no written plan and no resources or support provided to parents," described an interviewee.

One stakeholder shared that in instances where ORR declines to release a child to her parent, "Parents find another sponsor to complete the process. It's all a ruse because we know that the child wants to be with their parent and will simply go live with them post-release. And then people claim the kids are 'missing.' Rather than actually listen to children's wishes, identify the need, and provide supportive services; instead, it's all about CYA [cover your ass]." (*See: Children's Voices.*)

Our findings resonate with current litigation under *Lucas R. v. Azar* (2018) claims that ORR "regularly prolongs children's detention on the ground that their parents or other available custodians are allegedly unfit yet denies children and their proposed sponsors a meaningful or timely opportunity to be heard on the matter." The Lucas R. preliminary injunction requires the implementation of an appeal processes for both category 1 and category 2 sponsors.

As a result, ORR has incorporated an appeal process into its policy guide. However, participants described that process as deeply flawed, putting the onus on the sponsor and the child to contest the government's determination in a video hearing and without representation. For children detained as a "risk to the community," no best interests assessment is required in order for the government to continue placement (leading, in many cases, to indefinite detention). This procedure exists despite the TVPRA mandate that *all* children be placed according to their best interests. In short, participants to this study have described the new appeal process as "Orwellian" and noted that the success of the implementation is not apparent at this time. Procedures for non-parent relatives remain in litigation.

Recommendations

1. ORR should partner with external child welfare experts within and outside of HHS to review its family reunification processes to ensure its alignment with research-informed, child welfare best practices. This includes:
    - ORR should promptly release children to a parent or legal guardians (category 1 sponsors) or immediate relative (category 2 sponsors) absent allegations of abuse, abandonment, or neglect.
    - ORR should promptly release children to distant relatives and unrelated adults (category 3 sponsors). Although more vetting may be required, in collaboration with child welfare experts, ORR should consider mechanisms for reunification as quickly as possible.

- ORR should continue and expand the "category 2 initiative" so that children can be evaluated by HHS staff before separation from a relative at the border, allowing for direct observation of the child and relative together, preventing the trauma of separation in some cases, and facilitating joint travel of the child and sponsor to their intended destination.
- ORR should conduct a survey of its providers to ensure contracts are made only with agencies who are well-trained and able to perform disability- and trauma-informed, culturally and linguistically appropriate assessments to avoid unnecessary delay.
- For home studies prompted by the presence of disability alone, ORR should remove requirements for additional background checks and fingerprinting.
- For home studies prompted by the presence of past abuse alone, ORR should remove requirements for additional background checks and fingerprinting.
- ORR must promulgate regulations employing a child welfare interpretation of the TVPRA's overly broad (and unintentionally harmful) mandatory home study requirement for any child "who has been a victim of physical or sexual abuse under circumstances that indicate that a child's health or welfare has been significantly harmed or threatened." This definition should be as restrictive as possible especially considering that many migrant children passing through ORR custody are victims of some form of abuse.
- ORR must promulgate regulations and develop policies to comport with the TVPRA's mandatory home studies for children with disabilities under the ADA but that do not engage in discrimination against children and youth with disabilities.

2. Congress and ORR should align federal policy with best practices in child welfare by reducing its reliance on congregate care facilities to detain children and prioritizing the safe and expeditious release of children with parents, guardians, and family members (category 1 and 2 sponsors).
3. ORR should track and report data on home studies by state and zip code in order to identify gaps and opportunities in service provision.
4. ORR should track and report data on TVPRA-mandated home studies coding the statutory basis for the home study (physical abuse, sexual abuse, trafficking concern, disability, or where the sponsor presents a clear risk).
5. ORR should collect information on specific languages spoken by children and sponsors to increase services within those communities.

6. ORR should clarify their metrics for measuring the length of time a child remains in custodial placement. Except for distinct internal review processes, ORR should make the "length in custody" the key metric for reporting how children experience government custody—abandoning the current "length of stay" calculus which is fraught.

7. ORR should flag and require robust reviews for all children whose length of custody is 30 days or longer and for children who have been transferred to a new facility from a current ORR facility. A review should occur every 30 days thereafter by ORR supervisory staff.

8. ORR should establish a clear and accessible administrative process to appeal ORR release (and by default custody) determinations. While the mechanisms incorporated under Lucas R. are a step in the right direction, these should be the floor. Restriction on liberty is a foundational right that must not be denied to children in the name of protection. All children and sponsors should be given access to counsel and a court hearing when their custodial release, and thereby their right to liberty, is denied.

MEDICAL CARE

Article 24 of the UNCRC recognizes the rights of children to "the highest attainable standard of health" and that states should "strive to ensure that no child is deprived of his or her right of access to such health care services." This includes preventative care, primary health, pre- and post-natal health, and health education.

Upon entering ORR custody, children undergo an initial medical health screening (a physical) within 48 hours, including screening for infectious diseases, a dental exam (as needed), and immunizations. Children are prescribed needed medications, specialized diets, and at times, referred to specialists or for emergency health services. In addition, ORR policy indicates that children should have access to reproductive health services, including pregnancy tests, emergency contraception and, when applicable, comprehensive family planning services. Payment for care while children are in custody is managed through a third-party.

Finding: ORR provides quality care for children with documented or visible medical conditions.

60% of survey respondents indicated that ORR provides adequate medical care either "some" or "most of the time." Interviewees indicated that ORR provides quality medical care when children are relatively healthy (e.g., provision of a physical) or when there is a clear-cut diagnosis of a

physical condition. An interviewee explained, "I think ORR does a really good job at addressing the medical needs of kids who have documented medical conditions—tuberculosis, cystic fibrosis, diabetes, or genetic diseases. What the system struggles with are the less visible medical and mental health needs." Several observed that ORR has approved life-saving surgeries and essential treatments for children with pre-existing conditions while in ORR custody.
(*See: Children with Disabilities*.)

Finding: Limited access to specialized medical services
When asked to rank the top three barriers to accessing specialized services for children in federal custody, survey respondents indicated: 1) ORR's treatment authorization requests process, 2) the availability of specialists/providers, and 3) follow-up and monitoring of children's access to specialized medical services.

1. ***Treatment authorization requests:*** Respondents shared a lack of clarity in policies and procedures regarding who can request evaluations and how ORR evaluates treatment authorization requests for specialized health services (particularly for external psychological or psychiatric evaluations), specialized services such as speech or physical therapy, or other diagnostic services including. One participant shared, "It really depends on the FFS if they are willing to entertain the request." An interviewee concurred, "One day the FFS says 'no' and the next, another FFS covering their shift says 'yes.' The facts didn't change. I wish we could point to a clear policy to evaluate the requests." Another participant added, "I don't how the FFS is supposed to effectively evaluate the request. Last I checked none of them are medical professionals."
2. ***Availability of specialists/providers (especially in rural or remote areas):*** Respondents shared that identifying the availability of services or delays in scheduling may prevent children from accessing services. A participant shared, "It takes time to identify a specialist, and where we are located [in rural Texas], those services just don't exist or if they exist, they are a 2-hour drive away." Another participant shared, "When I call to schedule, appointments may not be available for weeks, so we make the first available, but then ORR is pressuring us for faster appointments. It's out of my control." Some participants shared that they navigate these delays by developing relationships with local health care systems or even specific providers to establish priority scheduling for children in ORR custody. One interviewee explained, "Once the higher ups realize that kids are detained and may be detained until they get in for an appointment, most have been willing to work with us."
3. ***Insufficient follow-up and monitoring*****:** Interviewees report that there is often insufficient follow-up and monitoring of the specialized care and therapies for children with specialized health needs. One interviewee shared, "Part of it is a staffing issue. We must have a staff member accompany the child off-site. This takes them away from the supervision of multiple

children on-site." Another participant shared, "Children don't have direct access to providers so if they have follow-up questions about the diagnosis, medication or therapies, so we do our best to play telephone with providers." As a result of this "telephone," complex medical information is relayed to the child and/or parent by a case manager rather than a medical provider. "A lot gets lost in translation literally and figuratively," explained one stakeholder.

As discussed below, limited access to specialists is consequential particularly for children's mental health. An interviewee explained, "I worked with a young girl who clearly was suffering. We pushed and pushed for an assessment. It took nine months to get the FFS to approve a service we ultimately secured pro bono. She was diagnosed with major depressive disorder, but for those nine months, she suffered needlessly." Another interviewee explained, "It's a race between the mental health diagnosis and accruing a number of severe behavioral incident reports that determines a child's outcome—either a therapeutic placement or secure [facility]."

Finding: Inadequate support for sponsors in securing medical care for children delays release

With the rare exception that a child requires emergency surgery, children's need for medical care should not delay their release. Per ORR policy, children with medical needs must have follow-up services or other arrangements in place prior to their discharge. Yet, 42% of survey respondents indicated that sponsors' inability or failure to schedule medical appointments may delay a child's release.

A physician who routinely works with unaccompanied children concluded, "I have not seen a lot of support for the sponsor. They're just like, 'Sponsor, figure this out.' And the sponsor is desperate to get the child out. They're trying, but they just don't have any direction on medical insurance. They don't know how to manage it." Another interviewee reflected the same concern, "In most instances, there's not going to be a [post-release] case manager right away helping them access health care. So, we're asking the sponsor to make this appointment, but a lot of times that also holds up the release."

Yet another participant lamented that, "We have kids, especially those who had home studies, who need a specific appointment scheduled as contingent upon their release, but 1) the sponsor doesn't know where to begin to locate a specialist, 2) the kid isn't even in their custody yet so they aren't sure when to schedule it if there is availability, and 3) kids can't apply for CHIP [Children's Health Insurance Programs] until they live in the state where they are seeking medical care. It's a lot of chicken and the egg."

It is important to note that undocumented children do not qualify for federally funded programs like Medicaid, and children's coverage through ORR's third-party contractor ends when they leave HHS custody. Twelve states and Washington DC provide critical state-based health coverage for all low-income children regardless of legal status through Children's Health Insurance Programs (CHIP). Even in these states, providers shared that there are significant delays in applying for CHIP resulting from a lack of communication between ORR, facility staff, post-release providers (where applicable), and sponsors on the date of a child's imminent release, eligibility criterion, and application procedures. Our findings echo recent research on systemic barriers to meeting the medical and mental health needs of unaccompanied children following release.

Finding: There is a disconnect between ORR policy and youths' access to reproductive health services.

Under ORR policy, facilities must provide full access to reproductive rights, including prenatal care, family planning and reproductive health services (e.g., pregnancy tests, emergency contraception, and abortion), and emergency health services. In practice, however, because ORR facilities are licensed by state child welfare authorities, ORR facilities follow state policy on reproductive concerns and decision-making regarding age of consent, parental consent, and parental notification.

Elsewhere in the report, we discuss ORR efforts to place pregnant teens in states that provide for reproductive health and the restricted control of youth in making decisions about their health care and parenting choices while in federal custody. (*See: Pregnant and Parenting Teens, See: Mental Health.*) Here, we focus on the availability of resources for youth with reproductive health needs.

Data indicate that youth face difficulties receiving appropriate and timely care specifically with pregnancy-related situations. One participant shared, "There is a lack of availability in the medical clinics that we bring kids to. Sometimes it takes weeks to get her into an OBGYN. We face a lot of pressure from ORR to be getting them into those appointments but sometimes they don't exist for new patients."

One interviewee highlighted detrimental consequences from delayed responses to reproductive care. "For example, if the child wants to terminate a pregnancy, but they're close to some sort of deadline in the state where they're currently at, they might need some sort of transfer. Transfers sometimes happen quickly and sometimes don't. A lot of red tape can mean that a person might need a later term abortion as opposed to an earlier term abortion."

Recommendations

1. ORR should establish a simple, transparent process for a child, family member, the child's attorney, or an appointed Child Advocate to request specialized medical evaluations and therapeutic services with clear evaluative criterion and create a transparent appeal process for treatment denials with an external panel of medical professionals.
2. ORR should not make release contingent upon services if parent/sponsor called but could not secure an appointment. Calling to schedule an appointment is sufficient evidence of intention to secure services if/when they become available. This can be addressed further by ORR via post-release services.
3. Facilities should enhance communication and develop relationships with community health systems to meet the specialized health needs of children while in custody to ensure their timely access to care.
4. ORR and Vera Institute for Justice should expand LOPC programs to support sponsors who need assistance in identifying and scheduling medical and mental health appointments for children post-release and to apply to CHIP, when available. In states without CHIP, ORR should provide health insurance for the first three months following release to ensure greater continuity of care.
5. ORR should provide all sponsors with a stipend for 90+ days of prescriptions provided to children while in custody.
6. ORR should prioritize contracts for new facilities in areas of robust, high quality medical services nearby.

MENTAL HEALTH

Many children entering federal custody have experienced violence or trauma in their countries of origin, stressful life experiences, dangerous journeys, and inhospitable conditions of detention upon arrival. As a result, children may experience a broad range of mental health symptoms, particularly depression, post-traumatic stress, and anxiety. Detention itself can be disorienting to young people as they grapple with a lack of freedom and uncertainty of who to trust whether in CBP or ORR custody. So too, young people contend with considerable anxiety about their futures, including whether they will be reunited with family or permitted to remain in the U.S.

Within 72 hours of entering ORR custody, ORR policy instructs facility staff to conduct an intake assessment which includes questions about the reasons for the child's migration, past experiences of violence or abuse, and any mental health history and concerns. ORR policy requires that children receive weekly individual and group counseling. Requests for specialized diagnostic and mental health services provided outside of detention are reviewed by the federal field specialist (FFS) on a case-by-case basis.

Finding: Providers identify that children do not receive high quality mental health care.

Article 24 of the UNCRC indicates that children have a right to "the highest attainable standard of health" When asked "Do children in ORR custody receive the highest standard of mental health care?", 90% of respondents shared that they believe that children do not receive the highest standard of mental health care in ORR facilities. Stakeholders identified multiple factors influencing the quality of care, including high caseloads for clinicians (33%), a lack of cultural competency (24%), limited bi-cultural and bilingual staff (26%), and treatment modalities (e.g., group counseling) that do not meet the individualized needs of children (24%). Interviewees highlighted that Indigenous language speakers and Afghan youth in particular struggle to receive linguistically and culturally appropriate mental health care, identifying instances where cultural beliefs and practices are pathologized (e.g., visions diagnosed as hallucinations), or telephonic interpretation is not utilized in therapy sessions.

> ***According to survey respondents, 90% shared that children in ORR facilities do not receive the highest standard of quality mental health care.***

Finding: Children suffer from detention fatigue which adversely impacts their mental health.

Interviewees shared that young people grapple with past traumas in tandem with detention fatigue which adversely impact their mental health. Interviewees describe detention fatigue as children struggling with confinement and a lack of freedom with symptoms ranging from mild stress, anxiety, or depression; "acting out" behaviorally; to threats to harm oneself or abscond from custody. Researchers have documented how young people describe their experiences of ORR facilities—a regimented schedule in 30-minute increments, fluorescent "lights that never turn off," the constant din of noise from other children, and screaming at night of children awakening from nightmares. They likewise contend with shame or failure for being apprehended, emotionally difficult phone calls with family members, and uncertainty of their futures.

An interviewee shared, "Kids' biggest mental health challenge is 'detention fatigue' which includes distress due to the reunification process, lack of clarity and transparency about the progress of their case and being separated from family. Therapeutic services often do not address these issues.

> ***The most therapeutic intervention is reunification and post release services."***

Another participant added, "Kids are being restricted in ways they've never been before and held in settings separated from their families, among strangers they don't know. The longer they are in custody, they experience symptoms of detention fatigue, including insomnia, irritability and worsening depression. This is exacerbated by frustrations with their legal cases or if they receive bad news from home."

Interviewees shared that facility staff are not always attuned or effectively trained to detention fatigue. One participant explained, "Staff perceive children are acting out or are a behavioral problem rather than understanding that these behaviors are a natural reaction to abnormal experiences of trauma."

An interviewee explained how staff may inadvertently penalize children for behavioral outbursts resulting from detention fatigue: "In my experience, SIRs [significant incident reports] come from staff's non-understanding of trauma.

> ***"Children get caught in a vicious, institutionally fabricated cycle, ultimately being punished for their trauma with increased time in detention."***

The participant went on to express that all staff interacting with children—not just clinicians—should receive better training on trauma-informed care and de-escalation techniques. (*See: Safety and Protection. See: Staffing and Training.*)

Finding: Release from custody can be contingent upon children's disclosures to sponsors or family in home country.

Many survey respondents and interviewees alike described examples of children feeling compelled to disclose past histories of child abuse, rape, HIV+ diagnoses, sexual orientation, pregnancy, and paternity to their family members or prospective sponsors. While there is no specific ORR policy on disclosing this type of information or level of detail, our research shows that this practice occurs regularly across facility types and locations. The rationale, a family reunification specialist explained, is "We want children to have close relationships with their sponsors and get the care they need. If the sponsor doesn't know what they are getting into, then they can't effectively support the child."

Staff described experiences of both FFS and third-party reviewers known as case coordinators expressly requesting children to disclose often-traumatic experiences as contingent upon their release from federal custody. "Sometimes it's a specific request, and sometimes it isn't, but it is

understood," one individual explained. "Over time, we learn that kids are getting stuck in care because a child hasn't disclosed to mom that her uncle abused her back home. The quicker she discloses, the quicker she gets released. So, yeah, it isn't a policy per se, but the repeated requests make it clear that this is the expectation."

An attorney shared the experience of a young client who was compelled to disclose how she was raped in route to the U.S., "She said that she felt so victimized by having to write out how she was raped. It took her several weeks, and the case manager was getting impatient that it was taking so long. Then she had to read it to her mother over Zoom. She had decided to just leave it in the past and not revisit it. She has every right to handle her pain and the trauma she suffered in her own way." Stakeholders anguish over balancing a need to for the sponsor to be able meet the child's trauma-based needs with abject deprivation of agency (and additional harm) associated with a forced disclosure. In all instances, respondents recognized that "forced disclosure is not the answer."

These disclosures also occur related to pregnancy and paternity. A stakeholder explained that often they want to know the paternity of a child for pregnant and parenting teens "in order to evaluate if they were abused, trafficked, in a forced marriage, or if the pregnancy results from statutory rape. We need to know who the father is to make this determination."

Still other stakeholders shared that they encourage disclosures of gender identity or sexual orientation in order to ensure a child will "feel comfortable in their new home" and "so parents can begin to understand their child better." According to ORR policy, a Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, and Asexual (LGBTQIA+) youth's sexual and gender identities are confidential, and "is only shared when disclosure is necessary for medical or mental health treatment or the youth requests the information be shared for a particular purpose."

These encouraged—and in some instances, compelled—disclosures are contrary to best practices in working with trauma survivors and LGBTQIA+ youth. A participant shared, "Some children show great wisdom and self-reflection, expressing that numbing the trauma in detention is actually what helps them to manage the day to day. Compelling them to describe the trauma they suffered when they aren't ready is inflicting yet-another trauma."

Interviewees described that these disclosures create considerable anxiety for children, at times leading to self-harm and suicidality, and frequently result in children being stepped up to a higher level of care. One interviewee analogized, "It's like setting their house on fire and refusing to show them how to use a fire extinguisher." The disclosures, the participant described, exacerbate symptomatology without equipping children or their families with the tools to begin to process and heal from trauma.

Finding: ORR has limited mechanisms for monitoring the use of prescription medication.

ORR has policies and procedures on how staff must ensure the safe, discreet, and confidential provision of medications to children, the secure storage of medications, and the controlled administration and disposal of all drugs. Yet, less clear are the guidelines and safeguards for the use and monitoring of psychotropic medication or other medications used to regulate behavior, such as melatonin or other sleep-inducing medications. When psychotropic medication is prescribed, our research reveals several concerning patterns across facility types and locations.

Lack of parental involvement or consent: In most states, health care providers require consent from a minor's parent or legal guardian to prescribe medication. While in ORR custody, unaccompanied children are under the legal guardianship of the federal government; thus, in some instances legal consent can be given by ORR (with the FFS as its proxy). Our research found that attempts to include parents in medical and mental health decisions, including medication, vary considerably across facilities and even by provider. Participants shared confusion as to if the FFS or someone else in ORR can consent and when/if they are required to follow state law. One participant shared, "We see lots of medically complex cases, so we regularly consult and involve parents in decisions about treatment, medication or surgery, yet it isn't the same for psych[iatric] meds. They aren't as involved."

Other participants shared that the lack of involvement stems from the following reasons: balancing high caseloads with the additional time needed for parental involvement; parents not participating in sessions due to availability, interpreter access, technology access, and/or limitations with telehealth visits (e.g., state law can restrict access to telehealth visits when out-of-state or out-of-country, etc.); non-specialists (case managers) delivering information about medications to parents rather than the prescribing provider themselves; cross-cultural communication challenges to explaining medication use to parents with little to no exposure to psychotropic medication or with differing understandings of mental health; and a desire to protect the child's confidentiality from their parent(s).

Children's loss of autonomy: Some states have provisions that allow children to consent to specific types of treatment and medications, including mental health care whereby children can often consent at younger ages. In ORR custody, we found that children have limited opportunity to consent to take or not take medication. Stakeholders shared that in some instances, health providers (e.g., nurse practitioners, physician assistants, primary care physicians, etc.) prescribe psychotropic medications without explaining the purpose of the medication or without using an interpreter. "Often children don't have a full information and understanding of what they are told to take and why," a case manager shared. Children may experience adverse side-effects including drowsiness, disrupted sleep, and weight gain whereby they wish to discontinue medication or

have limited access to follow-up visits to modify dosage. Others described witnessing children being told "to just take it" and "do what you're told" when children ask questions or express a desire to stop taking medications. (*See: Children's Voices.*)

Limited monitoring and investigations, especially in residential treatment centers: Survey respondents and interviewees shared concerns about limited oversight and monitoring of medication use in facilities, especially in residential treatment centers (RTCs). At the time of writing, there are three in-network RTCs and several out-of-network RTCs. An attorney shared, "There is so little appetite at ORR to investigate the use [of psychotropic medications] and so few mechanisms for us to report its abuse other than looking for a sympathetic FFS or suing. It's just not productive for us, nor safe for kids." Some attorneys who work routinely with RTCs voiced concerns about ORR's occasional use and limited monitoring of out-of-network facilities which may overuse psychotropic medications for children.

Concerns of provider (over)use and ORR's limited monitoring of prescription medication have come under continued scrutiny, including the Office of the Inspector General (OIG). In response to ongoing litigation under *Lucas R. v. Azar* (2018), providers identified a precipitous decline in the number of children prescribed psychotropic medication. *Lucas R. v. Azar* litigation contends, and OIG echoes, that the government regularly places minors in ORR facilities where they are administered powerful psychotropic medications for weeks, months, or years, without procedural safeguards and without providing notice to or obtaining the consent of their parents, even when those parents are present in the United States and readily available to grant or withhold consent.

The *Lucas R. v. Azar* stipulated settlement agreement (November 2023) and approved settlement agreement (May 2024) make some promising changes to ORR's use and monitoring of psychotropic medications, including requiring informed consent from a child's parent or close relative sponsor in most cases, providing for informed assent from children over 14 years old, protecting children and their consenters from retaliation for withholding or withdrawing consent to psychotropic medications, and increasing oversight of the administration of psychotropic medications across the ORR system. These impending shifts in policy and institutional practice will provide critical safeguards for children in ORR custody.

Finding: A custodial, congregate care setting is anathema to trauma-informed care.

Trauma-informed care generally describes how providers can better serve people who have experienced traumatic life events. In practice, trauma-informed care means assessing and modifying services to include a basic understanding of how trauma impacts the life of an individual seeking services and creating opportunities for survivors to exhibit control and autonomy over the conditions and choices that impact their lives. Mental health clinicians we interviewed for this study consistently shared the challenges of providing trauma-informed care within the federal custodial system for unaccompanied children:

Children have limited control and autonomy over their lives while in federal custody**:** Mental health clinicians identified several challenges of providing effective, trauma-informed care from a space of confinement. One participant shared, "By definition, detention cannot be a trauma-informed space for young people. Their developmental needs, separation from family, and liberation are all being controlled by a government entity. Unaccompanied minors do not have autonomy while in ORR custody." Another participant added, "It's unclear to me, as a clinician, how I can really be trauma-informed when I work in a system that is so antithetical to restoring the autonomy, agency and control of children over their own lives." One participant recommended, "These kids are being held in a place that is not designed for children. Children need to be in less restrictive placements to receive trauma-informed and trauma-responsive care. Kinship and community-based care are the child welfare gold standard worldwide, not institutional care."

ORR policies and facility practices at times prioritize administrative needs over child-centered practices**:** Interviewees identified how ORR administrative processes at times are prioritized over trauma-informed care and child welfare best practices. Some attributed this tension to a lack of child welfare expertise within ORR administration and among facility staff that enlist more compliance-based approaches without understanding how trauma impacts children. This explanation was particularly prevalent among those who work in larger facilities and among staff with high caseloads. An interviewee illustrated, "The obfuscation of information on family reunification prevents facilities from being trauma-informed." Others pointed to the ways immigration enforcement historically has shaped ORR policies and practices through an emphasis on containment, monitoring, and surveillance over the best interests of children.

***There is limited understanding of how trauma impacts children's behaviors**:* Several clinicians pointed to a lack of understanding of how trauma impacts children's behavior. (See the above discussion on detention fatigue.) One individual attributed this limited understanding, in part, due to a lack of training and qualified staff, "Children in federal custody are actively being traumatized, and ORR staff, me included, are complicit. The three shelters where I have worked have

provided minimal therapeutic services; many mental health staff are not required to be licensed; and therapy sessions are monitored and surveilled."

> ***Another critiqued ORR policies and institutional practices that penalize children for their traumas, "ORR created instruments like SIRs when kids tell us about the trauma that led them to flee and then those are used as justification to detain them longer. Kids are literally being punished for being traumatized. It creates a cascade of barriers—home studies, assessments, forced disclosures—while their freedom hangs in the balance." (See: Safety and Protection.)***

These findings are consistent with research on the challenges of providing trauma-informed care in congregate care settings and the importance of family and family-like placements to ensure children's health and well-being.

Recommendations

1. Pursuant to *Lucas R. v. Azar*, ORR is required to conduct a needs assessment across its network. To advance this directive, ORR should partner with child mental health clinicians and child welfare experts to evaluate ORR's mental health service delivery policies and practices, identifying ways to ensure ORR mental health services are consistent with child welfare best practices.
2. ORR should issue clear guidance to ORR federal field specialists and all stakeholders that a child should not be compelled to disclose abuse, LGBTQIA+, or paternity as a contingency of their release from federal custody and that sponsors should not be denied on the basis that they are unaware of information that children choose not to disclose. If ORR determines that a child cannot be safely released unless the sponsor is aware of the child's mental health needs, disclosures should be limited to the information necessary to enable the sponsor to access services for the child.
3. ORR should establish a robust system for monitoring the use of prescription medication both in ORR facilities and out-of-network placements with particular attention to actively involving children and parents in decision-making. Consistent with existing recommendations made to the proposed federal regulations:
    - ORR should identify which individuals are authorized to offer consent, specifically "a child's parent or legal guardian, whenever reasonably available, followed by a close

relative sponsor, and then the unaccompanied child themself (if the child is of sufficient age and a doctor has obtained informed consent)." Care provider staff should never be permitted to authorize consent.

- ORR should ensure that consent was offered freely without undue influence or coercion.
- ORR oversight of administration should include "reviewing cases flagged by care providers and conducting additional reviews of the administration of psychotropic medications in high-risk circumstances, including but not limited to cases involving young children, simultaneous administration of multiple psychotropic medications, and high dosages."
- ORR should engage qualified, child and adolescent, medical professionals who "are able to oversee prescription practices and provide guidance to care providers."

4. ORR should track all information relating to the administration of psychotropic medications, including data related to diagnoses, prescribing physician's information, name and dosage of medication, documentation of informed consent, and any emergency administration of medication.
5. To the extent practicable, ORR should prioritize geolocating children as close to family or sponsors as possible to facilitate their release. A child's release has been described adeptly as "the most therapeutic intervention" available.

RECREATION AND LEISURE

Leisure, recreation, and outdoor activity are critical for children's physical health, mental health, and social development. Physical benefits include improved strength and endurance, healthy bone and muscle development, motor development, weight management, and reductions in myopia (nearsightedness) risk. Time in the sun increases vitamin D production which leads to reduction of inflammation as well as modulation of cell growth, neuromuscular and immune function, bone growth and strength, and glucose metabolism. Even when the weather is not ideal, outdoor activity is essential for healthy childhood development. Leisure and recreation also have positive impacts on mental health by reducing anxiety, stress, and depression; improving academic achievement; and increasing self-esteem for children and adolescents. Physical activity helps to improve communication skills, develop friendships, increase athletic skills, model behavior development, enhance self-esteem and self-confidence, increase autonomy, and create feelings of community and belonging.

Recognizing the importance of recreation and leisure for child and youth development, ORR has policies that require children to have access to recreation and leisure, including daily outdoor activities, weather permitting. Consistent with HHS' Physical Activity Guidelines for Americans,

ORR guidelines stipulate that children should engage in at least one hour per day of large muscle activity and one hour per day of structured leisure time activities other than television. Where there is no educational instruction, ORR guidelines increase recreation and leisure to three hours per day. Similar to the CDC recommendations, these recreation and leisure activities are separate from the weekly physical education requirement typical in schools. Where there are insufficient on-site recreation areas at a facility, ORR directs facility staff to take the children to off-site parks, community recreation centers or other suitable locations and to provide a higher staff-to-child ratio in those instances.

While ORR guidelines on play, rest, and leisure are clear and quantifiable, they are not always followed. Our research finds that permanent facilities often do not have adequate outdoor spaces or amenities to meet the leisure and recreation requirements critical for healthy child development. While now closed, many of the emergency intake sites (EISs) and influx care facilities (ICFs) opened by the Biden administration in 2021 and 2022 did not meet the requirements for outdoor recreation and leisure despite the ORR policy mandate.

Finding: Outdoor spaces or amenities vary considerably across facilities, resulting in some facilities not meeting ORR requirements for recreation.

Children's access to outdoor space and recreational activities varies considerably by facility and location. Only 38% of respondents indicated that children are able to go outdoors to play. The reason for limited outdoor time varies by site including limited green space adjacent to facilities in urban areas, facilities located in neighborhoods that staff indicate are unsafe, fear of children absconding when taken to neighborhood parks, insufficient facility staff to meet staff-to-child ratios for off-site outings, and unsafe levels of heat in the summertime (especially in Arizona and Texas where the majority of facilities are located).

In addition, facilities appear slow to return to recreation and leisure activity levels prior to the onset of the COVID-19 pandemic which halted off-site activities, and at times replaced physical education time with outdoor play time. 25% of respondents reported that children "rarely" participate in off-site recreation. One participant shared that facility staff were "able to take children to museums, the aquarium, the zoo, on hikes, and concerts pre-COVID. Now, outings are much less, if at all." Some reported that children "spend all day inside: or "get an hour in a parking lot," making facilities "feel like jail."

Some other facilities have full-sized soccer fields, basketball courts, play structures for younger children, and ample options for outdoor play. These settings can be desirable to achieve recommended physical activity. In other facilities, children are allowed to go outside only once the sun

has set when heat levels are safe. Survey respondents additionally shared examples of urban facilities that rope-off a parking lot where there is "little effort to engage kids so they simply stand around." Technically, this standard meets federal requirements for outdoor time, yet the space and lack of organized activities are not conducive to large motor activity necessary for appropriate physical development.

In 2021 and 2022, ORR opened EISs and ICFs to house tens of thousands of unaccompanied children in converted convention centers, stadiums, and military bases. While our study focused only on ORR's permanent facilities, discussions of limited outdoor recreation and leisure activities in EISs and ICFs surfaced. Some reported that children in these intake and influx faculties were indoors 24/7. An attorney shared, "Those that had been actually in the EIS never got to go outside. Some of them were at convention centers because they'd come from CBP, where they also never went outside. So it had been for some of them, like many, many weeks at a time, that they hadn't been outdoors, period." Because EIS and ICF programs are not run as ORR programs, they are not required to meet the same licensing standards of permanent ORR programs.

Recommendations

1. ORR should ensure adequate physical space for large motor development and recreation and leisure for all youth within each facility.
2. ORR should expressly prohibit facilities from the substitution of outdoor physical education for outdoor leisure and play.
3. ORR should prioritize contracts for facilities with existing capacity for/capability and commitment to outdoor play and leisure. For example: urban facilities with existing space within the building for large motor development and adequate outdoor leisure time; facilities in hot climates with covered outdoor areas; and facilities with access to full-size sports fields (e.g., basketball, soccer) and appropriate serviced spaces (e.g., grass instead of concrete).
4. While ORR may need flexibility for truly unexpected influxes or increases in children arriving, ORR should be concurrently expanding state-licensed capacity in family-based and small-scale placements that can be flexed for use during such times.

ACCESS TO EDUCATION

Unaccompanied children arrive in the United States with a broad range of experiences with formal schooling. Some have completed a few years of instruction in their home countries while others are close to graduating from high school. Literacy rates and knowledge of the English language likewise vary considerably. The ORR Policy Guide requires facility staff to conduct an educational assessment to determine a child's "academic level" and "any particular needs" within 72 hours of placement. Care providers are required to provide educational services based on each child's "individual academic development, literacy level, and linguistic ability." The *Flores* settlement agreement stipulates that children receive a minimum of six hours of structured education in science, social studies, math, reading, writing, physical education, and English as a second language (if applicable). Our research finds that there is significant variability in educational assessments, learning conditions, and the quality of instruction across facilities.

Plyler v. Doe (1982) established the pivotal judicial decision that every child in the US has the right to equal access to public education. The right to equal access to educational services for children who are not "legally admitted" to the United States—which includes unaccompanied youth in federal custody—has been recognized as a human right and required by both federal and state law.

Our findings reveal that children who speak languages other than English and Spanish confront restricted access to linguistically- and culturally-appropriate materials. The varied quality of instruction is attributed, in part, to the disparate qualifications of instructors and the size of facilities. Large facilities in particular struggle to meet the diverse educational experiences and needs of children who may be recovering from dangerous migratory journeys and confronting uncertain futures. Our research likewise found that children in custody who do not attend public schools for prolonged periods of time, including children in transitional foster care, may lose months and even years of schooling.

Finding: Assessments, learning conditions, and quality of instruction vary considerably across facilities.

While ORR policy delineates requirements for the number of hours and subjects of instructions, assessments and instructional quality vary considerably across facilities. Staff shared that learning assessments often fail to capture the diverse educational levels of children in custody. In several Texas facilities, for example, participants shared that assessments are only conducted in Spanish. One interviewee explained, "Even if a child does not read, write, or speak Spanish, they are given the same test. They get zero on everything, and I just don't see anyone looking further to see why they are scoring zero. Is it because they are not literate in Spanish or because they have a learning disability? Or is it because they speak an Indigenous language and not Spanish?"

Another participant echoed the concern, "Oftentimes, Indigenous youth are identified as having developmental delays or assumed to have a learning disability of some kind, and in some instances even psychiatric conditions, when really, it's either linguistically or culturally, there is miscommunication. Good assessments should distinguish that."

In addition, we found considerable variation in the classroom conditions and quality of instruction. In smaller facilities and smaller classrooms, staff shared that they felt equipped to get to know their students, to assess their learning needs, to tailor instruction to their needs, and to select materials that were relevant to the lives and backgrounds of their pupils. In contrast, staff in extremely large facilities (500+ children) reported overcrowded classrooms and curriculum that repeated every 30 to 45 days.

> ***Another participant lamented, "Most of the tools to engage young people are taken out of our toolkit. There are restricted opportunities for experiential learning, field trips, experimentation, and other ways of engaging young people in the material. We don't know who will be in our class from one day to the next, so it makes it difficult to plan and to ensure any continuity for the kids who remain."***

Others shared that the curriculum was very "American-centric" and "assimilationist" whereby instruction focused on learning American history, politics, and values with little regard to the histories and cultures from around the world. Further, ORR requires facilities to provide materials in languages other than English to children. Across facilities, we found most programs had both instructional and reading materials in Spanish but struggled to provide materials in other languages. One participant shared, "When Afghan youth arrived, there were no worksheets, no books, no curriculum. It was a huge problem."

A participant who worked in several ORR facilities reflected, "Education in ORR facilities is mostly about behavior management. We have 35 to 50 kids in a room—all with different levels of experience with schooling, many who have been recently traumatized or are separated from their families—and we expect them to sit quietly and learn for six hours." Respondents described examples of behavioral charts to incentivize or to punish behavior, public shaming of children who do not behave, instructors threatening children with SIRs for misbehaving, and instructors telling children that their (mis)behavior influences their immigration cases and their release from ORR custody. "Threats are not conducive to learning," one respondent critiqued. "Often the first-time kids experience US education is [in] detention. If they are punished in the classroom for trauma-related behaviors or not being adequately assessed, they quickly become disenchanted with the education in the U.S."

Finding: There is considerable variation in the training and qualifications of teachers and retention of qualified teachers remains challenging.

Respondents reported a deficit of qualified instructors, yet reasons vary across regions. In California, Illinois, and New York, for example, respondents point to low salaries and poor benefits when compared to unionized teaching positions currently in demand in public schools. In other regions, administrators point to the challenges of teaching within the confines of detention rather than in community settings as dissuading teachers who might otherwise be interested in serving newcomer children. One interviewee observed, "We tend to hire recent graduates or ESL instructors with little to no training."

Yet, some instructors innovate to respond to the unique needs and settings in which they work. One respondent shared that a facility had a language lab with Rosetta Stone in a computer lab. "What a great resource! It allows students to start and continue at their own pace. They can learn English but if they already know English, they can learn another language. It is a very concrete, specific skill and a constructive use of their time. And helped teachers to manage the incredible diversity of experiences, and the abilities of children coming in and out of the classroom." A few facilities offer General Education Development (GED) programs for children who arrive with greater English or Spanish fluency and educational background.

Some participants lamented the difficulties associated with retaining instructors specifically with the challenge of working conditions. "Given the trauma histories of kids and how it shows up in the classroom, it can be incredibly challenging work." Without support and ongoing training, teachers quickly burn out. Many participants called for greater collaboration to ensure that children and teachers are set up for success in the classroom. This includes educators trained in effective assessments, trauma-responsive teaching methods, culturally appropriate instructional methods, relevant and inclusive curriculum, and sufficient professional development and support. (*See: Staffing and Training.*)

Finding: Children held in ORR custody for prolonged periods experience difficulty in the academic transition to public school.

Interviewees and survey respondents shared that there are several challenges confronting children who remain in ORR custody for prolonged periods. In addition to a repeating curriculum, children are typically placed in a classroom based on assessments of literacy or academic level rather than chronological age as is customary in the U.S. public school system. This can make the transition into public schools following release challenging. One educator in a large public school district serving newcomer children lamented, "The papers they bring from ORR mean nothing. It's just a bunch of worksheets if anything at all. It's lost time for students." Another stakeholder echoed the concern, "For the kids that are in custody for months, even years, they walk out of facilities with nothing to show for their educational achievements, except maybe some English that they've repeated in six week increments over and over."

Moreover, not all programs offer state-accredited education, including transitional foster care, some residential treatment centers, and some long-term foster care programs. Rather than integrate into the community and socialize in the space of school, some children in foster care are often taken to an off-site location for instruction. "Think of a one-room schoolhouse but without a certified teacher," one respondent shared.

According to ORR, facilities adapt or modify local educational standards to develop curricula and assessments and provide opportunities for learning advancement, such as independent study, special projects, pre-GED classes and college preparatory tutorials. Yet, interviewees consistently shared that there is little support for programs seeking to innovate learning opportunities for children.

Recommendations

1. ORR should partner with education researchers to develop culturally and linguistically appropriate assessments and curriculum for children while in custody, with attention to varied literacy and experiences with formal education systems as well as their social-emotional learning.
2. ORR should ensure that educational materials and services are available in primary languages of children in custody, including Indigenous languages.
3. ORR should incentivize facilities to pilot programs that partner with the local school district to provide instruction and/or to certify education provided in ORR facilities.
4. ORR should incentivize facilities to integrate experiential learning and field trips outside of the facility in their educational programming.
5. Children who remain in custody beyond 30 days or who are in transitional or long-term foster care should be enrolled in and attend local public schools such that they can receive credit for their education.
6. ORR and stakeholders should create professional learning communities to create opportunities for gathering and sharing and to share best practices, materials, and lesson plans.
7. ORR should ensure that children are provided with their full case file and educational record upon release.
8. ORR should follow state guidelines for assessing children with learning disabilities. (*See: Children with Disabilities.)*

ACCESS TO LEGAL COUNSEL

Upon apprehension, unaccompanied children are placed in deportation proceedings. With few exceptions, immigration law does not distinguish between children and adults. Adults and children alike—including infants—are held to the same evidentiary standards and credibility requirements, all without a court-appointed attorney. Legal representation is critical to children's long-term outcomes—children with representation are seven times more likely to be successful in their petitions for legal relief.

Under the Trafficking Victims Protection Reauthorization Act of 2008 (TVPRA), HHS "shall ensure, to the greatest extent practicable… that all unaccompanied [] children who are or have been in the custody of the Secretary or the Secretary of Homeland Security…have counsel to represent them in legal proceedings or matters and protect them from mistreatment, exploitation, and trafficking." Accordingly, HHS provides funding for legal service providers (LSP) to conduct Know Your Rights (KYR) presentations and legal screenings for all unaccompanied minors in their care, as well as "to the extent of available appropriations" to provide direct legal representation to specific children who are in or have passed through ORR custody.

Over the past decade, ORR has invested in expanding legal representation to unaccompanied children both in custody and following release. Currently, via its subcontractor Acacia Center for Justice, ORR provides direct representation at the government's expense to children in the Unaccompanied Refugee Minor (URM) programs; children in a long-term foster care (LTFC) or non-ORR residential treatment programs (RTP); children without a sponsor who are unable to be placed in LTFC; children in ORR custody who must appear before an immigration judge with the Executive Office of Immigration Review (EOIR), specifically for master calendar hearings and voluntary departure, and children placed in and released to the geographic area (geozone) of the LSP. With few exceptions, upon release from federal custody, children must locate and pay for an attorney to represent them in court. Locating a pro bono or low-cost attorney can be challenging, as service providers are overwhelmed with a demand for high-quality, affordable services.

Although access to counsel is mandatory to the greatest extent practicable under the TVPRA, our study identified several concerning gaps in children's access to counsel. These findings include: 1) ORR's KYR models remain insufficient to orient and screen children for legal relief; 2) direct representation for children in federal custody is limited; and 3) ORR's "universal representation" pilot is promising yet remains inadequate to meet the legal needs of children following release.

Finding: ORR's Know Your Rights model remains insufficient in orienting and screening children for legal relief.

Through its subcontractor Acacia Center for Justice, ORR contracts 43 legal service organizations around the country to provide KYR presentations within seven to ten business days of admission to an ORR facility. Through KYR, children learn about legal assistance, the right to legal representation (though not at government expense), the right to a hearing before a judge, the right to apply for asylum or other humanitarian relief, and the right to request voluntary departure. Following, providers typically conduct a 15 to 30 minute individual legal screening to provide a child information regarding their potential eligibility for immigration relief based on the interview. At that time, children also are evaluated for indicators of mistreatment, exploitation, or trafficking.

35% of survey respondents indicate that children in federal custody lack a basic KYR presentation and legal screening. The primary reasons include:

***Legal service provider staffing levels*:** The number of children in custody outpaces the staffing levels of many legal service providers, particularly those who cover large congregate care facilities in Texas and Arizona. Especially during the use of EISs and ICFs in 2020 to 2021 when some children quickly moved through ORR custody, staff were unable to keep pace with the

needs. A supervising attorney shared, "We did everything we could to keep up—relied on volunteers, hired more paralegals and expedited their training. It just wasn't enough."

***Coordination challenges with facilities*:** Some legal service providers shared that coordinating times to hold KYR presentations for children and making necessary arrangements for interpreters create delays. "A lot depends on the shelter coordinator. We've had coordinators who say that kids can't be taken out of 'class' for a KYR presentation. In the hierarchy of needs, I'd say a legal presentation and screening is more important than attending one English class." With some exceptions, facility administrators generally appear responsive to setting regular KYR presentations but struggle to identify children who need interpreters in advance of scheduled legal screenings. An attorney observed, "Most shelters don't regularly use translators, so it's a struggle to make arrangements. Clearly a child who speaks K'iche' needs a translator to be able to explain his situation. If I don't use one, then how do I really know if he might qualify for legal relief or not?"

Timelines for children in custody: The majority of legal service providers indicated that the uncertain timing of release to sponsor is a significant challenge to their ability to provide direct legal representation to children. For example, attorneys will not file a notice to appear (G28) and begin to build a child's legal case if they will be released imminently. The attorneys report a number of reasons why this is the case: 1) children are often released to another jurisdiction where it would be hard if not impossible for attorneys to maintain relationship or appear in court; 2) immigration judges often will not allow an attorney to withdraw from a child's case though the child has changed jurisdictions; and 3) there is no government funding for the representation of children who are facing imminent release. Related, attorneys shared that they attempt to prioritize representation for children who are aging-out of ORR care or whose ages ORR redetermines. "The uncertainty of the timing of release often leaves us scrambling on how to prioritize our limited time and energy to the most in need," explained an attorney. (*See: Aging out and Age redeterminations*.)

***Single screenings may be insufficient*:** Legal service providers additionally shared that one screening remains insufficient to effectively explain and identify if children quality for legal relief. Children may have considerable traumas related to violence, sexual assault, child abuse, and persecution. Establishing rapport in the space of detention is challenging, especially when children may be uncertain of whom they can trust. An attorney observed, "If a child doesn't feel comfortable coming out as LGBTQIA+ in detention, then we might miss the very basis on which their asylum claim rests. Many kids just need to be in a safe space and a trusting adult before disclosing some of the most devastating harms. It's challenging to build that rapport and trust within detention."

In 2023, ORR has expanded its post-release legal services whereby LSPs conduct KYR presentations and individual screenings post-release for children who were not screened while in ORR custody. This is a promising response to the legal needs of children, yet without federal investment in direct representation, children are simply provided referrals rather than direct representation.

Finding: Direct representation for children in federal custody is insufficient.

Nearly 50% of survey respondents indicated that most children are not given access to full representation on their immigration case while in ORR custody. For some of the very reasons children are not provided KYR presentations while in federal custody—LSP staffing, facility coordination challenges, uncertain timelines, and a single screening—attorneys shared that they are unable to provide direct representation of children in custody. In practice, this translates to LSPs guiding children in *pro se,* or self-representation. In contrast, all children requesting voluntary departure receive legal representation. An attorney remarked, "The irony isn't lost on me that we can represent children who want to leave our country but not those who want to stay."

For children who linger in ORR custody, they too may not receive adequate representation due to a number of factors. An attorney shared, "We had a 16-year-old who was SIJ [special immigrant juvenile] eligible in a shelter in Texas for over a year and there was no progress [due to state law/interpretation of state law that limits access to local courts for youth in ORR custody]. We couldn't get him into state court for SIJ because he was still held in the facility. They kept telling us he'd be sent to LTFC where the LSP could start his case, but ORR doesn't place 17-year-olds [in LTFC], so he got stuck. These restrictions made it impossible for him to access legal relief." In this example, restrictions include court jurisdictions that may not allow children to enter state and local courts while in federal custody, local interpretations of SIJ, and ORR's historic policy of not permitting children over 17.5 years old from entering federal foster care. Taken together, this constellation of factors and systems complicates legal providers' ability to represent children and, ultimately, children's access to immigration relief. Despite TVPRA overtures on access to counsel for migrant children in ORR custody, Congress has failed to adequately fund representation to ensure that children's rights are protected in federal custody and in immigration court.

Data likewise reveal that there are limited opportunities to screen or represent children in cases related to their custody or federal detention conditions—whether CBP or ORR. As we discuss above, there are limited opportunities for children to report abuse within facilities; an inadequate response from local child welfare authorities to child abuse allegations in ORR facilities; and ORR lacks transparent procedures for investigating and documenting abuse. (*See: Safety and Protection.)* Given these abovementioned factors, the inability to access legal counsel to discuss

detention conditions removes yet another safeguard for children. Some interviewees reported that children who speak up about abuse within facilities or the conditions of their care are transferred to other facilities, but with unclear modifications to the conditions or the treatment in question. Further, children who are "stepped up" to more restrictive placements or declined to be released from ORR custody also do not have access to legal representation via LSPs to appeal placement decisions, nor do their sponsors. Sponsors only have access to legal representation if they or their sponsors locate and pay for it themselves. (*See: Family Reunification.*) Survey respondents indicated that children receive attorney referrals for litigation on detention conditions only once they are released.

Finding: Universal representation pilots are promising.

Universal representation is defined as representation for *all* children regardless of the likelihood of success in their legal cases. ORR subcontractor Acacia Center for Justice is piloting universal representation program, called "case continuity," for a subset of children to receive government funded representation. In practice, two subsets of children benefit from this program:

- ***Children placed via geolocation***: Geolocation is when ORR places children in a facility and the child is then released in the same geozone (geographic area) of the LSP. For example, if ORR places a child in a Chicago facility and the child is then released to family in Chicago, the subcontracted LSP will provide legal representation to the child. This approach is advantageous for the LSP because they have already conducted a KYR presentation, pre-screened the child while detained, and in some instances, can begin the child's legal case prior to release. Timing is especially critical for 17-year-olds who may age-out of eligibility for SIJ at 18 years old. It is likewise advantageous for children to begin developing rapport and trust with an attorney, to alleviate the financial and logistical burden of finding legal representation, and to ensure high-quality legal representation following release.
- ***Children with formal legal representation handoffs***: If legal service providers file a Notice of Entry of Appearance as Attorney or Accredited Representative (G28) for a child while in ORR custody, once released to a sponsor, the partner legal service provider in the location of release will represent the child. For example, if the Chicago-based LSP files a G28 while the child is detained in a Chicago facility, upon release to family Los Angeles, the LA-based LSP contractually agrees to represent the child in her proceedings in Los Angeles. This "warm handoff," attorneys shared, creates critical continuity of representation for children and facilitates communication between LSPs in transferring their legal case.

Respondents unanimously agreed that the case continuity program is promising as it ensures children receive legal representation, and in turn, have a greater likelihood to receive legal relief. Attorneys identified several challenges to this model, especially related to timing of immigration hearings. In addition, attorneys in geozones such as Houston and Virginia/Maryland/Washington-DC report that ORR provides limited or no advanced notice that they will begin placing children via geolocation, leaving LSPs scrambling to meet an unanticipated need that they are contractually obligated to provide. Further, there are insufficient resources to meet the demand for legal representation for the two above-mentioned groups. This is reflective of national deficits in immigration attorneys needed to meet both the backlog of cases in US immigration courts, the number of new applicants, and insufficient funding for legal services appropriated by Congress and allocated by ORR.

Attorneys describe LSPs needing to "case triage" to manage this shortage in attorneys and funding. In practice, attorneys and accredited representatives describe declining to represent children perceived as "less sympathetic;" whose cases may be more complex or conversely, have no immediately-recognizable avenue for legal relief; or who are younger and presumed to "have more time to find representation." This triage strategy inadvertently denies defense to children who may be traumatized and uncomfortable sharing their experiences or sexual of gender identity with unfamiliar adults. Indigenous children who may speak less common languages or children with juvenile justice involvement, who have more challenging but equally meritorious claims, may also be turned away.

Further, children who migrated unaccompanied, but who never entered the ORR system or who "aged out" of ORRs representation guidelines, are left to find their own representation.

> ***As an attorney asked, "How about the kids that never go through ORR? Or other populations of kids who do go through ORR but don't get that warm handoff?"***

Recommendations

1. ORR should place children via geolocation, when possible, in order to ensure greater continuity of legal representation.
2. ORR should continue to invest in expanding universal representation, moving beyond referral-based services to direct representation for all children.

3. The Acacia Center for Justice should pilot new models for "Know Your Rights" to include a broader scope of children's rights and obligations, beyond immigration relief including rights and obligations in detention, family reunification, workplace rights, access to education, etc.

4. ORR and the Acacia Center for Justice should work together to remove barriers that prevent attorneys from defending corollary rights of children in ORR custody including detention conditions, family reunification delays or denials, and access to education and/or medical care, among other barriers. ORR proposed regulations to expand the range of LSP services does not go far enough to provide sufficient representation for the panoply of rights associated with migrant children held in government custody.

5. ORR and legal service providers should create innovative partnerships with community-based organizations and school districts to identify and ensure provision of legal services to all children moving through or out of ORR placement.

6. ORR, legal services providers, and other advocates should coordinate with states to advance state legislation to address the need for legal aid for unaccompanied children, including appropriations to ensure mandated legal representation or creating public defense program for immigration proceedings.

7. Legal services providers should consider partnering with law schools, bar associations, law firms, and philanthropic organizations to develop a strong pipeline of children's immigration attorneys and develop additional resources to address and prevent vicarious trauma and burn out.

CULTURE, IDENTITY, LANGUAGE, RELIGION

Unaccompanied children arrive from around the globe with diverse backgrounds, cultures, languages and religions. Child development scholars identify that the ability to express freely all facets of their identities is critical to children's identity development, sense of belonging, nurturing of caring and trusting relationships, growing self and social awareness, and critical thinking skills and decision-making. Upon entering federal custody, children find themselves separated from their families including adult siblings, relatives, adult caregivers, and often their ethnic, linguistic and religious communities–communities which provide critical support during difficult periods. Research shows that deprivation of a child's right to culture may result in diminished self-esteem, heightened vulnerability, exacerbated trauma, and conflict with peers and family over the short- and long-term.

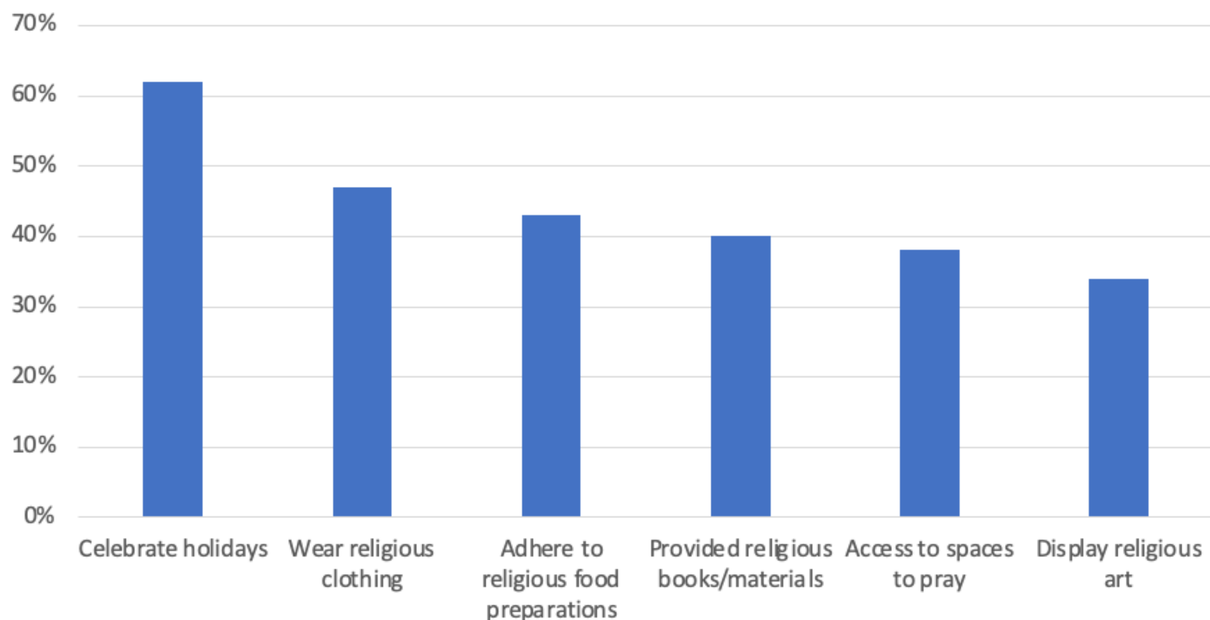
Within ORR facilities, our research finds that children confront a series of barriers and restricted access to expressing their cultures, valuing their identities, using their preferred language, and

practicing their religions. These barriers are at once administrative and attitudinal. Administratively, often overworked facility staff must provide for the diverse needs and backgrounds of children, often with limited expertise and cultural knowledge. Providing culturally and linguistically appropriate services requires time to secure community-based or religious resources and to make necessary arrangements to utilize interpreters with children and their families. Attitudinally, our research uncovered two intersecting biases—anti-Indigenous and anti-Black attitudes and promoting acculturation to white, middle-class norms for children.

Findings: Access to religion and religious practices vary across facilities.

ORR policy indicates that if a child requests religious information, or other religious items such as books or clothing, the facility staff "must provide materials in the child's native language, as long as the request is reasonable." Our research suggests that access to religious practice varies considerably across ORR facilities. Survey respondents representing varied facility types across 22 states shared that children are permitted to celebrate their holidays (62%), wear religious articles of clothing (47%), adhere to religiously informed food preparations (43%), provided religious materials/books (40%), granted access to designated spaces to pray (38%), and permitted to display religious art next to their beds (34%).

Figure 10: Survey respondents were asked: "Do children have access to the following religious permissions or practices in the facility where they work?"



ORR states that it encourages facilities to partner with clergy or local religious leaders to provide spiritual or religious services to children in custody—both onsite and offsite—with adherence to safety policies and procedures. We found that this access varies considerably based on religion and based on facility.

> ***One participant shared, "In the facilities where I've worked, I've seen access to religious traditions and practices really depend on the religion. Children have weekly access to Christian evangelical services; a pastor usually comes to the facility to lead these services. It's rare for children to be transported to a place of worship and even less so for non-evangelical services to be offered."***

For Muslim youth, religious accommodations often center on providing children salat times—five daily prayers. In Arizona, one participant shared, "We provide Muslim children time and space to pray, but transportation to a place of worship with an Imam is rare." In contrast, in another facility, a participant explained, "Children get a prayer rug but not a special place to pray. This has been especially challenging for Afghan youth in our care." Another respondent shared, "Access to religious traditions and practices really depend on the religion. Children have weekly access to Christian evangelical services; a pastor usually comes to the facility to lead these services. It's rare for children to be transported to a place of worship and even less so for non-evangelical services to be offered."

Yet another participant shared, "Sometimes children are restricted from practicing their religion or accessing what they need to practice their religion. When I raised these concerns, the supervisor was quick to correct these mistakes." This sentiment was echoed by another participant, "We have to do a lot of advocacy around religious services, appropriate food, and clothing for children in ORR custody."

There is also varied adherence to religiously informed food preparations, such as children who follow kosher or halal diets. One participant shared, "I worked with one kid who said he eats halal but then wanted a snack. We told him 'no' – you either eat halal or you don't. They can't have it both ways."

In addition, our study found that holidays typically celebrated within facilities are typically US and Christian holidays. When asked, an interviewee explained, "We are helping kids acculturate to the United States and celebrating these holidays are critical for them to learn about the U.S." ORR further highlights "access to religious services of the minor's choice" if possible. Indeed, ORR policy encourages facilities to provide "acculturation services" to help children "obtain the skills necessary to acculturate to the United States and to live independently and responsibly."

This desire to socialize children into a specific understanding of U.S. (Judeo-Christian) norms may come at the expense of respecting children's right to practice their cultures and religions while in ORR custody.

Finding: Under-utilization of interpretation services provided to children and sponsors

ORR policy indicates that facilities "must make every effort possible to provide comprehensive services and literature in the native language of each unaccompanied [] child; provide on-site staff or interpreters as needed; and allow unaccompanied [] children to communicate in their preferred language when they choose. All ORR-required documents provided to unaccompanied [] children must be translated in the unaccompanied [] child's preferred language, either written or verbally."

In spite of this written policy, consistent with other recent publications or language access within ORR, we found a pervasive underuse of interpreters across all facilities in languages other than Spanish. We also found insufficient or restricted access to interpretation at multiple points as a child moves though federal custody—in transfer from CBP custody to ORR placement, in initial identification of children's preferred language upon placement, and throughout the sponsorship process.

***Transfer from CBP custody to ORR placement**:* Following apprehension, CBP conducts an intake interview with unaccompanied children which includes questions regarding what language(s) they speak. Researchers have documented that CBP often does not accurately identify the child's first language, and thus does not necessarily communicate this information to ORR. Typically, participants shared, ORR aims to place a child in a facility where staff can speak their language. This is particularly true for speakers of Pashto, Dari, Arabic, Mandarin, Urdu, and to a lesser extent, French. In other instances, there is insufficient or nonexistent language capacity of staff or ORR places children in the first available open bed at the nearest facility along the US-Mexico border. Generally speaking, borderland facilities have less linguistic diversity than facilities in larger urban areas with established, linguistically diverse migrant populations. One individual shared, "I'm currently working with a child from [West African country] who was placed in our facility with all Central American children. The child feels isolated and uncomfortable and has difficulty navigating the language barrier. It is very socially isolating."

Another participant shared, "It's a real challenge for children who don't speak Spanish or English, but it helps them to acculturate to the US." As discussed further below, at times, interviewees framed "acculturation" as a justification for not providing cultural, language, or

religious services for children in facilities despite their rights to these services under ORR policy, US federal law, and international humanitarian law.

Identification of preferred language: Across roles of interviewees and types of facilities, survey respondents and interviewees indicated that children's preferred language is often presumed, and in some instances, ignored. This is particularly acute for Indigenous children from Latin American who facility staff presume speak Spanish rather than their Indigenous languages. As one participant noted, "Generally, staff do a poor job of acknowledging Indigenous children who speak languages other than Spanish, even while they are clearly struggling to understand what is said in Spanish. On the one hand, this is likely due to poor understanding of the wide cultural diaspora found in Central America. On the other hand, I've also seen it for minors from Turkey, where the minor is marked 'monolingual Spanish' when they have never been exposed to Spanish before entering ORR custody. It's mind boggling sometimes."

This concern was shared by various participants. One interviewee indicated that, "Haitian children may have any number of preferred languages—French, Creole, Spanish if they've lived elsewhere for a while, or English if they were living in the U.S. for years before they were apprehended. We can't assume. Best practice is: ask." An attorney explained, "Before meeting a child, sometimes I'll ask the case manager what the child's preferred language is so I can arrange an interpreter. And the staff doesn't know. You've had this child in custody for a week, how do you not know their preferred language? Have you not even asked?" This persistence of the issue was lamented by another interviewee, "I'm not sure why this continues to be an issue. The first thing I ask a child when I enter the room is: 'Do you speak another language in addition to Spanish?' And if they say 'yes,' I ask, 'would you prefer if we do this interview in that language? Sometimes they say 'no,' they're comfortable in Spanish and that's fine but a lot of times, they ask for a Mam or Akateco or K'iche' interpreter."

Limited use of interpreter services for detained children: When asked why language lines are not used or underutilized, staff described the inconvenience of scheduling telephonic interpreters when they can "get by" in Spanish. They explained that interpretation prolongs meetings with children amid their high caseloads. In addition, there was a general lack of awareness of children's language rights due to high staff turnover within facilities. One respondent shared, "It's not always about access. We have a great telephonic system that gives us access to over 70 languages. It's about time and scheduling." Another participant queried why in-person interpretation is disparately available: "Afghan children mostly had in-person interpreters, but Indigenous children usually do not get an in-person interpreter, even when there is a group of children who speak the same Indigenous language in the facility."

Limited use of interpreters for family reunification process: When case managers do not speak the same language as sponsors and do not use interpreters, interviewees shared that family reunification processes can stall, leaving children to linger in federal custody. This may result from the logistical challenges of arranging interpreters for international calls when parents have limited telephonic access or when languages require interpreters of harder to access languages, regional accents, or dialects. One participant explained, "I worked with a [Haitian-] Creole-speaking kid who ended up learning Spanish because he was in the shelter so long and figured that was the quickest way to get his needs communicated."

> ***Across facilities, respondents described case managers not providing sponsors adequate access to interpreters to fully understand the sponsorship process. And, when the process slows as a result, "Case managers will say the parents aren't completing the process," described one participant.***

Another interviewee echoed, "And then it's the sponsor's fault that they aren't doing what they are supposed to or they aren't looking for the documents they need."

> ***A respondent assessed, "There is an incredible amount of obstructionism and lack of cultural competence on the part of the shelter that prolong reunification for non-Spanish speakers."***

Interviewees offered examples of consequences that result from not using interpreters. Some described examples of children being flagged as trafficking victims, or conversely not identified as 'at risk' because of misinformation resulting from an absence of an interpreter.

Finding: Some children in care experience cultural or linguistic discrimination.

The overwhelming majority of children in ORR care are from Spanish-speaking countries in Latin America. Study participants observed both a presumed homogeneity of all Latin American children and/or observed that the norms within any given facility tend to favor the majority (linguistically Spanish-speaking and religiously Judeo-Christian). Stakeholders report that children from minority cultures, languages, and religions experience discrimination while in care.

One participant observed, "ORR thinks we, as a Latinx community, have a shared culture because we speak the same language. Obviously, that's not the case." This perception was also made in the context of the treatment of children in custody. One participant noted, "This system assumes that all Latinx culture looks the same—whether you are an Indigenous kid from

Guerrero, a Salvadoran kid from the capital, or a Honduran kid living on a ranch. Kids coming from dramatically different places and expectations and contexts, and there's very little space for curiosity to even inform ourselves as a program or for creating space to celebrate and reflect."

The homogenization of Latin American cultures has led to policies and procedures that further isolate and alienate particularly Indigenous and Afro-descendent children. For example, staff described prohibiting Indigenous language speakers from speaking their native languages and instead compelling them to speak Spanish with their peers and even with their families during weekly phone calls. Staff also report that children may be dissuaded from using their native language with other children and, at times, separated to different pods or during activities to ensure that staff can understand the conversations.

Participants also indicated that meal services catered primarily to Mexican cuisine. While respondents reported that ORR ensured halal food for Afghan youth when there was a large number youth in a single facility, it was unclear if there were similar accommodations elsewhere. One participant reported, "Children sometimes complain that the food offered is 'just Mexican food' and they do not have access to familiar foods they like." ORR assumes that food is culturally appropriate for all Latin American children even if diets vary considerably in their home countries. One respondent shared, "Children from outside Latin America often don't get culturally appropriate food. Ukrainian children complained that they were served rice and beans every day and that in Ukraine nobody eats beans."

The lack of cultural sensitivity presented itself in more overtly discriminatory manners as well. One study participant observed, "There is so much racism where I work. Just the other day, a colleague joked that the majority of kids we're getting are from Central America because they don't' love their kids like Mexicans do. I just don't know how you can untrain such long-standing cultural hatred."

Still others described that children feel discriminated against for not speaking Spanish or English, that family reunification processes are prolonged particularly for West African and Indigenous Central Americans, and that children's ages are being called into question due to miscommunication. Several interviewees pointed to linguistic miscommunication errors which lead to children's prolonged stays in federal custody and the deterioration of their mental and behavioral health. It was also reported that in intake assessments and clinical encounters, Indigenous children were diagnosed as with developmental delays, cognitive disabilities, with limited literacy, and in some instances as exhibiting psychotic symptoms because of a combined lack of linguistic and cultural understanding. (*See: Mental Health. See Safety and Protection*.)

Recommendations

1. ORR should allow children to attend religious services of their choice in the community.
2. ORR should make meal service responsive to children's religious and cultural needs.
3. ORR should adopt a multi-pronged approach to evaluating and monitoring children's language access and rights, including providing materials and signage in multiple languages, creating opportunities to ask a children's preferred language, funding in-person interpreters, and monitoring facilities' usage of interpreter line.
4. ORR should implement additional training on how to ask a child about their language preference (e.g., asking what languages they speak rather than asking whether they speak Spanish), Indigenous languages (e.g., explaining to staff that these are not dialects), and instituting formal screening protocols for Spanish or English proficiency when children speak another language.
5. ORR and facility directors should partner with Indigenous organizations to recruit Maya-language speakers and should incentivize the hiring of bi-lingual and bi-cultural staff through language stipends.
6. ORR should conduct monthly reviews of release and placement decisions for non-Spanish speaking children by someone other than the case manager.
7. ORR should partner with groups in the community to provide mentorship and cultural events for children in custody. Many facilities that held Afghan children allowed Afghan American volunteers to visit the children, and ORR established a formal mentorship program. This has not happened for children of other nationalities.
8. ORR should roll-out a series of trainings to enhance understanding of the diverse identities and regions from where young people migrate to combat implicit bias and to increase cultural sensitivity.
9. ORR should implement more robust non-discrimination policies, such as new training and reporting mechanisms if children feel that they are subjected to religious, language, or racial discrimination.

SPECIALIZED POPULATIONS

In the section that follows, we delineate key findings on specialized populations of young people in ORR custody. These include pregnant and parenting teens, children with disabilities, LGBTQIA+ youth, and children aging-out or aged-out of care. As we note in the methodology, there are other populations of youth, namely those under the age of 13 and youth in conflict with the law (and, thus, often in secure detention), for which we have insufficient data to draw sound conclusions. In addition, we have not specifically addressed Indigenous children as a separate group; instead, we have integrated some of their unique needs and experiences throughout the report. While separated for clarity of analysis, we fully recognize that children's social and political identities are multifaceted and intersectional, uniquely shaping how they experience ORR custody.

PREGNANT AND PARENTING TEENS

The U.S. Supreme Court's ruling in *Dobbs v Jackson Women's Health Organization* held that the Constitution did not confer a right to abortion. While *Dobbs* threw some states into chaos in terms of reproductive healthcare, federal policy, specifically through the U.S. Department of Health and Human Services, has clearly and vigorously upheld the panoply of rights associated with access to reproductive health care. Sexual and reproductive health and rights for all who can become pregnant, making decisions about their own bodies. Some young people already know they are pregnant when they arrive in ORR custody while others may learn, for the first time, that they are pregnant while in custody. In some instances, pregnancies are desired and/or planned while other pregnancies are unexpected or may result from rape or incest. Regardless of the circumstances, the pregnant person should be able to seek out counseling regarding a host of reproductive rights, including but not limited to their right to privacy and bodily integrity.

While in ORR custody, by policy, children and youth are supposed to have access to family planning services, including pregnancy testing, emergency contraception, and comprehensive information about and access to medical reproductive health services. According to ORR policy, pregnant minors receive non-directive options counseling and are referred to specialty care (e.g., Obstetrician/Gynecologist) for further evaluation and services. Given that ORR is a federal agency, youth have a right to abortion, though depending on where the youth is detained, state laws may restrict or prohibit access to abortion. If a youth requesting abortion is detained in a state where abortion access is restricted, ORR will, to the greatest extent possible, transfer the youth to an ORR program that is state-licensed to care for pregnant youth and in an appropriate location to support the youth's health care needs and access to abortion. It is important to note, regardless of location, some ORR providers have an explicit religious mandate which may not allow a child to access the full spectrum of reproductive rights under federal policy.

Some youths are apprehended with their young children or give birth while in federal custody. In the latter instance, the infant is a US citizen due to birth-right citizenship, resulting in ORR assuming custody of US citizen children. There are roughly 100 US citizen children in ORR custody each year. For both pregnant and parenting teens, ORR attempts to expedite their placement in transitional foster care or in specialized facilities for pregnant and parenting teens and for children under the age of 13 (termed "tender-age" by ORR).

Finding: ORR attempts to place pregnant youth in states that provide for reproductive healthcare access but still struggle at times to meet the needs of pregnant teens.

Interviewees shared that if CBP informs ORR that a minor in custody is pregnant, ORR attempts to place the child in a state where there is access to full reproductive rights. Often, CBP screenings do not identify pregnancy in advance of transfer. Respondents described children who articulate a desire for an abortion being transferred quickly to programs that can facilitate reproductive counseling and access to abortion, should a young person choose to have an abortion. However, some pregnant youths do not articulate a specific request regarding their reproductive options. One participant shared, "If a pregnant minor is not informed of her rights and options, especially in instances of pregnancy resulting from rape or incest, she may not proactively express a wish to learn about abortion. We can't rely on young people, especially those with multiple traumas while in detention and confronting so much uncertainty to tell us rationally and proactively exactly what they need."

As a result of the *Garza v. Azar litigation*, pregnant youth must be informed of and are entitled to access all pregnancy-related medical services and options for reproductive healthcare. Providing this information and access to these services is particularly challenging in states where even abortion counseling is legally prohibited or highly restricted. In these instances, the ORR federal field specialist (FFS) provides reproductive health counseling. Additionally, if youth are detained at a facility that has a religious exemption, they will also receive their reproductive health care counseling from the ORR FSS. Several interviewees identified that this stop-gap measure remains wholly insufficient because the FFS is neither a health care professional nor necessarily trained to provide reproductive health counseling. Moreover, it can be difficult for youth to feel comfortable and safe having these deeply private conversations with a government employee while they are detained. "This should be a conversation between a pregnant person and her healthcare provider, not the FFS or the case manager," explained a participant.

In states where abortion counseling is legal, ORR does not require a healthcare professional to administer the counseling. As a result, adolescents may receive counseling from facility staff instead of specially trained health care workers; and those staff may be guided by personal preferences or their organization's religious mandate. An interviewee expressed her hesitations, "I feel a little out of my element counseling teens about their birthing choices; I've never had child so how do I really know how to support them?" When asked why they were providing counseling rather than a healthcare professional, the case manager explained that teens have questions and concerns and the occasional health care appointments, especially early on in pregnancy, are insufficient, leaving case managers to function as counselors—either willingly or unwillingly. "I think most staff are well intentioned, sharing their opinions but it really isn't our role to tell pregnant girls what to do," another interviewee explained.

Finding: Facility staff are in a position to unduly influence decisions of pregnant and parenting teens.

The U.S. Supreme Court has determined that parents have a fundamental right to direct the care, custody, and control of their children. This Court also has determined that the government shall not interfere with this right unless and until a parent is proven unfit. ORR policy provides very little guidance on how facilities should work with pregnant and parenting teens, beyond their access to medical care and safety planning. In the absence of clear guidelines or procedures, our research finds that facility staff may overshadow the wishes of pregnant and parenting teens, including in their choices of providers, prenatal care, delivery, and newborn feeding and care.

One participant who specializes in working with pregnant teens shared, "Youth need assistance and counseling on their various options and decisions they have. It's in their best interests to be fully informed—from talking about their birthing plan, pain management, to deciding who their OB-GYN or midwife is. More often than not, these choices are made by ORR or the case manager without the teen's informed input."

Limited choice on providers and prenatal care: Staff across facilities and locations shared that youth have restricted choices in providers, prenatal care, and birthing plans. One participant noted, "Pregnant people who aren't in detention tend to have a lot more choice and agency in where they deliver and who is their trusted health care provider. For children in care, it's the closest hospital they can get to and who facility staff identify as the provider. It's not: do I feel comfortable with this person? Is the doctor giving me the information I need to make an informed decision? Instead, staff make the choice."

Another participant illustrated how pregnant teens lack a right to direct their prenatal care, "In the United States, we do far more genetic testing that other parts of the world and there are tests that are medically necessary and others that are not. This is a choice we give to all parents; unaccompanied parenting teens should be no exception."

Newborn feeding and care: Interviewees shared that parenting teens often have limited autonomy over decision-making regarding the feeding and care of their children. For example, new parents who are nursing are often advised to feed or pump every two hours, yet in custody lactating youth are not always able or allowed to do so in part because children are held to specific schooling and activity schedules for the general population. In addition, interviewees uniformly shared, teens do not have access to automatic breast pumps despite a clear medical need when lactating.

Interviewees described that case managers and staff often feel it is helpful to take "ownership of the child," that "staff know what is best," and that staff make choices regarding prenatal or

post-natal care rather than the youth themselves. Another interviewee shared, "In my experience, staff often present decisions on the newborn's care or feeding as if it is the only choice available. If there's a choice to make, the teen should decide what is best for her and her child." Several interviewees pointed to co-sleeping which researchers have documented, is both safe and customary in many cultures around the world yet is discouraged in federally contracted programs due to safety concerns.

Postpartum care: In facilities and transitional foster care, interviewees describe postpartum care as attending to the physical recovery of the mother and the physical health of the child. Given that postpartum depression is twice as prevalent among adolescents than adults following childbirth, greater attention is needed to incorporate the parenting youth's physical, mental, and emotional health. One physician shared, "It's challenging to be a new or even a teen parent, but then to lack the freedom to go for a walk or to take a nap if you need it, to be surrounded by family and loved ones, to adhere to the cultural practices around childbirth…it compounds postpartum depression. As much as we seek to attend to their needs, the best treatment I could prescribe is release from detention."

Recommendations

1. CBP and ORR should release pregnant youth expeditiously whenever safely possible.
2. Wherever possible, pregnant youth should be initially placed in states where full reproductive rights are safeguarded and where there is access to more than a single provider.
3. When appropriate placement or timely release are not possible, CBP and ORR should transfer pregnant youth to facilities in states where full reproductive rights are safeguarded and take all possible steps to mitigate the disruptions caused by transfer.
4. ORR should provide specialists, including doulas, lactation consultants, and teen pregnancy educators, to educate and orient pregnant and parenting teens on their rights.
5. ORR should provide mental health support and post-natal care services to address the emotional, psychological, and physical needs and challenges faced by pregnant and parenting teens.
6. ORR should prioritize new contracts in states where laws comport with federal policy with respect to the reproductive rights of children and youth.
7. ORR should prioritize new contracts with organizations that comply with agency policy on reproductive justice issues (as opposed to organizations guided by their religious mandate). Transferring pregnant youth to access health services due to an organization's religious mandated creates an unnecessary risk to their safety and well-being.

CHILDREN WITH DISABILITIES

There is no publicly available data on the number of unaccompanied children within federal custody that have a disability. The World Health Organization estimates that 15% of the world's population has a disability, and the US Center for Disease Control and Prevention estimates that 26% of Americans have a disability. Under the ADA a disability is defined as a physical or mental impairment that substantially limits one or more major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment. There are many types of disabilities that affect children in ORR custody, including physical impairments or mental health diagnoses (including trauma), activity impairments (e.g., hearing, vision, walking, etc.), and participation restrictions.

Section 504 of the Rehabilitation Act of 1973 protects individuals from discrimination based on their disability; this applies to the federal government and to employers and organizations that receive financial assistance from any federal department or agency, including ORR and its

subcontractors. In practice, this means that facilities must provide services in the most integrated setting appropriate to the needs of the child with a disability, such as providing auxiliary aids to afford an equal opportunity to participate in or benefit from programs or activities. Facilities must also ensure all programs, services, activities, and facilities are accessible while making reasonable modifications to policies and practices to avoid discrimination on the basis of disability. Despite these protections, our research reveals that ORR and facility staff struggle to adequately serve children with disabilities, including the provision of culturally informed and trauma-responsive care to children with mental health issues and mechanisms to assess learning disabilities. In addition, we found that children with mental health and trauma related disabilities are held in custody longer and under more restrictive settings.

Finding: Facilities struggle to provide specialized services to children with disabilities. Across facility types and location, data reveal that children with disabilities are adversely impacted by various points while in ORR custody, including initial placement, screening, evaluation, and in accessing services and support. In a previous section, we discuss how TVPRA-mandated home studies may delay their release from federal custody. (*See: Family Reunification.*)

Placement: Under current state licensing and ORR policy, facilities have limited discretion to accept a child into the placement, yet, in practice, it seems that ORR does allow facilities considerable discretion to reject a child from placement. As several participants observed, facilities may reject serving children with disabilities. An interviewee described, "Placement decisions blatantly discriminate against kids with disabilities. Facilities say their needs are too high or our licenses don't permit it. In some instances, this is true, but in many others, facilities don't want to get 'stuck' with high needs kids because it requires more staff time, energy, and kids remain in care longer."

> ***Another participant noted, "In the past six years, we have not received children with physical disabilities or specialized therapeutic needs. We never receive a child like that because we would just screen them out. We just can't accept that type of population."***

Other staff expressed concerns about their ability to provide for children with disabilities such as limited training or expertise. Several respondents described a perceived disincentive to accepting children with disabilities because their length of stay is often longer given their specialized needs. Facility staff reported abbreviated lengths of stay as metric for success with ORR. We understand that ORR believes that forthcoming regulations will allow the agency to exercise more control over facilities' acceptance of and care for children with disabilities; it remains unclear how those obligations will be enforced.

Screening, evaluation, and services: Until recently, ORR did not require facilities to identify or track children with disabilities in a systematic way. Following the *Lucas R v Azar* litigation, ORR now identifies children with disabilities via a checkbox on the intake form. "ORR is really starting from ground zero," described an interviewee. "The checkbox doesn't tell us the type of disability, any follow-up assessments or services that are needed, and ultimately, privileges children with visible disabilities, wholly overlooking children with less visible disabilities. Just yes or no." The *Lucas R v Azar* litigation will require major changes to the identification and tracking of children with disabilities, but at the time of writing, ORR has not yet implemented these changes.

Staff describe a number of barriers to accessing evaluation and services for children with disabilities. Barriers include: time to identify experts or specialized services amid high caseloads; availability of services, especially when children are held in areas where specialized services are limited or not available; wait times for evaluations amid uncertainty of how long a child will remain detained; availability of staff to accompany children to off-site appointments; and the cost associated with assessments and services. An interviewee shared, "In my 15 years of experience, typically specialized evaluations—whether for a disability or a trauma—are ignored or kicked down the road. Only when there is external advocacy from a child advocate or an attorney do we see external or specialized evaluations and services." The vast majority of children in federal custody do not have an attorney or a child advocate appointed to them.

Across facilities, interviewees identified ORR as more responsive to children with physical disabilities. "I've been pleasantly surprised by the care children with physical disabilities or complicated medical situations receive, but mental health and learning disabilities? Totally under the radar."

A case manager shared that she advocated for an evaluation from a speech pathologist for a child, but her supervisor routinely declined to pursue the evaluation. "Even the [telephonic] interpreter, who wasn't even in the room, said the kid was having trouble making certain sounds with his mouth. I kept escalating the request, but the FFS said it was probably just his [West African] language. They never got it checked out."

Finding: Learning disabilities are not diagnosed.

Pursuant to ORR policy, within 72 hours of a child entering a facility, staff assess a child's learning, including English language ability, literacy, and their academic level. ORR does not require any screenings for learning disabilities. That is, disability is not considered when placing children in a classroom. As a result, no specialized attention, services, tutoring, or aids are provided.

None of the survey respondents or interviewees were aware of special education services provided to children in facilities, except in some of the most restrictive placements within ORR's network. "It simply doesn't happen," explained one interviewee. "Either kids aren't with us long enough to evaluate or the kids that need evaluations end up getting transferred. Besides, this isn't *real* school. Kids don't get credit for what they do in the classroom." It is important to recall that children held in ORR facilities do not receive educational services through public schools nor do they have access to the same specialized screenings and programming for children in municipal school districts.

Another interviewee explained, "I think it's unrealistic to test kids. Even in the public schools, you have to fight for testing and IEPs [Individualized Education Plans]. Besides, kids have bigger issues than learning disabilities." Generally, if children are in custody for short periods of time, learning disabilities may not be flagged easily; however, according to staff, the failure to evaluate children in both short and long-term foster care is also an unmet need. An interviewee working with children in long-term foster care shared, "In my experience, there is a general unwillingness to screen, diagnose, or advocate for kids with disabilities. ORR and even foster care programs just don't see it rising up the hierarchy of needs, yet it can dramatically impact a child's development and desire to learn. It makes the difference long term from graduating or opting out." (*See: Access to Education*.)

Finding: Children with mental health and trauma related disabilities spend longer in custody in more restrictive settings.

Across states, interviewees describe how children are "stepped up" at times in response to disability-related symptoms, resulting in their prolonged stays in federal custody and often in more restrictive settings. A participant reflected on the disparate treatment between children with physical disabilities and children with mental health or behavioral health issues: "It's a stark contrast. For kids with mental or behavioral health issues, the ways their disabilities manifest create 'trouble'—it makes children harder to serve, resulting in children acting out or being combative. But if ORR, or even staff, took the extra step to appropriately diagnose and treat kids with non-physical disabilities, we'd actually be supporting [their] health instead of punishing them with SIRs and step-ups." As we document above and organizations have documented elsewhere, children with disabilities experience disproportionate use of significant incident reports (SIRs) and, as some interviewees contended, are punished for behavior that may result from their disability. One participant observed, "Without this understanding, staff effectively penalize kids for their disabilities." (*See: Safety and Protection.*)

Another participant echoed the needs for greater evaluations, assessments, and treatment to better understand children's behaviors and the ways detention might exacerbate traumas. She observed, "We've seen a lot of children with suspected disabilities having a lot of discipline issues and then trying to be pushed out of the program, whether through getting them transferred, getting their age re-determined, or convincing them that they want to go back home."

A participant observed that children with disabilities are caught in a vicious cycle: "The argument I often see is that children are not ready for community-based settings. So, on the one hand, children do not get access to evaluations, assessments, and appropriate treatment and get frustrated or act out. And, on the other hand, children are denied the opportunity for release.

> ***"The ORR system does not recognize the inherent harm of institutional settings and separation from family and community, especially for kids with disabilities."***

Interviewees described that, generally speaking, ORR functions as if secure facilities are better equipped to care for children with special needs. The *Lucas R. v. Azar* lawsuit alleged that ORR has a practice of transferring children with disabilities to unnecessarily restrictive facilities because of their disability. While more recent data are not publicly available, the lawsuit found that from November 2017 to March 2020, the average length of stay for children placed in secure and medium-secure facilities was 183.8 days. The lawsuit resulted in ORR discontinuing its contract with secure facility Shiloh Treatment Center in south Texas following its court-ordered closure, which found staff have drugged and abused children in care. Now, interviewees reported that ORR utilizes a secure facility in Arkansas described as akin to a juvenile jail, where there are reportedly no Spanish-speakers on staff to communicate with youth. Interviewees expressed concerns that out-of-network placements lack oversight from ORR and *Flores* monitors, leaving limited knowledge about the quality of treatment young people receive.

The recent settlement agreement resulting from *Lucas R. v. Azar* (November 2023) begins to address some of these findings, including additional safeguards for youth with disabilities, limitations on the use of psychotropic medications, limitations on placing children with disabilities in longer-term restrictive placements, and service plans that include disability programs without delaying family reunification. These are positive steps that should be concisely monitored and continuously evaluated.

Recommendations

1. ORR should enhance its guidelines to provide more specific and complete policies that ensure adequate and timely medical and mental health assessments and treatment for children with disabilities.
2. ORR should prioritize and develop community-based placements for children with specialized needs, moving toward diminished reliance on congregate care.
3. ORR should train staff on protocols for determining how best to identify a child for placement in community care. The inquiry should always be "What services can we provide this child to enable community-based placement?" rather than putting the burden on the child to prove they are "ready" for community care.
4. ORR should ensure that every child receives educational services, including special education assessments and services, consistent with what other students receive under federal and state law.
5. ORR should collaborate with researchers to increase the transparency and clarity of data by identifying specific populations of children who are subject to prolonged lengths of stay and multiple transfers.
6. ORR should prioritize and develop community-based placements for children with specialized needs, moving toward diminished reliance on congregate care.

LGBTQIA+ CHILDREN

Roughly 18% of the world's Gen Z population identifies as Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, and Asexual (LGBTQIA+), with 6% of Gen Z identifying as transgender. Research finds that LGBTQIA+ children are "disproportionately subject to violence by private citizens, family members, and government agents in their country of origin." This may result in LGBTQIA+ people being overrepresented among those migrating or fleeing from their home countries. So too, research finds that LGBTQIA+ adolescents experience higher rates of mental health diagnoses and higher rates of suicide risk and self-harm than their heterosexual peers. Taken together, LGBTQIA+ migrant youth in ORR custody require specialized protections and support.

Accordingly, ORR has adopted significant measures to ensure LGBTQIA+ children are treated with respect, do not experience discrimination based on LGBTQIA+ identity, and are entitled to human rights protections. ORR directs facilities to maintain confidential sexual orientation and gender identity; to use correct names and pronouns in accordance with the youth's gender identity; to house youth according to the youth's gender identity and housing preference, health and safety needs, and state and local licensing standards; to assess whether alternate restroom accommodations should be provided; to allow LGBTQIA+ young people to dress and express

themselves according to their gender identity; and to allow LGBTQIA+ children and youth to choose the gender of staff to conduct a pat-down search if necessary. ORR also bans isolation and segregation of LGBTQIA+ children solely based on sexual orientation and gender identity.

While these are important safe-guards, our research finds that these measures are selectively applied and remain insufficient in supporting the positive development and mental health of LGBTQIA+ children in federal custody. Despite ORR's efforts to safeguard protections for LGBTQIA+ children, there are few mechanisms in place to ensure staff are following ORR policy and protections, especially when facilities are licensed by states that have competing policies or where facilities are operated by organizations whose religious mandate does not recognize children's gender identity or sexual orientation.

Finding: Limited specialized mental health care is provided to LGBTQIA+ youth.

During initial intakes, children are asked about their sexuality and gender identity. If a young person identifies as LGBTQIA+, then all policies and protections envisioned in ORR policy immediately should come into effect. At the same time, two principal tensions emerge. First, if a child fails to immediately identify as LGBTQIA+ during the intake process, none of the protections included within ORR policy will be advanced. Failure to identify children as LGBTQIA+ may inadvertently result in harmful experiences in federal custody. A stakeholder who self-identified LGBTQIA+ shared, "Their sexuality or gender identity may be the very reason they fled their home. If a child doesn't feel safe, they won't disclose. It's very rare, in my experience, for kids to disclose their identity in a long list of checkboxes." Interviewees suggested that creating additional opportunities for children to disclose their sexual orientation and gender identity are needed.

Additional opportunities for disclosure include regular mental health counseling with licensed providers who are trained in serving LGBTQIA+ children and youth. Interviewees contended that this training currently remains limited not only for mental health providers but also for other staff. (*See: Staffing and Training.)* "It is really more up to the care provider's discretion if a child is able to receive mental health services based on their LGBTQIA+ identity," one participant observed. "Some clinicians have a background and training, while others rely on their personal politics which is absolutely unacceptable."

There remains considerable transphobia and homophobia in the United States. An attorney remarked, "The ORR system is no exception." Phobic attitudes left unaddressed complicate LGBTQIA+ youths' ability to share their gender identity or sexuality. As discussed above, interviewees additionally report children being compelled to disclose their sexual orientation or

gender identity to sponsors as a contingency of their release from federal custody. (*See: Mental Health.*)

Finding: Tensions exist between state and federal policy regarding rights and protections of LGBTQIA+ children.

ORR policy capitulates to state laws on distinct issues relating to care of LGBTQIA+ youth. As a consequence, accommodations and bathroom access for trans youth according to their identity or safety may not be practiced in all facilities. Take, for example, Texas, one of the states with the highest number of children in ORR custody. As of October 2023, Texas has blocked trans youth from medically transitioning and receiving proper medical care regarding their gender. A bill was recently proposed in the Texas house that would require juveniles in government facilities to be placed by their biological sex assigned at birth, in contradiction with federal guidelines. ORR facilities located in Texas similarly are not allowed to administer trans affirming medical care. To remediate disparate state practices, interviewees have indicated that ORR tries to place LGBTQIA+ youth in states with laws that comport with federal policy. However, this process relies on children self-disclosing their status.

Recommendations

1. ORR should enhance its guidelines to provide more specific and complete policies that ensure adequate, timely, and ongoing identification and assessment of the needs of LGBTQIA+ children in care.
2. ORR should enhance its guidelines to provide more specific complete policies that ensure adequate mental health care for LGBTQIA+ children in care.
3. ORR should ensure that LGBTQIA+ children have access to gender-affirming healthcare services.
4. ORR should develop concrete guidelines for ways their contracted facilities can create a safe space for LGBTQIA+ children including, but not limited to, ensuring the use of children's preferred names and pronouns, access to gender-safe bathrooms, access to counseling by staff who are specially trained, and access to peer/affinity groups.
5. ORR should track and report on data related to LGBTQIA+ children in ORR care.

6. ORR should develop guidelines for the immediate transfer of transgendered children to facilities to states with laws that comport with federal policy.
7. ORR should consider prioritizing new contracts in states where laws comport with federal policy with respect to care for LGBTQIA+ children.

AGING OUT AND AGE REDETERMINATIONS

While children are entitled to some specialized legal and custodial protections, those turning 18 while in ORR custody "age-out" of those protections. Young people aging out or aged out of custody may be transferred to adult detention. They are thrust into large-scale adult ICE facilities which the Office of the Inspector General found to have often unsafe and unsanitary conditions and where migrants are subject to harassment and punitive policies. They face imminent deportation, having lost the few but important child-specific legal benefits. For example, immigration law safeguards for unaccompanied children include eligibility for a Special Immigrant Juvenile visa designated for abused, abandoned, and neglected children or special safeguards designed to protect the interests of children in the asylum process.

An unaccompanied child may find themselves being transferred to adult custody for one of two reasons. As described above, a youth may age out of ORR (by turning 18 years of old), or the adolescent may be "age redetermined." Either mechanism abruptly terminates eligibility for child-specific protections. Children are shackled and taken to ICE detention.

Age redeterminations are especially fraught for adolescents in ORR custody. At any point in federal custody, ORR, ICE, facility staff, or third-party case coordinators may request an age redetermination of a child. The age redetermination process often enlists controversial medical exams to redetermine a person's age, often resulting in youth under age 18 being removed from ORR custody. Methods of age reassessments in federal custody include dental scans or radiographs of the clavicle or wrist or. Each method remains highly problematic and scientifically dubious when applied to a global population of migrant youth. For example, radiographs of the left wrist measure bone density associated with osteoporosis; yet consider that greater bone density also occurs amid malnutrition and stunting—a polemic affecting many of the tens of thousands of Central American children in federal custody each year. In fact, wrist and clavicle radiographs are compared to a standard atlas of bone development normed on a sample of Caucasian youths in the 1930s. Experts concur that the bone atlas does not account for ethnic, geographic, or socioeconomic variation in pediatric populations. Dental exams are similarly problematic because most methods of calculation were developed in homogenous Caucasian populations inappropriate for use in estimating ages of children with extremely diverse origins.

The use of radiographs was included in the 2008 Trafficking Victims Protection Reauthorization Act (TVPRA) to prevent unsubstantiated fears of older migrants trying to pass as children. The legislative history suggests that the utility of radiographs was of significant concern and led to language that limits age redeterminations to the "*non-exclusive* use of radiographs" (emphasis added). ORR policy indicates that "each case must be evaluated carefully based on the totality of all available evidence, including the statement of the individual in question." The policy also requires that medical assessments of age must "take into the individual's ethnic and genetic background." There is no requirement that HHS obtain the child's assent (or parental consent) before subjecting them to the medical procedure. Policy guidance requires that ORR only make age determinations "if there is a reasonable suspicion that a child in HHS custody is 18 years or older." However, there is no definition of what gives rise to "reasonable suspicion."

While some age-redeterminations may be appropriate, the mechanisms triggering the redetermination lack safeguards and are profoundly flawed, such that a sense of deep suspicion has been cast over the entire age redetermination process.

Finding: Limited continuity of care leaves children aging out with few options.

Children turning 18 years old are either transferred from ORR to ICE custody or released on recognizance (ROR). The Biden administration has encouraged ICE Field Office Juvenile Coordinators (FOJC) to enlist their discretion to approve ROR in instances where the youth is not a danger to themselves or the community. Interviewees report that children held in ORR's secure

facilities are less likely to benefit from ROR because they are perceived to be a "threat" due merely to their placement in secure. Yet, the use of SIRs has often been the justification for their placements in secure or therapeutic placements in the first instance, often leading to a perverse outcomes for children with SIRs. (*See: Safety and Protection*.)

ORR policy indicates that facility staff are required to issue a post-18 discharge plan two weeks prior to a child aging out of ORR custody. However, respondents report that these plans often are not issued when staff believe release to a sponsor is likely. In practice, respondents shared that ROR with corresponding post-18 plans usually result when requested by attorneys or child advocates. Those without an attorney or advocate (the vast majority of children) often do not benefit from this consequential advocacy and risk transfer to adult detention.

Further, in many instances, attorneys lament a lack of sufficient notice provided by facilities for children aging out who remain without a viable sponsor. An attorney shared, "It's not sufficient to look at birthdates on the census [of children in a specific facility]. We need timely and up to date information about their sponsorship options." One respondent lamented the two-week notice period as unworkable, "Two weeks is wholly insufficient to plan for a child at risk of aging out—it can take a month or more to line up a post-18 placement with an NGO [non-governmental organization], and last-minute sponsors need time to prepare. This should start—at a minimum—90 days before the child turns 18 and should be done in consultation with the LSP and child advocate, if appointed."

To prevent transfer to adult detention, ORR permits release to a non-secure placement such as a family member, shelter, or licensed facility capable of caring for an adult. Yet, even with advanced notice, all stakeholders expressed considerable and longstanding challenges in identifying placements for youth aging out of federal custody. In most states, young people are not eligible for state foster care and, owing to their undocumented status, are ineligible for federal benefits programs. In addition, individuals over the age of 18 are often ineligible for legal representation designated for children under ORR's contract with the Acacia Center for Justice.

For those who are transferred to adult detention, it can be a harrowing experience. Respondents described children being awoken in the middle of the night on their 18th birthday, shackled and transported to adult detention by uniformed ICE agents. Interviewees described meeting with youth prior to transfer to "cushion the blow" by warning them about "the reality that adult detention is much worse than ORR care." Some youths have no warning either about ICE arriving to remove them from ORR facilities, the conditions of adult detention, or, in instances of age-redetermination, that they will be transferred imminently. One respondent shared, "It is heartbreaking every time. As a case manager who cares about them, you're really horrified. I felt sick and broken… I don't know what to do because the law is very black and white." It is notable

that while ORR cannot retain custody after a child turns 18 years old, ORR is reported to have a small number of contract providers with "sister" programs that operate homes for youth aged 18 to 21 years old. In those locations, youth can be transferred within the contract provider's programming rather than transferred to adult detention.

Across geographic locations, stakeholders uniformly expressed an urgent need for government officials, immigration advocates, and child welfare professionals to work together to bridge this gap for children aging out or aged out of federal custody.

Finding: Lack of transparency and oversight in age redetermination requests leads to the perception that the process is punitive or otherwise abused.

Age redetermination occurs across ORR facilities, as well as in CBP custody, but with very limited transparency. There are multiple processes for verifying age including analyzing information provided by children and family members, access to consular databases and/or consular verification of birth certificates, and use of dental exams and bone scans (both of which are generally rejected in the medical community as appropriate mechanisms for age determination across race and ethnicity). The "reasonable suspicion" policy language, which authorizes an age redetermination, does not provide adequate guidance and, as a result, creates the perception that the process is used as punishment or is otherwise abused. Moreover, stakeholders repeatedly reported that, in practice, radiographs are dispositive in age determinations. However, ORR policy requires that each case be determined on a totality of the circumstances standard.

According to staff, attorneys, advocates and health professionals in our study, the reasons for age redetermination are typically because a minor "does not look like a child" or engages in behavioral disruptions while in custody. Several respondents representing children whose ages have been contested point to age redeterminations as "punitive" and "retaliatory" when a child is viewed as a "problem" or when staff "just want to be done with them." Most age redetermination requests occur while a child is detained yet can be reassessed at any point while in federal custody. For instance, an interviewee shared that one minor's age was reassessed after nearly two years in federal foster care.

Further, there is limited supervision and oversight of age redeterminations of children in federal custody. It remains unclear who solicits, conducts, and interprets the radiographs and if these physicians, dentists, or radiologists know how these reports are used. Several respondents shared that routine dental exams were later re-purposed for age redeterminations with radiographs sent off to another dentist to interpret. One attorney shared, "My client had an x-ray nine months before they decided to use it [for age redetermination] in a punitive way. The FFS thought this kid

was a pain in the butt. And he was being a pain in the butt, but in a very developmentally appropriate way. He was tired of detention."

These practices raise ethical and legal concerns–a child's assent nor parental consent are secured in advance (although it may be required under state law) and attorneys are not routinely informed in advance. A provider of such medical exams reported to us that ORR officials explained the purpose of the exam only when pressed. The participant ultimately declined to conduct the exam because it exposed a child to radiographs absent a medical need and because the respondent was uncomfortable with how the report might be misinterpreted. Another respondent reported that they conduct age assessments for ORR, interpreting clavicle and wrist radiographs despite having no specialized training to conduct these evaluations.

In addition, both dental and bone radiographs do not provide a finite number but a range to be interpreted. Indeed, the margin of error is up to 6 years. Based on ORR policy, the federal government should consider the lower threshold in the range as the child's age, also weighing corroborating evidence such as a child's testimony, available documents, and parental input. However, attorneys and staff alike report that in practice federal authorities singularly rely on the upward age range. For example, if dental exams indicate that a child is between 17 and 18.6 years old, ORR will presume the child is 18.6. These assessments pervert medical research by claiming "scientific certainty" where none exists. The use of dubious science coupled with limited oversight is deeply problematic for children and for ORR providers.

Finding: ORR reliance on scientifically dubious medical assessments to redetermine age has a racially discriminatory impact.

Scientifically, radiographs and dental scans aim to measure the magnitude of the difference between chronological age and skeletal age, yet medical researchers call into question this practice especially when applied to a global population of youth.

The discriminatory impact of these medical practices is well known in the field, among attorneys in particular. Lawyers shared, "The age redetermining methods are based upon [those of] white European descent," and "It's shocking to me that they still use these scientifically debunked dental scans." Still others referred to the practice as "well-documented junk science" and "a total waste of resources." A physician explained, "Dental records are very inaccurate" and the use of them in the ORR system is "creative forensic work."

In addition, respondents contend that requests are often deeply racialized, disproportionately affecting African youth. "It happens a lot with East and West African children. A lot of times, it

came from a lack of cultural sensitivity or knowledge," an interviewee shared. "Black children arrive and say I'm 15 years old. The CBP officer says [that] you don't look 15 to me. If the kid makes it to ORR, they do the dental or bone assessment, basically saying 'I don't care what the kid says. I don't care what the birth certificate says. They're clearly adults."

Recommendations

1. ORR should require post-18 planning to begin when a child reaches the age of 17.5.
2. ORR should provide funding for lawyers to represent children especially those who reach 17.5 years old and who are at risk of aging out of ORR custody.
3. ORR should provide both funding for and the appointment of a child advocate for every child aging out of ORR care and for all children for whom an age-redetermination is being *considered* (not after one is requested). Child advocates should weigh in on both the appropriateness of the age redetermination request and on the assessment process.
4. ORR should require notification to the Acacia Center for Justice or the child's attorney (if they have one) that an age redetermination is being considered.
5. ORR should incentivize stakeholders to create durable relationships with post-18 placements to ensure children aging out of ORR care are placed pursuant to their best interests as directed by the TVPRA.
6. ORR should prioritize contracts with care provider facilities that have existing "sister" programs that can transfer children to homes operated for youth 18 to 21 as part of the age-out plan.
7. ORR should invest in intermediate care for youth (18 to 21 years old) aging out of ORR custody, including housing, intensive case management and legal representation. ICE's Young Adult Case Management Program is deeply problematic and should not be viewed as a substitute for an investment that should be made by ORR whose priorities are less focused on detention and removal.
8. ORR should establish a meaningful definition of when there is "reasonable suspicion" that a child is over 18 years of age.
9. ORR should develop robust guidelines for the age determination process that includes, among other evidence available, an interview with the child, their parent if available, their attorney, and their appointed child advocate, and that provides clear instruction on how evidence should be weighed in any determination. We recognize that ORR has attempted

to address this in their proposed regulatory guidance, yet the guidance does not provide meaningful instruction to prevent the outcomes highlighted above.

10. Consistent with scientific research, ORR should prohibit the use of dental exams and radiographs to determine a child's age.
11. ORR should establish a robust, interdisciplinary internal review process for all age redeterminations made by the agency.
12. ORR should conduct comprehensive training on implicit and explicit bias in the age-redetermination process for all employees and care provider staff.

INFORMATION SHARING

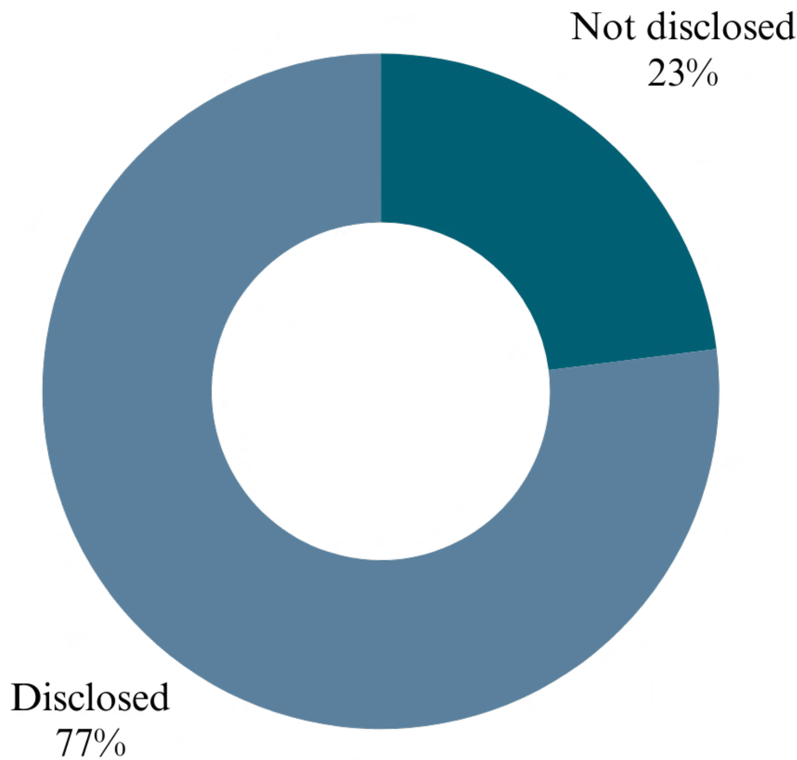
In May 2018, ORR, ICE, and CBP entered into a Memorandum of Agreement (MOA) mandating continuous information sharing on unaccompanied children, including information about the potential sponsor and all those living with them. Advocates and sponsors alike accused the Trump administration of enlisting children as "bait" to detain their undocumented sponsors and of intentionally slowing family reunification processes leaving children to languish in ORR facilities. Under this policy, sponsors coming forward to sponsor a child were arrested. In March 2021, the Biden administration signed an MOA revising consultation and information sharing in matters relating to unaccompanied children, effectively repealing many of the data sharing provisions. ORR policy now reads: "ORR is not an immigration enforcement agency and does not share information with the U.S. Department of Homeland Security, U.S. Department of Justice, or similar governmental entities for *immigration enforcement purposes*" (emphasis added).

Per the 2021 MOA, some information sharing continues. For example, DHS shares intake information with ORR and information on sponsors subject to home studies. The MOA indicates that ORR shares information with DHS regarding children's unauthorized absences from ORR facilities (e.g., absconding from ORR custody); abuse, arrests, violence, or deaths of children while in custody; age-redeterminations; alleged or suspected fraud, smuggling, trafficking of humans,

drugs, or weapons; and gang-related activity. In addition, current ORR disclosure agreements required for sponsors permit information sharing with law enforcement.

In practice, interviewees contend that ORR routinely continues to share children's information with DHS. In fact, 77% of survey respondents report experiences of ORR sharing children's confidential information with immigration enforcement in the past year.

Figure 11: Survey respondents were asked: "In the last year, has ORR disclosed confidential information of children with whom you work to DHS?"



Interviewees and survey respondents alike report that information sharing continues unabated. This information sharing impacts some sponsors' willingness to come forward. Further, our research finds that ORR's current information sharing policies and practices have devastating effects on children's placement, release from custody, and eligibility for immigration relief.

Finding: Legacies of information sharing, and Public Charge policies have a chilling effect on sponsors.

Interviews with staff from the Legal Orientation Program for Custodians (LOPC) program—the legal service providers funded by ORR to educate and otherwise work with sponsors—reveal

that the legacy of ORR information sharing has had a chilling effect on sponsors. “Despite assurances under the Biden administration, fear of apprehension endures for many families,” a respondent shared. “Families must calculate the risk of coming forward. It isn’t just about a parent’s potential deportation. If they are undocumented, they risk family unity with partners and other children in the U.S. or risk a loss of remittances that family back home depend on. It’s not a simple decision.”

In addition, LOPC providers identify how the Trump administration’s now-repealed Public Charge policy–whereby accessing public services would negatively impact the eligibility for legal relief—continues to impact sponsors’ willingness to come forward. “Sponsors may feel that any engagement with the U.S. government will adversely impact their status as legal permanent residents or their ability to adjust legal status in the future,” a provider shared.

The enduring impacts of these policies shape family reunification outcomes for children and have been reignited in an election year. “With the upcoming elections, and the possibility that Donald Trump will be the Republican nominee for President, these fears remain present in the lives of migrant families,” an interviewee explained. “ORR needs to firewall communication with DHS if we are to provide honest and transparent guidance to sponsors about the risks of sponsorship.”

Finding: Attorneys have difficulty securing up-to-date files to effectively represent children.

ORR maintains the discretion to approve or deny requests for information, weighing the availability of the information, the child’s privacy concerns, and the child’s providing consent. Respondents report that requests for institutional files have improved in recent years, both with a formal process to submit requests and a move toward digital records which reduce burdens on facility staff and facilitate more timely responses.

However, challenges in securing up to date files persist. Of survey respondents, 78% of attorneys indicate that ORR has denied access to information about the child they represent or serve. They identified two interrelated challenges: 1) released files are incomplete with no indication of which documents were omitted and why; and 2) attorneys do not receive routine updates. An attorney shared, “The only way that we know information was omitted is if it is referenced elsewhere in the file.” Another attorney explained, “We aren’t told what documents were omitted or denied. It may be a clinical note which is understandable, but more often than not, it is an SIR. We have to comb through the files to see what is missing.” Attorneys describe this as time-consuming and avoidable: “We are already spread so thin. Spending hours sifting through an institutional file hunting for clues of missing information is a disservice to children we are trying to represent.”

The incomplete or partial sharing of the institutional file with attorneys has consequences for children. An attorney stated, "For me, the issue becomes as much about what is excluded as what is selectively shared. There may be documents missing in the file request I make, but those documents are shared with DHS, making it difficult for me to adequately prepare for trial."

Second, LSPs indicated that there is no mechanism for routine file updates, which have implications for children's eligibility and access to legal relief. One respondent shared, "Record requests are processed too slow to respond to urgent needs such as a child has disclosed abuse or trafficking. With the child's assent, facility staff should be able to provide updates and critical information and to notify us immediately if there is an SIR." Another shared, "We are at the mercy of our relationship with staff to tell us about an update to the file that may impact a child's placement or legal status, which they aren't permitted to do." Yet another confirmed the issue, "I've gotten calls from case managers tipping me off that I need to re-request the file. There should be a process."

Finding: Information sharing can have devastating consequences for children's custody and immigration applications.

Our findings reveal that information shared between ORR and DHS can have devastating consequences for children. This includes impacting their eligibility for immigration relief, credibility in legal proceedings, and post-18 planning. As discussed above, the presence and accumulation of SIRs may result in children being stepped-up to more restrictive placements such as staff-secure, secure, and residential treatment programs and delay their release to sponsors (*See Safety and Protection*.)

So too, when shared with DHS, SIRs can impact immigration cases. Attorneys provided examples of DHS attorneys enlisting the number of SIRs in immigration proceedings as evidence that a child is undeserving of protections, lacks credibility, or is a threat to themself or others. An interviewee offered a distressing example: "When ORR shelter staff were beating a child in a room without cameras and other children went to help him, staff called police and claimed that child was the instigator. All of the child's record, including confidential information, was released to the government to be used against the child in their immigration proceedings, suggesting that he was violent."

Another attorney shared, "A scientifically dubious age redetermination can mean that a child loses eligibility for SIJ or that they are presumed to be lying from the start. It's often an insurmountable barrier to legal relief." (*See: Aging Out and Age Redeterminations*.) In many states, SIJ is only available for those under the age of 18 years old, thus an age redetermination indicating that a child is over 18 years old deems them ineligible for this important form of legal relief available

to children who have been abused, abandoned, or neglected. "There is no comparable relief for adults, so when that door closes, it won't reopen. For some, that is the only viable avenue for legal status in the U.S.," a respondent explained.

In another example, respondents shared how templates used by facility staff in post-18 planning were not updated to abide by the information sharing policy enacted in March 2021. One attorney described, "The child's post-18 plan had his mental health diagnosis in it" Another attorney shared, "Almost everything requested in the template is now impermissible under the new policy, but because the forms aren't updated in harmony with the info-sharing policy, they're just functionally providing it. As a consequence, the child was not approved for release on his own recognizance because the FOJC viewed the child as a threat to himself when the clinician actually didn't see any risk in his release." Nearly 20 months later at the time of our interviews, the forms were still not in compliance.

Recommendations:

1. ORR should respond to requests for information within 48 hours.
2. ORR should adopt a policy allowing any child to request that their attorney have full or partial access to their institutional record and to use the record in the way the client directs.
3. ORR should cease sharing children's case files with ICE, CBP, and DHS beyond what is essential for the safe and expeditious transfer of children to ensure greater administrative efficiency (e.g., information about medication, language, and/or disability if transferred to adult detention).
4. ORR should develop and ensure strict guidelines to ensure the confidentiality of sponsor's information.
5. ORR should ensure that information shared by children in counseling sessions is not shared with the child's case managers or any other ORR, HHS, or DHS employees, unless the child presents a substantial and imminent threat to themselves or a third party and that threat has been clearly documented.
6. ORR and facilities should update all institutional and internal forms to ensure up-to-date policy compliance.
7. ORR should establish a process with stakeholder input to indicate when information is excluded from file requests and to ensure updated files are sent routinely to attorneys and child advocates.

STAFFING AND TRAINING

Over the prior two decades, ORR has expanded exponentially the number and size of facilities for unaccompanied children—from roughly 13 facilities in 2003 to over 240 in 2024. Consistent with national employment trends, our research finds that organizations struggle to hire, train, and retain qualified staff since the COVID-19 pandemic. Facilities are not alone; legal service organizations and post-release service providers likewise struggle to meet staffing needs, especially when asked to expeditiously expand services in response to influxes of arriving children. Respondents across states and professions shared high levels of burn-out, secondary trauma, low-salaries, and limited support networks. A study surveying 700 asylum attorneys found that burnout and secondary trauma was endemic amongst lawyers working with migrants seeking protection in the United States. Congressional appropriation and ORR allocation of funding for legal services remains of vital importance. In addition to documenting these trends, we likewise showcase several promising practices for creating robust networks to share experiences and expertise and to create supportive professional communities.

Finding: Difficulty hiring and high levels of burnout lead to staffing shortages.

Across facilities and organizations, managerial staff shared challenges in hiring and retaining a well-qualified workforce that can provide the highest quality of care for young people. Programs in some states experience these staffing challenges more acutely (e.g., Texas and Arizona), while other states struggle to identify professionals with specialized backgrounds (e.g., attorneys in Virginia and California). Additionally, hiring managers shared challenges in identifying bilingual staff with child welfare expertise and feeling compelled to privilege language ability over specialized training in trauma, immigration, or child welfare.

Especially when Afghan youth entered into ORR custody in larger numbers, program directors expressed challenges in meeting the needs of children due to limited bi-cultural and bilingual staff, a lack of cultural awareness among staff, and the recency of trauma for many youths. "As a system, we failed to meet the needs of Afghan youth, so ORR started using out-of-network placements," shared one respondent. While acknowledging the considerable Congressional and institutional attention paid to the needs of Afghan and Ukrainian youth, another respondent identified, "The system also fails Indigenous youth for the very same reasons, and we have time to hire and train Maya [language] speaking staff. Mayan youth are not a new population in ORR."

Others identified challenges in meeting the shifting needs absent sufficient notice and planning. A respondent expressed their frustration, "We are asked to scale up quickly to meet needs and we simply can't. Every year, I feel like there's a lack of pre-planning and then it is used as justification to open up EIS and ICFs which use temp [temporary staffing] agencies for hiring. They are hiring warm bodies and disposable labor, not qualified professionals." Indeed, hiring for EISs and ICFs was conducted via the Federal Emergency Management Agency (FEMA) which in many instances contracted with disaster management companies and the military to quickly establish intake sites for unaccompanied children in 2021 to 2022. With diminished regulatory oversight, EISs and ICFs do not have the same staffing requirements and restrictions as permanent ORR facilities.

For children in ORR custody, vacancies have a direct impact on opportunities for outings (which require specific staff-to-child ratios), organizational capacity to accompany children to needed off-site medical, mental health and legal appointments, and staff's capacity to promptly advance family reunification processes. Organizationally, the inability to meet hiring quotas leads to non-placement of children, difficulty meeting ORR required staff-to-child ratios to keep facilities open, and loss of current or future funding. A participant shared, "We either scale up quickly or next year we lose the jobs we have. The stakes are high."

Across sectors, the demands on staff lead to high rates of burnout. Staff described experiencing secondary trauma, anxiety and depression, lack of or interrupted sleep, compassion fatigue, and low compensation. "Especially during the Trump administration, it felt like we were constantly under attack. It's a bit better now [under the Biden administration] but it's challenging work with few supports and considerable uncertainty," described a stakeholder.

Finding: Staff wish to participate in learning and support communities across the ORR network.

There is a desire among respondents to create learning and support communities across the ORR network. Several regions—namely Houston, Los Angeles, New York/New Jersey—have developed monthly stakeholder calls or working groups for those who serve unaccompanied children following release. These virtual meetings create opportunities to share experiences and programming updates and to host a series of external presenters, such as country conditions, mental health, or legal experts. These no- or low-cost networks troubleshoot issues confronting young people following release, provide mutual support, and assist post-release providers to coordinate services. Interviewees who work in facilities expressed a desire for similar opportunities to share experiences, innovations, and best practices by discipline. One participant shared, "I would love an opportunity to connect with other clinicians (take out to protect identify?) who are serving children in a similar capacity. This work is pretty isolating, especially if there are only a few clinicians at your facility, even less because I am more senior. This would provide relevant professional development and support which we need with such heavy work."

Similarly, educators in facilities expressed interest in meeting with other facility instructors. One respondent shared, "I just fell into this work. I have done some ESL work and speak Spanish. My supervisor does her best to provide support, but I really want to know what innovative ideas other teachers have to actually teach, not just manage behaviors of a constantly rotating group of kids. Some days it's just too much. Some support and some fresh energy would help not just me but the kids in my classroom too."

Finding: Need for more robust interdisciplinary training for both staff and legal service providers

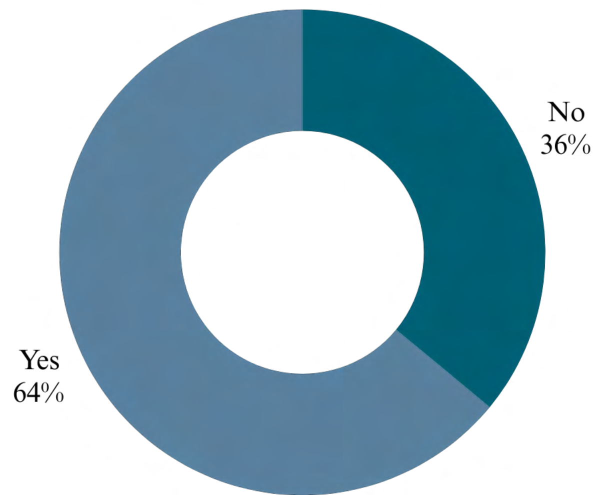
Newly hired staff in ORR facilities and legal service organizations participate in a series of preservice and ongoing training. In recent years, ORR has enhanced its training requirements to include topics such as serving LGBTQIA+ children; cultural sensitivity with regarding to discussing sex, sexual abuse, harassment, and sexual behavior; child trauma; resources for unaccompanied children following release; and working cross-culturally with children. Yet, staff

continue to report that training remains insufficient and ineffective. Many interviewees expressed feelings of unpreparedness to work with a trauma victim and were interested in learning tactics and techniques to support children who were experiencing flashbacks, intrusive thoughts, panic attacks, self-harm, and night terrors. Respondents shared:

- "Staff try their best, but we barely get any training in trauma-informed care or opportunities to better understand the cultural, political, social situations in the Northern Triangle. It impacts our work with kids."
- "In our shelter, the staff are a bunch of 20-year-olds whose parents were immigrants. Many of us were immigrants. We understood the struggle and the reasons why children and families immigrate. But we aren't equipped with the education and training on how to best support kids in our care. We trauma-bonded as staff because we had little support."
- "I feel like staff are trained on trauma-informed care once, and then the administration claims we are trauma-informed. It's clearly more involved than a 2-hour online training."
- "If ORR enlisted a strengths-based, trauma-informed lens, institutional responses to children's narratives would be completely different for so many children. We would recognize that children have voices, opinions, and power in how they understand their experiences and who they want to live with."

Further, 36% of legal services providers reported that they felt "not at all" or only "slightly" prepared to work with unaccompanied children**.** Our findings suggest that lawyers desire more legal training, specifically on immigration law and policy, evidentiary rules, and representing children in immigration court.

Figure 12:
Legal service providers were asked: "Do you feel prepared to work with children in ORR custody?"



Despite enhanced training requirements, ORR should evaluate training topics and modalities to ensure they are content-rich, research-informed, and engaging for new and continuing staff. When staff were surveyed on which training topics should be prioritized, they ranked the following topics in order of priority: trauma and child migration: causes, consequences, and mitigating effects; effective interviewing of children and youth; child and age-appropriate communication; child welfare: law, policy, and best-practices; and human trafficking.

Recommendations

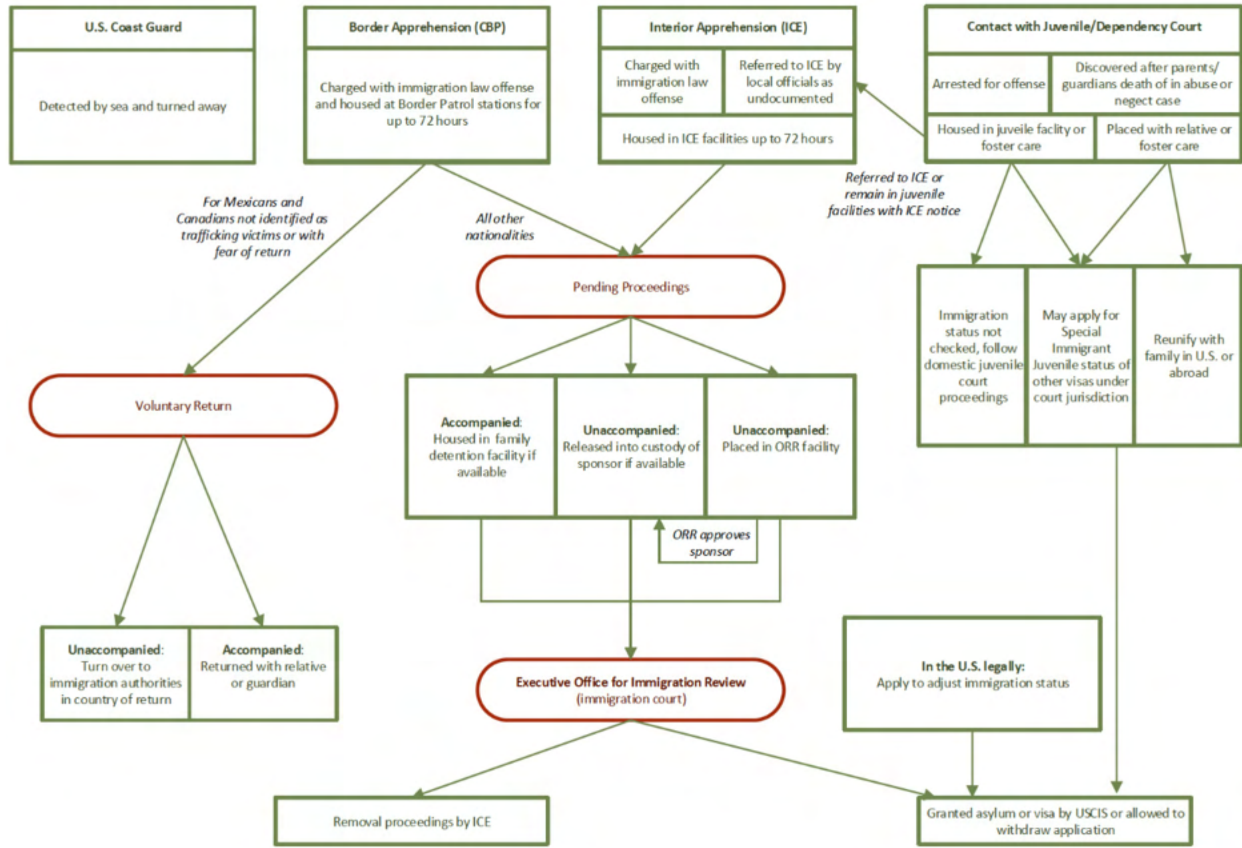
1. ORR should invest in creating spaces dedicated to stakeholder sharing and mutual support (based on discipline and/or professional role) across facilities to begin addressing high levels of burn-out and feelings of isolation.
2. ORR should require and confirm that monthly stakeholder meetings are happening in all regions.
3. ORR and stakeholders should partner with social work and psychology graduate programs to invest in a pipeline of bi-cultural, bilingual providers.
4. ORR and the Acacia Center for Justice should partner with law schools to invest in a pipeline of competent, trauma-informed legal service providers.
5. ORR, facilities, and legal service providers should revise staff onboarding and continuing education training on topics related to working cross-culturally, providing trauma-responsive care, and country conditions expertise related to emergent and specialized populations of children entering federal custody.
6. ORR should build self-care opportunities into all stakeholder funding.

ABOUT THE AUTHORS

Lauren Heidbrink, MA/MS, PhD. is an anthropologist and professor of human development at the California State University, Long Beach. Heidbrink is author of *Migrant youth, transnational families, and the state: Care and contested interests* (University of Pennsylvania Press 2014), an ethnography on unaccompanied child migration and detention in the United States. Her second book *Migranthood: Youth in a new era of deportation* (Stanford University Press 2020; published in Spanish with UNAM-CIMSUR 2021) examines the deportation of Indigenous youth in Central America and its enduring impacts on young people, their families and transnational communities. Heidbrink's research has been supported by a National Science Foundation, Wenner Gren Foundation, and the American Council of Learned Societies. She was awarded the Fulbright Schuman 70th Anniversary Scholar Award to conduct comparative research on child migration in Greece, Italy, Belgium, and the United Kingdom and a Fulbright fellowship in Guatemala (2024).

Sarah J. Diaz, J.D. LL.M., the Associate Director of the Center for the Human Rights of Children and Faculty in the School of Law at Loyola University Chicago. Professor Diaz has worked at the intersection of child migration and human rights since 2005 serving migrant children in various capacities including direct representation at the National Immigrant Justice Center and through her work as the National Case Director at the Young Center for Immigrant Children's Rights. Professor Diaz teaches immigration and refugee law-related courses at Loyola University Chicago and publishes widely on the intersection of international law and child migration. She is a graduate of Northwestern University's LL.M. program in International Human Rights Law.

APPENDIX



ENDNOTES

1. The Homeland Security Act (HSA) defines an unaccompanied child as someone who has no lawful immigration status in the United States; is under 18 years old; has no parent or legal guardian in the United States or no parent or legal guardian in the United States is available to provide care and physical custody (6 USC Sec 279(g)(2)). So too, the HSA uses the term "alien" to describe unaccompanied children, which is a derogatory term for those who are born outside of the U.S. Throughout the report, the authors have removed "alien" in order to not replicate this harm and instead inserted [] to mark its intentional omission. Further, we enlist the terms "children" and "youth" rather than "unaccompanied children" as a reminder that they are young people, irrespective of where they were born or a prescribed legal status.
2. Office of Refugee Resettlement. (2024). Fact sheets and data. Located at: https://www.acf.hhs.gov/orr/about/ucs/facts-and-data.
3. Data from 2010 through 2012 from: United States Border Patrol. (2020). Total unaccompanied alien children (0-17 Years Old) apprehensions by month. Located at: https://www.cbp.gov/sites/default/files/assets/documents/2020-Jan/U.S.%20Border%20Patrol%20 Total%20Monthly%20UAC%20Apprehensions%20by%20Sector%20%28FY%202010%20-%20FY%202019%29_0.pdf). Data from 2013 through 2016 from: U.S. Customs and Border Protection. (2023). United States Border Patrol southwest family unit subject and unaccompanied alien children apprehensions fiscal year 2016. Located at: https://www.cbp.gov/newsroom/stats/southwest-border-unaccompanied-children/fy-2016. Data for 2017 through 2019 from: U.S. Customs and Border Protection. (2024). Southwest land border encounters. Located at: https://www.cbp.gov/newsroom/stats/southwest-land-border-encounters. Data for ORR referrals from Office of Refugee Resettlement (2024). Fact sheets and data. Located at: https://www.acf.hhs.gov/orr/about/ucs/facts-and-data.
4. While not the subject of this report, the TVPRA's practice of repatriating Mexican children without assigning them equal rights and protections of other unaccompanied minors under the statute is a deeply harmful practice to Mexican children. See: The Young Center for Immigrant Children's Rights. (2019). Current border screening of unaccompanied children from Mexico has failed and should not be a model for 'reform.' Located at: https://static1.squarespace.com/static/597ab5f3bebafb0a625aaf45/t/5d6e8040e8fd10000177f1 fd/1567522881009/Young+Center+Explainer_CBP+Contiguous+Country+Screening+Has+Failed.pdf.
5. TVPRA provisions and screening procedure for children from contiguous countries make clear that some children from these countries will be transferred to ORR custody.
6. Stipulated Settlement Agreement, Flores v. Reno, No. CV 85-4544-RJK (C.D. Cal. Jan. 17, 1997). Located at: https://live-ncyl-ci. pantheonsite.io/sites/default/files/wp_attachments/Flores-Settlement-Agrement-.pdf; see also National Center for Youth Law, Flores v. Reno, https://youthlaw.org/cases/flores-v-reno (case docket).
7. The definition from the US Department of Health and Human Services, ORR's parent agency, also includes group homes of 7–12 children as congregate care. See: US Department of Health and Human Services. (2015). "A national look at the use of congregate care in child welfare." Located at: https://www.acf.hhs.gov/sites/default/files/documents/cb/cbcongregatecare_brief.pdf.
8. While there are limited exceptions in the Flores settlement agreement, the Settlement does not permit indefinite use of such placements without Flores standards/requirements (in influxes/emergencies the government must place children in a licensed program "as expeditiously as possible"). Nonetheless, this has occurred in the past under various administrations.
9. In fiscal year 2023, 61% of children in ORR custody were boys and 39% were girls. This represents a slight increase in females entering ORR custody since fiscal year 2022 (Office of Refugee Resettlement. (2024). Fact sheets and data. Located at: https://www.acf.hhs.gov/orr/about/ucs/facts-and-data).
10. In fiscal year 2023, 19% of children were 12 or younger, 12% were 13 years old, 34% were 14 to 15 years old, and 35% were 16 to 17 years old. This age distribution has remained roughly consistent over the past 7 years with a slight increase in children ages 12 or younger since fiscal year 2022. (Office of Refugee Resettlement 2024).
11. Desai, N. M., Adamson, M., Cohen, L. N., Wang, E., and Pirrotta, E. 2019 Child welfare & unaccompanied children in federal immigration custody: A data and research based guide for federal policymakers. Located at: https://youthlaw.org/sites/default/files/ attachments/2022-02/ Briefing-Child-Welfare-Unaccompanied-Children-in-Federal-Immigration-Custody-A-Data-Research-Based-Guide-for-Federal-Policy-Makers.pdf), p. 9.
12. Ibid. The annual average reached its highest of 62 days in 2019. (Office of Refugee Resettlement. (2024). Fact sheets and data. Located at: https://www.acf.hhs.gov/orr/about/ucs/facts-and-data).
13. Illinois Department of Human Services. (2020). Definition of terms. Located at: https://www.dhs.state.il.us/page.aspx?item=52211#a_toc77.
14. For ethnographic accounts of children in ORR custody, see: Heidbrink, L. (2014). Migrant youth, transnational families, and the state: Care and contested interests. Philadelphia: University of Pennsylvania Press. Terrio, S. J. (2015). Whose child am I?: Unaccompanied, undocumented children in US immigration custody. Berkeley: University of California Press. Ruehs-Navarro, E. (2022). Unaccompanied: The plight of immigrant youth at the border. New York: NYU Press.
15. The Family First Prevention Services Act of 2018 codified that children should be placed in the least restrictive setting appropriate to their needs, prioritizing family and small-group care. Family First Prevention Services Act. Public Law (P.L.) 115—123. Located at: https://www.acf.hhs.gov/cb/title-iv-e-prevention-program#:~:text=The%20Family%20First%20Prevention%20Services,candidates%20 for%20foster%20care%2C%20pregnant. See also, Casey Family Programs. (2022). What are the outcomes for youth placed in group and institutional settings? Located at: https://www.casey.org/media/22.07-QFF-SF-Group-placements_fnl-1.pdf. Chapin Hall and Chadwick

Center. (2016). Using evidence to accelerate the safe and effective reduction of congregate care for youth involved with child welfare. Located at: https://www.chapinhall.org/wp-content/uploads/effective_reduction_of_congregate_care_0.pdf.

16. Burrell, S. (2013). Trauma and the environment of care in juvenile institutions. Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress, p. 2.
17. Statz, M., & Heidbrink, L. (2021). Unintended trauma: the role of public health policy in the detention of migrant children. The Lancet Regional Health–Americas, 2. For research of the negative consequences of congregate care, see Berens, A. E. and Nelson, C. A. (2015). The science of early adversity: Is there a role for large institutions in the care of vulnerable children? The Lancet 386(9991): 388-398. For a discussion of the effects of immigration detention on children, see: UNICEF. 2019. Working paper: Alternatives to immigration detention of children. Located at: https://www.unicef.org/media/58351/file/Alternatives%20to%20Immigration%20Detention%20of%20Children%20(ENG).pdf: 2.
18. Linton, J. M., Griffin, M., Shapiro, A. J., & Council on Community Pediatrics. (2017). Detention of immigrant children. Pediatrics 139(5): 6–9.
19. The Annie E. Casey Foundation. (2020, Nov 13) Juvenile detention explained. Located at: https://www.aecf.org/blog/what-is-juvenile-detention. For an international comparison, see Ainsworth, F., & Thoburn, J. (2014). An exploration of the differential usage of residential childcare across national boundaries. International Journal of Social Welfare, 23(1), 16-24.
20. The Young Center for Immigrant Children's Rights is appointed as "child advocate" by ORR to advocate for the best interests of individual children and ensure that all decisions on behalf of an immigrant child take into consideration the child's best interests. The children served by the Young Center are those considered the most vulnerable. To learn more, see: The Young Center for Immigrant Children's Rights. Child advocate program. Located at: https://www.theyoungcenter.org/child-advocate-program. Flores monitors are independent monitors appointed by the Honorable Judge Dolly M. Gee to oversee compliance and investigate potential breaches of Flores Settlement Agreement. To learn more, see Appointment of independent monitor in the Flores settlement agreement. Located at: https://law.ucdavis.edu/sites/g/files/dgvnsk10866/files/media/documents/flores-pa-monitor.pdf.
21. From Congregate to Community-Based Care: Strengthening Reunification and Support of Unaccompanied Children, Women's Refugee Commission Report (forthcoming, 2024).
22. James, A. and Prout, A. (Eds). (1997). Constructing and reconstructing childhood: Contemporary issues in society. London: Routledge Falmer.
23. Kosher, H., and Ben-Arieh, A. (2020). Children's participation: A new role for children in the field of child maltreatment. Child Abuse & Neglect, 110 (Pt 1), 104429.
24. Valentine, I. Katz, C. Smyth, C. Bent, S. Rinaldis, C. Wade, C., & B. Albers. (2016). Key elements of child safe organisations – Research study. Sydney: Royal Commission into Institutional Responses to Child Sexual Abuse. Located at: https://www.researchgate.net/profile/Bianca-Albers/publication/334458723_Key_Elements_of_Child_Safe_Organisations_-_Research_Study_Final_Report/links/5d2c346392851cf44085046b/Key-Elements-of-Child-Safe-Organisations-Research-Study-Final-Report.pdf.
25. UNCRC Article 12 "1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child."
26. ORR considers children's wishes, often when those expressions are indicative of behavior deemed a safety concern or somehow problematic. Consider, for example, section 1.2.5: "indicators of escape risk include: the unaccompanied [] child has displayed behaviors indicative of escape or has expressed intent to escape," whereas section 2, "Safe and Timely Release from ORR Care" only references the child's expressed desire with respect to an appeal of a denial of release at 2.7.8 for the sole reason that ORR deems the child a danger to the community. (Office of Refugee Resettlement. (2024). ORR program policy guide. Section 1.1. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.)
27. Ibid.
28. UNICEF. (2023). Using data to achieve the Sustainable Development Goals (SDGs) for children. Located at: https://data.unicef.org/sdgs/.
29. Stafford, L., Harkin, J. A., Rolfe, A., Burton, J., & Morley, C. (2021). Why having a voice is important to children who are involved in family support services. Child Abuse & Neglect, 115, 104987.
30. "Safe and timely release (also known as 'family reunification') must promote public safety and ensure that sponsors are able to provide for the physical and mental well-being of children." (Office of Refugee Resettlement. (2024). ORR program policy guide. Section 2.1. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.)
31. Office of Refugee Resettlement. (2024). ORR program policy guide. Section 3.4.4. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.
32. It is important to emphasize that child advocates should not be used in lieu of directly soliciting and incorporating children's expressed wishes.
33. Grabell, M., Sanders, T., Sterin Pensel, S., (2018, December 21). In immigrant children's shelters, sexual assault cases are open and shut. ProPublica. Located at: https://www.propublica.org/article/boystown-immigrant-childrens-shelter-sexual-assault. Cohen, J. S., Eldeib, D.,

Sanchez, M. (2018, July 27). “Hidden in plain sight”: Hundreds of immigrant children and teens housed in opaque network of Chicago-area shelters. ProPublica. Located at: https://www.propublica.org/article/illinois-chicago-children-teens-immigration-shelters-heartland.

34. Office of Refugee Resettlement. (2024). ORR program policy guide. Section 1.2.3. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide. Issues related to safety include a child or youth being fearful of others, such as specific individuals who would seek to harm or exploit the child (e.g., smugglers, traffickers, drug cartels, or other organized crime groups), and a child or youth who is a material witness or a victim of crime. ORR collaborates with law enforcement officials on the placement of an unaccompanied [] child who has information that may be relevant to a criminal proceeding (e.g., “material witness”).

35. “Are victims of trafficking, at high risk for trafficking, or victims of other crimes, have a history of criminal, juvenile justice, or gang involvement, have a history of behavioral issues or violence, have special needs, disabilities or medical or mental health issues, have a history of substance abuse, are parenting or pregnant, may be subject to bullying (e.g., transgender youth), or present a risk of running away.” (Office of Refugee Resettlement. (2024). ORR program policy guide. Section 3.3.4. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.)

36. The ORR policy guide section on reporting and follow up related to sexual abuse is codified in Section 4.10 and related sections. (Office of Refugee Resettlement. (2024). ORR program policy guide. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.

37. The Prison Rape Elimination Act was signed into law in 2003. VAWA 2013 amended PREA to also include HHS facilities with custody of unaccompanied children. HHS issued an interim final rule (the IFR) in 2014 setting forth the relevant standards. In Fall of 2023 the ORR Unified Agenda of potential regulatory/deregulatory actions includes possible finalization of these standards as a final rule (estimated May 2024).

38. Office of Refugee Resettlement. (2024). ORR program policy guide. Section 4. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.

39. Office of Refugee Resettlement. (2024). ORR program policy guide. Section 4.1. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.

40. Fong, K. (2020). Getting eyes in the home: Child protective services investigations and state surveillance of family life. American Sociological Review, 85(4), 610-638. Kelly, L. (2021). Abolition or reform: Confronting the symbiotic relationship between” child welfare” and the carceral state. Stan. JCR & CL, 17, 255.

41. The proposed Unaccompanied Children program foundational rule includes provisions related to behavior management and calls to law enforcement at 410.1304. The Notice of Proposed Rulemaking (NPRM) describes the following at p. 68942: “Under proposed § 410.1304(b), involvement of law enforcement would be a last resort and a call by a care provider facility to law enforcement may trigger an evaluation of staff involved regarding their qualifications and training in trauma-informed, de-escalation techniques. ORR notes that calls to law enforcement are not considered a behavior management strategy, and care provider facilities are expected to apply other means to de-escalate concerning behavior. But in some cases, such as emergencies or where the safety of unaccompanied children or staff are at issue, care provider facilities may need to call 9–1–1. ORR also notes that proposed § 410.1302(f) describes requirements for care provider facilities regarding the sharing of information about unaccompanied children. Additionally, because ORR would like to ensure law enforcement is called in response to an unaccompanied child’s behavior only as a last resort in emergencies or where the safety of unaccompanied children or staff are at issue, ORR is requesting comment on the process ORR should require care provider facilities to follow before engaging law enforcement, such as the de-escalation strategies that must first be attempted and the specific sets of behaviors exhibited by unaccompanied children that warrant intervention from law enforcement.” The proposed regulatory text itself at 410.1304(b) (at p. 68992) reads: “b) Involving law enforcement should be a last resort. A call by a facility to law enforcement may trigger an evaluation of staff involved regarding their qualifications and training in trauma-informed, de-escalation techniques.”

42. Office of Refugee Resettlement. (2024). ORR program policy guide. Section 5.8.2. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide. Per ORR policy, significant incidents include (but are not limited to): abuse or neglect in ORR care; sexual harassment or inappropriate sexual behavior; staff code of conduct violations; contact or threats to a child while in ORR care from trafficking or smuggling syndicates, organized crime, or other criminal actors; incidents involving law enforcement on-site at the care provider; potential fraud schemes perpetrated by outside actors on children or their sponsors; and mental health concerns; and use of behavioral safety measures, such as restraints.

43. Office of Refugee Resettlement. (2024). ORR program policy guide. Section 5.8.2. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.

44. Young Center and National Immigrant Justice Center. (2022). Punishing Trauma: Incident Reporting and Immigrant Children in Government Custody. Located at: https://immigrantjustice.org/research-items/report-punishing-trauma-incident-reporting-and-immigrant-children-government-custody.

45. Ringel, J. S., Schultz, D., Mendelsohn, J., Holliday, S. B., Sieck, K., Edochie, I., & Davis, L. (2018). Improving child welfare outcomes: balancing investments in prevention and treatment. Rand Health Quarterly, 7(4), 10.

46. The United Nations Convention on the Rights of the Child (UNCRC, 1989, Article 9).

47. Casey Family Programs. (2023). How can we end the need for group placements in child welfare? Located at: https://www.casey.org/

ending-group-placements-principles/.

48. Fathallah, S., & Sullivan, S. (2021). Away from home: Youth experiences of institutional placements in foster care. Think Of Us. Located at: https://assets.website-files.com/60a6942819ce8053cefd0947/60f6b1eba474362514093f96_Away%20From%20Home%20-%20Report.pdf.
49. Office of Refugee Resettlement. (2023, September 27). HHS announces historic child welfare package to expand support and equity in child welfare system [Press release]. Located at: https://www.hhs.gov/about/news/2023/09/27/hhs-announces-historic-child-welfare-package-expand-support-equity-child-welfare-system.html.
50. Stipulated Settlement Agreement, Flores v. Reno, 507 U.S. 292 (1993) (No. CV 85-4544-RJK(Px).
51. ORR defines a "category 1" sponsor as a parent or legal guardian; "category 2" sponsor as a sibling, grandparent, or other immediate relative; and "category 3" sponsor as other sponsor, such as distant relatives and unrelated adult individuals. (Office of Refugee Resettlement. (2024). ORR program policy guide. Section 2. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide). For fiscal year 2022 data, see U.S. Department of Health and Human Services. (2024). Unaccompanied children information. Located at: https://www.hhs.gov/programs/social-services/unaccompanied-children/index.html.
52. Office of Refugee Resettlement. (2024). Fact Sheets and Data. Located at: https://www.acf.hhs.gov/orr/about/ucs/facts-and-data.
53. This length of stay was artificially high because so few children were entering custody as a result of Title 42 in which the children in custody were disproportionally without viable sponsors. See: Congressional Research Service. (2021). Unaccompanied alien children: An overview. R43599. Located at: https://crsreports.congress.gov/product/pdf/R/R43599.
54. According to Lucas R. v. Azar, from November 2017 to March 2020, the average length of stay for children placed in secure and medium-secure facilities was 183.8 days. Located at: https://youthlaw.org/sites/default/files/2022-03/Doc%20376.pdf.
55. Office of Refugee Resettlement. (2024). ORR program policy guide. Section 2.2.1. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.
56. It is important to note that in the vast majority of cases, there are no allegations of abuse, abandonment, or neglect for children held in federal custody. Child welfare experts in the domestic system indicate that CPS would decline to become involved absent allegations of abuse, abandonment or neglect.
57. For a discussion of the institutional logics that undergird the sponsorship process, see Heidbrink, L. (2017). Assessing parental fitness and care for unaccompanied children. RSF: The Russell Sage Foundation Journal of the Social Sciences, 3(4), 37-52.
58. If, for example, an uncle sponsors a child, the family would need to provide the child's, parent's, and sponsor's birth certificates to document their biological relationship. Most young people, especially when forced to flee, do not arrive with these documents.
59. Current ORR policy requires biometric and background checks of all potential sponsors and their adult household members. ORR submits fingerprint information of all sponsors to the Sex Offender Registry and State Criminal History Repository. Fingerprinting information is also sent to the Federal Bureau of Investigation and Child Abuse and Neglect for all non-related sponsors (category 2B and 3) and, in some instances for parents and family members (category 1 and 2A). In some cases, DNA testing is required. See: Office of Refugee Resettlement. (2024). ORR program policy guide. Section 2. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.
60. The Trump administration instituted these requirements but later removed them for adult household member (except in cases of home studies) and for category 1 and category 2A sponsors. The Biden administration did not change these fingerprinting requirements. Category 2B sponsors are still required to submit fingerprints, as are all sponsors and household members whenever there is a home study. (Office of Refugee Resettlement. (2024). ORR program policy guide. Section 2.5.1. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.) In September of 2019, then-ORR Director Jonathan Hayes testified to Congress that ORR facilitated the release of children in custody by ending most fingerprinting requirements for parents, grandparents, adult siblings, and adult household members. The pilot program was not about fingerprinting per se, as fingerprinting is one part of a multi-step family reunification process. However, ending most fingerprint requirements prevented family separation and avoided ORR custody by not separating children from family members. (See, minute 1:29:00 through 1:31:00 of: C-SPAN. (2019, September 18). Mental health needs of migrant children in custody. Located at: https://www.c-span.org/video/?464368-1/administration-officials-testify-migrant-children-mental-health.)
61. According to that, category 2B and 3 sponsors would be fingerprinted/FBI criminal history checked in all cases. Category 1 and 2A are fingerprinted/FBI criminal history checked "[w]here a public records check reveals possible disqualifying factors under 2.7.4; or where there is a documented risk to the safety of the unaccompanied child, the child is especially vulnerable, and/or the case is being referred for a home study.: There are additional field guidances that discuss additional situations (family groups, expedited releases, etc.), e.g., Field Guidance 10, 11, and 15. (Office of Refugee Resettlement. (2024). Unaccompanied children program field guidance. Located at: https://www.acf.hhs.gov/orr/policy-guidance/uc-program-field-guidance.)
62. Zip codes flagged for concern of potential trafficking or labor exploitation are mentioned in the DOL-HHS memorandum of agreement that were signed in March 2023. (Department of Labor and HHS' Administration for Children and Families. (2023). Inter-agency Data Sharing [Memorandum of Agreement]. Located at: https://www.acf.hhs.gov/sites/default/files/documents/main/23-MOA-096-between-DOL-WHD-and-HHS-ACF-Regarding-Inter-Agency-Data-Sharing-Agreement_0.pdf.)
63. Office of Refugee Resettlement. (2024). ORR program policy guide. Section 1. Located at: https://www.acf.hhs.gov/orr/policy-guidance/

unaccompanied-children-program-policy-guide.

64. TVPRA at 8 U.S.C. 1232(c)(3)(B).

65. Office of Refugee Resettlement. (2024). Fact sheets and data. Located at: https://www.acf.hhs.gov/orr/about/ucs/facts-and-data. At the time of publication, FY2023 data was not available. During FY2020, the Trump Administration implemented a 6-month closure of the border for all unaccompanied children until the decision was undone by U.S. Federal Court ruling.

66. The Americans with Disabilities Act of 1990 (42 U.S.C. 12102).

67. United States District Court, Central District of California, Western Division. Lucas R v. Azar (2022). Located at: https://youthlaw.org/sites/default/files/2022-08/Docket%20No%20391.pdf). Office of Refugee Resettlement. (2024). ORR program policy guide. Section 2.7.8. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.

68. At the time of writing, proposed federal regulations (Subpart C) propose a notice and appeal processes and procedures for parents or legal guardians of an unaccompanied child who are denied sponsorship.

69. In expounding upon the headway made in Lucas R., ORR should institute “policies requiring an automatic review of all pending Family Reunification Applications (“FRAs”) The first automatic review shall occur [45] days after the FRA is submitted and an automatic review shall occur every [45] days thereafter to determine what steps are needed to accelerate the minor’s safe release.” See, National Center for Youth Law. Lucas R v. Azar (2024). Located at: https://youthlaw.org/sites/default/files/2024-05/433%20-%20Order%20Granting%20Final%20Approval%20of%20Settlements%20of%20Plaintiffs%27%20Third%2C%20Fourth%2C%20and%20Fifth%20Claims%20for%20Relief.pdf. The Proposed Rule discusses review of a child’s individual care plan every 30 days. (Proposed Section 410.1302(e). Located at: https://www.federalregister.gov/documents/2023/10/04/2023-21168/unaccompanied-children-program-foundational-rule.) We concur with the proposed timeline of 30 days, but remain concerned that ORR’s review process is inadequate and superficial. To ensure children are expeditiously released and does not linger in custody, ORR should undertake a robust and meaningful review every 30 days.

70. Office of Refugee Resettlement. (2024). ORR program policy guide. Section 3. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide. Section 3.

71. Office of Refugee Resettlement. (2024). ORR program policy guide. Section 3.4.9. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.

72. Office of Refugee Resettlement. (2024). ORR program policy guide. Section 3.4.8. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.

73. Breier, J. and K. Fredricks. (2023). A path to meeting the medical and mental health needs of unaccompanied children in U.S. communities. Migration Policy Institute and American Academy of Pediatrics. Located at: https://www.migrationpolicy.org/research/medical-mental-health-needs-unaccompanied-children.

74. Office of Refugee Resettlement. (2024). ORR program policy guide. Sections 3.3. and 3.4. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.

75. For additional research and recommendations on meeting the health needs of unaccompanied children following release, please see Breier, J. and Fredricks, K. (2023). A path to meeting the medical and mental health needs of unaccompanied children in U.S. communities. Migration Policy Institute and American Academy of Pediatrics. Located at: https://www.migrationpolicy.org/research/medical-mental-health-needs-unaccompanied-children.

76. Castañeda, E., Jenks, D., Chaikof, J., Cione, C., Felton, S., Goris, I., Buck, L. and Hershberg, E. (2021). Symptoms of PTSD and depression among Central American immigrant youth. Trauma Care, 1(2), 99-118.

77. Fernandez, I. T., Chavez-Duenas, N, and Consoli, A.J. (2015). Guidelines for detention center personnel working with unaccompanied asylum-seeking minors. National Latina/o Psychological Association. Located at: https://www.nlpa.ws/assets/nlpa%20guidelines%20dentention%20center%20personnel%20jan%202015.pdf.

78. M. von Werthern, M., K. Robjant, Z. Chui, R. Schon, L. Ottisova, C. Mason, & C. Katona. (2018). The impact of immigration detention on mental health: a systematic review. BMC Psychiatry 18(382).

79. For limitations on therapy provided to children in ORR facilities, see Chiedi, J. M. (2019) Care provider facilities described challenges addressing mental health needs of children in HHS custody. (Report OEI-09-18-00341). Office of the Inspector General. Located at: https://oig.hhs.gov/oei/reports/oei-09-18-00431.asp?utm_source=website&utm_medium=asp&utm_campaign=uac-mental-health-report

80. Heidbrink, L. (2014). Migrant youth, transnational families, and the state: Care and contested interests. Philadelphia: University of Pennsylvania Press.

81. ORR subcontracts with non-governmental contractor who act as a local ORR liaison with care providers and stakeholders and who are responsible for making transfer and release recommendations. Case coordinators are assigned facilities on the basis of case coordinator-to-bed ratio. A case coordinator may be assigned to one or multiple facilities. Given the large size, some facilities may have multiple case coordinators. The current third-party contractor is General Dynamics Information Technology (GDIT).

82. Throughout this report, we enlist the acronym LGBTQIA+ rather than LGBTQI as utilized in ORR policy guidance in an effort to be inclusive.

83. Office of Refugee Resettlement. (2024). ORR program policy guide. Section 3.5.3. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.

84. Snapp, S. D., Russell, S. T., Arredondo, M., & Skiba, R. (2016). A right to disclose: LGBTQ youth representation in data, science, and policy. Advances in child development and behavior, 50, 135-159. See also, Llewellyn, C. (2021). Captive while waiting to be free: Legal violence and LGBTQ asylum applicant experiences in the USA. Sexuality Research and Social Policy, 18, 202-212.

85. This is not true in all states. In Texas, for example, the district court in Flores held that ORR was required to follow state law in the administration of psychiatric medications, including seeking consent from an authorized person or a court order for the administration of psychotropic medication. See https://youthlaw.org/sites/default/files/wp_attachments/Flores-MTE-order.pdf.

86. Chiedi (2019), supra note 79.

87. National Center for Youth Law. Lucas R v. Azar (2018). Located at: https://youthlaw.org/cases/lucas-r-v-azar.

88. National Center for Youth Law. Lucas R v. Azar (2024). Located at: https://youthlaw.org/sites/default/files/2024-05/433%20-%20Order%20Granting%20Final%20Approval%20of%20Settlements%20of%20Plaintiffs%27%20Third%2C%20Fourth%2C%20and%20Fifth%20Claims%20for%20Relief.pdf

89. United States District Court, Central District of California, Western Division. Lucas R v. Azar (2023). Located at: https://youthlaw.org/sites/default/files/2023-11/Psychotropic%20Medications%20Settlement.pdf.

90. Raja, S., Hasnain, M., Hoersch, M., Gove-Yin, S., & Rajagopalan, C. (2015). Trauma informed care in medicine. Family & Community Health, 38(3), 216-226.

91. Menschner, C. and Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Center for Health Care Strategies and the Robert Wood Johnson Foundation. Located at: https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf

92. The Family First Prevention Services Act of 2018 codified that children should be placed in the least restrictive setting appropriate to their needs, prioritizing family and small-group care. Family First Prevention Services Act. Public Law (P.L.) 115—123. Located at: https://www.acf.hhs.gov/cb/title-iv-e-prevention-program#:~:text=The%20Family%20First%20Prevention%20Services,candidates%20for%20foster%20care%2C%20pregnant. For an introduction to trauma-informed care for children, see Cutuli, J. J., Alderfer, M. A., & Marsac, M. L. (2019). Introduction to the special issue: Trauma-informed care for children and families. Psychological Services, 16(1), 1-6.

93. See Settlement Section III.A (p. 19): https://youthlaw.org/sites/default/files/2024-01/Disability%20Rights%20Settlement.pdf.

94. Lucas R counsel comments on the proposed Flores regulations also include some recommendations and are available here (see pp. 22-25): https://www.regulations.gov/comment/ACF-2023-0009-58376.

95. Schweikart, S. J. (2019). April 2018 Flores settlement suit challenges unlawful administration of psychotropic medication to immigrant children. AMA Journal of Ethics, 21(1), 67-72.

96. Ibid.

97. Glassy, D. & Tandon, P. (2024). Playing outside: Why it's important for kids. HealthyChildren.org. Located at: https://www.healthychildren.org/English/family-life/power-of-play/Pages/playing-outside-why-its-important-for-kids.aspx#:~:text=Children%20play%20harder%20outdoors%20than,to%20stay%20healthy%20and%20strong

98. Ibid.

99. Ibid.

100. Wang, C. (2022). The role of physical activity promoting thinking skills and emotional behavior of preschool children. Psychology: Research and Review, 35(1), 24-31. See also, Jackson, S. B., Stevenson, K. T., Larson, L. R., Peterson, M. N., & Seekamp, E. (2021). Outdoor activity participation improves adolescents' mental health and well-being during the COVID-19 pandemic. International Journal of Environmental Research and Public Health, 18(5), 2506-2023.

101. *Benefits of physical activity for children, adults, and adults 65 and older* (2023, July 17). Centers for Disease Control and Prevention. Located at: https://www.cdc.gov/physical-activity-basics/benefits/index.html

102. Office of Refugee Resettlement. (2024). ORR program policy guide. Section 3.3.8. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.

103. U.S. Department of Health and Human Services. (2008). Physical activity guidelines for Americans. Located at: https://health.gov/sites/default/files/2019-09/paguide.pdf.

104. Office of Refugee Resettlement. (2024). ORR program policy guide. Section 3.3.5. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.

105. National Center for Youth Law's EIS publication includes a breakdown of each EIS with a summary of recreational opportunities. Located at: https://youthlaw.org/sites/default/files/attachments/2022-06/EIS%20Briefing%20FINAL.pdf. Note also, that Influx Care Facilities are required to comply with the following: Activities according to a recreation and leisure time plan that include daily outdoor activity—weather permitting—with at least one hour per day of large muscle activity and one hour per day of structured leisure time activities (that

should not include time spent watching television). Activities should be increased to a total of three hours on days when school is not in session. (Office of Refugee Resettlement. (2024). ORR program policy guide. Section 7. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide).

106. A comprehensive review of those facilities, along with additional information on children's access to leisure, can be found at Desai, N., de Gramont, D., & Miller, A. (2021) Unregulated & unsafe: The use of emergency intake sites to detain immigrant children. National Center for Youth Law. Located at: youthlaw.org/unregulated-unsafe-emergency-intake-sites.
107. Flores Settlement, Exhibit 1, para 3-4. Located at: https://live-ncyl-ci.pantheonsite.io/sites/default/files/wp_attachments/Flores-Settlement-Agrement-.pdf.
108. Wiseman, A. W., Damaschke-Deitrick, L., Park, M. F., and Bell, J. C. (2020). Caught between a rock and a hard place: The gap between rights-related policies and educational opportunities for unaccompanied Im/migrant children in detention. Journal of Latinos and Education, 22(2), 855-869.
109. Ibid.
110. Office of Refugee Resettlement. (2024). ORR program policy guide. Section 3.3.5. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.
111. For example, INA 101(b) and (c) defines child as unmarried and under 21 years of age for purposes of receiving an immigration or naturalization benefit.
112. Snider, A., & Dibennardo, R. (2021). Representation matters: No child should appear in immigration proceedings alone. Vera Institute of Justice. Located at: https://www.vera.org/downloads/publications/representation-matters.pdf.
113. Trafficking Victims Protection Reauthorization Act of 2005 (TVPRA 2005), Pub. L. No. 109-164.
114. Office of Refugee Resettlement. (2024). ORR program policy guide. Section 3.7. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide. Section 3.7.
115. Office of Refugee Resettlement. (2024). ORR program policy guide. Section 3.7.2. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.
116. Office of Refugee Resettlement. (2024). ORR program policy guide. Section 3.7.1. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.
117. On average, less than 1% of children are ordered removed or accept voluntary departure from ORR custody.
118. Office of Refugee Resettlement. (2024). ORR program policy guide. Section 1.2.6. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide: An unaccompanied child may be placed in a long-term foster care (LTFC) setting, such as community-based foster care or a community-based group home. LTFC providers must ensure that each child is placed in a licensed foster home or group home and consider the child's preference, cultural, and linguistic needs when making placements. A child is a candidate for LTFC if they: Are expected to have a protracted stay of four months or more in ORR custody because they do not have a viable sponsor and/or the child is likely to be in ORR care for a prolonged time for other reasons; and are under the age of 17 and 6 months at the time of placement, unless waived by both the referring and receiving Federal Field Specialist (FFS), who will take into account the best interests of the child.
119. TRAC. (2024). Too few immigration attorneys: Average representation rates fall from 65% to 30%. Syracuse University. Located at: https://trac.syr.edu/whatsnew/email.240124.html#:~:text=News%20from%20TRAC%3A%20Too%20Few,Fall%20from%2065%25%20To%2030%25&text=(24%20Jan%202024)%20There%20is,been%20piling%20up%20for%20decades.
120. The proposed ORR foundational rule provides at pp. 68949-50: "Under proposed § 410.1309(b), ORR would fund legal services for the protection of an unaccompanied child's interests in certain matters not involving direct immigration representation, consistent with its obligations under the HSA, 6 U.S.C. 279(b)(1)(B), and the TVPRA, 8 U.S.C. 1232(c)(5). In addition to the direct immigration representation outlined in § 410.1309(a)(4), to the extent ORR determines that appropriations are available and use of pro bono counsel is impracticable, ORR may (but is not required to) make funding for additional access to counsel available for unaccompanied children in the following enumerated situations for proceedings outside of the immigration system when appropriations allow and subject to ORR's discretion in no particular order of prioritization: (1) ORR appellate procedures, including the Placement Review Panel (PRP) related to placement in restrictive facilities under § 410.1902, risk determination hearings under § 410.1903, and the denial of a release to the child's parent or legal guardian under § 410.1206; (2) for unaccompanied children upon their placement in ORR long-term home care or in an RTC outside a licensed ORR facility and for whom other legal assistance does not satisfy the legal needs of the individual child; (3) for unaccompanied children with no identified sponsor who are unable to be placed in ORR long-term home care or ORR transitional home care; (4) for purposes of judicial bypass or similar legal processes as necessary to enable an unaccompanied child to access certain lawful medical procedures that require the consent of the parent or legal guardian under state law and the unaccompanied child is unable or unwilling to obtain such consent; (5) for the purpose of representing an unaccompanied child in state juvenile court proceedings, when the unaccompanied child already possesses SIJ classification; and (6) for the purpose of helping an unaccompanied child to obtain an employment authorization document. ORR invites comment on these proposals under § 410.1309(b), and also with regard to how a mechanism might be incorporated into the rule to help prevent, or reduce the likelihood of, the zeroing-out of funding for legal representation, while also ensuring sufficient funding for capacity to address influxes." The provision of legal counsel to children for issues

related to the conditions of their care remains an area of concern.

121. Golberg, C. (2020). Legal aid for unaccompanied children in the U.S. illegally. National Conference of State Legislatures. Located at: https://www.ncsl.org/immigration/legal-aid-for-unaccompanied-children-in-the-us-illegally. Immigration Services Unit. Immigration Services Funding (ISF) Program. California Department of Social Services. Located at: https://www.cdss.ca.gov/inforesources/immigration/immigration-services-funding.
122. Iruka, I. U., Curenton, S. M., Sims, J., Harris, K., & Ibekwe-Okafor, N. (2021). Ethnic-racial identity formation in the early years. Durham, NC: Hunt Institute.
123. Office of Refugee Resettlement. (2024). ORR program policy guide. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.
124. For further discussion see, Rodriguez, S., & Acree, J. (2021). Discourses of belonging: Intersections of truth, power, and ethics in evaluation with migrant youth. American Journal of Evaluation, 42(2), 276-292.
125. Office of Refugee Resettlement. (2024). ORR program policy guide. Section 3. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.
126. Ibid.
127. Ibid.
128. Ibid.
129. Zelaya, Laura, "Fighting for Immigrant Children Must Include Fighting for Equitable Language Access" Medium, July 27, 2022. Located at: https://theyoungcenter.medium.com/fighting-for-immigrant-children-must-include-fighting-for-equitable-language-access-2cba252cfca9.
130. Gentry, B. (2020). O'odham niok? In indigenous languages, US "jurisprudence" means nothing. Chicanx-Latinx Law Review, 37(1), 29-64. See also, Gieselman, J. (2017). An invisible wall: How language barriers block Indigenous Latin American asylum-seekers. Transnat'l L. & Contemp. Probs., 27, 451-476.
131. ReproductiveRights.gov. Know your rights: Reproductive health care. U.S. Department of Health and Human Services. Located at: https://reproductiverights.gov/.
132. Office of Refugee Resettlement. (2024). ORR program policy guide. Section 3. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.
133. ACLU. (2023, August 18). Garza v. Hargan - Challenge to Trump administration's attempts to block abortions for Young Immigrant Women. Located at: https://www.aclu.org/cases/garza-v-hargan-challenge-trump-administrations-attempts-block-abortions-young-immigrant-women. See ORR's policy response to Garza here: Office of Refugee Resettlement. (2020, September 29). Medical services requiring heightened ORR involvement [policy memorandum]. Located at: https://www.acf.hhs.gov/sites/default/files/documents/orr/garza_policy_memorandum.pdf.
134. Washington v. Glucksberg, 521 U.S. 702 (1997). Located at: https://supreme.justia.com/cases/federal/us/521/702/.
135. Glaskin, K., & Chenhall, R. (Eds.). (2013). Sleep around the world: Anthropological perspectives. New York: Palgrave Macmillian.
136. World Health Organization (2011). World report on disability 2011. Located at: https://www.who.int/teams/noncommunicable-diseases/sensory-functions-disability-and-rehabilitation/world-report-on-disability.
137. ORR Policy does put limits on care provider discretion on placement. See: Office of Refugee Resettlement. (2024). ORR program policy guide. Section 1.3.3. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.
138. Young Center and National Immigrant Justice Center. (2022). Punishing trauma: Incident reporting and immigrant children in government custody. Located at: https://immigrantjustice.org/research-items/report-punishing-trauma-incident-reporting-and-immigrant-children-government-custody.
139. Lucas R. v. Azar, 2020 WL 2068698 (C.D. Cal. 2020). Located at: https://youthlaw.org/cases/lucas-r-v-azar. Lucas R., et al. v. Xavier Becerra, et al., 2022 WL 2177454 (C.D. Cal. 2022). Located at: https://youthlaw.org/sites/default/files/2022-03/Doc%20376.pdf.
140. Lucas R., et al. v. Xavier Becerra, et al., 2022 WL 2177454 (C.D. Cal. 2022). Located at: https://youthlaw.org/sites/default/files/2022-03/Doc%20376.pdf.
141. Engber, D. (2018, August 10). The Shiloh scandal is even worse than it seems. Slate. Located at: https://slate.com/technology/2018/08/immigrant-children-abuse-drugged-shiloh-treatment-center.html.
142. National Center for Youth Law. (2023, November 14). Landmark settlements mark a turning point in the treatment of children in immigration custody. Located at: https://youthlaw.org/news/landmark-settlements-mark-turning-point-treatment-children-immigration-custody.
143. Lucas R. v. Azar, 2020 WL 2068698 (C.D. Cal. 2020). Located at: https://youthlaw.org/cases/lucas-r-v-azar. National Center for Youth Law. (2023, November 14). Landmark settlements mark a turning point in the treatment of children in immigration custody. Located at: https://youthlaw.org/news/landmark-settlements-mark-turning-point-treatment-children-immigration-custody.

144. Gen Z is defined as those born between 1997 and 2012. Ipsos Global Advisor. (2023). LBGT+ Pride: A 30-country Ipsos global advisory survey. Located at: https://www.ipsos.com/sites/default/files/ct/news/documents/2023-05/Ipsos%20LGBT+%20Pride%202023%20Global%20Survey%20Report%20-%20rev.pdf.

145. Bennett, C. and Thomas, F. (2013) Seeking asylum in the UK: Lesbian perspectives. Forced Migration Review, 42, 25-28. See, e.g., Hopkinson, R. A., Keatley, E., Glaeser, E., Erickson-Schroth, L., Fattal, O., & Sullivan, M. N. (2017). Persecution experiences and mental health of LGBT asylum seekers. Journal of Homosexuality, 64(12), 1650–66.

146. Luibhéid, E., & Chávez, K. R. (2020). Queer and trans migrations. Champaign, IL: University of Illinois Press.

147. McDonald, K. (2018). Social support and mental health in LGBTQ adolescents: A review of the literature. Issues in Mental Health Nursing, 39(1), 16-29.

148. Office of Refugee Resettlement. (2024). ORR program policy guide. Section 3.5. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.

149. Office of Refugee Resettlement. (2024). ORR program policy guide. Section 3. https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.

150. Office of Refugee Resettlement. (2024). ORR program policy guide. Section 3.5.2. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.

151. Office of Refugee Resettlement. (2024). ORR program policy guide. Section 3.5.4. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.

152. Nguyen, A., & Melhado, W. (2023, January 9). Two Texas bills would restrict lessons about sexual orientation and gender identity in public schools. The Texas Tribune. Located at: https://www.texastribune.org/2023/01/09/texas-bills-sexual-orientation-gender-identity-florida-law/#:~:text=Patterson's%20HB%201155%20would%20extend,appropriate%20for%20various%20age%20groups.

153. Herrera, J. (2023, March 6). The Texas right's newest target: Transgender juvenile offenders. Texas Monthly. Located at: https://www.texasmonthly.com/news-politics/texas-legislature-transgender-juvenile-offenders/.

154. Office of the Inspector General. (2018). ICE's inspections and monitoring of detention facilities do not lead to sustained compliance or systemic improvements. U.S. Department of Homeland Security. Located at: https://www.oig.dhs.gov/sites/default/files/assets/2018-06/OIG-18-67-Jun18.pdf. See, e.g., Ryo, E. (2019). Understanding immigration detention: Causes, conditions, and consequences. Annual Review of Law and Social Science 15(1):97-115.

155. Heidbrink, L. and Diaz S. (2023). Denouncing medical practices that imperil unaccompanied youth. Harvard Public Health Review, 74: 10.54111/0001/VVV1.

156. Introna F. and Campobasso CP. 2006. Biological versus legal age of living individuals. In: Schmitt, A., Cunha, E., Pinheiro, J. (eds). Forensic Anthropology and Medicine. Humana Press. See also, Alasagheirin, M.H. and Clark M.A. (2018). Skeletal growth, body composition, and metabolic risk among North Sudanese immigrant children. Public Health Nursing 35(2): 91-99.

157. World Health Organization and UNICEF. (2021). Levels and trends in child malnutrition. Located at: https://www.who.int/publications/i/item/9789240025257.

158. Greulich, W.W. (1959). Radiograph Atlas of Skeletal Development of the Hand and Wrist. 2nd ed. Stanford, CA. See also, Kapadia, F., Stevens, J., and Silver, D. (2020). Dental radiographs for age estimation in US asylum. seekers: methodological, ethical, and health issues. American Journal of Public Health 10(12),1786–1789.

159. Solari, A.C. and Abramovitch, K. (2001). The accuracy and precision of third molar development as an indicator of chronological age in Hispanics. Journal of Forensic Science 47(3),531–535. See also, Lewis, J.M. and Senn, D.R. (2010). Dental age estimation utilizing third molar development: a review of principles, methods, and population studies used in the United States. Forensic Science International 201(1–3),79–83.

160. Willmann, C., Fernandez De Grado, G., Kolb, C., Raul, J. S., Musset, A. M., Gros, C. I., & Offner, D. (2023). Accuracy of age estimation using three dental age estimation methods in a young, large, and multiethnic patient sample. Dentistry Journal, 11(12), 288.

161. U.S. Congress, Public Law 110-457-Dec. 23, 2008. William Wilberforce Trafficking Victims Protection Reauthorization Act of 2008. Located at: https://www.congress.gov/110/plaws/publ457/PLAW-110publ457.pdf.

162. Ibid.

163. Office of Refugee Resettlement. (2024). ORR program policy guide. Section 1. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.

164. Office of Refugee Resettlement. (2024). ORR program policy guide. Section 1.6.2. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.

165. Office of Refugee Resettlement. (2024). ORR program policy guide. Section 1.6.1 Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.

166. Administration for Children & Families. (2021). Field guidance 9. Interim guidance: Age outs and post-18 planning. Located at: https://

www.acf.hhs.gov/sites/default/files/documents/orr/FG-9%20Interim%20Guidance%20Age%20Outs%20and%20Post-18%20Planning%20 2021%2002%2017.pdf.

167. Office of Refugee Resettlement. (2024). ORR program policy guide. Section 2.2.1. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.

168. This specific information is not discoverable in ORR's public data; however, it has been reported by at least one stakeholder participant.

169. See DHS Office for Civil Liberties and Civil Rights memo as helpful resource: Quinn, C.P. (2020, May 11). Age determination and birth certification verification procedures [memorandum]. U.S. Department of Homeland Security. Located at: https://www.dhs.gov/publication/retention-memo-cbp-crcl-investigation-concerning-age-determination-and-birth-certificate

170. Lewis, J. M., and Senn, D. R. (2010). Dental age estimation utilizing third molar development: a review of principles, methods, and population studies used in the United States. Forensic Science International, 201(1–3), 79–83.

171. Liversidge, H. M., Buckberry, J., and Marquez-Grant, N. (2015). Age estimation. Annals of Human Biology, 42(4), 299–301. Santiago, B. M., Almeida, L., Cavalcanti, Y. W., Magno, M. B., and Maia, L. C. (2017). Accuracy of the third molar maturity index in assessing the legal age of 18 years: a systematic review and meta-analysis. International Journal of Legal Medicine, 132(4), 1167-1184.

172. National Immigrant Justice Center. Ramirez et al. v. ICE et al. (2022). https://immigrantjustice.org/court_cases/garcia-ramirez-et-al-v-ice-et-al.

173. ICE's Young Adult Case Management Program rolled out in January 2023 and thousands of youth are being enrolled into the program. See NIJC, WRC, and the Young Center. (2023). ICE's new young adult case management program: Why it falls short of case management best practices and puts youth at risk. Located at: https://www.theyoungcenter.org/how-ices-new-young-adult-case-management-program-places-youth-at-risk.

174. For global best practices in age determinations, Italy's Zampa law uses the least invasive methods possible. A team of social science, medical and cultural experts meet with a young person under the oversight of a judge to ensure respect for the child's rights and all necessary safeguards are in place. See, Lelliott, J. (2018). Italy's Zampa law: Increasing protection for unaccompanied children. Forced Migration Review (57), 79-81.

175. The NPRM for the proposed Unaccompanied Children's program foundational rule addresses age determinations at p. 68954: "Under proposed § 410.1702, ORR would require that procedures for determining the age of an individual consider the totality of the circumstances and evidence rather than rely on any single piece of evidence to the exclusion of all others."

176. Women's Refugee Commission, National Immigrant Justice Center, and the Washington College of Law. (2019). Children as bait: Impacts of the ORR-DHS information-sharing agreement. Located at: https://immigrantjustice.org/sites/default/files/content-type/research-item/documents/2019-03/Children-as-Bait.pdf.

177. Sponsors were in fact arrested due to coming forward to sponsor children under this policy. See: Sands, G. (2018, December 10). ICE arrested 170 potential sponsors of unaccompanied migrant children. CNN. Located at: https://www.cnn.com/2018/12/10/politics/ice-potential-sponsors-arrests/index.html.

178. The Office of Refugee Resettlement, U.S. Immigration and Customs Enforcement, and U.S. Customs and Border Protection. (2021). Memorandum of Agreement between ORR, ICE, and CBP for consultation and information sharing in matters relating to unaccompanied children. Located at: https://www.aila.org/aila-files/001DBB72-F5E3-49B3-8629-820656C77642/21031235b.pdf?1697590507.

179. Office of Refugee Resettlement. (2024). ORR program policy guide. Section 5.10. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.

180. Office of Refugee Resettlement. (2023). Privacy notice: Parent/legal guardians completing the letter of designation for care of a child. Located at: https://www.acf.hhs.gov/sites/default/files/documents/orr/frp-english-v14.zip.

181. Duncan, W. and Horton, S. (2020, April 18). "Serious challenges and potential solutions for immigrant health during COVID-19." Health Affairs Forefront. Located at: https://www.healthaffairs.org/content/forefront/serious-challenges-and-potential-solutions-immigrant-health-during-covid-19.

182. Office of Refugee Resettlement. (2024). ORR program policy guide. Section 5.4.5. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.

183. Harris, L. M. and Mellinger, H. (2021). Asylum attorney burnout and secondary trauma. Wake Forest Law Review, 56, 733 – 826.

184. We note that there are dozens of different Indigenous and Afro-descendent linguistic communities in Mexico, Guatemala, Honduras, Belize, El Salvador and Nicaragua. In addition, there are over 600 Indigenous languages spoken in Latin America alone.

185. Prior federal appropriations language included requirements for influx facilities. ORR policy incorporated minimum standards from Flores for influx facilities. (Office of Refugee Resettlement. (2024). ORR program policy guide. Section 7.5.1. Located at: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide.)

186. For additional discussion of the impacts on providers, see Canizales, S. L. (2023). Caught in the dragnet: How punitive immigration laws harm immigrant community helpers. Contexts, 22(1), 38-43.

187. The Interim Final Rule containing training standards is located at: Department of Health and Human Services and Administration for Children and Families. (2014). Standards to prevent, detect, and respond to sexual abuse and sexual harassment involving unaccompanied children. Federal Register. Located at: https://www.federalregister.gov/documents/2014/12/24/2014-29984/standards-to-prevent-detect-and-respond-to-sexual-abuse-and-sexual-harassment-involving.
188. 56% of legal services providers reported feeling "moderately prepared," and only 1% felt "very prepared" to work with unaccompanied children.