



Federal Policy and State Licensing Standards for the Operation of Residential Facilities Housing Unaccompanied Migrant Children

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EXECUTIVE SUMMARY

Unaccompanied children (UCs) are children under the age of 18, without immigration documentation, who have no identified parent or legal guardian to care for them in the United States, as determined by immigration officials (6 U.S.C. § 279(g)(2)(2012)). These children may have migrated to the United States from other countries without a parent, family member, or guardian or been separated from their parents, family members, or guardians upon arrival to the United States. Many UCs do, in fact, have parents or other family members in the United States who can care for them and with whom they are eventually reunified. Though historically the vast majority of UCs have been older children, changes in migration and Trump administration policies, including family separations or the “zero tolerance” policy, increased the number of young children who were identified as unaccompanied children and placed in shelters in recent years, alarming advocates, policymakers, and researchers around the world. Unaccompanied children are children first, and a developmentally-centered approach to their care, at least on par with systems of care that house and care for other children in the United States, must be of utmost priority.

The federal Office of Refugee Resettlement (ORR) at the U.S. Department of Health and Human Services (HHS) funds a network of facilities, shelters, and services for UCs across the country. While UCs are in the custody of ORR, their rights and protections are guaranteed in the Trafficking Victims Protection Reauthorization Act of 2008 (TVPRA) and the *Flores* Settlement Agreement, which is a court settlement in place for over two decades that establishes requirements on the conditions in which immigrant children in federal custody may be detained or housed. ORR shelters and service providers are also required to abide by policies for care set by ORR, and, in addition, must comply with state law and be licensed by the state in which they operate. ORR’s policies must be consistent with TVPRA and *Flores*, but are not codified in federal law, meaning their standards of care (short of those protections required by TVPRA, *Flores*, and relevant state law) are subject to change.



Unaccompanied children are children first, and a developmentally-centered approach to their care, at least on par with systems of care that house and care for other children in the United States, must be of utmost priority.

The issue of UCs at the U.S.-Mexico border, including young children, reached a boiling point in early 2021, influenced by a confluence of factors. Several of former President Trump's previous policies reduced the number of asylum seekers who were allowed in the country—including the "Migrant Protections Protocols" (also known as the "Remain in Mexico" policy), which returned asylum seekers to Mexico to await their asylum hearings, and the Title 42 public health order issued by the administration, which closed the border to even UC asylum seekers during the COVID-19 pandemic. Other bureaucratic changes have also contributed to a backlog of asylum seekers, including children, waiting in Mexico for their cases to be heard. Layered on top of this, the economic and health catastrophes caused by COVID-19 and natural disasters have wreaked havoc in Latin America, as have recent natural disasters in Central America—compounding existing challenges and potentially contributing to an increase in migration. These factors, combined with the fact that the current ORR shelter system is at significantly reduced capacity to allow for social distancing and COVID-19 prevention, has caused a new level of stress on the system. President Biden has made this issue a priority, and in March of 2021 sent FEMA to the border to assist with unaccompanied children at the U.S.-Mexico border. Still, the challenges with capacity in the shelter system—including physical space and quality of care—are challenging and complex, and of the utmost importance to children's health, safety, and wellness.

No analysis to date has compared state licensing standards for UC shelters, as they relate to federal law, Flores, and federal ORR policy, to demystify the nested set of rules that regulate how these shelters operate and the experiences and conditions children experience. This report conducts such a review, with a focus on how state licensing standards and federal law, Flores, and publicly available ORR policies (current as of February 17, 2021), working in concert, support—or conversely, allow harm to—children's health, development, and wellness. Throughout, we highlight the needs of young children in particular, as they are an especially vulnerable and often overlooked segment of the UC population; however, many of the recommendations are supportive for UCs of all ages. Although beyond the scope of the present analysis, UCs may also be guaranteed rights under the state constitutions of the states in which ORR-funded shelters operate, and those shelters are also subject to state laws beyond state licensing requirements. This highlights the complexity of the nested systems in which UCs are embedded—as well as the complexity that advocates face to ensure their rights are preserved and their needs met. Of note, this analysis also does *not* review policies for care in U.S. Customs and Border Protection (CBP) or U.S. Immigration and Customs Enforcement (ICE) facilities.

In our analysis, we first identified the domains within federal ORR policy and state licensing standards that have a direct effect on the conditions children are exposed to and the experiences they have. We then examined sub-domains within each area and carefully reviewed licensing standards across these areas in every state with UC shelters. The domains we identified include:

1. Admission, assessment, and release processes
2. Personnel requirements
3. Provisions for basic needs
4. Health care services
5. Behavior and discipline policies
6. Developmental and educational services

Informed by our analyses, research, and the pillars of age-appropriate, trauma-informed, and culturally and linguistically responsive practices, we provide a set of top-line recommendations to ORR and aimed at improving the broader system in its humane treatment of children. We then analyze and provide a set of specific recommendations for each domain we reviewed. Wherever possible and appropriate, we aimed to align our recommendations with other national accreditation or professional standards that provide guidance on creating supportive environments for young children, including the American Academy of Pediatrics' [*Caring for Our Children National Health and Safety Performance Standards: Guidelines for Early Care and Education Programs*](#).

It must be noted that foster care placements or small family-like care settings are the most appropriate settings for children, especially young children, until they can be united with a sponsor. However, there are instances that inevitably arise where children will need to be placed in congregate care, for example, in situations when the number of children coming to our borders exceeds the number of available small setting placements. In such cases, it is critical that the settings that young children are placed in are developmentally appropriate, and that the people who are tasked with caring for them are competent, knowledgeable, and trained to support their health, well-being, and development.

SUMMARY OF FINDINGS

ORR's policies as laid out in *ORR Guide: Children Entering the United States Unaccompanied* are generally more detailed and comprehensive than state licensing standards, with some exceptions.

Our analysis found that it is generally *not* the case that ORR's policies are the "floor" and that state licensing standards go beyond basics.

There are gaps in ORR's policies related to child wellness, particularly as they pertain to caring for young children.

Gaps primarily exist in personnel requirements and developmental, behavioral, and educational supports for young children. Although officials at ORR have previously mentioned the existence of separate requirements for "tender age" facilities that serve young children, these policies do not appear to be publicly available.

ORR appears to have a detailed and thorough monitoring process for grantees. But the consistency and fidelity of implementation of the monitoring protocol is unclear. What's more, ORR and state licensing agencies do not share information about monitoring findings.

ORR's monitoring system is, on paper, more comprehensive than any state licensing monitoring system. However, a recent investigation by the U.S. Government Accountability Office (2020) found that ORR a) lacks clear instructions for grantees on when and how to report state licensing violations to ORR, b) lacks a centralized database logging all federal ORR monitoring activities and corrective actions for facilities, and c) has been out of compliance with their own policies to conduct regular monitoring site visits, provide prompt correct actions to facilities, and conduct audits related to sexual abuse and harassment prevention. Nearly all state licensing agencies reported that they do not regularly share state monitoring findings with ORR, and *all* reported that ORR does not share its monitoring findings with them.

State licensing standards are not specific to housing or supporting UCs.

In every case, UC shelters are licensed under a broader category that is not specific to UCs, including residential child care, group homes, child behavioral health facilities, and homeless shelters.

No state met all of the quality indicators we reviewed and many fell short of meeting all of the indicators even within a single domain.

State licensing standards vary significantly across state lines.

This may result in different experiences for children, based on what shelter they are sent to.

There are shortfalls in state licensing standards that are not otherwise addressed by TVPRA, Flores, or ORR policies across every domain we reviewed. For example:

Admission, orientation, assessment, and release processes. Nearly all states lack attention to the unique needs of young children in the admission, orientation, assessment, and release processes.

Personnel requirements. No states have caregiver-to-child staffing ratios that align with the minimum ratios specified in the American Academy of Pediatrics' *Caring for Our Children* standards, and most states do not require licensed health professionals (e.g., doctors, nurses, social workers, psychiatrists) to have expertise in children.

Provisions for basic needs. Only 2 states have developmentally responsive nutrition policies that explicitly include free access to water and snacks throughout the day for young children and on-demand bottle-feeding for infants.

Health care services. No states have a comprehensive developmental and behavioral screening protocol to specifically identify young children's physical and mental health care needs.

Behavior management and discipline. In 13 of 16 states, the practice of seclusion—or locking a child in a room without the ability to leave—is allowed in some shelter types, even for young children, and in some cases, for indefinite amounts of time. Trauma-informed and developmentally appropriate behavior support is rarely mentioned across states.

Developmental and educational services. All but 2 states fail to describe the environment and developmental and educational services that facilities must provide for young children, even though all states allow young children to be admitted to such facilities.

Accountability, monitoring, and waivers. Nearly all states allow facilities to apply for broad, non-specific waivers from any state licensing standard, even if the reason for requesting a waiver is purely financial and not in the best interest of children.

Even with the nesting of federal law, Flores, ORR policies, and state licensing standards, gaps that risk child safety, health, and well-being remain.

For example, ORR’s policies do not prohibit chemical restraint—the act of restraining a child with a chemical substance—and 7 states also allow it in some settings, without explicit differentiation by child age.

Though state licensing standards vary significantly across state lines and in many cases lack in quality, they serve an important monitoring function.

This added level of monitoring and accountability provides an additional layer of protection for UCs, which is particularly critical when the federal administration is not reliably protecting children’s rights and promoting positive experiences.

Informed by these findings and the research on child health, development, and well-being, we provide recommendations to the federal government and states.

Although this report does not review specific standards and operation procedures for CBP or ICE facilities, it is indisputable that the policies and actions of these agencies can be a grave threat to child safety, health, and well-being, and our goal of humanely caring for children. As such, we provide two overarching recommendations at the highest priority level.

one

CBP and ICE should never separate children from their parents, guardians, and siblings at apprehension, unless there is a credible safety threat to the child or suspicion of child exploitation or trafficking as determined by an authorized child welfare professional. Parents’ past criminal records, and especially misdemeanor charges and immigration status offenses, should not be used to justify separation. In addition, given the importance of a trusted, stable caregiver to children’s development, especially young children and those who have endured traumatic events, CBP and ORR should develop a strategy to keep children together with close family members, such as grandparents, with whom they have migrated, so long as an ORR-led investigation, implemented in partnership with a child welfare professional, confirms the relation and rules out safety threats or suspicions of child exploitation.

two

CBP should prioritize processing UCs and aim to transfer them to ORR custody faster than the required 72 hours. Recently, in spring 2021, UCs have been detained in CBP processing centers for an average of 120 hours (Alvarez & Sands, 2021), and children also remained in CBP custody in excess of this time limit under the Trump administration (DHS OIG, 2019). CBP processing centers are detention facilities, and detaining children in these facilities is extremely harmful to their health, wellness, and development. CBP should redirect funding to ensure that there are enough state-licensed child welfare professionals at the border to process such transfers in a timely manner, particularly during periods when larger numbers of children are coming to the U.S.

OVERARCHING RECOMMENDATIONS

In the following section we focus on overarching recommendations for ORR that we believe would make the system more transparent and accountable for improving the conditions young children experience in the shelter system. It must be noted that it is gravely insufficient to have the requirements that dictate the experiences of vulnerable children solely in ORR policy via a handbook; therefore, **the first priority should be to codify such protections and policies into federal law. There are, however, steps ORR can take to improve conditions now, in advance of Congress taking this urgent action.**

- 1 Given the wide variability in quality of state licensing standards currently, ORR should not assume their policies are the “floor” and that states will build on them to reach a higher threshold of quality for children. This lack of consistency and altogether absent considerations for the unique needs of unaccompanied children in state licensing standards warrant raising ORR’s policies dictating the conditions and services provided by shelters; in concert, states should raise the quality, monitoring, and accountability for the care of all children in their systems.
- 2 This increase in quality should include a close examination of the domains reviewed here, and in particular, include sections across every domain specific to young children. Although young children are a minority of unaccompanied children in ORR custody, they are a sizable percentage and may be more vulnerable given their sensitive developmental state. It is also one of the areas where ORR policies seem to be lacking most.
- 3 Well-established research (van IJzendoorn et al., 2020) supports prioritizing family-like settings to large congregate care settings. Domestic child welfare policy also continues to move strongly away from congregate care settings, most recently codified in the Family First Prevention Act of 2018. ORR should align with this and give strong funding priority to high-quality applicants offering foster placements and small shelter/group home settings (i.e., less than 25 beds), and phase out large congregate care shelters, especially for UCs who are likely to remain in ORR custody for longer periods of time or have no imminent date of release.
- 4 ORR should require that all applicants for shelter funding disclose any previous state licensing violations. Prior to housing children, ORR should proactively confirm that grantees have a license and have not had a pattern of licensing violations or previous licenses revoked.
- 5 ORR should develop a tracking system closely tied to a technical assistance system that identifies red flags pertaining to monitoring violations in order to deploy rapid supports and/or intervention and immediately respond when child safety, health, or well-being is threatened.
- 6 The lack of communication between states and ORR is concerning and allows for continued operation of a facility, even if a state agency has identified a major licensing violation. ORR should partner with states with facilities that house UCs and establish formalized data sharing agreements to inform one another about grantee red flags, concerns, and real time licensing and monitoring findings.
- 7 ORR’s post-release services for unaccompanied children are generally poorly funded, available only to a fraction of unaccompanied children, and even in those cases, minimal (with the exception of FY 2020 when a larger proportion of children in care received services, likely due to the much reduced number of children in the system at the time). ORR should extend post release services for all children (and Congress should fund such an expansion) and form memoranda of understanding with other HHS offices to ensure that UCs receive priority for other social services (for which they are eligible) in the community during and after their time in shelters. Head Start and WIC are particularly relevant to young children. They should also form similar agreements across other federal agencies, most notably, the Education Department, to ensure children have access to the services they are eligible for or entitled to post release.
- 8 ORR should ensure that any child without an identified sponsor or any child who has been in care for more than 60 days (except in cases of imminent release) receive developmental and educational services in community-based settings.

9

Historically, ORR has used some influx shelters repeatedly. Though they are only in operation during periods of increased child migration, the fact that the same influx shelters are sometimes repeatedly used warrants having the agencies that operate them go through the state licensing process. ORR should have a pool of state-licensed shelter facilities that are only activated in times of influx.

10

The fact that influx shelters are not currently subject to state licensing warrants a higher level of standard and scrutiny by ORR to compensate for the lack of state oversight. ORR should raise oversight and monitoring of influx or emergency shelter facilities, require them to meet the same requirements as regular facilities, and only allow them to delay full compliance with requirements that do not directly impact child health, safety and well-being.

11

Identifying which state licensing standards apply to ORR shelter facilities is extremely challenging. In addition, some of ORR's policies and procedures may be internal and not shared publicly, adding another layer of obscurity. Some policies may also be included in funding opportunity announcements, which can change with each cycle of funding. This information should not be hard to find. ORR should increase transparency of the shelter system by making public all relevant policies that affect shelter operations and child services. They should also develop and make publicly available a searchable database of ORR-funded facilities that includes the name of the facility, the level of placement according to ORR's designations (e.g., standard shelter, therapeutic placement, residential treatment center), the state in which the facility operates, the type of state license they are required to have, documentation of inspections/violations, and documentation of licensing waivers. (Such a database should not include addresses for facilities, as there may be safety and privacy concerns for children and staff.)

States could and should play a stronger role in ensuring positive experiences for unaccompanied children in the shelter system. This starts by closely revisiting their licensing standards, particularly the domains reviewed here, to assess the appropriateness and quality of the services facilities provide to children. There is a particular need to examine standards as they relate to the experience of younger children as our review finds major gaps in developmental appropriateness. The full report identifies several specific recommendations per domain that states can consider in improving the quality and safety of their systems. **In addition to standards, overhauling the waiver process is also a critical need, such that waivers should not be granted for standards that directly affect the health, safety, and wellness of children in care, including standards related to discipline, health, basic needs, among others.** These improvements will not only impact the experiences of UCs, but of children in the child welfare system more broadly, an issue of utmost importance.

CONCLUSION

The network of ORR shelters plays a central role in children's migration experiences. While congregate care is not the ideal placement for children, especially young children, there are some instances that may require it, making it essential that the shelter system is ready and available to serve children of all ages. Our review finds that federal law, ORR policies, and state standards these shelters are required to abide by are generally insufficient in their specificity given the unique needs of this population, lack in developmental appropriateness in most areas, and in many cases, do not go far enough to ensure the protection of children. The federal government must act to improve ORR policies today and prioritize codifying these protections into federal law immediately. States should use their leverage over facility licensing to strengthen their standards and provide a second layer of protection for children. Although there are inevitably challenges associated with increasing the quality of care, including cost and general supply of the specialized workforce needed to care for these children, the federal government and states should work toward the common goal of—and adequately invest in—protecting and humanely caring for unaccompanied children. That begins with holding shelter operators to a higher standard of care and funding them to provide such a standard. Combined, these reforms and others, can help ensure that when children reach our borders or our shores, they are cared for humanely and with a fundamental concern for their dignity, health, and well-being.

INTRODUCTION

Unaccompanied children (UCs) are children under the age of 18, without immigration documentation, who have no identified parent or legal guardian to care for them in the United States, as determined by immigration officials (6 U.S.C. § 279(g)(2)(2012)). Many UCs do, in fact, have parents or other family members in the United States who can care for them and with whom they are eventually reunified. These children may have migrated to the United States from other countries without a parent, family member, or guardian or been separated from their parents, family members, or guardians upon arrival to the United States. The vast majority of these children are from countries in the Northern Triangle of Central America: Guatemala (45%), Honduras (30%), and El Salvador (18%; data from FY 2019; HHS, 2020a). Though the number of UCs coming to the United States has fluctuated over the years, there has been a relatively steady increase since an unprecedented surge in 2012 (Chishti et al., 2019; Rosenblum & Ball, 2016), with the exception of 2020 when numbers fell sharply, primarily due to immigration policies enacted during COVID-19.

Children are identified as UCs upon being apprehended at the U.S.-Mexico border by Customs and Border Protection (CBP). Once identified as UCs, CBP must transfer children to the custody of the federal Office of Refugee Resettlement (ORR) at the U.S. Department of Health and Human Services (HHS) within 72 hours, absent exceptional circumstances (TVPR, 2008). ORR funds a network of facilities, shelters, and services for UCs across the country, where UCs are cared for until they can be released to a sponsor, which is usually a parent or other family member (Kandel, 2019). In FY 2019, 69,550 children were referred into ORR custody (HHS, 2020b). While UCs are in the custody of ORR, their rights and protections are guaranteed in the Trafficking Victims Protection Reauthorization Act of 2008 (TVPR) and the Flores Settlement Agreement, which is a court settlement in place for over two decades that establishes requirements on the conditions in which immigrant children in federal custody may be detained or housed. Under the terms of the TVPR and Flores, children must be placed in the least restrictive setting that is in the best interest of the child and receive a range of services to meet their basic needs, including basic needs, mental and physical health services, and educational opportunities. In addition, ORR shelters and service providers—including facilities and their staff, volunteers, contractors, subcontractors, and any other individual with regular contact with UCs in federal custody—are required to abide by ORR’s policies for care, although these policies are not codified in federal law and may change at any time,

without notice. Each ORR-funded facility must also comply with state law and be licensed by the state in which it operates (ORR, 2021 a). During increased periods of migration when there are not enough beds in their licensed facility network, ORR uses influx facilities to house children.

Over the last decade, the population of UCs has ranged from 66% to 77% male. The percentage of children under age 12 has ranged from 11% to 21% (ORR, 2021 b). However, in recent years, this pattern has shifted somewhat, at least in part due to policy changes. Under the Trump administration’s so-called “zero tolerance” policy, there were mass family separations of more than 5,000 children (Associated Press, 2019). After being separated from their families, these children were labeled as “unaccompanied” and referred to ORR. Around this same time, in June 2018, ORR implemented a new policy requiring all adults living with potential sponsors for UCs to submit fingerprints for background checks, which were also shared with U.S. Immigration and Customs Enforcement (ICE) (New York Civil Liberties Union, 2018). This policy contributed to substantial delays in releasing children from ORR custody. As a result of these policy changes, the numbers of UCs in ORR custody increased from 8,647 in April 2018 before full implementation of “zero tolerance” and expanded fingerprinting to 11,531 in June 2018, and culminating in a peak of 14,226 UCs in ORR custody in December 2018 (HHS, 2019). In the month that the “zero tolerance” policy was implemented, the number of UCs ages 0-5 in ORR custody increased by 59%, and those between the ages of 6-12 increased by 158% (HHS, 2020a). The shifts in the demographics of UCs entering ORR custody are notable. The fact that UCs have historically been older adolescents may, in part, explain the insufficient—or in some cases, altogether lack of—attention paid to the developmental appropriateness of certain facets of federal ORR policies and state licensing standards for facilities housing UCs. It should be noted that both of these policies were officially terminated under the Trump administration and the Biden administration has publicly rebuked them; therefore, this particular driver of increases in young children in UC facilities is unlikely to be a factor moving forward.

A long-established, compelling body of research finds that the first 8 years of life are especially consequential in setting children’s lifelong trajectories. The malleability and sensitivity of the brain during these early years make it so that positive experiences have an especially profound effect on development, while negative and traumatic experiences have especially consequential negative effects on development. This development unfolds in the context of adult-child

relationships. The primary caretakers of children are the single most important factors in determining positive or negative experiences. Children learn in the safe haven of healthy, responsive, warm, and secure relationships. Thus, although migration can be traumatic for children, the presence, dependability, and warmth of a primary caretaker can buffer negative experiences. Separating children from this caretaker is the single most harmful action that can be taken against a young child. This dynamic also places ORR-funded shelter personnel at particularly influential positions in either furthering harm, or mitigating it by fostering children's social and emotional wellness and development.

With the emergence of the COVID-19 pandemic globally in 2020, the policy and practice landscape affecting UCs has shifted dramatically. Perhaps most notably, the Centers for Disease Control and Prevention issued a public health order, Title 42, that effectively banned the entry of people and goods at U.S. borders, and CBP used this order as a pretext for expelling apprehended UCs and asylum-seeking families with young children without registering their cases or processing their asylum claims (Hackman et al., 2020; Kanno-Youngs & Semple, 2020). At least 8,800 UCs were expelled from the U.S. under Title 42 between March and August 2020 (Flores v. Barr, 2020). Nearly 600 of these UCs were held in unlicensed hotels prior to being expelled (Solis, 2020). Simultaneously, 1,061 UCs in ORR custody tested positive for the coronavirus between March and the beginning of December 2020 (Alvarez, 2020). The policies and practices implemented by DHS agencies during the pandemic appear to contravene federal protections guaranteed to UCs under the TVPRA and the Flores Settlement Agreement, and multiple lawsuits are pending. Although the number of children in ORR custody declined sharply in 2020, a confluence of factors has resulted in a sharp increase in the number of unaccompanied children at the border in the spring of 2021.

Several of former President Trump's previous policies reduced the number of asylum seekers who were allowed in the country—including the "Migrant Protections Protocols" (also known as the "Remain in Mexico" policy), which returned asylum seekers to Mexico to await their asylum hearings, and the Title 42 public health order. These policy changes, among others, have contributed to a backlog of asylum seekers, including children, waiting in Mexico for their cases to be heard. Layered on top of this, the economic and health catastrophes caused by COVID-19 have wreaked havoc across the globe, including in Latin America, as have recent natural disasters in Central America—compounding existing challenges and potentially causing an increase in migration (UNICEF, 2021). These factors, combined with the fact that the current shelter system is at significantly reduced capacity to allow for social distancing and COVID-19 prevention, has caused a new level of stress on the system. This stress can be particularly dangerous to children, especially young children,

if the shelter system is not ready and capable of caring for them in age and developmentally appropriate ways.

To date, we are not aware of any comprehensive policy reviews of publicly available federal ORR policies and state licensing standards governing the quality of care for UCs in the custody of ORR, though recent reports by UNICEF (2021), the National Center for Youth Law (Desai et al., 2021), Kids In Need of Defense (KIND, 2020), and the Government Accountability Office (2020) discuss specific facets of the issue and offer various child-centered policy recommendations. Immigration attorneys, child advocates, researchers, and policymakers at the state and federal level have called for compilation of this information, as even these practitioners and experts in the field do not have a clear picture of state licensing standards, as they relate to ORR requirements. Although most of this information is publicly available, it is in most cases extremely difficult to identify and access. Further, the nesting of federal law, Flores, ORR policies, and state licensing standards can be quite complex, and coordination between systems appears minimal. This report provides such an analysis, with an eye on developmentally responsive practices.

Throughout, we highlight the needs of young children in particular, as they are an especially vulnerable segment of the UC population; however, many of the recommendations applicable and supportive for UCs of all ages. We examined the publicly available federal ORR policies in the [ORR Guide: Children Entering the United States Unaccompanied](#) and state standards overall and in complement to each other, digging deeper into 6 specific issue areas that can greatly influence child development, health, and wellness:

1. Admission, orientation, assessment, and release processes
2. Personnel requirements
3. Provisions for basic needs
4. Health care services
5. Behavior and discipline policies
6. Developmental and educational services

We also examined federal and state monitoring protocols, and the extent to which states grant waivers to care facility operators for licensing standards in these specific issue areas. Within each issue area, we provide cross-cutting recommendations that would leverage the federal and state roles to ensure that all ORR facilities provide supports that foster a base level of safety and development, physical and emotional health, and wellness for children in these facilities. We believe that these recommendations offer a path forward through a child-centered policy agenda to improve care and promote well-being for young children in the UC system, and can be a stopgap measure until Congress acts on codifying protections for UCs in federal law.

METHODOLOGY

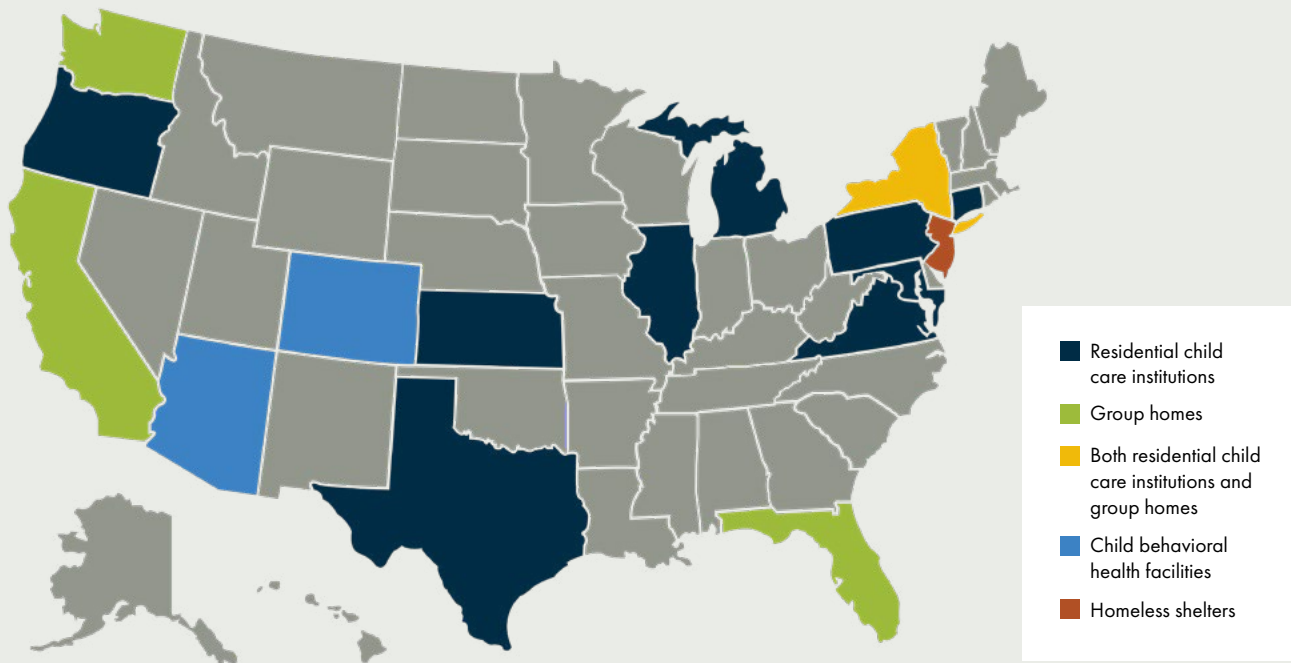
At the federal level, ORR outlines policies and procedures with which all ORR-funded facilities must comply in the [ORR Guide: Children Entering the United States Unaccompanied](#). We used this document (current as of February 17, 2021) as our proxy for ORR policies, but note that there may be other policies ORR does not make public that affect how shelters are operated. In addition, some requirements or standards for grantees may be included in funding opportunity announcements, which we did not review as part of this report. At the state level, there are no state licensing standards that are unique or specific to facilities housing UCs. In every state, facilities that care for UCs are licensed within a broader category, such as residential child care, group homes, or behavioral health facilities (see Appendix for state licensing agencies and facility designations).

In most cases, information regarding how ORR-funded facilities housing UCs were licensed in each state was challenging to locate, as were the actual state licensing standards. We started by obtaining a list of all the states with any type of ORR program, including transitional foster care, from ORR. We compared this list of 26 states to two maps created by [Reveal](#) and [ProPublica](#) documenting the names and addresses of ORR facilities they identified through

Freedom of Information Act requests.ⁱ We flagged states that appeared on the ORR list but not on either map as needing additional investigation to ascertain a) whether the state has only transitional foster care programs but no physical shelter housing UCs, and b) if the state does have physical shelters, how they are licensed. Of note, ORR describes the settings within their network with the following categories: “shelter facility, foster care or group home (which may be therapeutic), staff-secure or secure care facility, residential treatment center, or other special needs care facility” (ORR Guide § 1.1). They do not appear to provide any publicly available information regarding how their designations for placements map on to states’ facility type designations for state-level licensing, although information about ORR placement level has been provided for some facilities in previous HHS OIG reports (e.g., HHS OIG, 2020). For this analysis, we sought to focus on standard shelter facilities, which are the most common type of facility in the ORR network, and therefore we excluded facilities that were explicitly identified as residential treatment centers or juvenile detention facilities in name or on the Reveal and ProPublica maps.

ⁱ ORR does not publicly release addresses for shelters due to safety and privacy concerns for UCs and staff.

Licensing Category Designations



States With Known Facilities

We started by working through the states in which providers are already known to operate physical ORR-funded facilities. For each state identified as having at least 1 facility housing UCs, we searched state agency websites for a licensed facility search database. If such a database existed for the state, we entered the available information for the UC facilities and identified the licensing category. We then subsequently searched for the actual text of the licensing standards using Google and the following search query: “[state name] [licensing category] standards.” This generally yielded the state regulations and text of the licensing standards that apply to these facilities.

Some states have searchable databases for licensed day care and early learning providers, but not for other types of congregate care. In those instances, we searched via Google for news reports or publicly available incident reports and licensing violations associated with the shelter names and addresses in that state. These reports cite the specific regulations and licensing standards that have been violated, which allowed us to subsequently follow the same search protocol as above to retrieve the state licensing standards and then identify the licensing category. In cases where the maps provided only the name of the facility, but not the address or city, and no databases or news reports could be located, the websites of potential state licensing agencies (e.g., Department of Children and Families, Department of Health and Human Services) were reviewed. On these websites, we located the state’s definitions for each facility type, which usually provide great detail about the number and ages of children they can serve, whether the facility is for daytime or 24-hour residential care, etc. Using these definitions, we identified which category a facility housing UC would fit under and located the associated state licensing standards. In the case of Virginia, we identified that the one publicly named non-secure shelter is licensed as a children’s residential facility under two different licensing agencies: the Virginia Department of Social Services (DSS) and the Virginia Department of Behavioral Health and Developmental Services, which each have their own distinct licensing standards for children’s residential facilities. Through a [recent HHS OIG report about this specific facility](#), we were able to identify that the facility appears to follow the DSS licensing standards for children’s residential facilities for UCs; we analyzed those standards in this report. However, this finding highlights the complexity of licensing standards for these facilities, and it may be the case that facilities in other states are similarly licensed by multiple agencies.

States Without Known Facilities

When following up on the states listed on the ORR list but not present on the Reveal or ProPublica maps, we started by searching for news reports regarding ORR-funded shelter

facilities in the state. If the news reports included names or locations of the facilities or operating organizations, we followed the same search protocol as above, checking licensed facility databases, and then searching for reports of licensing violations, if needed. If we could not locate evidence of a physical facility, we searched for ORR-funded foster care programs in the state to confirm the existence of such programs (which would explain their presence on the state list provided by ORR).

Verification

Throughout this process, we reached out to contacts in state licensing agencies to confirm that we had identified the correct licensing category and relevant standards. We communicated with individuals in some states; however, it should be noted as a potential limitation of this analysis that we did not receive confirmation from state representatives of the licensing standards that we identified for all states.

Review of State Licensing Standards

After we located the licensing standards for each state, we reviewed the standards and flagged the relevant standards for each issue area and subdomain we were reviewing. We then compared how the federal ORR policies nested with the state licensing standards and identified where the federal policies did not address important basic indicators of health, safety or wellness for each subdomain. For those subdomain indicators not present at the federal level, we analyzed to what extent the indicators were present in each state’s licensing standards. We also considered whether each state had any red flags in their standards, which would indicate that UCs may be exposed to safety and health risks. Finally, considering the federal policies and state licensing standards cumulatively for each issue area, we developed recommendations. Of note, as ORR-funded facilities are also required to comply with state law in the state in which they operate, other state regulations beyond state licensing requirements may affect the treatment and care of UCs, but a comprehensive review of these regulations was beyond the scope of this review.

Additional States

After the conclusion of our analyses, the Government Accountability Office released a report (September, 2020) that identified additional states with UC shelters. We did not include those additional states in this analysis. Of note, organizations based in the [District of Columbia](#), [Georgia](#), [New Mexico](#), and North Carolina have received grant funding from ORR in recent years; however, there was no evidence as of July 2020 that any of these states currently have licensed and operational facilities housing UCs (GAO, 2020). The North Carolina organization, New Horizon Group Home LLC, previously operated one group home in the state but [had their license revoked in 2018](#) and was subsequently shut down.

Domain Deep Dive:

Summary of State Performance Across Domains

	Admission, Orientation, Assessment, Release	Personnel	Basic Needs		Health Care		Behavior Management and Discipline		Developmental and Educational Services	Accountability, Monitoring, and Waivers		Total
	Indicators met	Indicators met	Indicators met	Red flags?	Indicators met	Red flags?	Indicators met	Red flags?	Indicators met	Indicators met	Red flags?	Indicators met across all domains
Arizona	2/2	1/5	2/4	Yes	0/3	Yes	0/3	Yes	0/3	1/2	Yes	6/22
California	2/2	2/5	4/4		1/3	Yes	2/3	Yes	1/3	1/2	Yes	13/22
Colorado	1/2	1/5	0/4	Yes	1/3	Yes	1/3	Yes	1/3	2/2	Yes	7/22
Connecticut	0/2	0/5	4/4		0/3	Yes	0/3	Yes	1/3	2/2	Yes	7/22
Florida	0/2	0/5	3/4	Yes	1/3	Yes	2/3	Yes	2/3	2/2		10/22
Illinois	1/2	2/5	3/4	Yes	1/3	Yes	1/3	Yes	1/3	1/2		10/22
Kansas	1/2	2/5	2/4	Yes	1/3	Yes	0/3	Yes	1/3	0/2	Yes	7/22
Maryland	2/2	1/5	3/4	Yes	2/3	Yes	2/3		2/3	1/2	Yes	13/22
Michigan	1/2	1/5	2/4	Yes	1/3	Yes	2/3	Yes	0/3	1/2	Yes	8/22
New Jersey	0/2	1/5	2/4	Yes	0/3	Yes	0/3	Yes	0/3	0/2	Yes	3/22
New York	1/2	1/5	4/4	Yes	1/3	Yes	0/3	Yes	1/3	0/2	Yes	8/22
Oregon	1/2	1/5	2/4	Yes	2/3	Yes	1/3	Yes	0/3	1/2	Yes	8/22
Pennsylvania	1/2	1/5	2/4	Yes	2/3	Yes	1/3	Yes	1/3	0/2	Yes	9/22
Texas	2/2	3/5	2/4		3/3	Yes	3/3	Yes	2/3	2/2	Yes	17/22
Virginia	0/2	0/5	2/4	Yes	1/3	Yes	1/3	Yes	0/3	2/2	Yes	6/22
Washington	1/2	2/5	3/4	Yes	1/3	Yes	1/3	Yes	1/3	0/2	Yes	10/22

ADMISSION, ORIENTATION, ASSESSMENT, & RELEASE

Unaccompanied children (UCs) encounter numerous unfamiliar federal agents and agencies before they arrive in the care of the Office of Refugee Resettlement (ORR) and are placed in an ORR facility. This process of being in contact with unfamiliar adults and being transported to various locations alone may compound existing stress and trauma. In order to ensure that UCs are not subjected to further traumatization, it is important that ORR facilities have developmentally responsive and trauma-informed policies for admitting, orienting, and assessing the needs of UCs. Without strong assessment procedures, facilities are likely to obtain inadequate information about UCs' histories and needs, which can in turn contribute to insufficient or inappropriate service planning and provision. Child-focused release procedures are likewise essential for supporting UCs' transition to community and living with a sponsor. As periods of transition and change can be particularly stressful to young children and children who have experienced trauma, the entry and exit points to the ORR system must be attentive to child needs and support positive development, continuity, and reunification with families and sponsors.

Within this domain,

we specifically examined:

- **Initial assessment/evaluation processes:** Whether initial assessment procedures are 1) conducted by mental health professionals, 2) completed within a week of admission to the facility, 3) developmentally responsive and trauma-informed, and 4) involve collection of data on the child's development, physical and mental health, trauma history, behavior, family, language proficiency, educational needs, migration history and legal status, and other individual needs.
- **Service plan development:** Whether an individualized service plan 1) is required, 2) developed based on the results of the initial assessment, 3) created within 72 hours of the completion of the initial assessment, 4) by a team led by a mental health professional, and 5) includes developmentally, culturally, and linguistically responsive goals and services.
- **Release procedures and policies:** Whether release procedures 1) are specified and 2) include trauma-informed and culturally responsive practices.



SUMMARY OF ORR POLICIES & STATE LICENSING STANDARDS

Our analysis indicates that ORR’s written policies appear to extend much broader and more supportive practices for admission, orientation, assessment, and release than the state licensing standards. *Flores* and ORR’s agency policies require that facilities meet UCs’ basic needs (i.e., providing food and water and an opportunity to bathe) almost immediately upon entry and conduct an orientation and variety of screening measures shortly after admission (i.e., screening of initial needs, complete medical exam, educational skills and needs). A comprehensive evaluation must be conducted within 5 days of admission and include gathering information on development, family, legal and migration issues, physical health, substance use, mental health, relationships with adults, peers, and authority figures, strengths and weaknesses, and personal goals. Although ORR provides the assessment tool that must be used for this comprehensive evaluation, the level of training needed to complete this assessment is vague, stating only that the staff member must be “trained.” At the state level, only 6 states—Arizona, California, Kansas, Maryland, Pennsylvania, and Texas—have standards that require the initial assessment of the child to be conducted by a mental health or other professional-level service provider. *Flores* and ORR policies state that the initial evaluation should inform the development of a developmentally, culturally, and linguistically responsive service plan, but neither the individual(s) responsible nor a timeline for creating this plan are specified. Likewise, most states have vague or nonexistent requirements for the creation of the service plan or domains that need to be covered in the plan. Ten states require that service plans are developed by a mental health professional (or with input from a team that is led by a mental health professional), are individualized based on the initial evaluation results, and include goals and appropriate services needed to reach the goals.

In terms of release and reunification, *Flores* requires that UCs be released to sponsors “without unnecessary delay.” ORR provides no additional detail about the interpretation of “unnecessary delay.” If a UC is identified as having a disability under the Americans with Disabilities Act or as a victim of human trafficking or physical or sexual abuse, TVPRA requires that ORR conduct a home study before children are released to sponsors. Home studies involve a home visit, interviews, and a written report to evaluate “the potential sponsor’s ability to meet the child’s needs” (ORR Guide § 2.4.2). ORR policy also requires home studies for UCs under 12 years old who are expected to be released to a non-relative sponsor. ORR policy states that the third-party home study provider must contact the sponsor to initiate the home study process within 48 hours of accepting the referral and submit the written report with recommendations about release within 10 business days of the receipt. The third-party home study providers may request an extension beyond the 10 days from ORR (ORR Guide § 2.4.2). There is no policy for the total maximum timeline for completing the home study—i.e., the time from when the ORR facility makes the initial referral to the third-party home study provider until the time when the home study provider submits their written report. Although home studies can be critical to ensuring child safety, they can also have the unintended consequence of delaying unification with a sponsor, leaving the child in foster or congregate care for a longer period of time, which can be counterproductive to child mental health and well-being. Additionally, as part of the release process, ORR requires that UCs receive documentation related to their stay in ORR custody (ORR Guide § 2.8.2; 3.4.8). Post-release services may be recommended but are not required for all children. Of note, all UCs who receive home studies are required to receive mandatory post-release services (ORR Guide § 6.2). Overall, ORR policies on admissions and assessment processes are appropriate to the needs of UCs; however, gaps remain, including specific training requirements, timelines, and release procedures, that are, for the most part, not addressed at the state level.

The table on the following page identifies the critical indicators that we reviewed for this domain. We reviewed what indicators were covered in TVPRA, *Flores*, and ORR policies at the federal level first, and then evaluated whether remaining indicators were addressed in state licensing.

Critical Indicators for Admission, Orientation, Assessment, and Release

REQUIREMENTS UNDER TVPRA

- UCs who are not from contiguous countries must be transferred from CBP or ICE custody to the custody of HHS no later than 72 hours after UC determination, except in exceptional circumstances (8 U.S.C. § 1232(b)(3))
- UCs must be placed in the least restrictive setting according to their needs, considering danger to self and community, and risk of flight (8 U.S.C. § 1232(c)(2)(A))
- UCs may not be placed in secure facilities unless it has been determined that they pose a danger to self or others or have been charged criminally (8 U.S.C. § 1232(c)(2)(A))
- Placement in secure facilities must be reviewed at least monthly to determine if it continues to be the least restrictive setting (8 U.S.C. § 1232(c)(2)(A))
- UCs may only be released to a sponsor once the individual's identity and relationship to the child have been confirmed and it has been determined that the individual is capable of providing for the child's physical and mental well-being (8 U.S.C. § 1232(c)(3)(A))
- A home study must be conducted for UCs with disabilities, who have been victims of human trafficking or physical or sexual abuse, or when the sponsor poses a risk of abuse or neglect based on available evidence (8 U.S.C. § 1232(c)(3)(B))

REQUIREMENTS UNDER FLORES

- UCs generally must be transferred to the custody of a qualifying adult or a non-secure facility licensed by the state to provide residential, group, or foster care services to dependent children within 3 days
- UCs must be placed in the least restrictive setting appropriate for their age and needs
- Comprehensive orientation to the facility must be provided upon admission
- Comprehensive medical exam must be conducted within 48 hours of admission
- Individualized needs assessment must include intake forms, biographic data, special needs requiring immediate intervention, educational assessment and plan, family relationships and interaction with adults, personal goals, strengths and weaknesses, and relatives in the U.S. that could be potential sponsors
- Developmentally, culturally, and linguistically responsive individualized service and release plans must be developed based on the initial assessment
- Service plans must be implemented and coordinated through an operative case management system
- UCs must be released "without unnecessary delay"

ORR POLICIES

- UCs under age 13, UCs with special needs, and UCs who are pregnant or parenting are prioritized for placement in transitional foster care; children with any gang affiliation must be placed in secure facilities (ORR Guide § 1.2.2; 1.2.4; 1.4.1)
- Bath/shower and food and drink within 2 hours of admission (ORR Guide § 3.2.1)
- Initial screening within 24 hours of admission (ORR Guide § 3.2.1)
- The orientation to the facility must be developmentally and linguistically responsive and occur within 48 hours of admission (ORR Guide § 3.2.2)
- Educational skills and needs must be assessed within 72 hours of admission (ORR Guide § 3.3.5)
- UAC Assessment must be completed by a "trained staff member" within 5 days of admission (ORR Guide § 3.3.1)
- ORR facilities may share information about a UC's previously unreported criminal history or violent behavior with other children, care providers, ORR, and other agencies, which may affect their release (e.g., via deportation by ICE) (ORR Guide § 3.2.1)
- Safety plans must be developed when appropriate (ORR Guide § 3.3.4)
- Case reviews must be conducted at least every 30 days (or 90 days if the UC is in long-term foster care) (ORR Guide § 3.3.1)
- Post-release services may be recommended, but are not required (ORR Guide § 6.2)
- UCs must receive documentation of their medical and educational assessments, services, and results upon release (ORR Guide § 2.8.2; 3.4.8)
- UCs must receive a safety and well-being follow-up call 30 days after release (ORR Guide § 6.1)

Critical Indicators for Admission, Orientation, Assessment, and Release

continued

REMAINING INDICATORS EVALUATED IN STATE LICENSING REQUIREMENTS

	Initial assessment must be completed by mental health professional	Service plan is developed by a mental health professional (or with a team led by a mental health professional), is individualized based on assessment results, and includes goals and appropriate services to meet the benchmarks
Arizona	✓	✓
California	✓	✓
Colorado		✓
Connecticut	Did not meet any indicators	
Florida	Did not meet any indicators	
Illinois		✓
Kansas	✓*	
Maryland	✓	✓
Michigan		✓
New Jersey	Did not meet any indicators	
New York		✓
Oregon		✓
Pennsylvania	✓**	
Texas	✓***	✓
Virginia	Did not meet any indicators	
Washington		✓

*Kansas' licensing standards state that a licensed nurse or physician must complete the initial (health) assessment.

**Pennsylvania's licensing standards state that medical personnel or staff trained by medical personnel must complete the initial (health) assessment.

***Texas' licensing standards state that a "professional level service provider" must complete the initial assessment—this includes individuals with social work or nursing backgrounds.

NOTABLY POSITIVE & ALARMING STANDARDS

Some states had admission, orientation, assessment, and release standards that provided additional quality beyond federal law and ORR policies, but 4 states did not have either of the remaining critical indicators we reviewed at the state level in this area.

The following are examples of components of standards that were notably positive or notably alarming:

Notably Positive Standards

- Arizona and Colorado have more detailed guidance in the area of admissions, assessment, and service planning, likely because ORR-funded facilities in these states are categorized as child behavioral health facilities.

Notably Alarming Standards

- 14 states (all except California and Texas) do not address the needs of young children in their admissions, assessment, and release policies at all.



14 states (all except California and Texas) do not address the needs of young children in their admissions, assessment, and release policies at all.

RECOMMENDATIONS: ADMISSION, ORIENTATION, ASSESSMENT, & RELEASE

Recommendations for ORR

- ✔ Require that the initial assessment and service planning be completed by a licensed mental health professional with child expertise and including the child's parents/legal guardian, if possible.
- ✔ Ensure that all assessments, including the *UAC Assessment*, collect information relevant to the needs of young children, for example collecting information regarding early childhood development, feeding, and attachment and primary caregiver relationship history.
- ✔ Develop a data system for tracking child-level data on timelines to release/reunification across all UCs in ORR custody and identify and address, on at least a quarterly basis, reasons for excessive transfers and sources of delayed release/reunification within the network of ORR facilities and service providers. Follow up with facilities whose average length of stay exceeds the ORR network average to address sources of delay. Deidentify data and make aggregate information publicly available.
- ✔ Increase partnerships with other HHS offices to ensure that UCs have access to low-cost or free culturally and linguistically responsive social services in the community during their time in shelters and for post-release services, including Head Start and WIC. Specify that the ORR case manager, rather than the sponsor, should identify service providers and connect the child and sponsor via a meaningful hand-off. In instances where there are limited or no services near the sponsor, attempt to identify free or low cost remote or virtual services (and ensure families have the connectivity capabilities to establish a remote connection), or assist with providing funds to sponsors to support transportation to such services. This recommendation requires additional funding from Congress, particularly in lower resource or more remote communities.

Recommendations for States

- ✔ In facilities that serve young children, assign a primary caregiver or caseworker with experience and knowledge in early childhood development for each young child. This individual should facilitate the admissions process with the child, including accompanying the child through all of the steps and appointments with other professionals, in consultation with the child's family to the maximum extent possible. This caseworker/caregiver should continue to be the child's primary caseworker/caregiver and point of contact throughout the child's stay at the facility. Particularly in the initial days of admission to the shelter, it is important to minimize young children's exposure to multiple adults and allow each young child to develop a relationship with a primary caseworker with expertise in early childhood development.

PERSONNEL

As children involved with ORR are by definition “unaccompanied” and apart from family members while in ORR custody, the adults with whom the child has contact in ORR facilities are of particular importance. For young children who have experienced interrupted attachment from their primary caregiver and/or experienced trauma, adults who are warm, compassionate, and authoritative can foster healing, safety, health, and well-being. In order to ensure that there are a sufficient number of appropriately trained adults to provide quality supervision and care for young children in ORR facilities, guidelines for hiring and staffing must specify minimum education levels and experience working with children, include training on development and trauma and its manifestation in young children, require low caregiver-to-child and caseworker-to-child ratios, provide staffing of bilingual personnel and/or interpretation services, and include personnel who can facilitate connection to community-based resources.

Within this domain,

we specifically examined:

- **Required education and training for child care staff:** Whether child care staff 1) must be at least 18 years old, 2) have a high school diploma or equivalent, and 3) complete initial and annual in-service training related to development and trauma in young children.
- **Required education and training for caseworkers and health care providers:** Whether health care providers, including physicians, nurses, mental health professionals, 1) are required to be licensed and 2) must have expertise in working with children.
- **Language access policies:** Whether language access policies 1) exist and 2) specify that bilingual staff will be employed and/or interpretation services will be provided for children to be able to fully communicate with personnel.
- **Required caregiver-to-child ratios:** Whether caregiver-to-child ratios are 1) low enough to allow quality caregiving and supervision and 2) differentiated by age.
- **Required caseworker-to-child ratios:** Whether caseworker-to-child ratios are 1) specified and 2) low enough to allow quality case management.



SUMMARY OF ORR POLICIES & STATE LICENSING STANDARDS

Our analysis indicates that ORR’s publicly available policies offer relatively limited requirements for personnel and training, deferring to the qualifications required by state licensing agencies or including additional personnel requirements in grantees’ cooperative agreements, which were not reviewed for this report. ORR requires professional-level positions (e.g., mental health professionals, nurses, doctors) to be licensed (ORR Guide § 3.4.1), but does not explicitly describe qualifications for direct care staff, who likely spend the most amount of time with children directly. Notably, a recent HHS OIG report (2019b) found that facilities housing UCs experience difficulties with adequately screening employees’ qualifications—including conducting required FBI and Child Protective Services background checks to ensure child safety—as well as hiring and retaining employees with appropriate training and qualifications.

Education and training requirements are quite minimal and similar across states for care staff (e.g., 18 years old, diploma/GED, initial and annual training), as well as supervisor/administrator roles (e.g., bachelor’s degree in social work and 2-3 years of experience or master’s degree in social work and 1-2 years of experience, initial and annual training). However, the amount of detail provided about the requirements for care staff and the content of annual training for staff roles varies across states. For instance, California, New York, and Texas describe staff requirements and training in great detail, while other states’ standards, such as Colorado’s, simply say that the facility must have a written policy about these items. New York and Texas also have standards that require licensed health professionals to have expertise in working with children, specifically.

No bilingual personnel staffing policies are described in ORR’s policies, although their policies do indicate that facilities must make every effort to communicate with

and provide services for UCs in their primary language (ORR Guide § 3.3). Of note, some UCs speak indigenous languages or languages other than Spanish for which there may be limited staff, materials, or resources available. In some cases, ORR may utilize non-professionals with fluency in less common languages to support UCs from those language backgrounds. Although there may be challenges associated with increasing the quality of staff training and care, including cost and the general supply of the specialized workforce needed to care for these children, ORR should seek to balance personnel qualifications and language access to the best of their ability. The state licensing standards reflect limited guidance about language access: some states mention providing translated documents or interpretation services, but many do not describe any concrete policies for ensuring children can understand the situation they are in and access services in their primary language.

ORR policy outlines minimum caregiver-to-child ratios during waking and sleeping hours, but these ratios are not differentiated by age, and no minimum clinician-to-child ratio is provided in their policy guide (ORR Guide § 4.4.1). However, of note, minimum clinician-to-child ratios (1:12) do appear to be specified in grantees’ cooperative agreements, although an HHS OIG report has recently noted facilities’ difficulty complying with this requirement (HHS OIG, 2019a). No states have caregiver-to-child ratios that align with the minimum ratios specified in *Caring for Our Children* (CFOC 1.1.1.2). Of the 16 states we reviewed with ORR facilities, 14 have state licensing standards that provide caregiver-to-child ratios, but 5 of these—California, Kansas, Michigan, New York, and Virginia—do not provide ratios broken down by age groups (i.e., lower ratios for young children). Four states (Colorado, Connecticut, Maryland, and New Jersey) provide no caregiver-to-child ratio at all. Only California, Illinois, Kansas, New York, and Washington include a required caseworker-to-child ratio; all of these, except New York’s, align with the Council on Accreditation Service Standards.

The following table identifies the critical indicators that we reviewed for this domain. We reviewed what indicators were covered in TVPRA, *Flores*, and ORR policies at the federal level first, and then evaluated whether remaining indicators were addressed in state licensing.

Critical Indicators for Personnel

REQUIREMENTS UNDER TVPRA

- Federal personnel in HHS and other agencies who have contact with UCs must receive specialized training, including identifying children who have been victims of human trafficking or children who may be eligible for asylum

REQUIREMENTS UNDER FLORES

- Federal personnel must be trained in the terms of the Flores Agreement

ORR POLICIES

- Required care staff-to-child ratios are 1:8 during waking hours and 1:16 during sleeping hours (ORR Guide § 4.4.1)
- Medical professionals must be licensed and acting within their scope of practice (ORR Guide § 3.4.1)
- Mental health professionals must be licensed (ORR Guide § 3.4.1)
- Hospitals providing services must be accredited (ORR Guide § 3.4.1)

REMAINING INDICATORS EVALUATED IN STATE LICENSING REQUIREMENTS

	Training and education requirements for direct care staff include being 18 years old, having a H.S. diploma or G.E.D., completing initial and annual in-service training that includes orientation to the developmental needs of young children (<i>Caring for Our Children</i> 1.3.2.3)	Training and education requirements for licensed professional roles (nurses, physicians, behavioral health providers) include having expertise in children	Has an explicit policy about employing bilingual staff and/or providing interpretation services for children	Require caregiver-to-child ratios that are, at a minimum: ≤ 12 months: 1:3 13-35 months: 1:4 3-year-olds: 1:7 4-year-olds: 1:8 5-year-olds: 1:8 (<i>Caring for Our Children</i> 1.1.1.2)	Require caseworker-to-child ratios that are, at a maximum, 15 children for every 1 caseworker (Council on Accreditation Service Standards PA-CFS 2.09)
Arizona	✓				
California	✓				✓***
Colorado			✓		
Connecticut	Did not meet any indicators				
Florida	Did not meet any indicators				
Illinois	✓		✓*		
Kansas	✓				
Maryland	✓				✓
Michigan	✓				
New Jersey			✓		
New York		✓			
Oregon			✓**		
Pennsylvania	✓				
Texas	✓	✓	✓		
Virginia	Did not meet any indicators				
Washington	✓				✓****

*In Illinois' standards, providing language access is only explicitly identified in reference to explaining the rules and behavioral expectations of the facilities, not in any other domain/services.

**Licensing standards for Oregon only state that written materials must be provided in other languages, as indicated by the population served by the program; bilingual staff and interpretation services for children are not mentioned.

***Caseworker-to-child ratio provided only for group homes serving children under age 6 in California's licensing standards.

****Washington's licensing standards state that the minimum caseworker-to-child ratio is 1:15 in group receiving centers (in which children generally reside a maximum of 30 days); the ratio is 1:25 for group care facilities, which provide longer-term care.

NOTABLY POSITIVE & ALARMING STANDARDS

Most states' licensing standards lack detail regarding child-specific staff training, language access, and supervision by care staff and caseworkers.

The following are examples of components of standards that were notably positive or notably alarming:

Notably Positive Standards

None

Notably Alarming Standards


- Connecticut and New Jersey have extremely low requirements for care staff. In Connecticut's standards, no requirements are specified besides having a physical examination, including a TB test, before starting the position. Similarly, New Jersey's standards state only that care staff must be at least 18 years old, pass a TB test, and not have a communicable disease.
- No states have caregiver-to-child ratios that align with the minimum ratios specified in the American Academy of Pediatrics' *Caring for Our Children* (CFOC 1.1.1.2).





No state licensing standards have caregiver-to-child ratios that align with the minimum ratios specified in the American Academy of Pediatrics' *Caring for Our Children*.


RECOMMENDATIONS: PERSONNEL

Recommendations for ORR


-  Require care staff who interact with young children to meet the following minimum qualifications specified in *Caring for Our Children* (CFOC 1.3.2.3):
 - Be 18 years of age or older;
 - Have a high school diploma or G.E.D.;
 - Complete initial and annual in-service training that includes migration and immigration, early childhood development, attachment and the effects of disrupted attachment, social–emotional development, and childhood mental health (including trauma and its emotional and behavioral presentation in infants and toddlers through young adults);
 - Have access to consultation with a supervisor at all times.


-  Require licensed health professionals to have expertise in children. In congregate care facilities housing young children, require the facility to have a contract with at least one mental health service provider with expertise in infant/early childhood mental health.

-  Adopt minimum caregiver-to-child ratios that are differentiated by age and align with *Caring for Our Children* 1.1.1.2:
≤ 12 months: 1:3 13-35 months: 1:4 3-year-olds: 1:7 4-year-olds: 1:8 5-year-olds: 1:8

-  Adopt a minimum caseworker-to-child ratio that aligns with Council on Accreditation Service Standards PA-CFS 2.09: 1 caseworker for every 15 children, at a maximum.

Recommendations for States

-  Have an explicit policy about how bilingual staff will be hired and/or translation and interpretation services will be offered to children who have a primary language other than English.

-  Connect early childhood mental health consultation systems with licensed shelters housing young UCs to ensure that staff are supported in meeting the social and emotional health of young children.

PROVISION FOR BASIC NEEDS

Under the Trafficking Victims Protection Reauthorization Act and the Flores Agreement, federal immigration agencies caring for children are required to meet children's basic needs and honor their human rights. These include safety, food and water, physical spaces that are sanitary, accessible, and developmentally appropriate, clothing, and access to health care and education. For young children especially, basic needs and the physical environment in which they are met represent foundational building blocks for development. All children deserve access to the basic resources that will support their healthy development; ORR and states must ensure that UCs are actually given these tools to survive and grow.

Within this domain,

we specifically examined:

- **Nutrition and hydration policies:** Whether they 1) are developmentally and culturally responsive, 2) include free access to water and snacks throughout the day, and 3) include a feeding schedule with on-demand bottle-feeding for infants.
- **Parent communication policies:** Whether there is a policy 1) allowing a child to communicate freely with their parent, and 2) for facility staff to communicate with parents about their child's needs and services.
- **Provision of a child advocate:** Whether children are assigned a child advocate who ensures their best interests are met.
- **"Normalcy" policies:** Whether such a policy exists.
- **Clothing policies:** Whether children are provided 1) clean, 2) new or gently used, and 3) non-uniform clothing that is appropriate for 4) the weather and 5) their age.
- **Sanitation and hygiene policies:** Whether facilities have policies for 1) ensuring sanitation, 2) regular maintenance, and 3) child hygiene.
- **Physical accessibility policies:** Whether there are policies ensuring the physical space in facilities is accessible to children with physical disabilities.
- **Physical space policies (specifically related to bedrooms and bathrooms):** Whether 1) there are sufficient bedrooms and bathrooms to prevent overcrowding, and 2) children have separate bedrooms (i.e., not in a common space).
- **Sexual abuse and assault prevention policies:** Whether such policies 1) exist, 2) are developmentally, culturally, and linguistically responsive, and 3) involve immediate reporting requirements between state and federal systems.



SUMMARY OF ORR POLICIES & STATE LICENSING STANDARDS

Our analysis of ORR policies and state licensing standards for meeting children’s basic needs indicates relatively stronger quality, especially relative to the other issue areas we reviewed; however, this domain, like the others reviewed also lacked specific standards for young children. At the federal level, *Flores* requires that UCs must receive food, adequate access to hygiene, suitable living accommodations, privacy, clothes, acculturation services, freedom to communicate and visit with their family members, and freedom to observe their religious beliefs whenever possible. ORR’s publicly available policies also state that children must be provided with food that aligns with nutrition requirements from the USDA and Department of Health and Human Services. ORR policies also aim to foster a “normal” child experience for UCs, including ensuring, on paper, a minimum amount of phone time each week to call family members, free use of mail and email, and protection from invasive searches. Federal policies also outline detailed requirements for protecting UCs from sexual abuse and harassment and LGBTQI-related discrimination. In ORR-funded secure facilities, ORR is bound by the Prison Rape Elimination Act (PREA), which governs sexual harassment, abuse, and assault prevention in secure facilities. ORR developed similar supplemental policies in their non-secure facilities, but a recent investigation by the U.S. Government Accountability Office (2020) found that ORR is behind on conducting compliance audits related to sexual harassment, abuse, and assault prevention. Finally, ORR policies provide guidance about provision of child advocates for UCs. A child advocate promotes a child’s best interests in all domains and across the all systems and stakeholders unaccompanied children interact with. TVPRA requires that a child advocate be appointed to any child who ORR finds to be especially vulnerable (ORR Guide § 3.2). ORR’s criteria include 16 categories of risk that would qualify children for a child advocate, including trafficking victims, children age 12 and younger, children with disabilities, and children separated from their parents, among others.

Many of the ORR policies are quite broad and seemingly leave space for discretion on implementation at the grantee level. For instance, there is no explicit normalcy policy regarding how shelters must provide access to developmentally appropriate, typical childhood experiences and opportunities. Likewise, the requirement to provide suitable living accommodations and hygiene is not explained in great detail, and was the subject of litigation under the Trump administration. At the state level, 7 states had normalcy policies, 12 states have explicit policies about sanitation and hygiene, and 15 states require that children have separate bedrooms not in a common space of the facility. Only 6 states had policies that spoke to the importance of physical accessibility for children with disabilities, and these policies provided only limited information. Some states discussed ground floor accessibility, ramps, door width and height, and the importance of toilets and washbasins designed to accommodate. However, these facilities likely need to comply with building accessibility requirements under the American with Disabilities Act. Overall, the federal policies and state-level standards appear to be approaching a reasonable quality of care for addressing the most basic needs of children, although there are still gaps, especially for young children and children with disabilities.

The following table identifies the critical indicators that we reviewed for this domain. We reviewed what indicators were covered in TVPRA, *Flores*, and ORR policies at the federal level first, and then evaluated whether remaining indicators were addressed in state licensing.

Critical Indicators for Basic Needs

REQUIREMENTS UNDER TVPRA

- Appoint a child advocate for children deemed especially vulnerable by ORR

REQUIREMENTS UNDER FLORES

- UCs may only be detained in “safe and sanitary” facilities, with access to toilets, sinks, drinking water, food, adequate temperature control and ventilation, adequate supervision, suitable living accommodations, reasonable right to privacy, appropriate clothing, personal grooming items, emergency medical assistance
- UCs must be allowed visitation and contact with family members regardless of their immigration status
- UCs must have the ability to talk privately on the phone and have access to uncensored mail
- UCs must be allowed to observe and practice their religious beliefs, whenever possible
- UCs must be detained or housed separately from unrelated adults

ORR POLICIES

- Nutrition policies must align with the USDA and US Department of Health and Human Services and accommodate dietary restrictions and religious practices (ORR Guide § 3.3.9)
- UCs must be provided a minimum of two 10-minute phone calls to family members per week (ORR Guide § 3.3.10)
- UCs and their attorneys must have unlimited access to communicate by phone (ORR Guide § 3.3.10)
- Strip searches and visual body cavity searches of UCs are prohibited, except in secure care facilities (ORR Guide § 4.4.3)
- Pat-down searches of UCs are permitted by a staff member of the same gender, unless the UC is transgender or intersex or there are exigent circumstances (ORR Guide § 4.4.3)
- Policies for services, housing, clothing, and restroom use should be respectful of a LGBTQI UCs’ preferences and safety (ORR Guide § 3.5; 4.8.2)
- Facilities must have a zero-tolerance policy for sexual abuse, sexual harassment, and sexually inappropriate behavior and ensure this policy is communicated in an accessible way to UCs of all ages, levels of development/ability, levels of language proficiency, and gender identity and sexual orientation (ORR Guide § 4.2; 4.7.1)
- Staff contact or relationships with UCs outside of the facility while they are in custody and for 3 years after their discharge from ORR custody is prohibited (ORR Guide § 4.3.5)
- Facilities must have a response plan for incidents of sexual abuse that includes ensuring the safety of all children and providing immediate medical and mental health care for the victim (ORR Guide § 4.6)
- UCs who sexually offend with other children must be evaluated by a mental health professional within 72 hours and provided appropriate intervention if needed (ORR Guide § 4.9.3)
- All incidents of sexual abuse must be reported to the state licensing agency, CPS, local law enforcement, and federal ORR staff immediately but no later than 4 hours after learning of the alleged incident (if the alleged perpetrator is a staff member at the ORR facility, the incident must also be reported to the FBI, HHS OIG, and ORR) (ORR Guide § 4.10.2)

Critical Indicators for Basic Needs

continued

REMAINING INDICATORS EVALUATED IN STATE LICENSING REQUIREMENTS

	Has a policy requiring facilities to provide as much normalcy as possible for every child	Has a policy about how facilities must maintain sanitation, including regular maintenance	Has a policy about making the physical space of facilities accessible to children with physical disabilities	Children have separate bedrooms (not in a common space)	RED FLAG: Does not have a developmentally responsive policy for nutrition and feeding schedule, including free access to water and snacks throughout the day and on-demand bottle-feeding for infants
Arizona		✓		✓	
California	✓	✓	✓	✓	
Colorado	Did not meet any indicators				
Connecticut	✓	✓	✓	✓	
Florida	✓		✓	✓	
Illinois	✓	✓		✓	
Kansas			✓	✓	
Maryland		✓	✓	✓	
Michigan		✓		✓	
New Jersey		✓		✓	
New York	✓	✓	✓	✓	
Oregon		✓		✓	
Pennsylvania		✓		✓	
Texas	✓			✓	
Virginia		✓		✓	
Washington	✓	✓		✓	*

*Washington's standards outline a policy for bottle-feeding, but it does not explicitly state that the feeding schedule is on demand.

NOTABLY POSITIVE & ALARMING STANDARDS

Most states' licensing standards had reasonable standards for the minimum quality of care to meet children's basic needs.

The following are examples of components of standards that were notably positive or notably alarming:

Notably Positive Standards

- Of the 16 states reviewed with ORR facilities, 7 states had normalcy policies with attention to development and young children. Illinois described it in age appropriate language, stating that each child will be given the opportunity to participate in age, physical, culturally and mentally appropriate activities that provide opportunities for normal growth and development. Texas discusses normalcy in terms of reasonable and prudent parent standards and takes into consideration a child's age and level of maturity, cognitive, social and physical development, as well as behavioral and overall abilities. In addition, Washington provides a detailed normalcy statement that is also appropriate for the child's age and developmental level.
- Arizona, California, and Washington have standards that appropriately discuss the importance of children's hygiene, including young children (e.g. diapering, bedding, cleaning toys).

Notably Alarming Standards

- Concerningly, although all states' facilities admit young children, only 2 states (California and Texas) have developmentally responsive nutrition policies that explicitly include free access to water and snacks throughout the day for young children and on-demand bottle-feeding for infants.
- Colorado's licensing standards did not explicitly address any of the indicators we reviewed regarding basic needs.



Although all states' facilities admit young children, only 2 states (California and Texas) have developmentally responsive nutrition policies that explicitly include free access to water and snacks throughout the day for young children and on-demand bottle-feeding for infants.

RECOMMENDATIONS: PROVISION FOR BASIC NEEDS

Recommendations for ORR

- ✔ Ensure feeding, hygiene, and safe sleep practices are developmentally and age specific. HHS and USDA nutrition standards for young children should be explicitly referenced.
- ✔ Ensure children have the ability to freely communicate on demand with parents, families, and potential sponsors privately—for example, by phone, video, email, written correspondence, or in person.
- ✔ Establish developmentally appropriate normalcy standards, including a policy regarding how shelters must provide access to home-like, typical childhood experiences and opportunities for young children.
- ✔ Expand the child advocate recommendation criteria list to include any child that has experienced trauma and any other child who is deemed vulnerable (as opposed to “exceptionally vulnerable” as is currently stated), and provide guidance to grantees encouraging referrals. Congress should fund an expansion in the child advocate program to ensure that every unaccompanied child has an advocate, considering the vulnerability of these children as a group.

Recommendations for States

- ✔ Never approve waivers for standards related to basic needs for young children.
- ✔ Ensure that all shelters that house young children have developmentally and age-specific basic needs and normalcy standards.

HEALTH CARE

Many UCs arrive in the United States with injuries sustained during migration, chronic health conditions and disabilities, and pre-, peri-, and post-migration trauma. For young children in particular, whether these early physical and mental health needs are attended to may determine their developmental and health trajectories over the course of the lifespan. It is critical that UCs receive high-quality care for their physical and mental health during their stay at ORR facilities, as well as connection to community-based care after release to their sponsors.

Within this domain,

we specifically examined:

→ **Developmental and social-emotional/behavioral screening and assessment policies:**

Whether developmental and social-emotional/behavioral screening 1) is conducted, 2) includes screening for PTSD symptoms, depression, anxiety, and suicidality, and 3) is completed by a licensed mental health professional 4) within 72 hours of placement at the facility.

→ **Suicide prevention policy:** Whether such a policy 1) exists and 2) includes training for staff, an emergency protocol, risk assessment procedures, documentation of risk outcomes and next steps for staff.

→ **Type and frequency of medical, dental, and mental health services:** 1) Whether children are provided with routine medical and dental care according to their age and needs, as defined by the American Academy of Pediatrics. 2) Whether children are provided with regular individual and/or group mental health care, according to needs identified during screening. 3) Whether a medical doctor or nurse is on-call to service the facility 24 hours a day, 7 days a week.

→ **Policies related to children with chronic medical conditions, special healthcare needs, and disabilities:** Whether there are policies to evaluate and address the special health care needs of children with chronic health conditions, other special healthcare needs, or disabilities.

→ **Medication policies (including psychotropic and non-psychotropic medications):** Whether 1) staff must be trained to administer medication and 2) psychotropic medication policies require less invasive interventions first. Of note, attempting to communicate with the child's parents prior to the administration of psychotropic medication is also a critical indicator, however, in most states these standards are codified in state law, which were not reviewed for this report.



SUMMARY OF ORR POLICIES & STATE LICENSING STANDARDS

In examining ORR policies and state licensing standards for health care, one of the most complex issues is the process by which parental consent for health care is obtained. UCs are in the federal custody of ORR; however, parental consent processes for UCs must follow relevant state child welfare laws. Therefore, across different states, the child's parent may retain the right to consent or a judge may be able to provide consent. However, the extent to which UCs' parents—who may still reside in their home country—are contacted to make decisions about the care for their children is not clear.

Under the terms of *Flores*, ORR is required to provide a minimum level of physical and mental health care, including an initial medical exam, routine medical and dental care, emergency services, immunizations, and administration of medication in line with state and local laws, at least 1 individual counseling session per week with a social worker, and at least 2 informal group counseling sessions per week. As in many other areas, ORR does not provide much above and beyond these requirements, nor do they provide substantial guidance for care specific to young children. Further, a previous HHS OIG report identified concerns related to facilities' abilities to adequately meet UCs' mental health needs and services (HHS OIG, 2019a).

Only 2 states' standards discuss and elaborate on children receiving developmental, behavioral and mental health screening that must occur within 72 hours of admission, and no states have a comprehensive developmental and behavioral screening protocol. Thirteen states discuss regularly scheduled medical and dental care, although only Maryland, Pennsylvania, and Texas refer to guidance

from the American Academy of Pediatrics. Only 3 states (Maryland, Pennsylvania, and Texas) have a comprehensive health assessment policy that includes children with special health care needs and chronic conditions, and only 3 states (Maryland, Oregon, and Texas) mention a suicide prevention policy, with varying degrees of detail.

ORR policies specify that only a licensed health care provider may order nonprescription medications for UCs, but do not describe any protections or restrictions for the use of psychotropic medications, aside from general medication administration and management policies, such as locking up medications (ORR Guide § 3.4.4). Although ORR-funded facilities are required to follow state law, it is notable that ORR provides no additional guidance regarding the use of psychotropic medications with vulnerable UCs, as there have been lawsuits related to the misuse of psychotropic medication as a means to control the behavior of UCs in ORR facilities (Reuters, 2018). Alarming, the licensing standards of 14 of 16 states with ORR facilities do not have psychotropic medication policies that require attempting less invasive interventions first. However, as noted above, state child welfare laws—which exist in a different section of the administrative code and are beyond the scope of the present review—may include more detailed requirements about psychotropic medication that would also apply to UCs in ORR custody. This is the case in New York and Texas, two states which have residential treatment centers for UCs, and this may be the case in other states, as well. Across federal policies and state standards, there are several critical areas in which important health care services for young children are not adequately addressed.

The following table identifies the critical indicators that we reviewed for this domain. We reviewed what indicators were covered in TVPRA, *Flores*, and ORR policies at the federal level first, and then evaluated whether remaining indicators were addressed in state licensing.

Critical Indicators for Health Care

REQUIREMENTS UNDER TVPRA

- None in this domain

REQUIREMENTS UNDER FLORES

- Complete medical exam, including screening for infectious disease, required within 48 hours of admission (excluding weekends and holidays)
- Routine medical and dental care, emergency care, and family planning services must be provided
- Appropriate immunizations in accordance with the U.S. Public Health Service and CDC
- Administration of prescribed medication and special diets
- Appropriate mental health interventions when necessary
- At least 1 individual counseling session/week with a social work staff member, with the specific objectives of reviewing progress, establishing new short-term objectives, and addressing developmental and crisis-related needs
- At least 2 informal group counseling sessions/week, with time to meet staff, learn the rules of the program, discuss program management, and resolve problems (staff qualifications not specified)

ORR POLICIES

- UCs must be able to request their own health care and requests must be responded to within 48 hours (excluding weekends and holidays)
- Facilities must monitor for symptoms of communicable diseases at all times, report any suspected/confirmed cases to ORR, and follow ORR medical guidance regarding the management of cases
- Facilities must follow state and local laws about the provision of medication and ensure the safe, discreet, confidential provision of prescription and nonprescription medications and the secure storage and disposal of medication
- Only a licensed health care provider can order nonprescription medications for UCs

REMAINING INDICATORS EVALUATED IN STATE LICENSING REQUIREMENTS

	All children provided developmental and social-emotional / behavioral screenings for PTSD, depression, anxiety, suicidality, and more, by a licensed mental health professional within 72 hours of placement at facility	Has suicide prevention policy that includes training for staff, emergency protocol, risk assessment procedures, documentation of risk assessment outcomes and next steps for staff	All children are provided with regularly scheduled medical and dental care according to their age and needs, as defined by American Academy of Pediatrics	Red Flag: Does not have a policy for psychotropic medication treatment that involves attempting less invasive interventions first	Red Flag: No policy requiring 24/7 access to a doctor or nurse
Arizona	Did not meet any indicators				
California			✓		
Colorado			✓		
Connecticut	Did not meet any indicators				
Florida			✓		
Illinois			✓		
Kansas			✓		
Maryland		✓*	✓		
Michigan			✓		
New Jersey	Did not meet any indicators				
New York			✓		
Oregon		✓	✓		
Pennsylvania	✓		✓		
Texas	✓	✓**	✓		
Virginia			✓		
Washington			✓		

* Maryland's licensing standards state only that facilities must establish and follow procedures for suicide prevention and intervention, but do not further specify what the procedures must include.

**Texas' licensing standards require the collection of information about suicidality and suicide attempt history in initial assessments and specify reporting requirements for suicide attempts, but do not outline a comprehensive policy, risk assessment procedures, or prevention efforts.

NOTABLY POSITIVE & ALARMING STANDARDS

Some states were stronger or more detailed than others in specific domains of health.

The following are examples of components of standards that were notably positive or notably alarming:

Notably Positive Standards

- Texas has a detailed description of the frequency and content of medical, dental, and mental health screenings and care that exceed ORR policies.
- Maryland has a comprehensive and detailed health plan that includes somatic care, vision and audiological, immunization physical exam, emergency health, communicable diseases, and suicide prevention.

Notably Alarming Standards

- Arizona, Connecticut, and New Jersey do not have policies for any of the indicators that were reviewed in the health section.
- Only 5 states (California, Colorado, Connecticut, Illinois, and Texas) have a policy requiring an on-call nurse, doctor, or psychiatrist for the facility.
- 14 of 16 states with ORR facilities do not have psychotropic medication policies that require attempting less invasive interventions first.



Only 5 states (California, Colorado, Connecticut, Illinois, and Texas) have a policy requiring an on-call nurse, doctor, or psychiatrist for the facility.

RECOMMENDATIONS: HEALTH CARE

Recommendations for ORR

- ✓ Require a medical professional to be on call to service all facilities 24 hours a day, 7 days a week for emergencies.
- ✓ Require facilities to have policies to identify and support children with chronic health conditions, other special health care needs, and disabilities.
- ✓ Require facilities to attempt to obtain parental consent prior to administration of all prescription medication, including psychotropics, and require that prescription medication be prescribed and monitored by a pediatric medical professional.
- ✓ Require facilities to have a written plan about the administration and monitoring of psychotropic medication for children, aligned with recommendations contained within the [American Academy of Child and Adolescent Psychiatry's \(AACAP\) Recommendations](#) about the Use of Psychotropic Medications for Children and Adolescents Involved in Child-Serving Systems and the guidelines developed by the [AACAP Preschool Psychopharmacology Working Group](#). Plans should, at a minimum:
 - ensure behavioral and environmental intervention are considered as the default primary intervention to address behavior;
 - be conservative in their administration of such medication for children, and especially children under age 8, given the limited validity and reliability of psychiatric diagnoses in this age group, risk of side effects, potential impact on the developing brain, and limited research on psychotropic drug safety efficacy in young children;
 - obtain informed consent from authorized consenters prior to administering psychotropic medication;
 - obtain youth assent prior to administering psychotropic medication and explore alternatives if the child does not want to take the medication;
 - never administer psychotropic medication with the goal of managing or subduing the behavior of children who do not have psychiatric diagnoses and emotional/behavioral symptoms that warrant medication.
- ✓ Require grantees to have a suicide prevention and intervention program that includes considerations for suicide and self-harming behaviors in young children.

Recommendations for States

- ✓ Never approve waivers for standards related to physical and mental health care and well-being.
- ✓ Ensure that all shelters that house young children have developmentally and age-specific health care standards.
- ✓ Revoke licenses for facilities that have a pattern of using psychotropic medication on an emergency basis or that have failed to address corrective actions for misuse of psychotropic medication.

BEHAVIOR MANAGEMENT & DISCIPLINE

Behavior—including withdrawn or externalizing behavior—is the primary method by which young children communicate, particularly before they develop expressive language, and during periods of stress, after traumatic experiences, or when there is a disruption in routine. For UCs, all three of these situational contexts are likely—stress, trauma, and a change in routine. These are often layered on top of other challenges, like physical health ailments, specific distress from being away from a primary caregiver, detention, and introduction to a new and very different environment from their home, where they are surrounded by a new language and new caretakers and peers. Developmentally inappropriate environments and unresponsive caretakers only exacerbate these existing challenges and can be severely detrimental to children’s long term psychological well-being. Supporting and managing behavior using positive, developmentally responsive, and trauma informed approaches can support healing and positive social-emotional wellness. It is critical to the emotional safety and social well-being of UCs, and particularly young children, that all ORR-funded shelters have behavior and discipline plans that are developmentally appropriate, positive and supportive, and trauma-informed, and prohibit punitive punishment.

Within this domain,

we specifically examined:

- **Behavior management plans:** Whether there is an articulated behavior management plan that 1) is age and developmentally differentiated and appropriate, 2) is trauma-informed, 3) uses positive behavior supports, 4) explicitly states that the least restrictive and intensive approaches are used first, and 5) prohibits harsh or punitive punishment.
- **Required personnel training on behavior management, trauma, and social emotional development:** Whether there are personnel training requirements related to behavior management, trauma, and social-emotional development.
- **Manual restraint policies:** Whether manual restraint is 1) allowed only as a last resort in cases of a safety threat, 2) prohibited as a corrective disciplinary action, 3) employed only by trained staff, 4) employed only in restraint positions deemed safe, considering child age, development, and size, 5) appropriately and rapidly documented and reported, and 6) with articulated time limits.
- **Chemical restraint policies:** 1) Whether chemical restraint is allowed. 2) Whether there is differentiation based on age and development.
- **Mechanical restraint policies:** 1) Whether mechanical restraint is allowed. 2) Whether there is differentiation based on age and development.
- **Seclusion policies:** 1) Whether seclusion is allowed. 2) Whether there is differentiation based on age and development.
- **Corporal punishment policies:** Whether corporal punishment is allowed or explicitly prohibited.
- **Documentation and reporting serious incidents:** Whether there are documentation and reporting requirements to 1) the licensing agency and 2) ORR in cases of serious incidents.



SUMMARY OF ORR POLICIES & STATE LICENSING STANDARDS

Our analysis shows that *Flores* provides basic protections for UCs in terms of behavior management and discipline—specifically, prohibiting corporal punishment and use of punitive punishments that interfere with activities of daily living, exercise, medical care, correspondence privileges, or legal assistance. ORR also has some positive policies with respect to behavior and discipline, such as requiring certain safety parameters around restraint and prohibiting mechanical restraint. However, there are also some concerning policies. For example, ORR allows the practice of seclusion, defined as locking a child alone in a room without the ability to exit, in residential treatment centers (RTCs) and does not address the issue in other setting types (ORR Guide § 3.3.15). It does not place an upper time limit on seclusion, nor limits on the age or developmental level of the children who are subject to it. Further, ORR policies do not include specific reporting requirements for seclusion,ⁱⁱ making it impossible to gauge the extent to which this practice is used and abused, and on whom. There have been relatively few young UCs (under age 13) placed in RTCs in recent years (HHS, 2019, 2020a, 2020b); however, they are not prohibited from being in these settings, which means it is possible for young children to be subject to restraint or seclusion. Further, although ORR policy only explicitly allows emergency restraint or seclusion for UCs in RTCs, it does not explicitly address the issue in other settings. Given the lack of clarity between state licensing and ORR, the risks associated with seclusion and unsafe, inappropriate restraint, and the negative effects of these approaches on child health and well-being, we felt it important to examine these indicators at the state level, as well. Based on a recent HHS OIG report finding shelters have difficulty accessing external psychologists or psychiatrists to obtain referrals for children to transfer to RTCs (OIG, 2019a) and HHS OIG and GAO reports finding a lack of sufficient communication

between facilities and ORR about serious incidents (GAO, 2020; HHS OIG, 2020), it is possible that these issues may be salient for non-RTC shelter facilities. Some states explicitly allow seclusion, others explicitly prohibit it, while some do not reference it at all in the standards. It should be noted that some state child welfare policies may include requirements for restraint and seclusion that would apply to shelters housing UCs, but a review of those policies was outside the scope of this report.

ORR’s policies are also vague and lacking in detail in the requirement for a behavior management plan (ORR Guide § 3.3.13). Most states similarly lack detail in that domain. Even in states with some strong standards for behavior management and discipline, the vast majority (14 out of 16 states) do not require a comprehensive behavior management plan that includes the following basic features: use of positive behavioral interventions and supports, use of the least restrictive interventions first, trauma-informed practices, prohibition of punitive discipline practices, and differentiation by developmental stage and age. Behavior management plans can set the tone for discipline and guide staff on promoting positive behavior and responding to behavior they find challenging.

There is also a lack of required documentation and reporting requirements for serious behavior, discipline, or emergency incidents at both the federal and state levels. ORR requires some documentation, but is not specific about who it needs to be reported to (ORR Guide § 3.3.15). Most states also require documentation, but few require that incidents are reported to any external entity, including state licensing agencies or ORR. This lack of transparency, particularly on such a consequential domain of programmatic functioning, hampers the public’s, states’, and ORR’s abilities to monitor and hold programs accountable for using inappropriate discipline and putting children’s social-emotional health and wellness at risk.

The following table identifies the critical indicators that we reviewed for this domain. We reviewed what indicators were covered in TVPRA, *Flores*, and ORR policies at the federal level first, and then evaluated whether remaining indicators were addressed in state licensing.

ⁱⁱ Outside of settings that fall under the Children Health Act of 2000 (42 USC §290ii et seq.), which requires procedural reporting and training requirements regarding the use of restraints and involuntary seclusion in facilities that receive Medicaid and Medicare funding, specifically including facilities that provide inpatient psychiatric services for children under the age of 21 years. As noted above, ORR explicitly allows seclusion in residential treatment facilities, but does not explicitly allow or prohibit it in other setting types.

Critical Indicators for Behavior Management and Discipline

REQUIREMENTS UNDER TVPRA

→ None in this domain

REQUIREMENTS UNDER FLORES

→ Corporal punishment, humiliation, punitive interference with daily living activities (e.g., eating, sleeping) are prohibited.

ORR POLICIES

- Behavioral management policies must align with “best practice,” but no additional details are provided (ORR Guide § 3.3.13)
- All employees working with unaccompanied children in ORR facilities must receive initial training (before contact with children) and refresher training (at least annually) on the following topics: trauma commonly experienced by unaccompanied children and trauma-informed treatment/counseling/legal advocacy, but trainings on behavior management and social-emotional development are not specified (ORR Guide § 4.3.6)
- Mechanical restraint is prohibited (ORR Guide § 3.3.15)
- In residential treatment centers, manual restraint, chemical restraint, and seclusion are allowed as a last resort in an emergency situation, after less restrictive interventions have been attempted and only while the child or others are in imminent physical harm (i.e., cannot be used for discipline) (ORR Guide § 3.3.15)
- No maximum time limits are specified for manual restraint, chemical restraint, or seclusion (ORR Guide § 3.3.15)
- Staff must report use of restraint/seclusion within 24 hours, but agencies to whom report is submitted are not specified, nor are follow-up procedures/outcomes (ORR Guide § 3.3.15)
- Staff must discuss use of restraint/seclusion with the child within 48 hours (ORR Guide § 3.3.15)
- Supervisor must review use of restraint/seclusion within 72 hours, but follow-up procedures/outcomes are not specified (ORR Guide § 3.3.15)

REMAINING INDICATORS EVALUATED IN STATE LICENSING REQUIREMENTS

	Requires a behavior management policy requiring use of 1) positive behavior interventions and supports 2) least restrictive interventions first 3) trauma informed practices; 4) prohibiting punitive discipline and that is 5) differentiated by developmental stage and age	Requires personnel training on behavior management, trauma, and social-emotional development	Requires documenting and reporting emergency events and serious incidents to licensing agency within 24 hours	RED FLAG: Does not have a policy on physical/manual restraint that includes 1) staff training and certification requirements; 2) time limitations; 3) prohibition of the use of unsafe restraint positions	RED FLAG: Seclusion (or “isolation”) not explicitly prohibited	RED FLAG: Chemical restraint not explicitly prohibited
Arizona	Did not meet any indicators					
California		✓	✓*		*****	
Colorado		✓				
Connecticut	Did not meet any indicators					
Florida		✓	✓			
Illinois			✓			
Kansas	Did not meet any indicators				*****	
Maryland		✓	✓**			
Michigan	✓		✓			
New Jersey	Did not meet any indicators				*****	*****
New York	Did not meet any indicators				*****	
Oregon			✓***			
Pennsylvania			✓			
Texas	✓	✓	✓			
Virginia			✓****			
Washington		✓				

* California requires facilities to submit incident reports to the licensing agency by the next business day for use of manual restraint, runaway situations, and child contact with law enforcement while they are in the facility.

** Maryland has different timeframes for reporting different types of serious incidents (i.e., 1 hour to report to the licensing agency when a facility has discovered a child is missing/unaccounted for; 24 hours to report to the licensing agency when restraint has been used; 48 hours to report to the licensing agency when a report of suspected child abuse/neglect has been filed with local law enforcement/CPS).

*** Oregon requires reporting of “critical incidents” to the licensing agency within 1 business day.

**** Virginia only specifies required reporting within 24 hours in cases of serious injury, illness, or death.

***** California’s standards include language prohibiting confinement in playpens or other furniture for children under age 6, but does not explicitly prohibit seclusion. It explicitly allows it for older children.

***** Kansas’ standards prohibit use of “isolation” as punishment, unless their isolation policy has been approved by the Kansas Department of Social and Rehabilitation Services.

***** New Jersey’s standards state that residents have a right “to be free from restraint and confinement,” although “confinement” is not further defined.

***** New York allows seclusion in certain facility types and if it is included as part of a restraint policy.

NOTABLY POSITIVE & ALARMING STANDARDS

Some states were stronger or more detailed than others in specific domains of behavior and discipline, but no state had comprehensive and developmentally appropriate discipline and behavior guidelines. This is alarming for all children, but particularly for the youngest.

The following are examples of components of standards that were notably positive or notably alarming:

Notably Positive Standards

- California is one of only a few states that differentiates behavior guidance by age, with specific standards for children under age 6.
- Arizona has a more detailed restraint policy than most other states, with the lowest maximum duration of any state (5 minutes), and requires that restraint be employed only by personnel with at least annual training in crisis intervention, non-physical de-escalation skills and restraint methods, and only after all less restrictive interventions have been determined ineffective. (The standards do not, however, explicitly prohibit unsafe restraint positions, as reflected by the red flag in the table above.)

Notably Alarming Standards

- 12 out of 16 states do not have physical/manual restraint policies that require training, time limits, and prohibition of unsafe positions.
- 13 out of 16 state licensing standards reviewed do not explicitly prohibit seclusion.
- Michigan, New York, Oregon, and Texas all have alarming seclusion policies allowing young children to be secluded upwards of an hour or for an unlimited amount of time in some settings.



13 out of 16 state licensing standards reviewed do not explicitly prohibit seclusion.

RECOMMENDATIONS: BEHAVIOR MANAGEMENT AND DISCIPLINE

Recommendations for ORR

- ✔ Prohibit seclusion and chemical restraint for all children under all circumstances.
- ✔ Require safety parameters around the use of manual restraint, above and beyond existing ORR policies, including:
 - Requiring training and certification for individuals authorized to manually restrain children and at least annual continuing training in all settings.
 - Prohibiting unsafe holding conditions, considering child trauma and mental health, age, development, and size of the child.
 - Ensuring an upper time limit on manual restraint that is developmentally and age appropriate and no longer than 5 minutes.
 - Requiring the provision of on-call specialists, including mental health specialists, to assist in de-escalation.
- ✔ Prohibit the use of waivers for any policies related to discipline and behavior management, considering the child's physical, social, and emotional health are at stake.

Recommendations for States

- ✔ Never approve waivers for standards related to discipline and behavior issues.
- ✔ Require detailed behavior management plans that at the very least include:
 - Differentiation by development and age, with specific standards for very young children
 - Explicit grounding in prevention and positive behavior supports
 - Explicit trauma-informed principles and practices
 - Explicit requirements for caregivers to employ the least restrictive interventions first
- ✔ Ensure discipline and behavior management are part of the state's monitoring and accountability system, which includes reviewing records, conducting on-site visits, obtaining input from children and staff, and reporting any identified violations to ORR.
- ✔ Connect early childhood mental health consultation systems with all licensed shelters housing UCs to ensure that staff are supported in meeting the social and emotional health of young children.

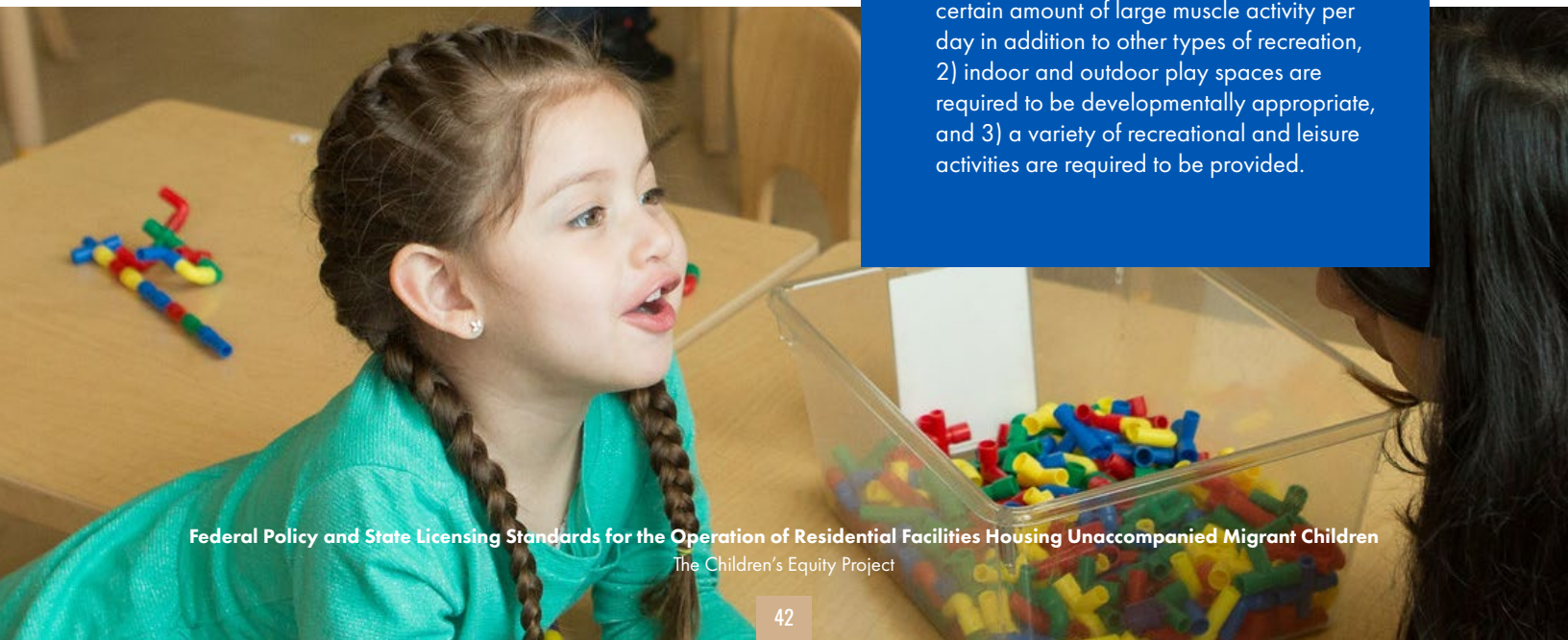
DEVELOPMENTAL/ EDUCATIONAL SERVICES

Most UCs stay in shelter facilities for an average of 65 days before being discharged (as of fiscal year 2019; HHS, 2020a). However, in some cases, UCs live at ORR facilities for much longer periods of time (Bogado & Lewis, 2020). Whether their stay spans weeks or months, it is critical that their developmental and educational progress is supported in these facilities as appropriately as possible. For young children and children with disabilities, early intervention and provision of a stimulating, nurturing environment with adequate supports to explore and learn is especially essential. Children with disabilities are also guaranteed the right to a free, appropriate public education (FAPE), regardless of immigration status, under the Individuals with Disabilities Education Act (IDEA), and therefore, ORR-funded facilities must comply not only with providing such services for children with known disabilities, but also identifying children who may have an eligible disability but have not yet been identified. All children with disabilities are also guaranteed other protections under the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. The education that UCs receive while they reside in these facilities should be comparable to what is received by their peers who are not in such facilities. These facilities should also support UCs' transition to community-based schools after release by giving parents/guardians appropriate information about school enrollment/procedures and transferring academic records to children's new schools.

Within this domain,

we specifically examined:

- **Learning and education policies:** Whether 1) children are provided with access to similar public education as children not living in ORR facilities, and 2) teachers providing educational services are required to be licensed/certified by the state board of education. 3) Whether there are policies requiring provision of nurturing, developmentally responsive early childhood education for children below school age.
- **Policies for language access in the educational setting:** Whether such policies exist.
- **Policies for transferring academic records to children's subsequent school upon release:** Whether such policies exist.
- **Policies for physical activity and recreation/play/structured leisure time:** Whether 1) children are required to have a certain amount of large muscle activity per day in addition to other types of recreation, 2) indoor and outdoor play spaces are required to be developmentally appropriate, and 3) a variety of recreational and leisure activities are required to be provided.



SUMMARY OF ORR POLICIES & STATE LICENSING STANDARDS

Our analysis found that *Flores* and ORR have some positive policies to ensure a minimum quality of education and developmental supports, including conducting an initial assessment of UCs' educational skills and particular needs they may have within 72 hours of admission; providing instruction in a classroom setting in main academic subjects and English as a Second Language for 6 hours a day, Monday through Friday, throughout the entire calendar year; and requiring that academic reports and progress notes be provided to the UC and their sponsor upon release to facilitate transfer to the child's next school.

However, in many cases, the amount of detail in ORR's policies is lacking, and often, these gaps are not addressed in state standards either. For instance, ORR does not require teachers in these facilities to be certified. Only Illinois and New York explicitly require teachers in these facilities to meet the training and certification requirements of the state board of education; 8 additional states specify that educational programs provided by the facility must be approved/accredited by the local district or state board of education but do not explicitly describe requirements for teacher licensure. ORR does not describe educational programs for young children or mention at what age a child must start receiving 6 hours of instruction a day; only California and Florida have policies outlining the kind of environment and services that must be provided for young children.

Although all educational programs in the U.S. must provide a free, appropriate public education (FAPE) to children with disabilities under federal law (i.e., IDEA), neither ORR policy nor most of the state standards—except Maryland and Texas—describe how facilities must meet the needs

of children with disabilities. Even still, these states' licensing standards in this area are generally minimal and only describe procedures for cases when a child already has an IEP, which almost universally will not apply to UCs with disabilities. One recent monitoring investigation in California (Disability Rights California, 2019) found that ORR was not providing the special education evaluations and services required under IDEA for immigrant children held in ORR-funded facilities in California, unless they were placed in ORR's most restrictive setting in the state, the Yolo Juvenile Detention Center (which has since terminated its contract with ORR, as of January 2020). These findings raise serious concerns about violations of IDEA's Child Find provision and the rights of children with disabilities to receive services in the least restrictive setting appropriate for their needs. Although the investigation was limited to California, given the lack of attention to these issues in ORR's policies and in other state licensing standards, these problems may be pervasive. *Flores* and ORR policies require services and materials to be provided in the UC's primary language to the maximum extent possible; no states have policies describing what kinds of language supports are offered for children attending schools in these facilities. In terms of physical activity, *Flores* outlines that each child must have at least 1 hour of large muscle movement time and 1 hour of structured leisure time, with additional time on weekends and holidays. Nine states—California, Connecticut, Illinois, Maryland, Michigan, New York, Texas, Virginia, Washington—further require facilities to create policies to ensure developmentally appropriate indoor and outdoor physical activities and leisure time.

The following table identifies the critical indicators that we reviewed for this domain. We reviewed what indicators were covered in TVPRA, *Flores*, and ORR policies at the federal level first, and then evaluated whether remaining indicators were addressed in state licensing.

Critical Indicators for Developmental/Educational Services

REQUIREMENTS UNDER TVPRA

- None in this domain

REQUIREMENTS UNDER FLORES

- Instruction in a classroom for 6 hours a day, Monday through Friday, throughout the entire year
- Educational services must be appropriate to the UC's level of development and communication skills
- At least 1 hour of large muscle activity and 1 hour of structured leisure activity required per day (3 hours total on days when school is not in session)

ORR POLICIES

- UCs must have their educational skills and needs assessed within 72 hours of admission (ORR Guide § 3.3.5)
- Instruction must be for 6 hours a day (ORR Guide § 3.3.5)
- Education policies do not specify at what age full-time instruction is required (ORR Guide § 3.3.5)
- Services and materials must be provided in the primary language of each UC in ORR custody to the maximum extent possible and/or interpretation services must be provided (ORR Guide § 3.3.7)
- UCs must be allowed to communicate in their preferred language (ORR Guide § 3.3.7)
- Academic reports and progress notes must be included in UCs' case files and provided to UCs upon release (ORR Guide § 3.3.5)

REMAINING INDICATORS EVALUATED IN STATE LICENSING REQUIREMENTS

	Education services are required to be provided by teachers licensed/certified by the state board of education	Has a policy for providing early childhood education in a nurturing, developmentally responsive environment for children younger than school-age	Has a policy for supporting the needs of children with disabilities and Individualized Education Plans (IEPs)
Arizona		Did not meet any indicators	
California		✓	
Colorado	✓*		
Connecticut	✓*		
Florida	✓*	✓	
Illinois	✓*		
Kansas	✓*		
Maryland	✓*		✓
Michigan		Did not meet any indicators	
New Jersey		Did not meet any indicators	
New York	✓		
Oregon		Did not meet any indicators	
Pennsylvania	✓*		
Texas	✓*		✓
Virginia		Did not meet any indicators	
Washington	✓*		

*States with standards that specify that educational programs provided by the facility must be approved/accredited by the local district or state board of education but do not explicitly describe requirements for teacher licensure.

NOTABLY POSITIVE & ALARMING STANDARDS

Most states licensing standards have very limited information about educational services provided for children in care, perhaps because standards are not specific to UCs and were primarily written with children in the child welfare system in mind.

The following are examples of components of standards that were notably positive or notably alarming:

Notably Positive Standards

- New York’s state licensing standards specify the education and certification requirements for general education teachers, special educators and principals.
- California has standards outlining the kind of nurturing environment that facilities must provide for young children, including a family-like setting, a plan for indoor and outdoor activities designed to meet the developmental and therapeutic needs of the children and provide ever-increasing opportunities for self-care, and a consistent daily schedule that balances group and individual activities, active and quiet play, structured and flexible play, rest, eating, toileting, and individual attention from the houseparent or child care worker.

Notably Alarming Standards





- New Jersey’s licensing standards do not have any educational requirements beyond the facility maintaining a list of the school name and location that each child attends.





ORR does not require teachers in these facilities to be certified. Only Illinois and New York explicitly require teachers in these facilities to meet the training and certification requirements of the state board of education; 8 additional states specify that educational programs provided by the facility must be approved/accredited by the local district or state board of education but do not explicitly describe requirements for teacher licensure.

RECOMMENDATIONS: DEVELOPMENTAL/EDUCATIONAL SERVICES

Recommendations for ORR

-  Ensure that children, including young children, receive a developmentally and age appropriate educational skills and needs assessment within 72 hours of admission.
-  Require that all educational programs within ORR-funded facilities be accredited, and that early learning services are provided for all children below school age, with an emphasis on social-emotional development. Ensure that any child without an identified sponsor or any child who has been in care for more than 60 days (except in cases of imminent release) receive developmental and educational services in community-based settings.
-  Require all teachers be trained in trauma and childhood migration, licensed/ certified by the state board of education, and, for younger children, have at least an entry-level credential to work with young children. Encourage and incentivize UC shelters to employ in their educational programs teachers who have ESL certification and are bilingual in the primary languages represented among UCs.
-  Require grantees to ensure that all children who may have a disability receive a comprehensive 504 evaluation and/or comprehensive psychoeducational evaluation to determine potential eligibility for special education services. The process for referral for a 504 or IFSP/IEP should follow the same process as in the general population. However, the initiation of any referral for an initial psychoeducational evaluation should never delay the release of a UC from ORR custody; any progress made on the initial evaluation should be coordinated with the multidisciplinary team at the UC's receiving school.

Recommendations for States

-  Connect early care and learning workforce development, training, and technical assistance systems with all licensed shelters housing UCs to ensure that personnel in these facilities are adequately supported in fostering the development and learning needs of all UCs.
-  Connect IDEA systems with all licensed shelters housing UCs to ensure the educational needs of children with disabilities are lawfully met.

ACCOUNTABILITY, MONITORING, & WAIVERS

Federal policies and state licensing standards are only as good as their mechanisms for ensuring accountability. Without appropriate methods to monitor compliance, what is written in policy is much less consequential. It is also critical to consider the provision of waivers for certain licensing standards or federal policies. Clear monitoring and accountability are particularly important, given the complex interplay between the federal ORR, state-level refugee resettlement coordinators and services, state-level licensing agencies, and other state-level agencies that may be involved in oversight of state laws that affect UCs or ORR-funded facilities. These systems must maintain bidirectional communication and have clear policies for monitoring compliance at state-licensed and ORR-funded facilities, issuing corrective action when facilities are out of compliance, implementing increasing consequences/penalties for continued compliance problems, and providing waivers from state licensing requirements only under limited and specific conditions.

Within this domain,

we specifically examined:

→ **Monitoring:** What monitoring protocols exist to facilitate accountability and oversight of facilities' compliance with state licensing standards, what corrective action policies are in place for lack of compliance, and content and frequency of site visits (announced and unannounced) by the state licensing agency. We aligned our thresholds for monitoring visits (i.e., 1 pre-licensure visit and 1 unannounced visit per year) with the standards outlined in the Child Care and Development Block Grant, as those are considered baseline standards for protecting child health and safety in child care settings.

→ **Waivers/exemptions:** Whether facilities may receive waivers or exemptions from having to comply with part/all licensing requirements, and under what conditions these waivers/exemptions are granted.

SUMMARY OF ORR POLICIES & STATE LICENSING STANDARDS

Our analysis indicates that ORR has a rather robust federal accountability and monitoring system on paper. Based on their policies, ORR must conduct day-long site visits at least monthly and week-long site visits every 2 years, in addition to requiring facilities to conduct their own internal monitoring and submit progress reports to ORR every quarter (ORR Guide § 5.5.1). When violations of ORR policies are identified during internal monitoring or site visits, ORR issues a corrective action plan and required timeline for coming into compliance, as well as describes the disciplinary consequences for not resolving the problem within the specified timeframe (ORR Guide § 5.5.2). During regular sexual abuse prevention audits every 3 years, the facility has 90 days to comply with any corrective action plans (ORR Guide § 4.12). ORR has detailed policies regarding reporting significant and emergency incidents (notwithstanding gaps in discipline reporting described previously), including reporting to local law enforcement, Child Protective Services, state licensing agency, and the FBI, depending on the situation (ORR Guide § 4.10.2).

Despite this rather strong foundation for monitoring compliance, advocates have cited grave concerns with the actual implementation of the monitoring protocol. A recent investigation by the U.S. Government Accountability Office (2020) found serious issues regarding implementation of ORR’s monitoring policies and communication between state licensing agencies and ORR. The investigation found that ORR a) does not consistently review grant applicants’ state licensing status or previous allegations/violations when considering applications, b) lacks clear instructions for grantees on when and how to report state licensing violations to ORR, c) lacks a centralized internal database for logging all federal ORR monitoring activities and corrective actions that is accessible by the entire federal ORR monitoring team, and d) has been out of compliance with their own policies to conduct regular monitoring site visits, provide prompt correct actions to facilities, and conduct audits related to sexual abuse and harassment prevention. Further, nearly all state licensing agencies reported that they do not regularly share state monitoring findings with ORR, and *all* reported that ORR does not share its monitoring finding with them. Similarly, a

recent HHS OIG report concluded that ORR’s serious incident reporting system does not sufficiently capture information that is important for oversight of abuse in facilities, nor allow for ORR to immediately respond to situations that threaten child safety or examine patterns of abuse or violations within or across facilities (HHS OIG, 2020). As with all ORR policies described here, the difference between ORR’s policies on paper and in real-world implementation is unclear, but may be significant based on recent GAO and OIG reports and advocate anecdotes. Additionally, although ORR requires care providers to describe their facility grievance procedures to children in their orientation to the program (ORR Guide § 3.2.2), ORR does not have their own policy for grievances that is specific to UCs.

There are also gaps in federal policy and state standards related to monitoring and accountability. Of note, additional monitoring, enforcement, and waiver requirements that apply to these facilities may exist in other sections of states’ administrative codes outside the licensing standards; however, all states’ licensing standards discuss accountability and monitoring requirements to some extent. Only 5 states require both a pre-licensure inspection and at least one unannounced licensing compliance inspection annually, which means that the state licensing agency in most states may not be physically on site to identify deficiencies or lack of compliance with state-level standards on a regular and unannounced basis. And, although most states’ standards include a specific policy describing how the licensing agency follows up on complaints or deficiencies in compliance, the frequency of monitoring, specificity of the corrective action and potential consequences, and promptness of the timeline for coming into compliance varies across states.

Further, all but 2 states allow broad, non-specific waivers from compliance with licensing standards. This means that facilities can apply to be exempt from having to comply with minimum standards for health and safety or provide other basic services—even if the reason for requesting a waiver is purely financial. These waivers and exemptions therefore represent an enormous potential loophole for facilities to evade their responsibility to comply with the state licensing requirements that are in place to ensure a minimum quality of care for young, vulnerable children.

The following table identifies the critical indicators that we reviewed for this domain. We reviewed what indicators were covered in TVPRA, *Flores*, and ORR policies at the federal level first, and then evaluated whether remaining indicators were addressed in state licensing.

Critical Indicators for Accountability, Monitoring, and Waivers

REQUIREMENTS UNDER TVPRA

→ None in this domain

REQUIREMENTS UNDER FLORES

→ Implementation of the terms of *Flores* is overseen by the U.S. District Court for the Central District of California

ORR POLICIES

- Facilities must have their own internal monitoring processes and conduct monitoring and evaluation on a quarterly basis (ORR Guide § 5.5.5)
- Facilities must submit performance progress reporting to ORR on a quarterly basis (ORR Guide § 5.6.1)
- Facilities must conduct internal incident reviews of all allegations of sexual abuse or harassment in ORR care within 30 days of every investigation by an oversight entity (ORR Guide § 4.11.1)
- ORR conducts day-long site visits at least monthly and week-long site visits no less than every 2 years to monitor compliance with ORR policies, state licensing, and the minimum standards for care and timely release of UCs in TVPRA and *Flores* (ORR Guide § 5.5.1)
- When a facility is out of compliance, ORR issues a corrective action, timeframe for resolving the problem, and disciplinary consequences for not resolving the problem within the timeframe (ORR Guide § 5.5.1; 5.5.2)
- Facilities must undergo sexual abuse prevention compliance audits once every 3 years; if an auditor finds the facility “does not meet standard,” a corrective action plan is developed and the facility has 90 days to comply (ORR Guide § 4.12.1)
- Significant incidents must be reported to ORR (and the state licensing agency, CPS, and/or local law enforcement, if applicable) within 4 hours of learning of the significant incident (ORR Guide § 5.8.1; 5.8.2; 5.8.5)
- Emergency incidents must be reported to 911, local law enforcement, CPS, and the ORR Intakes Hotline immediately; a Significant Incident Report must also be submitted (ORR Guide § 5.8.1)

REMAINING INDICATORS EVALUATED IN STATE LICENSING REQUIREMENTS

	At least one pre-licensure inspection is required and at least one unannounced licensing compliance inspection is required annually	Has a policy describing how the agency follows up on complaints or deficiencies in compliance with licensing standards	RED FLAG: Broad, non-specific waivers [†] permitted
Arizona	✓*		****
California		✓	
Colorado	✓	✓	
Connecticut	✓	✓	
Florida	**	✓	
Illinois		✓	
Kansas	Did not meet any indicators		
Maryland		✓	*****
Michigan		✓***	
New Jersey	Did not meet any indicators		
New York	Did not meet any indicators		
Oregon		✓	
Pennsylvania		✓	
Texas	✓	✓	
Virginia	✓	✓	*****
Washington		✓	

[†] Alternately, waivers are referred to as ‘exceptions,’ ‘exemptions,’ and ‘variances’ in some states.

* Arizona’s standards require a pre-licensure inspection and annual compliance inspection, unless a facility is found deficiency-free on a compliance inspection, in which case the facility will not have an inspection for 24 months.

** The sections of Florida’s standards related to on-site visits, grievance procedures, and exemptions have been repealed, effective 10/2016, and it appears that nothing has replaced them, as of April 2021; therefore, current licensing standards for the frequency or nature of inspections and monitoring are unclear.

*** Michigan’s standards state that the chief administrator of the facility must conduct an annual assessment of the facility’s compliance with the licensing standards and develop and implement a written plan to correct rule violations, rather than the licensing agency developing and requiring a corrective plan.

**** Arizona’s standards allow a facility to be provisionally licensed for up to a year “if the director believes that the immediate interests of the patients and the general public are best served if the institution is given an opportunity to correct deficiencies;” the standards state that the facility must carry out a plan to eliminate deficiencies, but the timeline and enforcement of this plan is not detailed.

***** Maryland’s standards allow non-specific variances and waivers as long as permitted by federal/state law and “the health, safety, and well-being of the children in the program is not jeopardized” by granting the variance/waiver.

***** Virginia considers “variances” if the licensee demonstrates that the implementation of a standard would impose a substantial financial or programmatic hardship and the variance would not adversely affect the safety and well-being of persons in care.

NOTABLY POSITIVE & ALARMING STANDARDS

Most states do not specify the frequency or intervals for unannounced on-site monitoring inspections within their licensing standards. However, most do describe, at least minimally, the procedures for developing a corrective action plan if deficiencies are found during monitoring and conditions for suspending or revoking a license.

The following are examples of components of standards that were notably positive or notably alarming:

Notably Positive Standards

- Connecticut's standards require inspections and review of licensed facilities at least every 90 days.
- Oregon's standards include a detailed description of procedures when a facility is found to be in violation of the licensing standards, including creating a corrective action plan with a timeline for correcting deficiencies, potentially imposing conditions on a facility's license while corrections are pending, imposing civil penalties, notifying the facility's governing board and other governmental agencies or units that have contracts with the facility, and suspending or revoking a license.
- Texas' policy handbook states that at least one unannounced monitoring inspection is required every 6 months during the first 12 months after a non-expiring license has been issued. The policy handbook also provides extensive detail regarding inspections, deficiencies, and corrective actions.

Notably Alarming Standards






- 14 out of 16 states allow broad, non-specific waivers from compliance with part or all of the licensing standards.








14 out of 16 states allow broad, non-specific waivers from compliance with part or all of the licensing standards.

RECOMMENDATIONS: ACCOUNTABILITY, MONITORING, AND WAIVERS

Recommendations for ORR

-  Establish clear lines of communication and data sharing agreements with state licensing agencies.
-  Require grantees to report violations of state licensing standards that affect child health and safety to the ORR Federal Field Specialist Team. At least quarterly, search available state licensing databases to identify grantee state licensing violations, if any exist.
-  Develop a monitoring system that is closely tied to a technical assistance system in order to deploy rapid support and/or intervention in cases of noncompliance, particularly when child health, safety, and wellness is at risk. Ensure monitoring system tracks child-level data, including on transfers between ORR facilities and timelines to release/reunification across all UCs in ORR custody, administration of psychotropic medication, and use of restraint or seclusion, among other key child wellness indicators discussed here. Ensure monitoring data are constantly updated and monitored and alert ORR leadership of non compliance findings for red flags.
-  Increase frequency of comprehensive in-person monitoring visits at least once a year and more often if the grantee has previously been found out of compliance with ORR policy or state licensing.
-  Develop grievance procedures that include mechanisms for child, potential sponsor, or child advocate complaint and allow complaints to be made directly to ORR.

Recommendations for States

-  Eliminate broad waivers that exempt licensees from any licensing standard.
-  Eliminate waivers on domains that directly affect health, safety, and well-being of children.
-  Develop a searchable online licensing database for state licensed facilities, if one is not already in place. Such databases should be similar to states' licensing databases for early learning and care facilities—i.e., including the name of the facility, license number, documentation of inspections/violations, and documentation of licensing waivers.
-  Ensure that the consequences for licensing violations—including revocation of a license—are explicit, clear, time delimited, and prioritize children's health, safety, and well-being.
-  Communicate violations that affect child health and safety to the ORR Federal Field Specialist Team and ORR Headquarters, and do so immediately if the license was revoked.



LEGAL SERVICES AND CHALLENGES FOR UCS IN ORR FACILITIES

Under the terms of TVPRA, ORR-funded facilities must provide legal orientation presentations to potential sponsors that, at a minimum, cover the sponsor's responsibility to attempt to ensure the child appears for their immigration proceedings and to protect the child from mistreatment or trafficking (8 U.S.C. § 1232(c)(4)). As noted in the ORR Guide § 2.2.5, the Legal Orientation Program for Custodians that provides these presentations also provides information about possible free legal counsel (pro bono legal services) for the child during the immigration court process. The Case Manager for each UC is responsible for informing potential sponsors about all procedures related to the child's case, including attending a presentation on legal services.

Under the terms of *Flores*, ORR-funded facilities must permit visits from attorneys and provide legal services information (e.g., the availability of free legal assistance, the right to be represented by counsel at no expense to the government, the right to a removal hearing before an immigration judge, the right to apply for asylum or to request voluntary departure in lieu of deportation), as well as services designed to identify relatives in the U.S. and in other countries and assistance to obtain legal guardianship when necessary for release.

RECOMMENDATIONS

The federal government should provide all UCS, including the youngest UCS, with the right to legal counsel. ORR should ensure legal services have been identified and secured before placing children at new facilities; ORR should make every effort to meet the same standard in periods of increased migration.

SPECIAL SECTION: ORR INFLUX FACILITIES

Influx shelters are funded on an emergency basis when the number of children migrating to the U.S. is greater than the total number of available beds in regular ORR-funded shelters. Under the terms of *Flores*, the transfer of UCs to a **non-secure, state-licensed** facility may be delayed in periods of influx, although ORR must transfer UCs “as expeditiously as possible.” Per ORR policy, UCs may be placed at an influx facility when ORR’s operational capacity (i.e., net bed capacity of state-licensed shelters and transitional foster care programs) is at or exceeding 85% for at least 3 days. When operational capacity drops below 85% for at least 7 consecutive days, ORR must discontinue placements of UCs at influx facilities (ORR Guide § 7.2.2). UCs must be transferred to a state-licensed facility or discharged from influx care facilities within 90 days of admission, including the day of admission and the day of transfer/discharge. If such a transfer is not possible, the case manager must document, each week after the 90-day mark, why the UC has not been transferred—for instance, due to medical concern/quarantine or likely release to a sponsor within 30 days (ORR Guide § 7.3).

Influx facilities have many of the same requirements as regular shelters, with the significant exception of not needing to be licensed by the state. They are also much more likely to receive waivers than non-influx, regular facilities. The justification for this lack of licensure requirement is that these facilities are only open for short periods of time and must be activated quickly to address an emergency need for beds. It is important to note, however, that ORR has historically used some of the same facilities or shelter operators as influx facilities repeatedly, such as Carrizo Springs Influx Care Facility in Carrizo Springs, Texas and Homestead Temporary Shelter for Unaccompanied Children in Homestead, Florida. If such is the case, ORR should consider establishing a stable pool of influx facilities that are state licensed and can quickly be activated in times of emergency need.

Clearly, these facilities are less preferable than regular ORR-funded facilities, but in some cases, may be necessary to ensure children are not backlogged at CBP facilities for longer than the absolute minimum amount of time necessary for processing. That said, because of the complete absence of state licensing and oversight of these facilities, ORR should also raise the standards and frequency and intensity of monitoring protocol, while still ensuring that they are

able to be rapidly activated to house children in emergency situations. Following widespread criticism of the overuse of these facilities, ORR revised its policies in September 2019 to make explicit the conditions for using supplemental, unlicensed influx care facilities and the services they must provide. The requirements for services provided in these facilities were improved during this revision, especially related to minimum mental health care services required. See the recent report by the National Center for Youth Law (Desai et al., 2021) for additional information about the experiences and needs of UCs in influx facilities, as well as detailed recommendations for improving operation and monitoring of these facilities—with which we have aligned many of our recommendations in this area.

The following is a review of ORR policies for influx shelters, and recommendations for improving this particular part of the shelter system.

ADMISSIONS, ORIENTATION, ASSESSMENT, AND RELEASE

- UCs should, “to the extent feasible,” meet the following criteria in order to be placed at an unlicensed influx care facility: a) be expected to be released to a sponsor within 30 days, b) be age 13 or older, c) speak English or Spanish as their preferred language, d) not have a known disability, behavioral health issues, medical or dental issues, e) not be a pregnant or parenting teen, f) not have reduced legal services as a result of a transfer to an unlicensed facility, g) not be a danger to self or others (ORR Guide § 7.2.1).
- Additional considerations that would recommend against placement in an unlicensed influx facility include: a) being part of a sibling group with a child 12 years or younger, b) being subject to a pending age determination, c) being involved in a home study or an active investigation with state licensing, child protective services, or law enforcement, d) being scheduled to be discharged in 3 days or less, e) turning 18 within 30 days of the transfer, f) having known medical or health issues or missing immunizations, g) not having a current docket date in immigration or family court nor an attorney of record (ORR Guide § 7.2.1).

- Within 4 hours of admission, a UC must be added to the ORR database, offered a meal and/or snack, be given an opportunity to bathe, provided with lice treatment as needed, be given clean clothing, and have the notice of placement in an influx care facility explained to them and signed (ORR Guide § 7.4).
- Within 24 hours of admission, the influx care facility must provide the UC with all documents from the Legal Resource Guide; explain to the UC the rules, grievance procedures, sexual abuse reporting procedures; complete the Initial Intakes Assessment; contact the child’s family to notify them of the placement, explain that the placement is temporary and that they will be notified of another transfer, ask about potential sponsors that live in the U.S., and inform them of the application process for safe, timely release to a sponsor (ORR Guide § 7.4).
- After the initial waiver, ORR may grant subsequent waivers for 60 days “if ORR determines such standards remain operationally infeasible.” ORR may not grant more than 4 consecutive 60-day waivers to an individual facility. ORR notifies Congress of any waivers granted to influx care facilities (ORR Guide § 7.6; 7.6.1).
- All influx care facilities must provide emergency clinical services if a child requests to meet with a mental health clinician or requires immediate clinical interventions. This requirement may not be waived (ORR Guide § 7.6).
- For any unlicensed influx care facility in operation for more than 3 consecutive months, ORR will conduct a minimum of 1 comprehensive monitoring visit during the first 3 months and then will conduct visits on a quarterly basis (ORR Guide § 7.10).

STAFFING RATIOS

- The same staffing ratios required for state-licensed, ORR-funded facilities apply to influx care facilities (ORR Guide § 7.7)
- ORR may grant a 60-day waiver for non-compliance with this requirement. ORR is prohibited from granting more than 4 consecutive waivers to an individual facility (ORR Guide § 7.6; 7.7).

REQUIRED SERVICES

- ORR requires that influx care facilities comply “to the greatest extent possible” with state child welfare laws and regulations and state and local building, fire, health and safety codes (ORR Guide § 7.5).
- Unlicensed influx care facilities are also required to “deliver services in a manner that is sensitive to the age, culture, native language, and needs” of UCs, and “develop an individual service plan for the care of each child” (ORR Guide § 7.5).
- ORR requires unlicensed influx care facilities to comply with Section 3.4 of the ORR Guide §, which relates to medical clearance and vaccination of children before they enter the facility (ORR Guide § 7.5.2).
- As of September 2019, influx care facilities must provide the same required services as outlined for state-licensed facilities in the ORR federal policies (much of which is required under the terms of *Flores*) (ORR Guide § 7.5.1).

WAIVERS AND MONITORING

- ORR may grant an initial waiver to an influx care facility if the policies are “operationally infeasible” and the facility has been active for a period of less than 6 consecutive months (ORR Guide § 7.6).

Recommendations for ORR

Strongly avoid placing children under the age of 14, children with physical/mental health needs or with unique language needs (e.g., having a language disorder, speaking an indigenous language or other language in which resources are not commonly available), or children without an identified sponsor at influx facilities.

Make every attempt to limit the length of stay for any child in an influx facility to a maximum of 30 days before they are transferred to a licensed facility or released to a sponsor.

Develop a strategic plan to expand the number of available licensed beds so that the agency is able to act quickly if additional funds are appropriated and so as to avoid influx facilities being used in excess of 90 days.

Establish a set pool of influx shelters that are “on call” and activated in cases of increased child migration. This pool of shelters, with the exception of those under federal jurisdiction, should be licensed by the state and be in compliance with the standards of the *Flores* Agreement on the first day that the facility is operational.

Limit the number of waivers for influx care facilities to 1 (i.e., require compliance with all policies within 60 days) and expand increased monitoring to all influx care facilities that have waivers.

Conduct at least 1 in-person comprehensive monitoring site visit each month that the influx facility is operating.

OVERARCHING TAKEAWAYS

Informed by our review and research, we provide a set of overarching learnings. These key takeaways inform a set of recommendations not specific to any particular domain, but relevant to overall ORR and shelter operations, licensing, state–federal communication, and data systems.

ORR’s policies as laid out in *ORR Guide: Children Entering the United States Unaccompanied* are generally more detailed and comprehensive than state licensing standards, with some exceptions.

Our analysis found that it is generally **not** the case that ORR’s policies are the “floor” and that state licensing standards go beyond basics.

There are gaps in ORR’s policies related to child wellness, particularly as they pertain to caring for young children.

Gaps primarily exist in personnel requirements and developmental, behavioral, and educational supports for young children. Although officials at ORR have previously mentioned the existence of separate requirements for “tender age” facilities that serve young children, these policies do not appear to be publicly available.

ORR appears to have a detailed and thorough monitoring process for grantees. But the consistency and fidelity of implementation of the monitoring protocol is unclear. What’s more, ORR and state licensing agencies do not share information about monitoring findings.

ORR’s monitoring system is, on paper, more comprehensive than any state licensing monitoring system. However, a recent investigation by the U.S. Government Accountability Office (2020) found that ORR a) lacks clear instructions for grantees on when and how to report state licensing violations to ORR, b) lacks a centralized database logging all federal ORR monitoring activities and corrective actions for facilities, and c) has been out of compliance with their own policies to conduct regular monitoring site visits, provide prompt correct actions to facilities, and conduct audits related to sexual abuse and harassment prevention. Nearly all state licensing agencies reported that they do not regularly share state monitoring findings with ORR, and *all* reported that ORR does not share its monitoring findings with them.

State licensing standards are not specific to housing or supporting UCs.

In every case, UC shelters are licensed under a broader category that is not specific to UCs, including residential child care, group homes, child behavioral health facilities, and homeless shelters.

No state met all of the quality indicators we reviewed and many fell short of meeting all of the indicators even within a single domain.

State licensing standards vary significantly across state lines.

This may result in different experiences for children, based on what shelter they are sent to.

Even with the nesting of federal law, *Flores*, ORR policies, and state licensing standards, gaps that risk child safety, health, and well-being remain.

For example, ORR’s policies do not prohibit chemical restraint—the act of restraining a child with a chemical substance—and 7 states also allow it in some settings, without explicit differentiation by child age.

Though state licensing standards vary significantly across state lines and in many cases lack in quality, they serve an important monitoring function.

This added level of monitoring and accountability provides an additional layer of protection for UCs, which is particularly critical when the federal administration is not reliably protecting children’s rights and promoting positive experiences.

OVERARCHING RECOMMENDATIONS

Informed by these findings and the research on child health, development, and well-being, we provide recommendations to the federal government and states.

Although this report does not review specific standards and operation procedures for CBP or ICE facilities, it is indisputable that the policies and actions of these agencies can be a grave threat to child safety, health, and well-being, and our goal of humanely caring for children. As such, we provide two overarching recommendations at the highest priority level.

one

CBP and ICE should never separate children from their parents, guardians, and siblings at apprehension, unless there is a credible safety threat to the child or suspicion of child exploitation or trafficking as determined by an authorized child welfare professional. Parents' past criminal records, and especially misdemeanor charges and immigration status offenses, should not be used to justify separation. In addition, given the importance of a trusted, stable caregiver to children's development, especially young children and those who have endured traumatic events, CBP and ORR should develop a strategy to keep children together with close family members, such as grandparents, with whom they have migrated, so long as an ORR-led investigation, implemented in partnership with a child welfare professional, confirms the relation and rules out safety threats or suspicions of child exploitation.

two

CBP should prioritize processing UCs and aim to transfer them to ORR custody faster than the required 72 hours. Recently, in spring 2021, UCs have been detained in CBP processing centers for an average of 120 hours (Alvarez & Sands, 2021), and children also remained in CBP custody in excess of this time limit under the Trump administration (DHS OIG, 2019). CBP processing centers are detention facilities, and detaining children in these facilities is extremely harmful to their health, wellness, and development. CBP should redirect funding to ensure that there are enough state-licensed child welfare professionals at the border to process such transfers in a timely manner, particularly during periods when larger numbers of children are coming to the U.S.

In the following section we focus on overarching recommendations for ORR that we believe would make the system more transparent and accountable for improving the conditions young children experience in the shelter system. It must be noted that it is gravely insufficient to have the requirements that dictate the experiences of vulnerable children solely in ORR policy via a handbook; **therefore, the first priority should be to codify such protections and policies into federal law. There are, however, steps ORR can take to improve conditions now, in advance of Congress taking this urgent action.**

1 Given the wide variability in quality of state licensing standards currently, ORR should not assume their policies are the “floor” and that states will build on them to reach a higher threshold of quality for children. This lack of consistency and altogether absent considerations for the unique needs of unaccompanied children in state licensing standards warrant raising ORR’s policies dictating the conditions and services provided by shelters; in concert, states should raise the quality, monitoring, and accountability for the care of all children in their systems.

2 This increase in quality should include a close examination of the domains reviewed here, and in particular, include sections across every domain specific to young children. Although young children are a minority of unaccompanied children in ORR custody, they are a sizable percentage and may be more vulnerable given their sensitive developmental state. It is also one of the areas where ORR policies seem to be lacking most.

3 Well-established research (van IJzendoorn et al., 2020) supports prioritizing family-like settings to large congregate care settings. Domestic child welfare policy also continues to move strongly away from congregate care settings, most recently codified in the Family First Prevention Act of 2018. ORR should align with this and give strong funding priority to high-quality applicants offering foster placements and small shelter/group home settings (i.e., less than 25 beds), and phase out large congregate care shelters, especially for UCs who are likely to remain in ORR custody for longer periods of time or have no imminent date of release.

4 ORR should require that all applicants for shelter funding disclose any previous state licensing violations. Prior to housing children, ORR should proactively confirm that grantees have a license and have not had a pattern of licensing violations or previous licenses revoked.

5 ORR should develop a tracking system closely tied to a technical assistance system that identifies red flags pertaining to monitoring violations in order to deploy rapid supports and/or intervention and immediately respond when child safety, health, or well-being is threatened.

6 The lack of communication between states and ORR is concerning and allows for continued operation of a facility, even if a state agency has identified a major licensing violation. ORR should partner with states with facilities that house UCs and establish formalized data sharing agreements to inform one another about grantee red flags, concerns, and real time licensing and monitoring findings.

7 ORR’s post-release services for unaccompanied children are generally poorly funded, available only to a fraction of unaccompanied children, and even in those cases, minimal (with the exception of FY 2020 when a larger proportion of children in care received services, likely due to the much reduced number of children in the system at the time). ORR should extend post release services for all children (and Congress should fund such an expansion) and form memoranda of understanding with other HHS offices to ensure that UCs receive priority for other social services (for which they are eligible) in the community during and after their time in shelters. Head Start and WIC are particularly relevant to young children. They should also form similar agreements across other federal agencies, most notably, the Education Department, to ensure children have access to the services they are eligible for or entitled to post release.

8 ORR should ensure that any child without an identified sponsor or any child who has been in care for more than 60 days (except in cases of imminent release) receive developmental and educational services in community-based settings.

9 Historically, ORR has used some influx shelters repeatedly. Though they are only in operation during periods of increased child migration, the fact that the same influx shelters are sometimes repeatedly used warrants having the agencies that operate them go through the state licensing process. ORR should have a pool of state-licensed shelter facilities that are only activated in times of influx.

10

The fact that influx shelters are not currently subject to state licensing warrants a higher level of standard and scrutiny by ORR to compensate for the lack of state oversight. ORR should raise oversight and monitoring of influx or emergency shelter facilities, require them to meet the same requirements as regular facilities, and only allow them to delay full compliance with requirements that do not directly impact child health, safety and well-being.

11

Identifying which state licensing standards apply to ORR shelter facilities is extremely challenging. In addition, some of ORR's policies and procedures may be internal and not shared publicly, adding another layer of obscurity. Some policies may also be included in funding opportunity announcements, which can change with each cycle of funding. This information should not be hard to find. ORR should increase transparency of the shelter system by making public all relevant policies that affect shelter operations and child services. They should also develop and make publicly available a searchable database of ORR-funded facilities that includes the name of the facility, the level of placement according to ORR's designations (e.g., standard shelter, therapeutic placement, residential treatment center), the state in which the facility operates, the type of state license they are required to have, documentation of inspections/violations, and documentation of licensing waivers. (Such a database should not include addresses for facilities, as there may be safety and privacy concerns for children and staff.)

States could and should play a stronger role in ensuring positive experiences for unaccompanied children in the shelter system. This starts by closely revisiting their licensing standards, particularly the domains reviewed here, to assess the appropriateness and quality of the services facilities provide to children. There is a particular need to examine standards as they relate to the experience of younger children as our review finds major gaps in developmental appropriateness. The full report identifies several specific recommendations per domain that states can consider in improving the quality and safety of their systems. **In addition to standards, overhauling the waiver process is also a critical need, such that waivers should not be granted for standards that directly affect the health, safety, and wellness of children in care, including standards related to basic needs, health, and discipline, among others.** These improvements will not only impact the experiences of UCs, but of children in the child welfare system more broadly, an issue of utmost importance.

CONCLUSION

There is no greater judge of a country’s moral character than how they treat children.

Although the United States has always underfunded social services for children and has one of the highest child poverty rates of any wealthy country in the world, the treatment of young children at the U.S.-Mexico border under the Trump administration undoubtedly stained America’s reputation and has rightfully been the subject of global condemnation. Many of the atrocities broadcast on television of children afraid and crying in crowded CBP facilities have not occurred in ORR shelters. Still, many of these same traumatized children eventually ended up, and many remain, in the ORR shelter system for weeks or months.

The network of ORR shelters and group home facilities plays a central role in children’s migration experiences. They have the power to begin to heal, or at least mitigate further harm—or conversely, exacerbate trauma, health, and psychological challenges. Our review finds that the federal law, *Flores* requirements, ORR policies, and state standards that these shelters are required to abide by are generally insufficient in their specificity to the unique needs of this population, lack in developmental appropriateness in many areas, and in several cases, do not go far enough to ensure the protection of children, especially the youngest children. Though these issues are not new, they are of particular concern and relevancy now, when the numbers of unaccompanied children at the U.S.-Mexico border are increasing rapidly, overwhelming a system that was already under-funded and operating under limited capacity during the pandemic. The federal government must act to improve ORR policies immediately and prioritize codifying further protections for UCs into federal law.

Although immigration policy is generally considered almost exclusively federal in nature, the federal requirement of state licensing gives states a significant leverage over the conditions young immigrant children experience in shelters. States should use this leverage to strengthen their licensing standards and provide a second layer of protection for UCs that would not only benefit this group of children, but all children in their child welfare systems.

Although there are inevitably challenges associated with increasing the quality of care, including cost and general supply of the specialized workforce needed to care for these children, the federal government and states should work toward—and adequately invest in—the common goal of protecting and humanely caring for unaccompanied children. This begins with holding shelter operators to a higher standard of care and funding them to provide such a standard. The reforms recommended here can help ensure that when children reach our borders or our shores, they are cared for humanely and with a fundamental concern for their dignity, health, and well-being.

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APPENDIX

STATE LICENSING INFORMATIONⁱⁱⁱ

State	Licensing Category for ORR Facilities for Unaccompanied Children & Links to Licensing Standards	Licensing Agency
Arizona	Behavioral Health Facilities – Child	AZ Department of Health Services, Health Care Institutions Licensing
California	Group Homes (Part 1 , 2 , 3 , 4 , 5 , 6)	CA Department of Social Services, Community Care Licensing Division, Children’s Residential Program
Colorado	Residential Child Care Facilities Providing Mental Health Services	CO Department of Human Services, Office of Behavioral Health
Connecticut	Child Care Centers	CT Department of Children and Families
Florida	Group Homes	FL Department of Children and Families
Illinois	Child Care Institutions	IL Department of Children and Family Services
Kansas	Residential Centers (for Children and Youth)	KS Department for Children and Families, Foster Care and Residential Facility Licensing Division
Maryland	Residential Child Care Programs (Part 1 , 2)	MD Department of Human Services, Office of Licensing and Monitoring
Michigan	Child Caring Institutions (Emergency rules regarding manual restraint adopted temporarily as of 07/2020)	MI Department of Health and Human Services, Child Welfare Licensing Division
New Jersey	Emergency Shelters for the Homeless	NJ Department of Community Affairs, Bureau of Rooming and Boarding House Standards
New York	Child-Caring Agencies – Institutions, Group Homes, or Foster Family Boarding Homes	NY Office of Children and Family Services
Oregon	Child-Caring Agencies – Residential Care Agencies	OR Department of Human Services
Pennsylvania	Child Residential Facilities	PA Department of Human Services
Texas	General Residential Operations	TX Department of Family and Protective Services
Virginia	Children’s Residential Facilities (Additional monitoring requirements)	VA Department of Social Services
Washington	Group Care Facilities	WA Department of Children, Youth, and Families

Note: As of July 2020, the District of Columbia, Georgia, New Mexico, and North Carolina have received funding for ORR, but there is no evidence that ORR-funded facilities are currently licensed and operating in these states.

ⁱⁱⁱ The state licensing standards we reviewed were the most up-to-date that were available on public licensing agency websites throughout 2020. Licensing standards are subject to change, so we provide links here to the most recently available licensing standards as of April 14, 2021, as a reference and resource to readers.