



Child Welfare & Unaccompanied Children in Federal Immigration Custody

A Data and Research Based Guide for Federal Policy Makers

Authors



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The National Center for Youth Law is a non-profit law firm focused on transforming the multiple public systems serving vulnerable children – including child welfare, juvenile justice, education, mental health, and public health – such that these children receive the supports they need to advance and thrive. NCYL’s Immigration Team uses a combination of litigation, policy, training, and education to protect the rights of children in federal immigration custody as well as immigrant children in the child welfare and juvenile justice systems. For further information on the issues presented in this briefing, please contact Neha Desai (ndesai@youthlaw.org; 510.899.6577). Website: youthlaw.org.

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Data Methodology

Data analysis provided in this document was performed on the monthly *Flores* data reports provided by the U.S. Department of Justice (“DOJ”) from January 2018 to October 2019. Records provided by the DOJ use an A-number to identify each unaccompanied child. An initial analysis of these A-numbers was performed to verify that each A-number is unique to each unaccompanied child identified in the monthly reports. Verified A-numbers were then used to link records for each unaccompanied child to their different placements in Office of Refugee Resettlement (“ORR”) custody. Demographics and detention characteristics, such as length of custody and number of transfers, were calculated at the individual level, and then aggregated at the monthly level for summary statistics. Program characteristics, such as average daily census and average lengths of custody, were calculated by aggregating data at the program level. Data calculations and analysis were performed in SAS statistical software, and charts and tables were created using Tableau data visualization software.

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Overview

Prior to 1997, the United States made no special provisions for the detention of immigrant children. These children were subject to the same harsh and hazardous conditions as adults in detention, with no concern for their unique vulnerability. In 1997, the *Flores* Settlement Agreement established basic standards governing the custody, detention, and release of children in federal immigration custody. These standards are based on fundamental child welfare principles, namely that detention is harmful and that children should be reunified with their families as quickly as possible.

Over twenty years later, there is a robust research consensus supporting these principles. Additionally, we now have over two decades of lessons learned from the implementation of the *Flores* Settlement Agreement. This Guide summarizes those lessons and synthesizes the research and data that should ground future policy.

The Guide is organized around seven basic child welfare principles and offers discrete recommendations for changes in practice that will allow us to animate these principles for unaccompanied children. While many of the same principles are relevant for accompanied children, who are in federal immigration custody with family, this Guide is focused on the particular experience of children detained in custody alone.

The Guide outlines principles and recommendations regarding where children should be placed, the length of time children spend in custody, and what services children need. Finally, the Guide suggests specific compliance measures to ensure that child welfare standards are meaningfully implemented, and children's rights are protected.

A Glossary of Terms is located on page 26.

Summary of Recommendations:

Placement Length and Type

1. Children must be released from government custody as quickly as possible.

- Require consistent, independent evaluation of Office of Refugee Resettlement (“ORR”) policies and practices to ensure that they do not create unnecessary barriers to release.
- Require the identification and adoption of best practices to expedite children's reunification with sponsors.
- Require facilities whose average length of stay exceeds the average to undergo a review and implement corrective actions.
- Afford due process protections to children when their length in detention exceeds a certain amount of time, including automatic monthly reviews and a meaningful opportunity to participate in these reviews.
- Minimize transfers amongst facilities unless a transfer promotes the child's best interests.

2. Children must be placed in the most home-like setting possible.

- Incentivize contracts with smaller facilities.
- Increase funding for Transitional Foster Care placements, Long-Term Foster Care placements, and Unaccompanied Refugee Minor placements, especially for children with special needs.

3. Children must be placed in state licensed facilities and facility contracts must be routinely re-evaluated for performance, including average length of time that children are detained before release.

- Significantly limit the use of unlicensed influx facilities.
- Require that licensing violations at contracted facilities be routinely checked and that contracts be reevaluated based on compliance with state law and priorities around expeditious release.

4. Children must not be transferred to restrictive facilities without a compelling justification and meaningful due process.

- Limit the use of restrictive facilities to narrow and enforceable criteria and end the practice of sending children to secure facilities based only on a risk of self-harm.
- Ensure children receive meaningful due process before they are transferred to a more restrictive placement, such as a staff-secure or secure facility, or residential treatment center.
- Develop stronger safeguards against indefinite restrictive placements.

Services

5. Children must have access to meaningful, trauma-informed mental health services in ORR shelters.

- Increase the quality, quantity, and diversity of trauma-informed mental health services in shelter settings.
- Ensure children have access to private and confidential mental health counseling.
- Ensure that children are released as soon as possible and that mental health needs do not prolong a child's detention.
- Ensure psychotropic medications are not used as a substitute for meaningful mental health services and are not administered without informed consent and other basic protections.

6. Children must have access to quality education and regular recreation.

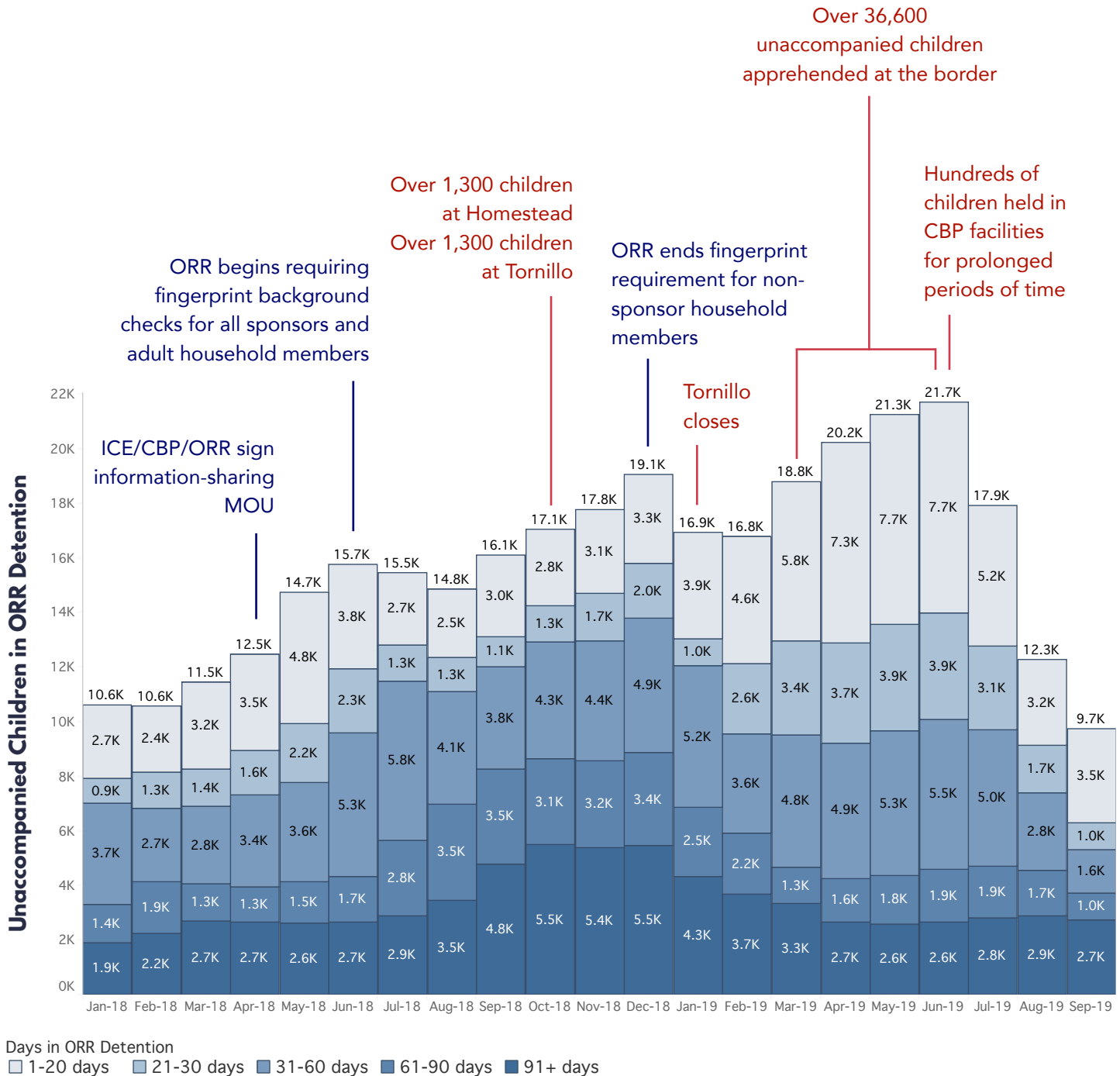
- Require facilities to follow state educational standards regarding curriculum and teacher qualifications
- Require facilities to tailor education services to an individual child's needs, especially if the child has a disability.
- Require a whole student approach that addresses personal, social, emotional, cultural, intellectual, and work skills in addition to academic content.
- Require facilities to meet or exceed the physical activity guidelines of the President's Council on Sports, Fitness & Nutrition.

Compliance

7. Children's rights must be protected through robust independent monitoring and data collection requirements.

- Establish a permanent, independent, multi-disciplinary oversight committee to monitor facilities where children are detained and review data.
- Require the accurate collection, analysis, and publication of meaningful data regarding children in federal immigration custody.

The past two years have been marked by policy changes that dramatically lengthened the amount of time immigrant children spent in detention. This in turn increased the number of children in custody, led to the opening of multiple influx facilities, and created a dangerous backlog at Customs and Border Protection (“CBP”) facilities.



1: Children must be released from government custody as quickly as possible.

Too many children are detained in government custody for prolonged periods of time.

The Office of Refugee Resettlement (“ORR”) is tasked with safely and expeditiously releasing unaccompanied children from federal custody. It must make “prompt and continuous efforts” toward family reunification and release children “without unnecessary delay” to their sponsors.¹ ORR’s network of contracted facilities stretches across the United States.

Over the past few years, there has been significant variation in children’s average length of detention in ORR custody. For example, across all placement levels, the average length of detention was 59 days in May 2018 and 93 days in November 2018. There has also been significant variation in children’s average length of detention between different ORR shelters, as well as significant variation in children’s average length of detention between shelters operated by the same contractor. Within ORR’s network of shelters, the average length of detention ranged from a low of 31.4 days to a high of 96.2 days.

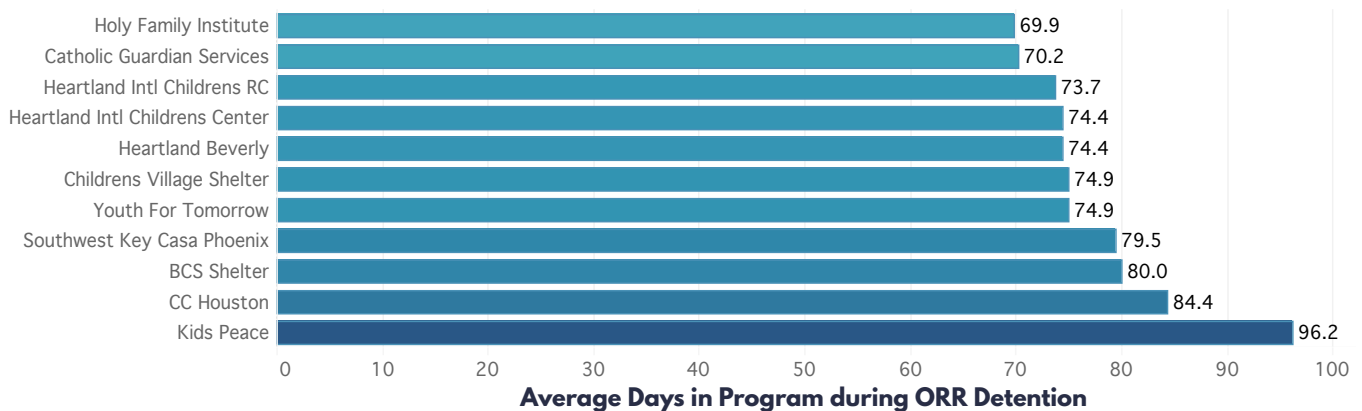
Children in ORR custody currently have no meaningful opportunity to challenge their placements, regardless of the length of time they have spent in custody.

“I pray to God that I get to leave here. I feel so alone, especially now that my cousin has left and I am still here. . . .

I feel sad and hopeless because I don’t know when I will be released or why I haven’t been released. . . . It feels like we are prisoners here because we have been here for so much time.”

*Child
Influx Facility*

ORR Shelters with the Longest Length of Detention January 2018 - September 2019



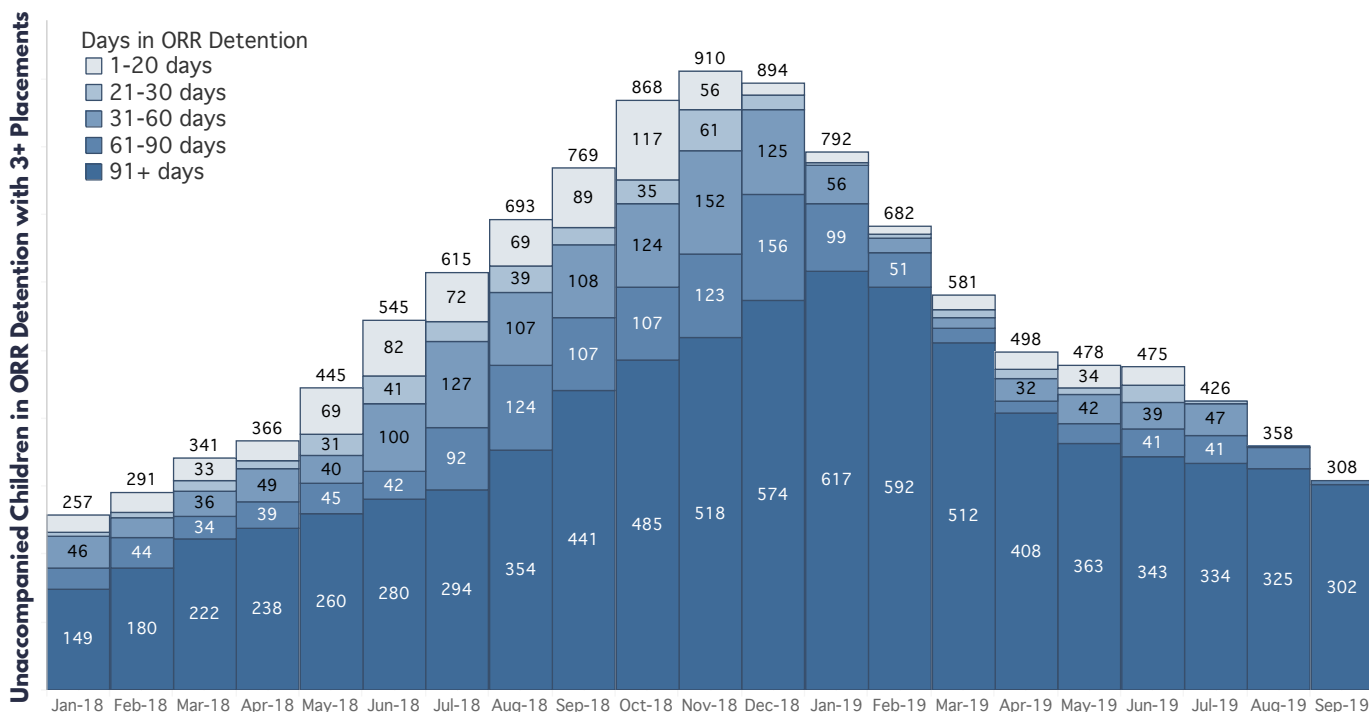
Detention and separation from family members inflicts long-lasting harm on children.

When children are held in government custody apart from their primary caregivers for long periods, they suffer profound and long-lasting injury. The American Academy of Pediatrics has explained that “highly stressful experiences, like family separation, can cause irreparable harm, disrupting a child’s brain architecture and affecting his or her short- and long-term health. This type of prolonged exposure to serious stress—known as toxic stress—can carry lifelong consequences for children.”² Studies of immigrant children detained in the United States reveal high rates of PTSD, anxiety, depression, and suicidal ideation.³

Multiple transfers may increase the overall length of time children are in custody.

A substantial number of children have been placed in multiple ORR facilities during their time in detention. 1,463 children were held at three or more facilities, and 228 children were held at four or more facilities from January 2018 to September 2019. A majority of these children were never placed in a more restrictive facility, therefore their transfers do not include a step-down into a less restrictive environment.

Children in ORR Detention with 3 or More Placements January 2018 - September 2019



When children are transferred to a new facility, they are forced to enter a new environment – with new staff and new peers – and are forced to rebuild those connections. They also lose their relationship with their prior case manager. This can lead to delays in release from ORR custody, as the new case manager develops familiarity with the child’s potential sponsors and options for reunification.

Placement instability is detrimental to the fundamental goals of child welfare - safety, permanency, and well-being.

Research indicates that placement instability – the transfer of children between multiple child welfare placements – inflicts additional emotional, psychological, developmental, and neurological harm on children. Multiple child welfare placements have been found to lead to “delayed permanency outcomes, academic difficulties, and struggles to develop meaningful attachments.”⁴ One study, which controlled for children’s behaviors at entry into foster care, found that children with multiple placements had between a 36 percent and 63 percent greater risk of developing behavioral challenges than did children in stable placements.⁵

Placement instability can delay or disrupt mental health treatment, educational services, and – critically – case management and reunification services. Placement transfers during crucial times in a child’s family reunification process can also escalate children’s negative behaviors, which can lead to additional placement transfers.⁶

ORR facilities have reported that children with longer lengths of detention “experienced more stress, anxiety, and depression.”⁷ While prolonged detention is associated with increasing harm, even children detained for less than two weeks can experience lasting distress that negatively impacts their mental, physical, and emotional health and development.⁸

A primary factor in recovering from such trauma is reunification with a parent or other trusted adult. Without the presence of trusted caregivers, children are often unable to cope with the psychological trauma and stress associated with detention.⁹

“I feel like I am a prisoner here, but I have not done anything wrong. Every morning I wake up crying because I want to be with my family. It is difficult for me to be here because I don’t know what is going to happen to me.”

*Child
Influx Facility*

Recommendations

- Require consistent, independent evaluation of ORR policies and practices to ensure that they do not include unnecessary barriers to release.
- Require the identification and adoption of best practices to expedite children’s reunification with sponsors.
- Require facilities whose average length of detention exceeds the average to undergo a review and implement corrective actions.
- Afford due process protections to children when their length of detention exceeds a certain amount of time, including automatic monthly reviews and a meaningful opportunity to participate in these reviews.
- Minimize transfers amongst facilities unless a transfer promotes the child’s best interests.

2: Children must be placed in the most home-like setting.

The majority of children in ORR custody are detained in large-scale facilities.

ORR's network of state-licensed care provider facilities stretches across the United States. Within that network, there are a significant number of large facilities that house unaccompanied children – some of them holding over one thousand children at a time.

Between January 2018 and September 2019, more than half of the unaccompanied children in ORR facilities were detained in facilities that held over two hundred children. For example, Southwest Key Casa Padre shelter, a converted Walmart Supercenter,¹⁰ can hold over 1,400 children at a time.

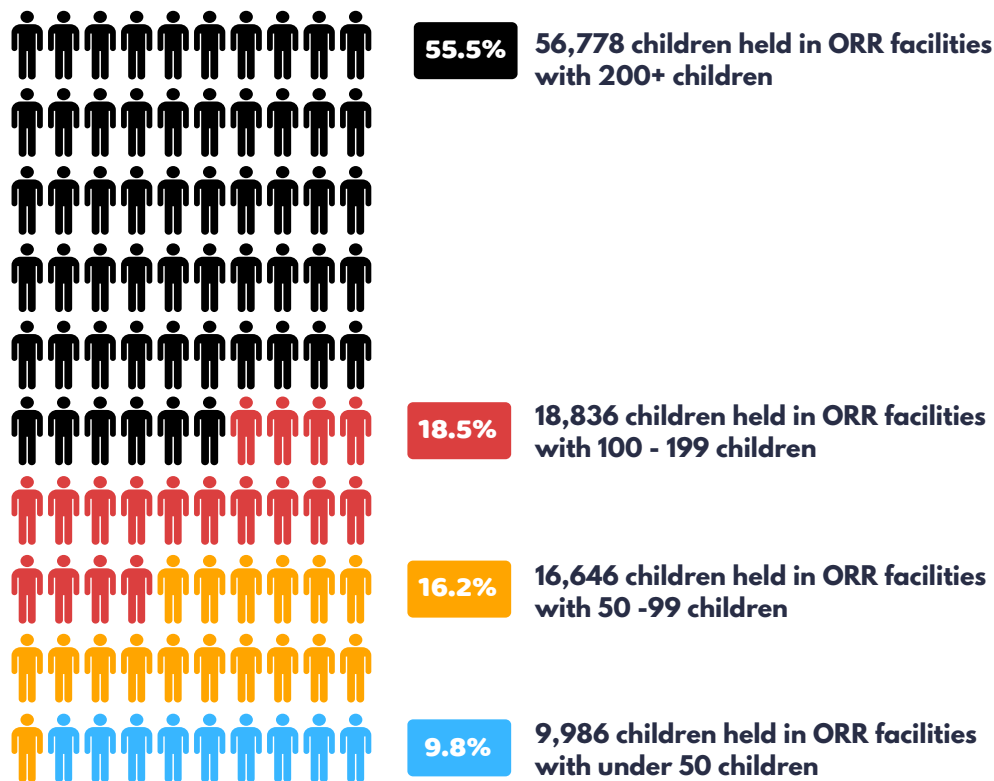
Thirty-three ORR facilities regularly hold more than 100 children at a time. By contrast, in the state child welfare context, foster care group homes typically house between 7 to 12 children.¹¹

“We are only given 15 minutes to eat. If you aren't done it doesn't matter. There are always people who haven't finished their meals because they weren't given enough time. We are given only 30 minutes of recreation a day. . . .

I have one teacher who teaches me all of the subjects and she barely teaches us anything . . . We are only given 5 minutes to shower each night and if we take longer the officers rush us.”

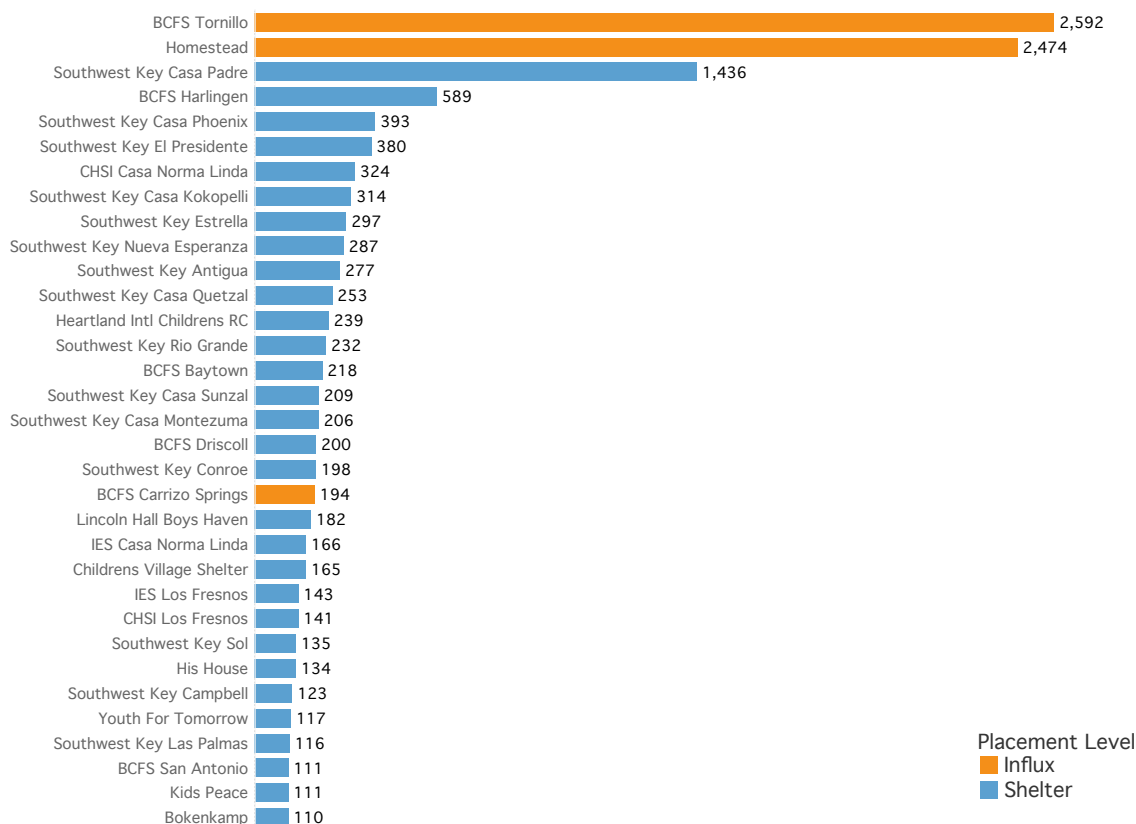
*Child
Influx Facility*

Size of Largest Program Unaccompanied Children Held in During ORR Detention January 2018 - September 2019



*This chart does not include children in ORR Transitional or Long-Term Foster Care.

ORR Facilities Detaining 100 or More Children, by average daily census January 2018 - September 2019



Maximum Monthly Average Daily Census of Unaccompanied Children in ORR Detention

The federal government has detained children for prolonged periods of time in large, unlicensed influx facilities.

The *Flores* Settlement requires ORR to place unaccompanied minors in non-secure facilities that are licensed to care for dependent children, with limited exceptions.¹² In the event of an “emergency or influx,” the district court has held that children in DHS custody may be held in unlicensed facilities for 20 days, “if 20 days is as fast as [the government], in good faith and in the exercise of due diligence, can possibly go in screening family members . . .”¹³ The *Flores* Settlement does not place a hard limit of 20 days on the length of time that the government may detain children.

Over the past year and half, ORR has increasingly relied on large, unlicensed influx facilities to detain unaccompanied children for prolonged periods of time. ORR has detained children at three unlicensed influx facilities – Homestead Detention Center (“Homestead”) in Homestead, Florida, Tornillo Detention Center (“Tornillo”) in Tornillo, Texas, and Carrizo Springs Detention Center (“Carrizo Springs”) in Carrizo Springs, Texas.

“The [influx] facility is very secure. . . . The people in charge have said that if you leave without permission, they will file a report against us.

The doors are always locked. [The staff] accompany us for meals and tell us what we can do. They change throughout the day. We can’t even go to the bathroom with a [staff member] accompanying us.”

*Child
Influx Facility*

ORR opened Homestead in February 2018.¹⁴ Homestead was not licensed by the state of Florida and was not regulated by state child welfare and foster care authorities. Homestead had 24-hour surveillance and monitoring by security guards and staff and was surrounded by a chain-link fence. The facility was operated by contractor Comprehensive Health Services, Inc., a private, for-profit company. The average daily cost to house a child at an influx facility such as Homestead was approximately \$775 per day.¹⁵ While Homestead stopped housing children in July 2019, HHS indicated that Homestead was “fully active” through September 2019, costing taxpayers \$720,000 per day.¹⁶

In June 2018, ORR opened a second unlicensed facility, Tornillo. Although Tornillo had space for 400 children when it first opened, it later increased its capacity to 3,800 children.¹⁷ Similar to Homestead, Tornillo housed children in a restrictive and regimented environment. Children slept in rows of hundreds of bunk beds in enormous canvas tents.¹⁸

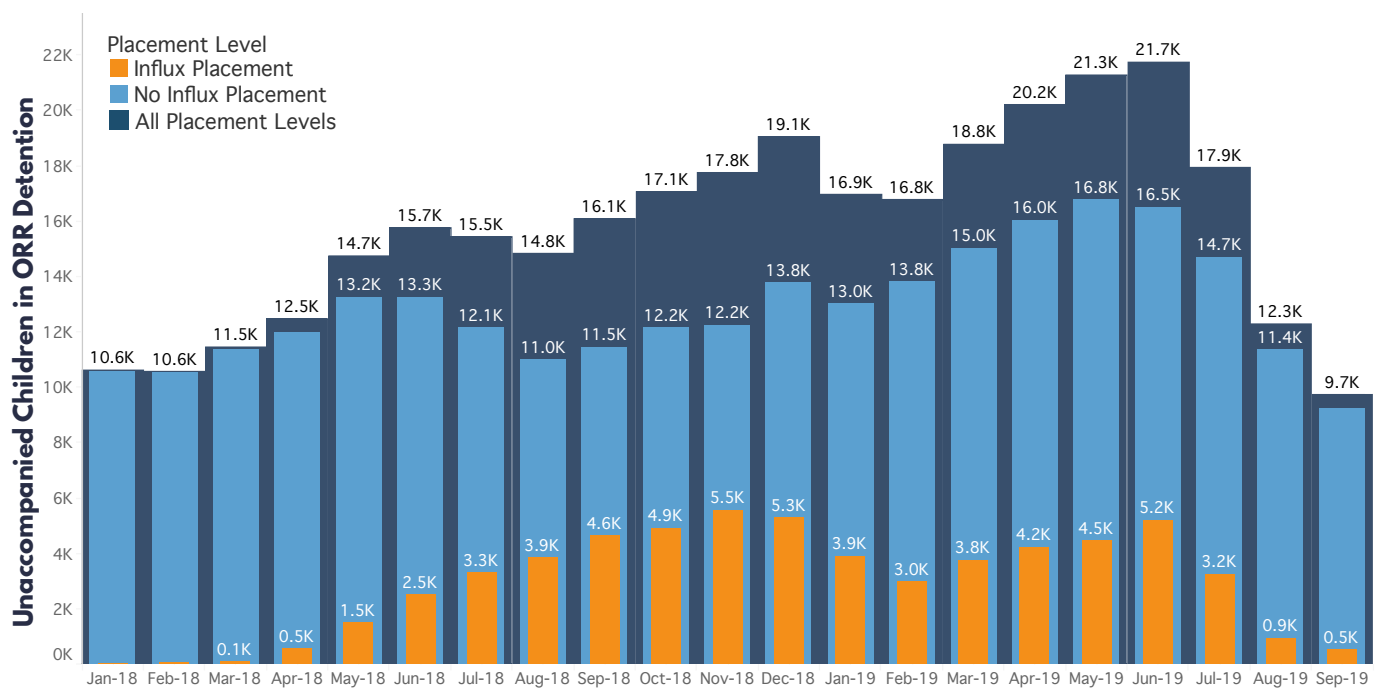
In June 2019, ORR opened a third unlicensed influx facility, Carrizo Springs. Unlike Tornillo and Homestead, Carrizo Springs was open for only a few weeks.¹⁹ At its maximum, Carrizo Springs held less than 200 children. In August 2019, HHS officials stated that they were planning to move away from large emergency shelters.²⁰

“There are many rules here. You cannot hug a friend or touch anyone. You cannot try to leave. If you commit any errors, a supervisor will write a report about you. If you get a report, you have to stay here for fifteen days longer. During that time, you will not be given information about your case. . .

I follow all the rules here because I do not want to commit any errors and I do not want any reports about me. I do not want to be detained here any longer.”

*Child
Influx Facility*

Children in Influx Facilities in ORR Detention January 2018 - September 2019



Institutionalization in large-scale facilities harms children’s cognitive, physical, and psychological development.

The harmful effects of institutionalization and large-scale congregate care on children’s health and welfare are well established. Child welfare experts have found that “children of all ages need long-term, committed adult connections in order to develop” and congregate care facilities “mirror too closely aspects of maltreatment that set children up for lifelong developmental challenges.”²¹ While congregate care facilities may provide for a child’s basic survival needs, the lack of reliable adult-child relationships is profoundly detrimental to children’s short- and long-term health outcomes.

In considering the harm inflicted on children by institutional settings, the Center on the Developing Child at Harvard University summarized the essential findings of research into child neglect.²² The Center’s key findings include:

- “Building the foundations of successful development in childhood requires responsive relationships and supportive environments. Because responsive relationships are both expected and essential, their absence is a serious threat to a child’s development and well-being.
- **Children who experience significantly limited caregiver responsiveness may sustain a range of adverse physical and mental health consequences that actually produce more widespread developmental impairments than overt physical abuse.**
- Neglect disrupts the ways in which children’s brains develop and process information, alters the development of biological stress-response systems, **is associated with significant risk for emotional and interpersonal difficulties, and is associated with significant risk for learning difficulties and poor school achievement.**”

“I often feel sad and depressed here. . . Other children here are also very sad. They cry a lot. . . They do not have the energy, they do not have any hope, they do not want to talk with anyone, and they are not motivated to play.”

*Child
Influx Facility*

For children housed in institutions, the “lack of individualized adult responsiveness can lead to severe impairments in cognitive, physical, and psychosocial development.”

*The Science of Neglect,
Center on the Developing Child,
Harvard University*

State and federal law disfavor housing children in congregate care facilities.

Recognizing the harms of institutional placements, many state child welfare agencies have moved away from placing children in congregate settings. The number of children who were placed in a group home or institution decreased by 37 percent between 2004 and 2013.²³ In 2018, Congress passed the Family First Prevention Services Act, which incentivizes states to reduce the use of congregate care facilities and increase the use of licensed family foster homes.²⁴ This legislation recognizes the importance of family-based care for the long-term health and well-being of children. With limited exceptions, the federal government will not reimburse states for children placed in group care settings for more than two weeks.²⁵

While the ORR network does include community-based placements, such as the Transitional Foster Care, Long Term Foster Care, and Unaccompanied Refugee Minor placements described below, there are generally far more eligible children than placements available.

Recommendations

- **Incentivize contracts with smaller facilities.**

As explained above, the use of large institutions to house children is profoundly detrimental to children’s growth and development. The lack of individualized attention is especially consequential for children with special needs. Therefore, ORR should prioritize the placement of children into smaller group homes that can provide individualized care and attention. Additionally, ORR should provide incentives for smaller group homes to contract with ORR, decreasing the need to hold children in large facilities.

- **Increase funding for Transitional Foster Care placements, especially for children with special needs.**

Transitional Foster Care (“TFC”) is an initial community-based placement option for unaccompanied children “under 13 years of age, sibling groups with one sibling under 13 years of age, pregnant/parenting teens, or unaccompanied alien children with special needs.”²⁶ Children in TFC placements are placed with foster families, but may attend school and receive other services at the ORR TFC care provider facility site.

- **Increase funding for Long-Term Foster Care placements, especially for children with special needs. Expand eligibility for Long-Term Foster Care placements.**

Long-Term Foster Care (“LTFC”) is a community-based foster care placement for unaccompanied children who are determined likely to be in ORR custody for an extended period of time.²⁷ Children in LTFC placements are typically placed in licensed foster homes, attend public school, and receive community-based services.²⁸

For children that do not have any viable sponsors, known as Category Four children, LTFC placements are critical. In 2016, the Government Accountability Office called the use of Category Four designations “rare”²⁹ and a former ORR Director estimated the percentage to be under 10% of the total ORR population.³⁰ However, as of June 2019, Category Four children represented approximately one-third of all children in ORR custody.³¹ The increase in the number of Category Four children without a potential sponsor can be attributed to a confluence of factors - all tied to the legitimate fear potential undocumented sponsors have in coming forward to the government to sponsor a child.

There are not enough LTFC placements to meet the current need. Without the option of an LTFC placement, these children will remain in ORR facilities indefinitely.

- **Increase funding for Unaccompanied Refugee Minor program placements.**

The Unaccompanied Refugee Minor program (“URM program”) provides licensed care placements to certain eligible unaccompanied children.³² While most URM placements are in licensed foster homes, other placements may be used according to a child’s needs, such as therapeutic foster care, group homes, residential treatment centers, or independent living programs.

3: Children must be placed in state licensed facilities and facility contracts must be routinely re-evaluated for performance and average length of time that children are detained before release.

Over the past two years, the federal government has detained children in unlicensed facilities as well as in facilities with significant licensing violations.

With limited exceptions, the *Flores* Settlement requires that DHS and HHS place children in non-secure facilities that are “licensed by an appropriate State agency to provide residential, group, or foster care services for dependent children.”³³ Licensed facilities must comply with all applicable state child welfare laws and regulations. Over the past year and a half, ORR has detained thousands of children in unlicensed influx facilities, as well as in licensed facilities with multiple licensing violations.

As discussed earlier, between February 2018 to July 2019, ORR operated three unlicensed influx facilities: Homestead, Tornillo, and Carrizo Springs. **Tens of thousands of children passed through these facilities during that time – and none of these facilities held a state child welfare license or were subjected to state child welfare inspections.**

Children have also been held for prolonged periods of time in shelters with multiple state licensing violations. In 2018, most of contractor Southwest Key’s 16 shelters were operating under month-to-month “variances” granted by the state to permit them to hold up to 150% of their original licensed capacity.³⁴ Southwest Key was granted these variances even though state inspectors identified more than 246 licensure “deficiencies” at Southwest Key facilities over the past three years. These deficiencies included the improper use of physical force on children, staff intoxication, improper medical treatment, and under-supervised children harming themselves.³⁵

Detained children have also been the victims of sexual abuse and harassment in licensed ORR facilities. Between 2015 and 2018, ORR received 178 allegations of sexual abuse and harassment against staff at contracted facilities.³⁶ These complaints ranged “from inappropriate romantic relationships between children and adults, to touching genitals, to watching children shower.”³⁷ Since 2015, three employees at Southwest Key shelters in Arizona have been arrested on allegations of molesting immigrant children.³⁸

“Nearly every adult working with children in the U.S. — from nannies to teachers to coaches — has undergone state screenings to ensure they have no proven history of abusing or neglecting kids. One exception: thousands of workers at two federal detention facilities holding 3,600 migrant teens in the government’s care.”

Caregivers for 3,600 Migrant Teens Lack Complete Abuse Checks,
Associated Press, Dec. 10, 2018.

State and federal law require child welfare systems to place children in licensed facilities.³⁹

The importance of state licensure for child welfare systems is reflected in both state and federal law. Federal law requires states receiving funding under Title IV-E of the Social Security Act to maintain standards for foster families and child care institutions which are “reasonably in accord with recommended standards of national organizations” and include standards related to “admission policies, safety, sanitation, and protection of civil rights . . .”⁴⁰ Every state employs a licensing regime to ensure that every facility housing children meets minimum health and safety standards.⁴¹ These licensing requirements are based on years of research and experience regarding child welfare policy and practice.

The licensing regime has two main prongs:

1. Each state must have licensing standards and policies to ensure the safety and well-being of children placed in residential facilities; and
2. Each state must have the ability to ensure compliance with those standards.⁴²

These licensing regimes delineate the standards that a facility must meet and, critically, provide a system to monitor the facilities through a combination of on-site inspections, rapid responses to reports of violations, and follow-up to ensure compliance with the state’s licensing standards. State standards include strict requirements regarding staff qualifications and training, caregiver ratios, individual treatment plans and educational support, appropriate disciplinary methods, medical consent and confidentiality, and disability accommodations, among others.⁴³

States employ compliance schemes to ensure facilities abide by standards and regulations, including (1) on-site inspections, (2) rapid responses to reports of violations, and (3) follow-up to remedy such violations. In addition to requiring annual on-site inspections, a functioning licensing process under state law requires the licensing authority to respond quickly to reports of violations of licensing standards as well as reports of maltreatment and abuse.⁴⁴ To this end, “[a]ll states” require that reports of maltreatment be initiated “in a timely manner, generally within 72 hours,” and even faster when a child may be in imminent danger.⁴⁵

Recommendations

- **Significantly limit the use of unlicensed influx facilities.**

Children should only be held in facilities that hold state licenses for the care of children. The lack of any external oversight or regulation for influx facilities is extremely concerning for detained children’s health, safety, and welfare. ORR should prioritize the development of contracts with smaller, licensed facilities and only use influx facilities in extreme and unforeseen circumstances.

- **Require that licensing violations at ORR facilities be routinely checked and that contracts be reevaluated based on compliance with state law and priorities around expeditious release.**

ORR must re-evaluate its contracts with facilities based on each facility’s compliance with state law. Multiple ORR-contracted facilities have been in violation of state licensing requirements and yet ORR continues to renew their contracts. Continuing to renew these contracts directly endangers children’s safety and welfare. ORR must also re-evaluate its contracts with facilities based on each facility’s performance and average length of time that children are detained before release.

4: Children must not be transferred to restrictive facilities without a compelling justification and meaningful due process.

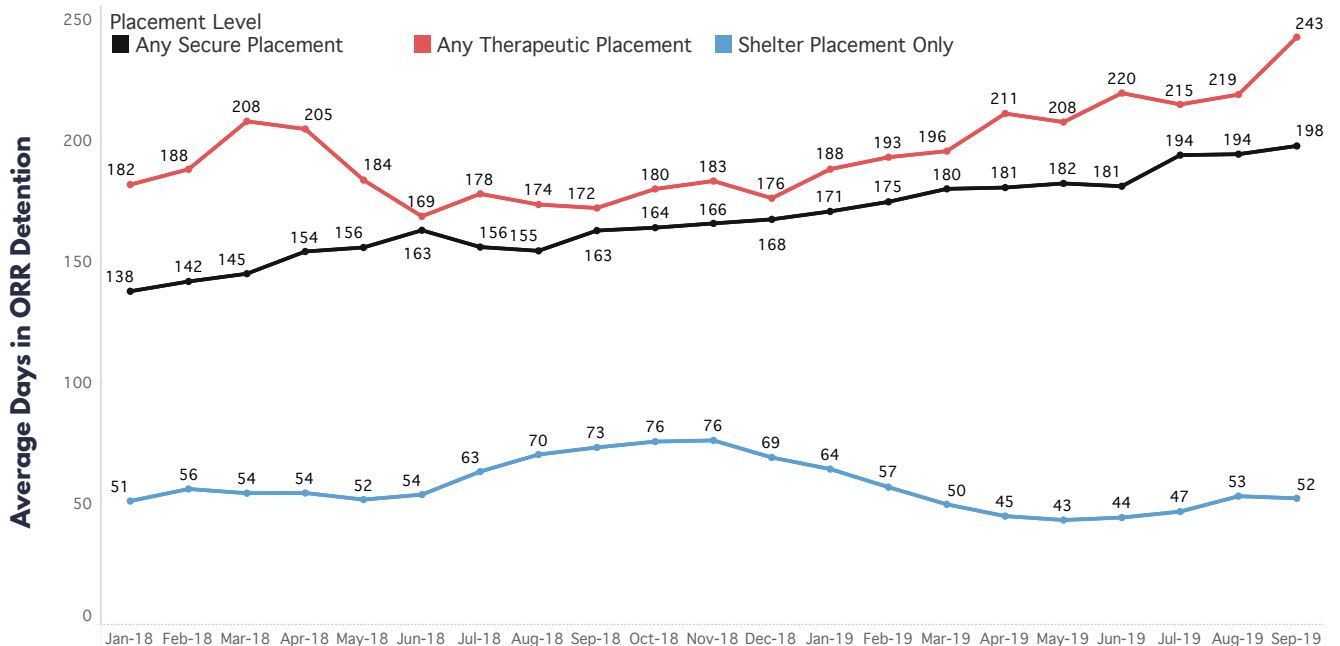
Children in ORR custody who are stepped up to more restrictive placements are detained significantly longer than children placed in shelters.

Most children in ORR custody live in shelters licensed by the state to care for dependent children. However, some children in ORR custody are transferred – or “stepped-up” – to much more restrictive placements, such as secure facilities, staff-secure facilities, and residential treatment centers. Secure facilities are state or county juvenile detention centers. Staff-secure facilities and residential treatment centers place varying levels of restriction on children’s movement.

Under the Trafficking Victims Protection Reauthorization Act, children can be placed in a secure facility if they pose a danger to themselves or others or have been charged with a criminal offense.⁴⁶ The Flores Settlement Agreement also delineates circumstances in which children can be placed in more restrictive settings.⁴⁷

While some children are stepped-up due to formal charges that have been filed against them in the juvenile justice system, others are stepped-up due to allegations by staff or clinicians that may be arbitrary and unfounded. Unaccompanied children who are stepped-up to restrictive placements remain in ORR custody much longer on average than unaccompanied children in shelter settings.

Average Length of Detention for Children in Secure, Therapeutic, and Shelter Facilities January 2018 - September 2019



***This chart does not include children placed in ORR Transitional or Long-Term Foster Care at any time.**

In September 2019, the average length of detention for discharged children who were placed only in ORR shelters was 52 days. In comparison, discharged children who had any placement in staff-secure or secure facilities were detained an average of 198 days, and discharged children who had any placement in residential treatment centers or therapeutic placements were detained an average of 243 days.

Despite these profound consequences, children are given no opportunity to challenge the reasons for their step-up before they are transferred. Many are awakened in the middle of the night and transported to a more secure facility without any prior notice. Children with disabilities are at particular risk of being pushed out of shelter settings and segregated in inappropriately restrictive institutions.⁴⁸

When a child is transferred out of a shelter and “stepped-up” to a more restrictive facility, they lose the relationships and semblance of stability they may have built in their prior placement and are sometimes separated from their siblings or other close family members.⁴⁹ Children in restrictive facilities also face a substantial loss of liberty.⁵⁰ A step-up to a secure facility can result in indefinite placement in juvenile detention.⁵¹ Children are placed in secure cell-block units where they live in single cells, have limited time outdoors, and may experience physical restraint.⁵²

“I sleep in a locked jail cell. The beds are thin mattresses on top of a block of cement and we don’t get pillows. I have a make-shift pillow that I make out of my sweaters or other clothes. . . The guards also push us, pepper spray us, and place the handcuffs excessively tight – to the point that wrist injuries frequently occur.”

*Child
Secure Facility*

“Soon after, I was transferred to [Secure Detention Facility]. I was woken up at 4:00 in the morning and put on a plane. The staff did not tell me where I was going. The staff put very heavy shackles on my feet and they really hurt. They kept the shackles on for the whole plan ride, which was six hours long.”

*Child
Secure Facility*

Detention in restrictive facilities harms children’s mental and physical health.

Detention in any setting and for any length of time is unsafe for children and can lead to long-term psychological harm.⁵³ This harm is caused in part by unsafe and stressful conditions of confinement, unstable placements, a lack of supportive family and community networks, and the absence of appropriate opportunities for education, recreation, and normal social development.⁵⁴ Transferring children to more restrictive facilities exacerbates all of these conditions.

Research demonstrates that the most effective interventions for behavioral challenges are therapeutic approaches focused on counseling and skills-building rather than coercion and control.⁵⁵ This is consistent with evidence that the effects of toxic stress can be addressed by strengthening protective relationships and giving children a nurturing and stable environment.⁵⁶

By contrast, the coercive and stressful environment of a more secure detention facility makes it difficult to benefit from any mental health and educational services provided.⁵⁷

“Being detained for such a long time has made me feel really bad. I never used to have such problems with depression or anxiety, but since I have been detained I have become much more frustrated. Being detained at [Secure Detention Facility] makes me feel like I am going crazy. I am always alone with my thoughts and bad memories of things that have happened to me run through my head all day. I don’t know how I can improve my mental health if I am kept in a cage.”

*Child
Secure Facility*

Federal and state law and policy reflect the widely accepted position that children and communities are better off when children are not incarcerated.⁵⁸ A longstanding body of research has established that detaining children interferes with healthy development, exposes youth to abuse, undermines educational attainment, and puts children at greater risk of self-harm.⁵⁹ Detaining children in secure juvenile detention facilities is associated with increased rates of depression and suicidal ideation.⁶⁰ Research has demonstrated that incarceration exacerbates pre-existing trauma.⁶¹ One study showed that for one-third of incarcerated youth diagnosed with depression, the onset of the depression occurred after they began their incarceration.⁶²

Recommendations

- **Limit the use of restrictive facilities to narrow and enforceable criteria and end the practice of sending children to secure juvenile detention based only on a risk of self-harm.**

Secure facilities should be used as a last resort – only when there is clear and convincing evidence that a child poses a serious danger to others and cannot be safely housed in a less restrictive setting. Children experiencing suicidal thoughts or engaging in self-harm require trauma-informed mental health treatment, not punitive and counterproductive placement in juvenile detention.

- **Ensure children receive meaningful due process before they are transferred to a more restrictive placement, such as a staff-secure or secure facility, or residential treatment center.**

Children should receive advance notice of a step-up to a more restrictive facility and an opportunity to contest this decision in a pre-transfer hearing before a neutral arbiter. Any notice should include a detailed explanation of the reasons for the proposed transfer and provide adequate time for a child to access legal counsel and prepare a defense. The child should have an opportunity to view and rebut the evidence against them and to explain why a transfer is not necessary. If the neutral arbiter decides to approve a transfer, this decision should be provided to the child in writing and reviewable in federal court.

- **Develop stronger safeguards against indefinite restrictive placements.**

If a child must be placed in a restrictive facility, they should remain there no longer than necessary. Any child in a restrictive facility should receive an automatic review of their placement every month, including an opportunity for a hearing before a neutral arbiter. As part of this monthly review, children held in residential treatment facilities or out-of-network facilities should receive a detailed evaluation by a qualified psychologist or psychiatrist of the reasons for their continued placement and a specific plan for transitioning to a less restrictive placement. Children should be “stepped-down” to a less restrictive facility as soon as possible, without waiting for a monthly review.

5: Children must have access to meaningful, trauma-informed mental health services in ORR shelters.

ORR facilities struggle to provide adequate mental health services to children.

The majority of children in federal immigration custody have survived serious trauma. While children are in its custody, the government has an obligation to care for their mental health “in the least restrictive setting” appropriate.⁶³ The *Flores* Settlement Agreement requires all children to receive one individual counseling session and two group counseling sessions each week.⁶⁴ Yet mental health services in ORR shelters currently fall far short of meeting children’s needs.

In a recent report, the HHS Office of Inspector General found widespread concern among ORR care providers and mental health clinicians that they are not equipped to address the severe trauma children have experienced.⁶⁵ These problems are especially apparent in unlicensed influx facilities.⁶⁶

Even where mental health services are sufficiently staffed, the services provided are often not confidential. Confidentiality is crucial to effective mental health care and is a bedrock ethical principle for mental health professionals.⁶⁷ Yet children in ORR custody sometimes lack privacy from staff or other children when speaking with their counselors.⁶⁸ Children also have legitimate fears that information they disclose to their counselors will be used against them to justify a transfer to a more restrictive facility or to undermine their immigration case.⁶⁹ Immigration attorneys have increasingly observed the government using ORR files containing confidential medical and psychological records as evidence in immigration court.⁷⁰ This lack of confidentiality is incompatible with strong therapeutic relationships.

“When I feel really upset, and I feel like I might want to hurt myself, the staff do not help me. It would be helpful if I could talk with someone when I feel this way, but there is no communication with anyone. I don’t feel like I’m able to talk with anyone or get the help that I need. I am so desperate to leave this place.”

*Child
Residential Treatment Center*

“The act of ‘stepping up’ an immigrant child in ORR detention merits transparency to both the child and to any legal representative of that child.

It is inhumane to place children with suicidal ideation and other mental health needs in the most restrictive ORR settings.”

*Disability Rights California,
The Detention of Immigrant
Children with Disabilities in
California*⁷⁴

Because ORR shelters lack the resources to provide children with the care they need, children with mental health needs are often transferred, or “stepped-up”, to residential treatment centers, staff-secure, or secure detention centers. These step-ups risk further damaging children’s mental health, as restrictive institutional environments increase the trauma of detention.⁷¹ Children are also more likely to be placed on psychotropic medications in these more restrictive facilities. Historically, ORR failed to obtain informed consent prior to administering psychotropic medications.

Step-ups also punish the most vulnerable children and discourage them from seeking help. As Disability Rights California observed in a recent report, “children recognize that the penalty for reporting suicidal thoughts or self-harming acts in ORR custody is juvenile hall.”⁷² This report found that 81% of immigrant children detained at Yolo County Detention Facility were “detained at the facility due to self-injurious behavior, behavioral problems, or mental health diagnoses.”⁷³ As explained in detail on page 16, step-ups also significantly prolong a child’s time in custody.

Unaccompanied children typically experience unique trauma before, during, and after their migration to the United States.⁷⁵

Childhood traumatic experiences can alter the brain's responses to stress and cause children to lose their sense of safety and control.⁷⁶ Unaccompanied children often experience trauma before, during, and after migration.

Before Migration	War and political conflict; lack of food, water, shelter, and medical care; forced displacement; gang violence; threats of physical and sexual violence or murder; death of a loved one
During Migration	Extreme deprivation of food, water, shelter, and medical care; hazardous travel, often long distances by foot or unsafe transportation; death of - or prolonged separation from - a caregiver, family member, or other important person; direct or indirect exposure to physical and sexual violence; gender-based violence; human trafficking and financial exploitation
After Migration	Federal immigration detention; extreme poverty; discrimination/bullying/hate crimes based on race, ethnicity, sexuality, religion, or native language; separation from family members; community violence

Children who have experienced trauma need a safe and stable environment where they can rebuild supportive relationships and regain a sense of security. Strong family relationships can play a critical role in helping children build resiliency.⁷⁷

By contrast, detention of any kind is associated with long-term psychological harm for children.⁷⁸ This danger is especially acute when children are deprived of trauma-informed mental health care and instead punished for failing to abide by strict rules or for normal reactions to trauma. Uncertainty about the future and frequent changes in placements also contribute to negative mental health outcomes.⁷⁹

“My counselor at [Residential Treatment Center] told me that the reunification process was generally much slower, if not completely halted, when you are in the RTC program because you are receiving treatment. They told me that the law required that I complete my RTC and then step back down to a shelter before I could be reunited with family.

Now I have been in the shelter level for the past two months, but I have still not been released to my family.”

*Child
Shelter*

Recommendations

- **Increase the quality, quantity, and diversity of trauma-informed mental health services in shelter settings.**

Children must have access to a continuum of mental health care services capable of responding appropriately to symptoms of trauma. These services should be provided to the greatest extent possible in a shelter setting without disrupting a child's placement and existing relationships. In providing trauma-informed treatment at the shelter level, facilities can avoid stepping up children to more restrictive facilities and prolonging their detention.

- **Ensure children have access to private and confidential mental health counseling.**

A child's mental health information must be kept confidential in accordance with professional ethical standards and applicable state and federal laws. This information should never be used against a child in removal proceedings.

- **Ensure that children are released as soon as possible and that mental health needs do not prolong a child's detention.**

Children are sometimes held in ORR custody simply because they are not deemed sufficiently "mentally stable" for release. This is profoundly counterproductive, as longer stays in detention are associated with deteriorating mental health.⁸⁰ ORR must ensure that a child's family reunification process is never delayed or paused because of a child's mental health or behavioral needs and that any concerns about a child's mental health are weighed against the serious harms of continued detention.

- **Ensure psychotropic medications are not used as a substitute for meaningful mental health services, and not administered without informed consent and other basic protections.**

The administration of psychotropic medication to children should only occur in conjunction with evidence-based psychosocial interventions and collaborative mental health services.⁸¹ Although psychotropic medications may be beneficial for some children, they can have long-term adverse effects, including serious physical side effects.⁸² Therefore, medications should be prescribed only when necessary and for the shortest time possible, with close attention to ensuring informed consent and continuity of care.⁸³

6: Children must have access to quality education and regular recreation.

Some ORR facilities do not provide adequate education and recreation to children in their custody.

Under the *Flores* Settlement, the government must provide every detained child with education services and recreation activities.⁸⁴ Facilities are required to individually assess every child’s educational needs, create an educational plan, and provide educational services appropriate to the child’s developmental level in a structured classroom setting.⁸⁵ Facilities are also required to provide daily outdoor activity and structured recreational activities.⁸⁶

Flores counsel have received multiple reports from class members and attorneys that state-licensed ORR facilities are providing inadequate education and inconsistent recreation.

Examples include:

- Children receiving inappropriate instruction for their literacy levels;
- Instructors mistreating children;
- Children with disabilities not receiving individualized education services;
- Facility staff limiting children’s access to recreation activities for weeks at a time as punishment.

“All of my teachers yell at me all the time and treat me like a dog. It makes me feel terrible. Sometimes I fear that my teacher is going to hit me. . . .

[They] give me a score of zero on assignments that I fail to complete in English . . . The staff don’t offer to help me understand any of the lessons.”

*Child
Residential Treatment Center*

At ORR’s unlicensed influx facilities, education services as well as recreational activities are merely “encouraged . . . to the extent practicable.”⁸⁷ Reports from detained class members and attorneys indicate that the quality of education and recreation at these unlicensed facilities is woefully inadequate.

Examples include:

- Children receiving “a single hour of class time” over the course of a day;⁸⁸
- Children placed in classes with 50-100 other children;
- Instructors leading classes with loudspeakers so that they can be heard;
- Instructors frequently repeating the curriculum, leading many children to complete redundant work;
- Children with disabilities not receiving individualized education services;⁸⁹
- Instructors lacking state accreditation.⁹⁰

“Because there are no roofs on our classrooms, we can hardly hear anything that is said.

All the noise from other classrooms makes it so loud that our ears hurt. I can’t concentrate at all. I feel like I’m not learning anything at all because I can’t hear the teachers when the[y] speak.”

*Child
Influx Facility*

Education is critical for children’s cognitive, behavioral, and emotional development.

Depriving children of an adequate education inflicts academic, psychological, and economic harm and undermines children’s ability to gain the skills needed for adulthood.⁹¹ For young children, the lack of access to an educational environment impedes their cognitive, behavioral, and social-emotional development.⁹² For older youth, the lack of access to appropriate learning environments negatively impacts adolescent brain development.⁹³ Learning environments and experiences shape teens’ abilities to remember key information, perform complex mental tasks, engage in higher order thinking, and regulate their emotions.⁹⁴ Research shows that interrupting children’s education for even a short period of time hinders their long-term academic success.⁹⁵

“[Education] is the very foundation of good citizenship. Today it is a principal instrument in awakening the child to cultural values, in preparing him for later professional training, and in helping him to adjust normally to his environment. In these days, it is doubtful than any child may reasonably be expected to succeed in life if he is denied the opportunity of an education.”

Brown v. Board of Education,
347 U.S. 483, 493 (1954).

Recreation is essential to children’s mental and physical development.

Recreational activities are essential to the healthy cognitive, physical, social, and emotional well-being of children and youth.⁹⁶ The benefits of recreation on childhood brain development are extensive – including improved thinking, mental performance, focus, memory, and attention.⁹⁷ Through play, children learn to regulate their behavior, negotiate social relationships, and build creative problem-solving skills.⁹⁸ A lack of play can lead to behavioral problems when children are deprived of healthy ways to handle external stressors.⁹⁹

Recreational activities also significantly benefit children’s physical health and can help prevent childhood conditions such as depression, asthma, obesity, high blood pressure, atherosclerosis, sleep apnea, and Type 2 diabetes.¹⁰⁰ The importance of recreation to children’s well-being is reflected in state law requirements for child welfare placements¹⁰¹ and international law regarding the rights of children.¹⁰²

Recommendations

- Require facilities to follow state educational standards regarding curriculum and teacher qualifications.
- Require facilities to tailor education services to individual children’s needs, especially if the child has a disability.
- Require a whole student approach that addresses personal, social, emotional, cultural, intellectual, and work skills in addition to academic content.
- Require facilities to meet or exceed the physical activity guidelines of the President’s Council on Sports, Fitness & Nutrition.¹⁰³

7: Children’s rights must be protected through robust independent monitoring and data collection requirements.

Monitoring and data collection are essential to the protection of children in state and federal custody.

Child welfare agencies need consistent and comprehensive data to properly evaluate their services and ensure the well-being of children in their care.¹⁰⁴ Data collection enables child welfare agencies to track a child’s pattern of placements, length of time in custody, and experiences in care.¹⁰⁵

Federal law recognizes the vital importance of data collection for child welfare systems. The Adoption and Safe Families Act of 1997 (“ASFA”) requires HHS to issue an annual report assessing state performance on a number of child welfare outcomes.¹⁰⁶ These include multiple measures relevant to children in immigration detention, including data related to child abuse and neglect in care, the length of time in care, placement stability, and placement of children in group homes or institutions.¹⁰⁷

The Flores Settlement Agreement currently provides a mechanism for both monitoring of conditions and data oversight.

Under the *Flores* Settlement Agreement, *Flores* counsel can interview children detained in federal immigration custody to monitor compliance with the Settlement. Since 1997, *Flores* counsel have routinely visited facilities throughout the country and interviewed detained children. These visits have brought to light critical information regarding violations of children’s rights under the Settlement and have proven essential to the protection of detained children.

Additionally, the Settlement requires the government to provide a monthly report to *Flores* counsel that lists certain information for every minor detained in government custody for more than 72 hours.¹⁰⁸ Although this monitoring and data collection will continue for as long as the Settlement remains in effect, no mechanism exists for these two critical functions to continue permanently.

“It’s really bad at [Secure Detention Facility]. It’s a jail and I sleep in a small, locked cell with a small opening to see the outside of the cell. We are locked up inside a lot. We almost never go outside. We are stuck inside concrete walls all the time. I want to be able to see the sky more.”

*Child
Secure Facility*

Recommendations

- **Establish a permanent, independent, multi-disciplinary oversight committee to monitor facilities where children are detained and review data.**

Congress should establish a permanent oversight mechanism to protect the rights of detained immigrant children. This committee must have unobstructed access to detention facilities in order to confidentially interview children and advocate for individual children. It must also have the ability to independently review data collection and obtain responses (and corrective action, as needed), regarding the accuracy and integrity of the data.

- **Require the accurate collection, analysis, and publication of meaningful data regarding children in federal immigration custody.**

To facilitate legislative and public monitoring, the Department of Health and Human Services (HHS) and Department of Homeland Security (DHS) should be required to develop a systematic data collection system modeled on the ASFA Child Welfare Outcomes Report.

At a minimum, the government should publish the following data each month, broken down by placement level (shelter, transitional foster care, long-term foster care, influx, staff-secure, secure, and therapeutic or residential treatment) and individual facility:

- Total census of children in DHS and HHS custody;
- Average length of custody (total time in detention);
- Average length of stay (time spent at most recent placement);
- Filled percentage capacity at each DHS and HHS placement;
- Filled percentage capacity of total DHS and HHS placements.

Conclusion

A child's health, safety, and welfare are best protected by their family, not the state. This truth is borne out by well-established research as well as decades of experiences of child welfare systems throughout the United States.

For the period of time in which unaccompanied children are in federal immigration custody, our country must do better. We must use the data and research we have to provide for this vulnerable population in a way that, at the very least, does no further harm, and at best, promotes their best interests.

“The children should be home with their parents. The government makes lousy parents.”

*Lynn Johnson
Assistant Secretary, HHS
Admin. for Children & Families
Dec. 18, 2018*

Glossary of Terms

Term	Definition
Department of Homeland Security (“DHS”) ¹⁰⁹	The federal agency that oversees U.S. Customs and Border Protection (“CBP”) and U.S. Immigration and Customs Enforcement (“ICE”), among others.
U.S. Customs & Border Protection (“CBP”) ¹¹⁰	The federal agency within the Department of Homeland Security (“DHS”) that is responsible for enforcement of immigration laws at the borders of the U.S. CBP manages the ports of entry and detention facilities along the border.
U.S. Immigration & Customs Enforcement (“ICE”) ¹¹¹	The federal agency within the Department of Homeland Security (“DHS”) that is responsible for enforcement of immigration laws in the interior of the U.S. (as opposed to enforcement at the borders). ICE manages over 130 detention facilities throughout the U.S.
Department of Health & Human Services (“HHS”) ¹¹²	The federal agency that has custody and must provide care for every unaccompanied child in government detention (through the Office of Refugee Resettlement, “ORR”). HHS does not play a role in the apprehension or initial detention of unaccompanied children prior to their referral to HHS custody and HHS is not a party to the child’s immigration proceedings.
Office of Refugee Resettlement (“ORR”) ¹¹³	<p>ORR is a department within the U.S. Department of Health and Human Services (“HHS”), Administration for Children & Families. ORR is tasked with providing assistance and support to refugees, asylees, and unaccompanied children.</p> <p>If unaccompanied children are apprehended by Department of Homeland Security (“DHS”) immigration officials, they must be transferred to ORR custody. ORR is required to place these children in the least restrictive setting possible while in federal custody.</p> <p>ORR’s network of contracted facilities stretches across the United States and includes different placement levels, such as shelters, residential treatment centers, staff-secure, and secure facilities.</p>
Unaccompanied Alien Child (“UAC”) or Unaccompanied Child (“UC”) ¹¹⁴	A child who (1) has no lawful immigration status in the United States; (2) has not attained 18 years of age; and (3) has no parent or legal guardian in the United States, or no parent or legal guardian in the United States is available to provide care and physical custody.

A-Number (“A#”)	The “alien registration number” or “A-number,” this is the official tracking number that immigration authorities assign to noncitizens in the U.S.
Shelter	Most children in ORR custody live in shelters licensed by the state to care for dependent children. The <i>Flores</i> Settlement requires that DHS and HHS place children in non-secure facilities that are “licensed by an appropriate State agency to provide residential, group, or foster care services for dependent children,” with limited exceptions. ¹¹⁵ Licensed facilities must comply with all applicable state child welfare laws and regulations.
Residential Treatment Center (“RTC”)	A residential treatment center is a licensed 24-hour residential facility, although not licensed as a hospital, whose primary purpose is the provision of mental health treatment.
Secure or Staff-Secure Facility	Secure facilities are state or county juvenile detention centers. Staff-secure facilities place varying levels of restriction on children’s movement.
“Step-Up”	Some children in ORR custody are transferred – or “stepped-up” – to restrictive placements, such as secure facilities, staff-secure facilities, and residential treatment centers. Under the Trafficking Victims Protection Reauthorization Act, children can be placed in a secure facility if they pose a danger to themselves or others or have been charged with a criminal offense. ¹¹⁶ The <i>Flores</i> Settlement Agreement also delineates circumstances in which children can be placed in more restrictive settings. ¹¹⁷
Transitional Foster Care (“TFC”)	Transitional Foster Care (“TFC”), also referred to as “short term foster care,” is an initial community-based placement option for unaccompanied children “under 13 years of age, sibling groups with one sibling under 13 years of age, pregnant/parenting teens, or unaccompanied alien children with special needs.” ¹¹⁸ Children in TFC placements are placed with foster families, but may attend school and receive other services at the ORR TFC care provider facility site.
Long-Term Foster Care (“LTFC”)	Long-Term Foster Care (“LTFC”) is a community-based foster care placement for unaccompanied children who are determined likely to be in ORR custody for an extended period of time. ¹¹⁹ A child is only eligible for LTFC placement if they are 1) expected to be detained for four or more months due to lack of a viable sponsor; 2) potentially eligible for immigration relief; and 3) under the age of 17 years and 6 months at the time of placement. ¹²⁰

<p>Unaccompanied Refugee Minor Program (“URM”)</p>	<p>The Unaccompanied Refugee Minor program (“URM program”) provides licensed care placements to certain eligible unaccompanied children. ORR may refer children to a URM program if they meet the eligibility requirements, which require that the child be: under 18 years old, unaccompanied, and either a refugee, entrant, asylee, victim of trafficking, certain category of Special Immigrant Juvenile Status holder, or U-Visa holder.¹²¹</p>
<p>Removal Proceedings¹²²</p>	<p>The process whereby an immigration judge determines whether an immigrant is removable from the United States and his or her eligibility for relief under the Immigration and Nationality Act (“INA”). If an immigrant is deported, they could be barred from returning to the U.S. for many years.</p>
<p>Congregate Care¹²³</p>	<p>Generally, a placement setting of a group home (a licensed or approved home providing 24-hour care in a small group setting of 7 to 12 children) or an institution (a licensed or approved child care facility operated by a public or private agency and providing 24-hour care and/or treatment typically for 12 or more children who require separation from their own homes or a group living experience). These settings may include child care institutions and residential treatment facilities.</p>

Endnotes

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4. Casey Family Programs, *What impacts placement stability?*, Oct. 3, 2018, <https://www.casey.org/placement-stability-impacts/> (citing Michael Rutter & L. Alan Sroufe, *Developmental psychopathology: Concepts and Challenges*, 12 DEVELOPMENT & PSYCHOPATHOLOGY 265 (2000)).
5. *Id.* (citing David M. Rubin, Amanda O'Reilly, Xianqun Luan & A. Russell Localio, *The impact of placement stability on behavioral well-being for children in foster care*, 119 PEDIATRICS 336 (2007)).
6. *Id.* (citing William Pelech, Dorothy Badry & Gabrielle Daoust, *It takes a team: Improving placement stability among children and youth with Fetal Alcohol Spectrum Disorder in care in Canada*, 35 CHILDREN & YOUTH SERVS. REV. 120 (2013)).
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10. See Kim Barker & Nicholas Kulish, *Inquiry into Migrant Shelters Poses Dilemma: What Happens to the Children?* N.Y. TIMES, Jan. 5, 2019, <https://www.nytimes.com/2019/01/05/us/southwest-key-migrant-shelters.html>.
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12. *Flores Settlement* ¶ 19.
13. *Flores v. Lynch*, 212 F. Supp. 3d 907, 914 (C.D. Cal. 2015), *aff'd in part, rev'd in part and remanded*, 828 F.3d 898 (9th Cir. 2016). Note that this case was decided in the context of children in family detention facilities, not children in influx facilities.
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27. *Id.*; see also Office of Refugee Resettlement, U.S. Dep’t of Health & Human Servs., *Children Entering the United States: Placement in ORR Care Provider Facilities*, Sec. 1.2.6, <https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-1> (A child is only eligible for LTFC placement if they are 1) expected to be detained for four or more months due to lack of a viable sponsor; 2) potentially eligible for immigration relief; and 3) under the age of 17 years and 6 months at the time of placement).
28. ORR Guide to Terms, *supra* note 26.
29. See Kay E. Brown, *Unaccompanied Children: HHS Can Improve Monitoring of Their Care, Testimony Before the S. Comm. on the Judiciary*, 114th Cong., Feb. 23, 2016, <https://www.judiciary.senate.gov/imo/media/doc/02-23-16%20Brown%20Testimony.pdf>.
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31. *Id.*
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