

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**THE OFFICE OF REFUGEE  
RESETTLEMENT NEEDS TO  
IMPROVE ITS OVERSIGHT  
RELATED TO THE PLACEMENT  
AND TRANSFER OF  
UNACCOMPANIED CHILDREN**

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Christi A. Grimm  
Inspector General

May 2023  
A-06-20-07002

# *Office of Inspector General*

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## Report in Brief

Date: May 2023

Report No. A-06-20-07002

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
**OFFICE OF INSPECTOR GENERAL**



### Why OIG Did This Audit

The Office of Refugee Resettlement (ORR), a program office of the Administration for Children and Families (ACF) within HHS, manages the Unaccompanied Children (UC) Program, which serves children with no lawful immigration status in the United States. This report builds on OIG's previous oversight of ORR's efforts to protect children.

Our objective was to determine whether ORR followed its policies, procedures, and guidance both when making initial placements of unaccompanied children in care provider facilities and when transferring children between those facilities. As part of this audit, we determined whether ORR conducted adequate oversight of transfers of unaccompanied children.

### How OIG Did This Audit

ORR officials provided us with data on 55,359 initial placements and 3,757 transfers that occurred during our audit period of January 1 through September 30, 2019. From these initial placements and transfers, we selected and reviewed the documentation for a statistical sample of 70 initial placements and 50 transfers. We also reviewed judgmental samples of (1) 9 placements and transfers for facility types not included in our statistical sample, (2) 30 transfers that occurred 0 to 7 days after placement, and (3) 11 children with multiple transfer denials.

## The Office of Refugee Resettlement Needs To Improve Its Oversight Related to the Placement and Transfer of Unaccompanied Children

### What OIG Found

We found that ORR faced challenges when making initial placements during an influx period. ORR did not consistently make initial placements within 24 hours during influx periods because of capacity issues and lack of intake specialist staff. Additionally, ORR did not adequately document placement decisions or placement designations for children with special concerns or needs. Furthermore, we determined that: (1) for the statistical sample of transfers, some were missing supporting documentation; (2) for the judgmental sample of transfers of children into restrictive placements, some of the required documentation was not completed or missing; (3) ORR did not maintain documentation for the reason(s) each child was denied a transfer; and (4) ORR faced challenges transferring children with both behavioral and mental health needs. These errors occurred because ORR had limited quality control procedures, lacked oversight to ensure documentation was retained by care providers, and did not have a process in place to track denied transfers.

### What OIG Recommends and Administration for Children and Families Comments

We recommend that ORR: (1) strengthen oversight of initial placements by addressing challenges with bed space capacity and intake specialist staffing during influx periods to ensure that a placement is made within 24 hours of each referral and Intakes Placement Checklists are completed for children with special needs or concerns, (2) strengthen oversight of transfers between ORR care provider facilities by requiring that all transfer documentation be maintained in the UC Portal and by developing procedures for tracking and reviewing that documentation, (3) review restrictive setting placement denials and take action as needed to ensure an appropriate placement for each child, and (4) assess the need to expand its network capacity to serve the needs of children with mental health and behavioral issues.

In written comments on our draft report and commenting on behalf of ORR, ACF concurred with our recommendations and described actions taken to address our findings. ACF stated that ORR is building upon its network of standard beds among ORR care providers and adding bed capacity options for periods of influx. ORR also hired more intake specialists. ORR has developed phased improvements to strengthen oversight of transfer documentation, including clarification of timelines for completing transfer documents in the UC Portal, publishing substantive changes to its transfer policy and procedures, and digitizing documentation to be maintained in the UC Portal. Additionally, ORR created a workgroup to conduct a weekly review of restrictive setting placement denials and to flag specific in-network providers that continually deny placements for corrective action. Finally, ACF stated that ORR has significantly improved its capacity for serving the needs of children with mental and behavioral health issues by engaging with several out-of-network therapeutic facilities and expanding its in-network facilities.

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## INTRODUCTION

### WHY WE DID THIS AUDIT

The Office of Refugee Resettlement (ORR), a program office of the Administration for Children and Families (ACF) within the Department of Health and Human Services (HHS), manages the Unaccompanied Children Program (UC Program). The UC Program serves children who have no lawful immigration status in the United States and who have no parent or legal guardian in this country, or none available, to assume custody and care for them.<sup>1</sup> ORR is responsible for the safe placement of children in a timely manner and in the least restrictive setting that is in the best interests of the child. To address the needs of the children they serve, ORR provides funds through cooperative agreements or contracts with care providers that house and care for the children.

This report builds on the HHS Office of Inspector General's (OIG's) previous oversight of ORR's efforts to protect children and focuses on the initial placement of unaccompanied children at an ORR care provider facility and any subsequent transfers of children between care provider facilities.

This report does not address the placement and transfer process that takes place at emergency intake sites (EISs).<sup>2</sup> OIG has completed or is conducting reviews that address certain aspects of care and service provision at EISs.<sup>3</sup>

### OBJECTIVE

Our objective was to determine whether ORR followed its policies, procedures, and guidance both when making initial placements of unaccompanied children in care provider facilities and when transferring children between those facilities. As part of this audit, we determined whether ORR conducted adequate oversight of the transfers of unaccompanied children.

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<sup>1</sup> 6 U.S.C. § 279(g)(2).

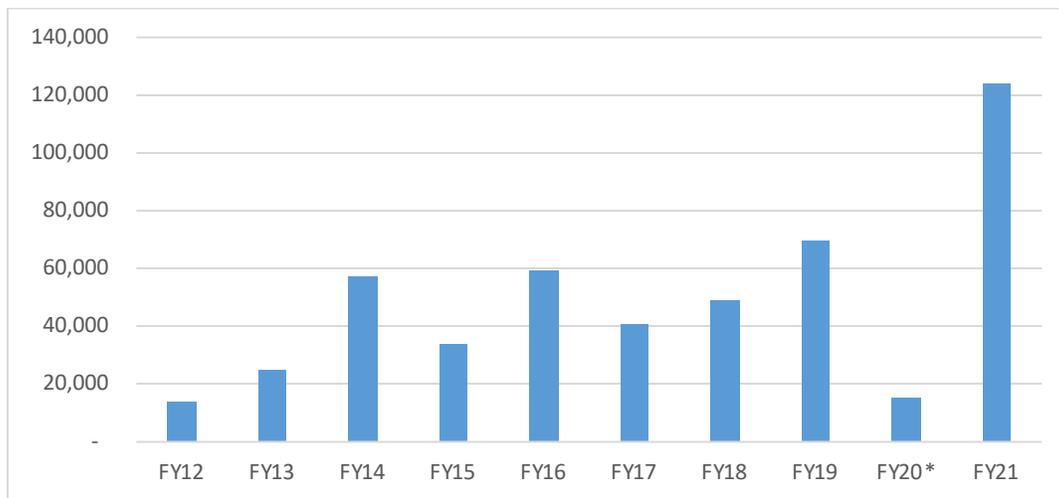
<sup>2</sup> In response to the spring 2021 influx of unaccompanied children, ORR established EISs, which were a new type of provider facility designed to meet immediate sheltering needs for mass care with basic standards when there is a severe shortage of licensed facilities and influx care facilities (ICFs). Our audit period, from January through September 2019, preceded the establishment of EISs.

<sup>3</sup> We have one, ongoing review: OEI-07-21-00250, available at [Safe and Efficient Release of Unaccompanied Children to Sponsors \(hhs.gov\)](#). We have three, completed reports: *Office of Refugee Resettlement's Influx Care Facility and Emergency Intake Sites Did Not Adequately Safeguard Unaccompanied Children From COVID-19*, A-06-21-07002, June 2022, available at <https://oig.hhs.gov/oas/reports/region6/62107002.pdf>; *Operational Challenges Within ORR and the ORR Emergency Intake Site at Fort Bliss Hindered Case Management for Children*, OEI-07-21-00251, September 2022, available at <https://oig.hhs.gov/oei/reports/OEI-07-21-00251.asp>; and *The Office of Refugee Resettlement Needs To Improve Its Practices for Background Checks During Influxes*, A-06-21-07003, May 2023, available at <https://oig.hhs.gov/oas/reports/region6/62107003.pdf>.

## BACKGROUND

Before Federal fiscal year (FY) 2012, between 7,000 and 8,000 children were served annually in the UC Program. In FY 2012, the Department of Homeland Security (DHS) referred 13,625 unaccompanied children to HHS. The number of children referred to HHS continued to increase (reaching 69,488 in FY 2019) until FY 2020, when the number of referrals fell to 15,381 because of a U.S. public health order responding to the COVID-19 pandemic—implemented in March 2020—to suspend entry of certain noncitizens at or near the U.S. borders, resulting in the expulsions of most unaccompanied children upon attempting to enter the United States. Following a court injunction and a change in policy, the number of children referred to HHS in FY 2021 surged to 124,047. (See exhibit.)

**Exhibit: Unaccompanied Children Referred to HHS**



\* Referrals in FY 2020 were the lowest since FY 2012 because of the implementation of the COVID-19 public health order that limited entry at U.S. borders.<sup>4</sup>

### Office of Refugee Resettlement Care Provider Network

Federal law requires safe and timely placements of children in the least restrictive setting that is in each child's best interest.<sup>5</sup> To address the needs of children, ORR provides funds through cooperative agreements or contracts to several types of facilities in its care provider network, including shelters, foster care or group homes, staff secure or secure care facilities, and

<sup>4</sup> Referrals in FYs 2020 and 2021 are outside of our audit period but were included to provide relevant context.

<sup>5</sup> 8 U.S.C. § 1232(c)(2).

residential treatment centers (RTCs).<sup>6, 7</sup> In FY 2019, ORR provided funding to approximately 174 facilities and programs in 22 States. Most are licensed or accredited under the laws of their respective States. Because of the large fluctuations in the numbers of children arriving throughout the year, ORR maintains a mix of standard beds, which are available year-round at licensed care facilities, and temporary beds, including those at influx care facilities (ICFs) that can be added or removed as needed. This bed management strategy allows ORR to accommodate changing flows in unaccompanied children referrals. A child typically remains in ORR's care until an appropriate sponsor who can assume custody is located in the United States.

ORR is responsible for coordinating the care and placement of unaccompanied children who are in Federal custody and ensuring the interests of the children are considered when making decisions and taking actions related to the care of the child, including making and implementing placement decisions.<sup>8</sup> ORR makes two types of placement decisions: initial placements into a care provider facility or other setting, and transfer placements between care providers.<sup>9</sup> ORR makes initial placements and transfers of children within its network of care provider facilities as per *The ORR Guide to Children Entering the United States Unaccompanied*, January 2015 (ORR Guide) and internal guidance from *The UAC Manual of Procedures*, August 2017 (UMAP).<sup>10, 11</sup>

ORR policies for placing children in its custody into care provider facilities are based on legal requirements as well as child welfare best practices to provide a safe environment and place each child in the least restrictive setting appropriate for the child's needs.<sup>12</sup> ORR care providers must make every effort to place and keep children in the least restrictive settings that meet

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<sup>6</sup> A staff secure facility maintains stricter security measures, such as higher staff-to-child ratios for supervision. A secure care facility has a physical security structure and is the most restrictive placement option for children. See Appendix F for care provider facilities' level of care.

<sup>7</sup> An RTC is a subacute, time-limited, interdisciplinary, psycho-educational, therapeutic, and 24-hour-a-day structured program with community linkages provided through noncoercive, coordinated, and individualized care as well as specialized services and interventions. RTCs provide highly customized care and services to individuals following either a community-based placement or more intensive intervention, with the aim of moving individuals toward a stable, less intensive level of care or independence (ORR Guide, Guide to Terms, March 26, 2016).

<sup>8</sup> 6 U.S.C. § 279.

<sup>9</sup> ORR Guide § 1.1, January 27, 2015.

<sup>10</sup> The ORR Guide was issued in January 2015 and revisions to specific sections are made periodically. We applied the relevant section applicable during our audit period.

<sup>11</sup> UMAP was issued in August 2017, and revisions to specific sections were made in October 2018 (Version 2). We applied the relevant procedure applicable during our audit period.

<sup>12</sup> ORR Guide § 1.1, January 27, 2015.

their needs. For children who are initially placed in a least restrictive setting, care providers must provide support services and interventions when appropriate to help keep the children in the setting.<sup>13</sup> If a child is placed in a restrictive setting,<sup>14</sup> care providers provide services to facilitate the child's successful transfer to a less restrictive setting when the child is ready.<sup>15</sup> The care provider staff, in collaboration with ORR staff, review a placement of a child in a restrictive setting at least every 30 days to determine whether a new level of care is more appropriate.<sup>16</sup>

ORR care providers must maintain comprehensive, accurate, and up-to-date case files as well as electronic records on children. Electronic records include those on the care provider's network drives and those on the Unaccompanied Children Portal (UC Portal). According to ORR, the UC Portal is a secure, web-based system that allows personnel from ACF and care providers to enter and retrieve information about children. The UC Portal is the system of record for referrals and initial placements of all unaccompanied children. Additionally, the UC Portal includes documentation of any completed transfers of unaccompanied children between care provider facilities. The UC Portal system tracks a child's time in ORR custody from the time of initial placement through discharge.

### **Initial Placement at an ORR Care Provider Network**

Children are in ORR custody because they are present in the United States without lawful immigration status and do not have a parent or legal guardian in the United States available to assume care and physical custody. Most of the children in ORR care were apprehended while crossing the U.S. border. The referring agency refers each child to ORR's care, and referrals may be made to ORR 24 hours a day, 7 days a week. Most referrals come to ORR by an automated data link from DHS into the UC Portal. Agents of other apprehending agencies may also refer unaccompanied children to ORR by email or a call to the ORR Intakes Hotline. Children referred to ORR custody are in a pending status and remain in the custody of the referring agency until the ORR Intakes Team makes a placement designation for the child.<sup>17</sup>

The ORR Intakes Team has procedures in place for obtaining additional background information from a referring agency, including a child's age, gender, sibling group(s), known medical or mental health issues, and whether special concerns or needs are known. ORR uses this information to determine an appropriate placement at an available care provider facility based

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<sup>13</sup> ORR Guide § 1.4.1., January 27, 2015.

<sup>14</sup> Appendix F describes types of care provider facilities.

<sup>15</sup> ORR Guide § 1.4.1, January 27, 2015.

<sup>16</sup> ORR Guide § 1.4.2, October 10, 2018.

<sup>17</sup> Children must be transferred to ORR within 72 hours barring exceptional circumstances (8 U.S.C. § 1232(b)(3)).

on available bed space.<sup>18</sup> ORR attempts to identify and designate a placement of an unaccompanied child within 24 hours of an initial referral, whenever possible.<sup>19</sup>

Prior to an initial placement designation, the ORR Intakes Team contacts the care provider to confirm bed space availability, and the facility must accept the placement unless the child does not meet established facility-specific criteria.<sup>20</sup>

For children with special concerns or needs or who may pose a danger to themselves or others, the ORR Intakes Team along with the Federal Field Specialist (FFS) designate the child for special placement. The ORR Intakes Team completes an Intakes Placement Checklist if an unaccompanied child:

- has a juvenile or adult criminal history, including involvement in human trafficking or smuggling;
- has had prior acts of violence or threats while in Government custody;
- has gang or cartel involvement, or both;
- has had a prior escape(s) or attempted escape(s) from Government custody;
- has mental health concerns; or
- has a history of or displayed sexually predatory behavior.<sup>21</sup>

On the basis of the information collected for the Intakes Placement Checklist, an ORR Intakes Team member recommends a level of care for the child. The ORR Intakes Team reviews the Intakes Placement Checklist with the FFS, the FFS makes the final decision on the level of care, and the ORR Intakes Team designates the child's placement based on that level of care.<sup>22</sup>

For placing an unaccompanied child who has medical or mental health issues, the ORR Intakes Team consults with the FFS, the ORR Medical Services Team, or an ORR Supervisor about the

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<sup>18</sup> ORR Guide § 1.3.1, January 27, 2015.

<sup>19</sup> To designate a placement, ORR identifies an appropriate facility, confirms the facility has available bed space, and then assigns the child to be placed at that facility (ORR Guide § 1.3.2, October 10, 2018).

<sup>20</sup> UMAP, 2018 (Version 2), § 1.3.3. The ORR Guide § 1.3.3 (January 27, 2015) provides more specific information related to reasons that facilities may deny an ORR placement request.

<sup>21</sup> ORR Guide § 1.3.2, October 10, 2018.

<sup>22</sup> Ibid.

placement. A child with serious mental health issues may be placed into an RTC only if the child is determined by a licensed psychologist or psychiatrist to be a danger to self or others.<sup>23</sup>

After the care provider accepts a placement, ORR requests that the referring agency contact the care provider to establish points of contact for communication and work out logistics for transporting the child to the care provider facility. The referring agency generally transports the child to the care provider facility, and ORR takes custody of the child upon admittance at the care provider facility.<sup>24</sup> A child admitted into a more restrictive setting is informed of the reason for the placement. The child is asked at admittance to read and sign a Notice of Placement in Restrictive Setting. The document is printed in English and Spanish or translated if the child's preferred language is other than English or Spanish. If the child refuses to sign, the care provider annotates the document, noting that the child refused to sign.<sup>25</sup>

Periodically, ORR may experience influx periods during which the number of children apprehended while coming into the United States exceeds ORR's standard capabilities to process and provide shelter for the children in a timely manner. During those influx periods, ORR arranges for opening ICFs to meet the need. ICFs provide temporary emergency shelter and services for unaccompanied children. ICFs may not be licensed or may be exempted from State and local licensing agencies, or both.<sup>26</sup> A child designated for an ICF must meet criteria such as: (1) be between 13 and 17 years old, (2) not belong to a sibling group with one or more sibling(s) 12 years old or younger, (3) be medically cleared and vaccinated, (4) not turn 18 within 30 days of transfer to an ICF, and (5) not have a set docket date in an immigration or State or family court.<sup>27</sup> Figure 1 on the following page illustrates the steps ORR takes in the initial placement process.

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<sup>23</sup> ORR Guide § 1.3.2, October 10, 2018.

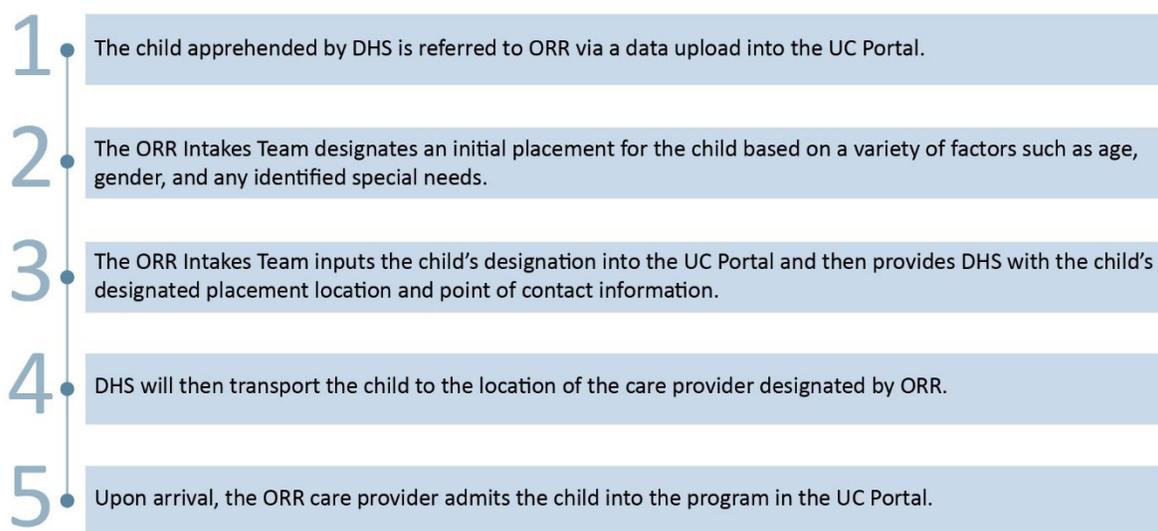
<sup>24</sup> ORR Guide § 1.1, January 27, 2015.

<sup>25</sup> UMAP, 2018 (Version 2), § 1.2.4.

<sup>26</sup> ORR Guide § 1.7, March 21, 2016, Repealed. ORR Guide § 7.1, September 18, 2019.

<sup>27</sup> ORR Guide § 1.7.2, March 21, 2016, Repealed. ORR Guide § 7.2.1, September 18, 2019.

**Figure 1: DHS Referral and ORR Initial Placement of an Unaccompanied Child\***



\* The DHS referral and ORR initial placement activities depicted in this figure describe the general initial placement process from January 1 through September 30, 2019, which is our audit period. These general steps continue to reflect the current process for initial placement. We understand that some initial placements may not follow the process depicted.

### **Transfers Within the ORR Care Provider Network**

While children are in ORR custody, case managers continually assess each child to determine whether a current placement is appropriate or needs to be changed. Case managers consider: information from the referring agency; child assessment tools; interviews; the location of a child's sponsor or family in the United States; records from local, State, and Federal agencies; and information from stakeholders,<sup>28</sup> including a child's legal service provider, attorney of record, or child advocate, as applicable. Should a case manager determine that an alternative placement would better meet a child's needs, the case manager must initiate a transfer request either within 3 business days of identifying the need for a routine transfer or immediately in urgent situations.<sup>29</sup> Also, within 3 business days of identifying the need for a transfer, the sending case manager needs to ensure that the child is cleared for transfer by requesting that the sending facility medical coordinator or other medical staff complete the Medical Checklist for Transfers (medical checklist). The sending case manager will generate a Transfer Request in the UC Portal (Transfer Request form) and compile the transfer request file, which is sent to all

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<sup>28</sup> Stakeholders include the Receiving Case Manager; Sending/Receiving Immigration and Customs Enforcement Field Office Juvenile Coordinator; U.S. Immigration and Customs Enforcement Office of Chief Counsel; Executive Office for Immigration Review Court Administrator; U.S. Legal Service Provider or Attorney of Record; Sending/Receiving Case Coordinator; Sending/Receiving FFS; and Child Advocate, if applicable (UMAP, 2018 (Version 2), § 1.4).

<sup>29</sup> ORR Guide § 1.4, April 22, 2016.

parties involved in the transfer process.<sup>30</sup> The receiving care provider must accept the transfer request within 1 business day and notify case coordinators and the FFS of the decision. The FFS completes the ORR decision section of the Transfer Request form within 24 hours and notifies the case coordinator that the final release decision was completed in the UC Portal.<sup>31</sup>

Additionally, ORR care providers may conduct a group transfer of children due to a bed capacity change at a facility, a change in program requirements that would eliminate a care provider from the list of approved facilities, an emergency event, or a natural disaster.<sup>32</sup>

In some cases, a child in ORR care will be stepped up to a more restrictive level of care or stepped down to a less restrictive level of care.<sup>33</sup> A step-up transfer may occur when the case manager, case coordinator, and FFS determine that the child's behavior, criminal history, or self-disclosures require that a child be placed in a more restrictive environment. For a child placed in a restrictive setting, the care provider staff—in collaboration with the case coordinator and the FFS—are required to review the placement at least every 30 days to determine whether a new level of care is more appropriate.<sup>34</sup>

A step-down transfer may occur when the care provider and ORR determine that a child no longer poses a danger to self or others or no longer presents an escape risk. In making a step-down decision, ORR considers criteria identified in making a secure placement and considers any mitigating factors based on an assessment of the child's current functioning and behavior, previous conduct, self-disclosures, and criminal or delinquency history. The care provider documents the underlying assessment used to make this determination in the child's case file. If the care provider and FFS determine that a new level of care is appropriate, the care provider uses the transfer process to transfer the child to another care provider.<sup>35</sup>

As part of the transfer process, a care provider facility may deny ORR's request for a placement only due to a lack of available bed space, because the child's placement would conflict with the care provider's State or local licensing rules, or because placement of a child with a significant physical or mental illness for which the referring Federal agency does not provide a medical

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<sup>30</sup> The transfer request file contains all supporting documents related to the transfer (e.g., assessments, case manager notes, clinical notes, health records, educational records, and any other significant documentation).

<sup>31</sup> UMAP, 2018 (Version 2), § 1.4.

<sup>32</sup> ORR Guide § 1.4.5, April 22, 2016.

<sup>33</sup> In addition to step-up and step-down transfers, ORR transfers children between facilities that have the same level of care. These transfers are sometimes made due to program closures, emergencies, or natural disasters. OIG characterizes ORR transfers between facilities that have the same level of care as lateral transfers.

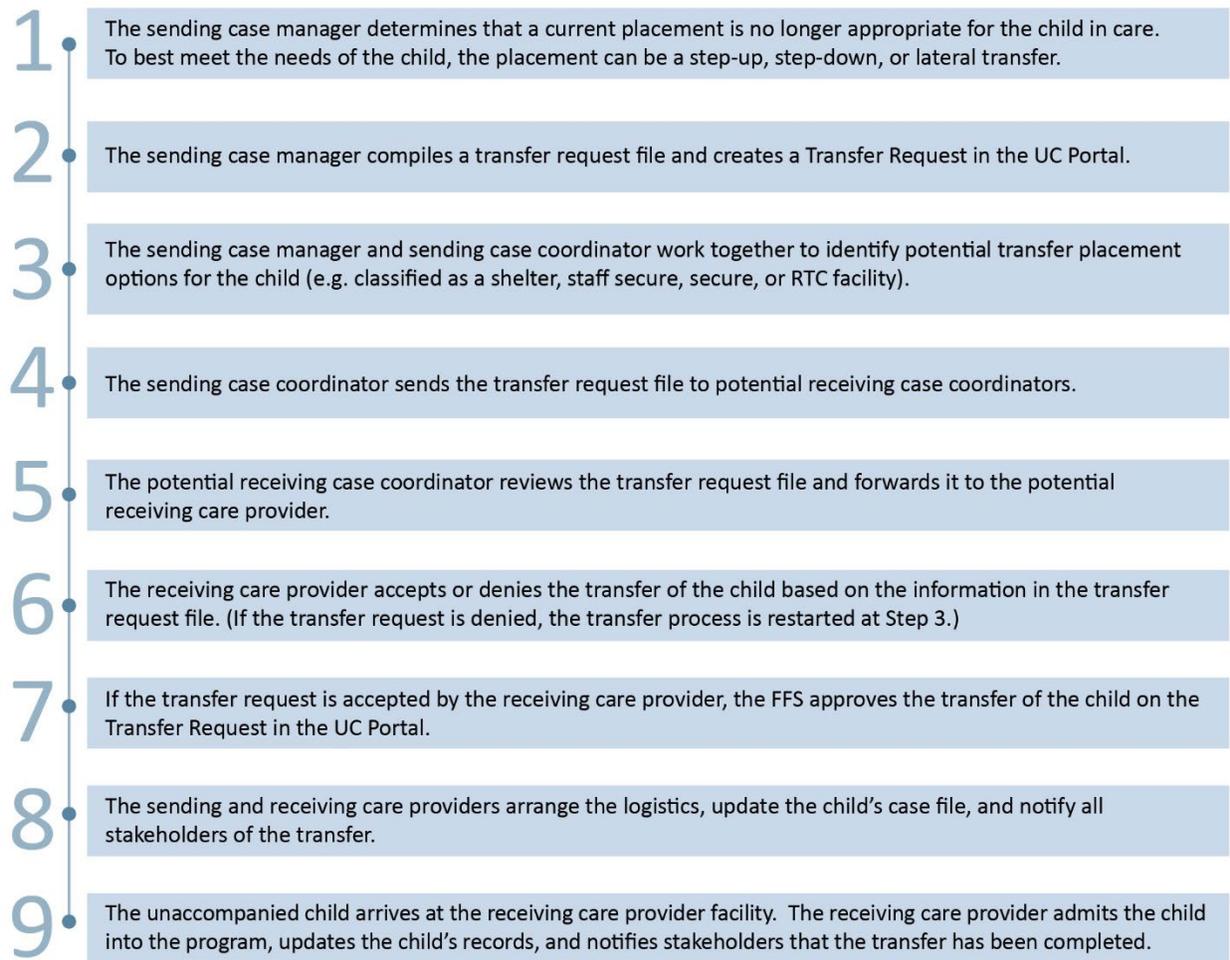
<sup>34</sup> ORR Guide § 1.4.2, October 10, 2018.

<sup>35</sup> Ibid.

clearance, or medications, or both, would conflict with the care provider’s State or local licensing requirements. If the provider denies the placement for any of these reasons, the receiving care provider will send an email to the sending case coordinator explaining the reason for the transfer denial, and the sending case coordinator will refer the child to an alternative care provider for a transfer. ORR may follow up with the care provider about a placement denial, if needed, “to find a solution to the reason for the denial.”<sup>36</sup>

Figure 2 illustrates the steps taken to transfer children within the ORR care provider network.

**Figure 2: Transfers Within the ORR Care Provider Network\***



\* The transfer within the ORR care provider network depicted in this figure describes the general, unaccompanied child transfer placement process used from January 1 through September 30, 2019, which is our audit period. These general steps continue to reflect the current process for transfers. We understand that some transfers may not follow the process depicted.

<sup>36</sup> ORR Guide § 1.3.3, January 17, 2015.

## HOW WE CONDUCTED THIS AUDIT

Our audit covered the initial placement designations and transfers between care provider facilities from January 1 through September 30, 2019. ORR officials provided us with 59,116 lines of initial placement and transfer data, 55,359 lines of initial placement data,<sup>37</sup> and 3,757 lines of transfer data.<sup>38</sup>

To determine whether ORR followed its policies, procedures, and guidance when making initial placements of unaccompanied children in care provider facilities funded by ORR and when transferring children between those facilities, we: (1) selected a statistical sample of 70 initial placements and 50 transfers that occurred during our audit period to estimate the numbers and percentages of any placements and transfers during the audit period that did not follow ORR policies and procedures,<sup>39</sup> (2) selected a judgmental sample of 6 initial placements and 3 child transfers into restrictive settings to examine initial placements and transfers into care provider facility types that were not selected in the statistical sample, (3) selected a judgmental sample of 30 transfers that occurred from 0 to 7 days after placement to determine the reason for each transfer, and (4) selected a judgmental sample of 11 children with multiple transfer denials during our audit period to determine the reason(s) for the denials. We verified that the judgmental sample items were distinct from the statistical sample items selected. We reviewed the supporting documentation and case files for each sample item to determine whether ORR and its care providers followed ORR's policies and procedures when making placement and transfer decisions.

We held discussions with ORR officials to gain an understanding of ORR requirements for initial placements, transfers, special placements, and denials. For the unaccompanied children selected as part of the stratified random samples and judgmental samples, we reviewed the ORR case files and determined the extent to which ORR complied with Federal requirements and its internal guidance.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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<sup>37</sup> Each line of initial placement data is for a placement for an unaccompanied child that occurred during our audit period. During our audit period, 55,335 children were initially placed in ORR custody.

<sup>38</sup> Each line of transfer data is for a unique transfer that occurred during our audit period. An unaccompanied child may be transferred more than once. During our audit period, 3,354 children were transferred between care provider facilities.

<sup>39</sup> The statistical sample of 50 transfers consisted of 46 lateral transfers, 3 step-up transfers, and 1 step-down transfer.

Appendix A contains the details of our audit scope and methodology, Appendix B contains ORR requirements, Appendix C contains the statistical sampling methodology, Appendix D contains the sample results and estimates, Appendix E contains descriptions of ORR and care provider positions involved in the care and placement of children, Appendix F contains descriptions of ORR care provider facilities, and Appendix G includes extended narratives of children in the sample of denied transfers.

## FINDINGS

ORR faced challenges when making initial placements during an influx period. Specifically, ORR did not consistently make initial placements within 24 hours during an influx period because of capacity issues and intake specialist staffing.<sup>40</sup> Additionally, ORR did not adequately document placement decisions or placement designations for children with special concerns or needs.

In addition, ORR did not ensure that ORR staff and care provider facility staff followed ORR policies and procedures when transferring children between care provider facilities. Specifically, we determined that:

- for the statistical sample of transfers, some were missing evidence to support:
  - the case manager determination that a transfer was necessary,
  - that the medical checklist had been completed,
  - an assurance that the receiving facility had accepted the transfer, or
  - that the attorney of record had been notified of the transfer when required;
- for the judgmental sample of child transfers into restrictive placements, some were missing evidence to support that:
  - the medical checklist had been completed or
  - the attorney of record had been notified of the transfer when required;
- ORR did not maintain documentation for the reason(s) each child was denied a transfer; and

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<sup>40</sup> ORR attempts to identify and designate placement for a child within 24 hours whenever possible (ORR Guide § 1.3.2, October 10, 2018). During an influx, ORR may not always be able to designate placement within 24 hours (ORR Guide § 1.3.5, May 5, 2016). Therefore, we are not considering placements over 24 hours during an influx as errors.

- ORR faced challenges transferring children with both behavioral and mental health needs.

These errors occurred because ORR staff and care provider facility staff did not document information critical to the transfer of unaccompanied children. Specifically, ORR had limited quality control procedures to ensure that documentation external to the UC Portal was uploaded, lacked oversight to ensure that care providers retained documentation such as medical checklists and email communication pertaining to the transfers, and did not have a process in place to track denied transfers.

On the basis of the results of our statistical sample, we estimated that ORR would be unable to provide supporting documentation for 3,607 of 3,757 transfers (96 percent) that occurred during our audit period. (See Appendix D.) Without adequate documentation in the UC Portal, OIG could not be assured that ORR staff and care provider facility staff followed its policies and procedures pertaining to transfers.

Failure to collect the required information may impact ORR's ability to determine whether it has enough care providers—specifically RTCs and staff secure care providers—at the appropriate level of care to handle children with both mental health and behavioral issues. Also, without adequate documentation in the children's records and UC Portal, ORR is unable to determine why facilities are denying transfers when bed space is available or have assurance that children are placed in the least restrictive setting most appropriate for individual needs. Additionally, ORR's lack of oversight may impact operational decision making regarding bed capacity in ORR's network, related funding, and accurate reporting to ACF management and stakeholders. Determining why a transfer to a restrictive placement was denied would also be beneficial to ORR in additional efforts, such as determining whether additional funding opportunities are needed to support care providers that operate restrictive placements.

#### **ORR FACED CHALLENGES WHEN MAKING INITIAL PLACEMENTS DURING AN INFLUX PERIOD**

When making an initial placement decision, the ORR Intakes Team identifies appropriate and available bed space at a care provider facility or other care provider that is not within the ORR care provider network and contacts the care provider to confirm availability. ORR attempts to identify and designate a placement for an unaccompanied child within 24 hours of the initial referral, whenever possible.<sup>41</sup>

When a child may present a danger to self or others, the ORR Intakes Team is required to complete an Intakes Placement Checklist that includes all available information on the child's

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<sup>41</sup> ORR Guide § 1.3.2, October 10, 2018. ORR acknowledges that emergencies or influxes may prevent the prompt (within 24 hours) initial placement of children in care provider facilities (ORR Guide § 1.3.5).

history and conditions.<sup>42</sup> The ORR Intakes Team and the FFS use this information to designate the child’s initial placement.

From the statistical sample of 70 initial placements we reviewed, we found that ORR made appropriate initial placement designations. However, 52 of the 70 initial placements occurred during an influx period; for 37 of those 52 initial placements, ORR took more than 24 hours to make a placement designation after the referral was received.<sup>43, 44</sup> Table 1 shows the timeliness of initial placement designations during and outside an influx.

**Table 1: Timeliness of Initial Placement Designation**

	<b>Designation Made Within 24 Hours</b>	<b>Medical Delay*</b>	<b>Designation Made After 24 Hours</b>	<b>Initial Placement Designations Made</b>
During Influx Period	11	4	37	52
Outside Influx Period	17	1	0	18
<b>Total</b>	<b>28</b>	<b>5</b>	<b>37</b>	<b>70</b>

\* A medical delay occurs when a child becomes ill and is unable to travel.

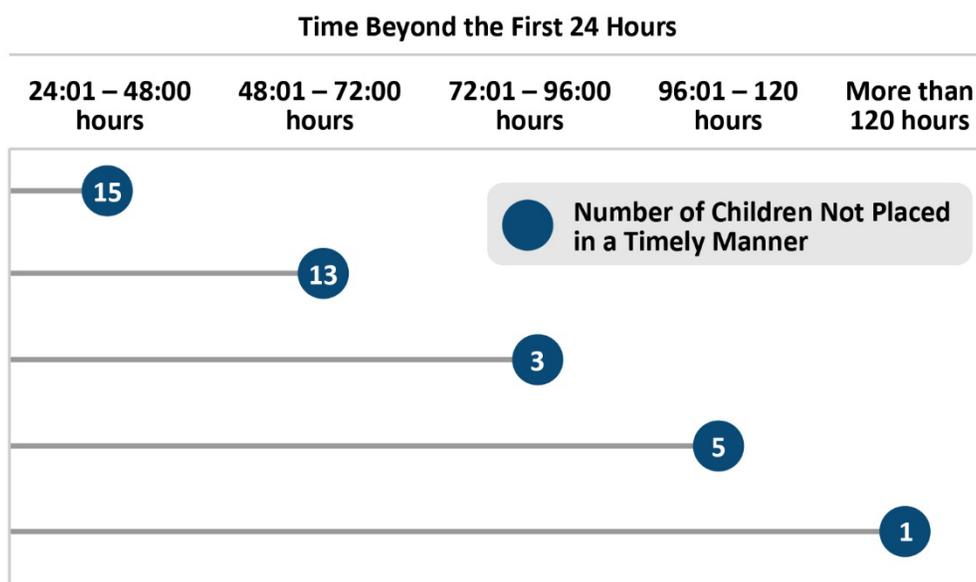
The 37 initial placements that took more than 24 hours each spanned anywhere between 27 and 182 hours. (See Figure 3 on the following page.) The child who remained in DHS care for 182 hours, or 7.5 days, was 11 years old.

<sup>42</sup> ORR Guide § 1.3.2, October 10, 2018.

<sup>43</sup> Historically, ORR has experienced periods when DHS referred a significantly greater number of children than at other times of the year. ORR Guide § 1.3.5, May 5, 2016.

<sup>44</sup> ORR attempts to identify and designate placement for a child within 24 hours whenever possible (ORR Guide § 1.3.2, October 10, 2018). During times of influx, ORR may not always be able to designate placement within 24 hours (ORR Guide § 1.3.5, May 5, 2016). Therefore, we are not considering placements after 24 hours as errors.

**Figure 3: Initial Placements After 24 Hours**



For the child who remained in DHS custody for 182 hours, DHS informed ORR via email that the child’s birth date on the referral was incorrect. On the basis of the revised birth date, the child did not meet the licensing requirements for the initial placement shelter designated by the ORR Intakes Team. Therefore, DHS asked for the child to be redesignated.<sup>45</sup> According to documentation provided, 4 days later DHS requested an update regarding the child’s placement. At that time, ORR indicated that the child would be redesignated. ORR was unable to provide a reason for the delay in redesignating the child. However, an ORR official indicated that the delay may have been due to limited bed capacity.

For the six judgmentally selected initial placements for children with special needs or concerns who were placed into restrictive settings, we found two initial placements were completed as per ORR procedures. For one of the six initial placements into a restrictive setting, ORR was unable to provide the Intakes Placement Checklist. For the three remaining initial placements into restrictive settings, we found that ORR did not fully complete an Intakes Placement Checklist, which led to eight instances of missing information, as shown in Table 2 on the following page.

<sup>45</sup> When a child is unable to be placed for any reason at the care provider facility that ORR originally designated, a second placement designation is made that is referred to as a “redesignation.”

**Table 2: Intakes Placement Checklist Instances of Missing Information**

Documentation	Instances of Missing Information			Total Instances of Missing Information
	Sample #1	Sample #2	Sample #3	
FFS Placement Decision		1	1	2
Final Placement Determination		1	1	2
Designated Placement		1	1	2
Explanation of FFS Override of the Intakes Team’s Recommendation	1	1		2
<b>Total</b>	<b>1</b>	<b>4</b>	<b>3</b>	<b>8</b>

ORR says it faces challenges when placing unaccompanied children during influx periods because the numbers of daily referrals for placement vary greatly between normal operations and during an influx (ranging from approximately 100 to 400 children). An ORR official stated that capacity is the greatest challenge to placing unaccompanied children within 24 hours. Capacity issues occur when the number of unaccompanied children entering the United States is high and care provider facilities have limited bed space. When making a placement designation or recommendation, ORR’s primary considerations for placement are age and gender; additional considerations are whether children have siblings or family units. States generally license care provider facilities to provide residential care to a specific number of unaccompanied children according to age and gender, which affects where each child may be placed.

Additionally, during our audit period ORR-contracted intake specialist positions were not always fully staffed. During 2019, ORR funded 13 intake staff positions from February through May and 15 positions in June and July. However, from February through July only 10 or 11 contracted staff positions were filled. ORR explained that this was due to staff leaving and onboarding during the month. Additionally, ORR noted that the background check clearance process and onboarding can take from 2 to 4 months.

ORR officials also stated that the ORR contractor authorized staff to work overtime during the influx, enlisted assistance from former intake specialists and field staff, and added an additional intake specialist during placement shifts to handle special placements and expedite regular placements.

For those children with special needs or concerns placed in restrictive settings, the Intakes Placement Checklist is to be completed by the Intakes Team, which then meets the on-call FFS supervisor to discuss the recommended placement. It is the Intakes Team’s responsibility to complete the Intakes Placement Checklist. ORR officials stated that the final version of the form may have been misfiled and that, therefore, they were unable to locate the final version of the Intakes Placement Checklist that was completed.

By not making an initial placement within 24 hours of a referral, ORR prolongs a child's stay in DHS custody. DHS facilities have been found to not consistently provide some special protections for children in their care.<sup>46</sup> Some of these special protections include additional requirements for food, clothing, and access to showers after 48 hours. A placement designation delay lengthens the time it takes for a child to be placed at a care provider facility that is responsible for providing a safe environment and in the least restrictive setting appropriate for the child's needs. Additionally, ORR was unable to conduct adequate oversight of the initial placement of children with special needs or concerns in a restrictive setting without all information being documented on the Intakes Placement Checklist.

### **ORR COULD NOT DEMONSTRATE THAT IT FOLLOWED POLICIES AND PROCEDURES FOR TRANSFERS**

From the statistical sample of 50 transfers we reviewed, we found that ORR did not ensure that procedures were followed for 48 transfers or was unable to provide sufficient documentation to support that the transfers were completed as per ORR policies and procedures. Specifically, we determined that some sampled transfers were missing evidence to support that: (1) the case manager had determined that a transfer was necessary, (2) the medical checklist had been completed, (3) the receiving facility had accepted the transfer, or (4) the attorney of record had been notified of the transfer when required. On the basis of the results of our statistical sample, we estimated that ORR staff or care provider facility staff would be unable to provide documentation to support that they had followed ORR policies and procedures related to 3,607 (or 96 percent) of the 3,757 transfers that occurred during our audit period.

Additionally, for the three judgmentally selected children transferred into restrictive settings, we found that ORR was unable to provide documentation that the transfers were completed as per its policies and procedures. Furthermore, we determined that for transfers of children into restrictive placements: (1) ORR was missing evidence to support that the medical checklist had been completed and the attorney of record was notified of the transfer when required, (2) ORR did not maintain documentation for the reason(s) each child was denied a transfer, and (3) for the 11 children with both behavioral and mental health needs we reviewed, ORR faced challenges transferring each child to a care provider that could meet the child's needs during our audit period.

### **ORR Was Unable To Provide Documentation That Transfers Were Necessary**

Case managers employed by ORR care providers "continuously assess [the children] in their facilities' care to review whether their placements are appropriate."<sup>47</sup> ORR policy states that if

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<sup>46</sup> OIG-20-38, [Capping Report: CBP Struggled to Provide Adequate Detention Conditions During 2019 Migrant Surge \(dhs.gov\)](#), pp. 18–20.

<sup>47</sup> UMAP 2018 (Version 2), § 1.4.

the transfer of a child is deemed necessary, ORR care providers must make transfer recommendations within 3 days of identifying the need for a transfer for routine transfers and immediately in urgent situations.<sup>48</sup>

For 16 of the 50 transfers, ORR was unable to provide documentation of the sending facility case manager's determination that a placement was inappropriate and that a transfer was necessary. ORR guidance does not indicate whether the case manager should document in the UC Portal when a determination has been made that a child's current placement is inappropriate and a transfer is necessary. However, ORR officials informed us that a determination should be documented on the Transfer Request form. For the 16 children, the need for a transfer was not documented on a Transfer Request form. Therefore, we were unable to determine when each transfer determination was made.

### **ORR Was Unable To Provide a Medical Checklist for Some Transfers**

UMAP requires all children to be medically cleared for transfer. Medical personnel are required to complete a Medical Checklist for Transfers or a Medical Checklist for Influx Transfers (medical checklist) to medically clear children for transfer.<sup>49</sup> Additionally, a copy of the medical checklist is to be uploaded into the UC Portal.

For 39 of the 50 transfers, ORR was unable to provide a medical checklist.<sup>50</sup> ORR provided a medical checklist for the 11 remaining children; however, 5 of the medical checklists were not completed. Missing was information confirming three medical tests with negative results, one screening for current medical symptoms and conditions, one verification of an adequate supply of medication for the transfer, two verifications that a child had no mental health issues, and the name of the medical official and completion date for one completed medical checklist. The remaining six medical checklists were fully completed. In one of the transfers for which a medical checklist had been fully completed, the child had a medical condition that required consultation and clearance to travel from the ORR Division of Health for Unaccompanied Children (DHUC). ORR was unable to provide the email support that DHUC had been consulted and cleared the child prior to transfer. For two of the three transfers into a restrictive setting reviewed in the judgmental sample, ORR was unable to provide the medical checklist.

This occurred because ORR did not conduct adequate monitoring to ensure that care provider facilities were following ORR procedures for uploading the medical checklist into the UC Portal.

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<sup>48</sup> ORR Guide § 1.4, April 22, 2016.

<sup>49</sup> The Medical Checklist for Transfers is completed when a child is transferred from one ORR care provider to another care provider. The Medical Checklist for Influx Transfers is completed when a child is transferred to an ICF.

<sup>50</sup> Two transfers occurred during emergency events: a hurricane and flooding. Therefore, we did not consider these to be errors.

ORR conducts monitoring visits of care providers no less than once every 2 years. A visit includes a case file review. However, ORR selects a random sample of files to review, which may or may not include case files that included children who had been transferred. Therefore, ORR may not have assurance that care providers are following procedures related to transfers. Without documentation of a completed medical checklist, the ORR care provider has no assurance that a child had been medically cleared for transfer, and ORR runs the risk of a child not being medically fit for travel or potentially exposing others in another care provider facility to a contagious disease.

### **ORR Was Unable To Provide Documentation That the Receiving Care Provider Accepted the Transfer Request Within 1 Business Day**

The receiving care provider must accept a transfer request within 1 business day and notify all case coordinators and the FFS of its decision.<sup>51</sup> Each State has its own licensing requirements for ORR-funded care providers operating within that State. If a care provider is unable to accept a transfer because it would violate a State licensing requirement, the receiving care provider will email the sending case coordinator the reason for the denial, and the sending case coordinator will refer the transfer to an alternative care provider.<sup>52</sup>

We were unable to determine whether the receiving care providers accepted the transfer requests within 1 business day and whether they notified all case coordinators and the FFS with their decisions. We were also unable to determine whether the receiving care providers notified all case coordinators and the FFS about why the program was unable to accept the transfer. For 31 of 50 transfers, ORR was unable to provide documentation that the receiving care provider had accepted the transfer request within 1 business day and notified all case coordinators and the FFS with its decision or explained why the program was unable to accept the transfer. For 17 of the 50 transfers, OIG determined that the transfers were part of group transfers and were not subject to the 1 business day acceptance procedure. For the remaining two transfers, ORR provided emails that supported that the receiving care provider had accepted the transfer request within 1 business day.

ORR policy and procedures do not require an email acceptance to be uploaded into the UC Portal. However, ORR policy requires care providers to maintain accurate and up-to-date case files including electronic records.<sup>53</sup> ORR's reliance on emails that are not maintained in the UC Portal does not allow ORR to conduct adequate oversight of care provider facilities to ensure that they are following ORR policies and procedures. The failure of the receiving care provider to accept the transfer within 1 business day may delay the transfer of a child to a more appropriate facility and receiving necessary services. Failure to document acceptance

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<sup>51</sup> UMAP 2018 (Version 2), § 1.4.

<sup>52</sup> Ibid.

<sup>53</sup> ORR Guide § 5.6.2, October 10, 2018.

of a transfer for a child may prevent ORR from having a complete record of the care and services requested for the child while in ORR custody.

### **ORR Was Unable To Provide Documentation That the Attorney of Record or Legal Service Provider Was Notified of a Transfer**

ORR requires referring care providers to notify all designated stakeholders, including a child's attorney, if applicable, of a transfer. Within 24 hours prior to a physical transfer, the sending care manager should inform the attorney of record or legal service provider that the child is transferring to a different immigration court jurisdiction and that a motion for a change of venue needs to be prepared and filed.<sup>54</sup>

Case files for 6 of the 50 transfers indicated that each child had an attorney or legal services provider. However, for five of the six children ORR was unable to provide a copy of the email notifying the child's attorney or legal service provider of the child's physical transfer. The Transfer Request form indicated that a notification had been made, but there was no way for ORR to determine whether contact had been made within 24 hours of the transfer because the form does not require a date and time, and there is no field in the UC Portal to record a date and time that an attorney of record is notified. For the sixth child, an attorney of record was documented on the Transfer Request form, but the form also indicated that the attorney of record was not notified. Additionally, for two of the three transfers into restrictive settings reviewed in the judgmental sample, ORR was unable to provide a copy of each email notifying the child's attorney of record or legal service provider that the child was going to be physically transferred.

ORR policies and procedures do not require an email to a child's attorney to be uploaded into the UC Portal. However, ORR policy requires care providers to maintain accurate and up-to-date case files, including electronic records. Because the email to the child's attorney was not uploaded into the UC Portal, ORR does not have assurance that the child's attorney or legal service provider was contacted about the child's transfer. Additionally, the Transfer Request form does not require the date and time, and there is no field in the UC Portal to record the date and time. If a child's attorney is not notified of a transfer, a motion for a change of venue might not be filed and the child could miss an immigration hearing. An unaccompanied child in ORR custody who fails to appear for an immigration hearing may be removed in absentia.<sup>55</sup> Because ORR relies on email that is not maintained in the UC Portal, ORR cannot ensure that care provider facilities are following ORR policies and procedures.

Additionally, the Transfer Request form does not clearly indicate whether a child has an attorney or a legal service provider. The Transfer Request form includes the question, "Has the

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<sup>54</sup> UMAP 2018 (Version 2), § 1.4.

<sup>55</sup> 8 CFR § 1003.26(c).

minor’s attorney been contacted?” Responses available are “yes” and “no,” and include a space for the attorney of record’s name and phone number. According to ORR officials, a “no” response would typically indicate that a child did not have an attorney or legal service provider. Also, the Transfer Request form does not include fields for a care provider to document the date and time that a child’s attorney or legal service provider was contacted.

The failure of ORR and its care provider facilities to follow ORR policies and procedures related to maintaining transfer documentation could result in a receiving facility not having sufficient information to ensure that a child’s needs will be met. The lack of guidance to document specific dates and information in the UC Portal—for example, a determination that a transfer is necessary—prevents ORR from conducting adequate oversight of transfers of unaccompanied children and ensuring that children are being cared for in the least restrictive setting appropriate for their needs.

### **ORR DID NOT MAINTAIN ACCURATE RECORDS FOR CHILDREN WHO WERE DENIED TRANSFERS**

After ORR requests a placement in a particular facility, the care provider may deny ORR’s request for placement for only these reasons: (1) a lack of available bed space; (2) placement of the child would conflict with the care provider’s State or local licensing rules; or (3) placement of a child with significant physical or mental illness for which the referring Federal agency does not provide a medical clearance or medications, or both, would conflict with the care provider’s State or local licensing requirements. ORR may follow up with a care provider about a placement denial, if needed, “to find a solution to the reason for denial.”<sup>56</sup> In addition, care providers must maintain comprehensive, accurate, and up-to-date unaccompanied children case files and electronic records that are kept confidential and secure at all times and are accessible to ORR upon request. The care provider’s file documents all services provided, information about a child’s progress, barriers to the child’s progress, and the outcome of the case.<sup>57</sup>

ORR did not maintain comprehensive documentation on reason(s) why each child was denied a transfer to a care provider. The transfer request file, which contains all supporting documentation related to a transfer, is emailed among and used by all parties (i.e., case coordinators, the FFS, and other stakeholders) involved in the transfer of a child.<sup>58</sup> However, not all supporting documents for the transfer request file are stored in the UC Portal. This requires care provider staff to send emails to relevant parties at key stages in the transfer request process. Specifically, when the need for a transfer to a restrictive setting is identified, the sending case coordinator sends an email to all potential receiving care providers and waits for a response regarding acceptance of the transfer. If a care provider is unable to accept the

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<sup>56</sup> ORR Guide, § 1.3.3, January 27, 2015.

<sup>57</sup> ORR Guide, § 5.6.2, October 10, 2018.

<sup>58</sup> UMAP 2018 (Version 2), § 1.4.

transfer because of State licensing requirements, the receiving care provider emails the sending case coordinator. A Transfer Request form is updated in the UC Portal with the placement designation after a receiving care provider has accepted a transfer request. Therefore, most of the communications effort related to transferring a child to a restrictive setting is done through emails and not captured in the UC Portal unless a transfer has been accepted. In the UC Portal, there is no summary or record of a request for transfer or the reason why a receiving care provider did not accept a transfer after a transfer request was denied.

Without summarizing or documenting in a central location reasons for a transfer denial, ORR is unable to examine the reasons for denials, identify possible efforts to mitigate issues at care providers that lead to transfer denials, or make improvements to the transfer process. Additionally, ORR is unable to ensure that children are placed in the least restrictive setting most appropriate to meet their needs. By maintaining a summary or record of denied transfers and the reasons for the denials, ORR would be able to identify possible efforts to support programs that operate restrictive placements by mitigating issues that lead to the transfer denials.

### **ORR WAS UNABLE TO TRANSFER CHILDREN WITH BOTH BEHAVIORAL AND MENTAL HEALTH NEEDS**

ORR policies for placing children in care provider facilities are based on child welfare best practices aimed at providing a safe environment and placing each child in the least restrictive setting appropriate for the child's needs. Most children are placed in the ORR's least restrictive settings, which include shelter facilities, foster care, and group homes (which may be a therapeutic home).<sup>59</sup> ORR also has two levels of care for children assessed to be a danger to themselves or others, have a criminal history, or require close supervision. These more restrictive levels of care are staff secure and secure care facilities. If a child has a severe mental health issue in addition to serious behavioral concerns, or a criminal or delinquency history warranting placement into a restrictive level of care, ORR may place the child in an RTC or other therapeutic setting.<sup>60</sup> A child may be placed in an RTC only if the child is determined by a licensed psychologist or psychiatrist to be a danger to self or others. During our audit period,

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<sup>59</sup> ORR Guide, § 1.2, January 27, 2015. For purposes of its Unaccompanied Refugee Minor Program, ORR has defined a therapeutic group home as providing on-site treatment planning and services in a non-secure setting for children or youth with significant emotional or behavioral problems who have the capacity to engage in community-based activities. Treatment services typically include individual and group therapy and/or counseling, behavior modification, recreational therapy, or skill building. Therapeutic group homes offer a less restrictive environment than residential treatment but are more restrictive than therapeutic foster homes (*ORR Guide to Eligibility, Placement, and Services for Unaccompanied Refugee Minors*, § 2.3.4, September 17, 2021).

<sup>60</sup> ORR Guide, §§ 1.2.4 and 1.4.6, October 10, 2018.

there were six staff secure facilities, one therapeutic staff secure facility, three secure care facilities, and two RTCs in ORR's care provider network.<sup>61</sup>

From June through September 2019,<sup>62</sup> a total 82 children in ORR custody were denied transfer a total of 210 times. Of the 82 children who were denied transfer, we judgmentally selected 11 children who were denied transfers a total 67 times to conduct an in-depth review to determine why these children were denied transfers multiple times. Table 3 on the following page identifies the facilities and number of times each of the 11 children in our sample was denied a transfer into a more restrictive setting.

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<sup>61</sup> A therapeutic staff secure facility provides a combination of close supervision and intensive support and clinical services (e.g., in-depth counseling). See *The Office of Refugee Resettlement's Incident Reporting System Is Not Effectively Capturing Data To Assist Its Efforts To Ensure the Safety of Minors in HHS Custody*, OEI-09-18-00430, June 2020.

<sup>62</sup> We selected a judgmental sample from ORR's data for 4 months in our audit period (June through September 2019).

**Table 3: Denial of Transfer Placements to a Restrictive Setting for 11 Children**

<i>Care Provider That Denied the Transfer</i>	<i>Instances of Transfer Denials</i>										
	<i>Sample # 1</i>	<i>Sample # 2</i>	<i>Sample # 3</i>	<i>Sample # 4</i>	<i>Sample # 5</i>	<i>Sample # 6</i>	<i>Sample # 7</i>	<i>Sample # 8</i>	<i>Sample # 9</i>	<i>Sample # 10</i>	<i>Sample # 11</i>
<b>Therapeutic Group Home</b>										1	
<b>Therapeutic Staff Secure</b>		1	1			2		1		2	
<i>Denial due to Therapeutic Staff Secure at capacity*</i>									1		
<b>Staff Secure</b>		5	3	1	2	3	4	4	3		6
<i>Denial due to Staff Secure at capacity*</i>		3	1		1	2	3	2			
<b>Secure</b>				4		2					
<b>Residential Treatment Center</b>	2	1	2	2	2						
<b>Total</b>	<b>2</b>	<b>10</b>	<b>7</b>	<b>7</b>	<b>5</b>	<b>9</b>	<b>7</b>	<b>7</b>	<b>4</b>	<b>3</b>	<b>6</b>

\* “Denial at capacity” indicates that the care provider did not have available bed space and was not accepting placements at that time.

We found that 5 of the 11 children were denied placement at an RTC despite having the required recommendation from a medical professional. The care providers requesting the transfers were seeking a higher level of care for the children because they had a lack of impulse control, suicidal ideations, were self-harming, had been repeatedly admitted to a behavioral hospital, or needed intensive psychotherapy. However, RTC care providers did not accept transfers of the children due to their aggressive and threatening behavior toward staff or peers. In some cases, the RTCs stated that a child’s behavioral issues were not related to mental health needs, or that a child was not appropriate for an RTC setting because of the child’s diagnosis. Most requests to transfer these children to secure care and staff secure care facilities were also denied. The secure care and staff secure care providers denied the transfers because they could not provide the mental health and specialized care these children needed. An example of these denied placements follows.

**Example: Denial of Transfer to a Residential Treatment Center**

A child residing in a shelter was admitted to a psychiatric hospital for anger and depression and given a psychiatric evaluation. A transfer to an RTC was recommended. The RTC care provider denied placement because the child displayed aggressive and noncompliant behavior, and was considered an escape risk. At one point, the child had been denied placement to RTC and staff secure facilities nine times. The child was never admitted to an RTC program but was

eventually transferred to a staff secure facility. The child aged out of the program 2 months after being admitted to the staff secure facility.

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The other six children, none of whom were recommended for RTC placement between June and September 2019, were denied transfers into therapeutic staff secure, staff secure, and secure care facilities. For these children, the care providers requesting the transfers were seeking a new placement for each child due to being aggressive and disruptive or because of being considered an escape risk. However, due to the mental health needs of the children, therapeutic staff secure and staff secure care providers denied placements because they thought the children needed a higher level of care or therapeutic care than they were licensed to provide. Additionally, certain staff secure facilities were open campuses and were not able to accept children who were considered escape risks.<sup>63</sup> Secure care providers denied placements at their facilities because the children did not meet the criteria for placements in a secure care facility. An example of these denied placements follows.

#### **Example: Denial of Transfer to a Therapeutic Staff Secure Provider**

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A child with a history of severe psychological, physical, and sexual abuse residing in a shelter was referred for a transfer to a therapeutic staff secure care provider. The care provider could not accept the transfer at the time because the child had recently assaulted and threatened staff members at the shelter. The care provider's policy did not allow accepting a child who had assaulted an adult within the previous 6 months. The transfer request was elevated to a staff secure facility. However, the transfer was denied by six staff secure care providers because two of the facilities were at capacity, and the other four care providers could not accept the child due to mental health needs. The child ran away from the shelter less than 1 month after the last denial was received.<sup>64</sup>

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ORR may lack enough care providers that are equipped to handle children with both mental health and behavioral issues. In 2019, there were two RTC facilities, eight staff secure facilities, and only one therapeutic staff secure facility in operation.<sup>65</sup> In addition to the lack of bed space for children with behavioral and mental health issues, ORR must respect the State licensing

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<sup>63</sup> The secure care provider self-identified as being an open campus and described this as meaning that doors remain unlocked and that it's a hands-off program.

<sup>64</sup> The child ran away outside our audit period. Our review of this child's case file did not extend beyond our audit period; therefore, we could not determine whether the child was later re-admitted to the UC program.

<sup>65</sup> In response to OIG recommendations in *Care Provider Facilities Described Challenges Addressing Mental Health Needs of Children in HHS Custody*, OEI-09-18-00431, September 2019, ACF stated that as of January 1, 2021, ORR had expanded and fully funded its therapeutic direct care providers for a total of 11 therapeutic programs.

requirements of care providers within its network, and care providers may not accept children who do not meet their facilities' licensing requirements.<sup>66</sup> Therefore, RTCs may deny children who do not meet RTC criteria, and staff secure facilities may not accept children who require mental health services that the facilities are not licensed to provide. As a result, children needing specialized care for both mental health and behavioral issues may not be getting the care or services they need. Additionally, care providers risk staffing shortages, and their employees risk fatigue due to the extra care required for children needing one-on-one supervision.<sup>67</sup> Children who need specialized care but remain at a shelter could pose a danger to themselves and others.

See Appendix G for more details on the 11 children selected for review.

## RECOMMENDATIONS

We recommend that the Office of Refugee Resettlement:

- strengthen oversight of initial placements by addressing challenges with bed space capacity and intake specialist staffing during influx periods to ensure a placement is made within 24 hours of each referral and Intakes Placement Checklists are completed for children with special needs or concerns;
- strengthen oversight of transfers between care provider facilities by requiring that all transfer documentation be maintained in the UC Portal and by developing procedures for tracking and reviewing that documentation;
- review restrictive setting placement denials and take action as needed to ensure that, in the future when transfer is recommended, children will be able to obtain an appropriate placement; and
- assess needs to expand the Office of Refugee Resettlement's network capacity to serve the needs of children with mental health and behavioral issues.

## ADMINISTRATION FOR CHILDREN AND FAMILIES COMMENTS

In written comments on our draft report and commenting on behalf of ORR, ACF concurred with our recommendations and described actions taken to address our findings. To strengthen the oversight of initial placements and reduce the time children spend in DHS custody, ACF stated that ORR is building upon its network of standard beds among ORR care providers and

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<sup>66</sup> Care providers are licensed, certified, or accredited by an appropriate State agency to provide residential care for children. State licensing requirements also may vary from State to State.

<sup>67</sup> For more information on the risks of staff shortages from one-on-one supervision, see the report *The Office of Refugee Resettlement's Incident Reporting System Is Not Effectively Capturing Data To Assist Its Efforts To Ensure the Safety of Minors in HHS Custody*, OEI-09-18-00430, pp. 15–16, June 2020.

adding bed capacity options that can quickly and safely respond to periods of influx. ACF also stated that ORR reduced the average time between referral and initial placement by hiring more intake specialists that now provide year-round, 24-hour-a-day coverage of placement designations.

ACF also stated that ORR has developed phased improvements that are being implemented to strengthen oversight of transfer documentation, including clarification of expectations and timelines for completing transfer documents in the UC Portal, publishing substantive changes to its transfer policy and procedures, and digitizing documentation to be maintained in the UC Portal.

ACF stated that ORR created a workgroup to conduct a weekly review of restrictive setting placement denials and to flag specific in-network providers that continually deny placements for corrective action.

Finally, ACF stated that ORR has made significant improvements to assess and address its capacity to better serve the needs of children with mental health and behavioral issues. Specifically, ORR has hired a Field Supervisor for Special Populations to oversee care and treatment services for children in restrictive settings, and in June 2022 expanded the supervisor's responsibilities to include seeking and coordinating increased mental health and treatment services for children in shelters needing specialized placement. In addition, ORR engaged with several out-of-network therapeutic facilities to aid in providing treatment for children with mental health or behavioral needs, and drafted additional requirements in its Cooperative Agreements Addenda for secure care facilities, staff secure facilities, residential treatment centers, and therapeutic group homes that requires care providers provide or have access to services for children with mental health and behavioral issues, including substance use and anger management concerns.

ACF's comments are included in their entirety as Appendix H.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE:

Our audit covered 59,116 lines of unaccompanied children initial placement and transfer data provided by ORR. There were 55,359 lines of initial placement data and 3,757 lines of transfer data. These placements and transfers occurred between January 1 and September 30, 2019 (audit period).

To determine whether ORR followed its policies, procedures, and guidance when making initial placements of unaccompanied children in care provider facilities funded by ORR and when transferring children between those facilities, we: (1) selected a statistical sample of 70 initial placements and 50 transfers occurring during our audit period to estimate the numbers and percentages of any placements and transfers during the audit period that did not follow ORR policies and procedures, (2) selected a judgmental sample of 6 initial placements and 3 transfers of children into restrictive settings (to examine initial placements and transfers into care provider facility types that were not selected in the statistical sample), (3) selected a judgmental sample of 30 transfers that occurred from 0 to 7 days after placement to determine the reason for each transfer, and (4) selected a judgmental sample of 11 children with multiple transfer denials during our audit period to determine the reason for each denial. We verified that the judgmental sample items were distinct from the statistical sample items selected. We reviewed the supporting documentation and case files for each sample item to determine whether ORR and its care providers followed ORR's policies and procedures when making associated placement and transfer decisions.

We conducted our audit work from December 2019 through November 2022.

We did not assess the overall internal control structure of ORR or ORR's document management system. Rather, we limited our review to ORR's policies and procedures for initially placing and transferring children within ORR's network of care providers.

### METHODOLOGY

To accomplish our objective, we:

- reviewed Federal guidance related to ORR's responsibility for the care and placement of unaccompanied children;
- reviewed ORR's organizational chart;
- reviewed ORR's policy and guidance related to initial placements and transfers of unaccompanied children;
- interviewed ORR officials and contractors to gain an understanding of the following:

- ORR's policy and guidance related to placement and transfers,
  - the UC Portal system and data available in the portal,
  - the initial placement process, and
  - the transfer request process;
- selected a statistical sample of 70 initial placements and 50 transfers of children within our audit period;
  - selected a judgmental sample of 6 initial placements and 3 transfers of children into restrictive settings (in order to examine initial placements and transfers into care provider facility types that were not selected in the statistical sample);
  - identified a group of 425 transfers that occurred from 0 to 7 days after a placement and selected a judgmental sample of 30 from this group (excluding transfers selected in the statistical sample) based on the restrictive setting of each facility and the number of days after initial placement;
  - evaluated an ORR 6-month study on denied transfers and selected a judgmental sample of 11 unaccompanied children with multiple transfer denials from June through September 2019;
  - reviewed supporting documentation and case files for each sample item to determine whether ORR and its care providers followed ORR policies and procedures when making placement and transfer decisions;
  - discussed with ORR officials issues found with specific sample items;
  - estimated, using the results of our statistical sample, the percentage and number of any initial placements and transfers that were not made as per ORR policies and procedures for unaccompanied children placement and transfer; and
  - met with ORR officials to discuss our findings.

## **APPENDIX B: OFFICE OF REFUGEE RESETTLEMENT REQUIREMENTS**

### **ORR Guide: Children Entering the United States Unaccompanied Requirements**

#### **ORR Standards for Placement and Transfer Decisions**

ORR Guide, § 1.2 (Jan. 27, 2015)

There are two types of placement decisions: the initial placement into a care provider facility or other setting and transfer placements between ORR care providers. Although the circumstances and procedures for initial placement and transfer vary, ORR applies the same child welfare model to both types of care delivery.

ORR makes every effort to place children and youth within the ORR-funded care provider network. However, there may be instances when ORR determines there is no care provider available within the network to provide specialized services needed for special needs cases. In those cases, ORR will consider an alternative placement. An ORR Supervisor and ORR Project Officer must approve these placements.

ORR must approve all transfers and releases while a child is in its custody, except in emergency situations in which a care provider may temporarily transfer placement of an unaccompanied child. In those emergency situations, the care provider must notify ORR of the transfer within 8 hours.

#### **Secure and Staff Secure Care Provider Facilities**

ORR Guide, § 1.2.4 (Oct. 10, 2018)

ORR has two levels of care for unaccompanied children who are assessed to be a danger to themselves or others, have a criminal history, or require close supervision. Staff secure facilities provide a heightened level of staff supervision, increased communication, and services to control problem behavior and prevent escape. Secure facilities are for youth who require the strictest level of supervision. Secure care providers have a secure perimeter, major restraining construction inside the facility, and procedures typically associated with correctional facilities.

ORR may place youth in a staff secure or secure setting at initial placement or through a transfer to another facility from the initial placement. ORR provides the youth notice of the reasons for placement in a secure or staff secure facility.

If a child has a severe mental health issue in addition to serious behavioral concerns or criminal/delinquent history warranting placement into a restrictive level of care, ORR may place the youth in an RTC or other therapeutic setting. ORR provides the youth notice of reasons for placement in an RTC or therapeutic setting.

## **ORR Placement Designation**

ORR Guide, § 1.3.2 (Oct. 10, 2018)

The ORR/Intakes Team identifies appropriate and available bed space at a care provider, the ORR-funded facility, or other setting that provides care for the child and contacts the care provider to confirm availability. ORR attempts to identify and designate a placement for the unaccompanied child within 24 hours of the initial referral whenever possible.

In cases in which a child or youth may present a danger to self or others, ORR staff use a standardized checklist (the “Intakes Placement Checklist”) to input all available information on the unaccompanied child’s history and condition.

The ORR/Intakes Team uses the Intakes Placement Checklist if the unaccompanied child has:

- a juvenile or adult criminal history, including involvement in human trafficking or smuggling;
- prior acts of violence or threats while in Government custody;
- gang/cartel involvement;
- prior escape(s) or attempted escape(s) from Government custody;
- mental health concerns; or
- sexual predatory behavior.

Based on the responses, the Intakes Team member recommends a level of care for the unaccompanied child. The ORR Intakes Team reviews the Intakes Placement Checklist with an ORR/FFS Supervisor. The ORR/FFS Supervisor makes a final placement decision on the level of care, and the Intakes Team designates the unaccompanied child’s placement based on that level of care.

## **Initial Placements in the Event of an Emergency or Influx**

ORR Guide, § 1.3.5 (May 5, 2016)

Historically, ORR experiences periods when a significantly greater number of unaccompanied children are apprehended than at other times of the year. These periodic intervals are called an “influx.” In addition to an influx, a natural disaster or other emergency may prevent the prompt (within 24 hours), initial placement of unaccompanied children in care provider facilities.

ORR has procedures in place to make sure that care providers are available to accommodate these influx intervals and make initial placements as quickly as possible while successfully providing the range of services that ORR requires for every unaccompanied child.

### **Transfers Within the ORR Care Provider Network**

ORR Guide, § 1.4 (Apr. 22, 2016)

Because an unaccompanied child's placement needs can change, the care provider conducts ongoing assessments of his or her needs throughout the child or youth's stay in ORR custody. Care providers also take into consideration information from the referring Federal entity; child assessment tools; interviews; location of the child's sponsor or family in the U.S.; records from local, State, and Federal agencies; and information from stakeholders, including the child's legal service provider, attorney of record or Child Advocate, as applicable, when making transfer recommendations.

If an alternative placement would better meet the child's individual needs, care providers must promptly make transfer recommendations within 3 days of identifying the need for a transfer for routine transfers and immediately in urgent situations.

The Case Coordinator identifies the most appropriate care provider based on the individual's needs and the bed capacity within the ORR network.

Once the FFS approves a transfer request, the referring and receiving care providers coordinate logistics, including the transfer date (generally within 3 days). The referring care provider notifies all designated stakeholders of the transfer (for example, the child's attorney).

### **Least Restrictive Setting**

ORR Guide, § 1.4.1 (Jan. 27, 2015)

Care providers must make every effort to place and keep children and youth in a least restrictive setting. For children who are initially placed in a least restrictive setting, care providers must provide support services and effective interventions, when appropriate, to help keep children in the setting.

### **30 Day Restrictive Placement Case Review**

ORR Guide, § 1.4.2 (Oct. 10, 2018)

At the time of referral, the ORR Intakes Team, in collaboration with an ORR/FFS Supervisor, uses a standardized Intakes Placement Checklist to determine the initial placement of an unaccompanied child with a juvenile or criminal background, violent offenses, serious behavioral concerns, and/or potential for escape. See 1.3.2 ORR Placement Designation.

At least every 30 days, the care provider staff, in collaboration with the Case Coordinator and the ORR/FFS, review the placement of an unaccompanied child into a secure, staff secure, or

RTC facility to determine whether a new level of care is more appropriate. The ORR/FFS may allow the review to take place earlier than 30 days, particularly if new information indicates an alternative placement is more appropriate. The care provider staff documents that basis for continued placement in a secure, staff secure, or RTC facility in the unaccompanied child's case file and provides the information to the youth's attorney of record, legal service provider, or Child Advocate, on demand. The FFS consults with Supervisory ORR staff for unaccompanied children who have resided in a secure RTC care facility for over 90 days. The FFS consults with Supervisory ORR Staff regarding the placement every 30 days thereafter until the unaccompanied child is stepped down or discharged. Unaccompanied children may remain in an RTC placement only if a licensed psychiatrist or psychologist has determined that they are a danger to themselves or others.

### Step-Ups and Step-Downs

Step-ups and step-downs refer to the transfers within the ORR network of care to a more restrictive level care or to a less restrictive level of care, respectively.

Step-ups may occur when a more restrictive level of care is needed for the safety of the unaccompanied child or others. The care provider Case Manager, Case Coordinator, and ORR/FFS staff review the case to determine whether the unaccompanied child's behavior, criminal history, or self-disclosures require placement in a more restrictive environment, using factors identified in section 1.2.4.

Step-downs may occur when ORR, in its discretion, determines the unaccompanied child no longer poses a danger to self or others, or no longer presents an escape risk (for staff secure step-downs only).

### **Residential Treatment Center Placements**

ORR Guide, § 1.4.6 (Oct. 10, 2018)

Care providers request a transfer to an RTC for an unaccompanied child who has a psychiatric or psychological issue that cannot be addressed in an outpatient setting.

An unaccompanied child may be placed into an RTC only if the youth is determined to be a danger to self or others by a licensed psychologist or psychiatrist. In assessing dangerousness, ORR uses the criteria for secure placement in section 1.2.4.

### **UAC Manual of Procedures Requirements, 2018 (Version 2)**

#### 1.3.2 ORR Designates Placement

Within 3 hours, if possible, but not more than 24 hours, ORR Intakes uses placement considerations to identify a care provider. ORR Intakes attempts to place the unaccompanied child in a care provider facility as close as possible to the point of apprehension while considering the individual needs of the unaccompanied child. ORR Intakes consults with the

FFS supervisor and/or DHUC in special cases (such as an unaccompanied child with mental health, medical issues, or a criminal or violent background).

ORR Intakes identifies available and appropriate bed space at a care provider by reviewing the “Capacity Management” tab in the UC Portal, which automatically updates available beds by State, facility, and types of facilities. Note: Care providers MUST verify information in their facility daily by 9:00 a.m. so that the UC Portal will generate an accurate report of the number of unaccompanied children in care and the number of open beds.

ORR Intakes inputs all available information on the unaccompanied child’s criminal history or behavioral concerns into the Intakes Placement Checklist. The on-call FFS supervisor must approve all placements when Intakes uses the Intakes Placement Checklist to designate placement. The FFS supervisor decides whether the recommended care provider type associated with the Intakes Placement Checklist is a suitable placement for the unaccompanied child. Each placement is assessed on a case-by-case basis.

After receiving the Intakes Placement Checklist, the care provider scans and uploads the form into the UC Portal after electronically admitting the unaccompanied child into the program. The care provider generates the Notice of Placement in a Restrictive Setting and populates the unaccompanied child biographical information and care provider facility information.

### 1.3.3 Care Provider Accepts Placement

ORR Intakes contacts the care provider on placement. The care provider must accept placement unless the unaccompanied child does not meet established facility-specific criteria.

### 1.3.4 UC Transferred to ORR Custody

ORR Intakes:

- requests that DHS or other referring Federal agency contact the care provider to provide notice of travel arrangements, including expected arrival date and time of the unaccompanied child at the care provider’s location and the contact information for the transporting officials;
- assists the care provider and referring agency with logistics; and
- ensures the referring Federal agency has correct contact information for the care provider and is aware of any limitations or restrictions to the day/time the unaccompanied child can be accepted by the care provider.

The receiving care provider accepts the unaccompanied child, his or her belongings, and supporting documentation that is provided by DHS. The care provider requests missing information/documents from DHS or other sources as needed. If DHS cannot provide

medical/mental health/safety concerns documents, or criminal juvenile records, the care provider requests the documents from Customs and Border Patrol and copies the assigned FFS within 1 business day of admitting the unaccompanied child.

Within 48 hours, the care provider facility uploads all available documents to the UC Portal under the case management tab. A hard copy also goes into the unaccompanied child's case file.

#### 1.4 Transfers within the ORR Care Provider Network

The sending case manager continuously assesses the unaccompanied children in their facilities' care to review whether their placements are appropriate. If the sending case manager identifies an unaccompanied child whose placement is inappropriate under ORR policy, he/she must perform the following steps within 3 business days:

- The sending case manager ensures that the unaccompanied child will be medically cleared for transfer by requesting that the sending medical coordinator or other medical staff complete the Medical Checklist for Transfers. Once completed, the medical coordinator saves a hard copy and uploads an electronic copy in the Health tab of the UC Portal.
- The sending case manager should generate a Transfer Request in the UC Portal and then compile and send via email to all parties involved a file of all supporting documentation related to the transfer (Transfer Request File). Some of the documentation emailed as part of the Transfer Request File are:
  - unaccompanied children assessments,
  - updated case review,
  - Medical Checklist for Transfers,
  - case manager notes,
  - intake/admission assessments,
  - child trafficking screening results,
  - clinician notes, and
  - psychological evaluation (required for therapeutic care).
- The receiving care provider must accept the transfer request within 1 business day and notify all case coordinators and FFS with its decision. If a program is unable to accept the transfer because of State licensing requirements, the receiving care provider emails the sending case coordinator with the reason, and the sending case coordinator re-refers the transfer to an alternative care provider.
- Immediately upon notification of the acceptance (but no later than the next business day), the sending case coordinator documents the recommendation of the Transfer Request in the UC Portal. The FFS then completes the ORR Decision section of the

Transfer Request in the UC Portal within 24 hours, making sure to fill out the three fields “Decision,” “Date of Decision,” and the “Name of the ORR Decision Maker.” The FFS also replies with a followup email to the case coordinator notification of transfer acceptance email that the final release decision was completed in the Transfer Request in the UC Portal.

- Within 24 hours prior to the physical transfer, the sending case manager informs the attorney of record that the child is being transferred to a different immigration court jurisdiction, and a change of venue motion needs to be prepared and filed.
- Immediately after the unaccompanied child’s transfer, the sending case manager ensures the Transfer Request and Tracking Form and the Discharge notification are completed in the UC Portal.

## APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

### SAMPLING FRAME

The sampling frame was an Excel spreadsheet consisting of files from ORR that, when combined, contained 59,121 lines of data documenting the initial placement (a placement by the ORR Intakes Team) of each child into an ORR facility or the transfer of a child between ORR facilities during our audit period.

In addition, after constructing our sampling frame and selecting our sample, we identified five lines in the sampling frame that did not represent initial placements or transfers. Accounting for these items, our final sampling frame contains 59,116 initial placements or transfers of unaccompanied children. None of the excluded items appeared in our sample.

### SAMPLE UNIT

The sample unit was one ORR placement of an unaccompanied child (initial or transfer).

### SAMPLE DESIGN

We used a stratified random sample. The sampling frame was divided into two strata based on type of placement (initial or transfer). The specific strata are shown in Table 4.

**Table 4: Sample Design for UC Initial Placements and Transfers**

Stratum #	Placement Type	Frame Count	Sample Size
1	Initial Placements	55,359	70
2	Transfers	3,757	50
<b>Total</b>		<b>59,116</b>	<b>120</b>

### SOURCE OF RANDOM NUMBERS

We used the OIG, Office of Audit Services (OAS) statistical software to generate the random numbers.

### METHOD OF SELECTING SAMPLE UNITS

We sorted the items in each stratum by migrant number, date of admission, and month, and then we consecutively numbered the transactions in each stratum. After generating the random numbers for these strata, we selected the corresponding frame items.

### ESTIMATION METHODOLOGY

We used the OIG-OAS statistical software to estimate the number and percentage of initial

placements and transfers that did not follow ORR policies and procedures during our audit period. We calculated our estimates using the final sampling frame size of 59,116. For each of these characteristics, we calculated a point estimate and a two-sided, 90-percent confidence interval.

**APPENDIX D: SAMPLE RESULTS AND ESTIMATES**

**Table 5: Sample Results**

<b>Stratum</b>	<b>Number of Placement Type</b>	<b>Sample Size</b>	<b>Number That Did Not Follow ORR Policies and Procedures</b>
<b>1 – Initial Placements</b>	<b>55,359</b>	<b>70</b>	<b>0</b>
<b>2 – Transfers</b>	<b>3,757</b>	<b>50</b>	<b>48</b>
<b>Total</b>	<b>59,116</b>	<b>120</b>	<b>48</b>

**Table 6: Estimated Number and Percentage of Initial Placements and Transfers in the Sampling Frame That Did Not Follow ORR Policies and Procedures  
(Limits Calculated at the 90-Percent Confidence Level)**

<b>Estimate Description</b>	<b>Number</b>			<b>Percent</b>		
	<b>Point Estimate</b>	<b>Lower Limit</b>	<b>Upper Limit</b>	<b>Point Estimate</b>	<b>Lower Limit</b>	<b>Upper Limit</b>
Initial Placements	0	0	2,317	0.0%	0.0%	4.2%
Transfers	3,607	3,306	3,729	96.0%	88.0%	99.3%

## APPENDIX E: DESCRIPTION OF ORR AND CARE PROVIDER POSITIONS

Below are job descriptions of positions involved in the care and placement of unaccompanied children in ORR custody. These descriptions are from the ORR Guide.<sup>68</sup>

**Care Provider** – A care provider is an ORR-funded program that is licensed, certified, or accredited by an appropriate State agency to provide residential care for children, including shelter, group, foster care, staff-secure, secure, therapeutic, or residential treatment care for children.

**Case Manager** – The Case Manager is the care provider staff member who coordinates assessments of unaccompanied children, individual service plans, and efforts to release unaccompanied children from ORR custody. Case Managers also ensure that all services for children and youth are documented and maintain case files for unaccompanied children.

**Case Coordinators** – Case Coordinators are ORR, non-governmental contractor field staff who act as local ORR liaisons with care providers and stakeholders and who are responsible for making transfer and release recommendations. ORR Case Coordinators are assigned to care providers on the basis of an ORR Case Coordinator-to-bed ratio; therefore, an individual ORR Case Coordinator may be assigned to one or several care providers, and a care provider with a large bed capacity may have more than one ORR Case Coordinator.

**Child Advocate** – A Child Advocate is an independent third party who is appointed by ORR for select unaccompanied children to make recommendations to various stakeholders regarding the best interest of a child.

**Clinician** – The Clinician is the care provider staff member who provides clinical or counseling services, or both, for unaccompanied children and provides oversight for the unaccompanied child's mental and emotional health.

**Legal Service Provider** – A legal service provider is an ORR-funded contractor, sub-contractor, grantee, or sub-grantee who coordinates legal services and pro-bono representation for unaccompanied children in ORR custody.

**Medical Coordinator** – A medical coordinator is a care provider staff member who makes medical and dental appointments on behalf of unaccompanied children in care and maintains logs on an unaccompanied child's health-related information.

**ORR Federal Field Specialist (FFS)** – The ORR FFS acts as the local ORR liaison with care providers and stakeholders. An ORR/FFS is assigned to multiple care providers within a determined region and serves as the ORR regional approval authority for unaccompanied children transfer and release decisions.

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<sup>68</sup> ORR Guide: Guide to Terms, March 21, 2016.

**ORR/Headquarter Staff (ORR/HQ)** – ORR/HQ staff members work at headquarters and are typically assigned to one of the following teams: ORR/Intakes Team, which receives referrals of unaccompanied children from Federal agencies for placement of unaccompanied children and designates the initial placement of unaccompanied children into care provider facilities; ORR/Medical Services Team, which is responsible for adjudicating Treatment Authorization Requests and providing consultation and technical assistance in relation to the UC Program procedures on medical services to ORR staff and grantees; and the ORR/Project Officer Team, which is responsible for the programmatic and technical aspects of applications and grants and for monitoring facilities.

## APPENDIX F: DESCRIPTION OF ORR CARE PROVIDER FACILITIES

Below are descriptions of care provider facilities from the ORR Guide.<sup>69</sup>

**Extended Care Group Home** – An extended care group home is a type of residential care provider that provides a group home setting in which the unaccompanied child may attend public school. Unaccompanied children who may be in ORR custody for an extended period may be eligible for this type of placement.

**Group Home** – A group home (may be a therapeutic home) is a care provider facility that offers a group home setting and that specializes in caring for specific populations (e.g., teen mothers). A group home, which is run by 24-hour staff or house parents, typically houses 4 to 12 unaccompanied children.

**Influx Care Facility** – A type of care provider that is opened to provide temporary emergency shelter and services for unaccompanied children during an influx or emergency. Influx care facilities may be opened on federally owned or leased properties, in which case the facility would not be subject to State or local licensing standards, or at facilities otherwise exempted by the State licensing authority.

**Long Term Foster Care** – Long term foster care is ORR-funded, community-based foster care to which eligible unaccompanied children are transferred after a determination is made that they will be in ORR custody for an extended period of time. Unaccompanied children in ORR long-term foster care typically reside in licensed foster homes, attend public school, and receive community-based services.

**Residential Treatment Center (RTC)** – An RTC is a sub-acute, time-limited, interdisciplinary, psycho-educational, and therapeutic 24-hour-a-day structured program with community linkages provided through non-coercive, coordinated, individualized care, specialized services, and interventions. RTCs provide highly customized care and services to individuals following either a community-based placement or more intensive intervention, with the aim of moving individuals toward a stable, less intensive level of care or independence. ORR uses an RTC at the recommendation of a psychiatrist or psychologist or with ORR Treatment Authorization Request approval for an unaccompanied child who poses a danger to self or others and does not require inpatient hospitalization.

**Secure Care** – A secure care provider is a facility with a physically secure structure and staff able to control violent behavior. ORR uses a secure facility as the more restrictive placement option for an unaccompanied child who poses a danger to self or others or has been charged with having committed a criminal offense. A secure facility may be a licensed juvenile detention center or a highly structured therapeutic facility.

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<sup>69</sup> ORR Guide: Guide to Terms, March 21, 2016.

**Shelter Care** – A shelter is a residential care provider facility in which all of the programmatic components are administered onsite in the least restrictive environment.

**Staff Secure Care** – A staff secure care provider is a facility that maintains stricter security measures, such as a higher staff-to-unaccompanied children ratio for supervision, than a shelter to control disruptive behavior and prevent escape. A staff secure facility is for unaccompanied children who may require close supervision but do not need placement in a secure facility. Service provision is tailored to address an unaccompanied child’s individual needs and to manage the behaviors that necessitated the child’s placement into this more restrictive setting. The staff secure atmosphere reflects a more home-like setting rather than secure detention. Unlike many secure care providers, a staff secure care provider is not equipped internally with multiple locked pod or cell units.

**Therapeutic Foster Care** – Therapeutic foster care is a foster family placement funded by ORR for unaccompanied children whose exceptional needs cannot be met in regular family foster care homes and consists of intensive supportive and clinical services in the homes of specially trained foster parents. Foster care programs work in collaboration with foster parents to provide interventions, treatment, protection, care, and nurturance to meet the medical, developmental, and/or psychiatric needs of unaccompanied children. The unaccompanied child typically attends public school and receives community-based services.

**Transitional Foster Care** – ORR transitional foster care is synonymous with ORR short-term foster care. Transitional foster care is an initial 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 children with special needs. Unaccompanied children are placed with foster families in the ORR network of care but may attend school and receive most service components at the care provider site.

## **APPENDIX G: EXTENDED NARRATIVE OF CHILDREN IN DENIED TRANSFERS SAMPLE**

Below is an extended narrative of the 11 children in our judgmental sample of denied transfers. The names of the children in the extended narrative are pseudonyms used to protect the identities of children in ORR care. Our case file review for the 11 children was limited to documentation regarding transfer requests and denials that occurred from June through September 2019.<sup>70</sup> ORR provided us with an update on the locations of the children as of March 2022.

### **EXAMPLE 1 – Omar, age 16**

At the time of our audit, Omar was at a therapeutic group home (TGH). RTC care providers twice denied Omar a transfer. The TGH was seeking a transfer due to Omar's outbursts and property destruction. Omar was given a cognitive evaluation and was diagnosed with an intellectual disability. Omar also received a psychological evaluation as well as weekly (or as-needed) psychological followups. The psychologist recommended an RTC placement for Omar due to ongoing problems with impulse control and low IQ scores. However, the RTC care providers denied transfers for Omar for safety and licensing reasons. One RTC care provider was concerned about Omar's physical aggression and destruction of property. Both RTC care providers thought Omar's diagnosis made an RTC setting inappropriate. One RTC care provider said that according to State licensing standards RTC programs do not accept minors with low IQ scores because these children cannot effectively engage in their treatment. Omar was eventually transferred to a shelter facility in 2020 before being released to State custody. The date of the release to State custody was not provided.

### **EXAMPLE 2 – Ciro, age 13**

At the time of our audit, Ciro was at a shelter. Ciro was denied a transfer 10 times by therapeutic staff secure, staff secure, and RTC care providers. Ciro was given a mental health evaluation due to suicidal comments and dangerous behavior toward others. The psychologist recommended a therapeutic residential care setting where Ciro could receive intensive counseling sessions and psychotherapy to help with trauma. After the evaluation, the shelter sought placement at an RTC and a TGH. The TGH care provider denied placement because it felt Ciro needed a higher level of care, such as an RTC, due to homicidal and suicidal thoughts. However, the RTC care provider denied placement for safety reasons. Ciro was considered to have had sociopathic tendencies in his home country and aggressive behavior while in ORR's care. Due to Ciro's violent, threatening, and disruptive behavior, the shelter care provider next sought placement at a staff secure facility. The shelter requested transfers to a staff secure facility eight times. Three of those requests were denied because the staff secure care providers were at capacity. Ciro was denied a transfer by the other staff secure care providers due to his homicidal and suicidal ideations. The staff secure care providers also recommended

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<sup>70</sup> We selected a judgmental sample from ORR's data for only the months of our audit period, which was June through September 2019.

a higher therapeutic level of care than they could provide. In their denials, most of the staff secure care providers referred to the psychologist's recommendation for an RTC placement. Ciro was eventually in 2020 transferred to a TGH. As of March 2022, Ciro was still under ORR's care in long-term foster care (in a nontherapeutic setting).

### **EXAMPLE 3 – Armando, age 14**

At the time of our audit, Armando was at a shelter. Armando was denied a transfer seven times by therapeutic staff secure, staff secure, and RTC care providers. He was hospitalized multiple times due to self-harming behavior. During an outpatient progress visit, a transfer to an RTC facility was recommended to address his behavioral problems. The shelter requested the transfer due to Armando's aggressive and sexually inappropriate behavior. However, because of this behavior, the RTC care providers denied the transfer for safety and licensing reasons. The RTC care providers said Armando had "manipulated staff" or displayed "manipulative behavior" in an attempt to be hospitalized rather than stay at the shelter. It was noted on several occasions, through proper screenings, that Armando did not meet criteria for hospitalizations because he denied suicidal ideations or urges to self-harm. One RTC care provider said Armando's diagnosis appeared to be more behavioral in nature and that his aggression and sexualized behavior were not appropriate for an RTC placement. Armando was denied placement at one staff secure facility because the facility was full. The therapeutic staff secure and other staff secure care providers stated that they could not accept Armando due to licensing or admissions criteria, physical aggression, and sexual behavior. In their denials, the care providers also referred to the RTC recommendation as a reason for not accepting the transfer. Armando remained at the shelter until requesting a voluntary departure to return to his home country in January 2020.

### **EXAMPLE 4 – Otilia, age 17**

At the time of our audit, Otilia was at a shelter. Otilia was denied a transfer seven times by RTC, Staff Secure, and Secure Care providers. Due to anger and depression, Otilia was admitted to a psychiatric hospital and given a psychiatric evaluation. The psychiatrist recommended residential treatment care. The shelter requested a transfer based on the RTC recommendation. However, the RTC denied the transfer due to Otilia's aggressive and noncompliant behavior, as well as being an escape risk. The transfer request was resubmitted to the same RTC the following month and was again denied. Attempts to place Otilia at out-of-network RTC care providers also failed.<sup>71</sup> The shelter sought a transfer to a secure care provider after the RTC providers denied the shelter's request. However, the two secure facilities denied the transfer for licensing and specific facility limitations. The secure facilities

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<sup>71</sup> If an unaccompanied child exhibits significant mental health needs or significant special needs that cannot be met within the ORR care provider network, the child may be transferred to a State-licensed, out-of-network facility. Out-of-network facilities are expected to meet each child's mental health, medical, and behavioral needs while ensuring being able to provide services that are sensitive to the child's age, culture, native language, gender orientation, and other special needs. (ORR draft document *Transferring Outside the ORR Care Provider Network*, July 24, 2019.)

cited Otilia's RTC referral, suicide attempts, and need for medications as their reasons for not accepting Otilia. A staff secure care provider also denied a transfer due to the RTC recommendation. Otilia remained at the psychiatric hospital for more than 3 months until the shelter resubmitted the transfer request, and the staff secure care provider eventually accepted placement. However, within the month of arriving at the staff secure facility, Otilia was admitted to another psychiatric hospital, and a transfer to a secure facility was requested. The transfer request was submitted to the same two secure care providers who had previously denied the transfer. The two secure care providers again denied placement. Otilia remained at the staff secure facility until aging out of the program in November 2019, less than 2 months after the last two transfer requests were denied.

#### **EXAMPLE 5 – Victor, age 17**

At the time of our audit, Victor was at a shelter. Staff Secure and RTC care providers denied Victor's transfer five times. Victor was admitted to a behavioral hospital due to aggressive behavior toward staff and harm to self and others. The shelter requested a transfer to a Staff Secure facility. One Staff Secure care provider denied the transfer because its facility was full. The other Staff Secure facilities denied the transfer for safety and licensing reasons. Staff Secure care providers were concerned about Victor's aggressive and threatening behavior toward staff and peers. The Staff Secure care providers said they also could not accept Victor due to suicidal ideations, self-harming behavior, and need for mental health services. The psychiatrist at the behavioral hospital recommended therapeutic placement to help Victor strengthen coping skills, improve impulse control, and cease suicidal ideations. The DHUC Medical Officer recommended an RTC placement after reviewing Victor's file. The RTC care providers denied the transfer due to Victor's physically aggressive and threatening behavior. One RTC care provider thought Victor had manipulated his way into being hospitalized. The other RTC care provider thought a therapeutic staff secure facility would provide him with a more structured environment. Victor remained at the shelter until being released to a sponsor in December 2019.

#### **EXAMPLE 6 – Eugenio, age 17**

At the time of our audit, Eugenio was at an RTC. Eugenio was denied a transfer nine times by staff secure, therapeutic staff secure, and secure care providers. The RTC requested the transfer due to physically aggressive behavior and being an escape risk. However, the staff secure and therapeutic staff secure care providers denied the transfer because of Eugenio's continued need for mental health services and because their facilities were "open campuses" and not equipped for a child with a history of escape attempts. The secure care providers denied placement because Eugenio's behavior was more suited for staff secure placement and did not meet the criteria for a secure care placement. The transfer was also denied twice because the staff secure care providers were full. Eugenio remained at the RTC until aging out of the program in February 2020.

#### **EXAMPLE 7 – Homero, age 17**

At the time of our audit, Homero was at a shelter. Homero was denied a transfer seven times by Staff Secure care providers due to sexually inappropriate behavior. The shelter requested the transfer due to continued disruptive behavior. Staff secure care providers could not accept Homero because they were not licensed to handle children with sexually inappropriate behavior, or they were unable to provide Homero with a personal room. The transfer was also denied three times because staff secure care providers were at capacity. Homero remained at the shelter until aging out of the program in October 2019, more than 3 months after the request for transfer was made.

#### **EXAMPLE 8 – Cristobal, age 17**

At the time of our audit, Cristobal was at a shelter. Cristobal was denied a transfer seven times by staff secure and therapeutic staff secure care providers. The shelter requested the transfer to find Cristobal a stable environment due to a traumatic past. However, the staff secure care providers denied the transfer due to aggressive behavior, including credible threats toward staff and the child's need for mental health treatment. The therapeutic staff secure care provider stated that it could not accept Cristobal due to assaultive behavior and because the facility is a "hands off" facility that does not accept any youth who assaulted an adult during the previous 6 months. The transfer was also denied twice due to staff secure care providers being full. Cristobal ran away from the shelter in October 2019, a month after the request for a transfer was made and after our audit period ended. We do not know whether Cristobal was found.

#### **EXAMPLE 9 – Patricio, age 15**

At the time of the audit, Patricio was at a shelter. Patricio was denied a transfer four times by Staff Secure and therapeutic Staff Secure care providers. The shelter requested the transfer due to Patricio's physical aggression and escape threats. Three Staff Secure care providers denied the transfer for licensing reasons as their admittance criteria did not allow accepting Patricio due to mental health needs, including a recent mental health hospitalization. The therapeutic Staff Secure care provider denied the transfer because Patricio would have been influenced by disruptive children at its facility at that time. Patricio remained at the shelter until being released to a sponsor in February 2020.

#### **EXAMPLE 10 – Ezequiel, age 12**

At the time of our audit, Ezequiel was at a shelter. A therapeutic group home and therapeutic staff secure care providers denied Ezequiel a transfer three times because they felt Ezequiel needed a level of care that they could not provide. Ezequiel was eventually transferred to an

RTC, 4 months after the first transfer request. Ezequiel was later discharged to the Unaccompanied Refugee Minors Program.<sup>72</sup> The date of the discharge was not provided.

**EXAMPLE 11 – Felipe, age 16**

At the time of our audit, Felipe was at a shelter. Staff secure care providers six times denied Felipe a transfer. The staff secure care providers denied the transfers, stating that Felipe needed a more restrictive facility due to self-disclosed criminal activity. Felipe was transferred to a secure facility within 11 days from the time the staff secure transfer requests were made. Felipe was eventually stepped down to a staff secure facility in October 2019 and voluntarily departed the United States to return to Felipe’s home country in February 2020.

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<sup>72</sup> The Unaccompanied Refugee Minors Program is the ORR-funded foster care services program available pursuant to 8 U.S.C § 1522(d), which established legal responsibility under State law to ensure that unaccompanied minor refugees and other eligible children receive the full range of assistance, care, and services available to all foster children in the State.

## APPENDIX H: ADMINISTRATION FOR CHILDREN AND FAMILIES COMMENTS



### ADMINISTRATION FOR **CHILDREN & FAMILIES**

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March 10, 2023

Juliet T. Hodgkins  
Principal Deputy Inspector General  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Ms. Hodgkins:

The Administration for Children and Families (ACF) appreciates the opportunity to respond to the Office of Inspector General (OIG) draft report titled, *The Office of Refugee Resettlement Needs To Improve Its Oversight Related to the Placement and Transfer of Unaccompanied Children* (A-06-20-07002). ACF's Office of Refugee Resettlement (ORR) is dedicated to ensuring the safety and well-being of children in our care from the moment they enter our custody from the Department of Homeland Security (DHS) or other federal entities, to when they are safely placed with a vetted sponsor who has undergone a robust screening process. The health and safety of children in ORR care is ORR's congressional mandate. To ensure children referred to ORR are placed in a safe environment where they will receive child-friendly services, ORR has long relied upon standard bed capacity from care provider facilities located across the United States. During periods of influx, ORR may experience challenges due to limited bed capacity, including placement and transfer delays. To best predict program resources, such as staffing and bed capacity needs, ORR works closely with its federal partners to identify trends and patterns.

While ORR has faced strains on its bed capacity, staffing resources, and the efficiency of its normal policies and procedures during previous emergency and periods of increased referrals, notably in fiscal year (FY) 2014 and FY 2019, the Coronavirus Disease 2019 (COVID-19) pandemic in 2020 placed even greater pressures on ORR's limited resources and posed new challenges. ORR's network of standard bed capacity was reduced by up to 40 percent due to the combined impacts of COVID-19 mitigation measures, such as the need to set aside space for isolation and quarantine needs, and staffing issues, including health considerations. ORR is required to maintain certain child-to-caregiver ratios in its facilities, and when sufficient staff were unavailable for various reasons during the pandemic (such as absences due to exposure to or infection with COVID-19, or personal caregiving responsibilities for an ill family member), the number of children able to be housed in a particular facility had to be reduced accordingly. COVID-19 required ORR to develop an agile response strategy to bed capacity acquisition and staffing recruitment, and to reevaluate existing policies and procedures to ensure the agency was adapting to these new challenges.

After low numbers of children referred from DHS in FY 2020, ORR experienced an increase in FY 2021 and 2022. ORR continues to assess capacity and staffing needs, and areas where ORR can strengthen policies and procedures on an ongoing basis in light of evolving trends by closely evaluating DHS projections, emerging issues that affect child health and safety, and immigration patterns.

Since OIG's audit in 2019, ACF has made several improvements to ORR's placement and transfer procedures such as expanding the ORR Intakes Team from nine to 24 full-time Intake contractors, reducing ORR's average time between DHS referral and placement to less than 24 hours, and developing a series of phased improvements to strengthen the oversight of the transfer process and necessary documentation. Additionally, ORR has engaged several out-of-network therapeutic facilities to aid in providing treatment for unaccompanied children with mental health or behavioral needs.

Please find our comments and response to the draft report recommendations below. ACF concurs with all four of OIG's recommendations and has already taken steps to implement the OIG recommendations to improve ORR's placement and transfer process.

**Recommendation 1:**

ORR should strengthen oversight of initial placements by addressing challenges with bed space capacity and intake specialist staffing during influx periods to ensure that a placement is made within 24 hours of each referral and Intakes Placement Checklists are completed for children with special needs or concerns.

**Response:** ACF concurs with this recommendation.

ORR has actively worked to strengthen the oversight of initial placements and reduce the time children spend in DHS custody once they have been identified as an unaccompanied child. This is being done through several lines of effort, including expanding bed capacity by building upon the network of standard beds among ORR's care providers and adding additional bed capacity options that quickly and safely respond to periods of influx. ORR has also focused on strengthening intakes specialist staffing by hiring more staff and ensuring they are trained in completing the ORR's *Intakes Placement Checklist* for children who may require placement in a restrictive setting, such as a staff secure or secure facility.

One of ORR's primary mission areas is to place unaccompanied children in a shelter suitable to their needs with services appropriate for children while a case manager works to identify and vet potential sponsors. ORR is continuously evaluating sponsor placement policies to ensure children are both safely placed and not spending more time in ORR custody than necessary. Reducing the length of care (LOC) for children meet our child-centered goal to safely limit the amount of time spent in congregate care while also keeping ORR's bed capacity available for children pending a placement designation in DHS custody. LOC is one factor ORR uses to assess capacity needs. Other factors include closely monitoring and reviewing several variables: number of children being referred, referral projections, and migration trends; DHS referral and ORR initial placement timelines; since 2020, COVID-19 infection rates and its impact on staffing and bed capacity; and total operational bed capacity across ORR's network of care provider facilities, including standard capacity availability and projections.

In FY 2019, ORR received 69,488 referrals of unaccompanied children. This, at the time, was the highest number of referrals ORR had ever received in a fiscal year. Due to COVID-19 impacts and application of Title 42 by the prior Administration—a practice later enjoined by a federal district court in November 2020 and stayed in January 2021—FY 2020 saw a precipitous drop in referrals to 15,381. In FY 2021, ORR received an unprecedented 122,731 referrals of unaccompanied children. In response to this historic increase, ORR, in partnership with other federal agencies, oversaw the largest and fastest expansion of emergency bed capacity suitable for children in an emergency response setting. Fourteen Emergency Intake Sites (EIS) were mobilized to provide shelter for children who were in DHS border facilities, which were experiencing dangerous overcrowding. DHS border facilities are not designed, equipped, or staffed to care for children for extended periods of time.

Though the number of children in ORR care has declined significantly since Spring 2021, referrals to the program continue to be high. ORR continues to focus its capacity efforts on: (1) maintaining sufficient standard shelter capacity that can adapt to evolving program needs; and (2) establishing sufficient reserve capacity such as Influx Care Facilities (ICF), which are intended to be used to ensure ORR can continue to accept all referrals from DHS within the legally mandated timeline—72 hours, absent exceptional circumstances.

As opposed to relying on emergency facilities, ORR's preference is to place children into standard care provider facilities, including State-licensed shelters, group homes, and transitional and long-term foster care, while sponsorship suitability determinations proceed, and immigration cases are adjudicated. To meet the evolving needs of the Unaccompanied Children (UC) Program, since 2019, ORR has increased its network of standard beds by:

- safely reactivating beds that were impacted by COVID-19 restrictions;
- initiating actions with current providers to provide additional bed capacity through recipient-initiated supplements;
- engaging non-governmental organizations and governmental jurisdictions to expand bed capacity; and
- publishing notices of funding opportunities (NOFOs) for current or new programs.

The ORR Project Officer (PO) Team, along with ORR federal field staff, continue to work closely with the grantees to expand bed capacity. For example, if a grantee is struggling to hire or retain critical staff positions such as clinicians, POs work closely to identify solutions to recruit and retain such staff. The primary driver for bed unavailability continues to be staffing shortages in relation to ORR's required staffing ratios of one clinician for every 12 children; one Youth Care Worker for every eight unaccompanied children during waking hours; one Youth Care Worker for every 16 unaccompanied children during sleeping hours and the case management ratio outlined in the care provider's Cooperative Agreement. During the COVID-19 pandemic and other hiring and staffing shortages, some care provider programs struggle to fulfill ORR's Youth Care Worker ratio during waking hours. ORR has worked with internal stakeholders to safely adjust staffing ratios and hiring requirements in such limited circumstances, to continue to meet state requirements, and in keeping with child welfare best practices, to ensure that staffing shortages do not prevent programs from operating. One way that care providers are expanding capacity is by safely increasing bed capacity that were

negatively impacted by COVID-19 protocols, such as the need to hold bedspace in reserve for quarantine and isolation purposes. Recalibrating staffing and bedspace requirements to align with current needs and resource constraints promotes the operational flexibility necessary to ensure timely placement regardless of the challenges confronting the agency.

ORR continues to fulfill its legal responsibility to receive children quickly and safely from DHS, provide them with appropriate child-centered care, and place them with a vetted sponsor. Pursuant to the William Wilberforce Trafficking Victims Protection Reauthorization Act (TVPRA) of 2008, barring exceptional circumstances, any department or agency of the Federal Government that has an unaccompanied child in custody is required to transfer the child to the Secretary of Health and Human Services (HHS) no later than 72 hours after determining that such child is unaccompanied. The ORR Intakes Team considers factors described in ORR UC Program Policy Guide Section 1.2.1 to identify a care provider when making placement decisions or recommendations, respectively, for unaccompanied children. The ORR Intakes Team attempts to place a child in a care provider facility as close to the point of custody transfer as possible, while considering the individual needs of the child. The ORR Intakes Team also consults with the ORR Federal Field Specialist (FFS) Supervisor, ORR's Division of Health for Unaccompanied Children (DHUC), or both, when making a placement determination in special cases such as children with medical or mental health concerns, or children with behavioral needs.

ORR places children in facilities that provide services and treatment, in accordance with their state licensing requirements and each child's individual care needs. To ensure placement in an appropriate facility, ORR's Intakes Team critically reviews the information provided by the referring agency, typically DHS, and identifies the least restrictive setting that is in the best interest of the child. Until ORR receives the referral, ORR has no visibility into the child's background or needs and is dependent on the information furnished by federal partners in making initial placement decisions. In cases where there are gaps in information provided during the referral process, ORR must work closely with federal partners to identify and fill those gaps to ensure that the most appropriate placement for the child is made at the outset.

ORR's Intakes Team is a crucial first component in the placement process. ORR's Intakes Team now operates 24 hours a day, seven days a week, year-round to accept referrals and find placement for children and youth within ORR's network of care providers. Per ORR policy, in cases where a child may present a danger to self or others, ORR's Intakes Team uses a standardized checklist (the "*Intakes Placement Checklist*") to include all available information on the unaccompanied child's history and condition. The ORR FFS Supervisor then makes a placement decision on the level of care based on the information provided to the Intakes Team, and the Intakes Team designates the child's placement. The ORR FFS Supervisor may only decide to place a child in a restrictive facility, such as secure or staff secure facility, if clear and convincing evidence supports that placement.

Since 2019, there have been extensive improvements to the Intakes Team. In 2019, the team consisted of nine full-time Intakes contractors that worked shifts scheduled to process incoming referrals from 9:00AM–9:00PM Eastern Standard Time (EST). Intakes would make placement designations until all children referred that day had a designated placement or until available bed capacity was filled, in which case new referrals had to be placed at 9:00AM the following day. As of February 2023, the ORR Intakes Team has expanded to include 24 full-time Intake

contractors, plus three additional vacant positions the agency is actively working to fill. Since December 2021, ORR has had full shift coverage to process all referrals and make placement designations 24 hours a day, seven days a week, 365 days a year, with the ORR Intakes Team working across three shifts to process incoming referrals:

- Shift 1: 7:00AM–3:00PM EST
- Shift 2: 3:00PM–11:00PM EST
- Shift 3: 11:00PM–7:00AM EST

As of February 2023, ORR’s average time between referral and initial placement at an ORR care provider facility is between 17–21 hours, consistently less than the TVPRA requirement of within 24 hours. This is a significant improvement over 2019’s average time of 27 hours and demonstrates the effectiveness of the steps taken thus far to enlarge and strengthen the ORR Intakes Team. ORR also continues to address bed capacity challenges, which can lead to placement delays, by expanding network options.

**Recommendation 2:**

ORR should strengthen oversight of transfers between ORR care provider facilities by requiring that all transfer documentation be maintained in the UC Portal and by developing procedures for tracking and reviewing that documentation.

**Response:** ACF concurs with this recommendation.

Transfer of children between ORR care provider programs is an elaborate process requiring close coordination among case managers from both the sending and receiving care facilities, sending and receiving case coordinators, the sending medical coordinator or other medical staff, ORR FFS staff, and other stakeholders such as attorneys and Child Advocates, as is appropriate to the case. ORR recognizes that oversight of the transfer process should be strengthened to ensure that all transfer documentation that is currently sent through e-mail is incorporated into the UC Portal and that there are clear procedures for tracking and reviewing that documentation.

A care provider facility’s access to transfer documentation is critical to supporting the safety and well-being of unaccompanied children. Per ORR UC Program Policy Guide Section 1.4, the process begins when the referring case manager completes the *Transfer Request* form in the UC Portal’s Discharge Tab, which makes the initial recommendation to the case coordinator and the FFS for a transfer based on the needs of the child and whether their current placement can provide the services necessary to ensure the child’s well-being. Transfer referrals are sent to the contracted case coordinator who then sends transfer requests to the new placement provider and that case coordinator manages e-mails regarding a provider’s acceptance or denial of acceptance for the transfer request. The referring case manager concurrently completes the *Initial Transfer Request File*, which contains a host of documents including the Transfer Request form, the UC Assessment, updated Case Review, clinical notes, birth certificates, DHS and immigration court records, and any other significant documentation. The referring case coordinator reviews the *Transfer Request File* and consults with the case manager to decide if a transfer to an alternate placement will better meet the unaccompanied child’s individual needs or identifies a more appropriate alternative placement. Referring medical coordinators or the medical team are responsible for completing the *Medical Checklist for Transfers* within three-days of identifying a

child’s need of a transfer. The process of refusal, acceptance, or need for another placement only occurs between the case manager and the case coordinator. Any reasons for transfer denial must be in accordance with UC Program Policy Guide Section 1.3.3. Once a transfer package is complete, the ORR FFS will review the *Transfer Request File* and approve or deny the request.

Among the documents involved in the transfer process, many are stored in the UC Portal, such as the *Transfer Request* form, child assessments, Medical Checklist for Transfers, Intakes and admissions notes, and clinical notes. These documents are all accessible to those with equities in facilitating the transfer process, such as case managers, case coordinators, medical coordinators, and FFS. However, not all supporting documents for the *Transfer Request File* are stored in the UC Portal, which requires some level of out-of-system communication through email in order to ensure all the relevant stakeholders have the necessary documents and information related to the transfer request. For example, attorney or legal service provider notifications of a transfer occur outside the UC Portal via email or phone call to ensure those stakeholders are timely informed of the progress and can flag immediate concerns. The transfer process is complex in terms of documentation and internal stakeholder engagement to ensure children’s needs are being met. ORR has taken steps to improve how documentation is tracked and reviewed with the goal to consolidate the process of transfer initiation and completion into the UC Portal itself.

To improve and strengthen the transfer process and oversight of the documentation involved, ORR developed a series of phased improvements that are already being implemented. The first phase of improvements to the transfer process took place on November 21, 2022, with ORR’s revisions to the transfer request procedures.<sup>1</sup> These revisions included a clarification for expectations and timelines for care provider case managers, case coordinators, and FFS for completing the *Transfer Request* form in the UC Portal. The technical revisions also clarified current procedures for what information must be completed in the Transfer Request form and allow for standardized collection of and tracking the length of time it takes from initiating a transfer request to the acceptance of a transfer request. Further, the revisions also allowed for greater program accountability and oversight for accepting a transfer request within required timeframes.

Additionally, to further clarify the new procedures and improve transfer request documentation, ORR’s Policy Coordination and UC Portal team are currently developing two separate forms that differentiate between a *Transfer Request*, which is completed when a need for a child’s transfer to another care provider is identified and recommended by the referring case manager, and a *Transfer Placement*, which is completed once a new placement has been identified and confirmed by the receiving care provider. These forms would be completed in the UC Portal. These changes have an anticipated roll-out in Summer 2023. When this improvement is implemented, ORR will be able to better track transfer data. Obtaining this more granular information on transfer requests will assist ORR staff in identifying where there may be additional obstacles to securing transfer placements, such as for transfers to long-term foster care, as well as other types of transfers such as step-up and step-down transfers. Publishing these revisions will also help ORR have greater oversight of care providers and hold them accountable to timelines for acceptance and denial of a transfer case.

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<sup>1</sup> Please refer to Version 5 of the ORR UC Manual of Procedures (UC MAP) Section 1.4 for additional information.

When the new transfer documentation redesign is published, ORR will subsequently publish substantive changes to its transfer policy and procedures to accompany the transfer request redesign with an anticipated release, at this time, of Summer 2023. ORR will train its care providers prior to this release to ensure understanding and compliance with all new policy and procedures. A third phase of these updates to the transfer process will be used to develop a queue of pending transfer requests in the UC Portal so that care providers can review cases and accept or deny requests for placement within the UC Portal, further reducing reliance on manual procedures. Finally, a planned fourth phase of updates to the transfer process will allow the UC Portal to reflect new program definitions, ensuring foster parent contact information is collected, and digitizing the form to be maintained in the UC Portal to give ORR staff easier access to foster home placement (and subsequent changes in foster home placement) information in UC Portal.

**Recommendation 3:**

ORR should review restrictive setting placement denials and take action as needed to ensure an appropriate placement for each child.

**Response:** ACF concurs with this recommendation.

Since its inception in 2019, ORR’s *Flores* Compliance Workgroup, comprised of the ORR FFS Supervisor of Special Populations, the ORR FFSs who cover specialized programs, the ORR DHUC, the ORR Policy Unit, and the ORR Field Office Juvenile Coordinator, oversees the weekly review of restrictive setting placement denials, as well as current placements in restrictive settings. The *Flores* Compliance Workgroup reviews the Notice of Placement (NOP) for each unaccompanied child who is in a restrictive level of care (both within and outside the ORR provider network) to determine if they are placed appropriately. The *Flores* Compliance Work Group reviews the NOP for each child to ensure the form(s) have been completed correctly and clearly articulate the reasons why the child is in their current placement. ORR utilizes the NOP criteria and supporting case record to determine if the child is an appropriate candidate for a restrictive placement (along with re-evaluations into a less restrictive setting). Psychological or psychiatric evaluations, or both as available, are reviewed to support a restrictive placement recommendation. Lastly, ORR’s Workgroup examines the totality of the case to determine if the child does in fact require a transfer. Concurrently, the case manager is assessing if the child has a pending family reunification and can safely unify with their sponsor. ORR will always release a child to their vetted sponsor rather than prolonging ORR care.

In addition, the ORR DHUC monitors unaccompanied children who are on psychotropic medications and consults with the programs’ attending physicians and staff throughout their time in ORR care. DHUC also reviews the child’s medical documentation and will follow up with the FFS and or care provider if there are further questions or discrepancies regarding placement, placement recommendation, and medication regime. The FFS issues corrective actions if any of the NOPs are not in compliance with ORR policy and procedures, provides technical assistance to the care providers, and updates the *Flores* Compliance Workgroup on the children’s progress. Further, the ORR Policy Unit reviews all NOPs to ensure they are completed correctly, and the form adequately explains why a child is placed in their respective level of care. Additionally, they provide policy guidance to the workgroup and field staff and update the FFS on what

programs may require a corrective action, technical assistance, or follow up. Finally, the Field Office Juvenile Coordinator, in conjunction with the ORR Policy Unit, provides updates on any site visits, upcoming court hearings as it relates to special populations, and supports ORR on any training or guidance to programs. In totality, on an as needed basis, the *Flores* Compliance Workgroup provides training and technical assistance to ORR care providers on completing the NOP, policy and procedures for transferring children to specialized care providers, and ensures children are appropriately placed in the least restrictive level of care at the outset.

If an unaccompanied child requires a transfer to a restrictive level of care, ORR requires that all in-network placement options be explored. ORR in-network care providers can only deny a request for placement in accordance with ORR UC Program Policy Guide Section 1.3.3. There must be lack of available space; placement of a child would conflict with the care provider's State or local licensing rules; or placement of a child with a significant physical or mental illness for which the referring Federal agency does not provide a medical clearance and/or medications that would conflict with the care provider's State or local licensing requirements. If all in-network programs do not accept a child, the FFS will send the case to the FFS Special Populations Team who assist with out-of-network placement options, as further demonstrated in ORR UC Program Guide Sections 1.2.4, 1.4.2, and 1.4.6. The Special Populations Team has fostered relationships with out-of-network providers to ensure a placement can be timely identified after all internal options have been exhausted. Additionally, the contracted case coordinator and the ORR FFS are always involved in reviews of all restrictive setting placement denials. If either the *Flores* Compliance Workgroup or the FFS and case coordinator observe a pattern of specific in-network care providers continually denying placements, they flag the denials for the assigned ORR PO and issue corrective action.

**Recommendation 4:**

ORR should assess the need to expand its network capacity to serve the needs of children with mental health and behavioral issues.

**Response:** ACF concurs with this recommendation.

Since 2019, ORR has made significant improvements to assess and address its network capacity to better serve the needs of children with mental health and behavioral issues. ORR has hired a Field Supervisor for Special Populations to oversee care and treatment services for children in secure, staff secure, and residential treatment center placements. This supervisor's responsibilities have expanded since June 2022 to include seeking and coordinating increased mental health and treatment services for shelter cases needing specialized placement.

In response to increased need for bed capacity for children with greater mental health needs, ORR has successfully increased capacity and expanded providers over the last few years. Since 2019, ORR engaged several out-of-network therapeutic facilities to aid in providing treatment for unaccompanied children, such as Acadia, Devereux, Laurel Ridge, New York Presbyterian Morgan Stanley Children's Hospital, United Health Services, Trinity Health, Vista Del Mar and Star View as well as existing ORR grantees Rite of Passage, KidsPeace and Youth for Tomorrow. ORR continued efforts to engage new partners to further support this special population and expand ORR's network capacity of providers who could also meet this need.

While challenging to identify and maintain, ORR prioritized securing specialized providers for these types of housing for children to safely serve their needs.

In addition to expanding its network of providers for this specific shelter need, ORR has undertaken efforts to ensure continued funding and expansion. Between October 2018 and December 2023, ORR will have extended grants for seven therapeutic programs. ORR has also published standing notices of funding opportunity (SNOFOs) announcements for staff-secure, and secure programs and plans to publish SNOFOs for therapeutic group homes, and residential treatment centers in May 2023.<sup>2</sup> ORR anticipates that approximately 35 additional awards will be granted through these SNOFOs. Additionally, ORR has drafted additional requirements in its Cooperative Agreement Addenda for secure, staff secure, residential treatment centers, and therapeutic group homes to enhance therapeutic services for minors in specialized placements. Such language includes a requirement that care providers must provide or have access to services for unaccompanied children with mental health and behavioral issues, including substance use issues and anger management concerns.

Furthermore, DHUC's Mental and Behavioral Services Team is working to integrate clinicians as part of the care providers' medical teams to ensure clinicians and medical professionals are working together to assess the health needs of every child in ORR care. DHUC is educating primary care physicians on mental health resources available in the community so that some children can be treated at the shelter level instead of being stepped up to a more restrictive placement. Additionally, DHUC is focused on providing trainings on trauma informed care so that providers can recognize trauma-related behaviors and how to address them.

Again, thank you for the opportunity to review and comment on this report. Please direct any follow-up inquiries on this response to Scott Logan, Office of Legislative Affairs and Budget, at (202) 401-4529.

Sincerely,



January Contreras,  
Assistant Secretary  
Administration for Children and Families

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<sup>2</sup> The secure SNOFO was published on January 12, 2023, at [www.grants.gov/web/grants/view-opportunity.html?oppId=344685](http://www.grants.gov/web/grants/view-opportunity.html?oppId=344685) and the staff-secure SNOFO was published on February 23, 2023, at [www.grants.gov/web/grants/view-opportunity.html?oppId=345053](http://www.grants.gov/web/grants/view-opportunity.html?oppId=345053).