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Via Email and US Mail

Cindy Huang
Director, Office of Refugee Resettlement
U.S. Department of Health & Human Services
330 C ST S.W., Room 5123
Washington, DC 20201
cindy.huang@acf.hhs.gov

**Re: Findings from the Monitoring of the Long Beach Convention
Center Emergency Intake Site**

Dear Director Huang:

Disability Rights California (DRC) protects and advocates for the rights of all people with disabilities in the State of California, regardless of their ethnicity, cultural background, language, or immigration status. DRC is the state and federally mandated Protection & Advocacy system for the state of California. As part of our Congressionally mandated access authority, DRC investigates immigration detention facilities across the state.

Long Beach Immigrant Rights Coalition (LBIRC) is building and sustaining a thriving immigrant-led movement to end the criminalization of immigrants and secure bold protections and opportunities that allow immigrant communities to thrive. LBIRC supports the leadership development of immigrant leaders through political education, leadership programs, wellness resources, and shared advocacy. LBIRC advocates and organizes to transform the systems and power structures (i.e. laws, budgets and policies) that impact our community. LBIRC is a regional hub for information, services, and resources for the immigrant community and

builds partnerships; the Coalition is an integral force in local, state, and national coalitions that are advancing intersectional movements for justice.

DRC partnered with LBIRC to monitor the Long Beach Convention Center Emergency Intake Site (“LBCC EIS” or “Facility”) on July 2, 2021. We spoke with leadership staff, toured the facility, and interviewed 16 children over the course of about 5 hours.¹ This letter summarizes our findings.

I. Facility Information

The capacity of the LBCC EIS was 1000 children; 800 in the general living areas and 200 in the COVID isolation living area. At the time of our monitoring visit there were 582 children in the Facility. The population consisted of 1 person who was identified as male and 581 were identified as female. The children in the Facility were from Central America, South America, and the Caribbean. The primary language spoken by the children in the Facility was Spanish but other dialects were spoken as well.²

The Facility was split up into intake, recreation, and living areas. The living areas were separated into “pods” of about 30 cot beds each that were evenly spaced out on the open convention center floor. The pods were separated by dividers and walkways for access. The COVID isolation tent was inside the facility and separated from the other living areas. At the time of our visit, 61 children had tested positive for COVID and were in the isolation living area.

The Facility reported a staff to children ratio of 15:1, and 8:1 for children 6-12 years old. The average length of stay since opening in April was 20 days, while the average length of stay since May 31st was 9.6 days. Most of the children we interviewed had been at the facility for between 8-10 days, while one child had been there for 34 days. The facility was set to close on August 2, 2021.³

¹ We were limited in terms of how many children we could interview based on programming schedules.

² The Facility had translation services to accommodate children and families that spoke different dialects.

³ We received information that the Facility no longer contained children as of July 23, 2021.

II. Disability Identification and Tracking

The Facility did not have a specific identification and tracking system for children with disabilities. Staff reported that any children with an “obvious” disability would be transferred to another location. The Facility reported that they could not accommodate children with mobility disabilities. Several children we spoke with discussed issues related to mental health (see below) that are potentially signs of a disability. Without a system to identify and track disabilities the Facility may not be able to provide adequate accommodations and ensure those accommodations follow children to their next living situation.

The Facility did not have a grievance system for specifically tracking disability-related issues. The grievance form we were provided also does not let a child identify whether they are making a disability-related request or complaint. Additionally, there were no staff specifically designated to coordinate and respond to any disability-related issues or grievances.

III. Medical Treatment

Medical treatment at the Facility was contracted and subcontracted out to different local and out-of-state providers. The main contractor for LBCC EIS was a company called DRC Emergency Services,⁴ a disaster management company. The medical care was run by UCLA Health, who ran the intake process and ongoing medical treatment. The mental health care was run by Comprehensive Health Services (CHS).

A. Mental Health

Facility staff reported that children were offered group counseling sessions on a weekly basis and individual counseling as needed. Staff clarified that services offered were not “therapy” as the groups or sessions offered did not rise to that level of treatment. The facility grouped the counseling sessions into age groups of 5-12 years old and 13-17 years old.

Two children we interviewed reported that group counseling sessions were not happening as regularly as once per week. One child reported to us that

⁴ Not related to or affiliated with Disability Rights California.

they did not get individual follow-up for mental health services that they requested. Two others reported that they did not believe they were offered mental health services. Finally, one child was feeling distressed because they did not believe that the sessions they were being given were helping them with their mental state.

B. Medical and Dental

Medical treatment was provided at the intake area at a centralized medical treatment area. Children reported that they had been seen by medical staff and provided with initial medical evaluations. However, during our interviews one child reported being prescribed pills but not knowing what they were for.

C. Dental

The Facility did not offer on-site dental care and that dental care was limited. The Facility limited dental care because of the children's short average length of stay. One child reported to us that they had a filling fall out but after two days were still waiting to see the dentist.

IV. Education

The Facility did not provide traditional or core education instruction. The lack of traditional instruction was again justified by the children's short length of stay. The education program at the Facility was described as thematic and relying heavily on art as an education tool. Children were organized into educational classes by ages of 5-7 and 8-17 years old. The facility had two to three instructors per area and 26 instructors total. The Facility reported that all instructors spoke Spanish. The instructors were additionally used for other tasks, such as counting inventory, when needed. The education program did not have any coordination with the local school district.

The education team also did not have a specific tool to identify children with intellectual or developmental disabilities. The system for identification explained by staff involved a case worker flagging additional needs based on reviewing a child's writing or schoolwork. Staff explained writing assignments were sprinkled into the curriculum, rather than a core component.

V. Case Management

Children reported issues of access and communication with their case management workers. Two children mentioned that it took five and eight days respectively for them to be assigned case workers. Another child reported that it had been five days since they heard from their case worker. Several children also mentioned that their case workers were being switched every two days. None of the children we spoke to at the Facility had an estimate of their departure date, despite several of them having contact with their sponsors. Most children also did not have a clear idea of the status of their case or the difference between their case worker and an attorney. One child reported the lack of knowledge and communication about her case was emotionally distressing.

VI. Conditions of Confinement/Miscellaneous

A. Outdoor Recreation

Children who tested positive for COVID were required to stay in the indoor tent for all programming for 10 days before being retested. From our observations of the grounds, there appeared to be ample space to accommodate the children in isolation to have time outside the Facility in the outdoor recreation space safely. This would be in-line with CDC guidance, which lists outdoor activities as among the safest.⁵

In regards to recreational outdoor time for the general population, one child reported that they were only getting 30 minutes of outside time. According to staff and the Facility programming schedule children are required to be provided with at least one hour of outdoor recreation time.

B. Food Services

More than half of the children we interviewed reported issues with the food being provided at the facility. The reports included undercooked food, bland

⁵ See CDC, "Choosing Safer Activities," (May 28, 2021), <https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/participate-in-activities.html>; see also David Leonhardt, "A Misleading C.D.C. Number," *New York Times*, (May 11, 2021), <https://www.nytimes.com/2021/05/11/briefing/outdoor-covid-transmission-cdc-number.html> (listing outdoor transmission rates from several studies and estimates at less than one percent).

food, lack of vegetables, and general unfamiliarity with the food being provided to them.

C. Interaction with Care Workers

Two children reported that they felt uncomfortable with the care workers supervising their unit. As a result, one child did not feel comfortable asking to use the restroom at night because of the gender of their care worker. Another child did not feel comfortable approaching their care worker about bullying that was happening to them.

VII. Legal Information Access

Children were provided with an orientation packet that includes legal rights information and referrals for assistance with their immigration proceedings. As with adults, undocumented children are not provided with or have the right to free legal representation while in custody. Therefore, children as young as five years old who stayed in this facility are required to navigate the immigration system alone if they do not have help from a guardian or attorney.

ORR guidelines also require that children be provided with a Know Your Rights presentation within 10 days of arriving at the Facility. Several children reported that they did not remember or were unsure of whether they had been provided with the Know Your Rights training.

VIII. Recommendations

Emergency Intake Sites like LBCC EIS are a symptom of the failure of the immigration system as it exists today. The LBCC EIS made a valiant effort to safely and quickly process children coming across the border but facilities like it are not designed to provide the necessary and trauma-informed services for this population. We encourage ORR to phase out EISs as quickly as possible.

Rather than short-term band-aid solutions like the EIS sites, we urge the Biden administration to address the root causes of unaccompanied child migration, and ensure that children who migrate can be with trusted caregivers and receive the support they need to thrive.

The following are our specific recommendations based on our experience with children's immigration detention and this monitoring visit:

- Phase out Emergency Intake Sites as soon as possible and do not expand them.
- Adopt and publish clear guidelines to ensure that particularly vulnerable children are not placed in Emergency Intake Sites.
- Ensure unaccompanied children have immediate and consistent access to legal counsel, trauma-informed child advocates, and interpretation services.
- Adopt robust case management standards and oversight mechanisms to improve the quality and timeliness of case management services children receive at Emergency Intake Sites. Every child must meet with a case manager within their first three days at an Emergency Intake Site and receive consistent case updates from their case manager.
- Ensure ORR and contractors have functioning systems to identify and track children with disabilities in order to provide necessary accommodations.
- Provide meaningful and effective mental health services, including individualized treatment plans.
- Offer basic literacy and numeracy classes alongside regular course content to support student growth and transition into a new education system.
- Ensure children have daily access to outdoor recreation, including children in COVID isolation.
- Establish a safe and rapid process for keeping children together with trusted non-parental caregivers at the border.
- Improve the reunification process to more quickly place children with family or sponsors in the US by working with trusted community-based organizations. These partnerships should also work to improve the number of case workers per child, and alleviate stress on each child by providing them with greater transparency and information on their own case.

- Provide post-release services to children exiting Emergency Intake Sites, including connecting particularly vulnerable children with social and legal services.
- Implement a robust system of oversight for facilities that house immigrant children. This oversight should include strong enforcement mechanisms to hold facility operators and detaining agencies responsible for civil and human rights violations.

We are available to discuss the above findings and recommendations. Please contact us with any questions.

Sincerely,



Richard Diaz
Staff Attorney
Disability Rights California



Gaby Hernandez
Executive Director
Long Beach Immigrant Rights Coalition

CC: Robert Garcia, Mayor of Long Beach
DRC Emergency Services
UCLA Health
Comprehensive Health Services (CHS)