Comment on Provisions Related to Disability and Psychotropic Medication in the Unaccompanied Children Program Proposed Foundational Rule

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1. INTRODUCTION

December 4, 2023

Submitted via https://www.regulations.gov/commenton/ACF-2023-0009-0001

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Administration for Children and Families
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: HHS Docket No. ACF-2023-0009, Comments in Response to Proposed Rulemaking: Unaccompanied Children Program Foundational Rule

Dear Mr. Biswas:

The Bazelon Center for Mental Health Law and the Young Center for Immigrant Children's Rights submit this comment alongside the undersigned organizations, law clinics, academics, and law firms in response to the Office of Refugee Resettlement's (ORR) Notice of Proposed Rulemaking on the Unaccompanied Children Program Foundational Rule[1] ("Proposed Rule") to address sections of the Proposed Rule that relate to children with disabilities and the administration of psychotropic medications.[2] Many of the signatories to this comment have extensive experience providing legal, child advocate, social, mental health, or other services to and advocating on behalf of children with disabilities, including unaccompanied children with disabilities.

We deeply appreciate the Proposed Rule's recognition of the rights of children with disabilities in ORR custody and the need for greater oversight of the administration of psychotropic medications across the care provider network. It is clear that ORR has heard the concerns of advocates and made a concerted effort to include disability rights protections throughout the Proposed Rule.

[1] Unaccompanied Children Program Foundational Rule, 88 Fed. Reg. 68908 (Oct. 4, 2023) (to be codified at 45 C.F.R. pt 410).
[2] Many of our organizations have also joined separate comments addressing other provisions of the Proposed Rule.

We support provisions of the Proposed Rule that reflect obligations that ORR and its providers have under Section 504 of the Rehabilitation Act, including that ORR must generally place children with disabilities in integrated programs and must make reasonable modifications to its programs, provision of services, equipment and treatment, so that children with disabilities can have equal access to the programs in the most integrated setting appropriate. Likewise, the Proposed Rule takes an important step forward by acknowledging ORR's responsibility to provide effective communication and auxiliary aids and services, and requiring ORR to provide affirmative support for sponsors in accessing and coordinating services to care for children with disabilities in their communities.

However, the Proposed Rule does not fully implement ORR's legal duties and maintains ORR's overreliance on restrictive settings for youth with higher needs. Nor does the Proposed Rule acknowledge the harms of continued detention and separation as a balancing factor in making release decisions. Additionally, the provisions relating to the administration of psychotropic medications are too general to adequately protect children's rights or ensure meaningful oversight.

In the following comment, we encourage ORR to clarify certain aspects of the Proposed Rule and strengthen protections for children with disabilities and those prescribed psychotropic medications. We have suggested specific language in some sections but also make more general recommendations regarding ORR's approach. We reproduced full provisions of the Proposed Rule with our edits reflected for clarity but the absence of edits to language in any particular section of the Proposed Rule should not be interpreted as an endorsement of that language.

2. CHILDREN WITH DISABILITIES

a. Definitions

i. *Special needs unaccompanied child*

Proposed Revisions:

410.1001

~~***Special needs unaccompanied child*** means an unaccompanied child whose mental and/or physical condition requires special services and treatment by staff. An unaccompanied child may have special needs due to alcohol or substance use, serious emotional disturbance, mental illness, intellectual or developmental disability, or a physical condition or chronic illness that requires special services or treatment. An unaccompanied child who has suffered serious neglect or abuse~~

~~may be considered a special needs minor if the child requires special services or treatment as a result of neglect or abuse.~~

Standard program means any program, agency, or organization that is licensed by an appropriate State agency, or that meets other requirements specified by ORR if licensure is unavailable in the State to programs providing services to unaccompanied children, to provide residential, group, or transitional or long-term home care services for dependent children, including a program operating family or group homes~~, or facilities for special needs unaccompanied children~~. A standard program must meet the standards set forth in § 410.1302. All homes and facilities operated by a standard program~~, including facilities for special needs unaccompanied children,~~ shall be non-secure. ~~However, a facility for special needs unaccompanied children may maintain that level of security permitted under State law, or under the requirements specified by ORR if licensure is unavailable in the State, which is necessary for the protection of an unaccompanied child or others in appropriate circumstances.~~

Comment: For the reasons outlined in the Preamble, we support omitting the term "special needs unaccompanied child" from the Final Rule.[3] "Special needs" is a disfavored term in the disability community and is seen as degrading. We agree that it is unnecessary to reference "facilities for children with special needs" in the definition of standard program. We also support replacing "special needs" with "individualized needs" in other sections of the Final Rule.

ii. *Qualified interpreter*

Proposed Revisions:

410.1001

Qualified interpreter means:
(1) For an individual with a disability, an interpreter who, via a video remote interpreting service (VRI) or an on-site appearance, is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. Qualified interpreters include, for example, sign language interpreters, oral transliterators, and cued-language transliterators. **A qualified interpreter for an individual with a disability must adhere to generally accepted interpreter ethics principles, including client confidentiality.**

[3] *See* 88 Fed. Reg. 68915-16, 68920-21, 68925.

Comment: The definition of a qualified interpreter for a limited English proficient individual includes a requirement that the interpreter "[a]dheres to generally accepted interpreter ethics principles, including client confidentiality." This ethics requirement must be included in the definition of a qualified interpreter for an individual with a disability to make clear that individuals with disabilities are entitled to the same confidentiality and ethical protections as limited English proficient individuals.

b. Needs Assessment and Services

i. *Needs assessment*

Proposed Revisions:

410.1106 Unaccompanied children who need particular services and treatment.
(a) ORR shall assess each unaccompanied child in its care to determine whether the unaccompanied child requires particular services and treatment by staff to address their individual needs while in the care of the UC Program.
Assessments must be evidence-based, trauma-informed, developmentally appropriate, culturally competent, and conducted in the child's preferred language. ORR shall adopt strength-needs assessments for children whose behavior indicates a need for services and or supports. An unaccompanied child's assessed needs may require particular services, equipment, and treatment by staff for various reasons, including, but not limited to disability, alcohol or substance use, a history of serious neglect or abuse, tender age, pregnancy, or parenting.
(b) ORR shall provide a prompt evaluation/individualized assessment of a child's needs due to disability under the following circumstances: (i) if a child, or the child's attorney or child advocate, requests an evaluation; (ii) if the child is psychiatrically hospitalized or evaluated for psychiatric hospitalization, or (iii) if the child is being considered for transfer to a restrictive setting based on danger to self or others. Such evaluation will be conducted by a qualified professional and will consider the child's need for reasonable modifications and auxiliary aids and services. A pending evaluation of a child due to suspected or identified disability shall not delay the release of a child.

410.1302 Minimum standards applicable to standard programs. Standard programs shall . . . (c) Provide or arrange for the following services for each unaccompanied child in care . . . (2) An individualized needs assessment that shall include . . . (iii) Identification of the unaccompanied child's **individualized**

~~special~~ needs including any specific problems that appear to require immediate intervention;

Comment: Although we support ORR's commitment to assessing each unaccompanied child's needs, the Proposed Rule does not provide sufficient detail to ensure that such assessments will be meaningful and accurate. In Section 410.1106, the Final Rule should specify that assessments must be evidence-based, trauma-informed, developmentally appropriate, culturally competent[4], and conducted in the child's preferred language.[5]

We applaud ORR's statement in Section 410.1106 that the purpose of assessments is "to determine whether the unaccompanied child requires particular services and treatment by staff to address their individual needs while in the care of the UC Program." We agree that the goal of the assessments described by ORR in Sections 410.1106 and 410.1302(c)(2) should generally not be diagnosis, but rather, identification of the services and supports which would be most helpful to the specific unaccompanied child to increase their well-being and reduce any disruptive behavior, including and anticipating post-release by recommending supports and services for the child in the community.[6] Needs assessments and integrated placement determinations for children with disabilities should be just as timely as assessments and integrated placement determinations for children without disabilities. These assessments should not delay a child's release.

ORR should adopt strength-needs assessments for children whose behavior indicates a need for services and/or supports. ORR need not create an entirely new system to find and "diagnose" these children. Typically, children who require "particular services and treatment . . . to address their individual needs," such as unaccompanied children with serious mental health conditions, will be readily identifiable. Strength-needs assessments are assessments to identify the child's needs (in addition to symptoms) and strengths that can be used as an aid to treatment. For example, what needs does the child have that are being met by

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[4] Regarding cultural competence, we note, however, that in recent years in the social work field, professionals have shifted the focus from being culturally competent to being culturally responsive and aware, as well as to practice cultural humility. Professionals may not truly achieve full competence in another individual's culture that is not their own. For example, revisions to the NASW Code of Ethics Standard 1.05 included a change in the title from "Cultural Competence and Social Diversity," to "Cultural Awareness and Social Diversity." This change was based on literature and discussions that social work professionals realistically cannot become competent in all cultures. Rather, social workers can and should focus on ongoing learning to improve their skill set and meet the needs of clients with diverse cultures. ORR should consider incorporating cultural responsiveness into its practices as well.

[5] *See, e.g.,* Proposed Rule §§ 410.1210(d), 410.1304(a).

[6] *See, e.g.,* Lisa Conradi et al., U.S. Dep't of Health & Human Serv., Admin. for Children & Families, Children's Bureau, *Screening, Assessing, Monitoring and Using Evidence-Based Interventions to Improve Well-Being of Children in Child Welfare* (2014).

the child acting out (i.e., the underlying function of the child's behavior) and what activity might the child engage in to otherwise meet the child's needs? If the child is stressed, what needs must be met for the child to feel less stressed? And what activity that the child values and enjoys would help the child feel less stressed? The assessment process must determine the root cause of the stress and make changes necessary to address or ameliorate it. Behavior is a form of communication. Focusing only on diagnosing a child and cataloging symptoms provides limited benefit when it comes to treatment. It does not address the root causes of the behavior.

To be effective in identifying a child's needs, an assessment should be performed by a qualified individual with expertise in/experience with the child's particular disability. This qualified individual may be someone who ideally the child has some familiarity with and trusts, or the assessment may be performed with a known and trusted companion present or nearby if appropriate. For the purposes of assessment, a child must be observed in the most natural, comfortable/familiar/community-based setting possible.[7] For most children, this means that strength-needs assessments in a detention setting are unlikely to be as effective as assessments upon release to a community setting. These assessments should be conducted in whole or part post-release for the majority of children, unless that child is being considered for a placement in a more segregated setting for disability-based reasons. This is additional support for timely assessments that do not delay a child's release.

Furthermore, ORR must comply with its specific obligations to children with disabilities under Section 504 of the Rehabilitation Act. In some situations a more formal evaluation for disability is required to ensure children's Section 504 rights are protected. Section 410.1106 should specify that if a child (or the child's attorney or child advocate) requests an evaluation, if the child is psychiatrically hospitalized or evaluated for psychiatric hospitalization, or if the child is being considered for transfer to a restrictive setting based on danger to self or others, the child will receive a prompt evaluation/individualized assessment of the child's needs due to disability conducted by a qualified professional; such evaluation will consider the child's need for reasonable modifications and auxiliary aids and services. Children or their lawyers or child advocates should also have the right to request an independent evaluation of the child's individualized needs due to disability by a provider of their choice and at no cost to the child. We recommend that ORR cover or reimburse for reasonable costs of independent evaluations in order to mitigate potential barriers to procure this external resource so as not to

[7] *See* Nat'l Ctr. for Youth Law, Guidance for Mental Health Professionals Serving Unaccompanied Children Released from Government Custody (2021), https://youthlaw.org/sites/default/files/attachments/2022-03/2021_Guidance-for-Mental-Health-Professionals-Serving-Unaccompanied-Children-Released-from-Government-Custody.pdf.

cause unreasonable delays for a child's release or transfer to a less restrictive setting. The Final Rule should further specify that a pending evaluation of a child due to suspected or identified disability shall not delay the release of a child.

Assessments for unaccompanied children with disabilities must also be individualized and based on current medical knowledge and the best available objective evidence, including evaluations of the services and supports that would enable children to live with family (e.g., parents, kin, foster family, therapeutic foster family, or adoptive family).

Children with disabilities should be placed in the most integrated setting appropriate to their needs, which will always be in the community, and almost always with a family. Services must be provided as needed to enable children to live in family and community settings, unless the provision of such services would amount to a fundamental alteration.[8]

ii. *Service plans for children with disabilities*

Proposed Revisions:

410.1302(e) Develop a comprehensive and realistic individual service plan for the care of each unaccompanied child in accordance with the unaccompanied child's needs as determined by the individualized needs assessment. Individual plans must be implemented and closely coordinated through an operative case management system. Service plans should identify individualized, person-centered goals with measurable outcomes and with steps or tasks to achieve the goals, be developed with input from the unaccompanied child, and be reviewed and updated at regular intervals. **The child's service plan should be cooperatively developed by a group of persons that includes the child and persons knowledgeable about the child, such as the child's parent or legal guardian, the child advocate, the child's attorney, and the child's treating professionals.** Unaccompanied children ages 14 and older should be given a copy of the plan, and unaccompanied children under age 14 should be given a copy of the plan when appropriate for that particular child's development. Individual plans shall be in that child's native language or other mode of auxiliary aid or services and/or use clear, easily understood language, using concise and

[8] *Olmstead v. L.C. by Zimring*, 527 U.S. 581 (1999); *Katie A. ex rel. Ludin v. Los Angeles County*, 481 F.3d 1150 (9th Cir. 2007); *United States v. Florida*, No. 12-60460 (S.D. Fl. July 14, 2023). We note that while the Proposed Rule uses both "least restrictive setting" and "most integrated setting" separately and in combination, "most integrated setting" is the relevant legal standard for children with disabilities. For a child with a disability, the most integrated setting appropriate to meet their needs is also the least restrictive setting.

concrete sentences and/or visual aids and checking for understanding where appropriate.

(1) If a child is determined to have one or more disabilities, the child's service plan shall identify a child's disability-related needs, including any specific triggers of a child's disability-related behaviors where relevant, and set out the services, supports, and reasonable modifications the child will receive, including education services and a plan for prompt release.

(2) A service plan for a child with a disability placed in a congregate care program shall be regularly reviewed to determine what reasonable modifications and additional services and supports are required to place the child in the most integrated setting appropriate. The most integrated setting appropriate is presumed to be a family setting.

(3) A service plan for a child with a disability shall be reviewed within 14 days of a change of placement to a more segregated setting (including any step up to a more restrictive setting).

(4) A pending service plan shall not delay the release of a child.

410.1311(d) Where applicable, ORR shall document in the child's ORR case file any services, supports, or program modifications being provided to an unaccompanied child with one or more disabilities.

Comment: We welcome the Proposed Rule's requirement that programs develop an individual service plan for each child with the input of the child (Section 410.1302(e)), and that a child's services, supports, and program modifications be documented in the child's case file (Section 410.1311(d)).

The Final Rule should set out more specific requirements for unaccompanied children with disabilities. In particular, if a child is determined to have one or more disabilities, the child's individual service plan (ISP) should identify a child's disability-related needs, including any specific triggers of a child's disability-related behaviors, and set out the services, supports, and reasonable modifications the child will receive, including a plan for prompt release. The child's service plan should be cooperatively developed by a group of persons that includes the child and persons knowledgeable about the child, including the child's parent or legal guardian, the child advocate, the child's attorney, and the child's treating professionals.[9] The Final Rule should further specify that a pending service plan shall not delay the release of a child.

ORR staff or contractors making decisions about the unaccompanied child's individualized service plan and placement decisions should also be

[9] *See, e.g.*, 34 C.F.R. §§ 104.35(c), 104.36.

knowledgeable about supporting a child with mental health or other disabilities in a family home with home and community-based services and about the full range of services available to children in ORR custody. Additionally, the unaccompanied child's personal preferences should be given primary consideration and the unaccompanied child's participation sought (and supported) in the decision-making process regarding their ISP and placement.

ISPs must state that changes in placement to more segregated settings will require new individualized assessments and reviews of service plans within 14 days, including as feasible before a placement change is made to a more segregated setting. Updated assessments and reviews of service plans must be conducted regularly, including when a child's placement is to a segregated setting, to determine if a child can be placed in a family setting with reasonable modifications and additional services and supports.

Comprehensive and realistic individual service plans, as described in Section 410.1302(e) must include services that meet the needs of unaccompanied children with mental health disabilities. For children with serious mental health conditions, these services will include care coordination, crisis intervention services, and a range of intensive community services to promote and support the child while the child is living with a family, and the child's well-being.

ISPs for unaccompanied children with disabilities must include the provision of services in the most integrated setting appropriate to their needs. Placement in the most integrated setting appropriate for an unaccompanied child with a disability is in the best interest of the child.[10]

iii. *Educational services*

Proposed Revisions:

410.1302 Standard programs shall: . . . (c) Provide or arrange for the following services for each unaccompanied child in care: . . .
(3) Educational services appropriate to the unaccompanied child's level of development, communication skills, and disability, if applicable, in a structured classroom setting, Monday through Friday, which concentrate primarily on the

[10] Brief of Am. Acad. of Pediatrics et al. as Amici Curiae Supporting Appellee and Affirmance, *United States v. Florida*, No. 12-60460 (11th. Cir. Nov. 15, 2023) (amicus brief from pediatric medical experts, professional medical associations, and public health, family, and disability advocacy organizations supporting principle that it is almost always more appropriate and more effective for children with complex medical needs to be cared for at home than in an institution); Sandra L. Friedman et al., *Out-Of-Home Placement for Children and Adolescents with Disabilities—Addendum: Care Options for Children and Adolescents with Disabilities and Medical Complexity*, 138 Pediatrics 1, 3 (Dec. 2016), https://bit.ly/3QsJzvq (family placements are in the best interest of the child).

development of basic academic competencies and secondarily on English Language Training (ELT), including . . .
(iv) Children with disabilities shall receive needed program modifications (such as specialized instruction), reasonable modifications, or auxiliary aids and services to ensure that they have an equal opportunity to engage in educational programming. Care providers must ensure their communication with children with disabilities in educational settings is as effective as their communication with children without disabilities to afford an equal opportunity for children with disabilities to engage in the UC program.

Comment: We welcome the Proposed Rule's reference to adapting educational services to a child's disability in Section 410.1302(c)(3). For clarity, the Final Rule should incorporate language from the Preamble that ORR will ensure children with disabilities receive needed "program modifications (such as specialized instruction), reasonable modifications, or auxiliary aids and services" and that care provider facilities must ensure that their communication with children with disabilities is as effective as their communication with children without disabilities in terms of affording an equal opportunity to engage in the UC Program.[11]

A child's need for educational accommodations should be developed and documented as part of their individual service plan. Because the Department of Education has specialized expertise in Section 504 rights in educational programs, the Final Rule should cross-reference the requirements in the Department's Section 504 regulations as applicable to ORR.[12]

For more information on crisis de-escalation and behavior support strategies, please see the following section commenting on Section 410.1304.

iv. *Behavior support plans*

Proposed Revisions:

410.1304 Behavior support ~~management~~ and prohibition on seclusion and restraint.
(a) Care provider facilities must develop **positive** behavior **support** ~~management~~ strategies that include evidence-based, trauma-informed, and linguistically responsive program rules and behavior support ~~management~~ policies that take into consideration the range of ages, ~~and~~ maturity**, and strengths** in the

[11] 88 Fed. Reg. 68937.
[12] *See* 34 C.F.R. § 104.31 *et seq*.; *see also* HHS Proposed Rule, *Discrimination on the Basis of Disability in Health and Human Service Programs or Activities*, § 84.54, 88 Fed. Reg. 63392, 63504 (Sept. 14, 2023)(cross-referencing 34 C.F.R. § 104.33).

program; that are culturally sensitive to the needs of each unaccompanied child; **and that take into consideration a child's disability or particular needs. The behavior support strategies must prioritize children's safety and well-being by adopting positive behavioral support interventions, which may include restorative practices.** The behavior ~~management~~ **support** strategies must not use any practices that involve negative reinforcement or involve consequences or measures that are not constructive and are not logically related to the behavior being regulated. Care provider facilities must not:

(1) Use or threaten use of corporal punishment, significant incident reports as punishment, unfavorable consequences related to family/sponsor unification or legal matters (e.g., immigration, asylum); use forced chores or work that serves no purpose except to demean or humiliate the child, forced physical movement, such as push-ups and running, or uncomfortable physical positions as a form of punishment or humiliation; search an unaccompanied child's personal belongings solely for the purpose of behavior management; apply medical interventions that are not prescribed by a medical provider acting within the usual course of professional practice for a medical diagnosis or that increase risk of harm to the unaccompanied child or others; and

(2) Use any sanctions employed in relation to an individual unaccompanied child that:

(i) Adversely affect an unaccompanied child's health, or physical, emotional, or psychological well-being; or

(ii) Deny unaccompanied children meals, hydration, sufficient sleep, routine personal grooming activities, exercise (including daily outdoor activity), medical care, correspondence or communication privileges, or legal assistance.

(3) Use prone physical restraints, chemical restraints, peer restraints**, or any type of restraint that restricts blood flow to the brain,** for any reason in any care provider facility setting.

(4) **Use any form of seclusion or restraint that is contraindicated based on the child's disability, health care needs, medical management plan, behavior intervention plan, medical or psychiatric condition, or is inconsistent with a child's individual service plan, individualized education program or individualized family service plan.**

(b) Involving law enforcement should be a last resort **and only in emergency safety situations**. A call by a facility to law enforcement ~~may~~ **shall** trigger an evaluation of staff involved regarding their qualifications and training in trauma-informed, de-escalation techniques, **including an analysis of whether the child's individual service plan was followed and whether reasonable modifications or additional services and supports could have prevented**

the call to law enforcement. **Contact between an unaccompanied child and law enforcement leading to restraint, arrest or transfer of custody shall trigger after-care services for the unaccompanied child.**

(c) Standard programs, RTCs, **and secure facilities** are prohibited from using seclusion as a behavioral intervention **or as a response to a child with a disability**. Standard programs**,** ~~and~~ RTCs**, and secure facilities** are also prohibited from using restraints, except as described at paragraphs (d) and ~~(f)~~ **(g)** of this section.

(d) Standard programs, RTCs, **and secure facilities** may use personal restraint only in emergency safety situations **and only after first attempting other interventions set out in the child's individual service plan or behavior intervention plan. Any restraint must end immediately upon the cessation of the imminent danger of serious physical injury to self or others.**

~~**(e) Secure facilities, except for RTCs:**~~

~~**(1) May use personal restraints, mechanical restraints and/or seclusion in emergency safety situations.**~~

~~**(2) May restrain an unaccompanied child for their own immediate safety or that of others during transport to an immigration court or an asylum interview.**~~

~~**(3) May restrain an unaccompanied child while at an immigration court or asylum interview if the child exhibits imminent runaway behavior, makes violent threats, demonstrates violent behavior, or if the secure facility has made an individualized determination that the child poses a serious risk of violence or running away if the child is unrestrained in court or the interview.**~~

(e) Care providers must provide all mandated services under this subpart to the unaccompanied child to the greatest extent ~~practicable~~ under the circumstances while ensuring the safety of the unaccompanied child, other unaccompanied children at the secure facility, and others.

(f) Any use of personal restraint or seclusion shall be reported to ORR and shall trigger an evaluation of staff involved regarding their qualifications and training in trauma-informed, de-escalation techniques, including an analysis of whether the child's individual service plan was followed and whether reasonable modifications or additional services and supports could have eliminated the need for restraint or seclusion.

(g) Care provider facilities may only use soft restraints (e.g., zip ties and leg or ankle weights) during transport to and from secure facilities, and only when the care provider believes a child poses a serious risk of physical harm to self or others or a serious risk of running away from ORR custody.

Comment: We appreciate the Proposed Rule's commitment in Section 410.1304 to evidence-based, trauma-informed, and linguistically responsive program rules and behavior management policies, as well as the requirement that policies be

culturally sensitive and take into consideration the range of ages and maturity in the program. The provision should be strengthened, however, to better protect children with disabilities or other heightened support needs and reduce the need for restraint-related interventions and use of law enforcement.

i. Strengths-based approach and positive interventions

We recommend that the regulatory language require care providers to utilize a positive, strengths-based approach that recognizes that all children have strengths and capacities to develop whatever qualities are nurtured and affirmed in them.[13] ORR is not a law enforcement or correctional agency, and its role is not to 'manage' children's behavior. We recommend ORR revise the term 'behavior management' to 'positive behavioral support.' This revision is in keeping with current behavioral science and will help ensure that ORR and care providers focus on supporting children's healthy behavioral development rather than managing and controlling children's behavior to conform with expectations that discount their individual needs and strengths.

Evidence supports that strength-based interventions lead to more positive mental health outcomes than traditional corrective behavior management strategies for all children.[14] A strength-based approach supports children in developing positive behaviors by focusing on affirming their best qualities and strengths, rather than their negative characteristics. Developing a strengths-based system of positive behavioral supports and interventions is consistent with federal best practices.[15] In the education context, for example, the Department of Education recommends implementing evidence-based, multi-tiered behavioral frameworks to help improve overall climate, safety, and achievement for all children, including children with disabilities.[16] A Positive Behavioral Interventions and Supports (PBIS) model provides an effective framework for integrating trauma awareness in system-wide social, emotional, and behavioral support, "rather than focusing on trauma as a separate and perhaps competing initiative."[17]

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[13] *See, e.g.*, Heather Forkey et al., Am. Acad. of Pediatrics Council on Foster Care, Adoption & Kinship Care, *Trauma-Informed Care*, 148 Pediatrics 9 (2021), https://publications.aap.org/ pediatrics/ article/148/2/e2021052579/179781/Trauma-InformedCare-in-Child-Health-Systems.

[14] *See, e.g.*, Huiting Xie, *Strengths-Based Approach for Mental Health Recovery*, 7 Iran J. Psych. Behav. Sci. 5 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3939995/.

[15] U.S. Dep't of Education, Guiding Principles for Creating Safe, Inclusive, Supportive, and Fair School Climates at 9 (Mar. 2023), https://www2.ed.gov/policy/gen/guid/school-discipline/guiding-principles.pdf.

[16] U.S. Dep't of Education, Dear Colleague Letter on the Inclusion of Behavioral Supports in Individualized Education Programs, Aug. 1, 2016, https://sites.ed.gov/idea/files/dcl-on-pbis-in-ieps-08-01-2016.pdf.

[17] Lucille Eber et al., Ctr. on Positive Behavioral Interventions & Supports, *Integrating a Trauma-Informed Approach within a PBIS Framework* at 1 (May 2020), https://ww1.odu.edu/content/dam/odu/col-dept/ efl/docs/trauma-informed-pbis-brief.pdf.

The Department of Education and the Department of Justice recommend embedding Restorative Practices into positive behavioral support frameworks to "address the needs of students, promote positive behavior, build on student assets, and develop social emotional skills and well-being."[18] There is extensive evidence on the success of restorative justice practices in the decades since their adoption as a non-punitive alternative to discipline in schools and juvenile justice programs.[19] Restorative Practices exist in many forms to include proactive approaches (developing community, engaging in social-emotional learning, and focusing on youth empowerment and resilience-building practices) and reactive responses (addressing disciplinary infractions, repairing harm, and restoring relationships) which care providers can adapt to meet the needs of children in their program.[20]

ii. Rights of children with disabilities

To adequately safeguard the rights of children with disabilities, Section 410.1304 must require that behavior support strategies take into consideration a child's disability or particular needs that cause staff or others to believe that an evaluation for services, including but not limited to, those required by Section 504 of the Rehabilitation Act, might be appropriate. Specifically, if a child has one or more disabilities, the child's individual service plan (ISP) should include the triggers of a child's disability-related behaviors, if any, and individualized responses which staff should attempt to de-escalate a situation. If a child exhibits persistent behaviors that threaten their safety or that of others, this should trigger a reevaluation of their ISP by the same group of knowledgeable persons that developed the plan.

[18] U.S. Dep't of Education, Guiding Principles for Creating Safe, Inclusive, Supportive, and Fair School Climates at 9 (Mar. 2023), https://www2.ed.gov/policy/gen/guid/school-discipline/guiding-principles.pdf.
[19] *See, e.g.*, Rosa Town et al., *Self-management, self-care, and self-help in adolescents with emotional problems: a scoping review*, Eur. Child & Adolescent Psych. (Dec. 2022), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9840811/pdf/787_2022_Article_2134.pdf; Tyler E. Smith et al., *Self-management interventions for reducing challenging behaviors among school-age students: A systematic review,* Campbell Systematic Reviews (2022), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8902300/pdf/CL2-18-e1223.pdf; Annie E. Casey Found., *Helping Kids in Foster Care Learn to Manage Their Emotions and Behavior*, (Feb. 2018), https://www.aecf.org/blog/helping-kids-in-foster-care-learn-to-manage-their-emotions-and-behavior; Sarah Klevan, Building a Positive School Environment Through Restorative Practices. Learning Policy Institute Oct. 2021), https://learningpolicyinstitute.org/product/wce-positive-school-climate-restorative-practices-brief; Off. of Juvenile Just. & Delinquency Prevention, Restorative Justice for Juveniles Literature Review: A Product of the Model Programs Guide (Aug. 2021), https://ojjdp.ojp.gov/model-programs-guide/literature-reviews/restorative-justice-for-juveniles.
[20] *Id.*

iii. Restraints and seclusion

Children with disabilities are at high risk of being subjected to personal restraints or being placed in seclusion because of their disability-related behavior.[21] These practices are ineffective, traumatizing, and can cause long-term damage to children's mental health.[22] We welcome the prohibition in Proposed Rule Section 410.1304(a)(3) on the use of prone physical restraints, chemical restraints, or peer restraints for any reason for all care provider facilities, including secure facilities. We further support the Proposed Rule's bar on the use of seclusion as a behavioral intervention in standard programs and RTCs. Seclusion should also be prohibited in secure programs, where children tend to have elevated mental health needs and have in the past been subjected to seclusion for weeks at a time.[23]

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[21] U.S. Dep't of Education, Dear Colleague Letter: Restraint and Seclusion of Students with Disabilities at 2, Dec. 28, 2016, https://www2.ed.gov/about/offices/list/ocr/letters/colleague-201612-504-restraint-seclusion-ps.pdf (Noting also that in the school context, "[a] school district discriminates on the basis of disability in its use of restraint or seclusion by (1) unnecessarily treating students with disabilities differently from students without disabilities; [or] (2) implementing policies, practices, procedures, or criteria that have an effect of discriminating against students on the basis of disability or defeating or substantially impairing accomplishment of the objectives of the school district's program or activity with respect to students with disabilities."); Disability Rights California, Protect Children's Safety and Dignity: Recommendations on Restraint and Seclusion in Schools (2019), https://www.disabilityrightsca.org/system/files/file-attachments/Restraint_and_Seclusion_Report.pdf; Disability Rights California, The Lethal Hazard of Prone Restraint: Positional Asphyxiation (2008), https://www.disabilityrightsca.org/system/files/file-attachments/701801.pdf.

[22] *Id.*; *see also* Substance Abuse & Mental Health Serv. Admin. (SAMHSA), *Trauma and Violence* (2022), https://www.samhsa.gov/trauma-violence ("Studies have shown that the use of seclusion and restraint can result in psychological harm, physical injuries, and death to both the people subjected to and the staff applying these techniques. . . Beyond the physical risks of injury and death, it has been found that people who experience seclusion and restraint remain in care longer and are more likely to be readmitted for care."); Staff of S. Health, Educ, Labor, & Pensions Comm., Dangerous Use of Seclusion and Restraints in Schools Remains Widespread and Difficult to Remedy: A Review of Ten Cases (2014), https://files.eric.ed.gov/fulltext/ED544755.pdf ("Even if children suffer no physical harm as the result of the use of seclusion and restraints, studies have shown they remain severely traumatized and may even experience post-traumatic stress disorder. As a result of their experiences, children who have been restrained have reported nightmares, anxiety, and mistrust of adults in authority.").

[23] Juvenile Law Ctr., Solitary Confinement & Harsh Conditions, https://jlc.org/issues/solitary-confinement-other-conditions (last accessed Nov. 17, 2023). The U.N. Convention on the Rights of the Child, which abolishes juvenile solitary confinement, has been ratified by every country except the United States. Convention on the Rights of the Child, art. 37, Nov. 20, 1989, 1577 U.N.T.S. 3. *See also* Joseph Calvin Gagnon, *The Solitary Confinement of Incarcerated American Youth During COVID-19*, 291 Psychiatry Res 113219 (Sep. 2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7286258/. A growing number of courts have recognized the unique harms that are inflicted on juveniles when they are placed in solitary confinement. *See, e.g., Doe by and through Frazier v. Hommrich*, No. 3-16-0799, 2017 WL 1091864, at *2 (M.D. Tenn. Mar. 22, 2017) (granting a preliminary injunction preventing a detention facility from placing juveniles in solitary confinement and describing how "courts around the country have found increased protections for juveniles and persons with diminished capacities from inhumane treatment under the Eighth and Fourteenth Amendments"); *V.W. by and through Williams v. Conway*, 236 F. Supp. 3d 554, 583, 590 (N.D.N.Y. 2017) (issuing a preliminary injunction to enjoin a county and its officials "from imposing 23-hour disciplinary isolation on juveniles" and recognizing "there is a broad consensus among

At a minimum, any use of personal restraint or seclusion against a child with a disability should trigger the same evaluation of staff as calls to law enforcement, including an analysis of whether the child's ISP was followed and whether reasonable modifications and additional supports and services could have eliminated the need for restraint or seclusion.

More specifically:

If ORR does choose to allow seclusion and physical restraint in secure facilities, it must be only when:

(1) The unaccompanied child's behavior poses an imminent threat of serious physical injury to self or others based on objective evidence and the interventions set out in the child's ISP or safety plan have been attempted without diminishing the risk. Factors that should be considered include: the nature, duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures or the provision of auxiliary aids or services[24] will mitigate the risk.;
(2) Less restrictive interventions would not be effective in stopping such imminent danger of serious physical injury;
(3) The seclusion or physical restraint ends immediately upon the cessation of the imminent danger of serious physical injury to self or others;
(4) The seclusion or physical restraint allows the child to communicate, while secluded or restrained, in their primary language or primary mode of communication; and

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the scientific and professional community that juveniles are psychologically more vulnerable than adults"); *Turner v. Palmer*, 84 F. Supp. 3d 880, 884 (S.D. Iowa 2015) (denying qualified immunity to officials who placed a juvenile with psychiatric issues in solitary confinement and noting that "[t]raditionally, juvenile detainees are afforded greater constitutional protection"). Placement of a mentally-ill detainee in solitary confinement "raises a genuine concern that the negative psychological effects of his segregation will drive him to self-harm." *Wallace v. Baldwin*, 895 F.3d 481, 485 (7th Cir. 2018). As the Third Circuit has explained, confinement of a detainee should be assessed "in light of his mental illness," recognizing the "growing consensus" that solitary confinement "can cause severe and traumatic psychological damage, including anxiety, panic, paranoia, depression, post-traumatic stress disorder, psychosis, and even a disintegration of the basic sense of self identity." *Palakovic v. Wetzel*, 854 F.3d 209, 225 (3d Cir. 2017). Especially in regard to children, courts must be mindful of a child's age, mental health issues, and duration and nature of confinement when assessing the use of solitary time in detention. *See J.H. v. Williamson Cnty., Tennessee*, 951 F.3d 709, 718 (6th Cir. 2020).

[24] As used throughout this comment, "auxiliary aids or services" are defined as in the Department of Health and Human Services' Section 504 regulations. *See* 45 C.F.R. § 84.10. We recommend that ORR adopt the proposed definition of "auxiliary aids or services" from the Consortium for Constituents with Disabilities (CCD) comment to the Notice of Proposed Rulemaking on Discrimination on the Basis of Disability in Health and Human Service Programs or Activities. Consortium for Constituents with Disabilities, Comment on Notice of Proposed Rulemaking on Discrimination on the Basis of Disability in Health and Human Service Programs or Activities (Nov. 13, 2023), https://www.c-c-d.org/fichiers/CCD-HHS-504-Comments-DocketNo2023-19149-111323.pdf.

(5) The least amount of force necessary is used to protect the unaccompanied child or others from the threatened injury.

Furthermore, the use of seclusion and especially physical restraint should not be a planned intervention included in the child's ISP, safety treatment plan, or behavioral intervention plan. Each instance of seclusion or restraint should be immediately reported to ORR.

ORR or care provider staff must never use seclusion or restraint (a) that can be life threatening, that is, that restricts breathing or restricts blood flow to the brain, including prone and supine restraint; (b) that is contraindicated based on the child's disability, health care needs, medical management plan, behavior intervention plan, medical or psychiatric condition, or (c) is inconsistent with an individualized education program or an individualized family service plan (as defined in section 602 of the Individuals with Disabilities Education Act (20 U.S.C. § 1401)) or a plan developed pursuant to Section 504 of the Rehabilitation Act (29 U.S.C. § 794) or Title II of the Americans with Disabilities Act (42 U.S.C. § 12131 *et seq*.).

iv. Calls to law enforcement

We agree with ORR's proposed language in Section 410.1304(b) that law enforcement should only be called as a "last resort" in response to an unaccompanied child's behavior. As ORR has already stated in its commentary to this provision, calls to law enforcement are not a behavior management strategy.[25] The Final Rule should also make clear that involving law enforcement should only occur in emergency safety situations.

For a child with a disability, a call to law enforcement should trigger a mandatory evaluation of the staff involved, including whether the child's ISP was appropriately followed, whether reasonable modifications should have been provided prior to, in lieu of, or during the law enforcement involvement, and whether reasonable modifications could have eliminated the need for law enforcement involvement.[26] A call to law enforcement should also trigger a reevaluation of the child's ISP and need for additional services or modifications.

[25] 88 Fed. Reg 68942.

[26] As the Department of Justice has recognized, "[l]aw enforcement responses to mental health crises are not only ineffective, they increase the likelihood that children whose needs could be met with behavioral health services will instead enter the juvenile justice system." Letter from Kristen Clarke, Assistant Attorney General, Civil Rights Division, U.S. Dep't of Justice, *United States' Investigation of Maine's Behavioral Health System for Children Under Title II of the Americans with Disabilities Act* 1, 13 (June 22, 2022), https://www.justice.gov/crt/case-document/file/1514441/download.

We appreciate that the evaluation described in Section 410.1304 includes review of staff qualifications and training in de-escalation techniques. An effective and evidence-based de-escalation strategy would encompass three principles:

- (1) A mental health response must be presumed for a mental health crisis. ORR should invest in crisis services, including mobile crisis services that do not involve law enforcement and children's Assertive Community Treatment (ACT) services,[27] so that trained mental health professionals treat the child, in place of a law enforcement response, which typically exacerbates the situation. The Department of Justice has stated in a recent findings report that "law enforcement responses to mental health crises are not only ineffective, they increase the likelihood that children whose needs could be met with behavioral health services will instead enter the juvenile justice system."[28] A law enforcement response to an unaccompanied child experiencing a mental health crisis will not address the root of the issue—the child's mental health—but instead may result in legal penalties, further traumatize the child,[29] and likely prolong their detention. In some instances, a law enforcement response can result in increased uses of force, physical harm, and even serious physical injury or death that could have been avoided by using de-escalation techniques and providing mental healthcare.

- (2) Law enforcement should never be called if reasonable modifications or other services could be provided to the child to de-escalate the behavior in question and remediate concerns. Care providers must plan for safety concerns by documenting the triggers of a child's behavior in their individual service plan and outlining planned interventions to de-escalate crisis situations. The Department of Justice, for example, found that Minneapolis and the Minneapolis Police Department (MPD) violated Title II of the ADA by responding to most behavioral-health related calls with law enforcement and they therefore must make reasonable modifications to their policies, programs, and activities to avoid this result. The Department of Justice's report stated that providing a behavioral health response to a behavioral health call is an example of a reasonable modification that can and should be made to prevent law enforcement involvement.[30] Section 504 is read in parallel to Title II of the ADA.[31] The reasonable

[27] *Id.* at 16.
[28] *Id.* at 13.
[29] Investigation of the City of Minneapolis and the Minneapolis Police Dep't, U.S. Dep't of Justice, Civil Rights Division, and U.S. Attorney's Office, at 61 (June 16, 2023).
[30] Investigation of Minneapolis, at 65-66.
[31] *See* U.S. Dep't of Justice, Civil Rights Division, Memorandum re: Coordination of Federal Agencies' Implementation of Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act (Apr. 24, 2018), https://www.justice.gov/crt/page/file/1060321/download; *see also Durand v. Fairview*

accommodations provided must afford unaccompanied children with disabilities an equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others.

- (3) Law enforcement should only be called as a last resort, and for children with a disability, only when that child poses an imminent threat of serious physical injury to others that cannot be mitigated with reasonable modifications or other services. In determining whether an unaccompanied child presents an imminent threat, ORR should, based on objective evidence, consider the following factors: the nature, duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures or the provision of auxiliary aids or services will mitigate the risk."[32] Research demonstrates that law enforcement responses to people with mental illness should be avoided whenever possible because the threat to public safety is usually small while the risk of harm to the individual is very large.[33] Contact between law enforcement and people experiencing mental health crises—even when officers respond alongside mental health workers—should be limited to only the rarest exceptions because of the potentially dire consequences.

c. <u>ORR Placement Array</u>

Proposed Revisions:

410.1311(b) ORR shall administer the UC Program in the most integrated setting appropriate to the needs of unaccompanied children with disabilities in accordance with 45 C.F.R § 85.21(d), unless ORR can demonstrate that this would fundamentally alter the nature of its UC Program. **An integrated setting is one that enables people with disabilities to live as much as possible like people without disabilities and is presumed to be a community setting.**

Health Servs., 902 F.3d 836, 841 (8th Cir. 2018) ("Although there are differences between the ADA and the [Rehabilitation Act], . . . the case law interpreting the two statutes is generally used interchangeably."); *Wright v. New York State Dep't of Corr.*, 831 F.3d 64, 72 (2d Cir. 2016) (in the context of analyzing claims brought under Section 504 and Title II of the ADA, stating "[b]ecause the standards under both statutes are generally the same and the subtle distinctions between the statutes are not implicated in this case, 'we treat claims under the two statutes identically'" (quoting *Henrietta D. v. Bloomberg*, 331 F.3d 261, 272 (2d Cir. 2003))).

[32] 28 C.F.R. § 35.139(b).

[33] Legal Defense Fund & Judge David L. Bazelon Ctr. for Mental Health Law, *Advancing an Alternative to Police: Community-Based Services for Black People with Mental Illness* (2022), https://www.bazelon.org/wp-content/uploads/2022/07/2022.07.06-LDF-Bazelon-Brief-re-Alternative-to-Policing-Black-People-with-Mental-Illness.pdf.

Comment: We welcome the Proposed Rule's recognition of ORR's legal obligation to administer the UC program in the most integrated setting appropriate to the needs of unaccompanied children. As detailed below, the Final Rule should adopt more specific requirements to ensure that ORR meets this obligation in practice.

ORR is subject to Section 504 of the Rehabilitation Act's integration mandate and the U.S. Supreme Court's holding in *Olmstead v. L.C*. (Lois Curtis), which require that individuals with disabilities be served in the most integrated setting appropriate to their needs and not be unnecessarily segregated or held in institutional settings.[34]

ORR's proposed definition of the "most integrated setting" in the Preamble is one that "enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible."[35] While we recognize this a commonly-used definition, we suggest, as the Consortium for Constituents with Disabilities did in its comments regarding the Department of Health and Human Services (HHS) proposed Section 504 regulations, that the definition of the most integrated setting in the Final Rule be revised to read: "a setting that enables people with disabilities to live as much as possible like people without disabilities."[36] Such a definition would align with consensus among the disability rights community,[37] the intent of the ADA,[38] guidance from the Departments of Justice and Housing

[34] *See Olmstead v. L.C. by Zimring,* 527 U.S. 581 (1999)*;* 45 C.F.R. § 84.4(b)(2); 45 C.F.R. § 85.21(d).
[35] 28 C.F.R. § 35 app. A.
[36] Consortium for Constituents with Disabilities, Comment on Notice of Proposed Rulemaking on Discrimination on the Basis of Disability in Health and Human Service Programs or Activities (Nov. 13, 2023), https://www.c-c-d.org/fichiers/CCD-HHS-504-Comments-DocketNo2023-19149-111323.pdf (more than sixty disability organizations signed onto these comments, reflecting broad consensus among the disability rights community).
[37] *Id.* at 57.
[38] *See PGA Tour, Inc. v. Martin*, 532 U.S. 661, 675 (2001) (Congress enacted the ADA to meet a "'compelling need' for a 'clear and comprehensive national mandate' to eliminate discrimination against disabled individuals, and to integrate them 'into the economic and social mainstream of American life'") (citing S. Rep. No. 101-116, p. 20 (1989); H. R. Rep. No. 101-485, pt. 2, p. 50 (1990)), and National Archives, Transcript of Statement by the President July 26, 1990 (1990), https://www.archives.gov/research/americans-with-disabilities/transcriptions/naid-6037493-statement-by-the-president-americans-with-disabilities-act-of-1990.html (last visited Oct. 25, 2023) (the ADA signals the end of the "unjustified segregation and exclusion of persons with disabilities from the mainstream of American life").

and Urban Development,[39] and the widely accepted Key Principles for Community Integration for People with Disabilities (2014).[40]

Regardless of how "most integrated setting" is defined, for unaccompanied children with disabilities, the most integrated setting appropriate to their needs will always be in a community setting, and almost always be living with a family. HHS has recognized that, in the child welfare context, there is a presumption that the most integrated setting is a family setting. It has also recognized that long-term placement in congregate settings should never be considered the most integrated setting.[41] Children should live and receive services in a family setting unless that setting presents a significant risk to the health or safety of the child that cannot be mitigated through the provision of reasonable modifications including services. ORR should release unaccompanied children with mental health or other disabilities to sponsors in the community as expediently as possible.

To meet its obligations under Section 504 and *Olmstead*, ORR should also invest in developing and expanding upon services that support children living in a family setting, rather than investing in detention. If a child with a disability is able to live and receive services in a family setting, they should be receiving services in a family setting or transferred to a family setting as expeditiously as possible, not in an institution or facility.

In order to ensure that ORR provides a sufficient array of placement options, the regulations and Preamble should describe the "continuum of family settings" that ORR must provide. That continuum is this:

- Whenever appropriate to the child's needs, an unaccompanied child with a disability should live at home with their parents or sponsor, with any necessary services and supports provided in their home and community.

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[39] *See* U.S. Dep't of Justice, Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C., Question 1 (2020), https://www.ada.gov/resources/olmstead-mandate-statement/ (last visited Oct. 25, 2023) ("integrated settings are those that provide individuals with disabilities opportunities to live, work, and receive services in the greater community, like individuals without disabilities"), and U.S. Dep't of Housing & Urban Dev., Statement of the Department of Housing and Urban Development on the Role of Housing in Accomplishing the Goals of Olmstead (2013), https://www.hud.gov/sites/documents/olmsteadguidnc060413.pdf ("within the context of housing, integrated settings enable individuals with disabilities to live like individuals without disabilities").

[40] Community Integration for People with Disabilities: Key Principles (2014), https://www.bazelon.org/wp-content/uploads/2017/10/Key-Principles.pdf (recognizing that "individuals with disabilities should have the opportunity to live like people without disabilities" and providing examples of community integration in the contexts of employment, housing, choice, and everyday life).

[41] *See* HHS Proposed Rule, *Discrimination on the Basis of Disability in Health and Human Service Programs*, 88 Fed. Reg. 12345 (Sept. 14, 2023).

Kinship placements are critical to keeping the child connected to family, culture, and community.

- If no suitable sponsor is available, the unaccompanied child may be placed in foster care in a family setting, including (when appropriate) therapeutic foster care. Therapeutic foster care[42] is considered the least restrictive form of out-of-home therapeutic placement for children and youth with severe emotional disabilities.[43] The goal of this setting is to mimic a natural, nurturing family home.[44] It consists of coordinated mental health and other support services that are provided to a foster parent or caregiver, in which the foster parent/caregiver becomes an integral part of the child's team. Wraparound supports can and should still be delivered in these settings, with an emphasis on including the foster caregivers in the process of developing and delivering the individualized service plan (ISP).
- Only once these options have been exhausted, along with the timely provision of reasonable modifications and services (with adjustments as necessary), can congregate care be considered for a child with a disability, and then only for as brief a time as is necessary.

Unaccompanied children with disabilities must be afforded an opportunity to participate in and benefit from family placements that is equal to that afforded to unaccompanied children without disabilities. The integration mandate requires ORR to make family placement options available for unaccompanied children with disabilities and provide children with services in the community rather than in institutional settings. Indeed, ORR already provides healthcare to unaccompanied children within custody and assists in accessing services outside of custody through post-release services, but the current services are insufficient to fulfill ORR's integration obligations. Expanding upon these services is necessary to fulfill ORR's responsibilities under Section 504 and *Olmstead* and is not a fundamental alteration. As HHS recognized in its recent Section 504

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[42] It is not clear from ORR's recent Request for Information (RFI) on its Continuum of Care whether ORR's proposal for Therapeutic Group Home Care comports with these ideologies. Indeed, reference to these settings as "group homes" raises integration concerns and we would disagree that a congregate setting of this nature is "not considered a restrictive placement." ORR should, in its Continuum of Care, develop a therapeutic foster care program to care for children in custody and provide training to help family members provide therapeutic foster care, including training in implementing positive behavioral supports, and to receive in-service clinical supervision and support. *See* Yael Cannon, *There's No Place Like Home: Realizing the Vision of Community-Based Mental Health Treatment for Children*, 61 DePaul L. Rev. 1049 (2012). Furthermore, the National Council on Disability and the Surgeon General have highlighted that "therapeutic foster care programs are inexpensive to start because of limited facility and staff costs" – costing, according to one study, "half as much as residential treatment center programs." *See* Nat'l Council on Disability, *Youth with Disabilities in the Foster Care System: Barriers to Success and Proposed Policy Solutions* (2008), https://www.ncd.gov/publications/2008/02262008.

[43] *See generally* Yael Cannon, *There's No Place Like Home: Realizing the Vision of Community-Based Mental Health Treatment for Children*, 61 DePaul L. Rev. 1049 (2012).

[44] *Id.*

NPRM, “providing services beyond what a [recipient] currently provides” . . . “may not be a fundamental alteration.”[45]

i. *Placement of children who need particular services*

Proposed Revisions:

410.1106 Unaccompanied children who need particular services and treatment. . . .

If ORR determines that an unaccompanied child’s individualized needs require particular services and treatment by staff or particular equipment, ORR shall place the unaccompanied child, ~~whenever possible,~~ **in a licensed program in which ORR places children without such needs, but which provides services for their individualized needs in the most integrated setting appropriate. Similarly, if an unaccompanied child has a disability, ORR shall place the unaccompanied child** in a licensed program in which unaccompanied children with disabilities can **live like ~~interact with~~** people without disabilities to the fullest extent possible, and shall make reasonable modifications to its programs, including the provision of services, equipment and treatment, so that children with disabilities can have equal access to the program in the most integrated setting appropriate.

Comment: We appreciate ORR’s commitment to providing services to meet children’s needs and to placing unaccompanied children with disabilities in integrated settings. The last sentence of this provision is unclear, however, as it begins with an ORR determination that an unaccompanied child requires particular services and treatment by staff but then refers to children with disabilities. As the Preamble recognizes, children who require particular services and treatment are not necessarily synonymous with children with disabilities.[46] For clarity, the Final Rule should address children with individualized needs and children with disabilities separately.

As we stated previously in our commentary to Section 410.1311(b), the most integrated setting is a setting that enables people with disabilities to live as much as possible like people without disabilities. Placement decisions for unaccompanied children with disabilities, however, are often made by ORR staff or contractors who are insufficiently trained, rushed, have limited information on resources and services available to unaccompanied children with disabilities, and

[45] HHS Proposed Rule, *Discrimination on the Basis of Disability in Health and Human Service Programs or Activities*, 88 Fed. Reg. 63487 (Sept. 14, 2023).
[46] 88 Fed. Reg. 68925.

have few placement options from which to choose.[47] To address this, we have proposed a "continuum of family settings" above. We also recommend a review process to ensure that placements in segregated settings are as brief as possible because even a short-term stay in congregate care or institutional settings can cause significant harm.[48]

In addition, medication management and individualized therapeutic services can and should be provided in non-secure settings. There is no reason for ORR to require children to be placed in residential treatment centers (or similar settings) for these services. The U.S. Surgeon General warned over 20 years ago that "residential treatment has not shown substantial benefit to children and youth with mental health problems," and highlighted the likelihood of "adverse effects."[49] Research has documented the inherent harms of even so-called "therapeutic" institutional settings.[50] If staff in non-secure settings do not have training to provide therapeutic services, it would be a reasonable modification for personnel to be provided with needed training or for personnel with needed training to be hired to work in non-secure settings.

ii. *Care provider facility types*

Proposed Revisions:

410.1102 Care provider facility types.
ORR may place unaccompanied children in care provider facilities as defined at § 410.1001, including but not limited to shelters, group homes, individual family homes, **therapeutic foster family homes**, heightened supervision facilities, or secure facilities, including RTCs. ORR may place unaccompanied children in out-

[47] Even if children with disabilities are not segregated from children without disabilities in an institutional setting, the institutional placement is still considered a segregated setting. *G.K. v. Sununu,* No. 21-cv-4-PB, 2021 U.S. Dist. LEXIS 170962 (D.N.H. 2021).
[48] *See, e.g.*, U.S. Dep't of Health & Human Serv., Substance Abuse & Mental Health Serv. Admin., Mental Health: A Report of the Surgeon General, at 176-78 (1999), http://download.ncadi.samhsa.gov/ken/pdf/surgeongeneralreport/C3.pdf; Richard P. Barth, Institutions vs. Foster Homes: An Empirical Base for a Century of Action, at 7 (June 17, 2002); Nat'l Council on Disability, Youth with Disabilities in the Foster Care System: Barriers to Success and Proposed Policy Solutions (2008), https://www.ncd.gov/publications/2008/02262008.
[49] U.S. Dep't of Health & Human Serv., Substance Abuse & Mental Health Serv. Admin., Mental Health: A Report of the Surgeon General, at 176-78 (1999)
[50] *See, e.g.*, Nat'l Disability Rights Network, Desperation without Dignity: Conditions of Children Placed in For Profit Residential Facilities (2021), https://www.ndrn.org/resource/desperation-without-dignity/; Richard P. Barth et al., *Outcomes for youth receiving intensive in-home therapy or residential care: A comparison using propensity scores*, 77 Am. J. of Orthopsychiatry 497 (2007); Casey Family Programs, What are the outcomes for youth placed in congregate care settings? (Feb. 2018), https://www.casey.org/what-are-the-outcomes-for-youth-placed-incongregate-care-settings/; Annie E. Casey Found., Reconnecting Child Development and Child Welfare: Evolving Perspective on Residential Placement (2013).

of-network (OON) placements under certain, limited circumstances. In times of influx or emergency, as further discussed in subpart I of this part, ORR may place unaccompanied children in facilities that may not meet the standards of a standard program, but rather meet the standards in subpart I.

Proposed Revisions:

410.1103(d). Considerations generally applicable to the placement of an unaccompanied child.
(b) ORR considers the following factors that may be relevant to the unaccompanied child's placement, including: . . .
(8) Disability. **ORR will provide children with disabilities equal access to community-based placements such as individual family homes.**

Comment: We welcome ORR's stated preference for placing unaccompanied children in transitional and long-term home care settings rather than large congregate care facilities and moving toward a community-based care model.[51] To ensure children with disabilities have equal access to community-based placements, ORR must prioritize outreach and grants to community-based care providers that can serve children with a variety of disabilities.[52]

Whether or not ORR chooses to incorporate the term "community-based care" into the Final Rule, the Final Rule should explicitly state that ORR will provide children with disabilities equal access to community-based placements such as individual family homes and that children in restrictive placements will be assessed and eligible for step down to a foster care placement. Additionally,

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[51] *See* 88 Fed. Reg. 68919-20.

[52] *See, e.g.,* Letter from Kristen Clarke, Assistant Attorney General, Civil Rights Division, U.S. Dep't of Justice, *United States' Investigation of Maine's Behavioral Health System for Children Under Title II of the Americans with Disabilities Act*, 17 (June 22, 2022), https://www.justice.gov/crt/case-document/file/1514441/download ("Maine must invest in its behavioral health system by recruiting, training, and maintaining a pool of providers that can meet the demand for community-based services, including in rural areas and for children with intense needs. This includes recruiting and supporting more Treatment Foster Care parents by providing necessary resources and services to families participating in the program."); Civil Rights Division, U.S. Dep't of Justice, *Investigation of Nevada's Use of Institutions to Serve Children with Behavioral Health Disabilities*, 24 (Oct. 4, 2022), https://www.justice.gov/crt/case-document/file/1540506/download ("Services the State should ensure are available and accessible include intensive in-home supports and services, intensive care coordination, crisis response, peer support, therapeutic foster care, and respite."); Letter from Vanita Gupta, Principal Deputy Assistant Attorney General, Civil Rights Division, U.S. Dep't of Justice, *United States' Investigation of the West Virginia Children's Mental Health System Pursuant to the Americans with Disabilities Act*, 27 (Jun. 1, 2015), https://www.ada.gov/olmstead/documents/west_va_findings_ltr.pdf ("West Virginia should expand in-home and community-based mental health service capacity throughout the state to minimize or eliminate unnecessary institutionalization, prolonged institutionalization, and heightened risk for institutionalization, and to reduce the risk youth with disabilities will end up in settings that are not designed to provide mental health care, such as detention centers, correctional facilities, and jails.").

children with disabilities should be included in the groups prioritized for community-based placement[53] and Section 410.1102 regarding care provider facility types should explicitly include therapeutic foster family homes.

As HHS has elsewhere recognized, "[c]ongregate care should never be considered the most appropriate long-term placement for children, regardless of their level of disability."[54] As discussed above, unaccompanied children with disabilities should be served in the most integrated setting appropriate to their needs.[55] Facilities are not community-based care and are never the most integrated setting.

iii. *Placement denials*

Proposed Revisions:

410.1103

(f) A care provider facility must accept the placement of unaccompanied children as determined by ORR, and may deny placement only for the following reasons:

(1) Lack of available bed space;

(2) Placement of the unaccompanied child would conflict with the care provider facility's State or local licensing rules;

(3) Initial placement involves an unaccompanied child with a significant physical or mental illness for which the referring Federal agency does not provide a medical clearance; or

(4) In the case of the placement of an unaccompanied child with a disability, the care provider facility **and ORR** conclude **the care provider facility** is unable to meet the child's disability-related needs, without fundamentally altering its program, even by providing reasonable modifications and even with additional support from ORR.

(g) Care provider facilities must submit a written request to ORR for authorization to deny placement of unaccompanied children, providing the individualized reasons for the denial. Any such request must be approved by ORR before the care provider facility may deny a placement. ORR may follow up with a care provider facility about a placement denial to find a solution to the reason for the denial.

(h) If a care provider denies placement to a child with a disability under any of the subsections of 410.1103(f), ORR will promptly find another placement for the child in the most integrated setting appropriate.

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[53] 88 Fed. Reg. 68919; Off. of Refugee Resettlement, ORR Unaccompanied Children Program Policy Guide § 1.2.2.

[54] HHS Proposed Rule, *Discrimination on the Basis of Disability in Health and Human Service Programs or Activities*, 88 Fed. Reg. 63392, 63415 (Sept. 14, 2023).

[55] *See* commentary to Section 410.1311(b).

Comment: We welcome the Proposed Rule's intention to impose stricter guidelines on placement denials by care providers and to require authorization from ORR for placement denials, as placement denials have historically been, and continue to be, a significant obstacle to the placement of unaccompanied children with disabilities in integrated settings. Children with disabilities have remained in unnecessarily restrictive placements even after ORR and provider staff have determined that they should be stepped down to a less restrictive placement, because ORR is unable to find a less restrictive facility that is willing to accept the child's referral for placement.

In particular, we have seen unaccompanied children with disabilities face unjust denials of placement by ORR's foster care programs. Currently, placement in long term foster care takes into consideration "the child's mental, emotional, behavioral, and physical health needs" and "the child's ability and commitment to live in a family and community-based setting."[56] In our experience, decisions about supposed community readiness fail to take into account reasonable modifications or additional services and supports that could enable community placement and have been influenced by implicit bias, paternalism, and ableism and have led to placement denials by less restrictive settings. We have also seen providers hide behind state licensing requirements, without a full analysis and explanation of why they are unable to meet a child's needs. These obstacles are comparable to those faced by children with disabilities in the domestic child welfare system, which has led to enforcement actions by the Department of Justice and class action lawsuits.[57] We are heartened by steps ORR has taken within the regulations and elsewhere to ensure that providers do not explicitly or

[56] Off. of Refugee Resettlement, ORR Unaccompanied Children Program Policy Guide § 1.2.6 ORR Long Term Foster Care, https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide-section-1#1.2.6. Likewise, placement in the Unaccompanied Refugee Minors (URM) program requires the youth to "be ready for community-based placement." Off. of Refugee Resettlement, ORR Guide to Eligibility, Placement, and Services for Unaccompanied Refugee Minors (URM) Section 1.2, https://www.acf.hhs.gov/orr/policy-guidance/orr-guide-eligibility-placement-and-services-unaccompanied-refugee-minors-urm.

[57] *See, e.g.,* Preamble to HHS Proposed Rule, *Discrimination on the Basis of Disability in Health and Human Service Programs or Activities*, 88 Fed. Reg. 63392, 63415 (Sept. 14, 2023) ("[D]espite the recognition that congregate care should not be a default placement for children, many children and older foster care youth continue to face potentially discriminatory barriers to placements in family-like foster home settings that can meet their needs. For example, class action lawsuits have been filed in several jurisdictions challenging the practice of denying foster children, including those with disabilities, placement in the most integrated setting appropriate to children's needs and of placing them in inappropriate settings such as hotels and refurbished juvenile detention centers."); *see also* Letter from Kristen Clarke, Assistant Attorney General, Civil Rights Division, U.S. Dep't of Justice, *United States' Investigation of Maine's Behavioral Health System for Children Under Title II of the Americans with Disabilities Act* (Jun. 22, 2022), https://www.justice.gov/crt/case-document/file/1514441/download; Civil Rights Division, U.S. Dep't of Justice, *Investigation of the State of Alaska's Behavioral Health System for Children* 16 (Dec. 15, 2022), https://www.justice.gov/opa/press-release/file/1558151/download.

implicitly discriminate against youth with disabilities when accepting or denying placement.

ORR *and* the care provider facility have an obligation to determine whether a facility can meet a child's disability-related needs. Importantly, if a care provider does deny placement to a child with a disability under this policy, ORR retains an independent obligation to place the child in the most integrated setting appropriate to their needs.[58] The Final Rule should explicitly state that if a care provider denies placement to a child with a disability under any of the subsections of 410.1103(f), ORR will promptly find the child another placement in the most integrated setting appropriate.

iv. *Out-of-network placements*

Proposed Revisions:

410.1001 Definitions
Out of network placement (OON) means a facility **licensed by a state to care for dependent children** that provides physical care and services for individual unaccompanied children as requested by ORR on a case-by-case basis, that operates under a single case agreement for care of a specific child between ORR and the OON provider. OON may include hospitals, restrictive settings, or other settings outside of the ORR network of care.

410.1102
ORR may place unaccompanied children in care provider facilities as defined at § 410.1001, including but not limited to shelters, group homes, individual family homes, heightened supervision facilities, or secure facilities, including RTCs. ORR may place unaccompanied children in out-of-network (OON) placements under certain, limited circumstances. In times of influx or emergency, as further discussed in subpart I of this part, ORR may place unaccompanied children in facilities that may not meet the standards of a standard program, but rather meet the standards in subpart I. **An unaccompanied child may be placed in an OON facility only if it is the most integrated placement appropriate. ORR shall ensure that an unaccompanied child placed in an OON facility receives the same minimum services as a child placed in a standard ORR program, including the minimum standards outlined in Section 410.1302. The criteria for placement in or transfer to a restrictive placement within the ORR network also apply to transfers to or placements in OON facilities at the same level of restriction.**

[58] *See* 45 C.F.R. § 85.21(d).

Comment: The definition of "care provider facility" in Section 410.1001 of the Proposed Rule excludes out-of-network (OON) facilities. An OON facility is separately defined as "a facility that provides physical care and services for individual unaccompanied children as requested by ORR on a case-by-case basis, that operates under a single case agreement for care of a specific child between ORR and the OON provider. OON may include hospitals, restrictive settings, or other settings outside of the ORR network of care." Proposed Rule § 410.1001.

Pursuant to this definition, not all OON facilities are secure placements, yet the Proposed Rule does not specify that OON placements must abide by state licensing requirements, or even that they must follow the requirements of a standard program. Moreover, Proposed Rule Section 410.1102 states that ORR may place children in out-of-network facilities "under certain, limited circumstances" but it does not specify what those circumstances are. Proposed Rule Section 410.1105(c)(2) provides criteria for OON RTC placements but no other OON placements.

These gaps in the Proposed Rule undermine the rights of children in out-of-network placements. In the past, some unaccompanied children placed out-of-network have not received minimum required services, such as educational services and outdoor recreation.[59] Indeed, we have seen that care and treatment provided by OON facilities can vary widely, in both positive and negative ways. Thorough vetting and independent oversight of OON facilities is especially critical and we appreciate the Preamble's reference to consulting with non-governmental stakeholders such as protection and advocacy (P&A) agencies to assess out-of-network facilities.[60] We would welcome further discussion with ORR about policies and procedures for using and monitoring OON facilities.

To ensure unaccompanied children placed in out-of-network programs have the same rights and protections as other unaccompanied children, the Final Rule should state that children may be placed in an OON program only if it is the most

[59] *See Flores v. Barr*, No. CV-85-4544-DMG, Exhibit J, Declaration of Class Member at Nexus Children's Hospital, ECF 1039, at ¶ 10 (C.D. Cal. Nov. 23, 2020) ("I do not have school here. I have not had any school at Nexus the entire time I have been here."); *Flores v. Barr*, No. CV-85-4544-DMG, Exhibit I, Declaration of Class Member at Nexus Children's Hospital, ECF 1039, at ¶¶ 10-11 (C.D. Cal. Nov. 23, 2020) ("I spend eight hours a day in my room . . . I have school once a week on Wednesdays. A teacher comes in for an hour and a half and we go over math, English, and language arts. I do my homework on Tuesdays and it takes me most of the day.").

[60] 88 Fed. Reg. 68925; *see also* Nat'l Disability Rights Network, Desperation without Dignity: Conditions of Children Placed in For Profit Residential Facilities (2021), https://www.ndrn.org/resource/desperation-without-dignity/.

integrated placement appropriate, that OON programs must be state-licensed to care for dependent children, and that children in OON programs must receive all the minimum services for standard programs, including those specified in Proposed Rule Section 410.1302. A child must not be transferred to a restrictive OON placement unless they meet the criteria for transfer to the same level of restrictive placement within the ORR network.

d. Restrictive Placement

i. *Less restrictive alternatives*

Proposed Revisions:

410.1105(a) Before placing a child with a disability in a restrictive placement, consistent with Section 504 of the Rehabilitation Act, 29 U.S.C. § 794(a), ORR shall consider whether there are any reasonable modifications to the policies, practices, or procedures of an available less restrictive placement or any provision of auxiliary aids and services that would allow the unaccompanied child with a disability to be placed in that less restrictive facility. Consideration of less restrictive placements shall include consideration of placement in a community setting, such as therapeutic foster care.

410.1105(a)(2) ORR will not place an unaccompanied child in a secure facility (that is not an RTC) if less restrictive alternatives in the best interests of the unaccompanied child are available and appropriate under the circumstances. **ORR shall not place an unaccompanied child with a disability in a secure facility (that is not an RTC).** ORR may place an unaccompanied child in a heightened supervision facility or other non-secure care provider facility as an alternative, provided that the unaccompanied child does not pose a danger to ~~self or~~ others **that cannot be eliminated by a modification of policies, practices or procedures, or by the provision of auxiliary aids or services**.

410.1601(b) ***Restrictive care provider facility placements and transfers.*** When an unaccompanied child is placed in a restrictive setting (secure, heightened supervision, or residential treatment center), the care provider facility in which the child is placed and ORR shall review the placement at least every ~~**30**~~ **14** days to determine whether a new level of care is appropriate for the child. If the care provider facility and ORR determine in the review that continued placement in a restrictive setting is appropriate, the care provider facility shall document the basis for its determination and, upon request, provide documentation of the review and rationale for continued placement to the child's

attorney of record, legal service provider, and/or child advocate. **In determining whether there is a less restrictive placement available to meet the individualized needs of an unaccompanied child with a disability, ORR must consider whether there are any reasonable modifications to the policies, practices, or procedures of an available less restrictive placement or any provision of auxiliary aids and services that would allow the unaccompanied child with a disability to be placed in that less restrictive facility. Consideration of less restrictive placements will include consideration of placement in a community setting, such as therapeutic foster care.**

410.1901 Restrictive placement case reviews
(a) In all cases involving placement in a restrictive setting, ORR shall determine, based on clear and convincing evidence, that sufficient grounds exist for stepping up or continuing to hold an unaccompanied child in a restrictive placement **and that the child cannot safely be placed in a less restrictive facility with reasonable modifications to the policies, practices, or procedures of an available less restrictive placement or any provision of auxiliary aids and services**. The evidence supporting a restrictive placement decision shall be recorded in the unaccompanied child's case file.

(b) ORR shall provide an unaccompanied child with a Notice of Placement (NOP) no later than 48 hours after step-up to a restrictive placement, as well as every ~~**30**~~ **14** days the unaccompanied child remains in a restrictive placement.

Comment: We welcome the Proposed Rule's recognition in the Preamble that "[i]n determining whether there is a less restrictive placement available to meet the individualized needs of an unaccompanied child with a disability, consistent with Section 504 of the Rehabilitation Act, 29 U.S.C. § 794(a), ORR must consider whether there are any reasonable modifications to the policies, practices, or procedures of an available less restrictive placement or any provision of auxiliary aids and services that would allow the unaccompanied child with a disability to be placed in that less restrictive facility."[61]

This is an essential safeguard to protect children's rights and fulfill ORR's obligations under Section 504. As the Department of Justice has recognized, "[w]ith access to timely and appropriate services, even children with intensive behavioral health needs and a history of congregate facility placement are able to return to or remain in family homes where they are more likely to have improved clinical and functional outcomes, better school attendance and performance, and

[61] 88 Fed. Reg. 68923-24; *see also* 88 Fed. Reg. 68924 (discussing RTC placement).

increased behavioral and emotional strengths compared to children receiving care in institutions."[62]

The Proposed Rule itself, however, does not mention any mandatory analysis of reasonable modifications and auxiliary aids and services to permit a child to be placed in a less restrictive facility. If these considerations are not included in the regulatory text, it will not be clear to regulated parties that they are required to undertake this analysis. To adequately protect children's rights, the consideration of reasonable modifications and auxiliary aids and services to facilitate less restrictive placement must be explicitly incorporated into the Final Rule and apply both to an initial transfer decision and to a child's 30-day restrictive placement case review (Sections 410.1105, 410.1601, & 410.1901). The "clear and convincing evidence" standard for restrictive placement (Section 410.1901) must include a determination by clear and convincing evidence that a child cannot safely be placed in a less restrictive facility with additional accommodations or services.[63]

Finally, dangerousness determinations should comply with Section 504 of the Rehabilitation Act. As such, placement criteria for a secure facility should not include the assessment that a child is a danger *to themselves*.[64] In addition, the Proposed Rule should make explicit that a child with a disability will not be deemed to pose a danger *to others* unless they pose a "direct threat," which by regulation means a "significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices or procedures, or by the

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[62] U.S. Dep't of Justice, *Investigation of the State of Alaska's Behavioral Health System for Children*, 10 (Dec. 15, 2022) https://www.justice.gov/opa/press-release/file/1558151/download; *see also* HHS Proposed Rule, *Discrimination on the Basis of Disability in Health and Human Service Programs or Activities*, 88 Fed. Reg. 63392, 63415 (Sept. 14, 2023) ("This DOJ finding [in Alaska] cited, and is consistent with, research in the field . . . To meet the integration mandate for foster children's services, State agencies must often coordinate different supports and services to support community placements."); Letter from Kristen Clarke, Assistant Attorney General, Civil Rights Division, U.S. Dep't of Justice, United States' Investigation of Maine's Behavioral Health System for Children Under Title II of the Americans with Disabilities Act 9 (June 22, 2022), https://www.justice.gov/crt/case-document/file/1514441/download (Maine's juvenile detention facility "is also a segregated setting [] for incarcerated children with behavioral health needs who could be supported in their families' homes or Treatment Foster Care if community-based behavioral health services were available to them.").

[63] These additional protections will also help maintain placement stability. Multiple child welfare placements have been found to lead to "delayed permanency outcomes, academic difficulties, and struggles to develop meaningful attachments." Casey Family Programs, *What impacts placement stability?* (May 12, 2023), https://www.casey.org/placement-stability-impacts/. Placement instability can delay or disrupt legal services, mental health treatment, educational services, and – critically – case management and reunification services. Placement transfers during crucial times in a child's family reunification process can also escalate children's negative behaviors, which can lead to additional placement transfers. *Id.*

[64] Although the TVPRA permits placement in a secure facility based on danger to self, 8 U.S.C. § 1232(c)(2)(A), it does not require ORR to use this criteria.

provision of auxiliary aids or services."[65] The direct threat standard under the ADA and Section 504 does not consider *a threat to self* as an adequate reason to deny reasonable modifications for a child to receive care in a more integrated setting. Reasonable modifications for these children should include delivery of crisis intervention and stabilization services in a non-secure setting.

Consistent with the Department of Justice's position on Section 504's integration mandate, the Final Rule should also specify that the consideration of less restrictive alternatives will include consideration of community-based placement options such as therapeutic foster care.

If ORR determines that a child with a disability's placement in a less restrictive setting amounts to a direct threat, even with reasonable modifications, the child should be placed in a Qualified Residential Treatment Program rather than a secure juvenile detention facility. An extensive body of research has definitively established that secure placement is profoundly harmful to children and especially inappropriate for children with disabilities.[66] Due to the harm that secure placement poses to children, we propose that the Final Rule state in Section 410.1901(b) that "ORR shall provide an unaccompanied child with a Notice of Placement (NOP) no later than 48 hours after step-up to a restrictive placement, as well as every **14** days the unaccompanied child remains in a restrictive placement."

Changes in placement to more segregated settings will require new individualized assessments. Updated assessments must be conducted regularly, including, when a child's placement is in a segregated setting, to determine if a more integrated setting, such as a family placement, is appropriate.

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[65] *See* HHS Proposed Rule, *Discrimination on the Basis of Disability in Health and Human Service Programs or Activities*, 88 Fed. Reg. 63392, 63499, 63507 (Sept. 14, 2023); 28 C.F.R. §§ 35.139, 35.104. *See also Hargrave v. Vermont*, 340 F.3d, 27 (2d Cir. 2003) ("whereas the 'direct threat' defense requires the person to pose a risk of harm to others…"); *Schl. Bd. Of Nassau Cnty. v. Arline*, 480 U.S. 273 (1987); *Bay Area Addiction Research and Treatment v. City of Antioch*, 179 F.3d 725, 735 (9th Cir. 1999).

[66] *See, e.g.*, Sue Burrell, *Trauma and the Environment of Care in Juvenile Institutions*, Nat'l Ctr. for Child Traumatic Stress, 1, 4 (2013), https://www.nctsn.org/resources/trauma-and-environment-care-juvenile-institutions; Substance Abuse & Mental Health Serv. Admin. (SAMHSA), National Guidelines for Child and Youth Behavioral Health Crisis Care, Pub. No. PEP22-01-02-001 (2022); Lauren H. K. Stanley & Shamra Boel-Studt, *The Influence of Youth Gender and Complex Trauma on the Relation Between Treatment Conditions and Outcomes in Therapeutic Residential Car*e, J. Child Adolesc. Trauma, 93, 94 (Mar. 2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7900294/; Mary Dozier et al, *Consensus Statement on Group Care for Children and Adolescents: A Statement of Policy of the American Orthopsychiatric Association*, Am. Journal of Orthopsychiatry, Vol. 84, No. 3, 219, 221 (2014), https://www.apa.org/pubs/journals/features/ort-0000005.pdf; *Doe 4 v. Shenandoah Valley Juv. Ctr. Comm'n*, 985 F.3d 327, 330-34 (4th Cir. 2021); NIJC & the Young Ctr. for Immigrant Children's Rights, Punishing Trauma: Incident Reporting and Immigrant Children in Government Custody (Sept. 2022), https://www.theyoungcenter.org/overhaulsirreport.

ii. *Restrictive placement based on disruptive behavior*

Proposed Revisions:

410.1105(a)(3) ORR may place an unaccompanied child in a secure facility (that is not an RTC) only if the unaccompanied child: . . . (iii) ~~Has engaged, while in a restrictive placement, in conduct that has proven to be unacceptably disruptive of the normal functioning of the care provider facility, and removal is necessary to ensure the welfare of the unaccompanied child or others, as determined by the staff of the care provider facility (*e.g.,* substance or alcohol use, stealing, fighting, intimidation of others, or sexually predatory behavior), and ORR determines the unaccompanied child poses a danger to self or others based on such conduct.~~

410.1105(b)(2) In determining whether to place an unaccompanied child in a heightened supervision facility, ORR considers if the unaccompanied child**:** ~~**(i)** Has been unacceptably disruptive to the normal functioning of a shelter such that transfer is necessary to ensure the welfare of the unaccompanied child or others;~~
. . .
410.1105(d) If a child with a disability is considered for step up to a more restrictive facility based on their behavior, the child shall receive a manifestation determination with due process protections to determine whether the child's behavior is linked to their disability and/or is the result of a failure to provide the child with the reasonable modifications and services the child needs. If a child's behavior is determined to be a manifestation of their disability or a failure to provide needed modifications and services, ORR must conduct a functional behavioral assessment and develop (or review) a behavior intervention plan for the child before changing the child's placement.

Comment: We appreciate the Proposed Rule limiting the "unacceptably disruptive" criteria for secure placement to behavior that occurs in a restrictive facility, such that unacceptably disruptive behavior in a shelter would not lead to immediate step up to a secure facility.[67] However, the "unacceptably disruptive" criteria for placement in either a secure or heightened supervision facility is inappropriately vague and creates a high risk that children will be punished for behaviors that are a manifestation of their disabilities. As discussed above, a child whose behavior is deemed disruptive should be given services and supports necessary to meet their particular needs instead of being stepped up to a more restrictive setting.[68] The Final Rule should eliminate this criteria.

[67] 88 Fed. Reg. 68923.
[68] *See* U.S. Dep't of Justice, Investigation of the State of Alaska's Behavioral Health System for Children, 10 (Dec. 15, 2022) https://www.justice.gov/opa/press-release/file/1558151/download; Nat'l Council on Disability, *Youth with Disabilities in the Foster Care System: Barriers to Success and Proposed Policy*

At a minimum, if a child with a disability is considered for step up to a more restrictive facility based on their behavior, the Final Rule should require a manifestation determination to determine whether the child's behavior is linked to their disability and/or is the result of a failure to provide the child with the reasonable modifications and services the child needs. This could be similar to the manifestation determination required under the Individuals with Disabilities Education Act (IDEA).[69] If a child's behavior is a manifestation of their disability, ORR must conduct a functional behavioral assessment and develop (or review) a behavior intervention plan for the child instead of changing their placement.[70] This framework developed in the educational sphere is appropriate given that a transfer to a more restrictive placement will necessarily involve a change in the child's educational placement.

iii. *RTC placement criteria*

Proposed Revisions:

410.1105(c) Criteria for placing an unaccompanied child in an RTC. (1) An unaccompanied child with serious mental health or behavioral health **needs** ~~issues~~ may be placed into an RTC only if the unaccompanied child is evaluated and determined to be a danger to self or others by a licensed psychologist or psychiatrist consulted by ORR or a care provider facility, which includes a determination by clear and convincing evidence documented in the unaccompanied child's case file or referral documentation by a licensed psychologist or psychiatrist that an RTC is appropriate. In assessing danger to self or others, ORR uses the criteria for placement in a secure facility at paragraph (a) of this section. (2) ORR may place an unaccompanied child at an OON RTC when a licensed clinical psychologist or psychiatrist consulted by ORR or a care provider facility has determined that the unaccompanied child requires a level of care only found in an OON RTC either because the unaccompanied child has identified needs that cannot be met within the ORR network of RTCs or no placements are available within ORR's network of RTCs, or that an OON RTC would best meet the unaccompanied child's identified needs. (3) The criteria for placement in or transfer to an RTC also apply to transfers to or placements in OON RTCs. Care provider facilities may request ORR to transfer an unaccompanied child to an RTC in accordance with § 410.1601(d). **ORR shall**

Solutions (2008), https://www.ncd.gov/publications/2008/02262008 (*citing* Richard P. Barth, *Institutions vs. Foster Homes: An Empirical Base for a Century of Action* (2002)); Melissa Schober et al., A Safe Place to Be: Crisis Stabilization Services and Other Supports for Children and Youth 9 (2002), https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/nasmhpd-a-safe-place-to-be.pdf.

[69] *See* 20 U.S.C. § 1415(k)(1)(E); *see also* 34 C.F.R. § 104.35(a).

[70] *Id.*

not consent to a child's placement in an RTC when the child has a disability and, with services or reasonable modifications, the child can be served in a more integrated setting.

Comment: The term "serious mental health and behavioral issues" should be replaced by "serious mental health and behavioral needs" to focus on the child's needs and reduce stigma. The following language should be added to the regulatory text to Section 410.1105(c): "ORR shall not consent to a child's placement in an RTC when the child has a disability and, with services or reasonable modifications, the child can be served in a more integrated setting."

e. Release to Sponsors

i. *Sponsor evaluation*

Proposed Revisions:

410.1311(e)(1) In addition to the requirements for release of unaccompanied children established elsewhere in this part and through any subregulatory guidance ORR may issue, ORR shall adhere to the following requirements when releasing unaccompanied children with disabilities to a sponsor:
~~**(1) ORR's assessment under § 410.1202 of a potential sponsor's capability to provide for the physical and mental well-being of the child must necessarily include explicit consideration of the impact of the child's disability or disabilities.**~~

410.1202(f) ORR shall evaluate the unaccompanied child's current functioning and strengths in conjunction with any risks or concerns such as:
…
(3) History of behavioral issues;
(5) Any individualized needs, including those related to disabilities or other medical or behavioral/mental health issues. **Consideration of the impact of a child's disability or disabilities must also include explicit consideration of the potential benefit to the child of release to a community placement with a sponsor and the effect of continued ORR custody on the child. A child's disability is not a reason to delay or deny release to a sponsor unless the sponsor is incapable of providing for the child's physical and mental well-being despite documented efforts by ORR to educate the sponsor about the child's needs and to assist the sponsor in accessing and coordinating post-release services and supports**;

410.1202(h) ORR shall assess the potential sponsor's:
(1) Understanding of the unaccompanied child's needs;

(2) Plan to provide adequate care, supervision, and housing to meet the unaccompanied child's needs;
(3) Understanding and awareness of responsibilities related to compliance with the unaccompanied child's immigration court proceedings, school attendance, and U.S. child labor laws; and
(4) Awareness of and ability to access community resources.
…

410.1202(j) The mere presence of the risks and concerns related to a potential sponsor listed in Section 410.1202(d-h) are not necessarily disqualifying.

Comment: Several provisions of the Proposed Rule related to release to sponsors (Sections 410.1202(f), 410.1202(h), 410.1311(e)(1)) require consideration of a child's disability as part of ORR's evaluation of a potential sponsor. Without more context and explanation of what it means to consider a child's disability, these provisions could lead care providers to discriminate against children with disabilities by adding obstacles to release not faced by children without disabilities. ORR has a legal obligation to ensure children with disabilities have an equal opportunity to obtain the benefit of prompt release and may not use methods of administration that have the effect of impairing the release of children with disabilities or provide a qualified individual with a disability with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement, as that provided to others.[71]

Because we believe consideration of disability is well-covered elsewhere, we recommend removing Section 410.1311(e)(1) ("ORR's assessment under § 410.1202 of a potential sponsor's capability to provide for the physical and mental well-being of the child must necessarily include explicit consideration of the impact of the child's disability or disabilities."). Should ORR decide to maintain this provision, we recommend that the Final Rule should specify that ORR's consideration of the impact of a child's disability or disabilities must also include explicit consideration of the potential benefit to the child of release to a community placement with a sponsor and the potential harm of continued ORR custody on the child. As the Supreme Court held in *Olmstead*, "unjustified institutional isolation of persons with disabilities is a form of discrimination. . . [C]onfinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."[72]

[71] See 29 U.S.C. § 794(a); 45 C.F.R. § 85.21(b)(1), (3); 28 C.F.R. § 35.130.
[72] *Olmstead v. L.C.*, 527 U.S. 581, 600 (1999).

If the sponsor needs support or training to meet the disability-related needs of the child being placed, such support and training should be provided as a reasonable modification for the child and to enable the child to live in the most integrated setting.

In making such assessments, the Final Rule must make clear that ORR cannot make decisions about the appropriateness of placement in a family home based on speculation, stereotypes, or generalizations that a family member or potential sponsor cannot adequately care for a child because of the child or a family member's disability. Likewise, decisions about appropriateness of placement in a family home should be culturally responsive and explicitly consider the child and family's unique culture.

As noted in the Preamble, the Final Rule should explicitly state that the risks and concerns listed in Section 410.1202 are not necessarily disqualifying.[73] The Final Rule should further make clear that a child's disability is not a reason to delay or deny release to a sponsor unless the sponsor is incapable of providing for the child's physical and mental well-being despite documented efforts by ORR to educate the sponsor about the child's needs and to assist the sponsor in accessing and coordinating post-release services and supports. This will be the rare case. Although we welcome references to ORR support for sponsors elsewhere in the Proposed Rule, this assistance must also be directly tied to the sponsor evaluation process to make clear that sponsors should not be denied prior to such support being offered.[74]

All aspects of the sponsor evaluation and release processes must also be accessible to people with disabilities. For example, for a child with a behavioral disability, sponsors may need assistance post-release in understanding and applying for behavioral supports for the child, or education about how to attend IEP meetings and ensure that a child's educational needs are being met. Evaluations should also be in plain language and at appropriate literacy levels.

ii. *Post-release services*

Proposed Revisions:

410.1311(e)(2) In planning for a child's release and conducting PRS, ORR and any entities through which ORR provides PRS shall make reasonable modifications in their policies, practices, and procedures if needed to enable

[73] 88 Fed. Reg. 68929.
[74] *See* Proposed Rule §§ 410.1203(f), 410.1311(e)(2).

released unaccompanied children with disabilities to live in the most integrated setting appropriate to their needs, such as with a sponsor. ORR is not required, however, to take any action that it can demonstrate would result in a fundamental alteration in the nature of a program or activity.

Comment: We appreciate the Proposed Rule's explicit reference in Section 410.1311(e)(2) to reasonable modifications in the provision of post-release services (PRS) to enable children to live in integrated placements with their sponsors. Because children are referred to post-release services only at the end of the release process, some children with disabilities may need reasonable modifications to enable their prompt release before PRS officially begins. The Final Rule should make clear that ORR will make reasonable modifications both in release planning and in conducting PRS.

This modification to the regulatory language is critically important to address delays in release for unaccompanied children with disabilities, who are held in ORR custody disproportionately longer than unaccompanied children without disabilities. Some unaccompanied children with disabilities are thus excluded from and denied the full benefits of ORR's PRS programs, services, and activities. Section 504 provides that reasonable accommodations must be provided to unaccompanied children with disabilities to ensure that they are able to participate in ORR services and activities to the same extent as unaccompanied children without disabilities, including post-release services.

All children with disabilities who wish to receive more intensive post-release services and who could benefit from such services should receive service planning conducted by a child and family team that develops a plan of services and supports that can be wrapped around a family. In this model, each child receives individualized services, based on their unique strengths and needs and delivered pursuant to an individualized service plan (ISP) developed with the involvement of the child, parent, and foster parent. The system of care must ensure that services identified in ISPs are accessed and delivered in a coordinated and therapeutic manner. These services, such as case management,[75] counseling, independent living supports, community-based mental health services, other medical care, and transportation, should be sensitive to cultural differences and must be trauma-informed. Research has consistently found that the provision of these kinds of home and community-

[75] Effective case-management for unaccompanied children with disabilities is the key to effective post-release services. ORR should look to the Medicaid EPSDT model for its case-management program. Case management should include (1) initial assessment of an eligible individual; (2) development of a specific care plan; (3) referral to services; and (4) monitoring. Enclosure A, Technical Assistance Tool, Optional State Plan Case Management, CMS.Gov (2008), https://www.cms.gov/regulations-and-guidance/legislation/deficitreductionact/downloads/cm_ta_tool.pdf.

based services for youth with disabilities, including youth with serious emotional and behavioral needs, has made significant improvement in the quality of life for these children, youth, and families.[76]

Expanding upon the services ORR already provides through its post-release services is a reasonable modification for unaccompanied children with disabilities, especially where, as here "modifications align" with the agency's "own stated goals and obligations."[77] This requires clarification in the Final Rule to help ensure compliance and that the intent of the regulation is realized. We thus urge ORR to provide more clarity in the Final Rule about what constitutes a fundamental alteration in this context.

For example, as explained above in our discussion of the most integrated setting, it is not a fundamental alteration for ORR to provide unaccompanied children with services in the community. ORR already provides post-release services "to facilitate a continuum of care and provide support for children transitioning into their new communities."[78] Under ORR's framework for providing PRS to unaccompanied children, all children with disabilities, including mental health disabilities, should receive them.[79]

iii. *Release delays*

Proposed Revisions:

410.1311(e)(3) ORR shall not delay the release of a child with one or more disabilities solely because post-release services are not in place before the

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[76] *See, e.g.*, Sheila Pines, Nat'l Tech. Assistance Ctr. for Children's Mental Health, Building Systems of Care: A Primer (2002), https://gucchd.georgetown.edu/products/PRIMER2ndEd_FullVersion.pdf; *Katie A. ex rel. Ludin v. Los Angeles County*, 481 F.3d 1150 (9th Cir. 2007).

[77] *See United States v. Florida*, No. 12-60460 (S.D. Fl. July 14, 2023) (*citing Henrietta D. v. Bloomberg*, 331 F.3d 261, 280-81 (2d Cir. 2003) (upholding as a reasonable modification an order requiring agency to follow existing law and procedures); *United States v. Mississippi*, 400 F. Supp. 3d 546, 576 (S.D. Miss. 2019) (finding provision of community-based services reasonable where United States showed that the state "already has the framework for providing the[] services and can more fully utilize and expand that framework to make the services truly accessible"); *Disability Advocates, Inc. v. Paterson*, 598 F. Supp. 2d 289, 335-36 (E.D.N.Y. 2009) ("Where individuals with disabilities seek to receive services in a more integrated setting—and the state already provides services to others with disabilities in that setting—assessing and moving the particular plaintiffs to that setting, in and of itself, is not a 'fundamental alteration.'"); *Messier v. Southbury Training Sch.*, 562 F. Supp. 2d 294, 332-34, 339-42 (D. Conn. 2008) (plaintiffs' requested service expansion, which was consistent with defendants' publicly stated plans, was reasonable); *cf. Haddad v. Dudek,* 784 F. Supp. 2d 1308, 1330-31 (M.D. Fla. 2011) (providing a service already in a state's service system to additional individuals is not a fundamental alteration).

[78] Off. of Refugee Resettlement, ORR Unaccompanied Children Program Policy Guide § 6 Post-Release Services, https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide-section-6 (current as of Nov. 14, 2023).

[79] ORR provides that all children who receive a home-study, which includes children with disabilities, should receive post-release services. *Id.*

child's release. **ORR shall not delay the release of a child with one or more disabilities because of a pending assessment or a pending individual service plan.**

Comment: We appreciate the Proposed Rule's statement that ORR will not delay a child's release because post-release services are not yet in place. As discussed above, the Final Rule should further specify that a pending assessment for disability or the development of a service plan for a child with a disability will not delay a child's release to an otherwise suitable sponsor.

f. Notice of rights and procedures

Proposed Revisions:

410.1311(a) ORR must provide notice to the unaccompanied children in its custody of the protections against discrimination under Section 504 of the Rehabilitation Act at 45 CFR part 85 assured to children with disabilities in its custody. ORR must also provide notice of the available procedures for seeking reasonable modifications or making a complaint about alleged discrimination against children with disabilities in ORR's custody. **Notices will comply with Section 508 and the most updated Web Content Accessibility Guidelines (WCAG) standards and be provided in a manner that is fully accessible to the individual needs of the unaccompanied child and in a way they effectively understand regardless of spoken language, reading comprehension, or disability to ensure equal access for all eligible children, including those with limited English proficiency.**

410.1311(c) ORR shall provide reasonable modifications needed for an unaccompanied child with one or more disabilities to have equal access to the UC Program. ORR is not required, however, to take any action that it can demonstrate would result in a fundamental alteration in the nature of a program or activity. **ORR will set up an accessible, child-friendly procedure for children, child advocates, or attorneys to request reasonable accommodations or auxiliary aids or services for an unaccompanied child, or for any person to make a complaint about disability discrimination, and will promptly respond to any requests or complaints.**

410.1306(c)(6): Standard programs and restrictive placements shall provide information regarding grievance policies and procedures **consistent with 45 C.F.R. § 84.7** in the unaccompanied children's native or preferred language, depending on the children's preference, and in a way they effectively understand. **Grievance policies and procedures must be provided in a manner that is**

accessible to children with disabilities and complies with current Section 508 standards.

Comment: Because the notice of rights in Proposed Rule Section 410.1311(a) involves the rights and procedures of children with disabilities, it is important to clarify that these notices will be provided in a manner that is accessible to children with disabilities. We suggest adding language akin to that of Proposed Rule Section 410.1210(b) requiring that services "comply with Section 508 and the most updated Web Content Accessibility Guidelines (WCAG) standards and be provided in a manner that is fully accessible to the individual needs of the unaccompanied child and in a way they effectively understand regardless of spoken language, reading comprehension, or disability to ensure equal access for all eligible children, including those with limited English proficiency."[80]

Additionally, although Proposed Rule Section 410.1311(a) requires notice of available procedures for requesting reasonable modifications or making a complaint about alleged discrimination against children with disabilities, the Proposed Rule does not state what those procedures entail. The Final Rule should specify that ORR will set up procedural safeguards to request reasonable accommodations or make a complaint about disability discrimination, including easily accessible, child-friendly procedures, and will promptly respond to any requests or complaints.[81]

In the Preamble discussion of Section 410.1109 ORR seeks comments on "steps ORR should take to ensure that it provides effective communication access to unaccompanied children who are individuals with disabilities."[82] We appreciate ORR's interest in ensuring that youth with disabilities can understand what is said or written and can communicate effectively. Effective communication is an individualized process and must take into account the child's abilities and preferences but also the nature, length, complexity, and context of the communication.[83] For example, effective communication could look different when the child is in a classroom versus at a soccer practice. Proposed Section 410.1302(e) includes good examples of tools for effective communication, such as using: the child's preferred language; auxiliary aids or services; clear, easily understood language, with concise and concrete sentences; visual aids; and checking for understanding where appropriate. The Preamble includes others: qualified sign language interpreters, Braille materials, audio recordings, note-

[80] For more on Section 508 and WCAG standards, *see generally* U.S. Gen. Serv. Admin, https://www.section508.gov/.
[81] *See, e.g.,* 34 C.F.R. § 104.36.
[82] 88 Fed. Reg. 68927.
[83] *See generally* U.S. Dep't of Justice, ADA Requirements: Effective Communication (last updated Feb. 28, 2020), https://www.ada.gov/resources/effective-communication/.

takers, and written materials. Others include text-to-speech/screen reader software; communication boards; or handheld devices or tablet devices with symbols that generate speech through synthetically produced or recorded natural (digitized) means. Effective communication can also be multimodal, permitting children to use a combination of modes to communicate.

ORR and providers should give primary consideration to the choice of aid or service requested by the child. The child's preference should be honored unless ORR or the provider can demonstrate that another equally effective means of communication is available, or that the use of the means chosen would result in a fundamental alteration or in an undue burden. Auxiliary aids and services must be provided in a timely manner, and in a way that protects the privacy and independence of the child.

To improve effective communication, ORR must also have a clear process for requesting and receiving auxiliary aids and services in a timely manner, as discussed above; and require training for providers on the request process and effective communication in general. Comprehensive and ongoing staff training is a critical piece of ensuring effective communication. If front line staff are not aware of ORR's effective communication policies and processes, or do not know how to implement them, problems can arise.

g. Oversight

Proposed Revisions:

410.1501 Data on unaccompanied children – Care provider facilities are required to report information necessary for ORR to maintain data in accordance with this section. Data include: . . . (f) Information gathered from assessments, evaluations, or reports of the child; ~~and,~~ (g) Data necessary to evaluate and improve the care and services for unaccompanied children; **(h) Data related to disability, including: (I) the number of children in ORR custody identified as having a disability; (II) Identified disabilities, placements, step-ups, step-downs, and length of stay for children with disabilities; and (III) the child's need for reasonable modifications or other services, and information related to release planning.**

Proposed new provisions:

Protection and Advocacy Agencies
ORR will affirmatively cooperate with Protection and Advocacy agencies (P&As) across its network, provide reasonable unaccompanied access as required in other facilities, and provide information to P&As regarding

disability law compliance in all facilities where unaccompanied children are held.

504 Coordinator
ORR will designate a staff member as a Section 504 coordinator to oversee the agency's compliance with Section 504 of the Rehabilitation Act and the agency's treatment of children with disabilities. This Section 504 coordinator must have authority to respond to complaints and approve additional resources for children with disabilities. ORR may designate an employee of the Office of the Ombuds to serve in this role.

Comment: Proposed Rule Section 410.1501 sets out data that care providers are required to report to ORR. It is unclear whether this data will include sufficient information to enable ORR to provide effective oversight of the treatment of unaccompanied children with disabilities.[84]

Required data should include, at a minimum, whether a child has been identified as having a disability, the child's diagnosis, the child's need for reasonable modifications or other services, and information related to release planning. Such data should be compiled in a manner that enables ORR to track how many children with disabilities are in its custody, where they are placed, what services they are receiving, and their lengths of stay.

In addition, ORR should designate a staff member as a Section 504 coordinator to oversee the agency's compliance with Section 504 of the Rehabilitation Act and the agency's treatment of children with disabilities. This Section 504 coordinator must have authority to respond to complaints and approve additional resources for children with disabilities.

Independent oversight is also critical to ensuring the rights of children with disabilities. Protection & Advocacy Agencies (P&As) have statutory authority to monitor facilities where individuals with disabilities live. Thus, we appreciate the Preamble's reference to consulting with non-governmental stakeholders such as P&As to vet out-of-network facilities.[85] ORR's consultation with P&As should not be limited to out-of-network placements, however. The Final Rule should state that ORR will affirmatively cooperate with P&As across its network, provide reasonable unaccompanied access as required in other facilities, and provide

[84] *See Armstrong v. Schwarzenegger*, 622 F.3d 1058, 1074 (9th Cir. 2010) (explaining that "[b]ecause the regulations implementing the ADA require a public entity to accommodate individuals it has identified as disabled . . . some form of tracking system is necessary in order to enable [defendants] to comply with the Act" (quoting *Armstrong v. Davis*, 275 F.3d 849, 876 (9th Cir. 2001)).
[85] 88 Fed. Reg. 68925.

information to P&As regarding disability law compliance in all facilities where unaccompanied children are held.

3. PSYCHOTROPIC MEDICATION

a. Consent

Proposed Revisions:

410.1310(a) Except in the case of a psychiatric emergency, ORR shall ensure that~~, whenever possible,~~ authorized individuals provide informed consent prior to the administration of psychotropic medications to unaccompanied children.

(i) "Authorized individuals" means a child's parent or legal guardian, whenever reasonably available. If a child's parent or legal guardian is not reasonably available, an authorized individual may be an immediate relative sponsor. If neither a parent or legal guardian nor an immediate relative sponsor is available, the unaccompanied child can serve as the authorized individual (if the child is of sufficient age and permitted to consent under state law). Care provider staff are not authorized individuals for purposes of providing informed consent to psychotropic medications.

(ii) In the case of a psychiatric emergency, any administration of psychotropic medication shall be documented; the child's authorized consenter shall be notified as soon as possible; and the care provider and ORR shall review the incident to ensure compliance with ORR policies and avoid future emergency administrations of medication.

(iii) No child or sponsor shall be subjected to retaliation or punishment for withholding or withdrawing consent for any psychotropic medication. A decision not to consent to psychotropic medication or refusal to take medication shall not be relied upon, even in part, to transfer a child to a more restrictive setting.

Comment: Although we welcome the Proposed Rule's attention to the critical issue of informed consent to the administration of psychotropic medications, proposed Section 410.1310(a) fails to provide meaningful protection to children prescribed psychotropic medications. In particular, the Proposed Rule does not define who would qualify as "authorized individuals" and would permit the agency unlimited discretion to decide who is authorized to provide consent for a child. The Final Rule should specify that the term "authorized individuals" means a child's parent or legal guardian, whenever reasonably available, followed by a close relative sponsor, and then the unaccompanied child themselves (if the child is of sufficient age and permitted to consent under state law). Care provider staff must never be considered authorized individuals for the purpose of informed consent to psychotropic medication.

In addition, the term “whenever possible” in Proposed Rule Section 410.1310(a) should be eliminated. The proposed regulatory text already includes an exception for psychiatric emergencies. Outside the context of a psychiatric emergency, ORR must ensure that an authorized individual provides informed consent.

In the case of true psychiatric emergencies, the Final Rule should require that any emergency administration of psychotropic medication be documented, that the child’s authorized consenter be notified as soon as possible, and that the care provider and ORR review the incident to ensure compliance with ORR policies and avoid future emergency administrations of medication.

While we appreciate that Proposed Rule Section 410.1304 bars providers from “apply[ing] medical interventions that are not prescribed by a medical provider acting within the usual course of professional practice for a medical diagnosis or that increase risk of harm to the unaccompanied child or others,” as a form of behavior management, we suggest adding language to Proposed Rule Section 410.1310 stating that refusal to consent to the use of psychotropic medication shall not lead to punishment or retaliation. This includes situations where youth initially consent but later change their mind. Nor should refusal to consent be used to step up youth to more restrictive placements; youth are not to be coerced into taking medication as a condition of placement. Relatedly, psychotropic medications should not be used as a behavior management tool in lieu of or as a substitute for identified psychosocial or behavioral supports required to meet a youth’s mental health needs. In our experience, providers have used SIRs to document psychotropic medication non-compliance in ways that suggest that youth who refuse to take their medications are being difficult or oppositional; and the record of SIRs then used to step up youth to more restrictive settings.

b. <u>Oversight</u>

Proposed Revisions:

410.1310(b) ORR must ensure meaningful oversight of the administration of psychotropic medication(s) to unaccompanied children, **including by reviewing cases flagged by care providers and conducting additional reviews of the administration of psychotropic medications in high-risk circumstances, including but not limited to cases involving young children, simultaneous administration of multiple psychotropic medications, and high dosages. ORR oversight shall be led by a child and adolescent psychiatrist with the requisite knowledge and experience to effectively oversee the administration of psychotropic medications to unaccompanied children.**

410.1501 Data on unaccompanied children – care provider facilities required to report certain information, including "(f) Information gathered from assessments, evaluations, or reports of the child; and, (g) Data necessary to evaluate and improve the care and services for unaccompanied children. . . **(i) Data related to psychotropic medications, including children's diagnoses, the prescribing physician's information, the name and dosage of the medication prescribed, documentation of informed consent, and any emergency administration of medication.**

Comment: We strongly support greater oversight by ORR of the administration of psychotropic medications to unaccompanied children. It is not clear, however, what the "meaningful oversight" referenced in Proposed Rule Section 410.1310(b) will consist of. We encourage ORR to revise the Proposed Rule to incorporate the examples provided in the Preamble.[86]

Further, to ensure meaningful oversight, ORR must engage qualified professionals who are able to oversee prescription practices and provide guidance to care providers. For this reason, the Final Rule should specify that oversight will be conducted by a child and adolescent psychiatrist.[87]

Further, ORR must gather sufficient data on unaccompanied children who are prescribed and administered psychotropic medications to provide oversight. Section 410.1501 of the Proposed Rule should require that care providers report information relating to the administration of psychotropic medication, including children's diagnoses, the prescribing physician's information, the name and dosage of the medication prescribed, documentation of informed consent, and any emergency administration of medication. Such data should be compiled in a manner that enables ORR to track how psychotropic medications are administered across the network and in individual facilities.

4. CONCLUSION

We thank ORR for the opportunity to comment on the Proposed Rule. We are encouraged by ORR's commitment to meeting the individualized needs of children with disabilities in its care. The changes we offer to the Proposed Rule would help ORR achieve its goal of providing the specialized care young people need while they wait to be united with their families and communities in the United States and would further protect the disability justice rights of all youth in ORR custody. We urge ORR to adopt our recommendations to improve protections for youth in the Final Rule.

[86] 88 Fed. Reg. 68951.
[87] *See*, *e.g.*, Proposed Rule § 410.2003(b) (specifying qualifications of the Office of the Ombuds).

For any questions or concerns about this comment, please contact Anne Kelsey at akelsey@theyoungcenter.org.

Sincerely,

Acacia Center for Justice
Advocates for Basic Legal Equality, Inc (ABLE)
Alabama Disabilities Advocacy Program
Alianza Americas
American Psychiatric Association*
*The APA signs onto this comment where applicable, specifically the comments on Section 410.1501.
Americans for Immigrant Justice
Angry Tias and Abuelas of the RGV
Arizona Center for Disability Law
Autistic Self Advocacy Network
Bazelon Center for Mental Health Law
Capital Area Immigrants' Rights (CAIR) Coalition
Catholic Charities Baltimore, Esperanza Center
Catholic Charities Atlanta
Center for Public Representation
Central American Resource Center - CARECEN- of California
Child and Adolescent Psychiatrist
Church World Service
Community Legal Services in East Palo Alto
Creating Opportunities Family Network
Dignidad/The Right to Immigration Institute
Diocesan Migrant & Refugee Services
Diocesan Migrant and Refugee Services Inc/Estrella del Paso
Disability Law Center (MA)
Disability Law Center of Utah
Disability Rights Arkansas
Disability Rights California
Disability Rights Center - NH
Disability Rights Clinic, Syracuse University College of Law
Disability Rights DC at University Legal Services
Disability Rights Education and Defense Fund (DREDF)
Disability Rights Florida
Disability Rights Maryland
Disability Rights Michigan
Disability Rights New Jersey
Disability Rights Oregon
Disability Rights South Carolina
Disability Rights Washington
Empowering Pacific Islander Communities

Fieldstone Partnership Inc.
Florence Immigrant and Refugee Rights Project
Florida Legal Services, Inc.
Galveston-Houston Immigrant Representa
Grassroots Leadership
HIAS Pennsylvania
Hope Border Institute
Houston Immigration Legal Services Collaborative
Human Rights Initiative of North Texas
Immigrant Defenders Law Center
Immigration Center for Women and Children
Immigration Counseling Service
Indiana Disability Rights
International Rescue Committee
JFCS Pittsburgh
Just Neighbors
Justice in Motion
Juvenile Law Center
Kentucky Protection and Advocacy
Kiva Centers
La Raza Centro Legal
Law Office of Daniela Hernandez Chong Cuy
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Legal Services for Children
Los Angeles Center for Law and Justice
LSN Legal LLC
Lutheran Social Services of the National Capital Area (LSSNCA)
Martinez & Nguyen Law, LLP
Minnesota Disability Law Center at Mid-Minnesota Legal Aid
Muscular Dystrophy Association
National Center for Parent Leadership, Advocacy, and Community Empowerment (National PLACE)
National Disability Rights Network (NDRN)
National Federation of Families
National Immigrant Justice Center
National Immigration Law Center (NILC)
Native American Disability Law Center
North Dakota Protection & Advocacy Project
OneAmerica
Open Immigration Legal Services
Physicians for Human Rights - Student Advisory Board
Project Lifeline
Rocky Mountain Immigrant Advocacy Network
Safe Passage Project

South Asian Public Health Association
South Dakota Voices For Peace
The Immigration Project
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