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

Re: **Unaccompanied Children Program Foundational Rule, Office of Refugee Resettlement (ORR), Administration for Children and Families (ACF), U.S. Department of Health and Human Services (HHS); 88 Fed. Reg. 68908; RIN 0970-AC93; ACF-2023-0009**

Dear Mr. Biswas

We write on behalf of the undersigned organizations and individual experts 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 the sections of the Proposed Rule that relate to the conditions in which unaccompanied children are held in standard programs.

We have extensive experience providing legal, child advocate, social, mental health or other services to and advocacy to unaccompanied children in ORR custody. Collectively, we have deep experience in the areas of enforcing constitutional due process rights, child welfare, the ORR release and reunification process, child development, child migration, language and cultural competency, and service provision for unaccompanied children prior to and following release from ORR custody, among other things. We have seen that children fare best in home-like settings in which they have developmentally appropriate ways to engage in decisions that impact them and form trusting relationships with peers and adults. We know that increased size and restrictiveness in a custodial setting exacerbates the negative impacts of federal custody on children and impedes prompt release to sponsors. We have also seen that federal custody can cause increased trauma and impede healing rather than providing a setting in which young people can recover from their past traumatic experiences. Things like language access and safe autonomy are essential to ensuring appropriate conditions for children in ORR custody. Adopting elements of law enforcement and immigration enforcement has historically caused significant harm to the children in ORR custody. ORR must decline to adopt any law enforcement or immigration enforcement role in its care and custody of unaccompanied children.

[1] Unaccompanied Children Program Foundational Rule, 88 FR 68908 (Oct. 4, 2023) (to be codified at 45 C.F.R. pt. 410).

Importantly, our comments' narrow focus does not constitute an endorsement of other segments of the Proposed Rule, though we have joined or led separate comments providing stakeholder input on other sections. In the following comment, we express appreciation for aspects of the Proposed Rule, encourage ORR to improve upon certain sections of the Proposed Rule, and oppose or request significant revision of certain sections of the Proposed Rule.

I. Subpart A (§§ 410.1001; 410.1002; 410.1003)

a. Trauma-Informed Care

We appreciate ORR's stated commitment to providing trauma-informed care to the young people in its custody using the CDC and SAMHSA's info-graphic framework, as explained in the preamble to the Proposed Rule. (p. 68916). While helpful, the CDC/SAMHSA framework does not provide enough detail or information to understand how ORR will apply such a framework in the context of UC custody.

We urge ORR to provide a more specific definition of a trauma-informed approach in proposed § 410.1001 that includes not just the recognition of trauma and recovery paths and the avoidance of re-traumatization but also policies affirmatively aimed at reducing the short- and long-term impacts of trauma on the children in its care. A more specific definition or additional definition could include a definition of "traumatic stress.".[2]

In addition, ORR's final rule should require that trauma-informed practices be evidence-based. Simply providing for a child's basic needs is insufficient to promote healthy development when there is not a reliable caregiver-child relationship[3], as is the case in most "standard placements" as defined in the proposed regulations. Because many, if not most, of the children in ORR care have experienced trauma, the regulation or implementing guidance should incorporate concrete practices reflecting a trauma-informed approach as it applies to unaccompanied children in the distinct contexts in which they interact with ORR.[4] For example, ORR should establish policies that avoid or reduce disruption to

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[2] *See, e.g.*, Shonkoff, J. P., Garner, A. S., *The Committee on Psychological Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care, & Section on Developmental and Behavioral Pediatrics* (2012) The lifelong effects of early childhood adversity and toxic stress. *Pediatrics, 129*(1), e232–e246, https://doi.org/10.1542/peds.2011-2663 (describing traumatic stress as being the excessive or prolonged activation of physiological stress response systems in the absence of, or insufficiency of protective relationships that reinforce adaptations to stress); Sege, R. D., Amaya-Jackson, L., AAP Committee on Child Abuse and Neglect, Council on Foster Care, Adoption, and Kinship Care, AACAP Committee on Child Maltreatment and Violence, & National Center for Child Traumatic Stress (2017) Clinical considerations related to the behavioral manifestations of child maltreatment. *Pediatrics, 139*(4). https://doi.org/10.1542/peds.2017-0100

[3] Center on the Developing Child, Harvard University. (2013). InBrief: The science of neglect. https://developingchild.harvard.edu/resources/inbrief-the-science-of-neglect/

[4] *See, e.g. See, e.g.*, Julian D. Ford et al., *Etiology of PTSD: What causes PTSD?* in Posttraumatic Stress Disorder: Scientific and Professional Dimensions 81-132 (2nd ed. 2015); Julian D. Ford et al., *Treatment of Children and Adolescents with PTSD* in Posttraumatic Stress Disorder: Scientific and Professional Dimensions 367-411 (2nd ed.

trusting relationships with ORR caregivers and peers (e.g., by avoiding parallel transfers of UCs between placements in the same level of restrictiveness, unless there is a compelling reason to transfer a child specifically related to that child's best or expressed interests and needs), in recognition of the guiding principles of trustworthiness and transparency, peer support, and empowerment and choice.

Recommendation 1: § 410.1001
Trauma-informed means a system, standard, process, or practice that realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in unaccompanied children, families, staff, and others involved with the system; and ~~responds by~~ fully ~~integrating~~ **[ADD] integrates evidence-based practices and** knowledge about trauma into policies, procedures, and practices~~, and seeks to~~ **[ADD] in order to promote healing and** actively resist retraumatization.

b. Placement Decisions

We are encouraged to see that ORR has explicitly included youth participation in decision-making as a foundational principle that applies to the care and placement of unaccompanied children in § 410.1003(d).

Although elaborated as a foundational principle, the regulations do not specify how UCs will be included in the decision-making process or how their well-being in care (both expressed and observed) will be assessed and weighed when making care, placement, and/or release decisions. We urge ORR to provide specific regulations requiring the recorded participation of UCs in major decision-making processes as outlined in each of their subsections in addition to being listed as a foundational principle in Subpart A.

For example, UC's preferences regarding placement (geographic, facility-type, desire to be placed with relatives or individuals with whom they have existing relationships, desire to be transferred) should be recorded in notices of placement and/or other documentation related to placement and release.

Recommendation 2
We urge ORR to provide specific regulations requiring the recorded participation of UCs in major decision-making processes as outlined in each of their subsections in addition to being listed as a foundational principle in Subpart A.

2015); Kristine M. Kinniburgh & Margaret E. Blaustein, Treating Traumatic Stress in Children and Adolescents: How To Foster Resilience through Attachment, Self-Regulation, and Competency (2nd ed. 2018). Robert D. Sege, et al., *Clinical Considerations Related to the Behavioral Manifestations of Child Maltreatment*, 139 Pediatrics 4 (2017), https://doi.org/10.1542/peds.2017-0100; Laurence Steinberg et al., Age of Opportunity: Lessons From the New Science of Adolescence (2014).

II. Subpart B (§§ 410.1101-1104; 410.1107)

a. Community-Based Care Model & state-licensed family-based or small-scale placements

We support ORR's consideration of a community-based care model for inclusion in the final regulation, as described in the preamble to the proposed regulations. (p. 68919). Such a model is in line with federal and state child welfare policies, which recognize the importance of allowing young people in government custody to experience normal childhood freedoms and opportunities to the greatest extent possible.[5] In addition, the Preventing Sex Trafficking and Strengthening Families Act directs state child welfare institutions to support normalcy for children in their care, including by adopting a "reasonable and prudent parenting standard"[6] in child care institutions and ensuring children have opportunities to engage in developmentally appropriate activities.[7] This law recognizes that the opportunity to participate in normal childhood experiences is critical for the healthy social, emotional, and cognitive development of children and adolescents.[8]

In keeping with best practices, we encourage ORR to limit the number of young people permitted in any group home setting as prescribed by evidence-based research.[9] We urge ORR to ensure that community-based care placements are home-like settings, including the ability to move about freely within the home, to have input into their own schedule and participation in community and/or family activities, and to have private spaces and privacy while in the home. These placements should be free from restrictions commonly found in congregate care settings like requiring children to walk in single-file lines to move through the facility or having to use the restrooms in groups or shifts. In keeping with this understanding of a community-based care placement, we suggest ORR provide a definition of "least restrictive environment" in Proposed Rule § 410.1001 that establishes that the least restrictive

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[5] *See, e.g.,* 42 U.S.C. § 671(a)(1); Ca. Welf. & Inst. Code § 16001.9; Cal. Code Regs. tit. 22 § 84067(b)(5); Col. Rev. Statutes § 19-7-101; Fl. Statutes § 409.145 (3)(b)(e); Tx. Admin Code § 748.1101(b)(3)(D).

[6] This standard "means the standard characterized by careful and sensible parental decisions that maintain the health, safety, and best interests of a child while at the same time encouraging the emotional and developmental growth of the child." 42 U.S.C. § 675(10)(A).

[7] 42 U.S.C. §§ 671(a)(1); 675(5)(B), 10(A). *See also* Admin. for Child. & Families, New Legislation - *Public Law 113-183, the Preventing Sex Trafficking and Strengthening Families Act* at 3 (Nov. 4, 2015), https://www.acf.hhs.gov/sites/default/files/documents/cb/im1403.pdf.

[8] *See* Children's Bureau, U.S. Dep't of Health & Hum. Serv., *Promoting Normalcy for Youth in Care*, 17 Children's Bureau Express (May 2016), https://cbexpress.acf.hhs.gov/article/2016/may/promoting-normalcy-for-youth-in-care/a728c8cf1b52c150517620efe54bcb52; Annie E. Casey Found., What Young People Need to Thrive: Leveraging the Strengthening Families Act to Promote Normalcy 2-3, 13-15 (Nov. 13, 2015), https://www.aecf.org/resources/what-young-people-need-to-thrive; Jennifer Pokempner et al., Juvenile L. Ctr., Promoting Normalcy for Children and Youth in Foster Care 4-5 (May 2015), https://jlc.org/sites/default/files/publication_pdfs/JLC-NormalcyGuide-2015FINAL.pdf.

[9] *See* Children's Bureau, U.S. Dep't of Health & Hum. Serv., A National Look at the Use of Congregate Care in Child Welfare (May 2015), https://www.acf.hhs.gov/sites/default/files/cb/cbcongregatecare_brief.pdf; Mary Dozier et al., *Institutional Care for Young Children: Review of Literature and Policy Implications*, 6 Soc. Issues & Pol'y Rev. 1, https://doi.org/10.1111/j.1751-2409.2011.01033.x.

setting means the most home-like setting possible where children have freedom of movement, community integration, and choice in activities to the greatest extent possible.

Community integration must be a key component of any community-based care model, regardless of whether it is an individual family placement or a small group placement. This includes ensuring that children have developmentally appropriate opportunities to choose their own activities, attend public schools, participate in extracurriculars, and move around within the home and the communities in which they live. State child welfare policies recognize that an essential aspect of ensuring a normal childhood is providing children the opportunity to engage in extracurricular activities and have social contacts in the community.[10]

We note that a key component of a community-based care model must be a realistic and age-appropriate understanding of development and behavior. Although challenging authority and rules is a natural part of adolescence, children in government custody often experience consequences for normal misbehavior out of proportion to how that misbehavior would be treated in a family setting.[11] Even relatively minor misbehavior can follow children throughout their time in custody.[12] This can create high levels of stress and lead children to feel like they are living under unfair levels of scrutiny.[13] It is critical that children in ORR custody in any type of placement be provided transparent and consistent information about the consequences of an adverse behavioral report and that such reports do not compromise a child's opportunities going forward, including the opportunity to receive a placement in a home-like setting.

We also strongly support ORR's vision that caregivers would be held to the Reasonable and Prudent Parent Standard (42 U.S.C. § 675(10)(A)) to make daily decisions for the child as needed. As advocates for unaccompanied children, we support the inclusion of a community-based care model in the final rule. Rather than being aspirational, ORR should commit to increasing the percentage of such placements over time on a specific and measurable timeline.

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[10] *See* Ca. Welf. & Inst. Code § 16001.9 (personal rights of children in children's residential facilities including the rights to "To attend school and participate in extracurricular, cultural, and personal enrichment activities consistent with your age and developmental level" and "have social contacts with people outside of the foster care system, including teachers, church members, mentors and friends."); Col. Rev. Statutes § 19-7-101 (children in foster care have the right to "[r]eceiv[e] an appropriate education, having access to transportation, and participating in extracurricular, cultural, and personal enrichment activities consistent with the youth's age and developmental level" and "have social contacts with people outside the foster care system, such as teachers, church members, mentors, and friends"); Fl. Statutes § 39.4085 (children in out-of-home care are "entitled to participate in age-appropriate extracurricular, enrichment, and social activities."); N.C. Gen. Statutes § 131D-10.1 (foster child's bill of rights includes the right to "[p]articipation in school extracurricular activities, community events, and religious practices"); Tx. Family Code § 263.008 (children must be informed of their rights to "participation in school-related extracurricular or community activities" and "interaction with persons outside the foster care system, including teachers, church members, mentors, and friends").

[11] *See* Annie E. Casey Found., What Young People Need to Thrive: Leveraging the Strengthening Families Act to Promote Normalcy 3, 10 (Nov. 13, 2015), https://www.aecf.org/resources/what-young-people-need-to-thrive.

[12] *Id.* at 10.

[13] *Id.*

Furthermore, we encourage ORR to expand use of the "Reasonably Prudent Parent Standard" to shelter settings and we recommend the final regulations ensure that children in shelters are able to participate in age-appropriate extracurricular activities and community engagement to support their emotional and developmental growth. This is especially necessary for the well-being of children with longer lengths of stay. Additionally, ORR should prioritize developing community-based placements that can accommodate the needs of children with disabilities.

We further appreciate and encourage ORR's general preference for housing children in small-scale or home-care placements, as described in the preamble to the proposed regulation. (p. 68919) We note that a placement with 25 children, described as a "small-scale shelter" in the preamble, is still a congregate care facility. For the reasons explained above, we encourage ORR to move as expeditiously as possible toward a community-based care model with placements that are family-based or provide a home-like setting for a family-sized number of children placed in the same facility (e.g., group-home setting). We note that smaller placements would enable ORR placements to be less restrictive and allow greater normalcy, community engagement, participation in decision-making and age-appropriate extracurricular activities, and reduced environmental stress for children in ORR custody. Smaller placements alone do not guarantee a less restrictive environment, however, and as described above small-scale placements must be paired with true community integration and policies to ensure children have age-appropriate freedom of movement and ability to engage in activities of their own choosing. ORR should prioritize developing family-based and/or community-based placements that can accommodate the needs of children with disabilities.

We likewise urge ORR to publish a timeline for achieving a complete transition to a Community Based Care Model. In the published timeline, ORR should include benchmarks for increasing proportions of UCs housed in community-based care placements until a complete transition is achieved providing home-like community-based care placements to all UCs in ORR custody unless such a placement is not in a child's best interests.

In addition, we understand that the *Flores Settlement Agreement* (FSA) asks ORR to make reasonable efforts to provide state-licensed placements in those geographic areas where DHS encounters the majority of unaccompanied children. This provision of the FSA requires *state-licensed* placement, not *any* placement. By omitting the word "state-licensed" from § 410.1103(e), the Proposed Rule could be read to favor unlicensed placement in a state such as Texas over licensed placements elsewhere. We encourage ORR to add the requirement for state-licensed placement to this factor and include an explicit consideration of the best interests of the child if such a consideration mitigates against placement in close proximity to geographic entry points.

Finally, while we support the consideration of "siblings in custody" as a factor in placement under § 410.1103(b)(13), we recommend that the language be broadened to "relatives in custody." In our experience, children have other relatives in custody other than siblings, such as cousins and other extended family. Some may even travel to the border with these relatives. These relatives can be a

significant source of comfort and stability as children adjust to a completely new environment in the care of strangers, apart from their parents and caregivers. ORR should consider whether a child has any relative in custody and whether the child would benefit from being placed in the same facility as that relative, when making placement decisions.

Recommendation 3
We support ORR adopting a Community Based Care Model in place of its current structure of primarily congregate care facilities. We urge ORR to define "community-based care" as placement in a home-like setting with freedom of movement and community integration and interaction. Community-based care placements should house a small family-sized number of UCs and should avoid adopting an institutional environment.

Recommendation 4: § 410.1001
[ADD] ***Least restrictive environment*** **means the most home-like setting possible where children have freedom of movement, community integration, and choice in activities to the greatest extent possible.**

Recommendation 5: §§ 410.1103 (b) and (e)
(b) ORR considers the following factors that may be relevant to the unaccompanied child's placement, including: . . . (13) ~~Siblings~~ **[ADD]** **Relatives** in ORR custody; (e) ORR shall make reasonable efforts to provide placements in those geographic areas where DHS encounters the majority of unaccompanied children, **[ADD]** **unless such placement is not in the best interests of the child, or no state-licensed facility is available in that geographic area.**

b. ORR should not adopt DHS's law-enforcement role in its assessment of whether a child is at risk of running away from ORR custody (§ 410.1107)

As ORR itself recognizes, it is "not a law enforcement agency, unlike the former INS." (pp. 68923, 68975). Inasmuch as the former INS had responsibility for placing class members in appropriate facilities prior to the TVPRA,[14] it is clear that HHS is the INS's successor solely regarding the *placement and care* of unaccompanied children.[15] For this reason, it is wholly inappropriate (and in many cases illogical) for

[14] Stipulated Settlement Agreement, *Flores v. Reno*, No. 85-4544 ¶¶ 12A and 19 (C.D. Cal. Jan. 17, 1997), https://youthlaw.org/sites/default/files/wp_attachments/Flores_Settlement-Final011797.pdf [hereinafter FSA].
[15] *See Flores v. Barr*, 934 F.3d 910, 912 n.2 (9th Cir. Aug. 15, 2019) ("[T]he Immigration and Naturalization Service's obligations under the Agreement now apply to the Department of Homeland Security and the Department of Health and Human Services[.]"); *Flores v. Johnson*, 212 F. Supp. 3d 864, 885 (C.D. Cal. 2015) (After an unaccompanied child is transferred from CBP to HHS custody, "it is then HHS's responsibility to comply with the provisions" of the Settlement governing transfer to a licensed program and release to sponsors.).

ORR to adopt the "immigration law context" to define and evaluate "risk of flight" as it proposes to do in the preamble to the Proposed Rule (p. 68915) and in Proposed Rule § 410.1107.[16]

Such a division is also reflected in the TVPRA. Under ORR's child welfare authority, the TVPRA *permits* HHS to consider a young person's danger to self, danger to the community, and risk of flight when making placement decisions.[17] In contrast, the TVPRA instructs that *Department of Homeland Security* (DHS) "shall consider placement in the least restrictive setting after taking into account . . . danger to self, danger to the community, and risk of flight" for children who reach 18 years of age and are transferred to DHS custody.[18]

Because HHS does not have any law enforcement authority, "risk of flight" in this context must be understood exclusively as flight from custodial ORR facilities or placements. In proposed regulation §410.1002 which defines "runaway risk", ORR recognizes the limits of its role, and appropriately defines "runaway risk" exclusively in relationship to the likelihood that a child will "attempt to abscond from ORR care." (p. 68981, § 410.1001).

However, ORR's adoption of immigration enforcement considerations when determining whether a UC qualifies as a runaway risk under § 410.1107 is deeply troubling. The majority of considerations are adopted from immigration law pertaining to and designed for adult immigrants according to the preamble to the proposed regulations. (p. 68915, FN 50) (citing *Matter of Guerra*, 42 I&N Dec. 37, 40 (BIA 2006) and INA 8 U.S.C. §§ 236(a) and 1226(a), which address adult custody redetermination (bond) hearings). Considerations that relate to the child's past interactions with the immigration court or their migration journey are unhelpful for evaluating runaway risk because most children have little or no control over the factors in consideration. ORR recognizes that compliance with immigration court requirements is the responsibility of the sponsor in proposed § 410.1203(c)(2) and should recognize the same when codifying considerations for evaluating a child's "runaway risk" here.

For example, whether a child has a prior removal order or failed to appear before DHS or the immigration court is widely considered to be the responsibility of the child's custodian rather than of the child themselves.[19] This is because children typically do not have independent ways to travel to

[16] In fact, The TVPRA only explicitly addresses ensuring a child's appearance at immigration proceedings in the context of the legal orientation presentations provided to children's custodians in cooperation with the Executive Office of Immigration Review (EOIR), provided to sponsors with whom UCs have been reunified.
[17] 8 U.S.C. § 1232(C)(2)(a) ("In making such placements, the Secretary *may* consider danger to self, danger to the community, and risk of flight") (emphasis added).
[18] 8 U.S.C. § 1232(C)(2)(b) (emphasis added).
[19] For example, there are specific statutory procedures for providing meaningful notice in the immigration context. INA § 239(a). When notice must be provided to a minor under the age of fourteen, 8 C.F.R. § 1003.14 establishes additional service requirements, including serving a close adult relative of the minor. As stated above, the purpose of serving an adult relative and conservator of a minor under the age of fourteen is to ensure that "the person *responsible for ensuring that an alien appears before the Immigration Court*" is apprised of the minor's scheduled court date *and* legal obligations to appear and to maintain an up-to-date address with the Immigration Court. *Matter of Amaya*, 21 I&N Dec. 583, 585 (BIA 1996) (emphasis added). The requirement that the head of the

immigration court, have difficulty navigating court calendaring and scheduling systems, and in many cases are deported solely because their parent received a removal order. Furthermore, only accompanied children are ever granted "bond" as riders on their parents' cases. A breach of bond would likely be because of the activity of the adult with whom the child traveled and not the child themselves.

Information related to indebtedness to smugglers is again often out of the hands of the child and is unlikely to impact the short time immediately after arrival that children remain in ORR custody. As advocates who have worked with thousands of UCs, we have not observed that indebtedness correlates with whether or not children want to or try to escape from ORR custody. In addition, there are serious cultural, linguistic, and bias-related implications of including this as a consideration in determining whether a child is at risk of trying to run away from ORR custody. It leaves an unacceptable risk of error in making a determination that is likely to result in unnecessarily restrictive placements for children.

These immigration enforcement criteria have little or nothing to do with the likelihood that a child will attempt to abscond from ORR custody. Instead, they go well beyond the scope of the definition of "runaway risk" in proposed § 410.1002. ORR's proposed use of these criteria is misplaced at best, and at worst veers dangerously into law enforcement territory.

Insofar as these considerations are intended to mirror considerations enumerated in the FSA, such adoption is inappropriate because those considerations and responsibilities lie with DHS and not ORR. The TVPRA does not authorize or require ORR to consider the immigration law related "risk of flight" factors listed in paragraph 22 of the FSA – that law enforcement obligation falls squarely with DHS. Just as ORR removed "voluntary departure" as a factor in considering "runaway risk" notwithstanding paragraph 22 of the FSA (p. 68926), ORR should not codify other immigration enforcement related considerations when evaluating "runaway risk". ORR's explanation in the preamble to the Proposed Rule suggesting that the FSA requires ORR to consider the factors laid out in § 410.1107 when determining if a child is a runaway risk while allowing ORR to remove "voluntary departure" as a factor is contradictory. (pp. 68925-26). In consideration of our improved understanding that the factors in paragraph 22 of the FSA are largely out of the control of children, and that they do not, in practice, correlate with children's desire to or attempts to abscond from ORR custody (like voluntary departure), ORR should eliminate proposed § 410.1107(a)-(b) and (e) as factors in determining whether a child is a "runaway risk."

institution where the individual resides and a near relative be served also applies to all individuals who are deemed mentally incompetent and individuals who are confined and unable to understand the nature of proceedings against them. 8 C.F.R. § 103.8(c)(2)(i).

c. Evaluation of likelihood that a child is a "runaway risk" should be specific to the context of ORR, be holistic, and should include a "clear and convincing" standard. (§ 410.1107)

ORR should clarify in § 410.1107(c)-(d) that "runaway risk" determinations "must be made in view of a totality of the circumstances and should not be based solely on a past attempt to run away," as defined in § 410.1001. In considering whether a child is a "runaway risk", ORR should limit the factors considered to actual attempts to escape and/or reasonably credible and concrete plans or threats to run away while in ORR custody.

We further urge ORR to require that the burden be on ORR to show that any attempts or threats to run away be "credible" by "clear and convincing" evidence. These modifying requirements are found elsewhere in the Proposed Rule (e.g. §§ 410.1105; 410.1901) when ORR makes a determination that leads to a more restrictive placement for a child. The same standard should apply here. Specifically, § 410.1107(d) is vague and is drafted to include developmentally appropriate behavior and statements for young people in custody who have no actual intent to run away. In its final rule, ORR should specify that "behaviors indicative of flight" and "expressed intent to run away" must be shown by clear and convincing evidence that leads staff to be reasonably certain that the child will imminently attempt to abscond from custody.

We discourage ORR from including § 410.1107(e) as a consideration in evaluating the risk that a child will attempt to run away from ORR custody where that consideration results in increased restrictiveness of the child in custody. Instead, we suggest ORR codify a process by which if ORR suspects that a child has formed an inappropriate bond with an adult outside of custody, ORR immediately refers the child for appointment of a child advocate and convenes a group of trusted and expert adults to work together with the child to address concerns and identify solutions. This could include safety planning, therapeutic interventions, or other solutions identified in collaboration with the child.

We note that the term "trauma bond" has "no medical standard for diagnosis . . . nor any agreed upon definition."[20] According to the U.S. Department of State, "there is no definitive understanding of trauma bonding's prevalence within trafficking situations and not all trafficking victims experience it."[21] For these reasons, we caution ORR against incorporating any determination that a child is experiencing a "trauma bond" with an adult into decisions that impact restrictiveness of a placement or other decisions beyond how to provide the best and most appropriate services to the child. If ORR does include the concept of "trauma bonding" in the final rule, it should be used only in order to provide services "responsive to the impact of the survivor's relationship with their trafficker."[22] Fundamentally,

[20] Off. to Monitor & Combat Trafficking in Persons, U.S. Dep't of State, Trauma Bonding in Human Trafficking, (June 2020), https://www.state.gov/wp-content/uploads/2020/10/TIP_Factsheet-Trauma-Bonding-in-Human-Trafficking-508.pdf.
[21] *Id.*
[22] *Id.*

ORR "must be cautious not to replicate trauma bonding within [its] own programs, wherein the service provider assumes the simultaneously protective and coercive role the trafficker previously played in the [child's] life."[23]

ORR should include additional processes in a final rule addressing when a runaway risk assessment is triggered. Any assessment must also include consideration of mitigating factors and must include the child's clinician and at least one other care provider who knows the child well. A holistic evaluation of the individual child requires consideration of the length of custody and the impact of custody on the child's wellbeing; the child's typical behavior and development in ORR care; applicable trauma-informed practices; any disabilities and an understanding of common trauma responses in children. Inclusion of such factors would align with ORR's proposed definition of "runaway risk" in § 410.1001.

Many of these considerations may counsel against increased restrictiveness and instead suggest implementation of accommodations for children experiencing high levels of traumatic stress leading to a desire to run away. We urge ORR to provide a variety of responses and adjustments available if a care provider identifies that a child is likely to try to abscond from ORR custody. For example, considering ways to provide a child with increased autonomy in appropriate, safe, and pro-social settings within custody could be an appropriate response to underlying causes of a desire to run away. Another example would be evaluating alternative therapy modalities for children who are not served by the standard clinician-child talk-therapy model.

Finally, we suggest incorporating certain guardrails to ensure that children are not erroneously identified as runaway risks and that their placement is not unnecessarily restrictive. We suggest that ORR be required to make a referral to a child advocate for any child being evaluated to determine whether he or she is a "runaway risk." Where a runaway risk determination results in increased restrictiveness in a placement (including restrictions limiting off-site activities, requiring heightened child surveillance, and requiring restraints or restrictions in transit), the child and/or their sponsors, parents, or service providers should have an opportunity to request review and reconsideration of whether the child is a runaway risk. The reviews could follow the same process as placement reviews brought before the PRP under proposed § 410.1902, because any restriction imposed based on a determination that a child is a runaway risk implicates the child's placement environment.

Recommendation 6: § 410.1107
[ADD]: <u>Runaway risk determinations must be made in view of a totality of the circumstances and should not be based solely on a past attempt to run away.</u> When determining whether an unaccompanied child is a runaway risk for purposes of **[ADD]: <u>ORR</u>** placement decisions, ORR **<u>[ADD] must meet the following requirements.</u>** ~~considers, among other factors, whether~~: ~~(a) The unaccompanied child is currently under a final order of removal.~~ ~~(b) The unaccompanied child's immigration history includes:~~

[23] *Id.*

~~(1) A prior breach of a bond;~~
~~(2) A failure to appear before DHS or the immigration court;~~
~~(3) Evidence that the unaccompanied child is indebted to organized smugglers for the child's transport; or~~
~~(4) A previous removal from the United States pursuant to a final order of removal.~~
~~(c)~~ [ADD] (a) The unaccompanied child has previously absconded or attempted to abscond from State or Federal custody.

[ADD] (b) ORR considers whether t~~T~~he unaccompanied child has displayed behaviors indicative of flight or has expressed **[ADD] or made statements expressing a reasonably credible intent or concrete plan** to run away. **[ADD]: Emotional and behavioral reactions triggered by everyday life do not constitute active runaway planning or a runaway attempt. Verbal statements, alone, do not constitute active runaway risk. An assessment of runaway risk must evaluate both the child's verbal statements of a desire to run away and any actions taken to facilitate running away, including, but not limited to: (i) Identifying means of egress; (ii) Seeking information on maps and roads adjoining the facility; or (iii) Purchasing transit tickets.**

~~(c) Evidence that the unaccompanied child is indebted to, experiencing a strong trauma bond to, or is threatened by a trafficker in persons or drugs.~~

[ADD]: (c) ORR has exhausted the use of additional or different services, trauma-informed accommodations within the child's current placement, or adjustments made to the child's care plan could mitigate or eliminate the child's desire to run away;

(d) ORR must show by clear and convincing evidence that the child is reasonably certain to attempt to run away from ORR custody to make a determination that a child is "runaway risk". This determination must be made before ORR adds restrictions to the child's current placement and/or before stepping a child up to a more restrictive physical placement.

(e) If a child is determined to be a "runaway risk" ORR must also make a referral for the appointment of a child advocate for the child. If a child previously absconded from ORR custody, the child must be re-assessed in the seven (7) days following a runaway attempt or unauthorized absence to determine whether the child still presents a runaway risk.

(f) A child, the child's sponsor, attorney, or child advocate may request that ORR care providers and/or an independent HHS hearing officer reconsider a determination that a child is a runaway risk (and any accompanying restrictions imposed on the child as a result) at any time following such a determination. Requests must be in writing, and the child, their attorney, their child advocate, and/or their sponsor must be able to inspect the evidence forming the basis of the runaway risk determination within a reasonable time before the reconsideration is conducted. The child and/or the child's representatives may submit additional evidence and argument to the care provider and/or hearing officer in advance of a reconsideration.

III. Subpart D: Licensing

We strongly condemn ORR's proposal to forgo state licensing for any placement, including standard placements, for any reason, including a certain state's unwillingness to license facilities for unaccompanied children. ORR must require and obtain state licensing for all standard program and secure placements (§§ 410.1001, 410.1301-02).

I. The Proposed Rule Dismantles State Licensing Requirements in Clear Violation of the Flores Settlement Agreement (FSA)

i. *The State Licensing Requirement is a Material Term of the Flores Settlement.*

For more than 80 years, there has been consensus within the child welfare field that facilities that care for children must be licensed by state authorities to ensure that such facilities meet fundamental health and safety requirements.[24] Over the past eight decades, states have developed capacity and expertise to license these facilities – capacity and expertise that the federal government lacks. This critical state-based licensing requirement was a central feature in negotiating and agreeing to protections for immigrant children in federal custody. Under the *Flores* Settlement Agreement (FSA) that resulted from these negotiations, immigrant children must generally be placed in state-licensed facilities and these facilities must "comply with all applicable state child welfare laws and regulations" and abide by other minimum standards.[25]

State licensing agencies have the independence, administrative infrastructure, specialized expertise, and enforcement authority to monitor facilities housing immigrant children and ensure they meet state child welfare standards.[26] The federal district court for the Central District of California and the Court of Appeals for the Ninth Circuit have each recognized that the Settlement's state licensing requirement is a material term of the agreement.[27] As the Ninth Circuit Court of Appeals explained, the purpose of the state licensing requirement is to "use the existing apparatus of state licensure to independently review detention conditions."[28]

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[24] Neha Desai, Emma McGinn, & Laura Alvarez, Nat'l Ctr. for Youth Law, *Correcting Course: Restoring the critical protection of placement in licensed facilities for children in federal immigration custody* 4 (Apr. 2023), https://youthlaw.org/resources/correcting-course; *see also* Child Care Tech. Assistance Network, Admin. for Child. & Families, *National Database of Child Care Licensing Regulations*, https://licensingregulations.acf.hhs.gov/.

[25] FSA ¶¶ 12(A), 19, Ex. 1.

[26] Neha Desai, Emma McGinn, & Laura Alvarez, Nat'l Ctr. for Youth Law, *Correcting Course: Restoring the critical protection of placement in licensed facilities for children in federal immigration custody* 7 (Apr. 2023); *see also* 26 T.A.C. §§ 745.211, 243, 605; 26 T.A.C. §§ 748.1225, 1223, 1531, 1501; 26 T.A.C. § 748.1101(b)(6); 22 C.C.R. § 101173; Fla. Admin. Code Ann. R. §§ 65C-4.009, 65C-46.003(5)(a), (d) (state statutes as examples of what licensing requirements encompass).

[27] *Flores v. Johnson*, 212 F. Supp. 3d 864, 879-80 (C.D. Cal. 2015), *aff'd in part, rev'd in part sub nom; Flores v. Lynch*, 828 F.3d 898, 906, 910 (9th Cir. 2016).

[28] *Lynch*, 828 F.3d at 906.

State licensing is such an essential protection for children that it is the only requirement that both the plaintiffs and the government agreed should survive even after the termination of the Settlement. A 2001 amendment to the FSA states that "[a]ll terms of this Agreement shall terminate 45 days following defendants' publication of final regulations implementing this Agreement. Notwithstanding the foregoing, the INS shall continue to house the general population of minors in INS custody in facilities that are state-licensed for the care of dependent minors."[29]

Of course, licensing alone does not ensure the safety of children, but it is a prerequisite for ensuring a baseline of core requirements to which facilities must adhere and a vital structure for accountability. Far more must be done to ensure the well-being of children placed in these facilities, but all of it must be built upon the core infrastructure that state licensing provides.

ii. The Proposed Rule Violates the Flores Settlement's State Licensing Requirement.

Paragraph 6 of the FSA defines a "licensed program" as "any program, agency or organization that is licensed by an appropriate State agency to provide residential, group, or foster care services for dependent children, including a program operating group homes, foster homes, or facilities for special needs minors."[30] The language in the FSA makes clear that the state's role in licensure is key to the licensing scheme. Proposed Rule § 410.1001 would replace the "licensed program" of the FSA with a "standard program." Under Proposed Rule § 410.1001, "[s]tandard 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." (emphasis added).

According to the preamble to the Proposed Rule, "[t]he proposed definition of 'standard program' is broader in scope to account for circumstances wherein licensure is unavailable in the state to childcare facilities that provide residential, group, or home care services for UC." (p. 68967). The proposed definition of "standard program" cannot replace the FSA's requirement of a "licensed program." The Proposed Rule's reference to "other requirements specified by ORR" is vague and in no way substitutes for the child welfare standards or independent oversight provided by state licensure.[31]

The Proposed Rule also eliminates the FSA's "licensed program" requirement in provisions that relate to release rather than ORR placement. Proposed Rule § 410.1201 details the order of preference

[29] *Flores v. Barr*, 407 F. Supp. 3d 909, 915 (C.D. Cal. 2019).
[30] FSA ¶ 6 (emphasis added).
[31] *See Flores v. Barr,* 407 F. Supp. 3d 909, 919 (C.D. Cal. 2019) (holding that placing *Flores* class members in facilities that follow federal standards instead of state licensure "is more than a minor or formalistic deviation from the provisions of the *Flores* Agreement, as '[t]he purpose of the licensing provision is to provide class members the essential protection of regular and comprehensive oversight by an *independent* child welfare agency.'" (quoting Order re Pls.' Mot to Enforce at 14 [Doc. # 177])).

for release of a minor from ORR custody. The language mirrors that of Paragraph 14 of the FSA, except that subsection (5) refers to "a standard program willing to accept legal custody" as opposed to "a licensed program willing to accept legal custody." This alteration means that an unaccompanied child could be released from ORR custody for long-term placement in a facility that is not licensed or monitored by any state. Moreover, it is not even clear what "a standard program willing to accept legal custody" means in the release context because the Proposed Rule defines "standard program" within the framework of ORR care providers.

The Final Rule must reintroduce a state licensing requirement in every provision of the Proposed Rule where the FSA requires state-licensed placement. The definition of "standard program" must be expanded to require state licensing. This alone would be insufficient to make the Proposed Rule consistent with the FSA, however, as the Proposed Rule sometimes replaces the term "licensed placement" with other terms such as "appropriate placements" or simply "placements."

For example, Paragraph 12(A) of the FSA states that "[t]he INS will transfer a minor from a placement under this paragraph to *a placement under Paragraph 19*" within a certain timeframe, unless a list of exceptions apply.[32] Paragraph 19 of the FSA establishes the requirement of placement in a licensed program. Proposed Rule § 410.1101(b) replaces the language from Paragraph 12(A) of the FSA with the following: "ORR identifies an *appropriate placement* for the unaccompanied child…." (emphasis added). By replacing "placement under Paragraph 19" – which refers to placement in a licensed facility – with "appropriate placement," the Proposed Rule violates the FSA's state licensing requirement.

As another example, the language in Proposed Rule § 410.1103(e) not only violates the state licensing requirement of the FSA but could lead to unlicensed placements being favored over state-licensed placements. Paragraph 6 of the FSA provides that the government "shall make reasonable efforts to provide *licensed placements* in those geographic areas where the majority of minors are apprehended, such as southern California, southeast Texas, southern Florida and the northeast corridor."[33] Proposed Rule § 410.1103(e), by contrast, states that "ORR shall make reasonable efforts to provide *placements* in those geographical areas where DHS encounters the majority of unaccompanied children." (emphasis added). By omitting the term "licensed" from this provision, the Proposed Rule violates the FSA state licensing requirement. In addition, the Proposed Rule appears to create a preference for unlicensed placements in states such as Texas and Florida over licensed placements in other geographic areas. This undermines the purpose of Paragraph 6 and the FSA as a whole.

[32] FSA ¶ 12(A) (emphasis added).
[33] FSA ¶ 6 (emphasis added).

iii. *The Proposed Rule Allows Programs to Avoid State Licensure Requirements Even Where a State has a Licensing Framework Available.*

Several provisions of the Proposed Rule allow programs to avoid state licensing requirements, even in states that have a licensing framework available. This is inconsistent with the state licensing requirement of the FSA.[34]

Proposed Rule § 410.1302(a) states that standard programs shall: "Be licensed by an appropriate State or Federal agency, or meet other requirements specified by ORR if licensure is unavailable to programs providing services to unaccompanied children in their State, to provide residential, group, or foster care services for dependent children." The language in this section seems to permit programs to choose between three options: (1) state licensing, (2) federal licensing, or (3) "if licensure is unavailable" to programs in a certain state, then the program is required to "meet other requirements specified by ORR." As explained above, the "other requirements specified by ORR" are not a substitute for state licensing as required by the FSA. Further, Proposed Rule § 410.1301(a) permits federal licensing as an alternative to state licensing even in states that have a licensing framework available to ORR grantees in clear violation of FSA licensing requirements.

It is unclear from the drafting of this subsection how the contemplated federal licensure scheme will interact with the "other requirements specified by ORR." [35] In a footnote in the preamble, ORR states that "[s]eparate from this notice of proposed rulemaking and *in the spirit of* current FSA requirements, ACF is currently developing a notice of proposed rulemaking that would describe the creation of a Federal licensing scheme for ORR care providers located in states where licensure is unavailable to programs serving unaccompanied children." (p. 68916 n.52) (emphasis added). The Proposed Rule does not offer *any* detail regarding this potential federal licensing scheme or any assurances that federal licensing will incorporate the minimum standards and oversight mechanisms of state licensure. Without information on federal licensing or any detail on the "other requirements specified by ORR," stakeholders cannot fully and adequately respond to the Proposed Rule. In any event, substituting federal licensure for state licensure is inconsistent with the FSA.

In addition, the Proposed Rule includes several federal preemption provisions (e.g. Proposed Rule §§ 410.1302, 410.1307(c)(2), 410.1801(b)(15), 410.1401(d)) stating that "[i]f there is a potential conflict between ORR's regulations and State law, ORR will review the circumstances to determine how to ensure that it is able to meet its statutory responsibilities." There is no parallel language in the FSA. These provisions could be interpreted broadly to give ORR discretion to ignore state licensing requirements if the office perceives a conflict. Such an interpretation would be inconsistent with the FSA's state licensing scheme. Therefore, we propose that this federal preemption language be followed by qualifying language stating: (1) state licensure is required, and (2) if a conflict between ORR's

[34] FSA ¶ 6.

[35] In fact, no provision in the Proposed Rule makes clear what the "other requirements specified by ORR" will include. *See* §§ 410.1001, 410.1302(a)-(b).

regulations and state law arises, the state-licensed program must still follow state licensure requirements.

iv. *The Proposed Rule Impermissibly Allows ORR and Care Providers to Violate State Law.*

The FSA requires that licensed programs "comply with all applicable state child welfare laws and regulations and all state and local building, fire, health and safety codes".[36] Proposed Rule § 410.1302(b), by contrast, allows programs to abide by federal requirements instead of following state law if licensure is unavailable in their state. There is no justification for this exception. Even if it were permissible to operate standard programs without state licenses, there is no reason those programs should not be required to follow state child welfare laws and state and local building, fire, health, and safety codes. ORR has no expertise in topics such as building and fire safety and no authority to authorize care providers to violate state and local law. However, if state or local laws deprive an unaccompanied child of a right they would enjoy in another state, ORR should transfer the child to a state that better protects their rights.

Proposed Rule § 410.1001 (definition of "Standard Program") requires all homes and facilities to be "non-secure," whereas Paragraph 6 of the FSA requires them to be "non-secure as required under state law." The omission of "as required under state law" could allow for a departure from state law requirements even in states that license ORR facilities. Further, even if licensure is unavailable in a state, the state law definition of "non-secure" should still control because states have greater expertise on the specific requirements of non-secure facilities in the child welfare context. Without the "required under state law" clause, ORR could adopt a definition of non-secure that permits much more restrictive conditions than are currently permissible.[37]

For the same reasons, if ORR chooses to retain the reference to "a facility for special needs unaccompanied children" in the definition of "standard program" in Proposed Rule § 410.1001, it is impermissible to replace the "level of security permitted under State law" with undefined "requirements specified by ORR if licensure is unavailable in the State."

v. *The Proposed Rule Contemplates Placement in Out of Network (OON) Facilities That Are Not Defined as Meeting Either State Licensing or "Standard Program" Requirements.*

Proposed Rule § 410.1001 introduces the term "care provider facility," which is defined as "any physical site that houses unaccompanied children in ORR custody, operated by an ORR-funded program that provides residential services for children, including but not limited to a program of shelters, group homes, individual family homes, residential treatment centers, secure or heightened supervision facilities, and emergency or influx facilities." Notably, the definition states that "[o]ut of network (OON) facilities are not included within this definition." In the same proposed section, an OON facility is defined

[36] FSA Ex. 1.

[37] *Cf, Flores v. Barr,* 407 F. Supp. 3d 909, 920 (C.D. Cal. 2019) (rejecting DHS definition of "non-secure").

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.” 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. For consistency with the FSA, the Final Rule must state that any non-secure OON placement shall be state-licensed and meet the other requirements for licensed facilities outlined in the FSA. Any secure OON placement must satisfy the secure placement criteria in Paragraph 21 of the FSA.

vi. *The Proposed Rule Permits Unlicensed Placement Without the Safeguards of FSA Paragraph 12A.*

Paragraph 12A of the FSA provides that “minors shall be separated from delinquent offenders.” This protection does not appear in the Proposed Rule. The preamble (p. 68922) to the Proposed Rule states that this provision was not included because paragraph 12A relates to the initial apprehension or encounter of unaccompanied children. However, paragraph 12A is not limited to initial apprehension. Rather, it covers situations where “there is no one to whom the INS may release the minor pursuant to Paragraph 14, and no appropriate licensed program is immediately available for placement pursuant to Paragraph 19”.

The definition of licensed program in paragraph 6 of the FSA specifies that a licensed program must be “licensed by an appropriate State agency to provide residential, group, or foster care services for *dependent* children” (emphasis added). These two paragraphs of the FSA work together: prior to licensed placement, unaccompanied children must be separated from delinquent offenders; after licensed placement, children must be placed in a facility licensed by the state to serve dependent (rather than delinquent) children.

Because the Proposed Rule permits children to be placed in “standard programs” that lack state licensure as well as in unlicensed emergency and influx facilities, it offers no assurances that unaccompanied children will be treated as dependent rather than delinquent minors. Moreover, as noted above, the Proposed Rule does not specify any required standards for out-of-network facilities. This would permit ORR to place children in out-of-network facilities that are licensed for minors adjudicated delinquent, in violation of the FSA.

The Final Rule must specify that until an unaccompanied child is placed in a program licensed by the state to provide services for dependent children, the child shall be separated from delinquent offenders (except as provided in Paragraph 21 of the FSA).

Recommendation 7: § 410.1302(a)-(b)
Standard programs shall: (a) Be licensed by an appropriate State ~~or Federal agency~~, ~~or meet other requirements specified by ORR if licensure is unavailable to programs providing services to unaccompanied children in their State~~, to provide residential, group, or foster care services for dependent children. (b) Comply with all applicable State child welfare laws and regulations and all State and local building, fire, health, and safety codes, ~~or other requirements specified by ORR if licensure is unavailable in their State to care provider facilities providing services to unaccompanied children~~. If there is a potential conflict between ORR's regulations and State law, ORR will review the circumstances to determine how to ensure that it is able to meet its statutory responsibilities **[ADD]** **while maintaining state licensure**. It is important to note, however, that if a State law or license, registration, certification, or other requirement conflicts with an ORR employee's duties within the scope of their ORR employment, the ORR employee is required to abide by their Federal duties **[ADD]** **while consulting with ORR legal teams to determine appropriate action.**

Recommendation 8: § 410.1305(b)
§ 410.1305(b): Standard programs and restrictive placements shall meet the staff to child ratios established by their respective States ~~or other~~ licensing entities~~, or ratios established by ORR if State licensure is not available~~; and

IV. Subpart D (§§ 410.1300 *et seq.*): Standard Program Conditions

a. ORR should codify at least current minimum standards for education services, access to outside communication for children, and privacy.

We urge ORR to strengthen its standard of care to, at a minimum, meet the current standards provided to UCs in ORR care. Proposed § 410.1302(c)(3) lacks a guarantee of a minimum number of hours of education services. Although this provision requires educational services in a structured classroom setting Monday through Friday and meets the minimum requirements of the FSA, the proposed regulation ensures far less than ORR realizes is appropriate and necessary for children's well-being. ORR's current Policy Guide (§ 3.3.5) requires a minimum of six hours of structured education, Monday through Friday. We urge ORR to codify both the days during which instruction is offered and a minimum number of hours of education each day, as it does in the current Policy Guide.

Similarly, the limited phone/video calls guaranteed in proposed § 410.1302(c)(10) are a marked step backwards from the recent improvements that ORR has made to the phone call policy in the Policy Guide. As of June 26, 2023, Policy Guide § 3.3.10 requires *daily minimum* 10-minute calls from M-F (or 50 minutes of phone time throughout the weekdays), as well as 45-minute calls on weekends, holidays, and the child's birthday, and additional calls as needed in exceptional circumstances. In stark contrast, proposed § 410.1302(c)(10) only provides for "at least 15 minutes of phone or video contact three times a week with parents and legal guardians, family members, and caregivers located in the United States and abroad." Contact with family and maintaining important relationships is essential to children's

wellbeing while in ORR care,[38] and the final rule should reflect ORR's commitment to ensuring children are able to enjoy the support of their loved ones and maintain important relationships through phone and video contact while in custody.

The regulations should also make clear that these standards also apply to children whose parents and legal guardians, family members, and caregivers are in federal government (e.g. ICE or U.S. Marshal Service) custody. Such an amendment would also ensure that ORR is complying with its obligations under the settlement agreement in *Ms. L v. Immigration and Customs Enforcement*, which requires HHS to coordinate with federal, state, and local agencies to facilitate communication between parents in those agencies' custody and children in ORR custody, in cases where the parent and child were apprehended together and then separated by the federal government.[39] Under the settlement agreement, which has been preliminarily approved by the court, ORR is required to "offer separated children information about how to request telephone contact with their parent or Legal Guardian."[40] In cases where the parent is detained in ICE custody, ORR is required to "coordinate [with ICE] to facilitate contact between a parent or Legal Guardian and their child within 48 hours of the child arriving to the ORR care provider."[41] Given the benefit to children in ORR custody from regular contact with parents and other family members, ORR should be similarly facilitating communication and ensuring contact within 48 hours for all children with parents and other family members who are detained in federal government custody.

Finally, ORR indicates in the preamble to the proposed regulation that care providers should encourage and enable in-person visitation with family and sponsors. (p.68938) We urge ORR to consider codifying these same protections in cases where a child's parent or caregiver is in the custody of the federal government (e.g. ICE or U.S. Marshal Service). Such a guarantee would require prompt coordination with the entity holding the parent or caregiver. In addition, the proposed regulation does not include any provision providing for in-person visitation specifically. We encourage ORR to incorporate such guidance into the final rule, including visits between a child and parent or caregiver who is in federal custody.

Proposed § 410.1302(c) lacks a guarantee of a reasonable right to privacy as required by the FSA. Proposed § 410.1801(b)(12) includes such a guarantee for children placed in EIFs by ensuring that such children enjoy a reasonable right to privacy, including the right to generally wear their own clothes,

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[38] *See generally* Young Ctr. for Immigrant Child. Rights, *Preserving Family Ties: Ensuring Children's Contact with Family While in Government Custody* (2023), https://static1.squarespace.com/static/597ab5f3bebafb0a625aaf45/t/639d0488ec01c36f79d75f1c/1671234696414/Phone_Calls_Final_Report.pdf.

[39] Proposed Settlement Agreement, *Ms. L. v. ICE*, Case No. 18-cv-00428 (S.D. Cal. Oct. 16, 2023), ECF No. 711-1, pp. 37-38.

[40] Proposed Settlement Agreement, *Ms. L. v. ICE*, Case No. 18-cv-00428 (S.D. Cal. Oct. 16, 2023), ECF No. 711-1, pp. 38.; Order Granting Preliminary Approval of Proposed Settlement; Preliminarily Certifying Settlement Classes; Approving Class Notice, *Ms. L. v. ICE*, Case No. 18-cv-00428 (S.D. Cal. Oct. 24, 2023), ECF No. 717.

[41] Proposed Settlement Agreement, *Ms. L. v. ICE*, Case No. 18-cv-00428 (S.D. Cal. Oct. 16, 2023), ECF No. 711-1, pp. 38.

have a private space for storage of personal belongings, talk privately on this same right is not provided to children placed in standard programs. We urge ORR to ensure the same privacy protections for children placed in standard programs under proposed § 410.1302(c). Such protections are required by the FSA for all children in custody, and they must be incorporated into this subpart in the final rule.

Recommendation 10: § 410.1302
(c)(10) Visitation and contact with family members (regardless of their immigration status **[ADD] or being in federal custody)** which is structured to encourage such visitation. Standard programs should provide unaccompanied children with at least ~~15~~ [ADD] 10 minutes of phone or video contact ~~three times a week~~ **[ADD] daily Monday through Friday (or 50 minutes of phone time each working week) and as well as 45-minutes of phone or video contact on weekends, holidays, and the child's birthday, and additional calls as needed in exceptional circumstances,** with parents and legal guardians, family members, and caregivers located in the United States **[ADD], including those in federal immigration or law enforcement custody,** and abroad, in a private space that ensures confidentiality and at no cost to the unaccompanied child, parent, legal guardian, family member, or caregiver. **[ADD] Standard programs must also develop programs that encourage regular in-person visitation between UCs and relatives and/or sponsors.** The staff shall respect the unaccompanied child's privacy while reasonably preventing the unauthorized release of the unaccompanied child; **[ADD] (14) A reasonable right to privacy, which includes the right to wear the child's own clothes when available, retain a private space in the residential facility, group or foster home for the storage of personal belongings, talk privately on the phone and visit privately with guests, as permitted by the house rules and regulations, receive and send uncensored mail unless there is a reasonable belief that the mail contains contraband.**

b. ORR should strengthen minimum standards for health services and activities and clarify physical space standards beyond "suitable living accommodations."

We suggest ORR adopt minimum physical space requirements to ensure children's right to have access to outdoor spaces and indoor spaces for gross motor activities, in addition to sufficient space in their other living spaces to move freely, socialize, and maintain comfortable and safe distances from other children and/or staff when necessary. This should be incorporated into regulations addressing minimum standards applicable to standard programs (§ 410.1302). These could be clarified as being part of "suitable living arrangements" guaranteed in § 410.1301(c)(1).

We also urge ORR to incorporate unstructured leisure time and the ability to choose leisure activities (structured and unstructured) as developmentally appropriate into proposed § 410.1302(4). This is particularly important for adolescent UCs who require safe and pro-social ways to exercise autonomy and practice decision-making.[42]

[42] *See generally* Annie E. Casey Found., The Road to Adulthood: Aligning Child Welfare Practice With Adolescent Brain Development (2017), https://assets.aecf.org/m/resourcedoc/aecf-theroadtoadulthood-2017.pdf; UCLA Ctr. for the Developing Adolescent, *The Developing Adolescent Brain* (undated),

Finally, ORR must strengthen and clarify its healthcare service provisions. It should specify that it will use pediatric specialists and will address health needs that arise outside of the envisioned care time frames. ORR should bring mental health interventions in line with Medicaid Early and Periodic Screening, Diagnostic, and Treatment benefit coverage when medically necessary. Finally, to the extent possible, ORR should help coordinate medical record keeping in such a way as to promote continued accurate health records following release.

Recommendation 11: § 410.1301(c)
(c) Provide or arrange for the following services for each unaccompanied child in care: (1) Proper physical care and maintenance, including suitable living accommodations **[ADD]: <u>that permit staff and UCs to maintain a safe and comfortable distance from others at all times and that provide access to outdoor and indoor spaces large enough for gross motor activities</u>**…

Recommendation 12: § 410.1302(c)
(c)Standard programs shall . . . provide or arrange for the following services for each unaccompanied child in care . . . (4) "Activities according to a recreation and leisure time plan that include daily outdoor activity, weather permitting, at least one hour per day of large muscle activity and one hour per day of structured leisure time activities, which do not include time spent watching television. **[ADD] <u>As developmentally appropriate, unstructured leisure time and the ability to choose leisure activities (structured and unstructured) must be available during recreation and leisure time.</u>** Activities must be increased to at least three hours on days when school is not in session;"

Recommendation 13: § 410.1307
(b) Standard programs and restrictive placements shall be responsible for: (1) Establishment of a network of licensed healthcare providers established by the care provider facility, including specialists, emergency care services, mental health practitioners, **[ADD] <u>pharmacy services</u>**, and dental providers that will accept ORR's fee-for-service billing system; (2) A complete medical examination (including screening for infectious disease) within 2 business days of admission, excluding weekends and holidays, unless the unaccompanied child was recently examined at another **[ADD] <u>ORR</u>** facility. **[ADD] <u>As part of the initial medical examination, providers shall ask and document in the file whether the child had medication that was confiscated or provided by DHS. An initial dental exam shall be done if a child is</u>**

https://developingadolescent.semel.ucla.edu/topics/item/facts-about-the-developing-adolescent-brain; Karen Brown, *Positive Youth Development: The Key to Keeping Youth Out of the Juvenile Justice System*, 29 ABA Child L. Prac. 1 (2010), https://www.americanbar.org/content/dam/aba/administrative/child_law/pyd.pdf.

~~unaccompanied children are~~ still in ORR custody 60 to 90 days after admission~~; an initial dental exam,~~ or sooner if directed by State licensing requirements, **[ADD]** **or if a dental concern arises;**

(3) Appropriate immunizations as recommended by the Advisory Committee on Immunization Practices' Child and Adolescent Immunization Schedule and approved by HHS' Centers for Disease Control and Prevention. **[ADD]** **Programs shall enter all vaccines they administer into state registries, if they exist, and all vaccine records must be provided to sponsors upon release. Where available, programs shall review vaccination records from other countries and record appropriate vaccines in the child's records**;

. . .

(6) Appropriate mental health interventions **[ADD]** **at minimum equivalent to Medicaid Early and Periodic Screening, Diagnostic, and Treatment benefit coverage** when **[ADD]** **medically** necessary;

….

(c) (1) Initial placement and transfer considerations--(i) Initial placement. Consistent with § 410.1103, when placing an unaccompanied child, ORR considers the child's individualized needs and any specialized services or treatment required or reasonably requested. Such services or treatment include but are not limited to access to **[ADD]** **pediatric** medical specialists, family planning services, and medical services requiring heightened ORR involvement. When such care is determined to be medically necessary during the referral, intake process, Initial Medical Exam, or at any point while the unaccompanied child is in ORR custody, or the unaccompanied child reasonably requests such medical care while in ORR custody, ORR shall, t**o** the greatest extent possible, identify available and appropriate bed space and place the unaccompanied child at a care provider facility that is able to provide or arrange such care, is in an appropriate location to support the unaccompanied child's healthcare needs, and affords access to an appropriate **[ADD]** **pediatric** medical provider who is able to perform any reasonably requested or medically necessary services.

c. Increased oversight of care providers and protections for UCs relating to behavior management (§§ 410.1103(f); 410.1303 (f); 410.1304).

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, especially for those with disabilities.

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. [43] The Final Rule should explicitly state that if a care provider denies placement to a child with a disability

[43] *See* 45 C.F.R. § 85.21(d).

under any of the subsections of § 410.1103(f), ORR will promptly find the child another placement in the most integrated setting appropriate.

We also appreciate the additional detailed guidance and protections for UCs in § 410.1303-04 requiring a trauma-informed and child welfare approach to reporting behavior and incidents and prohibiting the use of inappropriate behavior management techniques in Standard Placements. We especially support Proposed Rule sections prohibiting the use or threat of incident reporting as "a way to manage behavior, as a basis for a child's step up to a restrictive placement, or as the sole basis for refusal to step a child down to a less restrictive placement." § 410.1303(f)(3)-(4).

We likewise especially appreciate the additional oversight built into Proposed Rule § 410.1304(b) to ensure that "involving law enforcement should be a last resort." We suggest additionally requiring an investigation into whether de-escalation and trauma-informed techniques were used in the specific incident that spurred law enforcement involvement. We also urge ORR to replace "may" with "shall" in order to ensure consistent oversight and consistent expectations around law enforcement involvement for UCs in custody.

Recommendation 14: § 410.1304(b)
(b) Involving law enforcement should be a last resort. A call by a facility to law enforcement ~~may~~ **[ADD]: <u>shall</u>** trigger an evaluation of staff involved regarding **[ADD] <u>whether they continue to have the qualifications and skills required to work in the setting in which they are assigned, and whether they have sufficient</u>** ~~their qualifications and~~ training in trauma-informed, de-escalation techniques."

d. <u>The Proposed Rule must strengthen shelter staff's language identification practices because many children are not provided language access in their best and preferred languages.</u>

We welcome Proposed Rule's broad guarantees of language access to unaccompanied children. However, while the language is strong on its face, we are concerned because it lacks provision and guidance instructing shelter staff on how to correctly identify children's primary and preferred languages, and then consistently provide them with high-quality language access in that language. We recommend that ORR include language access in its internal monitoring system and provide a point person and dedicated email for language access complaints.

ORR must also improve its language identification protocols. In our experience, lack of timely and accurate language identification continues to present significant obstacles to the fair and efficient reunification of unaccompanied children. We urge ORR to use the Proposed Rule to set parameters around language identification and to increase accountability when shelter staff do not provide adequate language access to unaccompanied children.

Legal services providers (LSPs) like the Florence Project rely on shelter rosters to schedule Know Your Rights (KYR) legal orientations. LSPs conduct separate presentations for Spanish-speakers and

speakers of other languages. Shelters provide LSPs with names of children as well as their primary language, which are used to schedule KYR presentations. However, shelters frequently mis-identify children's primary languages, often assuming that all children from Mexico and Central America speak Spanish, even though many of them speak indigenous languages as their first and preferred language. The Florence Project recently reviewed a snapshot of data from one week of KYR presentations and found that shelter staff assigned the wrong language to about 25 percent of children on the roster.

As a result of language misidentification, a significant number of children present for the Spanish-language KYR presentations and legal intake do not speak Spanish. The KYR presentations are interactive workshops that educate children about their rights and obligations, the EOIR hearing process, and the most common forms of relief. These are complex legal concepts to teach young people. Children then role-play EOIR hearings by assuming the role of the judge, ICE attorney, the interpreter and respondent. We then meet with each child individually after the presentation to provide a legal intake and identify if the child is eligible for legal relief. We inform the child of that eligibility and explain that we will refer the child to a local LSP post-reunification.

However, if a child's language has been incorrectly identified, many of the children miss critical information because they are reunified before we can schedule the child for a KYR presentation in their best language. Because they have not established a relationship with their legal services provider while in ORR custody, they are less likely to engage in services after release including referrals to local pro bono attorneys.

To ensure correct language identification, staff must proactively approach children, who may feel intimidated by the process or unaware of their language rights and options to seek language services, such as having qualified interpreters without delay and written translations of vital information. This should be done at the earliest point of contact and evaluated throughout the duration of the child's care and time in the ORR funded shelter.

Language access plans of other federal agencies that have wide contact with speakers of languages other than English and NGO resources could provide a valuable starting point. Some of these include:

- Using an "I Speak...Language Identification Guide" language poster or guide developed by the DHS Office of Civil Rights and Civil Liberties (http://www.dhs.gov/xlibrary/assets/crcl/crcl-i-speak-booklet.pdf)
- For indigenous languages without a written form, ICE's Juvenile and Family Residential Management Unit (JFRMU) created an intake tool to determine indigenous languages. In it, a PowerPoint presentation that asks listeners to raise their hand when their primary language is spoken. The presentation cycles through 12 indigenous languages that are spoken aloud. When an indigenous speaker is identified, intake staff seek language assistance services. The individual's primary language is subsequently listed on their

identification card to aid communication while they are at the Family Residential Center (FRC).[8]

- A map of Guatemala showing which regions speak which languages, similar to the graphic below produced by CIELO. If children can identify the town or region they are from, shelter staff can identify the primary language spoken in that region.

The burden of acquiring language services should not fall on the children who do not use English as their primary language. We urge ORR to add the following requirements to the Proposed Rule and to its sub-regulatory guidance to strengthen language identification procedures and requirements to develop and use appropriate language identification materials:

- ORR must work with language access professionals to create standardized and culturally appropriate tools for language identification.
- ORR must require shelter staff to use those tools to correctly identify a child's primary and preferred language as soon as the child is placed in ORR custody.
- ORR must work with language access professionals to create a mechanism to track that child's primary and preferred language so that ORR and shelter staff use that language to communicate with the child throughout the stay in ORR custody.
- ORR funded shelters should engage in formal data collection, have a record of the child's language preference, and schedule interpreters in advance of each interaction to provide meaningful and timely language support.

- Staff should also be trained on how to make an accurate language match for Indigenous languages, which require collecting geographical information about the child's place of origin and verifying language at the beginning of each interaction.
- Finally, ORR should include language access as part of its internal compliance section with a designated email and point person who can respond to concerns about lack of language access provision.

Recommendation 15: § 410.1302
(c)(8)(ii) An initial intakes assessment **must be conducted at the child's initial placement in ORR custody, including use of a verified, standardized, and culturally appropriate language identification tool**, covering biographic, family, migration, health history, substance use, and mental health history of the unaccompanied child. If the unaccompanied child's responses to questions during any examination or assessment indicate the possibility that the unaccompanied child may have been a victim of human trafficking or labor exploitation, the care provider facility must notify the ACF Office of Trafficking in Persons within twenty-four (24) hours; (d) Deliver services in a manner that is sensitive to the age, culture, ~~native language,~~ and the complex needs of each unaccompanied child. **[ADD] ORR shall track a child's preferred language and shall deliver services in the child's preferred language. ORR shall create a language access email inbox and point person within the agency to receive and address complaints regarding language access issues. If ORR is unable to identify a qualified and competent interpreter in the child's preferred language, ORR must refer the case to the ORR Ombuds office, the child advocate, and the local legal services provider.**

V. Subpart G: § 410.1601: Transfer of Unaccompanied Child Within ORR Care Provider Facility Network (Not Including Transfers to Restrictive Settings)

a. § 410.1601(a): General requirements for transfers.

While we support the mandate for continuous reassessment of children's placement in the least restrictive setting in the best interests of the child, the Proposed Rule goes beyond the TVPRA by making this determination "**subject to** considerations regarding danger to self or the community or runaway risk."[44] The TVPRA does not place this condition on the placement determinations; on the contrary, the TVPRA says that the HHS "Secretary **may consider** danger to self, danger to community, and risk of flight."[45] As discussed below throughout our comment, ORR should decline to take on a law enforcement role, and must limit such considerations, particularly when they result in more restrictive placement. Many of the undersigned organizations have experienced instances where ORR relies heavily or rashly makes decisions based on the danger to self, danger to community and/or risk of flight to transfer a child to a more restrictive setting. This is contrary to the TVPRA and FSA where a child's

[44] Proposed Rule, § 410.1601(a).
[45] 8 U.S.C. § 1232(c)(2)(A) (emphasis added).

placement in a least restrictive setting in the best interests of the child should be the main consideration.[46]

We support ORR's heightened involvement with children with certain medical conditions, including the requirement for a meeting between ORR and the facility staff prior to a transfer. In addition, we strongly recommend that any appointed child advocate be required to attend that meeting. This is consistent with the TVPRA's mandate that child advocates be given access to materials to advocate for the children's best interests.[47] The child advocate's participation is particularly important in cases where children are medically vulnerable and quick decisions are being made about their well-being without parental consent and often without taking into consideration the expressed wishes of the child.[48] The child's appointed child advocate would be in the best position to ensure that facility staff and ORR are having a meaningful discussion that considers all the factors that go into a child's best interest placement determination as required by law.[49]

Recommendation 16: § 410.1601
(a) An unaccompanied child shall be placed in the least restrictive setting that is in the best interests of the child~~, subject to considerations regarding~~ **[ADD]. The care provider facility may consider** danger to self or the community and runaway risk." (2) For an unaccompanied child with acute or chronic medical conditions, or seeking medical services requiring heightened ORR involvement, the appropriate care provider facility staff **[ADD], any appointed Child Advocate,** and ORR shall meet to review the transfer recommendation.

b. Advance notice of transfer to interested parties (§ 410.1601(a)(3))

We support ORR's inclusion of legal service providers and child advocates in the Proposed Rule for advance notice. Including these interested parties is consistent with the TVPRA, DOJ's ongoing practice of allowing accredited representatives to perform duties normally performed by licensed attorneys to increase representation, and consistent with the overall push by undersigned organizations to provide legal representation to all UCs who are in and out of ORR care.

In addition, we urge ORR to strengthen this section by clarifying that the 48 hours do not include Saturdays, Sundays, and federal holidays. While ORR facilities continue to make placement decisions regardless of the days of the week, many interested parties observe business working hours from Monday through Friday. Without this clarification, interested parties could receive the notice on a Saturday, and lose an opportunity to advocate for their client's placement. These interested parties are often in possession of important information that facility staff and ORR lacks. This information can

[46] 8 U.S.C. § 1232(c)(2)(A); *see also* FSA.
[47] *See* 8 U.S.C. § 1232(c)(6).
[48] *See Lucas R. v. Azar,* No. 18-5741, 2018 WL 10111336, at *10-13 (C.D. Cal. Nov. 2, 2018), *order amended and superseded,* No. 18-5741, 2018 WL 7200716 (C.D. Cal. Dec. 27, 2018).
[49] 8 U.S.C. § 1232(c)(2)(A).

include for example how a transfer can affect a child's legal case, a child's expressed wishes, information about family connection, and/or other permanency considerations that should all be factored into the placement decision.

In addition, it is our experience that ORR regularly, and in many cases unnecessarily, relies on the "unusual and compelling circumstances" to provide notice following the transfer. Frequently, care providers delay in notifying attorneys and child advocates until after transfer has taken place. Not only do such sudden transfers without due notice cause unnecessary disruptions in services, they cause significant psychological stress to children and risk retraumatizing children. We object to providing less notice to interested parties of a child's transfer simply based on concerns that a child might runaway.

It is not unusual for children to express a desire or attempt to run away from shelter placements. Running away from foster care has been a longstanding and intractable problem.[50] Extensive study of the issue has shown that placement instability, declining mental health, excessive restriction in placements, and lack of autonomy are key contextual and systemic factors that prompt youth decisions to run away. It is important to consider these factors and train staff to recognize early warning signs.[51] However, a child's risk of running away should be considered for the purposes of placement only to the extent that the placement provides access to the services and care that the child needs to reduce runaway risk.

Providing 24 hours less notice to interested parties of a decision to transfer youth who wish to run away will do more to disrupt services to the youth than mitigate the risk of escape. In addition to care providers, child advocates and attorneys can provide essential support to youth by helping them build healthy coping mechanisms, identify and affirm ways they can exercise autonomy, mediate conflict with care providers and develop forward-looking safety plans. Advance notice of transfer decisions also enables attorneys, child advocates and other interested parties to coordinate with receiving care providers to ensure adequate accommodations are in place for children and help minimize the stress of placement instability. Such support is critically important for all youth, regardless of whether or when they express a desire to run away.

Recommendation 17: § 410.1601(a)
(3) Within 48 hours **[ADD] , not including Saturdays, Sundays, or federal holidays,** prior to the unaccompanied child's physical transfer, the referring care provider facility shall notify all appropriate interested parties… (i) Where the safety of the unaccompanied child or others has been threatened; **[ADD] or** (ii) ~~Where the unaccompanied child has been determined to be runaway risk consistent with § 410.1108; or~~ ~~(iii)~~ Where the interested party has waived such notice

[50] Andrea Nesmith, *Predictors of running away from family foster care*, 85(3) Child Welfare 585 (2006).
[51] *See* Kaela Byers et al., *"I Ran to Make a Point": Predicting and Preventing Youth Runaway from Foster Care*, 7 Child & Adolescent Soc. Work J. 1 (June 2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10244860/pdf/10560_2023_Article_930.pdf.

c. Ensuring continued access to medical care (§ 410.1601(a)(4))

We strongly support the 30-day supply of medications for all transfers and in addition, urge you to specify that the medication supply will be accompanied by prescription for refills where applicable. Obtaining a prescription can often be delayed when switching care providers. In our experience, it is not uncommon for ORR to transfer unaccompanied children to another facility out of state, including children who are taking powerful psychotropic medication. It is extremely important that children's medication does not lapse, particularly for children suffering from acute and chronic conditions. It is well documented that lapses in medicine can cause harmful effects on people who have been taking medicine for some time.[52] We recognize that the Proposed Rule does already require that a child be transferred with all health records, but we strongly believe that the rule should specify that any refill prescription should accompany the 30-day medical supply. This will ensure quick access to the prescription and another safeguard to make certain that transfer staff have the adequate instructions for administering the medicine. In the context of ICE detention, some of the undersigned organizations have documented cases where the transfers of medical records are incomplete and/or delayed even where transfers occur within the same care providers from facility to facility.

Recommendation 18: § 410.1601(a)
(4)(iii) 30-day medication supply **[ADD], accompanied by a refill prescription**, if applicable

VI. Subpart H: Age determinations (§§ 410.1001; 410.1700 *et seq*.)

While we recognize ORR's obligation to make a prompt determination of the age of individuals in its care and custody, ORR must have clear procedures and procedural protections in place to prevent wrongful age determinations. The consequences of erroneous age determination are great. A mistaken age determination means that a child will be sent to an adult detention facility with almost no recourse for the mistake, losing access to the range of services and protections to which children are entitled. Given these severe consequences, it is critical that ORR ensures that its age determination processes are fair, reliable, consistent, and ensure due process.

We note several examples below where we believe that ORR should add additional clarity and procedural protections its age determination procedures. We also provide a suggested structure for the age determination process that balances ORR's need for swift and accurate age determinations with the child's interest in a full and fair adjudication of the matter.

[52] Marcus M. Reidenburg, Weill Med. Coll. of Cornell Univ., *Adverse Effects of Suddenly Stopping a Medicine* (May 23, 2011), https://pre.weill.cornell.edu/cert/patients/suddenly_stopping_medicine.html.

a. ORR should eliminate or reduce the use of medical age determinations to prevent wrongful age determinations.

Between 2018 and 2022, the Florence Project for Immigrant and Refugee Rights (FIRRP) represented and provided legal orientation to about 50 children who went through the age determination process. Almost all of them asserted that they were children, and many had multiple forms of evidence of their minority, including consulate-verified birth certificates, sworn statements, medical records, and school records. However, in almost all these cases, ORR relied solely on dental radiograph reports to establish that the children were adults, in violation of the TVPRA.[53] The statute requires that multiple forms of evidence be taken into account and that ORR cannot rely solely on a radiograph to determine age.[54] FIRRP successfully represented many of these children before the federal district court to challenge the age determination and their custody with adults in ICE detention centers, but the physical and psychological harm that they incurred while waiting for a decision in ICE custody was significant. We found that there was no way to challenge the age determination within ORR, even when it was clear that ORR violated the statutory requirements of the age determination.

To prevent further harm from wrongful age determinations, the proposed regulations should eliminate or drastically reduce ORR's use of medical or dental examinations as part of its age determination procedures. Within the medical community, there is a great deal of doubt about the reliability and utility of age assessments based on medical tests. The Department of Homeland Security's Office of the Inspector General found that "medical professionals we spoke with expressed skepticism that a radiographic exam could be used to discover specifically whether an individual has attained 18 years of age."[55]

Radiographs of bones to assess age are not sufficiently precise to provide valuable insight regarding a person's age because children grow at wildly different rates. According to Tim Cole, a professor of medical statistics at University College of London, bone radiographs can provide the wrong answer as to whether someone is 18 up to one-third of the time.[56] Researchers reviewing bone radiographs of adolescents found that the average chronological age for wrist maturity was 17.6 years with a *margin of error of 1.3 years*.[57] In other words: 61% of people will have fully matured bones in their wrist before turning 18, rendering a finding of mature bones almost meaningless in determining whether a person is over 18.

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[53] Brittny Mejia, *U.S. is using unreliable dental exams to hold teen migrants in adult detention*, L.A. Times (June 2, 2019), https://www.latimes.com/local/lanow/la-me-ln-immigrant-age-migrants-ice-dental-teeth-bangladesh-20190602-story.html.
[54] 8 U.S.C. § 1232(b)(4).
[55] Off. of Inspector Gen., Dep't of Homeland Security, Age Determination Practices for Unaccompanied Alien Children in ICE Custody 10 (Nov. 2009), https://tracfed.syr.edu/tracker/dynadata/2010_01/OIG_10-12_Nov09.pdf.
[56] Andy Coghlan, *With no paper trail, can science determine age?*, New Scientist, May 9, 2012, https://www.newscientist.com/article/mg21428644-300-with-no-paper-trail-can-science-determine-age/.
[57] A. Aynsley-Green et al., *Medical, statistical, ethical and human rights considerations in the assessment of age in children and young people subject to immigration control*, 102 BRIT. MED. BULL. 17, 39 (2012), https://academic.oup.com/bmb/article/102/1/17/312555.

Dental examinations to determine age are equally unreliable. After the age of 14, dental age assessment is based entirely on the development and eruption of the third molar (or wisdom tooth).[58] However, wisdom tooth growth varies dramatically. One study found that mature third molars can be seen in individuals as young as 15 years old; whereas some individuals as old as 25 years still did not have mature third molars.[59] Age assessments of adolescents based on wisdom teeth growth have an accuracy of only ±2 to 4 years.[60] Furthermore, the timing of eruption of the third molar depends on ethnicity,[61] gender,[62] socio-economic status, and even birth weight.[63]

At best, radiographs can only provide an "age range" of the person in question.[64] Given the practice's limitations and unreliability, ORR should not include them in the age determination process at all. In our experience, these are particularly prejudicial for children nearing their 18th birthday because the exams inflate the likelihood that the child is over 18. Many of the radiograph reports that the Florence Project reviewed give a very broad range of, for example, 16-24 years, with a 75% probability that the child is over 18. Given that child's proximity to his 18th birthday, the age determination's inaccuracy gives the erroneous impression that the child is already an adult.

Further, the Proposed Rule lacks a definition of the term "medical age assessment." The only guidance provided to ORR staff is that they should resolve "[a]mbiguous, debatable, or borderline forensic examination results" in favor of finding that the child is a minor. This language presents a dual problem: without definition, almost any guess about age using medical terminology or techniques could be considered a "medical age determination," and as lay people, ORR staff are not equipped to determine whether or not these tests have "ambiguous, debatable, or borderline forensic examination results." Moreover, given that many experts in the medical community have concluded that age assessments based on bone and dental radiographs are unreliable and imprecise, all forensic examination results should be deemed debatable and resolved in favor of finding that the individual is a child.

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[58] Nishant Singh et al., *Age estimation from physiological changes of teeth: A reliable age marker?*, 6 J. OF FORENSIC DENTAL SCI. 113 (2014).
[59] Aynsley-Green. *supra* n.57 at 34.
[60] *See* Ines Willershausen et al., Review Article, *Possibilities of Dental Age Assessment in Permanent Teeth: A Review*, S1 DENTISTRY 1, 3 (2012) (citations omitted).
[61] *See* Andreas Schmeling et al., *Review Article, Forensic Age Estimation*, 113 Deutsches Ärzteblatt Int'l 47 (2016); *see also* Willershausen, *supra* note 60 at 2 (citations omitted).
[62] *See* A.S. Panchbhai, Review, *Dental Radiographic Indicators, A Key to Age Estimation*, 40 DENTOMAXILLOFACIAL RADIOLOGY 199, 211 (2011) (citing Ana C. Solari & Kenneth Abramovitch, *The Accuracy and Precision of Third Molar Development as an Indicator of Chronological Age in Hispanics*, 47 J. FORENSIC SCI. 531 (2002)).
[63] *See* B.S. Manjunatha & Nishit K. Soni, Review Article, *Estimation of age from development and eruption of teeth*, 6 J. OF FORENSIC DENTAL SCI. 73 (2014).
[64] *Id.*

It is particularly crucial that ORR requires that all medical age determinations take into account an individual's ethnic and genetic background, just as the ORR policy guide requires.[65] This consideration is key because "radiographs of a person's bones or teeth cannot produce a specific age due to a range of factors affecting an individual's growth. These include normal biological variation, as well as cultural and ethnic differences."[66] Comparisons should be based on images taken from the same population as the subject;[67] but atlases of radiograph images do not exist for children from many countries in Asia, Africa or the Middle East.[68] Even when comparative normative images do exist, at best chronological age correlates to ±2 years of maturity age, and in some entirely normal children, this may be discordant by as much as 4 to 5 years.[69] In the 50-60 dental radiograph reports that the Florence Project has reviewed, we have never seen comparison between similar populations. For example, the dental measurements of youth from Bangladesh were compared with white Americans, and the teeth of a Somali youth were compared with samples from an African American. This negatively affects their reliability of the results. We urge ORR to abandon the use of medical age determinations or, at a minimum, strictly limit their use and require greater scientific rigor to improve accuracy.

Finally, we urge ORR to require the informed consent of any child who receives radiographs as part of the age determination process. Radiographs expose youth to small but not inconsequential amounts of radiation. While such risks are acceptable when undertaking clinical diagnostic imaging, if radiographs are used purely for legal purposes, then this could be considered a breach of medical ethics in some cases.[70]

b. <u>The "reasonable suspicion" standard required to initiate an age determination should be replaced with the higher "probable cause" standard and youth must be provided with procedural safeguards.</u>

ORR notes that its current policy and practice only allow it to conduct an age determination if there is a "reasonable suspicion" that the person is over 18 years of age. In our experience, we have found that ORR Federal Field Specialists have used their broad discretion to conduct age determinations without a reasonable basis.[71] We ask that ORR use this opportunity to protect against unwarranted age

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[65] Off. of Refugee Resettlement, ORR Unaccompanied Children Program Policy Guide: Section 1.6: Determining the Age of an Individual without Lawful Immigration Status (Apr. 13, 2022), https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide-section-1#1.6.

[66] Off. of Inspector Gen., Dep't of Homeland Security, Age Determination Practices for Unaccompanied Alien Children in ICE Custody 6 (Nov. 2009), https://tracfed.syr.edu/tracker/dynadata/2010_01/OIG_10-12_Nov09.pdf.

[67] *See* Schmeling *supra* note 61 at 44, 46.

[68] Aynsley-Green, *supra* note 57 at 24.

[69] *Id.* at 34.

[70] *See, e.g.*, Edel Doyl et al., *Guidelines for best practice: Imaging for age estimation in the living*, 16 J. FORENSIC RADIOLOGY & IMAGING 38, https://doi.org/10.1016/j.jofri.2019.02.001 ("Medico-legal considerations for forensic imaging include Justification (risk versus benefit) in relation to "*non-medical imaging exposure*", as well as obtaining valid consent.")

[71] *See L.B. v. Keeton,* No. 18-03435, 2018 WL 11447076, at *6 (D. Ariz. Oct. 26, 2018) (Holding that "[t]here is no apparent plausible construction of the TVPRA, or the ORR Guide, under which an ORR official's nonspecific,

determinations by requiring ORR to provide probable cause that the child is an adult. This would require specific and articulable reasons why the staff member believes that the age determination process should be initiated.[72] ORR should require that staff document those reasons and provide this documentation to the person in question before initiating the process. Finally, ORR should require that the child in ORR care be appointed an attorney and referred for appointment of a child advocate at the initiation of the age determination and that those persons should have an opportunity to challenge whether ORR has provided sufficient reasonable suspicion to begin the age determination process. ORR should not be permitted to remove an individual from ORR custody until they have had an opportunity to consult with legal counsel and have a complete adjudication of the age determination issue. A person who claims to be a child must be treated as such unless and until proven otherwise.

c. ORR should clarify how field staff should weigh evidence regarding age.

The Proposed Rule states that "If an individual's estimated probability of being 18 years or older is 75 percent or greater according to a medical age assessment, and the totality of the evidence indicates that the individual is 18 years old or older, ORR must determine that the individual is 18 years old or older." If ORR continues to use medical age determinations, we urge ORR to add additional definitions and procedural protections to assist staff in making these determinations. For example, FIRRP has represented dozens of children who had significant evidence of minority, including consulate-verified birth certificates, school and immunization records, and multiple statements from friends and family. However, ORR gave exclusive weight to dental radiograph reports showing that the children had a 75 percent or higher possibility of being over 18. We urge ORR to add additional protections delineating how each piece of evidence should be weighed in examining the "totality of the evidence." We ask that ORR define each piece of evidence as equal in weight, such that the children noted above with four pieces of evidence in favor of minority should be found to be minors even though ORR has one piece of evidence in favor of majority. This clarification would greatly simplify the process for ORR field staff and would standardize the age determination process around the country.

We are also concerned that several key terms in this section of the proposed regulation are not defined, including the statement that "[a]mbiguous, debatable, or borderline forensic examination results are resolved in favor of finding the individual is a minor." ORR field staff lack the expertise to interpret those terms. As noted above, most medical age determinations can provide only the broadest possible range of ages and are "debatable" forms of evidence of age. Asking field staff to assess or weigh that science is impractical and invites bias and error. Further, ORR should place procedural protections around the age determination process, including providing the child, counsel, and the child advocate with all proof of age that ORR is considering and a requirement that ORR consider additional evidence provided at any time in the process.

unsubstantiated speculation of what they perceive to be adult behavior suffices as "evidence" that may be considered and relied upon in making an age determination").

[72] *See Maryland v. Pringle,* 540 U.S. 366 (2003) (defining probable cause).

Finally, we ask that the list of documentation that ORR may consider in making an age determination include statements from other family members or family friends with personal knowledge of the youth's age. This would make the HHS guidance consistent with that of ICE, which also allows for consideration of statements written by those with personal knowledge of age.[73] As written, it only mentions statements from parents or legal guardians or statements from other persons apprehended with the individual. We have had several clients who only had non-immediate family members able to provide statements. Adding those persons to the list will help prevent confusion about whether those statements should be considered.

We suggest the following procedural protections be included in the final rule. Given the invasiveness of a medical age determination, the heightened probable cause standard is more appropriate than reasonable suspicion standard. The following recommendations are in line with the ORR Policy Guide.

Recommendation 19: § 410.1702

Procedures for determining the age of an individual must take into account the totality of the circumstances and evidence~~, including the non-exclusive use of radiographs,~~ to determine the age of the individual. ~~ORR may require an individual in ORR's custody to submit to a medical or dental examination, including X-rays, conducted by a medical professional or to submit to other appropriate procedures to verify their age. If ORR subsequently determines that such an individual is an unaccompanied child, the individual will be treated in accordance with ORR's UC Program regulations in this part for all purposes.~~

[ADD]: (a) ORR must promptly determine the age of each child in its custody within 14 days of placement in ORR custody.

(b) If ORR wishes to question a child's given age or determine whether a child is an adult, it must establish probable cause that the child is over 18.

(i) Probable cause exists where the ORR has trustworthy information sufficient to warrant a reasonable person to believe that the person in question is not a minor. ORR cannot rely solely on a child's race, country of origin or religion to establish probable cause.

(ii) A person's appearance, history of false or fraudulent statements, and a lack of identity document are complicating factors in the age determination process. These factors alone cannot be used to determine probable cause.

(iii) If ORR wishes to determine whether an individual in ORR custody is a child or an adult, counsel must be appointed, and the young person must be referred for appointment of a child advocate. They must be provided with evidence of probable cause for conducting an age re-determination. They may challenge whether ORR has probable cause via a complaint to a neutral and independent hearing officer.

[73] Off. of Inspector Gen. Dep't of Homeland Security, Age Determination Practices for Unaccompanied Alien Children in ICE Custody 4 (Nov. 2009), https://tracfed.syr.edu/tracker/dynadata/2010_01/OIG_10-12_Nov09.pdf.

(iv) If probable cause is established, the child's counsel and ORR may gather and submit any evidence in support of age to the hearing officer.

(v) To conduct medical age determination, ORR must select a medical age determination provider from a list of best-qualified and pre-approved specialists. Those specialists must be trained in the medical ethics of providing age determinations and must show that they have obtained informed consent in a language that the child understands before proceeding with the exam. ORR must also verify that the specialists do not have any substantiated complaints for medical malpractice.

(vi) Any medical age determination must take into account the child's ethnicity by comparing the child with persons of the same or similar ethnic group, gender, exposure to pathogens, previous serious illnesses, and history of malnutrition.
(vii) Each piece of evidence submitted has equal weight unless the opposing party can demonstrate that it has no evidentiary value (i.e, a guess, speculation, or conjecture)

(viii) The neutral hearing officer will weigh evidence and issue a written decision within five days of hearing.

(ix) The youth must remain in ORR custody until the process is fully adjudicated and cannot be transferred to ICE custody while in process. In general, a child who claims to be under the age 18 should be presumed to be so and should be treated according to the law and standards applicable to noncitizen children in immigration custody. Agency practices must start with a presumption that the individual is a child

In the alternative, we recommend that ORR adopt the language and standards below, found in the Children's Safe Welcome Act.[74] That legislation was proposed in both the House and Senate on July 13, 2022. The pertinent language is as follows:

Recommendation 20: ALTERNATIVE RECOMMENDATION for §§ 410.1702-04

"(g) Age Assessments.—

(1) IN GENERAL.—Any individual who claims to be under the age of 18 years shall be presumed to be so and shall be treated according to the law and standards applicable to noncitizen children in immigration custody, unless following an age assessment, it is established by clear and convincing evidence that the individual is 18 years of age or older.

(2) REQUIREMENTS.—

(A) IN GENERAL.—An age assessment may only be conducted if the Secretary or Secretary of Homeland Security has recent, credible, and documented evidence that the individual concerned is 18 years of age or older.

(B) CONSIDERATIONS.—If an age assessment is conducted, the Secretary and the Secretary of Homeland Security shall take into consideration, to the extent such information is readily available—

(i) written or photographic evidence;

(ii) statements and representations of the individual concerned and of the family and community members who know such individual; and

(iii) the relevant cultural and ethnic context.

[74] The full text of the bill is available at https://www.congress.gov/bill/117th-congress/house-bill/8349/all-info.

(C) PROHIBITED METHODS.—The Secretary or the Secretary of Homeland Security may not—
(i) conduct any medical age assessment that consists of imaging studies, such as bone or dental radiography, dental examinations, or height, weight, skin, or sexual maturity ratings; or
(ii) rely on the physical appearance of a child to justify an age assessment.
(D) LEGAL COUNSEL.—
(i) IN GENERAL.—An individual with respect to whom an age assessment is conducted shall be provided with legal counsel before receiving such assessment and may not be removed before receiving such counsel.
(ii) EVIDENCE.—Legal counsel provided under clause (i) shall be provided with all evidence upon which the Secretary or the Secretary of Homeland Security relies to justify conducting an age assessment or to support an age assessment determination."[75]

a. Conclusion

We thank ORR for the opportunity to comment on the Proposed Rule. We are encouraged by the provisions that support the prompt reunification and release of unaccompanied children. The changes we offer to the Proposed Rule would further strengthen these provisions. We urge ORR to adopt our recommendations and improve protections for youth in the Final Rule.

Sincerely,

Acacia Center for Justice
Advocates for Basic Legal Equality, Inc. (ABLE)
Alianza Americas
American Immigration Council
Americans for Immigrant Justice
Angry Tias and Abuelas of the RGV
Asian Pacific Institute on Gender-Based Violence
Capital Area Immigrants' Rights (CAIR) Coalition
Catholic Charities Baltimore, Esperanza Center
Center for Law and Social Policy
Central American Resource Center - CARECEN - of California
Community Legal Services in East Palo Alto
Dignidad
Diocesan Migrant and Refugee Services, Inc./Estrella del Paso
Empowering Pacific Islander Communities
Florida Legal Services, Inc.
Galveston-Houston Immigrant Representation Project
Grassroots Leadership
HIAS Pennsylvania

[75] *Id.*

Hope Border Institute
Houston Immigration Legal Services Collaborative
Human Rights Initiative of North Texas
Immigrant Defenders Law Center (ImmDef)
Immigrant Justice Task Force, Wellington United Church of Christ
Immigrant Legal Defense
Immigrant Legal Resource Center
Immigrants' Rights Clinic, Morningside Heights Legal Services, Inc., Columbia Law School
Immigration Center for Women and Children
Immigration Counseling Service
International Rescue Committee
JFCS Pittsburgh
Just Neighbors
Justice in Motion
Juvenile Law Center
Kids in Need of Defense (KIND)
La Raza Centro Legal
Law Office of Daniela Hernandez Chong Cuy
Law Office of Helen Lawrence
Law Office of Miguel Mexicano PC
Lawyers for Good Government
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
Massachusetts Immigrant and Refugee Advocacy Coalition
Michigan Immigrant Rights Center
Migration Matters
National Disability Rights Network (NDRN)
National Immigrant Justice Center
National Immigrant Law Center (NILC)
OneAmerica
Open Immigration Legal Services
Physicians for Human Rights - Student Advisory Board
Project Lifeline
Rocky Mountain Immigrant Advocacy Network
Safe Passage Project
Save the Children
South Asian Public Health Association
South Dakota Voices for Peace
The Immigration Project

UC Davis Immigration Law Clinic
United We Dream
VECINA
Women's Refugee Commission
Witness at the Border
Young Center for Immigrant Children's Rights

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