

February 23, 2015

The Honorable Sylvia Mathews Burwell
United States Department of Health and Human Services
Office of Refugee Resettlement
370 L'Enfant Promenade SW, 8th Floor West
Washington, DC 20024

RE: Comments on Standards to Prevent, Detect, and Respond to Sexual Abuse and Sexual Harassment Involving Unaccompanied Children, 79 FR 77767 (December 24, 2014)

Dear Secretary Burwell:

The signatories respectfully submit these comments regarding the Department of Health and Human Services's (HHS) interim Standards to Prevent, Detect, and Respond to Sexual Abuse and Sexual Harassment Involving Unaccompanied Children.¹ In its Interim Final Rule (IFR or interim standards), HHS has laid out a nearly comprehensive set of standards that, if fully implemented, will significantly increase the safety of children in your care. The signatories applaud the seriousness of this effort and the potential benefit it holds for the tens of thousands of incredibly vulnerable children who enter the United States each year without immigration status and unaccompanied by an adult relative.

Unfortunately, a discreet number of provisions of the IFR fall short of what the signatories believe is necessary to create an effective infrastructure for protecting these children. Below, the signatories respectfully recommend practical modifications to the interim standards in order to clarify HHS's intent, correct deficiencies, and suggest additional, important provisions that are absent at this time.

I. Signatories' Interest in the HHS Interim PREA Standards

The signatories share a commitment to ending sexual abuse of migrant children in HHS's care. As organizations concerned about human rights, immigrants' rights, civil rights and liberties, women's rights, and the rights of lesbian, gay, bisexual, and transgender people, the signatories listed below believe that full implementation of the Prison Rape Elimination Act (PREA)² is the best way to end the crisis of sexual abuse in facilities operated under contract with HHS.

The **American Civil Liberties Union (ACLU)**, for nearly 100 years, has been our nation's guardian of liberty, working in courts, legislatures, and communities to defend and preserve the individual rights and liberties that the Constitution and the laws of the United States guarantee everyone in this country. The ACLU takes up the toughest civil liberties cases and issues to defend all people from government abuse and overreach. With more than a million members, activists, and supporters, the ACLU is a nationwide organization that fights tirelessly in all 50 states, Puerto Rico, and Washington, D.C., for the principle that every individual's rights must be protected equally under the law, regardless of race, religion, gender, sexual orientation, disability, or national origin. The ACLU has long advocated on behalf of individuals in detention, including through its National Prison Project, whose Associate Director testified before the Prison Rape Elimination Commission and served on its Standards Development Expert Committee.

The **Center for American Progress** is an independent nonpartisan educational institute dedicated to improving the lives of Americans through progressive ideas and action. Building on the achievements of progressive

¹ *Standards to Prevent, Detect, and Respond to Sexual Abuse and Sexual Harassment Involving Unaccompanied Children*, Department of Health and Human Services, Interim Final Rule, December 24, 2014.

² Prison Rape Elimination Act of 2003, 42 USC §147, 117 Stat. 972, Pub. L. 108-79, 2003.

pioneers such as Teddy Roosevelt and Martin Luther King, our work addresses 21st century challenges such as energy, national security, economic growth and opportunity, immigration, education, and health care. We develop new policy ideas, critique the policy that stems from conservative values, challenge the media to cover the issues that truly matter, and shape the national debate. Founded in 2003 by John Podesta to provide long-term leadership and support to the progressive movement, CAP is headed by Neera Tanden and based in Washington, D.C.

Detention Watch Network (DWN) is a national coalition of approximately 200 organizations and individuals working to expose and challenge the injustices of the U.S. immigration detention and deportation system, and advocate for profound change that promotes the rights and dignity of all persons. DWN members are lawyers, activists, community organizers, advocates, social workers, doctors, artists, clergy, students, formerly detained immigrants, and affected families from around the country. They are engaged in individual case and impact litigation, documenting conditions violations, local and national administrative and legislative advocacy, community education and mobilization, social work and pastoral care. DWN's current campaigns include the End the Quota campaign, calling for an end to the detention bed quota that requires 34,000 immigrants be detained at any given time and Expose and Close, a series of reports about the nation's most egregious detention centers, calling for closure and a reduction of the detention system overall.

Just Detention International (JDI) is a health and human rights organization dedicated to putting an end to sexual violence in all forms of detention. JDI has three core goals for its work: to hold government officials accountable for prisoner rape, to promote public attitudes that value the health and safety of people behind bars, and to ensure that survivors of this type of violence get the help they need. The organization provides expertise to lawmakers, officials, counselors, advocates, and reporters on issues pertaining to inmate safety and the obligations of detention officials to prevent and respond to sexual abuse. JDI helped draft the Department of Justice's PREA standards and works nationwide with agencies implementing those standards.

Kids in Need of Defense (KIND) serves as a leading organization for the protection of unaccompanied children who enter the US immigration system alone and strives to ensure that no such child appears in immigration court without representation. We achieve fundamental fairness through high-quality legal representation and by advancing the child's best interests, safety, and well-being.

Lutheran Immigration and Refugee Service, founded in 1939, is the second largest refugee resettlement agency in the United States. It is nationally recognized for its leadership advocating with refugees, asylum seekers, unaccompanied children, immigrants in detention, families fractured by migration and other vulnerable populations. Through more than 75 years of service and advocacy, LIRS has helped over 500,000 migrants and refugees rebuild their lives in America.

The **National Center for Transgender Equality (NCTE)** is a national social justice organization devoted to ending discrimination and violence against transgender people through education and advocacy on national issues of importance to transgender people. By empowering transgender people and our allies to educate and influence policymakers and others, NCTE facilitates a strong and clear voice for transgender equality in our nation's capital and around the country. Because of the well-documented vulnerability of transgender people to sexual abuse in confinement settings, PREA implementation has been a major focus of NCTE's work over the last several years.

The Women's Refugee Commission advocates for policies and programs to improve the lives of refugee and displaced women, children and young people. The Migrant Rights and Justice program works to improve legislation and policy to ensure due process, safety and well-being of migrant women, families and unaccompanied children.

II. Overview of Sexual Abuse and Sexual Harassment of Migrant Children in HHS care

There is a crisis of sexual abuse of children in HHS custody. Until publication of these interim standards, the Office of Refugee Resettlement (ORR) had no effective plans to address this pressing issue. Many of the youth detained in facilities through ORR's unaccompanied minors program come to the United States to escape rampant violence and sexual abuse.³ Their journey to the U.S. includes multiple risks of physical, emotional, and psychological harm.⁴ Additionally, the majority of children in ORR facilities have recently been transferred from the custody of U.S. immigration agencies where allegations of abuse and neglect of detained children are longstanding and well-documented.⁵ As a result, a high percentage of these children enter ORR custody with a history of sexual abuse or attempted abuse. Everything we know about children in detention settings points to a history of sexual abuse as a leading indicator of an individual child's particular vulnerability to being victimized yet again while in custody.⁶

Another category of youth in detention that is vulnerable to sexual abuse are children who are, or are perceived to be, lesbian, gay, bisexual, or transgender, questioning, or intersex (LGBTQI). No comprehensive study has been done to date of the percentage of unaccompanied migrant children who fall within this category. However, all evidence points to an over-representation of LGBTQI youth in the ORR population.⁷ Federal research demonstrates that youth who are lesbian, gay, or bisexual are at significantly higher risk of abuse than heterosexual youth.⁸ While no federal data on transgender youth in detention have been released, transgender adults in jails and prisons were found to face the highest rates of sexual abuse of any demographic category studied so far.⁹ Of course, many youth who are, or are perceived to be LGBTQI, are also survivors of sexual and other physical abuse.

Despite these dynamics, ORR failed to put in place integrated policies and procedures to detect, prevent, and track instances of abuse. Prior to the interim standards, ORR had no systemic policies to guide service providers on their duties to prevent sexual abuse in their facilities. Instead, ORR relied on inadequate agency and state requirements or failed to consistently rely on effective state requirements. Further, ORR had no way to capture or review reports of sexual abuse across the program. On any given day, ORR was incapable of determining the number of sexual abuse reports it had received from youth in the prior week, month, or year.

It was tragically unsurprising then when, last year, the *Houston Chronicle* detailed that youth had reported 100 instances of staff-on-youth sexual abuse in the two years between March 2011 and March 2013.¹⁰ Noting that

³ In general, see *Forced from Home: The lost boys and girls of Central America*, Women's Refugee Commission, October 2012; *A Treacherous Journey: Child migrants navigating the U.S. Immigration System*, the Center for Gender and Refugee Studies and Kids in Need of Defense, February 2014; *Fostering Safety: How the U.S. Government can protect LGBT immigrant children*, The Center for American Progress, September 2014; and, *Children on the Run: Unaccompanied Children Leaving Central America and Mexico and the Need for International Protection*, UN High Commission for Refugees, March 2014.

⁴ *Id.*

⁵ See *Re: Systemic Abuse of Unaccompanied Immigrant Children by U.S. Customs and Border Protection*, American Civil Liberties Union et al., 2014; *Unaccompanied Immigrant Children: A Policy Brief*, National Immigrant Justice Center, 2014 No *A Culture of Cruelty: Abuse and Impunity in Short-Term U.S. Border Patrol Custody*, No More Deaths, 2011.

⁶ In general, see *Sexual Victimization in Juvenile Facilities Reported by Youth, 2008-09* and *Sexual Victimization in Juvenile Facilities Reported by Youth, 2012*, Bureau of Justice Statistics, January 2010 and June 2013 respectively.

⁷ See fn 3, *Fostering Safety*

⁸ See fn 6.

⁹ *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011-12, Supplemental Tables: Prevalence of Sexual Victimization Among Transgender Adult Inmates*, Bureau of Justice Statistics, December 2014 (BJS found that, on average over three studies, 34% of transgender survey respondents reported having been sexually abused in the prior 12 months).

¹⁰ *Crossing alone: Children fleeing to U.S. land in shadowy system*, Susan Carroll, *The Houston Chronicle*, May 24, 2014.

ORR had no internal tracking mechanism, the *Chronicle* was able to document these instances of abuse only through reviewing the hundreds of significant incident reports it received through a Freedom of Information Act (FOIA) request. The *Chronicle's* review found that ORR relied solely on local law enforcement to conduct criminal investigations and on state oversight agencies to conduct administrative investigations of the reports. Disturbingly, despite reports of sexual contact ranging from kissing to intercourse, no staff member was prosecuted for her or his conduct.

One likely reason for this failure to prosecute is that traditionally local law enforcement has been reluctant to investigate crimes when the victim is a federal detainee and, as a matter of practice, ORR often fails to seek the help of federal law enforcement agencies. Additionally, the quality of administrative investigations often varies greatly by state, and some cases were likely closed by state investigators when youth were transferred by ORR to another state (either to be united with family members or to access other programs). And when state administrative agencies did complete investigations, they rarely shared full reports with ORR. This means that any benefit from the administrative investigation, in terms of identifying deficient policies or practices, was completely lost.

Moreover, the *Chronicle's* FOIA review only tracked formal reports of staff-on-youth abuse. All indications are that the actual rates of abuse are much higher.¹¹ And the rates of youth-on-youth sexual abuse (reported or actual) are not accounted for by the *Chronicle* article at all.

The lack of structure and attention at all levels of the unaccompanied minors program that led to these reports of abuse continued into 2014. In recent months, though, staff from ORR and the Administration of Children and Families (ACF) have shown a marked increase in commitment to addressing sexual abuse of migrant youth. Thankfully, signatories believe that the interim standards cure a substantial number of the defects in ORR policy and practice. The staff of ORR, ACF, and HHS should be applauded for the depth and breadth of the interim standards, the efforts made to harmonize them with the migrant children's program, and the significant changes these standards will necessitate in ORR's existing policies and practices.

In that spirit, signatories respectfully provide the following comments in order to help HHS finalize standards that are sufficient to meeting the crisis of sexual abuse of the migrant children in its care. Where the signatories recommend changes to HHS's interim standards, it is with the intent of overcoming the complex circumstances that facilitate sexual abuse. In the end, the signatories' goal is the same as the one identified by the Department: "Sexual violence and abuse are an assault on human dignity and have devastating, lifelong mental and physical effects on an individual. HHS is committed to an absolute zero tolerance policy against sexual abuse and sexual harassment in its care provider facilities and seeks to ensure the safety and security of all UCs in its care."¹²

III. Recommended changes to Definitions (§411.5 and §411.6)

A. Delete definitions for "gender," "gender identity," and "sex."

Recommended final language:

~~Gender refers to the attitudes, feelings, and behaviors that a given culture associates with a person's biological sex.~~

¹¹ *Id* fn 6 and *Sexual Victimization in Juvenile Facilities Reported by Youth, 2012*, Bureau of Justice Statistics, June 2013. For instance, extrapolating from the BJS research, every child who submitted a formal report of an abuse represents five children who would disclose abuse through an anonymous survey.

¹² *Id.* fn 1, p. 10.

~~Gender identity refers to one's sense of oneself as male, female, or transgender.~~

~~Sex refers to a person's biological status and is typically categorized as male, female, or intersex. There are a number of indicators of biological sex, including sex chromosomes, gonads, internal reproductive organs, and external genitalia.~~

Comments:

Signatories recommend that the Final Rule omit the proposed definitions of gender, gender identity, and sex. These characteristics are not defined in the Department of Justice (DOJ) or Department of Homeland Security (DHS) PREA rules, or in numerous other federal civil rights regulations addressing gender identity. Signatories believe these terms are sufficiently clear as used in the IFR, and that the definitions provided are not helpful in understanding the rule. To the extent that elaboration of these concepts is needed for ORR or contractor staff or volunteers, this should be addressed through training and implementation efforts.

B. Modify definition of “transgender”

Recommended final language:

Transgender means a person whose gender identity (*i.e.*, internal sense of feeling male, ~~or~~ female, or another gender) is different from the person's assigned sex at birth.

Comments:

Signatories support the definition of transgender in the interim standards, which tracks the DOJ standards. Additionally, the definition should be enhanced to reflect the reality that male and female categories are not sufficient. It is now well-recognized that a person's deeply rooted gender identity may be something other than male or female. Updating the definition will demonstrate HHS's recognition of this diversity of identity.

C. Clarify definition of “emergency care provider facility”

Recommended final language:

Emergency care provider facility is a federal designation for a type of care provider facility that is temporarily opened to provide temporary emergency shelter and services for UCs during an influx and does not include any shelters designated as “emergency” or “short-term” under a state law, regulation, or policy.

Comments:

Some existing care provider facilities are designated as “emergency” or “short-term” under the relevant state licensing structures. Signatories recommend that HHS distinguish this state classification from the designation intended in the IFR. This state designation should not, and was not meant to, control for purposes of HHS's standards. Many of these state-designated “emergency” or “short-term” shelters can be kept open and in use for indefinite periods. One example of this is the I.E.S. Emergency Shelter in Harlingen, which has been used by ORR over a period of years. This recommended change simply clarifies that “emergency care provider” facilities are those set up by HHS, generally in cooperation with other federal agencies, to house children temporarily during a population influx.

D. Create definition for “care provider network”

Recommended final language:

Care provider network means any ORR grantee or contractor that operates or subcontracts with more than one care provider facility.

Comments:

ORR has a variety of contractual agreements with care provider facilities. The interim standards define “care provider facility” as a single facility. The final standards must also have a definition for a provider who runs multiple care provider facilities that are under contract with ORR.

E. Create definition for “one-on-one supervision”

Recommended final language:

One-on-one supervision means non-punitive supervision that includes direct line of sight supervision at all times, such supervision does not include any isolation – such as solitary confinement – that separates a child by sight and sound from other children.

Comments:

In its discussion of the IFR, HHS makes clear that “one-on-one supervision in ORR care provider facilities does not refer to the type of solitary confinement used by prisons. UCs are not forced to remain alone and in locked rooms. Instead, one-on-one supervision refers to direct line-of-sight supervision at all times.”¹³ Signatories agree with this principle and strongly recommend that HHS include the above definition in the final standards in order to formalize it.

F. Revise definition of sexual abuse

Recommended final language:

§411.6 Definitions related to sexual abuse and sexual harassment.

For the purposes of this part, the following definitions apply:

Sexual abuse means—

- (1) Sexual abuse of a UC by another ~~UC~~ youth confined in the same facility; ~~and~~
- (2) Sexual abuse of a UC by a staff member, grantee, contractor, or volunteer; and
- (3) Sexual abuse of a UC committed prior to entry into a care provider facility covered by this part, regardless of the perpetrator.

Sexual abuse of a UC by another ~~UC~~ youth confined in the same facility includes any of the following acts

...

¹³ *Id.* at p. 46.

Comments:

Signatories recognize that the overwhelming majority of children in ORR care are housed only with other children in ORR care. Because of this, youth perpetrators of sexual abuse against children in ORR facilities will almost always be another unaccompanied minor. However, signatories recognize that a percentage of children in ORR care are housed in facilities where they have contact with children under the care or custody of another agency. For instance, populations are mixed in some foster care facilities or therapeutic facilities, including those that house youth who have a history of being sex offenders. For this reason, signatories recommend that ORR adopt this slightly broader definition of youth perpetrators so that front-line staff in mixed population facilities will not be confused about whether to follow the final rule.

The new language in (3) above is intended to account for abuse that was committed prior to a child's placement in a care provider facility. As explained in more detail below, signatories are urging HHS not to limit services to children with a history of sexual abuse.

IV. Recommended changes to Subpart A

A. Apply a discreet number of standards to ORR secure care provider facilities (§411.10)

Recommended final language:

(a) This part applies to all ORR care provider facilities except ~~secure care provider facilities and~~ traditional foster care homes. ~~Secure care provider facilities must, instead, follow the Department of Justice's National Standards to Prevent, Detect, and Respond to Prison Rape, 28 CFR part 115.~~ Traditional foster care homes are not subject to this part.

(b) Secure care provider facilities must, ~~instead,~~ follow the Department of Justice's National Standards to Prevent, Detect, and Respond to Prison Rape, 28 CFR part 115 and must implement the following sections from this part:

1. 411.22(d-h);
2. 411.51(a) and (d);
3. 411.55(a) and (c);
4. Subpart H;
5. Subpart K;
6. 411.104(b-c);
7. 411.113(f); and,
8. 411.114(b).

Comments:

Unaccompanied children in secure care provider facilities that operate under the DOJ standards should not be excluded from certain portions of the HHS standards that address challenges that are unique to this population. And incidents of abuse in secure facilities must be reviewed by ORR along with incidents in other types of facilities. The first three bullets above reference services that are specifically needed by children in ORR custody but are not services available to children in typical state or local juvenile facilities. Binding secure care provider facilities to these few sections of HHS's standards will ensure that all ORR youth, regardless of where they are housed, have the same level of safety and recourse.

Similarly, the other identified sections listed above reflect the inherent administrative role ORR plays in monitoring the wellbeing of the children in its care. While DOJ's juvenile standards provide for a number of

important reporting, review, and record keeping tasks, those requirements do not apply to ORR. Therefore, the HHS standards must specifically require ORR to integrate reports of sexual abuse and harassment in secure care provider facilities into the oversight and reporting mechanism that ORR is creating for facilities governed by the interim standards. The final rule should strengthen those mechanisms by making sure to include incidents and outcomes from secure care provider facilities in all ORR reporting, data collection, and assessment activities.

B. Transformation of section (§411.10(d))

Recommended final language:

~~(d) For the purposes of this part, the terms related to sexual abuse and sexual harassment refer specifically to the sexual abuse or sexual harassment of a UC that occurs at an ORR care provider facility while in ORR care and custody. Incidents of past sexual abuse or sexual harassment or sexual abuse or sexual harassment that occurs in any other context other than in ORR care and custody are not within the scope of this regulation.~~

Unless otherwise noted, care provider networks, care provider facilities, and ORR shall treat all reports of sexual abuse and harassment the same regardless of where the alleged incident(s) occurred.

Comments

All youth in ORR custody who have been sexually assaulted need access to multiple routes of reporting and appropriate medical, mental health, and support services. The interim language in (d) suggests that youth who have been sexually assaulted outside of ORR custody will not be provided with the safety measures created by the standards. Signatories believe this is a mistake. Instead, HHS should explicitly affirm that youth will receive protection and services regardless of where and when they suffered abuse.

HHS acknowledges in the Introduction to the IFR that “[a] number of UCs in ORR care have been sexually abused prior to entering ORR custody.” As signatories mention above, this includes many children abused in their home countries, in transit to the United States, or in the custody of U.S. Customs and Border Protection (“CBP”). The vast majority of children in ORR custody are transferred directly from CBP custody, and ORR providers have documented—and reported—many allegations of abuse and neglect of children in those facilities.¹⁴ In fact, the Department of Homeland Security (“DHS”) has itself acknowledged “recurring problems”¹⁵ and oversight failures that jeopardize the safety and well-being of unaccompanied children in CBP detention facilities.¹⁶

Moreover, existing federal child protection laws establish affirmative abuse reporting obligations for federal employees and contractors, including detention facility employees, social workers, and counselors.¹⁷ There is no temporal or geographic limitation on this requirement—covered professionals must report suspected abuse

¹⁴ A series of ORR Special Incident Reports from March 2011 – March 2013, made public last year to the ACLU and others, contain dozens of allegations of abuse and neglect by immigration officials, the vast majority involving U.S. Border Patrol. *See also New York quietly expands role in caring for immigrant children*, Jessica Bakeman, *Capital New York*, Oct. 20, 2014, (“When the children arrive at New York-area airports from the federal facilities, they often require extensive medical care for broken bones that healed improperly or illnesses such as appendicitis and pneumonia, nonprofit officials said . . . ‘Some of them have not eaten for long periods of time,’ said Henry Ackermann, chief development officer at [ORR subcontracted] Abbott House.”).

¹⁵ *Improvements Continue at Detention Centers*, Department of Homeland Security Office of Inspector General, Press Release, Oct. 6, 2014.

¹⁶ Memorandum to DHS Secretary Jeh C. Johnson from DHS Inspector General John Roth on Oversight of Unaccompanied Alien Children 2-3, July 30, 2014.

¹⁷ 42 U.S.C. § 13031; 28 C.F.R. § 81.2–81.3.

allegations, regardless of when or where the abuse occurred.¹⁸ Interim part (d) is inconsistent with ORR providers' affirmative child abuse reporting obligations under established law, inviting confusion and potential liability.¹⁹ On the other hand, the recommended final language above affirms this existing obligation.

To the degree that certain requirements having to do with oversight of investigation or record keeping do not logically apply to instances of sexual abuse that occur outside of ORR custody, HHS can exempt these instances of abuse from the requirements. The baseline, however, should be that ORR responds to the needs of all children who have experienced sexual abuse, regardless of where it occurs.

V. Recommended Changes to Subpart B

A. Requirement that care provider networks designate a "Senior PSA Compliance Manager" (§411.11)

Recommended final language:

(d) Care provider networks must employ or designate a Senior Prevention of Sexual Abuse Compliance Manager (Senior PSA Compliance Manager) with sufficient time and authority to coordinate prevention efforts across the network. Care provider facilities must also employ or designate a Prevention of Sexual Abuse Compliance Manager (PSA Compliance Manager) with sufficient time and authority to develop, implement, and oversee the care provider facility's efforts to comply with the provisions set forth in this part and serve as a point of contact for the Senior PSA Compliance Manager (when the facility is part of a network) and ORR's PSA Coordinator.

Comments:

In order to facilitate greater consistency of care across multiple, connected care provider facilities, a network will need a Senior PSA Compliance Manager to track and review incidents of abuse and to review network-wide policies and procedures. While HHS has correctly focused on the need for facility-level leadership on PREA activities and an agency lead to coordinate ORR activities, the interim rule unintentionally ignores the role of care provider networks. These networks run or subcontract with multiple facilities and are an important component in the effort to create the safest possible conditions for youth. By requiring each network to have a network-wide leader on PREA implementation and compliance, the final rule will help networks enhance communication and cooperation between their component facilities and create better accountability for networks that have systemic problems keeping children safe.

B. Strengthening the contracting provisions (§411.12)

Recommended final language:

(a) Care provider networks and care provider facilities are required under existing contracts and cooperative agreements to abide by these standards and must be in compliance with them within 60 days of the publication of the final rule. ~~When contracting with or providing a grant to a care provider facility, ORR must include in~~

¹⁸ See *Attorney General Guidelines for Victim and Witness Assistance*, Office of Justice Programs, Office for Victims of Crime 18, May 2005, ("All Federal law enforcement personnel have obligations under State and Federal law to report suspected child abuse"); Assistant Attorney General's Memorandum to the General Counsel, United States Department of Veteran's Affairs 5, U.S. Department of Justice, Office of Legal Counsel, May 29, 2012 ("... section 13031 is best read to impose a reporting obligation on all persons who, while engaged in the covered professions and activities on federal lands or in federal facilities, learn of facts that give reason to suspect that child abuse has occurred, *regardless of where the abuse might have occurred or where the suspected victim is cared for or resides.*") (emphasis added.).

¹⁹ See 18 U.S.C. § 2258.

memorialize this obligation in any new contracts, contract renewals, cooperative agreements, or cooperative agreement renewals ~~the entity's obligation to adopt and comply with these standards.~~

Comments:

HHS has made clear through the IFR that all care provider facilities are required to be in compliance with the interim standards by June 23, 2015. Signatories applaud this aggressive timeline. Given that intent, parts of 411.12 are confusing in regard to existing contracts and cooperative agreements. Generally, contract obligations only become operational after a contract has been modified. Clearly, HHS has broad authority to require care provider networks and care provider facilities to modify policies and practices in the absence of a contract modification. Signatories therefore recommend that HHS modify 411.12(a) slightly to recognize this authority and alleviate any confusion about when a care provider network or care provider facility must be in compliance with the standards regardless of whether an underlying contract or agreement has been modified.

C. Setting minimum staffing ratios and maximum shelter population limits (§411.13)

Comments:

ORR uses a diverse range of facilities to house migrant youth. In the IFR, the agency chose not to follow the precedent set in the DOJ juvenile PREA standards of setting a minimum staff-to-youth ratio. Instead, the agency provides general guidance but leaves staffing decisions up to its care provider networks and care provider facilities. Signatories recommend that HHS revisit this decision. Minimum staffing ratios are common in efforts aimed at increasing safety for detained youth. HHS should include staffing ratios in its PREA implementation efforts as well.

However, signatories do not offer specific ideas for minimum staffing ratios at this time because of the diversity of facilities that HHS uses. Instead, signatories recommend that HHS identify a date by which it will issue a standard on staff-to-youth ratios. In the intervening time, HHS should review reports of abuse and the staffing in place at the care provider facility at the time of the reported abuse. HHS should also engage with experts on best practices for youth detention and its care providers to garner input. The final staff-to-youth ratios may well vary based on type of facility and time of day.

Signatories also urge HHS to look closely at the issue of the number of children in any one care provider facility. Currently, signatories believe that ORR has no nationwide limit on the number of children that may be housed in a care provider facility. Instead, ORR defers to state-by-state limits - in those states that have them. The Council on Accreditation, an international, independent, nonprofit, human service accrediting organization founded by Child Welfare League of America and Family Service America (now the Alliance for Strong Families and Communities) recommends that children be kept in small facilities. A recent report from the Bureau of Justice Statistics (BJS) would seem to support this recommendation. In trying to account for lower reported rates of abuse between one survey of state juvenile facilities and the next, BJS identified the movement of youth from larger to smaller facilities as one of four key factors.²⁰ In fact, BJS found that in its surveys from 2010 and 2012, “sexual victimization rates were two to three times higher in large facilities [holding more than 101 children] than facilities with 10 to 25 youth.”²¹

Given the growing consensus among children’s advocates and mounting data showing that kids are safer in smaller facilities, signatories strongly encourage HHS to also identify a date by which it will issue a standard on maximum populations for care provider facilities. In the intervening time, HHS should review available research

²⁰ *Sexual Victimization in Juvenile Facilities Reported by Youth*, 2012, p. 10-11.

²¹ *Id.* at 11.

on children's safety and the size of facilities, assess the implications a maximum populations standard will have on legal services and other outside community-based services, and gather input from experts, grantees, and contractors on best practices for youth custody.

D. Modifications to section on cross-gender viewing and searches (§411.14)

(a) Cross-gender pat-down searches of UCs must not be conducted except in exigent circumstances. ~~For a~~ For transgender and intersex UCs that identifies as transgender or intersex, the ORR care provider facility must ask the UC to identify the gender of staff with whom they would feel most comfortable conducting the search, and must honor this request absent exigent circumstances.

(d) Care provider facilities must permit UCs to shower, perform bodily functions, and change clothing without being viewed by staff, except: in exigent circumstances; when such viewing is incidental to routine room checks; is otherwise appropriate in connection with a medical examination or monitored bowel movement; if a UC is under age 6 and needs assistance with such activities; a UC with special needs is in need of assistance with such activities; or the UC requests and requires assistance. If the UC has special needs and requires assistance with such activities, the care provider facility staff member must be of the same gender as the UC when assisting with such activities. Youth will be informed, during shift change or as soon after as practicable, when a staff member of the opposite gender is, or is likely to be, conducting room checks or other duties in the youths' housing area at a time when the youth may be in a state of undress.

(e) Care provider facilities must not search or physically examine a UC for the sole purpose of determining the UC's genital or other physical characteristics. If the UC's genital or other physical characteristics are unknown, they may be determined during conversations with the UC, by reviewing medical records, or, if necessary, learning that information as part of a broader medical examination conducted in private by a medical practitioner.

Comments:

Signatories applaud HHS's interim standards on cross gender viewing and searches. The above recommended changes are important enhancements of the interim standard but only require minor adjustments. In (a), signatories believe the language used in the section can be made consistent with other sections and that the existing expectation, that the youth's request should be followed, needs to be more explicit.

In (d), signatories recognize that staffing of a facility may dictate that, on occasion, staff conduct room checks or other duties in an area that house youth of another gender. While signatories do not recommend that HHS adopt the DOJ's so-called "knock and announce" rule for these occasions, the above language would provide notice to the youth that a staff member of another gender may be entering their housing area as part of her or his duties. The recommended language attempts to make clear that youth do not need to be woken up or otherwise have their activities interrupted by any such notice. It simply must be given in a way that provides youth with the information they need to feel safe.

Finally, signatories believe that the goals of (e) are made clearer by the small change in language recommended above.

E. Strengthening sections related to translations (§411.15)

Recommended final language:

(c) All translations and interpretations will be done in a manner that recognizes cultural as well as linguistic differences. Care should be taken to make sure that terms and ideas used in translated materials are not just grammatically correct but are also ones that have cultural resonance for UCs.

~~(c)-(d)~~ In matters relating to allegations of sexual abuse or sexual harassment, the care provider facility must provide quality in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation by someone other than another youth. Care provider facilities also must ensure that any written materials related to sexual abuse and sexual harassment, including notification, orientation, and instruction not provided by ORR, are translated either verbally or in written form into the preferred languages of UCs.

Comments:

Signatories applaud HHS's efforts to meet the needs of migrant children with disabilities and limited English proficient children. Signatories also know that HHS already strives to have materials that are not just in languages other than English but that are culturally and linguistically sophisticated. Signatories strongly recommend that HHS memorialize that commitment in a new section (c). This section will indicate to care provider facilities that word-for-word translations or translations that do not account for different cultural norms will not be effective enough to meet the goal that HHS has laid out.

In (d), signatories recommend a change that comports with the suggested change to the definition of sexual abuse explained on page 7.

F. Testing the interpreting skills of new employees (§411.16)

Recommended final language:

(i) Care provider facilities must test the proficiency of a staff member's interpreter and/or translator abilities if the staff member will be expected to assist in meeting the requirements of § 411.15.

Comments:

ORR should ensure staff working with a UC population that has large numbers of non-English proficient children have basic competency in interpreting and/or translating if they will be expected or required to do so as part of their duties. Job applicants will have a wide understanding of linguistic terms like "proficient" or "fluent." For this reason, care provider facilities cannot simply take an applicant's word regarding her or his interpretation or translation skills. Signatories have discovered that some care provider facilities are relying on staff who do not have the appropriate level of skills. This has led to significant misunderstandings and compromised the ability of some youth to secure relief. Signatories are particularly concerned about staff having the skills to discuss all of the sensitive issues that come with educating youth, or receiving reports from youth, about sexual abuse. The above recommendation addresses that concern.

VI. Recommended changes to Subpart C

A. Strengthening the outside services and advocacy sections (§411.21)

Recommended final language:

(a) Care provider facilities must develop procedures to best utilize available community resources and services to provide valuable expertise and support in the areas of crisis intervention and counseling to most appropriately address victims' needs. Each care provider facility must establish, and document its efforts to establish, procedures to make available outside victim services following incidents of sexual abuse and sexual harassment; the care provider facility must attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available or if the UC prefers, the care provider facility may provide a licensed clinician on staff to provide crisis intervention and trauma services for the UC. The outside or internal victim advocate must provide advocacy for the youth throughout the facility's and agency's response to a report of abuse and provide emotional support, crisis intervention, information, and referrals.

(b) Where evidentiarily or medically appropriate, and only with the UC's consent, the care provider facility must arrange for an alleged victim UC to undergo a forensic medical examination as soon as possible ~~and~~ that is performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the facility must document its efforts to secure a SAFE or a SANE and have the youth examined by examination may be performed by a qualified medical practitioner.

Comments:

Signatories' recommendations in this section fall into two categories: documentation and scope of services. Both (a) and (b) will be stronger sections if they include documentation requirements. The included requirements are in line with those required by DOJ's juvenile PREA standards and are not burdensome to care provider facilities.

The additional recommended language in (a) makes clear that the role of the advocate is broader than that stated in the interim standards. In fact, interim section (c) already acknowledges this broader role in requiring that advocates be able to participate in investigations. The recommended language simply makes clear that, in addition to a support role, the advocate also plays a traditional advocacy role in making sure the youth receives the services and consideration required by the standards as a whole.

B. Clarifying the role of care provider networks and federal law enforcement agencies (§411.22)

(a) ORR, care provider networks, and care provider facilities must ensure that each allegation of sexual abuse and sexual harassment, including a third-party or anonymous allegation, is immediately referred to all appropriate investigating authorities, including Child Protective Services, the State or local licensing agency, and law enforcement. Care provider facilities also must immediately report each allegation of sexual abuse and sexual harassment to ORR according to ORR policies and procedures. Either the care provider network or care provider facility has an affirmative duty to keep abreast of the investigation(s) and cooperate with outside investigators. The care provider network or care provider facility must also request a full report of investigations undertaken by Child Protective Services, the State or local licensing agency, and law enforcement and forward any reports to ORR. Care provider networks and care provider facilities should make clear to local and state agencies that all such reports must comply with applicable State and local child abuse confidentiality laws and regulations.

(b) ORR also must make contact with Child Protective Services, the State or local licensing agency, and law enforcement. ORR must also remain informed of ongoing investigations by the internally tracking open investigations and keeping updated on developments in the investigation. and ORR must also fully cooperate in any investigation as necessary.

(c) Care provider networks or care provider facilities must maintain or attempt to enter into a written memorandum of understanding or other agreement specific to investigations of sexual abuse and sexual harassment with the law enforcement agency, designated State or local Child Protective Services, and/or the State or local licensing agencies responsible for conducting sexual abuse and sexual harassment investigations, as appropriate. Care provider facilities must maintain a copy of the agreement or documentation showing attempts to enter into an agreement.

(d) Care provider networks or care provider facilities must maintain documentation for at least ten years of all reports and referrals of allegations of sexual abuse and sexual harassment.

(e) ORR ~~must~~ will refer an allegation of sexual abuse to the Department of Justice or other investigating authority for further investigation where such reporting is in accordance with its policies and procedures and any memoranda of understanding and when local administrative or law enforcement investigation is deemed inadequate by the PSA Coordinator or ORR does not receive a state or local agency's full report of an investigation.

(f) All allegations of sexual abuse that occur at emergency care provider facilities operating on fully Federal properties must be reported to the Department of Justice in accordance with existing federal law, ORR policies and procedures, and any memoranda of understanding.

(g) ORR shall ensure that any alleged UC victim of criminal sexual abuse is connected with a legal service provider who can explain the UCs possible eligibility to apply for a U nonimmigrant visa or other potential immigration relief arising out of the abuse.

(h) The PSA Coordinator, or his or her designee, shall work directly with local or federal law enforcement to help a qualified youth secure a completed USCIS Form I-918, Supplement B when that youth reports being the victim of a crime and has been helpful in the criminal investigation.

Comments:

The recommended changes to this section are important and stem directly from the experiences of advocacy organizations trying to secure criminal investigations and/or child protection investigations of incidents of abuse. In some cases, law enforcement or child protection agencies refused to investigate allegations, claiming a lack of jurisdiction because the child was in federal custody or the child later moved to another jurisdiction. The recommended language gives care provider networks, care provider facilities, ORR, and state and local agencies clear guidance to prevent these issues in the future.

In (a) and (d), signatories note where “care provider networks” should also have responsibility for referring reports, securing written agreements, and keeping records. Signatories additionally recommend that either a care provider network or a care provider facility be required to request a full report of a state or local agency’s investigation and forward it to ORR.

In (b), (e), and (f), signatories lay out clearer guidance on ORR’s oversight responsibilities and when it must request federal criminal and administrative investigations. The interim standards do not require an adequate amount of ongoing oversight by ORR. The agency cannot rely solely on care provider networks and care provider facilities to make sure proper investigation are being conducted. Instead, it must take commonsense steps to engage with local and state investigative agencies and track the progress of those agencies.

Additionally, ORR must take a more active role when local or state investigations are non-existent or inadequate. Due to the monitoring provisions in (b), ORR will be in a better place to bring in federal investigative

resources if a local or state investigation is stalled or closed too soon. And, ORR must make sure that investigations that are conducted are done so fully. In signatories' experience, state CPS agencies often refuse to divulge their reports and only release the basic conclusion such as "substantiated" or "unsubstantiated." In these cases, ORR has no understanding of how an agency reached its conclusion and whether the investigation found any deficient policies or practices. Therefore, if a local or state investigative agency does not provide a full report of its investigation to a care provider network or care provider facility, ORR must seek assistance from federal investigators.

In addition, ORR must make sure that children who were abused or who participated in investigations of abuse know they will be protected for doing so. One tool that exists for encouraging participation in criminal investigations is the U nonimmigrant status (U visa). The recommendations for provision (g) provide additional guidance to help care providers understand who has responsibility for providing U visa information and what that information should contain. Traditionally, survivors of sexual abuse in ORR confinement facilities have received little, if any, information or assistance in applying for a U visa.

Similarly, the recommended language for new subsection (h) is meant to help prevent qualified local and federal personnel from declining to assist a detainee with a U visa application. The experiences of advocacy organizations demonstrate that youth who should be able to submit a U visa are prevented from doing so when appropriate law enforcement personnel decline to complete Supplement B.

Finally, the recommended language for new subsection (h) is meant to discourage qualified local and federal personnel from improperly declining to issue a U visa Supplement B certification. Advocacy organizations report that youth who may qualify for U visa protection are prevented from seeking a U visa when appropriate law enforcement personnel decline to complete Supplement B.

VII. Recommended changes to Subpart D

A. Changes to staff training (§411.31)

Recommended final language:

(a2) The right of UCs and staff to be free from sexual abuse and sexual harassment and from retaliation for reporting sexual abuse and sexual harassment, regardless of where it occurred.

(a7) How to communicate effectively and professionally with UCs and treat UCs in a non-discriminatory manner, including communication with and treatment of UCs who are lesbian, gay, bisexual, transgender, questioning, or intersex;

(a11) Sensitivity and awareness regarding past trauma that may have been experienced by UCs, possible behaviors of youth with trauma and abuse histories, and appropriate ways of responding to those behaviors.

(a14) Information on how to distinguish between consensual sexual contact and sexual abuse between youth.

(b) All current care provider facility staff and employees who may have contact with UCs must be trained within six months of the effective date of these standards, and care provider facilities must provide refresher information, as appropriate, but no less than once every other calendar year.

(c) Employees hired after January 1, 2016 must complete this training prior to having unsupervised contact with children.

(d) Care provider facilities must document that staff and employees who may have contact with UCs have completed and understood the training.

Comments:

Signatories applaud the scope of the employee training outlined in the interim rule. With this breadth of information, care provider facility employees will be much better prepared to carry out the interim standards in a competent and sensitive manner. Signatories recommend three additional topics: (1) make sure that staff understand how to behave in a non-discriminatory manner; (2) ensure that training regarding potential past trauma experienced by children addresses behavioral manifestations of trauma and how to appropriately respond; and, (3) help all employees understand that the facility has a responsibility to distinguish between consensual and abusive sexual contact between youth. Also, the addition of “regardless of where it occurred” in (a2) clarifies for staff that retaliation is never permitted.

The other recommended changes have to do with making sure this comprehensive training is effective. Signatories are glad that the interim standards include a requirement for refresher trainings. Given the scope of information and the complexity of some of these topics, ongoing exposure to best practices is essential. Adding a time requirement to (b) makes good sense and once every two years would not be overly burdensome for care provider facilities.

Signatories also appreciate that current staff are required to participate in the training within six months of the release of the IFR. In (c), signatories recommend a requirement that new employees attend the training prior to having unsupervised contact with children. This requirement would mean that all staff working directly with children would be provided with guidance and information on how to keep them safe.

Finally, the additional requirement in (d) would require that all staff who attend the training be tested on their understanding of key information from it.

B. Strengthening UC education requirements (§411.33)

Recommended final language:

(a) At intake and periodically thereafter, UCs must be notified and informed that of the care provider facility’s has a zero tolerance policies for policy against all forms of sexual abuse, and sexual harassment, and retaliation for reporting abuse, and the available way to report abuse in an age and culturally appropriate fashion and in accordance with §411.15. Within 7 days of intake and periodically thereafter, UCs must be provided with a safety orientation that includes, at a minimum:

(1) An explanation of the UC's right to be free from sexual abuse and sexual harassment as well as the UC's right to be free from retaliation for reporting such incidents, regardless of where it occurred;

(4) An orientation on using the phones with the preprogrammed numbers for reporting abuse per § 411.51(a);

(6) An explanation that no staff member, contractor, or volunteer can help the UC’s immigration case or prospects for timely family reunification in exchange for sexual contact or hurt the UC’s immigration case or impede family reunification if the UC refuses to allow sexual contact or other sexual abuse.

(e) Care provider facilities must make available and distribute for the UC’s possession and at-will review a pamphlet in accordance with §411.15 that contains, at a minimum, the following:

Comments:

Signatories appreciate that HHS has included an education requirement for youth. However, the interim standard may not be as effective a model as is needed. Signatories strongly recommend that youth get basic information upon intake so that they are aware of the core policy and a minimum number of their rights. Then, once they have had time to acclimate to the care provider facility, but no later than 15 days after arrival, the youth will participate in a comprehensive education class that covers at least the topics identified above.

Among those topics, signatories believe that the youth should be explicitly told that they can report and receive services for incidents of abuse that occurred outside of ORR custody. They should also be shown how to use the pre-programmed reporting numbers on the facility's phone(s). And, time should be taken to explain to the youth that no staff member can help or hurt the youth's immigration case or prospects for reunification regardless of what the staff member promises or threatens. One reason child migrants are so vulnerable to coercion, particularly during an influx, is that they have so much to lose by being removed from the United States. Savvy predators use that dynamic to coerce these kids into situations in which the children will be abused.

Finally, in signatories' experience, children in care provider facilities often do not have regular access to handouts. Instead most care provider facilities provide the rights and policies materials to the child, have the child sign a document saying they received them, and then staff typically put the documents into the child's case file. The recommended change to (e) would fix this problem when it comes to material about preventing and reporting sexual abuse.

C. Ensuring quality training for medical and mental health care staff (§411.34)

Recommended final language:

(d) Within 60 days of the publication of this rule, ORR shall identify model training for medical and mental health care staff and share that training with all care provider networks or care provider facilities.

Comment:

Depending on the location of a facility there may be a limited number of available medical and mental health practitioners who are willing or able to work with a care provider network or care provider facility. Due to the specialized nature of training for this population, ORR can ensure higher quality, more consistent trainings by identifying or creating a model training that can be taught by on-site staff.

D. Improving assessment of risk for sexual victimization (§411.41)

Recommended final language:

(2) Any gender nonconforming appearance or manner or ~~Self-identification as lesbian, gay, bisexual, transgender, questioning, or intersex; and whether the resident may therefore be vulnerable to sexual abuse or sexual harassment;~~

(c) This information must be ascertained through conversations with the UC during the intake process and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, care provider facility behavioral records, and other relevant documentation from the UC's files. Only clinicians or other mental health or medical staff specifically trained in the assessment tool are permitted to talk with UCs to gather information about their sexual orientation or gender identity, prior sexual victimization, history of engaging in sexual abuse, mental health status, and mental disabilities for the purposes of the

assessment required under paragraph (a) of this section. Care provider facilities must affirmatively provide UCs an opportunity to discuss any safety concerns or sensitive issues privately.

(d) The training required by 411.41(c) must include advice on creating a welcoming environment, overcoming cultural barriers that some UCs may face in disclosing this type of information, and use of active listening skills.

Comments:

Assessing children for potential vulnerabilities is one of the most important advancements in the interim standards. Signatories recommend a few small changes and additional training for staff to make the good interim assessment guidelines even stronger. The first recommendation is a simplification of interim language about LGBTQI children that seems overly cumbersome.

The two recommendations outlining which staff will do the assessments and what training they would receive on the tool come from signatories' shared field experience observing assessments having a negative effect on detainees. Part of the benefit of doing these assessments should be to increase the sense of safety and well-being of the children in ORR care. Clinicians and other mental health or medical staff, who already do in-depth assessments of children in ORR care, are best situated to engender that sense of safety and well-being.

However, without proper training, the assessment, even when performed by a skilled health care professional, can feel like an invasion of privacy and, in some cases, the beginning of sexual abuse —particularly for youth with a prior history of sexual abuse. Providing these particular staff members with guidance and guidelines for doing effective assessment interviews will increase the quality of information obtained, the morale of staff, and the overall sense of wellbeing among the children.

Finally, given the sensitive nature of the questions asked during an assessment interview, care provider networks or care provider facilities should be required to proactively offer that the interview take place in a private setting. One way of doing this consistently is to have the interviews conducted by medical or mental health care staff who see youth in private settings all the time.

E. Creating safer housing through better use of assessment information (§411.42)

Recommended final language:

(c) When making assessment and housing assignments for a transgender or intersex UCs, including whether the UC should be assigned to a male or female care provider facility or housing area within a co-ed facility, the care provider facility must consider on a case-by-case basis whether a placement would best ensure the UC's health and safety. Placement must be consistent with a the-UC's gender self-identification unless the UC objects to such placement or the facility documents a need for a different placement based on an assessment of the effects of a housing assignment on the UC's health and safety. If the care provider facility determines that the youth will not be placed in housing consistent with the youth's gender identity, it must consult a medical or mental health professional as soon as practicable on in making this assessment. The care provider facility must also not base housing assignment decisions of transgender or intersex UCs solely on the identity documents or physical anatomy of the UC; a UC's self-identification of their gender and self-assessment of safety needs must always be taken into consideration as well. An identity document may include but is not limited to official U.S. and foreign government documentation, birth certificates, and other official documentation stating the UC's sex. The care provider facility's housing assignment of a transgender or intersex UCs must be consistent with the safety and security considerations of the care provider facility, ~~State and local licensing standards,~~ and housing and programming assignments of each transgender or intersex UCs must be regularly reassessed to review any threats to safety experienced by the UC.

(d) Lesbian, gay, bisexual, transgender, questioning, or intersex UCs shall not be involuntarily placed in particular housing, bed, or other assignments, or limited in any privilege or opportunity solely on the basis of such identification or status, nor shall agencies consider lesbian, gay, bisexual, transgender, questioning, or intersex identification or status as an indicator of likelihood of being sexually abusive.

(e) Transgender and intersex UCs must be given the opportunity to shower separately from other UCs and any other youth.

(e) Care provider facilities must not, for the purpose of preventing sexual abuse, restrict a UC's manner of dress or grooming on the basis of gender.

(f) Care provider networks or care provider facilities are only allowed to use one-on-one supervision of particularly vulnerable youth in rare circumstances. Any such supervision should be extremely limited in duration and cannot restrict participation in regularly required services, including but not limited to daily large-muscle exercise, required educational programming, and social and medical services.

(g) Care provider networks or care provider facilities are not allowed to use isolation in order to protect a particularly vulnerable youth except in extreme circumstances and then not for a period of time beyond four hours during times when youth are generally awake. When isolation is used in order to protect a particularly vulnerable UC, the care provider facility must note the use of isolation in a significant incident report and note how long the youth was isolated. A care provider network's Senior PSA Compliance Manager and a care provider facility's PSA Compliance Manager should be copied on any significant incident report executed under this subsection.

Comments:

Gathering information about a child's particular vulnerability is only useful if it is effectively used to keep the child safe. The interim standards identify some of the key factors in providing this safety. However, signatories are concerned about a number of gaps, particularly in relation to LGBTQI youth.

Section (c) should be more protective of transgender and intersex youth. First, it should make clear that the requirement for individualized decision making includes assessing whether a youth is safest when housed based on the youth's gender identity or sex identified at birth. Care provider facilities should expect to house youth based on their gender identity except when the youth feels safer in other housing or the facility can identify a legitimate and specific safety concern with doing so. Additionally, the requirements for safe placement for transgender and intersex youth should eliminate the caveat regarding State and local licensing standards, which the DOJ rule does not include. Signatories are not aware of any state or local licensing standard that clearly prohibits placing youth consistent with their gender identity. In addition, refusing to house youth consistently with their gender identity would likely constitute unlawful discrimination under federal and state nondiscrimination laws and constitutional standards.

Youth should also not be forced to be housed in LGBTQI specific housing. Such housing may be used if it is completely voluntary on the part of the child. The PSA Coordinator should evaluate whether the placement is truly voluntary. The final standards should also track the DOJ juvenile PREA standard in requiring that transgender and intersex children be given the opportunity to shower separately from other youth. Finally, no care provider facility should restrict a child's gender expression – even if the facility believes that doing so is safer for the youth. A facility must commit itself to protecting all children regardless of any bias other youth or staff have toward anyone with a non-traditional gender expression.

Additionally, the final standards should include specific prohibitions on the overuse of one-on-one supervision and on nearly any use of isolation for a child's protection. It is common for youth facility staff in particular to believe that separation of any kind is in a child's best interest if that youth is particularly vulnerable to abuse. However, one-on-one supervision can be stigmatizing and can limit a youth's access to programs and productive socialization.

Of course, isolation can be even more damaging. In the signatories' experience, children in ORR custody, whether in shelter or secure placements, have reported being isolated in a room during the daytime hours without contact with other children for several days at a time. Even short periods of isolation can have particularly negative consequences for youth, including raising the risk of suicide and exacerbating emotional and mental health needs. Isolating a child who may have been a recent victim of sexual abuse adds these negative effects to an already traumatic experience. Isolating children who may be at risk of victimization has the effect of singling those youth out for punishment based solely on safety concerns. When isolation is used, ORR must require that care provider networks and facilities document the use and the duration in a significant incident report that is copied to the relevant PSA Compliance Manager(s).

For these reasons, signatories strongly recommend that HHS severally limit any use of isolation as a means of protecting particularly vulnerable children. Also, a care provider facility must document its use of isolation for this purpose and share that documentation with PSA Compliance Managers, as appropriate.

VIII. Recommended changes to Subpart F

A. Increasing privacy related to reporting (§411.51)

Recommended final language:

(c) A care provider facility must ensure that UCs have as much privacy as possible when reporting sexual abuse, including the ability to make reports over the phone outside of earshot of any staff, contractor, or volunteer.

Comments:

Signatories understand that, despite existing policies requiring private communications, children in ORR custody are often in the presence of care provider facility staff when speaking to attorneys over the phone. While the interim standards already imply that youth should be able to report privately, signatories believe that an explicit requirement should be added. Obviously, youth will be more likely to provide a full report of sexual abuse or attempted abuse when they can do so in private, particularly when the perpetrator was a member of staff. Additionally, the steps that care provider facilities will have to take to create privacy for reporting sexual abuse will lead to greater privacy when youth are speaking to attorneys or other entities where privacy is required.

To the greatest extent possible, a youth should be able to request to use a phone without that request signaling to staff that the youth is reporting abuse.

B. Improving the grievance process (§411.52)

Recommended final language:

(a) The care provider facility must implement written policies and procedures for identifying and handling time-sensitive grievances that involve an immediate threat to UC health, safety, or welfare related to sexual abuse and sexual harassment. All such grievances must be reported to ORR according to ORR policies and procedures. Additionally:

(1) A UC who alleges sexual abuse must be able to submit a grievance without submitting it to a staff member who is the subject of the complaint; and,

(2) Such grievance cannot be referred to a staff member who is the subject of the complaint.

(e) A care provider facility may not put any time limit on when a UC may file a grievance having to do with sexual abuse or harassment.

Comments:

The recommended additions to (a) and (e) are in line with requirements from the DOJ juvenile standards. Signatories believe that both of these recommendations should be adopted to make clear that using a grievance form -- instead of making an oral allegation -- to report sexual abuse or harassment does not diminish a child's protections. A care provider network's or care provider facility's existing grievance cannot unintentionally limit when or to whom a youth may make a report of sexual abuse or harassment.

C. UC access to outside confidential support services (§411.53(c))

Comments:

Signatories have no substantive changes to the interim standards on outside confidential support services. However, signatories do want to note that, per shared field observations, many children in care provider facilities do not have the freedom or the access to send mail. According to the *Flores* Settlement Agreement's minimum standards of care, children must have access to "receive and send uncensored mail."²² However, this right has yet to be fully protected or implemented by ORR. ORR will need to commit sufficient implementation resources to make sure this provision creates a realistic and meaningful way for children to communicate with support services.

D. Third-party reporting (§411.54)

Recommended final language:

ORR must establish a method to receive third-party reports of sexual abuse and sexual harassment and must make available to the public and all ORR grantees and sponsors information on how to report sexual abuse and sexual harassment on behalf of a UC. Such methods shall include, at minimum, telephonic and electronic methods of reporting that accommodate multiple languages.

Comments:

Currently ORR does not have a policy in place for ensuring sponsors and other service providers who are not facility care providers can report incidents of abuse. To the greatest extent possible, ORR should work with providers who conduct sponsor care trainings to incorporate this information into their training materials. Two examples of potential partners are EOIR's Legal Orientation Program for Custodians (LOPC) or LIRS's Sponsor Orientation Programs at finger-printing sites. Additionally, ORR should include this information in every sponsor's reunification packet. Because sponsors may be non-English language speakers or be of limited literacy,

²² The Flores Settlement Agreement, Case No. CV 85-4544-RJK(Px) at Exhibit 1, para. 12; Available at: <http://web.centerforhumanrights.net:8080/centerforhumanrights/children/Document.2004-06-18.8124043749.5>

ORR should ensure there is a telephonic means of reporting and that a sponsor can report such incidents in a language of their choosing.

E. UC access to attorneys or other legal representatives and families (§411.55)

Recommended final language:

(a) Care provider facilities must provide UCs confidential access to their attorney or other legal representative in accordance with the care provider's attorney-client visitation rules. In the event the UC does not have an attorney, ORR will ensure the child receives a follow-up know your rights presentation by the contracted legal service provider. The care provider's visitation rules must include provisions for immediate access in the case of an emergency or exigent circumstance. The care provider's attorney-client visitation rules must be approved by ORR to ensure the rules are reasonable and appropriate and include provisions for emergencies and exigent circumstances.

(c) Each UC who has made a report in accordance with §411.51, shall be provided a child advocate.

Comment:

That vast majority of children in ORR custody do not have an attorney or legal representative. Instead these children have access to legal representatives through the contracted legal service provider. Children who have made reports of sexual abuse or harassment will need additional confidential support and legal services. ORR should ensure an immigration legal service provider is notified to provide a rights presentation and to reassess whether they can represent a child. Also, since children do not have a parent or legal guardian available to advocate for their best interests, children should be appointed a child advocate consistent with the Trafficking Victims Protection Reauthorization Act (TVPRA) of 2008, section 235(c)(6). Child advocates have proven to be critical in situations where a child has made a decision that is contrary to their safety and best interests.

IX. Recommended changes to Subpart G

A. Improving reporting requirements (§411.61).

Recommending final language:

(a) All care provider facility staff, volunteers, and contractors must immediately report to ORR according to ORR policies and procedures, ~~and to State or local agencies in accordance with mandatory reporting laws, to any other state or local licensing agencies, and, where applicable, to the care provider network's Senior PSA Compliance Manager and appropriate federal agencies:~~ any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment ~~that occurred while a UC was in ORR care;~~ retaliation against UCs or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. ORR must review and approve the care provider facility's policies and procedures and ensure that the care provider facility specifies appropriate reporting procedures.

~~(d) Care provider facility staff must report any sexual abuse and sexual harassment allegations to the designated State or local services agency under applicable mandatory reporting laws in addition to law enforcement and the State and local licensing agency.~~

Comments:

As drafted, section (a) and (d) seem to be largely repetitive. For the purposes of creating a set of standards that are as effective and easy to read as possible, signatories recommend that HHS adopt the above suggested change.

Additionally, the above recommendations clarify that a care provider network's or care provider facility's responsibilities for reporting are not limited by whether the abuse took place in ORR care. As signatories have made clear above, ORR care providers must report abuse allegations in a manner consistent with existing child protection laws and those laws are not limited by when or where the abuse took place.

B. Forwarding DHS reports of abuse care provider facilities and care provider networks (§411.63)

Recommended final language:

(d) Upon receiving an allegation that a UC was sexually abused or sexually harassed while in DHS custody, the care provider facility whose staff received the allegation must immediately notify ORR, but no later than 24 hours after receiving an allegation. ORR will then report the allegation to DHS in accordance with DHS policies and procedures. Upon receiving a report from DHS or another agency that a UC was abused in an ORR facility, ORR shall immediately notify the relevant care provider network or care provider facility.

Comments:

As drafted, the interim standard envisions circumstances in which the care provider facility will receive reports of abuse at another facility. HHS should also have policies in place requiring ORR to promptly inform the relevant care provider network or care provider facility of any reports of abuse it receives directly from DHS (in accordance with § 6 CFR 115.63 or § 6 CFR 115.163) or any other agency.

C. Coordinated response (§411.65)

Recommended final language:

(e) Any child who has been sexually abused, regardless of where the abuse occurred, must be offered post-release social services when released from ORR custody to a sponsor.

Comment:

Currently the average time a child is in ORR care ranges from 7 to 30 days. As such, children have a very limited amount of time to receive any services while in ORR custody. Additionally, unaccompanied children, by their legal status, are made all the more vulnerable upon release because they have limited access to medical and mental health services. Post-release social services have been instrumental in connecting released children and their sponsors to services that can help them locate community-based services. Evidence-based, independent research conducted at the request by LIRS has found that post-release social services are instrumental in ensuring a child's access to basic services and the child's ability to address the past trauma they experienced, which often only manifests itself after a period of time following reunification with family.²³ This best practice is also consistent with the Trafficking Victims Protection Reauthorization Act (TVPRA) of 2008, section 235(c)(B), which requires that children receive home studies and post-release social services upon release when: "a child who has been a victim of physical or sexual abuse under circumstances that indicate that the child's health or welfare has been significantly harmed or threatened."

²³ *Post-release: Linking Unaccompanied Immigrant Children to Family and Community*, Benjamin J. Roth, PhD & Breanne L. Grace, PhD, University of South Carolina, School of Social Work, *release forthcoming*

D. Making the protection against retaliation section easier to read (§411.67).

(a) Care provider facility staff, contractors, volunteers, and UCs must not retaliate against any person who reports, complains about, or participates in an investigation of alleged sexual abuse or sexual harassment.

(b) For the remainder of the UC's stay in ORR custody following a report of sexual abuse or sexual harassment, ORR and the care provider facility must monitor to see if there are facts that may suggest possible retaliation by UCs or care provider facility staff and must promptly remedy any such retaliation. ORR and the care provider facility must also monitor to see if there are facts that may suggest possible retaliation by UCs or care provider facility staff against any staff member, contractor, or volunteer and must promptly remedy any such retaliation. Items ORR and the care provider facility should monitor include but are not limited to any UC disciplinary reports, housing or program changes, negative performance reviews, or reassignments of staff.

(c) Care provider facilities must discuss any changes with the appropriate UC or staff member as part of their efforts to determine if retaliation is taking place and, when confirmed, immediately takes steps to protect the UC or staff member.

Comments:

Signatories offer no substantive changes to this section. Signatories do believe, however, that the standard will be easier to read if it is separated into three sections as shown above.

X. Recommended changes to Subpart H

Coordinating review of reports from same care provider network (§411.71)

Recommending final language:

(b5) The PSA Coordinator, or designee, will work with a care provider network's Senior PSA Compliance Manager to review reports of abuse across a specific network at least twice a year. The review will look for patterns of abuse or systemic problems that are leading to or contributing to abuse within the network.

Comment:

This change is in line with signatories' recommendation that HHS take into account the role care provider networks will play in recognizing and addressing dynamics that may facilitate sexual abuse network-wide. By making sure that ORR discusses a network's response to any reports of abuse with the Senior PSA Compliance Manager twice a year, HHS will be creating a regular system for assessment and improvement across multiple, connected facilities.

XI. Recommended changes to Subpart J

A. Religious or moral objections²⁴

Comments:

²⁴ LIRS refrains from joining this section of the comment. However, LIRS does believe that ORR should be committed to providing services to children in a timely and respectful way.

In the Section-by-Section discussion of Subpart J of the IFR, HHS notes that some existing or potential grantees or contractors may have religious or moral objections to providing with, or referring children to, certain services and proposes three options for working around those objections. Signatories believe that HHS should delete this language from the final rule.

ORR has a legal obligation²⁵ to provide UCs with timely, unimpeded access to all legally permissible services and it should be done in a manner that is respectful and non-stigmatizing. The specific services outlined in Subsection J, including medical and mental health care and access to emergency health services, are a core part of an effective response to a report of sexual abuse and are absolutely crucial to the population ORR serves.

In addition to striking the language in question, HHS should include safeguards to ensure that children get the services they are entitled to even if they are in the care of providers with existing contracts or grants that allow for these kinds of opt-outs. Safeguards should include a system to ensure that ORR is notified in advance of any objections providers have to providing children with, or referring to, services covered by the final rule. Once notified, the final rule must require ORR to put in place a plan to guarantee that all children served by those providers have access to the full range of legally permissible services and to closely monitor the arrangement to ensure that the plan works in practice.

If HHS is unwilling to strike the language as a whole, it should include these robust safeguards and remove the third of the three options described in the IFR. All three options would be harmful to children, even with these safeguards in place. The third option, which requires a grantee to notify ORR *only* when a child in its care requires services to which it objects, would create particularly serious barriers to care and result in stigmatization and undue delay. Signatories do not believe these barriers could be meaningfully addressed by safeguards. When emergency contraception is one of the services that would be affected, delay of only a day can be the difference between whether the treatment is effective. And, given the stigmatization that many survivors of abuse already feel, HHS should be particularly sensitive to adding to a survivor's trauma by making a child go through a disrespectful process to access care to which she or he has a legal right. This option should be removed and replaced by a requirement for advance notification described above.

B. Clarifying the sections related to ongoing medical and mental health services (§411.93)

Recommended final language:

(a) Care provider facilities must offer ongoing medical and mental health evaluations and treatment to all UCs who are victimized by sexual abuse or sexual harassment ~~while in ORR care and custody.~~

(d) Care provider facilities must ensure that UCs at risk of pregnancy after an incident of abuse ~~female UC victims of sexual abuse by a male abuser while in ORR care and custody~~ are offered pregnancy tests, as necessary. If pregnancy results from an instance of sexual abuse, care provider facility must ensure that the victim receives timely and comprehensive information about all lawful pregnancy-related medical services and timely access to all lawful pregnancy-related medical services. In order for UCs to make informed decisions regarding medical services, including, as appropriate, medical services provided under §411.92, care provider facilities should engage the UC in discussions with family members or attorneys of record in accordance with §411.55 to the extent practicable and follow appropriate State laws regarding the age of consent for medical procedures. ORR will ensure the UC is provided counsel, as needed, to comply with state laws regarding consent or notification requirements and will ensure that the child has timely access to state courts.

²⁵ *Flores v. Reno*, No. CV 85-4544- RJK(Px) (C.D. Cal. Jan. 17, 1997).

(e) Care provider facilities must ensure that UC victims of sexual abuse ~~that occurred while in ORR care and custody~~ are offered tests for sexually transmitted infections as medically appropriate.

Comments:

Signatories' above recommendations address limitations on services, who may become pregnant after an assault, and parental consent laws. The recommendations to remove limitations on who qualifies for services are in line with, and explained by, signatories' related recommendations throughout this comment.

Signatories also recommend that HHS slightly modify its interim language pertaining to youth who may get pregnant after a sexual assault. Signatories understand HHS's intent in using gendered language but believe that the same result can be achieved with language that does not unintentionally exclude any group of survivors or perpetrators. For instance, the current language would unintentionally exclude a transgender boy who could become pregnant after being sexually abused by a male staff member.

Signatories further recommend that ORR add language in (d) to respond to parental consent laws. In many states, the laws require parental consent in order to access certain medical services. When it comes to children in ORR care, states may require that ORR provide consent or that the child secures judicial approval because the youth does not have parents or legal guardians available to them. If state law allows, ORR should provide consent. If state law does not allow ORR to provide consent, then children in ORR care should have access to an attorney qualified to represent the youth before a state court regarding access to these services. ORR should provide the needed legal services and access to the courts whenever necessary.

C. Creation of §411.94 – Privacy for Medical and Mental Health Assessments and Care

(f) Care provider facilities, care provider networks, and ORR must ensure the confidentiality of all services provided per Subsection J, including medical and mental health assessments and services. Documents related to assessments and services may not be released without the child's consent or the consent of a legal guardian in the case of child who is under the age of understanding. A care provider facility must document consent.

Comments:

ORR must implement policies and procedures that protect children's privacy rights consistent with the *Flores* Settlement Agreement.²⁶ Signatories have documented instances in which ORR has violated a child's right of privacy and shared sensitive medical or mental health information with DHS without appropriate consent.²⁷

Such protections are also good policy. Children are more likely to seek services if they know that their confidentiality will be respected. The recommended language for §411.94 accomplishes both of these goals.

XII. Recommended changes to Subpart K

A. Strengthening section on incident reviews (§411.101)

(a) When an incident of sexual abuse or harassment occurred, or was alleged to have occurred, within a care provider facility, care provider facilities, in conjunction with their ORR Program Officer, must conduct sexual abuse or sexual harassment incident reviews at the conclusion of every investigation of sexual abuse or sexual

²⁶ The *Flores* Settlement Agreement, Case No. CV 85-4544-RJK(Px) at Exhibit 1, paragraph 12.

²⁷ See e.g., *Halfway Home: Unaccompanied Children in Immigration Custody*, Women's Refugee Commission, Feb. 2009, at pages 20-21, 39.

harassment and, where the allegation was either substantiated or unable to be substantiated but not determined to be unfounded, prepare a written report recommending whether the incident review and/or investigation indicates that a change in policy or practice could better prevent, detect, or respond to sexual abuse and sexual harassment. In preparing its report, the review team shall:

- (1) Ordinarily conduct the review within 30 days of the conclusion of the investigation.
- (2) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse;
- (3) Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, questioning, or intersex identification, status, or perceived status; or, gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility;
- (3) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;
- (4) Assess the adequacy of staffing levels in that area during different shifts; and,
- (5) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff.

(b) The care provider facility and, when applicable, the care provider network must implement the recommendations for improvement or must document its reason for not doing so in a written response. Both the report and response must be forwarded to ORR's PSA Coordinator. Care provider facilities or, when applicable, care provider networks also must collect accurate, uniform data for every reported incident of sexual abuse and sexual harassment using a standardized instrument and set of definitions.

Comments:

As drafted, the interim guidance on incident reviews is not as strong as it should be. Signatories suggest the above, borrowed heavily from the DOJ juvenile PREA standards, as a more effective infrastructure for reviews. By adding a suggested timeline for the review, requiring that certain demographic characteristics be considered, mandating on-site examination, and requiring consideration of how an increased use of technology may better protect children in ORR care, signatories anticipate that HHS will create more reliable and helpful incident reviews.

Additionally, signatories believe that the ORR Program Officer, who has a unique monitoring role, should be required to participate in the incident reviews and should be in communication with the PSA Coordinator regarding incidents of abuse.

B. Adding category to demographic information (§411.102)

Recommended final language:

(d2) The demographic background of the victim and perpetrator (including citizenship, nationality, age, actual or perceived sexual orientation and gender identity, and sex) that excludes specific identifying information;

Comments:

Signatories agree that standardized data collection should include specific demographic information. Signatories suggest adding the above characteristics to the list of information that is to be collected.

XIII. Conclusion

Signatories offer the above comment with the intent to improve HHS's interim standards. Signatories applaud the Department's thorough response to the crisis of abuse of children in its care. The interim standards provide a good starting place and the above comments are intended to correct a number of deficiencies in the overall structure. If left unaddressed, these deficiencies would compromise the impact of the standards and the efforts by ACF, ORR, care provider networks, and care provider facilities to respond to reports of abuse. Signatories look forward to final standards that are able to accomplish the Department's stated regulatory goal and the underlying statutory goal of PREA – ending sexual abuse of children in ORR care provider facilities.

Sincerely,

American Civil Liberties Union
Center for American Progress
Detention Watch Network
Just Detention International
Kids in Need of Defense (KIND)
Lutheran Immigration and Refugee Service
The National Center for Transgender Equality
The Women's Refugee Commission

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