3900 Residential Regulations Public Comment

Purpose

The Office of the Youth Ombudsperson (OYO) appreciates the opportunity to review and provide feedback on the proposed Chapter 3900 residential regulations during the public comment period. This memorandum identifies additional areas for consideration based on recurring concerns the OYO has identified through youth interviews, complaints and grievances, facility visits, and systemic oversight activities. These recommendations are intended to strengthen accountability, improve youth outcomes, and ensure consistent implementation of protections across residential settings throughout the Commonwealth.

The OYO continues to observe a consistent pattern across residential care: responsibilities affecting youth safety, well-being, education, healthcare, permanency, and family engagement are often unclear, lack defined timeframes, and are not consistently measured. As a result, implementation varies among providers, counties, and regions, with youth experiences shaped by local practice, staff capacity, and provider interpretation rather than uniform statewide standards.

Counties, probation departments, licensors, and oversight entities frequently identify concerning practices but cannot require corrective action because the regulations do not clearly establish obligations, assign responsibility, or define measurable expectations. Consequently, providers may remain technically compliant while youth continue to experience educational disruption, communication barriers, inadequate language access, inconsistent discharge planning, unmet basic needs, and excessive use of restrictive procedures.

Chapter 3900 provides an important opportunity to address these gaps by establishing clear responsibilities, measurable standards, and enforceable requirements that promote consistency across all licensed residential settings.

Education Stability, Educational Access, and Meaningful Instruction

Education is a critical determinant of long-term youth outcomes, yet educational disruption remains one of the most common concerns identified through OYO oversight.

Placement in a group home often disrupts youth's education. Youth frequently report missing days or weeks of school because of transportation barriers and enrollment delays, as well as interruptions in special education services and overall educational progress. The OYO has also observed situations in which responsibility for educational continuity is assumed to belong to another system partner, resulting in delays in enrollment, incomplete record transfers, missed educational opportunities, and failure to initiate a Best Interest Determination (BID) meeting

when a youth is placed outside of their school catchment area. Although federal and state policy prioritizes educational stability, implementation remains inconsistent across jurisdictions. Without clearly assigned responsibilities and enforceable timelines, youth may lose access to critical educational protections during placement.

The OYO is particularly concerned about educational disruption in juvenile justice settings when youth are removed from classroom instruction due to behavioral incidents or restrictive procedures. Although facilities may provide alternative educational activities, youth frequently report receiving only worksheets or independent assignments with limited teacher interaction. These removals often lack adequate documentation, accountability, and administrative review.

The absence of consistent statewide standards has resulted in prolonged educational disruption and inconsistent instructional practices. Educational access should be measured by meaningful instruction rather than the receipt of assignments alone.

The OYO recommends requiring all facilities to:

- Ensure all school-age youth are enrolled in school within a defined timeframe following placement (e.g., 14 business days).
- Monitor and report daily school attendance.
- Submit a Best Interest Determination (BID) referral within one business day of placement, participate in the BID process, coordinate the youth's participation, and complete all necessary follow-up to support timely school enrollment.
- Upon admission, collaborate with the appropriate educational stability personnel, education liaison, school district representative, parent, educational decision-maker (if different from the parent), case manager, and other relevant stakeholders when placement may affect school enrollment or attendance.
- Ensure youth are able to participate in IEP and all other educational meetings.
- Document efforts to maintain youth in their school-of-origin whenever possible.
- Track educational outcomes, including attendance, credits earned and transferred, graduation progress, suspensions, expulsions, school changes, and other educational disruptions occurring during placement.

The OYO recommends requiring facilities with on-grounds schools to:

- Implement and monitor all special education services and accommodations.
- Document the reason, duration, and educational services provided whenever a youth is removed from classroom instruction.
- Prohibit exclusion from educational programming as a disciplinary measure except when necessary to address an immediate safety concern and require documentation of efforts to minimize missed instructional time.

- Provide meaningful educational instruction during any classroom removal, including teacher interaction, instructional support, academic feedback, and engagement with educators. DHS should clarify that worksheets, packets, and independent assignments alone do not satisfy this requirement.
- Conduct a review with the school administrator whenever a youth is removed from classroom instruction for more than 10 school days, consistent with Pennsylvania suspension requirements.

Language Access and Meaningful Participation

Youth and families with limited English proficiency (LEP) often face barriers to understanding and participating in decisions affecting their care. Through its oversight, the OYO has encountered youth who were unable to understand their rights, request assistance, or effectively communicate with staff due to language barriers. The OYO has come across several facilities without formal language access policies, interpretation and translation service contracts, and consistent access to qualified bilingual staff. Instead, these facilities rely on informal communication (i.e. hand gestures) or automated translation tools, such as Google Translate, which can be inaccurate and fail to convey important nuances. Youth have reported feeling pressured to communicate in English rather than their preferred language to comply with facility expectations and fit in with their peers.

Youth may conceal their limited English proficiency out of fear, embarrassment, or a desire to avoid standing out. When language access depends on available resources or staff capacity rather than enforceable standards, meaningful participation becomes inconsistent and inequitable. Despite its importance to youth engagement and due process, language access is largely absent from the proposed regulations.

The OYO recommends requiring facilities to:

- Adopt and implement a written language access policy and procedures for youth and families with limited English proficiency.
- Inform youth and families, in their preferred language, of their right to receive free interpretation and translation services.
- Maintain a language access contract for qualified interpretation and translation services.
- Provide qualified interpretation services during meetings, case planning, disciplinary proceedings, grievance processes, healthcare encounters, family meetings, and other communications affecting a youth's rights, services, or care.
- Translate critical documents, including rights notifications, grievance procedures, disciplinary notices, discharge plans, and any document a youth is required to sign or that is used to communicate important information to the youth, into the youth's preferred language.

- Document each youth's preferred language, identified language needs, and language access services provided in the case record.
- Provide initial and annual language access training for all facility staff.
- Prohibit reliance on automated translation tools, such as Google Translate, as a substitute for qualified interpretation and translation services.
- Prohibit the use of informal interpreters, including family members and minor children.
- Provide language access services at no cost whenever a youth or family member requests assistance, demonstrates limited English proficiency, is identified by another individual as needing language assistance, or otherwise has difficulty communicating effectively in English.

Civil Rights, Nondiscrimination, and Cultural Inclusion

Through its oversight, the OYO has consistently heard from youth that respect, acceptance, and the ability to express their identities are essential to their sense of safety and belonging in residential placement. At the same time, the OYO continues to receive concerns related to cultural expression, religious practice, gender identity, sexual orientation, and racial identity. Some youth reported being prohibited from wearing religious attire, participating in faith practices, or openly discussing aspects of their identity. Others reported being assigned to housing units that did not affirm their gender identity.

Although many facilities strive to support youth appropriately, the proposed regulations provide limited guidance regarding these protections. Clear, statewide standards would promote consistent practice and reduce reliance on individual facility interpretation. The regulations should explicitly prohibit discrimination and ensure equitable treatment and access to services for all youth.

The OYO recommends requiring facilities to:

- Adopt and enforce policies prohibiting discrimination based on race, color, national origin, religion, disability, sex, sexual orientation, gender identity and expression.
- Ensure youth are free to practice their religion, including discussing their beliefs with others, possessing and sharing religious texts and items, and participating in communal worship.
- Permit youth to wear religious attire and articles of faith, including hijabs, yarmulkes, kufis, crosses, and similar religious items.
- Provide opportunities for youth to participate in cultural and religious observances consistent with their beliefs.

We adopt the Pennsylvania LGBTQ+ Youth Work Group’s recommendations, related to the rights and protections of LGBTQ+ youth in residential placement.

Family Engagement and Notification Requirements

Parents and caregivers frequently report learning about significant incidents involving their children long after they occur. Through its oversight, the OYO has identified delays in notifying families of injuries, hospitalizations, physical altercations and other serious events. Even when notification is eventually provided, delayed communication can undermine trust and exclude families from important decisions affecting their child's care and safety.

Family engagement should extend beyond treatment planning to include timely communication regarding events affecting a youth's safety, well-being, and treatment. The proposed regulations currently limit parental notification to injuries requiring hospital treatment, leaving families unaware of many other significant events.

The OYO recommends requiring facilities to notify parents, guardians, and other legally authorized parties within established timeframes of any event that affects a youth's health, safety, placement, or education, including but not limited to:

- All injuries
- Physical altercations
- Medical assessment and/or treatment beyond routine care
- Any suicidal ideation, suicide attempt, or self-harm behavior
- Restraint, exclusion, and seclusion incidents
- Allegations of abuse or neglect
- Any medication changes
- School changes or educational placement decisions
- All transfers and discharges

Facilities should also be required to document all notifications, including the date, time, recipient, method of communication, and any unsuccessful attempts to contact parents, guardians, or other legally authorized parties.

In addition, the OYO recommends that DHS:

- Establish minimum standards for family communication and visitation, including documentation and periodic review of any restrictions.
- Apply notification requirements to parents, guardians, placing agencies, case managers, lawyers, and, when appropriate, juvenile probation departments and the courts.
- Review and expand the current threshold for reportable incidents to ensure significant events affecting youth safety, treatment, and permanency are consistently communicated.

Youth Grievances, Anonymity, Anti-Retaliation, and Independent Oversight

Many youth are reluctant to raise concerns while in placement because they fear retaliation, believe their concerns will not result in meaningful change, or are unaware of external resources, including ombudsperson agencies. Youth have reported uncertainty about their rights and discomfort filing grievances when they know the staff member involved will see the complaint and be able to identify them. The lack of an anonymous grievance process can discourage youth from reporting concerns. Youth have expressed concerns that staff and facility leadership do not take grievances seriously. In some instances, youth reported that staff discarded their written grievances in the trash in front of them.

The OYO has learned of a practice in which facilities informally resolve grievances without formally documenting them, resulting in the loss of important information about recurring concerns and limiting accountability. Accessible grievance procedures, meaningful confidentiality protections, and independent oversight are essential to ensuring youth can safely report concerns and that facilities identify and address systemic issues.

The proposed regulations expand youth rights and grievance procedures. Additional safeguards are needed to ensure these protections are effective in practice.

The OYO recommends requiring facilities to:

- Provide youth with information about local and state ombudsperson agencies and other external avenues for assistance upon admission and throughout placement.
- Establish a process that allows youth to submit grievances anonymously and requires timely investigation and written responses.
    - Prohibit facility staff and leadership from requiring youth to put their name on the grievance form.
- Prohibit staff and leadership from discouraging, interfering with, delaying, or retaliating against youth for filing grievances or contacting oversight entities.
- Document, track, and retain all formal and informal grievances and complaints.
- Establish standardized grievance timelines, appeal procedures, and anti-retaliation protections.
- Regularly review grievance data to identify patterns, recurring concerns, and opportunities for corrective action.

Facility Safety, Security, and Contraband

Youth in residential placement have a right to safe and secure living environments. The OYO has received reports of unauthorized individuals on facility grounds, staff bringing prohibited items into facilities, and youth accessing nicotine products, vape devices, drugs, and alcohol. Youth

have also reported concerns related to inadequate supervision and security, including instances in which youth were able to leave facility grounds without permission.

Because residential facilities function as both treatment settings and temporary homes, clear standards regarding visitor access, staff conduct, and contraband control are essential. The proposed regulations would benefit from additional requirements to promote safe and secure residential environments.

The OYO recommends requiring facilities to maintain policies and procedures addressing:

- Unauthorized individuals on facility grounds
- Visitor screening, approval, supervision, and documentation
- Visitor logs and tracking requirements
- Staff under the influence of alcohol, cannabis, or other substances
- Alcohol, cannabis, and drug use on facility grounds
- Staff possession, distribution, or facilitation of access to nicotine products, vape devices, alcohol, drugs, or other prohibited items.

Violations involving unauthorized access, staff misconduct, or contraband should be treated as reportable incidents requiring prompt review, documentation, and corrective action.

Basic Needs, Nutrition, and Daily Living Conditions

A youth's daily living environment directly impacts their safety, well-being, dignity, and overall placement experience. Through facility visits, youth interviews, and complaint investigations, the OYO has identified issues related to food access, hygiene products, clothing, personal belongings, and other basic needs.

Food access is among the most common youth-filed concerns. Youth have reported missing meals because they lacked cooking skills, returned from approved activities after kitchen hours, were unable to independently access available food, or otherwise needed assistance. Youth have also reported concerns regarding inconsistent snack access, food quality, and limited availability of culturally appropriate or religiously compliant meals. Basic nutrition should not depend on a youth's independence level, schedule, or ability to advocate for themselves.

The OYO has observed significant variation among facilities regarding access to hygiene products, specifically menstrual products, seasonally appropriate clothing, personal belongings, and other daily necessities.

The current regulations do not clearly define providers' responsibilities for ensuring youth's nutritional and basic needs are met when youth cannot independently meet those needs, including minimum expectations for staff assistance and support. Clear statewide standards are needed to promote consistency and accountability across residential settings.

The OYO recommends that DHS require facilities to:

- Provide and serve three nutritionally adequate meals daily, as well as ongoing access to snacks and drinking water.
- Reserve meals or provide alternative meal options for youth returning late from approved activities, including work, night school, extracurricular activities, visitation, treatment appointments, religious activities, or other approved outings.
- Provide staff assistance with meal preparation when youth are unable to prepare meals independently.
- Ensure meals accommodate documented cultural needs and preferences.
- Establish minimum standards for access to hygiene products, including gender-specific hygiene items, basic personal care items, clean bedding, and laundry services.
    - Ensure menstrual products are available in bathrooms 24/7.
- Ensure youth have access to adequate and seasonally appropriate clothing.
    - Provide additional clothing when indoor temperatures require it.
    - Ensure youth have timely access to seasonally appropriate clothing regardless of family or funding availability.
- Establish standards for youth access to and storage of personal belongings.
- Document and promptly address situations in which youth lack access to basic necessities.
- Prohibit withholding clothing, hygiene products, personal belongings, or other necessities as punishment or behavior management.

The OYO recommends that DHS:

- Provide clarity that additional portions of served meals, or "seconds," must be provided to youth when requested.

Access to food, clothing, hygiene products, personal belongings, and other basic needs should be treated as fundamental conditions of care, health, and dignity. Every youth in residential placement should have consistent access to these necessities regardless of placement type, level of independence, behavioral needs, or daily schedule.

Use of Law Enforcement

Youth often describe law enforcement involvement in residential settings as confusing and unnecessarily punitive. The OYO has identified instances in which behaviors that could have been addressed through de-escalation, behavioral interventions, or clinical support instead resulted in law enforcement involvement. The OYO is concerned that some youth become increasingly involved in the juvenile justice system because residential facilities rely on law enforcement to manage behavioral incidents. Clear standards are needed to ensure residential

facilities remain treatment-focused environments and that law enforcement involvement is limited to situations involving an imminent threat to the safety of the youth or others.

The OYO recommends requiring facilities to:

- Document and periodically review all contacts with law enforcement.
    - Documentation should include the circumstances, justification, and outcome of each law enforcement contact.
        - The justification should explain why less restrictive interventions were insufficient and why law enforcement assistance was necessary.
- Prohibit the use of law enforcement as a behavioral management strategy.

Law enforcement involvement should be monitored to reduce unnecessary criminalization of youth behavior and promote the use of developmentally appropriate, trauma-informed interventions whenever possible.

Restrictive Procedures, Restraints, Exclusion, Seclusion, and Youth Safety

The OYO appreciates DHS' efforts to strengthen standards governing restrictive procedures through enhanced staff training, individualized restrictive procedure plans, debriefing requirements, and data collection. These proposed changes represent meaningful progress toward reducing restrictive interventions and promoting trauma-informed responses to youth behavior.

Restrictive procedures nevertheless remain among the most significant concerns raised by youth in residential placement. Through youth interviews, complaint investigations, facility visits, and our review of seclusion practices, the OYO has identified inconsistent use, documentation, and oversight of restraints, exclusions, and seclusions across facilities. Similar incidents are often classified differently, documentation may conflict with youth or staff accounts, and existing regulations do not always provide sufficiently clear, enforceable standards. Greater consistency and transparency are necessary to ensure restrictive procedures remain emergency interventions used only when necessary to protect youth or others from immediate harm.

For additional details regarding seclusion, see the OYO's 2024 issue report.

The OYO recommends that DHS:

- Establish standardized statewide definitions for reportable incidents, including restraints, exclusions, and seclusions.
- Establish clear statewide standards defining when a seclusion event begins and ends.
    - Clarify that seclusion ends only when the door is unlocked and the youth is permitted to leave the room and return to normal programming or activities, regardless of whether the youth has calmed or fallen asleep.

- Establish detailed standards for required observation checks, including direct visual confirmation of a youth's condition and safety. Effective monitoring requires staff to physically approach the room, directly observe the youth, verify the youth's condition, and confirm the youth's safety and well-being.
- Expand public reporting and analysis of facility-level restrictive procedure data to identify trends, outlier facilities, and potential disparities in the use of restrictive interventions.

The OYO recommends requiring facilities to:

- Photograph visible injuries resulting from reportable incidents.
- Retain incident reports, photographs, surveillance footage, and related documentation for a minimum period established by DHS.
- Provide relevant documentation to licensors, placing agencies, auditors, and authorized oversight entities upon request.
- Ensure supervisory review whenever incident documentation is incomplete, inconsistent, or conflicts with available evidence.
- Document any educational, therapeutic, recreational, visitation, or treatment services missed because of a restrictive procedure.
- Provide alternative educational services whenever instruction is interrupted because of a restraint, exclusion, seclusion, room confinement, or removal from programming.

Regarding restraints:

- Not use refusal to follow directions, verbal disrespect, noncompliance, refusal to participate in programming, attempts to walk away, or property destruction alone as justification for restraint.
- Document the specific safety threat that necessitated the restraint, rather than solely the youth's response to staff intervention.
- Document any staff-initiated physical intervention preceding a restraint, including the nature and purpose of the intervention.
- Discontinue the use of touch prompts, unnecessary physical proximity, and raised voices to de-escalate youth, as these interventions may instead escalate youth behavior.
- Prohibit staff from unnecessarily escalating interactions and then relying on the resulting escalation to justify a restrictive procedure.
- Analyze patterns involving staff whose interactions disproportionately result in restraints.

Regarding exclusion and room confinement:

- Treat involuntary room confinement or restriction from programming, common areas, education, recreation, or peer interaction as exclusion when a youth is directed to remain in a location or otherwise reasonably believes they are not free to leave, regardless of whether staff explicitly prohibit the youth from leaving.

- Prohibit exclusion, room confinement, or group restrictions for administrative convenience, staffing shortages, incident reporting, investigations, shift changes, or other operational purposes.
- Prohibit collective restrictions based on the actions of one or more youth.
- Document the reason, duration, authorization, and services missed during any exclusion or room confinement.
- Require supervisory review of exclusions extending beyond a specified period.
- Demonstrate that each exclusion is based on an individual youth's immediate safety risk rather than operational needs.

Regarding seclusion:

- Document all required observation checks and the staff member completing each check.
- Verify and document all required medical assessments and clearances.
- Require youth to sign the seclusion log at the conclusion of seclusion.
- Require supervisory review of every seclusion event within 24 hours.
- Notify PA DHS and the county placing agencies whenever a youth approaches or exceeds regulatory time limits.
- Conduct periodic audits comparing incident reports, observation logs, surveillance footage, and youth interviews to verify compliance.

These recommendations are intended to ensure restrictive procedures are necessary, individualized, time-limited, trauma-informed, transparent, and subject to meaningful oversight.

Missing Youth Prevention and Response

When youth leave their placement facility without permission, the response often focuses primarily on locating the youth and completing required reporting. The OYO's experience indicates that youth frequently leave placement because of underlying factors such as family concerns, unmet needs, interpersonal conflict, or feeling disconnected from their placement. These factors are not always immediately recognized or articulated by youth, and the OYO has identified recurring incidents in which facilities do not assess or address the reasons youth leave.

A comprehensive response should emphasize prevention, relationship-building, and continuous improvement. Individualized prevention planning and return debriefings should involve the youth, their treatment team, and a therapist or other licensed behavioral health professional to identify contributing factors, assess unmet needs, and develop strategies to reduce future incidents.

The OYO recommends requiring facilities to:

- Develop individualized prevention plans for youth with a history of leaving placement without permission, with input from the youth, their treatment team, a therapist or other licensed behavioral health professional, as appropriate.
- Engage families following missing youth incidents, when appropriate.
- Conduct a therapeutic debriefing upon the youth's return with participation from the youth's therapist or another licensed behavioral health professional, when the youth does not have an assigned therapist, to identify contributing factors, assess unmet needs, and develop strategies to reduce future incidents.
- Document contributing factors, clinical recommendations, and actions taken to reduce future incidents.
- Periodically review missing youth incidents to identify trends, implement corrective actions, and improve prevention efforts.

Staffing Stability and Workforce Accountability

Youth routinely identify relationships with staff as one of the most important factors affecting their placement experience. Consistent and supportive staff promote stability, trust, and engagement, while frequent turnover and reliance on temporary staff can contribute to inconsistency and disruption in care. The OYO has identified concerns related to staffing shortages, high turnover rates, and workforce instability that affect the quality and continuity of youth services in congregate care services.

Workforce stability should be viewed as a youth outcome issue, not solely an operational concern. In interviewing youth, the OYO learned of situations in which staffing limitations restricted youth access to recreation, community activities, and other programming. For example, when only one staff member is available to supervise a unit and some youth do not wish to participate in an activity, youth reported that the entire unit will be required to remain at the facility rather than allowing interested youth to participate. These practices can limit opportunities for youth to engage in meaningful activities and demonstrate the impact of workforce instability on daily youth experiences.

Quality care depends not only on meeting staffing ratios, but also on maintaining a stable workforce that allows youth to develop consistent relationships with staff and access appropriate programming and services.

The OYO recommends requiring facilities to collect and monitor data related to:

- Staff turnover
- Vacancy rates
- Overtime utilization
- Use of temporary staff
- Staff retention

- Staffing-related impacts on youth programming, activities, and services, including cancellations or restrictions due to staffing limitations

Workforce instability can contribute to safety concerns, inconsistent service delivery, reduced access to programming, and diminished youth outcomes. Monitoring workforce factors is necessary to ensure staffing practices support safe, consistent, and therapeutic residential environments.

Discharge Planning and Transition Supports

Youth and families frequently report receiving little information about discharge timelines, expectations, or available supports until shortly before leaving placement. Through complaint investigations and facility oversight, the OYO has identified youth who exited placement without confirmed educational arrangements, healthcare appointments, behavioral health services, housing plans, or other essential supports.

The OYO has identified instances in which facilities treated discharge planning as optional when a youth left under emergency, involuntary, administrative, or otherwise unexpected circumstances. In one case, after an administrative discharge, a facility classified a youth as "AWOL" after the youth left the facility and transported herself to the county children and youth agency to await placement. The facility asserted that the youth's "AWOL" status relieved it of any responsibility to complete discharge planning or documentation.

Emergency or unplanned departures often place youth at the greatest risk of educational disruption, gaps in healthcare and behavioral health treatment, housing instability, and loss of community supports. These circumstances should not relieve facilities of their responsibility to coordinate a safe transition.

Successful transitions require planning that begins at admission, includes youth and families, establishes clear responsibilities, and continues throughout placement. Chapter 3900 should make clear that discharge planning is an ongoing process, not an activity completed shortly before discharge, and that these obligations apply regardless of whether a youth's departure is planned, emergency, involuntary, administrative, or otherwise unexpected.

The OYO recommends requiring facilities to:

- Initiate discharge planning upon admission that addresses education, healthcare, medication continuity, housing, employment, family and community supports.
- Develop measurable discharge objectives, timelines, and assigned responsibilities for transition tasks.
- Include youth, families, placing agencies, and care team members in discharge planning.

- Document barriers that prevent timely completion of discharge planning requirements and corrective actions taken to address those barriers.
- Apply discharge planning requirements regardless of whether discharge is planned, emergency, involuntary, or unexpected.
- Initiate transition coordination immediately upon learning that a discharge, transfer, hospitalization, detention admission, or placement disruption is likely to occur.
- Prohibit using a youth's "AWOL" or missing status, hospitalization, arrest, detention, or emergency transfer as justification for failing to complete discharge planning.
- Document all efforts to coordinate education, healthcare, medication continuity, housing, employment, family reunification, and community supports following emergency or unplanned discharges.
- Notify the placing agency when discharge planning requirements cannot be completed before discharge and complete outstanding transition activities as soon as practicable thereafter but no later than 14 business days.

Data Collection, Transparency, and Continuous Improvement

Consistent, standardized data is essential to identifying systemic issues, evaluating facility performance, and improving outcomes for youth. The OYO frequently encounters concerns that cannot be meaningfully assessed because facilities do not collect or report comparable information on key indicators of youth well-being. Without this data, it is difficult to determine whether facilities are meeting youths' needs or identify trends requiring intervention.

The proposed regulations appropriately require data collection on restrictive procedures. The OYO recommends DHS extend similar reporting requirements to other key measures of youth experience and outcomes, including:

- Educational access and attendance
- Grievances and grievance outcomes
- Family engagement and notification compliance
- Missing youth incidents
- Law enforcement involvement
- Hospitalizations and emergency department visits
- Staffing stability
- Youth satisfaction and feedback
- Discharge outcomes

A robust data framework is essential to identifying systemic concerns, measuring facility performance, and supporting continuous quality improvement.

Privacy, Communication, and Personal Property Rights

Communication with family, trusted adults, attorneys, advocates, and oversight entities is essential to youth well-being while in placement. The OYO regularly receives concerns regarding communication restrictions, lack of privacy, and confiscation of personal belongings. The OYO has observed significant variation among facilities regarding youth access to phones, video calls, mail, personal property, and confidential communications. Current regulations provide limited guidance regarding when communication may be restricted, how restrictions should be documented, and what protections should exist to preserve youth privacy, family connections, and confidential communications.

During meetings with facility leadership and through oversight activities, the OYO identified facilities that required youth to open mail in the presence of staff, shake the contents to inspect for contraband, and permit staff to visually review or scan the contents of the correspondence. The OYO has also encountered instances in which facilities retained or confiscated correspondence based solely on the content of the communication, including letters containing profanity or other language that staff considered inappropriate. The OYO recognizes that facilities have a legitimate responsibility to prevent drugs, weapons, and other contraband from entering residential programs. However, those safety concerns must be balanced with youth's rights to privacy and confidential communication.

Rather than relying on practices that require staff to read, scan, or otherwise review the contents of personal correspondence, DHS should:

- Distinguish in the regulations between inspecting mail for contraband and reviewing or censoring the content of correspondence.
- Establish minimum standards governing youth access to the phone, video calls, and written communication with family and other approved supports.
- Establish standards governing searches of youth rooms and personal belongings.
- Establish privacy protections for bathrooms, showers, changing areas, and other personal spaces.

The OYO recommends requiring facilities to:

- Use the least intrusive methods available to detect physical contraband, including visual inspection for tampering and mail screening technology designed to identify contraband.
- Document and implement communication restrictions imposed by the court, county placing agency, children and youth services, and/or juvenile probation.
- Restrict or interrupt youth communications only when necessary to address an immediate safety concern or to comply with a court, county, or agency directive, and document the reason, duration, and source of the restriction or interruption.

- Require supervisory review of all communication restrictions or interruptions initiated by facility staff.
- Protect confidential communications with attorneys, courts, youth ombudsperson agencies, advocates, clergy, and other authorized oversight entities.
- Document the confiscation of personal property and maintain procedures for its return.

Youth should not lose meaningful access to family, advocacy, privacy, or personal property simply because they reside in a residential setting.

Health Care, Behavioral Health Care, and Medication Oversight

Youth entering residential placement often have significant physical, behavioral health, developmental, and trauma-related needs. The OYO has observed delays in accessing care, inconsistent follow-up after health crises, gaps in continuity of care, and limited oversight of medication practices. In one case, a youth transferring between two locations operated by the same provider was at risk of running out of a prescribed psychotropic medication because no continuity of care plan had been established. The interruption was ultimately avoided through the OYO's coordination with the youth's behavioral health managed care organization, highlighting the need for clearer regulatory requirements governing continuity of care during placement transitions. Families also report limited communication regarding medication changes, treatment decisions, and continuity of care during placement transitions. These experiences highlight the need for clearer regulatory requirements assigning responsibility for continuity of care and medication management during transfers and other placement changes.

The OYO recommends that DHS:

- Establish enhanced oversight and monitoring requirements for psychotropic medications.

The OYO recommends requiring facilities to:

- Develop continuity of care plans whenever a youth transfers between placements within an established timeframe.
- Ensure timely follow-up after emergency department visits, hospitalizations, suicide attempts, and other significant medical or behavioral health incidents.
- Document informed consent for treatment and medications.
- Notify parents/guardians and legally authorized decision-makers of medication changes, for effective discharge planning.
- Coordinate with healthcare provider to document and monitor medication side effects.
- Conduct post-incident clinical assessments following restraints, seclusions, suicide attempts, self-harm incidents, and other behavioral health crises.
- Coordinate with providers, counties, managed care organizations, schools, and medical professionals to support continuity of care.

Youth should receive timely, coordinated, and developmentally appropriate health care regardless of placement type or location.

Conclusion

The Office of the Youth Ombudsperson (OYO) supports DHS' efforts to modernize Pennsylvania's residential regulations and appreciates the significant improvements reflected in the proposed Chapter 3900 framework. The recommendations in this memorandum are informed by recurring concerns identified through youth interviews, complaint investigations, facility visits, and systemic oversight. They reflect situations in which youth experienced harm, educational disruption, barriers to communication, unmet needs, or reduced accountability because existing regulations were unclear, incomplete, or difficult to enforce.

The OYO has repeatedly observed gaps in accountability where providers, counties, schools, healthcare entities, and other system partners lacked clearly defined responsibilities. In other cases, concerning practices persisted because existing regulations did not establish clear, enforceable standards, limiting the ability of licensors, placing agencies, and oversight entities to require corrective action.

Chapter 3900 presents an opportunity not only to modernize Pennsylvania's residential regulations, but to clarify expectations, assign responsibility, strengthen accountability, and better protect youth across all residential settings. The OYO respectfully submits these recommendations to help ensure that youth protections are clearly defined, consistently applied, and enforceable throughout the Commonwealth.

Pennsylvania's residential regulations should reflect a simple principle: every youth deserves safe, equitable, developmentally appropriate care, and every entity responsible for that care should be held accountable for providing it.

Appendices

Appendix A

PA 3900 Comment from Lambda

Appendix B

OYO Report the Use of Seclusion at the Philadelphia Juvenile Justice Services Center

July 7, 2026

RE: Comments Regarding Proposed Amendments to Regulation #14-559: Residential Services for Children and Youth

Caitlin Robinson, Director of Bureau of Children and Family Services
Pennsylvania Department of Human Services
Human Services Building
625 Foster Street
Harrisburg, PA 17120

Submitted by email to: ra-pwocyf3900sreview@pa.gov

Dear Ms. Robinson,

The undersigned organizations appreciate the opportunity to comment on the proposed amendments to Chapter 3900 of Pennsylvania Regulation #14-559: Residential Services for Children and Youth. We are dedicated to improving the outcomes of lesbian, gay, bisexual, and queer ("LGBQ") and transgender, non-binary, and gender diverse ("TNGD") (collectively "LGBTQ+") children and youth in Pennsylvania's out-of-home care systems. We write in support of the proposed amendment's efforts to promote inclusion, as well as provide suggestions for further improvement. These organizations include Lambda Legal, the oldest and largest national legal organization dedicated to achieving full recognition of the civil rights of lesbian, gay, bisexual, transgender, and queer ("LGBTQ+") people and everyone living with HIV through impact litigation, education, and policy advocacy; the Youth Law Center, a national organization that advocates to transform the foster care and juvenile justice systems so that children and youth can thrive; and the Pennsylvania Commission for Fairness & Justice (PCFJ), which was established in 2005 by all three branches of Pennsylvania government to promote fairness and justice in the Commonwealth by identifying and addressing systemic barriers, reducing bias and discrimination in all forms, and working to ensure that justice is accessible, impartial, and grounded in the dignity and humanity of every individual.

We write largely in support of the proposed regulations, especially regarding the Pennsylvania Department of Human Services' ("DHS") inclusion of policies directly considering TNGD youth and children in Pennsylvania's out-of-home care systems. However, we have identified aspects that could be strengthened for Pennsylvania's youth, and specifically for TNGD youth, including regulations related to: (1) Planning and enforcement; (2) Specific rights of youth at admission; (3) Searches; (4) Access to gender affirming care; (5) Housing and accommodations; and (6) Confidentiality.

BACKGROUND

An effective child welfare system must respond to and meet the needs of all the children it serves and implement evidence-based best practices. Unequivocally, child welfare systems must, consistent with professional standards and the constitutional rights of children placed in state custody and out of home, ensure equitable treatment of TNGD children and youth and promote support, acceptance and empowerment for them. Consequently, we applaud the proposed regulation's prohibition on discrimination on the basis of a child's gender, gender identity or expression, and sexual orientation, § 3900.32(a), the more holistic consideration of children's sexual orientation, gender identity, or gender expression ("SOGIE"), as well as the requirement that youth be provided clean, seasonal clothing that is age and gender-expression appropriate. § 3900.31(u). Similarly, we are in full support of requirements for staff to receive thirty hours of training focused on how gender, race, ethnicity, and sexual orientation impact the youth and children in out-of-home care. § 3900.57(b)(13).

Through our advocacy for and with LGBTQ+ children, and from hearing from LGBTQ+ children with lived experience in foster care themselves, we have learned that inclusive and equitable policies are critical for keeping youth safe, promoting permanency, and ensuring well-being.[1] LGBTQ+ youth are overrepresented in the child welfare system compared to their non-LGBTQ+ peers—approximately one third of youth in foster care identify as LGBTQ+,[2] compared to less than ten percent of youth in the United States overall.[3] While LGBTQ+ children and youth have the same basic needs as all other children in the child welfare system, due to systemic bias and individual prejudice against LGBTQ+ people, these youth have unique challenges and needs while in care.[4] It is well-documented that discrimination against children based on race, sex, religion, sexual orientation, immigration status, disability status, or a combination of these factors tangibly and negatively impacts their health and wellbeing.[5] As a result of discrimination and stigma related to their SOGIE while in care, LGBTQ+ children and youth experience higher

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[1] Alex Citrin et al., *Safe Havens II: Interactive Report* (2024), https://lambdalegal.org/safe-havens-report/safe-havens-full-report/.

[2] Theo G. M. Sandfort, *Experiences and Well-Being of Sexual and Gender Diverse Youth in Foster Care in New York City: Disproportionality and Disparities*, 7 (2019), https://www1.nyc.gov/assets/acs/pdf/about/2020/WellBeingStudyLGBTQ.pdf; University of Maryland School of Social Work, *The Cuyahoga Youth Count: A Report on LGBTQ+ Youth Experience in Foster Care*, 5 (2021), https://www.kinnect.org/wp-content/uploads/2022/03/Cuyahoga-Youth-Count-Report.pdf?_gl=1*wgr58q*_ga*MTgyOTA3NTAxNi4xNjkxMjc4Njk3*_ga_PNSPYWKHN1*MTY5MjYyMTIyMS4yLjEuMTY5MjYyMTIzNy4wLjAuMA..&_ga=2.165535484.2130621086.1692621222-1829075016.1691278697.

[3] Kerith J. Conron, *LGBT Youth Population in the United States*, The Williams Inst. (2020), https://williamsinstitute.law.ucla.edu/publications/lgbt-youth-pop-us/.

[4] The Annie E. Casey Foundation, *LGBTQ in Child Welfare: A Systematic Review of the Literature*, 3 (2016), https://assets.aecf.org/m/resourcedoc/aecf-LGBTQ2inChildWelfare-2016.pdf.

[5] Maria Trent et. al., *The Impact of Racism on Child and Adolescent Health*, 144 Pediatrics 2 (2019); Am. Psych. Assoc., *Stress in America™ 2019*, 4 (2019), https://www.apa.org/news/press/releases/stress/2019/stress-america-2019.pdf.

incidences of physical and emotional harm and discrimination.[6] In addition, they face increased likelihood of juvenile justice involvement,[7] psychiatric hospitalization,[8] and multiple placement disruptions.[9] LGBTQ+ children and youth are also at elevated risk for placement in congregate care,[10] experiencing homelessness,[11] and becoming victims of trafficking.[12] The proposed regulations represent an important step towards protecting this vulnerable population.

RECOMMENDATIONS

However, DHS should amend some aspects of the proposed regulations, specifically those regarding: (1) Planning and enforcement; (2) Specific rights of youth at admission; (3) Searches; (4) Access to gender affirming care; (5) Housing and accommodations; and (6) Confidentiality.

Enforceability

Current provisions only require new protections for LGBTQ+ youth be codified through facility-specific policies. *See, e.g.,* § 3900.42(e) (requiring facilities to develop new search policies to better protect LGBTQ+ youth). While facility-level policies are important, relying primarily on each facility to create, interpret, and implement its own policies risks uneven application and disparate enforcement.

This concern is significant where compliance monitoring only effectuates through licensing requirements. *Licensing review alone may be insufficient* to ensure facilities meaningfully implement policies protecting LGBTQ+ youth in daily practice. For example, intake requirements should go beyond adopting internal policies addressing SOGIE. Rather, the regulations should require facilities to assess SOGIE-related needs before admission and prohibit facilities from accepting a TNGD youth unless they can affirmatively meet those needs.

As a matter of licensing, any facility authorized to admit youth should be required to accommodate youth of all SOGIEs. A facility must be able to safely and affirmatively

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[6] Bianca Wilson & Angeliki Kastanis, *Sexual and Gender Minority Disproportionality and Disparities in Child Welfare: A Population-Based Study*, 58 Child. & Youth Serv. R. 11, 15–16 (2015); The Annie E. Casey Foundation, *LGBTQ in Child Welfare: A Systematic Review of the Literature* (2016), 3, https://assets.aecf.org/m/resourcedoc/aecf-LGBTQ2inChildWelfare-2016.pdf.

[7] Angela Irvine & Aisha Canfield, *The Overrepresentation of Lesbian, Gay, Bisexual, Questioning, Gender Nonconforming and Transgender Youth Within the Child Welfare to Juvenile Justice Crossover Population*, 24 J. Gender Soc. Pol'y & L. 243, 246 (2015).

[8] Bianca Wilson et. al., *Sexual and Gender Minority Youth in Foster Care: Assessing Disproportionality and Disparities in Los Angeles*, The Williams Inst. (2014), 7, https://williamsinstitute.law.ucla.edu/wp-content/archive/SGM-Youth-in-Foster-Care-Aug-2014.pdf.

[9] M. Martin et. al., *Out of the Shadows: Supporting LGBTQ Youth in Child Welfare through Cross-System Collaboration*, Ctr. for the Stud. of Soc. Pol'y (2016), 8, https://bettercarenetwork.org/sites/default/files/Out-of-the-Shadows-Supporting-LGBTQ-youth-in-child-welfare-through-cross-system-collaboration-web.pdf.

[10] Wilson (2015) at 11.

[11] Martin et. al. at 10.

[12] *Id.* at 26.

accommodate a youth's TNGD-related needs, including adequate policies and training for staff, before admitting TNGD youth. Without clearer regulatory mandates, the current framework risks creating protections that lack sufficient enforceability—leaving vulnerable TNGD youth dependent on facilities' case-by-case discretion rather than on guaranteed, consistent standards of care.

To ensure TNGD youth are protected, DHS should revise the regulations to include *concrete, enforceable* requirements. At minimum, the regulations should:

(1) Require pre-admittance SOGIE assessments;
(2) Prohibit admission where a facility cannot accommodate SOGIE considerations;
(3) Make SOGIE accommodation an un-waivable condition of licensure;
(4) Require written implementation plans, with procedures for documentation and reporting;
(5) Amend § 3900.31 to create *uniform, specific* TNGD-youth-accessible grievance procedures and protections against retaliation that are responsive to the needs of TNGD youth, providing facilities with a minimum acceptable baseline;
(6) Include specific enforcement measures and consequences for facilities that are not in compliance, such as corrective action plans, heightened monitoring, penalties, restrictions on admissions, suspension, or license revocation.

§ 3900.31. Notification of rights and grievance procedures & § 3900.32. Specific rights

While we applaud the new requirements that facilities include SOGIE considerations, we recommend that facilities should provide, *prior to or at admission*, an *orientation* to living in the facility for each child and, as appropriate, the child's parent, guardian or custodian, or child-placing agency. This orientation should also include *instructions for filing grievances* should a young person's rights be violated. The orientation should be provided in a developmentally appropriate, culturally competent, and confidential manner that includes all of the elements listed below.

Providing all youth in Pennsylvania's out-of-home care facilities, and particularly TNGD youth, with such an orientation is consistent with DHS's broader commitment to mitigating the compounded harm youth often experience in these systems. Facilities should therefore be required to clearly disclose the scope and limitations of available care at admission, as transparency is a core component of creating safer youth-focused environments.[13]

Importantly, the draft requires that facilities inform youth and parents of their grievance process. Youth and families also have a right to file a complaint with DHS. This is a method of enforcement and accountability that is separate and apart from the facility's internal grievance policy. We ask that this right be included in § 3900.32 and notification of this right be included in

[13] Nat'l Child Traumatic Stress Network, *Introduction*, https://www.nctsn.org/trauma-informed-care/family-youth-provider-partnerships/introduction.

§ 3900.31 to ensure that this critical avenue for complaint and accountability is made clear to youth and families.

§3900.31 should be amended to include the following (additions underlined):

Facility management and facility staff shall do all of the following:
(1) Guarantee that a child or youth and the child's or youth's parent have the right to lodge a grievance with the facility, orally or in writing, for an alleged violation of a child's or youth's rights under this chapter or civil rights without fear of retaliation.
(2) Guarantee that a child or youth and the child's or youth's parent have the right to file a grievance with the Department of Human Services, orally or in writing, for an alleged violation of a child's or youth's rights under this chapter or civil rights without fear of retaliation.

We recommend § 3900.32 be revised as follows (additions underlined):

(t) A child or youth has the right to be informed of the facility's discipline policy.
(u) A child or youth has the right to clean, seasonal clothing that is age and gender-expression appropriate.
(v) A child or youth has the right to a detailed orientation upon their entry into a facility, including:

(1) Information regarding the inherent diversity of facility staff and youth populations, including race, religion, ethnicity, SOGIE, disability, and other considerations;
(2) General rules of the facility, including expectations for (1) facility staff and (2) youth housed in the facility;
(3) Information regarding the services offered in the facility;
(4) Information regarding the facility's behavior management practices;
(5) Notice of each child's rights related to SOGIE, including protections concerning names and pronouns, clothing, grooming, hygiene products, housing, searches, privacy, programming, confidentiality, and freedom from harassment, discrimination, and retaliation;
(6) The facilities' obligations and procedures regarding SOGIE-related disclosures, especially those without youth's express permission;
(7) The process for requesting accommodations related to SOGIE;
(8) The grievance procedures available to children, including how to file a confidential complaint, how the facility will protect children from retaliation, and available information about the third party who would process/hear the complaint; and
(9) The right to file a complaint with DHS.

§§ 3900.41-42. Person and property searches; Appropriate use of person and property searches.

We appreciate DHS's effort to make search and pat-down procedures more responsive to the needs of TNGD youth. Allowing a TNGD youth to identify the gender of staff who may conduct a pat-down or visual search is an important harm-reduction measure, and we support the requirement that any deviation from the youth's stated preference be documented in the youth's record and search log.

Yet, searches of children and youth remain highly invasive and potentially traumatic, particularly for LGBTQ+ youth, who are more likely to have histories of sexual abuse and involvement with law enforcement.[14]

At minimum, DHS should clarify that searches may be conducted only when individualized circumstances make the search reasonably necessary to address a *specific* and *articulable* safety concern. Searches should *not* be routine, automatic, punitive, or based on a youth's SOGIE, sex characteristics, clothing, appearance, or perceived nonconformity. Searches should not be practiced at all in youth dependency proceedings, nor should they *ever* be performed to ascertain a child's physical anatomy or genitalia status.[15]

DHS should also provide more concrete guidance on the meaning of "circumstances [that] demand immediate action." § 3900.42(e)(8). As drafted, this vague and overbroad language risks allowing abusive conduct to slip through the cracks. This regulation should be defined narrowly, such as where staff have a specific, articulable basis to believe that immediate action is necessary to prevent imminent physical harm and waiting for appropriate staff would materially increase that risk.

Finally, § 3900.42(e)(9)'s requirement that two staff members be involved in a search should ensure the observer is subject to the same confidentiality and training requirements for protecting TNGD youth. While DHS rightly takes the necessary step of requiring a second staff member as a safeguard, the presence of multiple adults can also increase the invasiveness and humiliation of a search.[16] The regulation should specify that only one staff member may physically conduct the search, that any witnessing staff member must be necessary for safety or accountability, and that all staff involved must comply with the youth's stated gender preference, confidentiality rights, and trauma-informed care needs.

DHS should amend § 3900.42(e) as follows (additions underlined):

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[14] Joel Mittleman, *Adverse Childhood Experiences Among LGBTQ+ High School Students: National Evidence From the 2023 Youth Risk Behavior Survey*, 115 Am. J. Pub. Health 1137, 1141–43 (2025); Joshua Arrayales et. al., *Law Enforcement and LGBTQ People*, The Williams Inst.,16 (2025), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Police-Interactions-LGBTQ-Nov-2025.pdf.

[15] *See* Shannan Wilber & Jason Szanyi, *Model Policy: Transgender, Gender Nonconforming, and Intersex Youth in Confinement Facilities*, Nat'l Ctr. for Lesbian Rts. & Ctr. for Child. L. & Pol'y, 16 (2019), https://sogiecenter.org/wp-content/uploads/2023/01/TGNCI-Model-Policy.pdf.

[16] Juv. L. Ctr., *Addressing Trauma: Eliminating Strip Searches*, 2 (2020), https://jlc.org/sites/default/files/attachments/2020-04/AddressingTrauma-EliminatingStripSearch%20March%202020.pdf

(3) The criteria that warrant the need for a search. Reasonable cause must be clear and articulable, meaning that the suspicion can be explained orally or in writing in reasonable and understandable terms. Searches must never be conducted with the sole or incidental purpose of determining a young person's sex or genital status.

(8) A requirement that facility staff shall provide a transgender or intersex child or youth the opportunity to request and confirm in writing their preference that staff of a particular gender conduct any pat down or visual search of the child or youth. Facility staff shall comply with the child's or youth's request absent exigent circumstances and shall document any deviation from the child's or youth's stated preference. If a child or youth does not indicate a preference, the staff member of the child's or youth's self-identified gender shall perform the search. Only one staff member will conduct the search. Both staff members present must comply with the youth's stated gender preference, confidentiality rights, and trauma-informed care needs.

Access to Gender-Affirming Care

We were disappointed to see no discussion of access to gender affirming medical care ("GAC") for youth in out-of-home care. We strongly and unequivocally encourage DHS to develop concrete, clear, and actionable policies on this life-saving medical issue.[17]

GAC can be a critical part of affirmation of a TNGD youth's gender identity and an component of treatment for gender dysphoria (a mental health condition resulting from mismatch between a person's sex assigned at birth and gender identity), that can reduce depression, anxiety, suicidal ideation, and self-harm.[18] GAC is medical care that is provided after consultation with a qualified health care professional. GAC has been endorsed by major medical associations as a safe and effective treatment for gender dysphoria and related mental health conditions.[19] GAC, like other forms of healthcare, should be made available under the guidance of qualified healthcare providers. DHS should specify that TNGD youth have a right to adequate health and medical care, including GAC, and children in Pennsylvania's out-of-home-care system are guaranteed this care, when recommended by qualified physicians. Proposed § 3900.32(q) fleshes out the right to appropriate medical care and provides an opportunity to specify GAC.

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[17] For an example of excellent policy on this issue, *See*: Wilber & Szanyi, at 16.

[18] Myeshia N. Price & Amy E. Green, *Association of Gender Identity Acceptance with Fewer Suicide Attempts Among Transgender and Nonbinary Youth* 8 Transgender Health 56, 63 (2023); The Trevor Project, *2024 U.S. National Survey on the Mental Health of LGBTQ+ Young People* (2024), https://www.thetrevorproject.org/survey-2024/.

[19] Heather Boerner, *What the Science on Gender-Affirming Care for Transgender Kids Really Shows*, Scientific American (May 12, 2022), https://www.scientificamerican.com/video/what-the-science-on-gender-affirming-care-for-transgender-kids-really-shows/; Jason Rafferty et al., *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142 American Academy of Pediatrics 1, 4 (2018) (reaffirmed in 2022).

We recommend amending § 3900.32(q) as follows (additions underlined):

(q) A child or youth has the right to appropriate medical, dental, vision, mental health, behavioral health and drug and alcohol abuse and addiction services, rehabilitation and treatment consistent with the laws of this Commonwealth and for which the child or youth qualifies.
(1) This right includes information related to services under this subsection, including, but not limited to, medication and medication options and the opportunity to communicate a preference regarding a treatment plan, medication or medication options.
(2) This right includes the opportunity to consent to medical and mental health treatment consistent with applicable law.
(3) This right includes covered gender-affirming health care and gender-affirming mental health care, and is subject to existing laws governing consent to health care for minors and nonminors and does not limit, add, or otherwise affect applicable laws governing consent to health care.[20]

Housing and Accommodations

Inclusion for TNGD youth in out-of-home care also requires more guidance on accommodations *within* those out-of-care facilities. TNGD youth and children who are affirmed in their identifies see a dramatic reduction in the risk for depression, anxiety, suicide, and self-harm.[21] Relatedly, TNGD youth with access to an affirming physical space (whether that be their living space or otherwise) see a 35% reduction in suicidality.[22] Providing TNGD youth and children with a sleeping space and/or bathroom facility that affirms their gender identity is essential for ensuring a healthy, safe, and affirming placement.

Appropriate placement for TNGD youth requires both guidelines and flexibility to accommodate the needs of individual youth. Clearer guidance regarding how TNGD youth are to be assigned to sleeping areas, bedrooms, and/or bathroom facilities is needed. Juvenile detention facilities in particular would benefit from further guidance, as youth in juvenile detention facilities are covered by the Prison Rape Elimination Act's ("PREA")[23] prohibition against segregating inmates solely on the basis of LGBTQ+ status.[24] Both to comply with this federal floor and ensure the needs and desires of TNGD youth themselves are respected, we urge DHS to develop more

[20] Cal. Welf. & Inst. Code § 16001.9(22)(A) (West).
[21] Price & Green at 63.
[22] The Trevor Project, *LGBTQ & Gender-Affirming Spaces* (Dec. 3, 2020), https://www.thetrevorproject.org/research-briefs/lgbtq-gender-affirming-spaces/.
[23] *See* 34 USC § 303; 28 C.F.R. Part 115. The Pennsylvania Department of Corrections implements the PREA through Policy Statement DC-ADM 008.
[24] 28 C.F.R. §115.42(g); 28 C.F.R. §115.242(f) (identical).

concrete and specific recommendations on this issue. Because segregating TNGD youth from their peers must never be the default solution,[25] we request DHS promulgate policies that at minimum:

(1) Prohibit automatic assignment of TNGD youth to bedroom/bathroom facilities based on their sex assigned at birth;
(2) Mandate including youth in conversations regarding their individualized needs (including emotional needs and physical safety) and prioritizing the placement and facility use they feel will best meet their needs for all bedroom/bathroom assignments;
(3) Ensure all youth (whether TNGD or not) have access to private, individual spaces for bathing and changing clothes; *and*
(4) Ensure all youth (whether TNGD or not) have access to individual sleeping spaces upon request and/or when necessary to assure the youth's physical safety.[26]

For instance, DHS may amend § 3900.83(b) (Bedroom accommodations) as follows (additions underlined):

(b) Facility policies and procedures shall address the process and criteria used to address individual child or youth needs specific to the child's or youth's bedroom assignment. The promulgated policies must not mandate that transgender, nonbinary, and gender-diverse youth be automatically assigned to bedroom facilities based on their sex assigned at birth. Facility policy must mandate including youth in conversations regarding their individualized needs (including emotional needs and physical safety) and prioritizing the placement use they feel will best meet their needs for all bedroom assignments.

We recommend § 3900.84(e) (Bathrooms) be amended as follows (additions underlined):

(e) Toilets, showers and bathtubs shall be made private by partitions or doors. All youth must have access to private, individual facilities for bathing and changing clothes. In facilities with gendered restrooms, transgender, nonbinary, and gender-diverse youth must not be automatically assigned to restrooms according to their sex assigned at birth. Facility policy must also mandate including youth in conversations regarding their individualized needs (including emotional needs and physical safety) and prioritizing the facility use they feel will best meet their needs for all bathroom assignments.

[25] Isolation causes documented physical, psychological, and emotional harm to youth. *See, e.g.*, Joseph Calvin Cagnon et. al., *The Council for Exceptional Children, Division of Emotional and Behavioral Health's Position Statement on Solitary Confinement*, 47 Behavioral Disorders 282, 283–85 (2022).

[26] These recommendations were based on model policies implemented by Allegheny County. *See* Allegheny Cnty. Dep't of Hum. Serv., *LGBTQ+ Standards of Practice*, 13–14 (2015), https://www.alleghenycounty.us/files/assets/county/v/1/government/health/documents/lgbtq/lgbtq-standards-of-practice-2-2-21.pdf.

Confidentiality

Though we appreciate that SOGIE must now be included in a child's records, we request more guidance on how this information will be protected. Documentation of confidential information in a child's file is a form of disclosure when other individuals have access to that file. Disclosing a child's gender identity or expression before that child is ready—also known as "outing"—may expose LGBTQ+ youth to serious physical and mental harm.[27] LGBTQ+ youth who are involuntarily outed are more likely to experience depressive episodes and feel unsupported within their living environment.[28]

In light of these grave consequences, we encourage DHS to develop clearer policies that protect and otherwise limit access to paper/electronic records and copies of a child's file; how a child can request these files be sealed; and available recourse should this information be improperly disclosed by staff.[29] While we acknowledge that the context of out-of-home care may sometimes require SOGIE be shared, we believe both providers and youth would benefit from having these specific instances identified explicitly. Communication with TNGD youth about if, when, and with whom SOGIE can be shared should begin with the child's orientation at a facility and continue throughout their stay. At its core, Pennsylvania's policy must center around the individual best suited to understand the benefits and consequences of disclosing this sensitive, deeply personal information—LGBTQ+ youth themselves—and work with them (and their mental health provider, where applicable) on when and how to share information with parents or guardians if required by law or policy.

CONCLUSION

We appreciate DHS's inclusion, consistent with professional child welfare standards, of the specific needs of LGBQ+ and TNGD youth placed in residential and secure facilities and the need for explicit nondiscrimination requirements that protect them from harm. We urge DHS to add the additional recommendations we have suggested to ensure Pennsylvania's TNGD children and youth are safe while in the state's custody and care, and exit facilities ready to thrive.

Thank you for the opportunity to comment. Please reach out to Currey Cook at ccook@lambdalegal.org if you have any questions regarding this comment.

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[27] *See, e.g.,* The Trevor Project, *Age of Sexual Orientation Outness and Suicide Risk* (Oct. 10, 2022), https://www.thetrevorproject.org/research-briefs/age-of-sexual-orientation-outness-and-suicide-risk-oct-2022/ (discussing heightened suicidality and negative mental health outcomes among LGTBQ+ youth who are outed).

[28] Peter S. McCauley et. al., *Stress of Being Outed to Parents, LGBTQ Family Support, and Depressive Symptoms Among Sexual and Gender Diverse Youth*, 34 J. Rsch. on Adolescence 205, 217 (2024).

[29] For an example of a comprehensive policy on this topic, *See generally*: Nat'l Ctr. for Lesbian Rts. & Ctr. for Study of Soc. Pol'y, *Guidelines for Managing Information Related to Sexual Orientation & Gender Identity and Expression of Children in Child Welfare Systems*, (2013), https://cssr.berkeley.edu/cwscmsreports/documents/Information%20Guidelines%20P4.pdf.

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City of Philadelphia
OFFICE OF THE YOUTH OMBUDSPERSON

Use of Seclusion at the Philadelphia Juvenile Justice Services Center

November 18, 2024

Signature of Inspector General:	Signature of Youth Ombudsperson:
*Signature of Associate:	Signature of Associate:

I. Introduction

In November 2022, former Mayor Jim Kenney established the Office of the Youth Ombudsperson (OYO) via Executive Order 5-22. in response to a long-documented history of Philadelphia youth facing abuse and harm in residential placements. As established, the OYO's primary responsibilities are to drive youth engagement and complaint activity, and then monitor and evaluate the action taken by the City in response. Working together with its agency partners – the Department of Human Services (DHS), the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) and its contractor, Community Behavioral Health (CBH) – the OYO ultimately seeks to improve the City's various complaint resolution processes, compliance with applicable laws, efficiency, impartiality, and transparency, all in the interest of providing the best possible care to Philadelphia youth in child welfare, juvenile justice, or behavioral health residential placements. Accordingly, the OYO has been in a unique position to evaluate one such residential site, the Philadelphia Juvenile Justice Services Center (PJJSC), the DHS-operated secure youth detention facility.

Based on substantial evidence – including (i) notable complaint activity; (ii) direct OYO observations; (iii) youth interviews; (iv) departmental policy flaws; and (v) questionable practice and documentation – it is apparent that youth "seclusion" at the PJJSC has been overly employed and not in strict compliance with applicable laws that are designed to ensure the safety and well-being of youth in detention. The OYO offers this report in an effort to elevate this concern and call for targeted and swift reform to bring the PJJSC's use of seclusion into compliance with the law.

It is important to note that since its inception, the OYO has been in close and continuous communication with DHS, where leadership and staff have shown a commitment to our collective mission, sharing information and openly working to integrate the OYO into new and existing internal control functions. As such, this report represents several months of real-time collaboration and a joint commitment to the best interests of our youth population.

II. Background: The Philadelphia Juvenile Justice Services Center & Regulatory Authority

The PJJSC is Philadelphia's DHS-operated secure youth detention facility. In this capacity, the PJJSC is designed to securely house youth who have been arrested and court-ordered to remain in secure detention while their case is processed or while awaiting transfer to a juvenile placement facility. While at the PJJSC, these youth attend school and participate in recreational, therapeutic, and life skills programming.

Chapter 3800 of the Pennsylvania Code Title 55 (often referred to as the "3800 Regulations") governs the operation of child residential and day treatment facilities in the Commonwealth of Pennsylvania. The 3800 Regulations note that for most residential facilities, "Seclusion, defined as placing a child in a locked room, is prohibited. A locked room includes a room with any type of door-locking device, such as a key lock, spring lock, bolt lock, foot pressure lock or physically holding the door shut."

*The primary evaluator of the cases and issue in this report was former Associate Youth Ombudsperson, Ciara Sheerin. The majority of the report was completed/written prior to her departure from the OYO, but was finalized after her departure. This report and her contribution does not reflect her new place of employment.

However, secure detention facilities like the PJJSC may employ "seclusion" under very limited and heavily regulated conditions, as defined in §3800.274:

§3800.274. Additional Requirements

(17) The following requirements apply to the use of seclusion *[in qualifying secure facilities]*:

(i) Oral or written authorization by supervisory staff is required prior to each use of seclusion.

(ii) The use of seclusion may not exceed 4 hours, unless a licensed physician, a licensed physician's assistant or registered nurse examines the child and gives written orders to continue the use of seclusion. Reexamination and new written orders are required for each 4-hour period the seclusion is continued. If seclusion is interrupted for any purpose and reused within 24 hours after the initial use of seclusion, it is considered continuation of the initial seclusion period.

(iii) A staff person shall observe a child in seclusion at least every 5 minutes.

(iv) The physical needs of the child shall be met promptly.

(v) A child in seclusion shall be checked and observed by a supervisory staff person who is not continually observing the child as required in subparagraph (iii), at least every 2 hours the seclusion is used.

(vi) The use of seclusion for any child may not exceed 8 hours in any 48-hour period without a written court order.

(vii) A room used for seclusion shall meet the conditions as specified in § 3800.212(e) (relating to exclusion).

(18) Mechanical restraints and seclusion may not be used simultaneously for any child.

(19) The use of any combination of mechanical restraints and seclusion for any child may not exceed 6 hours in any 48-hour period without a written court order.

As detailed, there are strict and well-defined legal limitations on the amount of time that a youth may be placed in seclusion, as well as specific requirements outlining the need for medical evaluations, vigilant staff observations, supervisory approval, and court orders in some cases. These limitations and requirements are in place to ensure that youth are locked alone in their rooms only when absolutely necessary. This is in response to research and practice findings that have demonstrated that lengthy periods of isolation, such as seclusion, do not reduce violence, may increase recidivism, have negative psychological effects, and may carry other penalties such as losing phone calls or visitation.[1] Therefore, these provisions contemplate a serious intervention that must be closely controlled.

[1] As cited in: Council of Juvenile Correctional Administrators. (2015). Council of Juvenile Correctional Administrators Toolkit: Reducing the Use of Isolation [Toolkit] Retrieved from https://nicic.gov/series/cjca-toolkit.

III. Complaint Activity & Direct OYO Observations

Within a period of six months, the OYO received four (4) official complaints regarding the use of seclusion at the PJJSC.

Complaint 1. In February 2024, the OYO received a complaint from a confidential source alleging that several youth at the PJJSC were being held in seclusion following a fight in their housing unit. At the time of the complaint, it was reported that at least one youth was on day eight (8) of seclusion, in potential violation of §3800.274(17)(ii) and (vi).

Complaint 2. In April 2024, the OYO received a second complaint from a confidential source regarding the use of seclusion in two housing "pods" (used to describe a housing area within a unit) at the PJJSC following a fight. The complainant alleged to the OYO that two full pods of youth were placed on seclusion for extended periods. The complainant stated that the youth were told they would be on "lockdown" for 30 days and that the youth were not attending school and were eating in their rooms during their period of seclusion. The complainant believed that the youth were on their third day of seclusion, in potential violation of §3800.274(17)(ii) and (vi).

Complaint 3. In May 2024, the OYO was conducting programming at the PJJSC when a youth asked to speak to an OYO staff member. The youth reported that he and other youth were often held in seclusion in their rooms following altercations, and that seclusion was used at least monthly on his pod. He reported that he had personally experienced this once, for a 24-hour period. He stated that other youth involved in the same altercation were held in seclusion for three (3) days, but he was held for less time due to his lesser role in the altercation. He stated that during his 24-hour seclusion, he was permitted to leave his room to shower, but he did not attend school and ate his meals in his room. The youth's allegations indicate potential violation of §3800.274(17)(ii)[2] and (vi).

Complaint 4. In June 2024, the OYO was conducting programming at the PJJSC when a youth asked to speak to an OYO staff member. The youth reported that since being at the PJJSC, he had been placed in seclusion on up to five (5) distinct occasions. He reported that he was typically held in seclusion for three to four (3-4) days. However, on one occasion he was locked in his room for seven (7) days, and another period lasted ten (10) days, in potential violation of §3800.274(17)(ii) and (vi).

Upon receiving each complaint, the OYO promptly notified DHS for review and potential corrective action, as required by Executive Order 5-22. The OYO also requested that DHS provide all documentation governing the use of seclusion in connection with these specific allegations and as a matter of general policy and practice.

Direct OYO observations are notably consistent with these reports. Starting in April 2024, the OYO began a series of site visits to the PJJSC to deliver engagement and educational programming to the youth population. Each week, the OYO delivers a two-hour presentation for up to twelve (12) youth living in a designated pod. During these site visits, OYO staff has frequently observed at least one youth who was in seclusion – locked in their room – prior to the presentation and throughout its duration, with no notable staff or supervisory interaction, in possible violation of §3800.274(17)(iii) and (v).

[2] Upon notifying DHS of this complaint, the OYO and DHS decided to group it with the second complaint from April 2024 so that DHS could investigate them simultaneously. Interview notes were provided to DHS.

IV. Agency Response & Youth Interviews

Prior to the OYO, as a matter of DHS general practice, complaint activity at the PJJSC was addressed directly by staff in DHS' Juvenile Justice Services (JJS) unit – essentially the same group of personnel responsible for the administration of the PJJSC. After the OYO raised concerns about the independence of this process, DHS leadership promptly reassigned the review process to the Performance Management & Technology (PMT) unit of DHS – a system reform that must be recognized.

In response to the complaint activity between February and May 2024, PMT personnel conducted a series of youth interviews at the PJJSC, seven (7) of which were conducted in the presence of an OYO staff member. In each of these seven (7) cases, without prompting, the youth openly spoke about seclusion, expressing that they had either experienced it themselves or witnessed other youth subjected to the practice.

One youth reported that "room time" is typically for one to two (1-2) days and that youth can only leave their room to use the bathroom. Another youth stated that "lockdown" can last for weeks, and food is slid under the door. A third youth reported that that if you refuse to go to court, you are placed on a three-day "lockdown." That youth also stated that everyone gets phone calls on Mondays, Wednesdays, and Fridays, but if you are placed on "lockdown" on Wednesday and remain in there until Friday, you do not receive your Wednesday and Friday phone call, resulting in an extended period between any outside contacts.

After receiving additional PJJSC complaint activity in June 2024, PMT personnel interviewed a random sample of six (6) PJJSC youth. Once again without prompting, all six (6) youth reported times in which they were sent to their rooms for extended periods of time, typically up to four (4) days.

V. PJJSC Policy Manual Flaws

In April 2024, the OYO received and reviewed the then-active PJJSC policy manual, which included some instruction on the use of seclusion. Notably, however, there were a number of significant discrepancies between the PJJSC's internal seclusion policy and the applicable 3800 Regulations cited above.

For example, while the PJJSC seclusion policy required that a youth be observed by staff every five (5) minutes and that this observation be logged; it did not mention that a second-level supervisory observation should occur every two (2) hours, as expressly required by §3800.274(17)(v).

The PJJSC seclusion policy also stated that medical staff must provide a written order for any use of seclusion beyond eight (8) hours in a 48-hour period, but §3800.274(17)(ii) imposes this requirement upon any use of seclusion beyond four (4) hours in a 24-hour period. Additionally, the PJJSC seclusion policy did not mention the need for a court order to authorize seclusion lasting more than eight (8) hours in a 48-hour period, as outlined in §3800.274(17)(vi).

Notably, the PJJSC policy manual prohibited seclusion beyond four (4) hours. But there was no additional guidance to staff about how to calculate that time and/or toll this limitation over several days, as contemplated in §3800.274(17)(ii).

Shortly following the initial review of the PJJSC policy manual, OYO staff communicated these discrepancies to DHS and the PJJSC leadership, who acknowledged some misalignment and indicated that the manual would be revised and reissued at a later date. On October 29, 2024, the OYO received a revised seclusion policy from the PJJSC.

VI. Questionable Practices & Documentation

In August 2024, the OYO received the observation logs for all documented uses of seclusion at the PJJSC between April 2024 and July 2024. Review of these logs showed some glaring inconsistencies, which raised questions about the integrity of these records as well as questions about the use of seclusion within the PJJSC.

First, there was one documented instance during this time period when staff openly noted that a youth was placed in seclusion while also subject to mechanical restraints. This is a direct violation of §3800.274(18), which expressly bans the simultaneous use of these practices. When informed of this issue, PJJSC leadership reflected that this was very concerning and counter to their written internal seclusion policy. This raises concerns that written PJJSC policies may not always translate to practice. Examples such as this one indicate that line staff may not be implementing seclusion in accordance with PJJSC policy, and supervisors may not be doing a thorough review of the seclusion logs before signing off on them.

Second, although the seclusion logs recorded line staff observations, there was no indication of supervisory observation every two (2) hours, as required by §3800.274(17)(v). The OYO spoke to PJJSC leadership about this issue, who verbally reported that supervisory staff should be initialing the logs each time they observe the youth. While the OYO did find a few instances in the logs of this occurring, the majority of them did not demonstrate this in practice.

Third, there were numerous documentation issues in the seclusion logs, including conflicting and duplicative accounts, which raised credibility concerns. For example, seclusion logs for April 22nd, 2024, documented at least 20 youth – two full pods – who were placed in seclusion for several hours. But for each of these cases, there were two different logs – one reporting the seclusion period as occurring between 1:30PM and 4:50PM and a second recording the seclusion period as 2:00PM to 4:00PM. On all the associated seclusion logs, there were also conflicting statements about the youths' behaviors – one documenting youth as "calm" and another documenting those same individuals as "irate" at the same recorded time. Further, many of these records just repeated the exact same information for several different youth who were in seclusion at the same time. For example, the aforementioned logs for April 22nd, 2024, reported that an entire pod – nine (9) different children – were secluded for the exact same time period until they all fell asleep at precisely 4:50PM, raising concerns about the credibility of the logs. It is highly unlikely that each of these nine (9) youth, who were placed in seclusion in individual rooms, would all simultaneously fall asleep at 4:50PM. This suggests that the seclusion documentation may not accurately reflect each use of seclusion.

VII. Changes to PJJSC Policy & Practice

DHS and the PJJSC have made several changes to their policies and practices in order to correct the flaws noted by the OYO, which demonstrates their ongoing commitment to collaboration and upholding the rights of youth in their care.

As previously mentioned, DHS has committed to adding greater independence to the investigation of complaints at the PJJSC by having the PMT unit conduct interviews with random samples of youth, as opposed to the JJS unit being solely responsible for handling complaint activity.

Additionally, DHS and JJS staff and leadership have already begun much of the work needed to address the identified flaws in the facility's internal seclusion policy and practice. They have completed initial revisions to the facility's seclusion policy and have implemented more immediate changes to the facility's actual practice of seclusion.

For example, PJJSC leadership has shared that supervisors have been making rounds to all of the units to communicate instructions directly to line staff and observe compliance to these changes in practice, such as correctly employing seclusion and limiting its duration when it must be used. They have also created and shared an updated medical document that will be used along with the seclusion logs when seclusion lasts longer than four hours. Additionally, they report that they are working with staff to reduce the use of seclusion overall.

VIII. Analysis & Recommendations

DHS deserves credit for taking these initial steps and engaging with the OYO in good faith throughout this process. However, viewing the evidence on the whole – (i) notable complaint activity; (ii) direct OYO observations; (iii) youth interviews; (iv) departmental policy flaws; and (v) questionable practice and documentation – it is readily apparent that youth at the PJJSC are routinely subject to seclusion that is not in compliance with the law.

The OYO has received and reviewed the updated internal PJJSC seclusion policy. Although we acknowledge that important revisions were made, more changes are needed to ensure full compliance with the 3800 Regulations. To this end, we expect to have ongoing conversations with PJJSC leadership and DHS. Staff should also be retrained on the revised policy, and PJJSC leadership should create and disseminate written materials documenting expectations for full compliance with the 3800 Regulations. Once the PJJSC policy manual is finalized, it is the OYO's recommendation that the City Law Department conduct regular reviews to ensure ongoing compliance with the applicable laws.

In addition to finalizing the PJJSC policy manual, PJJSC leadership should also explicitly inform youth when their seclusion period is officially over. This practice will ensure that youth know when they can leave their rooms. It also ensures that youth can accurately report on the use of seclusion, such as how often it is employed and how long it is used for.

There continue to be issues of legal interpretation surrounding the practice of seclusion at the PJJSC that indicate a need for ongoing conversations between DHS, the PJJSC, the OYO, and the City Law Department. Some of these conversations have already been happening.

For example, the PJJSC's practice thus far has been to consider seclusion officially ended if a youth takes a nap or if nighttime sleeping hours begin because the youth is no longer considered to be a danger to themselves or others when asleep. This position is reflected in the seclusion observation logs as, in many of them, the final observation that staff members recorded indicated the youth had fallen asleep or that bedtime hours had started. The OYO has opined that seclusion is defined in the 3800 Regulations as placing a youth in a locked room and is not premised on the youth's presenting behavior. Additionally, the PJJSC leadership team has relayed in conversations with the OYO that if seclusion is reused for a new incident, then the seclusion clock is restarted for each new use of seclusion, even if it is within 24 hours of the last use. The OYO's interpretation of the 3800 Regulations in this matter is that if seclusion is interrupted and then continued within 24 hours of the initial use of seclusion, it should not be considered a separate and new period of seclusion. Both of these examples pose issues of legal interpretation that are being collectively discussed so that the finalized PJJSC policy manual can reflect the law accurately.

DHS and PJJSC leadership have also raised some operational concerns about the transaction costs of strict compliance with the 3800 Regulations, citing safety concerns regarding youth who are in seclusion and still pose a threat to themselves or others, but who cannot legally remain in seclusion any longer without a court order. Specifically, the concern is that it will not be possible to obtain required court orders to continue the use of seclusion past eight hours due to judge availability during non-business hours. The OYO recognizes that this poses a potential barrier to implementation. Despite this, it seems difficult to justify any deviation from statutory requirements that are very specific and clear. For our youth, the risk associated with stretching the acceptable practice of seclusion – as defined by the policymakers – far outweighs possible operational concerns.

The OYO recommends that the PJJSC and DHS consider alternatives that may mitigate this issue without compromising the statutory requirements around seclusion. Such alternatives could include moving youth to an area where they will not engage in fighting and are supervised by a staff member, such as an empty unit or a recreation area (like a gym or classroom). However, these alternatives require that the PJJSC remain under capacity so that alternative areas are open for youth, and staff are available for one-on-one supervision as needed. This emphasizes the need for all system stakeholders to prioritize solutions that address overcrowding so that the PJJSC can utilize the practice of seclusion safely and in compliance with the law.

Ultimately, we must do a better job of listening to our youth, crediting their experiences, and responding accordingly. We believe that the OYO is an important new tool that can do this, and trust that, together with DHS, we can collectively amplify youth voices and initiate change.

For more information about the Office of the Youth Ombudsperson – including complaint forms and educational resources for youth, parents, and family – please visit our City website at https://www.phila.gov/departments/office-of-the-youth-ombudsperson/.