

COALITION OF MOTHERS

Submitted by email to infocollection@acf.hhs.gov

Date: September 23, 2026

To: Office of Refugee Resettlement, Administration for Children and Families, U.S.
Department of Health and Human Services

Re: Proposed Information Collection Activity; Mental Health Assessment Form and Onsite Health Intervention Form, OMB No. 0970-0509, 91 Fed. Reg. 46,935 (July 27, 2026), FR Doc. 2026-15087

I. Who We Are

The Coalition of Mothers is an organization of mothers working on the policies that shape our children's lives: a parent's place in her child's medical care, child protection, and the rights of families. We comment on the proposed revision of the Mental Health Assessment Form and the new Onsite Health Intervention Form, OMB No. 0970-0509. Our attached white paper, *The Parent Nobody Asks*, sets out the full record and sources for what follows.

II. Our Position

We are writing about one sentence. The notice says that the Office of Refugee Resettlement (ORR) will begin sharing health information from these forms with the Department of Homeland Security (DHS) when a child with healthcare needs is identified for repatriation. It offers this as the safeguard: "Prior to sharing mental health information with DHS, ORR will request consent from the child." 91 Fed. Reg. at 46,936.

Our objection is simple. **No minor should ever be the one who signs away the privacy of his or her own mental health records.** The notice sets no minimum age. As written, a seven-year-old can be handed this form. No school would accept a seven-year-old's signature on a field trip form. No pediatrician would accept it for a flu shot. Every adult who has raised or taught a child knows why: a child that age cannot weigh what she is giving up, to whom, or for how long. A signature from her is not consent. It is compliance.

That leads to the question the notice never answers, and the one every mother asks first: **who is standing with this child?** The notice does not mention a parent, a legal guardian, a sponsor, an attorney, or a child advocate. It names only the child and the agency doing the asking.

We do not object to the purpose the notice gives. A child who is sent home on a daily medication should arrive with the medication, the dose, and the allergy list. Any mother would want that. Our objection is to who gets asked.

III. Questions Addressed

The Department asked for comment on four points. We address two: (a) whether the collection will have practical utility, and (c) the quality, utility, and clarity of the information to be collected.

IV. What We Ask the Agency to Consider

A. No child should consent alone to this disclosure, at any age

ORR's own rules already recognize that a child in its custody cannot simply be handed a consent form. When a doctor wants to give a child a psychotropic medication, the regulation lists who may consent, in order: "the child's parent or legal guardian, followed by a close relative sponsor, and then the unaccompanied child themselves if the child is of sufficient age and a doctor has obtained informed consent." 45 C.F.R. § 410.1310(a)(1). ORR's implementation plan for the *Lucas R.* settlement, which this notice cites as authority, allows a child to act as consenter only at "age 16 or 17," and states that "ORR staff are not authorized consenters." The ORR Policy Guide requires the written consent of a parent or legal guardian before shelter staff may put confidential information about a child under 14 into testimony or an affidavit. Policy Guide § 5.3.2.

We recognize that the medication rule lets an older child consent as a last resort. The disclosure in this notice calls for a stricter rule, not a looser one. A medication is prescribed for the child's own benefit, by a doctor who must first obtain informed consent. A disclosure to DHS gives the child no treatment at all. It sends what the child has told a counselor to the agency carrying out her return. If ORR will not let a child under 16 accept a medication on her own, it should not let a child of any age agree on her own to this.

Federal law outside ORR follows the same design. For a child's health information, research participation, school records, and Head Start records, the rule starts with a parent's permission, seeks the child's agreement in addition, and substitutes another protector when a parent is unavailable or unsafe. See 45 C.F.R. §§ 164.502(g)(3), 46.408; 34 C.F.R. § 99.30(a); 45 C.F.R. § 1303.22(a)(1). Our position is that an adult must give consent every time. An older child's own agreement should also be required, in addition to an adult's consent and never in place of it, and an older child's objection should end the matter.

B. Who is standing with this child?

Congress defines a child as unaccompanied when "there is no parent or legal guardian in the United States," or when "no parent or legal guardian in the United States is available to provide care and physical custody." 6 U.S.C. § 279(g)(2)(C). That describes where the parent is. It does not say the parent is gone, cannot be reached, or has lost the right to be asked about her own child. ORR's own release policy lists "Parent or legal guardian" as its first sponsor category. Policy Guide § 2.2.1. Where a parent or legal guardian can be reached, that parent should decide.

Where no parent can be reached, or where there is reason to believe a parent was involved in trafficking or abuse, the decision still belongs to an adult, and it should be an adult whose only duty is to the child. It should not be the child, and it should not be ORR. ORR is the custodian making the request, and it cannot also be the one who agrees to it. Congress has already provided the right people. It directed HHS to ensure that these children have counsel "to the greatest extent practicable," 8 U.S.C. § 1232(c)(5), and it authorized independent child advocates "for child trafficking victims and other vulnerable unaccompanied alien children," 8 U.S.C. § 1232(c)(6)(A). The notice mentions neither.

C. About one in four of these children is twelve or younger

ORR's published data show that children ages 0 to 12 made up 24 percent of the children in its care in fiscal year 2024, up from 15 percent in fiscal year 2022. The seven-year-old in our example is not

hypothetical. Children that young are in ORR's care, and under this notice any one of them could be asked to sign.

D. Look at who is asking and who receives the answer

The adult who asks for the child's signature works for the agency that houses the child, feeds the child, and decides when the child is released. The agency that receives the information is the one carrying out the child's return. A child in that position says yes because a grown-up in charge asked. Mothers know this about children. It is the reason we do not let them sign things alone.

ORR's medication rule sees the problem. It requires that consent be given "voluntarily, without undue influence or coercion," and it promises no retaliation for saying no. 45 C.F.R. § 410.1310(a)(2). The notice makes no such promise. It does not even say what happens if the child refuses. In one place it says ORR "will request consent." In another it says the information "must be shared with DHS." Both cannot be the rule.

E. What happened the last time

ORR has connected child welfare information to immigration enforcement before, and the government's own record shows what followed. In June 2018, ORR began sharing potential sponsors' identifying information and fingerprints with Immigration and Customs Enforcement (ICE). HHS's Inspector General found that, until February 2019, this information could be used for immigration enforcement, which "may have discouraged potential sponsors from coming forward." Children's average stay reached "a high of 93 days" in November 2018 before falling to 48 days by April 2019, and facility staff reported that longer stays brought "more instances of self-harm and suicidal ideation." HHS OIG, OEI-09-18-00431, at 4-5, 12-13 (Sept. 2019). In March 2021, HHS and DHS terminated the 2018 agreement behind that practice, describing it as an agreement that "undermined the interests of children and had a chilling effect on potential sponsors." HHS and DHS Joint Statement on Termination of 2018 Agreement (Mar. 12, 2021).

In February 2020, the Washington Post reported that notes from a teenager's therapy sessions in an ORR shelter had been passed to ICE and used against him in immigration court. Twenty-three senators asked the Inspectors General of both departments to investigate, and their letter quotes then-Secretary Alex Azar telling Congress that "this was a mistake, it should not have been happening." Letter of Sen. Feinstein et al. (Mar. 4, 2020). ORR's Policy Guide now tells care providers they "must not include clinical or mental health information" in incident reports that go to DHS "unless required by mandatory reporting laws." Policy Guide § 5.8.8 (rev. Aug. 1, 2024). When ORR finalized its 2024 rule, commenters asked it to keep counseling records separate from immigration files and away from enforcement absent the child's request or a court order. ORR declined. 89 Fed. Reg. 34,384, 34,441-42 (Apr. 30, 2024).

That history is a practical utility problem. When a child welfare program's information travels to enforcement, the people the program depends on, parents, sponsors, and children, become less willing to come forward. This proposal opens a new road to DHS for the kind of information the Policy Guide keeps off the old one. We ask the agency to explain how the two fit together, and to learn from the last time.

V. What We Ask the Agency to Do

1. **No minor consents alone.** Before any mental health information about a child goes to DHS, require the written consent of an adult, every time, whatever the child's age. Where a parent or legal guardian can be reached, that parent or guardian gives it, following the order in 45 C.F.R. § 410.1310(a)(1).
2. **Name the adult when no parent can be reached.** When no parent or guardian can be reached, or when ORR has reason to believe a parent was involved in trafficking or abuse, the decision should go to an independent adult charged with the child's best interests, such as a child advocate appointed under 8 U.S.C. § 1232(c)(6) or a court-appointed guardian. Never ORR staff, and never the child alone. If no such adult is available, no mental health information should be shared.
3. **Notify the child's lawyer first.** Notify the child's attorney or legal service provider before any request is made, and give them time to speak with the child and with the consenting adult.
4. **Give older children a voice, not the pen.** For a child 14 or older, the age at which the *Lucas R.* plan already requires a child's assent to medication, require the child's agreement in addition to the adult's consent. A child's objection should stop the disclosure.
5. **Make no mean no.** State on the form, in the child's language and the consenting adult's, that refusing has no effect on the child's care, placement, release, or legal case, and that consent can be withdrawn.
6. **Publish the consent form.** The notice does not include the paper a child would be asked to sign or the words staff would use to explain it. Publish both with the 30-day notice so the public can comment on the real thing.
7. **Send the care plan, not the chart.** Limit what DHS receives to the items the notice lists. No therapy notes and no narrative history. Put in writing that DHS may use the information for the child's care during return and for nothing else, and remove the "must be shared" language as applied to mental health information.

VI. Closing

The purpose behind this change is a good one. A child on daily medication should not lose it on the way home. But the notice asks the wrong question. It asks whether the child will sign. The question it should ask is who is standing with this child. For every child, at every age, the answer should be a responsible adult: a parent where one can be reached, and an independent advocate where one cannot. We thank the agency for the opportunity to comment.

Respectfully submitted,

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President and Co-Founder

Coalition of Mothers

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Attachment: *The Parent Nobody Asks* (white paper)