August 25, 2026

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Unaccompanied Alien Children Bureau
Office of Refugee Resettlement, Administration for Children and Families
U.S. Department of Health and Human Services
Washington, D.C.

[Submitted via Regulations.gov]

Re: Comment from the Academic Pediatric Association, American Academy of Child and Adolescent Psychiatry, American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Pediatric Society, American Psychiatric Association, Association of Medical School Pediatric Department Chairs, National Association of Pediatric Nurse Practitioners, Society for Adolescent Health and Medicine on the notice of proposed rulemaking (NRPM) RIN 0970-AD26.

Dear Mr. Biswas:

On behalf of the Academic Pediatric Association, American Academy of Child and Adolescent Psychiatry, American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Pediatric Society, American Psychiatric Association, Association of Medical School Pediatric Department Chairs, National Association of Pediatric Nurse Practitioners, Society for Adolescent Health and Medicine, we welcome the opportunity to respond to the notice of proposed rulemaking (NPRM) RIN 0970-AD26 published on June 26, 2026, by the Office of Refugee Resettlement (ORR) within the Administration for Children and Families at the U.S. Department of Health and Human Services (Docket No. ACF-2026-0199).

As medical and mental health clinicians for children and families, we write to express our strong concern that the NPRM will cause significant and permanent harm to unaccompanied children. If finalized, the NPRM would codify policy changes to sponsorship vetting that would prolong unaccompanied children's stays in ORR custody and prevent children from being unified with sponsors and from living in communities. Additionally, the NPRM would permit ORR to conduct invasive physical examinations of unaccompanied children to identify tattoos and markings. These proposed policy changes are unnecessary, harm unaccompanied children, and put these children at risk of re-traumatization and sexual abuse. For these reasons and those detailed in the comments that follow, ORR should immediately withdraw the NPRM and instead prioritize policies that promote and strengthen – rather than undermine – the health and safety of unaccompanied children.

**The NPRM is inconsistent with ORR's mission**

The NPRM is antithetical to ORR's statutory mandate and represents a fundamental shift of ORR from a child welfare agency to a law enforcement agency. In creating the Unaccompanied Children's

program, Congress charged ORR with the placement, care, custody, and release of unaccompanied children who arrive in the United States without a parent or legal guardian and without lawful immigration status, transferring these functions from an immigration enforcement agency to ORR, a child welfare agency.[1] Congress further reinforced ORR's child welfare mission by enacting the Trafficking Victims Protection Reauthorization Act (TVPRA), which requires any federal agency with custody of an unaccompanied child to transfer the child to HHS within 72 hours and mandates ORR promptly place unaccompanied children "in the least restrictive setting that is in the best interest of the child." [2]

Child welfare best practices prioritize children being placed in safe, stable, and nurturing kinship or foster care settings that promote permanency, support children's healthy development, and address the effects of trauma with the overarching goal of family reunification.[3] The Children's Bureau within the Administration for Children and Families of the U.S. Department of Health and Human Services states that congregate care settings are not a substitute for family and should only be used on a time-limited basis when youth require services that are unavailable in a less restrictive environment.[4]

The proposed changes to sponsor vetting will lead to increased lengths of stay for unaccompanied children in ORR custody and directly contradicts ORR statute, which require ORR to "release a child from its custody without unnecessary delay."[5] Additionally, increased lengths of stay for unaccompanied children contradicts ORR's own definition of "best interest of the child," which requires the agency to consider factors such as the unaccompanied child's expressed interests, mental and physical health, and the length or lack of time the unaccompanied child has lived in a stable environment."[6]

The preamble to the NPRM acknowledges that the proposed changes in 45 C.F.R. § 410.1202(b) and (c) to sponsor vetting "may increase the overall time a[n] [unaccompanied child] spends in the custody and care of ORR," noting that the average length of care increased from 49 days in February 2025 to 189 days in December 2025.[7] Current ORR data shows an average length of custody at 194 days in June 2026.[8] This represents a steady and deeply troubling increase from FY2024 and FY2025, where average lengths of stay were 30 days and 117 days, respectively.[8]

The proposed rule would worsen the current situation and would create a chasm between ORR's mandate from Congress and its actual care of children. Changes to ORR's sponsor vetting processes since 2025 have already resulted in children with a family member available to safely care for them being refused timely release, defying child welfare best practices.[9, 10, 11, 12] For example, recent reporting from Connecticut details a 5-year-old spending over 100 days in federal custody despite having a family member nearby and available to care for her.[13] A 13-year-old has been in a Texas shelter for over eight months as of July 20, 2026, despite his mother desperately wanting to care for him.[14] In another recent instance, a 6-year-old spent over half a year in an ORR shelter, while her mother worked to secure her release.[15] The stories of these children are discussed in further detail below, but they are all examples of children who should be living in communities and attending school, but instead are being denied that opportunity in direct contradiction to ORR's mission and statutory mandate. The NPRM, if finalized, will mean more children are kept away from their families and confined to institutional settings. Neither statute nor TVPRA support such an outcome.

**ORR did not adequately consider the specific harms to children of prolonged stays in federal custody**

Children and adolescents require permanency, stability, and a sense of belonging in a family to support optimal health and well-being. Similar to the domestic child welfare system, congregate care shelters run by ORR are not designed to care for children for long periods of time. Major medical associations, including the American Academy of Pediatrics, the American College of Physicians, and many others, have long documented the harms of detaining children.[16, 17] It has been well established that prolonged stays in congregate care settings are harmful to child health and development and that children should be reunified with their families as quickly as possible. Prolonged stays in congregate care settings increase children's exposure to peer-on-peer or adult-on-child sexual abuse. Unaccompanied children already suffer from the effects of being separated from their families. Keeping children in government custody for prolonged periods of time leads to cumulative and severe negative mental health and developmental outcomes with lifelong health impacts.

*Mental health harms*

Prolonged exposure to highly stressful situations — known as toxic stress — can disrupt a child's brain architecture and affect his or her short- and long-term health. A parent or a known caregiver's role is to mitigate these dangers. When robbed of that buffer, children are susceptible to a variety of adverse health impacts including learning deficits and chronic conditions such as depression, posttraumatic stress disorder and even heart disease.[18] The longer children remain in these congregate settings, the more likely they are to experience toxic stress which leads to adverse health outcomes, especially for their mental health.

In its 2019 report on the challenges of addressing unaccompanied children's mental health needs, the HHS Office of Inspector General (OIG) found that longer stays in ORR custody led to higher levels of defiance, hopelessness, and frustration among children, along with more instances of self-harm and suicidal ideation.[19] Mental health clinicians interviewed as part of the report described that "a child's mental health often deteriorates as the length of their stay in ORR custody increases."[19] One of the six OIG recommendations in the report was that ORR should take all reasonable steps to minimize the time that children remain in ORR custody.[19]

The levels of posttraumatic stress disorder (PTSD), anxiety, and depression are much higher in unaccompanied children compared with accompanied immigrant children.[20, 21] A recent analysis of nearly 5,000 children held in government custody across four countries found rates of PTSD increased the longer children were held in custody, ranging from 6.5% for children held for 30 days to 100% of children held for 12 months.[22] Below are specific examples of mental health harms to unaccompanied children as a result of prolonged lengths of stay in custody:

- In a July 2026 article from the Texas Tribune, a 13-year-old child in ORR custody for over eight months has been prescribed various psychotropic medications to help quell his anxiety, refused to talk to anyone at times, and was recently admitted into a psychiatric hospital because his anxiety had become debilitating.[14]

- A July 2026 report from CT Insider highlighted a story about a 5-year-old girl who languished in custody for 118 days, even though her mom was nearby and had a bedroom waiting for her. Dr. Laine Taylor, a board-certified child and adolescent psychiatrist affiliated with the Yale Child Study Center, evaluated the 5-year-old and found the girl was experiencing disrupted sleep due to having nightmares, avoiding conversation about her family, and manifesting anxiety through her play. Dr. Taylor stated the child's prolonged separation from her mother, "represents a significant risk to her emotional developmental, and psychological well-being" and that "Such conditions exceed what would be considered developmentally tolerable stress and warrant serious clinical concern."[13]
- A 14-year-old child who had been held in ORR custody for over a year said the shelter "felt like a prison." The child experienced significant trauma in his home country and during his journey to the U.S. to seek asylum. His family fled Honduras because local gangs threatened to kill his family. En route to the U.S., the child and his family were kidnapped by suspected drug cartel members but were able to escape.[14]
- A 7-year-old boy in ORR custody for multiple months told his mother in May 2025 that he was confused as to why he was still in custody and that his mother "must not want him after all" because he was not being released to her care.[23]
- 17-year-old Xavier and his 13-year-old sister were in U.S. custody for six months when he told immigration lawyers that he and his sister were struggling in ORR custody and felt stuck and imprisoned. They stated the separation from their mother has been especially difficult because of the trauma they experienced prior to arriving in the U.S. A legal complaint from May 2025 stated that Xavier and his sister "cry frequently and Xavier's younger sister has experienced severe deterioration of her mental health."[24]

*Physical and developmental harms*

Children who have been separated from their families can face immediate health problems, including physical symptoms like headaches and stomach pain, changes in body functions like eating and sleeping; behavior problems like anger, irritability, and aggression; and difficulty with learning and memory. Memory loss is frequently seen in legal immigration relief evaluations across all ages.[25] Common physical health impacts reported among asylum-seeking children globally who have spent time in government custody include malnutrition, dental disease, somatic complaints such as headaches and bedwetting, and vitamin D deficiency.[26] It is also well-established that adverse childhood experiences such as family separation increase the long-term risk of serious chronic and life-threatening conditions such as diabetes, cancer, and heart disease.[27]

In addition to health challenges, separated children can experience developmental trauma, which is defined as the impact of early, repeated trauma and loss occurring within a child's important relationships.[28] Developmental trauma impacts children's brain development and can lead to delays like those in speech, gross and fine motor skills, and regression in behaviors like toileting.[18] In addition to developmental trauma, unaccompanied children may also miss out on opportunities to advance their education. Below are examples of physical, developmental, and educational harm to unaccompanied children as a result of prolonged lengths of stay in custody:

- A 14-year-old named Miguel spent 167 days in ORR custody. In a sworn statement, Miguel stated that he cried often, and the stress brought headaches and fevers. He was "desperate to feel his father's hug again."[29]
- A 14-year-old boy named Diego was re-apprehended by Border Patrol in November 2025 and re-referred to ORR despite having previously been released to live with his father. It has been difficult for him to adjust to life in custody as he misses being able to go outside for fresh air and being able to talk with his friends. Diego states he doesn't feel that he is learning anything while in ORR custody because "the lessons are too easy and basic. He is being taught to name fruits in English when he should be a freshman at his public high school.[30]
- A 16-year-old girl named Renesme had been released to her father after he was vetted and approved by ORR in 2023. In November 2025, she was detained by immigration authorities while in a car with a friend. Renesme is concerned that she's not receiving academic credit for school and that she will need to repeat 11th grade and will not be able to finish her three-year Junior ROTC certificate, which she has been working towards in the hopes of serving in the U.S. military.[30]

Children who spend time in institutions are more likely to have poor physical, mental, and social-emotional development than their peers who grow up in family-based care.[31] Although ORR-funded shelters must meet certain standards of care, they are not a substitute for family-based care. Forcing children into institutional settings when family is available to provide care is simply family separation through regulation.

**Searching a child for gang-related tattoos and markings causes major harm and is highly unnecessary**

In addition to codifying changes to sponsor vetting, the NPRM at 45 C.F.R. § 410.1103(h) proposes a new requirement to have ORR examine children for gang-related tattoos and markings to align with Public Law 119-21, which provided funding, but not legal authority, for these intrusive searches. The NPRM attempts to invent legal justification that doesn't exist in statute by positing that searching children for tattoos and markings can help determine "whether an unaccompanied child poses a danger to themself or others." Existing regulations do not provide authority for anyone other than a licensed medical provider to physically examine unaccompanied children and explicitly state that ORR facilities shall not "apply medical interventions that are not prescribed by a medical provider acting within the usual course of professional diagnosis or that increase risk of harm to the unaccompanied child or others."[32] The proposed examinations are highly unnecessary and increase risk of harm to children by subjecting them to inappropriate and traumatic searches by ORR staff who are not appropriately trained to conduct such examinations.

Unaccompanied children are a uniquely vulnerable group; many are fleeing poverty, gang violence, abuse, neglect, sexual violence, and natural disasters.[33] Unaccompanied children are frequently subjected to violence in their home countries and continue to be victims of violence throughout their migration journey.[34] Many unaccompanied children develop medical and mental health problems as a result of the trauma caused by forced labor, sex and labor trafficking, and exploitation. Trauma is defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) as an event,

series of events, or circumstances experienced by a person as physically or emotionally harmful that can have long-lasting adverse effects on the person's functioning and well-being (emotional, physical, or spiritual).[35]

Because unaccompanied children are a uniquely vulnerable population with high exposure to trauma, it is imperative that every interaction with ORR staff is trauma-informed and does not retraumatize the child. Trauma-informed care is defined by the National Child Traumatic Stress Network as medical care in which all parties involved assess, recognize, and respond to the effects of traumatic stress on children, caregivers, and health care providers.[36] Any provider who examines, interviews, or otherwise interacts with a child needs to adopt a trauma-informed, rights-based, culturally responsive approach to care for patients suspected of experiencing trafficking and exploitation.[37] ORR's mission is aligned with these principles, as the agency states its role is to promote the health, well-being, and stability of unaccompanied children "through culturally responsive, trauma-informed, and strengths-based services."[38]

A physical examination of a child's body, particularly if conducted by individuals who lack specialized pediatric training and experience, is a medical act that has the possibility, of traumatizing or re-traumatizing a child, where the child re-experiences a previously traumatic event.[39] The U.S. Supreme Court has emphasized the "inherently harmful, humiliating, and degrading" nature of strip searches, which have caused documented harm.[40] The removal of clothing, loss of privacy, physical positioning, unexpected touch, and loss of control are documented re-traumatizing triggers.[41] Strip searching a child for tattoos or markings falls under ORR's own definition of child abuse and neglect as an act "which results in serious emotional harm or exploitation."[6]

Medical societies, including the AAP, have long held that examinations of children who have experienced trauma "should not result in additional physical or emotional trauma."[42] Any physical examination of a child should only be performed by a licensed pediatric clinician specifically trained to provide child-centered, culturally responsive, trauma-informed medical care, in an appropriate clinical setting, with a trained chaperone, and with the child's consent or assent and an explanation of each step. The child, if of a developmentally appropriate age, should be asked if they prefer having pediatric medical provider of the same gender, and this should be provided. The AAP's policy on the use of chaperones and clinical guidance on examining children establishes these safeguards, which are especially important for children who have experienced abuse, exploitation, or other trauma.[43, 44]

Additionally, physical searches of children are highly unnecessary and duplicative to the Independent Medical Examination (IME) that unaccompanied children are required to receive within two business days of admission to ORR custody, which already addresses tattoos and markings. Page one of ORR's IME form includes specific screening for history of abuse, including gang-related victimization. Page two of the form includes a skin exam that specifically notes whether an unaccompanied child has tattoos. Page three of the IME form includes complaints, symptoms, and diagnoses for 'Skin, Hair, and Nails' where a medical examiner would note the presence of tattoos.[45]

As medical and mental health experts, we understand that the safety of unaccompanied children in ORR custody is paramount. The proposed 45 C.F.R. § 410.1103 claims that examination for tattoos and

other markings is for the sole purpose of determining whether an unaccompanied child "poses a danger to self or others." A physical examination of a child is highly unnecessary to make this determination, as there are validated screening tools to assess whether a child poses a danger to themselves or others. These validated tools require a dialogue between the child and a trained clinician, not a physical examination, and include mental health screening tools such as the National Institute of Mental Health Ask Suicide-Screening Questions,[46] the Suicidal Behaviors Questionnaire-Revised,[47] the Patient Health Questionnaire – 9 Adolescent Version,[48] and the Patient Safety Screener.[49] To determine if a child is at risk of harming others, medical and mental health clinicians rely on the Structured Assessment of Violence Risk in Youth (SAVRY) rating form. Mental health clinicians use various sources of information including conversations with the child, interviews with parents and caregivers, and school reports to complete the risk assessment.[50] None of the validated risk instruments include tattoos as an item and youth violence experts caution against using tattoos and markings as a basis for detention decisions because they are not a reliable predictor of individual behavior.[51]

There may be a narrow scope of when searching a child for markings would be appropriate, such as circumstances when a child is physically harming other children and openly discussing gang affiliation. These unique circumstances would require appropriate guardrails. In these situations, ORR's Unaccompanied Children Program Policy Guidance section 3.3.13 states that behavior management strategies employed by ORR providers must meet child welfare best practice standards and utilize trauma-informed, linguistically responsive and evidence-based child-behavior management practices that take into consideration the age and maturity of the child.[52] In situations where there is clear and convincing evidence that a child poses a danger to themselves or others and/or is at risk of running away, the child may be placed in a more restrictive facility such as a residential treatment center or other therapeutic setting.[52] However, according to ORR guidance, this would only happen if a licensed pediatric psychologist or psychiatrist evaluates the child and makes a determination that the child poses a danger to themselves or others.

**Tattoos and markings are unreliable indicators of gang affiliation, trafficking and exploitation**

Gang-related tattoos and trafficking branding tattoos are virtually indistinguishable from ordinary tattoos. A tattoo or marking alone cannot conclude a person is affiliated with a gang without additional evidence. The same symbols often cited as gang markers — crowns, stars, clocks, roses, religious imagery, hometown and sports references — are extremely common among people with no gang affiliations and are unreliable evidence in determining gang affiliation.[53] Several studies find that even trained investigators reached inconsistent, unreliable conclusions when assessing the same markings and that branding tattoos are routinely mistaken for gang-related markings.[54] Many of the markings ORR intends to search for in fact overlap with the branding that traffickers place on trafficked and exploited children.[55]

As medical and mental health clinicians, we are concerned that misidentified markings could lead children to be placed in more harmful, restrictive settings. The presence of a tattoo or marking on a child's body is not sufficient to determine whether a child should be placed in a more restrictive setting. Existing regulations on behavior management for unaccompanied children prohibit the use

of any practices that "involve negative reinforcement or involve consequences or measures that are not constructive and are not logically related to the behavior being regulated."[5] Restrictive placements are exceedingly harmful to children and youth; it harms their development, exacerbates their pre-existing trauma, puts them at greater risk of self-harm, and exposes them to abuse.[56] In addition to re-traumatizing an already vulnerable population, the proposed vetting of unaccompanied children for gang-related tattoos and markings would likely cause additional harm if utilized to house children in more restrictive settings.

Finally, the NPRM explicitly requested comments around "which mechanisms ORR should use to determine whether a child may have been involuntarily tattooed or that a tattoo might be an indicator of potential exploitation, abuse, or trafficking" (45 C.F.R. § 410.1103). As medical and mental health clinicians, we implore ORR to utilize tools developed by HHS and expert partners to screen children for trafficking and exploitation including, "Core Competencies for Human Trafficking Response in Health Care and Behavioral Health Systems" that outlines essential skill sets for practitioners to identify, support, and care for victims of trafficking and exploitation using trauma-informed approaches. [57]

**Conclusion**

Thank you for the opportunity to provide feedback on the NPRM. For the reasons stated above, we strongly oppose this NPRM and urge ORR to immediately rescind it. Instead, we implore ORR to advance policies that strengthen, rather than undermine, the reunification of unaccompanied children with family members.

Sincerely,

Academic Pediatric Association
American Academy of Child and Adolescent Psychiatry
American Academy of Family Physicians
American Academy of Pediatrics
American College of Physicians
American Pediatric Society
American Psychiatric Association
Association of Medical School Pediatric Department Chairs
National Association of Pediatric Nurse Practitioners
Society for Adolescent Health and Medicine

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