

The Parent Nobody Asks

Why no child should consent alone to sharing mental health information with the Department of Homeland Security

A white paper by the Coalition of Mothers, September 2026

Submitted with the Coalition's comment on OMB No. 0970-0509, 91 Fed. Reg. 46,935 (July 27, 2026)

Executive Summary

On July 27, 2026, the Office of Refugee Resettlement (ORR) proposed revisions to the forms its clinicians use to assess the mental health of unaccompanied children in federal custody.¹ The revision adds a new use for the information: sharing it with the Department of Homeland Security (DHS) when a child with healthcare needs is identified for repatriation. The notice offers one safeguard, in one sentence: "Prior to sharing mental health information with DHS, ORR will request consent from the child."²

That sentence names the child and no one else. It sets no minimum age. It does not mention a parent, a legal guardian, a sponsor, an attorney, or a child advocate. It does not say what happens if the child says no. This paper makes four points.

First, unaccompanied does not mean parentless. Congress defined an unaccompanied child by whether a parent is in the United States and available to provide care, not by whether a parent exists. ORR's own release policy puts parents first.

Second, federal law does not treat a child's signature as consent to share sensitive information. From health privacy to school records to research involving children, the federal pattern starts with a parent's permission, seeks the child's agreement in addition, and substitutes an independent protector when a parent is unavailable or unsafe. ORR's own consent rules for children in its custody follow the same design. The notice abandons it.

Third, the notice would let ORR hand this form to a seven-year-old. Children 12 and younger made up 24 percent of the children in ORR's care in fiscal year 2024. A signature from a young child, obtained by the agency that controls where she sleeps and when she leaves, for a disclosure to the agency carrying out her return, is compliance, not consent.

Fourth, ORR has opened this kind of door before, and the government itself later said it did harm. In 2018 ORR began sharing sponsor information with immigration enforcement. HHS's Inspector General reported that the practice may have discouraged sponsors, and that children's stays

¹ Admin. for Children & Families, 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, <https://www.federalregister.gov/documents/2026/07/27/2026-15087/proposed-information-collection-activity-mental-health-assessment-form-and-onsite-health>.

² 91 Fed. Reg. at 46,936.

and distress grew. In 2021, HHS and DHS terminated the agreement behind it, calling it an agreement that “undermined the interests of children and had a chilling effect on potential sponsors.”

Our recommendation in one sentence: before any mental health information about a child goes to DHS, an adult must consent every time, whatever the child’s age: a parent or legal guardian wherever one can be reached, and an independent adult charged with the child’s best interests wherever one cannot, with an older child’s agreement required in addition and her objection honored.

1. What the Notice Proposes

The notice seeks a three-year extension, with changes, of OMB No. 0970-0509. It revises the Mental Health Assessment Form, merges two public health investigation forms into a single Onsite Health Intervention Form, and expands the stated purposes of the data to include sharing health information with DHS “when a child in ORR custody has healthcare needs and is identified by DHS for repatriation.”³ The information to be shared includes the child’s name, alien number, and date of birth; active diagnoses or concerns that require management; allergies; current medications and dosages; isolation or quarantine requirements; health-related accommodations, including durable medical equipment; and health-related travel restrictions.⁴

The notice states its purpose plainly: “The purpose of sharing this data is to ensure children receive healthcare services and accommodation as recommended by their treating healthcare providers.”⁵ We accept that purpose. A child who goes home on a daily medication should arrive with the medication, the dose, and the allergy list. Any mother would want that.

What the notice leaves out is the problem. It names no DHS component and no DHS system of records. It sets no retention period and no limit on how DHS may use what it receives.⁶ It does not say what happens if a child refuses. And it states the rule two ways. In one place it says that when a child with a condition requiring daily management is identified for repatriation, relevant information from the child’s treatment plan “must be shared with DHS.”⁷ In another it says ORR “will request consent from the child.”⁸ Both cannot be the rule for mental health information.

Finally, the consent form itself is not in the record. The notice invites the public to request copies of the proposed collection by email,⁹ but the paper a child would be asked to sign, and the words staff would use to explain it, have not been published.

2. Unaccompanied Does Not Mean Parentless

Congress defined an unaccompanied alien child as a child under 18 with no lawful immigration status for whom “there is no parent or legal guardian in the United States,” or for whom “no parent or

³ 91 Fed. Reg. at 46,936.

⁴ *Id.*

⁵ *Id.*

⁶ See 91 Fed. Reg. 46,935 to 46,937. The notice refers only to “the Department of Homeland Security (DHS)” and to ORR’s own “secure, electronic system of record.” *Id.* at 46,935.

⁷ *Id.* at 46,935-36.

⁸ *Id.* at 46,936.

⁹ See *id.* at 46,935-36.

legal guardian in the United States is available to provide care and physical custody.”¹⁰ ORR’s regulations use the same definition.¹¹

The words that matter are “in the United States.” The definition describes where a parent is and whether that parent can take physical custody here. It does not say the parent is dead, unknown, unfit, or stripped of the right to be asked about her own child. Nothing in the definition assumes the child has no living parent, and ORR’s release system is built on the expectation that many do.

ORR’s release policy ranks potential sponsors, and the first category is the parent: “Category 1: Parent or legal guardian.”¹² An agency that looks first to a child’s parent when deciding who should care for her cannot treat that same parent as irrelevant when it wants to send the child’s mental health information to DHS.

The Supreme Court has described the parent’s role in the same terms for a century. It has called the interest of parents in “the care, custody, and control of their children” “perhaps the oldest of the fundamental liberty interests recognized by this Court.”¹³ It has explained that “[t]he law’s concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life’s difficult decisions.”¹⁴ And it has said that “[t]he child is not the mere creature of the State.”¹⁵

We state the limits of those cases candidly. None of them decides whether ORR must ask a parent abroad before sharing a child’s records with DHS, and *Parham* itself paired parental authority with review by a neutral factfinder to protect the child. That is the model we ask ORR to adopt: an adult with responsibility for the child decides, and independent safeguards protect the child’s own interests. What the cases do not support is the opposite model, in which the government’s custody of a child quietly removes every adult from the decision.

3. How Federal Law Treats a Child’s Sensitive Information

Across very different programs, federal law follows the same pattern when a child’s sensitive information is at stake. An adult with legal responsibility for the child gives permission. The child’s own agreement, called assent, is sought in addition when the child is old enough. And when a parent is unavailable or is the danger, the law does not hand the decision to the child. It substitutes another protector.

¹⁰ 6 U.S.C. § 279(g)(2)(C)(i)-(ii).

¹¹ 45 C.F.R. § 410.1001.

¹² ORR, Unaccompanied Children Bureau Policy Guide § 2.2.1 (rev. Aug. 8, 2025), <https://acf.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide-section-2>.

¹³ *Troxel v. Granville*, 530 U.S. 57, 65 (2000) (plurality opinion).

¹⁴ *Parham v. J.R.*, 442 U.S. 584, 602 (1979).

¹⁵ *Pierce v. Society of Sisters*, 268 U.S. 510, 535 (1925).

Authority	Whose permission it requires	What it shows
HIPAA Privacy Rule, 45 C.F.R. § 164.502(g)(3)(i)	A parent, guardian, or person acting in loco parentis with authority under applicable law must be treated as an unemancipated minor's personal representative. ¹⁶	The default decision maker for a child's health information is the responsible adult. A provider may decline to treat an adult as the child's representative where abuse or danger is reasonably believed. ¹⁷
Research involving children, 45 C.F.R. § 46.408	"[A]dequate provisions are made for soliciting the permission of each child's parents or guardian," in addition to the child's assent, judged by "the ages, maturity, and psychological state of the children involved." ¹⁸	Assent and permission are different, and both are required. If parental permission is not a reasonable protection, "an appropriate mechanism for protecting the children" must be substituted. ¹⁹
Protection of Pupil Rights Amendment, 20 U.S.C. § 1232h(b)	No student may be required to submit to a survey, analysis, or evaluation revealing "mental or psychological problems of the student or the student's family" without, for an unemancipated minor, "the prior written consent of the parent." ²⁰	When a program run by the Department of Education asks about a child's mental health, Congress chose written parental consent.
FERPA, 34 C.F.R. § 99.30(a)	"The parent or eligible student shall provide a signed and dated written consent" before education records are disclosed, subject to listed exceptions. ²¹	A school-age child's records are released on a parent's signature, not the child's.
IDEA, 34 C.F.R. § 300.622(a)	"Parental consent must be obtained before personally identifiable information is disclosed" to outside parties, subject to listed exceptions. ²²	The same rule protects children with disabilities.
Head Start, 45 C.F.R. § 1303.22(a)(1)	Programs must "obtain a parent's written consent before the program may disclose such PII from child records," subject to listed exceptions. ²³	HHS itself uses parental consent for the records of the children it serves.

None of these provisions governs ORR directly. We cite them for their design, which is consistent across programs.

Federal law does sometimes let a minor control her own health information. Under HIPAA, that happens when the minor lawfully consented to the underlying care on her own, as some states allow adolescents to do for particular kinds of treatment.²⁴ That exception exists so an adolescent can get help she might not otherwise seek. It was not written for a federal custodian seeking a child's signature to send her records to the agency carrying out her return, and no one suggests it was meant for a seven-year-old.

¹⁶ 45 C.F.R. § 164.502(g)(3)(i).

¹⁷ 45 C.F.R. § 164.502(g)(5).

¹⁸ 45 C.F.R. § 46.408(a)-(b).

¹⁹ 45 C.F.R. § 46.408(c).

²⁰ 20 U.S.C. § 1232h(b)(2).

²¹ 34 C.F.R. § 99.30(a).

²² 34 C.F.R. § 300.622(a).

²³ 45 C.F.R. § 1303.22(a)(1).

²⁴ 45 C.F.R. § 164.502(g)(3)(i).

4. ORR's Own Consent Rules

ORR does not need to look outside its own program for the right design. It already has one.

When a doctor wants to give a child in ORR custody a psychotropic medication, the regulation names three categories of authorized consenter, 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.”²⁵ Consent “must be obtained voluntarily, without undue influence or coercion,” and ORR “will not retaliate” against a child or consenter who refuses.²⁶ The child may have “the assistance of counsel.”²⁷

ORR’s implementation plan for the *Lucas R.* settlement, which the notice lists as authority, is stricter still. It defines a child consenter as a child “age 16 or 17, from whom a doctor has obtained informed consent,” requires the assent of children 14 and older, and states that “ORR staff are not authorized consenters.”²⁸

The Policy Guide applies a similar structure to a child’s confidential information. Care provider staff may put confidential information into testimony or an affidavit for a child 14 or older with the child’s written consent, and for a younger child “the care provider should seek the written consent of the child’s parent or legal guardian.”²⁹ And ORR’s regulations require that, before a child’s assessment and counseling begin, care providers give the child “a written notice of the limits of confidentiality” and explain it orally in the child’s language “in a way they can effectively understand.”³⁰

Measured against its own rules, the notice is an outlier. For a prescription, the parent is asked first and the child last. For testimony about a child under 14, the parent is asked. For sending a child’s mental health information to DHS, the notice asks the child alone, at any age, and the request comes from ORR, the custodian the *Lucas R.* plan bars from serving as consenter.

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.

²⁵ 45 C.F.R. § 410.1310(a)(1).

²⁶ 45 C.F.R. § 410.1310(a)(2).

²⁷ 45 C.F.R. § 410.1310(c).

²⁸ ORR, Implementation Plan for the *Lucas R.* Psychotropic Medication Settlement Agreement 8 & n.5, 9 (Feb. 7, 2025), https://acf.gov/sites/default/files/documents/orr/Implementation_Plan-Lucas-R.-Psychotropic-Medication.pdf; see *Lucas R. v. Becerra*, No. 2:18-cv-05741 (C.D. Cal.).

²⁹ ORR Policy Guide § 5.3.2, <https://acf.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide-section-5>.

³⁰ 45 C.F.R. § 410.1306(c)(1).

5. A Signature Is Not Consent

The seven-year-old

The notice sets no minimum age. 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 2022.³¹ As written, the notice would allow a seven-year-old to 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.

What the research shows

The research on children's decision making supports what mothers already know, and it also cautions against overstatement. In a study of 96 subjects at ages 9, 14, 18, and 21, Weithorn and Campbell found that "9-year-olds appeared less competent than adults with respect to their ability to reason about and understand the treatment information provided," while "[o]verall, 14-year-olds did not differ from adults."³² A larger study of 927 adolescents and 466 young adults found that "[y]ouths aged 15 and younger performed more poorly than young adults, with a greater proportion manifesting a level of impairment consistent with that of persons found incompetent to stand trial."³³

We draw a measured conclusion. Older adolescents can reason well about decisions in a calm setting, which is why we ask that their agreement be required. Younger children cannot be presumed to understand what they are authorizing. And none of these studies tested a child in custody, asked by her custodian to release mental health information to an enforcement agency. That setting is harder, not easier.

Who asks, and who receives

The adult who asks for the child's signature works for the agency that houses the child, feeds her, and decides when she is released. The information goes to the agency carrying out her return. A child in that position says yes because a grown-up in charge asked.

Federal ethics standards recognize the problem. The Belmont Report, the foundation of federal research ethics, states that an agreement "constitutes a valid consent only if voluntarily given," and that voluntariness "requires conditions free of coercion and undue influence."³⁴ Federal rules for research with prisoners require "[a]dequate assurance" that participation will not affect parole, with each prisoner "clearly informed in advance" of that fact, because a choice made in "the limited choice environment of the prison" cannot be taken at face value.³⁵

³¹ ORR, Unaccompanied Children Facts and Data (age breakdown by fiscal year), <https://acf.gov/orr/about/ucs/facts-and-data>.

³² Lois A. Weithorn & Susan B. Campbell, *The Competency of Children and Adolescents to Make Informed Treatment Decisions*, 53 Child Dev. 1589 (1982) (abstract), <https://pubmed.ncbi.nlm.nih.gov/7172783/>.

³³ Thomas Grisso et al., *Juveniles' Competence to Stand Trial: A Comparison of Adolescents' and Adults' Capacities as Trial Defendants*, 27 Law & Hum. Behav. 333 (2003) (abstract), <https://pubmed.ncbi.nlm.nih.gov/12916225/>.

³⁴ Nat'l Comm'n for the Protection of Human Subjects of Biomedical & Behavioral Research, *The Belmont Report* pt. C.1 (1979), <https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/read-the-belmont-report/index.html>.

³⁵ 45 C.F.R. § 46.305(a)(2), (a)(6).

These are research standards, not rules that govern ORR. But they show how the federal government responds when a person in its custody is asked to agree to something: it adds protection. The notice subtracts it.

Our position

An adult must give consent every time, whatever the child's age. 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.

6. Who Stands With the Child

The question the notice never answers is the one every mother asks first: who is standing with this child?

Where a parent or legal guardian can be reached, the answer is the parent. 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. Federal law already works this way. When parental permission is not a reasonable protection, “for example, neglected or abused children,” the research rules require that “an appropriate mechanism for protecting the children” be substituted.³⁶ For certain research involving children who are wards, they require “appointment of an advocate for each child who is a ward,” who “agrees to act in, the best interests of the child” and “is not associated in any way” with “the guardian organization.”³⁷ HIPAA lets a provider decline to treat an adult as a child's representative where the provider reasonably believes the child has been or may be subjected to abuse by that person.³⁸

The ward rule deserves a direct word. When the institution holding a child has its own interests in a decision, federal law adds an independent adult. It does not ask the child to stand in for one. ORR is in exactly that position here. It is the custodian making the request, and it cannot also be the one who agrees to it. That is the same reason the *Lucas R.* plan bars ORR staff from serving as consenters.

Congress has already supplied the right people for these children. It directed HHS to ensure, “to the greatest extent practicable,” that unaccompanied children have counsel.³⁹ It authorized independent child advocates “for child trafficking victims and other vulnerable unaccompanied alien children,” and provided that an advocate “shall not be compelled to testify or provide evidence in any proceeding concerning any information or opinion received from the child.”⁴⁰ Congress protected what a vulnerable child tells her advocate from use in proceedings. The notice mentions neither counsel nor advocates.

Child advocates are not appointed for every child. That is why our recommendation names a kind of person rather than one program: an appointed child advocate where there is one, and otherwise a court-appointed guardian or another independent adult charged with the child's best interests who plays no role in the child's custody, placement, or immigration case.

³⁶ 45 C.F.R. § 46.408(c).

³⁷ 45 C.F.R. § 46.409(b).

³⁸ 45 C.F.R. § 164.502(g)(5).

³⁹ 8 U.S.C. § 1232(c)(5).

⁴⁰ 8 U.S.C. § 1232(c)(6)(A).

7. What Happened the Last Time

ORR has connected child welfare information to immigration enforcement before. The record of what followed comes from the government's own reports.

2018: sponsor information and the chilling effect

On April 13, 2018, ORR, Immigration and Customs Enforcement (ICE), and Customs and Border Protection signed a memorandum of agreement on consultation and information sharing in unaccompanied children's cases.⁴¹ HHS's Inspector General later described what followed. "[I]n June 2018, ORR began requiring all parents or legal guardians and adult members of their households to submit fingerprints," and "also began sharing with Immigration and Customs Enforcement (ICE) the identifying information and fingerprints of all potential sponsors and adult household members. Until February 2019, this information could be used for immigration enforcement purposes, which also may have discouraged potential sponsors from coming forward."⁴²

Children waited longer. The average length of stay rose from 55 days for children released in January 2018 to "a high of 93 days for children who were released from ORR custody in November 2018," and after ORR changed its screening requirements, "[b]y April 2019, the average length of stay had declined to 48 days."⁴³ Facility staff told the Inspector General that "longer stays resulted in higher levels of defiance, hopelessness, and frustration among children, along with more instances of self-harm and suicidal ideation."⁴⁴ These findings came from site visits to 45 ORR-funded facilities and interviews with approximately 100 mental health clinicians.⁴⁵

On March 12, 2021, HHS and DHS jointly announced the termination of the 2018 agreement, describing it as an agreement that "undermined the interests of children and had a chilling effect on potential sponsors," and replaced it with a new one.⁴⁶

2020: therapy notes

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.⁴⁷ On March 4, 2020, twenty-three senators asked the Inspectors General of HHS and DHS to investigate, writing that "ICE attorneys used information revealed by children to their therapists as they sought to remove those

⁴¹ HHS Office of Inspector General, *Care Provider Facilities Described Challenges Addressing Mental Health Needs of Children in HHS Custody*, OEI-09-18-00431 (Sept. 2019), <https://oig.hhs.gov/oei/reports/oei-09-18-00431.pdf>, n.22.

⁴² *Id.* at 4-5.

⁴³ *Id.* at 13 & exhibit 3 (the January 2018 figure appears in Exhibit 3).

⁴⁴ *Id.* at 12.

⁴⁵ *Id.*, Report in Brief.

⁴⁶ HHS & DHS, Joint Statement on Termination of 2018 Agreement (Mar. 12, 2021), <https://www.hhs.gov/about/news/2021/03/12/hhs-and-dhs-joint-statement-termination-2018-agreement.html>; see Unaccompanied Children Program Foundational Rule, 89 Fed. Reg. 34,384, 34,612 n.10 (Apr. 30, 2024) (citing the replacement agreement dated Mar. 11, 2021).

⁴⁷ Hannah Dreier, *Trust and Consequences*, Wash. Post (Feb. 2020), <https://www.washingtonpost.com/graphics/2020/national/immigration-therapy-reports-ice/>. We rely on this reporting only for the account it gives; the congressional record that followed is cited next.

children from the United States.”⁴⁸ The senators’ letter quotes then-Secretary Alex Azar telling Congress that “this was a mistake, it should not have been happening.”⁴⁹

ORR’s Policy Guide now directs that care providers “must not include clinical or mental health information in Significant Incident Reports (SIRs) or historical disclosures that are reported to DHS unless required by mandatory reporting laws.”⁵⁰ The notice would open a new route to DHS for the kind of information the Policy Guide keeps off the old one, and it does not explain how the two fit together.

2024 and 2025: the protection ORR declined to write, and the one it removed

When ORR finalized its Foundational Rule in 2024, commenters asked it to provide that ORR case files, including “counseling and case management notes and records,” would be “maintained separately from the child or sponsor’s immigration files (‘A-files’)” and provided to enforcement “only at the request of the individual (child or sponsor) or by judicial order.”⁵¹ ORR declined, responding that “ORR does not maintain ‘A-files’ on either unaccompanied children or potential sponsors.”⁵² Another commenter urged ORR to codify “restrictions on the sharing of information or notes from mental health counseling provided to children in ORR custody.”⁵³ ORR again declined, pointing to existing confidentiality protections.⁵⁴ The question this notice raises was put to ORR two years ago, and ORR chose not to write the protection into its rule.

In March 2025, HHS went the other direction for sponsors. An interim final rule deleted the 2024 provision that had barred ORR from sharing potential sponsors’ immigration status information with enforcement: “ORR removes the prohibition on sharing immigration status information relating to potential sponsors with law enforcement and immigration enforcement entities.”⁵⁵ HHS relied on 8 U.S.C. § 1373,⁵⁶ which concerns “information regarding the citizenship or immigration status, lawful or unlawful, of any individual.”⁵⁷ Nothing in that statute, or in the 2025 rule, requires ORR to send a child’s diagnoses, medications, or counseling information to DHS. The 2026 proposal must stand on its own justification.

The lesson

Twice in the past eight years, ORR opened a channel between the care of children and immigration enforcement. Both times, the government itself later acknowledged the harm: a Secretary who told Congress the therapy notes practice was “a mistake,” and two departments that said the 2018

⁴⁸ Letter from Sen. Dianne Feinstein et al. to the Inspectors General of HHS and DHS (Mar. 4, 2020), <https://www.judiciary.senate.gov/press/dem/releases/feinstein-durbin-murray-call-for-investigation-on-use-of-confidential-therapy-sessions-to-deport-children>.

⁴⁹ *Id.*

⁵⁰ ORR Policy Guide § 5.8.8 (rev. Aug. 1, 2024).

⁵¹ 89 Fed. Reg. at 34,441-42.

⁵² *Id.* at 34,442.

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ Unaccompanied Children Program Foundational Rule; Update To Accord With Statutory Requirements, 90 Fed. Reg. 13,554, 13,555 (Mar. 25, 2025).

⁵⁶ *Id.* at 13,554.

⁵⁷ 8 U.S.C. § 1373(a).

agreement “undermined the interests of children.” A mother learns from the first time. We ask ORR to do the same.

8. ORR’s Strongest Arguments, and Our Answers

“DHS needs this information to keep a child’s care going during repatriation.”

This is ORR’s best argument, and we agree with its premise. But continuity of care is a reason to send necessary information. It is not an answer to who may authorize sending it. The notice itself treats mental health information as different by adding a consent step. Our disagreement is over whose consent counts. And much of what a child needs for travel, such as allergy information, equipment, quarantine status, and travel restrictions, is not mental health information at all.

“By definition, these children have no parent available.”

By definition, they have no parent available in the United States to provide care and physical custody. That is a statement about custody and location, not about whether a parent can be reached to answer a question about her own child. ORR’s release system already begins with parents and legal guardians. Where a parent truly cannot be reached, our recommendation supplies an independent adult rather than leaving the child alone.

“Older adolescents can decide, and some laws let minors control their own records.”

We agree that older adolescents deserve a real voice, which is why we ask that their agreement be required and their objection honored. But the laws that let a minor control her own records do so because she sought particular care on her own. This disclosure is not care the child sought. It is a request from her custodian to send her information to an enforcement agency. Here the child’s voice should work as a veto, not as the only signature.

“Involving parents or advocates will delay repatriation.”

A consent process can run while a return is being arranged. Where no adult can be reached in time, ORR should share only what is needed for safe travel and document why no adult could be reached. It should not fill the gap with a child’s signature.

9. Recommendations

1. **An adult consents every time.** Before any mental health information about a child is shared with DHS, require the written consent of an adult, whatever the child’s age. A child’s signature alone is never sufficient.
2. **The parent comes first.** Where a parent or legal guardian can be reached, that parent or guardian decides, following the order ORR already uses in 45 C.F.R. § 410.1310(a)(1). Document reasonable efforts to reach a parent.
3. **An independent adult when no parent can decide.** 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 goes to an independent adult charged with the child’s best interests: an appointed child advocate under 8 U.S.C. § 1232(c)(6) where there is one, or otherwise a court-appointed

guardian or other independent adult with no role in the child's custody, placement, or immigration case. Never ORR staff, and never the child alone.

4. **Notify the child's lawyer first.** Notify the child's attorney of record or legal service provider before any request is made, with time to consult with the child and the consenting adult.
5. **A voice for older children.** For a child 14 or older, the age at which the *Lucas R.* plan already requires assent, require the child's agreement in addition to the adult's consent. The child's objection stops the disclosure.
6. **No penalty for no.** State in writing, 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 before information is sent.
7. **Publish the consent form.** Publish the consent form, the staff script, and the instructions with the 30-day notice, so the public can comment on the real instrument.
8. **Send the care plan, not the chart.** Limit anything shared to the categories listed in the notice. Exclude therapy notes, counseling narratives, and history. Provide in writing that DHS may use the information only for the child's care during return.
9. **Reconcile the rule.** State whether consent is a condition of sharing mental health information, remove the "must be shared" language as applied to it, and explain how the proposal fits with Policy Guide § 5.8.8.

10. Scope and Limits of This Paper

We quote only primary sources: the notice, statutes, regulations, agency policy and data, a court-approved implementation plan, Inspector General reports, and the congressional record. Where we mention news reporting, we say so and rely on the congressional record that followed. The education, research, and privacy rules in Section 3 do not govern ORR directly; we cite them for their design. The Supreme Court cases in Section 2 are background principles, not holdings on this question. We have not seen the consent form ORR would use, because it has not been published. That is one of our requests.