

REBEKAH RICKS

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 I Am

I submit this comment in my individual capacity. I am a mother, a former classroom teacher, and a legislative strategist who has worked on parental rights and child protection policy, including anti-trafficking legislation, for more than twenty years. My attached white paper, *The Children Who Stop Talking*, contains the full analysis and sources for what follows.

II. My Position

The notice would let the Office of Refugee Resettlement (ORR) ask a child, alone and at any age, to authorize sending her mental health information to the Department of Homeland Security (DHS): “Prior to sharing mental health information with DHS, ORR will request consent from the child.” 91 Fed. Reg. at 46,936.

I oppose that mechanism for three reasons. It will cost ORR the disclosures its anti-trafficking duty depends on. It asks a child to authorize a record whose destination, lifespan, and uses the notice does not disclose, and which she cannot take back. And no child, at any age, should be the only person asked.

I do not oppose the purpose. A child going home on medication should arrive with her treatment plan. My objection is to how the notice proposes to get there.

III. Paperwork Reduction Act Criteria Addressed

This comment addresses criterion (a), whether the collection will have practical utility; criterion (b), the accuracy of the burden estimate; and criterion (c), the quality, utility, and clarity of the information collected. 44 U.S.C. § 3506(c)(2)(A).

IV. The Argument

A. *The children who stop talking*

Congress directed HHS, together with DHS, the Attorney General, and the Secretary of State, to “establish policies and programs to ensure that unaccompanied alien children in the United States are protected from traffickers and other persons seeking to victimize or otherwise engage such children in criminal, harmful, or exploitative activity.” 8 U.S.C. § 1232(c)(1). One month before this notice, ORR reported that its own investigations had found cases in which “former UAC became victims of crimes by their sponsors, including incidents of trafficking and sexual assault,” and concluded that

new requirements were “necessary to effectuate its statutory duties to protect UAC from trafficking and exploitation.” 91 Fed. Reg. 38,582, 38,584-85, 38,589 (proposed June 26, 2026).

Trafficking and abuse usually come to light only when a child decides it is safe to talk, and confidentiality shapes that decision. In a randomized trial of 562 adolescents, a physician’s assurance of confidentiality raised the share willing to disclose sensitive information about sexuality, substance use, and mental health from 39 percent to 46.5 percent. Ford et al., 278 JAMA 1029 (1997). ORR’s rules require that every child be given “a written notice of the limits of confidentiality” before assessment and counseling begin. 45 C.F.R. § 410.1306(c)(1). If this proposal is adopted, that notice must tell children that what they say may reach DHS. The children with the most to tell will have the most reason to stay quiet.

Existing protections do not close the gap. The confidentiality statute for trafficking and crime victims binds DHS, the Department of Justice, and the Department of State, not HHS, and it protects a person only as “the beneficiary of an application for relief.” 8 U.S.C. § 1367(a)(2). The child I worry about most has not yet told anyone, has no application, and has no protection. Downstream confidentiality cannot help a child who never speaks. No study measures how much less ORR’s children would disclose under this proposal, which is exactly why ACF should measure it before changing what children are told.

B. A record the child cannot call back

The notice says the information goes to “DHS” and nothing more. It names no component, no system of records, no retention period, and no limit on use or onward disclosure. DHS’s own records notices show why that matters. The A-File, DHS’s official immigration record, lists “Medical information” among its contents, is used in immigration court and federal litigation, and is transferred to the National Archives “100 years after the individual’s date of birth.” 82 Fed. Reg. 43,556, 43,557, 43,560, 43,564 (Sept. 18, 2017). Its routine uses permit disclosure “[t]o foreign governments for the purpose of coordinating and conducting the removal of individuals to other nations under the INA.” *Id.* at 43,563. I do not assume the information would go there. The point is that the notice does not say, and a child cannot consent to what she has not been told.

Once sent, the information cannot be called back. Even under HIPAA, revocation does not reach information a provider has already disclosed after having “taken action in reliance thereon.” 45 C.F.R. § 164.508(b)(5). The Privacy Act does not cover most of these children, 5 U.S.C. § 552a(a)(2), and DHS has exempted the A-File from the Act’s access and amendment procedures. 82 Fed. Reg. at 43,564.

A diagnosis does not by itself make a person inadmissible, and I do not claim otherwise. But a childhood record can matter later. CDC instructs immigration medical examiners to review “any historical medical records” for a history of harmful behavior. CDC, Technical Instructions for Panel Physicians: Mental Health (Aug. 4, 2025). The Attorney General has held that adjudicators “may consider a respondent’s mental health” in deciding whether a person convicted of a particularly serious crime is a danger to the community. *Matter of B-Z-R-*, 28 I&N Dec. 563 (A.G. 2022). And when a child in federal custody turns 18 and moves to DHS, DHS weighs her “danger to self.” 8 U.S.C. § 1232(c)(2)(B).

C. A consent no one could give

Informed consent has “three elements: information, comprehension and voluntariness.” *The Belmont Report* pt. C.1 (1979). The notice fails the first before anyone reaches the others, because a child cannot be told what the notice does not say. Comprehension depends on “maturity and language,” *id.*, and these are children, many carrying trauma and many speaking languages other than English. Voluntariness is strained when the request comes from the agency that controls the child’s placement and release, for the benefit of the agency carrying out her return.

My position follows. **No child, at any age, should be the only person asked.** An adult must consent every time: a parent or legal guardian where one can be reached, and otherwise an independent adult charged with the child’s best interests. An older child’s agreement should be required in addition, and her objection honored. ORR’s own medication rule asks the parent first. 45 C.F.R. § 410.1310(a)(1). A disclosure to DHS that gives the child no treatment at all deserves at least as much protection.

D. Eight minutes

The notice estimates 0.13 hours, less than eight minutes, per Mental Health Assessment Form response. 91 Fed. Reg. at 46,936. A real consent conversation about DHS, through an interpreter where needed, followed by contact with a parent or an independent adult, cannot fit in that time. Either the estimate leaves out the work or the work will not be done. I ask ACF to revise the estimate.

V. My Requests

1. **An adult consents every time.** No child, at any age, should be the only person asked. Require the written consent of a parent or legal guardian where one can be reached, and otherwise of an independent adult charged with the child’s best interests who has no role in her custody, placement, or immigration case. Require an older child’s agreement in addition, and honor her objection.
2. **Name the recipient.** Identify the DHS component, the system of records, the governing records notice, and the retention schedule for any information shared.
3. **Keep it out of immigration files.** Provide that mental health information shared for continuity of care will not be placed in the A-File or any enforcement system, will be deleted when the child’s return is complete, and will not be disclosed onward.
4. **Limit the use.** Provide in writing that DHS may use the information only for the child’s care during return, and never in removal proceedings, custody or detention decisions, or enforcement against the child, a sponsor, or family members.
5. **Send clinical information to clinicians.** Route treatment summaries directly to the receiving caregiver or provider, and give DHS only what is needed for safe travel. DHS’s own records notice already limits continuing-care disclosures to information that is “relevant and necessary.” 82 Fed. Reg. at 43,563.
6. **Study the effect first.** Before changing what children are told about confidentiality, assess how the change will affect disclosures of trafficking, abuse, and exploitation, and publish the assessment.

7. **Publish the consent instrument and revise the burden estimate.** Publish the consent form, staff script, and instructions with the 30-day notice, and revise the time estimate to reflect a real consent process.

VI. Closing

Congress told the federal government to protect these children from traffickers. The most important tool ORR has for that is a child who trusts the adult across the table enough to tell the truth. I ask ACF not to trade that trust for a signature, and not to let a child be the only one asked. Thank you for the opportunity to comment.

Respectfully submitted,

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Attachment: *The Children Who Stop Talking* (white paper)