

The Children Who Stop Talking

Trafficking identification, permanent records, and the limits of a child's consent under OMB No. 0970-0509

A white paper by Rebekah Ricks, September 2026

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

Executive Summary

The Office of Refugee Resettlement (ORR) proposes to share health information from its mental health forms with the Department of Homeland Security (DHS) when a child with healthcare needs is identified for repatriation. Before sharing mental health information, the notice says, ORR “will request consent from the child.”¹ This paper examines the proposal from two directions the notice does not address: what it will do to the conversations ORR depends on to find trafficked and abused children, and what happens to a child's information after it leaves ORR.

The children who stop talking. Congress made protecting unaccompanied children from traffickers part of the federal government's job, and one month before this notice ORR itself said that duty justified new burdens on its own process. Abuse and trafficking usually come to light only when a child decides it is safe to talk. Research on adolescents shows that confidentiality assurances change what young people are willing to disclose. A child who learns that what she tells a counselor can travel to DHS has a reason to say less, and the children with the most to tell have the most reason to stay quiet.

A record the child cannot call back. The notice does not say which part of DHS receives the information, which system of records it enters, how long it is kept, or how it may be used. If it enters the A-File, DHS's official immigration record, the governing notice lists medical information among its contents, provides for transfer to the National Archives 100 years after the person's date of birth, and authorizes disclosures that include foreign governments coordinating removal. A child who changes her mind has no practical way to retrieve what was sent.

A consent no one could give. Informed consent requires disclosure of what is being authorized. The notice does not disclose it. Even a capable adult could not give informed consent on the terms published. A child certainly cannot, and no child, at any age, should be the only one asked.

My recommendation: before any mental health information about a child goes to DHS, require an adult's consent every time; name the receiving system and its retention and use rules; send clinical information to the child's next caregiver rather than into an immigration record; and

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>. The quoted sentence appears at 46,936.

study the effect on children’s disclosures before changing what they are told in the counselor’s office.

1. What the Notice Says, and What It Leaves Out

The notice expands the purposes of the Mental Health Assessment Form to include “sharing relevant health data captured on the MHAF with DHS when a child in ORR custody has healthcare needs and is identified by DHS for repatriation.”² It lists the categories to be shared: identifying information, active diagnoses or concerns that require management, allergies, current medications and dosages, isolation or quarantine requirements, health-related accommodations, and health-related travel restrictions.³ It adds: “Prior to sharing mental health information with DHS, ORR will request consent from the child.”⁴

Read closely, the notice is precise about what leaves ORR and silent about where it goes. It refers only to “the Department of Homeland Security (DHS).”⁵ It names no DHS component, such as Immigration and Customs Enforcement, Customs and Border Protection, or Citizenship and Immigration Services. It names no DHS system of records. It sets no retention period, no limit on DHS’s use of the information, and no rule against onward disclosure. It says nothing about what happens if a child refuses, and elsewhere it says that relevant treatment plan information “must be shared with DHS.”⁶

It is also worth being precise about what the notice does not propose. It does not say DHS will receive complete therapy files. My argument does not depend on that. It depends on the fact that a child is being asked to authorize a disclosure whose destination and consequences the notice does not disclose.

2. Congress Made Finding Trafficked Children Part of the Job

The statute governing these children is titled “Enhancing efforts to combat the trafficking of children.”⁷ It directs the Secretaries of Health and Human Services and Homeland Security, 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 It requires policies to ensure that children are “safely repatriated.”⁹ And it makes ORR’s Director responsible for “ensuring that the interests of the child are considered in decisions and actions relating to the care and custody of an unaccompanied alien child.”¹⁰

² 91 Fed. Reg. at 46,936.

³ *Id.*

⁴ *Id.*

⁵ *Id.* at 46,935.

⁶ *Id.* at 46,935-36.

⁷ 8 U.S.C. § 1232.

⁸ 8 U.S.C. § 1232(c)(1).

⁹ 8 U.S.C. § 1232(a)(1).

¹⁰ 6 U.S.C. § 279(b)(1)(B).

ORR has recently said the same thing in its own words. In a proposed rule published June 26, 2026, one month before this notice, ORR reported that “HHS’s own internal investigations have revealed documented cases of criminal prosecutions related to the use of fraudulent foreign documents in sponsor applications in which former UAC became victims of crimes by their sponsors, including incidents of trafficking and sexual assault.”¹¹ It concluded that its proposed requirements were “necessary to effectuate its statutory duties to protect UAC from trafficking and exploitation, even if these proposed additional requirements would result in additional time needed to approve the release of UAC to sponsors.”¹²

The oversight record shows why that concern is warranted. HHS’s Inspector General found in 2024 that “[i]n 16 percent of children’s case files, one or more required sponsor safety checks lacked any documentation indicating that the checks were conducted,” and that “[i]n 22 percent of cases, ORR did not conduct timely Safety and Well-Being Follow Up Calls.”¹³ DHS’s Inspector General found in 2025 that “the addresses ICE had for 31,322 of the 448,820 UACs were either blank, undeliverable, or missing apartment numbers.”¹⁴ These are findings about gaps in screening and monitoring. They are not counts of missing or trafficked children, and I do not present them that way. What they show is that once a child leaves ORR’s care, the government’s ability to learn what is happening to her is limited. What a child says while she is still in ORR’s care matters all the more.

The consequence for this notice is simple. A policy that makes children less willing to talk to ORR’s clinicians works against the duty Congress assigned and ORR has just reaffirmed.

3. Disclosure Is a Process, and Confidentiality Makes It Possible

Children rarely disclose abuse all at once, and they rarely disclose it first to authorities. In a study of 4,339 Swedish high school seniors, most of those who had experienced sexual abuse had told someone, but “[g]irls and boys disclosed most often to a friend of their own age. Few had disclosed to professionals. Even fewer said that the incident had been reported to the authorities.”¹⁵ The authors concluded that “[m]uch is hidden from the adult society, especially from professionals and the legal system.”¹⁶

Confidentiality changes what young people are willing to say. In a randomized trial of 562 adolescents, a physician’s assurance of confidentiality “increased the number of adolescents willing to disclose sensitive information about sexuality, substance use, and mental health from 39% (68/175) to 46.5% (178/383),” and increased the number willing to seek future health care “from 53% (93/175) to 67% (259/386).”¹⁷

¹¹ Unaccompanied Children Program Foundational Rule; Sponsor Assessment Update To Include Proof of Identity, Background Check, Placement, and Income Verification Standards, 91 Fed. Reg. 38,582, 38,584-85 (proposed June 26, 2026).

¹² *Id.* at 38,589.

¹³ HHS Office of Inspector General, *Gaps in Sponsor Screening and Followup Raise Safety Concerns for Unaccompanied Children*, OEI-07-21-00250 (Feb. 2024), <https://oig.hhs.gov/reports/all/2024/gaps-in-sponsor-screening-and-followup-raise-safety-concerns-for-unaccompanied-children/>.

¹⁴ DHS Office of Inspector General, *ICE Cannot Effectively Monitor the Location and Status of All Unaccompanied Alien Children After Federal Custody*, OIG-25-21, at 5 (Mar. 25, 2025), <https://www.oig.dhs.gov/sites/default/files/assets/2025-03/OIG-25-21-Mar25.pdf>.

¹⁵ Gisela Priebe & Carl Göran Svedin, *Child Sexual Abuse Is Largely Hidden from the Adult Society: An Epidemiological Study of Adolescents’ Disclosures*, 32 Child Abuse & Neglect 1095 (2008) (abstract), <https://pubmed.ncbi.nlm.nih.gov/19038448/>.

¹⁶ *Id.*

ORR's own regulations make confidentiality the first thing a child hears. Before the assessment and counseling begin, care providers must give the child "a written notice of the limits of confidentiality" and explain it orally in her language "in a way they can effectively understand."¹⁸ If this proposal is adopted, that notice will have to tell children that what they say may be shared with DHS. Honesty requires it. The question is what a child who has been trafficked, abused, or threatened will choose to say after hearing it.

The population makes the question urgent. When UNHCR interviewed 404 unaccompanied or separated children from El Salvador, Guatemala, Honduras, and Mexico, it found that "no less than 58% of the 404 children interviewed were forcibly displaced because they suffered or faced harms that indicated a potential or actual need for international protection."¹⁹ That is not a trafficking statistic, and I do not use it as one. It shows that a large share of these children carry histories that matter to their safety and that come to light only when the child tells someone.

No study has measured how much less ORR's children would disclose if their mental health information could go to DHS, and I do not claim a number. That absence is the point. Before changing what children are told at the start of every counseling relationship, ACF should find out what the change will cost, because the practical utility of a mental health assessment depends on what the child is willing to say.

4. The Protection Gap Before a Child Speaks

Existing law shields some victims' information from immigration authorities, but only after the victim has come forward. The main statute bars officials of DHS, the Department of Justice, and the Department of State from permitting use or disclosure of information relating to a person "who is the beneficiary of an application for relief" as a trafficking victim, a crime victim, or a battered spouse or child.²⁰ It does not bind HHS. It attaches to an application. And the protection "ends when the application for relief is denied and all opportunities for appeal of the denial have been exhausted."²¹

HHS's Office on Trafficking in Persons issues Eligibility and Interim Assistance Letters through which foreign national minors, including unaccompanied children, who have experienced a severe form of trafficking become eligible for federal benefits and services.²² That help, too, begins with someone learning what happened.

The child this proposal most endangers is the one before any of these protections exist: the child who has not yet told anyone she was trafficked, who has no application pending and no letter issued, and whose first disclosure would happen in a counselor's office. Downstream confidentiality protections cannot help a child who never speaks.

¹⁷ Carol A. Ford et al., *Influence of Physician Confidentiality Assurances on Adolescents' Willingness to Disclose Information and Seek Future Health Care: A Randomized Controlled Trial*, 278 JAMA 1029 (1997) (abstract), <https://pubmed.ncbi.nlm.nih.gov/9307357/>. The comparison is between adolescents who heard no mention of confidentiality and those who heard either a conditional or an unconditional assurance.

¹⁸ 45 C.F.R. § 410.1306(c)(1).

¹⁹ UNHCR, *Children on the Run: Unaccompanied Children Leaving Central America and Mexico and the Need for International Protection* (2014), <https://www.unhcr.org/us/children-run>.

²⁰ 8 U.S.C. § 1367(a)(2).

²¹ 8 U.S.C. § 1367(a).

²² HHS Office on Trafficking in Persons, *Child Eligibility Letters*, <https://www.acf.hhs.gov/otip/victim-assistance/child-eligibility-letters>.

5. Where the Record Goes

Because the notice does not name the receiving system, I cannot say where a child's information would be kept, and I do not assume. But DHS's own published records notices show what is at stake, and they are what a child would need to understand before her consent could be called informed.

The A-File is DHS's central immigration record. Its governing notice describes it as "the official record of an individual's immigration history," used "in immigration proceedings before U.S. Department of Justice (DOJ) immigration judges and the Board of Immigration Appeals (BIA)," and as "the official record used in Federal court litigation."²³ Its categories of records include "Medical information."²⁴ Its retention rule reads: "DHS/USCIS transfers A-Files to the custody of NARA 100 years after the individual's date of birth."²⁵ Its index records "are permanently retained."²⁶

The A-File's routine uses reach well beyond a child's trip home. Routine Use HH permits disclosure "[t]o foreign governments for the purpose of coordinating and conducting the removal of individuals to other nations under the INA; and to international, foreign, and intergovernmental agencies, authorities, and organizations in accordance with law and formal or informal international arrangements."²⁷ A routine use is a permission, not proof that any particular record will be sent anywhere. But a child asked to consent would need to know that the permission exists.

DHS already knows how to write a narrower rule. In the same notice, Routine Use FF allows disclosure to arrange "continuing medical care," but "only such information that is relevant and necessary" for that purpose. Routine Use GG limits disclosures about a person who, "due to a condition such as mental illness, may pose a health or safety risk" to information "relevant to the health or safety risk" and the means to mitigate it, such as "the individual's need to remain on certain medication for a serious mental health condition."²⁸ That is the right model for this proposal: the information needed to keep a child's treatment going, and nothing more.

6. A Consent That Cannot Be Taken Back

Even under HIPAA, revoking an authorization does not undo what has already happened. A person "may revoke an authorization provided under this section at any time, provided that the revocation is in writing, except to the extent that: (i) The covered entity has taken action in reliance thereon."²⁹ Once information has been sent, revocation stops future disclosures. It does not retrieve the copy.

Other routes to correction are closed to most of these children. The Privacy Act defines an "individual" as "a citizen of the United States or an alien lawfully admitted for permanent residence."³⁰ And for the A-File, DHS "has exempted this system from the notification, access, and

²³ DHS/USCIS/ICE/CBP-001, Alien File, Index, and National File Tracking System of Records, 82 Fed. Reg. 43,556 (Sept. 18, 2017), as modified by 90 Fed. Reg. 61,409 (Dec. 31, 2025), at 43,557.

²⁴ *Id.* at 43,560.

²⁵ *Id.* at 43,564.

²⁶ *Id.*

²⁷ *Id.* at 43,563.

²⁸ *Id.* at 43,563.

²⁹ 45 C.F.R. § 164.508(b)(5).

³⁰ 5 U.S.C. § 552a(a)(2).

amendment procedures of the Privacy Act, and those of the Judicial Redress Act (JRA) if applicable, because it is a law enforcement system.”³¹

A decision that cannot practically be reversed, about a record that may be kept for a century, is exactly the kind of decision the law ordinarily reserves for adults.

7. Why a Childhood Record Can Matter Later

This argument is easy to overstate, so I will be careful. A mental health diagnosis does not by itself make a person inadmissible to the United States. The statute requires a disorder “and behavior associated with the disorder that may pose, or has posed, a threat to the property, safety, or welfare of the alien or others.”³² CDC’s instructions to immigration medical examiners state that “neither harmful behavior nor the physical or mental disorder or non-CSA substance use disorder alone makes an applicant medically inadmissible.”³³

The same instructions show why history matters. Harmful behavior includes “[s]erious psychological or physical injury to the applicant or to others (e.g., a suicide attempt or child abuse).”³⁴ The examining physician should ask about “[t]he applicant’s history of diagnosed mental or physical disorders” and should “[r]eview other relevant records (if available), such as police, military, school, and employment, and any historical medical records, that might provide a history of harmful behavior or substance use.”³⁵ In fiscal year 2024, the State Department reported 624 immigrant visa ineligibility findings and 260 nonimmigrant findings on this ground, a category that combines physical and mental disorders; 387 and 21, respectively, were overcome.³⁶

Mental health evidence can also matter in immigration court. The Attorney General has held that “[i]mmigration adjudicators may consider a respondent’s mental health in determining whether an individual, ‘having been convicted by a final judgment of a particularly serious crime, constitutes a danger to the community of the United States.’”³⁷ It can protect a person too: the Board of Immigration Appeals has held that when an asylum applicant “has competency issues that affect the reliability of his testimony,” the judge “should, as a safeguard, generally accept his fear of harm as subjectively genuine.”³⁸ And when a child in federal custody turns 18 and is transferred to DHS, the statute directs DHS to take into account “the alien’s danger to self, danger to the community, and risk of flight” in deciding placement.³⁹

None of this means a childhood diagnosis will be used against a child. It means that a record created for a child’s trip home can be relevant to decisions made about her years later, by people she will never meet, and that she cannot evaluate that possibility on a form.

³¹ 82 Fed. Reg. at 43,564.

³² 8 U.S.C. § 1182(a)(1)(A)(iii)(I).

³³ CDC, Technical Instructions for Panel Physicians: Mental Health (updated Aug. 4, 2025), <https://www.cdc.gov/immigrant-refugee-health/hcp/panel-physicians/mental-health.html>.

³⁴ *Id.*

³⁵ *Id.*

³⁶ U.S. Dep’t of State, Report of the Visa Office 2024, Table XIX, <https://travel.state.gov/content/dam/visas/Statistics/AnnualReports/FY2024AnnualReport/Table%20XIX.pdf>.

³⁷ *Matter of B-Z-R-*, 28 I&N Dec. 563, 563 (A.G. 2022).

³⁸ *Matter of J-R-R-A-*, 26 I&N Dec. 609, 609 (BIA 2015).

³⁹ 8 U.S.C. § 1232(c)(2)(B).

8. No One Can Consent to Consequences No One Has Disclosed

American law built informed consent around adults. The foundational statement is that “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body.”⁴⁰ Consent is meaningful only when it is informed: “[t]rue consent to what happens to one’s self is the informed exercise of a choice.”⁴¹ The Belmont Report describes the consent process as having “three elements: information, comprehension and voluntariness.”⁴² The American Medical Association directs physicians to “[a]ssess the patient’s ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.”⁴³

Measured against those elements, the notice fails before capacity even enters the picture.

Information: a child cannot be told which DHS office receives her records, which system holds them, how long they are kept, who else may see them, or whether refusing changes anything, because the notice does not say. **Comprehension:** the Belmont Report recognizes that a person’s “ability to understand is a function of intelligence, rationality, maturity and language,”⁴⁴ and these are children, many of them carrying trauma and many of them speaking languages other than English.

Voluntariness: the request comes from the agency that controls the child’s placement and release, for the benefit of the agency carrying out her return. The Belmont Report warns that unjustifiable pressures arise when “persons in positions of authority or commanding influence” urge a course of action, especially where sanctions are possible.⁴⁵

Capacity makes it harder still. In a study of subjects aged 9, 14, 18, and 21, 9-year-olds “appeared less competent than adults with respect to their ability to reason about and understand the treatment information provided,” though 14-year-olds, overall, did not differ from adults.⁴⁶ In a study of 927 adolescents and 466 young adults, “[y]ouths aged 15 and younger performed more poorly than young adults.”⁴⁷ Older adolescents can reason well in calm settings. That is why I believe an older child’s agreement should be required. It is not a reason to make her the only one asked, in custody, about a record she cannot take back.

My position: 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 an independent adult charged with the child’s best interests where one cannot. An older child’s agreement should be required in addition, and her objection honored.

⁴⁰ *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 129 (1914).

⁴¹ *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972).

⁴² 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>.

⁴³ AMA Code of Medical Ethics Op. 2.1.1, <https://code-medical-ethics.ama-assn.org/ethics-opinions/informed-consent>.

⁴⁴ *Belmont Report*, *supra*, pt. C.1.

⁴⁵ *Id.*

⁴⁶ 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/>.

⁴⁷ Thomas Grisso et al., *Juveniles’ Competence to Stand Trial*, 27 Law & Hum. Behav. 333 (2003) (abstract), <https://pubmed.ncbi.nlm.nih.gov/12916225/>.

9. Eight Minutes

The notice estimates that each Mental Health Assessment Form response takes a mental health professional 0.13 hours, based on 250 professionals completing 12.3 responses each, for 399.8 hours a year.⁴⁸ That is less than eight minutes per form. The same revision adds a healthcare provider acknowledgement and signature section authorizing record sharing with ORR.⁴⁹

An honest consent conversation with a child about sharing her mental health information with DHS cannot fit inside that estimate. It would require explaining the new limits of confidentiality at the outset, through an interpreter where needed; explaining what would be shared, with whom, for how long, and with what consequences; confirming that the child understood; and, under my recommendation, reaching a parent or an independent adult. Either the estimate does not include this work, in which case it is inaccurate, or the work will not be done, in which case the consent will not be real. I ask ACF to revise the estimate under the Paperwork Reduction Act's accuracy criterion.⁵⁰

10. A Better Design

Continuity of care does not require an immigration record. Federal hospital rules show the ordinary model: at discharge, a hospital sends "all necessary medical information pertaining to the patient's current course of illness and treatment" to "the appropriate post-acute care service providers and suppliers."⁵¹ Clinical information follows the patient to the people who will treat her next.

Applied here, that model separates three things. **Travel safety:** DHS receives what its officers need to move a child safely, such as medications to be given during travel, allergies, equipment, quarantine status, and travel restrictions. **Clinical continuity:** the fuller treatment summary goes from the treating clinician directly to the receiving caregiver, child welfare authority, or health provider. **Immigration records:** diagnosis labels, therapy content, and history stay out of immigration and enforcement systems unless a statute specifically requires them. That design serves the purpose the notice states without risking that a child's mental health history ends up in a record kept for a century.

11. The Agency's Strongest Arguments, and My Answers

"This is narrow continuity-of-care sharing, not an enforcement pipeline."

The notice's purpose is narrow. Its safeguards are not written down. A narrow purpose with no named recipient, no retention limit, and no use limit is not a narrow program. If the sharing is truly limited to care, ACF can say so in binding terms and name the system.

"Asking for the child's consent solves the privacy problem."

Asking is not the same as obtaining informed, voluntary consent, and the notice defines neither. It does not say whether refusal is honored, whether it carries consequences, whether consent can be

⁴⁸ 91 Fed. Reg. at 46,936 (Estimated Response Time for Respondents).

⁴⁹ See 91 Fed. Reg. 46,935 (description of proposed changes).

⁵⁰ 44 U.S.C. § 3506(c)(2)(A)(ii); see 91 Fed. Reg. 46,935 (requesting comment on "the accuracy of the agency's estimate of the burden of the proposed collection of information").

⁵¹ 42 C.F.R. § 482.43(b).

limited to some items, or whether a lawyer or advocate may be present. A child cannot consent to terms that have not been disclosed.

“Existing confidentiality laws already prevent misuse.”

They protect some victims after they come forward. They do not protect the child who has not yet spoken, and the main statute does not bind HHS at all. Access controls limit who can open a file. They do not limit what the file can be used for.

“A diagnosis alone has no immigration consequence.”

That is correct as to inadmissibility, and I have said so. But records can matter in medical examinations, dangerousness determinations, and custody decisions at 18. The question is not whether harm is certain. It is why an immigration record should hold a child’s mental health history at all when her treatment can continue through a clinical handoff.

12. Recommendations

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 that would apply to 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.
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.

13. Scope and Limits

I rely on primary sources throughout, and I say so where a source is research or reporting rather than law. I have not assumed that ORR’s information will enter any particular DHS system, because the notice does not say; naming it is one of my requests. I do not claim that a diagnosis makes a child

inadmissible, or that the Inspector General findings count missing or trafficked children. No study has measured how this proposal would change what ORR's children disclose, and I do not offer a number. The research and ethics standards I cite do not govern ORR directly. I cite them for how the federal government ordinarily protects people whose consent is sought while they are in its custody.

About the Author

Rebekah Ricks is 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. She lives in Winter Haven, Florida.