Testimony of

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Chairwoman DeLauro, Ranking Member Cole, and Members of the Committee, it is my honor to appear on behalf of the Department of Health and Human Services (HHS). My name is Lynn Johnson, I am the Assistant Secretary of the Administration for Children and Families (ACF), a division within HHS. ACF is the nation's preeminent human services agency, and fosters the health and well-being of individuals, families, children, and communities. We provide leadership, partnership, and resources for the compassionate and effective delivery of human services. Part of that work has been to help address the humanitarian crisis at our southern border, and so I want to start off by thanking this committee, and your staff, for all of your work in passing the recent emergency supplemental appropriation to address humanitarian needs.

Before joining this administration, I served as the executive director of Jefferson County Human Services in Colorado, overseeing the county's Head Start program, as well as programs on the workforce, career and family services, child welfare, justice services and community assistance. The highlight of my experience in Jefferson County was building on the Head Start Program. We created a community initiative to end poverty through quality education and opportunities for low income families and children. This initiative enabled them to break the cycles of generational poverty. When I left, the success of this program and the individuals participating was inspiring. Prior to this position, I ran my own consulting firm, which dealt with mental health, high risk youth, developmental disabilities, child welfare and early childhood education. I previously served as the chief of staff to Colorado Lieutenant Governor Jane E. Norton in 2003, and from 1999 to 2002 was a policy advisor to Colorado Governor Bill Owens. Before joining the Owens administration, I served as a senior specialist with the U.S. Courts as a probation and

parole officer. I was responsible for direct supervision of offenders with mental health problems and offenders convicted of sex offenses.

ACF administers more than 60 federally funded human services programs—from child care to child welfare, to child support enforcement and human trafficking. One of these programs is the Unaccompanied Alien Children (UAC) Program, which is managed by the Office of Refugee Resettlement (ORR). Congress moved the UAC program from the former Immigration and Naturalization Service (INS) to ORR when Congress enacted the Homeland Security Act of 2002. ORR provides care and custody to unaccompanied alien children, which are defined by statute as children: who have no lawful immigration status in the United States; who have not attained 18 years of age; and with respect to whom there is no parent or legal guardian in the United States who is available to provide care and physical custody.[1]

To be clear, ACF and ORR are not immigration enforcement agencies. We do not set or implement the nation's immigration enforcement policies. Nor do we incarcerate any children. ORR care provider facilities *are not prisons.*

. ORR's UAC program *is* a child welfare agency with a national scope, focused on providing care and services to an especially vulnerable population. ORR is obligated under federal law to accept custody and provide care to any child who another federal agency determines is a UAC, with only limited exceptions.[2] As Assistant Secretary, I have made it a priority to help ensure

[1] 6 U.S.C. §279(g)(2)
[2] 8 U.S.C. §1232(b)(2)

that ORR fulfills its responsibility to deliver care while working to discharge children to suitable sponsors quickly but safely.

Specifically, over the past six months I have approved or overseen a series of operational directives that have helped reduce the length of stay in ORR facilities by accelerating the safe discharge of children to their sponsors, with priorities given to parents, legal guardians, and close adult relatives. These directives have accelerated discharges by modifying the background check process for sponsorship suitability determinations. Accompanying each directive is a detailed analysis explaining how the change would not compromise the safety of UAC

We have taken action to reduce our length of care because families provide the best care and structure for children, not the federal government. I know this from my firsthand experience managing domestic child welfare systems. ORR's UAC program provides safe and nurturing care for children, but long term congregant care is never the goal of residential programs, especially where there are properly-vetted family members able and willing to provide for the child, and the child does not present a danger to themselves, their family or the community.

While we continually strive to maintain an appropriate length of care, ORR-run facilities—whether licensed or unlicensed, large or small—are always better equipped to serve children than any border patrol facility. Therefore, we have made it a priority to obtain as much capacity as possible, by using both state-licensed beds as well as influx beds, in order to help ensure that children are transferred to an ORR care provider facility as quick as possible.

Unfortunately, the process for obtaining state-licensed bed capacity is time-consuming, so it is not always possible to increase permanent bed capacity to keep pace with sharp increases in referrals, like the ones we've experienced this year. The state licensing process can take anywhere from six to nine months, depending on the physical plant and any alterations a facility may require before it can house children in accordance with state-licensing standards. This process also includes obtaining all necessary permits and Life Safety code inspections by appropriate state and local officials. Care providers also must hire sufficient staff, meeting required supervision ratios under state and federal rules, and conduct background checks on staff. Staff must also attend a variety of pre-employment training including on child trauma, UAC Program specific trainings, and trainings related to the duties of mandatory reporters. These are just a few examples of issues that can add to or complicate the timeline to bring a licensed shelter on board.

Of course, the federal government cannot force non-profit agencies to become ORR care providers, and we are facing increasing difficulty in attracting new grantees in the current environment.

An additional factor that can have a direct effect on our ability to find suitable partners in caring for these minors is the growing amount of misinformation about how the UAC program operates. Some of our shelters face near constant protests, some of which begin peacefully, but at times, have turned chaotic and disruptive to the operations of caring for those minors at the shelter; and we are under a constant barrage of counterproductive rhetoric. This includes gross factual

misstatements by politicians (for example, comparing ORR facilities to concentration camps) which are then repeated in the media.

I am very concerned that such factual misstatements will cause additional trauma and fear to UAC and scare off potential grantees, which will ultimately hurt ORR's ability to deliver care. To understand this concern, you must first understand our typical process for competing grants. We solicit funding opportunity announcements (FOAs) publicly, but are beholden to only those applicants who choose to apply for an award. The applicants are then evaluated against the announcement and competitively scored prior to a decision to award a grant. Once a grant is awarded, the new grantee must appropriately staff the facility (including going through requisite training and background check requirements); obtain the necessary permits and licenses to operate; and other paperwork requirements before opening their doors to receive children. We cannot expect qualified not-for-profit applicants to go through the arduous grant application process if success means facing endless political attacks, without regard to the challenges inherent in caring for the UAC population, or the quality of the care provided.

Like the state licensing process, the number of children arriving at the border is outside the control of HHS. Migration numbers may vary considerably one year (or month) to the next and are largely unpredictable. A phenomenon that began in FY 2012 was the sudden mass migration of children and families from Central America to the United States border. In the years prior to FY 2012, roughly 6,000-7,000 UAC were referred to ORR each year. In FY 2012, that number rose to over 12,000. These numbers jumped dramatically in FY 2014, to approximately 57,500 and again in FY2016 to over 59,000. This fiscal year has seen another dramatic increase in the

number of referrals. We have surpassed the historic record set in FY 2016, with more than 61,000 UAC referrals and counting, and we still have over two months to go before the end of FY 2019. Unpredictable and dramatic fluctuations in referrals of UAC are inherently challenging to manage, and the challenge is compounded by the lead time required to open a state-licensed facility.

In instances where we must bring on additional capacity quickly, we rely on influx care facilities to supplement our state-licensed permanent capacity and help ensure that we can place children in ORR care from CBP custody as expeditiously as possible. Though influx facilities are often brought online before being able to meet state licensing, they are undoubtedly a safe, quality environment for UACs in our care. One such facility, originally identified and funded under President Obama's administration in December 2015 to address a migration surge, is the Homestead Influx Care Facility (which many on this subcommittee have visited). This facility has served more than 23,000 children since it opened. Without Homestead, thousands more children would have been remained at CBP facilities on the border, which are not designed to serve the needs of unaccompanied alien children, for extended periods of time, worsening this crisis.

Many have raised concerns about Homestead based on incorrect information. For instance, we've heard inaccurate statements that the Homestead facility is unlawfully holding children beyond 20 days as mandated by the *Flores* Settlement Agreement (FSA). The "20 day rule," however, is applied to ICE family residential centers. It does *not* apply to any ORR facilities, which is a good thing. ORR may discharge a child only to a suitable sponsor. If there is no

suitable sponsor, then ORR cannot lawfully discharge the child on his or her own recognizance.[3] More importantly, discharge to an unsuitable sponsor would endanger the child.

The truth is that the length of stay for children placed at Homestead is on average shorter than that of children in the rest of our network. Children placed at Homestead have an average length of stay of 36 days. While most children who enter an ORR care provider facility are likely to remain there for no longer than 45 days before ultimately being released, they will receive a wide array of services during their stay. More generally, ORR has a policy in effect that ensures that UAC do not remain in influx facilities for longer than 90 days (with limited exceptions). Those services include (but are not limited to): basic shelter and their own bed, adequate food (three hot meals a day plus snacks), daily showers, access to toilets, personal grooming items and clothing; weekly visits with clinicians (and more if needed); medical and dental care, including vaccinations in accordance with CDC recommendations; group counseling; case management services – including family reunification services; education services; acculturation and adaptation services; time for recreation and leisure (beyond just television); and legal services (including information about the child's rights; legal screenings; and in some instances government funded representation in immigration court).

As ORR brings more permanent, state-licensed capacity online, ORR will stop placing children at influx care facilities. Once sufficient capacity is available, children who have not yet been released from Homestead (or another influx care facility) will be transferred to permanent, licensed beds. As of July 3rd, ORR has stopped new placements at Homestead.

[3] 6 U.S.C. §279(b)(2)(B)

Ultimately, I envision a system where ORR is able to support enough permanent capacity that influx care facilities are rarely needed, if ever. My goal and that of our team is for ORR to succeed in providing the very best model of care for children, without significant reliance on influx facilities – not just during my tenure as Assistant Secretary, but into the future, regardless of who is in the White House and who controls Congress. I want a business model to efficiently run ORR during surges and during times of calm. This is my priority. It is time to stop reacting to crises and move to a new normal for this program. Politics has no place when it comes to child safety and their best interest – these are matters of shared concern across party lines.

That being said, I am proud of the federal career staff who operate ORR's UAC program. And I am thankful for the hard work and diligence our care provider grantees and contractors who provide expert services and facilitate the safe release of children to their families under the direction of our federal career staff.

I am equally proud to report that based on our ramping up of additional capacity, the actions that we took to reduce length of care, and the downward trend of recent referral numbers, there are no children pending placement over 72 hours in border patrol facilities.[4] Despite the challenges noted in my testimony, ORR plans to have up to 20,000 licensed beds available by the end of 2020.

[4] There are case by case exceptions for children who may be unfit to travel are in the care of a hospital or medical provider while still under DHS custody.

Thank you again, Chairwoman DeLauro and Ranking Member Cole, for your hard work to help make this happen – the supplemental funding is helping address a continuing crisis at our southern border, and is ensuring that vulnerable children are properly placed with HHS.

I look forward to answering your questions.