



Testimony of

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Chairwoman DeLauro, Ranking Member Cole, and Members of the Committee, it is my honor to appear before this subcommittee, on behalf of the Department of Health and Human Services (HHS). My name is Jonathan Hayes. I am the Director of the Office of Refugee Resettlement (ORR) and I manage the Unaccompanied Alien Children (UAC) Program.

I became the permanent director earlier this year, and it is a privilege to serve in this role alongside the ORR career staff. I am continually impressed with the level of commitment and professionalism I see in the ORR career staff and our grantees on a daily basis. The culture of leadership within ORR directly impacts our day-to-day operations and goals, as well as the staff who carry out our round-the-clock operations in service of some of the world's most vulnerable children. I have visited nearly 50 UAC care provider shelters across the United States over the last year so that I could see firsthand the quality of care that ORR staff and grantees provide to the unaccompanied alien children and to hear directly the perspectives and input from our teams in the field, so I can better understand ways to improve our services and overall mission.

My strong desire is to ensure the safety and well-being of the children in our care in a manner that is consistent with the law and empowers the career professionals and senior staff at ORR. As the Director of ORR, I am committed to making decisions that are in the best interest of each child in ORR's care and custody.

Prior to my time at ORR, I worked for two Members of the U.S. House of Representatives for approximately eight years. That experience provides me with firsthand knowledge of the

important role that you and your staff members have in ensuring federal programs operate successfully.

UAC Program Overview

I am here today to report on the current state of ORR's influx operations during this unprecedented time of high arrivals of UAC, including conditions at our temporary influx care facilities, as well as influx service provision and standards. I will also provide Congress with details of the Department's plan on how it will spend the \$2.88 billion from the Emergency Supplemental Appropriations for Humanitarian Assistance and Security at the Southern Border Act.

I would like to first express the Department's appreciation and gratitude to Congress for passing the emergency humanitarian aid package. Immediately upon enactment of the supplemental appropriations, we restored the full range of services for UAC, including those that we were unable to provide during the anticipated deficiency due to appropriations law limitations.

The Homeland Security Act of 2002 (HSA) and the William Wilberforce Trafficking Victims Protection Reauthorization Act of 2008 (TVPRA), as amended, govern the UAC program. So do certain provisions of the Flores Settlement Agreement (FSA). As defined by the HSA, if a child under the age of 18 with no lawful immigration status is apprehended by another federal agency, and no parent or legal guardian is available in the United States to provide care and custody of the child, then the apprehending agency may determine that the child is a UAC and transfer them to ORR for care and custody.

ORR does not apprehend migrants at the border or enforce the immigration laws. The Department of Homeland Security (DHS) and the Department of Justice (DOJ) perform those functions.

The number of UAC entering the United States during this fiscal year has risen to levels we have never before seen. As of July 15, DHS has referred more than 61,000 UAC to us – the highest number in the program’s history. By comparison, HHS received 59,170 referrals in FY 2016 – the previous highest number of *annual* referrals on record.

HHS currently has less than 11,000 children in our care, though this number fluctuates on a daily basis. The number of children in our care is down from a recent high of over 13,700 just last month; this decline is due to decrease in daily referrals over the last few weeks, and ORR’s ability to maintain a steady high discharge rate of UAC placement with sponsors. As of June, the average length of time that a child stays in HHS’ custody is approximately 42 days, which is a dramatic decrease of 53 percent from late November 2018, when the average length of care was 90 days. During my tenure at ORR, we have issued four operational directives and revised our policies and procedures with the specific aim of a more efficient and safe release of UAC from our care and custody.

HHS operates nearly 170 state-licensed care provider facilities and programs. These care providers include group homes; long-term, therapeutic, or transitional foster care; residential treatment centers; staff-secure and secure facilities, and shelters. Our facilities provide housing, nutrition, routine medical care, mental health services, educational services, and recreational activities such as arts and sports – services that are similar to the domestic child welfare system. Grantees operate

the facilities, which are licensed by the state authorities responsible for regulating residential child care facilities. And while ORR's temporary hard sided influx care facilities are not required to obtain state licensure, children who reside at these locations generally receive the same level of care and services to UAC as a state-licensed facility.

The UAC program bed capacity has expanded and contracted over the years, driven by fluctuations in the number of UAC referred to HHS and the average time children remain in ORR care.

To respond to these fluctuations, HHS has developed processes for bringing both permanent and temporary UAC housing capacity online as needed. HHS has a bed capacity framework with grant and contract mechanisms that provide standard permanent bed capacity, with the ability to add temporary beds. That arrangement helps HHS to accommodate changing flows in the number of referred UAC.

HHS cares for all children until they are released to a suitable sponsor, which is usually a parent or close relative, while they await immigration proceedings. Children may also leave HHS' care if they return to their home countries following an immigration judge's order of removal, turn 18 years of age, or gain legal immigration status.

After HHS releases children and youth from its custody to a sponsor, we offer case management services to those who would benefit from ongoing assistance by a social service agency. Post-release case management services are offered by a network of ORR-funded non-profit service providers. ORR encourages the use of evidence-based child welfare practices that are culturally-

and linguistically-appropriate to the unique needs of each individual and are rooted in a trauma-informed approach. Providers focus on helping released children and youth find and access education, medical and behavioral health care, legal services, community programming, and more. Providers may also offer intensive case management to children and their families if they need support for specific challenges.

These services are not mandatory and released minors and their sponsors may choose to participate or not in these services. Once UAC are released to sponsors, they are no longer in the custody of ORR, and ORR does not have legal responsibility for them.

State of the UAC Program

Licensed Care Provider Facilities

It is the expressed desire and goal of the political and career leadership of ORR to expand our capacity in such a manner that as many children as possible are placed into permanent state-licensed facilities or transitional foster care while their sponsorship suitability determinations or immigration cases are adjudicated (in the event there is no sponsor available).

A minimum of \$866 million of the emergency supplemental funding was provided to increase licensed shelters' capacity – both for new and existing shelters. ORR does expect to exceed this minimum budget requirement. We are working with HHS' Administration on Children, Youth, and Families, as well as non-governmental organizations to leverage state child welfare providers and their provider networks to expand our own network of community-based residential care.

By December 31, 2020, we anticipate that we will have increased permanent, state-licensed shelters (including foster care) to up to a total of 20,000, which almost doubles current permanent capacity. These beds will be funded by a combination of the supplemental funding as well as discretionary funds requested in the President's 2020 Budget. This addition will provide HHS with a necessary supply of permanent, state-licensed beds so that we will not need to place UAC in temporary influx sites.

It takes approximately six to nine months to open new licensed facilities. The start-up process includes the grant making process; retro-fitting the facility to meet specific physical plant requirements for licensed facilities; licensing of the facility by the state; and recruiting, vetting, hiring, and training of staff, among other activities. I am happy to report that our most recent funding opportunity announcement – which closed in May – is leading to new grant awards that will support approximately 3000 more permanent state-licensed beds.

Influx Care Provider Facilities

Some care provider facilities work solely with populations of children who need specialized care including pregnant or parenting girls, infants and small children, and those with mental health conditions. This limits the availability of permanent state-licensed bed space for other children during influxes.

The supplemental appropriations allow \$1.9 billion for general purposes, and HHS estimates that less than \$100 million of this funding will be spent to support influx operations.

In the short-term, HHS aims to have up to 3,000 additional temporary beds available this fiscal year at influx care facilities in anticipation of continued high arrivals at the southern border, so that UAC do not remain in U.S. Border Patrol stations, which are not designed or equipped to care for children.

Up to 1,600 temporary beds will be set up at Fort Sill in Oklahoma, which is the only Department of Defense (DoD) facility being prepared to temporarily house UAC in hard-sided structures. HHS does not use DoD funds for UAC influx operations.

HHS used Fort Sill in 2014 as a temporary influx site, and again chose this location based on a number of factors relevant to child welfare, which included size, types of housing structures, and time considerations. HHS was given close to 30 DoD properties to assess for suitability to temporarily house children in our care. After a careful review, we identified only eight that could potentially serve as an influx site.

I would like to note that among these eight facilities, certain ones did have soft-sided structures for living quarters. However, HHS seeks to limit the use of soft-sided structures except as a last resort to prevent children from lengthy stays in U.S. Border Patrol stations. After consulting with the DoD, three of the military facilities were potentially prepared to house UAC on site in hard-

sided structures, and then two of those facilities were later removed as options. Fort Sill was therefore our only viable option.

This temporary site will be used during hurricane season in the event that HHS needs to evacuate children and staff from our temporary influx site in Homestead, Florida; to prevent backups of UAC in U.S. Border Patrol stations; or to address any other emergent issues that could cause a temporary inability to use one of our regular shelters.

HHS is also in the process of setting up 1,400 temporary beds in Carrizo Springs, Texas. HHS has re-engineered the site, which was formerly a lodging facility for oil and gas workers, so that children are being sheltered in renovated hard-sided structures, while semi-permanent soft-sided structures are being used for support operations.

HHS operates a temporary influx care facility, in Homestead, Florida, which has been in use, on-and-off, since 2016. Children at Homestead live in hard-sided dormitories, have access to dining halls, educational classrooms, indoor and outdoor recreational spaces and fields, and on-site medical facilities.

HHS has detailed policies for when children can be sheltered at a temporary influx care facility. The minor must be a youth between 13 and 17 years of age; have no known special medical or behavioral health conditions; have no accompanying siblings age 12 years or younger; and be able to be discharged to a sponsor quickly – among other considerations.

HHS strives to provide a quality of care at temporary influx care facilities that is parallel to our state-licensed programs. Children in these facilities can participate in recreational activities and religious services appropriate to the child's faith, and receive case management, on-site education, medical care, legal services, and counseling.

We recognize that many of these children have experienced traumatic childhood events and that migration and displacement can cause ongoing stress. On-site care providers are specially trained in techniques for child-friendly and trauma-informed interviewing, assessment and observation, and deliver services that are sensitive to the age, culture, native language, and needs of each child. This includes clinicians, who are able to do crisis intervention, group and individual counseling sessions, and support children as they make what are often emotionally difficult phone calls to their families. If a child is found to have a mental health need that cannot be addressed at the care facility, we will transfer them to a more appropriate setting.

While children at our temporary influx sites do not attend local schools, classes are built into the daily schedule, and instructors are bilingual.

Legal services staff provide children in our care with Know-Your-Rights presentations in the minor's native language within seven to 10 days of referral to ORR, a Legal Resource Guide, and legal screenings that assess a child's background, journey into the United States, family, and history of persecution, violence, and abuse.

HHS is the primary regulator of the temporary influx care facilities and is responsible for their oversight, operations, physical plant conditions, and service provision. While states do not license or monitor influx care facilities, they operate in accordance with the Flores Settlement Agreement, the Homeland Security Act of 2002, the Trafficking Victims Protection Reauthorization Act of 2008, the Interim Final Rule on Standards to Prevent, Detect, and Respond to Sexual Abuse and Sexual Harassment Involving Unaccompanied Alien Children, and ORR policy and procedures.

HHS monitors temporary influx care facilities through assigned Project Officers, Federal Field Specialists, Program Monitors, and an Abuse Review Team, and all have the authority to issue corrective actions if needed to ensure the safety and wellbeing of all children in HHS's care.

As required under the supplemental appropriations package, HHS will ensure "influx shelters are only used as a last resort, meet child welfare standards, and include frequent monitoring;" provide a "15 day notification prior to opening an influx facility;" and "ensure, when feasible, certain children are not placed at influx facilities, including children who would be expected to be there for longer than 30 days."

Services to Children

A minimum of \$100 million was provided to support legal services, child advocates, and post-release services. HHS does expect to exceed this minimum budget allowance, however. HHS will use the supplemental appropriation to fund the expansion of its legal services contracts to accommodate influx capacity, new state-licensed bed capacity, and to continue legal services into

fiscal year (FY) 2020. The minimum legal services required by statute and the Flores Settlement Agreement are a notice of rights and information about pro bono legal assistance. ORR legal services contracts include this, as well as legal screening and legal representation for children who have immigration cases initiated while in ORR custody.

Case Management and Care Coordination

HHS plans to spend \$19 million of the supplemental appropriation for case management and care coordination, which includes hiring an additional 20 Federal staff for field operations. This amount exceeds the minimum required in the supplemental appropriations bill.

Strategic Improvements

HHS plans to spend \$4 million to hire project officers and program monitors, and for the development of a UAC discharge rate improvement plan. This amount exceeds the minimum required in the supplemental appropriations bill.

Office of Inspector General (OIG) Oversight

Five million dollars will be transferred to OIG for oversight of the UAC Program. We look forward to continuing to work with the OIG as they provide us with valuable oversight and evaluation of our program.

Program Administration

HHS will spend up to \$25 million from the supplemental appropriation to extend and expand the contract staff support and modernize the UAC Portal, which is ORR's online case management platform that contains detailed information on each child in care, as well as guidance, procedures, trainings, field guidance, sponsor handbook, and more.

Conclusion

The UAC Program provides care and services to children every day and our work is driven by child welfare principles. HHS is quickly expanding its state-licensed network of shelters to ensure that it can keep pace with the humanitarian crisis at the U.S.-Mexico border. Based on the anticipated growth, HHS expects its need for additional bed capacity to continue, despite placing children with sponsors at historically high rates over recent weeks. Given the unpredictable nature of migration, HHS must ensure it has sufficient capacity to address needs as they emerge.

My top priority and that of my team is to ensure the safety and well-being of the children who are placed temporarily in HHS custody as we work to quickly and safely release them to suitable sponsors. HHS is also working with our colleagues at DHS and DOJ to ensure that we have the information necessary to safely and quickly release children from HHS custody.

Thank you for your support of the UAC Program and the opportunity to discuss our important work. I will be happy to answer any questions you may have.