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. As the Director of the Office of Refugee Resettlement (ORR), I oversee the Unaccompanied Alien Children (UAC) Program.

I am joined today by Commander Jonathan White, an Officer in the U.S. Public Health Service Commissioned Corps, currently assigned to the Office of the Assistant Secretary for Preparedness and Response at HHS. Commander White is a clinical social worker and emergency manager and served as the Federal Health Coordinating Official for the interagency mission to reunify children separated from their parents in ORR care as of June 26, 2018. He also previously served as the Deputy Director at ORR. He has not prepared written testimony but is here to answer your questions.

Thank you for the opportunity to discuss with you today the HHS Office of Inspector General (OIG) report titled, “Care Provider Facilities Described Challenges Addressing Mental Health Needs of Children in HHS Custody.” HHS is committed to addressing the mental health needs of UAC in the custody of ORR. We welcome the report as we continually improve the mental health services provided to the children in our care.

I will start with a brief overview of the UAC program. I will then address OIG’s findings and recommendations and inform the subcommittee on current and future ORR activities to strengthen mental health care for UAC in HHS care and custody.

Program Overview

HHS operates nearly 170 state-licensed care provider facilities and programs in 23 states. HHS has different types of facilities, including group homes; long-term, therapeutic, or transitional foster care; residential treatment centers; staff-secure and secure facilities; and shelters in order to meet the different needs of the minors in our care. ORR awards grants to independent service providers who operate programs to support UAC on ORR's behalf. ORR grantees operate the facilities, which are licensed by the responsible state agency. Every state has its own licensing standard. Even within a state, different types of facilities may not be licensed by the same state agency or be required to follow the same regulations and standards as other facilities. However, all programs must follow ORR policy with respect to the care of UAC in HHS custody.

In addition to our traditional state-licensed facilities, ORR also operates influx care facilities, which receive UACs when ORR's licensed bed capacity is strained by surges of referrals. HHS has detailed policies for when children can be sheltered at a temporary influx care facility. The minor must be 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.

These facilities by their nature as emergency facilities are not required to be state-licensed; however, they must adhere to ORR policies and provide required services. ORR 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 faith-based services, and

they receive case management, on-site education, medical care, legal services, and counseling. ORR also requires influx facilities to have emergency clinical services available if needed. ORR will transfer a child out of an influx facility based on the needs of that child.

Mental health services are available at all of our facilities. ORR policy requires, at a minimum, that UAC in ORR state-licensed facilities receive an individual counseling session and two group counseling sessions with a clinician every week. Additional mental health services are available as needed.

ORR also requires facilities to provide routine medical and dental care, educational services, legal services, and recreational activities such as arts and crafts and large muscle activity.

The children in ORR custody have a unique set of needs. ORR provides services to children from a wide range of backgrounds and cultures who speak a variety of languages. As documented in the OIG report, many of the children placed in ORR custody are victims of violence and abuse and have experienced severe trauma in their countries of origin and during their journeys to the United States. The mental health professionals working with UAC must be bilingual and be qualified to assist traumatized children, yet the OIG report acknowledges the general shortage of qualified practitioners. There is a greater shortage of pediatric mental health practitioners, and that shortage is even greater given the language skills which are also needed. Those qualification requirements create great difficulties in both recruiting on-site staff as well as finding referrals for additional services in the communities around the facilities.

Further complicating the recruitment of qualified mental health practitioners is the location of most ORR facilities. The Flores Settlement Agreement (FSA), which created the framework for ORR services, includes a requirement that the government make reasonable efforts to find licensed facilities near the locations where a majority of UAC are encountered. As a result, most ORR facilities are near the Southern border in rural areas that tend to lack mental health services generally, let alone the specialized services required for UAC. OIG recognized this shortage of services in its report.

ORR is committed to facing and overcoming these challenges. We have already taken steps to address many of the concerns described in the report, including greatly reducing average length of time a child spends in ORR custody.

I would like to thank Congress for assisting in these efforts and, in particular, the $4,000,000 appropriated in Fiscal Year 2019 to the National Child Traumatic Stress Initiative, a program within the Substance Abuse and Mental Health Services Administration (SAMHSA), for mental health services for UAC. ORR is collaborating with the National Child Traumatic Stress Network (NCTSN), a grantee of SAMHSA, to expand mental health services for UAC. ORR is looking forward to continuing to work with both government and non-governmental partners to strengthen mental health services for UAC. I also hope Congress will continue to support these efforts.

Report Methodology

Before discussing the specifics of the OIG report, I would like to address the methodology of the report that OIG itself identified. First, the report is a qualitative analysis from interviews with program staff and federal staff, examination of employee records, and OIG's own assessment of the facilities. OIG did not independently verify the information that was provided in these interviews. Nor did OIG independently review health records or perform clinical assessments of the quality or reasonableness of the services provided to UAC. Additionally, OIG did not investigate whether programs were in compliance with ORR policies related to mental health. OIG visited 45 sites in the ORR network, so the report's findings do not reflect the experience of all ORR providers. Finally, the OIG investigation took place at a time when ORR was experiencing changes to the UAC population that were outside of ORR's control. As the report notes, at the time of the investigation, ORR was experiencing a surge of UAC referrals generally, and in particular, a high number of referrals of young children. The increased demand, especially for age-appropriate services for young children, created additional challenges for ORR and care providers.

The methodology provides the context necessary to better understand the findings and recommendations in the report. I will now address each recommendation and the findings associated with that recommendation, and will describe ORR's current activities related to that recommendation.

Report Recommendations

Recommendation 1: Identify and disseminate evidence-based approaches to addressing trauma in short-term therapy.

One challenge identified in the report is that some clinician staff told OIG that they are often unprepared to assist children with the severe trauma experienced by UAC. The report documented that some clinicians felt they were unprepared for the level of trauma experienced by the children and the toll that would take on their own mental health. Treating children with severe trauma is complicated and is only made more complicated by the relatively short amount of time children reside in ORR custody – ORR's average length of care as of August 31, 2019 is 50 days. Some clinicians told OIG that they were concerned about asking children to revisit their trauma when it was unclear whether the child would be in custody long enough to make progress in addressing their trauma fully.

ORR's mission remains to unify children with a suitable sponsor as expeditiously and safely as possible. For this reason, most children do not stay in ORR care for long periods. Based on the clinical expertise of the mental health professionals on staff, the focus of mental health services has been to stabilize children and provide them with a sense of security. However, program staff assess each child's mental health needs and provide additional services as appropriate.

ORR is working to provide clinicians with tools to strengthen mental health services. Recently, ORR collaborated with the NCTSN to develop a 4-part webinar series on addressing trauma in UAC. The webinar covers trauma 101, building cultural competence, and recommendations for reducing providers' own stress. The webinar also provides information on recognizing trauma in

older children, and there is a separate portion on recognizing trauma in children under 6 years of age. The webinar is available online through the NCTSN Learning Center and participants may receive continuing education credits for completing the courses. ORR is working with NCTSN to develop additional resources.

ORR also offers post-release services (PRS) to some UAC. If a child does need mental health services after they leave ORR care, a PRS caseworker will work with both the child and the sponsor to find services in their community. The caseworker meets with the child and the sponsor to ensure the child's needs are being met. ORR is working to expand the number of UAC that receive PRS.

Recommendation 2: Develop and implement strategies to assist care provider facilities in overcoming obstacles to hiring and retaining qualified mental health clinicians.

OIG identified significant external challenges to hiring and retaining qualified mental health clinicians. These challenges include finding bilingual staff with the experience and qualifications necessary to work with UAC in the locations surrounding ORR-funded facilities. In addition to finding applicants with the right set of qualifications, public misunderstanding about ORR and the UAC program has also made recruitment more difficult. For example, contrary to some reports in the press, HHS does not apprehend migrants at the border, nor does it enforce immigration laws. The Department of Homeland Security (DHS) and the Department of Justice (DOJ) perform those functions. Also, ORR does not have jurisdiction over children who arrive with an adult parent; DHS is responsible for these families. HHS' UAC Program is a humanitarian child welfare

program, designed for the temporary care of UAC until they can be safely released or unified with family or other sponsors.

ORR is working on a number of strategies to address these challenges including developing an internship program so that colleges and universities can place interested students in ORR facilities. ORR is working to increase its presence at job fairs in the areas where recruitment has been difficult to assist programs in outreach to potential candidates. ORR is also providing additional funding for continuing education programs for clinicians.

Recommendation 3: Assess whether to establish maximum caseloads for individual mental health clinicians.

ORR currently has a staffing ratio of one clinician for every 12 children; however, OIG noted that there is no maximum caseload for clinicians. Despite the staffing ratio, clinicians may have different caseloads based on the demand for services. For example, one clinician may have a smaller caseload because of the significant mental health needs of one child, so another clinician may accommodate a larger caseload.

ORR will evaluate the current ratio policy with input from subject matter experts both within HHS and outside the agency. ORR will also determine whether a maximum caseload requirement is needed in addition to a staffing ratio. ORR is hopeful that the recruitment efforts discussed above will help more evenly distribute caseloads among staff clinicians.

Recommendation 4: Help care provider facilities improve access to mental health specialists.

As I mentioned before and OIG notes in the report, there is a national shortage of qualified mental health professionals, especially bilingual ones. This not only affects ORR's ability to recruit qualified staff to work at facilities, but also its ability to find mental health professionals to provide specialized treatment that cannot be provided by facility staff. The negative public perception of ORR which stems from inaccurate or misleading reporting about the UAC program also hinders recruitment.

ORR allows programs to seek services from providers outside of ORR's network to meet the health needs of UAC in care. ORR has an underwriter that identifies and facilitates referrals to providers. The Division of Health for Unaccompanied Children (DHUC) at ORR works with ORR's underwriter to identify additional providers in areas surrounding ORR facilities. DHUC also identifies tele-health providers that can provide appropriate services when in-person options are not available.

Recommendation 5: Increase therapeutic options for children who require more intensive mental health treatment.

One type of facility that ORR operates are residential treatment centers (RTCs). RTCs are specialized facilities providing higher levels of care for children who require it. There are two RTCs in the ORR network, although programs can refer UAC to out-of-network RTCs as necessary. The *Flores* court approved ORR policy which requires a referral from a licensed

psychologist or psychiatrist, and additional approvals are required at the ORR headquarters level before a child can be placed in an RTC. These requirements ensure it is in the best interest of the child to be placed in an RTC. Further, DHUC provides training to Federal Field Specialists on the appropriate use of RTCs, pursuant to which referral to an RTC should only be considered after all appropriate out-patient services have been exhausted. The small number of RTC beds can also slow transfer of UAC to these facilities when deemed appropriate. ORR continues to engage new providers to add capacity.

Recommendation 6: Take all reasonable steps to minimize the time that children remain in ORR custody.

OIG identified that the longer a child remains in custody, the more significant their mental health needs become.

I believe that a child should not remain in ORR care any longer than the time needed to find an appropriate sponsor for the child. A central part of ORR's mission is to release children from custody as quickly as possible while still ensuring the safety of the child.

To that end, and during my tenure as Director of 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. These directives followed an assessment of ORR's operations to see if the current policies and procedures were necessary for the safety of children. Based on that assessment, ORR concluded that operations could be modified to both ensure safe releases as

well as timely ones. Following the directives, the average length of care dropped. At the time OIG conducted its visits, the average length of care was 83 days. It is now 50 days, a 40% reduction. ORR will continue to assess the efficiency of its operations to improve the process for release and reduce the time a child remains in custody.

Conclusion

My top priority and that of my team is the safety and well-being of children in the temporary care of HHS. We welcomed this report because it explained the services ORR currently provides and identified the obstacles we face in providing those services. My team is ready to face those obstacles and overcome them with help from our partners and with the continued support of Congress.

Thank you for the opportunity to discuss our important work. Commander White and I will be happy to answer any questions you may have.