Testimony of

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Chair Nadler, Ranking Member Collins, and members of the Committee, it is my honor to appear today, 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 caring culture of 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 UAC. I also heard the perspectives and input from our teams in the field, which allowed me to 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 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 would like to first express the Department's appreciation and gratitude to Congress for passing the Emergency Supplemental Appropriations for Humanitarian Assistance and Security at the Southern Border Act. 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 present in theUnited States, or no parent or legal guardian in the United States is available to provide care and custody of the child, then the apprehending agency determines that the child is a UAC and transfers them to ORR for care and custody.

HHS does not apprehend migrants at the border or enforce immigration laws. The Department of Homeland Security (DHS) and the Department of Justice (DOJ) perform those functions. HHS' UAC Program is a humanitarian child welfare program, designed for the temporary care of UAC, until a time in which they can be safely released or reunified with family or other sponsors.

**Current State of the Program**

The number of UAC entering the United States during this fiscal year (FY) 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 second highest number on record.

HHS currently has fewer 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, where 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 yet safe release of UAC from our care and custody. Accompanying each directive is a detailed analysis explaining how the change would not compromise the safety of UAC.

**Identification and Reunification of Separated Children**

HHS is currently complying with the preliminary injunction order set by the Ms. L. Court on June 26, 2018.

In general, DHS separated the parents from their children for reasons recognized by the Ms. L. Court, and agreed upon between DHS, HHS, and ACLU. Those reasons include unverified

familial relationship/fraud, criminal history, a communicable diseases, danger to the child, or lack of parental fitness. DHS has also separated adults from children based on lack of parentage.

Once HHS receives information from DHS that a child has been separated from a potential parent, we first establish communication with the separated adult, whether they are in the custody of DHS's Immigration and Customs Enforcement, DOJ"s Federal Bureau of Prisons, or DOJ's U.S. Marshals Service. HHS works to confirm parentage and to confirm the separation.

As of July 08, 2019, HHS discharged 562 of these minors through removal with their parents, ORR's sponsorship process, or voluntary departure.

**Services While in Custody**

HHS is deeply committed to the physical and emotional wellbeing of all children in its temporary care. Staff at care provider facilities are trained in techniques for child-friendly and trauma-informed interviewing, ongoing assessment, observation, and treatment of the medical and behavioral health needs of the children, including those who have been separated from their parents. Care provider staff are trained to identify children who have been smuggled (i.e. transported illegally over a national border) and/or trafficked into the United States. Care providers must deliver services that are sensitive to the age, culture, and native language of each child.

Each care provider program maintains ORR-approved policies and procedures for interdisciplinary clinical services, including standards on licensing and education for staff,

according to staff role or discipline. Staff who are required to have professional certifications must maintain licensure through continuing education requirements, and all care provider staff must complete a minimum 40 hours of training annually.

When a child enters ORR's care, care provider staff assess each child's needs, including special concerns such as family separation, known medical or mental health issues, and other risk factors.

All children participate in weekly individual counseling sessions with trained social work staff, where the provider reviews the child's psychosocial wellbeing progress, establishes short term objectives for addressing trauma and other health needs, and addresses developmental and crisis-related needs, including those that may be related to family separation. Clinical staff may increase these once-a-week sessions if a more intensive approach is needed. If children have acute or chronic mental health illnesses, ORR refers them for mental health services in the community.

Children also participate in informal group counseling sessions at least twice a week. The sessions give newly arrived children the opportunity to become acquainted with staff, other children in care, and the rules of the program and provides an open forum where everyone has an opportunity to speak. Together, children and care providers make decisions on recreational activities and resolve issues affecting the children in care. For example, children at one temporary influx facility requested that they be allowed to conduct religious services themselves

in lieu of an outside faith leader, and they then started to lead their peers in weekly faith-based services, appropriate to the child's faith, for those who wanted to participate.

**State-Licensed and Temporary Shelter Capacity**

HHS operates nearly 170 state-licensed care provider facilities and programs across the United States. 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 licensing authorities responsible for regulating such residential child care facilities.

It is the expressed desire and goal of both the political and senior 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 are made or their immigration cases are adjudicated (in the event there no sponsor available).

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 – almost doubling current 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.

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.

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

HHS aims to have up to 3,000 additional temporary beds available this fiscal year at temporary influx care facilities in anticipation of continued high arrivals at the southern border and to facilitate the expeditious transfer of UAC out of U.S. Border Patrol facilities, which are not designed or equipped to care for children.

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.

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 faith-based services, and receive case management, on-site education, medical care, legal services, and counseling.

As required under the emergency 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 in care for an extended period.

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.

**Post-Release Services**

After HHS releases children from its custody to a sponsor, we offer case management services to those 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 find and access education, medical and behavioral health care, legal services, community programming, and other services. 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 children and their sponsors may choose to participate or not in these services. Once children are released to sponsors, the sponsors assume legal responsibility for them. ORR has no statutory authority over UACs after they are discharged from its care.

**Conclusion**

The UAC Program provides care and services to the 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. And while referral rates have declined over recent weeks, given the unpredictable nature of the program, 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.