Testimony of

Jonathan H. Hayes
Director
Office of Refugee Resettlement
Administration for Children and Families
U.S. Department of Health and Human Services

Before the

Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
United States House of Representatives
September 19, 2019

Chair DeGette, Ranking Member Guthrie, and members of the Subcommittee, 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 in that role 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 over 50 UAC care provider facilities 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 field team, 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 both the law and prevailing child welfare best practices, and that 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 oversight role that you and your staff have in ensuring federal programs operate successfully.

UAC Program Overview

In the Homeland Security Act of 2002 (HSA), Congress placed the responsibility of care for UAC with ORR and not with a law enforcement agency. The HSA defines an unaccompanied alien child as a person under the age of 18; with no lawful immigration status; and without a parent or legal guardian present in the United States available to provide care and custody of the child. Once an apprehending agency determines that the child is a UAC, that agency is responsible for referring the child to ORR for care and custody.

Congress instructed ORR to ensure that the best interests of the child are considered when providing care and custody for children. All of us at ORR take this responsibility to heart and work every day to ensure the safety and well-being of the children in our custody.

To that end, based on the provisions of the HSA, the William Wilberforce Trafficking Victims Protection Reauthorization Act of 2008 (TVPRA), as amended, and provisions of the Flores Settlement Agreement (FSA) which I discuss in further detail below, HHS has built a network of dedicated care providers, developed rules and standards for care for those providers, and created mechanisms of oversight to ensure compliance.

HHS's role in the lives of UAC is often misunderstood. 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. ORR does not have jurisdiction over children that arrive with an adult parent; DHS is responsible for those families. HHS' UAC Program is a humanitarian child welfare program, designed for the temporary care of UAC, until 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 September 16, 2019, DHS has referred more than 67,000 UAC to us, which is the highest number in the program's history. By comparison, HHS received 59,170 referrals in FY 2016, which is the second highest number on record.

HHS currently has fewer than 6,000 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 a few months ago in June. This decline is due to a decrease in daily referrals over the last few months, and ORR's ability to maintain a steady high discharge rate of UAC placement with sponsors. As of July, the average length of time that a child stays in HHS' custody is approximately 50 days, which is a dramatic decrease of over 40 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.

On August 23, 2019, the Office of the Federal Register published a joint rule by HHS and DHS for the Apprehension, Processing, Care, and Custody of Alien Minors and Unaccompanied Alien Children. The regulations should replace and terminate the 1997 FSA by implementing the FSA's terms, consistent with the HSA and the TVPRA, with some modifications to reflect intervening statutory and operational changes. The rule will become effective October 22, 2019. DOJ filed a motion with the district court with jurisdiction over the FSA on August 30, 2019; as a result, ORR believes that the FSA should terminate on October 7, 2019.

For HHS, the final rule codifies standards for the temporary care, placement, and release of UAC in the custody of ORR. HHS carefully considered comments from the public, and made changes to the proposed regulations based on those comments. The rule outlines care provider licensing requirements, considerations for special needs minors, procedures during an emergency or influx, transportation of UAC, and age determinations.

<u>Identification and Reunification of Separated Children</u>

HHS is currently complying with the preliminary injunction order issued by the *Ms. L v. ICE* court on June 26, 2018. ORR, in coordination with its counterparts at DHS, continues to provide status reports to the court and the plaintiffs.

As of September 6, 2019, ORR has only 27 children of *Ms. L.* class members in care.
In general, DHS separates parents from their children for the reasons allowed by the *Ms. L.* Court. Those reasons include unverified familial relationship/fraud, criminal history, a communicable diseases, danger to the child, or lack of parental fitness.

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 circumstances around separation. In addition to the services it provides to UACs, HHS works with its DHS counterparts to reunify children of *Ms. L.* class members wherever appropriate, consistent with the Court's orders.

Services While in Custody

HHS is deeply committed to the physical and emotional wellbeing of all children temporarily in our 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 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.

ORR provides a wide range of medical services to the children in care. These services include a complete medical examination, routine medical and dental care, mental health services, and emergency health services.

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 based on a child's individual needs. If children have acute or chronic mental health illnesses, ORR refers them for offsite mental health services or placement at Residential Treatment Centers.

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 Facility 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. 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 no sponsor is available.

By December 31, 2020, we anticipate that we will have increased permanent, state-licensed facilities, including foster care. These beds will be funded by a combination of the supplemental funding appropriated earlier this year as well as discretionary funds requested in the President's 2020 Budget.

It takes approximately six to nine months from the posting of a funding opportunity announcement 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 3,000 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 over 2,000 temporary beds available at temporary influx care facilities when our network of licensed beds is operationally full, to facilitate the expeditious transfer of UAC out of U.S. Border Patrol facilities, which are not designed or equipped to care for children. Note, given the current low occupancy, ORR is not sheltering children at either temporary influx facility at this time.

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 HSA, the TVPRA, the FSA, 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. On October 22, 2019, the final rule on the Apprehension, Processing, Care, and Custody of Alien Minors and Unaccompanied Alien Children should become effective and replace the FSA. The final rule substantively implements the FSA, including those provisions governing the operation of influx facilities.

HHS monitors temporary influx care facilities through assigned Project Officers, Federal Field Specialists, Program Monitors and all have the authority to issue corrective actions for

noncompliance. ORR can also remove children from facilities and stop placements altogether to ensure the safety and wellbeing of all children in HHS's care.

Recently, several local governments have expressed their unwillingness for ORR to open a licensed facility in their community. The unease of some officials about ORR facilities is understandable due to confusion about the conditions in those facilities and ORR's role in the care of UAC. While understandable, the hesitation or refusal to license an ORR facility impedes ORR's ability to increase permanent bed capacity, which may lead to a reliance on influx facilities and a backup of children in U.S. Border Patrol stations. ORR is working to address the concerns of local officials to avoid those outcomes by explaining the services children in care receive and distinguishing ORR from immigration enforcement agencies so that new facilities can be licensed and used to provide shelter to vulnerable children.

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 custodial authority over UAC 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 facilities 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. While referral rates have declined over recent weeks, given the unpredictable nature of the program, HHS must ensure that 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 am happy to answer any questions you may have.