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Before the

Committee on Homeland Security and Governmental Affairs
United States Senate

July 7, 2015

Chairman Johnson, Ranking Member Carper, and members of the Committee, thank you for inviting me to discuss the Department of Health and Human Services' (HHS) responsibilities regarding unaccompanied children. In my testimony today, I will describe the role that HHS plays in relation to unaccompanied children under Federal law, and then discuss a set of key developments in relation to our responsibilities since the Committee's hearing on this topic last summer.

Role of the Office of Refugee Resettlement

Under the Homeland Security Act of 2002, (P.L. 107-296), an unaccompanied alien child (UC) means "a child who (A) has no lawful immigration status in the United States; (B) has not attained 18 years of age; and (C) with respect to whom – (i) there is no parent or legal guardian in the United States; or (ii) no parent or legal guardian in the United States is available to provide care and physical custody."

Most children referred to the Unaccompanied Children Program, both historically and currently, are from Honduras, Guatemala, and El Salvador. There are a number of reasons that unaccompanied children embark on the dangerous journey from their home countries to the United States. Some of these children are fleeing from poverty and violence in their home country, seeking to rejoin family members already here, and/or hoping to find work to support their families in their home countries. The age of these unaccompanied children, their separation from parents and relatives, and the perilous journey they undertake make them especially vulnerable to human trafficking, exploitation, and abuse on their way to the United States.

In recent years, the number of unaccompanied children referred to HHS's Unaccompanied Children Program each year was generally in the range of 6,000 to 7,000 until fiscal year (FY) 2012. Those numbers increased from 2012 through 2014, from 13,625 in FY 2012 to 24,668 in FY 2013 to 57,496 in FY 2014. As I will discuss later, the number has fallen considerably in the last year, though it is still high relative to caseloads prior to FY 2012.

Historically, the great majority of unaccompanied children were males over the age of 14. While older males still comprise the majority, in recent years, the share that are female and younger have both increased. Between 2012 and 2014, the share of unaccompanied children who are female has grown from 23 percent to 34 percent, and the share of children 12 and under has grown from 11 percent to 21 percent. In addition, in 2012 only one percent of children referred to us were ages five and under while in 2014 this number rose to three percent.

Most unaccompanied children arrive at the border between U.S. and Mexico, and when they do, the Department of Homeland Security (DHS) refers children to the HHS Office of Refugee Resettlement (ORR) within 72 hours, except in exceptional circumstances, after determining that the child is an unaccompanied child.

When unaccompanied children are referred to ORR, they are cared for in one of a network of shelters while staff work to determine if they have appropriate sponsors with whom they can live while awaiting immigration proceedings. HHS funds shelters through grants to non-profit organizations. HHS currently funds shelters in 15 states, but the majority of shelters are within 250 miles of the Southern border. Upon arrival at a shelter, a child is provided with a complete

medical examination within 48 hours. This examination includes a general medical screening, which is conducted by either a doctor or nurse practitioner. All children receive age appropriate care including vaccinations as well as screening for tuberculosis and certain other communicable diseases.

Soon after a child arrives, trained staff conduct an initial interview. This interview is used as a first round of HHS screening to determine whether the child may be a victim of abuse, a crime, or human trafficking. The screening also indicates if the child may have any immediate mental health needs. If a mental health concern is detected during this screening, such as a history of trauma or violence, additional screenings are completed by specially-trained mental health clinical staff or case managers with clinical experience. These screenings determine whether the child requires specialized services, such as a home study conducted by a grantee case worker, typically a social worker, prior to his or her release to a sponsor (if an appropriate sponsor is available). The screenings also determine whether the child is a potential victim of human trafficking and, therefore, eligible for the additional services and legal assistance available to certain trafficking victims in the United States.

Pursuant to Federal law and the Settlement Agreement in *Flores v. Reno*, a consent agreement entered into in 1997, a child in HHS care receives medical, dental, and mental health services; education services; recreational opportunities; a legal rights presentation and access to legal services; access to religious services; case management services which include services to identify a parent, relative, or other appropriate sponsor; and clinical counseling on a weekly basis

to treat any mental and emotional health issues, like depression or post-traumatic stress, for example.

Placement of an unaccompanied child with a sponsor

The William Wilberforce Trafficking Victims Protection Reauthorization Act of 2008 (TVPRA) requires that we seek to place children in the least restrictive setting that is in the best interest of the child, taking into consideration any danger the child may pose to him or herself or to others in the community and any risk of flight. Generally, such a setting is with a sponsor. Accordingly, while a child is in a shelter, we seek to identify an appropriate sponsor for the child. Initially, we seek to place a child with a parent or a close relative. If that is not possible, we explore whether it is possible to place the child with a more distant relative (such as a second cousin) or a family friend. If it is impossible to identify an appropriate sponsor, and the child does not return to his or her home country, the child will remain in an HHS shelter or be placed in foster care until the child turns 18 or until the immigration proceedings are completed, whichever occurs first. If the immigration proceedings have not completed or a final order of removal has been issued, HHS remands the youth to the custody of DHS when the child turns 18.

Before placing a child with a sponsor, HHS goes through a set of steps to ensure that a sponsorship will be safe and appropriate. In accordance with the TVPRA, we require verification of a sponsor's identity and relationship to the child. To meet this requirement, we require care provider staff to complete and document a thorough assessment of the child's past and present relationships to potential sponsors, whether family or non-relative. HHS care provider staff evaluates the nature and extent of the sponsor's motivation to care for the child. If

the child is not being released to a parent or legal guardian, the care provider staff considers the child's parent's or legal guardian's perspective on a child's potential release to a particular sponsor. This process is accomplished through interviews, careful review of submitted documentation, and outside confirmation of a sponsor's identity. These steps, along with any information the child provides to care provider staff, allows us to verify a sponsor's identity and relationship to the child.

In addition, the potential sponsor is required to undergo a background check and complete an assessment that identifies risk factors and other serious concerns. The background check consists of a public records check for the sponsor for criminal history, self-reporting by the sponsor of criminal history or domestic violence, and interviews with the child by a trained professional to uncover any criminal or domestic violence concerns about the sponsor. A psychosocial assessment of the child and the sponsor is also completed by case managers and clinicians, using a standard set of questions for every child and prospective sponsor. A background check based on fingerprints is required if the sponsor is not the child's parent or legal guardian or if any concerns are raised, including if there is concern for the child's safety. We perform these checks on all non-parent, legal guardian sponsors and on parents, legal guardians, if there is a known criminal history, documented risk to the safety of the unaccompanied child, the child is especially vulnerable, and/or the case is being referred for a mandatory home study. The fingerprints are taken and run against the Federal Bureau of Investigation and DHS databases.

In certain cases, case workers perform home studies as an additional safety measure. Home studies are required, under the TVPRA, if:

1) The child is a victim of a severe form of trafficking;

2) The child is a special needs child with a disability as defined in section 3 of the Americans with Disability Act of 1990;

3) The child has been a victim of physical or sexual abuse under circumstances that indicate that the child's health or welfare has been significantly harmed or threatened; or

4) A child's proposed sponsor clearly presents a risk of abuse, maltreatment, exploitation, or trafficking based on all available objective evidence.

Currently, home studies are done in seven to ten percent of cases before children are released to sponsors. Post-release services are performed for all cases in which a home study was conducted, in order to help link the child and the sponsor with community services or to provide other on-going assistance.

In the great majority of cases, we are able to place a child with a parent, relative, or other appropriate sponsor. As of May 31, 2015, approximately 90 percent of children who were released from shelters in FY 2015 were released to a parent, relative, or non-relative sponsor. The remainder of those released were remanded to DHS' custody because they had reached 18 years of age; were repatriated to their country of origin; or were placed in the Unaccompanied Refugee Minor (URM) program.

Post-release Responsibilities

As part of the placement process, HHS informs potential sponsors of their responsibility for ensuring the child appears at all appointments and court proceedings related to his or her immigration case and report to ICE for removal if subject to a removal or voluntary departure order. The sponsor must also agree to notify EOIR and DHS of any change of address, as well as attend a legal orientation provided by EOIR if it is available in the community where the sponsor resides. It is then up to the child, and the sponsor, to ensure that the child attends proceedings. Additionally, HHS coordinates with EOIR and informs EOIR of the current address of the sponsor at the time of release in order to assist EOIR's LOPC providers in their outreach efforts. HHS is not a party to the child's immigration case.

Once a child has been placed with a parent, relative, or other sponsor, the care and well-being of the child becomes the responsibility of that individual. For the great majority of children who are released to sponsors, HHS does not provide ongoing post-release services; rather, those services are limited to children for whom there had been a home study, and to a limited number of other children who have been determined to have mental health or other needs and who could benefit from ongoing assistance from a social welfare agency.

While we seek to ensure that all releases are safe and appropriate, we are aware that in some circumstances, a child may subsequently develop concerns about his or her placement. In April of this year, HHS expanded its ORR Help Line, initially intended to handle calls from potential sponsors, to also receive calls from children. Prior to release to a sponsor, HHS tells each child about the Help Line and provides him or her with a wallet card that reminds the child to call the

toll-free Help Line number if he or she needs help and to call 911 if he or she is in immediate danger. In addition, HHS will offer post-release services to the child and sponsor if the child was placed within 180 days and the placement has disrupted or is at risk of disruption. In the event that post-release service case workers or the Help Line workers are concerned about a child's safety, they are required under state and local laws to report those concerns to state or local child protective services.

Management of Child's Information

Since 2006, case information about children in HHS care has been entered into a secure, web-based database by our grantees. In January 2014, ORR updated the data system to what is now known as the Portal. The Portal has the ability to house demographic information along with child assessments and other case information, such as reports of abuse or neglect while in HHS care or prior to the child's arrival in the U.S. We continue to develop enhanced data reporting capabilities on the Portal.

HHS has strong policies in place to ensure the confidentiality of unaccompanied children's personal information and the security of the Portal database. These children may have histories of abuse or may be seeking safety from threats of violence. They may have been trafficked or smuggled. HHS does not release information about individual children that could compromise the child's location or identity.

Key Developments since July 2014

The number of arriving unaccompanied children has fallen significantly since the summer of 2014. In FY 2014, ORR received a total of 57,496 referrals from DHS. One third of those arrivals came in May and June of 2014. Arrival numbers began falling in July, and in the first eight months of FY 2015, ORR received fewer than 18,000 referrals of unaccompanied children and released over 15,000 unaccompanied children to sponsors. Historically, arrivals have been highest in the early months of summer; last May, we received 9,431 referrals; this May, the number was 3,350. HHS has approximately 4,000 children in its care as of June 30.

In substantial part, the number of unaccompanied children has fallen over the past year, because the Federal Government has engaged in an aggressive, coordinated, multi-agency response to provide humanitarian care for unaccompanied children while also improving foreign government cooperation, increasing border security, and providing assistance to governments in Central American countries to curb the flow of unaccompanied children.

In response to the increase of unaccompanied children at the Southwest border in FY 2014, the President directed the Secretary of Homeland Security to establish an interagency group, the Unified Coordination Group (UCG), to ensure unity of effort across the Administration. HHS and DHS are the lead agencies for the Federal management and care of unaccompanied children. The UCG has an ongoing role to facilitate requests from DHS or HHS, if needed, which may include additional capability, operational coordination, planning support, situational assessment, and critical transportation core capabilities.

Operating the Unaccompanied Children Program presents multiple challenges because of uncertainties about how many children will arrive and when. The U.S. government has continued to take steps to deter families and children from making the dangerous journey to the United States in the first place. Incorporating lessons learned from last summer, HHS has also adjusted a number of its practices to efficiently and effectively respond to both seasonal and unexpected fluctuations in migration while also maintaining high standards of care for this vulnerable population.

Because of the large seasonal fluctuations in arrival numbers, it is appropriate to have a mix of "standard" beds that are available year-round, and "temporary" beds that are called upon as needed in the event of a seasonal increase in arrivals. Accordingly, HHS developed a bed capacity framework for FY 2015 designed to make standard shelter capacity more adjustable by having a sufficient base number of standard beds, with the ability to quickly add temporary beds. This model, implemented in November 2014, reduces funding during periods of low capacity while preserving the ability to respond to future increases.

In recognition of the seasonality of migration, HHS directed providers operating shelter and foster care facilities with 50 or more beds to revise their proposed FY 2015 budgets to maintain capacity but reduce operating costs by a target of 25 percent between August and February, which is typically the low season for the program. Because arrival numbers remained lower than anticipated, ORR notified grantees to extend the low season an additional month through March 2015. In addition to these changes, HHS also delayed the delivery of approximately 1,200 additional beds until February 2015, which were originally scheduled to come online in mid-

September 2014. These actions are expected to result in FY 2015 savings of approximately $100 million relative to the grantee-submitted budget requests, representing a reduction of approximately 21 percent of the proposed budget amounts for those grantees.

As of June 2015, ORR has facilities in 15 states, with a capacity of 7,700 permanent beds. In addition, HHS has plans in place that would allow us to add up to approximately 6,000 additional temporary beds upon 30 days' notice, if needed and pending funding availability. At this time HHS is not expecting to deploy temporary shelters in FY 2015, but it is important for the Federal Government to be prepared to provide humanitarian care as rapidly as possible given the myriad of factors that can impact migration flows. Accordingly, in May 2015, HHS awarded five contracts for services related to temporary shelters for unaccompanied children with a combined contract minimum award amount totaling $6.1 million. These contract vehicles can be engaged to provide flexible options for the following services on a regional basis throughout the United States: shelter staffing, wrap-around services, training and technical assistance to shelter providers, transportation, and medical and clinical staffing and equipment. HHS will conduct outreach to elected officials and other stakeholders if temporary shelter capacity is determined to be needed.

In recent years, HHS has improved the efficiency of its case processing while ensuring that children's needs are carefully reviewed and sponsor background is checked. As a result, HHS has reduced the average length of stay of a child in shelter care from 72 days in FY 2011 to 34 days in FY 2015. While we continue to look for efficiencies, we must be mindful of the need to not truncate the processes in ways that risk the safety of children.

Since last year, HHS has created a Division of Policy within ORR to focus on strengthening policies to govern the care of unaccompanied children and their placement with sponsors. We have posted multiple policies on the ORR website, and will continue to add more in the coming months. For example, we have posted policies describing the background checks required before a child is released to a sponsor and safeguards that must be in place to prevent sexual abuse or sexual harassment of the unaccompanied children.

In addition, in December 2014, HHS published its interim final rule (IFR) for implementation of Standards to Prevent, Detect, and Respond to Sexual Abuse and Sexual Harassment Involving Unaccompanied Children as required by the Prison Rape Elimination Act of 2003 (PREA). The IFR outlines safeguards that all ORR facilities must implement to protect children in ORR custody from sexual abuse. The IFR requires facilities to adopt zero tolerance policies, appoint a compliance manager to oversee implementation of appropriate safeguards and training, conduct criminal background checks during the hiring process, maintain minimum staffing levels, and conduct unannounced rounds, and use monitoring to maintain surveillance of youth/staff and youth/youth interaction.

As noted previously, we have expanded our Unaccompanied Children Help Line to receive calls from children concerned about the safety of their placements. In addition, in March of this year, we enhanced our background check process to require child abuse and neglect checks in all cases involving non-relative sponsors. While we do not provide post-release services in all cases, we have expanded the provision of post-release services, effective July 1. We will now provide post-release services to all children released to a non-relative sponsor, and to recently released

children who have contacted the ORR Help Line for assistance and either are no longer living with their sponsor or are having serious conflict with their sponsor. In addition, effective July 1, we have expanded the implementation of home studies for all children ages 12 and under being released to non-relative sponsors.

Under Federal law, HHS has a responsibility to ensure that unaccompanied children receive counsel to the greatest extent practicable and, consistent with section 292 of the Immigration and Nationality Act (i.e., stating that a person in removal proceedings before an immigration judge shall have the privilege of being represented, but at no expense to the Government), making every effort to utilize pro bono counsel. We continue to actively work to expand the availability of pro bono counsel and other legal services for unaccompanied children On June 15th, HHS issued a request for proposals for contractors to provide legal services to unaccompanied children; including pro bono legal representation to the greatest extent practicable, direct representation to the greatest extent practicable, screenings for legal relief eligibility and human trafficking; friends of the court services; and Know Your Rights presentations for children in HHS shelters. In addition, because there are not enough pro bono counsel, in September 2014, HHS provided funds to two grantees to hire attorneys to provide post-release legal representation to unaccompanied children in cities where a large percentage of children are expected to be released to sponsors and their removal proceedings are expected to be held. We believe that this expansion of representation will improve efficiency in the immigration courts, as the caseload has increased due to the previous increase of unaccompanied children crossing the southern border.

Conclusion

We welcome working with this Committee and Congress in efforts to improve the program. Thank you for the opportunity to discuss this critical issue with you. I would be happy to answer any questions.