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**Testimony**

Statement by
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on
**Challenges at the Border: Examining the Causes, Consequences, and Responses to the Rise in Apprehensions at the Southern Border**

before
**Committee on Homeland Security and Governmental Affairs**
**United States Senate**

**Wednesday July 9, 2014**

Chairman Carper, Ranking Member Coburn, and members of the Committee, thank you for inviting me to discuss the Department of Health and Human Services' (HHS) responsibilities in relation to unaccompanied children. I very much appreciate the opportunity to provide information about our program and the children we serve.

Today, I would like to share with you the steps HHS takes to care for these children once they are referred to HHS' custody, HHS' responsibilities to identify appropriate sponsors with which children can live while awaiting immigration removal proceedings, and the challenges we face as a result of the increased numbers of unaccompanied children.

**Services for Children**

Pursuant to law, unaccompanied children, i.e., children under the age of 18 who have no legal immigration status in the United States and who either do not have a parent or legal guardian in the United States or who do not have a parent or legal guardian in the United States that is available to provide care and physical custody of the child, come into HHS' care once they are referred to us by the Department of Homeland Security (DHS). Under existing law, DHS must notify HHS within 48 hours of determining an alien is an unaccompanied child and transfer such child to us within 72 hours of such determination, absent exceptional circumstances. Most of the children referred to HHS are from Guatemala, Honduras, and El Salvador. Historically, the majority of children arriving were males over the age of 12. This continues to be true. However, during the past year, the Administration for Children and Families (ACF) experienced an increase in the population of females and children under the age of 12. The number of children in our care

varies from day to day as children are released to sponsors or returned to their home country, and newly arrived children are placed with us. Currently, HHS has approximately 9,000 children in its care across the nation. These children are cared for in our permanent and emergency capacity shelters.

HHS funds shelters through grants to non-profit organizations, many of which are faith-based service providers, and several of which are state and local governments. Upon their arrival into one of the HHS' shelters, the children are provided with a complete medical examination within 48 hours. This examination includes a general physical exam or medical screening and is conducted by either a doctor or nurse practitioner. All children receive age appropriate care including vaccinations as well as screening for tuberculosis.

Soon after the children come to us, trained provider staff conduct an initial interview of each child. This interview is used as a first round of HHS screening to determine whether the child may be a victim of abuse, a victim of a crime, or a trafficking victim. The screening also tells us if the child has any immediate mental health needs. If a mental health concern is detected during this screening, 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, a home study conducted by a grantee case worker, typically a social worker, prior to his or her release to a sponsor (if a sponsor is available), and whether the child is a potential victim of trafficking and therefore eligible for the additional services and legal assistance available to foreign trafficking victims in the United States.

Pursuant to federal law and the *Flores* Settlement Agreement, while children are in our care, each child 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.

The Trafficking Victim's Protection Reauthorization Act (TVPRA) requires that we seek to place children in the least restrictive setting that is in the best interest of the child. Generally, such a setting is with a sponsor. This may be a parent, relative, or other appropriate sponsor.

Most children who are placed in our shelters have parents or other relatives already living in the U.S. To date in fiscal year 2014, approximately 95 percent of children released were released to a parent, relative, or non-relative sponsor. Of the remaining five percent of children not released to a sponsor, some are remanded to the DHS' custody because they reach 18 years of age. Others are repatriated to their country of origin and a very small number may become eligible for the Unaccompanied Refugee Minor program.

HHS has a strong process for ensuring a potential sponsor is an appropriate care provider. In accordance with the TVPRA, we require verification of a sponsor's identity and relationship, if any, to a child before placing a child with a sponsor. To meet this requirement, we require care provider staff to complete and document a thorough assessment of the child's past and present family relationships and relationships to non-relative potential sponsors. HHS care provider staff

evaluate the nature and extent of the sponsor's motivation for wanting to care for the child. If the child is not being released to a parent or legal guardian, the care provider staff consider the child's parent 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. This process, 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 background checks and complete an assessment process that identifies risk factors and other serious concerns. The background check consists of a public records check of the sponsor for criminal history, self-reporting by the sponsor of criminal history or domestic violence, interviews with the child to uncover any criminal or domestic violence concerns about the sponsor, and a written assessment of the child and the sponsor completed by case managers and clinicians. A fingerprint background check is required if any concerns are raised, including if there is concern for the child's safety, or if the sponsor is not the child's parent or legal guardian. The fingerprints are then verified with FBI and DHS databases.

An additional safety measure is in our performance of home studies on potential sponsors. Home studies are required, under the TVPRA of 2008, for the following conditions:

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.

As part of the placement process, HHS notifies potential sponsors of their responsibility for ensuring the child appears at all appointments and court proceedings related to his or her immigration case. HHS also informs sponsors of their responsibility to notify DHS and the U.S. Department of Justice Executive Office for Immigration Review (EOIR) of address changes, within ten days of any such change. HHS provides notification to DHS of the name, address, telephone number, and relationship to the child of the sponsor 24 hours prior to release to the sponsor. Additionally, HHS coordinates with EOIR and informs EOIR of the reunification status and current address of the sponsor at the time of release. It is important to note that HHS does not decide a child's immigration status and 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. HHS may require that the sponsor and child receive post-release services. In the event that post-release service case workers find the home

unsafe they are required under state and local laws to report those conditions to state or local child protective services.

Currently, between 10 and 13 percent of children receive home studies prior to their release, and post-release services must be performed for all cases in which a home study was conducted. The purpose of post-release services is to help link the child and the sponsor with community services or other on-going assistance.

In those cases where a sponsor is not identified to care for a child, the child will remain in our care until he or she reaches the age of 18 or until the child obtains a lawful immigration status. In those cases where a lawful immigration status is obtained, or the child receives a letter of eligibility from HHS as a victim of trafficking, the child may be eligible to apply for placement into the HHS Unaccompanied Refugee Minor (URM) foster care program. HHS provides grants to 15 states which serve approximately 1,400 URM children and youth in foster care. The URM program traditionally has served unaccompanied refugee children who are identified in countries of first asylum as requiring foster care upon their arrival in this country. HHS works with two national voluntary agencies, the United States Conference of Catholic Bishops and the Lutheran Immigration and Refugee Service, to identify placement in affiliated agencies under contract with state refugee coordinator offices. While most children in the URM program are placed in licensed foster homes, other licensed care settings are utilized according to children's individual needs, such as therapeutic foster care, group homes, independent living, or residential treatment centers.

**Challenges**

In HHS' responsibilities for unaccompanied children, our immediate challenge concerns the current unprecedented growth in the number of unaccompanied children arriving at the Southwest border. In recent months, the number of children arriving has greatly exceeded the number of available places for children in HHS' shelters, negatively impacting our ability to timely accept custody of these children from DHS. We are actively working with DHS, the Department of Defense, and other federal agencies through the coordination efforts of FEMA to both expand our facilities and to identify additional efficiencies to shorten the amount of time that children are with us, without jeopardizing child safety. Thus in order to reduce the time children spend in DHS custody, we are seeking to reduce the length of time that children remain in our care before being placed with a sponsor who can care for them safely and appropriately while their immigration case is processed, and second working to increase our shelter capacity.

The average length of time that a child is in HHS' custody has been reduced from 72 days to 34 days over the past three years. During this time, HHS focused on identifying and implementing procedures that could streamline the process of identifying and placing the child with an appropriate sponsor without increasing risks to child safety or well-being. In implementing these procedures, HHS was able to reduce the per capita cost of providing services to an unaccompanied child by over 50 percent. The procedures to accomplish this included:

- Shortening the timeframe for initial identification of parents, relatives, or other sponsors;

- Developing a streamlined set of procedures;
- Reducing the amount of time it takes sponsors to submit a completed sponsor application packet;
- Reducing the timeframe from approval of release to actual discharge;
- Developing training for care provider staff on streamlined procedures.

Despite the progress we have made in reducing the average length of stay in our care, it remains a challenge to balance the need to quickly release the children from our care while continuing to ensure that children are released to safe and appropriate sponsors. We have consulted with clinical staff, child welfare experts, and attorneys in creating assessment policies, procedures, and forms for both the children and potential sponsors and are confident they are comprehensive in determining the existence of risk and the safety of a release.

Second as we work with federal partners to develop additional facilities, HHS faces challenges in seeking to expand facilities to new locations, in part because of misconceptions about the impact of HHS shelters on local communities. Some community members are concerned about whether these children present safety risks to a community where the shelter is located. However, the overwhelming majority of these children have no criminal record, have not participated in gang activities, and manifest no behavioral problems while in our care. In many cases, the children report that they are fleeing gang violence and forced recruitment into criminal gangs as well as generalized violence in their home country. In addition, many of the children seek to reunite with family members already in the United States. HHS would not release into the community any child who is a danger to himself or others in the community. For the small number of children who do pose a threat, those children remain in our secure detention facilities until they are returned to their country of origin or remanded to the care of DHS upon reaching the age of 18. Of the approximately 9,000 unaccompanied children in the custody of HHS at any one time, only between 25 and 45 are in our secure detention facilities, less than one-quarter of a percent.

Community members may also have questions concerning whether having a shelter in a community presents health risks to area residents. As I previously stated, these children all receive medical screenings and receive age-appropriate vaccinations. Further, we take great precautions to ensure the public's health should we identify a child with a communicable disease. Children who have serious physical and mental health issues or have had exposure to a communicable disease are normally not transferred or moved until they have been cleared by a medical provider. Medical clearance documentation includes the results of all laboratory tests and any other diagnostic testing.

**Conclusion**

This is a very complex situation with a number of challenges. We would welcome working with this Committee and Congress in efforts to address it. Again, thank you for the opportunity to discuss this critical issue with you. I would be happy to answer any questions.

Last revised: July 14, 2014