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Many States Lack Information To Monitor Maltreatment in Residential Facilities for Children in Foster Care

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Why OIG Did This Study

States oversee residential facilities, and ACF provides funding and oversight to States for children in foster care who meet certain eligibility requirements. Policymakers, news media, and advocacy groups have raised concerns about the effectiveness of oversight efforts to protect children in these settings. To assess how States monitor child maltreatment that occurs in residential facilities, we surveyed each State child welfare agency.

What OIG Found

Many States reported missing or incomplete information in key areas that could support enhanced oversight of residential facilities for children, although collecting and sharing this information is not required by Federal law.

- Nearly one-third of States could not identify patterns of maltreatment in residential facilities within their State.
- States had limited awareness of maltreatment that occurred across chains of residential facilities operating in multiple States.
- States reported challenges monitoring the safety of children placed in out-of-State residential facilities.
- Thirteen States did not consistently report to the national maltreatment database whether children who experienced maltreatment were living in a residential facility.

What OIG Recommends

1. ACF should provide guidance and technical assistance to States to build data collection and monitoring capabilities that are foundational to effective oversight of maltreatment in residential facilities.
2. ACF should help States to improve their abilities to monitor patterns of maltreatment and performance across chains of residential facilities operating in multiple States.
3. ACF should take steps to improve inter-State communication when children are placed in out-of-State residential facilities.
4. ACF should work with States to improve reporting of placement data in the National Child Abuse and Neglect Data System.

ACF did not concur with the first recommendation, as initially drafted, and concurred with the other three recommendations. OIG has revised the first recommendation.

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BACKGROUND

OBJECTIVE

To assess how States monitor maltreatment that occurs in residential facilities for children in foster care.

States monitor and license residential facilities that receive Federal funding; however, policymakers, news media, and advocacy groups have raised concerns about the effectiveness of oversight efforts to protect children in these settings. These sources have reported on instances of abuse and neglect (collectively referred to as maltreatment) that occurs in residential facilities, including cases of physical violence, sexual assault, and improper restraints across nationwide chains of facilities.[1] Additionally, these sources have raised concerns about States' oversight of children placed in out-of-State facilities, including children who experienced maltreatment while placed in out-of-State facilities that had histories of maltreatment or inadequate staffing.[2] However, little information is publicly available about maltreatment that occurs in residential facilities.[3]

Residential facilities for children in foster care

Title IV-E of the Social Security Act (SSA) established the Federal foster care program, which helps States provide out-of-home care for more than 600,000 children.[4, 5] Each State child welfare agency from all 50 States, the District of Columbia, and Puerto Rico is responsible for implementing its foster care program and receives Federal funding for children who meet certain eligibility requirements. The Administration for Children and Families (ACF) provides funding and oversight for this program.

Children in foster care are placed in a variety of settings that may include nonrelative foster family homes, relative foster family homes, and residential facilities. For this evaluation, the term "residential facility" refers to any non-foster family home placement that a State licenses for 24-hour care and supervision in which a State may place children in foster care who are Title IV-E eligible (this includes group homes, residential treatment facilities, and emergency shelters). These settings are also sometimes referred to as congregate care. In fiscal year (FY) 2021, States reported that about 49,000 children were placed in residential facilities.[6]

Federal legislation and oversight of residential facilities

The Family First Prevention Services Act (Family First)[7] was enacted to turn the focus of the child welfare system toward keeping children safe with their families, to avoid

the trauma that can result when children are placed in out-of-home care.[8] Family First limits Title IV-E foster care maintenance payments for any child in a child care institution—such as a residential facility—to 14 days, except when certain requirements are met.[9] Family First promotes the use of residential facilities as a limited strategy to support the complex clinical needs of children and youth with significant exposure to trauma.

States and local agencies are responsible for overseeing residential facilities for children. States are required to establish and maintain licensing policies that are reasonably in accord with national standards, including those relating to safety.[10] Additionally, each State is required to have child abuse and neglect reporting laws that require certain professionals and institutions to report suspected maltreatment to the State-designated agency responsible for receiving such reports.[11, 12] Each State defines child abuse and neglect on the basis of a minimum definition set by Federal law.[13]

ACF is responsible for overseeing States' efforts to ensure the safety and well-being of children in foster care, including those who are placed in residential facilities. ACF's oversight includes periodic Child and Family Services Reviews of each State's child welfare system to assess whether a State complies with its Title IV-E plan requirements. ACF conducts onsite reviews that include an assessment of the timeliness of State investigations of reports of child maltreatment for a sample of children.[14] Additionally, ACF provides guidance and technical assistance to States.

Federal maltreatment data

The primary source of national data on child maltreatment is the National Child Abuse and Neglect Data System (NCANDS), a federally sponsored data collection effort that includes annual data on child abuse and neglect.[15] Each year, NCANDS data are submitted to the maximum extent practicable by all States, the District of Columbia, and Puerto Rico and are analyzed and reported by ACF.[16] Some of the data elements include information about the characteristics of the children involved in each case, including their living arrangements and other risk factors; the type of maltreatment; child protective services' findings; and the services provided to the child. NCANDS data are used to measure the performance of several Federal programs and are an integral part of ACF's Child and Family Services Reviews as well as ACF's annual reports to Congress.[17]

Out-of-State foster care placements

States sometimes place children out of State when a suitable in-State placement option is not available. In FY 2021, nearly 2,400 children were placed in out-of-State residential facilities across the country.[18]

The Interstate Compact on the Placement of Children (ICPC) sets forth requirements and procedures for the placement of foster children from one State into another State. The ICPC is a statutory agreement between all States, the District of Columbia,

and the U.S. Virgin Islands that sets requirements that must be met before a child can be placed out of State.[19] The goal of the ICPC is to ensure that prospective placements are safe and suitable before approval and to ensure that the individual or entity placing the child remains legally and financially responsible for the child following their placement. The ICPC requires receiving States to supervise children in an approved placement when requested by the sending State; however, ICPC requirements exclude placements in residential treatment centers and group homes.[20]

Related Work

This work is part of a broader portfolio of completed and ongoing OIG reports on States' oversight efforts to protect children in foster care from maltreatment. OIG has issued several reports that reviewed States' oversight processes to ensure that licensing requirements are met for foster care group homes.[21] In 2017, OIG audited States' compliance with requirements for recording and investigating allegations and referrals of maltreatment for children in foster care in California, Texas, and New York.[22] Each report found that the State did not always ensure that allegations of maltreatment of children in foster care were recorded and investigated in accordance with Federal and State requirements. OIG made recommendations to California, Texas, and New York, and all these recommendations have been implemented.

Methodology

Data sources and analysis

We developed a survey that included questions on States' actions to monitor potential patterns of maltreatment that occur in residential facilities and States' enforcement actions to address maltreatment that occurs in residential facilities. We received responses from child welfare agencies in each of the 51 States (for purposes of this report, we refer to the District of Columbia as a State).[23] We instructed States to refer to the timeframe of FYs 2018 through 2022. We defined "residential facilities" as any non-foster family home placement (e.g., group homes, residential treatment facilities, and emergency shelters) that a State licenses for 24-hour care and supervision in which a State may place children in foster care who are Title IV-E eligible. We followed up with select States to collect additional details or clarifying information. We reviewed qualitative data obtained from surveys and followup communication with States. We then identified the most salient takeaways related to how States monitor and address maltreatment allegations of children living in residential facilities and for whom the agency has placement and care responsibility.

Additionally, we analyzed the FY 2021 NCANDS child file data to identify the extent to which States reported children's living arrangements in their maltreatment data.

Limitations

This study is limited to the self-reported information provided to us by States—we did not independently verify every State's statements. Additionally, due to the open-ended nature of many of our survey questions, States varied in the amount of detail and in the specific topics that they wrote about in their survey responses. Some of the practices or challenges that we identified as themes may have also occurred in other States that did not write about those specific topics in their survey responses.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Nearly one-third of States could not identify patterns of maltreatment in residential facilities within their State

We found that 16 States did not have information they would need to identify patterns of maltreatment in residential facilities within their State. Although Federal law does not require States to collect this information, States' abilities to identify patterns of maltreatment within a facility and across chains of facilities within their State is limited without this information. This lack of data hinders State agencies' abilities to identify systemic issues within residential facilities or chains of facilities. See Appendix A for more information about the States included in the following findings.

The other two-thirds of States were able to report some information about the occurrence of multiple reports of maltreatment within facilities and across chains of facilities. A few of these States provided examples of how routine monitoring had helped them provide targeted oversight of residential facilities. However, many of these States did not provide clear indications as to whether they routinely monitored for patterns or trends of maltreatment within residential facilities.

Eight States were unable to identify whether multiple incidents of maltreatment had occurred in an individual residential facility

Eight States reported that they could not provide data on whether multiple incidents of maltreatment had occurred within an individual residential facility. In some of these States, identifying reports within a facility required substantial, manual effort. In cases in which the perpetrator of maltreatment was an employee of a residential facility, some of these States were not able to link that employee to the facility in which they worked.

> "We can pull the data on a specific facility and through a manual effort determine the reports received for that specific facility, but this takes **considerable effort** and is done on an as-needed basis."
>
> *– State child welfare agency*

Although half of States were able to identify facilities with multiple reports of maltreatment during our review period, many of these States did not indicate whether they routinely monitored for patterns or trends of maltreatment within residential

facilities. A few States, however, provided examples of how they tracked maltreatment and actions they took to address patterns of maltreatment when identified, including revoking facilities' licenses when it was deemed necessary. States that do not routinely collect and monitor information on facility-specific patterns of maltreatment are unable to effectively identify facilities that warrant such corrective actions. In addition, two States reported that they had taken steps in recent years to begin collecting facility-level data on maltreatment.

Fourteen States were unable to provide data on incidents of maltreatment across chains of facilities within their State

Fourteen States were unable to provide data showing whether incidents of maltreatment had occurred in facilities with the same owner (i.e., chains of facilities) within their State. Further, of the States that could provide data, many did not indicate whether they used their data to routinely identify patterns or trends of maltreatment within chains of residential facilities. Without the ability to collect and monitor these data, States' oversight of chains of facilities is limited. One State reported that this type of tracking was not possible within its data system. Another State reported that it did not collect this information because tracking facility ownership was not required.

Some of the States that did track patterns of maltreatment across chains of facilities reported taking actions including increasing monitoring activities, implementing corrective action plans, and reducing or ceasing placements in facilities within the chain, as necessary. In one case, a State reported that it terminated its contract with the parent company, ending the relationship with all facilities owned by that chain. States that do not track maltreatment patterns across chains of residential facilities cannot identify systemic issues within organizations that similarly warrant enhanced oversight.

States had limited awareness of maltreatment that occurred across chains of residential facilities operating in multiple States

Thirty-two States reported that they did not formally monitor whether residential facility owners in their State also operated residential facilities in other States. Although this type of monitoring is not required by Federal law, States' abilities to identify patterns of maltreatment in chains of facilities that operate across multiple States are limited without this information. Some States reported that they did not engage in this type of monitoring because requirements for residential facilities are different in each State; therefore, a chain's performance in another State was not necessarily a concern for their State. Other States reported that they were aware of facility owners in their State that also operated out-of-State facilities, but this information was often collected informally. For example, one State reported that it was aware of out-of-State chains due to informal discussions with facility staff or from news media. Conversely, a few States reported that they required facility owners to

disclose any out-of-State facilities during a facility's initial licensing and during the licensure renewal process.

Fourteen States reported that they monitored and were aware of chains of facilities within their State that also operated in other States. Of those 14 States, 5 States reported that they did not share information about facilities associated with the chain with the other States. Of the nine States that reported sharing information about chains of residential facilities with other States, most shared information only when it was requested by another State or when children were placed in out-of-State facilities. Of these States, two reported that they did not receive any requests for this type of information from other States during the review period.

> "If the information from other States revealed **systemic concerns** that might impact the quality of care across an organization, then [our State] might use the information to launch an investigation into the parent organization."
>
> *– State child welfare agency*

Twenty-seven States reported that it would be useful to have information from other States on chains of facilities that operate across States. States reported that they would be interested in information including facility ownership, the types of services provided, and licensing information. States also expressed interest in facility-specific data related to maltreatment, such as inspection reports and enforcement actions taken against a facility in another State. In one case, a State learned of concerns regarding restraint practices in an out-of-State facility owned by a national chain. The State met with representatives from the chain to discuss the concerns and ensure that no practices or protocols that were used in those out-of-State facilities were being used in facilities in their State. Other States suggested that a formalized process for sharing this type of information, such as a national database of residential facility information, could be helpful.

Although several States emphasized that information from other States on chains of facilities that operate across States would be helpful in guiding their out-of-State placement decisions, States also noted that this information could be used to inform licensing decisions and monitoring of facilities within their State that are part of chains. For example, one State wrote that information from other States might help them target enforcement actions for potentially problematic chains of facilities. Additionally, another State noted that these data could help identify facility owners that provide high-quality care, which could offer insights into best practices that could be shared with other facilities. However, a few States noted that the usefulness of this information could be limited due to differences in State requirements and the populations served by each facility, and another State was uncertain how it would use this type of information.

States reported challenges monitoring the safety of children placed in out-of-State residential facilities

States reported challenges monitoring the safety of children placed in out-of-State residential facilities. Many States reported that they placed few, if any, children in out-of-State facilities; however, it is critical to ensure the safety of each child in State custody. States reported that they must rely on the receiving State to notify them of any reports of maltreatment and that typically, States had limited access to information regarding maltreatment that did not directly involve a child from their State. This limits States' awareness of patterns or trends of maltreatment in out-of-State facilities in which they place children, which could be used to inform placement decisions. States also reported that some States were more consistent with communication than other States.

States varied in how they monitored the safety of children placed in out-of-State residential facilities. Some States reported that they relied on the receiving State to monitor the safety of individual children placed in an out-of-State facility (e.g., by conducting monthly visits with the child), and other States maintained that responsibility themselves by sending staff to the out-of-State facilities to visit children.[24] However, several States reported that staff time and transportation costs posed challenges for monitoring the safety of children placed out of State. Four States reported conducting some visits of children they have placed out of State virtually. Two States reported that they had formal licensing or certification processes to approve out-of-State facilities for placement of children from their State; other States reported they did not have the authority to implement similar processes.

"[Placing children out of State] **poses a financial barrier** to agencies that are required to pay for private child placing agencies or [State] staff to fly out-of-State to complete visits every 30 days to meet the Federal home visit requirements."

– State child welfare agency

Similarly, some States reported that differing standards and methods for monitoring and enforcement between States can also pose challenges when they place children in out-of-State facilities. Receiving States conduct investigations of maltreatment and determine appropriate enforcement actions; however, two States reported conducting their own investigations when alleged maltreatment involved a child they had placed out of State. However, one State reported that its ability to investigate these allegations of maltreatment of children in out-of-State placements may be restricted, including challenges in accessing records from out-of-State facilities. Another State noted that it receives regular requests from multiple States for information about reports on facilities in which these States have placed children. The State reported that a formal process for these requests would be helpful.

"It would be helpful if there was a **national dashboard** or platform where issues/concerns or violations might be found more easily or provide notifications to [sending] States … so that timely action can be taken by each State concerning their children."

– State child welfare agency

Thirteen States did not consistently report to the national maltreatment database whether children who experienced maltreatment were living in a residential facility

According to FY 2021 NCANDS data, 10 States did not report the child's living arrangement for any incidents of maltreatment, and another 3 States did not provide this data for nearly all incidents of maltreatment.[25] NCANDS is the national maltreatment dataset, which is maintained by ACF on the basis of data voluntarily reported by States. NCANDS is an important data source for Federal oversight, and incomplete data on children's living arrangement limits Federal oversight of residential facilities. For example, using NCANDs data, we could not accurately quantify the extent to which children in residential facilities experienced maltreatment nationwide.

Seven States reported that they did not consistently collect living arrangement information with maltreatment reports.[26] Two States reported that their data on living arrangements did not align with the NCANDS definitions. Three States reported that they were in the process of adding living arrangement information to their NCANDS reporting with the development of new case management information systems, and other States expressed interest in technical assistance from ACF to become able to report these data.

CONCLUSION AND RECOMMENDATIONS

Although Federal policy has increasingly focused on keeping children safe with their families, residential facilities still play an important role in providing care for children who often have complex clinical or behavioral needs that require a higher level of care. Policymakers, news media, and advocacy groups have raised concerns about the effectiveness of oversight efforts to protect children in residential facilities. States oversee residential facilities to help ensure the health and safety of children placed in these settings, and ACF provides funding and oversight to States. However, we found that many States lacked important information that could support enhanced oversight of residential facilities for children.

Specifically, States reported lacking or incomplete information in four key areas that would enable them to identify patterns of maltreatment within residential facilities operating in their State and across States. First, we found that many States did not have the information they would need to identify patterns of maltreatment in residential facilities within their State. This included 8 States that were unable to identify whether child residential facilities had multiple incidents of maltreatment and 14 States that were unable to provide data on incidents of maltreatment across chains of facilities within their State. Second, we found that many States had limited awareness of maltreatment that occurred in residential facility chains that operated across multiple States. Third, we found that States had limited abilities to monitor the safety of children placed in out-of-State residential facilities. Finally, we found that in Federal maltreatment data, 13 States did not consistently report whether children who experienced maltreatment were living in a residential facility.

We recommend that ACF:

Provide guidance and technical assistance to States to build data collection and monitoring capabilities that are foundational to effective oversight of maltreatment in residential facilities

ACF should provide States with guidance and technical assistance on how collecting and monitoring data can better support States' overall responsibilities in overseeing children who are Title IV-E eligible and who are placed in residential facilities. This guidance should include recommendations that States have data capabilities to monitor patterns of maltreatment within individual residential facilities as well as patterns across facilities within their State that have the same owner. If such guidance and technical assistance are not effective in improving States' capabilities to identify and respond to patterns of maltreatment in residential facilities, then ACF should consider seeking statutory authority (in accordance with established HHS processes

for legislative proposals) to set minimum standards for such data collection and monitoring.

Help States to improve their abilities to monitor patterns of maltreatment and performance across chains of residential facilities operating in multiple States

ACF should help States to improve their abilities to monitor the performance of residential facility chains that operate across multiple States. This could include improving States' abilities to systematically collect information on patterns of maltreatment; facility ownership; licensing findings and citations; and the population of children served by each facility and the services provided. These data should be sufficiently reliable and consistent to help States and oversight agencies (e.g., ACF, HHS OIG) monitor chains of residential facilities that operate across the country. Also, this information could help States make more informed placement decisions to ensure the safety and well-being of children placed in out-of-State facilities.

Take steps to improve inter-State communication when children are placed in out-of-State residential facilities

ACF should take steps to improve inter-State communication when children are placed in out-of-State residential facilities. This could include providing additional guidance for States about when another State has placed, or is considering placing, a child in a facility in their State. This could also include facilitating a centralized location to share information between States such as reports of licensing violations and maltreatment.

Work with States to improve reporting of placement data in NCANDS

ACF should work with States to support States' consistent reporting of placement data in NCANDS, the national dataset on child maltreatment. This could include providing technical assistance to States to address limitations in their data systems and processes that prevent them from reporting placement data to NCANDS. Increased State reporting would improve the capability of State and Federal agencies to monitor trends in maltreatment across all placement types and across all States.

AGENCY COMMENTS AND OIG RESPONSE

ACF did not concur with the first recommendation, as initially drafted, and concurred with the other three recommendations. OIG has revised the first recommendation.

ACF did not concur with our first recommendation, which initially recommended that it set standards for how States should collect and monitor data related to maltreatment in residential facilities, seeking legislative authority as necessary. ACF stated that it does not have statutory authority to require States or Tribes to collect specific data relating to residential facilities or to specify requirements for State or Tribal monitoring of the data for these facilities, and that seeking such authority would be unprecedented. OIG continues to be concerned about limitations in States' abilities to identify systemic problems or patterns of maltreatment in residential facilities, which puts children at risk of additional harm, and we continue to recommend that ACF take action to improve States' capabilities. However, in light of ACF's feedback, we have revised our recommendation to focus on ACF first providing guidance and technical assistance to States toward this end. If such guidance and assistance do not result in improvements to States' oversight capabilities, then we ask ACF to consider taking steps (in accordance with established HHS processes) to seek statutory authority to establish standards. We look forward to ACF's response to this revised recommendation in its Final Management Decision.

ACF concurred with our second recommendation, which is for it to help States to improve their abilities to monitor the patterns of maltreatment and performance across chains of residential facilities operating in multiple States. ACF stated that it will plan technical assistance activities in the current and next fiscal years to support States in improving their abilities to monitor patterns of maltreatment and performance across chains of residential facilities operating in multiple States. We appreciate ACF's planned efforts to assist States in improving their monitoring of maltreatment, and we will review further details on these plans and their implementation to determine whether they fulfill this recommendation.

ACF concurred with our third recommendation, which was for it to take steps to improve inter-State communication when children are placed in out-of-State residential facilities. ACF stated that it will continue to leverage existing constituency groups with foster care managers across the Nation to improve inter-State communication and to learn about and share best practices for monitoring when children are placed in out-of-State residential facilities. We appreciate ACF's efforts to facilitate communication and information sharing among States, and we will review documentation of these efforts to determine whether they fulfill this recommendation.

ACF concurred with our fourth recommendation, which is for it to work with States to improve reporting of placement data in NCANDS. ACF stated that it will continue to

work with States through ongoing NCANDS technical assistance efforts. We will review documentation of ACF's NCANDS technical assistance efforts and determine whether they work to improve States' reporting of placement data in NCANDS.

For the full text of ACF's comments, see Appendix B.

APPENDICES

Appendix A: States Included in Selected Findings

State	Not able to identify multiple incidents of maltreatment **within a facility**	Not able to identify multiple incidents of maltreatment **across chains of facilities**	No data on **child's living arrangement** in FY 2021 **NCANDS data***	Did not **monitor** whether residential facility owners also **operated in other States**	Did not **share information** about chains of facilities with other States
AK				X	*NA*
AL	X	X	X*	X	*NA*
AR				X	*NA*
AZ	X	X			*NA*
CA		X		X	*NA*
CO				X	*NA*
CT					*NA*
DC					X
DE				X	*NA*
FL					
GA				X	*NA*
HI		X	X*		X
IA			X		
ID			X	X	*NA*
IL			X		
IN					
KS				X	*NA*

State	Not able to identify multiple incidents of maltreatment **within a facility**	Not able to identify multiple incidents of maltreatment **across chains of facilities**	No data on **child's living arrangement** in FY 2021 **NCANDS data***	Did not **monitor** whether residential facility owners also **operated in other States**	Did not **share information** about chains of facilities with other States
KY					*NA*
LA			X	X	*NA*
MA		X		X	*NA*
MD	X			X	*NA*
ME				X	*NA*
MI	X	X			
MN				X	*NA*
MO			X	X	*NA*
MS		X		X	*NA*
MT	X	X		X	*NA*
NC		X	X	X	*NA*
ND	X			X	*NA*
NE				X	*NA*
NH			X	X	
NJ		X		X	*NA*
NM		X	X		
NV	X	X	X	X	*NA*
NY				X	*NA*
OH				X	*NA*
OK				X	*NA*
OR					*NA*
PA	X	X		X	*NA*

State	Not able to identify multiple incidents of maltreatment **within a facility**	Not able to identify multiple incidents of maltreatment **across chains of facilities**	No data on **child's living arrangement** in FY 2021 **NCANDS data***	Did not **monitor** whether residential facility owners also **operated in other States**	Did not **share information** about chains of facilities with other States
RI					X
SC					X
SD			X		X
TN			X*		
TX					*NR*
UT				X	*NA*
VA					*NA*
VT	*NR*	X		X	*NA*
WA				X	*NA*
WI					
WV				X	*NA*
WY				X	*NA*
Total included in finding	**8**	**14**	**13***	**32**	**5 (of 14 applicable States)**

Source: OIG analysis of State survey responses, 2023.
Note: Collecting and sharing the information described in these findings is not required by Federal law.
NR = No response given.
NA = Not applicable. These States were not asked this question either because they reported that (1) they did not monitor whether residential facility owners also operated residential facilities in another State, or (2) they did not have any chains of facilities in their State that also operated in other States.
*Nearly all of the NCANDS reports from three States were missing the child living arrangement variable (85 percent of reports from Alabama, 98 percent of reports from Hawaii, and 96 percent of reports from Tennessee).

Appendix B: Agency Comments

Following this page are the official comments from ACF.

ADMINISTRATION FOR CHILDREN & FAMILIES

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May 24, 2024

Ann Maxwell
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Dear Ann Maxwell:

The Administration for Children and Families (ACF) appreciates the opportunity to respond to the Office of Inspector General (OIG) draft report titled, *Many States Lack Information To Monitor Maltreatment in Residential Facilities for Children in Foster Care*, OEI-07-22-00530. Please find our comments and response to the draft report recommendations below.

Recommendation 1: Set standards for how States should collect and monitor data related to maltreatment in residential facilities, seeking legislative authority as necessary.

Response: ACF non-concurs with this recommendation.

Ensuring the health and safety of children placed in residential facilities is critical. ACF has several mechanisms in place to promote good practice that can help states address concerns about foster children placed in residential facilities. ACF has authority to monitor the title IV-E program through the Child and Family Services Reviews (CFSRs) authorized under 1123A of the Social Security Act. Further, ACF provides resources to help child welfare professionals develop and work with citizen review panels (CRPs) authorized under sections 106(c)(4)(A)(iii) of the Child Abuse Prevention and Treatment Act (CAPTA). ACF also routinely provides related technical assistance (TA) to jurisdictions.

However, residential facilities do not directly receive title IV-E funding. Instead, state and Tribal title IV-E agencies pay for these placements and then submit a claim for a portion of this payment for eligible children. ACF does not have statutory authority to require states or Tribes to collect specific data relating to these facilities or to specify requirements for state or Tribal monitoring of the data for these facilities. Some such data collection and/or specifying such requirements for monitoring are under the jurisdiction of other federal and state agencies. Further, standards for how states should collect and monitor data related to maltreatment in residential facilities would be an unprecedented requirement.

While ACF regularly responds to inquiries by Congress with respect to ways in which to strengthen the title IV-E program and provides feedback to Congress when they approach ACF for technical assistance on a legislative or policy proposal, ACF cannot unilaterally propose legislation independently from the U.S. Department of Health and Human Services. Therefore, ACF respectfully non-concurs with this recommendation.

Recommendation 2: Assist States to improve their abilities to monitor the patterns of maltreatment and performance across chains of residential facilities operating in multiple States.

Response: ACF concurs with this recommendation.

ACF's Children's Bureau (CB) provides a variety of services and supports to the child welfare field to improve practices and achieve better outcomes for children, youth, and families. In addition, CB is committed to supporting States so that they have the tools they need to ensure that children in foster care who are placed in residential facilities, particularly when children are placed out of their home states, are closely monitored. The CB will plan TA activities in the current fiscal year and ongoing to the next fiscal year to support States in improving their abilities to monitor patterns of maltreatment and performance across chains of residential facilities operating in multiple States. Further, CB will continue to leverage existing constituency groups with foster care managers across the nation to improve inter-State communication and to learn about and share best practices for monitoring when children are placed in out-of-State residential facilities.

Recommendation 3: Take steps to improve inter-State communication when children are placed in out-of-State residential facilities.

Response: ACF concurs with this recommendation and would refer to the response to the preceding recommendation as to the CB's ongoing efforts to improve inter-State communication when children are placed in out-of-State residential facilities.

Recommendation 4: Work with States to improve reporting of placement data in NCANDS.

Response: ACF concurs with this recommendation and will continue to work with States to improve reporting of placement data in the National Child Abuse and Neglect Data System (NCANDS) through ongoing TA efforts.

The CB's NCANDS Technical Team has developed strong relationships with the states that enhance CB's understanding of states' needs and limitations. Each year, the NCANDS Technical Team creates a Technical Assistance Plan with a summary of each state's needs prioritized by reporting timeframes and special focus areas, as indicated by the CB, Office on Child Abuse and Neglect, other federal agencies, legislators, researchers, and other stakeholders. Providing TA to states is a key component of supporting states' ability to improve reporting overall and to submit high-quality NCANDS data files that comply, to the extent practicable, with the Child Abuse Prevention and Treatment Act reporting requirements.

The CB's NCANDS Technical Team provides a variety of services and supports, such as webinars, technical bulletins, virtual meetings, email discussions, and phone conferences to regularly facilitate information sharing on a range of issues, including reporting of placement data. As needed, NCANDS Technical Team members provide one-on-one TA to states to assist with data mapping, construction, extraction, and data submission and validation. NCANDS Technical Team members will continue to coordinate and provide TA to states during State Annual TA Calls in preparation for the next data collection cycle and at any time throughout the year upon request.

Thank you again for the opportunity to review this draft report. Please direct any follow-up inquires to Nicholas Vucic, Director of ACF's Division of Legislative and Regulatory Affairs, Office of Legislative Affairs and Budget, at (202) 870-3065.

Sincerely,

Jeff Hild
Principal Deputy Assistant Secretary
Administration for Children and Families,
performing the delegable duties of the Assistant Secretary for Children and Families
U.S. Department of Health and Human Services

ACKNOWLEDGMENTS AND CONTACT

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This report was prepared under the direction of Brian Whitley, Regional Inspector General for Evaluation and Inspections in the Kansas City Regional Office, and Dana Squires, Deputy Regional Inspector General.

Contact

To obtain additional information concerning this report, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov. OIG reports and other information can be found on the OIG website at oig.hhs.gov.

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ENDNOTES

[1] U.S. Senate Committee on Health, Education, Labor and Pensions, news release, *Murray, Wyden Demand Answers on Mistreatment at Youth Residential Treatment Facilities*, July 22, 2022. Accessed at https://www.help.senate.gov/chair/newsroom/press/murray-wyden-demand-answers-on-mistreatment-at-youth-residential-treatment-facilities on Oct. 19, 2023. American Public Media Reports, *Youth Were Abused Here*, Sept. 28, 2020. Accessed at https://www.apmreports.org/story/2020/09/28/for-profit-sequel-facilities-children-abused on Oct. 2, 2023. "Hope, Help, Harm," Aug. 11, 2020, *The Philadelphia Inquirer*. Accessed at https://www.inquirer.com/news/inq/devereux-advanced-behavioral-health-abuse-children-pennsylvania-20200811.html on Oct. 2, 2023. National Disability Rights Network, *Desperation without Dignity: Conditions of Children Placed in For Profit Residential Facilities*, Oct. 2021. Accessed at https://www.ndrn.org/wp-content/uploads/2021/10/NDRN_Desperation_without_Dignity_Final.pdf on Oct. 16, 2023.

[2] ProPublica, *Thousands of Foster Children Were Sent Out of State to Mental Health Facilities Where Some Faced Abuse and Neglect*, Mar. 11, 2020. Accessed at https://www.propublica.org/article/illinois-dcfs-children-out-of-state-placements on Oct. 4, 2023. National Disability Rights Network, *Desperation without Dignity: Conditions of Children Placed in For Profit Residential Facilities*, Oct. 2021. Accessed at https://www.ndrn.org/wp-content/uploads/2021/10/NDRN_Desperation_without_Dignity_Final.pdf on Oct. 16, 2023.

[3] Government Accountability Office, *HHS Should Facilitate Information Sharing Between States to Help Prevent and Address Maltreatment in Residential Facilities*, GAO-22-104670, Jan. 2022. Accessed at https://www.gao.gov/assets/gao-22-104670.pdf on Oct. 16, 2023.

[4] SSA §§ 470–479b.

[5] States reported that 606,031 children were served by the foster care system in fiscal year 2021. ACF, *The AFCARS Report*. Accessed at https://www.acf.hhs.gov/sites/default/files/documents/cb/afcars-report-29.pdf on Dec. 28, 2023.

[6] OIG analysis of Adoption and Foster Care Analysis and Reporting System (AFCARS) FY 2021 data. This was the most recent available AFCARS data as of March 7, 2024.

[7] Family First was enacted in 2018 by Division E of the Bipartisan Budget Act of 2018 (P.L. 115-123, Feb. 9, 2018). It amended Titles IV-B and IV-E of the SSA.

[8] ACF, *Family First Prevention Services Act (FFPSA)*. Accessed at https://capacity.childwelfare.gov/about/cb-priorities/family-first-prevention on Jan. 25, 2024.

[9] 42 U.S.C. § 672(k).

[10] 42 U.S.C. § 671(a)(10)(A).

[11] 42 U.S.C. § 671(a)(9)(A). Additionally, the Child Abuse Prevention and Treatment Act (CAPTA), as amended, requires mandated reporting. 42 U.S.C. § 5106a(b)(2)(B)(i).

[12] Additionally, States generally require residential facilities to report other types of incidents, such as harm not perpetrated by an adult, suicide attempts, and running away.

[13] The Federal minimum definition is found in CAPTA. To receive CAPTA funding, a State's definition of "child abuse and neglect" must, at a minimum, include "[a]ny recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation [ ]; or an act or failure to act, which presents an imminent risk of serious harm." 42 U.S.C. § 5101, Note, 2. State's definitions must also include sex trafficking victims. 42 U.S.C. § 5106g(b)(1).

[14] ACF, *Child and Family Services Reviews: Onsite Review Instrument and Instructions*, page 10, June 2022. Accessed at https://www.acf.hhs.gov/sites/default/files/documents/cb/cfsr-r4-osri-nonfillable.pdf on Aug. 5, 2022.

[15] The 1988 CAPTA amendments directed the Department of Health and Human Services to establish a national data collection and analysis program. Subsequent amendments to CAPTA have led to new data collection requirements, many of which are incorporated into NCANDS. To receive CAPTA funding, States are required to work with the Secretary "to the maximum extent practicable" to provide specific data about children who have been mistreated. 42 U.S.C. § 5104(a).

[16] 42 U.S.C. § 5106a(d). Data elements that States report are listed in §§ 5106a(d)(1)-5106a(d)(18). Data are reported on the basis of the FY calendar, which begins on October 1 and ends the following September 30. States are required to report data to the maximum extent practicable; therefore, States may not report information related to all NCANDS elements annually, depending on their data capabilities and other factors.

[17] ACF, *About NCANDS*. Accessed at https://www.acf.hhs.gov/cb/fact-sheet/about-ncands on Oct. 16, 2023.

[18] OIG analysis of Adoption and Foster Care Analysis and Reporting System (AFCARS) data, Oct. 2023.

[19] American Public Human Services Association, *ICPC FAQs*. Accessed at https://aphsa.org/AAICPC/AAICPC/icpc_faq_2.aspx on Oct. 18, 2023.

[20] ICPC, Regulation 11.3.

[21] *Some Ohio Group Homes Did Not Always Comply With Foster Care Health and Safety Requirements* (A-05-16-00049) Sept. 15, 2017. *Some Massachusetts Group Homes for Children in Foster Care Did Not Always Comply With State Health and Safety Requirements* (A-01-16-02500) Dec. 13, 2017. *Some Oklahoma Group Homes Did Not Always Comply With State Requirements* (A-06-16-07004) Sept. 27, 2017.

[22] *California Did Not Always Ensure That Allegations and Referrals of Abuse and Neglect of Children Eligible for Title IV-E Foster Care Payments Were Properly Recorded, Investigated, and Resolved* (A-09-16-01000) Sept. 21, 2017. *Texas Did Not Always Ensure That Allegations and Referrals of Abuse and Neglect of Children Eligible for Title IV-E Foster Care Payments Were Recorded and Investigated in Accordance With Federal and State Requirements* (A-06-15-00049) May 23, 2017. *New York Did Not Always Ensure That Allegations and Referrals of Abuse and Neglect of Children Eligible for Title IV-E Foster Care Payments Were Recorded and Investigated in Accordance With State Requirements as Required By Federal Law* (A-02-15-02014) Oct. 23, 2017.

[23] Multiple State agencies may be responsible for different aspects of oversight of child residential facilities; therefore, we requested that State child welfare agencies coordinate their survey responses with all relevant agencies.

[24] ICPC, Regulation 11.3, states that a receiving State must supervise a child placed pursuant to an approved placement under ICPC if supervision is requested by the sending State, and (a) the sending agency is a public child placing agency; (b) the agency that completed the home study for placement of the child in the receiving State is a public child placing agency; and (c) the child's placement is not in a residential treatment center or a group home.

[25] OIG analysis of NCANDS FY 2021 data, Oct. 2023. NCANDS defines the child's living arrangement variable as "the environment in which a child was residing at the time of the alleged incident of maltreatment." Reporting on the child's living arrangement includes 14 different settings, one of which is "Group Home or Residential Treatment Setting." *National Child Abuse and Neglect Data System (NCANDS) Child File, FY 2021* [Dataset], National Data Archive on Child Abuse and Neglect, https://doi.org/10.34681/H0RA-QN30.

[26] Another two States did not respond to this question.