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CHILD WELFARE

HHS Should Facilitate Information Sharing Between States to Help Prevent and Address Maltreatment in Residential Facilities

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Why GAO Did This Study

News media have reported several incidents of youth being maltreated by staff employed at residential facilities. Some of these youth were in the child welfare system and some had special needs. States oversee these facilities, and often contract with private providers to operate them. Little information is publicly available about incidents of maltreatment in federally funded residential facilities for youth. GAO was asked to review this issue.

This report examines (1) how selected states help prevent and address maltreatment in federally funded residential facilities, (2) the challenges selected states face in reporting and collecting maltreatment data, and (3) the additional steps suggested by stakeholders to address maltreatment and how relevant federal agencies are supporting state efforts. GAO interviewed state officials in four states—Arkansas, California, Massachusetts, and the Washington, D.C.—that were selected using federal data on high and low percentages of youth in residential facilities and recommendations from subject matter experts, among other factors; conducted discussion groups with residential facilities administrators and former residents of facilities; and reviewed relevant federal and state laws, regulations, and agency documents.

What GAO Recommends

GAO recommends that HHS, in consultation with Education, facilitate information sharing among states on promising practices for preventing and addressing maltreatment in residential facilities. HHS agreed with the recommendation.

View [GAO-22-104670](#). For more information, contact Kathryn A. Larin at (202) 512-7215 or larink@gao.gov.

What GAO Found

Several state agencies—including those responsible for child welfare, facility licensing, and education—work with federally funded residential facilities for youth to help prevent and address incidents of maltreatment, according to officials in four selected states. Maltreatment could include either abuse or neglect, and could result in injuries or even death. State agencies try to prevent the maltreatment of youth by requiring background screenings of facility staff, training staff, and increasing interagency coordination, among other things. When maltreatment occurs, states may respond in various ways, such as prohibiting a facility from taking in new residents or revoking its license.

Differing interpretations of what constitutes maltreatment may result in facilities over- or under-reporting incidents, thereby complicating states' data collection efforts, according to state officials and other stakeholders. In response, selected states have taken steps to make it easier for residential facility staff to determine what types of incidents they should report, such as by providing facilities with technical assistance on states' legal reporting requirements.

Stakeholders and discussion group participants suggested additional steps that states could take to identify and address maltreatment in residential facilities, including improved facility staff and state investigator training, improved oversight, and increased provider accountability (see figure). Officials from the Departments of Health and Human Services (HHS) and Education emphasized that states are primarily responsible for oversight of residential facilities and efforts to prevent maltreatment; however, the agencies told us that they support states' efforts by providing technical assistance and guidance. Nonetheless, some officials in the four selected states reported having minimal contact with or receiving little to no information from federal agencies, including HHS's Administration for Children and Families (ACF), the federal agency responsible for administering federal programs that provide for the safety of youth. HHS's strategic plan highlights the importance of disseminating strategies to prevent child maltreatment. By facilitating information sharing among states about promising data collection practices, training, oversight, and strategies for holding facilities accountable through stronger enforcement mechanisms, HHS could help states prevent and minimize further trauma for youth in these facilities and potentially save lives.

Stakeholder groups and discussion group participants suggested additional steps that states could take to address maltreatment in residential facilities, including:



Source: GAO graphic based on interviews with stakeholder and discussion group participants. | GAO-22-104670

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Abbreviations

AFCARS	Adoption and Foster Care Analysis and Reporting System
CAPTA	Child Abuse Prevention and Treatment Act
DD Act	Developmental Disabilities Assistance and Bill of Rights Act of 2000
Education	U.S. Department of Education
FDA	U.S. Food and Drug Administration
HHS	U.S. Department of Health and Human Services
IDEA	Individuals with Disabilities Education Act
NDACAN	National Data Archive on Child Abuse and Neglect
P&As	Protection and Advocacy Systems
Title IV-E	Title IV-E of the Social Security Act

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January 24, 2022

The Honorable Robert P. Casey, Jr.
Chairman
Subcommittee on Children and Families
Committee on Health, Education, Labor, and Pensions
United States Senate

The Honorable Robert C. “Bobby” Scott
Chairman
Committee on Education and Labor
House of Representatives

The Honorable Katherine M. Clark
House of Representatives

News media have reported several incidents of youth being maltreated, and sometimes killed, by staff employed at residential facilities.¹ Some of these youth were in the child welfare system and had emotional or behavioral issues, and some had special needs. Most youth enter the child welfare system because of abuse or neglect, and further abuse or neglect by residential facilities’ staff and other residents may exacerbate their trauma.²

Child welfare policymakers and practitioners rely on state officials to voluntarily report child maltreatment data to the U.S. Department of Health and Human Services (HHS), including data on incidents in

¹For the purpose of this study, we use the term “maltreatment” to refer to both abuse and neglect, including sexual assault, physical and medical neglect, and serious physical and emotional harm. Our review included various types of residential facilities, including schools; treatment programs for youth with behavioral, emotional, mental health, and substance abuse issues; homes for pregnant teens; and homes that specialize in supporting and treating youth with severe emotional disorders. The U.S. Department of Health and Human Services refers to residential facilities as congregate care settings.

²Trauma is a widespread, harmful, and costly public health problem, and its effects are especially detrimental to youth. Any frightening, dangerous, or violent event that threatens a child or their loved ones can potentially be traumatic. While not every child who experiences trauma will suffer lasting effects, trauma significantly increases the risk of mental health problems, difficulties with social relationships and behavior, physical illness, and poor school performance. GAO, *Children Affected by Trauma: Selected States Report Various Approaches and Challenges to Supporting Children*, [GAO-19-388](#) (Washington, D.C.: Apr. 24, 2019).

residential facilities. These data are used to understand the extent and circumstances of maltreatment and to develop prevention strategies. In our 2008 report on this topic, we found that maltreatment by residential facilities staff is likely to be greater than reported by HHS due to state challenges in collecting and reporting facility-level information.³ We also found that while all states have a process in place to license and monitor residential facilities, monitoring practices were inconsistent, oversight gaps existed, and federal authority was limited. In addition, we found that federal agencies inconsistently addressed state noncompliance with federal program requirements, such as federally-supported child welfare programs. The report recommended enhanced oversight to improve the health and safety of youth in residential settings and more robust data collection.⁴

More than a decade after our 2008 report, minimal information is available to the public about incidents of maltreatment in federally funded residential facilities for youth. This report examines 1) how selected states prevent and address maltreatment in federally funded residential facilities, 2) challenges selected states face in reporting and collecting data on maltreatment by staff in residential facilities, and 3) additional steps stakeholders suggest to address maltreatment in residential facilities, and how relevant federal agencies are supporting state efforts.

To address these objectives, we conducted telephone interviews with officials in Arkansas, California, Massachusetts, and Washington, D.C. who oversee and monitor residential facilities that serve youth who are in the child welfare system or attend residential schools that are funded through Title IV-E of the Social Security Act (Title IV-E), Medicaid, or the

³GAO, *Residential Facilities: Improved Data and Enhanced Oversight Would Help Safeguard the Well-Being of Youth with Behavioral and Emotional Challenges*, [GAO-08-346](#) (Washington, D.C.: May 13, 2008).

⁴HHS did not implement the recommendation that directed the agencies to enhance their oversight of state accountability for youth in residential facilities. HHS indicated that it was conducting state oversight consistent with existing statutory authority and resources. Other recommendations, exploring barriers to states reporting data to the National Child Abuse and Neglect Data System and the U.S. Attorney General obtaining access to the National Child Abuse and Neglect Data System and other sources of data to help target civil rights investigations, were implemented.

Individuals with Disabilities Education Act.⁵ States were selected using the most recently available federal data at the time of selection that show those with high and low numbers and percentages of youth in residential facilities.⁶ We also considered recommendations by subject matter experts and locations that represent different regions across the United States. Washington, D.C. was selected because it was among eleven states that did not report to HHS 2019 data on maltreatment by group home and residential facility staff.

In each state, we conducted semi-structured interviews with officials from state education, child welfare, and licensing offices, among others.⁷ In addition, we spoke with representatives of state protection and advocacy organizations.⁸ In total, we interviewed officials from 15 state agencies and four protection and advocacy organizations. We also reviewed

⁵For the purpose of this report, we refer to Washington, D.C. as a state. Title IV-E of the Social Security Act authorizes the large majority of federal funding dedicated to child welfare, with funds available for specific foster care and adoption expenses, specific kinship guardian expenses, and allowable prevention services and programs. See 42 U.S.C. §§ 671(e), 672(a)(1), 673(a)(1), 673(d). The Individuals with Disabilities Education Act makes a free appropriate public education available to eligible youth with disabilities and authorizes funding to assist states in providing special education and related services to those youth. See 20 U.S.C. §§ 1411(a)(1), 1412(a)(1). Medicaid is used to support treatment costs for youth in residential programs, including youth in psychiatric residential treatment facilities. See 42 U.S.C. § 1396n(l)(4)(C)(ii); see also 42 C.F.R. § 441.151. A psychiatric residential treatment facility is any non-hospital facility that provides psychiatric services to individuals under the age of 21 in an inpatient setting (known as the psych under 21 benefit). 42 C.F.R. § 483.352. In 2021, there were 349 state-certified psychiatric residential treatment facility providers, according to the Centers for Medicare & Medicaid Services.

⁶HHS's Adoption and Foster Care Analysis and Reporting System fiscal year 2019 data; Education's Individuals with Disabilities Education Act Section 618 Data Products: Static Tables, Child Count and Educational Environments, 2018.

⁷We also spoke with officials from two state agencies—Massachusetts' Department of Mental Health and Arkansas' Office of Long Term Care—involved in monitoring their state's psychiatric residential treatment facilities, a non-hospital facility with a provider agreement with a state Medicaid agency that provide Medicaid-covered inpatient psychiatric services for individuals under the age of 21.

⁸States vary in how they license and monitor youth in residential facilities. Licensing standards under Title IV-E generally require residential facilities to meet a minimum level of care for youth, and include standards addressing health, protection, and safety of youth, according to HHS. State Protection and Advocacy Systems work at the state level to protect individuals with disabilities by empowering them and advocating on their behalf. Under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act) in order to receive certain federal funding, a state or territory must have a protection and advocacy system. Pub. L. No. 106-402, § 143(a)(1), 114 Stat. 1677, 1714, codified at 42 U.S.C. § 15043(a)(1).

relevant state child welfare and education agency documents. To supplement the information obtained during interviews with state officials, we interviewed individuals from 11 stakeholder groups knowledgeable about residential facilities, as well as examined selected state laws and regulations.

In addition, we conducted three virtual discussion groups—two with residential facilities administrators and one with individuals who previously lived in residential facilities and currently work or volunteer in the child welfare system. The two groups of administrators included cohorts representing child welfare facilities and residential schools. Discussion group participants were from various states, including Florida, Indiana, Massachusetts, South Carolina, Utah, and Wisconsin, and were chosen with the assistance of a membership organization composed of residential treatment programs. The information obtained in our interviews and discussion groups is not generalizable, but provides examples of experiences with and responses to maltreatment in residential facilities among state officials, stakeholder group representatives, and discussion group participants.

To determine what support federal agencies provide to states on issues regarding oversight of residential facilities for youth, we conducted telephone interviews with, and solicited written responses from, HHS's Administration for Children and Families' Children's Bureau, the Centers for Medicare & Medicaid Services, and the U.S. Department of Education's (Education) Office of Special Education and Rehabilitative Services and Office for Civil Rights. We also reviewed relevant agency documents, such as HHS's annual Child Maltreatment reports and Education's Restraint and Seclusion: Resource Document.

We also obtained data that states voluntarily report to HHS. HHS collects and maintains the data in its National Child Abuse and Neglect Data System. Although we reviewed and analyzed maltreatment data on incident types—such as physical or sexual abuse, medical neglect, or emotional harm, and by the race and ethnicity of the victim—we

determined the data to be insufficiently reliable for our reporting purposes because of concerns about the completeness of the data.⁹

We conducted this performance audit from December 2020 to January 2022 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Defining Maltreatment

Although there is no standard definition of maltreatment across states, federal law provides a foundation for states to define maltreatment by identifying a set of acts or behaviors that constitute child abuse and neglect. Federal law defines child abuse and neglect as, at a minimum: *“any 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*

⁹As initially noted in our 2008 report, factors such as missing data and inconsistencies in how states collect and report data to HHS affect the reliability of maltreatment data for residential facilities. In 2019, 11 states reported no incidents of maltreatment involving group home and residential facility staff. According to HHS officials, in 2019, three states were unable to report maltreatment data about incidents involving residential facilities staff. In one instance, the state did not consistently identify whether the individuals maltreating youth were facility staff, a parent, or other individuals. In another state, according to HHS, the child protective services agency does not have jurisdiction under state law to investigate allegations of abuse and neglect in facilities, so they were unable to report on these incidents. In the third state, an individual working as facility staff is not held culpable under state statute, rather, the facility itself is considered to be a “subject” (perpetrator) of the maltreatment report. HHS officials said that it is possible that the other states did not have any incidents of maltreatment involving group home and residential facility staff. In addition to missing data and inconsistencies reporting maltreatment involving group home and residential facility staff, some states do not consistently identify the race and ethnicity of victims of maltreatment.

*exploitation, or an act or failure to act, which presents an imminent risk of serious harm.*¹⁰

Each state has its own definitions of child abuse and neglect that are based on the definition provided by federal law. Generally, state laws define physical abuse as “any non-accidental physical injury to the child” and can include striking, kicking, burning, or biting the child, or any action that results in a physical impairment of the child, according to a report on state requirements created by the Child Welfare Information Gateway, a service of the Children’s Bureau.¹¹ In approximately 42 states, according to the report, the definition of abuse also includes acts or circumstances that threaten the child with harm or create a substantial risk of harm to the child’s health or welfare.¹² Neglect is frequently defined as the failure of a parent or other person with responsibility for the child to provide needed food, clothing, shelter, medical care, or supervision to the degree that the child’s health, safety, and well-being are threatened with harm, according to the report. In addition, ten states specifically define medical neglect as failing to provide any special medical treatment or mental health care needed by the child, and five states define medical neglect as the withholding of medical treatment or nutrition from disabled children with life-threatening conditions. The report found that all states include sexual abuse in their definitions of child abuse, and some states specify various

¹⁰The Child Abuse Prevention and Treatment Act (CAPTA), Pub. L. No. 100–294, as amended by the CAPTA Reauthorization Act of 2010, Pub. L. No. 111–320, § 142, 124 Stat. 3459, 3482 (codified at 42 U.S.C. § 5101, note). CAPTA further defines sexual abuse as including: the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or the rape, and in cases of caretaker or interfamilial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children. 42 U.S.C. § 5106g(a)(4). A child can also be considered a victim of child abuse and neglect and of sexual abuse if the child is identified by a state or local agency employee as being a victim of sex trafficking as defined in 22 U.S.C. § 7102(12), or a victim of severe forms of trafficking in persons as defined in 22 U.S.C. § 7102(11). 42 U.S.C. § 5106g(b)(1).

¹¹U.S. Department of Health and Human Services. Children’s Bureau. Child Welfare Information Gateway. *Definitions of Child Abuse and Neglect*. Washington, D.C.: 2019. GAO did not independently verify the information on state laws included in this report. This publication is a product of the State Statutes Series prepared by Child Welfare Information Gateway. The publication states that while every attempt had been made to be complete, additional information on these topics may be in other sections of a state’s code as well as agency regulations, case law, and informal practices and procedures.

¹²The word “approximately” is used to stress the fact that the states frequently amend their laws. This information is current through March 2019.

acts as sexual abuse such as sexual intercourse by a caregiver with a person younger than age 18.

In residential facilities, maltreatment may include both abuse and neglect. Abuse can range from staff members taunting or threatening youth to physical abuse, such as punching, slapping, or sexually assaulting them. Incidents of neglect can include a lack of supervision by facilities staff, such as failing to respond to suicide attempts or failing to prevent residents from running away. In some instances, staff injure youth while attempting to restrain them, which may result in maltreatment allegations and findings.

Residential Facilities

For this report we focused on residential facilities that serve 1) youth in foster care and 2) youth with disabilities whose special education needs are best met in residential facilities.¹³ On September 30, 2019, 43,823 youth in foster care lived in residential facilities, and in 2018, 11,546 youth, ages 3 to 17, with special needs lived in residential facilities, including residential schools.¹⁴ According to a 2015 study conducted by HHS, a significant proportion of youth in foster care who lived at some

¹³Other youth may be placed in residential facilities. For example, some youth who are at risk of running away or are a danger to themselves or others may be placed in a facility by their parents. Additionally, some youth are placed in residential facilities through the juvenile justice system as an alternative to incarceration. Private facilities that do not receive government funding and residential facilities serving youth in the juvenile justice system are outside the scope of our review.

¹⁴HHS collects case-level information from state and tribal Title IV-E agencies on all children in foster care. For additional information, see HHS' Adoption and Foster Care Analysis and Reporting System (AFCARS) fiscal year 2019 data. The National Data Archive on Child Abuse and Neglect (NDACAN) defines group homes as licensed or approved homes that provide 24-hour care for children in a small group setting that generally includes seven to 12 children. NDACAN defines institutions as child care facilities operated by a public or private agency that provide 24-hour care and/or treatment for children who require separation from their own homes and a group living experience. These facilities may include child care institutions, residential treatment facilities, maternity homes, etc. An institution generally cares for more than 12 children. The Individuals with Disabilities Education Act (IDEA) requires each state to submit data to Education about children with disabilities who receive special education and related services under Part B of the IDEA, including children in residential facilities. 20 U.S.C. § 1618(a)(1)(A)(iii). Education considers a youth who lives in a public or private residential facility or residential school during the school week and is enrolled in an education program as receiving services. This includes children with disabilities receiving special education and related services, at public expense, for greater than 50 percent of the school day in public or private residential facilities.

point in a residential facility had been diagnosed with a mental disorder, had behavioral health issues, or had clinical disabilities other than a diagnosed mental disorder.¹⁵

Although states oversee residential facilities, they often contract with private nonprofit providers to operate facilities, and sometimes with for-profit providers. For example, Arkansas and Massachusetts contract with 59 and 217 residential facility providers, respectively. Neither state operates residential facilities.

State licensing agencies have employment requirements, such as age and educational attainment, for staff who work in residential facilities. Staff who work directly with residents are responsible for assisting them with various aspects of daily living, including supervising residents to protect them from abuse and neglect and assisting them in the development of self-help and social skills.

Federal funding and requirements

HHS and Education administer programs that provide funding for services that support youth in foster care and those with special needs, including those who live in residential facilities (see table 1). HHS's Administration for Children and Families is responsible for administering child welfare programs, including programs that provide for the safety and well-being of children and youth.

¹⁵U.S. Department of Health and Human Services. Administration for Children and Families. Children's Bureau. *A National Look at the Use of Congregate Care in Child Welfare*. May 13, 2015.

Table 1: Selected Sources of Federal Funding that Support Foster Care and Special Needs Youth in Residential Facilities

	Agency and Subagency	Program Authority	Purpose
Department of Health and Human Services	Administration for Children and Families	Title IV-E of the Social Security Act ^a	Payments to help states cover the costs of operating foster care, adoption, and guardianship assistance programs, including the cost of food, clothing, shelter, and daily supervision, among other items, that help meet a child’s basic needs. These payments also may include the reasonable and necessary costs of administering and operating certain residential institutions.
	Centers for Medicare & Medicaid Services	Section 1905(a)(16), (h) of the Social Security Act	Provide Medicaid-covered inpatient psychiatric services for individuals under the age of 21 in a psychiatric residential treatment facility, a non-hospital facility with a provider agreement with a state Medicaid agency.
Department of Education	Office of Special Education and Rehabilitative Services	Individuals with Disabilities Education Act	Payments assist states with the education costs of eligible youth attending public or private residential schools. Ensures students with a disability are provided with a free appropriate public education that is tailored to their individual needs.

Source: GAO review of federal program information and related laws. | GAO-22-104670

^aUnder 42 U.S.C. § 672(k), a state may only claim Title IV-E foster care maintenance payments for 14 days on behalf of an eligible child placed in certain residential settings. The four types of residential placement settings where states may claim Title IV-E maintenance payments for longer than 14 days include: 1) a qualified residential treatment program, 2) settings providing specialized care for pregnant and parenting youth, 3) supervised independent living settings for youth over age 18, or 4) settings providing specialized care for youth who are at-risk of sex trafficking.

In addition to authorizing funds for services, federal law imposes requirements for states receiving Title IV-E funding meant to ensure the safety of youth. Under Title IV-E, as part of its state plan, each state must designate an authority responsible for establishing and maintaining standards for child care institutions, which we have included in our definition of residential facilities. These standards must be reasonably in accord with recommended standards of national accreditation organizations for institutions, including standards related to admission policies, safety, sanitation, and civil rights protections.¹⁶ Child care institutions must also be fully licensed according to the state’s standards

¹⁶42 U.S.C. § 671(a)(10)(A). The three major national accreditation organizations for residential facilities include the Council on Accreditation, the Commission on Accreditation of Rehabilitation Facilities, and the Joint Commission. Accrediting organizations are private, peer-based, member-funded organizations designed to encourage and promote high-quality care. Under Title IV-E, qualified residential treatment programs must be accredited by a not-for-profit accrediting organization such as the Council on Accreditation, the Commission on Accreditation of Rehabilitation Facilities, and the Joint Commission in order to receive Title IV-E foster care maintenance payments for more than 14 days on behalf of an eligible child. 42 U.S.C. § 672(k)(4)(G).

in which the facility is located.¹⁷ Further, adults working in residential facilities must undergo fingerprint-based checks of national crime information databases or alternative background check procedures. Qualified residential treatment programs must also employ a trauma-informed treatment model designed to address the needs of youth with serious emotional or behavioral disorders. Also, under the Centers for Medicare & Medicaid Services regulations, youth placed in psychiatric residential treatment facilities are protected from use of restraints and seclusion used as a means of coercion, discipline, convenience or retaliation, which can lead to injuries and allegations of maltreatment.¹⁸ Specifically, federal regulations state that restraint and seclusion should not be used as coercion, discipline, convenience, or retaliation, and must not result in harm or injury.¹⁹

State and local agencies are primarily responsible for overseeing residential facilities for youth receiving federal funding, including licensing these facilities and investigating incidents of maltreatment. In addition, protection and advocacy organizations, which serve as independent, governor-appointed bodies in each state, have the authority to monitor and investigate maltreatment in some residential facilities that care for youth with disabilities.²⁰

¹⁷42 U.S.C. § 672(c)(2)(A).

¹⁸42 C.F.R. § 483.356(a)(1). Restraint means a “personal restraint,” “mechanical restraint,” or “drug used as a restraint.” Seclusion means the involuntary confinement of a resident alone in a room or an area from which the resident is physically prevented from leaving. 42 C.F.R. § 483.352.

¹⁹42 C.F.R. § 483.356(a)(1), (3).

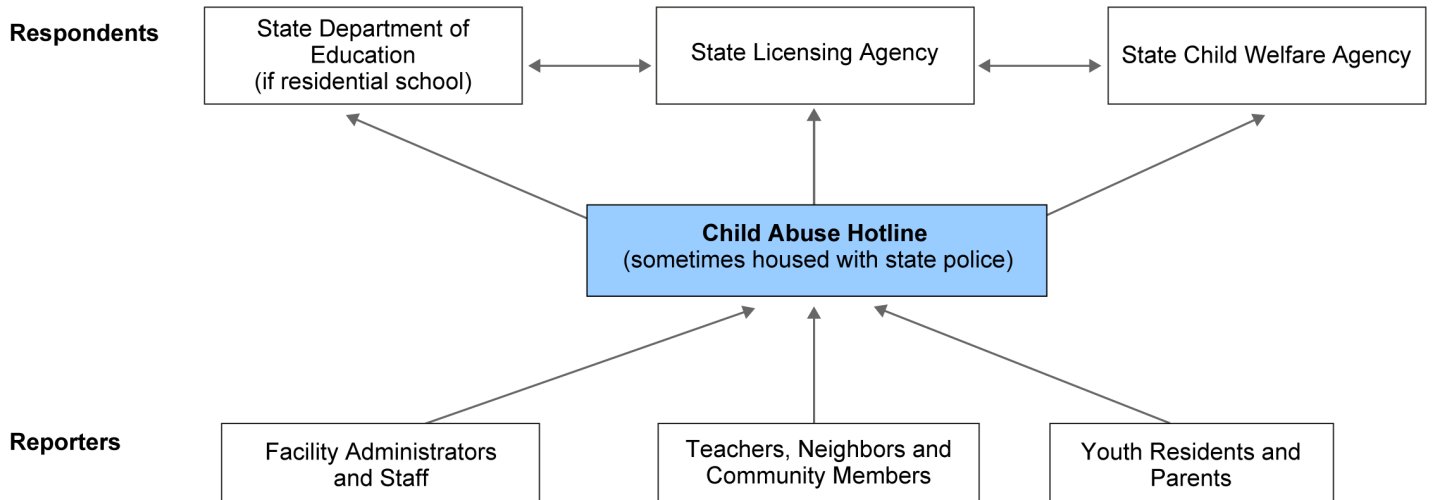
²⁰States receive funding under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act) for the creation of protection and advocacy systems (P&As). The DD Act and other authorizing statutes give P&As the authority to advocate for the rights of individuals with disabilities. The DD Act states that each P&As must have the authority to “pursue legal, administrative, and other appropriate remedies or approaches to ensure the protection of, and advocacy for, the rights of such individuals within the State. . .” 42 U.S.C. § 15043(a)(2)(A)(i). P&As use a range of remedies to advocate for individuals with developmental disabilities, including self-advocacy assistance, negotiation and litigation. Under the DD Act, P&As also have the authority to investigate abuse and neglect in any setting where a person with intellectual or developmental disabilities receives services. See 42 U.S.C. § 15043(a)(2)(B). With this authority, they may access and monitor both facilities and records to ensure that people’s rights are protected. U.S. Department of Health and Human Services, Administration for Community Living. Accessed September 2021. <https://acl.gov/programs/aging-and-disability-networks/state-protection-advocacy-systems>.

Selected States Use Various Strategies to Prevent and Address Maltreatment by Staff in Residential Facilities

Multiple Agencies in Selected States Respond to Maltreatment

In each of the four selected states—Arkansas, California, Massachusetts, and Washington, D.C.—responsibility for working with federally funded residential facilities to prevent and address incidents of maltreatment are spread across several different state agencies, including child welfare, licensing, and education. Each of these agencies has different, though sometimes overlapping, responsibilities. (See fig. 1.)

Figure 1: Agencies in Selected States Generally Responsible for Responding to Maltreatment of Youth in Residential Facilities



Source: GAO graphic based on interviews with state officials. | GAO-22-104670

Generally, state laws and policies dictate the manner in which selected states receive reports of suspected maltreatment by residential facilities staff. In each of the four states we reviewed, residential facilities staff are mandated reporters and are required by law to follow specific procedures to report maltreatment if they suspect that abuse or neglect has

occurred.²¹ For example, in Washington, D.C., any staff member who is required to report maltreatment must notify the head of the facility, who is then required to make the report.²²

Suspected incidents of maltreatment are reported to and investigated by the state's designated agency, which in the selected states is either child welfare and/or the police, and in some instances the licensing agency. In the selected states, child welfare staff or special police units, together or independently, investigate reports of suspected abuse or neglect to determine if maltreatment occurred. In addition to child welfare staff and special police units, licensing officials, depending on the circumstances of the incident, may participate in investigations or obtain information from child welfare officials or police. According to licensing officials in three states, staff will determine if the suspected maltreatment resulted from licensing violations; for example, inadequate training or staffing ratios, or failure to complete background checks.

In Arkansas and Massachusetts, the two selected states that have psychiatric residential treatment facilities, investigations are triggered by "serious occurrences," a term used by the Centers for Medicare & Medicaid Services that may include instances of maltreatment. Facility providers are required to report serious occurrences to state Medicaid agencies and protection and advocacy organizations.²³ State Medicaid agencies are responsible for investigating serious occurrences and taking enforcement actions when facilities do not comply with Medicaid requirements regarding federal psychiatric residential treatment facilities.

²¹CAPTA requires each state to have provisions or procedures for an individual to report known and suspected instances of child abuse and neglect, including a state law for mandatory reporting by individuals required to report such instances. 42 U.S.C. § 5106a(b)(2)(B)(i). In most states, social workers; teachers, principals, and other school personnel; counselors, therapists, and other mental health providers; and child care providers are required to report abuse and neglect.

²²D.C. Code § 4-1321.02(b) (2021).

²³A serious occurrence includes a resident's death; serious injury, such as burns, lacerations, bone fractures, and injuries to internal organs; and suicide attempt.

Selected States Require Staff Screening and Training and Have Reported Increased Interagency Coordination to Prevent Maltreatment

Our four selected states have state licensing standards for new staff regarding background checks and fingerprinting. For example, in Washington D.C., new hires are required to undergo a criminal records check before beginning work at any facility. If the facility wants to hire someone who has been convicted of fraud, drug-related offenses, or their equivalent, the facility has to obtain the written approval of the licensing agency and the contracting entity, such as the state child welfare agency. Individuals who have been convicted of child abuse, spousal abuse, child pornography, and similar offenses cannot work in residential facilities. Further, prospective and existing staff must undergo a child protection registry check prior to commencing work at any facility. A couple of discussion group participants told us that their states have taken similar steps to ensure that information about staff with histories of maltreatment is shared with providers. According to one participant, staff involved in a substantiated incident of severe abuse or neglect cannot be rehired by a child welfare provider in the state. Providers in the state are made aware of how many substantiated allegations or pending investigations individuals have against them. However, one participant told us that there is no regional mechanism for sharing this information with providers from other states. According to the participant, this is a blind spot that may result in providers hiring staff with histories of maltreatment. Arkansas officials told us that they try to avoid hiring individuals with histories of maltreatment by conducting background checks for any state an employee has resided or worked in within the last 5 years.

Once hired, facility staff receive varying levels of training on a range of topics to prevent maltreatment. All of the selected states require training for various facilities in areas such as behavior management, appropriate boundaries for physical and verbal interactions, suicide awareness, CPR, and first aid. Additionally, all of the selected states' licensing standards address training on the use of restraints.²⁴ For example, Massachusetts

²⁴Seclusion and restraint are dangerous and traumatic not only to the individuals subjected to these practices, but also for the staff implementing them, according to an issue brief published by HHS' Substance Abuse and Mental Health Services Administration. U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. *Promoting Alternatives to the Use of Seclusion and Restraint—Issue brief #1: A National Strategy to Prevent Seclusion and Restraint in Behavioral Health Services*. Rockville, MD: 2010.

requires that facility staff successfully complete at least 16 hours of training in the prevention and use of restraints before being allowed to restrain a resident. The training must include information on the needs and behaviors of the population served, relationship building, de-escalation methods, avoiding power struggles, the physiological impact of restraint, and monitoring physical signs of distress and obtaining medical assistance, among other topics. California requires that direct care staff receive 8 hours of training before working unsupervised with children; a portion of the training must include instruction in trauma-informed care.²⁵

In addition to training and enhanced screening, Massachusetts is attempting, among other things, to increase interagency collaboration to help prevent and respond to maltreatment in residential facilities. The state has set up an interagency advisory committee on restraints that meets on a quarterly basis to analyze restraint data and review feedback from program providers on the use of restraint in their facilities. In addition, the state's child welfare, licensing, and education agencies are creating a single online reporting system to streamline the reporting of maltreatment to the appropriate agencies, according to state education officials.

Efforts to Identify and Address Maltreatment Include Routine Monitoring and Penalty Assessments

States are required to ensure the well-being of youth in residential facilities and, according to officials in our selected states, monitoring activities may include site visits and reviewing contracts. The officials stated that child welfare and licensing staff conduct routine visits to facilities serving youth in foster care to meet with youth or to monitor operations, respectively. Similar to other selected states, in California, social workers are required to visit youth at least once a month and half of the visits should occur at the youth's residence, according to state officials. During these visits, staff are to assess the emotional and

²⁵According to the Substance Abuse and Mental Health Services Administration, a program, organization, or system that is trauma-informed (1) realizes the widespread impact of trauma and understands potential paths for recovery; (2) recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; (3) responds by fully integrating knowledge about trauma into policies, procedures, and practices; and (4) seeks to actively resist re-traumatization. U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD.: 2014.

physical condition of youth and provide or arrange for the provision of services in the case plan.²⁶ Officials from three state child welfare agencies and a mental health agency told us that they also review facilities' contracts to monitor compliance. For example, Arkansas' child welfare agency staff compare information in facilities' monthly reports with performance indicators, such as notifying the child abuse and neglect hotline of all cases of suspected abuse or neglect and adhering to the agency's incident reporting policy. In Massachusetts, child welfare staff make announced and unannounced visits to ensure providers are in compliance with their contracts.

State child welfare and licensing officials in three of our selected states also said they track the number of reports of maltreatment at facilities to identify trends and make quality improvements. California's licensing agency maintains a public website that lists the number of maltreatment complaints filed against each licensed facility in the state. According to California's licensing officials, regional staff assess facilities' compliance with licensing standards by reviewing case files, and may follow up with technical assistance.

In addition to licensing staff, officials from three education agencies told us that their staff monitor residential schools about every 3 years. According to Massachusetts officials, during monitoring visits, staff review licensing requirements, health and safety requirements, staffing plans, and training requirements, among other things. Officials in two states told us that staff may also conduct unannounced visits to residential schools if they think children are in immediate danger or there are issues of concern.

However, stakeholder groups and state agency officials said monitoring youth in out-of-state facilities is difficult because the state placing the youth often must rely on licensing information and maltreatment reports from the state where the facility is located. Stakeholders added that it is difficult for child welfare and education officials to know how youth are doing when they cannot visit with them each month. According to one stakeholder, youth who are placed out-of-state do not receive regular visits from parents, social workers, or court appointed special advocates. According to a Protection and Advocacy study, youth may be placed out

²⁶A case plan is a written document that, among other things, discusses how the youth's placement is consistent with their best interests and special needs, and includes a plan for ensuring they receive safe and proper care and appropriate services.

of state because of lack of in-state resources.²⁷ Washington, D.C. officials established an interagency committee dedicated to monitoring the wellbeing of youth placed in residential facilities out-of-state, including coordinating outreach to providers and state agencies in other states to discuss allegations of maltreatment. We previously found that increasing information sharing among state agencies was a high priority for states to improve the oversight of youth wellbeing in residential facilities.²⁸

Depending on the circumstances of an incident of maltreatment—for example, whether it is substantiated or a facility is found to be out of compliance with child welfare, licensing or education standards—states may respond in various ways. They may place the facility on a corrective action plan, prohibit it from taking in new residents, send a letter of reprimand, revoke its license, and depending on the severity of the maltreatment, refer the incident to law enforcement.²⁹ Massachusetts officials reported that corrective action may include updating or rewriting policies (such as requiring supervisors to be on the facility floor at least once per shift and completing a checklist of what was observed), or demonstrating proof of staff training on new policies.

Selected State Officials and Stakeholders Cited Challenges for Facility Staff and Residents Reporting Maltreatment and Agencies Collecting Data

²⁷Disability Rights Washington, *Out-of-State Youth Plead: Let Us Come Home, Report and Recommendations* (October 2018).

²⁸[GAO-08-346](#).

²⁹In response to maltreatment, education agencies may revoke the certificate that authorizes residential schools to serve youth, according to education officials in two states.

Fear of Retaliation and Lack of Corroboration May Prevent Facility Staff and Residents from Reporting Maltreatment

Agency officials in selected states and representatives of stakeholder groups cited challenges that may prevent residential facilities staff and residents from reporting incidents of maltreatment. Some of these challenges include fear of retaliation from providers, a lack of corroboration to substantiate incidents when they occur, and the inability of some youth to communicate and inform others of their maltreatment.

- **Fear of retaliation.** Agency officials and representatives of stakeholder groups said maltreatment may not be reported for fear of retaliation in several forms. For example, providers may discourage or attempt to prevent staff and residents from reporting incidents to state agencies to avoid consequences for their facilities, according to agency officials in two states, a protection and advocacy organization representative, and a representative from a stakeholder group. Staff members may also fear that reporting maltreatment could ruin their career or result in negative media attention for themselves or their employers, according to one agency official. In some facilities where maltreatment is widespread, a culture of silence may discourage reporting, according to an agency official at a second agency. In addition, youth residents may worry that reporting incidents will prolong their stay in the facility or they will be punished by having privileges taken away, according to a representative from a stakeholder group.
- **Lack of corroboration.** Youth who report maltreatment may not be believed without eyewitnesses to corroborate their allegations, according to an agency official and a stakeholder group representative. A representative of another stakeholder group told us that reports by youth are often dismissed unless there are multiple eyewitnesses, which they said is not usually the case. However, agency officials in two states said that focusing only on substantiated incidents as opposed to uncorroborated complaints can hide problems at facilities.
- **Inability to communicate.** Some youth cannot speak or communicate with others, preventing them from informing anyone of their maltreatment, according to agency officials in two states and a representative of a stakeholder group. For example, non-verbal residents who are maltreated may have to rely on residents who witnessed an incident to report it on their behalf, according to one

agency official. A second agency official said youth with communication challenges are particularly vulnerable to abuse because they are unable to report it. Additionally, some youth do not understand the process for filing maltreatment complaints and do not know who to report incidents of maltreatment to when they occur, according to the stakeholder group representative.

In response to these challenges, certain states have taken steps to make it easier for residential facility staff and residents to report incidents of maltreatment to state agencies. For example, in Arkansas state employers and supervisors cannot prohibit an employee or volunteer from directly reporting child maltreatment to the state child abuse hotline, which has helped encourage reporting, according to agency officials.³⁰ To corroborate incidents when there are no eyewitnesses, participants in both of our discussion groups with facility administrators told us they often use cameras to monitor the campus and common areas of their facilities, which allows them to review footage to confirm whether maltreatment occurred. In addition, Massachusetts requires all facilities licensed by the state's Department of Mental Health to employ human rights officers who assist patients in the exercise of their rights.³¹ Massachusetts policy states that human rights officers should make a special effort to monitor and assist persons who are not capable of advocating for themselves. Agency officials said that in addition to human rights officers, some facilities that serve youth employ peer mentors who help youth understand their experiences and learn to self-advocate. Additionally, a representative from a stakeholder group said that one facility in its state conducts personal rights check-ins with residents and their families, so residents have a clear understanding of their rights and who to contact when incidents occur. During these check-ins, residents are asked if they feel safe and they are encouraged to share any concerns that they may have.

Differing Interpretations of Maltreatment Make Data Collection Challenging for Selected State Agencies

Differing interpretations of what constitutes maltreatment by residential facility administrators, staff, and state agencies may result in facilities over- or under-reporting incidents. This, in turn, complicates states' data

³⁰See Ark. Code Ann. § 12-18-402(c)(2).

³¹Mass. Gen. Laws ch. 27, § 27.14(1).

collection efforts, according to agency officials in three states, representatives of two protection and advocacy organizations, and four stakeholder group representatives. For example, residential facility administrators and staff who are mandated reporters of abuse and neglect who do not have a clear idea of what should be reported as maltreatment may over-report incidents because they do not want to risk failing to report maltreatment, according to a state agency official in Massachusetts. Specifically, the official said some facilities file maltreatment reports whenever a youth fails to return to the facility before curfew or misses a dose of medication, which could be viewed as neglect.³² These situations result in over-reporting because while they may be violations of contract standards or a resident's individual service plans, the official said their agency does not consider them incidents of maltreatment that facilities should report. A second agency official in Massachusetts said administrators and staff at one facility were filing a maltreatment report every time they had to physically intervene in response to a youth's behavior.³³

Overly narrow interpretations of maltreatment may also lead some facilities to under-report incidents to state agencies, according to stakeholder groups we spoke with. For example, a representative of a protection and advocacy organization said some residential facilities in its state do not consider pepper spraying youth as a means of controlling their behavior to be maltreatment. Representatives from a protection and advocacy organization in another state said that even though psychiatric residential treatment facilities are required to report serious occurrences, such as suicide attempts, providers may define serious occurrences so

³²In Massachusetts, the definition of neglect includes the failure by a caregiver, either deliberately or through negligence or inability, to take those actions necessary to provide a child with minimally adequate medical care and supervision. See 110 Mass. Code Regs. § 2.00 (2021).

³³In another example, involving a facility in Massachusetts, the Judge Rotenberg Educational Center, located in Massachusetts, uses electrical stimulation devices to reduce or stop self-injurious or aggressive behavior. In March 2020, the U.S. Food and Drug Administration (FDA) banned the use of electrical stimulation devices to treat those behaviors because the devices posed a number of health and safety risks—from physical injuries such as severe pain, skin burns, and tissue damage, to psychological injuries such as panic, anxiety, and post-traumatic stress disorder. Banned Devices: Electrical Stimulation Devices for Self-Injurious or Aggressive Behavior, 85 Fed. Reg. 13,312 (March 6, 2020). However, in July 2021, a federal district court ruled that the FDA did not have the statutory authority to ban a medical device for a particular use and vacated FDA's rule. *The Judge Rotenberg Educational Center, Inc. v. United States Food and Drug Administration*, 3 F.4th, 390 (D. D.C. 1990).

narrowly that they do not warrant reporting. Specifically, the representatives said that some facilities only report incidents as suicide attempts if a youth would have died from self-inflicted injuries had staff not found them in time. Conversely, these facilities do not report incidents of self-harm in which the youth would not have died from their injuries, even if they had suicidal intent.

As a result of facilities narrowly interpreting maltreatment, states may under-report to HHS the number of incidents of maltreatment by residential facilities staff. In our previous work, we found that inconsistent interpretations of maltreatment contribute to challenges that state investigators face in collecting child maltreatment fatality data and reporting it to HHS.³⁴ Among our four selected states, all but Washington, D.C. voluntarily reported some data on maltreatment by residential facility staff to HHS in 2019. Arkansas, California, and Massachusetts reported seven, six, and 55 incidents of maltreatment by group home and residential facility staff in 2019, respectively. In addition to helping states capture the full extent of maltreatment that occurs in facilities, collecting complete and accurate maltreatment data may assist states in identifying trends and patterns for further examination (see text box).

³⁴GAO, *Child Maltreatment: Strengthening National Data on Child Fatalities Could Aid in Prevention*, [GAO-11-599](#) (Washington, D.C.: July 7, 2011).

Comments on Maltreatment of Youth of Color in Residential Facilities

According to HHS, youth of color are over-represented in residential facilities, and Black male youth are almost 30 percent more likely to experience congregate care than other youth in foster care. State agency officials in one state, representatives of protection and advocacy organizations in two states, and a representative of a stakeholder group told us that youth of color are disproportionately subjected to maltreatment in residential facilities. The stakeholder said that youth of color are more likely to be placed in residential facilities and to be mistreated by facilities staff once placed. A protection and advocacy organization representative also told us that Black youth are physically restrained and pepper sprayed more often than other youth in residential facilities. Additionally, in our discussion group with individuals who lived in residential facilities as youth, two former residents said facility staff lacked cultural competency and were not equipped to provide care for youth from diverse racial and ethnic backgrounds. Our review found that insufficient data exists for us to examine this issue.

Source: GAO interviews and discussion group | GAO-22-104670

In response to these challenges, selected states provide technical assistance to facility administrators on the types of incidents they should report as maltreatment. For example, Washington D.C. officials said they offer webinars on reporting requirements, including the incident reporting process, and require an annual assurance of the facilities' understanding and adherence to the legal reporting requirements. Facility accrediting organizations sometimes also include standards for facilities they accredit to provide staff with technical assistance and training on the types of incidents they should report, according to a representative of a stakeholder group. Additionally, participants in both of our discussion groups with residential facility providers said their facilities provide staff with extensive training on how to report incidents of maltreatment, which covers the following subjects:

- the role of a mandated reporter;
- how to write incident reports; and
- how to differentiate the types of incidents for reporting purposes, including, according to one discussion group participant, medical incidents (when children are overmedicated or medication is used improperly), significant incidents (which include suicide attempts and hospitalizations), and errors (such as when a child is accidentally given the wrong medication or the wrong dose).

Stakeholders Suggested Additional Steps to Identify and Address Maltreatment and Selected State Officials Reported Minimal Involvement from Federal Agencies

Stakeholder Suggestions to Help Address Maltreatment Included Improved Training for Facility Staff and Investigators and Additional Mechanisms for Provider Accountability

Stakeholder groups and discussion group participants suggested additional steps that states could take to identify and address maltreatment in residential facilities, including improved training and oversight, and increased provider accountability.

Improved Training for Facilities Staff and State Investigators

Although residential facility staff in selected states receive some training, as previously noted, representatives from six stakeholder groups, a protection and advocacy organization representative, and discussion group participants said staff need better training to help prevent maltreatment. For example, participants from our discussion groups with residential facility administrators, and with former residents said facilities should train staff on the use of de-escalation techniques. De-escalation training may help staff avoid power struggles with youth that can lead to maltreatment.

Each of the states require training, but in some instances the requirements are vague. For example, Arkansas' licensing standards prohibit staff from physically restraining a youth until properly trained to do so, but do not specify the length of the training or topics covered. Likewise, a California official said that while the state has approved vendors to provide trauma-informed care and de-escalation training for facilities staff, the quality of training that staff receive is inconsistent and sometimes inadequate.

Discussion group participants also said staff should receive additional pre-service training before being allowed to work unsupervised with youth on topics such as maltreatment, brain development, and psychological

and physical safety. They added that in some facilities, staff receive one day of pre-service training, but these staff may not be sufficiently trained to work without supervision from more experienced staff or administrators. In our 2008 report, we found that insufficient training and a lack of supervision for staff were two primary causes of maltreatment in residential facilities.³⁵ According to a representative of a stakeholder group, staff also need additional support to help them with vicarious trauma, which can result from continuous exposure to victims of trauma.³⁶ Discussion group participants also said that frequently checking in with staff to ensure they feel supported and are not overwhelmed helps prevent maltreatment in facilities. For example, the participants said their facilities schedule regular meetings between staff and their supervisors and regularly assess and supervisors provide feedback on staff members' performance.

Representatives of a stakeholder group and a protection and advocacy organization we spoke with said that state police and licensing officials also need training to conduct thorough investigations of maltreatment allegations. For example, the protection and advocacy organization representatives told us that state police investigators responsible for investigating maltreatment allegations are not sufficiently trained to conduct thorough investigations. Additionally, one stakeholder representative said inadequate processes for investigating maltreatment prevent its state licensing agency from being able to substantiate many incidents. For example, state officials often investigate maltreatment complaints during the day when youth involved in the incidents are at school and unavailable for an interview. As a result, this stakeholder said the investigation does not consider the youth's testimony and relies only on the account of staff members accused of maltreatment, who often deny the allegations. In California, for instance, the HHS Office of Inspector General previously found that the state licensing division did not require analysts and supervisors to take mandatory complaint

³⁵[GAO-08-346](#).

³⁶According to the Department of Justice, negative reactions to vicarious trauma can include aggressive, explosive, or violent outbursts and behaviors, as well as difficulty managing emotions, among other things.

investigation training and it recommended additional training on best practices for investigations.³⁷

Improved State Oversight Specific to Maltreatment

State oversight of residential facilities is often fragmented and not sufficiently focused on maltreatment, according to representatives from three stakeholder groups and a protection and advocacy organization. For example, the protection and advocacy organization representative said that their state's licensing agency focuses on a wide array of issues including facilities' buildings and grounds, and may not pay adequate attention to preventing and investigating maltreatment. In addition, state child welfare agencies may not receive or collect data or reports about maltreated youth outside of foster care, according to a stakeholder we spoke with.³⁸ However, officials from one state child welfare agency said they updated their data system in 2020 to track maltreatment incidents of all youth in residential facilities.

In order to fill oversight gaps, a stakeholder representative said there should be one entity in each state that is solely responsible for responding to maltreatment in facilities, including investigating incidents and removing staff from facilities when incidents occur. While some states have ombudsman or child advocate offices that may investigate maltreatment, the stakeholder said they believe that these entities rarely have the authority to oversee or take corrective action against facilities. According to one state's ombudsman for foster care, their office recently received the authority to investigate complaints of maltreatment in residential facilities, but they do not have enforcement authority to issue citations or revoke licenses. However, licensing and child welfare officials in their state are not required to inform the ombudsman office of maltreatment incidents in facilities when they occur, according to the official.

³⁷Department of Health and Human Services, Office of Inspector General, *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-09-16-0100 (September 2017).

³⁸Some youth who reside in residential facilities are not in the foster care system and may instead be placed in these facilities by their parents or through the juvenile justice system.

Additional Enforcement Mechanisms for Provider Accountability

To hold facility providers accountable for maltreatment states need stronger enforcement mechanisms, according to representatives of two protection and advocacy organizations and a stakeholder group. For example, representatives of one protection and advocacy organization expressed the view that their state focuses on punishing individual staff, rather than holding facility operators accountable. Specifically, the representatives said that they believe the licensing agency in their state considers firing a staff member charged with maltreatment a sufficient resolution to an incident and takes no further action against the facility where the staff member worked, even if there have been multiple incidents of abuse. Additionally, representatives of a stakeholder group told us states are sometimes reluctant to take action against facilities because of concerns about the availability of beds or placements if facilities are closed. We previously found that retaining sufficient congregate care capacity to meet the needs of children and youth who require such care is challenging for certain states.³⁹

Even when state agencies take action against facilities due to maltreatment, such as by imposing financial sanctions or requiring corrective action plans, these actions sometimes do not adequately deter further infractions by providers, according to the representatives from two protection and advocacy organizations and a stakeholder group. For example, representatives for one protection and advocacy organization said that in their experience, the financial sanctions their state levies against facilities are too small to affect change and do not effectively deter future infractions. Representatives of a second protection and advocacy organization said their state has a process for elevating complaints against facilities to a board that has the authority to revoke facilities' licenses, but said they believe no complaints have been elevated to the board in at least two years. Members of the board told us they could not recall any incidents in which a facility's license was revoked due to maltreatment. However, they said this was because most cases are addressed by the state licensing and child welfare agencies before needing to be elevated to the board, either through corrective action plans or by no longer placing youths in facilities with many incidents of abuse.

³⁹GAO, *Foster Care: HHS Could Do More to Support States' Efforts to Keep Children in Family-Based Care*, [GAO-16-85](#) (Washington, D.C.: Oct. 9, 2015).

Federal Agencies Have Taken Limited Actions to Support State Oversight of Federally Funded Residential Facilities

HHS and Education officials told us that they collect some data from states, but oversight of residential facilities, including residential schools, is a state function.⁴⁰ State child welfare and education agencies report to HHS and Education the number of youth in residential facilities who received services through Title IV-E of the Social Security Act and the Individuals with Disabilities Education Act, respectively. Also, state child welfare agencies, with guidance from HHS, voluntarily report to HHS incidents of maltreatment by group home and residential facility staff that involve children in foster care.⁴¹ In addition, states are required to report the death of any psychiatric residential treatment facility resident to HHS' Centers for Medicare & Medicaid Services.

HHS's minimal oversight role includes the authority to cancel state approval of psychiatric residential treatment facilities that do not meet federal health or safety requirements, for example, a serious occurrence involving the death of a resident. HHS did not cancel state approval of any psychiatric residential treatment facilities during fiscal year 2020.

Federal officials told us that they support states in their efforts to oversee residential facilities and decrease maltreatment by providing technical assistance and guidance.

- **Maltreatment prevention.** HHS officials said that they have made available a variety of information and tools to help states reduce over-

⁴⁰According to HHS, it does not have any legal authority over residential facilities. Each state handles licensing and monitoring of residential facilities differently, including which state agency is designated to handle this responsibility. Education officials told us that they have little direct contact with residential providers. Education's Office for Civil Rights investigates some incidents of maltreatment that may potentially implicate federal civil rights laws, such as discipline, restraint and seclusion, corporal punishment, and sexual violence. However, Education officials said that if maltreatment has nothing to do with the education of a child, then the maltreatment issue falls outside its purview. Every 2 years, Education requires nearly all school districts to report incidents of restraint and seclusion.

⁴¹Each year, HHS provides states with technical assistance on reporting the number of youth in residential facilities eligible for services through Title IV-E of the Social Security Act and on incidents of maltreatment. With respect to the latter, each state designates one person as the state contact for data reporting. HHS officials said they provide these individuals with one-on-one assistance on how to validate and submit their data to HHS. Education provides technical assistance to states on reporting data under the Individuals with Disabilities Education Act.

reliance on congregate care, including publications generally supporting prevention of maltreatment in residential facilities.⁴² For example, an HHS-sponsored website includes pages devoted to out-of-home services and links to articles on “Transitioning to Trauma-informed Congregate Care” and “Engaging Families in Congregate Care,” as well as promising practices in residential facilities. In addition, according to HHS officials, one of its technical assistance centers has provided direct services to states, such as providing policy examples to support maltreatment investigations in residential facilities. The center has also provided training and technical assistance to states on various aspects of the Family First Prevention Services Act, some of which is specific to the oversight and monitoring of residential facilities, according to HHS officials. However, this training and technical assistance has not focused on improving or sharing best practices on data collection, training, oversight, and enforcement mechanisms to improve accountability of facility providers.

Education funds technical assistance centers that officials said may help prevent maltreatment in residential schools.⁴³ For example, one of the centers helps schools implement approaches to social, emotional, and behavioral support for students. The center, among other things, discourages the use of restraint and seclusion, which may lead to loss of learning time or more serious, and sometimes fatal, injuries to students, and encourages alternative approaches. These approaches include explicitly teaching social and emotional skills; providing positive, specific feedback; reinforcing accomplishments; and teaching and reinforcing de-escalation and self-regulation strategies.

- **Restraint and seclusion.** In 2012, Education, in cooperation with HHS’s Substance Abuse and Mental Health Services Administration, issued guidance to states and local education agencies on restraint and seclusion. Among other things, the guidance provides a framework for states and local education agencies to consider when

⁴²See the Child Welfare Information Gateway at <https://www.childwelfare.gov/> and Child Welfare Capacity Building Collaborative at <https://capacity.childwelfare.gov/>.

⁴³See the Center on Positive Behavioral Interventions & Supports at <https://www.pbis.org/> and The National Center for Pyramid Model Innovations at <https://challengingbehavior.cbcs.usf.edu/>.

developing and implementing policies and procedures.⁴⁴ The framework is meant to ensure that any use of restraint or seclusion in schools occurs only when there is an imminent threat of serious physical harm to the student or others, and that it is administered in a manner that protects the safety of all children and adults at school.⁴⁵

Although HHS and Education officials told us that they support states' oversight of residential facilities and efforts to decrease maltreatment, some of the child welfare, education, and licensing officials in our selected states reported having minimal contact with or receiving little to no information from federal agencies. A state agency official in one state said the federal assistance they have received has not been helpful. In addition, officials from two state agencies said it would be helpful if the federal government could share best practices or convene learning communities, and a representative from a protection and advocacy agency said that more federal guidance would be helpful. Additionally, HHS, as the lead agency on addressing issues related to the safety and well-being of youth, has not consulted with or shared its expertise with Education on issues related to preventing and addressing maltreatment in residential schools.

Although HHS has largely deferred to states to prevent and address maltreatment in residential facilities, the agency's strategic plan includes an objective to safeguard the public against preventable injuries and violence or their results.⁴⁶ The plan states that HHS can do this by disseminating evidence-based strategies to keep children and youth safe from violence and injuries, including child maltreatment. In a related document that discusses a core set of strategies for preventing child abuse and neglect, HHS notes that timely and reliable data are necessary

⁴⁴U.S. Department of Education, *Restraint and Seclusion: Resource Document* (Washington, D.C., 2012).

⁴⁵HHS' Substance Abuse and Mental Health Services Administration issued a series of issue briefs on restraint and seclusion. For additional information, see U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. *Promoting Alternatives to the Use of Seclusion and Restraint—Issue brief #1: A National Strategy to Prevent Seclusion and Restraint in Behavioral Health Services*. Rockville, MD: 2010.

⁴⁶See Department of Health and Human Services' Strategic Goal 3: Strengthen the Economic and Social Well-Being of Americans Across the Lifespan, Strategic Objective 3.2: Safeguard the public against preventable injuries and violence or their results, at <https://www.hhs.gov/about/strategic-plan/strategic-goal-3/index.html>.

to monitor the extent of child abuse and neglect and to evaluate the impact of prevention efforts. In addition, standards for internal control call for management to communicate quality information throughout reporting lines to enable personnel to perform key roles in achieving objectives and addressing risks.⁴⁷ By facilitating information sharing among states on promising data collection practices, training, oversight, and additional mechanisms for provider accountability in residential facilities, HHS could help states minimize further trauma for youth in these facilities and potentially save lives.

Conclusions

Many youth in residential facilities are in the child welfare system due to abuse or neglect, and further abuse or neglect by residential facilities staff may have lifelong consequences for youth. States and local agencies are primarily responsible for overseeing and attempting to prevent maltreatment from occurring in these facilities, including receiving and investigating maltreatment complaints when they occur. States also voluntarily report data to HHS on the incidents of maltreatment by group home and residential facility staff that involve youth in foster care. However, selected state officials and stakeholder groups told us that states face some challenges related to data collection, training, and imposing consequences and holding facilities accountable for maltreatment in these facilities. While HHS and Education provide states with some guidance and technical assistance on these issues, officials in the selected states we spoke to said the assistance they receive from federal agencies has been limited and, in some cases, not helpful. Some states have efforts underway to address these challenges, and opportunities to learn from such states and sharing information across states could be beneficial. HHS, in consultation with Education, is in a unique position to facilitate information sharing and disseminate best practices across states. These efforts could help states minimize additional trauma and better protect youth in residential facilities.

Recommendation for Executive Action

The Secretary of HHS should direct the Administration for Children and Families to, in consultation with Education, facilitate information sharing

⁴⁷GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: Sept. 2014).

among states on promising practices for preventing and addressing maltreatment in residential facilities for youth. (Recommendation 1)

Agency Comments

We provided a draft of this report to HHS and Education for review and comment. We received written comments from HHS, which are reproduced in appendix I. HHS concurred with our recommendation. The agency stated that the Capacity Building Center for States and Child Welfare Information Gateway are tasked with sharing information on promising practices to improve safety, permanency and well-being outcomes for children involved in the child welfare system. According to HHS, both entities will be directed to look for opportunities to promote promising practices for preventing and addressing maltreatment in residential facilities. Also, HHS noted that the Children's Bureau will plan to collaborate with the Department of Education on future products related to preventing and addressing maltreatment in residential facilities for youth. HHS and Education also provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the Secretaries of HHS and Education, congressional committees, and other interested parties. In addition, this report will be available at no charge on the GAO website at <https://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7215 or larink@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix II.



Kathryn A. Larin
Director, Education, Workforce, and Income Security Issues

Appendix I: Agency Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

December 14, 2021

Kathryn A. Larin
Director
Education, Workforce, and Income Security Issues
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Larin:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, ***"Child Welfare: HHS Should Facilitate Information Sharing Between States to Help Prevent and Address Maltreatment in Residential Facilities"*** (GAO-22-104670).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Melanie Anne Egorin

Melanie Anne Egorin, PhD
Assistant Secretary for Legislation

Attachment

**Appendix I: Agency Comments from the
Department of Health and Human Services**

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED – CHILD WELFARE: SHOULD FACILITATE INFORMATION SHARING BETWEEN STATES TO HELP PREVENT AND ADDRESS MALTREATMENT IN RESIDENTIAL FACILITIES (GAO-22-104670)

The U.S. Department of Health & Human Services (HHS) appreciates the opportunity from the Government Accountability Office (GAO) to review and comment on this draft report.

Recommendation 1

The Secretary of HHS should direct the Administration for Children and Families, in consultation with Education, facilitated information sharing among States on promising practices for preventing and addressing maltreatment in residential facilities for youth (Recommendation 1)

HHS Response

HHS concurs with GAO's recommendation to consult with Education to share information with States on promising practices for preventing and addressing maltreatment in residential facilities for youth.

The Children's Bureau's approach to technical assistance includes sharing information, including on best practices for prevention and addressing maltreatment in residential facilities. Specifically, the Capacity Building Center for States (the Center) and Child Welfare Information Gateway (Information Gateway) are tasked with sharing information on promising practices to improve safety, permanency and well-being outcomes for children involved in the child welfare system. They have developed and disseminated a variety of products and tools for child welfare agencies focused on helping states reduce over-reliance on congregate care, including those products generally supporting prevention of maltreatment in residential facilities. Examples include [a podcast on collaboration between child welfare and mental health](#), a series of products related to [practice issues in group and residential care](#), and an article on [effective strategies to engage families in congregate care and the benefits of doing so](#). In addition, the Center has provided direct services to states through technical assistance and information requests, providing policy examples to support the investigation of maltreatment in residential facilities and an assessment of service array availability related to Medicaid 1115 waivers. While most technical assistance is provided at the request of a State or jurisdiction, the Center and the Information Gateway will be directed to look for opportunities to promote promising practices for preventing and addressing maltreatment in residential facilities.

It is important to note that the Children's Bureau does not have direct legal authority over the licensing or operation of residential facilities, and each State handles the licensing and monitoring of facilities differently. For example, in some jurisdictions, the Department of Health is responsible for licensing and oversight of all residential beds, while the Department of Human Services is responsible for ensuring the safety of children. If the two entities do not work well together, there can be significant challenges to child safety. It may strengthen the GAO report to refer to CMS and ACF distinctly depending on the section of the report that applies to each Operating Division respectively.

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Department of Health and Human Services**

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SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT
REPORT ENTITLED — CHILD WELFARE: SHOULD FACILITATE INFORMATION
SHARING BETWEEN STATES TO HELP PREVENT AND ADDRESS
MALTREATMENT IN RESIDENTIAL FACILITIES (GAO-22-104670)**

The Children's Bureau will plan to collaborate with the Department of Education on future products related to preventing and addressing maltreatment in residential facilities for youth.

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Text of Appendix I: Agency Comments from the Department of Health and Human Services

December 14, 2021

Kathryn A. Larin Director

Education, Workforce, and Income Security Issues

U.S. Government Accountability Office 441 G Street NW

Washington, DC 20548

Dear Ms. Larin:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "Child Welfare: HHS Should Facilitate Information Sharing Between States to Help Prevent and Address Maltreatment in Residential Facilities" (GAO-22-104670).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Melanie Anne Egorin, PhD Assistant Secretary for Legislation

Attachment

**GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH
& HUMAN SERVICES ON THE GOVERNMENT
ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED –
CHILD WELFARE: SHOULD FACILITATE INFORMATION
SHARING BETWEEN STATES TO HELP PREVENT AND
ADDRESS MALTREATMENT IN RESIDENTIAL FACILITIES
(GAO-22-104670)**

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Department of Health and Human Services**

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Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact:

Kathryn A. Larin, (202) 512-7215 or larink@gao.gov

Staff Acknowledgments:

In addition to the contact named above, Andrea S. Dawson and Jamila Jones Kennedy (Assistant Directors), Ramona L. Burton (Analyst in Charge), Benjamin Netto DeYoung, and Tracie Sánchez made significant contributions to this report. Also contributing to this report were Jean L. McSween, Mimi Nguyen, James M. Rebbe, Almeta Spencer, and Kathleen L. Van Gelder.

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