United States Government Accountability Office

GAO

Report to the Chairman, Committee on Education and Labor, House of Representatives

May 2008

RESIDENTIAL FACILITIES

Improved Data and Enhanced Oversight Would Help Safeguard the Well-Being of Youth with Behavioral and Emotional Challenges

GAO-08-346

May 2008

GAO Accountability · Integrity · Reliability

Highlights

Highlights of GAO-08-346, a report to the Chairman, Committee on Education and Labor, House of Representatives

RESIDENTIAL FACILITIES

Improved Data and Enhanced Oversight Would Help Safeguard the Well-Being of Youth with Behavioral and Emotional Challenges

Why GAO Did This Study

Federal funding to states supported more than 200,000 youth in residential facilities in 2004, many seeking help to address behavioral or emotional challenges. However, federal investigations have identified maltreatment and civil rights abuses in some facilities. GAO was asked to provide national information about (1) the nature of incidents that adversely affect youth well-being in residential facilities, (2) how state licensing and monitoring requirements address youth well-being in these facilities, and (3) what factors affect federal agencies' ability to hold states accountable for youth well-being in residential facilities. GAO conducted national Web-based surveys of state child welfare, health and mental health, and juvenile justice agencies and achieved an 85 percent response rate for each of the three surveys. We also visited four states, interviewed program officials, and reviewed laws and documentation.

What GAO Recommends

GAO recommends that the Secretary of Health and Human Services (HHS) work to address state barriers in reporting maltreatment data for residential facilities, that the Attorney General work with federal agencies to access information for targeting civil rights investigations, and that the Attorney General and the Secretaries of HHS and Education work to enhance their state oversight efforts. GAO also discusses the implications of options that states, federal agencies, and Congress may use to safeguard and improve the civil rights and well-being of youth in residential facilities. While HHS and the Department of Justice (DOJ) generally agreed with our recommendations and suggested further action that could be taken, Education did not directly respond to the recommendations in its comments.

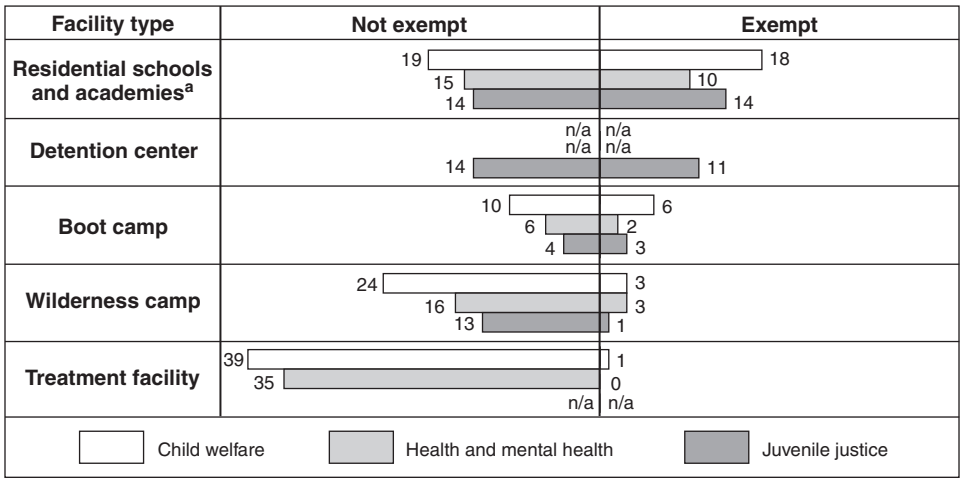
To view the full product, including the scope and methodology, click on GAO-08-346.To view the e-supplement online, click on GAO-08-631SP. For more information, contact Kay Brown, (202) 512-7215 or brownke@gao.gov.

What GAO Found

Youth in some residential facilities have experienced maltreatment including sexual assault, physical and medical neglect, and bodily assault that sometimes resulted in civil rights violations, hospitalization, or death. Survey respondents from 28 states reported at least one death in residential facilities in 2006. National data submitted to HHS from states show that 34 states reported 1,503 incidents of youth abuse and neglect by facility staff in 2005, but these data are understated due to state barriers in collecting and reporting facility-level information. Specific facility information that was reported and that could help target federal investigations was generally not shared with relevant agencies, such as DOJ's Civil Rights Division, because there was no formal mechanism to share this information.

All states have processes in place to license and monitor certain types of residential facilities, but state agencies reported several oversight gaps. Some government and private facilities—particularly juvenile justice facilities and boarding schools—are often exempt from licensing requirements by law or regulation. In addition, licensing standards do not always address some of the most common risks to youth well-being, such as suicide. State officials reported that they are unable to conduct annual on-site reviews at facilities, in part because of fluctuating levels of staff resources. Few state agencies reported suspending or revoking a facility's operating license, in some cases due to lack of alternatives in placing the displaced youth.

Number of State Agencies Reporting That They Do Not Exempt or Exempt Private Residential Facilities from Licensing Requirements, 2006



Source: GAO analysis of state agencies' responses to survey.

Note: Other agency responses included no such facility in the state, don't know, and no response.

[a]Residential schools and academies includes both government and private facilities.

HHS, DOJ, and Education hold states accountable for youth well-being under federal grant programs, but their authority is limited and monitoring practices are inconsistent. These agencies do not have the legal authority to hold states accountable for youth well-being in private residential facilities unless they serve youth under programs that receive federal funds. Agency officials also said they lack authority to require suicide prevention, and other requirements were inconsistent across programs. Agencies did not always include facilities in their state oversight reviews, and were inconsistent in addressing state noncompliance.

Contents

Tables

Figures

Abbreviations

AWOL	Absent Without Leave
CAPTA	Child Abuse Prevention and Treatment Act
CARF	Commission on Accreditation Rehabilitation Facilities
CMS	Centers for Medicare & Medicaid Services
COA	Council on Accreditation
CRIPA	Civil Rights of Institutionalized Persons Act
DOJ	Department of Justice
HHS	Department of Health and Human Services
JC	The Joint Commission
NCANDS	National Child Abuse and Neglect Data System
OJJDP	Office of Juvenile Justice and Delinquency Prevention
Education	Department of Education

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Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

May 13, 2008

The Honorable George Miller
Chairman
Committee on Education and Labor
House of Representatives

Dear Mr. Chairman:

Since the 1990s, government and private entities have established hundreds of residential facilities—including boarding schools and academies, boot camps, and wilderness camps—to serve youth with behavioral and emotional challenges. Nationwide, federal funding to states supported more than 200,000 youth in facilities in 2004, and an unknown number of youth were placed in facilities by parents or others. These facilities can provide youth who cannot be served in their communities with a less restrictive alternative to hospitalization or incarceration. However, annual investigations by the Civil Rights Division within the Department of Justice, have detailed incidents of abuse and neglect, which in some cases have been severe enough to result in hospitalization or death.

States are primarily responsible for ensuring the well-being of youth in facilities and other settings, and states vary in how they license and monitor facilities in accordance with individual state standards of care. In addition, in return for receiving funds under various federal grant programs, state agencies agree to comply with federal program requirements, including those related to youth well-being. These programs generally fall under the purview of three federal agencies: The Department of Health and Human Services (HHS) provides funds to states for child welfare, mental health, and substance abuse; the Department of Justice (DOJ), for serving delinquent youth; and the Department of Education (Education), for educating youth. These agencies have authority to hold states accountable for state-operated or private facilities that serve youth under federally funded state programs. However, the federal government does not have oversight authority for other private facilities that serve only youth placed and funded by parents or other private entities. In this report we refer to facilities that receive no government funding as exclusively private facilities.

In an October 2007 testimony on residential treatment programs for troubled youth we looked specifically at abuse and neglect of youth in certain types of private facilities.[1] This report provides national information about (1) the nature of the incidents that adversely affect the well-being of youth in government and private residential facilities, (2) how state licensing and monitoring requirements address the well-being of youth in residential facilities, and (3) what factors affect federal agencies' ability to hold states accountable for youth well-being in residential facilities. We are also providing information on options that states, federal agencies, and Congress may use to better promote youth well-being in residential facilities.

For purposes of this study, we defined residential facilities as those that require youth—ages 12 through 17—to reside at the facility and that provide program services for youth with behavioral and emotional challenges.[2] There are no uniform definitions for the types of residential facilities, and we worked with states to identify definitions that would be commonly understood, including boarding schools and academies, training and reform schools, wilderness camps, ranches, and treatment centers. We surveyed state child welfare, health and mental health, and juvenile justice directors in the 50 states, the District of Columbia, and Puerto Rico to determine how states oversee child well-being[3] in residential facilities. [4] We received at least one completed survey from each state except Puerto Rico, completed surveys from all 3 agencies in 33 states, and completed surveys from a total of 44 child welfare agencies, 45 health and mental health agencies, and 44 juvenile justice agencies. In the surveys, we asked about residential facilities that were government

[1] For additional information see GAO, *Residential Treatment Programs: Concerns Regarding Abuse and Death in Certain Programs for Troubled Youth*, GAO-08-146T, Washington, D.C.: Oct. 10, 2007.

[2] Our review included facilities that provided one or more of the following types of programs: juvenile justice, youth offender, juvenile delinquency, and incorrigibility programs; treatment programs for youth with behavioral, emotional, mental health, and substance abuse issues; homes for pregnant teens; schools for discipline or character education; and therapeutic group homes, such as a home that specializes in supporting and treating youth with severe emotional disorders.

[3] In this report, we use the term *states* to refer collectively to the 50 states plus the District of Columbia and Puerto Rico.

[4] We did not survey state education agencies, because they generally do not license residential facilities for youth.

operated; privately operated that received any government funds; 5 and privately operated with no government funding. This report does not contain all of the results from the survey. The survey and a more complete tabulation of the results can be viewed by accessing the following link: http://www.gao.gov/cgi-bin/getrpt?GAO-08-631SP. To further our understanding, we visited 4 states—California, Florida, Maryland, and Utah—and interviewed relevant officials. These states were selected based on the diversity of their state licensing and monitoring policies for residential programs; reports of child maltreatment; and geographic location. We also obtained state-reported data that HHS collects and maintains in its National Child Abuse and Neglect Data System (NCANDS). We reviewed federal statutes, regulations, and guidance concerning the roles and responsibilities of selected agencies, and interviewed HHS, DOJ, and Education officials, as well as national association representatives and other experts on residential facilities for youth. We analyzed reports, studies, evaluations, and other documents regarding state licensing and monitoring of residential facilities for youth, but the scope of our work did not include the quality of services provided at residential facilities. See appendix I for more information on our scope and methodology. We performed our work between November 2006 and April 2008, in accordance with generally accepted government auditing standards.

Results in Brief

Youth in some government and private residential facilities have experienced maltreatment including physical abuse, neglect or deprivation of necessities, and sexual abuse that sometimes resulted in death or hospitalization, but data limitations hinder efforts to quantify the problem. Survey respondents from 28 states reported at least one death in a residential facility in 2006, often in accidents or suicides that, in some cases, may have been attributable to a lack of supervision or neglect by staff. In terms of youth maltreatment, NCANDS data show that 34 states reported 1,503 incidents of youth abuse and neglect by facility staff in 2005, but these data are underreported. Many state agencies we surveyed reported having information gaps, in part due to barriers in collecting facility specific information on deaths and maltreatment for all or some facilities. Facility-specific information for facilities that states did report to

[5] Private facilities may receive government funds through contracts with state or county agencies to serve youth under state systems of care, such as juvenile justice, or as certified providers of care under government health insurance programs, such as Medicaid. Private funding may be provided by parents or others placing youth in a facility who are not under the cognizance of a government agency.

NCANDS was not shared with agencies, such as the DOJ Civil Rights Division, that may use such information to prioritize civil rights investigations at the federal level. DOJ annual reports convey the severity of maltreatment and civil rights violations uncovered by investigations in both government and private facilities receiving government funds across the nation.

All states have processes in place to license and monitor certain types of residential facilities, but state agencies reported several gaps in coverage that may place some youth at higher risk for maltreatment and death. First, some government-operated and private facilities—such as juvenile justice facilities and residential schools and academies—are often exempt from licensing requirements altogether by law or regulation. Additionally, licensing requirements do not always address suicide and other common risks to youth well-being, and requirements that do exist may be inconsistently applied across different types of agencies and facilities. For example, almost all state juvenile justice agencies we surveyed required facilities to have written suicide prevention plans, compared to about two-thirds of state child welfare and health and mental health agencies. State agencies also reported gaps in their monitoring processes for residential facilities. Some state agencies reported that monitoring did not occur at some facilities or reported that certain aspects of youth well-being, such as the quality of education programming and the use of psychotropic medications, were not included in their monitoring reviews. State officials also reported that they are unable to conduct yearly on-site reviews at facilities they monitor, because of fluctuating levels of staff resources committed by the state. Few state agencies reported taking action to suspend or revoke a facility's operating license, in some cases because the state had no alternatives for serving the youth who would have been displaced. Finally, interagency coordination to ensure that facilities are providing an appropriate education, or other specialized services, is often lacking. Several officials also noted the importance of increasing coordination to share monitoring results as agencies may place youth in common facilities within and across state lines.

HHS, DOJ, and Education all have oversight processes to hold states accountable for the well-being of youth under the grant programs they administer, but the scope of the agencies' oversight authority and different monitoring practices hinder their efforts. Most notably, these agencies do not have the legal authority to hold states accountable for youth well-being in private residential facilities unless they serve youth in state programs that receive federal funds. For facilities under federal purview, agency officials said that they do not have authority to modify youth well-being

requirements established in law, and such requirements vary by federal agency and program. For example, in comparing requirements across relevant HHS, DOJ, and Education programs, only HHS had requirements for states to address abuse and neglect prevention. Requirements were inconsistent even among programs within the same agency. HHS, for example, had requirements for states to address suicide prevention under Medicaid programs, but not under child welfare programs or programs for substance abuse and mental health. In monitoring state compliance with federal program requirements, agencies did not always include residential facilities in their oversight reviews. While on-site reviews conducted by DOJ specifically included these facilities, HHS reviews of states' child welfare systems targeted individual children, and did not necessarily include those in residential facilities. Federal agencies were also inconsistent in how they addressed state noncompliance with federal program requirements. In fiscal year 2007, for example, DOJ assessed financial penalties against 8 states and Puerto Rico, while other federal agencies reported that they did not assess penalties against noncompliant states.

Weaknesses in the current federal-state regulatory structure have failed to safeguard the civil rights and well-being of some of the nation's most vulnerable youth, and we discuss the implications of some options for action that states, federal agencies, and Congress may consider in any restructuring effort. In addition, we remain concerned about the gaps in reported data that have persisted over a decade since the reporting requirement has been in place. We are also making recommendations for action that federal agencies can implement now under the existing regulatory structure, including that the Secretary of Health and Human Services explore options to address state barriers in reporting maltreatment data for residential facilities; the Attorney General work with other federal agencies to access information that could help target civil rights investigations; and HHS, DOJ, and Education work to enhance their oversight of state accountability for youth well-being in residential facilities. HHS and DOJ either generally agreed, or did not disagree, with each of our recommendations. They also suggested further action that could be taken to address the report findings related to oversight for residential facilities. Education did not directly respond to the report recommendations but rather discussed its role and responsibilities for oversight of certain programs.

Background

In the continuum of care for youth with behavioral and emotional challenges, residential facilities can provide an alternative to

hospitalization or incarceration for youth who cannot live at home and receive services in their communities.[6] Youth in these facilities range from young children through those who are transitioning to adulthood. These youth can exhibit a wide range of challenging behaviors, including antisocial or suicidal behaviors, substance abuse, and delinquency.

The array of residential facilities reflects the diversity of the population they serve. There are no uniform definitions of residential facilities, and for those facilities treating children with mental illness, states reported at least 71 different facility types, according to a 2006 HHS report.[7] Facilities can provide a range of services, such as those for youth suffering from substance abuse or severe emotional disorders, either on-site or through links with community programs, including educational, medical, psychiatric, and clinical/mental health services. A wide range of government or private entities, including faith-based organizations, can operate these facilities. The cost to support youth in a residential setting can amount to thousands of dollars per month at some residential facilities.

Youth Maltreatment Data

HHS maintains and disseminates state-reported child abuse and neglect data in NCANDS to fulfill requirements in the Child Abuse Prevention and Treatment Act (CAPTA). Enacted in 1974, CAPTA established a focal point in the federal government to identify and address issues of child abuse and neglect in all settings, including residential facilities, and support effective methods of prevention and treatment.[8] Under CAPTA, all states receiving funds from the state grant program are required to work with HHS to provide—to the maximum extent practicable—specific data on child maltreatment, including the number of

[6] Parents may determine that it is best for some youth to live in an alternative setting, or youth who are at risk of running away or are a danger to themselves or others may be placed in a facility.

[7] U.S. Department of Health and Human Services, *State Regulation of Residential Facilities for Children with Mental Illness.* DHHS Pub. No. (SMA) 07-4167. Rockville, Maryland: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2006.

[8] Last reauthorized in 2003, CAPTA authorizes state grants to help states with their child protective service functions, and Children's Justice Act grants to improve states' investigation and prosecution of child maltreatment.

children reported to have been abused or neglected and the number of deaths resulting from abuse and neglect. [9]

In addition, CAPTA requires that states receiving grants have laws or programs in effect for the investigation of child abuse and neglect.[10] The law also requires states receiving grants to establish citizen review panels to review state and local child protection activities, which may include child fatality review committees established by states to review child fatalities for evidence of maltreatment, and to forward such cases for prosecution.

State Oversight Processes

States have systems in place to license a wide range of businesses, and have general licensing requirements that include obtaining permits for land use, meeting building and safety codes, and establishing a basis for taxation. Beyond these general licensing requirements, states may have additional requirements that are specific to a category of business declared by the owner, such as a residential facility, or more specific types of businesses within this category, such as a boarding school or wilderness camp. Some states have centralized all licensing and monitoring of facilities serving youth within a single agency, while other states have decentralized these functions among three or more different agencies, including state child welfare, mental health, and juvenile justice agencies. In addition, other agencies may provide oversight, such as the local fire and health departments, and the agency that places youth in the facility. State education agencies may also provide oversight for a facility's educational programs. Oversight activities typically include licensing or certifying government or privately operated facilities, investigating complaints, and monitoring facility compliance with state or local standards, but there are no minimum standards commonly used by licensing agencies.

States may also require residential facilities to seek accreditation in addition to obtaining a license to operate in their state. Accrediting agencies are private, peer-based, member-funded agencies designed to encourage and promote high-quality care. Accreditation is typically

[9] U.S. Department of Health and Human Services, *Child Maltreatment 2005*, Appendix A lists the required data elements.

[10] How a state organizes its child abuse and neglect reporting and investigation systems, and therefore whether it investigates and captures reports of abuse and neglect at exclusively private facilities, is the state's prerogative.

obtained by a self-initiated application and guided self-evaluation, followed by an on-site visit by a voluntary committee associated with the accrediting agency.[11] Some of the benefits to accreditation that states provide include strengthening confidence in the quality of care, fulfilling regulatory requirements in some states, and improving risk management and risk reduction.

Federal Oversight of Programs That Support Residential Facilities

Three federal agencies—HHS, DOJ, and Education—administer federal programs that states may use to support youth with community-based services while living at home or, when needed, in residential facilities or other settings. This support is provided primarily through certain subagencies, as shown in table 1.

Table 1: Selected Federal Funds That Can Be Used to Support Youth in Residential Facilities, by Federal Agency and Subagency

Agency and Subagency	Program authority and fiscal year 2007 funding	Purpose
HHS		
Administration for Children and Families	Title IV-B of the Social Security Act—$287 million	Support for state child welfare system
	Title IV-E of the Social Security Act—$6.9 billion	Support for state child welfare system
Substance Abuse and Mental Health Services Administration	Block Grants for Prevention and Treatment of Substance Abuse—$1.8 billion	Support for state substance abuse prevention and treatment systems
	Block Grants for Community Mental Health Services—$428 million	Support for state mental health systems

[11] Three major national accreditation organizations for residential facilities include the Council on Accreditation (COA), the Commission on Accreditation of Rehabilitation Facilities (CARF), and the Joint Commission (JC). COA partners with human service organizations worldwide to improve service delivery outcomes by developing, applying, and promoting accreditation standards. CARF is an independent, nonprofit accreditor of human service providers in the areas of behavioral health, child and youth services, and medical rehabilitation. JC accredits and certifies health care organizations and programs in the United States in an effort to improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations.

Agency and Subagency	Program authority and fiscal year 2007 funding	Purpose
Center for Medicare and Medicaid Services	Title XIX of the Social Security Act—$189.1 billion	Support for medical assistance for low-income persons
DOJ		
Office of Juvenile Justice and Delinquency Prevention	Juvenile Justice Delinquency Prevention Act—$320 million	Support for state juvenile justice system
Education		
Office of Special Education and Rehabilitative Services	Individuals with Disabilities Education Act—$11.8 billion	Support for state special education systems
Office of Elementary and Secondary Education	Elementary and Secondary Education Act as Amended by the No Child Left Behind Act of 2001—$14.7 billion	Support for state education systems

Source: GAO analysis of federal budget documents.

In 2004, HHS and DOJ reported that states served more than 200,000 youth in residential settings under certain federal programs for child welfare, mental health, and juvenile justice as shown in table 2.

Table 2: Estimated Number of Youth in Residential Settings per Latest Available Agency Data

	State agencies		
Placement	**Child welfare**	**Mental health[a]**	**Juvenile justice**
Number of youth	107,000	11,000	93,000

Source: Child welfare data: Child Welfare League of America: National Data Analysis System, Number of Children in Out-of-Home Care, by Placement Setting 2004.

Notes: Mental health data: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, National Survey of Substance Abuse Treatment Services, March 31, 2006.

Juvenile justice data: Office of Juvenile Justice and Delinquency Protection: Census of Juveniles in Residential Placement, 2006.

[a]According to HHS's Substance Abuse and Mental Health Services Administration officials, the approximately 11,000 youth include those receiving treatment at public and private facilities as of March 31, 2006, most with a primary focus of substance abuse treatment and many fewer with a mental health focus.

To receive federal funds under these programs, states generally develop and submit to the relevant agency a multiyear plan that addresses federal

program requirements.[12] The relevant federal agency reviews and approves state plans, along with any annual performance reports that states submit describing progress in meeting goals. Federal agencies also audit states' use of grant funds via reviews of state records and site visits in the settings where youth reside, such as residential facilities. States that fail to meet the required standards may face the withholding of federal funds.

Federal Investigations of Civil Rights Abuses in Residential Facilities

The Civil Rights of Institutionalized Persons Act (CRIPA), enacted in 1980, authorizes the Attorney General of the United States to conduct investigations and bring actions against state and local governments relating to conditions of confinement in institutions that are owned, operated, or managed by or provide services on behalf of, state or local governments.[13] Institutions covered by CRIPA include youth residential facilities.

CRIPA is implemented by the Special Litigation Section within DOJ's Civil Rights Division. Under CRIPA, the Special Litigation Section investigates covered facilities to determine whether there is a pattern or practice of violations of residents' federal rights. According to DOJ, to date, the Special Litigation Section has been successful in resolving the majority of CRIPA investigations that have uncovered unlawful conditions by obtaining voluntary correction or a judicially enforceable settlement designed to improve conditions.

[12] For example, states receiving Title IV-B funds are required to submit a 5-year child and family services plan that sets forth the goals that the state intends to accomplish and assurances that that states will review their progress.

[13] Whether a private facility is covered by CRIPA would depend on the level of governmental involvement. For example, if a state or local government enters into a contract with a private facility to house certain juveniles, the facility might be considered an institution covered by the statute. However, CRIPA states that privately owned and operated facilities are not covered by the statute where the only connection between the facility and the state is a state license or the facility's receipt of Medicaid and certain other federal payments on behalf of residents of the facility.

Fatalities and Maltreatment Occurred in Government and Private Facilities, but State and National Data Do Not Fully Capture the Extent and Nature of the Problem

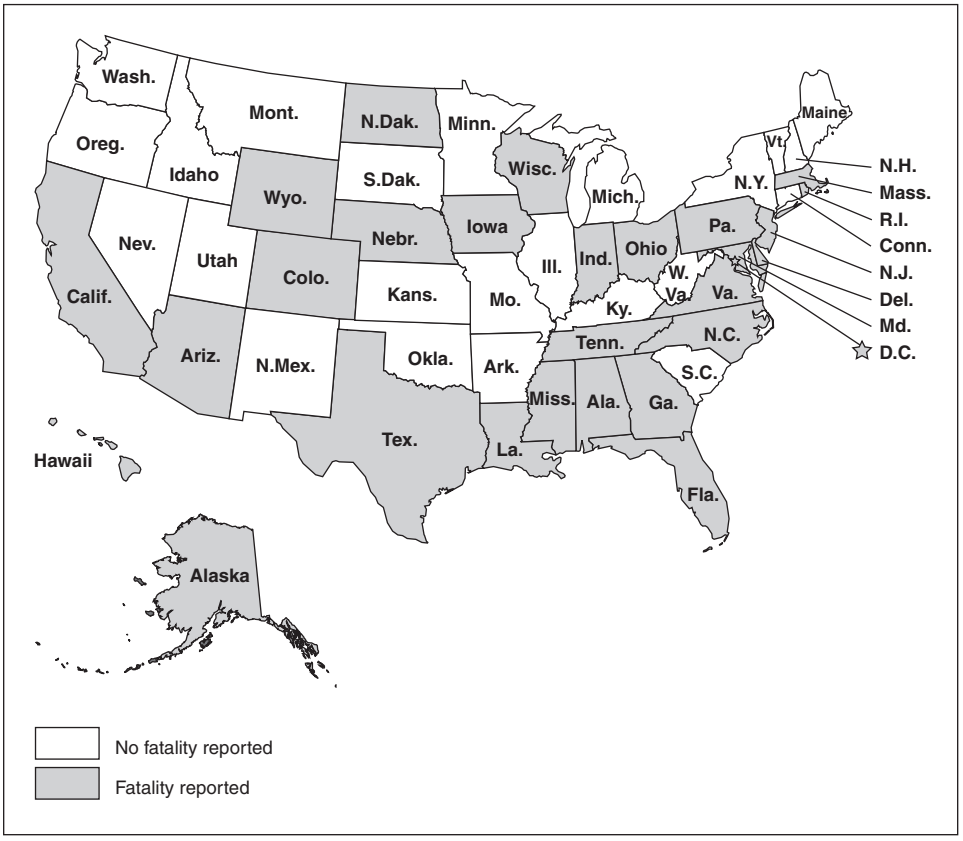
States we surveyed reported fatalities as well as incidents of physical abuse, sexual abuse, and neglect of youth in both government and private facilities in 2006, but data limitations hinder efforts to quantify the problem. Accidents and suicides—often attributable to a lack of supervision by staff—were among the most common types of youth fatalities, according to surveyed states; while in the four states we visited, the most common causes of youth maltreatment were abusive staff and lack of appropriate supervision. Many states had inconsistent or incomplete data on adverse incidents—especially from exclusively private facilities. National data, derived from state reports, suffer from these same limitations, leaving states with little opportunity to identify the extent of the problem and find solutions. State-reported information also fails to convey the severity of civil rights violations uncovered in some facilities each year—that show extreme cases of sexual assault, medical neglect, and bodily assault requiring hospitalization.

Youth Fatalities Occurred in Government and Private Facilities across the Nation, with Accidents and Suicide among the Primary Causes

Youth fatalities occurred in both government and private residential facilities, in states across the nation. Of the states we surveyed, 28 reported that at least one youth had died in this setting in 2006, as shown in figure 1.[14]

[14] We could not determine the number of deaths in each state because of the possibility of duplicative reporting across agencies.

Figure 1: States That Reported at Least One Fatality in Residential Facilities, 2006



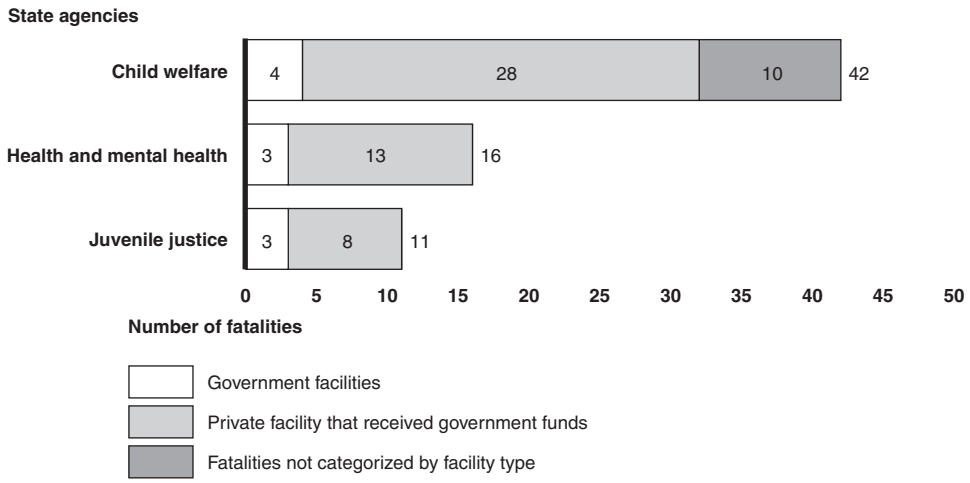
Source: GAO analysis of state agency responses to survey; map, Map Resources.

Note: The survey question was as follows: In 2006, how many youth aged 12-17 died in each of the following categories of residential facilities providing targeted services in your state? Include youth who died at the facility as well as youth in AWOL status or others who died or were pronounced dead outside the facility: (a) total deaths in 2006, (b) deaths of youth under the care and supervision of your agency at government-operated facilities, (c) deaths of youth under the care and supervision of your agency at private facilities that receive any government funds, (d) deaths of youth under parental or non-government custodial care at private facilities that receive any government funds, and (e) deaths of youth under parental or nongovernment custodial care at private facilities that do not receive government funds (including faith-based facilities).

Child welfare agencies reported more deaths in residential facilities than other agencies, and nearly three times as many states reported deaths in private facilities that received government funds than in government-operated facilities (see fig. 2). However, this may bear little or no relation to the relative risk of death in either facility type due to differences in the proportion and risk factors of youth served, among other factors. While no state we surveyed reported fatalities in exclusively private facilities, one or

more agencies in 45 states reported that they did not have data for these types of facilities.

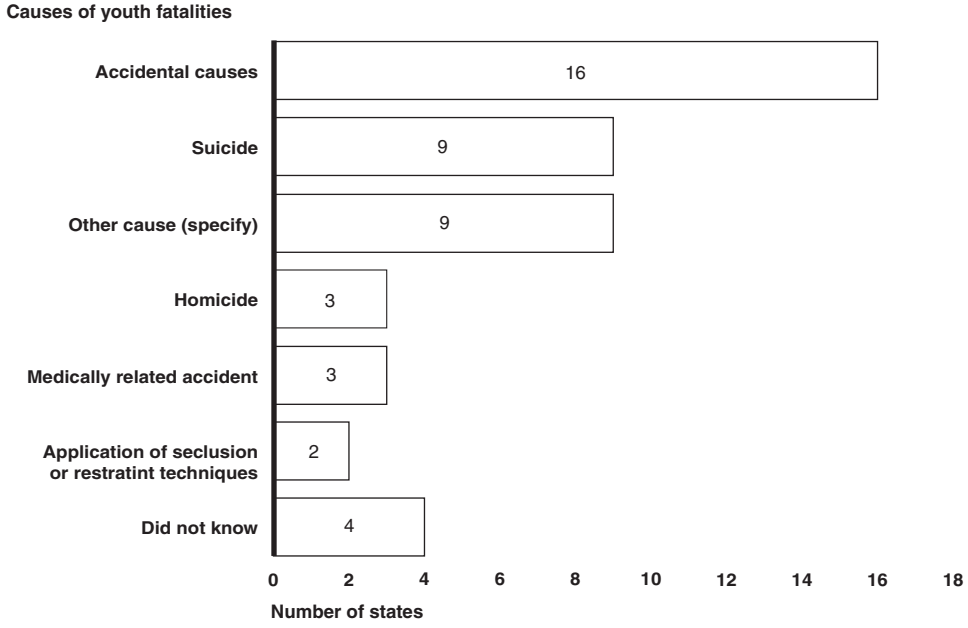
Figure 2: Number of State-Reported Fatalities by Type of Residential Facility and Agency, 2006



Source: GAO analysis of state responses to surveys.

In our survey, deaths in the 28 states were most often attributed to accidental causes (see fig. 3), but sometimes accidental deaths, if investigated, are attributable to abuse or neglect. In Florida, for example, juvenile justice officials said that a youth death in a county-operated boot camp was first classified as an accident, but after investigation by a child fatality review committee, was reclassified as a death caused by maltreatment and referred for prosecution.

Figure 3: Number of States That Reported Specific Causes of Youth Fatalities in Residential Facilities, 2006



Source: GAO analysis of state agency responses to survey.

Notes: The survey question was as follows: Of the total youth deaths that you reported, how many died from each of the following causes: (a) suicide, (b) homicide, (c) application of seclusion and restraint techniques, (d) medically related accident, (e) accident that occurred while in a runaway or AWOL status, (f) other accidental cause, and (g) other causes?

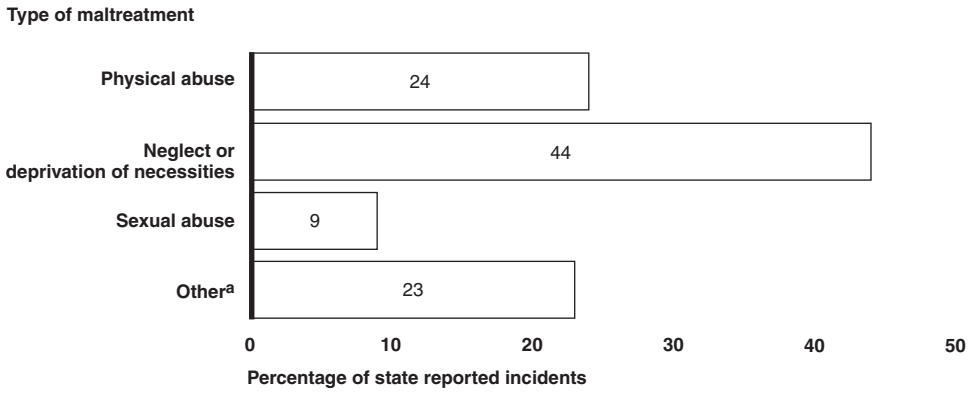
Other causes of youth fatalities in residential facilities include natural causes, choking, and internal bleeding.

Suicide was among the most common causes of fatalities in residential facilities reported by states we surveyed, and can be related in some instances to inadequate staff supervision and services. In Alaska, for example, a youth participating in a sex offender program hanged himself at night while residing in a private facility contracting with the state. After the state agency and the local law enforcement agency investigated, the facility corrected substandard practices in staffing, supervision, and clinical services. In Wisconsin, after three youth hanged themselves in private residential facilities under contract with a state agency, the state increased staff training and monitoring of residents and sponsored statewide suicide awareness and prevention training for those who work with youth in residential settings. See appendix II for more information on the results of suicide investigations in the states we surveyed.

Youth Maltreatment Was Primarily Related to Inexperienced Staff, Lack of Supervision, or Insufficient Training

States responding to our survey reported that they investigated complaints of physical abuse, sexual abuse, or neglect in both government and private facilities (49 states), including those that are exclusively private (37 states). Similarly, NCANDS data from 2005 showed that 34 states reported incidents of youth abuse and neglect in residential facilities. Of the 1,503 reported incidents, neglect was the most frequent cause of youth maltreatment, followed by physical abuse. (See fig. 4 and app. III.)

Figure 4: Percentage of State-Reported Incidents of Youth Maltreatment by Residential Facility Staff, Fiscal Year 2005



Source: NCANDS.

[a] "Other" incidents of youth maltreatment states reported to NCANDS include medical neglect and psychological or emotional maltreatment.

In the states we visited, abuse and neglect of youth in residential facilities was often associated with staff resource concerns—such as a lack of experienced staff, insufficient training, or lack of appropriate supervision—particularly in smaller facilities. In California, for example, county officials told us that adverse incidents were most likely to occur in contractor-operated six-bed group homes—frequently used by state probation and child welfare agencies—where the state reimbursement rate is generally not high enough to hire skilled personnel and provide staff with ongoing training, support, and oversight.

Another cause of youth maltreatment may be attributable to the improper application of seclusion and restraint, according to state officials. State officials in Florida said that improper application of seclusion and restraint techniques may result in staff restraining youth for too long, or with too much force, causing injury or death.

Data Limitations Preclude Identifying the Extent of the Maltreatment or Finding Solutions

State and federal information systems for tracking and reporting incidents of maltreatment have limitations in helping state and federal agencies monitor the well-being of youth in residential facilities and address outstanding problems. When available, comprehensive reporting of incident data can be used by state and federal agencies to assess the extent of maltreatment in residential facilities, inform risk assessments, target oversight resources, and develop policies to address trends. However, although states responding to our survey reported that the ability to collect and maintain data on all facilities in the state was a high priority, state officials we interviewed reported barriers in addressing these activities: First, the lack of authority under state law hinders many states from collecting data on certain facilities—such as exclusively private facilities—and expanding oversight to cover them; second, states that have such authority reported difficulties sustaining data collection in times of budget shortages. As a result, state officials said that the number of adverse incidents was likely more widespread and numerous than reported.

NCANDS, which is derived from state reports, suffers from these same limitations, as well as others. First, some states do not report data for residential facilities to NCANDS,[15] so it may understate the number of fatalities and maltreatments. Second, many states do not consistently identify whether the individual maltreating youth was facility staff, a parent, or other individual.[16] Finally, NCANDS only tracks fatalities resulting from maltreatment, not suicide or accidents that may be an indicator of neglect or another problem that needs resolution. Cognizant HHS officials said that its NCANDS contractor routinely works with states to improve data quality, but cannot enforce state participation as data reporting is voluntary under the law.

HHS highlighted the need to improve the quality of data reported by states in a 2005 report to Congress,[17] noting that national collection of data on

[15] In fiscal year 2005, 10 states did not submit reports showing the number of fatalities in residential facilities—2 states did not submit a report, 7 states did not track facility incident data in a format that could be shared with NCANDS, and 1 state involved in litigation did not report facility data.

[16] In 2005, 37 states were unable to consistently identify whether the individual maltreating youth was facility staff, a parent, or other individual.

[17] For additional information see U.S. Department of Health and Human Services, Administration on Youth and Families, *Child Maltreatment 2005* (Washington, DC: U.S. Government Printing Office, 2007).

child fatalities is complicated by the many steps that are needed to establish the cause of death. The report stated that while state child fatality review committees can investigate and help classify deaths correctly, they are not implemented in every community, nor do they have the resources to review each suspicious death of a child or adolescent. In this report, HHS suggested that Congress fund research on ways to improve national reporting of youth fatality data, including procedures for investigating and documenting the cause of fatalities.

Federal Investigations Highlight the Severity of Civil Rights Violations Occurring in Some Residential Facilities

In most facilities, youth maltreatment may occur infrequently as a result of isolated circumstances, but over the years, DOJ investigations of facilities serving youth have found a pattern or practice of civil rights violations, including physical and sexual abuse, medical neglect, and inadequate education in some government and private facilities receiving government funds. At the end of fiscal year 2006, the latest year for which data were available, DOJ's Civil Rights Division reported active cases involving over 175 facilities and 34 states.[18] Annual reports from the division over the past several years have documented their findings of youth maltreatment in certain juvenile justice or mental health facilities:

Physical and sexual abuse occurred without management intervention. In one facility, staff hit youth and slammed them to the ground. Staff hog-tied and shackled youth to poles in public places, and girls were forced to eat their own vomit if they threw up while exercising in the hot sun. Staff routinely broke the jaws of youth who showed disrespect in another facility. In some facilities, staff engaged in sexual acts with boys. Youth-on-youth violence occurred on an almost daily basis in some facilities, at times resulting in injuries that required hospitalization. Youth were sexually assaulted and threatened with sexual assault by other youth in some facilities, all without effective intervention from management.

Severe neglect resulted in poor education, suffering, and death. In a 1-year period at one facility, three boys committed suicide. In one suicide, staff lacked the appropriate tool to cut the noose from a victim's neck and also did not have oxygen in the tank they brought to help resuscitate him. The dental clinic at one facility was full of mouse droppings, dead roaches,

[18] For additional information see U.S. Department of Justice, *Department of Justice Activities under the Civil Rights for Institutionalized Persons Act, Fiscal Year 2006* (Washington, D.C. 2007).

and cobwebs; medications in the cabinet had expired over 10 years ago. In a state-operated mental health facility used by adolescents, older psychotropic medications, with serious side effects, were administered to sedate patients. One adolescent received 22 such psychotropic sedatives over a 2-month period. In another facility, youth were not provided with special education services as required by federal law.

DOJ's Civil Rights Division reports that it receives more credible allegations of violations of youth rights than it can investigate. During fiscal year 2006 alone, the division reported receiving approximately 5,000 citizen letters, hundreds of telephone complaints, and 135 inquiries from Congress and the White House. In the 26 years CRIPA had been in effect, through September 2006, the division investigated conditions in 433 facilities. Division officials said that they also receive many allegations of civil rights violations in exclusively private facilities, such as private boarding schools.

DOJ Civil Rights Division officials stated they rely on advocacy groups and media stories to identify investigations, but with additional sources of information, they could better target their scarce investigative resources. Division officials said that they were unaware that NCANDS tracked state-reported maltreatment data, and that obtaining case-level NCANDS information on the incidents of maltreatment and death occurring in specific facilities would be helpful. Division officials said that the results of federal agency monitoring reviews of states that highlight findings related to residential facilities would also be useful, but that there was no formal mechanism to share oversight findings for residential facilities under the purview of multiple federal programs. Except in one instance,[19] officials said that no federal agencies—including HHS, Education, and DOJ's Office of Juvenile Justice and Delinquency Prevention—were coordinating with DOJ's Civil Rights Division to provide pertinent oversight results.

[19] According to DOJ officials, the Civil Rights Division has been granted access to HHS's Centers for Medicare & Medicaid Services (CMS) database that contains the annual survey results for CMS oversight of residential facilities.

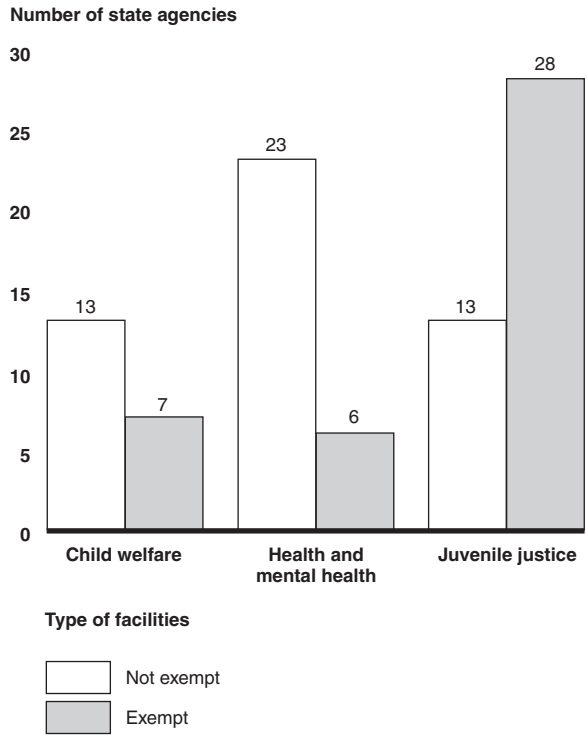
State Licensing and Monitoring Exclude Some Facilities and Do Not Address All Risks to Youth Well-Being

All states have processes in place to license and monitor certain types of residential facilities, but our survey identified several gaps that exempt certain types of facilities from oversight and allow some of the common causes of youth death and maltreatment to go unaddressed. These gaps include the fact that some types of government-operated and private facilities are exempt from licensing requirements, licensing requirements do not always address the primary causes of youth death and maltreatment, and state agencies inconsistently monitor facilities and share their monitoring results. Increasing coordination and information sharing among state agencies—both within and across states—was a high-priority activity states identified to improve the oversight of youth well-being in residential facilities.

Juvenile Justice Facilities and Residential Schools and Academies Are Often Excluded from Agency Licensing Requirements

All states reported licensing certain types of residential facilities for youth, but their responses to our survey also showed gaps in licensing coverage (see app. IV). Licensing all facilities, public or private, can help ensure that residential facilities meet the relevant standards for protecting youth well-being. Among state-operated facilities, juvenile justice agencies were more likely to exempt facilities from licensing than child welfare and mental health agencies (see fig. 5). The juvenile justice officials we interviewed said that this was because some state statutes do not require state-operated juvenile facilities to have a license in order to operate.

Figure 5: State Agencies Reporting the Licensing Status of State-Operated Residential Facilities That Serve Youth



Source: GAO analysis of state agencies' responses to survey.

Note: The survey question was as follows: Which, if any, of the following types of government operated facilities providing residential targeted (Child Welfare, Health Mental Health, Juvenile Justice) services for youth are currently exempt from licensing or monitoring in your state by statute or state regulation—state operated facilities? Response options were (a) exempt from licensing by our agency, (b) exempt from routine monitoring by our agency, (c) exempt from both (d) not exempt from either, (e) no such facility in state, (f) don't know, (g) no response.

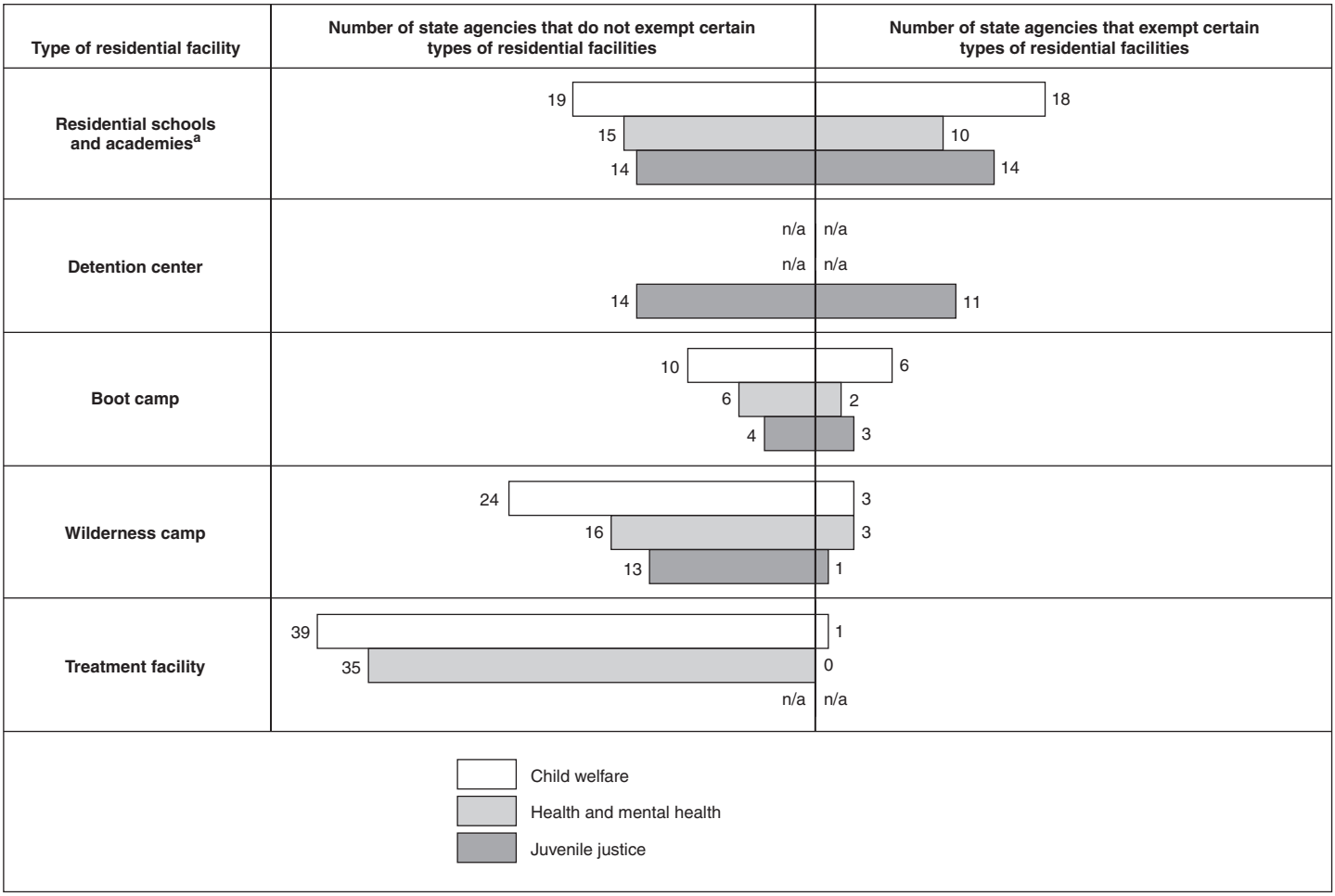
Many state agencies also reported that certain types of private facilities were exempt from licensing, regardless of whether they received some government funding or were exclusively private (see fig. 6). Private residential schools and academies—a category that includes boarding schools and training or reform schools—were exempted more often from licensing than other types of private facilities, according to survey respondents. Conversely, treatment facilities were the type most commonly required to have a license. Agencies in six states reported they

exempted faith-based facilities from licensure.[20] However, many agencies reported not knowing the licensing status of certain types of private facilities or reported that they did not have certain types of facilities in their state. Across agencies, states most often responded that they did not have private boot camps, ranches, and wilderness camps.[21]

[20] These six states were Arizona, Arkansas, Iowa, Maine, Missouri, and South Carolina. In addition, licensing officials we interviewed in Florida stated that faith-based facilities had the option of being licensed by the state or by a faith-based licensing authority. Note: The survey question was as follows: Which, if any, of the following types of private facilities providing residential targeted services for youth are currently exempt from licensing or routine monitoring in your state by statute or state regulation—Faith-based facilities? (a) exempt from licensure by our agency, (b) exempt from routine monitoring by our agency, (c) exempt from both, (d) not exempt from either, (e) no such facility in state, (f) don't know, (g) no response.

[21] Among state juvenile justice survey respondents, for example, 25 reported having no private boot camps in their state that received government funding, 22 reported having no ranches, and 17 reported having no wilderness camps. Somewhat fewer survey respondents reported not having exclusively private boot camps (19), ranches (17), and wilderness camps (14).

Figure 6: Number of State Agencies Reporting That They Do Not Exempt or Exempt Private Residential Facilities Receiving Government Funds from Licensing Requirements, 2006



Source: GAO analysis of state agencies' responses to survey.

Notes: The total number of agency responses for a specific facility type does not include instances in which agencies reported that there was no such facility in the state, they did not know, or that they did not respond.

The survey question was as follows: Which, if any of the following types of residences that provide targeted services for youth are currently exempt from licensing or routine monitoring in your state by statute or state regulations? The response options were (a) exempt from licensure, (b) exempt from monitoring, (c) exempt from both, (d) not exempt from either, (e) no such residence in the state, (f) don't know, and (g) no response.

[a]Responses for this type include all private facilities, not just those receiving government funding.

One reason that private residential facilities may be exempt from licensing requirements is that state agencies do not have the necessary statutory or regulatory authority. Regarding residential schools and academies, for example, all agencies in 15 of the 33 states that responded to all three agency surveys reported that they did not have either the authority or the regulatory responsibility to license these facilities.[22]

The lack of licensing for all facilities serving youth has several consequences. Within individual states, facility operators may bypass state licensing requirements by self-identifying their business as a type that is exempt from state licensing. In Texas, for example, a residential treatment program self-identified as a private boarding school is not regulated by the state licensing agency, but the same facility would be required to obtain a license if it self-identified as a residential treatment center or therapeutic camp. Inconsistent licensing practices across states can have implications as well. For example, a 2007 directory showed that Utah, which only recently implemented licensing requirements covering wilderness camps, was home to over 25 percent of registered wilderness programs in the United States.

Facility licensing is also important because parents and others considering placing youth in private facilities at their own expense do not always have the information they need to screen facilities and make an informed decision. In our testimony on private facilities last October, we described cases in which program leaders told parents their programs could provide services that they were not qualified to offer, claimed to have credentials in therapy or medicine that they did not have, and led parents to trust them with youth who had serious mental disabilities. One national association for programs serving youth with behavioral and emotional difficulties testified before Congress that state licensing was important because the field does not currently have the capacity to certify facility integrity.

Certain states have taken different approaches to improve oversight of residential facilities. Some states are considering laws that would expand their licensing authority for private facilities, while other states use alternative methods to provide protections for youth. For example, some

[22] Two of the 15 states—Massachusetts and Utah—have a central agency that is responsible for licensing residential facilities.

state agencies include requirements addressing youth well-being in contracts facilities must sign to serve youth under state care. Florida officials estimated that 85 percent of residential facilities in the state's juvenile justice system are private facilities under contract with the state. Florida's juvenile justice system uses the contract provisions to help ensure that facilities provide youth with needed services in compliance with agency regulations as well as state statutes.

Accreditation is another method used by some states in lieu of, or to augment, state licensing requirements. For example, Ohio and Wyoming require specific health-related facilities to obtain accreditation instead of licensure as a condition to serving youth under state care. Of the states responding to our survey, a greater number of health and mental health agencies compared to other agencies reported requiring facilities to be accredited by private organizations, due in part to conditions of participation for certain federal programs.[23] The accreditation process may require providers to meet higher standards than those required by state licensing bodies. However, accreditation does not necessarily ensure the safety and well-being of youth. Officials from an accrediting organization told us that they do not always inform the state if a facility's accreditation status has been suspended or limited; such information sharing is dependent on how well state agencies coordinate with them. In general, fewer states reported requiring accreditation than not across the three agencies we surveyed, as shown in appendix V.

State Licensing Standards Do Not Consistently Address Suicide and Other Identified Risks to Youth Well-Being

Licensing standards that states have in place for certain government and private residential facilities address many, but not all, of the most common risks to youth well-being that states had identified in our survey. Standards based on sound research can help ensure that youth receive minimum standards of care that address risks to well-being across facility types. Almost all states reported that when they required licensing, they required facilities to meet standards related to the safety of the physical plant, proper use of seclusion and restraint techniques, reporting of adverse incidents, and qualification requirements and background checks for

[23] For example, HHS's Medicaid program, a joint federal-state program to provide health care coverage for certain low-income, aged, or disabled individuals, requires that states providing inpatient psychiatric services in a nonhospital setting to individuals under age 21 must ensure that such services are accredited by one of three specified accrediting organizations or a comparable one recognized by the state.

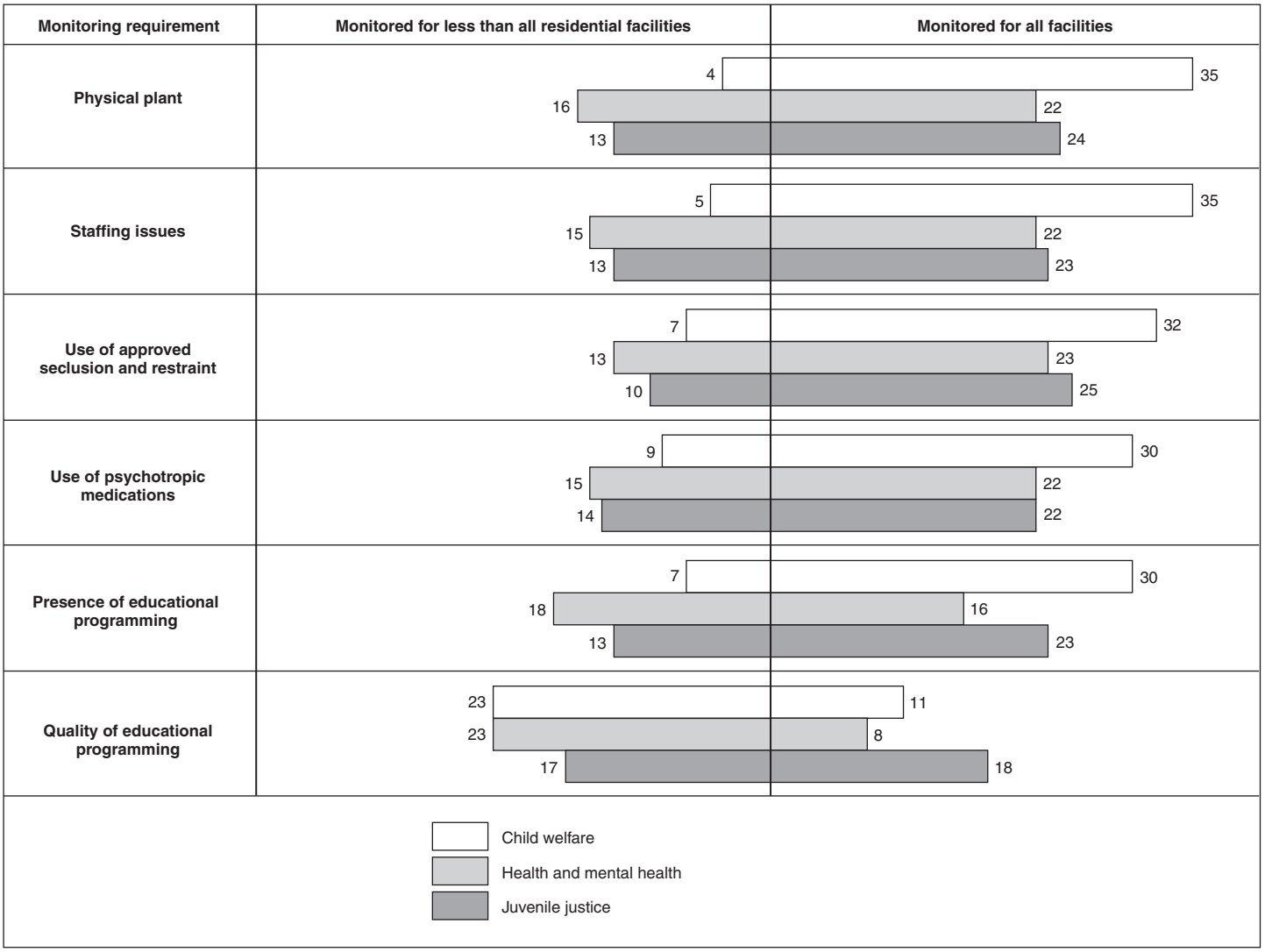
staff.[24] These standards can help reduce the risk of harm due to accidental causes and staff maltreatment. However, other requirements addressing risks to youth are less often included as a part of licensing. For example, while states reported that almost all juvenile justice facilities are required to have written suicide prevention plans, about a third of state child welfare and health and mental health agencies reported that they do not have similar requirements for government facilities. In addition, most of the agencies in our survey did not require private facilities to have written suicide prevention plans. (See app. VI.)

Monitoring May Not Be Comprehensive or Frequent Enough to Protect All Aspects of Youth Well-Being

State agencies reported monitoring youth well-being in residential facilities, but certain aspects of youth well-being were not included in all monitoring activities. Among six different aspects of youth well-being we asked about in our survey, the quality of educational programming and use of psychotropic medications were most likely to be reviewed at only some, or none, of the facilities monitored by child welfare, health and mental health, and juvenile justice agencies. Conversely, staffing issues were most often included in all monitoring reviews of government and private facilities. (See fig. 7 for results pertaining to private facilities that receive government funds, and app. VII for results pertaining to state-operated facilities, private facilities that received government funds, and exclusively private facilities.)

[24] The survey question was as follows: When your agency develops or opens a government-operated residential facility that provides targeted services to youth, is the facility required to meet state standards in any of the following areas? (a) pass inspection of physical plant, (b) provide evidence of safe child care practices, (c) have written procedures for reporting physical or sexual abuse or neglect of youth, (d) meet all staff qualifications requirements including training, (e) perform staff background checks, (f) meet specified staff-to-child ratios, (g) provide evidence of appropriate educational programming, (h) have procedures in place for use of approved seclusion and restraint techniques, (i) have written suicide prevention plans. A similar question was asked for asked for private facilities.

Figure 7: Aspects of Well-Being Monitored by State Agencies in Private Residential Facilities That Served Youth and Received Government Funding



Source: GAO analysis of state agencies' responses to survey.

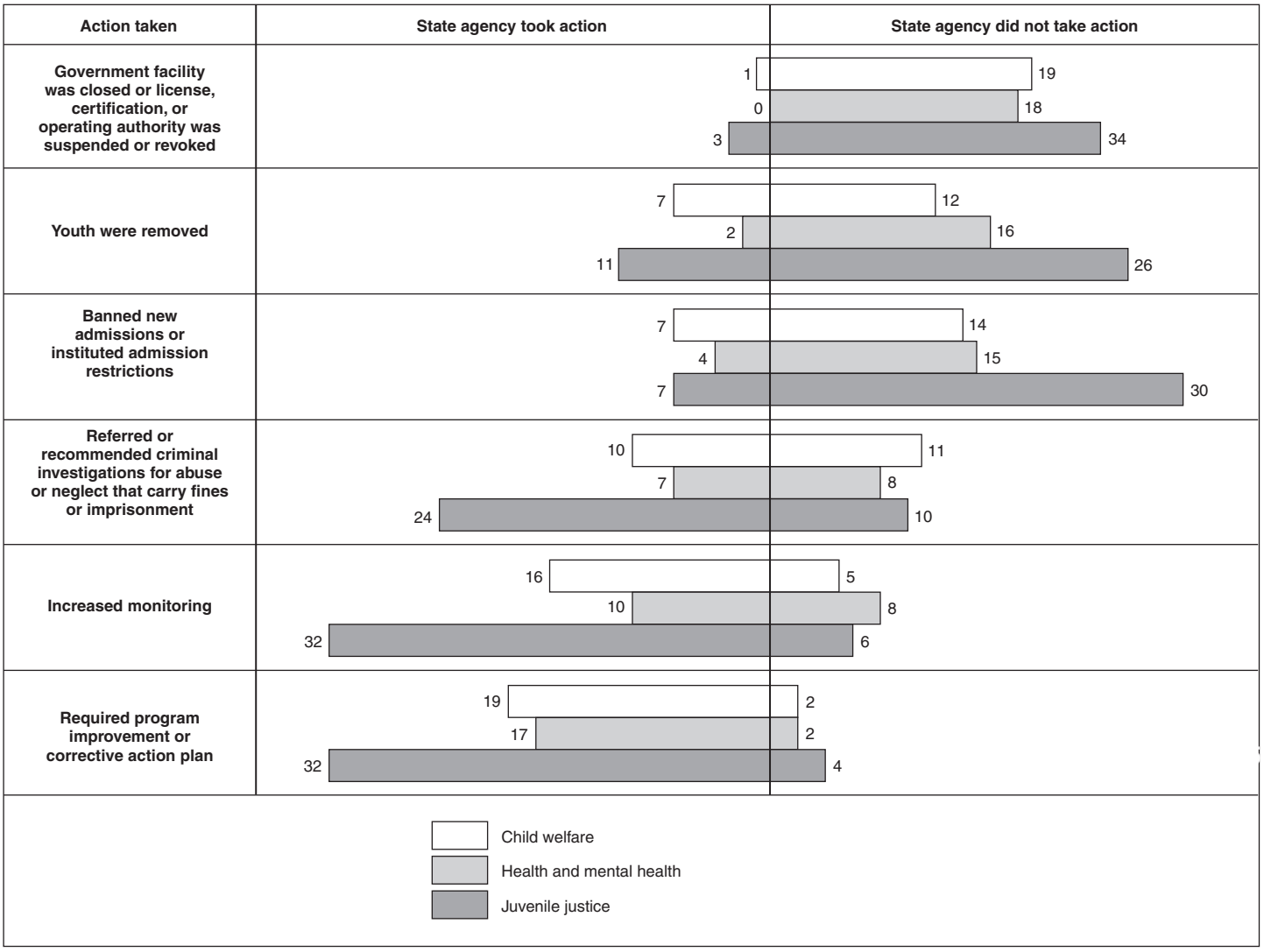
Note: The survey question was as follows: In 2006, did your agency routinely monitor or followup, or authorize for monitoring or followup, any of the following issues—in the absence of a complaint—at private residential facilities that received government funding providing targeted services for youth? Response options for this question were (a) yes, monitored for all; (b) yes, monitored for some; (d) no, did not monitor; (e) no such facility in the state; (f) don't know; (g) no response.

Three of the four states we visited reported that they were unable to meet their goals for conducting annual monitoring visits at residential facilities due to a lack of resources. Periodic on-site reviews to monitor facility

compliance with licensing requirements helps ensure that licensing standards are taken seriously, and that risks to youth well-being are quickly addressed. States reported that visiting facilities was necessary at least once a year, if not more often, to ensure that conditions for youth had not changed due to changes in personnel, ownership, or funding. However, the number of facilities visited each year depended on the fluctuating levels of resources committed by the state. In Maryland, agency officials said that state resources were redirected, as necessary, to meet state goals for monitoring residential facilities for youth. In Florida and Utah, however, agency officials said that imbalances between the current workload and staff resources constrained the state's capacity to conduct efficient, effective, and timely monitoring of residential facilities. A facility operator in California said that on-site monitoring had been as infrequent as once every 5 years.

State agencies reported on actions taken against facilities in the last 3 years, but few reported suspending or revoking a facility's operating license. A full range of enforcement options allows states to respond to maltreatment in accordance with the severity of the incident and to escalate penalties as necessary to help prevent reoccurrence. Survey respondents, however, often reported that they did not employ the full range of enforcement options against the residential facilities under their purview. For example, most state agencies in our survey reported taking action to increase monitoring of facilities with identified problems, or requiring corrective action plans (See app. VIII and fig. 8). Maryland state officials said that they may be less likely to close facilities when they fall below state standards if there is a shortage of facilities in the state, and closing the facility would limit the state's ability to serve the youth who would be displaced by a closing. In addition, these officials noted that shutting down a facility is extremely disruptive to the youth who are placed there. For these reasons, states may agree to keep a program open if a facility meets certain conditions. For example, we previously reported that, in West Virginia, a program's owners pleading no contest to the charge of child neglect resulting in death negotiated an agreement with the state to keep the program open in exchange for a change in ownership and management.

Figure 8: State Agency Actions Taken within the Last 3 Years against Government Residential Facilities



Source: GAO analysis of state agencies' responses to survey.

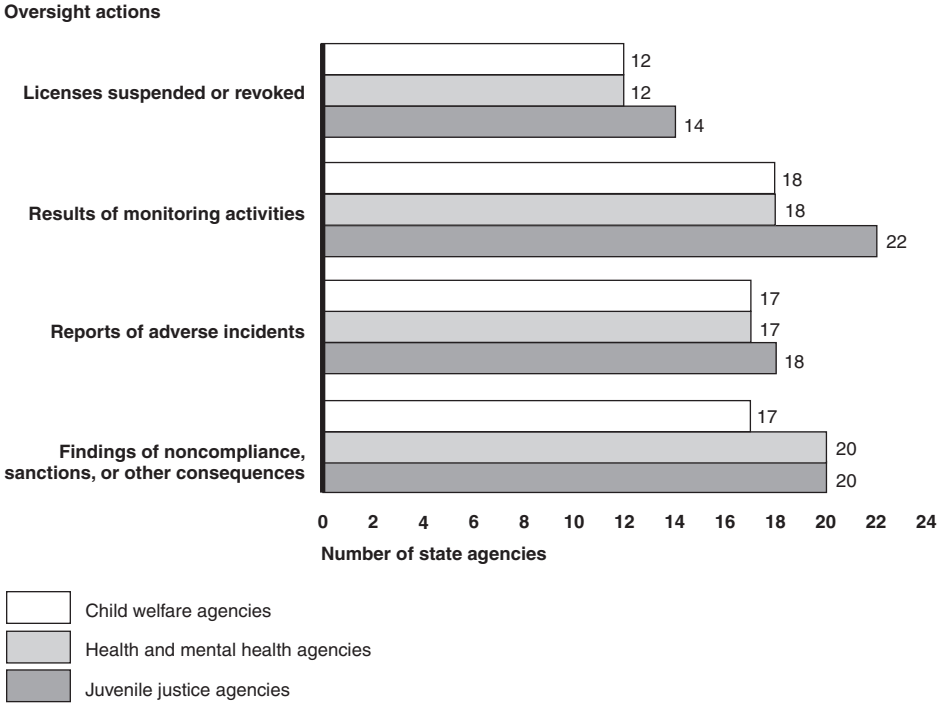
Note: The survey question was as follows: Over the last 3 reporting years, did your agency take any of the following actions at its government-operated facilities as a result of allegations or findings of noncompliance, improper operations, physical abuse or sexual abuse or neglect of youth, or other negative outcomes? Respondents could also answer "don't know" or "no response."

Coordination Needed within and among States for Youth Served by Multiple Agencies or across State Lines

Improving coordination to share information among state agencies was a high priority for improving oversight of residential facilities according to survey respondents. Such coordination is needed because some youth may have needs requiring a multi-agency response. A lack of coordination in these instances can result in situations where monitoring activities overlap at some facilities and aspects of youth well-being in other facilities fall through the cracks. Officials in the states we visited raised concerns that ensuring facilities have appropriate education programs for youth is particularly challenging unless state agencies coordinate their oversight efforts. Lack of coordination, particularly with the state education agency, has resulted in cases where facilities remain licensed to operate even though education quality is poor and youth may be unable to transfer education credits upon returning to schools within their communities.

Many state agencies we surveyed reported that they did not routinely share information with other state agencies regarding negative findings from their monitoring reviews of residential facilities, or when facility licenses were suspended or revoked (see fig. 9). Sharing such information is important because it may influence another agency's decision to place youth in the facility.

Figure 9: Number of State Agencies Reporting That They Did Not Routinely Share Oversight Information Regarding Certain Residential Facilities



Source: GAO analysis of state agencies' responses to survey.

Note: The survey question was as follows: What oversight information regarding residential facilities does your agency routinely share with other state or local government agencies or place on an accessible Web site? Response options for this question were (a) new licenses issued; (b) licenses suspended or revoked; (c) plans to expand or reduce programs; (d) schedule of upcoming routine monitoring activities (e.g., record reviews or site visits); (e) results of monitoring activities; (f) reports of adverse incidents; (g) findings of noncompliance, sanctions, or other consequences not listed above.

Improving coordination among agencies across states is also important because almost all states reported in our survey that they placed some youth in out-of-state residential facilities. These interstate placements can be initiated by state agencies or private parties, such as parents. Out-of-state placement is more difficult than in-state placement, but may be used when the demand for services exceeds the state's capacity, particularly for cases requiring highly specialized services—such as therapeutic treatment for youth who committed arson, or who were involved in gangs. State agencies or parents may also place youth in other states where family members reside. Table 3 shows the top five states in which state child welfare agencies we surveyed reported the greatest number of youth in out-of-state residential facilities.

Table 3: State Child Welfare Agencies Reporting the Greatest Number of Youth Placed in Out-of-State Residential Facilities

Sending state	Total number of youth	Number of placement states
California	1,903	26
Pennsylvania	593	18
Alaska	482	14
Rhode Island	330	11
Connecticut	282	13

Source: GAO analysis of state child welfare agency survey responses.

Note: The survey questions were as follows: (1) As of October 1, 2006, how many youth from your state were residing in residential facilities providing targeted services in other states? Response options: (a) number of youth under the care and supervision of your agency residing in facilities operated by another state or local government agency, (b) number of youth under the care and supervision of your agency residing in private facilities in the other state, (c) number of youth under parental or nongovernment custodial care residing in private facilities in the other state? Respondents could also check not available. And (2) On October 1, 2006, in what other states were youth under the care and supervision of your agency residing?

Another reason that interstate coordination is important is to ensure that agencies sending youth for placement in other states are able to screen out facilities that have had negative findings uncovered during monitoring reviews or have outstanding allegations of maltreatment. Such information may be particularly important in cases where state licenses cannot serve this purpose. Four of the top five states that received the greatest number of out-of-state youth (see table 4)—according to child welfare agencies we surveyed—exempted one or more types of facilities from state licensing requirements.

Table 4: State Child Welfare Agencies Reporting the Greatest Number of Youth Received from Other States for Placement in Residential Facilities

Receiving state	Number of youth	Number of sending states
Utah	1,827	38
Pennsylvania	1,778	5
Montana	1,060	5
Massachusetts	628	15
South Carolina	336	26

Source: GAO analysis of state child welfare agency survey responses.

Note: The survey questions were as follows: (1) As of October 1, 2006, how many youth under the care and supervision of other states, any trial jurisdictions, or countries other than the United States were residing in residential facilities providing targeted services in your state? Response options: Number of (a) youth placed in facilities operated by your state agency and (b) youth placed in private facilities in your state? Respondents could also check not available. And (2) On October 1, 2006, from what other states were youth aged 12 to 17 residing in residential facilities providing targeted services in your state?

Finally, our testimony last October showed that information sharing across states is also important because operators of programs shut down in one state for youth maltreatment or death due to negligence sometimes open new programs in another state, and states with weaker licensing and monitoring practices may be especially vulnerable to this practice. Our testimony last October highlighted a 1990 case where a wilderness camp operator moved from Utah to Nevada, and back to Utah as facilities were repeatedly shut down by authorities, and how many youth died in two of these programs.[25]

Federal Agencies Challenged to Address Weaknesses in State Oversight of Residential Facilities

HHS, DOJ, and Education all have oversight processes to hold states accountable for the well-being of youth in certain residential settings under the grant programs they administer. However, limitations in federal oversight authority and inconsistent monitoring practices hinder federal efforts to ensure that states are keeping youth in residential facilities safe from harm. Most notably, these agencies cannot hold state agencies accountable for conditions in private facilities unless the facilities serve youth in state programs supported by federal funds. When they did have the authority, agencies differed in their oversight practices regarding the extent that agencies had established program requirements specific to residential facilities, had conducted on-site reviews of residential facilities, and had taken actions to enforce compliance with federal requirements.

HHS, DOJ, and Education Cannot Hold States Accountable for Exclusively Private Facilities

HHS, DOJ, and Education have some authority to hold states accountable for certain aspects of youth well-being in facilities that serve youth under the grant programs they administer—whether state operated or private—but cannot hold states accountable for conditions in facilities that are exclusively private. The federal government has oversight authority in cases where states voluntarily choose to accept federal requirements in exchange for receiving federal

[25] GAO, Residential Treatment Programs: Concerns Regarding Abuse and Death in Certain Programs for Troubled Youth (GAO-08-146T, Washington, D.C.: Oct. 10, 2007).

program funds.[26] In practice, states have agreed to comply with federal oversight requirements in exchange for funds supporting their state systems of child welfare, health and mental health, juvenile justice, and education. Accordingly, under the federal programs that we examined at HHS, DOJ, and Education, states are accountable for ensuring that facilities receiving funds through these programs are in compliance with federal program requirements. However, these agencies cannot hold states accountable for conditions in exclusively private facilities.

Federal Requirements Do Not Always Address Suicide Prevention and Other Risks to Youth Well-Being

Federal agencies and programs do not always hold states accountable for addressing some of the primary risks to youth well-being in residential facilities. In comparing requirements across HHS, DOJ, and Education, only HHS reported requiring states to address abuse and neglect prevention under certain federal programs. (See table 5.)

Table 5: Federal Program Requirements for States That Address Certain Risks to Youth Well-Being in Residential Facilities

Agency and subagency	Abuse and neglect prevention	Suicide prevention	Use of seclusion and restraint	Education quality
HHS				
Child Welfare	Yes	No	No	Yes
Medicaid	Yes	Yes	Yes[a]	No
Substance Abuse and Mental Health	No	No	No	No
DOJ				
Juvenile Justice and Delinquency Prevention	No	No	No	Yes
Education				
Elementary and Secondary Education	No	No	No	Yes[b]
Special Education and Rehabilitative Services	No	No	No	Yes[b]

Source: Analysis of U.S. Department of Health and Human Services, DOJ, and Education documents.

[a]Applies only to psychiatric residential treatment facilities.

[b]Applies only to public agencies and children placed by public agencies in private facilities.

[26] Congress, as part of its spending power under Article I, Section 8, of the U.S. Constitution, can attach conditions to states' receipt of federal funds.

HHS, DOJ, and Education all reported that they do not have the authority to require that states have suicide prevention plans as a criterion for receiving funds under the grant programs that they administer, although HHS and DOJ have documented a need to address suicide prevention. The Centers for Disease Control and Prevention—which is part of HHS—issued a report that identified suicide as the third leading cause of death in 2004 among all U.S. youth.[27] In addition, a 2004 study commissioned by DOJ recommends increased mental health screening for suicide prevention among incarcerated youth.[28] DOJ officials we spoke with generally agreed with the need to focus on suicide prevention in residential facilities, and suggested that additional federal requirements in this area would be helpful. DOJ and HHS have Web sites that list resources states can use for this purpose, but HHS officials said that states are more responsive to a requirement or more specific agency guidance.

Similarly, agency officials said that federal programs also do not require that states ensure the proper use of seclusion and restraint practices, which have come under intense scrutiny in recent years. Researchers and clinicians have chronicled the inherent physical and psychological risks in each use of these types of interventions—including death, disabling physical injuries, and significant trauma. Currently, federal seclusion and restraint requirements cover youth placed in psychiatric residential treatment facilities that receive Medicaid payments. However, requirements do not extend to other types of facilities, and federal officials told us that these techniques continue to be used in ways that sometimes cause injury and death. HHS is preparing a draft notice of proposed rule

[27] For additional information see Department of Health and Human Services' Centers for Disease Control Morbidity and Mortality Weekly Report on *Suicide Trends among Youths and Young Adults Aged 10-24 years—United States, 1990-200*, (Atlanta, Georgia, Sept. 7, 2007 / 56(35); 905-908).

[28] National Center on Institutions and Alternatives. Juvenile Suicide in Confinement: A National Survey. February 2004.

making concerning the use of seclusion and restraint in nonmedical community-based children's facilities.[29]

Federal Oversight Does Not Ensure States Are Monitoring Youth Well-Being in Residential Facilities

Federal agencies have several means of ensuring that states are monitoring youth well-being in residential facilities that receive government funds, but perhaps one of the most rigorous is unannounced site visits to the youth's place of residence. According to the federal and state officials we spoke with, only an on-site visit to the facility can reveal whether services in the administrative reports are provided under conditions that ensure youth well-being. For example, DOJ officials observed that students in one of the facilities they visited received their educational instruction while in cages, and reported that it would have been difficult to detect this practice in an administrative review.

Among the federal agencies we reviewed, all included on-site visits to states to ensure compliance with federal requirements, but agencies did not always include visits to residential facilities. DOJ officials target juvenile justice facilities, such as correctional facilities and detention centers, during on-site reviews to determine state compliance with specific statutory requirements, but HHS oversight reviews of state child welfare systems do not necessarily include children in residential facilities. HHS selects a sample of child case files for site visits, and because most children are in foster home settings, residential facilities are usually not included.

Similarly, while federal agencies have authority to enforce state compliance with federal requirements, these provisions vary in their rigor and use, and only DOJ has levied financial penalties.[30] To date, HHS and Education have required state corrective action plans as a method of

[29] This draft notice has been submitted for departmental review and clearance. This rule is being promulgated in response to the Children's Health Act of 2000 (Pub. L. No. 106-310, Title XXXII, § 3208 (amending Title V of the Public Health Service Act)), which requires that public or private nonmedical, community-based facilities for children receiving support in any form from any program supported, in whole or part, with funds appropriated under the Children's Health Act, shall protect and promote the rights of each resident of a facility, including the right to be free from any restraint or involuntary seclusion imposed for purposes of discipline or convenience. The statute requires HHS to define in regulation the types of facilities covered by this provision's requirements.

[30] Federal funding was reduced by $1,552,200 among eight states and territories in 2007.

enforcement, but officials said that they may also assess financial penalties in the future.

Options for Taking Action to Promote Youth Well-Being in Residential Facilities

Protecting youth in residential facilities—many of whom are troubled and vulnerable to harm either from themselves or from others—requires particular vigilance on the part of parents and responsible governmental agencies. However, abuse, neglect, and civil rights violations documented in all types of residential facilities—government and private, licensed and unlicensed—show that the current federal-state oversight structure is inadequate to protect youth from maltreatment. States, federal agencies, and Congress have several options that they can use to improve standards of well-being for youth in residential facilities, monitor facility compliance with the standards, and take necessary corrective action. Although individual states are primarily responsible for taking action to improve the welfare of youth domiciled within their borders, federal agencies may establish additional safeguards for those youth that are served in residential facilities under federally funded state programs. Further, Congress has several options to consider—such as direct regulation of residential facilities, modifying conditions of participation for existing federal programs, and creating new program funding and requirements. Each of these options entails trade-offs among the cost to the government, the extent of federal involvement, and the extent that protections would apply to youth in various types of facilities.

- *States*. States could take action to improve the well-being of youth in residential facilities through their licensing processes, contract provisions, or accreditation requirements. Expanding licensing coverage would allow states to establish minimum standards for youth in all facilities, but may require state legislation to provide necessary authority, as well as increased funding for oversight and enforcement. Creating common contract provisions for facilities serving youth is another way state agencies could safeguard youth well-being across state agencies for those private facilities under contract with the state. Accreditation for all facilities that serve youth is another option that could benefit states in several ways. Accreditation by a national organization provides universal standards that are applied not only within states, but across state lines. Accreditation in lieu of licensing requirements may help minimize increases in state spending as a result of expanding oversight coverage.

- *Federal agencies*. Federal agencies could also take action by holding states accountable for the well-being of youth in residential facilities that participate in programs supported by federal funding—such as state child

welfare, health and mental health, and juvenile justice programs. Federal agencies could increase state accountability by modifying the conditions of participation for relevant programs. These program conditions could include priorities for placing youth first in facilities that are accredited or held to recognized standards of care, or include specific standards of well-being and oversight, such as suicide prevention and seclusion and restraint. This may be most effective if the federal agencies worked together to develop minimum standards for all relevant federal programs, possibly through an interagency council or the Office of Management and Budget. If the federal agencies determine they do not have authority to modify program conditions of participation, they could seek such authority from Congress. This option would not increase federal program spending, but federal agency action would not extend to exclusively private facilities.

- *Congress*. Congress also has several options to consider. These options include direct federal regulation of facilities that house youth under certain conditions, or establishing conditions of participation in existing or new federal programs.[31] These options are not mutually exclusive—some may be taken in combination with other federal or state action.

- *Direct regulation*. States have reported that thousands of youth are placed in out-of-state facilities, and we have previously testified before Congress on the extent of marketing and advertising across states lines. Under the Constitution, Congress would have a basis to directly regulate private facilities that participate in activities involving interstate commerce.[32] Congress might regulate such facilities by establishing a federal program that preempts state law and regulation, or provide states the option of carrying out an equivalent state program. These actions would result in increased federal spending. Congress could choose to minimize federal spending and oversight activities by requiring accreditation of residential

[31] See related discussion in a recent report by the Congressional Research Service, *Family Law: Congress's Authority to Legislate on Domestic Relations Questions*, Updated October 25, 2007, Washington, D.C. (RL31201).

[32] For example, the Commerce Clause serves as the basis for federal regulation of child pornography that moves in interstate or foreign commerce. Moreover, courts have found that the Child Support Recovery Act, which criminalizes failure to pay past child support obligations to a child residing in a different state than the parent, is a constitutional exercise of congressional authority under the Commerce Clause.

facilities by a national organization.[33] In considering a federal mandate, Congress may need to evaluate concerns about federal versus state responsibilities, practical feasibility, and the ability to offset attendant costs to the federal government. This option would have the benefit of capturing exclusively private facilities, but only those facilities that have the requisite connection to interstate commerce.

- *Add requirements in law to existing federal programs*. Congress could change existing program law to add requirements states must meet to receive federal programs funds. For example, it could include specific standards of well-being and oversight in areas where youth are known to be at risk, such as suicide prevention and seclusion and restraint. This would provide the advantage of developing minimum requirements for youth well-being that cut across agencies and programs. This option would not increase federal program spending. However, because it is directed at federal programs that provide funding to states, it would not safeguard youth in exclusively private facilities.

- *Establish a new federal program*. Congress could also establish a new federal program that would provide financial assistance to states that agree to comply with federal requirements, such as those to expand the scope and rigor of oversight to cover all residential facilities. This option would address oversight coverage for youth in all facilities in a state, but would be effective only in states that choose to comply with federal requirements in exchange for the new program funding. This option would also increase spending for the federal government.

Conclusion

States' freedom to legislate and the existing patchwork of federal legislation and oversight addressing youth well-being have led to substantial disparity in protecting the well-being and civil rights of some of the nation's most vulnerable youth. There are no easy solutions. However, states, federal agencies, and Congress have various options to consider in restructuring the current federal-state oversight system to better protect youth from harm. While Congress, federal agencies, and states will need time to consider these options, and weigh the trade-offs that each option

[33] The Centers for Medicare & Medicaid Services, for example, have accreditation requirements for certain facilities as a condition of payment under its programs. To be effective, this approach would require a mechanism to ensure that the accrediting body communicates any problems or loss of accreditation to the appropriate state and federal entities.

entails, more can be done now within the existing regulatory structure to address outstanding concerns.

State and federal agencies acknowledge the need for comprehensive and complete data for each case of death, maltreatment, and other adverse incidents that occur in residential facilities, but barriers remain in collecting and reporting this information. Absent complete data and mechanisms to share information among relevant state and federal oversight agencies, officials are missing opportunities to assess the full magnitude of child maltreatment in residential facilities and respond to the extent of their authority in addressing issues or targeting investigations, such as those conducted by DOJ's Civil Rights Division. Further, absent enhanced oversight among federal agencies, these agencies will continue to miss opportunities to use available information to address identified risks to youth and hold states accountable for youth well-being under the current regulatory structure. Unless sufficient accountability is set up within state or federal regulatory structures using the oversight processes provided by federal program authority, state licensing systems, national accreditation, or other options, the well-being and civil rights of youth in some facilities will remain at risk.

Recommendations for Executive Action

To help policymakers craft solutions that best address the magnitude of maltreatment and other threats to youth well-being in residential facilities, and also to facilitate federal oversight across states and agencies, we recommend that the Secretary of HHS take action to determine what barriers remain in those states that do not report case-file data for residential facilities to NCANDS and explore options to help states address existing barriers.

To help target federal civil rights investigations among states and facilities that can provide maximum benefit, we recommend that the U.S. Attorney General work with the Secretary of HHS to obtain access to the NCANDS case-file data for residential facilities. We also recommend that the Attorney General work with HHS, the Office of Juvenile Justice and Delinquency Prevention, and Education to obtain access to other sources of relevant information within relevant subagencies, such as HHS' Centers for Disease Control and Prevention.

To help ensure that the existing federal regulatory structure protects youth well-being across government and private residential facilities supported by federal programs, we recommend that HHS, DOJ, and Education work to enhance their oversight of state accountability for youth well-being in

residential facilities. Such efforts could include ensuring that residential facilities are included in federal oversight reviews and on-site visits to states.

Agency Comments and Our Evaluation

We provided a draft of this report to HHS, DOJ, and Education for comment. HHS' comments are reproduced in appendix X, and DOJ's comments are reproduced in appendix XI. Education's Office of Special Education and Rehabilitative Services provided comments on behalf of the department that are reproduced in appendix IX. HHS and DOJ also provided technical comments that we incorporated, as appropriate.

Federal Agency Comments on GAO Report Recommendations

Overall, HHS and DOJ either generally agreed, or did not disagree, with each of our recommendations. They also suggested further action that could be taken to address the report findings related to gaps in data and oversight for residential facilities. Education did not directly respond to the report recommendations but rather discussed its role and responsibilities for oversight of certain programs.

HHS did not agree or disagree with our recommendation that the Secretary take action to identify and help states address barriers in reporting case-file data for residential facilities to NCANDS, and DOJ did not comment on this recommendation. HHS stated that the number of states reporting case-level data and the quality of data submitted has improved over the years, and that its Administration for Children and Families (ACF) will continue to work with states to improve the collection of information wherever possible and feasible. We recognize that federal law provides states with some latitude in reporting data "to the maximum extent practicable." However, we remain concerned about the gaps in reported data that have persisted over a decade since the reporting requirement has been in place, which is why we have recommended that HHS take action to help address remaining barriers.

DOJ agreed with our recommendation that the Attorney General work with the Secretary of HHS to obtain NCANDS data that can help target civil rights investigations. HHS stated that ACF would be pleased to work with DOJ in implementing this recommendation; however, ACF was unclear how the NCANDS data would be useful in targeting investigations. As our report shows (see app. III), custom data analysis provided by HHS's NCANDS contractor provides important information on the number and type of maltreatment incidents by facility staff in each state that DOJ can use, in combination with other information sources, to prioritize investigations among states.

DOJ also agreed with our recommendation that the Attorney General work with its Office of Juvenile Justice and Delinquency Prevention, HHS, and Education to obtain access to other sources of relevant oversight information within the subagencies of these departments. HHS did not address this recommendation.

In regard to our recommendation that HHS, DOJ, and Education work to enhance their oversight of state accountability for youth well-being in residential facilities, DOJ and HHS indicated that they are conducting state oversight consistent with existing statutory authority and resources. In addition, DOJ cited several measures it has implemented, such as training and technical assistance to states as well as use of interdepartmental working relationships, which will help ensure that the existing federal regulatory structure protects youth well-being across facilities supported by federal programs. We agree that the efforts cited by DOJ can help to improve conditions for youth in residential facilities. However, given the continued reports of maltreatment in residential facilities by state agencies we surveyed, and results of investigations by DOJ's Civil Rights Division, we continue to recommend that HHS, DOJ, and Education seek to identify ways to enhance their oversight of state accountability for youth well-being. For example, HHS and Education could include residential facilities in federal oversight reviews. Also, our recommendations focus on agency actions that could be done or begun quickly under the current legal and regulatory framework; however, in our discussion of policy options we identify additional longer-term measures that federal agencies could consider taking. For example, agencies could modify the conditions of participation for relevant grant programs to require states to give priority to facilities that are accredited or held to recognized standards of care. We further note that if these agencies determine they do not have authority to do this, they could request it from Congress.

DOJ and HHS also commented on further actions that federal agencies could take beyond the GAO recommendations. Specifically, DOJ identified interagency coordination as an important way to enhance youth well-being in residential facilities and stated that the existing Coordinating Council on Juvenile Justice and Delinquency Prevention could be used for this purpose. DOJ suggested that this council could be a vehicle establishing minimum standards of care for all relevant federal programs. We offer a similar approach in our discussion of longer-term policy options. HHS noted the likely benefits of requiring facilities to notify parents of certain actions, such as disciplinary actions, restraint, or seclusion.

Finally, HHS stated that the report findings and recommendations should more prominently address the issue of unlicensed facilities. In our discussion of longer-term policy options, we note that states could improve the well-being of youth in residential facilities by expanding their licensing coverage, among other options. We also describe actions Congress could take to address gaps in licensing and oversight since, under the current framework, federal agencies do not have oversight authority for private facilities unless those facilities serve youth in state programs supported by federal funds. However, we also note that many facility types are licensed and that licensing alone, absent comprehensive standards, regular monitoring, and effective use of sanctions for noncompliance, cannot ensure youth well-being in residential facilities.

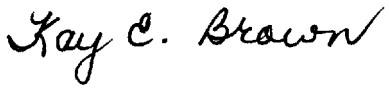
Education commented that while it is responsible for ensuring state compliance with certain federal education programs for youth—and recognizing that a protective and safe school environment is necessary for all students—it is not in the department's statutory or regulatory authority to ensure oversight of the total well-being of youth in residential facilities. Although Education would not be responsible for the total well-being of these youth, we believe that the report findings highlighting the gaps in safeguarding the educational well-being of youth in residential facilities warrant greater Education oversight of state accountability for the education of youth in residential facilities.

Federal Agency Comments on GAO Report Findings

HHS commented that table 5 of the report shows that the Substance Abuse and Mental Health Services Administration has no program requirements that address certain risks to youth well-being, and noted that the agency has no regulatory oversight of individual residential facilities at the local level. To clarify, the federal program requirements in table 5 do not relate to federal requirements for individual facilities, but to federal program requirements for state oversight of residential facilities, as stated. The report text following the table states the position of HHS, DOJ, and Education that they do not have the authority to require states to address these risks in their oversight of facilities.

Copies of this report are being sent to the Honorable Margaret Spellings, Secretary of Education; the Honorable Michael O. Leavitt, Secretary of Health and Human Services; the Honorable Michael B. Mukasey, U.S. Attorney General; and relevant congressional committees and other interested parties. We will also make copies available to others upon request. In addition, the report will be made available at no charge on GAO's Web site at http://www.gao.gov. Please contact me on (202) 512-7215 if you or your staff have any questions about this report. Other contacts and major contributors are listed in appendix XII.

Sincerely yours,



Kay E. Brown
Director,
Education, Workforce, and Income Security Issues

Appendix I: Objectives, Scope, and Methodology

We were asked to examine (1) the nature of the incidents that adversely affect the well-being of youth in residential facilities, (2) how state licensing and monitoring requirements address the well-being of youth in residential facilities, and (3) how federal agencies hold states accountable for youth well-being in residential facilities. We used multiple data collection methods to obtain this information. We conducted three Web-based surveys of state child welfare, health and mental health, and juvenile justice directors and conducted site visits in four states where we interviewed state officials. Because of overlapping state agency program jurisdictions, and differences in how residential treatment centers and the services they provide are defined, we were unable to quantify the number of residential facilities and youth served. We also interviewed federal child welfare, health and mental health, juvenile justice, and education officials and representatives from national organizations concerning state child welfare, health and mental health, and juvenile justice programs and federal roles and responsibilities for overseeing residential facilities. In addition, we reviewed several national studies and related GAO reports to identify adverse incidents affecting youth in residential facilities and key federal and state oversight policies and practices. Finally, we analyzed agency documentation, legislation, and other documentation related to child welfare, health and mental health, and juvenile justice programs and requirements. We performed our work between November 2006 and April 2008, in accordance with generally accepted government auditing standards.

For purposes of this study, we defined residential facilities as those that require youth—ages 12 through 17—to reside at the facility and that provide program services for youth with behavioral and emotional challenges. These types of facilities include (1) juvenile justice, youth offender, juvenile delinquency, and incorrigibility programs; (2) treatment programs for youth with behavioral, emotional, mental health, and substance abuse issues and homes for pregnant teens; (3) alternative schools, e.g., schools for discipline or character education; and (4) therapeutic group homes, such as a home that specializes in supporting and treating youth with severe emotional disorders. The types of residence

include schools, academies, camps, ranches, boarding homes, dormitories, treatment centers, and juvenile detention centers.[1]

Web-based survey

To obtain state perspectives on our objectives, we conducted three Web-based surveys of state child welfare, health and mental health, and juvenile justice directors in the 50 states, the District of Columbia, and Puerto Rico. The surveys were conducted using a self-administered electronic questionnaire posted on the Web. We contacted directors via e-mail announcing the survey and sent follow-up e-mails to encourage responses. The survey data were collected between May and September 2007. We received at least one completed survey from 50 states and the District of Columbia. We received completed surveys from 44 child welfare agencies, 45 health and mental health agencies, and 44 juvenile justice agencies. In 32 states and the District of Columbia, all three agencies completed the survey. We received at least one survey back from each state, except Puerto Rico. We invited Puerto Rico to participate in the survey but did not receive any response from its offices. This report does not contain all of the results from the survey. The survey and a more complete tabulation of the results can be viewed by accessing the following link: http://www.gao.gov/cgi-bin/getrpt?GAO-08-631SP.

Table 6: Status of State Agency Responses to GAO Survey on Residential Facilities for Youth

State	Child welfare	Health/mental health	Juvenile justice
States that responded to all three surveys			
Alaska	√	√	√
Ark.	√	√	√
Calif.	√	√	√
Colo.	√	√	√
Conn.	√	√	√
D.C.	√	√	√

[1] As a result of this definition, the following facilities were excluded from the review as they do not primarily serve adolescents or provide behavior modification services: (1) adult prisons; (2) hospitals, nursing homes, and facilities that serve youth who are medically fragile; (3) family or group foster care homes, orphanages, homeless shelters, halfway houses, and other facilities where the primary services are housing and ordinary child care; (4) recreational facilities such as summer sports camps; (5) college preparatory schools; and (6) facilities that serve only children under 12 years of age.

State	Child welfare	Health/mental health	Juvenile justice
Del.	√	√	√
Fla.	√	√	√
Ga.	√	√	√
Hawaii	√	√	√
Idaho	√	√	√
Ind.	√	√	√
Kans.	√	√	√
Mass.	√	√	√
Md.	√	√	√
Maine	√	√	√
Mich.	√	√	√
Minn.	√	√	√
Mo.	√	√	√
Mont.	√	√	√
N.C.	√	√	√
N.Dak.	√	√	√
Neb.	√	√	√
N.H.	√	√	√
N.Y.	√	√	√
Ohio	√	√	√
Pa.	√	√	√
S.C.	√	√	√
Tenn.	√	√	√
Utah	√	√	√
Va.	√	√	√
Wash.	√	√	√
Wis.	√	√	√
States that responded to two surveys			
Ala.	√	√	—
Ariz.	—	√	√
Iowa	—	√	√
Ill.	√	√	—
Ky.	—	√	√
La.	√	√	—
Miss.	√	√	—
N.Mex.	√	—	√
Okla.	√	—	√

State	Child welfare	Health/mental health	Juvenile justice
Ore.	√	—	√
R.I.	√	√	—
S.Dak.	√	—	√
Tex.	√	√	—
Vt.	—	√	√
W.Va.	—	√	√
Wyo.	√	√	—
States that responded to one survey			
N.J.	—	—	√
Nev.	—	—	√

Source: GAO analysis of state agencies' survey responses.

Note: √ = survey received, — = no survey received.

To develop the survey questions, we reviewed several national studies and related GAO reports to determine issues pertaining to the licensing and monitoring of residential facilities for youth. We analyzed agency documentation to identify the oversight roles and responsibilities of the departments of Health and Human Services, Justice, and Education. In addition, we examined related surveys administered by other organizations to identify relevant issues pertaining to adverse incidents affecting youth and state practices regarding their licensing and monitoring of residential facilities.

We worked to develop the questionnaire with social science survey specialists. Because these were not sample surveys, there are no sampling errors. However, the practical difficulties of conducting any survey may introduce errors, commonly referred to as nonsampling errors. For example, differences in how a particular question is interpreted, in the sources of information that are available to respondents, or how the data are entered into a database can introduce unwanted variability into the survey results. We took steps in the development of the questionnaires, the data collection, and data analysis to minimize these nonsampling errors. For example, prior to administering the survey, we pretested the content and format of the questionnaire with several states to determine whether (1) the survey questions were clear, (2) the terms used were precise, (3) respondents were able to provide the information we were seeking, and (4) the questions were unbiased. We made changes to the content and format of the final questionnaire based on pretest results. In that these were Web-based surveys in which respondents entered their responses directly into our database, there was a reduced possibility of data entry

error. We also performed computer analyses to identify inconsistencies in responses and other indications of possible error and called back respondents to verify responses as needed. We also collected paper documentation to support survey responses from the agencies in our case study states.

We used standard descriptive statistics to analyze survey questions. For certain open-ended survey questions, such as other causes of deaths and interstate locations where youth were placed, we used standard content analysis methods, including independent coding by two raters and tests of concurrence and rates of agreement. All disagreements between raters were resolved by discussion. In addition, an independent analyst verified that the computer programs used to analyze the data were written correctly.

While we asked state officials to complete the survey for their agency, some officials responded for their state as a whole. This includes Alaska and Nebraska's health, mental health, and substance abuse survey; Colorado's juvenile justice and rehabilitation survey; and Montana's child welfare services survey. In a few states, residential facilities are licensed by a central licensing agency whose information was not included among the three surveyed agency responses (e.g., Kansas' Department of Health and Environment; Massachusetts' Department of Early Education and Care; and Utah's Office of Licensing).

Site visits

We visited four states—California, Florida, Maryland, and Utah. We based our criteria for selecting these states on the following five criteria: (1) the breadth of state policies regarding processes for licensing and monitoring residential programs; (2) reports of child abuse, neglect, and fatalities; (3) administration of residential programs by states or by county governments; (4) initiation of broad changes to licensing and monitoring policies; and (5) geographic location of the state. During these visits, we interviewed state child welfare, health and mental health, and juvenile justice officials and collected relevant state agency policies and procedures and reports. In addition, we obtained information on adverse incidents and state licensing and monitoring practices from protection and advocacy agencies, state attorney general offices, state auditors, and U.S. Attorneys' offices in each of the four selected states. Information that we gathered on our site visits represents only the conditions present in the states and local areas at the time of our site visits. We cannot comment on any changes that may have occurred after our fieldwork was completed. Furthermore, our fieldwork focused on in-depth analysis of only a few

selected states. On the basis of our site visit information, we cannot generalize our findings beyond the states we visited.

NCANDS Data Reliability

We also obtained data on the extent, nature, and cause of youth abuse and neglect in residential facilities from Cornell University—the designated archive for the National Child Abuse and Neglect Data System (NCANDS). The Department of Health and Human Services (HHS) conducts extensive edit checks of the NCANDS for internal reliability. All edit check programs are shared with the states. HHS also funds the National Resource Center for Information Technology in Child Welfare. This resource center provides technical assistance to states to improve reporting to NCANDS, improve statewide information systems, and better utilize state data. We obtained NCANDS data for fiscal year 2005, the latest year for which such data are available, from Cornell University, the designated archive for NCANDS. We worked with representatives from Cornell who manage NCANDS to develop appropriate databases for identifying the extent, nature, and cause of youth abuse and neglect in residential facilities. Our analysis of NCANDS, however, showed that the reliability of the data could be affected by several factors, including missing state data, the differences in state definitions for NCANDS data elements, the nonparticipation of 2 states, and the inability of 37 states to identify the type of perpetrator in all instances of abuse and neglect. NCANDS data weaknesses are also summarized in the report. As a result of these issues, we found that it is likely that the total number of national incidents of abuse and neglect by residential facility staff is underreported.

Appendix II: Circumstances Surrounding State-Reported Suicides in Residential Facilities for Youth, 2006

Nearly all state-reported suicides occurred in licensed private residential facilities that received government funds. Generally, these residential facilities provided health and mental health services. Pennsylvania also reported that a suicide occurred in a government correctional facility that was not required to be licensed. Recommendations intended to address the circumstances surrounding state-reported suicides included steps to provide statewide training in suicide awareness and prevention and improved suicide prevention protocols in residential facilities.

Table 7: States Reporting Youth Suicides by Type of Facility, Authorization for Providing Services, and Related Investigatory Findings, 2006

State[a]	Type of facility in which fatality occurred	Type of authorization for providing services (licensure, accreditation, general contractor authority)	Findings and recommendations from related investigations
Alaska	Private treatment facility for health services that received government funds	Licensed	The state agency recommended physical modifications to the building and changed policies and procedures to address staffing, supervision, and clinical services.
Ariz.	Private treatment facility for health and mental health services that received government funds	Licensed	The investigations prompted recommendations to provide staff training on interventions and hire additional staff to be present during crisis episodes.
Calif.	Private group home for child welfare services that received government funds	Licensed	The state agency instructed the facility administrator to discuss with staff behaviors that may lead to suicide. The agency also recommended additional training for facility staff. In addition, facility staff and clients were to receive counseling regarding the incident. Following the investigation, the agency cited the facility for lack of care and supervision and closed it.
Iowa	Private facility for child welfare and juvenile justice treatment services that received government funds	Licensed and accredited	Residential facilities initiated improved suicide prevention protocols and one facility improved its communication among staff.
Neb.	Private treatment facility for health and mental health services that received government funds	Licensed and accredited	No formal recommendations resulted from the agency's internal investigation and it did not know whether other agencies made recommendations.
Pa.	Government correctional facility for juvenile justice services	Unlicensed (state did not require government facilities to be licensed)	The state agency contracted with an expert on suicides in residential facilities to provide recommendations for preventing future suicides.

State[a]	Type of facility in which fatality occurred	Type of authorization for providing services (licensure, accreditation, general contractor authority)	Findings and recommendations from related investigations
Tex.	Private treatment facility for health and mental health services that received government funds	Licensed	The state agency provided a residential facility with technical assistance on implementing policies to search for contraband that youth might bring to the facility.
Wis.	Private treatment facility for health and mental health services that received government funds	Licensed	The facility implemented a quality improvement plan that includes revisions to facility's policy on suicide precautions and staff orientation, development, and in-service training. In addition, the agency sponsored statewide training in suicide awareness and prevention for managers and others who work with youth in group homes and residential settings.

Source: GAO analysis of survey responses and additional state-reported information.

[a]Alabama did not respond to our request for additional information on the circumstances surrounding its reported suicide.

Appendix III: State-Reported Incidents of Staff Maltreatment of Youth in Residential Facilities, Fiscal Year 2005

NCANDS data show that 34 of 41 states that provide facility-level data reported incidents where residential facility staff maltreated youth in fiscal year 2005. Reported incidents of neglect or deprivation of necessities in each state generally exceeded other types of maltreatment, although certain states reported more cases of physical or sexual abuse. In 22 states, facility staff committed multiple maltreatments, as indicated by the number of maltreatment cases exceeding the number of unique perpetrators. Among the 10 states that did not provide facility level data, 7 states did not track data for residential facilities in a form that could be shared with NCANDS, 1 state did not report data in 2005 due to outstanding legal issues, and 2 states did not report any data to NCANDS.

Table 8: State-Reported Incidents of Staff Maltreatment of Youth in Residential Facilities, Fiscal Year 2005

			Maltreatment type						
State	Unique perpetrators	Unique maltreatments	Physical abuse	Neglect or deprivation of necessities	Medical neglect	Sexual abuse	Psychological or emotional maltreatment	Other	Unknown or Missing
Ala.	4	4	3	0	0	1	0	0	0
Ark.	2	2	1	0	1	0	0	0	0
Ariz.	9	18	0	17	0	1	0	0	0
Calif.	56	69	15	45	0	2	6	1	0
Colo.	25	70	8	54	0	4	2	0	2
D.C.	4	4	3	0	0	1	0	0	0
Fla.	46	87	7	52	4	6	6	12	0
Ill.	18	27	18	4	0	5	0	0	0
Ind.	47	75	27	36	0	12	0	0	0
Kans.	3	3	1	0	0	2	0	0	0
Ky.	15	17	9	4	0	4	0	0	0
La.	2	2	0	2	0	0	0	0	0
Mass.	95	153	29	116	0	8	0	0	0
Md.	1	1	0	1	0	0	0	0	0
Maine	1	1	0	0	0	1	0	0	0
Minn.	7	10	0	9	0	1	0	0	0
Mo.	27	34	11	6	2	15	0	0	0
Mont.	3	5	0	2	0	3	0	0	0
N.C.	45	71	4	56	1	6	0	4	0
Neb.	1	1	0	1	0	0	0	0	0
N.J.	66	66	12	45	6	2	1	0	0

N.Y.[a]	186	469	97	92	5	14	53	208	0
Ohio	18	18	9	3	0	6	0	0	0
Pa.	38	40	24	1	0	15	0	0	0
R.I.	24	36	3	10	0	0	1	22	0
S.C.	21	28	8	14	0	6	0	0	0
S.Dak.	2	7	0	6	0	1	0	0	0
Tenn.	36	53	30	14	1	8	0	0	0
Tex.	56	82	34	45	0	3	0	0	0
Va.	6	12	3	5	0	4	0	0	0
Vt.	1	2	0	0	0	2	0	0	0
Wash.	1	1	1	0	0	0	0	0	0
Wis.	9	9	0	4	0	4	0	1	0
W.Va.	12	26	6	13	0	1	6	0	0
State reported no incidents of abuse and neglect in residential facilities									
Del.		0							
Hawaii		0							
Idaho		0							
Iowa		0							
N.H.		0							
Nev.		0							
Utah		0							
State did not track data on abuse and neglect in residential facilities in a format compatible with NCANDS									
Alaska									
Conn.									
Mich.									
Miss.									
N.Mex.									
Okla.									
Wyo.									
State did not report data on abuse and neglect in residential facilities									
Ga.									
State did not report any NCANDS data									
N.Dak.									
Ore.									
Total	**887**	**1,503**	**363**	**657**	**20**	**138**	**75**	**248**	**2**

Source: NCANDS.

[a]According to NCANDS data archive officials, the large number of incidents in New York, including "other" maltreatment types, may be attributable to the child welfare agency's broader definition of what constitutes a residential facility and "other" types of abuse and neglect compared to narrower definitions used by other states. The comparability of data among states is difficult because of the variability in state definitions and state compliance with report requirements.

Appendix IV: Licensing Status for Selected Residential Facilities

Table 9: Licensing Status for Selected State-Operated Residential Facilities

Facility type and state agency	Required	Exempt	No such facility in state	No oversight
State-Operated facilities				
Child welfare	13	7	3	20
Health and mental health	23	6	1	14
Juvenile justice	13	28	2	1

Source: GAO analysis of state agencies' survey responses.

Note: Other responses included "Don't know" and "No response."

Table 10: State Agencies Reporting the Licensing Status for State-Operated Residential Facilities That Serve Youth

State	Child welfare	Health and mental health	Juvenile justice
Alaska	NO	NO	Exempt
Ala.	NO	NO	NS
Ariz.	NS	Required	Required
Ark.	NO	Required	NO
Calif.	Exempt	NR	Exempt
Colo.	Required	Required	Required
Conn.	Exempt	Exempt	Exempt
D.C.	DK	NO	Required
Del.	Exempt	Required	Exempt
Fla.	NO	Required	Exempt
Ga.	NO	Exempt	Exempt
Hawaii	NO	Required	Exempt
Iowa	NS	Required	Exempt
Idaho	NF	NF	Exempt
Ill.	NO	Required	NS
Ind.	Required	Required	Required
Kans.	Exempt	Required	Exempt
Ky.	NS	NO	Required
La.	NO	Required	NS
Mass.	NO	NO	Required
Md.	NO	Required	Exempt
Maine	NO	NO	Exempt
Mich.	Required	Required	Required

State	Child welfare	Health and mental health	Juvenile justice
Minn.	Required	Required	Required
Mo.	NO	Required	Exempt
Miss.	NO	Required	NS
Mont.	Required	Required	Exempt
N.C.	NO	Exempt	Exempt
N.Dak.	NF	NO	Exempt
Neb.	NO	Required	Exempt
N.H.	Required	NO	Exempt
N.J.	NS	NS	Exempt
N.Mex.	Required	NS	NF
Nev.	NS	NS	Required
N.Y.	NF	NO	Exempt
Ohio	Exempt	Exempt	Required
Okla.	Required	NS	Exempt
Ore.	NO	NS	Exempt
Pa.	Exempt	Exempt	Exempt
R.I.	Required	NO	NS
S.C.	Required	Required	Required
S.Dak.	NO	NS	Exempt
Tenn.	Required	Required	NF
Tex.	NO	Required	NS
Utah	NO	NO	Exempt
Va.	Required	Required	Required
Vt.	NS	NO	Exempt
Wash.	NO	Exempt	Exempt
Wis.	Required	NO	Exempt
W.Va.	NS	Required	Required
Wyo.	Exempt	NO	NS

Source: GAO analysis of state agencies' survey responses.

Notes: NF = no such facility in state, NO = no oversight, DK = don't know, NS = no survey, NR = no response.

The survey questions were as follows: Which, if any, of the following types of government-operated facilities providing residential [targeted; health, mental health, substance abuse; juvenile justice or rehabilitation] services for youth are currently exempt from licensing or monitoring in your state by statute or state regulation? State-operated facility: (a) exempt from licensing, (b) exempt from monitoring, (c) exempt from both, (d) exempt

from neither; (e) no such facility in state, (f) don't know, and (g) no response. The question was administered only to agencies that reported that their agency operates or has oversight over government-operated residential facilities providing services to youth age 12-17.

Table 11: Licensing Status for Selected Residential Facilities That Receive Government Funds

Facility type and state agency	Licensure required	Exempt from licensing	No such facility in state	Don't know or no response
Treatment Centers				
Child welfare	39	1	1	3
Health and mental health	35	0	2	8
Juvenile justice	N/A	N/A	N/A	N/A
Wilderness camps				
Child welfare	24	3	10	7
Health and mental health	16	3	9	17
Juvenile justice	13	1	17	13
Ranches				
Child welfare	14	3	20	7
Health and mental health	8	3	16	18
Juvenile justice	6	2	22	14
Boot camps				
Child welfare	10	6	20	8
Health and mental health	6	2	15	22
Juvenile justice	4	3	25	12
Residential schools and academies				
Child welfare	19	18	4	3
Health and mental health	15	10	1	19
Juvenile justice	14	14	5	11
Detention centers				
Child welfare	N/A	N/A	N/A	N/A
Health and mental health	N/A	N/A	N/A	N/A
Juvenile justice	14	11	6	13

Source: GAO analysis of state agencies' survey responses.

Table 12: State Child Welfare Agencies Reporting the Licensing Status for Selected Private Residential Facilities That Serve Youth and Receive Government Funding

State	Treatment facilities	Wilderness camps	Ranch	Boot camps	Residential schools and academies[a]
Alaska	NR	NR	NF	DK	NR
Ala.	Required	Required	Required	Required	Exempt
Ariz.	NS	NS	NS	NS	NS
Ark.	Required	Required	Required	DK	DK
Calif.	Required	NF	Required	NF	Exempt
Colo.	Required	Required	Required	NF	Required
Conn.	Required	Required	NF	NF	Exempt
D.C.	Required	DK	DK	DK	NF
Del.	Required	NF	NF	NF	Required
Fla.	Required	DK	DK	DK	Exempt
Ga.	Required	Required	NF	NF	Exempt
Hawaii	NR	NR	NR	NR	Exempt
Iowa	NS	NS	NS	NS	NS
Idaho	Required	Required	NF	NF	Required
Ill.	Required	DK	NF	DK	NF
Ind.	NF	Exempt	Exempt	Exempt	Required
Kans.	Required	NF	NF	NF	Required
Ky.	NS	NS	NS	NS	NS
La.	Required	Required	DK	NF	DK
Mass.	NR	NR	NR	NR	Required
Md.	Required	Required	Required	Required	Required
Maine	Required	NF	NF	NF	Required
Mich.	Required	Required	Required	Required	Exempt
Minn.	Required	NF	NF	NF	NF
Mo.	Required	Exempt	Required	Exempt	Exempt
Miss.	Required	NF	NF	NF	Required
Mont.	Required	Required	Exempt	Required	Required
N.C.	Required	Required	DK	Exempt	Exempt
N.Dak.	Required	NF	Required	NF	Exempt
Neb.	Required	NF	NF	NF	NF
N.H.	Required	Required	NF	NF	Required
N.J.	NS	NS	NS	NS	NS

State	Treatment facilities	Wilderness camps	Ranch	Boot camps	Residential schools and academies[a]
N.Mex.	Required	Exempt	Exempt	Exempt	Exempt
Nev.	NS	NS	NS	NS	NS
N.Y.	Exempt	NF	NF	NF	Exempt
Ohio	Required	NR	Required	Required	Exempt
Okla.	Required	Required	Required	Required	Required
Ore.	Required	Required	NF	Exempt	Required
Pa.	Required	Required	Required	Required	Exempt
R.I.	Required	Required	NF	NF	Required
S.C.	Required	Required	NF	Required	Exempt
S.Dak.	Required	NF	NF	NF	Exempt
Tenn.	Required	Required	NF	NF	Required
Tex.	Required	Required	NR	NR	Exempt
Utah	Required	Required	NF	NF	Required
Va.	Required	Required	Required	Required	Required
Vt.	NS	NS	NS	NS	NS
Wash.	Required	Required	Required	Exempt	Required
Wis.	Required	Required	Required	Required	Exempt
W.Va.	NS	NS	NS	NS	NS
Wyo.	Required	Required	NF	NF	Required

Source: GAO analysis of state agencies' survey responses.

Note: N/A = not applicable, NF = No such facility in state, DK = don't know, NS = no survey, NR = no response.

[a]The survey question for private residential schools and academies did not distinguish between private facilities that received government funding and those that did not.

The survey questions pertaining to private residential facilities that received or did not receive government funds for state child welfare, health and mental health, and juvenile justice agencies were as follows: Which, if any, of the following types of residences that provide [targeted; health, mental health, or substance abuse; juvenile justice and rehabilitation] services for youth are currently exempt from licensing or routine monitoring in your state by statute or state regulations: (a) exempt from licensure, (b) exempt from monitoring, (c) exempt from both, (d) not exempt from either, (e) no such residence in state, (f) don't know, and (g) no response? Check only one for each row.

Are residential educational institutions, such as schools or academies that specialize in serving students with behavior or discipline problems (e.g., providing discipline, character education, or behavior modification

training in addition to more traditional education), exempt from licensing or monitoring by your agency by statute or state regulation: (a) exempt from licensure, (b) exempt from monitoring, (c) exempt from both, (d) not exempt from either, (e) no such residence in state, (f) don't know, and (g) no response? Check only one for each row.

Table 13: State Health and Mental Health Agencies Reporting the Licensing Status for Selected Private Residential Facilities That Serve Youth and Receive Government Funding

State	Treatment facilities	Wilderness camps	Ranch	Boot camps	Residential schools and academies[a]
Alaska	Required	Required	NF	Required	Exempt
Ala.	Required	DK	DK	DK	Exempt
Ariz.	Required	Required	NF	DK	DK
Ark.	DK	DK	NF	DK	DK
Calif.	Required	NR	NR	NR	Required
Colo.	NR	NR	NR	NR	Required
Conn.	Required	Exempt	Required	NF	Exempt
D.C.	Required	NR	NR	NR	DK
Del.	Required	NF	NF	NF	DK
Fla.	Required	DK	DK	DK	NR
Ga.	NR	Required	Required	DK	Required
Hawaii	Required	Exempt	Exempt	Exempt	DK
Iowa	Required	NR	NR	NR	Required
Idaho	Required	Required	NF	NF	Required
Ill.	Required	Exempt	Exempt	Exempt	Required
Ind.	DK	DK	DK	DK	Required
Kans.	NF	NF	NF	NF	DK
Ky.	DK	DK	DK	DK	DK
La.	Required	DK	DK	DK	DK
Mass.	Required	Required	NF	Required	Required
Md.	Required	NR	NR	NR	Exempt
Maine	Required	DK	DK	DK	DK
Mich.	Required	Required	DK	DK	DK
Minn.	Required	NF	NF	NF	NF
Mo.	Required	DK	DK	DK	DK
Miss.	Required	NF	NF	NF	Required
Mont.	Required	Required	Exempt	Required	Required

State	Treatment facilities	Wilderness camps	Ranch	Boot camps	Residential schools and academies[a]
N.C.	Required	Required	NR	NR	Exempt
N.Dak.	NR	DK	DK	DK	DK
Neb.	Required	NF	Required	NF	Required
N.H.	Required	Required	NF	NF	Required
N.J.	NS	NS	NS	NS	NS
N.Mex.	NS	NS	NS	NS	NS
Nev.	NS	NS	NS	NS	NS
N.Y.	Required	DK	DK	DK	Exempt
Ohio	Required	NF	NF	NF	NR
Okla.	NS	NS	NS	NS	NS
Ore.	NS	NS	NS	NS	NS
Pa.	Required	Required	Required	Required	Exempt
R.I.	Required	NF	NF	NF	DK
S.C.	Required	NF	NF	NF	Exempt
S.Dak.	NS	NS	NS	NS	NS
Tenn.	Required	Required	Required	Required	Exempt
Tex.	Required	Required	Required	DK	DK
Utah	Required	Required	Required	NF	Required
Va.	Required	Required	NF	Required	Exempt
Vt.	Required	Required	NF	NF	Required
Wash.	DK	DK	DK	DK	NR
Wis.	DK	DK	DK	DK	DK
W.Va.	Required	Required	Required	NF	Required
Wyo.	NF	NF	NF	NF	DK

Source: GAO analysis of state agencies' survey responses.

Notes: NF = no such facility in state, DK = don't know, NS = no survey, NR = no response.

[a]The survey question for private residential schools and academies did not distinguish between private facilities that received government funding and those that did not.

Table 14: State Juvenile Justice Agencies Reporting the Licensing Status for Selected Private Residential Facilities That Serve Youth and Receive Government Funding

State	Detention centers	Wilderness camps	Ranch	Boot camps	Residential schools and academies[a]
Alaska	NR	NR	NR	NR	NR
Ala.	NS	NS	NS	NS	NS
Ariz.	DK	DK	DK	DK	Exempt
Ark.	Exempt	Exempt	Exempt	Exempt	Exempt
Calif.	DK	DK	DK	DK	DK
Colo.	Exempt	Required	Exempt	Exempt	Required
Conn.	Exempt	NF	NF	NF	Exempt
D.C.	Exempt	NF	NF	NF	NF
Del.	Required	NF	NF	NF	Required
Fla.	Exempt	Required	NF	NF	Exempt
Ga.	Exempt	Required	DK	DK	Required
Hawaii	Exempt	DK	NF	NF	DK
Iowa	Required	NF	NF	Required	Exempt
Idaho	Exempt	DK	DK	DK	DK
Ill.	NS	NS	NS	NS	NS
Ind.	Required	NF	NF	NF	DK
Kans.	NF	NF	NF	NF	NF
Ky.	Required	Required	Required	Required	Required
La.	NS	NS	NS	NS	NS
Mass.	Required	NF	NF	NF	Exempt
Md.	NF	NF	NF	NF	Required
Maine	DK	NF	NF	NF	DK
Mich.	DK	DK	DK	DK	NR
Minn.	Required	Required	Required	NF	Exempt
Mo.	DK	DK	DK	DK	Required
Miss.	NS	NS	NS	NS	NS
Mont.	NR	NR	NR	NR	Required
N.C.	NR	NR	NR	NR	Required
N.Dak.	Required	NF	Required	NF	NF
Neb.	NR	NR	NR	NR	NR
N.H.	Exempt	Required	NF	NF	Required
N.J.	NR	NF	NF	NF	DK

State	Detention centers	Wilderness camps	Ranch	Boot camps	Residential schools and academies[a]
N.Mex.	DK	DK	DK	DK	Exempt
Nev.	DK	NF	NF	NF	DK
N.Y.	Required	NF	NF	NF	Exempt
Ohio	Required	DK	DK	DK	Exempt
Okla.	Required	Required	DK	Required	Exempt
Ore.	Exempt	Required	NF	NF	Required
Pa.	Required	Required	Required	Required	Exempt
R.I.	NS	NS	NS	NS	NS
S.C.	NF	Required	NF	NF	Required
S.Dak.	NF	NF	Required	NF	NF
Tenn.	Required	Required	Required	NF	Required
Tex.	NS	NS	NS	NS	NS
Utah	Required	Required	NF	NF	Required
Va.	NF	NF	NF	NF	Exempt
Vt.	NF	Required	NF	NF	Required
Wash.	DK	NF	NF	Exempt	Exempt
Wis.	Exempt	DK	DK	NF	DK
W.Va.	Required	NF	NF	NF	NF
Wyo.	NS	NS	NS	NS	NS

Source: GAO analysis of state agencies' survey responses.

Notes: NF = no such facility in state, DK = don't know, NS = no survey, NR = no response.

[a]The survey question for private residential schools and academies did not distinguish between private facilities that received government funding and those that did not.

Table 15: Licensing Status for Selected Exclusively Private Residential Facilities

Facility type and state agency	Licensure required	Exempt from licensing	No such facility in state	Don't know or no response
Treatment centers				
Child welfare	30	3	3	8
Health and mental health	30	0	4	11
Juvenile justice	N/A	N/A	N/A	N/A
Wilderness camps				
Child welfare	18	3	11	12
Health and mental health	14	2	9	20
Juvenile justice	5	4	15	20
Ranches				
Child welfare	11	1	18	14
Health and mental health	11	2	12	20
Juvenile justice	2	5	17	20
Boot camps				
Child welfare	8	2	22	12
Health and mental health	6	1	14	24
Juvenile justice	0	5	19	20
Residential schools and academies				
Child welfare	19	18	4	3
Health and mental health	15	10	1	19
Juvenile justice	14	14	5	11
Detention centers				
Child welfare	N/A	N/A	N/A	N/A
Health and mental health	N/A	N/A	N/A	N/A
Juvenile justice	3	5	18	18

Source: GAO analysis of state agencies' survey responses.

Table 16: State Child Welfare Agencies Reporting the Licensing Requirements for Selected Exclusively Private Residential Facilities That Serve Youth and Receive No Government Funding

State	Treatment facilities	Wilderness camps	Ranch	Boot camps	Residential schools and academies[a]
Alaska	Required	Exempt	NR	NR	NR
Ala.	DK	DK	DK	DK	Exempt
Ariz.	NS	NS	NS	NS	NS
Ark.	Required	DK	DK	DK	DK
Calif.	Required	NF	Required	NF	Exempt
Colo.	Required	Required	Required	NF	Required
Conn.	Required	NF	NF	NF	Exempt
D.C.	Required	DK	DK	DK	NF
Del.	NF	NF	NF	NF	Required
Fla.	NR	NR	NR	NR	Exempt
Ga.	Required	Required	NF	NF	Exempt
Hawaii	NR	NR	NR	NR	Exempt
Iowa	NS	NS	NS	NS	NS
Idaho	Required	Required	NF	NF	Required
Ill.	Required	DK	NF	DK	NF
Ind.	NF	DK	DK	DK	Required
Kans.	Exempt	NF	NF	NF	Required
Ky.	NS	NS	NS	NS	NS
La.	Required	DK	DK	NF	DK
Mass.	NR	NR	NR	NR	Required
Md.	Required	Required	Required	Required	Required
Maine	NR	NF	NF	NF	Required
Mich.	Required	Required	Required	Required	Exempt
Minn.	Required	NF	NF	NF	NF
Mo.	Required	Exempt	Required	Exempt	Exempt
Miss.	Exempt	NF	NF	NF	Required
Mont.	Required	Required	Exempt	Required	Required
N.C.	Required	Required	DK	Exempt	Exempt
N.Dak.	NR	NR	NR	NR	Exempt
Neb.	Required	NF	NF	NF	NF
N.H.	DK	NF	NF	NF	Required
N.J.	NS	NS	NS	NS	NS

State	Treatment facilities	Wilderness camps	Ranch	Boot camps	Residential schools and academies[a]
N.Mex.	Required	DK	DK	DK	Exempt
Nev.	NS	NS	NS	NS	NS
N.Y.	Exempt	NF	NF	NF	Exempt
Ohio	Required	NR	NF	Required	Exempt
Okla.	Required	Required	Required	Required	Required
Ore.	Required	Required	NF	NF	Required
Pa.	Required	Required	Required	Required	Exempt
R.I.	Required	Required	NF	NF	Required
S.C.	NF	Exempt	NF	NF	Exempt
S.Dak.	Required	NF	NF	NF	Exempt
Tenn.	Required	Required	NF	NF	Required
Tex.	Required	Required	NR	NR	Exempt
Utah	DK	Required	Required	NF	Required
Va.	Required	Required	Required	Required	Required
Vt.	NS	NS	NS	NS	NS
Wash.	Required	Required	Required	NF	Required
Wis.	Required	Required	Required	Required	Exempt
W.Va.	NS	NS	NS	NS	NS
Wyo.	Required	Required	NF	NF	Required

Source: GAO analysis of state agencies' survey responses.

Notes: NF = no such facility in state, DK = don't know, NS = no survey, NR = no response.

[a]The survey question for private residential schools and academies did not distinguish between private facilities that received government funding and those that did not.

Table 17: State Health and Mental Health Agencies Reporting the Licensing Requirements for Selected Exclusively Private Residential Facilities That Serve Youth and Receive No Government Funding

State	Treatment facilities	Wilderness camps	Ranch	Boot camps	Residential schools and academies[a]
Alaska	Required	Required	NF	Required	Exempt
Ala.	Required	DK	DK	DK	Exempt
Ariz.	Required	Required	NF	DK	DK
Ark.	DK	DK	DK	DK	DK
Calif.	NR	NR	NR	NR	Required
Colo.	Required	Required	Required	NF	Required
Conn.	Required	Exempt	Required	NF	Exempt
D.C.	Required	NR	NR	NR	DK
Del.	Required	NF	NF	NF	DK
Fla.	Required	DK	DK	DK	NR
Ga.	Required	Required	Required	DK	Required
Hawaii	NF	NF	NF	NF	DK
Iowa	NF	NR	NR	NR	Required
Idaho	Required	Required	NF	NF	Required
Ill.	Required	Exempt	Exempt	Exempt	Required
Ind.	DK	DK	DK	DK	Required
Kans.	NR	NR	NR	NR	DK
Ky.	DK	DK	DK	DK	DK
La.	Required	DK	DK	DK	DK
Mass.	Required	Required	Required	DK	Required
Md.	NF	NF	NF	NF	Exempt
Maine	Required	DK	DK	DK	DK
Mich.	Required	Required	DK	DK	DK
Minn.	Required	NF	NF	NF	NF
Mo.	DK	DK	DK	DK	DK
Miss.	Required	Required	Required	Required	Required
Mont.	Required	Required	Exempt	Required	Required
N.C.	Required	Required	NR	NR	Exempt
N.Dak.	DK	DK	DK	DK	DK
Neb.	Required	NF	Required	NF	Required
N.H.	DK	DK	DK	DK	Required
N.J.	NS	NS	NS	NS	NS

State	Treatment facilities	Wilderness camps	Ranch	Boot camps	Residential schools and academies[a]
N.Mex.	NS	NS	NS	NS	NS
Nev.	NS	NS	NS	NS	NS
N.Y.	NF	DK	DK	DK	Exempt
Ohio	Required	NF	NF	NF	NR
Okla.	NS	NS	NS	NS	NS
Ore.	NS	NS	NS	NS	NS
Pa.	Required	NF	NF	NF	Exempt
R.I.	Required	NF	NF	NF	DK
S.C.	Required	Required	Required	Required	Exempt
S.Dak.	NS	NS	NS	NS	NS
Tenn.	Required	Required	Required	Required	Exempt
Tex.	Required	DK	Required	DK	DK
Utah	Required	Required	Required	NF	Required
Va.	Required	Required	NF	Required	Exempt
Vt.	DK	DK	DK	DK	Required
Wash.	DK	DK	DK	DK	NR
Wis.	DK	DK	DK	DK	DK
W.Va.	Required	NR	Required	NF	Required
Wyo.	Required	NF	NF	NF	DK

Source: GAO analysis of state agencies' survey responses.

Note: NF = no such facility in state, DK = don't know, NS = no survey, NR = no response.

[a]The survey question for private residential schools and academies did not distinguish between private facilities that received government funding and those that did not.

Table 18: State Juvenile Justice Agencies Reporting the Licensing Status for Selected Exclusively Private Residential Facilities That Serve Youth and Receive No Government Funding

State	Detention centers	Wilderness camps	Ranch	Boot camps	Residential schools and academies[a]
Alaska	NR	NR	NR	NR	NS
Ala.	NS	NS	NS	NS	NS
Ariz.	DK	DK	DK	DK	Exempt
Ark.	Exempt	Exempt	Exempt	Exempt	Exempt
Calif.	DK	DK	DK	DK	DK
Colo.	Exempt	Required	Exempt	Exempt	Required
Conn.	Exempt	NF	NF	NF	Exempt
D.C.	NF	NF	NF	NF	NF
Del.	NF	NF	NF	NF	Required
Fla.	Exempt	Exempt	Exempt	Exempt	Exempt
Ga.	NF	DK	DK	DK	Required
Hawaii	DK	DK	DK	DK	DK
Iowa	NF	NF	NF	NF	Exempt
Idaho	NF	DK	DK	DK	DK
Ill.	NS	NS	NS	NS	NS
Ind.	DK	DK	DK	DK	DK
Kans.	NF	NF	NF	NF	NF
Ky.	NR	NR	NR	NR	Required
La.	NS	NS	NS	NS	NS
Mass.	DK	DK	DK	DK	Exempt
Md.	NF	NF	NF	NF	Required
Maine	NF	NF	NF	NF	DK
Mich.	DK	DK	DK	DK	NR
Minn.	NF	NF	NF	NF	Exempt
Mo.	DK	DK	DK	DK	Required
Miss.	NS	NS	NS	NS	NS
Mont.	NR	NR	NR	NR	Required
N.C.	NR	NR	NR	NR	Required
N.Dak.	NF	NF	NF	NF	NF
Neb.	NR	NR	NR	NR	NR
N.H.	NF	NF	NF	NF	Required
N.J.	NR	NR	NR	NR	DK

State	Detention centers	Wilderness camps	Ranch	Boot camps	Residential schools and academies[a]
N.Mex.	DK	DK	DK	DK	Exempt
Nev.	DK	NF	NF	NF	DK
N.Y.	Required	Exempt	Exempt	Exempt	Exempt
Ohio	Exempt	Exempt	Exempt	Exempt	Exempt
Okla.	Required	DK	DK	DK	Exempt
Ore.	NF	Required	NF	NF	Required
Pa.	DK	DK	DK	DK	Exempt
R.I.	NS	NS	NS	NS	NS
S.C.	DK	DK	DK	DK	Required
S.Dak.	NF	NF	NF	NF	NF
Tenn.	Required	Required	Required	NF	Required
Tex.	NS	NS	NS	NS	NS
Utah	NF	Required	Required	NF	Required
Va.	NF	NF	NF	NF	Exempt
Vt.	NF	Required	NF	NF	Required
Wash.	NF	NF	NF	NF	Exempt
Wis.	DK	DK	DK	DK	DK
W.Va.	NF	NF	NF	NF	NF
Wyo.	NS	NS	NS	NS	NS

Source: GAO analysis of state agencies' survey responses.

Notes: NF = no such facility in state, DK = don't know, NS = no survey, NR = no response.

[a]The survey question for private residential schools and academies did not distinguish between private facilities that received government funding and those that did not.

Appendix V: State Agency Accreditation Requirements for Residential Facilities for Youth

Table 19: Number of States that Require at Least Some of the Residential Facilities That They License or Certify to Have Independent Accreditation

	Child welfare agencies		Health and mental health agencies		Juvenile justice agencies	
Facility type	Accreditation required for at least some	Accreditation not required	Accreditation required for at least some	Accreditation not required	Accreditation required for at least some	Accreditation not required
Government operated	8	15	16	12	12	29
Private receiving government funds	8	27	16	19	7	27
Exclusively private pay	4	26	5	21	2	11

Source: GAO analysis of state agencies' survey responses.

The survey questions were as follows: Are government-operated facilities, including county-operated facilities, required to have any of the following in order to provide residential [targeted; health, mental health, or substance abuse; juvenile or rehabilitation] services to youth: independent accreditation to provide services, such as Council on Accreditation (COA), Commission on Accreditation Rehabilitation Facilities (CARF), Joint Commission on Accreditation of Health Care Organizations (JCAHO): (a) required for all, (b) required for most, (c) required for some, (d) not required, (e) don't know, and (f) no response. Which if any of the following types of initial licensure or certification does your agency require for private facilities that plan to provide residential [targeted; health, mental health, or substance abuse; juvenile or rehabilitation] services to youth age 12 to 17 and receive [any government funds, e.g., facilities with state or county contracts or facilities certified to accept Medicaid or Medicare): independent accreditation to provide services, such as Council on Accreditation (COA), Commission on Accreditation Rehabilitation Facilities (CARF), Joint Commission on Accreditation of Health Care Organizations (JCAHO): (a) required, (b) not required, (c) don't know, and (d) no response. Which if any of the following types of initial licensure or certification does your agency require for private facilities that plan to provide residential [targeted; health, mental health, or substance abuse; juvenile or rehabilitation] to youth age 12 to 17 and receive no government funds (e.g., faith-based and other private facilities that are totally funded by the private sector): independent accreditation to provide services, such as Council on Accreditation, Commission on Accreditation Rehabilitation Facilities, Joint Commission on Accreditation of Health Care Organizations: (a) required, (b) not required, (c) don't know, and (d) no response.

Appendix VI: Selected State Licensing Standards for Residential Facilities for Youth

Table 20: Number of State Agencies Reporting That They Require Licensed Government-Operated and Private Residential Facilities to Meet Certain Standards, 2006

	Child welfare		Health and mental health		Juvenile justice	
Standards	**Government-operated facilities**	**Private facilities**	**Government-operated facilities**	**Private facilities**	**Government-operated facilities**	**Private facilities**
Pass inspection of physical plant						
Required for all	20	37	27	35	41	16
Required for less than all	2	0	1	1	2	0
Provide evidence of safe child care practices						
Required for all	19	35	23	30	37	16
Required for less than all	3	1	3	3	5	0
Have written procedures for reporting physical or sexual abuse or neglect of youth						
Required for all	21	37	28	35	43	16
Required for less than all	1	0	0	1	0	0
Meet all staff qualifications requirements, including training						
Required for all	20	36	26	34	42	16
Required for less than all	2	0	1	2	1	0
Perform staff background checks						
Required for all	21	37	26	31	43	16
Required for less than all	1	0	2	4	0	0
Meet staff-to-child ratios						
Required for all	20	34	22	28	32	15
Required for less than all	2	3	5	8	10	1

	Child welfare		Health and mental health		Juvenile justice	
Standards	**Government-operated facilities**	**Private facilities**	**Government-operated facilities**	**Private facilities**	**Government-operated facilities**	**Private facilities**
Provide evidence of appropriate educational programming						
Required for all	19	31	23	31	41	16
Required for less than all	2	1	6	4	2	0
Have procedures in place for use of approved seclusion and restraint techniques						
Required for all	19	34	23	31	41	16
Required for less than all	3	3	5	4	2	0
Have written suicide prevention plans						
Required for all	13	20	15	20	40	12
Required for less than all	8	14	9	13	3	4

Source: GAO analysis of state agencies' survey responses.

Note: Other responses included "Don't know" and "No response."

The survey questions were as follows: When your state develops or opens a government-operated residential facility that provides targeted services to youth, is the facility required to meet state standards in any of the following areas? (a) pass inspection of physical plant; (b) provide evidence of safe child care practices; (c) have written procedures for reporting physical or sexual abuse or neglect of youth; (d) meet staff qualifications requirements, including training; (e) perform staff background check; (f) meet specified staff-to-child ratios; (g) provide evidence of appropriate educational programming; (h) have procedures in place for use of approved seclusion and restraint technique; (i) have written suicide prevention plan. Are each of the following items required for private residential facilities providing targeted services for youth to obtain initial licensure from your agency? (a) pass inspection of physical plant; (b) provide evidence of safe child care practices; (c) have written procedures for reporting physical or sexual abuse or neglect of youth; (d) meet staff qualifications requirements, including training; (e) perform staff background check; (f) meet specified staff-to-child ratios; (g) provide evidence of appropriate educational programming; (h) have procedures in place for use of approved seclusion and restraint technique; (i) have written suicide prevention plan.

Appendix VII: Selected State Monitoring Requirements for Residential Facilities for Youth

Table 21: Number of State Agencies Reporting That They Monitored, for All or Less Than All, Selected Issues at Residential Facilities for Youth, 2006

	Child welfare			Health and mental health			Juvenile justice		
Issues	Government-operated facility	Private facility that received any government funds	Exclusively private facility	Government-operated facility	Private facility receiving government funds	Exclusively private facility	Government-operated facility	Private facility receiving government funds	Exclusively private facility
Physical plant									
Monitored for all	15	35	29	14	22	16	34	24	9
Monitored for less than all	6	4	6	13	16	14	8	13	14
Staffing issues (e.g., background checks, qualifications, ongoing training)									
Monitored for all	16	35	28	15	22	16	34	23	8
Monitored for less than all	6	5	7	13	15	14	7	13	14
Use of approved seclusion and restraint									
Monitored for all	14	32	26	14	23	13	32	25	10
Monitored for less than all	7	7	9	11	13	16	10	10	12
Use of psychotropic medications									
Monitored for all	13	30	24	13	22	12	27	22	9
Monitored for less than all	8	9	9	12	15	16	14	14	13
Number of complaints of physical or sexual abuse									
Monitored for all	13	34	27	15	26	15	34	28	12
Monitored for less than all	9	5	8	12	12	15	15	8	10

	Child welfare			Health and mental health			Juvenile justice		
Issues	Government-operated facility	Private facility that received any government funds	Exclusively private facility	Government-operated facility	Private facility receiving government funds	Exclusively private facility	Government-operated facility	Private facility receiving government funds	Exclusively private facility
Number of other complaints, if any (e.g. health or safety concerns)									
Monitored for all	15	32	26	16	26	14	33	28	10
Monitored for less than all	7	7	9	11	12	15	9	8	11
Presence of educational programming									
Monitored for all	15	30	24	13	16	12	35	23	9
Monitored for less than all	5	7	9	13	18	14	6	13	12
Quality of educational programming									
Monitored for all	6	11	6	7	8	6	27	18	8
Monitored for less than all	14	23	23	16	23	20	13	17	12

Source: GAO analysis of state agencies' survey responses.

Note: Other responses included "Don't know", "No response" and "No such facility in the state."

We asked state child welfare, health and mental health, and juvenile justice agencies the following question: In 2006, did your agency routinely monitor or follow up, or authorize for monitoring or follow up, any of the following issues—in the absence of a complaint—at government-operated residential facilities, private residential facilities that received government funding, and exclusively private pay residential facilities providing targeted services for youth? Response options for this question were: (a) yes, monitored for all, (b) yes, monitored for most, (c) yes, monitored for some, (d) no, did not monitor, (e) no such facility in the state, (f) don't know, (g) no response.

Appendix VIII: State Agency Actions Taken within the Last 3 Years against Government and Private Residential Facilities

Table 22: Number of State Agencies Taking Actions against Government and Private Residential Facilities within the Last 3 Years

	Child welfare		Health and mental health		Juvenile justice	
Action taken	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Government facility was closed or license, certification, or operating authority was suspended or revoked						
Government operated	1	19	0	18	3	34
Private license or authority to operate was suspended						
Private receiving government funds	11	21	4	18	9	16
Exclusively private	4	28	3	19	3	22
Private license or authority to operate was revoked or not renewed, or facility was closed						
Private receiving government funds	17	15	8	13	11	13
Exclusively private	7	25	3	18	1	23
Youth were removed						
Government operated	7	12	2	16	11	26
Private receiving government funds	26	9	13	8	18	12
Exclusively private	5	30	4	17	4	26
Banned new admissions or instituted admission restrictions						
Government operated	7	14	4	15	7	30
Private receiving government funds	27	8	16	6	22	7
Exclusively private	4	31	4	18	4	25
Referred or recommended criminal investigations for abuse or neglect that carry fines or imprisonment						
Government operated	10	11	7	8	24	10
Private receiving government funds	19	11	11	9	17	11
Exclusively private	6	24	3	17	7	21
Increased monitoring						
Government operated	16	5	10	8	32	6
Private receiving government funds	32	3	20	2	30	0
Exclusively private	6	29	8	14	8	22

	Child welfare		Health and mental health		Juvenile justice	
Required program improvement or corrective action plan						
Government operated	19	2	17	2	32	4
Private receiving government funds	35	0	22	1	28	1
Exclusively private	12	23	10	13	7	22

Source: GAO analysis of state agencies' survey responses.

We asked state child welfare, health and mental health, and juvenile justice agencies the following question: Over the last 3 reporting years, did your agency take any of the following actions at its government-operated facilities, private facilities that received government funds, or private facilities that did not receive government funds as a result of allegations or findings of noncompliance, improper operations, physical abuse or sexual abuse or neglect of youth, or other negative outcomes? Respondents could also answer "don't know" or "no response."

Appendix IX: Comments from the Department of Education

UNITED STATES DEPARTMENT OF EDUCATION

OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE SERVICES

APR 2 2 2008

THE ASSISTANT SECRETARY

Ms. Kay E. Brown
Director, Education, Workforce
And Income Security Issues
Government Accountability Office
441 G Street, NW
Washington, D.C. 20548

Dear Ms. Brown:

This is in response to your request for comments on the Government Accountability Office (GAO) draft report, "Residential Facilities: Improved Data and Enhanced Oversight Would Help Safeguard the Well-Being of Youth with Behavioral and Emotional Challenges" (GAO-08-346). We appreciate the opportunity to comment on the draft report.

The national surveys conducted by GAO for this draft report are not of State educational agencies (SEAs), the entities for which the U.S. Department of Education (Department) has oversight responsibility under the Individuals with Disabilities Education Act (IDEA). Instead, the national surveys conducted by GAO for this draft report were of State child welfare, health and mental health and juvenile justice agencies. The draft report includes approximately 50 pages of data tables showing significant variability in the extent, level and nature of State oversight of residential schools and academies, detention centers, boot camps, ranches, wilderness camps and treatment facilities. However, survey questions about the presence of educational programming and the quality of educational programming in the several States surveyed, in various settings, were not directed at SEAs. The draft report therefore gives only a partial picture of State monitoring of educational programs for students with disabilities who are publicly placed in residential facilities.

As noted in the draft report, States have the primary responsibility for ensuring the well-being of youth in residential facilities and other settings, and States are responsible for licensure, accreditation and monitoring of facilities in accordance with State standards of care. Some students "with emotional and behavioral challenges" cited in the GAO draft report's age cohort of 12-17 would be receiving services under the IDEA if they met the eligibility criteria for services under that law.

The role of the Department in administering the IDEA is to ensure that SEAs carry out their general supervision responsibilities in section 612(a)(11) of IDEA. Each SEA is responsible for ensuring that IDEA requirements are met in the State, and that each education program in the State, including programs administered by any other State or local agency, meets the education standards of the SEA. The Department's periodic

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monitoring of SEAs' implementation of the IDEA under section 616 of IDEA includes a review of State monitoring and oversight activities. This could include a review of the SEAs' procedures for monitoring special education programs for students with disabilities who are publicly placed in public or private residential facilities to ensure that such children and youth with disabilities receive a free appropriate public education. The IDEA regulations also include State complaint procedures requiring each SEA to adopt written procedures for resolving any signed written complaint at the State level, alleging that a public agency has violated a requirement of Part B of IDEA or the Part B of IDEA regulations. The Department monitors States' implementation of their complaint procedures to ensure that complaints are resolved in a timely manner.

States and the Secretary of the Interior are required to make annual submissions of data to the Secretary of Education and the public under section 618 of IDEA. These data include the number and percentage of children with disabilities, by disability category, who are educated in a variety of settings, including public or private residential facilities. Fewer than one half of one percent of all children receiving special education and related services are placed in a residential setting by a public education agency under IDEA. These residential placements are for students with significant cognitive disabilities, students who are blind or deaf, students with traumatic brain injury and other conditions, typically of low incidence, requiring intensive and specialized services not available in a less restrictive setting. Thus, residential settings are uncommon placements for serving children under IDEA.

Data on children with disabilities served under the IDEA (available on-line at { HYPERLINK "http://www.ideadata.org/" }) do not necessarily correspond to GAO's study categories of "behavioral and emotional challenges" nor do the age ranges match the study ranges, but IDEA data do give insight about placements. In Fall 2006, 9,373 students ages 6 through 21 with "emotional disturbance" served under IDEA were in residential facilities, while 7,741 students with emotional disturbance were served in correctional facilities. The latter facilities would presumably include the "detention center" category in the study. In comparison, roughly 450,000 students with "emotional disturbance" were served in all educational environments under IDEA.

In addition to children with disabilities served under IDEA, some children are served under the Prevention and Intervention Programs for Children and Youths Who Are Neglected, Delinquent, or at Risk (Title I, Part D of the Elementary and Secondary Education Act, as amended by the No Child Left Behind Act of 2001). Students provided supplemental educational services under Title I, Part D in institutional settings represent only a small percentage of all youth detained or serving sentences in juvenile or adult residential facilities. The role of the Department in administering the Title I, Part D program is to improve educational services for children and youth in local and State institutions for neglected or delinquent children and youth. The Department's monitoring of SEAs' implementation of the Title I, Part D program includes a review of State monitoring and oversight activities to ensure compliance with all statutory and regulatory requirements.

Some of the students described in the GAO draft report also may be receiving education and services pursuant to Section 504 of the Rehabilitation Act of 1973, which prohibits disability-based discrimination by the recipients of federal financial assistance. Among other things, at the elementary and secondary level Section 504 requires that qualified individuals with disabilities be provided with regular or special education and related aids and services that are designed to meet the needs of individuals with disabilities as adequately as the needs of individuals without disabilities are met. Section 504 is enforced by the Department's Office for Civil Rights (OCR) through complaint investigation, proactive compliance reviews and the provision of technical assistance. Additional information about Section 504 compliance activities is available from OCR at { HYPERLINK "http://www.ed.gov/ocr" }.

While it is not in the Department's statutory or regulatory authority through IDEA or Title I, Part D to ensure oversight of the total well-being of youth in residential facilities, we recognize that a protective and safe school environment, that is consistent with a State's responsibility for monitoring and oversight of school programs, is necessary for all students. Please let us know if you need additional information regarding activities underway at the Department to ensure appropriate oversight for State accountability for youth well-being in residential facilities and other settings.

Sincerely,

Tracy R. Justesen

Tracy R. Justesen

Appendix X: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary for Legislation

Washington, D.C. 20201

MAY 07 2008

Kay Brown
Acting Director,
Education, Workforce,
and Income Security Issues
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Brown:

Enclosed are the Department's comments on the U.S. Government Accountability Office's (GAO) draft report entitled: RESIDENTIAL FACILITIES: Improved Date and Enhanced Oversight Would Help Safeguard the Well-Being of Youth with Behavioral and Emotional Challenges (GAO 08-346).

The Department appreciates the opportunity to review and comment on this report before its publication.

Sincerely,

Jennifer R. Luong

for Vincent J. Ventimiglia, Jr.
Assistant Secretary for Legislation

Attachment

COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE U.S. GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: "RESIDENTIAL FACILITIES: IMPROVED DATA AND ENHANCED OVERSIGHT WOULD HELP SAFEGUARD THE WELL-BEING OF YOUTH WITH BEHAVORIAL AND EMOTIONAL CHALLENGES" (GAO-08-346)

GAO Recommendations

To help policymakers craft solutions that best address the magnitude of maltreatment and other threats to youth well-being in residential facilities, and also to facilitate federal oversight across states and agencies, we recommend that the Secretary of HHS take action to determine what barriers remain in those states that do not report case-file data for residential facilities to NCANDS and explore options to help states address existing barriers.

To help target federal civil rights investigations among states and facilities that can provide maximum benefit, we recommend that the U.S. Attorney General direct its Civil Rights Division to request access to HHS's NCANDs case-file data for residential facilities. We also recommend that the Attorney General have the Division query HHS, the Office of Juvenile Justice and Delinquency Prevention, and Education regarding other sources of relevant information within relevant subagencies, such as HHS' Centers for Disease Control and Prevention.

To help ensure that the existing federal regulatory structure protects youth well-being across government and private residential facilities supported by federal programs, we recommend that HHS, DOJ, and Education work to enhance their oversight of state accountability for youth well-being in residential facilities. Such efforts could include ensuring that residential facilities are included in federal oversight reviews and on-site visits to states.

HHS Response

As described in the report, the National Child Abuse and Neglect Data System (NCANDS) is a voluntary national data collection system. States are encouraged, to the extent practical, to report information for all data elements and technical assistance is provided to assist them in doing so. This Federal/State partnership has been very effective over the years in increasing the quantity and quality of information reported by States to the Federal Government on incidents of abuse and neglect reported to State Child Protective Service agencies.

The number of States or jurisdictions (including the District of Columbia and Puerto Rico) reporting case-level information has increased each year and for the most recent data available, Federal Fiscal Year (FFY) 2006, the number of States submitting case-level data increased to 51, up from 49 submitting case-level data for the FFY 2005 reporting year (the data used by GAO for the report).

COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE U.S. GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: "RESIDENTIAL FACILITIES: IMPROVED DATA AND ENHANCED OVERSIGHT WOULD HELP SAFEGUARD THE WELL-BEING OF YOUTH WITH BEHAVORIAL AND EMOTIONAL CHALLENGES" (GAO-08-346)

Addressing barriers to capturing more complete information on incidents of abuse and neglect, including child maltreatment-related fatalities occurring in residential facilities, will require continued improvements in the reporting of information on perpetrators and the reporting of case-level information on fatalities. ACF has seen improvements in both of these areas and ACF will continue to work with States to improve the collection of information on perpetrators and on fatalities, wherever possible and feasible.

ACF would be pleased to work with the Department of Justice (DOJ) to provide NCANDS information that DOJ might find useful; however, it is important to note that NCANDS captures no identifying information on individual children, perpetrators, or facilities and, therefore, ACF is unclear whether the information would prove useful in targeting civil rights investigations.

ACF's current oversight activities vis-à-vis GAO's third-paragraph recommendation are commensurate with existing statutory authority and resources.

A key issue for consideration would be a requirement that facilities inform parents/caregivers about the use of disciplinary action, restraint, seclusion or critical incidents to ensure that there are communications and to affirm a family's "right to know" what is happening with their child.

SAMHSA is listed in the report in Table 5 on page 36 as having no program requirements to address certain risks to youth well-being. It is important to note that SAMHSA has no legal authorization in this area. SAMHSA has taken extensive action within its legal authorities to address issues of seclusion and restraint, suicide prevention, etc., but does not have regulatory oversight of individual residential facilities at the local level.

The issue of unlicensed facilities should be more clearly addressed in the report and recommendations. While licensing issues are discussed on pages 24-26, there is only a very brief mention of State licensing systems in the conclusion and there are no recommendations related to this issue. It is SAMHSA's understanding that this was a reason that the study was conducted and therefore SAMHSA recommends that this issue be discussed prominently and in more detail.

2

Appendix XI: Comments from the Department of Justice

U.S. Department of Justice

APR 24 2008

Washington, D.C. 20530

Ms. Kay Brown
Acting Director, Education, Workforce, and
Income Security
Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Brown:

Thank you for the opportunity to comment on the draft Government Accountability Office (GAO) report entitled "Residential Facilities: Improved Data and Enhanced Oversight Would Help Safeguard the Well-Being of Youth with Behavioral and Emotional Challenges" (GAO-08-346). The Department of Justice (Department) understands the rationale behind the first two recommendations; the GAO has recommended additional efforts that may enhance oversight. With regard to the third recommendation, we believe that the Department's Office of Justice Programs' Office of Juvenile Justice and Delinquency Prevention (OJJDP) already has implemented measures that have started to and, over time, will achieve the results the GAO intended to bring about. Consequently, we believe it would be beneficial if the report highlighted the existing accomplishments of OJJDP.

To help target federal civil rights investigations among states and facilities that can provide maximum benefit, the GAO recommends that the Attorney General work with the Secretary of HHS to obtain access to the case data file found in the National Child Abuse and Neglect Data System for residential facilities. Also, the GAO recommends that the Attorney General work with HHS, the OJJDP, and Education to obtain access to other sources of relevant information within relevant sub-agencies, such as HHS' Centers for Disease Control and Prevention. The Department agrees with these two recommendations and intends to address our compliance in our statutorily required response to the Congress.

In its third recommendation, the GAO proposes that the Department, HHS, and Education work to enhance their oversight of state accountability for youth well-being in residential facilities. The OJJDP currently invests a considerable amount of resources for training and provides even more funding for technical assistance on this issue either at a state's request or proactively. For example, today, the OJJDP is intensively assisting two states with conditions of confinement issues while, at the same time, fulfilling the OJJDP's statutory obligations. In addition, in fiscal year 2007, the OJJDP Administrator

created a new working relationship with the Department's Civil Rights Division for the purpose of producing better coordinated responses with states. That relationship already has produced beneficial results. Finally, the OJJDP intends to continue providing oversight of state accountability for youth well-being in residential facilities to the full-extent of the OJJDP's applicable statutory authority, including federal oversight reviews and on-site visits to states. Including these accomplishments in the report would be worthwhile.

The OJJDP agrees with the GAO that working with HHS and Education is an important way to enhance youth well-being in residential facilities and that such effort can be coordinated, in part, through the Coordinating Council on Juvenile Justice and Delinquency Prevention (Council). One of the functions of the statutorily created Council is to coordinate all federal juvenile delinquency programs and all federal programs and activities involving detaining and caring for unaccompanied juveniles. Further, the Council is charged with examining how separate programs can be coordinated among federal, state, and local governments. The Department is a key player on the Council.

For the reasons given above, we recommend GAO's third recommendation include specific actions for each agency, and suggest that HHS and Education develop, in consultation with the Department of Justice and through the Council, minimum standards of care for all relevant federal programs.

If you have any questions, you or your staff may contact Richard Theis, Audit Liaison Group, on (202) 514-0469.

Sincerely,

Lee J. Lofthus
Assistant Attorney General
for Administration

Appendix XII: GAO Contacts and Staff Acknowledgments

GAO Contact

Kay E Brown, (202)512-7215, brownke@gao.gov

Staff Acknowledgments

Cindy Ayers (Assistant Director) and Arthur T. Merriam Jr. (Analyst-in-Charge) managed all aspects of the assignment. Kathleen Drennan, Vernette Shaw, and Mark E. Ward made significant contributions to this report, in all aspects of the work. In addition, Denise M. Fantone contributed to the initial design of the engagement; Carolyn Boyce provided technical support in design and methodology, survey research, and statistical analysis; Doreen Feldman and James Rebbe provided legal support; and Charles Willson assisted in the message and report development.

Related GAO Products

Residential Facilities: State and Federal Oversight Gaps May Increase Risks to Youth Well-Being, GAO-08-696T, (Washington, D.C.: April 24, 2008).

Residential Programs: Selected Cases of Death, Abuse, and Deceptive Marketing, GAO-08-713T, (Washington, D.C.: April 24, 2008).

Residential Treatment Programs: Concerns Regarding Abuse and Death in Certain Programs for Troubled Youth. GAO-08-146T. Washington. D.C.: October 10, 2007.

Child Welfare and Juvenile Justice: Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services. GAO-03-397. Washington, D.C.: April 21, 2003.

Mental Health: Extent of Risk from Improper Restraint or Seclusion Is Unknown. T-HEHS-00-26. Washington, D.C.: October 26, 1999.

Mental Health: Improper Restraint or Seclusion Use Places People at Risk. HEHS-99-176. Washington, D.C.: September 7, 1999.

Prison Boot Camps: Short-Term Prison Costs Reduced, but Long-Term Impact Uncertain. GGD-93-69 Washington, D.C.: April 29, 1993.

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