April 24, 2008

RESIDENTIAL FACILITIES

State and Federal Oversight Gaps May Increase Risk to Youth Well-Being

GAO Accountability · Integrity · Reliability

Highlights

Highlights of GAO-08-696T, a report to the Committee on Education and Labor, House of Representatives

Why GAO Did This Study

Nationwide, federal funding to states supported more than 200,000 youth in facilities seeking help for behavioral or emotional challenges in 2004. Recent federal reviews and investigations highlighted maltreatment in some facilities, resulting in hospitalizations and deaths. This testimony discusses (1) what is known about incidents that adversely affect youth well-being in residential facilities, (2) the extent that state oversight ensures youth well-being in these facilities, and (3) the factors that affect the ability of federal agencies to hold states accountable for youth well-being in residential facilities. This testimony is based on GAO's ongoing work, which included national surveys to state agencies of child welfare, health and mental health, and juvenile justice for the year 2006. GAO achieved an 85 percent response rate for each of the three surveys. The work also included site visits to four states (California, Florida, Maryland, and Utah) and discussions with the Departments of Education (Education), Justice (DOJ), and Health and Human Services (HHS). Interim work related to this testimony was completed between November 2006 and March 2008, in accordance with generally accepted government auditing standards.

What GAO Recommends

GAO recommendations will be included in its final report upon completion of ongoing work.

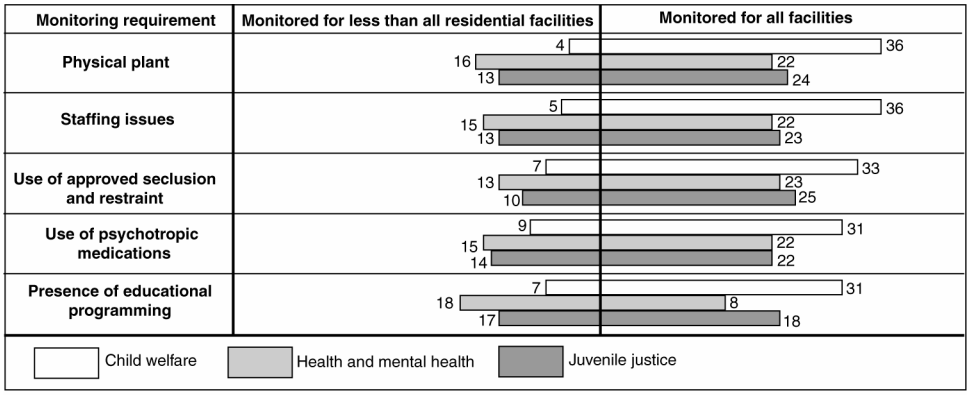
To view the full product, including the scope and methodology, click on GAO-08-696T. For more information, contact Kay E. Brown (202) 512-7215 or brownke@gao.gov.

What GAO Found

Survey respondents from 49 states reported investigating complaints of youth maltreatment in residential facilities in 2006, including physical abuse, neglect, and sexual abuse, and 28 states reported deaths. There were no discernable patterns in the types of facilities involved, including whether facilities were operated by government or private entities, or located in urban or rural areas. State officials said that the number of maltreatment incidents was greater than the total reported to HHS—1,503 incidents in 2005–due to barriers in data collection and reporting, including inconsistent funding and authority.

States license and monitor residential facilities, but state agencies reported oversight gaps that may place youth in some facilities at higher risk for maltreatment and death. Some types of facilities are exempt from state licensing requirements—primarily state operated juvenile justice facilities and private residential schools and academies. Licensing standards did not always address suicide prevention and other common risks. State agencies reported an inability to conduct yearly on-site visits to facilities because of fluctuating levels of staff resources dedicated by states, and infrequently sharing negative findings from their oversight results.

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

HHS, DOJ, and Education hold states accountable for youth well-being, but federal efforts are hindered by the scope of the agencies' oversight authority and practices. Most notably, these agencies do not have the authority to hold states accountable for youth in private residential facilities unless they serve youth in state programs that receive federal funds. For facilities that were under federal purview, federal requirements did not always address the identified risks to youth—including such risks as suicide and inappropriate use of seclusion and restraint—and program requirements were inconsistent. In monitoring state compliance, federal agencies did not always include residential facilities in their oversight reviews.