FACTSHEETS | OCTOBER 2025

Improving Safety and Oversight of Children in Residential Facilities

This factsheet provides an overview of the challenges associated with residential facility placements[1] in child welfare and solutions to improve safety and oversight of children in residential facilities. The information may be useful for State foster care managers, child welfare professionals, related State agencies, licensing bodies for residential facilities, and other partners.

WHAT'S INSIDE

[1] The term "residential facility" refers to a placement setting that provides structured, clinical treatment for children and their behavioral and mental health needs. It is a type of congregate care setting where children live together and are cared for by staff.

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BACKGROUND

The following recent Federal reports call attention to the challenges States face in monitoring child safety in residential facilities:

- *Many States Lack Information to Monitor Maltreatment in Residential Facilities for Children in Foster Care* (U.S. Department of Health and Human Services' Office of the Inspector General [OIG])
- *Child Welfare: Abuse of Youth Placed in Residential Facilities* (U.S. Government Accountability Office [GAO])
- *Warehouses of Neglect: How Taxpayers Are Funding Systemic Abuse in Youth Residential Treatment Facilities* (Senate Finance Committee)

The reports specifically highlight the following issues (OIG, 2024; GAO, 2024; Senate Finance Committee, 2024):

- Young people in residential facilities have experienced physical, emotional, and sexual abuse, including inappropriate use of restraints and overuse of psychotropic medications.
- Many States cannot identify patterns of maltreatment in residential facilities.
- States face oversight challenges in monitoring children in out-of-State residential facilities.
- Residential facility data reported to the National Child Abuse and Neglect Data System (NCANDS), the main data source for Federal oversight of maltreatment, is incomplete.
- Facility conditions are often unsafe, unsanitary, and lack home-like environments.
- Workforce challenges, including understaffing and a lack of training and supervision, contribute to safety issues.

Addressing the challenges highlighted in these reports and improving the safety of children in residential treatment facilities requires coordinated efforts and investment across Federal, State, and local systems. At the Federal level, the Family First Prevention Services Act (FFPSA) of 2018 has taken steps to address challenges in residential facilities by emphasizing the reduction of congregate care, encouraging placements in family settings, and requiring federally funded qualified residential treatment programs (QRTPs) to meet new, higher standards. This supports one of the most effective ways to reduce maltreatment in residential facilities and group homes via prevention: reducing the use of congregate care. However, addressing challenges in residential facilities goes beyond prevention. It also goes beyond Federal requirements, because many States use State or local funding to design their own residential programs, which are not subject to the same Federal standards. In addition, various State departments and licensing bodies share responsibility for the oversight of such facilities.

Improving safety in residential facilities requires a multitiered approach:

- **Federal level:** The role of the Federal Government involves strengthening Medicaid oversight of residential treatment facilities, enhancing data collection and transparency, enforcing title IV-E quality standards, and supporting cross-agency collaboration.

- **State level:** State-level agencies and departments play a role in enforcing licensing and accreditation standards, implementing cross-system coordination (e.g., child welfare, health, education, juvenile justice), monitoring out-of-State placements, and ensuring data-driven oversight.
- **Facility level:** Facilities can improve safety by establishing continuous quality improvement (CQI) systems, implementing trauma-informed care, maintaining appropriate staffing ratios, responding promptly to incidents, and elevating youth voice.

The following sections describe strategies to address challenges in residential facilities and improve safety and oversight, including interstate placements.

BEST PRACTICES FOR IMPROVING OVERSIGHT AND SAFETY

Improving safety and oversight at residential facilities requires collaborations across the various systems and departments that overlap in the operation and management of these facilities, including child welfare departments, health departments, facility administrators and staff, licensing agencies, courts, ombudsman offices, and others.

The leading approach for placements in residential facilities is confirming that stays are medically necessary and time-limited, and care is trauma-informed. Caseworkers, judges, and other professionals who play a role in the decision to place children in residential facilities can improve safety by following that guiding framework. It is a best practice to regularly revisit these placement decisions to determine whether the child is ready to transition to a family-based or kin home. The following are best practices to improve child safety and oversight during necessary stays in residential facilities.

STAFFING AND TRAINING

Workforce challenges and staffing ratios can contribute to supervision and oversight issues in residential facilities. The child welfare workforce has long struggled with high caseloads and workloads, turnover rates, and secondary traumatic stress associated with an emotionally difficult profession (Child Welfare Information Gateway, 2022). Recent reports on residential facilities have identified staff training as an area for improvement (GAO, 2022). Good hiring practices include checking criminal records and the child protection and adult abuse registries in all States where an employee resided within the last 5 years. FFPSA requires these practices, but residential facilities that do not receive title IV-E funding can also benefit from implementing them. In addition, proper staff-to-child ratios based on acuity levels or child needs and providing ongoing training are important. The following are examples of training or other professional development for residential facility staff and related professionals (GAO, 2022):

- **Preservice training.** Training in maltreatment, brain development, and psychological and physical safety is essential for staff who will work unsupervised with children.
- **Deescalation and crisis intervention training.** Training in how to respond to a child in distress may help staff avoid

power struggles with them that could lead to maltreatment. The Crisis Prevention Institute provides 10 tips for deescalation.

- **Trauma-informed care training**. Because trauma-informed care has many benefits for children (and is often a requirement for stays in residential facilities), staff should receive sufficient training on the topic.
- **Mandated reporter training.** Training to educate staff on the role of mandated reporters, how to write incident reports, and how to differentiate incidents for reporting purposes can prevent underreporting of maltreatment.
- **Training for licensing organizations, law enforcement, and others who may respond to maltreatment reports.** Failing to respond correctly to and investigate reports can allow maltreatment to persist. Differing State laws result in different agencies and organizations in each State responding to maltreatment reports in residential facilities. It would be beneficial for jurisdictions to make sure that the responding bodies are properly trained to conduct investigations and substantiate incidents.

In addition to these trainings, staff can benefit from ongoing supervision and secondary trauma support.

FACILITY DESIGN AND ENVIRONMENT

Safety in residential care depends heavily on the facility's layout and environmental conditions. The following practices can promote safe environments:

- Design physical spaces that promote safety and healing (e.g., by incorporating access to natural light and nature, comfortable furniture, and welcoming communal spaces)
- Remove environmental hazards (e.g., pollutants, pests, and poor sanitation)
- Ensure adequate privacy while maintaining appropriate supervision
- Provide sensory spaces for deescalation
- Promote home-like, rather than institutional, environments

YOUTH VOICE AND EMPOWERMENT

Young people living in residential facilities—and in any form of out-of-home care—should be treated as experts in their situations, with their voices valued and honored. For those who work directly with young people, authentic youth engagement involves building a trusting relationship; asking questions to understand their wants, needs, and concerns; being transparent and realistic about the details of their case; and taking a trauma-informed approach to supporting youth. In a residential care environment, the following best practices can help youth be appropriately involved and supported:

- **Establish confidential grievance procedures.** Youth deserve opportunities to express grievances related to safety or other issues without fear of repercussions. Processes should be accessible and understandable for youth.
- **Consult youth advisory boards and councils.** Solicit feedback on facility policies from youth advisory boards to embed youth voice in a facility's operations. Also, help young people who are living in residential facilities become involved in youth leadership groups if they choose.

- **Conduct regular surveys of youth about safety perceptions.** Regular opportunities for youth to anonymously share feedback can help facilities understand what is going well and what needs improvement.
- **Confirm all children in care are educated about and understand their rights.** The rights of youth in care vary by State, with some overarching Federal regulations (e.g., youth age 14 and older have the right to participate in case planning).
- **Assign independent advocates to each child.** Independent advocates, such as representatives from independent nonprofit organizations focused on youth rights and well-being, can support youth by speaking up about their rights and helping them navigate their time in residential care. This may include youth mentorship programs.

Empowering youth includes advocating for and supporting their mental health. A best practice—and required for federally funded QRTPs and applicable to other residential placements—is to have a qualified mental health professional review and confirm the necessity of the placement decision.

Family engagement is also a best practice at all levels of the child welfare continuum, which includes engaging the families of children living in residential facilities. The Children's Bureau-funded National Center for Adoption Competent Mental Health Services developed a brief on the topic, *Are We Practicing What We Preach? Family Partnership in Residential Care*.

MONITORING AND OVERSIGHT

Holding residential facilities accountable through monitoring and oversight is essential to preventing maltreatment. Oversight occurs at the Federal, State, and local levels. The Federal Government enacts policies and guidance for States, such as FFPSA, and enforces them through various mechanisms, such as the U.S. Centers for Medicare and Medicaid Services, which ensures that residential facilities serving Medicare and Medicaid beneficiaries meet Federal health and safety standards.

Licensing processes and requirements vary by State, as most residential facilities are licensed through a State entity (e.g., the social services department). The following are strategies jurisdictions can implement to improve monitoring and oversight of residential facilities:

- **Enforce licensing and accreditation standards.** States should regularly review facilities' contracts to monitor compliance and whether they continue to meet licensing and accreditation standards, including adherence to the agency's incident reporting policy. Opportunities to strengthen and improve licensing and accreditation standards may also exist (e.g., States may choose to hold non-QRTPs to the same standards as federally funded QRTPs).
- **Conduct unannounced and frequent visits.** An important part of enforcement is visits to facilities by licensing authorities and other involved departments (e.g., health departments, child welfare agencies, etc.). In Massachusetts, child welfare staff make both announced and unannounced visits to check if providers are in compliance with their contracts (GAO, 2022).
- **Dedicate one entity to respond to maltreatment.** Depending on the jurisdiction, a combination of entities

(e.g., social services departments, law enforcement, licensing bodies) is responsible for overseeing facilities, which may result in fragmented oversight that is insufficiently focused on preventing and investigating maltreatment (GAO, 2022). States may address this challenge by designating a single entity to respond to maltreatment, including investigating incidents and taking corrective action. The New York State Justice Center is an example of an oversight agency that was specifically designed to protect vulnerable children and adults from abuse and neglect, including those living in residential facilities.

- **Utilize robust incident reporting systems with follow-up investigations.** Establishing processes for reporting, responding to, and investigating incidents of maltreatment is essential to preventing future incidents.
- **Consult independent ombudsman programs to investigate complaints.** This provides an additional layer of oversight by an entity outside of the residential facility.
- **Collaborate with adjacent systems to share information about facility performance.** Partnering with other systems that may serve children and people in residential facilities (e.g., education, health, juvenile justice) can allow child welfare agencies to cross-check data and concerns about facilities. This includes practicing judicial oversight as a safety mechanism.
- **Monitoring out-of-State placements**. The Federal reports on oversight in residential facilities demonstrate that children living in out-of-State facilities may not receive the same oversight and monitoring as those living in-State.

Cross-Agency Collaboration in Oversight

One of the greatest challenges associated with monitoring and oversight of residential facilities is collaboration among the many agencies and entities that share responsibility for enforcing safety. Roles and responsibilities vary by State, and involved parties may include child welfare agencies, licensing agencies, law enforcement agencies, courts, health care and Medicaid departments, mental health providers, child advocacy organizations, and more. Cross-agency collaboration promotes more efficient operations and oversight. A lack of communication can result in a lack of oversight, ultimately compromising child safety.

DATA COLLECTION, SHARING, AND USE

Improving data collection, sharing, and use is a key component of increasing child safety and reducing maltreatment in residential facilities. An important first step is improving the reporting of NCANDS data, including the number of States that report and the quality of the data they report. States may also benefit from reviewing and refining data collected on residential facilities to identify challenges and areas for improvement. Data on the following categories may be helpful for regular safety and program quality monitoring (MacBlane & Sparks, 2024):

- Restraints or seclusions
- Critical incidents
- Maltreatment reports

- Direct care staff vacancies
- Clinical staff vacancies
- Staff tenure
- Length of stay
- Discharge
- Return to care

Tracking the number of maltreatment reports by facility can help States identify trends and take corrective action. For example, the California Department of Social Services uses data to improve oversight and accountability by maintaining, through its Community Care Licensing Division, a public website that lists the number of maltreatment complaints filed against each licensed facility in the State (GAO, 2022).

INTERSTATE PLACEMENTS

In fiscal year (FY) 2024, States placed nearly 5,270 children in out-of-State residential facilities (AAICPC, personal communication, July 18, 2025). They reported difficulty monitoring children in these facilities because the State placing them must often rely on licensing information and maltreatment reports from the State where the facility is located (GAO, 2022). Placements out-of-State may also hinder regular visits from parents, caseworkers, or court-appointed special advocates.

The Interstate Compact on the Placement of Children (ICPC), a statutory agreement between the 50 States, the District of Columbia, and the U.S. Virgin Islands, administers out-of-State placements through a multistep process that involves the sending State's ICPC office submitting a request to the receiving State's ICPC office. The Association of Administrators of the Interstate Compact on the Placement of Children (AAICPC), an affiliate of the American Public Human Services Association (APHSA), oversees the ICPC and its administrative procedures. Usually, the ICPC requires the receiving State to supervise youth placed in its State; however, it excludes placements in residential treatment centers and group homes. The sending agency is required to monitor and visit in accordance with applicable laws. In some cases, the residential facility may supervise children with limited regular contact from either State's child welfare agency.

It is important that States enhance cross-State communication and oversight to improve the safety, well-being, and outcomes of children in out-of-State residential facilities. The following strategies may support these efforts:

- **Develop specific partnerships and processes with nearby States.** Jurisdictions that are adjacent or regularly work together on out-of-State placements could benefit from developing specific processes and procedures for that State partnership. For example, Oregon and Washington child welfare agencies have a border agreement that allows for expedited processes in certain counties when placing children in kinship care across State lines, which may support more placements with family and fewer in residential facilities (Washington State Department of Social and Health Services & Oregon Department of Human Services, 2010). Adjacent States may also benefit from comparing and responding to varying State laws and policies, as

well as interpretations of Federal laws, since nuances (e.g., different definitions of maltreatment or mandated reporter guidelines) could result in unreported or underreported instances of maltreatment.

- **Share information beyond what is required.** For out-of-State residential facility placements, the ICPC requires only certain information (e.g., an acceptance from the receiving facility, approval of the placement by the receiving State ICPC), which limits the sending State's knowledge of a facility's safety and reputation. In addition, very few ICPC residential facility requests are denied; according to FY 2024 data from the AAICPC, approximately 1 percent were denied, 97 percent were approved, and 2 percent were withdrawn (personal communication, July 18, 2025). Receiving States can go beyond what the ICPC requires by sharing additional information with sending States about facilities. For example, if the child welfare agency in one State receives an ICPC request for a facility it does not use for in-State children, the ICPC office should notify the sending State so it can revisit its placement decision.
- **Use technology.** Prior to 2013, ICPC processes were antiquated in most jurisdictions, requiring agencies to submit physical paperwork across State lines. That changed in 2013, when APHSA and AAICPC developed the National Electronic Interstate Compact Enterprise (NEICE), an online system where States can quickly and securely exchange data and documents required by the ICPC. In addition to introducing technology into ICPC processes, the online system has reduced paperwork, sped up decision-making, reduced wait times for placements, and enhanced data collection and analysis (APHSA, n.d.). When States contribute to and use national data platforms, such as NCANDS, AFCARS, and NEICE, uniform participation can improve State-level operations and provide opportunities for Federal technical assistance.
- **Establish teams to monitor out-of-State placements**. Because children living in out-of-State residential facilities often do not receive regular visits from their States' child welfare agency (GAO, 2022), it may be beneficial to establish teams that conduct regular check-ins. For example, District of Columbia officials established an interagency committee to monitor the well-being of these children, including coordinating outreach to providers and agencies in other States to discuss allegations of maltreatment (GAO, 2022).
- **Limit out-of-State residential placements.** Because of challenges in monitoring children living in out-of-State residential facilities, it is a best practice to keep them in-State when possible. Developing and implementing strategies to improve in-State capacity may reduce reliance on out-of-State placements.

STATE-LEVEL PROMISING PRACTICES

WASHINGTON: PRIORITIZING IN-STATE BEHAVIORAL REHABILITATION SERVICES

The Washington State Department of Children, Youth, and Families (DCYF) has worked to reduce the number of children living in out-of-State facilities in part by increasing supports for in-State facilities. In 2019, the State Legislature increased its Behavior Rehabilitation Services (BRS) budget

to stabilize current providers and increase the number of providers and BRS beds available within the State. As a result of this and other efforts to keep youth in-State, the number of youth placed out-of-State decreased from 64 in 2019 to 7 in 2024 (DCYF, 2021; DCYF, 2025). Other strategies to keep youth within the State include higher levels of approval for out-of-State facility placements, increasing community engagement for youth at risk of being placed out-of-State, and issuing grant funding to BRS facility providers to renovate their spaces.

FLORIDA: RESIDENTIAL GROUP CARE ACCOUNTABILITY SYSTEM

In 2017, a State law went into effect requiring the Florida Department of Children and Families (DCF) to develop a statewide accountability system for licensed residential group care providers based on measurable quality standards. The resulting quality standards and comprehensive assessment tool, the Group Care Quality Standards Assessment (GCQSA), have been implemented statewide. The accountability system was developed with a diverse group of partners, including youth who experienced foster care, with the goal of transforming residential services through research-informed practice standards, ongoing assessment, and continuous quality improvement. The GCQSA measures a residential program's performance on 59 quality standards across eight domains:

1. Assessment, admission, and service planning
2. Positive, safe living environment
3. Monitor and report problems
4. Family, culture, and spirituality
5. Professional and competent staff
6. Program elements
7. Education, skills, and positive outcomes
8. Pre- and postdischarge processes

While the project team has published only baseline data thus far, continued data collection will allow them to establish performance trends to monitor service quality and the effectiveness of potential quality improvement efforts over time (Florida Institute for Child Welfare, 2023). In addition, the most recent report recommends adding outcome measures to the statewide accountability system to ensure that quality practices are resulting in positive youth outcomes.

MICHIGAN: UPSTREAM STRATEGIES TO PREVENT CONGREGATE CARE PLACEMENTS

The Michigan Department of Health and Human Services (MDHHS) reduced the number of children living in congregate care from more than 1,000 in 2019 to fewer than 400 in 2023 (Blancato et al., 2024). A major component of their reduction efforts was addressing upstream factors to strengthen placement stability and treat children's intensive mental and behavioral health needs. Upon finding that upstream interventions were not being fully utilized prior to referring children to congregate care, MDHHS leaders implemented the following strategies:

- Strengthen children's access to high-quality, community-based behavioral health services while in family-based placements.
- Increase placements with and supports for kin caregivers, where children experience more stability, fewer placement moves, and better behavioral and mental health outcomes compared with children in non-kin settings.

For more information, explore *Addressing Upstream Factors: Reducing the Number of Michigan Children in Congregate Care*.

VIRGINIA: CROSS-AGENCY COLLABORATION AND ACCOUNTABILITY

In Virginia, an Independent Assessment Certification and Coordination Team (IACCT) evaluates the clinical necessity of residential facility placements and provides ongoing oversight. The care coordination process involves families, providers, and assessors in service planning, and the IACCT continues to engage and follow up with the youth and their family throughout the placement period, including conducting reassessments. The IACCT process is administered by Virginia's Department of Medical Assistance Services, the agency that oversees the Medicaid program, exemplifying cross-agency collaboration between child welfare and Medicaid services. The process advances FFPSA objectives by validating clinical necessity, engaging families, and promoting accountability.

ARIZONA: CONGREGATE CARE REDUCTION TEAMS

In FY 2023, Arizona's congregate care placement rate was double the national average, with 20 percent of children living in group homes or institutions (Children's Bureau, 2025). As part of its efforts to reduce reliance upon these placement settings and to better align with the national average, the Arizona Department of Child Safety (DCS) developed its Congregate Care Reduction unit. Since launching in February 2024, the unit has focused on reassessing cases of children in congregate care and on identifying potential caregivers for them. The percentage of children in congregate care dropped to 16.8 percent as of July 2025 (personal communication, July 22, 2025). The Arizona DCS continues to work toward goals to reduce congregate care use to 10.5 percent and increase the percentage of days children spend in family-like settings from 77.9 percent to 85.0 percent.

ADDITIONAL RESOURCES

- **Decision-Making in Child Welfare for Improved Safety Outcomes (National Child Welfare Center for Innovation and Advancement [formerly the Capacity Building Center for States])** This brief provides an overview of relevant child welfare safety assessment tools and decision-making theories and frameworks.
- **Transformational Change Readiness Toolkit (Association of Children's Residential & Community Services)** This toolkit is designed to help organizations begin to transform their practices with a goal of reducing their reliance on providing predominantly residential interventions.
- **Addressing the Complex Needs of Youth: A Call to Action (APHSA)** This report uses survey findings from 125 health and human services agencies to explore how agencies define, assess, and manage youth with complex or high-acuity needs and outline policy and practice reforms to improve service delivery for these young people.

CONCLUSION

Numerous concerns exist about maltreatment occurring in residential facilities and the State's challenges in monitoring this issue, particularly for children living out of State.

When these placements are necessary for children to receive certain therapeutic treatment, stays should be time-limited and well-monitored. Additional steps jurisdictions can take to improve safety and oversight in residential facilities include improving data collection, sharing, and use; implementing improved hiring and training practices for facility staff; and strengthening licensing and accountability measures. States can address challenges related to interstate placements by using the NEICE system and by implementing oversight practices beyond what is required by the ICPC. The policy and practice strategies described in this factsheet provide jurisdictions with options they can implement to support child safety, well-being, and permanency.

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