Why Foster Children Are Sleeping in Offices and What We Can Do About It

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Key Points

- Efforts to deinstitutionalize foster care have significantly reduced placement capacity and forced older children and those with higher levels of need to live in a range of inappropriate settings—child welfare offices, emergency rooms, hotels, and homeless shelters.
- Deinstitutionalization efforts in juvenile justice, increasing acuity levels within the child welfare population, and the failure to develop alternative placements capable of serving the children and youth previously in congregate care have compounded the crisis.
- The federal government must exempt Qualified Residential Treatment Programs (QRTPs) from classification as institutions for mental disease under Medicaid, amend the Family First Prevention Services Act to provide an exemption from QRTP standards for programs serving youth in the juvenile justice system, and significantly increase federal investment in developing alternative placements to congregate care that can capably serve and support older youth and youth with higher levels of need.

Across the country, child welfare systems are struggling to find placements for children and youth in foster care—especially those who are older and have higher levels of need. While bed shortages have long plagued child welfare systems, a confluence of issues has caused the problem to metastasize into a crisis. These issues include increasing levels of need within the foster care population, financial challenges facing direct service providers, and ideological shifts that have driven new legislative and regulatory requirements and new restrictions on funding and administrative decision-making.

The result is that states and counties are rapidly losing residential treatment and congregate care capacity while struggling to recruit and retain foster homes capable of serving higher-needs foster children. Consequently, foster children across the country are increasingly being housed in a range of temporary settings, including county and state offices, hospitals, hotels, and shelters. These placements' unsuitability and frequency have attracted significant press attention.

An August 2022 story in the *Philadelphia Inquirer* investigated the Philadelphia Department of Human Services' use of its conference rooms as temporary housing for foster children. According to its own data, the department has housed more than 300 kids in its offices for at least one night over the previous year. Most nights, five to 10 children with complex needs are sleeping in the "childcare room," where

young children are comingled with teenagers. Safety concerns—including assault, vandalism, and trafficking—are rampant. Some children spend weeks if not months there. Children are likewise languishing for extended periods in other inappropriate settings such as emergency rooms and juvenile detention centers.[1]

Michigan is also suffering from a shortage of behavioral and psychiatric treatment programs. An August 2022 *Detroit News* article featured one 9-year-old foster child who spent at least six weeks in a hospital emergency department as he awaited placement. In the same article, the head of the Michigan Health and Human Services Department described the placement issue as "very pervasive."[2] The state is currently under federal court monitoring to develop corrective action to address these issues.

The crisis is perhaps most acute in Illinois, where, as reported by the Illinois Answers Project, the Illinois Department of Children and Family Services (DCFS) has documented since 2018 more than 2,000 cases of foster children being improperly held in inappropriate settings, including offices, shelters, and psychiatric hospitals. The DCFS director was held in contempt of court 12 separate times in 2022 for failing to provide an appropriate placement for foster children—the last finding centering on a 15-year-old girl who was held in a mental hospital for nearly six months while awaiting placement. Since 2015, the state has lost at least 460 children's residential treatment beds.[3]

In West Virginia and Montana, hundreds of foster youth have been sent to facilities out of state, where program quality is a concern, oversight is more difficult, and many have experienced unsafe and abusive situations, including improper restraint, isolation, and alleged sexual assault. According to West Virginia Public Broadcasting,[4] the lack of in-state youth mental health care is cited as a primary reason children are sent out of state. Likewise, in Montana, children are sent out of state due to bed shortages at in-state facilities, according to Kaiser Health News.[5]

These states are not outliers. Similar stories have emerged in Colorado,[6] Georgia,[7] New Mexico,[8] North Dakota,[9] Oregon,[10] Virginia,[11] and Washington,[12] among others.

Who Is Affected?

Of the nearly 400,000 children and youth who were in care on September 30, 2021, about one-third are age 12 and older.[13] While placement shortages persist across child welfare systems, they are most acute for older children, especially those with behavioral health challenges. Foster parents rarely sign up to host a teenager, and unfortunately these youth are the least likely to be adopted. Kinship care can be a solution for many older youth who come into the system, as relatives are more likely to take them in. However, states must support these families in navigating the licensing process and ensure they have access to sufficient resources and services to adequately support the youth in their care. Both kinship and foster families struggle to access essential support services in adjacent child-serving systems such as education. For children and youth who do not have kin able to take them in, the options are few.

Due to the combination of the maltreatment they experienced prior to removal and the trauma associated with being in care, foster children experience significantly higher levels of mental and behavioral health challenges than their peers do. Adolescence is a time when mental and behavioral health challenges often manifest or compound. Older foster youth often require placements that can provide a higher level of support to address their needs.

Meanwhile, the severity of behavioral and mental health problems experienced by children and youth entering foster care has also been steadily increasing, due largely to three major factors. First, states have reduced the number of children and youth they take into foster care by more than 30 percent since 2000,[14] effectively raising the threshold for removal and increasing the likelihood that children coming into foster care have experienced extensive abuse, neglect, adverse childhood experiences, and associated traumas.

Second, the US is experiencing a broader youth mental health crisis.[15] Rates of self-reported depression, anxiety, self-harm, related emergency room visits, and suicides among American youth are all increasing. These trends are also reflected among children and youth in foster care. Finally, deinstitutionalization efforts in other systems have caused many states to close juvenile detention centers,

funneling increasing numbers of youth who have previously been served in the juvenile justice system and cannot be sent home into the foster care system.

More recent research indicates that approximately four in five children and youth in congregate care have a mental health diagnosis.

Historically, child welfare systems have placed a significant number of older children with mental and behavioral health challenges in a range of congregate care programs, from community group homes to more restrictive residential treatment programs.[16] In 2015, the US Department of Health and Human Services Children's Bureau published "A National Look at the Use of Congregate Care in Child Welfare," a brief examining congregate care data trends across the country. The authors found that, compared to their peers in foster care, children who are placed in congregate care are three times as likely to have a mental health diagnosis and six times as likely to have had a "child behavior problem" cited as a contributing factor to their removal from home.[17] More recent research indicates that approximately four in five children and youth in congregate care have a mental health diagnosis.[18] The federal brief found that nearly 70 percent of the children in congregate care were age 13 and older.[19]

As systems have steadily shed congregate care capacity, though, they have not developed suitable alternative placements to serve the children who have historically been placed in these programs. At the very time when higher proportions of children in foster care require placements capable of delivering intensive mental health services and supports, systems' capacity for meeting these needs has shrunk.

An Evolving Approach to Congregate Care

There is a consensus in the child welfare field that foster children generally have better outcomes when they are placed in family-based settings whenever safe and appropriate. Acting from this principle, most child welfare systems have significantly reduced the number and percentage of foster children placed in congregate care over the past two decades. According to the 2015 Children's Bureau brief, the use of congregate care by child welfare systems declined by 37 percent between 2004 and 2013.[20]

Some states and service-provider associations have also pushed congregate care providers to transform their program models away from long-term boarding toward short-term, intensive stabilization and treatment with aftercare services that follow the child back into family-based care. California began implementing its Continuum of Care Reform (CCR) in 2015. CCR was designed to ensure that foster children live in family-based care whenever possible and reenvisioned congregate care as a short-term, therapeutic intervention. The state phased out lower-level community group homes and created a new licensing category of short-term residential therapeutic programs that are required to provide integrated, specialized, and intensive services and supports to children whose needs cannot be met in family-based care. California also invested significant state resources in developing alternative placements for children and youth who had previously been served in group homes, including additional foster parent recruitment and retention and expansion of therapeutic foster care.

The transformation of congregate care's role in the child welfare continuum has been inconsistent across the country; a few states have even increased its use in recent years. Growing frustration with this uneven pace of progress to reduce congregate care has spurred advocates and policymakers to pressure states into further action.

The Federal Government Steps In

Driven by the goal of keeping foster children in family-based placements and strictly limiting the use of congregate care, national advocates and legislators teamed up to advance new federal restrictions. In 2013, the Annie E. Casey Foundation released a policy brief, "When Child Welfare Works," calling for "system disincentives" to "ensure that group care is used exclusively as a short-term treatment intervention." The foundation proposed eliminating federal reimbursement for all forms of congregate

care for children under age 13, limiting the length of federal reimbursement for residential treatment to a maximum of 12 months for youth age 13 and older, and eliminating federal reimbursement for shelter care.[21]

In the same year, Sen. Orrin Hatch (R-UT) introduced Senate Bill 1518,[22] which proposed similar new restrictions and time limits on federal reimbursement for congregate care programs. Two years later, Sen. Hatch became chairman of the US Senate Finance Committee and began working closely with Sen. Ron Wyden (D-OR), the committee's ranking member, on a bipartisan foster care reform effort. One of Hatch's primary objectives in this process was to impose the "system disincentives" proposed by the Casey Foundation to reduce congregate care.

In May 2015, the Senate Finance Committee held a hearing titled "No Place to Grow Up: How to Safely Reduce Reliance on Foster Care Group Homes." Much of the hearing comprised anecdotes to illustrate how congregate care programs were "warehousing" children who did not need to be there, frequently overmedicating or abusing them and profiting off them.[23]

Several factors led to the development of this misguided narrative. First, some states have done an inexcusably poor job of overseeing and regulating congregate care programs, and as a result, there have been cases of horrifying abuse and even death of children residing in these programs. Second, there was definitional confusion about "congregate care" and the differences among the various types of programs referred to with that umbrella term. As a result, many policymakers had a hard time differentiating among programs intended to serve as a step down from locked detention for juvenile offenders, programs providing round-the-clock intensive mental health services, and programs that provided for transition-age youth to live independently as they approached adulthood.

Family First Prevention Services Act Implications

Following the Senate Finance Committee hearing, Congress began work on what is now known as the Family First Prevention Services Act (FFPSA). When enacted in 2018, the law imposed new restrictions on federal funding for all forms of congregate care despite warnings from some states about potential unintended consequences, including placement shortages and youth crossing over into other systems. Whereas historically the federal government had reimbursed states through Title IV-E for a broad range of congregate care placements for children in foster care, FFPSA established a new category of congregate care programs—qualified residential treatment programs (QRTPs)—and required direct service agencies to meet specific standards to remain eligible for federal reimbursement.

With few exceptions, programs that did not offer a therapeutic model and meet QRTP standards would be ineligible for federal funding after two weeks of placement, including community group homes and programs designed to "step down" youth from the juvenile justice system back into the community. Though FFPSA was ostensibly modeled after California's CCR initiative—which, despite significant state investments, was already struggling to achieve its goals—the two initiatives had significant differences, including that FFPSA invests essentially nothing in the development of congregate care alternatives. Passage of FFPSA and the resulting establishment in 2021 of restrictions on federal reimbursement have led to significant further reductions in state congregate care capacity.

At the same time, FFPSA also triggered a regulatory issue in the Medicaid program known as the institutions for mental disease (IMD) exclusion. Under the IMD exclusion, the federal government has historically prohibited Medicaid reimbursement for services to individuals under age 65 who are served in institutions with more than 16 beds that are primarily engaged in the "diagnosis, treatment or care of persons with mental disease."[24]

When Congress established the QRTP licensing category for children's residential treatment programs under FFPSA, it drew the Centers for Medicare & Medicaid Services' attention to these programs, which generally use Title IV-E funding to pay for room and board and Medicaid to pay for health and behavioral health care. As a result, most of the therapeutic residential programs that meet QRTP standards to remain eligible for Title IV-E reimbursement under FFPSA have simultaneously had to reduce their capacity to 16 or fewer beds to ensure their patients remain eligible for Medicaid

reimbursement. This has further reduced residential treatment facility capacity for foster children in states across the country.

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These changes have exacerbated the fiscal challenges that congregate care programs have long experienced. While we often hear that congregate care programs "profit" off children, the vast majority are actually nonprofit organizations, and their contracts with public systems typically do not cover the full cost of care for their residents, meaning they are forced to raise private funds to sustain their operations. Inflation, staffing challenges, increased compliance costs, and rising insurance premiums have all placed enormous stress on the fiscal viability of many programs. Having to operate at further reduced capacity due to the IMD exclusion is causing many of these programs to either go out of business entirely or close their doors to the foster care system and focus the delivery of their therapeutic services on other child populations, such as unaccompanied minors or children with acute behavioral challenges who are covered through their parents' private insurance plans.

Meanwhile, without federal support to develop alternatives to congregate care, states have no other options, resulting all too often in inappropriate office, shelter, and hospital stays. By delegating responsibility to states to resolve the question of where to place children and youth who have historically been served in congregate care, the federal government has shirked its responsibility to ensure the safety and well-being of all children in foster care. It has also helped create the current situation in which some of the most vulnerable children and youth in the system are falling through the cracks.

Recommendations

In the 1950s and 1960s, the United States began the process of adult deinstitutionalization as a response to growing awareness about the poor living conditions experienced by many residents of the country's psychiatric hospitals and homes. Unfortunately, this mental health reform effort was severely flawed, largely due to the country's failure to simultaneously invest in the development of sufficient community-based alternatives to institutional mental health care and inability to properly distinguish which individuals can be served through community-based services and which cannot. The outcomes of this failure are well-documented and include significantly high rates of homelessness and criminal justice system involvement for individuals suffering from mental health issues. The United States is currently making the same deinstitutionalization mistake in the field of child welfare.

To avoid the worst outcomes for children in need of intensive mental health services and reverse the placement trends outlined in this report, the country needs to reimagine the role of congregate care within the child welfare system. In line with the broader goals of FFPSA, we offer the following immediate and actionable recommendations to ensure that residential treatment facilities provide short-term, intensive, and developmentally appropriate mental health stabilization and treatment to foster children with acute needs while addressing the law's unintended consequences.

- Congress should pass legislation exempting QRTPs from classification as IMDs under Medicaid. This would expand the availability of the high-quality residential treatment programs identified in FFPSA as crucial components of the child welfare continuum. Similar exemptions already exist for psychiatric residential treatment facilities and inpatient psychiatric services provided in psychiatric hospitals or in the psychiatric wings of general hospitals.

- Under FFPSA, the federal government now allows three types of non-QRTP congregate care programs to maintain IV-E eligibility beyond two weeks: programs serving pregnant and parenting youth, programs providing supervised independent living for non-minor dependents who are at least

18 years old, and programs focused on sexually trafficked children and youth. Congress should amend FFPSA to allow ongoing Title IV-E reimbursement eligibility for congregate care programs designed to serve youth in the juvenile justice system as a fourth exempted programmatic category, while regulating how states comingle this population with other foster youth who have not crossed over into juvenile justice.

- The federal government and states must significantly increase investment in the development of alternative placements capable of serving older youth or youth with behavioral challenges. This includes ensuring the availability and accessibility of intensive behavioral health services in community-based placements, expanding the therapeutic foster home model, and providing strategic foster parent recruitment and retention efforts to increase the availability of foster homes that will take in the children and youth who have historically been served in congregate care.

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