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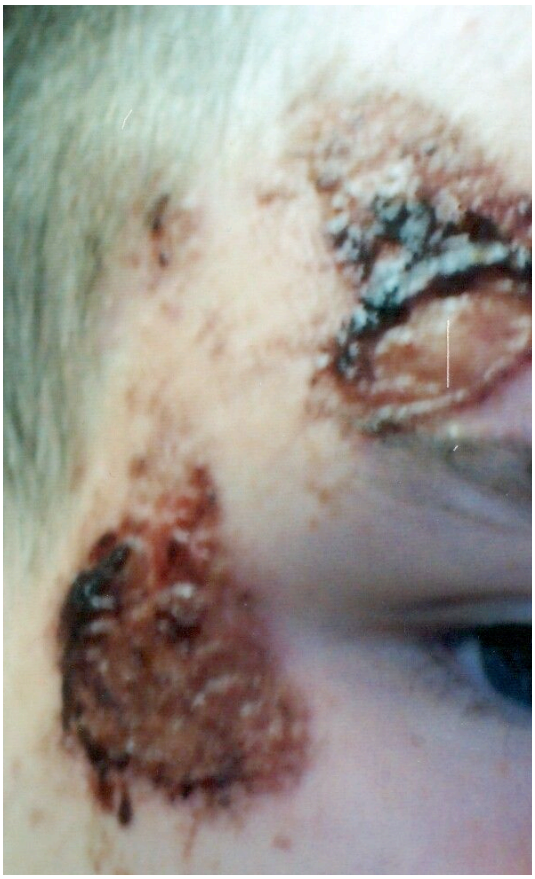

LOUISIANA'S FAILURE TO INSURE HEALTH AND SAFETY OF CHILDREN IN RESIDENTIAL FACILITIES

A report from
ADVOCACY CENTER
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FOREWORD

The Advocacy Center (AC) is the agency designated by the Governor of Louisiana and by federal law[1] to protect and advocate for the rights of individuals with disabilities in the State of Louisiana. As part of its mission, AC staff regularly visit people with disabilities and seniors in various types of residential facilities: nursing homes; group homes; board and care facilities; developmental centers; mental health hospitals; and any other place where people with disabilities and seniors live and receive care and treatment.

When we started visiting child residential care facilities five years ago, we expected to, and did, receive complaints from the residents about the care they received and the conditions in which they lived. We did **not** expect to see a system so out of control that these facilities fail to meet their residents' most basic needs.

Some of the conditions in these facilities, witnessed by our staff, were disturbing; some of the stories relayed by the young residents of these facilities were not only disturbing, but alarming. Some of the routine practices carried out by these facilities are clearly illegal; and the process by which the facilities are licensed is downright astounding.

We delved deeper, asking to see the official reports of the government agency that licenses these facilities. What we read in those reports only strengthened our resolve to focus attention on these facilities. We communicated and met with government officials to discuss individual complaints and systemic issues. **The responses we received from these officials, if any, were discouraging.**

I would like to acknowledge the hard work and dedication of the AC staff who visited the facilities, researched and compiled information, and wrote the report: Jeanne Abadie, Glyn Butler; Sharon Eubanks; Nell Hahn; Melissa Losch; Suzanne Miller; Stephanie Patrick; Deborah Sauder; Ginger Van Wart; Sarah Voigt; and Barbara Washington-Davis.

We hope that by shedding light on the true conditions in these child residential facilities, not only will conditions improve, but we, as a society, will seek and find better ways of caring for these vulnerable children.

We encourage you to take the time to read this report. **We hope the report compels you to join the ranks of those who advocate for children with disabilities or to strengthen your commitment to doing so.**

Lois Simpson
Executive Director
Advocacy Center

[1] The Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. § 15041 *et seq*., the Protection and Advocacy for Mentally Ill Individuals Act of 1986, 42 U.S.C. § 10801 *et seq*., and the Protection and Advocacy of Individual Rights program, 29 U.S.C. § 794e.

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EXECUTIVE SUMMARY

The Advocacy Center (AC) is the agency designated by the Governor of Louisiana and by federal law to protect and advocate for the rights of individuals with disabilities in the State of Louisiana.

Louisiana's Department of Social Services ("DSS") licenses more than 50 "child residential facilities" that provide 24-hour care to children. The majority of these children are either in the custody of the Office of Community Services, having been removed from their homes due to abuse or neglect, or in the custody of the Office of Youth Development.

Many of the children in such facilities have emotional and behavioral disorders or other disabilities.

For the last five years, Advocacy Center Client Advocates have regularly visited child residential facilities. Their first-hand observations document that these facilities often fail to provide proper medical, dental, and mental health care; fail to insure that staff are properly trained and supervised; fail to insure that children are properly supervised and treated with respect; fail to insure that children are not subjected to improper physical restraints, seclusion, or other loss of privileges; fail to provide clean, homelike, and well-maintained physical surroundings; fail to give children private means of communicating with family and friends; fail to provide a healthy, adequate diet; and neglect the educational rights of children with disabilities.

Louisiana's licensing statute for these facilities fails to provide an adequate framework for assuring the health, safety, and welfare of children in these facilities. Among the deficiencies of the statute are:

- That it grants final authority over residential facility licensing regulations and standards to two committees, none of whose members is required to be an expert in child residential care and treatment, and many of whose members are providers.
- That it allows the issuance of licenses without full regulatory compliance.
- That it requires the Department to seek the approval of the relevant committee before denying or revoking a facility's license, and gives the committee veto power over such action.
- That it does not permit DSS to assess civil fines and penalties when facilities violate minimum standards.

The Advocacy Center requested DSS's Bureau of Licensing reports for the years 2004-2006, and up to August of 2007. A review of these reports shows that a shocking number of the facilities had serious violations of minimum licensing standards including:

- 38% of the facilities had violations relating to staff criminal background checks;
- 62% of the facilities were found to violate minimum standards regarding children's medications;
- 53% of the facilities failed to assure that children received proper medical and/or dental care;
- 33% of the facilities were cited for not following proper procedures or violating procedures pertaining to abuse/neglect;
- 62% of the facilities were cited for not assuring their staff received all required annual training;

- 69% of the facilities were cited for not assuring that children were living in a proper physical environment;
- 36% of the facilities were cited for not having appropriate treatment plans or for inappropriate execution of children's treatment plans;
- 33% of the facilities were cited for not assuring that sufficient qualified direct service staff was present with the children as necessary to ensure the health, safety and well being of children.

Many facilities were found to be in violation of minimum standards on inspection after inspection. Specific examples of such repeat violators from across the State are discussed in the report.

In November 2007, the State Legislative Auditor issued a report of its audit of the Bureau of Licensing, which concluded that there were serious deficiencies in the State's licensing program. Among its findings were that 90% of the child residential facilities the auditor sampled had deficiencies when DSS had most recently renewed their licenses; that DSS lacks appropriate enforcement strategies and policies; and that between January 1, 2004 and May 30, 2006, DSS referred only two Class A child residential facilities, and no Class B child residential facilities, to the appropriate committee for license revocation.

The Department has recently published proposed revised regulations setting minimum standards and enforcement procedures for child residential facilities, which would eliminate many of the specific standards that are contained in the existing regulations, and would allow providers to be licensed even though they do not meet all, but only a percentage, of licensing standards. If adopted, they would represent a step backward in the enforcement of adequate standards in such facilities.

The Advocacy Center recommends that the Legislature adopt a more effective licensing framework, including civil fines and sanctions for facilities that violate standards; and that it insure that the Department has adequate resources for enforcement. The Department must not relax its licensing standards, and should enforce them much more aggressively. Complaints should be investigated thoroughly and promptly. Current deficiency information and validated investigation findings should be made available to the public on the Internet. More data should be collected to make sure that children in residential facilities are being served appropriately, and that they experience good outcomes. The State should greatly reduce the number of children kept in residential facilities by expanding opportunities for children to live in more integrated settings.

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OUT OF CONTROL:
LOUISIANA'S FAILURE TO INSURE HEALTH AND SAFETY OF CHILDREN IN RESIDENTIAL FACILITIES

INTRODUCTION

Louisiana's Department of Social Services ("DSS") licenses more than 50 "child residential facilities" that provide 24-hour care to children. Many of these facilities provide care to children who are in the custody of the State, not through any fault of their own, but because they have been victims of abuse or neglect.[2] Other children in child residential facilities are in the custody of the Office of Youth Development because they have committed offenses; but their behavior has not been extreme enough to warrant placement in more secure facilities maintained by OYD. Still other children are placed in child residential facilities by other states or by their parents on a private pay basis.

Because many of the children in such facilities have emotional and behavioral disorders or other disabilities,[3] Advocacy Center staff has visited child residential facilities regularly for five years to inform children and staff of the children's rights and to keep an eye on conditions in the facilities.

ADVOCACY CENTER STAFF OBSERVATIONS

Advocacy Center Client Advocates began regular visits to a limited number of child residential facilities throughout the state approximately five years ago.[4] Facilities were selected for visits based on previous problems; anecdotal evidence from children residing in the facilities, facility staff, and other adults who came into contact with residents and staff; licensing surveys; and news articles.

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[2] The Department of Social Services's Office of Community Services ("OCS") has custody of children removed from their homes because of abuse or neglect.

[3] The American Academy of Pediatrics has found that more than 80% of children in foster care have developmental, emotional, or behavioral problems. See Child Welfare League of America, *Standards of Excellence for Residential Services*, p. 13 (2004). According to a study conducted for the U.S. Department of Health and Human Services regarding children in foster care, about half of the foster children in out-of-home care (49%) were reported to need services for an emotional, behavioral, or attention problem, while almost two-fifths (39%) needed services to identify a learning problem or developmental disability. U.S. Department of Health and Human Services, Administration for Children, Youth and Families (November 2001). National Survey of Child and Adolescent Well-Being: One Year in Foster Care Report. Washington, D.C. at pages 127-128.
http://www.acf.hhs.gov/programs/core/ongoing_research/afc/nscaw_oyfc/oyfc_report.pdf.
This study found also that "children in group homes (59%) were significantly more likely than those in both foster homes and kin care settings to have received at least one specialty mental health service" at page 123-126, and children in group homes (21%) were significantly more likely than those in both foster homes (3%) and kin care settings (0%) to have been to a psychiatric hospital or unit." at page 123-126.

[4] From 2004 to 2008, Client Advocates from the Advocacy Center visited and met with the residents at 27 different Class A licensed child residential facilities. They met with residents of 19 of these facilities on three or more occasions during this period. Advocacy Center staff did not visit residents in 28 of the State's child residential facilities during this period.

During these visits, advocates spoke to the children about their rights, questioned children and staff about conditions, and conducted physical checks of the facilities as much as possible.

Based on Advocacy Center staff observations, many of these residential facilities fail to meet their residents' most basic needs. They deny children appropriate medical and dental care. They fail to select, train, and supervise staff appropriately, with the result that children are subjected to inappropriate physical restraints and loss of privileges. Their physical facilities are poorly maintained, in disrepair, and dirty. Educational rights of children with disabilities are often neglected. Children in such facilities are sometimes injured by other residents or staff, and many run away.

1. DENIAL OF MEDICAL, DENTAL AND MENTAL HEALTH CARE

Licensing standards assign responsibility for obtaining needed medical treatment to the child residential facilities.[4] However, the medical and dental health of children in child residential facilities is often neglected. According to reports that have been provided to the Advocacy Center (discussed in more detail in Section 2), DSS's Bureau of Licensing has cited the majority of facilities for violations of standards related to medical and dental care.

For example, at **Christian Acres, a facility in North Louisiana**, children complained to an Advocacy Center Client Advocate that the staff nurse refused to see them or treat their medical conditions when they went to her office. A teacher agreed, reporting that one of the children was sent to the nurse because he was bleeding and the nurse had refused to give him a band-aid. Findings from a report by the Bureau of Licensing dated February 1, 2007, regarding this same facility, are quoted below.

The facility was cited for failing to show that children always received prescribed medication on weekends and evenings, and failing to ensure that children received timely medical care.

[4] 67 L.A.C. §1913(N)-(R), *Louisiana Register*, V. 33, No. 12 (December 20, 2007) pp. 2712-13 (formerly 48 L.A.C. §7913(N)-(R)). The current version of the licensing regulations for Child Residential Facilities, published in the Louisiana Register in December 2007, moved Title 48 of the Louisiana Administrative Code to Title 67, and renumbered its sections. Provisions covering Child Residential Facilities, which formerly appeared in Title 48 L.A.C., Chapter 79, now appear at Title 67, L.A.C., Chapter 19, *Louisiana Register* V. 33, No. 12, pp. 2699-2756. Since the Bureau of Licensing surveys that are cited in this report were conducted using the regulations as they appeared in Title 48 of the Administrative Code, this report will cite to the regulations as they appeared in the Bureau of Licensing surveys when discussing those surveys, and to the current version when discussing current requirements.

In addition, the report noted that one child failed to receive medication because she did not have medical insurance. The report also noted that the facility had failed to document in children's medical records the specific treatments ordered as a result of emergency room visits.[5]

At **Hope Haven, a facility in the New Orleans area**, a Client Advocate met a child who complained she had not received her prescribed medication for three days.

The advocate discovered that the facility staff had failed to order a refill on her medication and were unaware the child was not receiving it.

Child residential facilities are supposed to ensure services to meet the mental health needs of the children, including "individual, group, and family counseling."[6] At several facilities regularly visited by the Advocacy Center, children complained that they have poor access to individual counselors through the facilities or local offices of mental health agencies. The Bureau of Licensing has cited one of these facilities for deficiencies in mental health services.[7]

2. STAFFING ISSUES

At many facilities, children report a lack of respect by staff. **Advocacy Center staff have observed facility staff yelling at the children, cursing, and discussing confidential, potentially embarrassing information about one child in front of a whole group of children.** During visits to some facilities, Advocacy Center Client Advocates **have observed facility staff talking outside with friends or on their cell phones for significant periods of time.** These workers do not appear to be supervising the children or providing care and treatment. Licensing reports confirm that there are significant failures in staff supervision and training at many facilities.

Staff turnover is very high – at some facilities, there are new staff there each time the Advocacy Center visits. **High staff turnover makes it difficult for the children and staff to develop relationships and for the facility to provide the safe environment these children need.**

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[5] Christian Acres, survey report dated 2/1/2007: Residents Health Records (§7909.O.1.a-c): *The Provider failed to maintain complete health records for each child including: c. a complete record of any treatment and medication provided for a specific illness or medical emergencies. *this is evidenced by medication administration records failed to show that medication was always received by child as ordered on weekends, evenings and explanations not always provided. **children's records failed to contain over the counter medication received from control center.*
Timely Competent Medical Care (§7913.O.4): *The Provider failed to ensure that a child received timely medical care when he was ill or injured as evidenced by children during 2 incidents of abuse allegations noted to have indication of medical attention being warranted however no evidence of medical [sic] received. **1 child in need of cholesterol monitoring.*
Records of Medical Examinations (§7913.O.5): Records *of emergency room visits do not specify treatment ordered*.
Physicians Written Order (§7913.R.5): *The Provider failed to ensure that residents as ordered by physician as evidenced by 1 resident failed to have received medication due to not having insurance. See also deficiency at §7909.O.1.a-c.*

[6] 67 L.A.C. §1913(M)(1)(e), *Louisiana Register*, V. 33, No. 12 (December 20, 2007) pp. 2712-13 (formerly 48 L.A.C. §7913 (M)(1)(e)).

[7] According to a report by the Department of Social Services, Bureau of Licensing dated January 15, 2005, Hope Youth Ranch was cited because a child who was admitted three months earlier was noted to need counseling related to grief, suicidal tendencies, and behavioral issues, yet those services had not been implemented.

At **Harmony Center's Longfellow Group Home in the Baton Rouge area**, an Advocacy Center Client Advocate has observed that children are allowed to sign themselves in and out of the home. Each time she has visited, at least one or two children are signed out.[8]

A Bureau of Licensing report dated August 8, 2005, cited the facility for violating licensing regulations regarding adequate staffing.

The Baton Rouge *Advocate* reported on October 6, 2007, that a 17-year-old resident raped an 11-year-old resident in the bathroom of this facility.[10]

When the Advocacy Center's advocate visited the facility in 2007, she observed that two boys were fighting on the bed in one of the bedrooms. Facility staff was not present, and the advocate had to call a worker from another area of the house to intervene.

3. INAPPROPRIATE RESTRAINTS AND LOSS OF PRIVILEGES

Advocacy Center Client Advocates often receive complaints from children about the use of physical restraints.

Children report that they are battered and bruised at the hands of staff and that restraints are commonly used to punish them for failure to follow commands, rather than to prevent harm to them or to others, as required by law.[11]

At **Hope Youth Ranch in North Louisiana**, Advocacy Center staff has observed ongoing problems with excessive use of restraints and related injuries, and children have complained of improper takedowns and restraints. In 2006, **a 10-year-old resident of the facility passed out**

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[8] 67 L.A.C. §1911(H)(3), *Louisiana Register*, V. 33, No. 12 (December 20, 2007) p. 2707 (formerly 48 L.A.C. §7911(H)(3)): "A Provider shall ensure that an adequate number of qualified direct service staff are present with the children as necessary to ensure the health, safety, and well-being of children. Staff coverage shall be maintained in consideration of the time of day, the size and nature of the Provider, the ages and needs of the children, and shall assure the continual safety, protection, direct care, and supervision of children.
(a) The Provider shall have at least one (1) adult staff present and awake for every six (6) children when children are present and awake.
(b) The Provider shall have at least one (1) adult staff present and awake for every twelve (12) children when children are present and asleep. In addition to required staff, at least one (1) staff person shall be on call in case of emergency."

[10] "Teen jailed in rape of boy, 11, at home" 10/6/07, Baton Rouge *Advocate*. In May of 2008, the Baton Rouge *Advocate* reported a rape of a resident of the Lester Roberts Group Home, another Harmony Center child residential facility in Baton Rouge, an the discovery of two earlier rape allegations during the investigation of the May rape. "State to inspect group homes," 6/4/08.

[11] 67 L.A.C. §1917(J)(1)(e), Louisiana *Register*, V. 33, No. 12 (December 20, 2007) p. 2717 (formerly 18 L.A.C. §7917(J)(1)) provides that "a provider shall not use any form of mechanical, physical, or chemical restraint. Passive physical restraint shall only be utilized when the child's behaviors escalate to a level of possibly harming himself/herself or others."

during a takedown. According to the OCS investigative report and facility reports, he urinated on himself and was not responsive when the nurse arrived. He was eventually transported to the hospital. **The OCS Child Protective Services report of its investigation of this incident, dated August 18, 2006, notes, "Licensing will be notified of a child care deficiency regarding improper restraint technique by both staff."**[12]

A review of the facility's next licensing inspection, dated October 4, 2006, reveals no citations regarding the use of restraint or seclusion or staff training deficiencies.

In another instance at **Hope Youth Ranch** in 2006, **Advocacy Center staff observed injuries to a resident, who reported that he had received these injuries while being restrained.** In this case, through interviews with facility staff and OCS, the Advocacy Center learned that the injury had not been reported by the facility to the child's OCS worker. After the Advocacy Center's intervention, the administrator of the facility reported that restraint procedures had been modified.

A review of the 2005 and 2006 licensing inspections of this facility reflects no citations related to excessive restraints or injuries to children. The facility was cited on August 31, 2005 for failure to consistently document follow-up training for staff, after internal investigations of abuse and/or neglect.

At the **Methodist Home for Children in New Orleans**,[13] a female resident complained that **a staff member forced her to lie face down on the carpet, and then placed his/her weight on the back of the resident's knees**.

Another older female resident at the same facility complained that a staff member forced her to lie on the ground by knocking the back of her knees with his legs.

Licensing surveys reviewed by the Advocacy Center from 2004 – 2007 showed that **the Bureau of Licensing cited 13 facilities for violations of Child Residential Care Minimum Standards on restraints**, 48 L.A.C. §7917(J) (now 67 L.A.C. §1917(J), *Louisiana Register*, V. 33, No. 12 (December 20, 2007) p. 2717). Those facilities are:

- Joy Home for Boys
- Rutherford I
- Rutherford II
- Rutherford III
- Rutherford IV
- Boys and Girls Village Foundation
- Christian Acres

[12] Though DSS's Child Protective Services report cited, *According to Dr. Moore, (X) has redness and petichiae from his chest up and that staff who was restraining him was putting too much pressure on his chest, restricting his airway which made him pass out,* Child Protective Services found insufficient evidence to validate the complaint of child abuse or neglect.

[13] The Methodist Home for Children in New Orleans recently relocated to Mandeville, LA and its name was changed to LA United Methodist Children & Family Services (MHCGN).

- Methodist Home for Children
- Sanctuary, Inc.--Boys Facility
- Sanctuary, Inc.–Girls Facility
- Cane River Children's Services
- New Directions at Greenbrier
- Harmony Center Vermillion Group Home

Most of these facilities were cited for performing physical restraint with only one staff person, while regulations require that two staff restrain a person. Two of the facilities were cited for restraining children other than at times when they were a danger to themselves or others.

On a visit to **Hope Youth Ranch** several years ago, an Advocacy Center Client Advocate saw a child sitting in a chair in the corner of the main living area, facing the wall.

He said that he had been punished in the chair for approximately seven days.

Through conversations with the children and facility staff, the advocate discovered that the facility had a written policy that required teens to sit in a chair in the corner of the main living area as a punishment for rule infractions. The chair faced the wall and the resident was allowed no contact with other teens while in the chair. The resident was not allowed to speak unless spoken to by the staff. **Each time the teen broke this rule, the punishment was extended. It could last up to six hours per day and could continue for days or weeks.** For more severe infractions, the child was forced to bring his or her mattress into the living room and sleep on the floor. **After the Advocacy Center's Client Advocate intervened, this practice was stopped and the behavior management policy was rewritten.**

4. POOR PHYSICAL CONDITION OF THE FACILITIES

The physical conditions at most child residential facilities are dismal. Drab, concrete block walls, torn and scarred linoleum, stained couches and broken furniture are commonplace. Routine facility maintenance is often deferred: window screens are often broken, light bulbs often burned out, and doors often do not close properly.

It would seem that the children who live in these facilities cannot help but feel that the general neglect of their physical surroundings reflects the fact that they, themselves, are discarded and unimportant.

At **Hope Haven**, Advocacy Center staff observed **rattraps, missing linoleum, and missing electrical outlet covers on one unit**. On the same unit, children reported the presence of a rat or mouse**.** Throughout the facility, children reported seeing and killing a large number of insects.

On one unit, Advocacy Center staff observed a divider that was falling down in one of the shower stalls, **mildew, and missing shower controls**. Three of the **shower stalls were not operational**. Children on one unit reported having to use an elaborate system that involved one child having to

flush the toilet or turn on water in a lavatory, in order for another child, who was showering, to be able to take a shower with water that was not too hot or too cold. One of the residents complained that during a nighttime thunderstorm, **the acoustical ceiling tile over her bed fell down**. Fortunately, the resident, who was in bed at the time, was not hurt.

She reported that some insulation and brownish water dripped on her.

Though the leak was repaired a short time after the incident, the ceiling tile was not replaced until a couple of months later. **It was not until months later that the facility finally agreed to close one unit until repairs could be completed**.

When a child residential facility owned by **Harmony, Inc.** on Vermillion Street in Lafayette was damaged by fire, residents were first lodged in a hotel, then moved into a temporary facility on Sixth St. in Lafayette. The Department had not previously licensed the Sixth Street facility, and it was not previously used as a child residential facility. When Advocacy Center staff visited the Sixth Street facility at the end of March 2008, they observed dirty conditions and a number of adults loitering nearby who said they were waiting for a homeless shelter in the area to open.

The Advocacy Center subsequently learned that the residents were being housed at the facility despite the fact that Office of Public Health had failed to approve its licensing due to numerous health violations, including the presence of rats and roaches and the lack of plumbing maintenance.

According to correspondence from the Bureau of Licensing, the Office of Public Health did not recommend the licensure of the facility until the end of April—almost eight weeks *after* children were placed there.

Cleanliness is another problem. Dirt and dust are the norm in many of these facilities. **Mold and mildew** are apparent in many bathroom areas. **Spiders, scorpions, flies and other insects** can be found in light fixtures, on windowsills, or crawling through the facilities. During a routine outreach and monitoring visit to **Hope Youth Ranch in North Louisiana**, one resident complained about mold and mildew in his dorm bathroom. Soon, many of the other 64 residents, especially the older ones, were echoing his complaints.

After investigation, the client advocate discovered that five of the six dorms were dirty, smelled bad and had evidence of mold and mildew.

Through a meeting with facility administration, the advocate discovered that, in the five dirty dorms, residents were totally responsible for cleaning their bathrooms, with very little supervision from staff. **Because state regulations prohibited children from being exposed to certain chemicals, these dorms were not being cleaned properly.**

Though this was standard operating procedure at the facility for at least two years, and though the facility was repeatedly cited by the Bureau of Licensing for violations of the standard relating to

routine maintenance and cleaning of the interior space,[14] **this situation did not change until after the Advocacy Center intervened.**

Findings from Bureau of Licensing surveys from 2004-2007 confirm that there are widespread problems in this area. During the time period over which the Advocacy Center reviewed licensing surveys, 36 of the 55 facilities that are currently open were cited for issues related to "physical environment."

Examples of some of these citations were holes in the walls, broken furniture, broken windows, missing doors, leaking showers and toilets, missing oven door, stopped up commodes and rodent droppings. As an example, on January 23, 2007, Boys and Girls Village Foundation was cited for having insect/rodent droppings in the pantry cabinet in the educational building and rodent droppings in the food pantry building. Also found in the food pantry building was a glue trap containing one recently dead rodent and one decaying rodent. Rodent droppings were also found in the kitchen area of the gym.[15]

[14] Licensing reports reflect citations for cleanliness of the facility (48 L.A.C. §7919(B)(2), now 67 L.A.C. §1919(B)(2), *Louisiana Register*, V. 33, No. 12 (December 20, 2007) p. 2717): "A provider shall ensure that there is evidence of routine maintenance and cleaning programs in all areas of the facility") on January 19, 2005, April 11, 2006, and October 4, 2006.

[15] The Bureau of Licensing report for this facility dated January 23, 2007 cited the facility for violating 48 L.A.C. §1713(L) because there was evidence of expired and rotten food in the refrigerator and evidence of food exposed to freezer air in the freezer.

Photos, taken by Advocacy Center staff, of interiors and exteriors of Child Residential Care Facilities.

Based on Advocacy Center staff observations, many of these residential care facilities fail to meet their residents' most basic needs.

Additional interior shots of facilities, the mission of which is to provide environments "similar to those of a normal family home in the community."

Dirt and dust are the norm; mold and mildew are apparent in many bathroom areas.

5. QUALITY OF LIFE ISSUES

Child residential facilities are supposed to be home-like. "The arrangement, appearance and furnishing of all interior areas of the facility shall be similar to those of a normal family home in the community."[16]

Most child residential facilities more closely resemble large institutions or prisons.

In **Hope Haven**, all windows are covered, which means that **children restricted to their units have no opportunity to see outside for days at a time**. At **Christian Acres**, a facility in North Louisiana, an Advocacy Center Client Advocate observed that children's **mattresses were extremely thin, dirty and had holes**. Children complained that the mattresses were uncomfortable. Two other facilities visited by Advocacy Center staff, **Novice House in Tallulah and Sanctuary Inc. - Boys Facility in Eunice**, **look more like old nursing homes** with dilapidated furnishings and walls, than like "normal family homes in the community".

Access to telephones and ability to make telephone calls in privacy are the subject of common complaints from residents of child residential facilities. Children are often placed at facilities miles from their homes, and their families have limited access to transportation or funds to make long distance calls.

Yet these children often complain that they do not have regular access to the telephone, and that they often have to "earn" the privilege of contacting family members. Children report that they lose telephone privileges for significant periods of time for infractions of facility rules.

During one visit to **Christian Acres**, children complained to an Advocacy Center Client Advocate that when they called people outside the facility collect, a message was broadcast to the recipient stating, "You are receiving a call from a correctional facility." The children also reported that they were unable to call toll-free telephone numbers, including that of the Advocacy Center and that it was difficult for them to obtain reasonably priced calling cards. **Though these children are in a residential facility, their experience is more like being incarcerated than like living in a normal family home.** At **Sanctuary Inc. - Girls Facility in Eunice**, residents complained to Advocacy Center staff that their phone privileges were often restricted and that **they were not allowed to make phone calls in private**. Though a report from the Bureau of Licensing dated January 30, 2006, indicated that the facility had been cited for violating standards relating to telephone access, the Advocacy Center's advocates confirmed that these problems continued eight months later.

Advocacy Center staff receives complaints about the food at child residential facilities on a regular basis. On the Controlled Intensive Units at Hope Haven, the Advocacy Center observed that the portions appeared small and children reported that, while **they were allowed second helpings of juice, there were no seconds on food**. AC staff reviewed the "weight control" menu at

[16] 48 L.A.C. §7919(B)(1), now 67 L.A.C. §1919(B)(1), *Louisiana Register*, V. 33, No. 12 (December 20, 2007) p. 2717.

this facility – one lunch consisted of pork and beans and tater tots. At the **Methodist Children's Home in New Orleans**, children reported that, for children with allergies, sandwiches were often substituted for planned meals.

One child reported that she was told to remove the seafood from her shrimp Creole after reminding the staff of her allergy. She reported that she did so and became ill.

Another child reported that she was served sandwiches regularly because she was not able to eat the planned meal due to allergies. **After the intervention of the Advocacy Center, this policy was changed and children with allergies were given adequate and appropriate alternative meals.**

Children often run away from these facilities. Bureau of Licensing surveys of **Boys and Girls Village in Lake Charles** dated April 30, 2004, November 30, 2004, and March 22, 2005, cite the facility for significant deficiencies related to physical environment and restraint use. **In May, 2006, the New Orleans *Times Picayune* reported that three children ran away from the facility, and two of them were killed after falling asleep on train tracks.**[17] The article stated that the facility had had 57 runaways in a two and a half month period in early 2006. The Bureau of Licensing report on the facility dated January 26, 2007 cited the facility for 25 deficiencies regarding such areas as physical environment, rights protection, and reporting of critical incidents, which could explain the high incidence of run-aways.

6. ACCESS TO RECREATION

At many facilities, **children report that they are provided with recreational opportunities only once or twice a month**. When Advocacy Center Client Advocates questioned children and staff as to why this is the case, they report staff shortages, vehicle maintenance issues, and lack of funding as excuses. Children have also complained about access to time outdoors each day.

According to children, this access is often very limited and contingent on the mood of the direct care staff. According to Child Residential Minimum Standards, children are to have access to appropriate recreation that is tailored to their interests.[18] However, **children have reported to Advocacy Center staff that entire groups are denied "outside time" as punishment for the behavior of one individual in the group**. Other children have reported that outside time in the evening is very limited unless volunteers are there. At **Hope Haven**, many children reported that posted unit schedules, which are supposed to indicate when recreational activities are provided, are not followed consistently. At other facilities, no schedules are posted, so it is difficult for advocates to determine how much recreation is provided.

[17] "Train hits, kills two teens AWOL from group home:, *Times-Picayune*, 5/18/06.

[18] 67 L.A.C. §1919(H)(1), *Louisiana Register*, V. 33, No. 12 (December 20, 2007) pp. 2710-11 (formerly 48 L.A.C. §7913(H)(1)) provides that "Provider shall have a written plan for insuring that a range of indoor and outdoor recreational and leisure opportunities are provided for children. Such opportunities shall be based on both the individual interests and needs of the children and the composition of the living group."

7. EDUCATIONAL ISSUES

The Advocacy Center has visited a number of facilities in which the educational rights of children with disabilities appear to be neglected. At several facilities, our staff has observed children whose disabilities should entitle them to Individualized Educational Programs ("IEPs") that provide special educational accommodations for their disabilities so that individualized goals can be attained.

Advocacy Center staff learned that these children either did not have current IEPs, or, if they did have them, the programs outlined on the IEPs were not being implemented.

Advocacy Center staff also observed children who had not been evaluated to determine whether they need special education services or accommodations, though they had discernable disabilities. Staff at several facilities cited problems in obtaining IEPs from previous schools. When a new IEP is written for a student at a residential facility school, the educational services and related services that the IEP provides often appear to be based on what is readily available at the facility, rather than on the student's individual needs.

Some facilities attempt to educate students on-site, rather than send them to community public schools. This deprives the children of the opportunity to meet and interact with children outside of the facility and to access extra curricular activities. Further, because so many of the children in residential facilities have disabilities, this practice results in segregation of children with disabilities from non-disabled peers. For example:

- At **Christian Acres**, children are not allowed to attend school off site unless they require a specific program (GED, Vo-tech) that is not offered at the facility.

- According to administrators, as interviewed by AC client advocates, at **Hope Youth Ranch in Minden and Cool Springs in Logansport**, children are never allowed to attend school off campus.

- At **Boys and Girls Village and Hope Haven, children must "earn" the right to attend school off campus by progressing through a "level" system.** They enter the facility on the bottom "level," and must exhibit good behavior over a period of time in order to be permitted to attend an off-site school. Yet, some of the children in these facilities are there because of a lack of foster placements—not for problem behavior.

The on-site schools often are inadequate. For example, when the Advocacy Center staff observed the on-site school at **Hope Haven**, students were being taught in a single classroom located in their dorm. **It appeared that all of the students were being taught the same material, though there was a considerable age range.** There appeared to be no accommodations such as those that would have been required on an IEP. Also at Hope Haven, Advocacy Center staff went to visit the classroom of a student with a hearing impairment, whose IEP called for her to have a sign-language interpreter. **No interpreter was present in the room, and the class was continuing without the interpreter.**

The student could not hear what was going on. The teacher complained to the Advocacy Center's staff person that the child was not paying attention or cooperating.

According to Bureau of Licensing reports, **New Directions at Greenbrier did not have an agreement with the Department of Education to operate the school that the children were attending.** These reports show that this facility was cited for not having an agreement with the Department of Education on September 27, 2006, December 4, 2006, and February 21, 2007.

At the on-site school at **Christian Acres**, where the school and facility staff did not seem to have a clear way to determine the classes into which each child should be placed, a child waited almost a year for special education services. **In several facilities where children attend school off campus, their initial placement within the school district has been the alternative school.**

THE LICENSING STATUTE IS INADEQUATE

Louisiana's licensing statute for these facilities fails to provide an adequate framework for assuring the health, safety, and welfare of children in these facilities. The Child Care Facility and Child-Placing Agency Licensing Act, L.R.S. 46:1403 *et seq*. ("the Licensing Act"), applies to day care centers, child residential facilities, and child placing agencies.

The Licensing Act creates two classes of licenses for such facilities, with different regulations and procedures applicable to each. The regulation of all Class A facilities[19] is carried out by a 20-member committee called the Louisiana Advisory Committee on Licensing of Child Care Facilities, §1406. This committee, appointed by the Governor, is made up of seven providers of the child care services that are regulated by the committee,[20] eight "consumers of child care services" selected "to insure a socioeconomic and ethnic balance" representative of the State's population, two "professional persons" (who need not have any expertise in child day care, child residential care, or child placement), and two representatives of the "educational community," one of whom is to be a specialist in early childhood education and the other a specialist in child development. **The committee members serve staggered three-year terms, without compensation, and there are no provisions for committee staff, frequency of meetings, or aspects of committee function.** The director of the division of licensing and certification of the Department of Social Services is a non-voting member of the committee.

The Licensing Act gives this committee, not the Department of Social Services, final authority over the regulations that govern the diverse group of facilities that hold Class A child care and child placement licenses. This committee must approve all rules, regulations and standards that govern Class A facilities, §1409(A).

The Act requires the Department to verify compliance with the minimum requirements for a license, and with all other state and local laws and regulations, before issuing a Class A license to a new applicant. However, it permits the Department to provide for the issuance of "temporary, provisional, or extended licenses," a situation that has allowed for licensure without full regulatory compliance.

Class B facilities, which do not receive federal, state, or local funds, are governed by a different committee - the Louisiana Committee on Private Child Care. All of the members this committee are elected by the owners of the facilities that are subject to these regulations, §1410. By statute, these elected members must be "affiliated with" the type of facility represented, §1410((C)(2).

The Louisiana Committee on Private Child Care develops the minimum standards that Class B facilities are required to meet,[21] and promulgates the rules and regulations governing the facilities.

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[19] Pursuant to §1412(D), this category includes all facilities that directly or indirectly receive state, local, or federal funding.

[20] Of the seven provider members, two must be providers of private, for-profit day care; two must be providers of non-profit, tax-exempt day care; one must be a provider of foster care.

[21] The statute does establish certain minimum requirements of fire safety, and health and sanitation for Class B facilities, §1410(C) and (D); provides that "no felon" shall be employed in one, though this may be waived, §1410(F); and provides that no one who has been treated for a psychiatric disorder shall be employed without a statement from a treating physician on file, §1410(G).

The Department of Social Services is required to issue a Class B license to any facility that reports to the Department the names of its owners and directors; a statement that neither the owners nor the directors have been convicted of a felony; and the name, address, and telephone number of the facility.

While the Department is required to inspect all facilities covered by the Act annually, and is required to investigate complaints, it is not required to refuse licensure to facilities that do not meet minimum standards.

It *may* deny, revoke, or refuse to renew a license, but only with the consent of the committee that oversees the facility, §1419. The Secretary of the Department is permitted to waive compliance with minimum standards if their economic impact is deemed too great to make compliance "impractical," so long as the health and well-being of the staff and/or children is not imperiled.

If it is determined that a facility is meeting the "intent" of a standard or regulation, the Department "may" deem that a Class A facility, and "shall" deem that a Class B facility, is meeting standards.

The statute does not permit DSS to assess civil fines and penalties when facilities violate minimum standards. And it requires the "advice and consent" of the appropriate committee in order for DSS to revoke a facility's license.

In 2005, an amendment to the Act was proposed,[22] which would have (among other things) eliminated the Louisiana Advisory Committee on Licensing of Child Care Facilities' veto power over Class A licensing regulations, and given the Department, not the Louisiana Committee on Private Child Care, the power to promulgate licensing regulations for Class B facilities. It also would have eliminated the committees' veto power over decisions by the Department to deny, revoke, or refuse to renew a license. **An amended version of this bill, Act 332, became law.**

Act 332 eliminated any major reforms.

It retained the role of both committees in approving or promulgating regulations, and acting upon licenses, and simply provided that if the committees failed to act on the Department's recommendations within a certain length of time, the Department's recommendations would become effective.

The regulatory scheme established by the Act is far too feeble and industry-friendly to assure adequate protection of children committed to the care of residential facilities in Louisiana.

The State has custody of most of the children in Class A facilities through the child welfare or the juvenile justice system. **These children are dependent upon these institutions for all of their daily needs—food, clothing, shelter, health care, access to educational resources, discipline, and social interactions.** The children are not free to leave.

[22] SB 155, 2005 Regular Session.

The State owes them rigorous enforcement of standards necessary to insure their health, safety, and welfare.

It owes them a system that adheres to the best evidence-based practices available for the care and supervision of children.

Further, **all children deserve equal protection under the law**. Under the current Louisiana statute, standards in Class B child residential facilities are lower than those in Class A facilities in the important areas of required staffing ratios, permissibility of corporal punishment, behavior management, sleeping accommodations, and emergency and safety plans.

Louisiana is the only state in the nation with two sets of standards for child day care centers.

The statutory scheme is clearly insufficient to insure strong, unbiased, and effective regulation of child residential facilities. By allowing committees drawn largely from the regulated industries, rather than disinterested Department officials, to establish and enforce the standards that residential facilities are required to meet, **Louisiana is shirking its duty to the children in its care.**[23] By failing to make adherence to minimum standards a clear and mandatory condition of obtaining and retaining a license to operate, and by failing to provide for a variety of tools, including a system of civil fines and penalties, for insuring facilities' compliance with the law, **the Legislature fails to provide the Department of Social Services with the tools it needs to do an effective job of enforcement**.

[23] The fact that these committees regulate diverse types of facilities, including adoption agencies and day care centers; that only two of the 15 members of the committee governing Class A residential facilities necessarily know anything about child residential facilities; that none of the members of the committee are required to have expertise in child residential care and treatment; and that the statute contains no requirements as to when the committees must meet and provides no compensation or staff for the committees—are all secondary to the overall inadequacies of the statutory scheme.

FACILITIES VIOLATE MINIMUM LICENSING STANDARDS

In 2006 and 2007, the Advocacy Center requested DSS to provide it with all of the inspection reports on all child residential facilities within the state. Advocacy Center staff reviewed all of these reports, and found that **facilities are repeatedly violating minimum standards in serious ways, including insufficient monitoring of children's medications, improper medical care, untrained staff, lack of appropriate individualized treatment plans, and insufficient staff coverage.** Many of the facilities have a pattern of violating the same standard over and over, in several successive surveys. Yet DSS has either been unwilling or unable to make them comply.

Despite the Advocacy Center's requests for all inspection reports for the period January 1, 2004, through August 16, 2007, the Bureau of Licensing did not furnish all of the facilities' inspection reports. The Department's website[24] lists, by date, the ten most recent inspections for each child residential facility and child care facility. Random checks show that one or more inspection reports were missing from those produced for a number of facilities. Nevertheless, the reports of the majority of inspections for all 55 facilities with current Class A licenses were reviewed by Advocacy Center staff, and each facility's violations in each area of the standards was noted.[25]

1. MANY OF THE FACILITIES ARE IN VIOLATION OF MINIMUM LICENSING STANDARDS:

The sheer number of child residential facilities with serious violations of minimum licensing standards, often repeated in inspection after inspection, is alarming. Examples of these violations are given below.

Twenty-one (21) facilities (38%) repeated the same violations over three consecutive survey visits, and 35 facilities (64%) repeated violations of standards over two consecutive survey visits, some with several repeat violations.

- Knowingly employing a person who was convicted of carnal knowledge of a juvenile.
- Knowingly employing a person who had been convicted of aggravated assault.
- Failing to produce satisfactory criminal record checks for employees on six out of six surveys.
- Employing nine staff who did not have criminal background checks on file, and failing to produce evidence that the criminal background checks had been requested. This same facility validated an incident of sexual abuse by a staff member.

[24] www.dss.state.la.us/departments/os/child_care_facilities_by_parish.html

[25] Currently, there are only two facilities with Class B licenses, those facilities are not considered in this section.

Thirty-four (34) facilities (62%) were found to violate minimum standards regarding children's medications. Examples of such violations included:

- Failing to give a child medication because the child did not remind them to do so.
- Failing to keep medications under lock and key.
- Several instances at a particular facility of prescribed medications (including psychotropic drugs) being unavailable.
- Administration of both a psychotropic drug that was supposed to have been discontinued, and a newly ordered psychotropic drug, for an entire week before the facility nurse discovered the error.
- 10 facilities had repeat violations in the area of medication administration.

Twenty-nice (29) facilities (53%) failed to assure that children received proper medical and/or dental care. Examples of such violations included:

- Failure to follow the advice of the physical exam, which caused a child to be hospitalized for gastrointestinal pain and spitting up blood.
- One child was shown to have cavities in need of restoration during a dental exam in September. In December, there was no evidence of follow-up by the facility.
- Failure to schedule a follow up to an abnormal pap smear for over nine months.
- One child was shot in the abdomen, but there was no record of the treatment or hospitalizations at the facility. At the same facility, a child was hospitalized for a suicide attempt. There was no record of treatment and no discharge record in the child's file.

Eighteen (18) facilities (33%) were cited for not following proper procedures or violating procedures pertaining to abuse/neglect. Examples of such violations included:

- Failure to investigate allegations of abuse, including an allegation of rape.
- Failure to prevent an employee accused of abuse from working with the accuser until the investigation concluded. The same facility failed to assure that the child was protected from harassment during the abuse/neglect investigation.
- One child while on "runaway" claimed she was sexually assaulted. There is documentation that when called, the director told the shift supervisor to tell the resident to take a "cold shower." The director says that he said the resident should take a shower. There was no evidence that medical treatment was sought for the sexual assault.

Thirty-four (34) facilities (62%) were cited for not assuring their staff received all required annual training,

- Of those 23 facilities, 13 had staff that did not have the required CPR and/or First Aid certification.
- 12 of the 23 facilities cited had repeat violations.

Thirty-eight (38) of the facilities (69%) were cited for not assuring that children were living in a proper physical environment. Examples include:

- Toilets and showers lacking doors.
- Exposed electrical wires.
- Broken windows.
- Dirty shower stalls and mildewed shower curtains.
- Strong urine stench in the hall and rodent droppings in the bedrooms.
- One facility was cited for rodent droppings in the pantry as well as a recently trapped mouse and a decaying mouse on a glue trap.

Twenty (20) facilities (36%) were cited for not having appropriate treatment plans or for inappropriate execution of children's treatment plans. Examples include:

- Having children perform work related tasks as "punishment" although this is not part of the treatment plan.
- Placing children in "lock down," without a policy describing what "lock down" is and under what circumstances it can be used.
- Restraining children inappropriately or in ways that contravene proper practice and procedure.
- One facility admitted a child noted to have counseling needs related to grief, suicidal tendencies and behavioral issues, yet no such treatment was included in her plan.

***Eighteen (18) facilities (33%) were cited for not assuring that sufficient qualified direct service staff was present with the children as necessary to ensure the health, safety and well* being of children. Examples include:**

- A facility that did not insure staff on duty were informed of a child's condition and suicidal tendencies. The child went into his room unsupervised and committed suicide.
- One facility had only one staff member on duty to supervise ten children. Six of the children went AWOL.
- One facility was noted to have 21 documented incidents of not assuring that the necessary number of qualified staff were on duty.
- One facility cited for inadequate staff had 14 incidents of runaways over the course of one month.

Eight (8) facilities (15%) were cited for violating the rights of the children in the facility, including:

- Sexual abuse of children by facility staff.
- Subjecting children who make complaints to fear of reprisal.

- Permitting children to be denied medication or scheduled school attendance as "punishment".
- Improperly restricting telephone communications or visits with family, friends, or legal counsel.

2. VIOLATIONS ARE REPEATED IN INSPECTION AFTER INSPECTION, WITH NO CONSEQUENCES AND NO MECHANISM FOR ENFORCING COMPLIANCE.[26]

Twenty-nine of the 57 licensed child residential facilities have been awarded contracts covering the period 2007-2010 to care for children in the custody of OCS. Most of these facilities have been repeatedly cited for serious deficiencies.

The facilities whose inspection records are described below[27] are representative of those we reviewed. Some were better—many were just as bad or worse.

OUR HOUSE, MONROE[28]

According to reports of the Bureau of Licensing the provider was cited for violations of regulations regarding required contents of employee personnel files in eight inspections from 2004 to 2007.[29] **In each of ten inspection reports provided to the Advocacy Center, the facility was cited for failing to have statements of good health, signed by a physician, on file for staff.**[30] According to the inspection reports that were provided to the Advocacy Center, it was cited for **failing to meet standards for the orientation and annual training of staff in seven inspections from 2004 through 2007**.[31] These standards include training in such matters as implementation of treatment plans, emergency and safety procedures, detecting and reporting abuse and neglect, children's rights, basic health practices and skills, crisis de-escalation and behavior management, restraint techniques, and safe administration of medications, including psychotropic drugs. **Our House was cited in seven inspection reports during this same period for failing to have documentation showing that all direct care staff had received CPR and First Aid certification, though this is a required standard**.[32]

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[26] Since the Bureau of Licensing surveys that are cited in this report were conducted using the regulations as they appeared in Title 48 of the Administrative Code, this report will cite to the regulations as they appeared in the Bureau of Licensing surveys when discussing those surveys. The current version of these regulations appears at Title 67 of the Louisiana Administrative Code, Chapter 19.

[27] Not all of the facilities described below have current contracts with Office of Community Services, though all house children who are in State custody.

[28] The Bureau of Licensing did not provide the Advocacy Center with a copy of the inspection report for Our House for October, 2006, though it was requested.

[29] The Bureau of Licensing reports dated February 18, 2004, July 20, 2004, February 3, 2005, July 18, 2005, September 29, 2005, January 5, 2006, June 20, 2006, and July 3, 2007 cite the facility for violations of 48 L.A.C. 7909(P), which requires the facility to have a personnel file for each employee that contains documentation of past experience, employment references, licenses and credentials, criminal background checks, and other information.

[30] 48 L.A.C. §7911(C).

[31] Bureau of Licensing reports dated July 20, 2004, February 3, 2005, July 18, 2005, September 29, 2005, January 5, 2006, June 20, 2006, and July 3, 2007 cite the facility for violations of 48 L.A.C. 7911(E) and (F).

[32] Bureau of Licensing reports dated July 20, 2004, February 3, 2005, July 18, 2005, September 29, 2005, January 5, 2006, June 20, 2006, and July 3, 2007 cite the facility for violations of 48 L.A.C. 7911(F)(3).

According to reports provided the Advocacy Center by the Bureau of Licensing, Our House was cited in nine out of ten inspections from February 2004 through July, 2007,[33] for **failing to maintain medical and dental records of the children in its care**. Our House was repeatedly cited, according to four different Bureau of Licensing surveys,[34] for **failing to require that providers of professional or special services to children in its care were adequately qualified and currently licensed or certified**. According to the inspection report dated July 3, 2007, Our House was cited for **failing standards aimed at assuring that professional/special service staff had appropriate work space, equipment, supplies, and other resources.**[35] According to Bureau of Licensing inspections reports, it was cited for **not arranging required medical examinations of children in its care in two inspections in 2004, three inspections in 2005, and in an inspection in 2006**. It was cited for **not meeting the Child Residential Care Minimum Standards regarding medication orders in virtually every inspection in 2004-2007**.[36] On July 3, 2007, Our House was cited by the Bureau of Licensing **for missing dosages of medications for children without explanation**.[37]

Bureau of Licensing reports reflect that Our House was **cited for not having a written description of the methods of behavior management on two successive inspections in 2005 and two successive inspections in 2006**; and that it was cited in all inspections in 2004, in all inspections in 2005, and in two inspections in 2006 for **failing to provide copies of the behavior management policy to children and their legal guardians upon admission**.

Bureau of Licensing reports show that Our House was cited in four successive inspections in 2005 and 2006 for **failing to ensure that there was evidence of routine maintenance and cleaning programs in all areas of the facility**. Again in 2007, according to the Bureau of Licensing survey dated July 3, 2007, Our House was cited for **failing to meet these standards, with such deficiencies as a hole in the floors and doors and a missing oven door in one facility**.

HARMONY CENTER, VERMILLION ST. GROUP HOME, LAFAYETTE[38]

According to the Bureau of Licensing survey reports provided to the Advocacy Center by the Department of Social Services, this residential facility was cited in three successive inspections in 2005,[39] and three successive inspections in 2006,[40] for **failing to maintain proper medical and/or dental records on children in its care**. In addition, Bureau of Licensing reports show that it was

[33] Bureau of Licensing reports dated February 18, 2004, July 20, 2004, February 3, 2005, July 18, 2005, September 29, 2005, January 5, 2006, June 20, 2006, November 30, 2006, and July 3, 2007.

[34] Bureau of Licensing reports dated February 18, 2004, June 20, 2006, November 30, 2006, and July 3, 2007.

[35] 48 L.A.C. §7913(M).

[36] Bureau of Licensing reports dated February 18, 2004, July 20, 2004, February 3, 2005, July 18, 2005, September 29, 2005, January 5, 2006, June 20, 2006, November 30, 2006, and July 3, 2007.

[37] The report states: *This is evidenced by medication administration records contained evidence of missed dosages without explanations for the 3 of 3 children*.

[38] The Bureau of Licensing did not furnish the Advocacy Center with the results of inspections of the Harmony Center, Vermillion St. Group Home, for August 2006, October 2006, or February 2007, though they were included in requests.

[39] Bureau of Licensing reports dated 2/2/05, 6/28/05 and 9/8/05.

[40] Bureau of Licensing reports dated 1/10/06, 3/28/06 and 5/24/06.

cited in two inspections in 2006[41] for **not having provided for appropriate dental treatment for residents**. In inspections in 2004, 2005, and 2006,[42] it was cited for **not following all proper procedures related to medication**, as outlined by Child Residential Care Minimum Standards.

In each year, 2004-2006,[43] reports from the Bureau of Licensing reports indicated that staff were not given appropriate orientation and/or annual training on such topics as implementation of treatment plans, reporting critical incidents, reporting suspected abuse and neglect, passive restraint procedures, basic health skills, CPR and first aid, and safe administration and handling of medications.

In 2004-2006,[44] it was cited for **failing to properly report a critical incident**, which could mean death of a child or serious threat to the child's health, safety or well-being to the child's parents or OCS, or to the Bureau of Licensing.

In five separate inspections, in 2005, 2006, and 2007,[45] it **failed to have appropriate treatment plans for children in its care**.

In ten separate inspections from 2004 through 2007,[46] the facility was cited for **not providing a proper physical environment meaning that its grounds and facilities were found not to be clean, safe, and/or in good repair**.

HARMONY CENTER, CHANGES GROUP HOME, LACOMPTE[47]

According to Bureau of Licensing reports, this facility was cited in ten successive inspections from 2005 to 2007[48] for **failing to maintain the proper physical environment of the facility**, according to the Bureau of Licensing survey reports. More specifically, the facility was cited for **not maintaining a proper interior and exterior environment** in 2006 and 2007, and for **not maintaining and repairing furniture in 2005**.

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[41] Bureau of Licensing reports dated 3/28/06 and 5/24/06.

[42] Bureau of Licensing reports dated 3/30/04, 2/2/05, 3/28/06.

[43] Bureau of Licensing reports show that this facility was cited for not having documentation that orientation was provided as required on 3/30/04, 8/23/04, 2/2/05, and 1/10/06. This facility was cited for not meeting standards set for annual training on 3/30/04, 8/23/04, 3/28/06, and 5/24/06.

[44] Bureau of Licensing reports dated 12/21/04, 2/2/05, 3/28/06, 5/24/06, and 1/30/07.

[45] Bureau of Licensing reports dated 2/2/05, 6/28/05, 3/28/06, 5/24/06 and 1/30/07.

[46] Bureau of Licensing reports dated 3/30/04, 8/23/04, 2/2/05, 6/28/05, 9/8/05, 1/10/06, 3/28/06, 5/24/06, 1/30/07, and 6/19/07.

[47] The Bureau of Licensing did not furnish inspection reports on Harmony Center, Changes Group Home for August and October, 2006, but no deficiencies were found in these inspections, according to the website.

[48] Bureau of Licensing reports dated June 9, 2005, August 29, 2005, April 27, 2006, March 2, 2006, July 25, 2006, February 7, 2007, March 15, 2007, May 30, 2007, and July 17, 2007.

HARMONY CENTER, LONGFELLOW GROUP HOME, BATON ROUGE[49]

Bureau of Licensing reports dated November 29, 2004 and August 5, 2005, reflect that this facility was **repeatedly cited for failing to report serous incidents, accidents, injuries, or elopements to the appropriate authorities**. The report dated November 29, 2004, states:

> *An incident involving a serious threat to the child's health, safety, or well-being failed to be reported to the parent/legal guardian/placing agency, Bureau of Licensing, and other appropriate authorities. Written notification failed to follow within 24 hours. A child was hit in the mouth by another child at the facility with a metal object. The child's mouth was cut and required stitches.*

The August 5, 2005 Bureau of Licensing report states:

> *An incident involving a serious threat to the child's health, safety, or well-being failed to be reported to the parent/legal guardian/placing agency, Bureau of Licensing, and other appropriate authorities. Written notification failed to follow within 24 hour. A child eloped from the home at 11:30 am on June 7, 2005. No notification of this elopement was sent to licensing. Also, the log book documents that there were several elopements in the month of July 2005, with two boys being 'AWOL' for more than two days.*

The Bureau of Licensing report dated November 29, 2004, also reports that the facility was cited for **not reporting an incident to the family or guardian, and for not properly documenting the incident in the child's file**. The report states:

> *A serious incident, accident or injury to a child, elopement, hospitalization, overnight absence from the facility without permission, and/or other unexplained absence failed to be reported to the parent/legal guardian/placing agency within 24 hours. The child's record failed to contain the following: b. a brief description of the incident; 'On 10/23/04 a child left the facility in night hours and got in an altercation with persons, other than residents at the facility, which resulted in a hospital emergency room visit due to injuries to the child's neck and head area. The incident reports (3) completed by the staff members who were on duty at the time of the incident only indicate that the child left the facility without permission. Those staff do not mention in their reports that the child got into a fight off of the facility grounds during which he received injuries that required medical attention.*

[49] The Bureau of Licensing did not furnish inspection reports on Harmony Center, Longfellow Group Home for six inspections that took place between August 4, 2005 and August 16, 2007, though all inspections were requested.

HARMONY CENTER, THE OAKS GROUP HOME, BATON ROUGE[50]

According to reports by the Bureau of Licensing, the Oaks Group Home was cited in 2004 for **failing to report a serious incident, accident or injury to a child, elopement, hospitalization, or other unexplained absence**. The Bureau of Licensing report for August 4, 2005, cited the facility for having **inadequate staff coverage** for the number of children in its care, per the Child Residential Care Minimum Standards. According to Bureau of Licensing Reports dated May 30, 2006, October 17, 2006, January 24, 2007, it was cited in three successive inspections for **failing to maintain a proper physical environment in its exterior space**. In three successive earlier inspections[51] it was cited for **failing to replace broken, run-down, or defective furnishings**.

A Bureau of Licensing report dated August of 2005, cited the facility for **failing to see that a child who had been referred for medical services actually received those services**. The citation states:

> *One child was referred to a pediatric dentist, a neurologist, and a physician that specializes in developing behavior management programs in January 2005. As of this date the child has not been seen by any of these specialists. The provider stated that this is due to the fact that OCS either failed to provide transportation, or sent transportation without the legal guardian and without assigning authority to this provider to accompany the child to the various medical appointments.*

Bureau of Licensing reports for this facility dated August 5, 2005, October 17, 2006, and January 24, 2007 reflect citations for **failing to maintain proper medical and dental records**, as required by Child Residential Care Minimum Standards.

HOPE HAVEN, MARRERO[52]

According to reports from the Bureau of Licensing, in six out of seven inspection reports during the period 2004 to 2006, Hope Haven was cited for **failure to comply and show proof of compliance with relevant standards of the Office of Public Health, Sanitarian Services** (two successive inspections in 2006); and the Office of the State Fire Marshal, Code Enforcement and Building Safety (two successive inspections in each year--2004, 2005, and 2006).

In October, 2004, a Bureau of Licensing report shows that the facility was cited for f**ailing to include in a child's case record reports of incidents of abuse, neglect, accidents or critical incidents, including use of passive physical restraints**.

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[50] The Bureau of Licensing did not furnish the report on an inspection of Harmony Center, The Oaks Group Home in April, 2007, though all inspections were requested.

[51] Bureau of Licensing reports dated November 29, 2004, August 5, 2005, and May 30, 2006.

[52] The Bureau of Licensing did not furnish the Advocacy Center with the results of inspections of Hope Haven, for October 2006, December 2006, or August 2007, though they were included in requests.

A Bureau of Licensing report dated June 15, 2006 shows that Hope Haven was cited for **failing to maintain complete health records including having a complete record of all immunizations provided**.

In reports from three successive years (October 10, 2004, June 3, 2005, June 15, 2006, and September 11, 2006), Bureau of Licensing documents show that the facility was cited for **failing to have documentation of satisfactory criminal record checks on file for all staff**. The Bureau of Licensing report dated June 3, 2005 stated that **one employee's records included a criminal record check from an unauthorized provider, showing that a current employee had a record of aggravated assault and resisting an officer**.

In four inspection reports from three successive years (2004, 2005, and 2006) the facility was cited for **failing to show documentation that employees had received training, as required by the Child Residential Care Minimum Standards, in CPR and first aid**.

Bureau of Licensing reports show that Hope Haven was cited on October 4, 2004 and June 15, 2006 for **failing to have sufficient staff present with the children**.

The Bureau of Licensing report dated October 4, 2004 reads:

> *The Provider failed to ensure that an adequate number of qualified direct service staff were present with the children as necessary to ensure the health, safety and well-being of children as evidenced by a significantly high number of incidents of runaway. There were 21 documented incidents on one unit in the first three weeks of September, alone. Staff coverage shall be maintained in consideration of the time of day, the size and nature of the Provider, the ages and needs of the children, and shall assure the continual safety, protection, direct care and supervision of children.*

The October 4, 2004 Bureau of Licensing report further cited the provider as follows:

> *The Provider failed to comply with required prohibited response to children by staff members as follows: denial of clothing to children with runaway behaviors.*

The June 15, 2006 survey report reads:

> *The Provider failed to ensure that an adequate number of qualified direct service staff were present with the children as necessary to ensure the health, safety and well-being of children as evidenced by two incidents of sexual activity between residents (3/27/06 and 6/06/06) indicating a lack of supervision.*

Bureau of Licensing reports from 2004, 2005, and 2006, show that Hope Haven was cited for **not providing a proper physical environment for the children, including having holes walls, lack of doors on toilet stalls, broken ceiling tiles in all bedrooms, and broken furniture**.

CHRISTIAN ACRES, TALLULAH[53]

According to a Bureau of Licensing Report dated February 1, 2007, the bureau cited the facility for **denying medication to a child due to the child's being on runaway status, and denying scheduled school attendance to a child who had threatened to run away**. The specific citation read:

> *Provider failed to ensure that child's rights are not violated as evidenced by * Staff denied child to obtain medication at scheduled time due to child's being on runaway status 1/8/07 and **3 residents were observed during survey being denied scheduled school attendance reportedly due a runaway threat.*

The same Bureau of Licensing report states that the facility was cited for **failing to include in children's case record reports of incidents of abuse, neglect, accidents, or critical incidents, including use of passive physical restraints**. The specific citation reads:

> *The child's case records failed to always contain reports as follows: incidents of abuse, neglect, accidents or critical incidents and the use of passive physical restraints, ex. record of fight and injury 1/8/07 for one resident, incident report of run for another resident during 1/07, incident report relative to allegation of abuse reported 12/29/06 failed to be on file.*

The same Bureau of Licensing report states that the facility was cited for **not having sufficient qualified staff on duty, as evidenced by staff not realizing one child had not returned from school, one child hiding on campus instead of going to school, and four residents smoking without staff knowledge**.[54]

According to Bureau of Licensing reports dated December 3, 2004 and March 30, 2005, this facility had already been **repeatedly cited for not having sufficient qualified staff on site at all times**.

According to the Bureau of Licensing report, Christian Acres was also cited on February 1, 2007 for **not providing timely, competent medical care as per the Child Residential Facility Minimum Standards**. The report states:

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[53] The Advocacy Center was not furnished with the results of inspections on June 19 and June 20, 2007, though they were included in its request.

[54] *The Provider failed to ensure that staff provide the necessary supervision needed to always account for the whereabouts of children in care as evidenced by *10/4/06 child was not reported as missing and having not returned from school on campus until 4:10pm though children though school is over at 3:00pm and staff are reportedly required to do a head count prior to leaving school building, during walk to cottage and again after arriving in cottage; Note: child and others later vandalized the school building; ** Incident report of 11307 indicated 4 residents were found in restroom on cottage smoking without staff knowledge *** during survey child observed hiding on campus though he reportedly suppose to be in school. No staff were observed in search for this child. Staff were observed in gym providing during P.E. time however reportedly no one staff had a group assigned to their care and supervision during this time.*

*The Provider failed to ensure that a child received timely medical care when he was ill or injured as evidenced by children during 2 incidents of abuse allegations noted to have indications of medical attention being warranted however no evidence of medical received. ** 1 child in need of cholesterol monitoring.*

According to the Bureau of Licensing report, Christian Acres was also cited on February 1, 2007 for **not placing appropriate limits on potentially harmful responses**. The report states:

*The provider failed to ensure that staff follows limits on potentially harmful responses as evidenced by staff acknowledged hitting a child 11/14/06 yet no further action or training noted as having been provided.** Staff notes indicated a child was required to make all beds as a result of an incident 1/24/07.*

Finally, though the facility was cited in December 2004 for **failing to have doors on its toilet stalls**, the same condition was noted on its February 2007 inspection.

THE LEGISLATIVE AUDITOR'S OFFICE IDENTIFIED SERIOUS DEFICIENCIES IN THE DSS LICENSING PROGRAM

In November, 2007, the State Legislative Auditor issued a report of an audit of the Department of Social Service's Bureau of Licensing, covering the period January 1, 2006, through May 30, 2007.

The methodology described in the report included interviews with staff of the Bureau of Licensing and other key personnel at DSS; requests for policies and procedures; interviews with national child care industry experts and reviews of relevant child care licensing publications; interviews with officials of state agencies in North Carolina, Tennessee, and Oklahoma regarding their licensing programs; attendance at a licensing visit and four follow-up visits at child residential facilities; attendance at two meetings of the Louisiana Advisory Committee on Licensing of Child Care Facilities; a tour of the largest child residential facility in the state; file reviews of licensing data on 30 randomly selected residential facilities that recently received an initial licensing visit, and 30 randomly selected residential facilities that received an annual licensing visit; examination of agendas and minutes of the Louisiana Advisory Committee on Licensing of Child Care Facilities and the Louisiana Committee on Private Child Care from January 2004 through May 2007; and examination of calendar 2006 complaint data.

The State Auditor reported the following findings:

- 58 Child Residential facilities were licensed by DSS as of May 2007.

- After a reorganization in 2007, the Bureau of Licensing had only eight classified positions to license facilities in seven programs, including 58 Child Residential Facilities, 56 Foster Care Agencies, 32 Adoption Agencies, 14 Emergency Shelters, 6 Transitional Youth Residences, and 2 Maternity Homes.

- DSS had yet to develop comprehensive policies and procedures to guide its licensing program. Though it has been licensing child residential facilities since 1990, it developed its first licensing policy, which pertains to criminal record check requirements, in 2007.

- Since the storms of 2005, DSS has issued "generic" or "extended" licenses to child care facilities on their anniversary dates, accompanied by a letter stating that the issuance of the license did not denote compliance with minimum standards. Prior to this time, DSS had a similar practice of issuing "provisional" six-month licenses to facilities that were not in compliance with minimum standards.

- Ninety percent of the child residential facilities the auditor sampled had deficiencies when DSS had most recently renewed their licenses.

- Officials in other states and national child care industry experts stated that issuance of a license should mean that the facility complies with minimum licensing standards, not merely (as is the case with Louisiana's generic, extended, or provisional licenses) a receipt for payment of licensing fees.

- Unlike licensing authorities in other states, Louisiana's child residential licensing authority has no specific, documented policies governing the process of receiving, prioritizing, and investigating complaints about child residential facilities.

- During 2006, DSS received 12 complaints against 9 child residential facilities, including complaints of abuse, inadequate supervision, corporal punishment, inappropriate discipline or discipline in violation of regulations, neglect, lack of adequate staff, and poor sanitation.

- DSS conducted on-site investigations of 8 of these complaints, but 7 of the 8 investigations were not conducted within an appropriate timeframe.

- DSS lacks appropriate enforcement strategies and policies. By law, it has only one enforcement strategy, which is to recommend a facility to the external committee for the denial, revocation, or non-renewal of a license.

- DSS has not promulgated any rules or regulations or developed any formal enforcement practices or procedures for enforcing minimum standards, including criteria for determining when to refer providers to the appropriate committee.

- According to the National Association for Regulatory Administration, for a licensing agency to protect children in out-of-home care, it must have an effective enforcement process. Effective enforcement requires the consistent application of a wide range of intermediate sanctions, including positive strategies such as frequent monitoring, technical assistance, and incentives, and negative strategies such as warnings, conditional licenses, and civil fines.

- The Louisiana Advisory Committee on Licensing of Child Care Facilities and the Louisiana Committee on Private Child Care do not have a formal recordkeeping system to track committee actions.

- Between January 1, 2004 and May 30, 2006, DSS referred only two Class A child residential facilities, and no Class B child residential facilities, to the appropriate committee for license revocation. The licenses of the two facilities that were referred to committee were revoked.

PROPOSED NEW REGULATIONS—A STEP BACKWARD

As this report was being finalized, the Department of Social Services published a Notice of Intent to promulgate new licensing regulations for child residential facilities.[55] The Advocacy Center is in the process of reviewing these proposed regulations, asking questions of Department officials at public hearings that are being held on them, and preparing written comments. It appears, however, that these regulations represent a step backwards in the enforcement of adequate standards in such facilities.

The proposed regulations eliminate many of the specific standards that are contained in the existing regulations. For example:

- Existing regulations state that new buildings must be non-institutional in design and appearance and physically harmonious with the neighborhood in which they are located, 67 L.A.C. §1905(A)(1), *Louisiana Register*, V. 33, No. 12 (December 20, 2007) p. 2700. There is no comparable provision in the proposed regulations.

- There is no requirement in the proposed regulations, as there is in the current regulations, 67 L.A.C. §1909(E), *Louisiana Register*, V. 33, No. 12 (December 20, 2007) p. 2703, that the facility have on file written agreements with outside agencies for professional for professional services or resources not available from the provider.

- The existing regulations, at 67 L.A.C. §1909(M) and (O), require the facilities to maintain much more complete records on each child than do the proposed regulations, §1105(E)(1). The proposed regulations do not require that facilities keep the child's placement agreement, the child's history including his or her educational background, quarterly status reports, reports of incidents of abuse or neglect, reports of child grievances, a summary of family visits, a summary of court visits, summaries from providers of specialized or professional services, and a discharge summary, in his or her file. Similarly, the proposed regulations only require the provider to gather medical, dental, and educational records "as available."

- Current regulations require the provider to have a detailed plan for fostering ongoing, positive communication and contact between children and their families, their friends, and others significant in their lives. 67 L.A.C. §1913(A). The proposed regulations contain no such requirement, and provisions designed to insure that the facility notifies children's parents and any placing agency of children's rights, its behavior management and disciplinary practices, visiting procedures, and complaint procedures, have been eliminated.

- Current regulations, 67 L.A.C. §1913(H) require plans for recreation that insure indoor and outdoor recreation opportunities, based on the interests and the needs of children. Also, providers are required to utilize recreational resources of their

[55] *Louisiana Register*, V. 34, No. 5 (May 20, 2008) pp. 934-952.

community when appropriate, to arrange transportation, and to restrict recreation only as part of a treatment plan. In the proposed regulations, the only recreation requirement is that the physical environment includes recreation space, §1107(E)(1).

- Proposed regulations eliminate requirements contained in the current regulations that menus follow specified guidelines, that they are to be developed in advance, that they contain a variety of foods, and reflect substitutions. Further, they eliminate requirements that at least three meals should be provided; that no more than 14 hours can pass between dinner and breakfast; that meals must be in accordance with religious beliefs; that no child shall be force fed, except upon physician order; and that staff who eat with children must eat the same meals the children eat. 67 L.A.C. §1913(L). The proposed regulations state only that children have the right to adequate, timely and nutritious food, §905--Minimum quality of care.

- There are no requirements in the proposed regulations similar to those in 67 L.A.C. §1913(M) that providers insure the provision of specialized services including physical therapy, occupational therapy, speech pathology and audiology, psychological and psychiatric services, social work services, or individual, group and counseling services.

- The requirements in the current regulations, 67 L.A.C. §1913(N)-(Q), concerning medical care, dental care, immunizations, and other health care have largely been eliminated. Under the proposed regulations, providers must ensure their staff are trained in how to "detect signs of illness or dysfunction that require medical or nursing intervention," §1105(C)(3)(e), but the regulations do not require providers to actually obtain needed care. Current regulations require providers to obtain medical and dental exams within a week of admission and at least yearly thereafter.

The provider is to be found in substantial compliance, and issued a license, if it is in compliance with 90% of standards classed as "mandatory;" 80% of standards classed as "critical;" and 70% of standards classed as "significant." Though it is far from clear how these percentages will be determined, this represents a significant relaxing of standards that providers must meet.

The proposed regulations also introduce the concept of "substantial compliance," allowing providers to be licensed even though they do not meet all, but only a percentage, of licensing standards.

Further, the proposed regulations permit the Department to "deem" that providers are in compliance with standards classed as "critical" or "significant" if they are accredited by a "DSS-approved accrediting body" which "periodically" inspects the facilities.

Thus, DSS may license facilities that it has not fully inspected, and which may not be inspected at least annually, as is currently done.

The proposed regulations make many other changes that appear to reduce the protections theoretically available to children in residential facilities under the current regulations.

The Advocacy Center believes that the answer to the problem of widespread non-compliance with minimum standards is not to relax or weaken the standards, but rather to strengthen and improve enforcement.

RECOMMENDATIONS

The Legislature should establish a more effective licensing framework:

- To insure the health, safety, and well-being of children in the care of residential facilities, the Department of Social Services must be given the power to promulgate regulations, to fine or otherwise sanction facilities that violate those standards, and to revoke facility licenses, without the approval of an external committee.

- In addition, because all of Louisiana's children deserve the same protection, the Legislature should adopt the Legislative Auditor's recommendation to eliminate the two-tier system of licenses for class A and class B residential facilities.

- This legislation should give the Bureau of Licensing the authority to issue stiff penalties, including monetary sanctions, to providers that render substandard care. Currently if a licensed facility violates the Department's standards, the Department's only recourse is to recommend revocation of the facility's license. The Bureau of Licensing would have more authority and control over the quality of services provided to children in Child Residential Care if the Bureau of Licensing had a broader array of sanctions.

- The agency or department responsible for insuring that Child Residential Facilities comply with minimum standards and provide quality care for children must be given adequate staff and funding to carry out its mission.

DSS should rigorously enforce licensing standards:

- DSS must develop fair and rigorous policies and procedures for enforcing licensing standards.

- DSS must end the practice of issuing licenses for facilities who violate minimum standards. Licenses should only be renewed for facilities that meet minimum standards at the time the license is issued.

- DSS should not adopt the proposed regulations contained in the Notice of Intent of May 20, 2008, which significantly relax and weaken the standards applicable to these facilities.

- DSS should require facilities that are found to have violated minimum standards to develop effective Quality Improvement Plans within ten days of receiving the report from the Bureau of Licensing, should closely monitor compliance with such plans, and should recommend license revocation for facilities that do not comply.

- Repeat violations of minimum standards should result in civil fines or penalties, when the power to levy such fines and impose such penalties is given the Department by the Legislature. Until then, repeat violations of minimum

standards should result in a recommendation to revoke the license of the facility.

- Current deficiency information should be made available to the public on the internet.

DSS should promptly and thoroughly investigate complaints:

- DSS should establish specific, documented policies governing the process of receiving, prioritizing, and investigating complaints about child residential facilities.

- Complaints should be investigated promptly and thoroughly, with priority given to the most serious complaints.

- Child Protective Services should report timely to the Bureau of Licensing any abuse or neglect complaints regarding child residential facilities or persons employed by such facilities. The results of investigations of such complaints should also be promptly communicated to the Bureau of Licensing.

- Results of complaint investigations should be made available to the public on the internet.

DSS should focus on gathering and making public information on how well or poorly residential facilities are doing:

- DSS should collect, maintain, and analyze data on how well residential facilities are doing in protecting, caring for, and educating the children in their care, and in making it possible for them to be reunified with their families or otherwise integrated into the community.

- This should include a longevity study of the children being served to determine if the services being provided are actually leading the children to an improved quality of life. Data on the number of children in such placements, the types of placement (OCS, OYD, private, and out-of-state), how often these children experience multiple placements; abuse and neglect in residential facilities; the efficacy of mental health services in such facilities; how well the educational needs of children in these facilities are met; how quickly these children are reunified with their families or adopted; and how successful these reunifications or adoptions are—all need to be intensively studied and evaluated.

DSS should reduce the number of children in residential facilities by access to placements and community services that have been empirically demonstrated to be effective in meeting children's needs:

- The cost of maintaining children in residential facilities is greater than the cost of providing services in more integrated settings, yet the benefit to children of placement in this type of facility – even if the facilities are made to comply with minimum standards—is extremely doubtful. The State must insure that these

facilities fully comply with minimum standards for the health and safety of children in their care, but should move quickly toward a system in which few, if any, children need to be segregated and confined in such facilities in order to receive adequate services.

CONCLUSION

Children who live in the child residential facilities in Louisiana deserve better treatment than is currently provided. The Advocacy Center calls on the the Louisiana Legislature, the Department of Social Services' Office of Community Services and the Bureau of Residential Licensing, the Office of Youth Development, and all advocates interested in the future of these children to work together to correct the problems that have been outlined in this report. The system can and should provide better care. Louisiana citizens should not be satisfied with the substandard care and treatment currently provided to these children. Louisiana owes its children living in residential care facilities an opportunity for successful adulthood. Children should be offered at least that.

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