REPORT OF INVESTIGATION

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AGENCY: Department for Community Based Services
Cabinet for Health and Family Services

INVESTIGATOR: Barbara Dickens

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I. BASIS FOR INVESTIGATION

The Office of Inspector General ("OIG") within the Finance and Administration Cabinet ("Finance") is responsible for conducting various investigations within the executive branch.

Under KRS 42.0147, Finance OIG initiated this independent investigation following a press release issued by the Auditor of Public Accounts on October 29, 2024 and preliminary report by the Commonwealth Office of the Ombudsman ("Ombudsman") on January 28, 2025. Both focused on stories about youth who were in the care of the Cabinet for Health and Family Services' ("CHFS") Department for Community Based Services (the "Department") and housed in nontraditional placements (NTPs). For this review, OIG examined reports, system data, studies, testimony, and interviewed five staff with direct oversight and involvement in the program. The Cabinet was provided an opportunity to review OIG's report and provide comment, and its response is attached to this report.

II. EXECUTIVE SUMMARY

For any child or youth in state Out of Home Care ("OOHC"), the Department seeks a longer-term, least restrictive and most family-like setting appropriate to the child's needs, such as with family, fictive kin, or licensed foster families. When these options are not available or appropriate, placements may include child-caring facilities or other residential settings. All placements must be appropriate depending on a child's unique educational, medical, and social-emotional needs. Historically, once a youth entered Department custody, a placement decision was made and remained in place until either the Department or service provider gave the other 14 days' notice to change placement. The change in placement was then made before the notice period expired.

In rare cases – 1% to 2%[1] – the Department may have difficulty identifying an appropriate placement that will accept a child based on his or her unique needs. If a traditional placement cannot be identified within the notice period, the child must go to NTP temporarily, until a traditional placement is found. This type of placement is sometimes referred to as "transitional" or "stop-gap."[2] An appropriate placement is usually determined in a matter of hours or days. Sometimes there are no children in NTP. For example, there were no children or youth in NTP for 15 days during the four-and-a-half-month period reviewed by the Auditor.[3] From January through November 2025, there were no children or youth in NTP during 25% of the time and only one child or youth in NTP during 40% of the time.[4] Thus, during more than two-thirds of the time, there was not more than one child or youth in NTP. Compare that with approximately 10,000 youth in or recently in the Department's OOHC program. The percentage of NTPs has remained low in comparison with number of youths in OOHC, despite increasingly acute needs and decreasing availability of placements equipped to meet those complex needs.

Beginning in 2022**,** the Department experienced a brand-new phenomenon: abnormal and unforeseen cases where placements were ending abruptly with such little notice a traditional placement could not be secured in time. Known as "placement disruption," these cases present an even more challenging set of circumstances for social services to identify an appropriate placement for a child with complex needs.

Based on our review, three main factors contribute to an increase in placement disruption and delays in identifying appropriate placements for children with complex needs:

1) Changes in Kentucky law intended to reduce a child's detention in the juvenile justice system;
2) Impact of the pandemic on children, youth, behavioral health service providers, and their staff; and
3) Changes to federal law that now require more stringent standards for child-caring placements.

The combination of these three factors has resulted in an increase in more behaviorally challenged and court-involved children and youth with complex unmet service needs, and at the same time a decline in the number of appropriate placements available at any given time. The cumulative impact of these three factors led to an increase in state use of NTPs nationwide.

The trend of placement disruption and increased use of NTPs is a well-documented issue that is happening all over the country.[5] For example, news reports indicate Tennessee's foster care system has struggled for years with significant challenges. Its resources are severely strained[6] and there

[1] Out of Home Care Population and Nontraditional Placements, 2022-2024, Central Office Tracking; *See* Division of Protection and Permanency Memorandum 24-02, Feb. 14, 2024, including Nontraditional Placement Tip Sheet, Feb. 2, 2024. *See also* "Children in the Custody of or Committed to the Cabinet and Children Experiencing Nontraditional Placement and/or Placement Instability, July 2022-Feb. 2025, TWIST.
[2] U.S. Health and Human Services Office of Inspector General, Office of Audit Services Survey Mar. 2024.
[3] Central Office Tracking.
[4] *Id.*, 1/1/2025-11/30/2025.
[5] Interview of Lesa Dennis, Commissioner, DCBS, p. 26. Testimony of Secretary Eric Friedlander, Senate Standing Committee on Families & Children, Feb. 11, 2025; KVS Health System, "The National Foster Care Placement Crisis: Why Are Kids Sleeping in Offices?" https://www.kvc.org/blog/the-national-foster-care-placement-crisis-why-are-kids-sleeping-in-offices-video/, Sept. 9, 2024.
[6] Greg Jones, "Tennessee faces a foster care crisis. Here are ways to be a part of the solution – Opinion," *The Tennessean*, Jan. 29, 2025; Jillian Taylor, "Inside Tennessee's foster care system, https://www.wbir.com/article/news/local/10news-today/foster-care-in-tennessee/51-1e36849f-f171-4bcb-9c75-56b3974d67f0, May 30, 2025.

have been reports of children and youth staying in nontraditional and other temporary placements.[7] Other states, such as Alabama, Illinois, Michigan, North Carolina, and West Virginia, also employ NTPs for children and youth in foster care with complex needs.[8] Alabama's Department of Human Resources is on the record explaining children in their state are sleeping in nontraditional placements due to the difficulty of finding placements for youth with more intensive care and service needs.[9] One North Carolina county reported the average stay in a county office building was eight weeks and the longest stay had been nine months.[10] In another North Carolina county, the Board of Supervisors voted in support of incentive pay for employees to work extra shifts to supervise the children staying in NTPs.[11] The reports from other states consistently describe the same factors seen in Kentucky, involving children or youth with more intensive and complex needs being unable to be placed in a very short timeframe in an traditional setting.

The Commonwealth responded immediately to this trend. In addition to a coordinated, targeted approach within the Department, it also collaborated on the national and regional levels to understand and address the issue and has implemented several nationally recognized and research-based strategies. In February 2024, the Inspector General for U.S. Health and Human Services (HHS) contacted the Department's Division of Protection and Permanency (the "Division") asking the state to fill out a national survey that the federal government is conducting to fully research the issue.[12] Many non-profits and research organizations have studied the issue due to its national scope. The Department's efforts are reducing the incidences of NTPs. The number of NTPs, the total sum of days in NTP and the number of unique children or youth in NTP decreased by approximately 50% in 2025 compared to 2024.[13]

The NTPs were carefully designed to provide a home-like environment in a safe location where there were appropriate staff and other supports. This office found no unsupervised youth, no youth without a furnished bedroom, and no youth without necessary supports during the NTP. NTP is used only as a last resort "stop-gap" measure pending a traditional placement. This office viewed three NTP placement locations and found them to be appropriately furnished, clean, and equipped with amenities necessary for these temporary placements.[14] In addition, the Department has developed procedures to ensure that the physical location, staffing and supports for the High Acuity Youth in NTPs are adequate. In some cases, NTPs may provide children with more access to services in one place than a traditional placement.[15]

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[7] Rachel Wegner and Kelly Puente, "Tennessee children are still sleeping in CDS offices despite transitional home expansion, "The Tennessean," Feb. 11, 2025; Ben Hall, "Kids sleeping in Tennessee DCS offices remains an ongoing issue," https://www.newschannel5.com/news/newschannel-5-investigates/dcs-investigations/kids-sleeping-in-tennessee-dcs-offices-remains-an-ongoing-issue, May 27, 2025.

[8] KVS Health System, "The National Foster Care Placement Crisis: Why Are Kids Sleeping in Offices?", https://www.kvc.org/blog/the-national-foster-care-placement-crisis-why-are-kids-sleeping-in-offices-video/, Sept. 9, 2024.

[9] Kathryn Bruch, "Alabama foster kids forced to sleep in DHR offices," https://www.wkrg.com/news/alabama-foster-kids-forced-to-sleep-in-dhr-offices/, July 25, 2025.

[10] Anna Roman, "Why children are sleeping in a Wake County government office building," The News & Observer, https://www.newsobserver.com/news/local/counties/wake-county/article311489574.html, Aug. 6, 2025.

[11] Eric Miller, "NC foster care crisis: Person County offers incentives to staff watching kids in DSS office," https://www.wral.com/story/nc-foster-care-crisis-person-county-offers-incentives-to-staff-watching-kids-in-dss-office/21487232/ June17, 2024.

[12] Email from Kevin Crowell, U.S. Health and Human Services Office of Inspector General, Office of Audit Services, Feb. 14, 2024.

[13] Central Office Tracking, 2024 and 2025 (through November).

[14] Site visits conducted: 1) YMCA Safe Place, Jefferson County, Jan. 29, 2026; 2) DCBS Office, Fayette County, Jan. 30, 2026; and 3) DCBS Office, Jan. 30, 2026, Shelby County.

[15] Interview of Kelli Root, Director, DPP, p. 29. See also Interview of Samantha Oerther, pp. 34-38.

III. BACKGROUND

A. Kentucky's Out of Home Care Program

Title IV-E of the Social Security Act established the Foster Care and Adoption Assistance Program in 1980.[16] The program provides federal funding to states to support daily supervision of children determined eligible under the program. Funds are available to assist with the costs of foster care maintenance for eligible children; administrative expenses to manage the program; and training for staff, foster parents, and some private providers. Enacted in 2018, the Family First Prevention Services Act (FFPSA) reformed the funding streams of Title IV-E for time-limited prevention services for mental health, substance abuse, and in-home parent skill-based programs for children or youth who are candidates for foster care, pregnant, or parenting youth in foster care and the parents or kin caregivers of those children and youth.[17] FFPSA shifted the focus by directing more funding toward preventing children from entering foster care instead of simply paying for foster care after children entered the program.

Within the Commonwealth, the services the Department in the Out of Home Care Program (OOHC) provides services from nine service regions throughout the Commonwealth: Eastern Mountain (EMSR), Cumberland (CSR), Southern Bluegrass (SBSR), The Lakes (TLSR), Two Rivers (TRSR), Salt River Trail (SRTSR), Jefferson (JSR), Northern Bluegrass (NBSR), and Northeastern (NESR). Regions are staffed with social service workers and clinicians, supervisors, Service Region Administrator Associates, Service Region Clinical Associates, and a Service Region Administrator (i.e. the regional manager).[18]

Additionally, each region within the Division of Service Regions employs at least one High Acuity Youth Specialist. This position was established in 2023 to support regional placement decision-making and coordination for youth with complex behavioral health or placement needs. The specialists report administratively to the Service Region Clinical Associate, and their work is coordinated through the Director of Services Regions by the Statewide High Acuity Coordinator to ensure consistency in practice and oversight across regions.

The Division of Protection and Permanency (DPP) maintains the primary programmatic responsibility for child welfare practice, including case management, permanency planning, and service coordination for children and families involved with the child welfare system. In this role, DPP provides clinical and policy guidance related to the needs of high acuity youth and collaborates with the Division of Service Regions to support appropriate placement planning and service delivery.

The DPP team supporting youth with complex needs is led by the Clinical Services Branch Manager and includes the Medical Director (a child psychiatrist), and PCC and PCP liaisons. In addition, New Vista, which operates the Children's Review Program (CRP), assigns one or two CRP representatives to each region to support the placement process.[19]

[16] Federal Payments for Foster Care and Adoption Assistance, 42 USC §§ 670-679.
[17] HR 1892 – 115th Congress (2017-2018), Bipartisan Budget Act of 2018, Title VII. 2018, Feb. 9. https://www.congress.gov/bill/115th-congress/house-bill/1892.
[18] Interview of Jennifer Shworm, Statewide High Acuity Coordinator, May 10, 2025; p. 5.
[19] *See* Oerther Interview; p 16.

B. Children and Youth in OOHC

Kentucky currently serves approximately 8,692[20] children in OOHC and at any given time DCBS is tracking and monitoring about 10,000 children and youth either in or recently in OOHC. All children in state custody have individualized needs that must be considered when finding an appropriate placement. However, some youth not only have a number of complex needs due to many factors but are also often multi-system involved (Department of Juvenile Justice (DJJ), Department of Behavioral Health and Development and Intellectual Disabilities (DBHDID), and DCBS, among others). As a result, finding and maintaining appropriate placement for youth with complex needs can be more challenging.

C. Three Factors Contributing to Placement Disruption and Delays in Identifying Appropriate Placements

1) Changes in Kentucky law intended to reduce a child's detention in the juvenile justice system;
2) Impact of the pandemic on children, youth, service providers, and their staff; and
3) Changes to federal law that now require more stringent standards for child-caring placements.

Three events have cumulatively contributed to the increase in the number and needs of youth with complex needs at the same time as a decrease in the providers able to handle their needs at the time of referral. Two legislative changes have affected this group of children and youth and the providers serving them. These changes had positive impacts but the effect on this small number of children and youth were likely not anticipated. Within this same timeframe, the foster care system, like everything else, was being impacted by the pandemic. The pandemic caused losses in personnel at the provider-level, and the isolation and loss of services also affected the progress and development of these children and youth.

In the 2014 Regular Session, the General Assembly passed comprehensive legislation to realign the goals of DCBS, the DJJ, the Department of Public Advocacy (DPA) and the Administrative Office of the Courts (AOC) to reduce detention of juveniles by, among other things, eliminating detention for status offenses such as truancy, running away, or other minor offenses that did not pose a risk of public safety and instead utilize evidence-based prevention strategies.[21] With a preference for diversion of charges instead of detention, the courts began to defer or leave charges unresolved. This had a negative effect on placement of children or youth in OOHC because the lack of resolution of charges presented an unknown factor for providers.[22] Since October 2021, the percentage of youth in our state welfare system involved in pre-disposition juvenile justice, out-of-state congregate care placements, and post-disposition secure juvenile justice placements all increased.[23]

Additionally, by 2021, the effect of the pandemic on staffing was well-documented. The increased staffing needs directly relate to the increased needs of children and youth. A study on the behavioral health industry's workforce noted the following about the impact of COVID-19:

- The pandemic led to a 72% increase in client severity and a 65% increase in case load of each service provider; and

[20] TWIST system data as of Dec. 7, 2025.
[21] 14 RS SB 200.
[22] Oerther Interview, pp. 25-26.
[23] Specialized Placement and Treatment Needs 2023 Preliminary Analysis, TWIST, Division of Permanency and Protection.

- Eighty-four percent (84%) of behavioral health workers and 78% of the general public said the people with the highest and/or most acute need for treatment were having difficulty receiving that treatment. [24]

The barrier to obtaining mental health treatment for children and youth was studied recently. While the number of inpatient psychiatric beds per 100,000 children remained flat from 2017 to 2020, the needs increased for children and youth. Additionally, the available beds are primarily in urban areas. That gap existed prior to COVID-19, but the study concluded the pandemic "highlighted that gap" between need and access.[25]

The American Psychological Association agreed that the need was increasing prior to COVID-19. As a part of its 2023 Trends report, it reported a 40% increase among youth of feelings of persistent sadness, hopelessness, suicidal thoughts, and behaviors.[26] The report noted that in addition to the social isolation and academic interruption, many youth lost a parent or other caregiver due to COVID-19, their parent or caregiver lost a job, or the youth themselves were victims of physical and emotional abuse during the pandemic.

Another study considered the issue of "boarding," which is the practice of holding patients in the emergency department while awaiting transfer. Children and youth with acute mental health crises commonly board in an emergency room and the amount of time to board has increased between 2017-2023 from 3 to 4 days, on average.[27] Nationwide, there is a severe shortage of child and adolescent psychiatrists, social workers, psychologists, and licensed professional counselors.

The Department has reported to the Kentucky legislature and to the federal administration regarding the increased needs of its children and youth and about provider gaps it has experienced. Cabinet and Department leadership and others have reported on the development of this issue, the likely causes, and the Cabinet's response at least 13 times:

- CHFS Task Force on August 17, 2022 and October 19, 2022;
- Child Welfare Oversight and Advisory Committee on October 12, 2022;
- Joint Meeting of the House and Senate on Health Services on January 12, 2023;
- House Budget Review Subcommittee on Health and Family Services on February 15, 2023;
- Senate Standing Committee on Families and Children on February 21, 2023;
- Budget Review Subcommittee on Health and Family Services on June 7, 2023;
- Kentucky Health and Human Services System Task Force on July 24, 2023 and October 16, 2023;
- Interim Joint Committee on Families and Children on August 24, 2023, October 25, 2023 and November 8, 2023; and
- Senate Families and Children Committee on February 11, 2025.

[24] "New Study: Behavioral Health Workforce Shortage Will Negatively Impact Society," National Council for Wellbeing, Apr. 25, 2023, thenationalcouncil.org/news/help-wanted.
[25] Haleigh Ehmsen, "Investigating the Youth Mental Health Crisis," *Northwestern Medicine, Northwestern University*, Feb. 14, 2025.
[26] Zara Abrams, "2023 Trends Report: Kids' mental health is in crisis. Here's what psychologists are doing to help," *American Psychological Association,* Jan. 1, 2023.
[27]Kathleen Snow, MD, MPH, et al., "Pediatric Mental Health Boarding: 2017-2023," *American Academy of Pediatrics*, March 1, 2025. *See also* Steven Berkowitz, "As the mental health crisis in children and teens worsened, the dire shortage of mental health providers is preventing young people from getting the help they need," The Conversation, https://theconversation.com/as-the-mental-health-crisis-in-children-and-teens-worsens-the-dire-shortage-of-mental-health-providers-is-preventing-young-people-from-getting-the-help-they-need-207476, Aug. 16, 2023.

As of the Division's March 2025 response to the HHS survey, Kentucky reported sufficient capacity in the Qualified Residential Treatment Programs (QRTPs) and non-QRTPs, but an insufficient capacity of beds or placements in all foster family homes and psychiatric residential treatment facilities. It reported that congregate care facilities' inability to hire and retain staff in congregate care was extremely challenging, and the state's difficulty in hiring and retaining caseworkers was moderately challenging.

The last factor that must be considered is the 2018 Family First Prevention Services Act ("Family First"), which raised the quality of services being provided but is considered to have reduced the number of providers due to the stringent initial and ongoing programmatic standards.[28] Family First requires provided services to be trauma-informed and evidence-based according to HHS regulation. Title IV-E reimbursement for placement became limited to two weeks unless the placement was a Qualified Residential Treatment Program (QRTP), a setting that specialized in prenatal or parent support, or supervised independent living for youth over 18 years old. Family First increased documentation, ongoing support requirements after discharge, and staffing requirements. QRTPs must have registered or licensed nursing staff and clinical staff onsite.[29]

KY DPP reported in the HHS survey that it has been extremely challenging for QRTPs to meet ratios, provide discharge planning and provide family-based aftercare support, and very challenging to provide specific services, use a trauma-informed care model, and obtain judicial approval/disapproval of placement within 60 days as required by Family First. While trauma-informed care and the other requirements of Family First may be vital to care for youth with complex needs, the result of implementation of Family First has been a rapid reduction of residential beds available to support them.[30]

Consequently, by 2022, the OOHC systems of Kentucky and many other states were experiencing the cumulative effects of juvenile justice reform to reduce youth detention (which occurred in many states during the same period),[31] the pandemic, and the effects of implementation of the Family First. The Department saw more children and youth who needed 24/7 supervision and care related to developmental and intellectual disabilities and/or high levels of autism spectrum disorder symptomology; youth with substances use disorder; youth or children with histories of physical aggression; youth who had eating disorders; and youth who needed Psychiatric Residential Treatment Facility (PRTF) beds. These youths also oftentimes show aggression to themselves, others, or property; display problematic sexual behaviors; have had six (6) or more placements within a year; are in acute hospitalization with no placement acceptances; or are being released from a detention center.[32]

The Department began analyzing youth in 2023 by looking at gender, age, and history to include justice involvement, termination of parental rights or parent death, neonatal substance exposure, exposure to parental substance abuse, sexual abuse, chronic abuse, whether there was an adoption disruption, and whether the youth came into care due to dependency. The Department looked for diagnostic trends, specifically attention deficit disorder, anxiety disorder, autism spectrum

[28] Oerther Interview, pp. 39-42.
[29] Family First Prevention Services Act (2018), HR 1892 – 115th Congress (2017-2018), Bipartisan Budget Act of 2018, Title VII. 2018, Feb. 9. https://www.congress.gov/bill/115th-congress/house-bill/1892.
[30] American Public Human Services Association (APHSA), *Addressing the Complex Needs of Youth: A Call to Action*, Jan. 2025, p. 2.
[31] Center on Budget and Policy, *State Juvenile Justice Reforms Can Boost Opportunity Particularly for Communities of Color,* Cortney Sanders, July 27, 2021, pp. 9-13.
[32] Specialized Placement and Treatment Needs 2023 Preliminary Analysis, TWIST.

disorder, intellectual or developmental disability, mood disorder, conduct disorder or trauma and stressor-related disorders. The Department then categorized the youth to track trends and understand the issue better:

- Youth with two or more nontraditional placement (NTP) episodes;
- Youth with three or more consecutive days in NTP;
- Youth who are placed out of state for treatment;
- Youth who have experienced three or more placement moves in a 90-day period (qualifying as "placement instability"); and
- Survivors of human trafficking.[33]

Nontraditional placements are defined by the state as short-term care solutions for children in OOHC for whom a current placement search has not identified any placement options.[34] For youth in the first two categories involving NTP, the Department identified two distinct populations/treatment needs. The first population are youth whose experiences have affected their ability to trust or rely upon adults. These youth experienced chronic abuse and neglect, are hyper independent as a response to their trauma, and need a treatment approach that allows them some decision-making in their care and treatment while they build trust and develop healthy relationships. The second population are adolescents who experienced complex trauma, which results in many of the same issues as the first population, but which also leads to functional impairments.[35] In both populations, it appears that many of these youth were confirmed to be or at least likely to have been exposed to substances in utero and likely experienced a significant loss, often a parent. Many of these youth experienced significant time in institutional facilities, making it necessary to incorporate community-based services to help them transition from that restrictive setting, and some had legally signed out of a treatment center because they were over the age of 16 but then needed another placement.[36]

While the actual number of youth with complex needs was relatively low, they proved to be more challenging to place, and understanding the specifics going on with these children and youth was necessary to help place them. Non-traditional placement has been the result of the confluence of the reduction of available adequate placement options and the increase in youth with complex needs.

This is a national problem. The American Public Human Services Association (APHSA) reported in January 2025 that of the 125 local health and human services agencies across the country that it surveyed, 57% reported an increase in out-of-state or out-of-jurisdiction placements among other atypical placements. The APHSA report stated:

> Between August 2023 and July 2024, agencies reported housing youth in inadequate locations such as offices, hotels, hospital emergency rooms, homeless shelters, and other spaces. Offices and hotels are frequently used, pointing to systemic bottlenecks when traditional options are unavailable or medical crises. Hospital and emergency rooms are also cited, reflecting their role as last-resort housing during behavioral or medical crises. Youth placed in homeless shelters further highlight the scarcity of age-appropriate or specialized care settings. These

[33] *Id.*
[34] Non-Traditional Placements Utilization and Definitions, aka Tip Sheet; Feb. 2, 2024.
[35] Specialized Placement and Treatment Needs 2023 Preliminary Analysis, TWIST.
[36] Specialized Placement and Treatment Needs 2023 Preliminary Analysis, TWIST. *See* Khoury Interview, p. 17.

patterns indicate a system struggling to manage overflow and meet the unique needs of high-acuity cases.[37]

D. OOHC Placement Process and Options

KRS 620.020(5) defines foster care as the provision of temporary 24-hour care for a child for a planned period of time if: (1) the child has been removed from his or her parents, or (2) the person exercising custodial control or supervision and subsequently placed in the custody of the cabinet and placed in a foster home or private child-caring facility or child-placing agency but remains under the supervision of the cabinet. DCBS is responsible for implementing the process to determine and expedite the placement of children who are in custody of or committed to the Department.[38] DCBS follows the placement assessment and level-of-care process established in 922 KAR 1:360, which aligns with the requirements of the federal Family First.[39]

Placement settings in OOHC should be in the least restrictive setting possible. An in-home placement with community supports (either with a parent, a relative-nonparent or fictive kin) is the least restrictive. Depending on the level of behavioral mental health support, the child may need the most restrictive placement, which is a psychiatric residential treatment program (PRTF)/Inpatient Substance Use Disorder Treatment Program (SUDTP)/Juvenile Sex Offender Treatment Program (JSOTP).[40] Figure 1 below shows the movement from non-restrictive/more community-based services to restrictive/increased services in a therapeutic setting. Consideration of each type of placement and the process necessary to place are covered in the DCBS Standard of Practice Manual,[41] which is based on federal and state laws and regulations.

Figure 1

As Figure 2 below shows, short term Crisis Intervention options are not considered a non-traditional placement in the OOHC program. These include emergency shelter, a crisis unit, or any hospitalization, whether acute medical/general care or psychiatric care, and whether admitted or not.

Figure 2

[37] American Public Human Services Association (APHSA), *Addressing the Complex Needs of Youth: A Call to Action*, Jan. 2025, p. 12.
[38] KRS 199.801.
[39] 922 KAR 1:360. See newvista.org/crp for process information, placement guidelines, FAQs related to the placement process.
[40] Dennis Interview, pp. 4-5.
[41] https://manuals-sp-chfs.ky.gov/chapter4/Pages/4-9.aspx.

There are various options for placement depending on the circumstances involved or youth's entry into OOHC. Per KRS 199.801 (2), DCBS must select a placement that is the "best alternative for the child that is in closest proximity to the child's home county, including considerations of the child's current early care and education provider or school, in order to promote educational stability to the extent practicable…." Under 922 KAR 1:360, when a child is referred to the Cabinet, it creates a packet of information for the independent gatekeeper entity, the Children's Review Program, to complete an assessment and determine the Level of Care for the child. The Level of Care packet includes detailed background on the child including their physical health needs, behavioral health needs, history of substance abuse or other significant behavioral issues such as sexual behavior and court involvement, and history of placements. The Level of Care increases as the needs of the child increase. A Level 3 referral, the highest level of needs, is a child who has significant treatment needs and requires a highly structured therapeutic setting.[42]

If the Department can place with the parent, relative or fictive kin or is able to place in a Department foster home, it moves forward with that placement and establishes the appropriate supports. If the appropriate placement is beyond one of the Department's foster homes, Kentucky contracts with New Vista to perform the services of the Children's Review Program, which conducts the assessments and assigns the Level of Care.[43] The assessment considers the strengths and needs of the child using an age-appropriate, evidence-based functional assessment tool approved by HHS to determine the best setting, and ideally the least-restrictive environment.

IV. APPLICABLE POLICIES AND PROCEDURES

The statutory and regulatory processes nationally and in Kentucky did not address placement disruptions for which there was no identified subsequent placement within the notice period, because that occurrence was and still is an anomaly in the normal process. Therefore, the Department worked closely with the Department of Juvenile Justice, the Administrative Office of the Courts, Department of Medicaid Services, DBHDID and the Children's Review Program to build a team and develop a process to address this phenomenon in late 2022.

The incidence of disruptions without an identified immediate placement began in mid-2022, and as a part of its response, the Department's Central Office made initial process changes to better track it. In January 2023, the Division began adding an option of NTPs to the TWIST database DCBS uses for OOHC so that these situations could be accurately documented. The Assistant Director of the Division communicated to the Service Regions via memorandum on February 14, 2024 along with an NTP Tip Sheet for guidance.[44] The Tip Sheet defined specific NTPs including Community Center, DCBS Office, Hospital (not admitted),[45] Hotel, Interim Caregiver, PCC/PCP Office, Place of Worship or State Park. It described various scenarios and explained the proper documentation of those settings in TWIST. It also emphasized that an NTP is a last resort option that should be used only when all other options have been exhausted. Further, if the temporary placement qualified as either a relative, fictive kin, foster parent, or other placement type, the Tip Sheet indicated the placement should be documented as that type of placement and not an NTP.

[42] 922 KAR 1:360, Sec. 4(3).
[43] Dennis Interview, p. 5.
[44] Protection and Permanency Memorandum (PPM-24-02) with Non-Traditional Placement Tip Sheet, Feb. 14, 2024.
[45] Note, technically a hospital setting is regulated by CHFS OIG and therefore, is not considered an NTP. Khoury Interview, p. 51.

Working with agencies and partners, the Department began ongoing analysis of children or youth who were tracking to be at risk for an NTP and also developed a process to follow for the 14-day notice period for those children or youth.

First, through data analysis provided by the OOHC Social Services Specialist, regions are monitoring youth needing intensive services for severe behavioral and emotional challenges. These youth have already had multiple placements, are at least a Level of Care II, and often are also involved with the juvenile justice system. System trends have shown that the placements of youth with these complex unmet needs have the potential for disrupting, so these youth are closely monitored within each region. Regular follow-up by each region's High Acuity Youth Specialist occurs to ensure that the services being provided at the time meet the youth's needs or are modified to meet the needs to prevent disruption of the placement. Regions have regular meetings to discuss youth at risk of NTP to consider what adjustments need to be made to prevent an NTP. [46]

Second, the Department follows a process to handle these situations.[47] Though the process varies slightly from region to region as resources vary across the state and is affected by what type of entity is giving notice, the process generally is follows:

- Notice is received that a placement is disrupting.
    - Notice by the Private Child Caring (PCC) Provider or the Private Child Placing (PCP) Provider, which is by contract required to be a 14-day notice,[48] is submitted in the Children's Review Program Portal. PCCs and PCPs agree by contract to provide a minimum 14-day notice. However, with the reduction in placements for youth with complex needs, more recently providers have agreed to take a child only if the Department either waives the notice requirement entirely or reduces it, which results in the Department negotiating a shorter notice period in order to get the child or youth placed.
    - Notice of a Department Foster Care placement is provided via the family directly to the social services worker.
    - Notice from an out of state provider or an intensive treatment center, a provider that accepts Medicaid, that a youth is being discharged or signed themselves out of a facility comes in to the social services worker by Aetna SKY or the MCO providing the services to the child or youth.
- All notices are put into TWIST, which generates a blast notification to the social service worker, their supervisor and a LISTSERV that includes Central Office staff and the Children's Review Program, and the notice is placed on a daily report that goes to all Service Regions of all children and youth who have two-week notices pending.
- If the child or youth is disrupting from a residential treatment setting, the notice is flagged of particular interest because that child or youth is likely going to need a similar Level of Care at another intensive treatment setting.
- The Clinical Administrator assigns the notice to a regional High Acuity Youth Specialist, who contacts the current placement to determine the reason for the notice to terminate the placement and whether, with additional supports, the placement can be maintained, using consistent talking points or guidance to ensure a comprehensive reconsideration process (referred to as "Placement Preservation").

[46] Oerther Interview, p. 7.
[47] Khoury Interview, pp. 9-18.
[48] Shworm Interview, pp. 10-11.

- Upon notice, the social service worker requests a search to identify all potential extended family members and contacts all foster placement options, if appropriate. The High Acuity Youth Specialist immediately works with the social services worker to update the child or youth's 886A form, which is a living document that contains relevant information on the child or youth. The 886A form is submitted electronically to CRP.
- Within two days of the updated 886A, the Children's Review Program submits a one-page summary of the child's needs and strengths and sends the one-pager and the updated 886A to appropriate providers.
- Providers have two days to accept or reject the referral and provide a reason for any rejection.
- If there are no acceptances, the Children's Review Program worker assigned to the service region will contact the child's team, which consults on next steps. This may include consultation with Clinical Services Branch or referral expansion to exceptional options, such as out-of-state placement for treatment.
- All providers' rejection reasons are reviewed to determine if additional information could be added to the 886A to encourage placement.
- If no placement is found with all regional sources, the youth is placed on the Daily Priority Placement Call, a statewide call using a multidisciplinary team approach. This call is attended by high level representatives of the Department of Behavioral Health, Developmental and Intellectual Disabilities, Juvenile Justice, Aetna SKY, Clinical Services branch, Medical Directors, Office of Children with Special Health Care Needs, and Department leadership to determine a traditional placement.[49] The youth who are discussed in this meeting are those currently in an NTP, expected to come into an NTP within the next 24-48 hours based on disruption notices, and those for whom no placements have been identified.
- If the notice period is imminently expiring without an identified placement, the regional High Acuity Youth Specialist secures staff and determines the location of an NTP.[50]

In the NTP, the Department provides the following general accommodations for a youth in a home-like setting:[51]

- Personnel staffed at a 2 to 1 ratio plus a security guard for every youth in NTP;
- A furnished bedroom with bed, bedding, nightstand, desk/study area, television, and technology access;
- Access to therapeutic services to address mental health needs;
- Food, clothing, hygiene products;
- Access to facilities to maintain hygiene;
- Education needs including transportation to school if enrolled;
- Medical services including medication management with nursing oversight;
- Additional training and supports for staff and foster parents;
- Extracurricular and recreational activities; and
- Enhanced visitation room access.

Actual locations vary from region to region because not all regions have the same facilities available; for example, not all regions have a state park. All regions have an office NTP. In one region, two churches have established homes to be used for this purpose. The selection of the most

[49] Dennis Interview, p. 7.
[50] Root Interview, p. 27.
[51] Dennis Interview, pp. 31-33.

appropriate NTP considers various factors like staffing, access to supportive services, and access to recreational activities. [52] Regions provide a structured schedule of basic and therapeutic support for the youth.[53] Therapeutic telehealth is provided through a contracted health partner.

V. FINDINGS

A. Generally

From 2017 through January 2025, many positive changes have occurred in placement trends in Kentucky. The main goal of the OOHC program is to return children and youth to homes. Home placements with parents, relatives or fictive kin increased steadily over that time.[54] Key partnerships, especially the University of Kentucky College of Social Work Kinship Navigator Program, have continued that trend, increasing placements with relatives and fictive kin from 18% to 29% in the past 21 months.[55]

Additionally, from 2017 to 2025, although foster care placements have remained relatively flat, there is a shift from Private Child Placing foster care placements to Department foster care placements, which allows a variety of community supports compared to the Private Child Placing supports only when in private foster care. Placements in Private Child Caring residential treatment facilities have decreased by about half, and children placed in psychiatric hospital care has remained relatively low, although the latter is likely due to the low number of inpatient psychiatric care beds for children and youth.[56] Therefore, the overall trend for traditional placements is trending in the right direction to meet the Department's and Family First's goals. However, for a relatively small number of the children in OOHC, the level of care needed is increasing and is driving the higher incidence of NTPs.

B. Non-Traditional Placements

1. NTPs in relation to children and youth served in OOHC

Non-traditional placements started becoming an issue in 2022, and the Department began tracking these occurrences at that time. Because they were atypical, the TWIST case management system was not originally set up to document these placements and tracking within TWIST began in early 2023. Additionally, as this problem evolved both nationally and, in the Commonwealth, decisions regarding classification changed.

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[52] Shworm Interview, pp. 19-26.
[53] DCBS NSR Daily Schedule for NTP; *See* Photos of Regional NTPs.
[54] Central Office Tracking, TWIST, OOHC Placement Setting Quarterly Utilization Jan. 2017-Jan. 2025.
[55] Central Office Tracking, TWIST, Statewide Foster Care FACTS Based on all children in OOHC on Jun. 2, 2024, TWS-W058. Central Office Tracking, TWIST, Statewide Foster Care FACTS Based on all children in OOHC on Mar. 1, 2026, TWS-W058.
[56] Central Office Tracking, TWIST, OOHC Placement Setting Quarterly Utilization Jan. 2017-Jan. 2025. Also, Shworm Interview, pp. 31-32: there has been a contraction in the number of providers of inpatient psychiatric care, and one large provider operates many of these beds. Therefore, if a child is rejected from a placement in a bed with one of that provider's PRTP, the child or youth is rejected from all of the PRTPs operated by that provider.

	Total # of Unique Youth in OOHC in calendar year	Total # of Unique Youth in NTP (DCBS Office, Hotel, State Park, Community Center or PCC/PCP Office) at any time during the Calendar Year)			% of Unique Youth in NTP (DCBS Office, Hotel, State Park Community Center or PCC/PCP Office) at any time during the Calendar Year)		
	TWIST	Central Office Tracking (excludes emergency removal, placement pending)	TWIST (includes emergency removal placement pending	TWIST (excludes emergency removal placement pending)	Central Office Tracking (excludes emergency removal, placement pending)	TWIST (includes emergency removal placement pending	TWIST (excludes emergency removal placement pending)
2022	14,283	35	26	18	.0025	.0018	.0013
2023	13,683	138	146	123	.0101	.0107	.0090
2024	13,815	165	186	155	.0119	.0135	.0112

As a result, the Department has been tracking this in the TWIST system since 2023 but also continued manual tracking in the Central Office. However, regardless of which data is considered, TPs make up a very small percentage, that is one to two percent (1-2%)[57] of placements for all OOHC as shown in the table above.[58]

A strong indicator of the need for a future NTP is whether the child or youth has experienced placement instability. Placement Instability, defined as three or more moves in a 90-day period, is used by the Department to predict likelihood of a future NTP and to prevent or mitigate the chances of a disruption without an identified placement.

A previous analysis of NTPs from January 1, 2023 to February 1, 2024 by the Division [59] highlights that a very small number of children and youth overall are experiencing significant placements issues. The Division found that at a particular point in time, there were 8,047 children or youth, and 11% of those were having three or more moves (meaning four placements) in a 90-day period (these children or youth experienced a total of 5,185 placements). There were 651 children or youth who experienced three or more moves in a 90-day period over the period of the analysis, and 214 youth had not only three or more moves in a 90-day period but also at least one of those

[57] Out of Home Care Population and Nontraditional Placements, 2022-2024, Central Office Tracking; *See* Division of Protection and Permanency Memorandum 24-02, Feb. 14, 2024, including Nontraditional Placement Tip Sheet, Feb. 2, 2024. *See also* "Children in the Custody of or Committed to the Cabinet and Children Experiencing Nontraditional Placement and/or Placement Instability, July 2022-Feb. 2025, TWIST.

[58] Out of Home Care Population and Nontraditional Placements, 2022-2024, Central Office Tracking. *Total number of unique youths in OOHC at any time during period**:** This is the unduplicated number of youths who were in out of home care (OOHC) at least 1 day during the reporting period. If a child entered and exited OOHC multiple times during the year, he/she is only counted once. (Source: TWS-M302); "Children in the Custody of or Committed to the Cabinet and Children Experiencing Nontraditional Placement and/or Placement Instability, July 2022-Feb. 2025, DCBS Division of Permanence and Protection.

[59] Placement Stability M403 1/1/2023-2/1/2024, NTP Central Office Tracking. Because placement instability is defined as 4 placements in a 90-day period, the analysis considers the time period before the actual date range. For example, on January 1, 2023, a child may have been experiencing placement instability because since October 1, 2022 the child has had at least 4 placements. Thus, although the analysis looks at a specific time period, it is necessary to look at the months prior to that selected time period to understand these situations. Additionally, because data entry could be delayed, the look back period is generally six months.

placements was an NTP. Eleven percent (11%) of the youth in OOHC averaged a total of seven placements from January 1, 2023 to February 1, 2024.

Placement Instability	CSR	EMSR	JSR	NSR	NBSR	SBSR	SRTSR	TLSR	TRSR	State	State Avg.
# youth in OOHC	778	612	811	598	1145	1181	1061	714	1147	8047	894
% youth in OOHC	10%	8%	10%	7%	14%	15%	13%	9%	14%	100%	11%
Total # placements on report	612	221	551	448	786	647	605	424	891	5185	576
% Total # placements on report	12%	4%	11%	9%	15%	12%	12%	8%	17%	100%	11%
# unique youth 3+ moves in 90 days	73	27	72	53	94	85	77	56	114	651	72
% unique youth 3+ moves in 90 days	11%	4%	11%	8%	14%	13%	12%	9%	18%	100%	11%
# unique youth placement instability + NTP	31	10	18	19	30	25	19	16	46	214	24
% placement instability + NTP in region	42%	37%	25%	36%	32%	29%	25%	29%	40%	33%	33%
# unique youth placed in intensive treatment setting	57	21	59	40	76	61	57	41	83	495	55
% unique youth placed in intensive treatment setting	78%	78%	82%	75%	81%	72%	74%	73%	73%	76%	76%
Average age	14	13	14	14	14	13	14	12	13		13
Gender % Male	37%	44%	40%	45%	47%	53%	43%	43%	39%	283	44%
Gender % Female	58%	48%	57%	51%	51%	47%	56%	55%	59%	352	54%
Gender % Nonbinary	5%	7%	3%	4%	2%	0%	1%	2%	2%	16	3%
Average # moves/child with placement instability	8	7	6	7	7	7	7	7	7	7	7
% youth in OOHC 3+ moves	9%	4%	9%	9%	8%	7%	7%	8%	10%	8%	

		CSR	EMSR	JSR	NSR	NBSR	SBSR	SRTSR	TLSR	TRSR	Statewide
NTP OOHC Trends	# NTP in 2023	19	12	20	34	49	18	16	19	52	239
	Sum of Days in NTP	28	16	111	177	150	45	76	109	174	886
	# of unique youth	16	6	15	15	21	14	16	12	33	148
	# of youth 2+ NTP episodes	2	3	5	7	9	1	1	4	13	45
	# youth in OOHC	818	633	815	605	1163	1177	1048	735	1175	8169
	% youth in OOHC	10%	8%	10%	7%	14%	14%	13%	9%	14%	
All NTP											
Child Trends	adoption disruption	6%	17%	13%	27%	38%	0%	29%	31%	21%	20%
	dependency	63%	67%	47%	40%	71%	57%	50%	77%	55%	58%
	justice involvement	44%	67%	53%	53%	43%	43%	21%	54%	52%	48%
	human trafficking survivor	6%	67%	0%	13%	5%	7%	0%	0%	7%	12%
2+ NTP											
Child Trends	Survivor of human trafficking										12%
	Active substance misuse										17%
	Experienced parent/caregiver death										21%
	Experienced sexual abuse by parent										29%
	Adoption disruption										31%
	Came from relative/fictive kin custodian										36%
	Substance exposure in utero										38%
	Experienced termination of parental rights										60%
	Dependency										64%
	Justice involvement										64%
Diagnostic Trends	Autism spectrum disorder										17%
	Intellectual or developmental disability										33%
	Trauma-related symptoms										38%
	Anxiety										38%
	Impulse control/conduct disorders										43%
	Mood disorders										45%
	Attention deficit disorders										76%
	Active substance use										17%

# of youth in OOHC statewide: *point in time report*; # of youth in out-of-home care in TWIST on the report run date (2/4/2024)
% of youth in OOHC statewide: % of youth in OOHC statewide are from this region
Total # placements on report: Total # of placements in the reporting period (1/1/2023 – 2/1/2024) for youth who met criteria (3+ moves/4 or more placements in a 90-day period)
% total placements on report: regional % of statewide total
 # unique youth 3+ moves in 90 days: count of individual youth who experienced 3 or more moves (4 or more placements) in a 90-day period in the reporting period. The reporting period is 1/1/2023 – 2/1/2024, and it looks back six months. This means that January 2023 might pull in placement moves from the previous six months
% unique youth 3+ moves in 90 days: regional % of statewide total
 # unique youth placement instability + NTP: count of individual youth who experienced 3 or more moves (4 or more placements) in a 90-day period and a nontraditional placement in the reporting period
% unique youth placement instability + NTP: regional % of statewide total **# unique youth placed in an intensive treatment setting:** count of individual youth who experienced 3 or more moves (4 or more placements) in a 90-day period and were ultimately placed in an intensive, restrictive treatment setting (RTF, PRTF, acute psychiatric hospital) in the reporting period.

Children and youth experiencing placement instability and ultimately an NTP have significant and likely worsening needs due to the placement instability, and their needs must be met by community supports and/or psychiatric care. Data show that 76% of those children and youth ultimately ended up in an intensive treatment setting such as a psychiatric hospital.

When potential PCC/PCP placements receive a referral, they must accept or reject that in the CRP provider portal and provide a reason. Children and youth who have experienced an NTP were consistently referred many more times for traditional placements than other youth not experiencing an NTP. When this tracking began in the summer of 2022, an average of 103 referrals were sent to all possible placements for a child or youth experiencing an NTP compared to an average of 65.6 referrals sent out for all youth to obtain a traditional placement. A year later, that gap had widened with referrals for a child or youth with an NTP reaching 201 possible placements and all youth at 75 possible placements. This trend improved slightly in the summer of 2024.[60] Where the child or youth had been in an NTP, an emergency shelter or DJJ Detention, PCC/PCP providers identified the basis for the rejections in approximately 40% of the situations as "teenager," suggesting the problems were associated with typical teen behavior such as vaping, breaking curfew, or talking back disrespectfully. In nearly 20% of the instances in which the children or youth had been in detention, the reason for rejection of the referral was the criminal history.[61]

Analysis was also conducted to understand what referral efforts led to an NTP outcome. The majority of the previous placements for youth experiencing an NTP were in a foster home or with relatives or fictive kin, and the subsequent placement setting, once achieved, was in a foster home but it took longer than the notice period to secure that subsequent placement.[62] Thus, the placement efforts to return the child or youth were achieved, but it took longer than most placements. Ongoing, detailed analysis is a critical component of the Department's strategy.

The Department's comprehensive NTP process, implementation of which is ensured through oversight by Department leaders and experts during its daily calls, is successfully reducing the incidence of NTPs.[63]

STATEWIDE NONTRADITIONAL PLACEMENT DATA			
Calendar Year	# NTP	Sum of Days in NTP	# Unique Youth
2024	238	667	163
2025	118	334	87

[60] Children's Review Program database
[61] *Id. See also*, Root Interview, p. 34.
[62] Central Office Non-Traditional Placement Tracking, TWIST.
[63] *Id.*, 1/1/2024-11/30/2025.

2. Comparison of Data from the Ombudsman

A previously released preliminary report of the Ombudsman looked at NTP data from the period June 10, 2024 through October 31, 2024. That report did not indicate how the Ombudsman gathered the data, but comparing this office's data with that information reveals the following:

Youth in Offices	DCBS Data[64]	Ombudsman Report
Cumberland Region	1	1
Eastern Mountain Region	3	2
Jefferson Region	4	2
Northeastern Region	7	4
Northern Bluegrass Region	9	12
Southern Bluegrass Region	8	4
Salt River Trail Region	9	10
The Lakes Region	0	1
Two Rivers Region	14	13
Statewide	**55**	**49**

[64] TWIST.

Additionally, this office reviewed the summarized data[65] of the Department and the Ombudsman, which showed the following for the same time period:

	DCBS Data	**Ombudsman Report**
All Summarized Data	***Number***	***Number***
Total Youth	55	49
Total Days	152	198
Average Length of Stay in Consecutive Days	2.27	4.04
% of Children Who Had Stays of only 1 day or less	47%	~50%
Maximum Length of Stay in Consecutive Days	16	35
Average Age of Youth in Years	15.1	13.8
Youth Under 10 years of Age	0	6
Minimum Age of Youth	10	1
Number Male/Female	32/23	30/19
Children Experiencing 5 or More Days in NTP		
Number of Youth	8	12
Average Age	16.09	15.25
Number of Male vs. Female	5/3	9/3
Average Age Male vs. Female	15.73/16.79	15.22/15.33
Children Experiencing 10 or More Days in NTP		
Number of Youth	3	6
Average Age	15.24	14.5
Number of Male vs. Female	3/0	5/1
Average Age Male vs. Female	**15.24**	**14.8**

The FAC OIG found important differences in the data reported by Ombudsman. Specifically:

- FAC OIG did not find that any of those children or youth were under the age of 10 and FAC OIG found no instance of a one-year-old in an NTP during the period;

[65] TWIST.

- FAC OIG determined the average age was 15 years old, not 13 years old;
- FAC OIG found that the longest stay was less than half (16 days) of the length that was determined by the Ombudsman (35 days);
- Both the data from FAC OIG and from the Ombudsman indicate that approximately 50% of these stays lasted up to one day only (until such time as a traditional placement was found);
- Additionally, FAC OIG found that the average stay was 2.27 days, almost half the number of days the Ombudsman reported (4.04); and
- FAC OIG found that three of the regions represented 58% of the total NTPs for the period, instead of the reported 70%.

FAC OIG is unable to determine the source of these discrepancies, but they could be the result of misclassification. NTPs do not include emergency shelters, crisis stabilization units, or acute care or psychiatric hospital stays, regardless of whether the child or youth is admitted to the hospital or remains in the emergency room, and no matter the number of days in those settings because all those settings are licensed. Within a licensed setting, the care is under the purview of the licensee (e.g., hospital).[66] Notably, placements in an emergency shelter and psychiatric hospital make up a very small number of traditional placements, because there are so few beds available in those settings. For example, there are currently no contracted emergency shelter beds in the entire state, and there were only a few available emergency shelter beds during the time period that was reviewed by the Auditor.[67] Therefore, some discrepancies may be due to misclassification of the setting. Additionally, a day is determined by the reimbursement process and less than 24 hours would be one day even if that child or youth was present in the NTP during two calendar days (e.g., overnight) until a traditional placement was identified.

C. Steps Taken and Planned for Addressing Non-Traditional Placements in the Nation and in Kentucky

Recognizing utilization of NTPs as an issue to address, the Department has worked in a variety of ways to support more traditional placements, while reducing the increase in the complex needs of children and youth in the system.[68]

1. Increased and/or enhanced rates for foster families and agencies:

- May 2022: Developed a way for agencies and foster parents to receive additional funding above their *per diem* rates to provide additional services to youth that have more complex needs as a temporary measure before addressing rates.
- May 2023: $40 million investment to adjust and increase daily *per diem* rates for private agencies statewide and provide a one-time stabilization payment for providers.
- 2023: Department for Medicaid Services increased PRTF I rate to $500 and PRTF II rate to $600.[69]
- The Cabinet led the Children's Behavioral Health Initiative, a comprehensive program with DJJ, AOC and education focused on children's behavioral health services.
- July 2024: Increased DCBS state foster home *per diem* rates for the first time since 2016.

[66] Root Interview, pp. 21-22; Khoury Interview, pp. 49-50.
[67] *Id.*, pp. 27-28.
[68] *See* testimony of Commissioner Lesa Dennis, Senate Standing Committee on Families & Children, Feb. 11, 2025.
[69] There are two levels of PRTFs, and Level II provides more intensive services.

- January 2025: $10 million investment to increase Therapeutic Foster Care Rates, reinforcing support for caregivers.

2. Expanded and increased staffing and training

- Summer 2022 to late Spring 2023: National Training Development Curriculum (NTDC) Caregiver Training launched a variety of new trainings for foster and adoptive parents to provide additional tools and resources to meet the needs of youth with complex needs. NTDC training began being piloted in the summer of 2022 and was rolled out to all regions in late spring of 2023.
- January 2023: Established a statewide high-acuity coordinator and placed high-acuity specialists in each of the nine service regions to focus on youth with placement challenges.
- January 2024: Virtual training provided to the Department staff who provide care and supervision to youth in NTP: Medication Administration for Non-Traditional Settings - A Guide for DCBS Staff.

3. Additional collaboration

- September 2022: Daily meetings with the Department's key partner agencies—including Juvenile Justice, Department for Medicaid Services (DMS), Behavioral Health, Developmental and Intellectual Disabilities, Aetna, and the Review Panel—to actively monitor and respond to youth in or at risk of NTP within 24 to 48 hours.
- December 2022: Regular meetings with Private Child Placing and Private Child Caring providers to analyze data and develop strategies for addressing the needs of youth with complex behavioral health challenges. Since October 2022, twelve convenings have been held to strengthen partnerships and expand solutions for NTP youth.
- January 2023: Nurse consultants who were assigned to each service region to oversee medication management for youth boarding in a non-traditional placement and to train local staff on each youth's specific medical needs began being included in the daily morning meetings on NTPs.
- May 2023: Regular meetings held with the High Acuity Specialists in which additional training and supports were shared to build further understanding and skill to assist in their role of working with youth in non-traditional placement and complex behavioral health needs.

4. Expanded services and support for foster parents and youth in OOHC

- November 2022: Expanded in-home services for foster parents and youth in OOHC for intensive in-home therapeutic services to youth and their foster parents, in addition to services traditionally provided in the foster home.
- August 2023: Partnership with Ramey Estep/ReGroup to provide telehealth services for youth in NTP, ensuring continuity of care for mental health supports and services despite placement instability.
- November 2023: Contracted with private agencies to provide prioritized emergency shelter services for youth with high acuity needs.
- February 2024: Pilot program with a private agency to provide targeted therapeutic services for children with complex needs in a smaller setting with more deliberation

over placement. This program was expanded to include an additional agency in October 2024.

- March 2024: Cross-departmental initiative consisting of the Department, Medicaid Services, Behavioral Health, Developmental and Intellectual Disabilities, and Juvenile Justice to address Children's Behavioral Health Services to concentrate on continuum of care that focuses on individualized services tailored to the unique needs of child.
- March 2024 and August 2024: Partnership with two national centers, the National Center for Diligent Recruitment and the National Center for Enhanced Post-Adoption Support f/k/a National Center for Post-Permanency Supports, to strengthen support across the continuum of care and develop strategies for recruiting foster parents that can support youth with complex needs.[70]
- May 2024: Contracted with River Valley for Specialized Acute Psychiatric Care to open a 10-bed unit providing intensive psychiatric services to youth with immediate, acute behavioral health needs.
- June 2024: Aetna implemented Flourish, an Intensive In-home Program to prioritize the Department's foster care youth and help stabilize youth aged 12 and up in the home.
- July 2024: Adopted federal standards to streamline the approval process for relatives and fictive kin as foster parents and created a new permanency outcome, Subsidized Permanent Custody, to provide long-term stability for children in kinship care.
- July 2024: Began an innovative partnership with University of Kentucky College of Social Work (UKCoSW) to expand its Kentucky Kinship Resource Center (KKRC). The KKRC is specifically designed to provide enhanced support accessible to participants in times of need, reduce placement instability, and increase caregiving capacity in Kentucky for kinship care, estimated to be one of the highest rates of kinship care in the country.[71] KKRC also launched its Kinship Navigator Program to reach caregivers early in their caregiving journey and began supporting service regions.[72]
- January 2025: Launched a specialized program to support youth's step down from residential treatment to a community foster care setting.
- July 2025: Contracted with Lexington Leadership Foundation and Baptist Fellowship Center in Louisville to support foster parent recruitment and retention. These groups work directly with local faith-based organizations to recruit and retain foster parents by providing respite and other supports.
- July 2025: KKRC Kentucky Kinship Navigator Program has Navigators supporting every service region.[73]

5. Focus on analysis and trends

- Summer 2022: Added trend data analysis to the OOHC Branch Social Services Specialist's role to predict incidents of placement instability to support all regions and the Central Office.

[70] Root Interview, p. 39.
[71] UK College of Social Work, *Meeting caregivers where they are: Kentucky Kinship Resource Center expands program,* https://socialwork.uky.edu/meeting-caregivers-where-they-are-kentucky-kinship-resource-center-expands-program/, July 1, 2024.
[72] UK College of Social Work, *Kentucky Kinship Resource Center continues its impact across the Commonwealth, https://socialwork.uky.edu/kentucky-kinship-resource-center-continues-its-impact-across-the-commonwealth/,* July 7, 2025.
[73] Id.

- July 2023: Initiated a partnership with Binti, a child welfare software provider, to implement a robust family finding program to interface with TWIST and allow DCBS to better identify, document, and track relatives of children involved in the child welfare system.

VI. CONCLUSIONS AND RECOMMENDATIONS

The NTPs occurring with children and youth in the Department's custody since mid-2022 represent a very small number of children or youth (1-2%)[74] overall, despite the increased acuity of the children and youth ***and*** declining availability of placements where their complex needs can be met. FAC OIG found the length of stay in NTP was 24 hours or less in more than 50% of the cases occurring in the period reviewed by the Auditor. On average, NTP stays were slightly longer than 2 days.

FAC OIG found no instances of youth sleeping in locations without adequate supervision or without being provided a furnished bedroom and necessary supports during the NTP.[75] The NTPs were carefully designed to provide a home-like environment in a safe location where there were appropriate staff and other supports. FAC OIG found the Department has used NTPs only as a stop-gap measure until a suitable traditional placement can be found, and that leadership is uniformly committed to preventing NTPs if possible.

In 2025, incidences of NTPs decreased significantly. More children and youth are being placed in homes with relatives or fictive kin. The Department's efforts to better understand the multifaceted, national issue and implement meaningful solutions for the children and youth of the Commonwealth are working.

FAC OIG recommends the following steps be taken by the Department to address handling of these situations.

- The Department should create a standard protocol for both the regional prevention strategies and the central office prevention strategy and, given the evolving of the nature, review it semi-annually to address new trends in placement instability. These strategies exist at the regional level, and leadership consistently articulates the process at the Central Office level, but there is not one standard operating procedure for handling them. There may be some nuances that relate to different challenges in one region from another, but the standard operating procedure is able to still account for that and, for the most part, the regional processes are similar. The standard protocol should be added to onboarding training for new employees.

- The Department should continue its ongoing, detailed analysis of each placement disruption to understand trends and develop strategies to address any new factors causing those disruptions.

- The Department should continue its ongoing efforts using technology to streamline the placement process, including the notice process for placement disruptions, to ensure all notices are acted upon immediately by the appropriate teams.

[74] *See* Footnote 48.
[75] See Footnote 15.

- The Department should work with the Children's Review Program to determine whether the referral process is efficient and effective or whether it is too burdensome for providers and leading to unintended consequences, i.e., rejections due to the volume and the response time.

- The Department should provide training and support not only to field staff but also regional and central office leadership to minimize the traumatic effects of working to support children experiencing placement instability.

Andy Beshear
GOVERNOR

CABINET FOR HEALTH AND FAMILY SERVICES
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Steven Stack, MD
SECRETARY

Lesa Dennis
COMMISSIONER

March 12, 2026

Barbara Dickens, Inspector General
Finance and Administration Cabinet
200 Mero Street, 5th Floor
Frankfort, KY 40622

Dear Ms. Dickens,

On behalf of the Cabinet for Health and Family Services ("Cabinet"), thank you for your diligent and thoughtful review. The Cabinet appreciates the opportunity to review this comprehensive examination of an issue that child welfare systems across the nation are currently confronting. We share your commitment to ensuring every child in Kentucky's care is safe and receives services in the most appropriate setting to meet their needs.

The Cabinet agrees with the report's central finding that a small number of children and youth in state out-of-home care and with complex behavioral health needs were temporarily placed in non-traditional settings when an appropriate placement could not immediately be secured. Additionally, the Cabinet finds your summation of the present situation, the factors that contributed to it, and the actions taken by the Department for Community Based Services ("Department") to be a balanced and accurate representation of the facts and events relevant to this matter.

To be clear, for every child in out-of-home care, the Department's priority is to place that child in the least restrictive, most family-like setting appropriate to meet their needs. Whenever possible, this includes placement with relatives, fictive kin, or certified foster families. When those options are not available or cannot safely meet a child's needs, residential treatment or other specialized placements may be required. In rare circumstances—generally affecting 1 to 2 percent of youth in out-of-home care—an appropriate placement cannot be immediately secured due to the child's unique and complex behavioral health or treatment needs. In those limited cases, a non-traditional placement (NTP) may be used temporarily as a last resort until a clinically appropriate placement can be identified.

These situations typically resolve quickly. During the four-and-a-half-month period reviewed in the audit, there were 15 days when no children were in a non-traditional placement, and for much of the period, no more than one child was in such a setting. This must also be viewed in the context of a system that serves approximately 10,000 youth in or recently involved in Kentucky's out-of-home care program, meaning these situations represent a very small fraction of placements.

As you clearly describe, multiple factors have contributed to this trend not only in Kentucky, but across the nation. Despite these challenges, the Cabinet has taken decisive steps to address the issue. Through coordinated internal efforts and collaboration with national partners, the Cabinet has implemented several research-based strategies to reduce reliance on temporary, non-traditional placements. These efforts are producing measurable results. In 2025, the number of non-traditional placements, the total number of days youth spent in those placements, and the number of unique youth impacted decreased by approximately 50 percent compared to 2024.

The Cabinet has also prioritized strengthening family-based placements. The Department currently supports 10 Kinship Navigators statewide through a partnership with the University of Kentucky (UK), helping relatives understand placement options, navigate the foster parent approval process, and access available supports. UK provides peer support for kin caregivers, as well. As a result of these efforts, 29 percent of youth in out-of-home care are now placed with relatives—up from 18 percent from approximately 18 months ago.

Even so, the Cabinet continues its efforts to further improve this situation and, in this spirit, welcomes and now responds individually to each of your recommendations:

- **The Department should create a standard protocol for both the regional prevention strategies and the central office prevention strategy and, given the evolving of the nature, review it semi-annually to address new trends in placement instability. … The standard protocol should be added to onboarding training for new employees.**

  The Department agrees with this recommendation and supports the development of a standardized protocol to guide both regional and central office prevention strategies related to placement stability. The Department continues to work with regional and central office teams to strengthen processes that allow for the early identification and monitoring of children with complex behavioral health, medical, or therapeutic needs. These efforts are intended to ensure that appropriate clinical and therapeutic supports are identified and implemented as early as possible to help prevent placement disruptions and reduce instability.

  The Department also agrees that these protocols should be incorporated into onboarding training for new employees and reinforced through ongoing professional development. The Department has established a new training partnership with the Council on Postsecondary

Education (CPE) and is working both to refresh existing training curricula and develop new learning opportunities for staff. This partnership is focused on strengthening workforce preparation and providing staff with the tools and knowledge needed to effectively support children with complex needs.

Additionally, the partnership with CPE includes enhanced evaluation of training programs to ensure that emerging child welfare trends, data analysis, and federal and state requirements are regularly reviewed and incorporated into training updates. The Department is already utilizing data related to youth experiencing placement instability to inform training priorities and practice improvements. Continued analysis of this data will help guide the development and refinement of protocols and training to better support staff and improve outcomes for children in the Department's care.

- **The Department should continue its ongoing, detailed analysis of each placement disruption to understand trends and develop strategies to address any new factors causing those disruptions.**

  The Department agrees with this recommendation and remains committed to the ongoing analysis of placement disruptions to better understand trends and identify strategies to improve placement stability for youth in our care. The Department is actively analyzing data related to this population, including diagnoses, number of placements, behavioral needs, and family dynamics, to help identify youth who may be at higher risk for placement disruption.

  This analysis allows the Department to intervene earlier and provide more targeted supports for youth with complex needs, with the goal of preventing disruptions before they occur. The data also informs training for new and existing staff so they are better equipped to support children with higher levels of behavioral health or therapeutic needs.

  In addition, the Department is using this information to work collaboratively with private child caring and placing agencies to strengthen services and enhance therapeutic environments to better serve this population. The data is also being used to support foster parents by informing the development of additional training opportunities. The Department has recently begun offering additional specialized training for foster parents focused on caring for older youth and youth with complex behavioral health needs.

  Further, the analysis supports the Department's diligent recruitment efforts to identify and support foster parents who are willing and prepared to care for older youth, youth with complex needs, and youth with intellectual or developmental disabilities. Ensuring that staff, providers, and foster parents have access to the appropriate training and supports is critical to improving placement stability.

  Finally, the Department's analysis is helping to identify gaps within the broader behavioral health service array for children. These insights are informing ongoing efforts to strengthen

partnerships with providers and expand service capacity so that youth with the most complex needs can access appropriate supports in a timely manner.

- **The Department should continue its ongoing efforts using technology to streamline the placement process, including the notice process for placement disruptions, to ensure all notices are acted upon immediately by the appropriate teams.**

  The Department agrees with this recommendation and continues to take steps to improve and streamline the referral and notice process. Efforts include the development of a revised referral form that is more streamlined and focused on a youth's clinical needs, strengths, and voice. The referral form includes a section to capture input directly from the youth, ensuring their perspective is reflected in the referral process.

  This work has been developed in collaboration with key partners, including child caring and placing agencies, youth with lived experience, Department staff and the Children's Review Panel. In addition, the Department continues to work with the Office of Application and Technology Services (OATS) to enhance the referral and notice processes within the case management system (iTWIST), with the goal of ensuring referrals are streamlined, more efficient and allows for notifications that are timely, actionable, and directed to the appropriate teams for prompt response.

- **The Department should work with the Review Panel to determine whether the referral process is efficient and effective or whether it is too burdensome for providers and leading to unintended consequences, i.e., rejections due to the volume and the response time.**

  The Department agrees with this recommendation, and the efforts described in the above recommendation to streamline the referral and notice process are aligned with this goal. The Children's Review Panel is an important partner in assessing the efficiency and effectiveness of the referral process.

  Current placement challenges for youth with complex behavioral health needs have resulted in an increased volume of referrals and re-referrals, many of which are sent statewide rather than first focusing on providers within the child's local community. This pattern largely reflects the limited availability of specialized treatment and placement options for youth with the most intensive needs.

  Streamlining the referral process to better highlight a youth's voice, strengths, and clinical needs is expected to improve the quality of information available to the Children's Review Panel when identifying appropriate providers for which referrals are sent. This more targeted approach should reduce the need for broad, mass referrals and allow providers to focus their time on reviewing referrals that align with the therapeutic services and supports their

agencies provide. Ultimately, this is expected to reduce administrative burden for providers while improving the likelihood of identifying appropriate placements more efficiently.

- **The Department should provide training and support not only to field staff but also regional and central office leadership to minimize the traumatic effects of working to support children experiencing placement instability.**

  The Department agrees with this recommendation. Supporting children who experience placement instability can also be challenging and emotionally taxing for the staff responsible for their care and support. Providing training and resources for field staff, as well as regional and central office leadership, is important to ensure staff are equipped to effectively support children with complex needs while also recognizing and addressing the impact this work can have on the workforce. The Department remains committed to strengthening training, guidance, and support systems that promote staff well-being and resilience while continuing to provide safe and appropriate care for children in our custody.

The Cabinet remains committed to continuing this work of expanding treatment capacity, strengthening family-based placements, and ensuring non-traditional placements remain rare, temporary, and used only as a last resort. We appreciate your thoughtful review and look forward to our efforts to strengthen services for Kentucky's children and families

Sincerely,

Lesa Dennis

Lesa Dennis
Commissioner