State Oversight of Children's Residential Care

Follow-up review highlights **August 2026**

State oversight has improved, but four statutory gaps remain.

13 of 19 recommendations complete; 2 more in progress

4 recommendations require legislative action

67% reduction in out of state placements for foster children

190 foster children in residential care (May 2026)

7 new facility case manager positions created to give each foster child in residential care a dual-caseworker structure

The department improved how it responds to all incidents and how it monitors foster youth placement contracts.

A cross-team protocol at the department now assigns priority levels and response timelines for incidents. A new process also formalizes contract monitoring for foster child placements, and a team tracks whether children are in the right placement type.

Priority level	Timeline	Definition
Priority 1 Immediate response	Investigate immediately, on-site within 2 business days, unless contradicted by law enforcement	Allegations that have caused, or are likely to cause, serious physical or psychosocial harm, injury, or death
Priority 2 Medium	Investigate immediately, on-site within 5 business days or conducted via records/video review	Allegations that may have caused physical or psychosocial harm, but immediacy is removed
Priority 3 Low	Investigation completed at next survey or within 90 days via records/video review	Allegations caused no actual harm or appear isolated or resolved

House Bill 723 codified five recommendations into law.

Effective July 1, 2026, House Bill 723 requires a youth bill of rights, at least one annual unannounced survey, a revised interview process, and restraint/seclusion reporting to Licensing.

Four gaps remain that only the Legislature can close.

1. **Legislative authority:** Licensing, law enforcement, and facilities each investigate abuse allegations under their own separate mandates, but no single entity is responsible for investigating and substantiating abuse allegations against facility staff.
2. **Child protection registry scope:** Idaho's registry only reaches parents, guardians, and custodians. Texas expanded its registry to include facility staff directly; Delaware created a separate legal definition for institutional abuse.
3. **Treatment oversight:** Licensing has no authority to assess whether treatment is being delivered or is appropriate for a child's needs.
4. **Restraint/seclusion transparency:** Facilities now report restraint and seclusion use to Licensing, but that data goes no further. Oregon publishes a public dashboard. Idaho has no equivalent.

Office of Performance Evaluations ope Idaho Legislature

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