Child Youth Care Forum (2009) 38:69–73
DOI 10.1007/s10566-009-9068-8

ORIGINAL PAPER

Invited Commentary on CAPTA and The Residential Placement: A Survey of State Policy and Practice

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Published online: 4 February 2009

Institutions care for our nation's most vulnerable, compromised, and traumatized children. These children's safety and developmental best interests take precedent over institutional self-interest, and their protection is fundamental to successful care and treatment. It was, therefore, a surprise that the survey results reported in this preliminary study designed to re-examine states' systematic response to institutional child protection authored by Overcamp-Martini and Nutton (2009) indicated difficulties engaging participation on the part of state representatives. Only 12 of 47 states responded and many of those child welfare state representatives who did respond were uninformed about important issues such as frequency of suspected (or substantiated) abuse, independency of investigations, the need for specialized protective services with specialized training, mechanisms for parental and child reporting, and outreach to advocacy organizations.

The article also points out that state and national protection and advocacy centers for persons with mental illness and developmental disabilities have been in the forefront of needed system and legislative initiatives to protect children in care and that the child welfare, social work, and juvenile justice professions have been late in coming to these legislative initiatives. If the field is to move beyond the acknowledged 1984 high-water mark for the protection of our vulnerable children in residential care then many states must address the inadequacy of their child protective services legislation.

The Fundamental Differences Between Family and State Care of Children

Any effective legislation concerning the safety and protection of children in out-of-home care must recognize the fundamental differences between familial care and care administered, regulated or supervised by states. These dimensions first articulated by George Thomas (1980) are worth citing.

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1. *Parental discretion is inherently broader than state discretion*. Parental discretion and their range of behaviors and choices that they make in the interests of their children are wider than state discretion. An example of this discretion is the fact that parents can choose the ease of "fast food" over nutritionally balanced meals cooked at home for the majority of their children's meals, whereby a residential facility's food choices are regulated or mandated by nutritional guidelines and never convenience.
2. *Provider responsibility for meeting standards and tests of adequacy exceed those applied to parents*. Parents rarely, if ever, are held to the same standards and tests of adequacy that are applied to professional care providers supported by or regulated through the public trust and public monies. If a child successfully commits suicide after the parent has been told that the child has that potential, there is little likelihood that that parent would face civil or criminal actions. If the child's death by suicide occurred in an out-of-home treatment setting, the professional would likely face a charge of civil and perhaps even criminal negligence.
3. *Foreseeability becomes a relevant criterion when making determinations*. Based on these previous dimensions, the relevant criterion for an abuse or neglect determination is foreseeability and not intent or severity. *Foreseeability is defined as the ability to anticipate consequences to conditions or actions.* Foreseeability is used in civil matters to determine an individual's or an organization's culpability. Levels of foreseeability (and also culpability) are determined by an individual's personal or professional expertise, and therefore, for example, a physician would be held to a higher standard of foreseeability in the diagnosis of disease than a layperson. The status, rank, or position of an individual can also influence the expectation of foreseeability and the eventual level of culpability for an action. This leads to situations in institutions where experienced and trained supervisors may be held culpable by the measure of foreseeability while their untrained and inexperienced subordinates would be free from similar culpability.
4. *The scope of culpability is greater in residential placement than in families*. In families, culpability for negligent or abusive actions or omissions rarely extends beyond the individuals who are directly responsible for those actions or omissions, to the grandparents for example. By the very nature of organizations there is potential for culpability to extend beyond those who commit the abuse, or allow the abuse to occur, to all levels of the organization from the board of directors to the direct care workers.
5. *Residential facilities are not commonly subject to public scrutiny.* Access to a family's children through school and neighborhood activities is generally daily, and when these children fail to attend schools or interact with neighbors and friends, suspicion grows and monitoring systems are often activated. Quite the opposite dynamics occur with children who reside in facilities. Notwithstanding access to facilities by governmental regulators, licensing boards and other certifying bodies, daily access by community members to children who reside in residential facilities is restricted by formal (and required through regulation) security procedures.

Essential Statutory Elements Necessary for Effective Out-of-home Care Investigations and Corrective Action

Appropriate state legislation reflecting the key differences between familial and out-of-home is the missing ingredient to an effective response to this vital child protective issue.

What would be the essential elements of any child protective legislation for children who reside in our institutions? I propose the following.

1. Establish specific definitions of abused and neglected children who reside in residential care that hold providers to a higher standard than parents. Outlaw certain caretaker behaviors such as hitting, kicking, choking, biting, burning and once these behaviors have been established to occur allow them to become prima facie evidence of abuse. Include not only caretaker behaviors, omissions, and actions that cause an injury but also behaviors, omissions, and actions that have a foreseeable risk of physical, mental or emotional injury or impairment. Make the violation of a regulation the basis for a report and the basis for a determination of abuse or neglect.
2. Mandate all medical, psychological, social work, and education professionals and volunteers employed or associated with a facility to report suspected child abuse and neglect.
3. Include all institutional paid staff from the executive director to the direct care worker as potential subjects of a report, as well as any other paid employee or volunteer associated with the facility.
4. Require specialized abuse and neglect units that meet the qualities of independency to investigate all reports of abuse and neglect in out-of-home care and establish specific and specialized procedures for institutional investigations.
5. All investigations of reports of child abuse and neglect should rest on three questions.
    a. Did the reported event occur independent of extenuating circumstances.
    b. Is the administrative authority culpable or not and if so what manner?
    c. Is the problem redressable? (Thomas 1982).
6. Incorporate the concept of foreseeability into the decision-making and determinations of abuse and neglect. Issues of severity of the injury or the intent of the caretaker should be irrelevant.
7. Require plans for prevention and remediation from institutions for all indicated or substantiated cases, and hold the facility and its management responsible if subsequent injuries or risks occur to those children because of a failure to implement those plans.

Although there are clear exceptions, major reforms in child protective services legislation in the majority of states in the mid to late twentieth century in the United States were brought on by highly publicized deaths of children at the hands of their parents. In recent years there has been a confluence of events and circumstances that has raised the awareness of how children die at the hands of their caretakers in facilities. Videotape made the general public aware of the circumstances of the death of Martin Lee Anderson in a Florida juvenile corrections facility. Publication of the series on restraint deaths in the *Hartford Courant* (Weiss et al. 1998), a survey of children's restraint deaths in the child protective literature (Nunno et al. 2006), an assessment of the physical and emotional restraint risk in the medical (Mohr et al. 2003; O'Halloran and Frank 2000), psychological (Day 2002, 2008) and nursing (Johnson 2007) literature, and national, international and professional initiatives (Nunno et al. 2008) to reduce restraint use, provide mental health and mental retardation advocacy and protection groups, child welfare, juvenile justice and the social work profession another opportunity to address the inadequacies in out-of-home child protection legislation and systems.

Organizational Initiatives to Reduce the Potential for Abuse and Neglect in Out-of-home Care

As is stated in the Overcamp-Martini and Nutton (2009) article, there should be additional specialized prevention and intervention systems necessary to hold providers to higher standards than those necessary for parents. I suggest additional strategies be used by agencies to reduce the numbers of critical incidents and therefore reduce risks to children in care.

1. Fully inform staff of their duties and responsibilities. All staff should be subject to a code of conduct that delineates their professional behavior with children in their care. The code of conduct should address issues of professional behavior, speech, dress, and boundaries, and include any legal responsibilities to report suspected abuse or neglect or other violations witnessed. Violations to the code of conduct should be spelled out clearly, as well as any employment consequences for violations to the code.
2. Ensure prompt and sustained organizational responses to code violations, critical incidents, reports of suspected abuse and neglect that include but are not limited to policy and procedures review, training review, supervisory review, risk review of each incident. Organizational responses should focus on long-term organizational learning and participatory management strategies.
3. Establish policies, procedures, and practices that confirm staff and team adherence to individual and group safety plans, individual crisis management plans for each child, treatment planning, prevention and remediation programs.
4. Publicize suspected abuse and neglect reporting and protection systems throughout the facility, and ensure that children and parents at intake know about that system and have free access to it.
5. Publish an annual report of all violations of licensing regulations, critical incidents, and cases of suspected and substantiated abuse and neglect.

Those professional caretakers providing care and treatment to physically, emotionally and psychologically compromised children assume a position of public trust in the care, protection, and supervision of those children. Within this public trust, all facilities must provide resources and services to children at a level commensurate with those children's developmental needs, at prescribed levels determined by state law, and by professional psychiatric, educational, and other clinical services. Duty demands that professional providers recognize basic risks to the child population that they serve, and that these professionals foresee and prevent unnecessary risks that may cause harm or a risk of harm. Personal safety is a basic need and fundamental right for compromised children. Anything less can be considered abusive or neglectful practice by the facility.

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