An Examination of Children's Residential Facilities

A Follow-Up on Virginia's Comprehensive Services Act

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Executive Summary

This study of children's residential facilities was undertaken in response to the 2007 Comprehensive Services Act Report's finding that Virginia facilities observed twelve fatalities between the years 2001 and 2006. Virginia officials hoped to understand the fatality rate of nearby and similar states to ascertain if Virginia's existing fatality rate falls within normal boundaries.

Analysts studied a sample of eight states' fatalities and regulations to designate the expected current framework of care. The current policy environment was taken into consideration in every state. The objective was to learn the fatality rate but was impeded by states' policies, which restricted access to such information. This difficulty prompted a change in the scope of the study. Responding to various degrees of openness, the analysts determined proxies for non-natural fatalities in the general population and in facilities to be used in conjunction with a thorough investigation of states' licensing regulations.

Analysts determined that, compared to other states, Virginia's regulatory framework is not negligent. Therefore, a disconnect between existing regulations and actual enforcement was hypothesized to be the leading area of concern. Concluding this study, the analysts formulated recommendations for the state of Virginia in regards to specifying the definition of such facilities, accessibility of information, and adherence to monitoring and enforcement mechanisms.

Introduction and Objective

The 2007 Comprehensive Services Act Report by the Joint Legislative Audit and Review Commission (JLARC) revealed that Virginia residential treatment facilities (RTF) had twelve non-natural child fatalities for the years 2001 through 2006. Investigators and state officials lacked the necessary evidence to determine whether these deaths are to be expected from this population or if they warrant specific attention and investigation. JLARC commissioned this analysis as a continuation of the intent of the original report in order to determine if Virginia's non-natural child fatality rate is comparable to the rates of neighboring and similar states.

For the purpose of this study, a residential treatment facility is defined as a twenty-four hour out-of-home care option for children that is larger than a group home (typically thirteen or more children) and is not solely a mental or psychiatric facility. While many children residing in RTFs may require Juvenile Justice intervention or other social services, these facilities are not detention centers or foster care. Children in RTFs may or may not be in the custody of the state. Children reside in these facilities because either they have emotional, physical, or behavioral problems or family situations that prevent them from being cared for at home or in a less restrictive environment.

To accomplish the study's objective, the process entailed contacting officials from eight states: Delaware, Kentucky, Maryland, New Jersey, North Carolina, Pennsylvania, Tennessee, and West Virginia. Five of these states border Virginia and were selected for examination because of assumed similarities in population and other regional characteristics. The remaining three states were chosen because they demonstrated particular similarities or differences to the state of Virginia. Prior to beginning the in-depth investigation, relevant literature was reviewed

to develop a broad understanding of issues surrounding RTFs. After establishing that base of knowledge, it was important to define the methodology, conduct research on all eight states, analyze the findings, and draw conclusions from those results.

Literature Review

Government reports, academic articles, and technical and industry evaluations were all part of a pertinent literature review. This review utilized various sources and perspectives to learn more about RTF's and child services, and a broad analysis shaped the direction of this research. The most illustrative examples are provided below.

One of the more valuable sources was a government review, the Congressional Research Service (CRS) Report for Congress on "Child Welfare: State Performance on Child & Family Services Reviews."[1] This statewide assessment, completed in 2005, examined how states and facilities compare by contrasting their functionality and how they meet seven specific facility goals. Three of these goals are relevant to this study: children being protected from abuse and neglect within the facility, children receiving adequate services for their physical and mental health needs, and children having permanence and stability in their living situation. Other standards within the CRS Report didn't apply to this analysis. Using these goals later in our research provided a benchmark by which to compare the current situation in Virginia's RTFs to the nationally accepted standard.

[1]Emilie Stoltzfus (2005) *Child welfare: State performance on child and family services reviews*.

A survey entitled "Evaluating and Monitoring the Impact of a Crisis Intervention System on a Residential Child Care Facility"[2] presented evidence strongly supporting specific staff training as a method of preventing and controlling major crises within facilities. This categorical distinction indicated that staff members trained in therapeutic crisis intervention are better equipped to deal with and prevent physical crises situations, which became a consideration in the state analyses later in this paper. Also, the study's author, Dr. Michael Nunno, became elemental in clarifying the understanding of the state of RTFs and was able to help redefine the scope of this research.

A different type of approach was used in the North Carolina Department of Health and Human Services Child Residential Survey Report, a survey of all child RTFs in North Carolina.[3] This source compiled lists of the most important regulatory areas and those areas with the greatest number of violations. The report indicated several areas of great importance that were included in the methodology for this research. Knowing the most common violations helped define the areas this report sought to discover in the states to be examined.

Two academic articles detailing the importance of balancing regulations and training requirements—overregulation versus underregulation—presented this analysis with an ideological argument taken into consideration in this report's conclusion.[4] Other relevant articles discussed the significance of RTFs in general, and one very dated article considered mortality rates in state facilities.[5]

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[2]M. Nunno and M Holden (2003) "Evaluating and Monitoring the Impact of a Crisis Intervention System on a Residential Child Care Facility," *Children and Youth Services Review, 25 (4),* 295- 315.
[3]North Carolina Department of Health and Human Services (2005) *Child Residential Survey Report.*
[4]Patricia Schene (1998) "Past, Present, and Future Roles of Child Protective Services," *The Future of Children, 18,* 23- 38.
[5]A.H. Thompson and Stephen C. Newman (1995) "Mortality in a child welfare population: Implications for policy," *Child Welfare,* 74(4), 843-857.

Methodology

The eight states of Delaware, Kentucky, Maryland, New Jersey, North Carolina, Pennsylvania, Tennessee, and West Virginia were chosen for their proximity and similarity to Virginia. They were divided among three analysts to gather data with the purpose of:

1. Cataloguing information about licensing and regulation requirements within each state;
2. Determining the current policy situation in each state regarding RTFs;
3. Determining each state's degree of openness to outside queries; and
4. Finding the number of non-natural RTF deaths in each state for the years 2001 to 2006.

These four goals established benchmarks to be used in a statistical analysis to determine the expected fatality rate within RTFs and also to establish the status of RTFs in each state.

Licensing and Regulation Requirements

Each state's regulatory code pertaining to children's RTF legislation is easily accessible online and was examined in full. Analysts sought information on six specific licensing areas deemed to be the most relevant to child safety and survival, as noted by JLARC's CSA report and in reference to the categories listed by the North Carolina Department of Health and Human Services Child Residential Survey Report. Those areas are:

1. Staffing;
2. Care of Children;
3. Restraints and Isolation Use;
4. Monitoring and Enforcement;

5. Record Keeping; and
6. Miscellaneous.

Within each area, analysts explicitly sought certain details of several regulatory aspects. Staffing was examined by determining whether each state's regulation code contains requirements for staff-to-child ratios, staff-to-child sleeping hour ratios, criminal background checks, education requirements, new staff orientation, training hours required, and first aid training.

Care of children was compared using each state's regulations regarding on-site medical care, statement of child's rights, and crisis guidelines.

Restraint and isolation use was determined by studying each state's regulations relating to the monitoring, prohibition, and documentation of restraints and isolation.

Analysts examined monitoring and enforcement by investigating the codes mandating the allocation of enforcement and complaint staff per facility.

The category of record keeping was determined by investigating each state's regulation standards to learn whether incident reports are required to be filed at the facility or state, whether facilities must create individual treatment plans for residents, track re-commitment rates, and provide information of progress or incidents to parents.

The miscellaneous category examines whether each state's regulation contains standards for physical facility and nutritional requirements, as well as any unique or extensive state requirements.

After examining each regulatory code, a state-by-state comparison of regulations was tabulated into a comprehensive table found in full in Appendix 1. This information is broken down categorically in the Discussion section of this paper.

Current Policy Situation

Each state's current policy environment regarding RTFs was determined in large part through researching licensing requirements. Analysis on this topic is discussed extensively in the Discussion section of this paper.

Degree of Openness

The degree of openness demonstrated by officials in each state was learned through investigation efforts of finding non-natural RTF deaths. This element of research is almost entirely subjective, and though it does indicate a level of transparency and accountability, is based in large part on the ability of analysts to find the appropriate state contacts to query for information and the response of such officials to inquiries on behalf of this investigation.

This benchmark ultimately led to a secondary objective and restructuring of scope, which will be elaborated on in the Discussion section of this paper.

Non-Natural Fatality Rate

Analysts contacted the states' relevant regulatory agencies seeking the number of children in residential treatment facilities and the number of deaths that occurred in the facilities between 2001 and 2006. A relevant regulatory agency is defined as the agency or agencies responsible for licensing and monitoring RTFs and the agency or agencies ultimately responsible for the safety, well-being, and survival of children within RTFs. Email was used as the primary source of contact, with telephone and voicemail as secondary sources of contact. Each state's response rate, defined as any feedback to the questions posed (containing valid data or not), was recorded and can be found in full in Appendix 3.

To complement state responses, analysts consulted two external experts for their opinions and validation. A telephone conversation with Cornell University's Dr. Michael Nunno was elemental in broadening the understanding of state incident reports. Email exchange with Mr. Junius Scott, Regional Program Manager for Region 2 of the Administration of Children, Youth and Families (ACF) under the Department of Health and Human Services, provided a federal perspective on the degree of openness states have in disclosing facts on child fatalities.

Proxies for fatality rates were developed to further complement the data. Analysts sought the rate of non-natural deaths for each state's population of children ages ten to nineteen in 2004, gathered from Arialdi M. Minino at the CDC.[6] The number of deaths in state-run juvenile correction facilities from 2002 to 2005 was gathered from the Bureau for Justice Statistics.[7] This proxy does not include city, county, or private facilities. The final proxy data is the number of deaths in RTFs that are linked to abuse and neglect, given by states, or gathered from online sources such as advocacy groups.[8] In conjunction, these numbers represent the minimum of deaths in facilities and provide alternative rates as benchmark comparison reference points for expected mortality rates. These proxy comparisons were developed to create a benchmark perspective of the current state of child welfare from state-to-state, in out-of-home treatment facilities, and in the general population. These benchmark comparisons provide an existing expected mortality rate for the general population and a special-needs population.

[6]National Vital Statistics System, National Center for Health Statistics.
[7]U.S. Department of Justice (2007) *Federal Justice Statistics Resource Center.*
[8]National MCH Center for Child Death Review (2003) *Child mortality data.*

Statistical Analysis

While conducting interviews with state officials, analysts also created a statistical framework based on rare statistics and the Poisson distribution to provide a method to determine if a prevailing fatality standard exists, and if so, if Virginia's mortality rate falls outside that prevailing standard established by the other eight states.

Survival analysis is an area of statistics regarding the death of biological organisms by measuring the rate or probability of an event occurring to that organism over a distinct period of time. Survival analysis literature considers death the "event" and the range of time exposed to certain conditions the "period of time." A survival analysis of at-risk children in residential treatment facilities based on time exposed to the facilities is the fundamental calculation of this analysis. The estimation of the expected number of children in facilities to survive uses the following information:

- The number of child deaths per facility; and
- How particular circumstances or the presence of certain facility traits, such as regulations, increase or decrease the child's odds of survival.

The need for this specific analytical framework arises from the difference between measuring a rare event, such as death in an at-risk population, and measuring a standard continuous dependent variable. Number of deaths in a facility is a count data, and counts per year tend to be low. Also, there are no negative deaths. For example, a state cannot have negative twelve deaths in RTFs. Therefore, a normal distribution that is centered and peaking around zero, with a continuous range of probable outcomes starting with negative infinity and ending with positive infinity, is not properly suited to measure deaths of children in RTFs. Probable outcomes from a sample of children in RTFs are restricted to positive integers of low value.

The distribution used in this analysis holds discrete events occurring within a specific time range constant and is known as the Poisson distribution. The importance of this distribution is that it expresses the probability of a number of events occurring in a fixed period of time.

Time is critical for two reasons. First, non-natural deaths are rare and infrequently occurring. A moment's snapshot will not be indicative of deaths in state facilities. For example, a state with a high level of deaths can suffer the same number of child deaths in a given year as a state with a low level of deaths. A wider time period is necessary in order to compare differences. The intrinsic nature of rare events (deaths) requires a period of time for its analysis. Secondly, the probability of a number of death events occurring must be independent of time since the last death event. Because of its unique relationship with time, non-natural deaths of children in RTFs need to be analyzed under the theory of survival that assumes death happens once for each subject.

Mortality data from the sample states within a fixed time period would be used to set up a statistical analysis of at-risk children in RTFs based on time exposed to the facilities. Survival curves generated from the analysis would indicate the probability of a child suffering a non-natural death during his or her time of stay. Ideally, the observed probabilities of children dying in state facilities would be nonexistent. The desired outcome from survival analysis would be low probabilities of death for children in RTFs where only the error term accounting for human treatment has an effect.

Results

After investigating states' licensing and regulation requirements, an extensive comparison of these requirements was tabulated and can be found in Appendix 1. A brief

summary of state-by-state licensing and regulation requirements and non-natural death findings can be summarized as follows.

Licensing and Regulation Requirements

For this element of comparison, analysts sought information on staffing, care of children, restraints and isolation use, monitoring and enforcement, record keeping, and miscellaneous information on general topics like nutritional requirements and any unique aspects of state regulation. Basic information about the licensing requirements of the eight states studied is set up below.

Delaware has the most detailed regulations of any state, although some contradictions were found. [9] Another crucial finding regarding Delaware is that this state only requires deaths to be reported to state officials.

Delaware

- Residential child care facility defined as "any facility that provides out-of-home, 24-hour care, protection and supervision for children who have either: behavioral dysfunctions; developmental, emotional, mental or physical impairments; or chemical dependencies."
- The licensing agency for Delaware is the Office of Children's Services within the Division of Family Services (DFS). The Secretary of DFS is a cabinet-level position.
- Licenses are issued annually and regulations state that "on-site inspections may be conducted without prior notice" but make no such requirement. Even during licensing renewal, there are no explicit requirements for monitoring facilities.

[9]Delaware Administrative Code (2007) "Services for children, youth and their families, Title 9."

Kentucky does not have monitoring and enforcement standards or staff, and therefore, incidents within facilities are likely to remain solely incidents in facilities.[10] There is little, if any, public knowledge of even large events such as deaths. Kathy Adams, Kentucky's Assistant Director in the Division of Protection and Permanency, confirmed that Kentucky had zero child fatalities in residential facilities in the years 2001 through 2006.[11]

Kentucky

- Defines a residential facility as providing 24-hour care and treatment-oriented service for children within state custody.
- The Cabinet for Health and Family Services oversees the administration and management of residential facilities, and a Board of Directors runs each residential facility.
- RTFs are licensed for two years at a time.

Maryland provided an exemplary state and is examined later in this paper as a case study.[12] Maryland has extensive oversight and accountability at both the local and state levels, and any incidents occurring within each quarter are reported immediately to the Governor or via a quarterly report, depending on the gravity of the offense.

[10]Kentucky Cabinet for Health and Family Services (2007) "Standards for child-caring facilities, 922 KAR 1:300."
[11]Email Kathy Adams 11/5/07
[12]Maryland Governor's Office for Children (2007) "Licensing and Monitoring of Residential Child Care Programs, subtitle 31.05."

Maryland

- RTFs defined as "a facility owned, leased, or operated by a licensee that provides: (a) residential services for youths such as care, diagnosis, training, rehabilitation; and (b) a group living experience."
- Overseen by the Department of Health and Mental Hygiene (DHMH), the Department of Human Resources (DHR), and the Department of Juvenile Services (DJS).
- All bureaus report directly to the Governor's Office on Children (GOC), which shares oversight responsibilities with Local Management Boards (LMB).

New Jersey presented difficulties during the investigation period.[13] Initially, New Jersey officials, including the liaison between the Department of Children and Families and Department of Youth and Family Services, informed analysts that there have been no deaths in New Jersey facilities since the mid-1990s. Later during research, while confirming related information with a federal official, analysts were told that New Jersey is "under a court-ordered child welfare reform effort, is facing current issues of child fatalities, and is sensitive to releasing information to the public about child fatalities."[14] This contradiction in data and unreliability of state officials casts doubt onto any information gleaned from New Jersey officials.

[13]New Jersey. Department of Human Services. (2005) "Manual of Requirements for Residential Child Care Facilities, chapter 127."
[14]Email with Junius Scott 11/7/07

New Jersey

- Observed by the Department of Children and Families (DCF) created in 2006 and the Division of Youth and Family Services (DYFS). DYFS ensures the safety, permanence and well-being of children and families, as well as handling referrals and investigations.
- Other involved agencies are the Division of Developmental Disabilities, Department of Human Services, State Department of Health, State Department of Education, and the State Department of Corrections.
- The Child Fatality and Near Fatality Review Board was established by the New Jersey Comprehensive Child Abuse Prevention and Treatment Act (CCAPTA) to review fatalities and near fatalities of children to identify causes, relationship to governmental support systems, and methods of prevention.

North Carolina's Office of the Chief Medical Examiner (OCME) is the agency responsible for examining all deaths, but OCME investigations define causes of death differently than its RTF's licensing and enforcement agencies.[15] This provides RTFs with an opportunity to classify a non-natural death in a way that would not warrant public attention. During this investigation, OCME claimed "the data you are requesting has not been collected over the years."[16]

[15]North Carolina Division of Social Services (2007) "Licensing services, subchapter 701: Minimum licensing standards for residential child care."
[16]Email with Jane Seo 11/6/07

North Carolina

- Licensing agency is the Division of Social Services (Child Welfare and Family Support Section) within Health and Human Services.
- Licenses are valid for one year, after which there is a ninety-day grace period for renewal.
- Defines child-caring institution as "a residential child-care facility utilizing permanent buildings located on one site for 10 or more children."

The state of Pennsylvania's regulation of residential facilities is highly decentralized.[17] The state sets standards and supervises compliance. However, reportable incidents are received and monitored by each county's regional Department of Public Welfare office. This makes monitoring and database management of incident reports inefficient. During this investigation, the Office of Child, Youth and Families disclosed that Pennsylvania groups together several types of facilities into one category, "institution," and cannot recognize recorded incidents as specific to a residential facility.[18]

[17]Pennsylvania Code (2007) "Child residential and day treatment facilities, chapter 3800."
[18]Email with Melanie A. Retherford 11/5/07

Pennsylvania

- Defines children's residential facilities as a "premise or part thereof, operated in a twenty four-hour period living in a setting in which care is provided for one or more children who are not relatives of the facility operator."
- Its licensing agency is the Office of Children, Youth and Families located within the Office of Licensing and Regulatory Management, under the Department of Public Welfare.
- Each facility shall develop written policies and procedures on the prevention, reporting, investigation, and management of reportable incidents. However, a designated enforcement and monitoring staff is not required by the state.

Tennessee was notable for two reasons: It was difficult to contact the relevant state agencies, and the state has the smallest requirements for annual training of all the eight states examined, six hours per year.[19] Analysts discovered two deaths listed by an online advocacy group (information that is used on the Benchmark Mortality Table on page 21 and in Appendix 2), but that information was unable to be verified by Tennessee's Department of Children's Services.

[19]Tennessee Department of Children's Services (2007) "Standards for residential child caring agencies."

Tennessee

- Regulatory agency for RTFs in Tennessee is the Department of Children's Services (DCS).
- "Residential child-caring agency" defined as "any institution, society, agency, or facility, whether incorporated or not, which either primarily or incidentally provides full-time care for thirteen (13) or more children under seventeen (17) years of age outside their own homes in facilities owned or rented and operated by the organization. For licensing purposes this definition is expanded to mean the full time care of thirteen (13) or more children in one or more buildings on contiguous property with one administrator."

West Virginia's policy motto is to ensure that entities offering quality childcare services are not overly-encumbered by regulation.[20] Title 78, series 18 of the West Virginia Department of Health and Human Services Legislative Rules states "It is also the policy of this State to ensure that those persons and entities offering quality child care services are not overly-encumbered by licensure, certification, and registration requirements, and that the extent of regulation of child care facilities be moderately proportionate to the size of the facility." The state asserts that the operator "shall report" specific situations but does not specify to whom. Thus, contacting regulatory authorities proved futile.

[20]West Virginia Code (2007) "State responsibilities for the protection and care of children, chapter 49-2-1."

West Virginia

- The Residential Child Care Unit located within the Division of Children and Adult Services of the Bureau for Children and Families within the West Virginia Department of Health and Human Resources is the entity responsible for the licensing process.
- Licenses are issued for up to two years with approval from the commissioner.
- Lacks a specific record-keeping organization.

Non-Natural Fatalities

Conflicting data from state officials and the questionable validity of the reported numbers of non-natural fatalities prompted analysts to contact a federal official and an academic research analyst with special interests—or jurisdiction—in residential facilities. Junius Scott, Program Manager for Region 2 of the Department of Health and Human Services' Administration on Children, Youth and Families (ACF) was the federal contact. Scott is the authority on child welfare data submitted by New Jersey to the federal government. He cited the National Child Abuse and Neglect Data System (NCADS), a national clearinghouse of statistics and relevant information reported by states, and disclosed that the federal government has difficulty urging states to disclose facts on child fatalities. Analysts discovered, after exploring the NCADS, that state participation in providing data to the system is voluntary. It is presumed, then, that states with fatality issues are less likely to voluntarily disclose lethal incidents in their residential facilities. Self-selection bias in the NCADS system prevents the use of this federal source.

Along with Junius Scott, Michael Nunno became a valuable resource. Nunno is the Principle Investigator for the Residential Child Care Project at Cornell University. His research

is focused on the protection of children in out-of-home care and on the designing and evaluating of crisis prevention and management systems for juvenile treatment, psychiatric, and correctional facilities. He disclosed that he was forced to resort to online newspapers for information on restraint and seclusion deaths for the lack of out-of-home care data. Nunno empathized with analysts and suggested the use of data from the Department of Juvenile Justice as a proxy for fatalities in at-risk youth in RTFs.

Discussions with Junius Scott and Michael Nunno prompted analysts to adjust the scope of this study. Residential treatment facilities cannot be studied or statistically examined by their unreliable and unavailable fatality data. Instead, states' facilities for children are examined through their regulations, benchmark fatalities of alternate populations of at-risk youth, and compared to a leading case study.

Establishing Benchmark Fatality

As a result of the difficulty in accessing the fatality data for residential treatment facilities, analysts made the decision to also search for alternative rates, which could provide a benchmark comparison for expected mortality rates. The first type used ("Population Rate") was the rate of non-natural deaths for the at-large population ages ten to nineteen in 2004. The second category ("DJJ Deaths") was the number of deaths in state-run juvenile corrections facilities from 2002 to 2005. This category does not include city, county, or private facilities. The final grouping ("RTC Deaths") takes place in residential treatment centers since 2001.

Benchmark Fatality Data[21]

State	Population Rate	DJJ Deaths	RTC Deaths
DE	34.8	0	2
KY	45.4	0	-
MD	29.5	1	1
NJ	20.4	0	2
NC	36.7	1	-
PA	29.9	0	3
TN	67.4	1	2
WV	45	0	1
VA*	26.6	0	12

These numbers were gathered from various online sources such as newspapers and advocacy groups, and they represent the bare minimum of deaths in facilities. Maryland is the only outside state in whose data there is relative confidence, and its data is only since 2004. Virginia is the exception because the total numbers from 2001 to 2006 were given in the CSA report, and therefore, are known. This chart is intended to present the numbers available relative to those numbers that are not currently available. While none of the columns are comparable to one another, they are intended to give an idea of both scale and variability between states. A full explanation of the table is given in Appendix 2.

Case Study: Maryland

In addition to the utilization of benchmark fatality rates, it was decided to develop a case study to closely examine one exemplary state, Maryland. Maryland's system of child welfare is very transparently outlined on the state's website. The Department of Health and Mental Hygiene (DHMH), the Department of Human Resources (DHR), and the Department of Juvenile Services (DJS) oversee residential facilities. This system was established when, in January 2001,

[21]Refer to Appendix 2.

DHMH, DHR, and DJS were directed to establish uniform systems to ensure reciprocal and cohesive care for children in the custody of the state. All bureaus now report directly to the Governor's Office on Children (GOC), established by Governor Robert Ehrlich by Executive Order in 2005. Another element of state oversight lies in the Local Management Boards (LMB), which also report to the GOC to ensure a continuity of coordinated delivery of state-run continuum of child welfare.

LMBs are the most localized form of oversight in Maryland residential treatment care. Board members are a point of authority in all of Maryland's 11 RTFs, and members have an obligation in the administrative duties, budget oversight, emergency procedures, and staffing requirements of every facility. In fact, Maryland regulates very few specifics about residential facilities; LMBs are highly authoritative. The accountability LMBs have in relation to the GOC ensures that state officials remain abreast of any incident in any facility.

LMBs are not only obligated to share information about facility residents with any state agency working with the child, but providers must also report incidents within 48 hours to state agencies. Further, LMBs must report these incidents to the GOC, which is in turn required to publish them in quarterly reports. These quarterly reports must include any incident that harmed a child, staff member, or the surrounding community, incidents that required law enforcement intervention, police reports, medical treatment, ambulatory or emergent care, and of course, facility deaths. These reports are available to the public online.

This highly stratified, very well-defined system is different from any structure in any of the other seven states in this study, but it must be noted that a 2006 RTF death prompted these reforms. Though the three systems were ordered to collaborate for more cohesive management in

2001, the 2006 death is what ultimately inspired this more expansive improvement. Maryland is the most definitive and exemplary state in this study.

Discussion

After reviewing the states individually, analysts isolated specific characteristics of the regulations for more careful consideration. Four categories were selected for intense study. They are:

1. Staffing Requirements;
2. Monitoring and Enforcement of Regulations;
3. Restraint Use; and
4. Incident reports Filed With the State.

All four areas are directly related to either safety or transparency.

Staffing Requirements

There are wide variations in staffing requirements, as seen in the table below. The first element of staffing requirements in the table is staff-to-child ratio. This ratio indicates the number of direct care staff members who must be physically present with the children at all times. The new staff orientation is the requirement set forth by the state that must be fulfilled before a direct care worker may have direct contact with residents as a part of their duties. Training hours required do not include orientation hours and are the training standards that every direct care worker must complete annually thereafter.

Staffing Requirements[22]

	Staff-to-Child Ratio	New Staff Orientation	Training Hours Required
Delaware	Less than 12 children, 1 staff. More than 12 children, 1:10. Secure Facility (automatic fail safe system) 1:5. Secure Facility (no automatic fail safe) 1:4. Shelter Care 1:5.	15 hours	If working more than 24 hours/week, requires 40 hours annually. All others, 20 hours annually.
Kentucky	Under 6 years, 1:5. Age 6 and older, 1:10. Treatment Center 1:6.	Initial training for full-time care staff, 40 hours. Initial training for part time, 24 hours.	16 hours annually.
Maryland	At least 1 staff worker awake and in building at all times.	-	-
	Local Management Boards dictate specific regulations for each facility and report those regulations to the governor's office for children.		
New Jersey	All 1:6	Must be trained in emergency procedures, HIV/AIDS prevention, suicide prevention, behavior and medication policy, restraining procedures, purpose of facility, etc.	-
North Carolina	Under 6 years, 1:5. Age 6 and older, 1:10. Supervisory staff must be within earshot.	Set by facility	Set by facility
Pennsylvania	Under age 6, 1:4. Age 6 and older, 1:8.	Specific requirements for at least 3o hours	Minimum 40 hours annually
Tennessee	All 1:8	Yes	6 hours annually
West Virginia	4 years old to school age, 1:12. School age, 1:16.	Yes	Minimum 40 hours annually
Virginia	Independent Living Programs, 1:15. Severely handicapped, 1:6. Mentally ill, 1:8. All else, over 4 years, 1:10.	Yes, within one calendar month of hire.	-

Staff-to-child ratios appeared to be a consistent requirement across the states, as each set at least a minimal standard. The variation was much greater in other categories. For instance, New Jersey requires numerous functional topics to be covered during new staff orientation

[22]Refer to Appendices 4 – 11.

instead of the hourly standards set forth by most other states. Another outlier observation was Tennessee, in the number of annual training hours required; the state sets the standard at six hours annually, the equivalent of one half hour per month, which might not provide enough time for even a minimal refresher course. However, observe that Virginia does not require any annual training.

Restraint Use

Although states consistently set standards for restraint use, some states chose to delegate the responsibility for setting such regulations to localities, management boards, or even facilities. West Virginia was the only state that prohibited all restraint use. On the other end of the spectrum was Kentucky, which requires that restraints be used only in emergencies by trained administrators and not as punishment, for convenience of staff, or on an ill child, but establishes no documentation requirement, has no monitoring standards, and does not required incidents to be reported to a higher authority.

Restraint Use[23]

	Restraint Prohibited	Standard Setting Body	Monitoring Requirements	Required Documentation
Delaware	Under age 6	State	Continual by trained staff	Yes
Kentucky	No	State	Trained staff	No
Maryland	No	State, Local, and Board	By local board	Yes; all incidents must be presented in publicly accessible quarterly report to governor
New Jersey	No	State and Facility	Visual contact every 15 minutes and staff must be within hearing distance. Child must be checked by medical personnel after use.	Facility record
North Carolina	No	State	Must be performed by trained staff and must be second staff member present	Yes
Pennsylvania	Chemical, mechanical and pressure point restraints prohibited	State and Facility	Every 10 minutes including documenting emotional changes in the child	Before, during and after restraint including the reason for the restraint, etc.
Tennessee	No	State	By 2 qualified staff members	Yes
West Virginia	Yes	State	-	-
Virginia	Chemical restraints prohibited	State	Must monitor	Date, time, staff involved, circumstances, reasons for restraints, duration, and methods

Analysts also examined the same categories of requirements for isolation. The standards appear to be similar between the use of restraint and isolation, though the level of risk is assumed to be much greater with restraint use, as no examples of children dying while in isolation were found.

[23]Refer to Appendices 4 – 11.

Incident Reporting

A facility is inherently assumed to be safe unless incidents are reported. Therefore, the last component used to examine state-licensed residential facilities is the quality of required incident reporting. It was discovered that many states require incident reporting only at the facility level, which no doubt contributes to some of the confusion analysts encountered when contacting state officials. Other states require filing reports directly to the state regarding incidents, with varying degrees of consequence.

As seen in the table below, some states require facilities to be open to the degree of providing information to the public, while other facilities are allowed to remain completely closed even to state officials. The regulations in this category are demonstrative of the problems analysts in this study and other investigators have had. It is intuitive that when facilities are secretive to the point of not informing parents of issues or events until the child dies, intervention and improvement opportunities are lost.

Incident Reporting[24]

	Location of Incident Report	Inform Parents of Incidents	Other Reporting
Delaware	Facility and state (state only for death)	-	Fire, death, injury, others available upon request
Kentucky	Facility	-	Individual treatment plans
Maryland	Filed at facility, reported to local social services department, filed at state licensing agency, and included in quarterly and annual reports to the governor	-	Any incident involving child, staff member, or surrounding community, incidents that require law enforcement intervention, police reports, medical treatment, ambulatory or emergent care, and death
New Jersey	Facility and state Office of Child Abuse and Neglect	Incidents involving any incident at the facility	-
North Carolina	Facility and state (state only for death)	Death only	Annual statistical report, any report alleging abuse or neglect and the results of that investigation, death, change of facility ownership
Pennsylvania	Facility and state	Yes	-
Tennessee	Facility	-	Monthly statistical report, annual report, change in location, death or life threatening injury, all major emergency situations
West Virginia	Facility and state	Yes	-
Virginia	Facility and state	Yes	-

[24]Refer to Appendices 4 – 11.

Monitoring and Enforcement

In summary, though there is wide variation between the states, the one indicator that was particularly significant in relation to the safety and well-being of children was monitoring and enforcement. As demonstrated in the comprehensive table below, most states have either delegated responsibility or are directly involved in maintaining safe environments for children, but monitoring and enforcement is sparsely practiced, if at all.

Comparative Regulations[25]

States	Staff Ratio	M&E	Restraint	IR to State
DE	X	X	X	X
KY	X		X	
MD		X	X	X
NJ	X		X	
NC	X	X	X	X
PA	X		X	X
TN	X	X	X	X
WV	X		X	X
VA*	X		X	X

Virginia is not the only state lacking the monitoring and enforcement standards, which indicates a potential actionable area. Virginia has regulations that, if followed, should prevent most non-natural deaths. The disconnect surfaces because of the lack of accountability from an authoritative source with the power to implement change or discipline an agency or facility.

[25]Refer to Appendices 4 – 11.

Conclusion and Policy Recommendations

In order to increase efficiency and reduce the mortality rate of Virginia's residential treatment facilities for children, three recommendations must be followed.

Firstly, residential facilities should be categorized independently. RTFs are typically lumped into one category of care systems. Other systems included in this category are starkly different from facilities—group homes and institutions for the mentally retarded, for instance. An independent category for treatment facilities will provide a basis to local, state, and federal officials as well as members of the public to judge the overall efficiency, safety, and accountability of residential facilities. This will also significantly improve the validity, replicability, and reliability of studies comparing any element of residential facilities, including fatalities therein.

Secondly, the Department of Social Services and Mental Health should provide information on RTFs to the public in an easily accessible format. One example of how this could be formatted is the table included in the CSA report[26] if it were accessible to the public and other officials on a relevant website and at appropriate agencies.[27] Additionally, the incompetence of the gatekeepers of an agency is a particular hindrance to finding information. If these individuals were informed of major occurrences and knew of accurate sources of information within the agency, the barriers to public knowledge would be greatly diminished.

The third and final recommendation is that the standards and regulations currently in place should be more strictly enforced. In particular, the requirements for staff who work directly with the children should be closely followed; the mechanisms to ensure compliance should be established; and violations, not tolerated.

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[26]Joint Legislative Audit and Review Commission to the Governor and General Assembly of Virginia (2007) *Evaluation of Children's Residential Services Delivered Through the Comprehensive Services Act.*
[27]Connecticut Office of the Child Advocate (2007) *Fatality Investigations.*

Comparison and examination of the sample states' regulations found no area in which Virginia is weak enough to expect an increase in children's exposure to danger. The problem does not appear to be in the creation of the regulations but in the application. The area of staffing is particularly important because the entire idea of a non-natural death is that there is a direct outside cause. When staff members are not following requirements (especially in the number of staff present at any given time who are paying direct attention to children), the chance of an accident or incident occurring is much greater. Without a significant effort to make sure that facilities are indeed following the rules, the regulations are useless. The same goes for enforcement. If there are no consequences when a violation is found, then there is no incentive for facilities to comply.

In Virginia, the mechanisms and the framework already exist to improve the system. There is room for improvement in several minor areas; however, the state of Virginia would not need to accommodate these changes with extensive budget reform or major system overhaul. It does not appear that Virginia lags behind other comparable states, but the state's goal should not be to share in the confusion and disjointedness that characterizes most states in this area. Virginia should strive to be the most open and responsive state not only out of obligation to the taxpayers and the public but out of duty to the most vulnerable Virginians, the children in its residential facilities.

Appendix 1: Licensing Standards Table

Staffing (1)

Staffing	Delaware	Kentucky	Maryland	New Jersey
Staff-to-Child Ratio	For a building with <12 children, 1 staff. For 13+ children, 1:10. For a secure residential facility with automatic fail-safe system, 1:5. For a secure residential facility without automatic fail-safe system, 1:4. Shelter care, 1:5.	1:10 (6 years of age+); 1:5 (under 6 years of age); 1:6 (treatment center)	State mandates only one staff worker awake in building at all times, otherwise left up to facilities to determine ratios	1:6; 1:20 (social services worker)
Staff-to-Child Ratio Sleeping Hours	For a building with <12 children, 1 staff not required to be awake. For a building with 13+ children, 1:16 and must be awake and in close proximity AND an extra employee who is on call and available to be at the facility in less than 30 minutes. For a secure residential facility with automatic fail-safe system, 1:10 with a minimum of two workers awake and on duty with an additional employee immediately available. For a secure residential facility without automatic fail-safe system, 1:6 with a minimum of two workers awake and on duty with an additional employee immediately available. Shelter care, 1:10.	1:12	Same	1:living unit (unspecified number of residents per unit)

Criminal Background Check	Yes	Criminal check prior to beginning employment and subsequently every 2 years thereafter; if employee is charged with violent sex crime--immediately removed from post	Background check and Child Protective Services clearance required; employees with any record of sexual or child abuse, rape, spousal abuse, homicide, etc. will not be hired	Very extensive report required prior to reporting for work; also must undergo Child Abuse Information background check
Education Requirement: Child Workers (BA)	No (21 years old and HS diploma)	-	21 years of age with high school diploma or 18 years of age with Associate's or Bachelor's degree	Requirements for directors, supervisors, social workers, recreational workers, etc.; those directly supervising children must be at least 18 years of age and have either Associate's or Bachelor's degree or high school diploma and one year experience
New Staff Orientation	15 hours	-	-	Training in emergency procedures, HIV/AIDS prevention, suicide prevention, homosexuality, behavior and medication policy, restraining procedure, purpose of facility, etc.
Training Hours Required	40 hours annually (if work 24+ hours/week) or 20 hours annually	FT care staff: 40 hours training; PT care staff: 24 hours training; 16 hours annually thereafter	-	-
First Aid Training	Yes, and must be one qualified for first and CPR on duty at all times	Included in new staff orientation	-	Included in new staff orientation
Annual Staff Evaluations	Yes	-	-	-

Staffing (2)

Staffing	North Carolina	Pennsylvania	Tennessee	West Virginia	Virginia*
Staff-to-Child Ratio	For children 6 years of age+, 1:10. For children under 6 years, 1:5. Includes supervisory staff within earshot.	1:8 for children 6 years of age+; 1:4 under 6 years of age	1:8	6 weeks to 24months- 1:4; 25- 35 months- 1:8; 4yrs to school age- 1:12; school age- 1:16; separate ratios for water activities	1:10; independent living programs- 1:15; children under 4- 1:3; for severely multi-handicapped children- 1:6; metal illness- 1:8
Staff-to-Child Ratio Sleeping Hours	Same	1:16 for children 6 years of age+; 1:8 under 6 years	Same	Same	1:16
Criminal Background Check	Yes	Yes	No (though does require there have been no prior offenses against children)	Performed on each staff member and volunteer by the Dept of Military Affairs and Public Safety, Criminal Identification Bureau, and an authorized agency in a previous state of residence	Yes

Education Requirement: Child Workers (BA)	-	No (HS diploma only)	No (HS diploma only)	Staff members are divided between qualified staff and non-qualified staff. Qualified staff are called 'teachers' and they need a certificate, credentials, or at least 12 college credits in early childhood education	Child workers' supervisors should have a BA and experience. Child workers just need a HS diploma and a resume
New Staff Orientation	Set by facility	Yes. Specific training requirements for at least 30 ours of training	Yes	Yes	Yes. Within one calendar month of hire
Training Hours Required	Facility sets requirements	At least 40 hours of training annually	6 hours annually	Minimum of 40	-
First Aid Training	Yes	Yes	-	Yes	Not required. However, there should be at least one adult trained and certified in first aid within the last 3 years and one adult trained in CPR at the facility at all times
Annual Staff Evaluations	Yes	-	Yes	-	-

Care of Children (1)

Care of Children	Delaware	Kentucky	Maryland	New Jersey
On-Site Medical Care	-	No mandated on-site medical care; require physical immediately after admission; records must be kept on facility grounds; children must have access (including transportation to and from) medical care	Must have access and telephone number to medical personnel; must have a complete physical within 30 days of admission; access to dental	On-site nurse required, with a 1:35 nurse:child ratio; physician must be accessible to children
Statement of Child's Rights	"Information Provided to Children and Their Parents," Grievance Procedure for Children	-	Each child shall: be treated with courtesy and respect; be treated with warmth and caring; receive positive recognition; be spoken to and treated in an age appropriate manner; and be protected from mental and physical abuse.	Extensive; Child's Bill of Rights must be posted in every room, given to every child & their parents/guardian, and given to staff
Crisis Guidelines	Yes and Facility sets guidelines for incidents such as fire, natural disasters, etc.	-	-	-

Care of Children (2)

Care of Children	North Carolina	Pennsylvania	Tennessee	West Virginia	Virginia*
On-Site Medical Care	-	-	-	-	Yes. Services of a licensed physician should be available on site as needed
Statement of Child's Rights	Yes	Yes. PA Code section 3800.3 is dedicated to Child's Rights; Notification of rights and grievances procedures, specific rights, and Prohibition against deprivation of rights	-	-	-
Crisis Guidelines	Fire drills and for physical control	Yes. Emergency medical plan	Only for physical control and isolation	None other than fire safety	Yes. Facilities are required to create emergency plans for missing persons, severe weather, loss of utility, severe injury, and emergency evacuation including alternative housing

Restraints and Isolation (1)

Restraints and Isolation	Delaware	Kentucky	Maryland	New Jersey
State Sets Standards	Yes	State requires restraints to be used in emergencies only and by trained administrators and not as punishment, for convenience of staff, or on an ill child	State requires that certain records be kept and on file-- type of restraint used, reason and duration for its use, what types of behavior management techniques were already used	State sets extensive standards, including obtaining parental approval to use restraints and medical check prior to using restraints
Facilities Set Standards	Recording standards	-	Facilities set standards for specific restraint use; approved and adhered to by local boards	Facilities also establish and maintain their own protocol
Require Monitoring of Restraints	Yes and trained staff	-	Dependent upon local monitoring board	Staff must maintain visual contact with child at least every 15 minutes and be within hearing distance; after using restraints, child must be checked by doctor or nurse
Prohibits Restraints	Prohibited under age 6	-	-	-

Document Each Restraint	Yes	-	Yes-- state requires documentation, individual facilities can require more documentation	Each restraint must be monitored and maintained in a facility record
Sets Standards on Isolation	Yes	-	State has vague standards, localities and facilities further define and establish them	Similar standards to restraint use; must not be used for children who are sick or suicidal; special standards for isolation rooms
Require Monitoring of Isolation	3.3.11.2.1 - every 30 minutes. 9.5.2.1 - continuous. (Contradicts itself)	-	Every ten minutes a child will be physically checked on; program administrator must approve isolation beyond one hour	Monitoring must be recorded
Document Each Isolation	Yes	-	Document events leading up to isolation, the time the child was in isolation, and reason(s) for extending isolation beyond one hour	See above

Restraints and Isolation (2)

Restraints and Isolation	North Carolina	Pennsylvania	Tennessee	West Virginia	Virginia*
State Sets Standards	Yes	Yes. General Standards defining restrictive procedures and appropriate use	Yes	Yes	Yes
Facilities Set Standards	No	Yes. Facilities are responsible for creating, along with the child's family, an individual restriction plan for every child to be revised biannually	Of minor punishments	Facilities shall have a written policy following state guidelines	Yes. Facilities should write policy on the conditions and length of confinement,
Require Monitoring of Restraints	Yes, qualified staff with 2nd staff member present	Yes. Manual restraint which is the only restraint that can be used under certain circumstances require another staff worker to monitor a restraint that lasts more than 10min, documenting the child's emotional changes and the duration of the restraint	2 qualified staff	Does not allow restraints	Yes
Prohibits Restraints	-	Chemical, Mechanical, and Pressure Points restraints are prohibited. Manual restraints are accepted under certain circumstances	-	Yes. Explicitly	Only chemical restraints are prohibited. Mechanical and Physical restraints accepted under certain circumstances

Document Each Restraint	Yes	Yes, as well as child's condition before during and after the restraint, the reason for it, etc	Yes	N/A	Yes. Date, time, staff involved, circumstances, reasons for restraints, duration, methods
Sets Standards on Isolation	Prohibits	Isolation should not be more than 60 minutes	Yes	Yes. Standards on the length and the reason to apply time-outs	Should be set by facility
Require Monitoring of Isolation	-	Every 5 minutes a staff member should check upon the child in isolation	Every 15 minutes	Yes. Time-outs should be within visual supervision and never behind closed doors	Yes. Every 30 minutes
Document Each Isolation	-	Yes (same as documenting for restraint)	Yes	-	Yes

Monitoring and Enforcement (1)

Monitoring and Enforcement	Delaware	Kentucky	Maryland	New Jersey
Designated Enforcement Staff	-	-	-	-
Designated Complaint Staff	Yes	-	-	-

Monitoring and Enforcement (2)

Monitoring and Enforcement	North Carolina	Pennsylvania	Tennessee	West Virginia	Virginia*
Designated Enforcement Staff	-	No. It is up to the facility to have an enforcement staff or not	-	-	-
Designated Complaint Staff	Yes	-	Yes	-	-

Record Keeping (1)

Record Keeping	Delaware	Kentucky	Maryland	New Jersey
Require Incident Report (Filed at Facility)	Yes	Report filed on facility and available to facility board	All incidents must be filed at facilities and reported to local social services department and then the state licensing agency	Report to be kept on file and shared with parents, parents of other residents
Require Incident Report (Filed at State)	For death	-	All incidents must be filed at facilities and reported to local social services department and then the state licensing agency	Report to Office of Child Abuse and Neglect must be made within one day of alleged abuse, neglect, or several other violations
Create Individual Treatment Plans (ITP)	Yes	ITP required within 21 days of admission; evaluation (with family if possibly) made every month; ITP board review at least quarterly; child is encouraged to participate as much as possible in ITP; child and guardian receive a copy of ITP	Must be created within 30 days of admission and must include preliminary evaluation and goals for child; must document that child and his/her guardian or parent were involved in the creation of the ITP; must also create a behavior plan	Extensive ITP must be made within 30 days of enrollment
Track Re-Commitment Rates	-	Not specifically, although records are kept at facilities; after 3 years, records moved to state facility; therefore, if a child is readmitted, it will be part of that child's record	Track recommitment rates, provide a discharge plan for parents and child; also recommend services outside the facility to further treatment	-
Inform Parents of Incidents	-	Unknown - parents are kept abreast of ITP progress, but no specifics on incident reporting	-	Parents must be notified not only of incidents involving their children, but of any incident at the facility (this reporting begins immediately upon enrollment)
Inform Parents by Progress Reports	-	See above	-	-
Required Reports by Department	Fire, Death, Injury. Others available upon request.	-	-	-

Record Keeping (2)

Record Keeping	North Carolina	Pennsylvania	Tennessee	West Virginia	Virginia*
Require Incident Report (Filed at Facility)	Yes	Yes	Yes	Yes	Yes
Require Incident Report (Filed at State)	Death	Each facility files an incident report and send it to the appropriate regional Department	Available upon request	Yes	Each facility files a report and sends it to the appropriate office
Create Individual Treatment Plans	Yes	Yes	Yes	-	Yes. An individualized 'service plan' is created within 30 days and should be revised quarterly
Track Re-Commitment Rates	-	-	-	Yes	-
Inform Parents of Incidents	Death	Yes	Unknown (though intend to include parents in planning sessions)	Yes	Yes
Inform Parents by Progress Reports	-	-	-	-	Yes. Through the revision of 'service plans'
Required Reports by Department	Annual statistical report, any report alleging abuse or neglect and results of investigation, death of a child, or change of ownership	-	Monthly statistical report, annual report, change in location, death or life threatening injury (immediately), all major emergency situations (ASAP)	-	-

Miscellaneous (1)

Miscellaneous	Delaware	Kentucky	Maryland	New Jersey
Physical Facility Requirements	Yes	Construction, sanitation, and building maintenance requirements	Facilities must apply halfway through their license to receive a mid-way evaluation as well; state has extremely strict and extensive licensing requirements and monitoring procedures, including announced and unannounced visits from auditors to inspect anything in the facility (meals, records, restraints, employee records, financial records, etc.)	Extensive
Nutritional Requirements	Will meet national standards	Basic	-	Extensive
Annual License Review	Yes	License fee; must notify state if any changes in ownership, location, or services provided; also must include a list of staff and board members	Maryland has state coordinating councils (SCC) and local coordinating councils (LCC) that regulate and define residence facilities. The Department of Child Services (DCS) monitors each SCC and LCC **very** strictly. Therefore, there is a lot of local authority that determines how needs will be met, but state agencies are involved in administration.	Perhaps not yearly, but 45 days prior to license expiring, facility must apply for re-approval

Miscellaneous (2)

Miscellaneous	North Carolina	Pennsylvania	Tennessee	West Virginia	Virginia*
Physical Facility Requirements	Yes	Yes. Detailed requirements	Yes	Yes. Detailed requirements on child proofing the facility. In addition, sanitation and health issues guidelines are added	Yes. Detailed requirements
Nutritional Requirements	Will meet national standards	Yes. Basic requirements on food quality and not withholding food from a child	Yes	Yes. Detailed guidelines on accessibility, quality, and planning of facilities' menus	Yes. Basic requirements on food quantity
Annual License Review	Annual license	-	Annual license	-	-

Appendix 2

Benchmark Fatality Data

State	Population Rate	DJJ Deaths	RTC Deaths
DE	34.8	0	2
KY	45.4	0	-
MD	29.5	1	1
NJ	20.4	0	2
NC	36.7	1	-
PA	29.9	0	3
TN	67.4	1	2
WV	45	0	1
VA*	26.6	0	12

The benchmark comparison for expected mortality rates was derived from several sources. The first type used ("Population Rate") was the rate of non-natural death for the at-large population ages ten to nineteen in 2004. The data was obtained from Arialdi M. Minino at the Centers for Disease Control.[28] Calculations were done to combine the ten to fourteen year old age group and then fifteen to nineteen year old age group. The numbers of deaths were added together as were the population figures for each. The population was then divided by 100,000. This result is then used as the divisor for the number of deaths. The resulting figure is the number of deaths per 100,000. The second category ("DJJ Deaths") was the number of deaths in state-run juvenile corrections facilities from 2002 to 2005. This category does not include city, county or private facilities. The data was obtained from the online resource of the Bureau of Justice Statistics.[29] There is no separation in this category for natural versus non-natural. The final grouping ("RTC Deaths") takes place in residential treatment centers since 2001. These numbers were gathered from various online sources, such as newspapers and advocacy groups,

[28]National Vital Statistics System, National Center for Health Statistics.
[29]US Department of Justice. Office of Justice Programs (2007) Deaths in Custody Statistical Table.

along with emails from various state representatives.[30] They represent the bare minimum of deaths in facilities. Maryland is the only outside state in whose data there is relative confidence, and its data is only since 2004. Virginia is the exception because the total numbers from 2001 to 2006 were given in the CSA report, and therefore, are also known. This chart is intended to represent what types of numbers are available relative to those numbers that are not currently available. While none of the columns are comparable to one another, they are intended to give an idea of both scale and variability between states.

[30]Coalition Against Institutionalized Child Abuse (2007); Child Welfare League of America "Number of Alleged Perpetrators to Children Who Died As a Result of Abuse and Neglect, By Relationship of Perpetrator to Victim"; Email with Karen Triolo 10/23/07 (Delaware); Maryland Governor's Office for Children (July 2007) "Quarterly Report on Group Home Monitoring Incidents and Monitoring Deficiencies."

Appendix 3

Response Rate

State	Response Rate	Ratio
Delaware	31%	4/13
Kentucky	50%	2/4
Maryland	71%	5/7
New Jersey	50%	3/6
North Carolina	60%	6/10
Pennsylvania	33%	2/6
Tennessee	53%	8/15
West Virginia	0%	0/7

The table above represents the level of difficulty the analysts encountered in acquiring any sort of information on this subject. In order to gain a better understanding of the responses given by each state, a response rate was calculated. This ratio is the number of responses received (helpful or otherwise) divided by the total number of contact attempts to state officials through either email or telephone. Throughout the information gathering process, there were a large number of people who simply never responded to emails and phone messages and who were interested in the inquiry but were unable to be of any assistance.

Appendix 4

Delaware

The licensing agency for Delaware is the Division of Family Services, and more specifically, the Office of Children's Services. In Delaware, a residential child care facility is "any facility that provides out-of-home, 24-hour care, protection and supervision for children who have either: behavioral dysfunctions; developmental, emotional, mental or physical impairments; or chemical dependencies." Licenses are issued annually and the regulations say that "on-site inspections may be conducted without prior notice" but make no such requirement. Even during licensing renewal, there are no explicit requirements for monitoring facilities.

Delaware does have an extensive system in place for complaint-based monitoring. Investigations can be initiated by the Office of Child Care Licensing, a complaint-based telephone hotline or the Institutional Investigative unit. Depending on the type and location of the complaint, these units may conduct a review. Delaware is proud of the fact that the Department Secretary is a cabinet-level position. Its intent is that this position will enable child welfare to be given much greater attention.

The regulations for Delaware are the most detailed of any state. For most categories, they are also some of the most stringent. However, there were some contradictions found within the regulations, such as one section requiring constant monitoring of isolation and another requiring the child be checked on every thirty minutes. Delaware does require that incident reports in the case of death be filed with the state. A staff member in the Office of Case Management stated "to my knowledge, Delaware has not experienced any child deaths while in the care and custody of a residential treatment center (since 1984). We have had 2 deaths regarding youth receiving

treatment in a RTC however the deaths occurred outside of the facility."[31] One of these deaths was during a home pass and the other during a field trip. Also, one of the deaths occurred this year while the date of the other is unknown. Further contact suggested that there may be more information in another location, but it was never found.

[31] Email with Karen Triolo 10/23/07

Appendix 5

Kentucky

Kentucky defines a residential facility as providing 24-hour care and treatment-oriented service for children within state custody. The state closely defines staff-to-child ratios, dictates education and facility requirements, and sets strict standards for restraint use. The Cabinet for Health and Family Services oversees the administration and management of residential facilities, and each residential facility is run by a Board of Directors. This Board convenes quarterly, and as a body, is responsible for the facility in their jurisdiction. Residential facilities are licensed for two years at a time, with an initial licensing fee of $100, and a $50 fee thereafter.

However, when attempting to contact the state regarding actual child welfare in their out-of-home treatment centers, including residential facilities, state officials were largely uninformed. The state does not have monitoring and enforcement standards or staff, and therefore, incidents within facilities are likely to remain just that: incidents in facilities. Little public outcry is evident in this state, arguably because there is no knowledge of the internal functionings of residential facilities.

After nearly five weeks of speaking with various state officials, one official, Ms. Kathy Adams, Kentucky's Assistant Director in the Division of Protection and Permanency, was able to confirm that Kentucky had zero child fatalities in residential facilities in the years 2001 through 2006.[32] Ms. Adams used the current and previous Child Fatality Coordinator to verify this information, and both confirmed that there were no records of a non-natural child fatality in a residential facility at the indicated times.

[32] Cite this source

Appendix 6

Maryland

In addition to the utilization of benchmark fatality rates, analysts employed the use of a case study to examine one exemplary state, Maryland. Maryland's system of child welfare is very transparently outlined on the state's website. Residential facilities are overseen by the Department of Health and Mental Hygiene (DHMH), the Department of Human Resources (DHR), and the Department of Juvenile Services (DJS). This system was established when, in January 2001, DHMH, DHR, and DJS directed to establish uniform systems to ensure uniform quality of care for children in the custody of the state of MD. All bureaus report directly to Governor's Office on Children (GOC), established by Governor Robert Ehrlich by Executive Order in 2005. Another element of state oversight lies in the Local Management Boards (LMB), which also report to the GOC to ensure a continuity of coordinated delivery of state-run continuum of child welfare.

LMB's are the most localized form of oversight in Maryland residential treatment care. Board members are a point of authority in all of Maryland's 11 residential facilities, and members have an obligation in the administrative duties, budget oversight, emergency procedures, and staffing requirements of every facility. In fact, Maryland as a state regulates very few specifics about residential facilities; LMB's are highly authoritative. However, the accountability LMB's have to the GOC ensures that state officials remain abreast of any incident in any facility.

LMB's are not only obligated to share information about facility residents with any state agency working with the child, providers must report incidents within 48 hours to state agencies. Further, LMB's must report these incidents to the GOC, which is required to publish them in

quarterly reports. These quarterly reports must include any incident that harmed a child, staff member, of the surrounding community, incidents that required law enforcement intervention, police reports, medical treatment, ambulatory or emergent care, and of course, facility deaths. These reports are available to the public online.

This highly stratified, very well-defined system is impressive, but it must be noted that a 2006 facility death prompted these reforms. Though in 2001, three systems were ordered to collaborate for more cohesive treatment, the 2006 death is what ultimately brought on this more expansive improvement. Maryland is the most definitive and exemplary state in this study.

Appendix 7

New Jersey

New Jersey presents an interesting case. Initially, while doing preliminary research into each state, analysts discovered that New Jersey has extensive laws and structures defining residential facilities and regulating and enforcing them. The Department of Children and Families (DCF) was created in 2006 by Governor Jon Corzine, and contains within it the Division of Youth and Family Services (DYFS). DYFS ensures the safety, permanence & well-being of children & families, as well as handling referrals and investigations. Such referrals are frequently initiated on behalf of the state's 24-hour hotline for reporting abuses, and a Special Response Unit investigates every allegation of abuse or neglect within New Jersey's out-of-home treatment system. Other involved agencies are the Division of Developmental Disabilities, Department of Human Services, State Department of Health, State Department of Education, and the State Department of Corrections.

Perhaps the most impressive, original feature of New Jersey's system was the Child Fatality and Near Fatality Review Board (Board). The Board was established by the New Jersey Comprehensive Child Abuse Prevention and Treatment Act (CCAPTA) to review fatalities and near fatalities of children to identify causes, relationship to governmental support systems, and methods of prevention. With this oversight in place, it seemed that New Jersey would offer a completely accountable system, a model of well-regulated and enforced residential facility care.

Andrea Van Dyke, the Liaison between DCF and DYFS, was willing to speak with analysts directly and immediately about New Jersey's reform efforts and current difficulties in finding the appropriate level of care for "low functioning" residents. Ms. Van Dyke informed us that there have been no deaths in New Jersey facilities since the mid-1990s at least. This

estimation conflicted with later data on New Jersey, and over the course of several conversations with Mr. Junius Scott, of the Department of Health and Human Service's Administration on Children, Youth, and Families, it was revealed that New Jersey actually has had deaths in RTF's since the mid-1990s, and is currently under a court-ordered reform. This finding cast doubt onto the rest of the data gathered from willing state officials, though it did provide an example of a state whose regulations and fatality reviews lag behind that of Virginia's.

Appendix 8

North Carolina

The licensing agency for North Carolina is the Department of Health and Human Services of which the Division of Social Services (Child Welfare and Family Support Section) is a part. Licenses are to be valid for one year after which there is a ninety-day grace period for renewal after which the license is to be automatically terminated if the license has not yet been renewed. In North Carolina, a child-caring institution is defined as "a residential child-care facility utilizing permanent buildings located on one site for 10 or more children."[33] During an attempt to find more information about the monitoring staff for the facilities, there was a great deal of confusion among staff reached by phone as to what was being asked. After being redirected several times and finally calling the department for Licensing of Child Care Homes, no staff member could be reached.

The regulations themselves cover a wide range of topics, though leave a great deal up to the discretion of the individual facilities, as there are few statewide regulations. Each facility sets the number of training hours to be required annually and the educational requirements for direct-care staff are minimal. An exception to the lack of statewide regulations is the use of restraint. North Carolina does require that this technique only be used by trained personnel with another staff member present. North Carolina also requires the filing of annual statistical reports including data on the deaths of children in facilities, which made the inability of the staff to locate this information all the more curious. The explanation received was that "there are 2 systems set up to review child fatalities: the office of the chief medical examiner (OCME) and division of social services (DSS). DSS only reviews cases of children who are involed [*sic*] with

[33] Cite the regs

CPS and are reported to the division by the county. OCME looks at all deaths but the office establishes their own definitions of causes of death" and then through further contact explaining that "the data you are requesting has not been collected over the years."[34] No deaths from North Carolina have appeared in any of the various online searches that have been done, but that certainly is not an indication that none have occurred.

[34] Email with Jane Seo 11/6/07

Appendix 9

Pennsylvania

Pennsylvania defines children residential facilities as a "premise or part thereof, operated in a twenty four- hour period living in a setting in which care is provided for one or more children who are not relatives of the facility operator." The state's regulation of residential facilities is highly decentralized and strict. Its licensing agency is the Office of Children, Youth and Families located within the Office of Licensing and Regulatory Management that is, in turn, under the Department of Public Welfare. Facilities' regulation is county- administered and state-supervised. The state of Pennsylvania sets standards and supervises compliance. However, reportable incidents are received and monitored by each county's regional Department of Public Welfare office. Reportable incidents are often caused by failure to comply to state's standards, yet each facility develops their own policy to report, investigate, and monitor non- compliance and incidents. The Pennsylvania Code states, "Each facility shall develop written policies and procedures on the prevention, reporting, investigation, and management of reportable incidents." Since state, county, and facility all partake on setting standards, regulations are strict yet heterogeneous.

Pennsylvania divides responsibility within its residential facilities between a director, a supervisor, and child care workers. The director and supervisor must have completed Bachelor's degrees. Childcare workers are required a minimum of thirty hours of training within one hundred and twenty days of hire. After initial training, at least forty hours of training are required annually. Pennsylvania's Code is centered on individualized care and protection. Its code includes a statement of child's rights, crisis guidelines, and individual treatment plans. The state

has strict standards on training, restraint use, isolation use, and requirement for incident reports. However, a designated enforcement and monitoring staff is not required by the state.

Pennsylvania's regulatory environment is strict yet decentralized. This makes monitoring and database management of incident reports inefficient. Upon contacting the Office of Children, Youth and Families to gather information on fatality numbers for Pennsylvania's residential facilities, our concern for the state's inefficient record keeping was validated. Melanie A. Rutherford from the Information and Data Management team of the Office of Child, Youth and Families disclosed that Pennsylvania groups together several typed of facilities into one category, 'institution,' and cannot recognize recorded incidents as residential facility specific. "We are unable to provide all of the information you are requesting due to limitations in our data system" was one of her statements, followed by, "Between January 1st, 2001 and June 30th, 2007 there were 21 deaths of children with a placement setting of 'Institution,' which encompasses more than just RTFs. We are not able to determine whether it was specifically an RTF…. Our detailed records on hand only go back that far."[35]

[35] cite email

Appendix 10

Tennessee

The regulatory agency for residential treatment facilities in Tennessee is the Department of Children's Services (DCS). The commissioner for DCS is also the commissioner for these facilities. In Tennessee, the terminology used in the licensing is "residential child-caring agency." The definition of these agencies is "any institution, society, agency, or facility, whether incorporated or not, which either primarily or incidentally provides full time care for thirteen (13) or more children under seventeen (17) years of age outside their own homes in facilities owned or rented and operated by the organization. For licensing purposes this definition is expanded to mean the full time care of thirteen (13) or more children in one or more buildings on contiguous property with one administrator." It should be noted that the last time the standards were revised was March of 1999, and since that time, the Tennessee Code Annotated has changed such that all references to the code are now invalid (Title 14 no longer exists) and should be updated. The code (T.C.A. 71-3-508 (a)) does call for regular and unannounced inspections to ensure that facilities are complying with the regulations. However, while Tennessee does have a staff designated to investigate all complaints, it was never possible to speak any staff member who works with the complaint based staff nor find anyone who could knowledgably discuss the standard investigatory staff.

In general, the regulations for Tennessee are fairly standard, though leave a great deal to the discretion of each individual facility. As a result, a large focus of the code is on administrative requirements. Tennessee has one of the smallest requirements for training annually (six hours) and a large section on the nutritional requirements for the children. Also, the

code allows for the child-to-staff ration to be exceeded by ten percent up to three days per week (never for infants), which was unique to Tennessee.

The response from the staff in Tennessee to the inquiries was generally pleasant but unhelpful. Repeated attempts were redirected to the main telephone number for DCS, which was a particularly unhelpful source. There is a telephone directory for staff located on the DCS website, but it requires knowing the name of the person one is trying to reach and thus makes it difficult to access anyone other than the main operator without other searching. The website itself could also use a functional makeover.

The two deaths listed on the benchmark mortality chart were discovered by an online advocacy group, and DCS was unable to verify the specific incidents. DCS utilizes an information request form and the process appeared to be relatively smooth and well functioning initially, however, there have been repeated delays and as of yet, the data has not been released.

Appendix 11

West Virginia

The Residential Child Care Unit located within the Division of Children and Adult Services of the Bureau for Children and Families within the West Virginia Department of Health and Human Resources is the entity responsible for the licensing process which includes: rulemaking, inspection, evaluation, and enforcement. All residential childcare treatment facilities must be issued a 'Child Care Licensing or Certification of Approval' to begin and continue operation in West Virginia. Licenses are issued for up to two years with approval from the commissioner. The commissioner also has the power to limit the age, sex, or type of problems of children allowed admission to a facility. The state's regulation is highly centralized. Its policy motto is to ensure that entities offering quality childcare services are not overly encumbered by regulation. Title 78, series 18 of the West Virginia Department of Health and Human Services Legislative Rules states "It is also the policy of this State to ensure that those persons and entities offering quality child care services are not overly-encumbered by licensure, certification, and registration requirements, and that the extent of regulation of child care facilities be moderately proportionate to the size of the facility."[36]

West Virginia's staffing regulations are detailed yet relaxed. For instance, the residential facilities' operator has minimum academic requirement of a high school diploma. The state's regulations strength is its concern with isolation and restraint use. West Virginia prohibits any from of restraint and isolation is defined solely as time-outs that are regulated by length, reason, and supervision. Despite well-developed staff and restraint regulations, investigation and reporting of complaints lacks strength. The state asserts that the operator "shall report" specific

36 cite the regs

situations but does not specify who to report. Moreover, it gives the operator options of who to report incident, such as the statewide child abuse and neglect hotline or the Department of Child Protective Services' county office. The lack of a specific record- keeping organization makes it difficult to research fatality data for West Virginia. Thus, contacting regulatory authorities proved futile.

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