Abuse and Neglect — What the Heck are We Talking About?

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A few years ago, had I seen a title like this - Sorting Out Different Perceptions of Abuse and Neglect — on a conference program, it would have convinced me that the sponsors had taken leave of their senses. After all, aren't abuse and neglect fairly self-evident terms? It ought not to take a great genius or a Philadelphia lawyer to decipher what these terms embrace.

But the more time I've spent examining this subject, the more confusing it gets. And recently, since the Commission has become responsible for conducting investigations under the New York Child Abuse Prevention Act of 1985 (CAPA) and under the federal Protection and Advocacy for Mentally 111 Individuals Act of 1986 (PAMII), while continuing to deal with the policies and regulations of the Office of Mental Health and the Office of Mental Retardation and Developmental Disabilities, all of which try to define these terms, my confusion has been confounded.

What were once simple concepts, of which I thought I had a ready grasp, have become a torturous exercise in intellectual gymnastics. For example, a proven report of a child being slapped and shoved by an employee at a facility might have to be declared not child abuse under the CAPA because there is insufficient evidence of serious physical injury or impairment of the child's physical, mental or emotional well-being. Yet this same conduct clearly would be abuse under the regulations of OMH/OMRDD, with a range of penalties up to and including the capital punishment of the work place — termination.

The more I studied, the more confused I became. In a broad sense, it became apparent that, to the extent that various human service systems use the abuse and neglect reporting system as a means of monitoring inappropriate conduct between staff and residents of their facilities or among residents, the breadth of their view varies tremendously.

Inconsistent Definitions

At one end of the spectrum is the Child Abuse Prevention Act of 1985 (CAPA) which, with regard to children in institutional and out-of-home placements, offers only a peep hole into inappropriate, neglectful or abusive conduct. The limited view that the CAPA offers is largely due to an "impact" test contained within its definitions. To meet the definition of abuse, it is not enough to show that a child was intentionally struck. There must also be proof that there was a degree of injury that caused or created a "substantial risk of death, serious protracted disfigurement, protracted impairment of physical or emotional health or protracted loss or impairment of function of any organ."

To constitute maltreatment, the physical injury must be "serious" (a term which is left undefined). And to meet the definition of neglect, there must be proof that the conduct at issue "impairs or places in imminent danger of becoming impaired, the child's physical, mental or emotional condition." Thus, much conduct that most of us, in common parlance, would consider abuse, mistreatment or neglect, does not meet this "impact" test

and is therefore, in the eyes of the CAPA, not child abuse. And therefore the CAPA concerns itself with very little of this abusive conduct.

At the other end of the spectrum is the Office of Mental Retardation and Developmental Disabilities, which opens a panoramic window into such conduct through regulations which broadly embrace a wide array of people and includes actions as well as omissions. The OMRDD Part 624 regulations, which apply to all facilities certified or operated by OMRDD, including those which serve children and which are covered by CAPA, explicitly reject this impact test by defining conduct as abuse or neglect "whether or not the client appears to be harmed or injured." OMRDD goes considerably farther and includes within its definitions of abuse and neglect the provision of "insufficient, inconsistent or inappropriate services, treatment or care to meet clients' needs."

Other agencies and laws fall somewhere in between CAPA and OMRDD in the breadth of their vision.

- OMH regulations deal only with acts of employees and do not address omissions.

- But the federal Protection and Advocacy for Mentally 111 Persons Act of 1986 (PAMII), which defines abuse and neglect in a variety of residential facilities, includes failures to act.

- OMH regulations, the PAMII Act, and Division of Alcoholism and Alcohol Abuse regulations cover the conduct of employees or staff only. The CAPA covers "custodians." OMRDD includes employees, volunteers, consultants, contractors, visitors, and others.

- Improper uses of restraint or seclusion are defined as abuse or neglect by PAMII, DOH, OMRDD and CAPA, but, ironically, not by OMH regulations, although OMH facilities and programs use these interventions most frequently, and although a number of patient deaths and serious injuries have resulted from their improper use.

- While most policies, laws or regulations proscribe sexual activity between staff and clients, few explicitly include unsuccessful staff attempts or solicitations of clients for sexual relations.

- Finally, while DSS regulations prohibit abuse and neglect in adult homes, and require the filing of incident reports, there are no definitions at all of these terms.

While I am implicitly criticizing a number of agencies for this state of affairs, let me also acknowledge our own culpability. The Commission itself promulgated draft regulations for the reporting of abuse and neglect which also defined these terms. While I believe we tried to do it more precisely, these definitions were also at variance with others which already existed. Fortunately, we came to our senses in the nick of time, aided by thoughtful protests, and avoided putting these regulations into effect.

Staff Confusion

The lack of consistent definitions of what conduct is considered abuse and neglect can leave staff confused and bewildered, particularly since many facilities are covered by more than one set of laws or regulations. For example, an employee of a state children's psychiatric center may be affected by the Federal PAMII Act, the OMH regulations and the CAPA of 1985, all of which define abuse and neglect, but each of which does it differently.

A skilled lawyer, with time for analysis and reflection, can probably tease out these distinctions, but how can one realistically expect a direct care worker to sort his way through this maze of contradictions and differing jeopardies and guide his conduct to comply with the law?

What Are the Objectives?

My own confusion prompted me to go back and rethink:

1. What it is that we are trying or should be trying to accomplish with these complex systems that have been created to report and investigate allegations of abuse and neglect in out-of-home placements.

2. How does our definition of the problem of abuse and neglect help or hinder us in achieving our objectives?

Definition is crucial for, as Mark Twain observed, "If the only tool you have is a hammer, you tend to treat every problem as if it were a nail."

Let me start with the governmental concerns that might be involved in developing and supporting an abuse and neglect reporting system for institutional or out-of-home residences.

First, when the government takes custody of an individual or authorizes a private agency to do so through the operation of law, there is a concomitant moral obligation and, arguably, a constitutional one as well, to protect that person from harm and to meet at least the basic needs of life. An abuse and neglect reporting system should play a role both in identifying potential harm to be avoided and in aiding government to adequately monitor its services to protect the people for whom it has assumed responsibility.

Second, by identifying and effectively dealing with individuals who are guilty of abuse and neglect, such a system should serve as a specific deterrent to these individuals, either by removing them from the environment, by punishing them or by rehabilitating them where appropriate.

Third, the existence and effective operation of an abuse and neglect reporting system should serve as a general deterrent to potential abusers against engaging in the proscribed conduct and thus serve as a valuable tool in preventing harm.

Finally, and often overlooked, an effective abuse and neglect system should facilitate identification of systemic deficiencies which may be contributing to the individual reports of employee misconduct.

Need for Better Definitions

Each of these purposes requires that the abuse and neglect system have a fair degree of precision: in defining the conduct which is harmful and from which people are to be protected; in providing clear notice to those whose behavior is to be affected of what it is they should or should not do to prevent abuse and neglect; and in providing due process to those who are accused of abuse and neglect. As the courts have often said, the first essential of due process is clear notice of the conduct that is proscribed.

Thus, it is important that those who are engaged in writing laws, regulations and policies that define abuse and neglect to meet these purposes, clearly understand the dangers of being either underinclusive (like CAPA) or overinclusive (like OMRDD).

In my personal view, the definitions of abuse, neglect and maltreatment in the CAPA, which are largely drawn from the family context, are underinclusive because they are unduly influenced by the proper deference the law gives to families in child-rearing practices. Such practices are influenced by personal philosophy, cultural and ethnic practices, religious beliefs, and so on. That deference, and the broad latitude that parents have and should have in child-rearing, led to the initial inclusion of the "impact test" in the Child Protective Services law. We have several thousands of years of human experience from which it is reasonable to conclude that parents will generally treat their children with love and with a sincere desire to do what's best for them. Thus, it is reasonable

to conclude that the state should not intervene in familial relationships unless there is a significant risk of serious harm to the child.

This same deference and the concomitant high "impact" threshold for defining abuse and neglect is entirely misplaced when it comes to the conduct of employees, custodians and others in institutions and out-of-home placements, where there are neither the historical nor biological reasons for a "hands-off' attitude. Indeed, the historical experience with institutions and other congregate care settings argues for a much wider window of scrutiny.

The existing underinclusive definitions have the anomalous result of officially seeming to condone much behavior that is considered abusive in other laws, regulations and policies, by characterizing it as not abuse pursuant to a law that was enacted to increase the protection offered to children in out-of-home placements.

To paraphrase Judge Friendly, we ought not to be required by law to leave our common sense at the door!

In my view, if the CAPA is to be as effective as it has the potential to be, it is essential that it focus principally on the conduct of the employee that is considered abusive or neglectful, rather than on the reaction of the child to such conduct. The actor's jeopardy should depend upon what he does or doesn't do rather than injecting as a "wild card" the child's response. And the clearer the law is in this respect, the stronger its deterrent effect should be.

As strongly as I feel that the law should not be underinclusive, I believe equally that laws and regulations should resist the temptation to be overinclusive. Sweeping definitions, which sound all-embracing but provide little practical guidance to those whose behavior is to be affected, don't help much. We need to be careful to avoid defining as abuse or neglect any conduct that does not equal satisfactory job performance or meet our aspirations for quality care.

Sweeping definitions, which create an illusion of all-encompassing protection, can rarely meet the test of reality. A rule must be reasonable and realistic to earn respect. If a law creates personal jeopardy, it must define a standard of conduct which its targets can realistically meet or else the law will fail to win the trust and respect of those it governs, and without this essential support, the protections it offers will be empty indeed.

Sixteen years ago, the Assembly Select Committee on Child Abuse observed:

> No set of laws — no matter how well intentioned or how well drafted—can succeed without the understanding, cooperation, and active assistance of professionals and the public. A law lives in the manner in which it is used.

That observation is still true.

The broad definitions of abuse and neglect in OMRDD regulations cover common conditions which exist in many institutions whereby clients receive "insufficient, inconsistent or inappropriate services...to meet their needs." For example, active treatment still remains a goal rather than a reality for many clients; others remain in inappropriate and overly restrictive residential settings; still others do not receive all of the services called for in their individualized habilitation plans. None of these conditions is a secret: they are apparent to any observer, certainly to the professional staff and directors and, if they have some observational handicaps, there are regular complaints and survey reports that call these deficiencies to their attention.

Yet abuse and neglect reports are rarely filed regarding such matters, apparently because few of the required reporters consider these broad definitions to embody realistic expectations for staff to meet at their personal peril. While this language may be of help as a statement of a program goal and of expectations for client care, to use this as a yardstick to brand employees as guilty of abuse or neglect and subject to discipline makes little sense, particularly since they often have little control over the circumstances that cause the failing. But, by tacitly sanctioning a widespread disregard of the clear language of the regulation, there is a danger of giving license to staff to selectively ignore other aspects of the law or regulations when it is inconvenient.

There is a real price we pay when we allow ourselves to carelessly define important concepts; when we try to use regulations with punitive sanctions to try to achieve goals we've failed at as managers and advocates. When we include everything, we ultimately include nothing. What else explains the rare instances in which reports of neglect are filed from these institutions given this broad definition?

Responsibility and Proportionality

Related to the confusion and difficulties caused by the problems of underinclusiveness and overinclusiveness are two other definitional and structural problems in abuse and neglect reporting systems.

First is the important question of who's responsible for the abuse and neglect.

Second is the fairness and proportionality of the sanction.

Both of these influence staff perceptions of the reasonableness and realism of the rules and thus affect reporting practices greatly.

Most policies and regulations on abuse and neglect are silent on the issue of responsibility beyond that of the person directly involved and, in practice, most of the weight for the failures of the system is borne on the lowest rung of the ladder, the direct care staff.

If the issue of supervisory responsibility for causing, or contributing to, or failing to prevent a dangerous condition with foreseeable harm is not addressed, and all the jeopardy lies with those who have the most contact with the residents, this can and does foster a strong reluctance on the part of the staff with the most direct knowledge, to report incidents. And, without their cooperation, the system will be ineffective.

Similarly, administrative responsibility for deficiencies in staff training, in policy guidance, in staff scheduling and so on, need to be addressed directly to ensure both an appropriate sharing of responsibility and an identification of corrective and preventive measures.

In short, beyond identifying individual responsibility for individual incidents of abuse and neglect, a good system for institutional abuse and neglect should have a mechanism for identifying and responding to larger scale problems where determining individual responsibility may be difficult, if not impossible. So, where large groups of residents are adversely affected by the lack of a needed service or by a dangerous condition, there should be a mechanism to report such program-wide or agency-wide neglect to prompt a review, assistance and correction, even if it is hard to find a "perpetrator" or a "subject." To leave such conditions unreported because it is unclear who is responsible simply breeds disrespect for the law.

Under the present system, investigators sometimes find themselves in the incongruous position of spending a great deal of time and investigative attention upon the alleged misdeeds of a single individual, while all around them is evidence of pervasive neglect of the basic needs of all the residents of the facility — a matter which the current reporting system deems not worthy of attention, reporting, investigation or remediation.

Having a mechanism to report such program-wide neglect will help direct attention to remedying the problem rather than to searching for a culprit and fixing a punishment. This type of mechanism should offer direct care staff a significant incentive to buy into and support the overall purposes of the abuse and neglect system. It will allow them to play a role in correcting problems that significantly affect not only the quality of care but the quality of working life and perhaps rid them of some of that sense of powerlessness that contributes to abusive behavior.

Another important and related definitional problem is grading the severity of abuse and neglect and determining proportional responses. Without condoning any abuse, we need to recognize that there is clearly a difference in severity between a slap or a hair pull and a broken arm or being choked into unconsciousness. There is a difference between having direct responsibility for having done such acts, and having derivative responsibility for not having foreseen or prevented such harm which, in some cases, may be the more culpable behavior.

Under the CAPA, if the act constitutes abuse or neglect, there is the same uniform response, regardless of severity or degree of responsibility — having the subject's name in the register, there to remain until 10 years after the victim of the abuse turns 18. The actual length of time varies not with the degree of severity or responsibility, but solely with the age of the victim. There is no way to earn rehabilitation or to clear one's record sooner. This uniform response is often grossly disporportionate to the conduct at issue and serves little valid public purpose. Instead, there is a growing belief that the perceived harshness of the sanction is influencing a reluctance to report allegations of child abuse and neglect from some out-of-home placements. While there is unquestioned value in maintaining a record of perpetrators of major or repetitive abuse of children, in order to facilitate better screening of employees and putative adoptive and foster parents, it is entirely possible that a system which captures and preserves isolated and momentary lapses of a non-serious nature with equal vigor can become counter-productive. There ought to be mechanisms in the law that allow for a recognition of earlier rehabilitation or correction in behavior, and does so in a reasonable and timely fashion.

From a disciplinary perspective, many agency directors likewise feel that abuse is abuse and there's only one fit punishment — termination. And, if they can get away with it, some agencies will terminate an employee simply upon the <u>allegation</u> of abuse. And they do. This conduct may make them appear to be vigilant guardians of their charges.

In my view, this is both unfair and short-sighted. Such conduct simply reinforces the wisdom of a code of silence among employees, and allows managers to avoid confronting their own obligations for providing training, supervision, correction and growth in their employees. It also communicates to employees the management's lack of regard for their worth.

<u>Standard of Proof</u>

Upgrading the standard of proof for indicating a case of child abuse or neglect from the current low threshold of "some credible evidence" to the standard used in most civil proceedings and labor contracts — "a fair preponderance of the credible evidence" - would likewise promote fairer treatment of accused abusers.

While a low threshold of proof makes sense in a familial context, where such a finding serves as a predicate to protective actions up to and including removal of a child from the home, there is less need for such a "hair-trigger" in institutional cases. Virtually any type of protective action involving the child can be taken by agency management without the need for a determination of child abuse or neglect. Actions involving employee discipline usually require the higher standard of proof in any event. Recognizing this in law may help agency managers use the results of Child Protective Services investigations to better effect. The current differences in definitions and standards of proof promotes duplicate investigations and a great deal of confusion about the effect of an "indication" or "unfounding" of a child abuse investigation upon a parallel employee disciplinary proceeding.

In the long term, fair and proportional discipline, which recognizes the value of each employee and the potential for rehabilitation and growth, are far more likely to succeed in reducing abuse and neglect than a harsh and punitive response for all but the most serious and repetitive offender. Indeed, we need to examine the potential of a restitution/community service model of response for most non-serious incidents of abuse and neglect. Fair treatment of employees is more likely to earn their respect and trust and their participation in problem-solving, than reflexive and harsh disciplinary reactions.

To recapitulate, an effective abuse and neglect reporting system requires clear and precise definitions of proscribed conduct that meet a test of reasonableness in expectations, that recognize program-wide and facility-wide system failures, that incorporate a concept of proportionality in classifying offenses and fixing sanctions. And the system itself needs to recognize varying levels of responsibility of supervisors and administrators for the incidents which occur.

If all of that doesn't sound like the search for the Holy Grail, let me add another requirement that, to all of us who know government and bureaucracy, will probably meet that test. It is simply this:

I believe it is desirable to have a common core in the definitions of abuse and neglect that addresses the common obligation of all programs, regardless of which state agency operates or certifies them, to provide for the basic needs of residents for adequate nutrition, clothing, shelter, medical care and protection from harm. This common core definition is desirable because:

1. Many programs are currently subject to multiple and inconsistent standards.

2. A common core would promote easier understanding of central concepts which are likely to account for the vast majority of incidents.

3. It would facilitate shared efforts among agencies at staff education and training of which there is always not enough.

4. It would help promote a clear and consistent set of values across all human service agencies concerning the obligation of care for vulnerable persons in their custody.

5. It would recognize that both staff and residents move from one class of facilities to another over time and would reduce the dependence on new training each time such movement occurs.

Of course, the concept of a common core recognizes that there may be special additions to the core definitions in different classes of facilities based on the special vulnerabilities or needs of their residents and the program goals of these agencies.

To implement this approach, I believe there is a real need to develop a single statutory abuse and neglect reporting system that covers children and adults in out-of-home placements and that provides a common blanket of protection regardless of which state agency operates or certifies the residential facility.

These aspirations may seem idealistic. Indeed they are and, to the skeptic, they may even seem naive.

But the words of Margaret Mead keep ringing in my ear:

> "Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it's the only thing that ever has."

Thank you.