EVIDENT CHANGE
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GROUP HOME AND CONGREGATE CARE

Literature Review

Evident Change began a review of recent research and literature related to child abuse and neglect within congregate care and group home settings. The intent of the literature review is to establish foundational knowledge in various areas related to establishing a standardized safety assessment for this setting, such as possible safety concerns, possible interventions, and vulnerabilities of youth in these settings. The review is broken down into subcategories focusing on various topics with a brief summary of relevant information and links to each article included.

GENERAL OVERVIEW

Institutions vs Foster Homes: The Empirical Base for a Century of Action

Barth (2002) examined the need for congregate settings and, through this lens, looked at victimization and abuse rates of youth in care. Abuse rates in residential care were 6% higher than in foster home settings. Specifically in group homes and congregate care, revictimization vulnerabilities and "becoming a perpetrator" increased the frequency of maltreatment within these settings.

Placement Movement in Out-of-Home Care: Patterns and Predictors

James et al. (2004) examined placement patterns through out-of-home care, looking at child characteristics that may predict patterns of placement movement.

Findings highlighted the significance of externalizing behavior problems as the main distinguishing predictor classifying patterns of movement. The odds of experiencing later stability, and multiple short stays in care, increased with progressively higher levels of externalizing behaviors. This is consistent with previous studies reporting a link between disruptive behaviors and placement instability. James et al. reported on studies that suggest placement disruptions might not only be precipitated by behavioral problems but also cause them, further propelling the child toward increasingly unstable patterns of placement movement.

MALTREATMENT IN CONGREGATE CARE (CHARACTERISTICS OF CHILDREN VULNERABLE TO ABUSE; INSTITUTIONAL RISK FACTORS AND CULTURES)

Abuse of Children in Foster and Residential Care

A retrospective study conducted in England examined the characteristics of sexual and physical abuse of youth in foster and residential care. Hobbs et al. (1999) found that 80% of children had been abused prior to entry into care, and this made them more vulnerable to repeat maltreatment in care. Children in residential care were six times more likely to be assessed by pediatrician for abuse than youth from the general population. Hobbs et al. recommended a required pediatric assessment for inadequately explained, unusual, repeated injuries and recommended that ongoing medical care be maintained as a safeguard against any ongoing abuse.

Care or Scare: The Safety of Youth in Congregate Care in New York City

A qualitative study of New York City's congregate care facilities was conducted to examine stakeholder perceptions of safety for youth 12 years and older. The study found that inappropriate staff conduct (e.g., restraints, isolation, deprivation, corporal punishment), peer-on-peer violence, and poor physical living conditions were the primary safety concerns raised through interviews (Freundlich et al., 2007). Notable from this study was that some young adult participants reported that their running from facilities was due to concerns for their safety within the facility itself. The study presented some unique vulnerabilities: LGBTQ youth were reported to be at a greater risk of peer violence, as were youth with sexualized behaviors who were placed with other youth. A primary solution for increasing safety from the staff perspective was an adequate number of staff who were also trained appropriately.

The Abuse of Children in Out of Home Care

Nunno and Rindfleisch (2007) discussed the intent of removal of children from their homes is to protect them from harm, when in reality they are experiencing maltreatment while in care at alarming rates. Children in care are reported at two to three times the rate of children who are with their families.

Critical Failures in a Regional Network of Residential Treatment Facilities

The Residential Treatment Center Evaluation Project conducted a case study aimed at evaluating conditions of residential treatment facilities. The results of the study included some general findings and recommendations: Staff ratios are important to maintain. Also needed are better and more consistent

oversight of the facilities themselves, better tracking of incidents for follow up, and less harsh punishments (Pavkov et al., 2010).

The Safety and Well-Being of Looked After Young People

Problems with definition and lack of conceptual clarity have resulted in methodological difficulty in the field of child welfare in agreeing on the incidence, prevalence, and other characteristics of abuse in care. In their study in the United Kingdom, Bown and University of Portsmouth (2010) investigated the views of 25 looked-after young people who had recently left a placement about their safety and well-being while in their previous placement. The study found that most participants felt safe, but some felt unsafe to varying degrees. Participants felt most safe from sexual harm and least safe from physical harm and bullying. Carers, other looked-after young people, and foster carers' own children were identified as the main sources of harm. Families were identified as the people who were most effective at listening and looking out for participants' safety and well-being.

Public Inquiries Into Residential Abuse of Children

Corby et al. (2011) did a deep dive into a historical context within Britain's child welfare system, presenting indicators of abuse and neglect that align with certain policy changes. There has generally been a large gap in the focus on abuse and neglect within residential settings in general.

Out of Home Placement to Promote Safety? The Prevalence of Physical Abuse in Residential and Foster Care (2014)

Euser et al. (2014) collected data in 2010 to evaluate and compare the rates of physical abuse between youth in foster and residential care as opposed to in the general population. Youth in residential care had more than three times more incidents of physical abuse than youth in the general population. Of the population in residential care, more boys reported physical abuse than did girls. Of the youth in residential care, 71% were physically abused by facility staff; 26% were physically abused by other adults in the facility such as strangers or teachers. The study's recommendations included maintaining proper staff-to-youth ratios, limiting mixed-age groups, and limiting mixed-gender groups.

Keeping Children Safe: Allegations Concerning the Abuse or Neglect of Children in Care

In the United Kingdom, Biehal et al. (2014) examined the number of allegations against foster carers and residential social workers, the proportion of these that are substantiated, and the characteristics of the children and adults concerned.

The study extrapolated from its sample that abuse and neglect likely happens more frequently in residential care (10–12 allegations per 100) than in the homes of foster carers (less than four per 100). Approximately the same proportion of these allegations were substantiated across each setting (between one fifth and one quarter depending on year). Substantiated allegations in residential care were much less likely than those in foster family homes to lead to young people being removed, with a removal rate of less than one in five for substantiated allegations in residential care.

Literature Review on the Outcomes for Survivors of Child Maltreatment in Residential Care or Birth Families

Carr et al. (2017) focused largely on reviewing *outcomes* for survivors of child maltreatment for individuals raised in birth families and those in long-term residential care. Average rates of sexual, physical, and emotional abuse within long-term care were 67%, 63%, and 71% respectively; and most participants had experienced multiple forms of child abuse. Risk and protective factors were discussed as related to negative outcomes associated with institutional abuse.

The study examined the issue of "structural neglect" in congregate care institutions. In this context, "structural neglect" refers to a failure to meet children's basic physical, developmental, and emotional needs due to inadequate and unstable staffing and limited physical resources. Structural neglect was associated with adverse physical health, mental health, and psychosocial outcomes. Rates of disorganized attachment were about three times higher in survivors of institutional neglect than in children raised in birth families.

SPECIALIZED CONSIDERATIONS AND POPULATIONS (SEXUAL ABUSE, PEER-ON-PEER VIOLENCE, LGBTQ YOUTH)

Child Welfare Systems and LGBTQ Youth Homelessness: Gender Segregation, Instability, and Intersectionality

Robinson (2018) focused specifically on LGBTQ youth and their experiences in care. Concerns related to stigmatization, isolation, gender segregation, and institutionalization were linked to this population of youth. LGBTQ youth of color experienced these issues even more often. The study found that LGBTQ youth

experienced more placement changes, higher rates of victimization in care, greater frequency of running away as a result, and greater frequency of aging out of care.

The Prevalence of Child Sexual Abuse in Out-of-Home Care: A Comparison Between Abuse in Residential and in Foster Care

Euser et al. (2013) conducted a study of child sexual abuse in the general population compared to residential and foster care. The study involved interviewing a balance of professionals working in these settings and youth within these settings. Findings showed a higher rate of reported sexual abuse in out-of-home care than in the general population; and compared to the overall out-of-home care population, a higher prevalence in residential care. Within residential care, 79% of perpetrators were other youth, 7% were facility staff, and 21% were unknown to the surveyors (total greater than 100% due to multiple incidents with the same perpetrator).

Child Sexual Abusers Working With Children - Characteristics and Risk Factors

In looking at risk factors for child sexual abuse, Turner and Briken (2015) focused on the individuals who sexually abuse youth in care; Turner and Briken also noted that it is believed many incidents of sexual abuse are never reported. The research identified that the following characteristics are more likely among individuals who sexually abuse youth in care: male, older, more educated, trauma history of their own, and perpetrate on more than one victim. Turner and Briken also identified that power held by staff resulted in coercion to maintain victimization in facilities.

Experiences of Sexual Victimization by Peers Among Adolescents in Residential Care Settings (2014)

Attar-Schwartz (2014) examined the risk factors and frequency of sexual behaviors by peers in residential care settings with a sample of 1,309 Jewish and Palestinian youth in Israel. In examining previous studies, they noted that a large focus was on physical violence and bullying, with less attention on sexual violence and maltreatment. In the month prior to the survey, just under 40% of the youth in the study reported experiencing at least one act of unwanted peer sexual behavior. Adjustment difficulties, physical violence by staff, and a lack of understanding or knowledge of the agencies' antiviolence policies were all risk factors for higher levels of victimization.

Peer Violence in Foster Care: A Review of the Research Evidence

Lutman and Barter (2016) offer insight on peer violence in foster care. This research found that a consistent response to bullying by system stakeholders helped reduce the frequency of peer violence during system involvement. It also highlighted that LGBTQ youth are at a higher risk for peer violence.

Bullying and Peer Violence Among Children and Adolescents in Residential Care Settings: A Review of the Literature

Mazzone et al. (2018) reviewed various literature related to bullying and peer violence in residential care settings. In terms of the type of peer violence perpetrated by youth, verbal victimization was reported to be the most common. Intimidation, physical victimization, and intimidation were other common forms. Peer violence can become a norm within a facility, and conformity can occur as a culture is set and hierarchies form amongst youth. Some vulnerabilities discovered involved younger youth, new youth to the facility, and youth with prior maltreatment. Facilities inappropriately mixing age groups also had a negative impact on the frequency of peer violence. The size of the institution was reported to have an impact on the victimization rates, as larger institutions tended to have less overall staff supervision and more opportunities for bullying by youth.

BEST PRACTICES FOR INVESTIGATING ALLEGATIONS AND ASSESSING CHILD SAFETY IN OUT-OF-HOME CARE

CWLA Best Practice Guidelines

The Child Welfare League of America (CWLA) and Casey Family Programs developed a set of child protective services (CPS) best practice guidelines (Child Welfare League of America, 2003). The guidelines focus on child safety within child welfare; specifically, for youth in out-of-home care. The article focuses primarily on foster homes and kin caregivers.

CAPTA and the Residential Placement: A Survey of State Policy and Practice

Overcamp-Martini and Nutton (2009) explored policies and practices within state child protective services across the nation. The Child Abuse Prevention and Treatment Act (CAPTA) was initially passed in 1974 and over time has helped shift a focus to youth in care at institutions. The study discovered that data about abuse or neglect within facilities were not tracked well, and the authors noted the need for a specialized protective services team to handle investigations of congregate care settings. One of the study's main findings was that independence of investigations by child welfare organizations from the institutions in which children are

placed has led to two issues: a lack of attention for children who are maltreated and concerns of conflicts of interest between organizations. It was recommended that state and facility licensing bodies set and monitor the standards in prevention but that CPS intervene and investigate any reported maltreatment.

Investigating Child Maltreatment in Out-of-Home Care: Barriers to Effective Decision-Making

DePanfilis and Girvin (2005) reported on a secondary analysis of a case review designed to assess the quality of investigations into maltreatment in out-of-home care and to explore possible barriers to effective decision making. The researchers explored factors that may have led to faulty decision making; findings included inadequate knowledge, information-processing errors, the task environment, perceptual blocks, and expressive blocks. Recommendations included changes such as more defined roles to avoid conflict of interest for facility staff, more careful supervision of workers to reduce perceptual blocks, and more resources for workers in order to enhance the task environment.

Maltreatment by Staff in Residential Care Facilities: The Adolescents' Perspectives

Attar-Schwartz (2011) looked at 32 residential care facilities to examine the prevalence of verbal and physical maltreatment of 1,324 Israeli adolescents. The multilevel model used looked at individual characteristics of the youth, characteristics of the facility, and relationships between maltreatment types. Larger institutions were found to have more stress overall and therefore higher rates of reported maltreatment. Some suggestions from the study included culturally sensitive interventions, interventions geared toward the entire facility and everyone there (including staff and youth), adequate training for staff, and increased monitoring. Boys were found to experience more physical maltreatment than girls. Racial/ethnic minority groups were also found to report more maltreatment.

Child Abuse in Residential Care Institutions in Romania

Romania implemented reform of their legal framework with regard to punishment in institutions. This affected the study outcomes from Rus (2012), as the study was conducted after the reform, and it demonstrated the lack of full acceptance by staff of reform practices as a result of deep-rooted cultural practice. The study involved a survey of 1,391 institutionalized youth in Romania. A total of 511 youth (311 boys and 200 girls) reported being abused by staff. Indicators of abuse included the institution size (the larger the institution, the more frequent the abuse). Additionally, frequency of punishment related to factors such as how trusting a youth's relationships were with institutional staff. The more trusting the relationship, the more likely punishment was to have occurred. Family visits were examined as a means of intervention for reducing punishment; when visits occurred, there were fewer punishment incidents.

2020 State Roundtable Report: Congregate Care

Pennsylvania established a state roundtable that later implemented a Congregate Care Workgroup to focus on tasks related to these settings (Office of Children and Families in the Courts, 2021). The workgroup made use of a panel of youth who were previously in congregate care settings, and the panel reported some trends: staff favoritism resulting in issues with reporting, unrealistic expectations for developmental needs, poor sanitation, lack of understanding of the grievance policy, and lack of privacy for telephone calls. Some youth described these settings as "fight clubs." Recommendations by panelists to address these concerns were time to decompress, better-trained staff, and more activities to keep busy.

Final report. Review of IAIU Investigations of Suspected Child Abuse and Neglect in DYFS Out-of-Home Care Settings in New Jersey

DePanfilis (2003) evaluated a representative sample of New Jersey DYFS Institutional Abuse Investigation Unit (IAIU) files to determine the degree to which investigations of reports of child abuse and neglect in out-of-home care were conducted pursuant to professional standards; including New Jersey laws, policies, and standards for investigating alleged reports of abuse or neglect in out-of-home placement.

The review found a routine failure to adequately investigate reports of maltreatment in out-of-home care or to ensure safety of children. Multiple systemic deficiencies were identified, including professionally unreasonable decision making, high number of prior reports against caregivers, failure to consider historical information and interview all witnesses, and a lack of timely investigations. One of the most significant findings from this study related to the poor quality of IAIU decision making. Based on the facts documented in the IAIU files, the IAIU findings decisions were professionally unreasonable 25% of the time. The review found numerous examples of cases that documented unjustified actions or omissions of the caregiver, resulting in substantial harm or risk of harm to children, but in which the IAIU investigation concluded with a finding of "not substantiated." This put children at serious risk of ongoing harm in out-of-home care settings that had not been closed for further DYFS placements.

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