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ABSTRACT

The pilot study reported in this document reviewed existing child abuse and neglect reports in mental health and mental retardation residential facilities in the state of New York. The study found that the annual reporting rate of abuse and neglect in these facilities was more than two times higher than for the state as a whole; it also found widely varying procedures and practices for reporting allegations of child abuse and neglect among different mental health facilities. Investigations of many of the reported abuse and neglect cases did not meet state guidelines. Other findings were that boys, children over 12, and children with conduct disorder diagnoses were high risk victims of child abuse and neglect and that unscheduled time periods and times when no clinical staff were readily available presented higher risk times for child abuse and neglect. Recommendations are grouped into the following categories: Ensuring the More Accountable Reporting of Allegations; Promoting Accountable and Thorough Investigations of Allegations; Enhancing Prevention Efforts; and Strengthening Oversight of the Reporting, Handling, and Investigation of Allegations. Appendixes provide tabular statistics on the 80 reported allegations, and a response to the draft report by the New York State Office of Mental Health and the New York State Office of Mental Retardation and Developmental Disabilities. (DB)

Child Abuse and Neglect in New York Mental Hygiene Facilities

An Assessment of Reports Filed Prior to Implementation of New York's Child Abuse Prevention Act of 1985

New York State Commission on Quality of Care for the Mentally Disabled

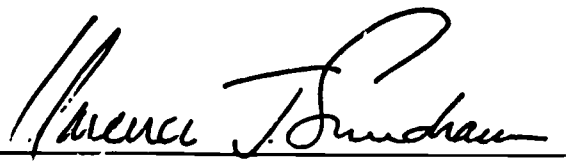
Preface

This study, which was undertaken by the Commission in preparation for assuming its new responsibilities under the Child Abuse Prevention Act of 1985, represents one of the first empirical studies of child abuse and neglect reports in mental health and mental retardation residential facilities. The study confirmed that children in these facilities are at higher risk of abuse and neglect than children in the general population. The annual reporting rate of abuse and neglect in these facilities, 4.4 reports per 100 children served, was more than two times higher than the annual reporting rate of abuse and neglect for the State as a whole, 2.1 reports per 100 children.

The Commission also found that there are widely varying rates of reported allegations of child abuse and neglect among different mental hygiene facilities that reflect both a varying incidence, as well as differing administrative and staff thresholds for what is reported. Additionally, the review indicated that investigations of many of the reported abuse and neglect cases did not meet stated guidelines of the New York State Office of Mental Health and the New York State Office of Mental Retardation and Developmental Disabilities.

More encouraging were the many review findings which identified significant trends in the characteristics of children involved in these allegations and the other circumstances surrounding the reported incidents. For example, the findings suggested that the boys, children over 12, and children with conduct disorder diagnoses were high risk victims of child abuse and neglect. The data also suggested that unscheduled time periods and times when no clinical staff were readily available presented higher risk times for child abuse and neglect. By shedding additional light on the nature and causes of child abuse and neglect in mental hygiene facilities, these trends may offer valuable advice for facility administrators and staff in the prevention of abuse and neglect in these programs.

Based on the findings of this review, the Commission has offered a number of specific recommendations to foster the more effective reporting, investigation, and prevention of child abuse and neglect in mental health and mental retardation facilities. These recommendations reflect the unanimous opinion of the Commission members and they have also been generally endorsed by the New York State Office of Mental Health and the New York State Office of Mental Retardation and Developmental Disabilities. Both Offices have also reported numerous activities and initiatives which they are already undertaking to ensure the prompt implementation of many of the recommendations proposed. The responses of both Offices to a draft of this report are included in the Appendix B.



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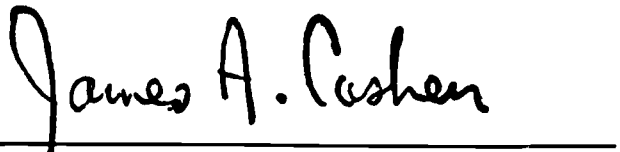

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Executive Summary

Prior to 1985, New York, like most states, had paid little attention to the issue of institutional child abuse. Existing statutes defined child abuse and neglect largely in the context of familial settings; reporting and investigatory standards for allegations of institutional child abuse were unclear; and actual practices varied widely. In addition, in most instances, investigations of these allegations were conducted by the institutional staff themselves, often with limited or no external oversight.

Responding to these deficiencies in State statutes, policies, and practices, as well as constituent complaints, the State Legislature passed the Child Abuse Prevention Act of 1985 (Chapters 676 and 677 of the Laws of 1985). The Act sought to rectify known problems in protective services for children in institutional settings and to provide a framework for accountable State policy in the area of institutional child abuse. An especially noteworthy provision of the Act altered the longstanding investigatory process for institutional child abuse in New York by mandating independent investigations conducted by a State agency not involved in the direct operation or management of the facility (Social Services Law §422.11). According to this provision, the NYS Commission on Quality of Care for the Mentally Disabled, an independent State oversight agency for mental hygiene services, was assigned investigatory responsibility for all allegations of child abuse and neglect in mental health and mental retardation residential facilities in the State.

Prior to the October 1, 1986 implementation date for the Act, and in recognition of the paucity of empirical data on child abuse and neglect in mental hygiene facilities, the Commission on Quality of Care decided to conduct a pilot study to gain a better understanding of these allegations and its new child abuse and neglect investigatory responsibilities. The Commission requested all mental hygiene facilities providing residential services to mentally disabled children to report all allegations of child abuse and neglect occurring during the six month period 9/1/85 - 2/28/86. This project involved the review of all 80 allegations of residential child abuse and neglect reported by mental health and mental retardation facilities for this period. Site visits were also made to 17 of these facilities over the course of the project to obtain more in-depth information about the nature and handling of child abuse and neglect allegations by the facilities.

The findings of the study substantiated the judgment of the Governor and State Legislature in recognizing that child abuse and neglect allegations in mental hygiene facilities often have not received the attention they warrant. Moreover, the findings revealed a number of important insights in understanding allegations of child abuse and neglect in mental hygiene facilities, as well as for ensuring the more effective handling, investigation, and prevention of these incidents.

Children at High Risk

The findings confirmed that institutionalized mentally disabled children constitute a high risk group for abuse and neglect. Based on the reported cases, the average annual reporting rate for these allegations in State mental hygiene facilities is more than two times greater than New York's reported 1986 statewide rate for all child abuse and neglect allegations (4.4 allegations per 100 children in the mental hygiene system versus 2.1 allegations per 100 children in the State's population). (See Report p. 5.)

Case disposition data indicated that 16 percent of the cases were determined to constitute child abuse or neglect, and, that in an additional 18 percent of the cases, the lesser finding of employee misconduct was made. Additionally, in two-thirds of the cases at least one corrective action was taken, and in nearly one-fifth of the cases at least one employee disciplinary action was taken. (See Report pp. 29 - 30.)

Poor Reporting Practices

The findings also strongly suggested widely ranging reporting procedures and practices for allegations of child abuse and neglect across facilities.

Reporting rates among different types of facilities ranged from 0 reports per 100 children served to nearly 10 reports per 100 children served, and the nature of reported allegations across facilities varied widely. Interviews with senior staff of reporting facilities also revealed that reporting criteria were not always uniform, and that inconsistent criteria were sometimes espoused by different staff within the same facility. It was apparent that certain "low reporting" facilities were far more likely than certain "high reporting" facilities to hold back reporting on allegations where there appeared to be little immediately known evidence, or where there was only a minor injury to the alleged child-victim. (See Report pp. 10 - 11.)

Other factors also influenced facility reporting rates. The higher reporting rates of mental health facilities versus mental retardation facilities, for example, were clearly associated with the capacity of most children in mental health facilities to self-report allegations (74 percent of the mental health reports were self-reported), as well as the prevalence of "acting-out" behavior patterns of many children served by these facilities. In contrast, the significant level of mental retardation and other functional disabilities among children in mental retardation facilities resulted in few self-reported cases (9 percent) and clearly influenced the lower reporting rate of these facilities. (See Report pp. 7 - 9.)

Finally, the data indicated that most children who self-reported abuse or neglect (63 percent) first told a clinical staff member. This suggests that a facility's relative emphasis on a strong individual clinician relationship for each child may also influence reporting rates. (See Report p. 8.)

Advice for Prevention

Especially encouraging were the number of findings which targeted the circumstances often associated with allegations of child abuse and neglect and the children and employees who are most often involved in these incidents. Several of these findings could be particularly helpful in designing appropriate prevention strategies.

For example, most reported allegations (92 percent) involved either no apparent injury or a minor injury to the alleged child-victim, and, equally important, the seriousness of the apparent injury was not significantly related to case disposition or the institution of corrective or disciplinary action. This finding reinforces the importance of facility vigilance in attending to all allegations regardless of the extent of apparent injury. (See Report p. 32.)

The findings also pinpointed unstructured time periods and "leisure time" areas (e.g., dayrooms, recreation areas, and sleeping areas) as the most common times/places where the reported allegations occurred. Very few of the allegations occurred in structured programs or classrooms. (See Report pp. 6 - 7.)

Additionally, the profile of the alleged victims in the cases studied clearly identified certain subgroups of children who appeared to be at higher risk of being involved in an abuse or neglect allegation. Boys over 12 years of age appeared significantly more vulnerable across all facilities. In mental health facilities, children prone to acting-out behavior and children with a psychiatric diagnosis of a conduct disturbance also fell in a higher risk group. In contrast, acting-out behavior by the alleged victim was a negligible factor in cases reported by mental retardation facilities. In these facilities, as contrasted with cases reported by mental health facilities, the alleged victim was often reported as a "passive recipient" of the alleged act of abuse or neglect. (See Report pp. 8 - 9.)

The data further revealed that, in many cases, more highly-trained clinical staff were not available to help out during acting-out episodes, or they arrived some time after the episode was underway. At many facilities, it appeared that direct care staff had not been trained either to deal with such behavior or encouraged to call clinical staff to the scene early. Commission follow-up indicated that few facilities had formal crisis procedures for bringing specially-trained clinical personnel to the scene of acting-out episodes involving clients/patients.

The need for additional training and clinical assistance for direct care staff in stress situations was further highlighted by the review's finding that nearly 80 percent of the alleged perpetrators had worked at the facility at least one year, and over half had worked at the facility more than three years. It was apparent that these episodes posed significant problems, not only for new recruits, but also for long-term employees. (See Report pp. 9 - 10.)

Investigatory Dilemmas and Flaws

The findings also clearly illustrated the many investigatory dilemmas associated with these cases. Nearly one out of every five of the allegations did not come to light until more than 24 hours after the event allegedly occurred, and one out of every two allegations was not witnessed by any adult other than the alleged perpetrator. Further, even when other adult (employee) witnesses were available, their accounts often related a substantially different account of the reported event. Compounding these problems for mental health facilities were the turbulent, spontaneous circumstances surrounding many of the reported incidents. Mental retardation facility officials, on the other hand, often had no immediately apparent informants as to the circumstances of the incident, as the alleged child-victim often could not tell his/her story, and other potential client witnesses were either unknown or equally unable to relate the circumstances of the event. (See Report pp. 21 - 23.)

Notwithstanding these difficulties, however, it was also clear that many of the investigations were flawed by investigator error or oversight. Supervisory oversight of the comprehensiveness and accuracy of prepared allegation reports and physical exam reports appeared poor. Early on in the cases, potentially valuable evidence was often lost by the delayed initiation of investigations and the failure to ensure that photographs were taken of visible injuries to the children. The findings also indicated that for more than 30 percent of the cases, all available employee and/or patient/client witnesses were not interviewed, and even when witnesses were interviewed, in more than one-third of the cases written statements were either not prepared at all, or they were not signed or dated by the interviewer or interviewee. (See Report pp. 23 - 26.)

In addition, external notifications to law enforcement officials and, in some cases, to the State Central Register, were apparently hindered by unclear facility operating guidelines for determining when these notifications were necessary. (See Report pp. 16 - 17.) Finally, and not surprisingly given the informality of other steps, formal written investigation reports were not prepared at all for 20 percent of the cases, and for nearly 40 percent of the cases where investigation reports were prepared, they were substantially not compliant with the Office of Mental Health and the Office of Mental Retardation and Developmental Disabilities guidelines for such reports. (See Report pp. 26 - 27.)

The uneven investigative performance by facilities appeared to result, in part, from the limited training which had been afforded to many staff investigators. Only 36 percent of the studied cases were investigated by a staff person who had completed the formal training program for abuse investigators, developed by the NYS Office of Mental Health and NYS Office of Mental Retardation and Developmental Disabilities. Further compounding these training limitations was the virtual absence of formal facility or Central Office supervisory accountability for the comprehensiveness of investigations. While facility incident review committees reportedly did discuss most allegations, they did not uniformly review final investigation reports. Reviews of investigation reports by the NYS Office of Mental Health and NYS Office of Mental Retardation and Developmental Disabilities also seemed erratic, and many reports, especially "unfounded" reports, were not reviewed at all. (See Report pp. 26 - 27.)

Recommendations

Based on these major findings, the Commission recommends a number of specific actions to ensure the more adequate reporting, investigation, and prevention of possible child abuse and neglect in mental health and mental retardation facilities. These recommendations have been shared with both the NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities. Both Offices have voiced support for these recommendations, and have indicated that they are already taking steps to ensure the prompt implementation of many of the suggested actions. (The Offices' responses to the draft report and the proposed recommendations are included in Appendix B of the report.)

I. Ensuring the More Accountable Reporting of Allegations

A. All mental health and mental retardation facilities serving children should develop explicit reporting procedures for allegations of child abuse and neglect, which are consistent with the expanded definition of institutional child abuse and neglect in the Child Abuse Prevention Act of 1985. The NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities should review and approve these developed procedures for facilities under their jurisdictions.

B. All mental health and mental retardation facilities should ensure that all employees are informed of their reporting responsibilities for allegations of child abuse and neglect, and that appropriate progressive corrective and/or disciplinary action is taken when an employee does not comply with these stated performance expectations.

C. The NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities should alert facilities under their jurisdictions of the important role of clinical staff in promoting patient/client self-reports of abuse and neglect allegations, and the potential important role of these staff in promoting family reporting by being available to families who may learn about abuse or neglect. In conjunction with this communication, mental health and mental retardation facilities should be encouraged to provide specialized training to their clinical staff in the detection of possible signs of abuse and neglect and to ensure that patients/clients and families have an opportunity to develop a personal relationship with a clinical staff member.

D. The NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities should develop clear operating guidelines for facilities under their jurisdictions to promote appropriate external notifications of child abuse and neglect allegations. Such guidelines are especially necessary to ensure more consistent and appropriate notifications to law enforcement officials and the State Central Register.

E. To ensure accountability for appropriate external notifications to law enforcement officials and the State Central Register, the NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities should require written, as well as oral, notifications to these bodies regardless of the response of these bodies to the initial oral report.

II. Promoting Accountable and Thorough Investigations of Allegations

A. In recognition of the high risk of children in mental health and mental retardation facilities for child abuse and neglect, as well as the many inherent dilemmas associated with investigating these cases, specialized training should be afforded to staff of all facilities who are assigned to investigate child abuse and neglect allegations. To assure the prompt availability of such training, the NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities, in cooperation with the NYS Division of the Budget, should develop a reasonable reimbursement mechanism to allow facilities to provide or otherwise ensure such training to relevant staff.

B. To ensure uniformly high standards for investigator training programs, these programs should be based on the manuals for special investigators developed by the NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities and these Offices should formally review and approve all such programs for facilities under their jurisdictions prior to reimbursement authorization.

C. To improve the quality of physical exam reports, the NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmen-

tal Disabilities should consider modifying the standard incident report form section for physician exam reports with designated sections for recording specific findings pertaining to each required content area (e.g. description of the injury, possible cause of injury, age of injury etc.) and with a specific reference to the physician's request that a color photograph be taken of any visible injury.

D. The NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities should reaffirm the importance of early initiation of investigations and the prompt gathering and preservation of evidence to facilities under their jurisdictions. These steps can be critical to the immediate protection of the child, and evidence lost at this stage sometimes cannot be reconstructed after some time has passed.

III. Enhancing Prevention Efforts

A. Prevention efforts to reduce the incidence of child abuse and neglect should be given a greater priority by the NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities, and by individual facilities under their jurisdictions. To this end, both Offices and individual facilities should, on a periodic basis, but at least annually, review all reported allegations of child abuse and neglect and identify systemic corrective and preventive actions.

B. Immediate action should be taken by the NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities to communicate to facilities under their jurisdictions certain findings of the Commission's review which have implications for the prevention of child abuse and neglect allegations. Specific attention should be directed to the following findings:

-specialized training for staff who are routinely assigned to high-risk patient/client settings;

-specialized training and retraining for staff in handling acting-out episodes with children;

-the importance of well-communicated crisis procedures to allow the prompt availability of specially-trained clinical staff when "acting-out" child behavior requires staff intervention and/or the restraint/containment of the child;

-the value of increased scheduled programming, especially during the late afternoons, early evenings, and weekends, in reducing the likelihood of incidents which can lead to abuse and neglect allegations; and

-the role of on-site clinical staff presence and supervision in reinforcing appropriate staff-child interactions and in reducing the incidence of allegations of abuse and neglect, particularly during late afternoon and early evening hours and on weekends.

IV. Strengthening Oversight of the Reporting, Handling, and Investigation of Allegations

A. The NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities should periodically review the reporting rates for child abuse and neglect allegations of facilities under their jurisdictions, as well as the nature of reported allegations to detect possible signs of poor reporting practices. On-site reviews should be conducted at all facilities which consistently evidence very low reporting rates and/or the absence of reports of less serious allegations.

B. The NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities should develop a reliable protocol for checking the quality of the investigations of allegations of child abuse and neglect by facilities under their jurisdictions. This protocol should ensure that a reliable sampling of all such investigations, including investigations of "unfounded" and "undetermined" cases are re-

viewed with a standard checklist. Among other key indicators, this checklist should include:

-comprehensiveness and accuracy of initial incident reports;

-prompt removal of alleged perpetrator from child caring responsibilities, where indicated for the safety of the alleged child-victim and/or other children;

-prompt initiation of the investigation of the allegation;

-conduct of physical exams of alleged child-victims, comprehensiveness of physician exam reports, and the availability of color photographs of visible injuries;

-prompt securing, sketching, and photographing of the scene of the incident, where appropriate;

-prompt attention and compliance with all appropriate external notifications;

-prompt interviews and appropriate signed written statements for all witnesses and informants, alleged perpetrators, and alleged child-victims;

-uniform attention to assessing and documenting the credibility of child testimony and the past work histories and work performance of alleged perpetrators; and

-comprehensive investigation reports.

C. Mental health and mental retardation facilities should ensure that their incident review committees take a formal role in reviewing the handling, investigations, and outcomes of incidents involving allegations of child abuse and neglect. These facilities are encouraged to develop a standard protocol for the review of these incidents by incident review committees which encompass the specific review criteria cited above.

Chapter I
Introduction

Prior to 1985, New York, like most states, had paid little attention to the issue of institutional child abuse. Existing statutes defined child abuse and neglect largely in the context of familial settings; reporting and investigatory standards for allegations of institutional child abuse were unclear; and actual practices varied widely. In addition, in most instances investigations of these allegations were conducted by the institutional staff themselves, often with limited or no external oversight.

Responding to these deficiencies in State statutes, policies, and practices, as well as constituent complaints, the State Legislature passed the Child Abuse Prevention Act of 1985 (Chapters 676 and 677 of the Laws of 1985). The Act sought to rectify known problems in protective services for children residing in institutional settings and to provide a solid framework for an accountable policy in the area of institutional child abuse. Drawn from a three-year study of institutional child abuse and neglect conducted by the New York State Senate Subcommittee on Child Abuse, the Act provides definitions of child abuse and neglect specifically targeted to residential care programs and explicit standards for reporting and investigating such allegations.

Three provisions of the Act are especially noteworthy. First, the Act required State agencies which run or license residential child care programs to develop operational standards for adequate custodial care in these institutions. Violation of these standards which results in physical or emotional impairment or potential impairment of a child, constitutes child neglect, according to the new statute (Social Services Law §412.9). Second, the Act expanded the concept of the "alleged perpetrator" beyond the single individual directly involved in the incident to examining the potential culpability for abusive or neglectful incidents to administrators, accountable for the overall operation of the program (Social Services Law §412.6).

Third, and perhaps most importantly, the Act altered the longstanding investigatory process for institutional child abuse in New York by mandating independent investigations conducted by a State agency not involved in the direct operation or management of the facility (Social Services Law §422.11). This latter provision gave major new investigatory responsibilities for institutional child abuse to the State Department of Social Services and the State's watchdog agency for mental hygiene services, the Commission on Quality of Care for the Mentally Disabled (Mental Hygiene Law §45.07(c)).

According to the statute, the Department of Social Services is responsible for conducting investigations of allegations of child abuse and neglect in residential programs operated or licensed by the State Division for Youth and the State Education Department, as well as child welfare residential facilities licensed by the Department.* The Commission on Quality of Care is required to conduct investigations of allegations of child abuse or neglect originating in the variety of institutional and community residential programs operated or licensed by the State Office of Mental Health and the State Office of Mental Retardation and Developmental Disabilities.

* Although the NYS Department of Social Services licenses and funds these programs, it is not involved in their daily operation or management.

Purpose of the Study

Prior to the October 1, 1986 implementation date for the Act, and in recognition of the paucity of empirical data on child abuse and neglect in mental hygiene facilities, the Commission on Quality of Care decided to conduct a pilot study to gain a better understanding of these allegations, and its new child abuse investigatory responsibilities. This project involved the review of 80 allegations of child abuse and neglect reported by State-operated and licensed mental health and mental retardation facilities over a six-month period. Site visits were also made to a number of mental health and mental retardation residential facilities serving children to discuss special issues relevant to the prevention, reporting, and investigation of child abuse allegations in these facilities. In addition, a comprehensive literature search was conducted to identify relevant research and resource materials to assist in staff training both for Commission child abuse investigators and staff in State mental hygiene facilities.

This report summarizes the findings and conclusions of the Commission's review of the 80 allegations, and our site visits to mental health and mental retardation facilities. A separate publication, *Institutional Child Abuse & Neglect: A Selected Annotated Bibliography,* provides a summary of the research and resource materials on institutional child abuse reviewed by the Commission. This bibliography includes a brief overview of the literature, annotated descriptions of each document reviewed, and information indicating how readers may obtain specific documents, many of which are unpublished, or out-of-print. The publication is also indexed for easy reference to topics of special interest.

Methodology

• Reviews of Reported Allegations

In September 1985, at the request of the Commission, the NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities sent letters to all residential facilities under their jurisdictions which serve children, requesting them to submit copies of all initial reports of child abuse and neglect allegations to the Commission. This letter also required facilities to send investigation reports and all other relevant documents pursuant to the facility's investigation to the Commission.

All facilities were required to submit documents on these reported allegations for the six-month period, September 1, 1985 - February 28, 1986. Administrators and staff at the facilities were also asked to cooperate with the Commission as it pursued its review of the reported allegations.

Trained Commission staff reviewed the submitted documents using a structured survey instrument. This instrument was designed to capture information about the nature and circumstances of the allegation; the characteristics of the alleged child-victim and the alleged perpetrator; the reporting, initial handling, and investigation of the allegation by the facility; and the outcome of the case. Commission staff also made follow-up phone calls to facilities to clarify confusing or conflicting information in filed documents, and to request additional information which was not initially reported.

Criteria for assessing the reporting, initial handling, and investigation of the allegations were drawn from existing regulations, policies, and guidelines of the State Office of Mental Health and the State Office of Mental Retardation and Developmental Disabilities, as well as statutory and regulatory standards governing institutional child abuse and neglect cases prior to the Child Abuse Prevention Act of 1985. Particularly useful summaries of these State requirements were available in the NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities manuals for special investigators.* It should also be noted that while criteria for the review were drawn from specific New

* *NYS OMH Manual for Special Investigators* (1983) and *NYS OMRDD Manual for Special Investigators* (1985)

York State statutes, regulations, policies, and guidelines, these criteria are also generally consistent with investigative guidelines and standards identified in the current literature on institutional child abuse and neglect. (Thomas, 1980; Smiles, 1982; *Child Abuse and Neglect Investigation Decision Handbook,* 1982)

Data recorded on the survey forms were first analyzed for all cases. Later, selected subgroups of cases were studied. These later analyses generally revealed few significant differences among subgroups of cases identified by race, sex, or age of the alleged victim. Significant differences between cases reported by mental health and mental retardation facilities were, however, common. Due to this finding, data observations are reported in aggregate, as well as by the primary population group served by the reporting facility (e.g., mental health versus mental retardation facilities).

•Site Visits to Mental Health and Mental Retardation Facilities

The eight mental health and nine mental retardation residential facilities visited over the course of the project included five State-operated children's psychiatric centers, three State-licensed mental health facilities, four State-operated centers serving children and adults with mental retardation and developmental disabilities, and five State-licensed residential providers for mentally retarded and developmentally disabled children.

Early scheduling of visits attempted to ensure a regionally representative sample of the various types of mental hygiene residential facilities in the State. As the project progressed, however, selection of facilities for site visits was increasingly determined based on document review findings. Specifically, facilities evidencing particular problems in reporting and investigation practices, as well as those evidencing "outstanding" practices were targeted for later site visits. Whereas this decision was based on the researchers' belief that more could be learned from targeting individual facilities for site visits, the decision also necessarily biased the sample. Due to this bias, site visit findings were carefully evaluated and presented only when they were also substantiated by empirical data findings from the case reviews of the 80 reported cases.

•Limitations

Although the review was based on the complete sample of 80 child abuse and neglect allegations reported by mental health and mental retardation facilities for a six-month period, it should be noted that only 12 of the 80 allegations studied were reported by mental retardation facilities. Due to this disproportionate distribution of mental health versus mental retardation reports, aggregate review findings tend to be more representative of mental health reports. To compensate for this bias, whenever findings differed significantly for allegations reported by mental health and mental retardation facilities, these differences are highlighted in the report of the findings.

This report was circulated in draft form to the NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities for comment and for review of the proposed recommendations. Both Offices agreed with the major report findings and endorsed the proposed recommendations. In addition, responses to the draft report also indicated that actions were already under way to ensure the prompt implementation of many of the recommendations.

Chapter II
The Reported Allegations

Over the six-month period, 80 reports of alleged child abuse and neglect were forwarded to the Commission from mental health and mental retardation facilities. Extrapolating these data to a 12-month time frame revealed an annual average reporting rate of 4.4 reported allegations per 100 children served in these facilities Statewide. This annualized reporting rate is more than three times greater than the 1986 Statewide reporting rate of child abuse and neglect allegations of 2.1 reports per 100 children in the State's population.

The average annual reporting rate for mental health facilities of 5.7 reports per 100 children served was, however, three times higher than the average rate for mental retardation facilities of 1.8 reports per 100 children served. (See Figure 1.). (More comprehensive tabular statistics related to all review findings are presented in Appendix A.)

Reporting rates among specific types of mental health and mental retardation residential modalities also varied. For both subgroups of facilities, the majority of reports were filed by State-operated programs, including State children's psychiatric centers (45 reports); children and youth units of State adult psychiatric centers (6 reports); and State developmental centers (6 reports). Only 23 of the 80 reports were filed by licensed mental health and mental retardation facilities, including residential treatment facilities for children with mental illness (16 reports); community-based intermediate care facilities for the mentally retarded (3 reports); private schools for the developmentally disabled (2 reports); a psychiatric unit of a general hospital (1 report); and a licensed community residence for persons with mental illness (1 report).

Figure 1 **Annualized Reporting Rates (Per 100 Children)**

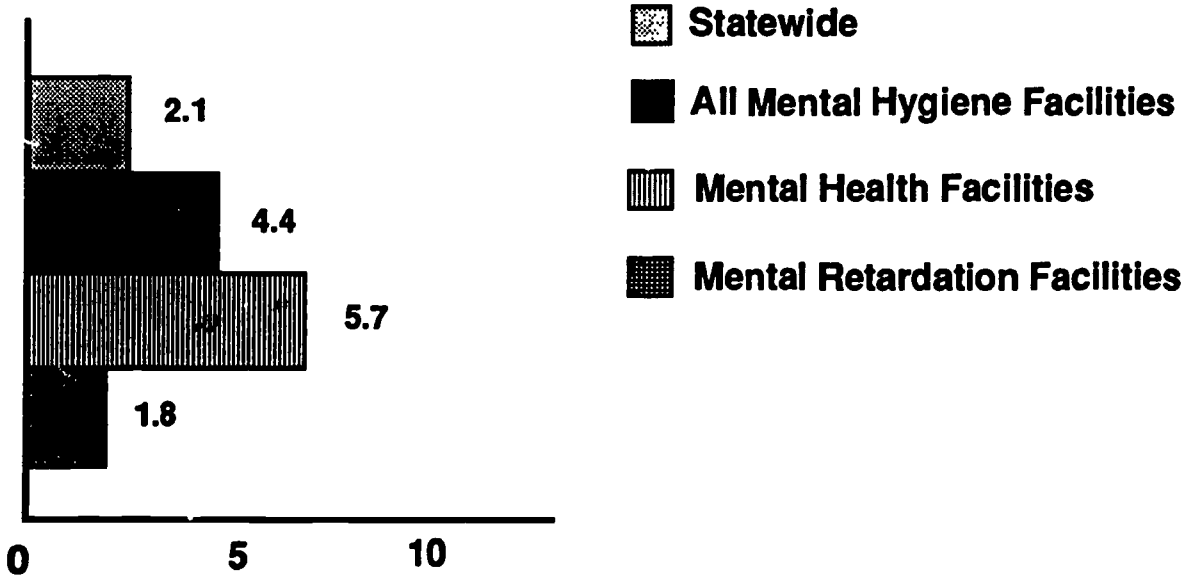
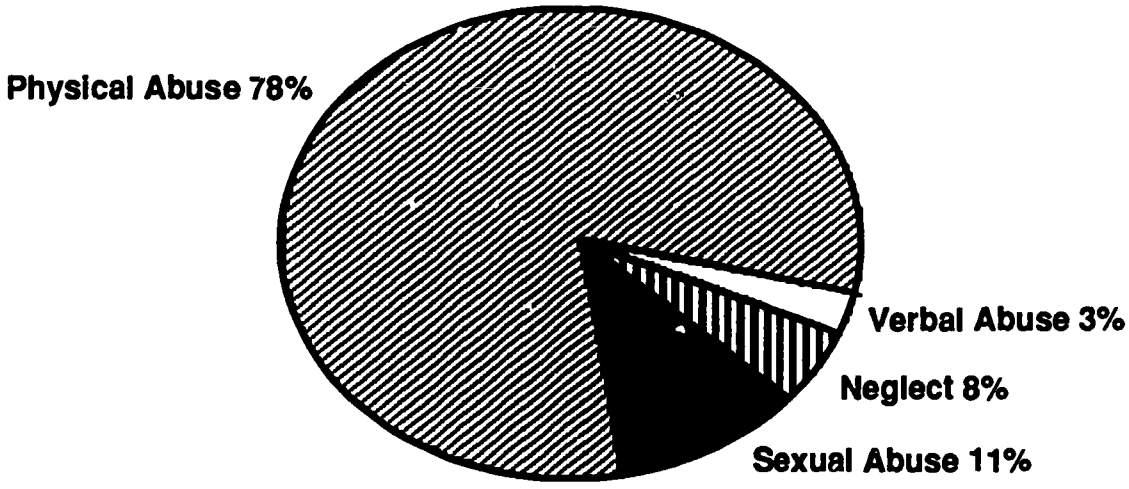


Figure 2

Reports By Type



Nature of the Reported Allegations

Seventy-eight (78) percent of the filed reports cited physical abuse as the primary allegation; 11 percent cited sexual abuse; 8 percent cited neglect; and 3 percent cited verbal or psychological abuse. (See Figure 2). Data also showed that few reports resulted in serious physical injury to the alleged child-victim. In 55 percent of the cases, no injury whatsoever was reported, and only 3 percent of the cases involved a physical injury more serious than a superficial scratch or cut, or a bruise. Three of the latter cases resulted in a need for hospitalization.

Although the nature of the allegations reported by mental health and mental retardation facilities were not significantly different statistically, certain differences worthy of attention in future studies of larger samples of cases were noted. For example, a considerably higher percentage of the reports filed by mental health facilities alleged physical abuse with no injury (39 versus 18 percent), whereas a considerably higher percentage of reports filed by mental retardation facilities alleged neglect (18 percent versus 6 percent).

Relatedly, although the overall reporting rate of allegations was considerably lower for mental retardation facilities than for mental health facilities, a higher percentage of cases filed by mental retardation facilities involved an injury to the alleged child-victim. Specifically, whereas 64 percent of the reports filed by mental retardation facilities involved an injury to the alleged child-victim, and 27 percent of these reports resulted in an injury requiring hospitalization, only 42 percent of the reports filed by mental health facilities involved any injury to the alleged victim, and none of these cases required hospitalization.

Reported Locations of the Allegations

Further analysis of the data revealed that almost all allegations reportedly occurred indoors (85 percent), but that very few (3 percent) occurred in formal program/classroom areas. This latter finding is particularly noteworthy since almost all children in these residential settings spend at least one-third of their waking hours on weekdays in school programs.

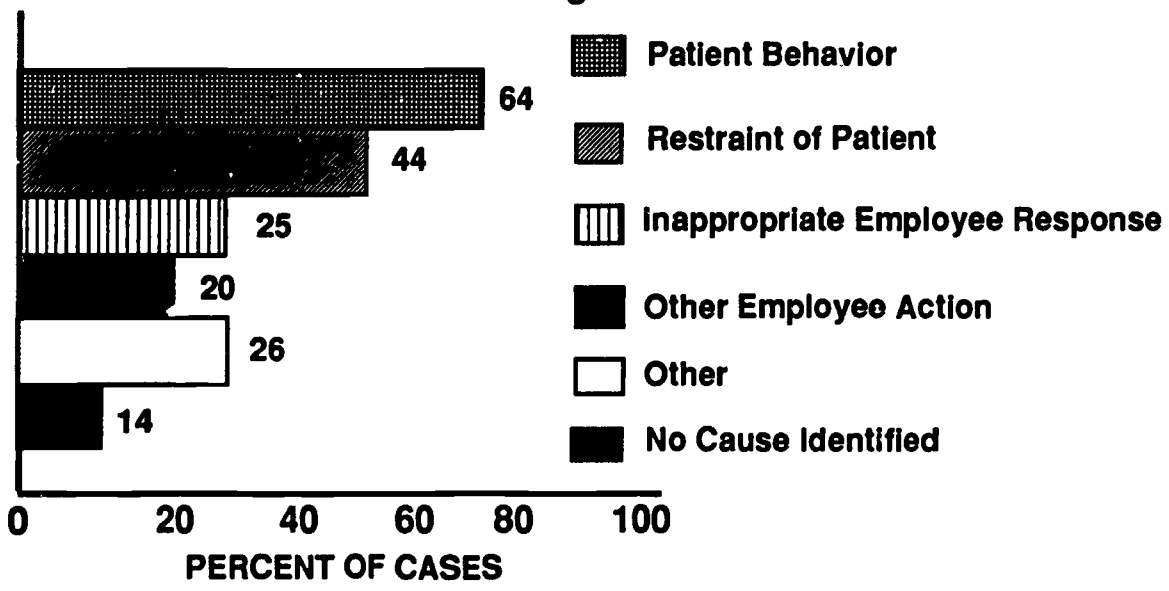
The most frequently reported specific locations for all reported allegations were sleeping areas (31 percent) and day room/living areas (14 percent). This finding, however, was largely reflective of reports filed by mental health facilities, and data analyses revealed significant differences between the reported locations of allegations filed by the mental retardation facilities ($p<.05$). Most notably, in 36 percent of the allegations filed by mental retardation facilities, the location of the alleged incident was reportedly "unknown." In contrast, "unknown" locations were cited in only 4 percent of the reports filed by mental health facilities. In addition, only 9 percent of the allegations filed by mental retardation facilities reportedly occurred in sleeping areas, whereas 35 percent of the allegations filed by mental health facilities reportedly occurred in these areas.

Reported Cause of the Incident

According to incident reports, investigation reports, and other documents submitted by reporting facilities, reporting facilities could usually identify at least one factor or event associated with causing or partially causing the incident. (See Figure 3). In 86 percent of the reports, the facility identified at least one factor/event causing or partially causing the incident, and in 63 percent of the reports, two or more factors/events were identified. Leading this list of factors and events was acting-out behavior of the alleged child-victim, noted in 64 percent of the reports. Other commonly noted factors/events were the physical restraint or containment of the alleged child-victim (44 percent of the reports), inappropriate employee response to a child's behavior (25 percent), and other actions by an employee (20 percent).

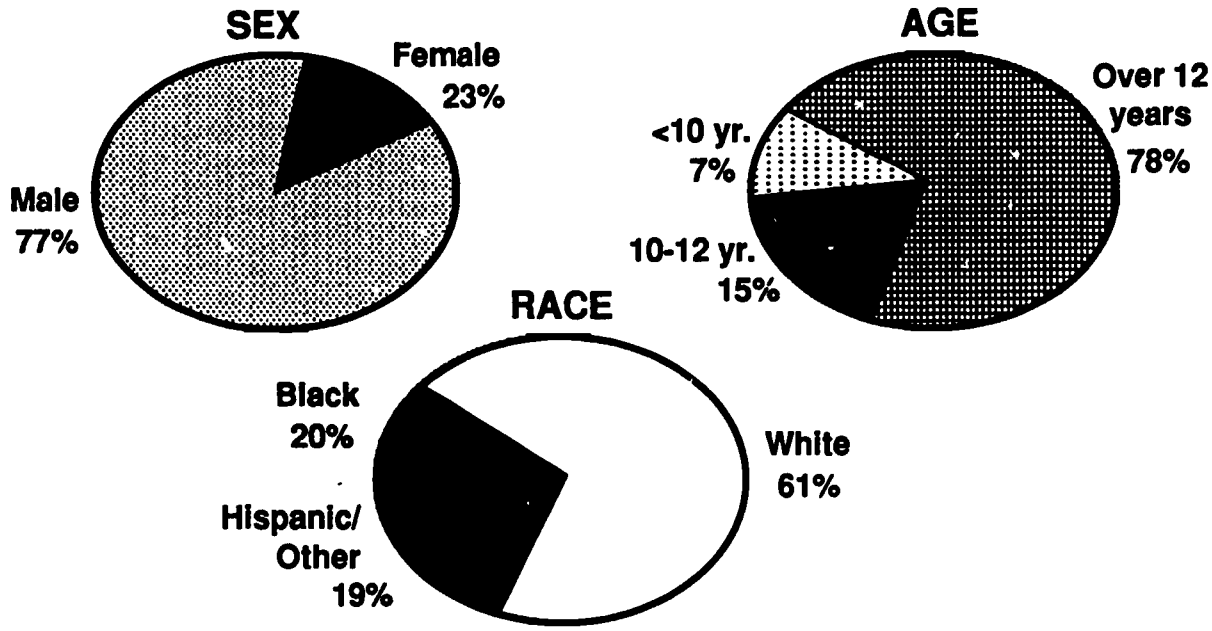
Again, however, when reports filed by mental health and mental retardation facilities were examined separately, strikingly different profiles emerged ($p<.05$). For example, a much larger percentage of the allegations filed by mental health facilities were attributed to the acting-out behavior of the alleged child-victim (71 percent versus 18 percent) and/or the physical containment or restraint of the alleged child-victim (49 percent versus 9 percent). Conversely, physical handicaps and/or seizures of the alleged child-victim were cited as relevant factors/events for 27 percent of the reports filed by mental retardation facilities, but none of the reports filed by mental health facilities.

Figure 3 Reported Cause(s) of Alleged Abuse/Neglect *



* Percent exceeds 100% because more than one cause was attributed to 63% of the allegations reported.

Figure 4 **Characteristics of Alleged Victims**



Reporters of the Allegations

"Initial" reporters of the allegations also differed significantly among reports filed by mental health versus mental retardation facilities ($p<.05$). Whereas nearly two-thirds of all cases (65 percent) were initially reported by the alleged child-victim, this aggregate finding was generally characteristic only of cases reported by mental health facilities. Although 74 percent of the cases filed by mental health facilities were initially reported by alleged victims, only 9 percent of the cases filed by mental retardation facilities were self-reported by alleged victims. In mental retardation facilities, the most common reporters were employees, other than the alleged perpetrator (noted in 55 percent of the cases), family members (noted in 18 percent of the cases), and hospital personnel (noted in 18 percent of the cases). While these three reporting sources accounted for 89 percent of the reports filed by mental retardation facilities, they accounted for only 11 percent of the reports filed by mental health facilities.

Self-reported child-victim cases were further examined to determine to whom the child first reported the allegation. In nearly two-thirds of these cases (63 percent), the child first reported the allegation to a clinical (professional) staff member. In approximately one-fourth of these cases (27 percent), the child first told a direct care staff member, and only in 2 of these cases did the child first tell an administrative staff member. Perhaps most surprisingly, the alleged child-victim first told a family member in only two cases.

Characteristics of the Alleged Victims

Approximately three-fourths of the 82 children alleged to have been abused in the 80 reports were males (77 percent) and over the age of 12 (78 percent).* (See Figure 4). Only 7 percent of the alleged victims were under 10 years of age, while 15 percent were 10, 11, or 12 years old. Racially, most alleged child-victims were white (61 percent); 20 percent were Black; 18 percent were of Hispanic origin; and one of the reported victims was a Native American.

* Two of the reported allegations, both filed by mental health facilities, identified two alleged child-victims.

With the exception of age, the data indicated similar demographic profiles for alleged victims identified in reports filed by mental health and mental retardation facilities. Alleged victims identified in mental retardation reports, however, were significantly younger than those identified in mental health facility reports ($p<.05$). Thirty-six (36) percent of the victims identified in reports filed by mental retardation facilities were under 10, whereas only 3 percent of the victims identified in reports filed by mental health facilities were under 10.

Not surprisingly, alleged victims identified in reports filed by mental health and mental retardation facilities also differed in their mental diagnoses. All but two of the alleged victims referenced in mental retardation facility reports had an official mental diagnosis of moderate to profound retardation, and the remaining two reported victims had diagnoses of infantile autism and specific developmental delay. In contrast, the mental diagnoses of the identified victims in mental health facility reports ranged the gamut of psychiatric conditions. By far the most commonly cited class of psychiatric diagnoses was conduct disturbances, noted in reference to 42 percent of the alleged victims. Other less commonly cited psychiatric diagnoses referenced in mental health facility reports included schizophrenic disorders (13 percent), hyperkinetic syndrome (13 percent), neurotic disorders (10 percent), and adjustment reactions (6 percent).

Also of interest was the finding that over the six-month reporting period, six of the alleged child-victims were identified in two reports. A closer look at these "repeater" child-victims indicated that all resided in mental health facilities: all were male; and all were over 12 years of age. Five of these six victims carried a conduct disturbance diagnosis, and all but one of these cases were associated with acting-out behavior of the alleged child-victim and/or the physical containment or restraint of the alleged child-victim.

The Alleged Perpetrators

A total of 97 alleged perpetrators were identified in the 80 reported allegations. Only one alleged perpetrator was identified in 80 percent of the reports; multiple alleged perpetrators were identified in 16 percent of the reports; and no alleged perpetrator was known/identified in 4 percent of the reports.*

Based on demographic and employment data, the profile of the alleged perpetrators that emerged was a male, direct care staff worker, between the age of 20 and 50, who had worked at the residential facility for longer than one year.** (See Figure 5).

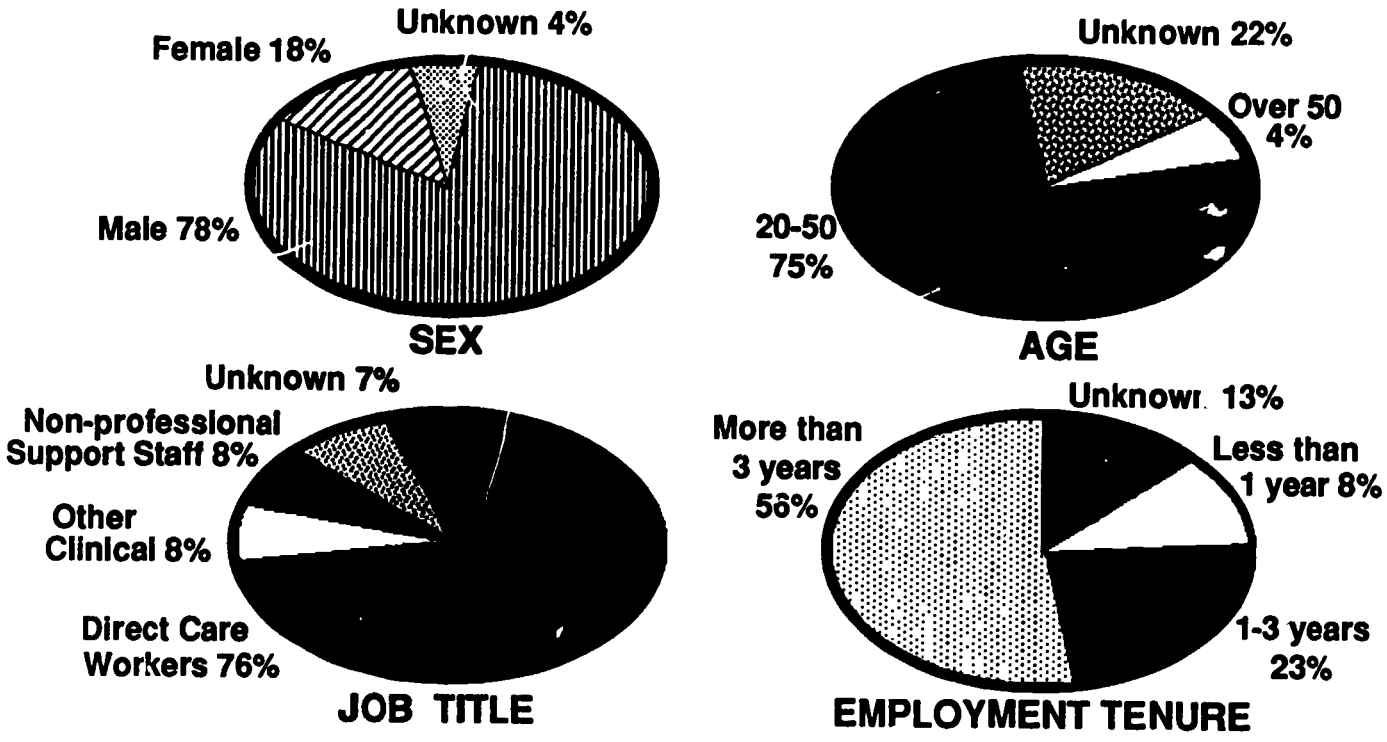
The data showed that 78 percent of the alleged perpetrators were male; 75 percent were between the ages of 20 and 50; and 76 percent were direct care staff workers. The data also indicated that 79 percent of the alleged perpetrators had worked at the facility for more than one year, and that 56 percent had worked at the facility for longer than three years.

To a large extent, this profile is predictable based on employee characteristics and job assignments in residential care facilities for children. For example, when children are on the living units in the early mornings, late afternoons and weekends — when most of the allegations reportedly occurred — their care and supervision is largely assigned to direct care staff. In addition, most direct care staff are young workers. Finally, male employees are more likely to be assigned to wards/living units serving male children, who

* In eight reports (10 percent) two alleged perpetrators were identified; in four reports (5 percent) three alleged perpetrators were identified, and in one report (1 percent) four alleged perpetrators were identified.

** Readers should note that data on alleged perpetrators were not uniformly available to the Commission, and that data on alleged perpetrators identified in reports filed by mental retardation facilities were unavailable in at least 50 percent of the cases. Thus, readers should be mindful that the presented profile is not necessarily representative of cases reported by mental retardation facilities.

Figure 5 Characteristics of Alleged Perpetrators*



comprised 77 percent of the alleged victims, and male employees are also more likely to be called upon when children "act out" or require physical containment or restraint. The only surprising feature of the profile was that nearly four out of every five employees identified as perpetrators were fairly long-term employees of the facility.

Among the 97 identified alleged perpetrators, it was also noteworthy that seven employees were identified in more than one report. All of these 15 cases involving a repeat alleged perpetrator were filed by mental health facilities, and further analysis revealed that the alleged repeat perpetrators did not differ significantly from other alleged perpetrators. In addition, the substantiation rate for the 15 cases involving repeat perpetrators (13 percent) was actually slightly lower than for the sample as a whole (16 percent), although over the six-month period repeat alleged perpetrators were more likely than other alleged perpetrators to be terminated or to accede to requests for "voluntary" resignations. One of the seven repeat perpetrators was terminated, and another voluntarily resigned. In contrast with this 29 percent termination/voluntary resignation rate, only an 8 percent termination/voluntary resignation rate was noted for alleged perpetrators identified in only one report.

Summary and Conclusions

The above portrait of the 80 reported allegations provides many insights for understanding child abuse and neglect in residential facilities for children with mental disabilities. First, the average annual reporting rate of 4.4 reports per 100 children served is more than two times higher than New York's 1986 statewide reporting rate for child abuse and neglect allegations of 2.1 reports per 100 children. This higher rate, despite acknowledged limitations in institutional reporting practices, confirms the literature's assertion that institutionalized children, and especially mentally disabled institutionalized children, are at high risk for abuse or neglect. (Harrell and Orem, 1980; Navarre, 1983; Hansen, 1983)

* Percentages do not always total 100 percent due to rounding.

Second, the data indicated that reports of abuse and neglect filed by mental health facilities versus mental retardation facilities are characterized more by their differences than their similarities. These differences warrant the careful attention of clinicians and policy makers concerned with prevention and protective services for children with mental disabilities in residential facilities. Our data suggest that everything from the nature of the reported allegations to the location where they occur to their precipitating factors to the age of the alleged victims differed for reports filed by the two classes of facilities.

The data findings also identified certain children who are more likely to be involved in allegations of abuse or neglect. Male children, over 12, who are diagnosed as having a conduct disturbance, clearly presented as a high-risk group. There was also indication that children are much less likely to become involved in an abuse allegation in structured program settings. Correspondingly, the findings pinpointed a need for better training and preparation for male direct care workers, who by design of job assignments, are most likely to assume caregiving responsibilities for high-risk resident groups and high-risk residential settings. This latter implication was reinforced by the finding that nearly 80 percent of the alleged perpetrators had been employed at the facility more than one year.

The findings also indicate variable reporting rates and practices between mental health and mental retardation facilities, as well as among specific types of facilities in each of these subgroups. Many factors, including the characteristics of the residential facilities and the children served, the availability of "self-reporters", and facility reporting procedures and practices, appeared to influence this variation in reporting rates. For example, the increased incidence of aggressive, assaultive behavior among some children served by mental health facilities appeared to influence the higher reporting rates of these facilities. It was also clear that the availability of children as "self-reporters" in mental health facilities influenced their relatively higher reporting rates. Conversely, the inability of many of the children in mental retardation facilities to self-report incidents of abuse or neglect, or perhaps even to comprehend the occurrence of such incidents, eliminated a major reporting source for these facilities.

The variation in reporting rates among facilities was also clearly influenced by reporting procedures and practices. Our site visits indicated that operational definitions for what constituted child abuse and neglect varied among facilities, and even among senior staff in the same facility. It was apparent that the reporting of an incident often depended on which staff persons were on duty, their perception of the seriousness of the complaint, and their immediate assessment as to whether the complaint was credible. Comparison of the types of incidents reported across facilities also indicated that "facility norms" for determining reportable abuse/neglect complaints varied. Some facilities, for example, routinely reported physical abuse complaints which resulted in no injury, while other facilities did not appear to report these incidents.

Finally, one of the most interesting potential correlates to reporting rates appeared to be the availability of a trusted clinician relationship for the child. Our data showed that over 60 percent of the alleged child-victims who were "self-reporters" first told a clinical staff member. This finding reinforces the critical importance of personal clinician-child relationships in residential child care facilities, suggesting that aside from their obvious therapeutic benefits, these relationships may also ensure the most viable channel for the reporting of abuse and neglect complaints. This finding may also have relevance for mental retardation facilities, where such trusted relationships between clinicians and visiting family members may also promote better reporting.

Chapter III
Initial Reporting and Handling of the Incidents

Based on filed documents and in some cases follow-up calls to the facility, Commission staff examined a number of issues associated with the facility's initial reporting and handling of the cases. These issues, which included timeliness and completeness of initial reports, immediate facility efforts to protect the alleged child-victim, early attempts to secure relevant evidence, and required notifications to external parties, can be critical in ensuring the immediate safety and well-being of the child. Ultimately, they may also be essential to the facility's ability to determine the events and circumstances surrounding the allegation, and whether abuse and/or neglect actually occurred. In recognition of the importance of these initial actions both the NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities manuals for special investigators outline specific guidelines related to these issues. (See Figure 6).

Timeliness of Reporting

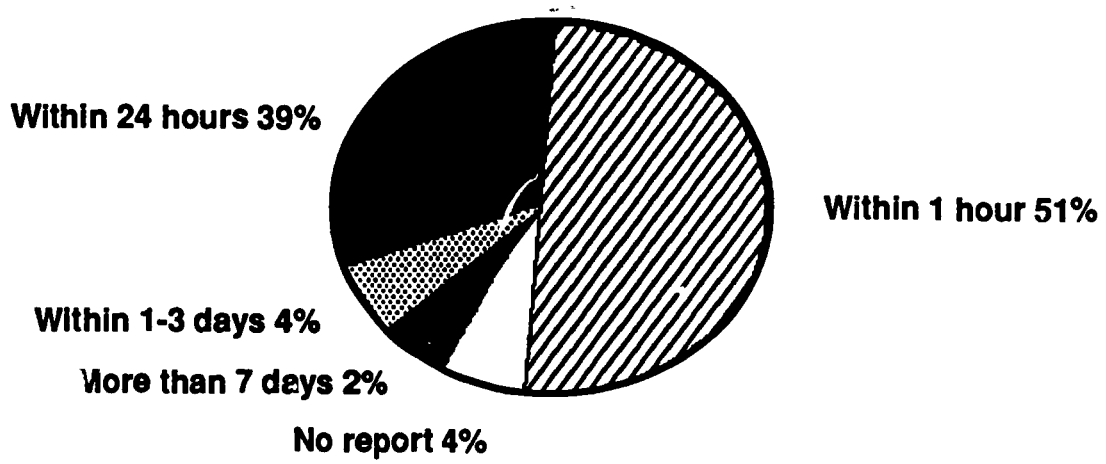
Timely reporting of allegations is dependent both on timely staff awareness of the alleged event and on timely staff documentation of this initial

Figure 6

Guidelines for the Initial Reporting and Handling of Child Abuse and Neglect Allegations

- Written reports of allegations should be prepared as soon as possible, and in all cases by the end of the same shift when the staff becomes aware of them.
- All allegations should be immediately reported to State Central Register for Child Abuse and Neglect.
- The facility should immediately address the needs of alleged child-victime(s) for treatment and protection.
- The facility should ensure a prompt physical exam of the alleged child-victim(s) by a qualified physician in all cases of suspected or actual injury. The facility should ensure that the alleged child-victim's parents or guardian are notified.
- Written reports should be legible and should clearly and accurately present all information known by the reporter.
- Physical exam reports of the alleged victim should adequately document: the general medical condition of the patient/client; the extent of presenting suspected injuries and their probable age and most likely causes; and any physical evidence (i.e., hair, carpet pieces, etc.) found on the trauma site.
- Photographs (color) should be taken of any visible injuries of the alleged child-victim.
- When possible, the immediate scene of the allegation should be promptly secured and investigators should take a photograph and make an accurate sketch of the scene.

Figure 7 Timeliness of Facilities' Abuse/Neglect Reporting



knowledge. In this review, the Commission found delays in one or both of these dimensions of the timeliness of reporting for approximately one-third of the studied cases.

Nearly one fifth (19 percent) of the allegations were not known to a facility staff person until more than 24 hours after the event reportedly occurred. Twelve (12) percent of the allegations did not come to a facility staff person's attention until more than three days after the event reportedly occurred.

In addition, although facility staff were usually conscientious in immediately filing a written report of known allegations, prompt written reports were not filed for 8 of the 80 reviewed cases (10 percent). For three of these cases, written reports were filed one to three days after a facility staff person had knowledge of the allegation, and for two cases, written reports were filed more than one week after a facility staff person had knowledge of the event. For the remaining three cases, a facility report form was never completed. (See Figure 7).

The data also indicated that delayed awareness of the alleged event by a facility staff person was significantly more common among reports filed by mental retardation facilities ($p < .05$). For example, fewer of the allegations filed by mental retardation facilities were known to a facility staff person within one hour of the time the event reportedly occurred (27 percent versus 49 percent). Additionally, while only 6 percent of the reports filed by mental health facilities were unknown to a facility staff person until more than one week after the event reportedly occurred, this was the case for 18 percent of the reports filed by mental retardation facilities. This finding is consistent with the previously cited finding that the location and precipitating events/causes of a higher percentage of the cases filed by mental retardation facilities were unknown. It appeared that a significant percentage of the reported allegations of child abuse and neglect in these facilities came to light some time after they allegedly occurred, and thereby, many of the circumstances surrounding them are unknown and cannot be determined.

Reporting to the State Central Register

The vast majority of the cases (95 percent) were reported, as required by State law, to the State Central Register for Child Abuse and Neglect. For

approximately half of the cases (53 percent), initial oral reports were filed within 24 hours of the facility's awareness of the allegation. Another 23 percent of the allegations were reported to the Register within one to three days of the facility's awareness of the allegation. More than four days elapsed, however, before 17 percent of the allegations were reported to the Register, and four of the allegations were *never* officially reported to the Register.

Follow-up on the four cases not reported to the Register revealed that all of these cases occurred at the same mental health facility. This facility offered a variety of rationales for the failure to report. In two cases, the facility indicated that immediate investigations showed the allegation to be false. In one case, the facility indicated that the immediate investigation clarified that the incident occurred, but that it did not constitute child abuse or neglect. In the fourth case, the facility indicated that the local Department of Social Services was the alleged child-victim's guardian, and that these personnel were notified in lieu of reporting to the Register.

Follow-up questions to facilities which delayed in reporting allegations to the Register indicated similar rationales and, particularly, a common practice that facilities would notify the Register only after an initial investigation indicated some credible evidence of abuse or neglect.

The State Central Register accepted 66 of the 76 filed reports. The 10 rejected cases were reportedly refused by the Register because they did not meet the existing state definition of child abuse.* Eight of these cases involved allegations of physical abuse, where there was no physical injury to the child, and in two cases the child initially making the allegation immediately retracted it.

Whereas the legitimacy of each of these decisions could reasonably be deemed consistent with the then existing state definition of child abuse and neglect, other reports of cases with similar circumstances were accepted by the Register. This apparent inconsistency in Register decisions to accept or reject reports was also noted during Commission field interviews. Many facility staff complained that Register decisions were variable and unpredictable, and that this inconsistency led to administrative confusion in determining when to file a report. This indecision was further fueled, according to facility administrators, by the time-consuming effort involved in getting through on Register phone lines, which were often busy for hours.

Immediate Attention to the Child-Victim

Reviews of the 80 reported cases indicated that facilities took prompt and appropriate actions to address the immediate treatment and protection needs of the alleged child-victims in 90 percent of the cases. The eight exceptional cases included one allegation of sexual abuse involving intercourse and one allegation of physical abuse with a known injury where the alleged child-victims were never examined by a physician; five allegations of physical abuse with a known injury where the child-victims were not examined by a physician until the next day, and one allegation of physical abuse with an injury in need of apparent medical attention where the child-victim was not seen by a physician until more than four hours after the injury was known to staff.

Facility documents were also checked to ascertain whether a physician promptly examined the alleged child-victim in all cases of alleged physical or sexual abuse where a possible injury may have occurred. Data revealed that in only two-thirds (66 percent) of these 72 cases did a physician examine the alleged victim. Filed reports, as well as Commission field visits, revealed that while the majority of facilities followed a standard practice of requiring physician exams for such

* As noted in Chapter I, the definition of child abuse and neglect prior to the implementation of the Child Abuse Prevention Act of 1985 did not reference neglect of basic custodial standards as an indication of child abuse and neglect.

cases, many facilities felt this was an unnecessary step in cases where no significant physical injury was known to staff.

External Notifications

State law and policies also require mental health and mental retardation facilities to notify certain external parties of all cases of alleged child abuse and neglect. These requirements are designed as protective measures for the child and to provide added assurance that the incident and its investigation will be adequately handled by the facility. Such required external notifications include prompt notification of the State Central Register for Child Abuse and Neglect, the alleged child-victim's parent(s) or guardian(s), certain oversight and advocacy bodies, and, in cases where a crime may have been committed, law enforcement officials.

As noted above, the State Central Register was orally notified of 95 percent of the reported cases, and follow-up written reports (DSS Forms 2221-A, 2222, and 2223) were made to the Register for all but eight of the relevant cases (i.e., those not refused upon oral report to the Register). Facilities also assured notification of parents or guardians in 88 percent of the cases. Similarly, state-operated facility administrators promptly notified the facility's lay oversight Board of Visitors in 88 percent of the cases.* Notification of the State's Mental Hygiene Legal Services (MHLS) was slightly less universal (noted in 78 percent of the cases) largely due to widespread ignorance of this requirement by licensed facilities. **

The question of appropriate notification of law enforcement officials was more complex to assess. Whereas state law requires such notification for all cases where there is evidence that a crime may have been committed, operational criteria for making this decision were apparently unclear to many of the reporting facilities.***

In the study's sample of 80 cases, only six cases were reported to law enforcement officials. These cases included three cases of alleged sexual abuse between an employee and a client, two cases of alleged employee neglect whereby deficient supervision may have contributed to sexual abuse of a client by a fellow client, and one case of alleged physical abuse where a police report was filed at the alleged child-victim's insistence.

Five other allegations of sexual abuse by an employee were not reported to the police, and two allegations of physical assault by employees — one where a client was allegedly struck with a rubber hose and another where a client was allegedly struck with a pool cue and tied up — were not reported to the police.

Upon closer scrutiny it was not always easy to identify the rationales facility administrators applied in making their decisions to notify law enforcement. Whereas, some of the above unreported cases appeared to lack credible evidence that a crime may have been committed, several

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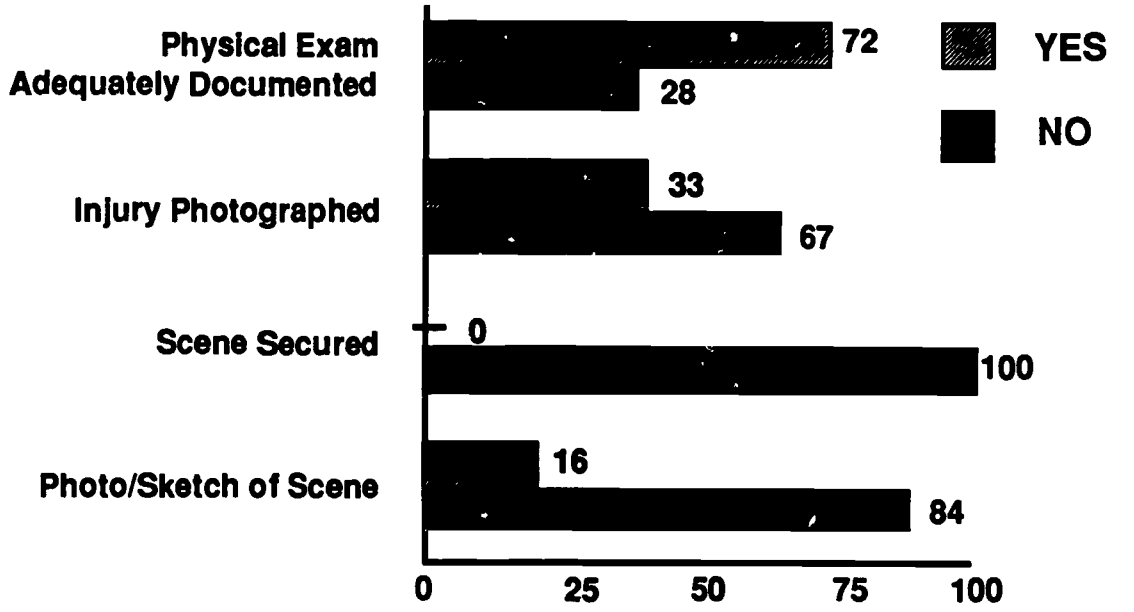
* NYS Mental Hygiene Law provides that all State-operated institutions for the mentally disabled shall have a lay oversight Board of Visitors which is charged to monitor the quality of care at the facility and to assure that unusual events, including allegations of abuse, are adequately investigated. As a part of their statutory responsibilities, Boards of Visitors are required to receive copies of all reports of possible abuse or neglect. (MHL § 7.21(b), § 7.33(h), §13.21(b), §13.33(h))

** Mental Hygiene Legal Services (MHLS) is a State-operated, statutorily created, legal advocacy service for patients/clients in New York State mental health and mental retardation facilities. Among their other statutory responsibilities, MHLS has the authority to investigate any allegation of abuse or neglect, and the requirement to receive reports of such allegations from mental hygiene facilities. In practice, State-operated facilities have been the most universally compliant with this reporting requirement. (MHL § 7.21(b) and § 47.03(e))

*** *Patient Abuse and Mistreatment in Psychiatric Centers: A Policy for Reporting Apparent Crimes to and Response by Law Enforcement Agencies*, NYS Commission on Quality of Care for the Mentally Disabled, 1985. *In the Matter of Lisa Cohen: The Need for a Policy in the Developmental Disabilities Service System for Reporting Apparent Crimes to Law Enforcement*, NYS Commission on Quality of Care for the Mentally Disabled, 1987.

Figure 8 Initial Investigation Flaws (Percent of Applicable Cases)



"reported" cases also appeared to have only meager credible evidence. Most critically, in four unreported cases, there appeared to be considerable evidence that the alleged event did occur, and that it may have constituted a crime.

Field interviews further substantiated that conflicting criteria were used by facility administrators in determining if police should be notified. Some facilities reportedly took a conservative approach of notifying police of all sexual abuse allegations and all physical abuse allegations resulting in a significant injury, regardless of the preliminary evidence. Others essentially pursued their investigations first, and if enough evidence surfaced to charge the employee, then police were notified. Some notified police in cases alleging sexual intercourse, but not in cases alleging sexual fondling.

In addition, facility rationales for these decisions were often not based, as required by law, on the availability of evidence that "a crime may have been committed," but on whether facility administrators believed their local law enforcement officials would respond. Many facility administrators reported that police were reluctant to respond. This opinion was confirmed by the study's finding that police did not respond in two of the six "reported" sample cases. Both of these cases involved sexual fondling, and according to facility staff, police respond only for sexual abuse allegations involving intercourse.

Initial Investigatory Steps

Certain initial investigatory steps taken shortly after an allegation becomes known can be critical to an adequate investigation. These steps include among others: an accurate initial written report of the allegation; a comprehensive and clear physician exam report, and securing and/or sketching or photographing the scene of the incident. As noted below, Commission reviews of the reported cases revealed many deficiencies in these important initial investigatory steps. (See Figure 8)

Quality of Reports

Whereas delays in facility knowledge or reporting of the allegations were noted in approximately one-third of the sample cases, in almost half of the cases filed reports were incomplete or contained obvious inaccuracies. Forty-eight (48) percent of the reports lacked essential known information (e.g., sex, age of child-victim) or contained obvious inaccuracies of known information (e.g., wrong location, conflicting times/dates of the alleged event, incomplete reports of who witnessed the allegations). It was also not uncommon

for the information on the facility's internal report form to conflict with information provided on the State Central Register report form (DSS Form 2221-A).

Comprehensive Physical Exam Reports

In 28 percent of the 58 cases* where a physical exam of the alleged child-victim had been conducted by a physician or a nurse, the physical exam report failed to describe the injury or injuries fully or neglected to comment upon the probable age or cause of the injury.** In addition, among the 27 cases where there was a visible physical injury upon a physical exam, only in 9 cases (33 percent) did the facility assure that a photo was taken of the injury. For 14 of the 23 cases filed by mental health facilities (61 percent of the relevant cases), and for *all* four of the relevant cases filed by mental retardation facilities, no photo of visible injuries was taken.

Securing, Sketching, and/or Photographing the Scene

While late reporting, missing information as to the location of the alleged event, and/or other circumstances made immediately securing the scene of the alleged event either impossible or irrelevant in 59 of the reported cases, in all 21 cases where the scene of the incident was immediately known and may have provided some clues in the investigation of the allegation, it was not secured. It was apparent, based on the data as well as information obtained during Commission field visits, that the reporting facilities did not recognize that immediately securing the scene was an important initial investigatory step.

Facilities also rarely took a photograph of the scene of the incident or reconstructed the scene with a sketch based on witnesses' accounts. Such steps were taken only in regard to seven reports, including six reports filed by mental health facilities and one report filed by a mental retardation facility. As with immediately securing the scene of the incident, it was apparent from the data and the facility site visits that most facilities did not view this investigatory guideline as important.

Summary

In summary, while the majority of the sample cases were initially reported and handled appropriately, specific problems plagued a sizeable minority of the cases studied. These problems ranged from the delayed knowledge or reporting of the allegations to the failure to provide timely physical exams and/or medical treatment for the alleged victim, to poorly documented incident and physical exam reports. The case reviews also revealed that nearly all facilities were lax in taking steps to obtain immediately available evidence, including taking photographs of visible injuries of the alleged child-victim and securing and/or photographing/sketching the scene of the incident.

In addition to these problems, the data suggested that State Register operators used variable criteria in "refusing to accept" reports, and that facility administrators used variable criteria in determining whether police should be notified. Finally, although other external notification were usually promptly made, it was noteworthy that for 12 percent of the relevant cases parents or guardians and the lay oversight Boards of Visitors were not notified, and that for 22 percent of the cases the Mental Hygiene Legal Service was not notified.

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* As noted above, physical exams were conducted by physicians in only two-thirds of the 72 cases (47 cases) alleging physical or sexual abuse. In an additional 10 cases, there was documentation that the alleged child-victim had been examined by a nurse.

** Recognizing that physicians and nurses are often not able to specify the age or likely cause of injury, criteria for the review required only that the physician/nurse reference these issues, if only to note that they were not determinable.

Together, these weaknesses have significant implications. The number of cases where the alleged child-victim was not afforded a medical exam may have diminished the capacity of the facility to evaluate and adequately provide for the alleged child-victim's treatment and protection needs. Valuable evidence may also have been lost in this oversight. Similarly, the late reporting of allegations, the poor quality of initial incident reports and physical exam reports, and the typical failure of facility investigators to secure, sketch, or photograph the scene of the incident got many of these investigations off to a poor start. Finally, systemic problems and confusion surrounding external notifications to the State Central Register and law enforcement officials suggest that these safety nets to ensure adequate child protection and follow-up on these complaints were not always properly in place.

Chapter IV
Investigations of the Allegations

Assessments of the investigations of the reported allegations were based on criteria set forth in NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities manuals for special investigators. These manuals were designed as comprehensive training handbooks for facility staff who are assigned responsibilities to investigate serious incidents, including allegations of abuse and neglect. Although there are minor differences in the two manuals, they are congruent in their articulation of the key investigation criteria used in this review. (See Figure 9). These key criteria are also consistent with the themes of the emerging literature on investigations of allegations of child abuse and neglect.

Prompt Initiation of Formal Investigations

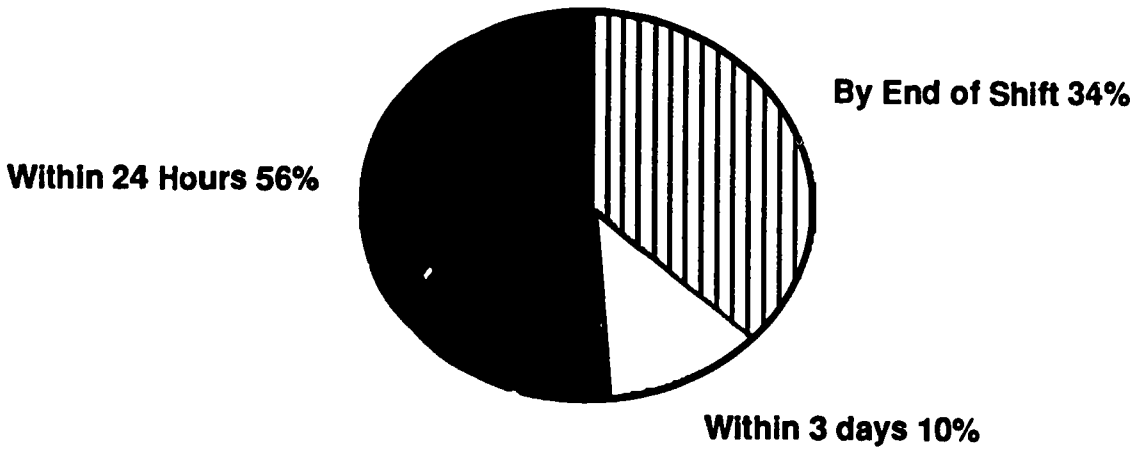
As noted above, investigations of approximately one-fifth of the studied allegations were initially hampered by the facility's delayed awareness of the incident (i.e., more than 24 hours after it allegedly occurred). Yet, even once facility staff became aware of the allegations, investigations often were not promptly initiated. (See Figure 10). For only 27 of the 80 allegations (34 percent) did the reporting facility initiate its investigation by the end of same shift when it became aware of the incident. While investigations for 45 of the remaining incidents (56 percent) were initiated within 24 hours, for eight

Figure 9

Guidelines for Conducting Investigations of Serious Incidents

- Investigations should begin promptly, and in all cases by the end of the shift when the incident occurred.
- Investigations should include interviews with all relevant employees, patients/clients, and other witnesses or informants.
- All interviews with witnesses and other informants should be documented in accordance with stated guidelines.
- The alleged-victim should be interviewed whenever possible, and such interviews should be documented in accordance with stated guidelines.
- The alleged-perpetrator should be interviewed (after he/she has been notified of any union contract rights), and such interviews should be documented in accordance with stated guidelines.
- In all cases where patient/client testimony is gathered the investigator should take steps, by interviewing relevant clinical staff and reviewing the patient's/client's clinical record, to make an assessment of the credibility of the patient/client.
- The investigator should formally review the work history/job performance of alleged perpetrators by reviewing personnel files and interviewing immediate supervisors.
- Written investigation reports should be prepared summarizing investigative steps taken, the circumstances of the incident, findings of fact, and the investigator's conclusion. Written witness statements and all other relevant documents should be included as attachments.

Figure 10 Timeliness of Facilities' Investigation



incidents (10 percent) investigations were not initiated until one to three days after facility staff first became aware of the allegation.

Field interviews, as well as follow-up calls to many facilities, indicated that it was common practice for a number of hours to lapse before even initial investigatory steps took place. In particular, it was apparent that the start of investigations for allegations which occurred during the evening or night shifts (i.e., 3:00 PM - 11:00 PM and 11:00 PM - 7:00 AM) were usually delayed until the day shift, and often until several hours after day shift staff reported for work. This delay often resulted in an inherent delay of at least 24 hours in interviewing relevant evening or night shift staff who had gone off-duty, and sometimes, due to staff "pass days," resulted in delays of more than two days in conducting these interviews. Relatedly, the investigations of allegations reported on weekends were usually postponed until Monday.

Availability of Eye Witnesses

An important dimension of an investigation of any event is the availability of eye witnesses. Witnesses are especially critical to the investigations of allegations of child abuse and neglect because their testimony is often crucial in clarifying conflicting testimonies of the alleged child-victim and the alleged perpetrator.

The data showed that for many of the studied allegations such eye-witnesses were unavailable. However, slightly more than half (51 percent) of the alleged events were witnessed by an employee other than the alleged perpetrator, and 38 percent were witnessed by a patient/client other than the alleged child-victim. Notably, while comparable percentages of the allegations filed by mental health and mental retardation facilities were witnessed by at least one employee other than the alleged perpetrator (51 percent and 55 percent, respectively), *none* of the allegations filed by mental retardation facilities were reportedly witnessed by clients, other than the alleged child-victim.

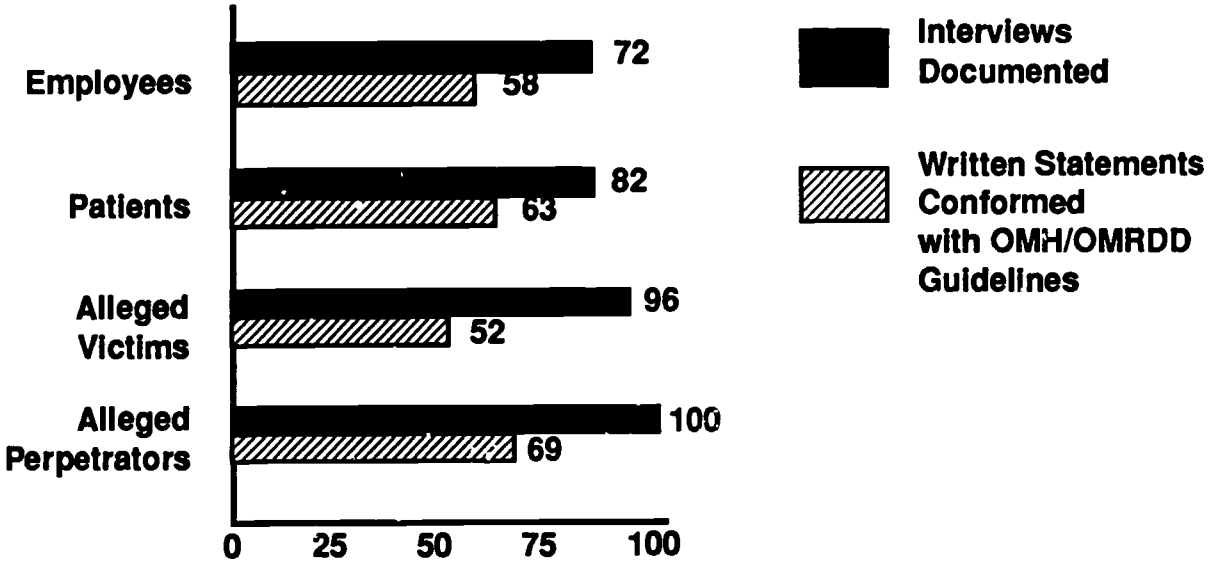
Perhaps most interesting, analysis of witnesses statements and accounts* indicated that in most cases witnesses did not corroborate the substance of the allegation as reported. Of the 41 reported incidents witnessed by other employees, only in six cases did *all* employee witnesses generally corroborate the allegation. In two other cases,

* As clarified in the next section, written witnessed statements were not always prepared. In these cases, witness accounts were usually summarized in the facility's final investigation report or closing summary on the incident.

Figure 11

Witnesses Interviewed and Statements Documented Appropriately

(Percent of Applicable Cases)



some, but not all employee witnesses generally corroborated the allegation. While the data showed that patient/client witnesses were more likely to corroborate the allegation, these witnesses did *not* corroborate the allegation as reported in 16 of the 30 relevant cases. *All* patient/client witnesses generally corroborated the substance of the allegation in only 6 of the 30 relevant cases. *Some, but not all* patient/client witnesses corroborated the allegation in 8 of the 30 relevant cases.

Interviews Conducted with Witnesses and Other Relevant Persons

Commission reviewers also sought to determine if the facility had conducted interviews with all witnesses to the alleged event, as well as all other relevant persons with possible knowledge of it (i.e., staff, patients/clients, and others in the immediate area or to whom the event was reported). This assessment was circumscribed by Commission knowledge of such available witnesses and informants as reported by the facility. Even within this constraint, however, the review revealed a number of cases where all known witnesses and other relevant informants were not interviewed, and more cases where written statements of such interviews were inadequate, or not available at all. (See Figure 11).

Among the 68 cases where filed documents revealed employee eye-witnesses to the event, employees in the immediate vicinity of the event, or other employees with knowledge of the event, all such employees were not interviewed in 28 percent of the cases. Among the 38 cases where filed documents referenced relevant patient/client witnesses or informants, all such patients/clients were not interviewed in 18 percent of the cases.*

Further study of the filed investigation reports indicated that in 6 of the 56 reports where employee witnesses/informants were interviewed, written statements were not prepared, and in 1 of

* Determination of relevant patient/client witnesses and informants was hampered by the failure of many reports to reference the presence of other patients/clients in the immediate vicinity. Specifically, whereas 37 of the reports referenced relevant employee informants who were not eye-witnesses, only eight of the reports referenced relevant patient/client informants who were not eye-witnesses.

the 31 reports where patients/clients witnesses/informants were interviewed, written statements were not prepared. More critically, among the 50 reports where written statements of employee interviews were prepared, these statements failed to meet one or more important criteria stated in OMH or OMRDD guidelines in 42 percent of the cases. Similarly, among the 30 reports where written statements of patient/client interviews were prepared, these statements failed to meet one or more important criteria stated in OMH or OMRDD guidelines in 37 percent of the cases. (See Figure 12 for a listing of OMH/OMRDD guidelines for written witness statements.)

The most common deficiency noted in the written statements was the critical one of failing to ensure that the interviewee and/or the interviewer signed the statement. Another common deficiency across both employee and patient/client interview statements was the failure to date the statement. Many statements also failed to comply with several of the more technical guidelines, like preparing statements from the first persons perspective or using the language and vocabulary of the interviewee. Often statements were simply investigator summaries of what he/she learned from the interview, and it was unclear whether the interviewee ever reviewed the statement at all.

One additional deficiency common to investigators' documentation of patient/client interviews was the failure to reference elsewhere in their investigation report an assessment of the patient's/client's credibility. Despite OMH and OMRDD guidelines specifying the importance of these assessments and their documentation, in only 9 of the 31 relevant cases did investigation reports or other attached documents make reference to this critical issue.

Interviews with the Alleged Child-Victim

In 68 of the 80 filed reports, documentation indicated that it was possible to interview the alleged child-victim. In 10 of the 11 reports filed by mental retardation facilities, however, filed documents indicated that the level of retardation and/or other disabilities of the alleged child-victim precluded such interviews.

In the vast majority of the relevant cases (96 percent), the alleged child-victim was interviewed in the course of the investigation. Written interview statements were prepared, however, in only 71 percent of the cases where the alleged child-victim was interviewed, and only in 52 percent of these cases did the prepared statements comply with established OMH/OMRDD guide-

Figure 12

Guidelines for Documenting Witness Statements

- Statements should be prepared promptly at the conclusion of an interview.
- Statements should be typewritten or handwritten in ink.
- Statements should preferably be written in the language and vocabulary of the interviewee.
- Statements should be written in the first-person perspective.
- Statements should be signed, noting the date and time, by the interviewee. In the case of a multi-paged document, interviewees should sign the bottom of each page.
- Statements should be signed and dated by the interviewer (investigator), as a witness.
- If statements are changed after completion, the interviewee should date and initial each change.

lines. Deficiencies noted in child-victim written statements were similar to those noted above for other witness/informant statements. Investigation reports and other filed documents also indicated that the alleged child-victim's credibility was frequently not referenced. In only 25 of the 68 relevant reports (36 percent) did the filed documents indicate that any review of the alleged child-victim's clinical record had been conducted. And, in only 14 of the 68 reports (21 percent) was there any documentation in the record regarding the alleged child-victim's credibility.

The above finding suggests an apparent standard practice of investigators, also noted in relation to the testimony of other patient/client witnesses and informants, not to explore the credibility of this testimony. Field site visits suggested that many investigators and senior facility staff believed that testimony of alleged child-victims and other patients/clients would not be valued as credible or reliable by their superiors and/or ultimately by labor-arbitrators.

This belief, which was often supported by facility staff's prior experiences with other cases, appeared to have a direct impact on investigators' diligence in evaluating patient/client testimony. This oversight was particularly disappointing in view of the fact that for almost half of the allegations (39 of the 80 cases) patients/clients, including the alleged victims, were the only source of direct information about the reported event, other than the alleged perpetrator.

Interviews with the Alleged Perpetrator

Filed documents indicated that in all of the 75 reported cases where an alleged perpetrator was identified, he/she was interviewed. Like investigator interviews with other categories of individuals, however, these interviews were sometimes not documented (17 of the 75 reports), and even when documented written statements often did not conform with established OMH/OMRDD guidelines (18 of the 58 cases where written statements were taken). The most commonly noted deficiencies in written statements of interviews with alleged perpetrators included no signature of the interviewee and/or the interviewer and no date on the statement.

For all cases where an alleged perpetrator was identified, reviewers also checked filed documents and made follow-up calls to facilities to clarify whether the facilities had in the course of their investigations reviewed the personnel files and/or interviewed the supervisors of the alleged perpetrators. This assessment revealed that investigators reviewed personnel files in only 38 percent of the relevant cases, including 25 of the 65 relevant reports filed by mental health facilities (38 percent) and 5 of the 10 relevant reports filed by mental retardation facilities (50 percent). Similar findings were noted regarding the conduct of interviews with the immediate supervisors of the alleged perpetrators. Such interviews were conducted in only 34 percent of the relevant cases, including 22 of the 65 relevant cases filed by mental health facilities (34 percent) and 6 of the 10 relevant cases filed by mental retardation facilities (60 percent).

Follow-up with facilities confirmed that it was common practice for investigators not to conduct formal reviews of alleged perpetrators' personnel files or to interview their supervisors in cases of suspected child abuse or neglect. This oversight appeared, in part, to reflect the relatively small size of most reporting facilities (less than 50 children residents), and the investigators' perceptions that significant events in alleged perpetrators' work histories and job performance would be well-known and, therefore, not require a formal review to uncover.

Nonetheless, it was significant that prior performance of alleged perpetrators — or even their tenure at the facility — were not documented in facility investigation reports or other filed documents for nearly two-thirds of the cases. For many cases, it appeared that only the immediate actions/performance of the alleged perpetrators were considered in the investigation, and that most investigators stopped short of considering

Figure 13

Guidelines for Written Investigation Reports

- Reports should present an overview of the incident, including a succinct statement of the "who, what, when, and where."
- Reports should provide a summary of available evidence, broken into three categories — medical, other physical evidence, and witness accounts.
- Reports should include the investigator's analysis of the evidence and point out its strengths and weaknesses.
- Reports should advise facility management on what happened and how it occurred.
- Reports should provide a basis for facility management decisions and actions, both interim and long-term.
- Reports should be prepared, signed, and dated by the investigator.
- Witness statements, and all other relevant documents should be included as attachments to the report.

whether prior events or incidents involving the alleged perpetrator may have shed additional light on the case.

Preparation and Quality of Investigative Reports

The Commission's assessment also included whether a written investigation report was filed, whether this report generally conformed to OMH/OMRDD guidelines, and whether there was documentation that the facility director and the facility's incident review committee had reviewed the report.* (See Figure 13 for a listing of OMH/OMRDD guidelines for final investigation reports).

The data revealed that written investigation reports were prepared by the reporting facility (or the respective OMH/OMRDD Regional or District Office) in 80 percent of the studied allegations. (See Figure 14). The nature, scope, and format of these reports varied widely, however. Some were extremely comprehensive and included numerous attachments delineating investigator activities and clear statements of his/her findings and conclusions. Others were very brief, informal narratives.

Overall, 39 of the 64 prepared investigation reports (61 percent) substantially complied with OMH/OMRDD guidelines for these reports. The remaining 25 reports often included only a brief summary of the investigator's major findings and conclusions and usually did not provide an overview description of the circumstances surrounding the allegation, a summary of the investigative steps taken, and/or a specific listing of the evidence gathered or the findings of fact. In the worst cases, no separate final investigation report, per se, was prepared, and the brief summary on the DSS reporting form (DSS Form 2223) was the only facility documentation of its investigation.

The facility director's review of the final investigation report was often difficult to ascertain. Although facility administrative staff generally indicated that this was routine practice, in 13 of the 64 cases where a final investigation report was

* Part 24 of the NYS Code of Rules and Regulations for mental hygiene facilities requires that all serious incidents be reviewed by the facility director and a committee of relevant persons.

prepared, documentation — even in the form of a transmittal letter or memo — was not available to indicate that the director had reviewed the report.

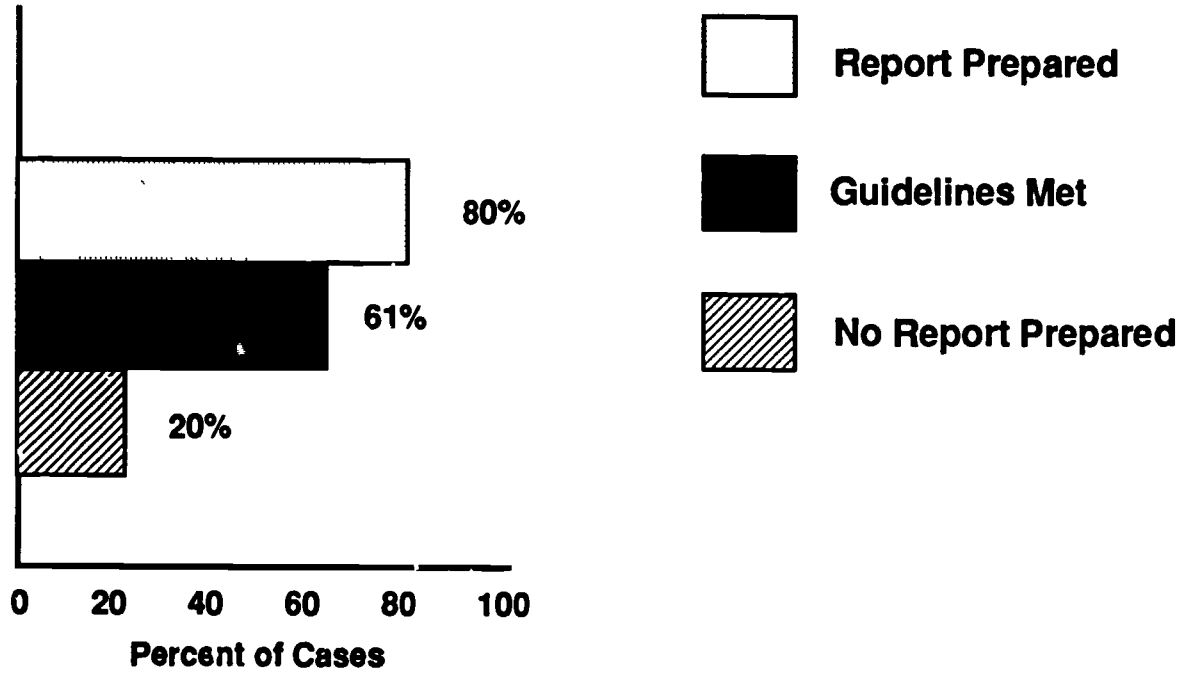
Similarly, it was not generally possible to determine, based on the filed documents, whether the facility's incident review committee had reviewed the final investigation report. Other documentation did indicate, however, that in 68 of the 80 cases, these committees did discuss the incident itself. Follow-up calls indicated that of the 12 cases remaining, nine cases were not reviewed by incident review committees and three cases were still pending review by these committees, more than 120 days after the incident reportedly occurred. Facilities generally did not offer explanations as to why selected incidents were not reviewed by incident review committees, although in one case, a facility reported that the allegation was unfounded, and that only founded abuse/neglect allegations were referred to the review committee.

Notably, whereas final investigation reports filed by mental health and mental retardation facilities were not generally differentiated in their quality, there was a general trend for reports prepared by State-operated facilities to be of higher quality than reports filed by licensed programs. In part, this finding reflects the better training programs in State facilities for the preparation of investigation reports. In addition, the State-operated facilities represented in the study's sample were also the larger facilities, and larger facilities are more likely to be able to easily assign dedicated staff time to the preparation of these reports.

Summary

These findings clarify the inherent difficulties facilities encountered in investigating many of the reported child abuse and neglect allegations. Nearly one fifth of the allegations did not come to the facility's attention until more than 24 hours after the event reportedly occurred, and thus "fresh" information of what had occurred was unavailable. In addition, only about half of the reported allegations (51 percent) were witnessed by employees other than the alleged perpetrator, and only 38 percent were witnessed by patients/clients other than the alleged victim.

Figure 14 **Quality of Formal Investigation Reports**



Further, even among those cases which were witnessed by others, there was often ambiguity or conflict in the perceptions and/or reports of what actually occurred. Specifically, whereas witnesses often concurred that the specific event occurred, they often gave different or differing reports as to the amount of force or physical contact exercised by the alleged perpetrator or the specific behaviors of the alleged child-victim which precipitated and/or shaped the staff person's intervention.

It was also apparent from reading reports and talking with facility staff that these incidents were frequently quick interactions, surrounded by considerable turmoil. These circumstances clearly could affect witnesses' recollections of events, especially in the many cases where witnesses were not interviewed until many hours or several days after the event occurred. Finally, it is impossible to overlook the impact of certain intrinsic features of institutional cultures — the code of silence among employees and the fear of retribution among patients/clients — in shaping the testimony of witnesses and other potential informants in these cases.

Compounding these inherent problems, however, were the poor investigation practices noted in many of the studied cases. For example, in approximately two-thirds of the cases, investigations were not promptly initiated once the facility had knowledge of the allegations, and in 10 percent of the cases these delays in initiating investigations extended until one to three days after the allegation was reported. In more than one-fourth of the cases, all employee witnesses and informants were not interviewed, and in nearly one-fifth of the cases interviews were not conducted with all patient/client witnesses and informants. In addition, written witness statements, including statements of alleged child-victims and alleged perpetrators were not prepared for approximately one-fourth of the cases, and even when these statements were prepared they frequently lacked essential conformance to stated guidelines, including failure to have the interviewee sign and date the statement. In at least two-thirds of the cases, investigators did not document their assessments of the credibility of patient/client testimony and did not formally review the work histories or work performance of alleged perpetrators.

Finally, and perhaps not surprisingly in view of the informality associated with many of the investigations, formal investigation reports were not filed at all for 20 percent of the cases, and for 39 percent of the cases where investigation reports were filed, these reports failed to meet essential OMH or OMRDD guidelines for these reports. Many of these reports were only summaries of the investigator's conclusions, with no information about investigative steps taken or the evidence which was evaluated.

In sum, it is clear that these investigations presented many difficulties to the reporting facilities. At the same time, review of the actual investigative steps taken raised many questions about the thoroughness of facility efforts, and particularly the degree to which many facilities took all available steps to uncover and/or to evaluate objectively all the circumstances and evidence relevant to the allegations.

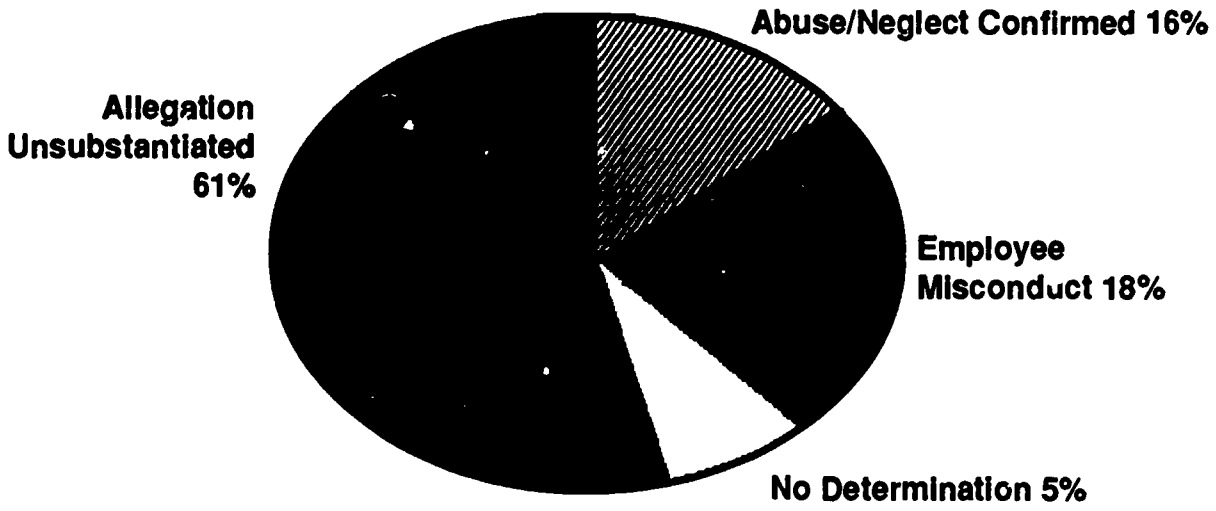
Chapter V
Case Disposition and Outcomes

A last step in the Commission's review examined the final dispositions of the reported allegations and the corrective and employee disciplinary actions taken in association with them. Commission staff also sought to determine whether certain circumstances and characteristics of the reported allegations, and/or compliance or non-compliance with specific guidelines in their investigation, were significantly related to the ultimate disposition of the cases.

Case Disposition

Facility investigation reports indicated that employee abuse or neglect or other employee misconduct was sustained for 34 percent of the reported allegations. (See Figure 15). Employee abuse or neglect was sustained in 16 percent of the reported allegations, including 12 of the 69 reports filed by mental health facilities (17 percent) and 1 of the 11 reports filed by mental retardation facilities (9 percent). Employee misconduct*, but *not* abuse or neglect, was sustained in another 18 percent of the cases, including 12 of the 69 reports filed by mental health facilities (17 percent) and 2 of the 11 reports filed by mental retardation facilities (18 percent). For 4 of the 80 reports facility investigations were closed with a conclusion that it was not possible to make a judgment on case disposition. These "undetermined" cases included 3 of the 69 reports filed by mental health facilities (4 percent) and 1 of the 11 reports filed by mental retardation facilities (9 percent).

Figure 15 **Facility Investigation Findings**



* For the purposes of the review a finding of employee misconduct included any specific reference in the facility report indicating that the employee had violated known facility policies or procedures, not complied with specific job performance standards, or used poor judgment in handling an aggressive situation with a client.

For 12 of the 13 cases where facility investigations sustained abuse or neglect, the cases were also filed as "indicated" cases to the Register. The one outstanding case was listed on the Register as "undetermined" because the facility had not filed a determination report. Upon follow-up, it was discovered that despite the facility administrator's conclusion that there was credible evidence that the alleged abuse had occurred, this mental health facility had simply forgotten to file the requisite form.*

The Commission's review also sought to determine the length of time between a facility's awareness of an allegation, and the facility's determination of the case disposition. This analysis indicated that 52 of the 80 cases (65 percent) were closed within 30 days; that 24 of the 80 cases (30 percent) were closed within 30 to 90 days; and that 3 cases (4 percent) required more than 90 days to close. Further, only approximately one-fourth of the cases (26 percent) were closed within one week's time.

Review of filed documents, as well as follow-up interviews with facility staff indicated that these cases generally consume considerable staff time, and that delays in interviewing witnesses are not uncommon due to employee pass days, leaves, etc. In addition, in a number of cases it was apparent that the facility had substantively completed its investigation several weeks before formal case closure. Formal closure of these cases had been delayed pending the completion of written investigation reports, other associated paperwork, or final review by the facility's incident review committee.

Corrective and/or Disciplinary Actions

Further analysis of 80 reports indicated that while employee abuse, neglect, or other misconduct was sustained for 34 percent of allegations, corrective and/or disciplinary actions were implemented in over two thirds of the cases, affirming the quality assurance value of reporting all such allegations in institutional settings.**

The facility reportedly took some corrective action, either in regard to the alleged child-victim, the alleged perpetrator, or overall facility administrative or supervisory procedures in 52 of the 80 studied cases (66 percent), and in many of these cases two or more actions were taken. (See Figure 16). These cases included 68 percent of the reports filed by mental health facilities and 54 percent of the reports filed by mental retardation facilities.

Commonly taken corrective actions, cited in at least 10 percent of the filed reports, included:

- Verbal counseling of the alleged perpetrator (25 percent of the reports);
- Training or re-training of the alleged perpetrator (23 percent of the reports);
- Counseling of the alleged child-victim (21 percent of the reports);
- Closer observation of the alleged child-victim (11 percent of the reports); and
- The establishment of a new facility procedure or policy (11 percent of the reports).

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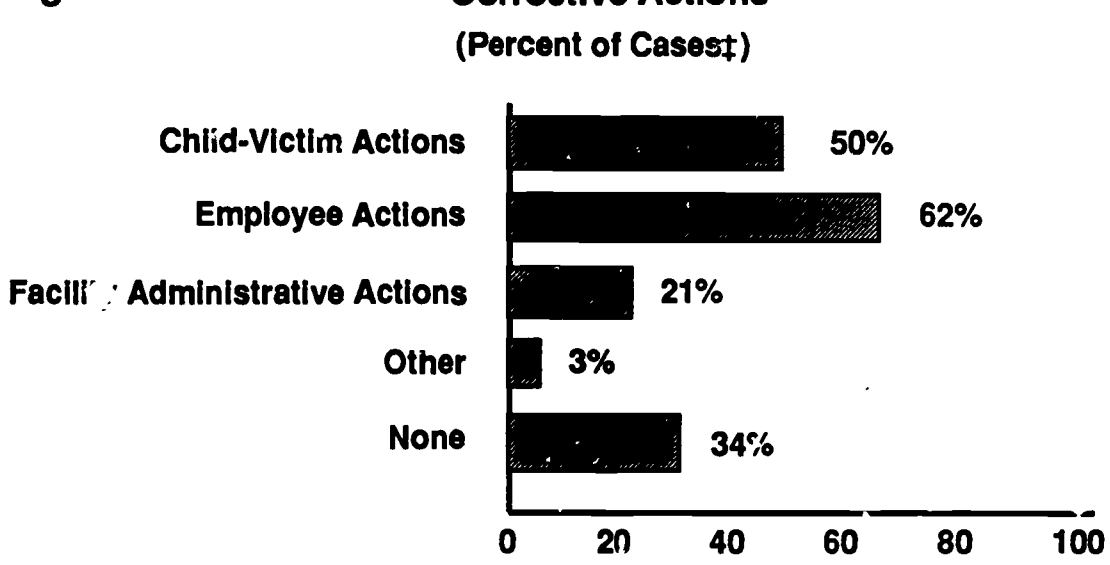
* Upon follow-up by the Commission, the facility did ultimately submit documentation to the Register that this case was indicated in April 1987, approximately 12 months after the facility had closed its own investigation of the case.

** Whereas filed facility documents at the time of case closure generally indicated "recommended" actions, follow-up calls to reporting facilities approximately six to eight months after case closure sought to determine whether the action was actually taken. It should be emphasized that reportedly implemented corrective or disciplinary actions were *not* verified by Commission staff.

Figure 16



‡ Percent exceeds 100% because more than one corrective action was taken in many cases

More drastic corrective actions related to alleged victims or perpetrators were less frequently taken by the facilities. For example, the alleged child-victim's treatment plan was revised in only 4 percent of the cases, and he/she was transferred to another living unit or facility in only 5 percent of the cases. Similarly, written (as opposed to verbal) counseling of the alleged perpetrator was a cited corrective action in only 6 percent of the cases. Facilities also relatively infrequently undertook major organizational or operational changes in response to the allegations, such as revision of patient/client placement procedures, changes in supervisory practices, or changes in staff schedules (6 percent of the reports).

When cases where corrective action was taken were compared with those where such action was not taken, few significant relationships were observed. Two of these relationships were, however, particularly noteworthy. First, corrective action was taken in all cases which involved an alleged perpetrator who had worked at the facility less than one year. Among cases involving longer tenured employees, such action was significantly less common (66 percent versus 100 percent, $p<.05$). Second, the data showed that corrective actions were significantly more common among those cases reported by licensed versus state-operated facilities (91 percent versus 56 percent, $p<.05$).

Employee disciplinary action was taken in regard to 15 of the reported cases, including 10 of the 13 cases where abuse or neglect was sustained upon facility investigation*, and 4 of the 14 cases where the facility concluded that other employee misconduct occurred. All but one of these cases were reported by mental health facilities.

A total of 18 specific types of disciplinary action taken in association with these 15 cases.** These actions included: formal written reprimands (4 cases), suspensions without pay (4 cases); loss of accrued leave credits (1 case);

* Among the remaining three cases where abuse or neglect was sustained, in two cases the alleged perpetrator received a written counseling memo, and in one case he was verbally counseled. (N B. The NYS OMH and OMRDD consider written counseling a step in progressive supervision. WRI en reprimands also differentiated from these counseling memos and constitute one of the least serious disciplinary actions.

** In 2 of the 15 cases more than one specific disciplinary action was taken.

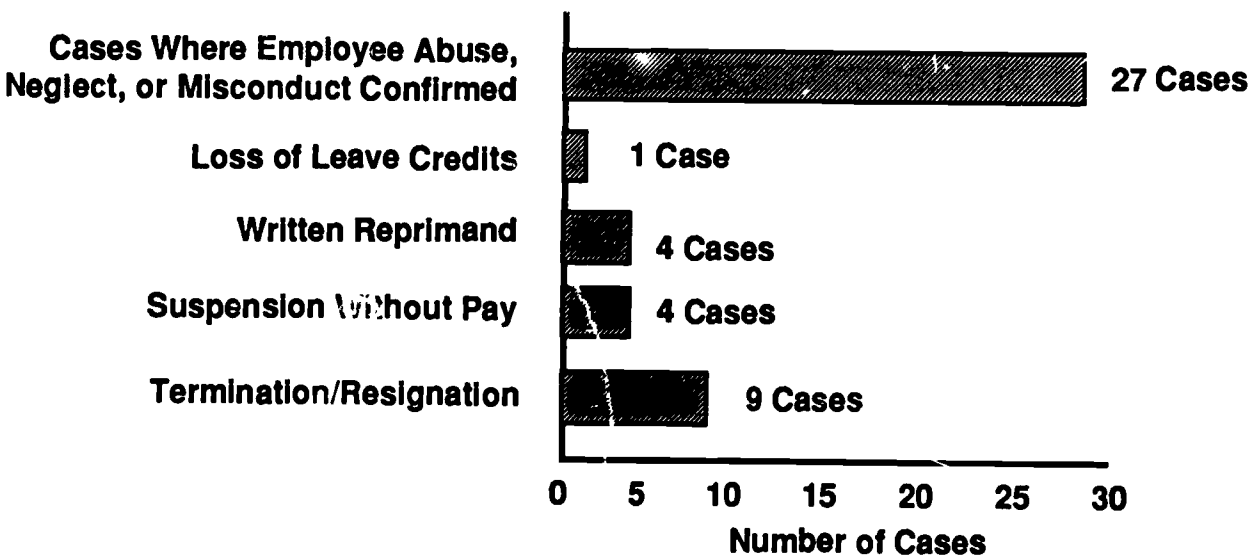
and terminations or requested resignations (9 cases). (See Figure 17). Also of interest was the finding that in all of the nine cases where employees left their jobs, as a result of the allegation, this outcome was reached without any formal labor-arbitration process. Three of these cases involved employees who, when asked to resign, voluntarily acceded to the request. Two additional cases involved employees of voluntary agency licensed facilities which had no formal labor arbitration process for such cases. Among the four cases reported by state-operated facilities, two involved probationary employees (who do not have grievance rights), and in two cases the employee chose not to grieve the case.

Relationship of Case Disposition to Other Variables Examined

Other interesting findings surfaced as case disposition data was related to other variables examined in the review. In conducting this analysis all reported cases were segregated into two subgroups: cases where employee abuse, neglect, or misconduct was determined upon facility investigation to have occurred, and cases where the facility investigation determined the allegation to be unfounded or where the investigation concluded with a finding of "undetermined." Of the 80 reported allegations, 27 cases fell in the former "founded" subgroup, and 53 fell in the latter "unfounded or undetermined" subgroup.

The analyses showed no significant differences between the two subgroups of cases in terms of the nature of the allegations (e.g., type of abuse, extent of injury, etc.), many of the variables describing the circumstances surrounding the allegations (e.g., location, availability of witnesses etc.), or the demographic characteristics of the alleged child-victim (e.g., age, sex, race, diagnosis etc.). In contrast, however, the two subgroups did differ significantly in terms of certain alleged perpetrator characteristics. Specifically, although female alleged perpetrators were generally underrepresented in the sample (22% of the studied perpetrators), the analysis showed that a higher percentage of the cases involving female versus male alleged perpetrators were founded (59 percent versus 28 percent, $p<.05$). Similarly, whereas only 21 percent of all alleged perpetrators had worked at the facility less than one year, the data showed that a higher percentage of the cases involving these shorter-tenured versus longer-tenured employees were founded (88 percent versus 30 percent, $p<.05$). Somewhat more predictably, cases where the initial documentation of the incident cited employee inappropriate

Figure 17 **Employee Disciplinary Actions**



behavior as a cause or partial cause of the incident were more likely to be founded (85 percent of these cases versus 15 percent of all other cases, p<.05).

Data analysis further showed a significant relationship between reporting facility-type and case disposition (p<.05). Whereas case disposition did not differ significantly for cases reported by mental retardation facilities versus those reported by mental health facilities, the data did show that cases filed by licensed facilities were more likely to be sustained than those filed by state-operated facilities (57 percent versus 23 percent, p<.05).

As could be predicted, eye witness corroboration of the allegation was also significantly associated with a facility finding of employee abuse, neglect, or misconduct (p<.05). For example, 83 percent of the cases where all employee witnesses corroborated the allegation were sustained, whereas only 28 percent of the allegations where such employee witness corroboration was not available were sustained by the facility. Similarly, a significantly higher percentage of the allegations where patient/client witness corroboration was available were sustained (83 percent versus 28 percent, p<.05).

The analysis also indicated significant differences between the two subgroups of cases on some variables assessing the thoroughness of the facility's investigation. Paradoxically, the data showed an inverse relationship between conduct of a physical exam and case substantiation as employee abuse, neglect, or misconduct (p<.05). Whereas 26 percent of the cases where a physical exam was conducted were founded, 47 percent of the cases where an exam was not conducted were founded. On several other variables, however, increased investigator thoroughness tended to be correlated with substantiation of the allegation as employee abuse, neglect, or misconduct. Specifically, a significantly higher percentage of the cases where the investigator assessed the credibility of patient/client testimony were founded as abuse, neglect, or misconduct than when the investigator did not (78 percent versus 24 percent for alleged patient/client witnesses or informants; 50 percent versus 24 percent for alleged child-victims, p<.05). Relatedly, 63 percent of the cases where employees' work histories were checked were founded, whereas only 13 percent of the cases where this step was not taken were founded (p<.05). Similarly, more of the cases where the alleged perpetrator's supervisor was interviewed versus those cases where he/she was not interviewed (54 percent versus 18 percent, p<.05) were founded .

In addition, while the quality of written interviewee statements (i.e. compliance/non compliance with OMH/OMRDD guidelines) did not differ between the two subgroups of cases for employee or patient/client witnesses and informants, it did for alleged perpetrators and alleged child-victims. There was a trend toward more adequately documented alleged perpetrator's and alleged child-victim's statements among those cases which sustained employee abuse, neglect, or misconduct. Forty (40) percent of those cases where alleged perpetrator's statements complied with OMH/OMRDD guidelines were founded, but only 7 percent of the cases where this compliance was not assured were founded (p<.05). Similarly, nearly four times as many of the cases where the alleged child-victim's statement complied with the guidelines were founded than those where this compliance was not assured (47 percent versus 12 percent, p<.05).

Finally and not surprisingly, the analysis further showed that corrective and disciplinary actions were more likely among the subgroup of cases where employee abuse, neglect, or misconduct was determined (p<.05). This finding was particularly evident for corrective actions targeted to the alleged perpetrator and employees generally, including such actions as training/retraining, verbal counseling, and new facility procedures or policies. It was also noted, however, that while some corrective action was taken in response to all cases in the founded subgroup, such actions were also taken for 50 percent of the cases in the unfounded/undetermined subgroup.

Summary

Case disposition and outcome data on the 80 reported allegations testified to the value of re-

porting and investigating these allegations. For approximately one out of every three of these allegations, facility investigations revealed some credible evidence substantiating that abuse, neglect, or other employee misconduct had occurred. Even more revealing was the finding that in response to more than two-thirds of the reported allegations, including 50 percent of those determined to be unfounded or undetermined, the facility took one or more specific corrective actions. Also of note was that in 77 percent of the cases where abuse or neglect was substantiated, employee disciplinary action was taken, and that in 6 of these 13 cases (46 percent) the employee was either terminated or voluntarily acceded to a request for his/her resignation.

The data also revealed some interesting observations about the relationship between case disposition and the other variables studied in the review. Although all of these findings, despite their statistical significance, must be considered preliminary pending further replication studies, they present some important observations for facility administrators and investigators. Perhaps the most important of these observations is that immediately known information or perceptions of the investigator may be strong influences in shaping his/her subsequent thoroughness in investigating the case. Specifically, it appeared that careful attention to assessing patient/client credibility, to reviewing alleged perpetrator's work histories and work performance, and to documenting alleged perpetrator's and alleged victim's testimony may be predicated on the investigator's initial attitude that the allegation may be true. This hypothesis was also supported by the strong relationship between the initial incident report's notation of employee inappropriate behavior and case substantiation.

Although it is natural and certainly not unjustified for investigators to take cases more seriously where the initial evidence is substantial, it appeared that this initial assessment may have also compromised the thoroughness of investigations of allegations where such evidence was not so immediately forthcoming. It appeared that certain potentially important investigatory steps were simply omitted for these latter cases.

It was also interesting that cases reported by licensed facilities and cases involving female and short-tenured alleged perpetrators appeared to be associated with higher substantiation rates. In the former case, this association may reflect the generally more informal labor-management arrangements in licensed versus state-operated facilities, and therefore the tendency of some licensed facilities to sustain cases with less evidence. Similarly, facilities may feel a need for less evidence to confirm employee abuse, neglect, or misconduct for short-tenured and particularly probationary employees. It is also probable that relatively new employees may be more prone to be involved in sustained incidents, simply because they may have less training and/or fewer coping skills to deal with the stressful situations often associated with these incidents.

It is more difficult to explain the higher substantiation rate among cases involving female alleged perpetrators, but it is noteworthy that these cases, as well as those in the other subgroups of cases with higher substantiation rates, were underrepresented in the study's overall sample. One could hypothesize that higher substantiation rates are related to low reporting rates. More clearly, it may be that when the implicit reporting threshhold is "high," those cases which are reported are more serious and/or they more obviously and immediately reflect evidence of employee abuse, neglect

Chapter VI
Conclusions and Recommendations

The data findings based on the 80 allegations studied substantiated the judgment of the Governor and State Legislature in recognizing that child abuse and neglect allegations in mental hygiene facilities often have not received the attention they warrant. Moreover, the findings revealed a number of important insights in understanding allegations of child abuse and neglect in mental hygiene facilities, as well as for ensuring the more effective handling, investigation, and prevention of these incidents.

Children at High Risk

The findings confirmed that institutionalized mentally disabled children constitute a high risk group for abuse and neglect. Reported cases indicated an average annual reporting rate for these allegations in State mental hygiene facilities more than two times greater than New York's reported 1986 statewide rate for child abuse and neglect investigations. Yet there is widespread belief that there is substantial underreporting of such allegations, suggesting that the actual dimension of the problem is greater than that which is reported.

Case disposition data indicated that 16 percent of the cases were determined to constitute child abuse or neglect, and that in an additional 18 percent of the cases, the lesser finding of employee misconduct was made. Additionally in two-thirds of the cases at least one corrective action was taken, and in nearly one-fifth of the cases at least one employee disciplinary action was taken.

Overall these findings suggest a high constructive-outcome rate for the reported cases, and they reaffirm the importance and quality assurance value of assuring stringent staff reporting procedures and practices for child abuse and neglect allegations in mental hygiene facilities.

Poor Reporting Practices

The data findings also strongly suggested, however, that such procedures and practices were not uniformly in place across facilities. The extremely variable reporting rates among different types of facilities ranging from 0 reports per 100 children served to nearly 10 reports per 100 children served strongly suggested uneven reporting procedures and practices. Data on the types of allegations filed by different facilities also indicated that facilities use different criteria and differing thresholds in determining whether to report an incident and/or whether to classify a reported incident as an allegation of child abuse or neglect.

Commission discussions with senior facility staff during on-site visits revealed even more direct evidence that reporting criteria were not always uniform, and that inconsistent criteria were sometimes espoused by different staff within the same facility. It was apparent that certain "low reporting" facilities were far more likely than certain "high reporting" facilities to hold back reporting on allegations where there appeared to be little immediately known evidence or where there was only a minor injury to the alleged child-victim.

It was also clear that certain other factors strongly influenced a facility's reporting rate. For example, the six times higher reporting rate for mental health facilities was apparently influenced by the high percentage of "self-reported" cases by the alleged child-victims in these facilities, as well as the prevalence of "acting-out" behavior patterns of many children served by these facilities. In contrast, the significant level of mental retardation and other functional disabilities among children in mental retardation facilities resulted in few "self-reported" cases (9 percent)

and clearly influenced the lower reporting rate of these facilities.

Finally, the data indicated that most children who self-reported abuse or neglect allegations first told a clinical staff member. This suggests that a facility's relative emphasis on a strong individual clinician relationship for each child may also influence reporting rates. Aside from suggesting that strong clinician-child relationship may enhance reporting, this finding also reinforces the importance of training clinical personnel to be especially sensitive to verbal and nonverbal cues, as well as minor injuries which may indicate possible abuse or neglect. This finding may also have relevance for mental retardation facilities which serve severely disabled children. Whereas the ability of these children to self-report allegations may be limited, the importance of clinical staff forging strong relationships with family members and other visitors and being readily available during common visiting times, especially on weekends, may similarly encourage families to report their suspicions, without fear of recrimination. Close clinician relationships with these clients may also attune them to subtle changes in behavior which may be clues to unreported abuse or neglect.

Advice for Prevention

Especially encouraging were the numerous data findings which targeted the circumstances often associated with allegations of child abuse and neglect and the children and employees who are most often involved in these incidents. Several of these findings could be particularly helpful in designing appropriate prevention strategies.

The data clarified, for example, that most reported allegations involved either no apparent injury or a minor injury to the alleged child-victim and, equally important, that the seriousness of the apparent injury was not significantly related to case disposition or the institution of corrective or disciplinary action. This finding reinforces the importance of facility vigilance in attending to all allegations regardless of the extent of apparent injury. It also has implications for the importance of clear facility guidelines to staff regarding the statutory definition of institutional child abuse and neglect and their reporting responsibilities. Additionally, it was interesting to note that despite their low reporting rate, mental retardation facilities had a higher incidence of allegations resulting in a known injury and in known serious injuries, suggesting perhaps that less serious incidents of possible abuse or neglect in these facilities may simply not be reported.

The data findings also pinpointed unstructured time periods and "leisure time" areas (e.g., day rooms, recreation areas, and sleeping areas) as the most common times/places where the reported allegations occurred. Very few of the allegations occurred in structured programs or classrooms.

This finding, which is consistent with other Commission data on institutional adult abuse allegations, suggests that prevention may also be linked to enhancing scheduled activities for children. It also indicates that training programs should alert staff to these high risk times and settings, and that facility administrators should ensure at least periodic clinical staff on-site supervision and assistance to all units during these hours.

The profile of the alleged victims in the cases studied clearly identified certain subgroups of children who appeared to be at higher risk of being involved in an abuse or neglect allegation and offered additional prevention advice. Boys over 12 years of age appeared significantly more vulnerable across all facilities. In mental health facilities, children prone to acting-out behavior and children with a psychiatric diagnosis of a conduct disturbance also fell in a higher risk group. In contrast, acting-out behavior by the alleged victim was a negligible factor in cases reported by mental retardation facilities. In these facilities, as contrasted with cases reported by mental health facilities, the alleged victim was often reported as a "passive recipient" of the alleged act of abuse or neglect. Like the findings related to the circumstances surrounding the reported allegations, these characteristics of the high risk alleged child-victim may help focus staff training/ prevention efforts and also alert administrators to specific living units which warrant higher staffing ratios and/or more carefully trained staff.

Relatedly, the finding that the preponderance of alleged perpetrators were relatively young male direct care workers also has implications for administrative practices. This portrait of the typical alleged perpetrator was virtually predictable based on the circumstances surrounding most of the reported allegations and the characteristics of the children involved in them. More clearly, young male direct care workers are also the most likely workers to be called to respond to acting-out episodes of residents.

However, there was little evidence that the male direct careworker had been adequately prepared for his high-risk position. Special training in handling acting-out episodes with children was clearly wanting, and even when training or retraining in this area was offered in response to an allegation, it was often targeted only to the alleged perpetrator and not offered to fellow workers.

In addition, in many cases more highly trained clinical staff were not available to help out during acting-out episodes, or they arrived some time after the episode was underway. At many facilities it appeared that direct care staff had not been trained either to deal with such behavior or encouraged to call clinical staff to the scene early. Commission follow-up indicated that few facilities had formal crisis procedures for bringing specially trained clinical personnel to the scene of acting-out episodes of clients/patients.

The need for additional training and clinical assistance for direct care staff in stress-situations was further highlighted by the review's finding that nearly 80 percent of the alleged perpetrators had worked at the facility at least one year, and over half had worked at the facility more than three years. It was apparent that these episodes posed significant problems not only for new recruits, but also for long-term employees.

Investigatory Dilemmas and Flaws

The data findings also clearly illustrated many of the investigatory dilemmas associated with these cases. Nearly one out of every five of the allegations did not come to light until more than 24 hours after the event allegedly occurred, and one out of every two of the allegations was not witnessed by any adult other than the alleged perpetrator. Further, even when other adult (employee) witnesses were available, their accounts often related substantially different accounts of the reported event.

Compounding these problems for mental health facilities were the turbulent, spontaneous circumstances surrounding many of the reported incidents. Mental retardation facility officials, on the other hand, often had no immediately apparent informants as to the circumstances of the incident, as the alleged child-victim often could not tell his/her story, and other potential client witnesses were either unknown or equally unable to relate the circumstances of the event.

Notwithstanding these difficulties, however, it was also clear that many of the investigations were flawed by investigator error or oversight. There appeared to be limited facility supervisory oversight to assure the comprehensiveness and accuracy of prepared incident reports or physical exam reports. Early on in the cases, potentially valuable evidence was also lost by the failure to initiate investigations promptly, and to ensure that photographs were taken of visible injuries to the child. Further, while required external notifications were usually assured, it was noteworthy that required notifications of parents or guardians and governmental oversight and advocacy bodies were not assured in 12 to 22 percent of the cases. In addition, external notifications to law enforcement officials, and, in some cases, to the State Central Register were apparently hindered by the unclear operating guidelines of facilities in determining when these notifications were necessary.*

Later investigatory actions were also not consistently assured for the studied cases. For more than 30 percent of the cases, all available employee and/or patient/client witnesses were not

* *Patient Abuse and Mistreatment in Psychiatric Centers: A Policy for Reporting Apparent Crimes to and Response by Law Enforcement Agencies*, NYS Commission on Quality of Care for the Mentally Disabled, 1985. *In the Matter of Lisa Cohen: The Need for a Policy in the Developmental Disabilities Service System for Reporting Apparent Crimes to Law Enforcement*, NYS Commission on Quality of Care for the Mentally Disabled, 1987.

interviewed. In addition, written statements of interviews with witnesses and informants, as well as of interviews with alleged child-victims and alleged perpetrators were sometimes not prepared. Even when these statements were prepared, in more than one-third of the cases they were not signed and/or dated by the interviewee and/or the interviewer, and in many cases it was not clear if the interviewee ever saw the prepared statement.

Investigators also frequently failed to reference an assessment of the credibility of children's testimony, including the testimony of the alleged child-victim. They were equally lax in conducting formal reviews of alleged perpetrator's work performance. Finally, and not surprisingly given the informality of other investigatory steps, formal written investigation reports were not prepared at all in 20 percent of the cases, and nearly 40 percent of the investigation reports prepared were substantially not compliant with the NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities guidelines for such reports.

This uneven investigative performance by facilities in handling the 80 reported cases appeared to result, in part, from the limited training which had been afforded to many staff investigators. Notably, only 36 percent of the studied cases were investigated by a staff person who had completed OMH's or OMRDD's training program for special investigators or any other substantial investigatory training program.

The analysis of the data on case disposition also indicated, however, that the investigator's initial assessment of the merits of the case influences the amount of energy and thoroughness put into the investigation. Not so unpredictably, investigators appeared to take less care with alleged perpetrators' and alleged victims' statements and to be less diligent in checking the work histories and past performance of alleged perpetrators when the immediately known information about a case did not appear to be substantial. Similarly, formal assessments of the credibility of alleged child victims and other children witnesses were significantly less commonly done in cases which were concluded as "unfounded" or "undetermined."

Further compounding these training and investigator performance limitations was the virtual absence of formal facility or OMH/OMRDD supervisory accountability for the comprehensiveness of investigations. While facility incident review committees did reportedly discuss most allegations, they did not uniformly review final investigation reports. Even when these reviews were conducted, few committees exercised a critical approach in checking for specific investigatory steps or in carefully reviewing the quality of witness statements. Similarly, Central Office review of investigation reports by OMH and OMRDD also seemed erratic, and it did not appear that all reports, and especially "unfounded" reports, received such reviews. In addition, like the reviews conducted by incident review committees, neither Central Office used a uniform checklist to monitor compliance with specific guidelines.

Significantly, both the NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities recognize the need to extend their formal investigator training programs to licensed facilities and to more personnel in State-operated facilities. They acknowledge, however, that the costs of these programs, particularly for relief staff to cover for personnel in training, are an obstacle in speedily ensuring that adequately trained investigative personnel are available to all facilities. Both agencies also acknowledge the uneven quality of investigations, and recognize the need to more carefully review final investigatory reports.

Recommendations

Based on these major findings the Commission recommends a number of specific actions to ensure the more adequate reporting, investigation, and prevention of incidents of possible child abuse and neglect in mental health and mental retardation facilities. The Commission believes that these recommendations will promote the achievement of the objectives of the Child Abuse

Prevention Act of 1985, and also assist mental health and mental retardation facilities serving children to undertake their legally mandated internal responsibility to ensure protection for children under their care and to appropriately handle and investigate all allegations of possible abuse and neglect.

Responses by the NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities to the draft report indicated substantial agreement with these recommendations and also outlined numerous activities and initiatives which have already been undertaken to ensure their prompt implementation.

I. Ensuring the More Accountable Reporting of Allegations

A. All mental health and mental retardation facilities serving children should develop explicit reporting procedures for allegations of child abuse and neglect, which are consistent with the expanded definition of institutional child abuse and neglect in the Child Abuse Prevention Act of 1985. The NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities should review and approve these developed procedures for facilities under their jurisdictions.

B. All mental health and mental retardation facilities should ensure that all employees are informed of their reporting responsibilities for allegations of child abuse and neglect, and that appropriate progressive corrective and/or disciplinary action is taken when an employee does not comply with these stated performance expectations.

C. The NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities should alert facilities under their jurisdictions of the important role of clinical staff in promoting patient/client self-reports of abuse and neglect allegations, and the potential important role of these staff in promoting family reporting by being available to families who may learn about abuse or neglect. In conjunction with this communication, mental health and mental retardation facilities should be encouraged to provide specialized training to their clinical staff in the detection of possible signs of abuse and neglect and to ensure that patients/clients and families have an opportunity to develop a personal relationship with a clinical staff member.

D. The NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities should develop clear operating guidelines for facilities under their jurisdictions to promote appropriate external notifications of child abuse and neglect allegations. Such guidelines are especially necessary to ensure more consistent and appropriate notifications to law enforcement officials and the State Central Register.

E. To ensure accountability for appropriate external notifications to law enforcement officials and the State Central Register, the NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities should require written, as well as oral, notifications to these bodies regardless of the response of these bodies to the initial oral report.

II. Promoting Accountable and Thorough Investigations of Allegations

A. In recognition of the high risk of children in mental health and mental retardation facilities for child abuse and neglect, as well as the many inherent dilemmas associated with investigating these cases, specialized training should be afforded to staff of all facilities who are assigned to investigate child abuse and neglect allegations. To assure the prompt availability of such train-

ing, the NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities, in cooperation with the NYS Division of the Budget, should develop a reasonable reimbursement mechanism to allow facilities to provide or otherwise ensure such training to relevant staff.

B. To ensure uniformly high standards for investigator training programs, these programs should be based on the manuals for special investigators developed by the NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities and theses Offices should formally review and approve all such programs for facilities under their jurisdictions prior to reimbursement authorization.

C. To improve the quality of physical exam reports, the NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities should consider modifying the standard incident report form section for physician exam reports with designated sections for recording specific findings pertaining to each required content area (e.g., description of the injury, possible cause of injury, age of injury etc.) and with a specific reference to the physician's request that a color photograph be taken of any visible injury.

D. The NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities should reaffirm the importance of early initiation of investigations and the prompt gathering and preservation of evidence to facilities under their jurisdiction. These steps can be critical to the immediate protection of the child, and evidence lost at this stage sometimes cannot be reconstructed after some time has passed.

III. Enhancing Prevention Efforts

A. Prevention efforts to reduce the incidence of child abuse and neglect should be given a greater priority by the NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities, and by individual facilities under their jurisdictions. To this end, both Offices and individual facilities should, on a periodic basis, but at least annually, review all reported allegations of child abuse and neglect and identify systemic corrective and preventive actions.

B. Immediate action should be taken by the NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities to communicate to facilities under their jurisdictions certain findings of the Commission's review which have implications for the prevention of child abuse and neglect allegations. Specific attention should be directed to the following findings:

-specialized training for staff who are routinely assigned to high-risk patient/client settings;

-specialized training and retraining for staff in handling acting-out episodes with children;

-the importance of well-communicated crisis procedures to allow the prompt availability of specially-trained clinical staff when "acting-out" child behavior requires staff intervention and/or the restraint/containment of the child;

-the value of increased scheduled programming, especially during the late afternoons, early evenings, and weekends, in reducing the likelihood of incidents which can lead to abuse and neglect allegations; and

-the role of on-site clinical staff presence and supervision in reinforcing appropriate staff-child interactions and in reducing the incidence of allegations of abuse and neglect, particularly during late afternoon and early evening hours and on weekends.

IV. Strengthening Oversight of the Reporting, Handling, and Investigation of Allegations

A. The NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities should periodically review the reporting rates for child abuse and neglect allegations of facilities under their jurisdictions, as well as the nature of reported allegations to detect possible signs of poor reporting practices. On-site reviews should be conducted at all facilities which consistently evidence very low reporting rates and/or the absence of reports of less serious allegations.

B. The NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities should develop a reliable protocol for checking the quality of the investigations of allegations of child abuse and neglect by facilities under their jurisdictions. This protocol should ensure that a reliable sampling of all such investigations, including investigations of "unfounded" and "undetermined" cases, are reviewed with a standard checklist. Among other key indicators, this checklist should include:

-comprehensiveness and accuracy of initial incident reports;

-prompt removal of alleged perpetrator from child caring responsibilities, where indicated for the safety of the alleged child-victim and/or other children;

-prompt initiation of the investigation of the allegation;

-conduct of physical exams of alleged child-victims, comprehensiveness of physician exam reports, and the availability of color photographs of visible injuries;

-prompt securing, sketching, and photographing of the scene of the incident;

-prompt attention and compliance with all appropriate external notifications;

-prompt interviews and appropriate written statements for all witnesses and informants, alleged perpetrators, and alleged child-victims;

-uniform attention to assessing and documenting the credibility of child testimony and the past work histories and work performance of alleged perpetrators; and

-comprehensive investigation reports.

C. Mental health and mental retardation facilities should ensure that their incident review committees take a formal role in reviewing the handling, investigations, and outcomes of incidents involving allegations of child abuse and neglect. These facilities are encouraged to develop a standard protocol for the review of these incidents by incident review committees which encompass the specific review criteria cited above.

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Appendix A

Tabular Statistics on the 80 Reported Allegations

List of Tables

Table 1: Annualized Reporting Rates per 100 Children Served by Auspice and Types of Facilities

Auspices and Types and Facilities	Number of Children	Number of Reports Filed in Six-Month Period	Annualized Reporting Rates Per 100 Children
TOTAL, ALL FACILITIES	**3605**	**80**	**4.43**
MENTAL HEALTH FACILITIES	2353	67	5.69
State Operated Mental Health Facilities	2030	51	5.03
Residential Treatment Facilities	323 *	16	9.91
Psychiatric Wards of General Hospitals/Community Residences for Mentally Ill	N.A.**	2	N.A.**
MENTAL RETARDATION FACILITIES	1252	11	1.76
State Operated Mental Retardation Facilities	534	6	2.25
Developmental Centers	471	3	1.27
Intermediate Care Facilities	45	0	0.00
Community Residences	18	0	0.00
Non State Operated Mental Retardation Facilities	718	5	1.39
Intermediate Care Facilities	388	3	1.55
Private Schools	212	2	1.89
Specialty Hospitals	70	0	0.00
Community Residences	48	0	0.00

* The NYS Office of Mental Health does not maintain data on the number of children served in residential treatment facilities. In view of the unavailability of these data, available census data were used to calculate reporting rates for these facilities. Since residential treatment facilities are long-term care facilities with an average length of stay of 18-24 months, this substitution had little adverse impact on the validity of the rates calculated.

** The NYS Office of Mental Health does not maintain statistics on the number of children in these modalities.

Table 2: Number and Percent of Reports by Auspice and by Type of Allegation and Extent of Medical Treatment Required

TYPE OF ALLEGATION*	Total Reports		Mental Health Reports		Mental Retardation Reports	
	N	%	N	%	N	%
Physical abuse	**63**	**78**	**55**	**80**	**8**	**73**
Physical abuse/no injuries	29	36	27	39	2	18
Physical abuse/injury/ first-aid	33	41	28	41	5	46
Physical abuse/injury/ Med Rx	1	1	0	0	1	9
Verbal/psychological abuse	**2**	**3**	**2**	**3**	**0**	**0**
Sexual abuse	**9**	**11**	**8**	**12**	**1**	**9**
Neglect	**6**	**8**	**4**	**6**	**2**	**18**
MEDICAL TREATMENT REQUIRED						
None	57	71	53	77	4	36
First aid only	17	21	13	19	4	36
X-rays, other ambulatory treatment by a physician	3	4	3	4	0	0
Hospitalization	3	4	0	0	3	27

* For reports where more than one type of allegation was cited, the primary allegation was used to classify the report.

Table 3: Number and Percent of Reports by Auspice and by Location of Incident

Location	Total Reports N	Total Reports %	Mental Health Reports N	Mental Health Reports %	Mental Retardation Reports N	Mental Retardation Reports %
Indoors	**68**	**85**	**61**	**81**	**7**	**63**
Day/living room	11	14	9	13	2	18
Sleeping area	25	31	24	35	1	9
Bathroom/shower	6	8	6	9	0	0
Hallway/staircase	6	7	6	8	0	0
Dining room	6	8	4	6	2	18
Program area	2	3	2	3	0	0
Recreation area	4	5	3	4	1	9
Off facility property	1	1	0	0	1	9
Other	7	9	7	10	0	0
Outdoors	**5**	**6**	**5**	**7**	**0**	**0**
Recreation area	1	1	1	1	0	0
Off facility property	2	3	2	3	0	0
Other	2	3	2	3	0	0
Unknown	**7**	**9**	**3**	**4**	**4**	**36**

Table 4: Number and Percent of Reports by Auspice and by Factor(s) Identified by the Facility as Causing or Partially Causing the Incident

Cause or Partial Cause	Total Reports* N	Total Reports* %	Mental Health Reports N	Mental Health Reports %	Mental Retardation Reports N	Mental Retardation Reports %
Acting out behavior by patient	51	64	49	71	2	18
Physical handicap of patient	2	3	0	0	2	18
Seizure/fainting by patient	1	1	0	0	1	9
Fall by patient	2	3	1	1	1	9
Action of other patient	7	9	6	9	1	9
Physical restraint/ containment of patient	35	44	34	49	1	9
Inappropriate response to patient behavior by employee	20	25	19	28	1	9
Other action of employee	16	20	12	17	4	36
Intoxication of employee	3	4	3	4	0	0
Drug misuse by employee	1	1	1	1	0	0
Faulty/inadequate equipment	1	1	0	0	1	9
Other	3	4	1	1	2	18
No cause identified	11	14	8	12	3	27

* Total number of reported causes (n = 153) exceeds the total number of reports because in 50 cases multiple causes were documented.

Table 5: Number and Percent of Reports by Auspice and by Source of Report

Source of Report	Total Reports N	Total Reports %	Mental Health Reports N	Mental Health Reports %	Mental Retardation Reports N	Mental Retardation Reports %
Alleged child-victim	52	65	51	74	1	9
Other patient/client	2	3	2	3	0	0
Alleged employee-perpetrator	8	10	8	12	0	0
Other employee	11	14	5	7	6	55
Family/relative	5	6	3	4	2	18
Hospital/emergency room	2	3	0	0	2	18

Table 6: Number and Percent of Cases Initially Reported by the Alleged Child-Victim by Auspice and by Whom Alleged Child-Victim First Notified

Whom Alleged Victim Notified First	Total Reports N	Total Reports %	Mental Health Reports N	Mental Health Reports %	Mental Retardation Reports N	Mental Retardation Reports %
Relevant Cases*	52	100	51	100	1	100
Professional clinical staff person	33	63	32	63	1	100
Direct care staff person	14	27	14	27	0	0
Administrative staff person	2	4	2	4	0	0
Family member	2	4	2	4	0	0
Other	1	2	1	2	0	0

* Fifty-two (52) of the 80 reports were initially reported by the alleged child-victim. Percentages reported in this table are based on these 52 relevant reports.

Table 7: Number and Percent of Reports by Auspice and by Sex, Age, and Race of Alleged Child-Victim

Demographic Characteristic	Total Alleged Victims N	%	Mental Health Alleged Victims N	%	Mental Retardation Alleged Victims N	%
Total*	**82**	**100**	**71**	**100**	**11**	**100**
Sex						
Male	63	77	55	78	8	73
Female	19	23	16	23	3	27
Age						
< 10	6	7	2	3	4	36
10 - 12	12	15	11	16	1	9
13 - 17	64	78	58	82	6	55
Race						
White	50	61	43	61	7	64
Black	16	20	13	18	3	27
Hispanic	15	18	14	20	1	9
Native American	1	1	1	1	0	0

* Eighty-two (82) alleged child-victims were identified in the 80 reported allegations. In two reports, two alleged child-victims were identified.

Table 8: Number and Percent of Reports by Auspice and by Sex, Age, and Race of Alleged Employee-Perpetrator

Characteristic	Total Perpetrators N	%	Mental Health Perpetrators N	%	Mental Retardation Perpetrators N	%
Total	**97**	**100**	**83**	**100**	**14**	**100**
Sex						
Male	76	78	72	87	4	29
Female	17	18	11	13	6	43
Unknown	4	4	0	0	4	29
Age						
<20	0	0	0	0	0	0
20 - 29	21	22	18	22	3	21
30 - 39	29	30	28	34	1	7
40 - 49	22	23	22	27	0	0
50 - 59	2	2	2	2	0	0
60 - 69	2	2	2	2	0	0
Unknown	21	22	11	13	10	71
Race						
White	28	29	24	29	4	29
Black	49	51	47	57	2	14
Hispanic	7	7	7	8	0	0
Other	1	1	1	1	0	0
Unknown	12	12	4	5	8	57
Job Classification						
Direct care staff	74	76	67	81	7	50
Other clinical staff	8	8	7	8	1	7
Other non-professional support staff	8	8	8	10	0	0
Unknown	7	7	1	1	6	43
Tenure at the Facility						
1 - 3 months	2	2	2	2	0	0
6 - 12 months	6	6	5	6	1	7
1 - 3 years	22	23	19	23	3	21
Longer than 3 years	54	56	52	63	2	14
Unknown	13	13	5	6	8	57

Table 9: Number and Percent of Reports by Auspice and by Timeliness of Facility's Awareness and of Facility Documentation Subsequent to Its Awareness of the Alleged Event

	Total Reports		Mental Health Reports		Mental Retardation Reports	
	N	%	N	%	N	%
Timeliness of facility awareness of alleged event						
Within 1 hour	37	46	34	49	3	27
Within 24 hours	28	35	23	33	5	46
Within 1-3 days	5	6	5	7	0	0
Within 4-7 days	3	4	3	4	0	0
More than 7 days	6	8	4	6	2	18
Unknown	1	1	0	0	1	9
Facility documentation of alleged event subsequent to its awareness						
Within 1 hour	41	51	38	55	3	27
Within 24 hours	31	39	25	36	6	55
Within 1-3 days	3	4	3	4	0	0
More than 7 days	2	3	2	3	0	0
No incident report	3	4	1	1	2	18

Table 10: Number and Percent of Reports by Auspice and by Timeliness of Facility Reporting to the State Central Register for Child Abuse and Neglect Subsequent to the Facility's Awareness of the Alleged Incident and Register's Acceptance/Non-Acceptance of the Report

	Total Reports		Mental Health Reports		Mental Retardation Reports	
	N	%	N	%	N	%
Facility reported incident to State Central Register						
Within 24 hours	42	53	35	51	7	64
Within 1-3 days	18	23	15	22	3	27
Within 4-7 days	9	11	9	13	0	0
More than 7 days	7	9	6	9	1	9
Not reported	4	5	4	6	0	0
State Central Register acceptance of report						
Accepted	66	82	55	80	11	100
Not accepted	10	13	10	14	0	0
Not applicable (i.e., cases not reported by facility)	4	5	4	6	0	0

Table 11: Number and Percent of Reports by Auspice and by Adequacy of Initial Investigatory Steps

Reporting/ Documenting Criteria	Total Reports N	Total Reports %	Mental Health Reports N	Mental Health Reports %	Mental Retardation Reports N	Mental Retardation Reports %
Facility incident report complete and accurate	41	51	34	49	7	64
Physician exam adequately documented*						
Yes	42	53	36	52	6	55
No	16	20	16	23	0	0
Not applicable	22	28	17	25	5	46
Photo taken of visible injury						
Yes	9	11	9	13	0	0
No	18	23	14	20	4	36
Not applicable	53	66	46	67	7	64
Scene of incident secured						
Yes	0	0	0	0	0	0
No	21	26	16	23	5	46
Not applicable	59	74	53	77	6	55
Photo/sketch taken of scene of incident						
Yes	7	9	6	9	1	9
No	37	46	32	46	5	46
Not applicable	36	45	31	45	5	46

* Includes all cases where physical exams were conducted by a physician or a nurse.

Table 12: Number and Percent of Reports by Auspice and by Time Lag Between Facility Awareness of Allegation and Facility Initiation of Investigation

Investigation Initiated	Total Reports N	Total Reports %	Mental Health Reports N	Mental Health Reports %	Mental Retardation Reports N	Mental Retardation Reports %
End of shift	27	34	25	36	2	18
24 hours	45	56	37	54	8	73
3 days	8	10	7	10	1	9

Table 13: Number and Percent of Reports by Auspice and by Availability of Witnesses and Corroboration of Substance of Allegation by Witnesses

	Total Reports N	Total Reports %	Mental Health Reports N	Mental Health Reports %	Mental Retardation Reports N	Mental Retardation Reports %
Witnessed by employees other than alleged perpetrators	**41**	**51**	**35**	**51**	**6**	**55**
- Corroborated by ALL employee witnesses	6	8	4	6	2	18
- Corroborated by some, but not all employee witnesses	2	3	1	1	1	9
Witnessed by patients/ clients other than alleged child-victim	**30**	**38**	**30**	**44**	**0**	**0**
- Corroborated by ALL patient/client witnesses	6	8	6	9	0	0
- Corroborated by some, but not all patient/client witnesses	8	10	8	12	0	0

Table 14: Number and Percent of Reports by Auspice and by Interviews Conducted with and Documented for Available Witnesses and Other Informants (Other Than Alleged Child-Victim and Alleged Employee-Perpetrator)

Witnesses/Informants	Total Reports N	Total Reports %	Mental Health Reports N	Mental Health Reports %	Mental Retardation Reports N	Mental Retardation Reports %
Employee						
Applicable cases	68	85	57	83	11	100
Interviews conducted*	56	82	46	81	10	91
Statements documented*	50	89	43	93	7	70
Statements conformed with OMH/OMRDD guidelines*	29	58	27	63	2	29
Patients/clients						
Applicable cases	38	48	38	55	0	0
Interviews conducted*	31	82	31	82	0	0
Statements documented*	30	97	30	97	0	0
Statements conformed with OMH/OMRDD guidelines*	19	63	19	63	0	0

* All percentages based on applicable cases

Table 15: Number and Percent of Reports by Auspice and by Interviews Conducted with and Documented for Alleged Child-Victim

Child-Victim	Total Reports N	Total Reports %	Mental Health Reports N	Mental Health Reports %	Mental Retardation Reports N	Mental Retardation Reports %
Applicable cases	68	85	67	97	1	9
Interviews conducted*	65	96	64	96	0	0
Statements documented*	46	71	46	71	0	0
Statements conformed with OMH/OMRDD guidelines*	24	52	24	52	0	0

* All percentages based on applicable cases

Table 16: Number and Percent of Reports by Auspice and by Interviews Conducted with and Documented for Alleged Employee-Perpetrator

Alleged Employee-Perpetrator	Total Reports N	Total Reports %	Mental Health Reports N	Mental Health Reports %	Mental Retardation Reports N	Mental Retardation Reports %
Applicable cases*	75	100	65	100	10	100
Interview conducted**	75	100	65	100	10	100
Statement documented**	58	73	51	74	7	64
Statement conformed with OMH/OMRDD guidelines**	40	69	37	73	3	43

* For 5 of the 80 reports, including 1 report filed by a mental health facility and 4 reports filed by mental retardation facilities, no employee-perpetrator was ever identified, and therefore he/she could not be interviewed.

** Percentage based on applicable cases.

Table 17: Number and Percent of Reports by Auspice and by Facility Investigative Steps to Review Alleged Employee-Perpetrator Work History and to Interview Supervisor of Alleged Employee-Perpetrator

Investigative Steps	Total Reports N	Total Reports %	Mental Health Reports N	Mental Health Reports %	Mental Retardation Reports N	Mental Retardation Reports %
Alleged employee-perpetrator work history reviewed	30	38	25	38	5	50
Supervisor of alleged employee-perpetrator interviewed	28	35	22	34	6	60

Table 18: Number and Percent of Reports by Auspice, Review by Facility Incident Committee, and by Adequacy of Written Investigation Report

Investigation Steps	Total Reports N	Total Reports %	Mental Health Reports N	Mental Health Reports %	Mental Retardation Reports N	Mental Retardation Reports %
Incident reviewed by facility incident review committee	68	85	59	86	9	82
Written investigation report prepared	64	80	57	83	7	64
Report conformed with OMH/OMRDD guidelines*/**	39	61	35	62	4	57
Report reviewed by facility director	51	80	45	79	6	86

* All percentages based on applicable cases.

** Assessments based on available documents.

Table 19: Number and Percent of Reports by Auspice and by Facility Case Disposition and by Case Disposition Documented to the State Central Register

	Total Reports		Mental Health Reports		Mental Retardation Reports	
	N	%	N	%	N	%
Facility Case Disposition						
Abuse/neglect confirmed	13	16	12	17	1	9
Employee misconduct confirmed, but abuse/ neglect not sustained	14	18	12	17	2	18
No abuse/neglect or employee misconduct confirmed	49	61	42	61	7	64
Undetermined	4	5	3	4	1	9
State Central Register Case Disposition						
Indicated	12	15	11	16	1	9
Unfounded	52	65	42	61	10	91
Not reported	6	8	6	9	0	0
Register refused the report	10	13	10	15	0	0

Table 20: Number and Percent of Reports by Auspice and by Corrective Action Taken

Corrective Action	Total Reports N	Total Reports %	Mental Health Reports N	Mental Health Reports %	Mental Retardation Reports N	Mental Retardation Reports %
Child-Victim Actions						
- treatment/medication plan reviewed	7	9	7	10	0	0
- treatment/medication plan revised	3	4	3	4	0	0
- closer observation ordered	9	11	7	10	2	18
- counseled	17	21	17	25	0	0
- relocated to another unit/facility	4	5	4	6	0	0
Employee-Perpetrator Actions						
- training/retraining	18	23	15	22	3	27
- verbal counseling	20	25	20	29	0	0
- written counseling	5	6	5	7	0	0
- closer supervision	6	8	4	6	2	18
Facility-Administrative/ Organizational Actions						
- corrected hazardous condition	2	3	0	0	2	18
- repaired faulty equipment	1	1	0	0	1	9
- established new facility policy/ procedure	9	11	8	12	1	9
- other significant administrative/ organizational or operational change	5	6	3	4	2	18
Other	2	3	1	1	1	9
None	27	34	22	32	5	46

Table 21: Number and Percent of Reports by Auspice and by Disciplinary Action Taken*

Disciplinary Action	Total Reports N	Total Reports %	Mental Health Reports N	Mental Health Reports %	Mental Retardation Reports N	Mental Retardation Reports %
None	64	80	56	81	10	91
Written reprimand	4	5	4	6	0	0
Suspension without pay	4	5	4	6	0	0
Loss of accrued leave credits	1	1	1	1	0	0
Terminations/Resignations	9	11	8	12	1	9

* Number of cases exceeds N of 80 cases, and total percentages exceed 100 percent because two cases, both reported by mental health facilities, involved more than one disciplinary action.

Appendix B

Response to Draft Report by the NYS Office of Mental Health and the NYS Office of Mental Retardation and Developmental Disabilities

NEW YORK STATE
OFFICE OF MENTAL HEALTH
44 Holland Avenue, Albany, New York 12229

STEVEN E. KATZ, M.D., Commissioner

August 21, 1987

Clarence J. Sundram
Chairman
Commission on Quality of Care for
the Mentally Disabled
99 Washington Avenue
Suite 1002
Albany, New York 12210

Dear Mr. Sundram:

Thank you for the opportunity to comment on the draft report Child Abuse and Neglect in Mental Retardation and Mental Health Facilities in New York. We have two general comments as well as specific responses to several recommendations.

During the past year, the Office of Mental Health has taken a number of positive steps to implement the Child Abuse Prevention Act of 1985. Many of these actions closely parallel recommendations in your draft report. These steps include the following:

- Issuance of revised policy directives on Incident Reporting and Investigation, Reporting Requirements for Alleged Child Abuse and Neglect, Missing Patient Incidents, and Reporting Requirements for Events Which May Be Crimes.

- The development of six draft policy directives on the safe and effective management of otentially dangerous patient behaviors, including a policy on the use of brief physical interventions.

- The development of proposed regulatory amendments for each type of residential care program for children or adolescents licensed or operated by OMH.

- The development and piloting of training models on child abuse prevention and child abuse identification and reporting.

- The establishment of a statewide committee to review and finalize a standard training curriculum on patient management.

We are somewhat concerned that readers of your report may surmise that OMH is deficient in these areas. Therefore, before it is issued, we recommend that a general statement be added to the Introduction which addresses this issue and our initiatives.

The second general comment relates to the mixing of abuse allegations from mental health and mental retardation facilities. We acknowledge that the small sample size (80 allegations) of this pilot study might dictate the combining of allegations from mental health and mental retardation facilities. However, as your report notes in several instances, there are major differences between the two agencies (e.g., reporting levels, number of physical injuries to the alleged child victim). In the future, we recommend that individual reports be completed for each state agency.

Our comments on specific recommendations are as follows:

Recommendation I.A. The draft report's first recommendation calls for explicit reporting procedures for allegations of child abuse and neglect. As was mentioned above, this recommendation has already been thoroughly addressed by OMH, and this should be acknowledged

Recommendation I.B. We request that the phrase "appropriate progressive disciplinary action" be expanded to "appropriate corrective and/or progressive disciplinary action". As you know, there are some instances when employee non-compliance with performance expectation calls for corrective actions rather than the more serious progressive disciplinary actions.

Recommendations I.D. and I.E. Clear operating guidelines for appropriate external notification of child abuse and neglect allegations, and of events which may be crimes, have been issued by OMH, and this needs to be acknowledged in the report.

Recommendation II.A. OMH fully supports this recommendation and requests that explicit mention be made of a reimbursement mechanism for costs associated with releasing staff for attendance at training.

Recommendation II.B. OMH supports this recommendation, but some clarification is needed. In facilities and programs licensed by OMH, it is expected that the provider agency will cover costs associated with training.

Recommendation II.C. As you know, OMH has recently revised its incident report form. If this recommendation remains, we will need to consider the usefulness of including these sections because only a very small percentage of incidents are abuse related.

Recommendation III.A. Clarification is needed regarding the roles and relationships between CQC, OMH Central Office, state-operated facilities, and licensed facilities. As is mandated by the CAPA legislation, OMH Central Office will provide CQC with an annual report of its abuse prevention efforts. State-operated facilities do submit annual patient abuse reports to OMH Central Office; these reports will be incorporated into OMH Central Office's report to CQC.

Recommendation IV.A. As part of its ongoing administrative oversight role, OMH Central Office does periodically review reporting rates and the nature of abuse and neglect allegations from its facilities. However, the decisions as to what is the appropriate management strategy (e.g., on-site reviews) depends on many factors and is the responsibility of OMH rather than CQC.

Recommendation IV.B. As was stated above, it is appropriate for CQC to identify the need for OMH to monitor the quality of facility abuse allegations. However, it is the role of OMH, rather than CQC, to select the most appropriate monitoring process.

Recommendation IV.C. As was stated above in regard to IV.A. and IV.B., OMH agrees with the recommendation that facility incident review committees take a formal role in reviewing the handling of child abuse allegations. However, it is the role of OMH, rather than CQC, to assist facilities in the implementation of this recommendation.

We appreciate the opportunity to comment on this pilot study and hope that they will be incorporated into the final report. Please contact Alice Lin, Ph.D., Senior Deputy Commissioner, Operations Division, at 474-7056 if you need additional information or clarification on any of our comments.

Sincerely,

Steven E. Katz, M.D.
Commissioner

STATE OF NEW YORK
OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES

44 HOLLAND AVENUE • ALBANY • NEW YORK • 12229
(518) 473-1997

ARTHUR Y. WEBB
Commissioner

July 22, 1987

Mr. Clarence J. Sundram
Chairman
Commission on Quality of Care
for the Mentally Disabled
99 Washington Avenue, Suite 1002
Albany, New York 12210

Dear Mr. Sundram:

This letter is in response to your June 17, 1987 correspondence which presented the draft report of the Commission's study of 80 child abuse and neglect allegations reported by mental health and mental retardation facilities for the six month period of September 1985 to February 1986.

OMRDD, throughout the spring and summer of 1986, had expressed our interest in the findings and outcome of the study. We had hoped to incorporate any significant findings of your study into our activities implementing CAPA of 1985. As a result of our review of this draft, OMRDD believes that the findings and recommendations reinforce our independent actions which were taken between 1985 and now.

Our review of the report's recommendations finds that they emphasize the need for an oversight process on the reporting and investigation of incidents of abuse/neglect. OMRDD has initiated many actions to provide this oversight. I would recommend that the final report give OMRDD due credit for its accomplishments to date. I also recommend that you emphasize that judgement should be used when applying the report findings and recommendations to the OMRDD system as only 11 (14%) of the cases included involved developmentally disabled children. Following are the specific actions OMRDD has in process. These are listed as they relate to each of your recommendations.

Recommendation I Ensuring the More Accountable Reporting of Allegations.

OMRDD has initiated actions to ensure accountable reporting of allegations. They are as follows:

- o OMRDD has aggressively addressed the Child Abuse Prevention Act of 1985 to ensure implementation by 10/1/86. Processes for reporting child abuse and maltreatment cases to CQC and State Central Register were established in OMRDD Regulation, Part 624 which was implemented as of 2/86. OMRDD protocols and processes were collaboratively developed with CQC's Director of Abuse/Neglect Investigations in the spring and summer of 1986 to ensure that these were consistent with CQC's requirements. These protocols were then published in the September

issue of The QA Network, presented at the September statewide DDQA meeting, and also presented to providers at the DQA's four provider training programs during October and November 1986 by CQC's Director of Abuse/Neglect Investigations Unit

- o OMRDD's Division of Quality Assurance has developed a survey protocol to ensure all procedures are being followed according to regulations. Reporting processes are also monitored through OMRDD's Serious Incident Reporting System within the Division of Quality Assurance.

- o OMRDD's Staff Development and Training, through a DSS grant, Prevention of Child Abuse Training Project, has developed a training manual, People Do Matter, which is intended to increase staff awareness of both prevention and reporting. A series of six, two-day pilot training programs were conducted statewide, during December 1986 and January and February 1987. Project staff then refined the curriculum and Train-the-Trainer sessions for representatives of B/DDSO were planned for the spring of 1987. Future training is projected in the fall of 1987 for voluntary providers.

- o OMRDD has made all its employees aware of their reporting responsibilities, and has disciplined or counseled employees when we became aware that they failed to report acts of abuse or neglect.

- o OMRDD has developed a protocol for reporting potential criminal incidents. CQC staff have worked closely with OMRDD and commented on the protocol. The finalized protocol is now ready to be submitted to senior staff for final approval. Reporting of criminal acts is also addressed in Part 624.

Recommendation II Promoting Accountable and Thorough Investigations of Allegations

OMRDD has the following activities in place which address this recommendation:

- o OMRDD's Office of Internal Affairs has sponsored training to staff designated as investigators at each B/DDSO during the last three years. The training is continuing and expanding its scope during the current fiscal year. Expanded OMRDD funding which has been partially matched with a grant from the Developmental Disabilities Planning Council to provide a one-day follow-up training session for those individuals who attended the three-day special investigator training programs. These follow-up sessions are planned to be conducted in the near future and will concentrate on reviewing and critiquing written investigation reports. Your observations on the conduct of investigations included in your study will be incorporated into these sessions.

- o Several regional three-day training programs on investigative techniques for both voluntary agency and state employees are planned.

The Special Investigations Manual which is currently in draft form is 95% complete. It is expected to be finalized in the next few months with only minor modifications. This manual will complement the Investigative Training Course.

Recommendation III Enhancing Prevention Efforts

OMRDD has the following processes in place directed at prevention:

- o OMRDD's Part 624 requires an annual review of all incidents and allegations of abuse in order to identify systemic corrective and preventive actions at the facility and at OMRDD.

- o As stated previously, Staff Development has developed the training manuals on prevention of child abuse for all staff involved with the care of children.

- o OMRDD's Part 633, Client Protection, addresses crisis procedures. OMRDD issued Guidelines for Behavior Management for the Agressive Client in March 1986.

- o OMRDD recognized the need for extended programming. It is OMRDD's belief that the extension of the hours during which clinical programming occurs in conjunction with the revised Active Treatment Model will provide an increased professional staff presence on the living units. This will increase programming and should reduce the amount of unstructured time.

Recommendation IV Strengthening Oversight of the Reporting, Handling and Investigation of Allegations

OMRDD has in place the oversight mechanisms listed below. These will be enhanced as the outcomes of these processes indicate:

- o As stated previously, OMRDD, through the SIRS maintained by the Division of Quality Assurance, provides the statewide monitoring of the reporting process and also analysis of the reports. A survey protocol has been developed by the Division of Quality Assurance's Bureau of Management and Program Evaluation to ensure these processes are properly being implemented and sufficient oversight is provided by the incident review committee. A program of reviews of Developmental Center client abuse investigations is now in the process of being developed by the Office of Internal Affairs. The items listed in your recommendation, IVB, will be incorporated into these revisions.

- o Incident review committees, either at the facilities per Part 624 or central office, are to take a formal role in the review of handling investigation and outcomes of allegations of abuse.

- o Oversight is also provided by the Division of Quality Assurance through its survey/certification process of Part 624.

OMRDD considers the incident reporting and investigation process an essential element in assuring that appropriate services are provided to those developmentally disabled persons we serve. We believe that the actions described above, which were planned and undertaken during the past two years, demonstrate our commitment and ability to provide the oversight and initiate appropriate action which will ensure that the investigation and reporting process has a positive impact on those we serve.

I repeat my recommendation that this information be considered in your final draft. It would not do justice to our efforts over the past two years to generalize your findings to the "mental hygiene" system. I believe that the record clearly demonstrates OMRDD's immediate response to the concerns raised by both the Governor and Legislature regarding institutional child abuse. Any comments you have on additional actions we could initiate to strengthen our current protocols would be appreciated.

Sincerely,

Elin M. Howe
Acting Commissioner

EMH/TJC