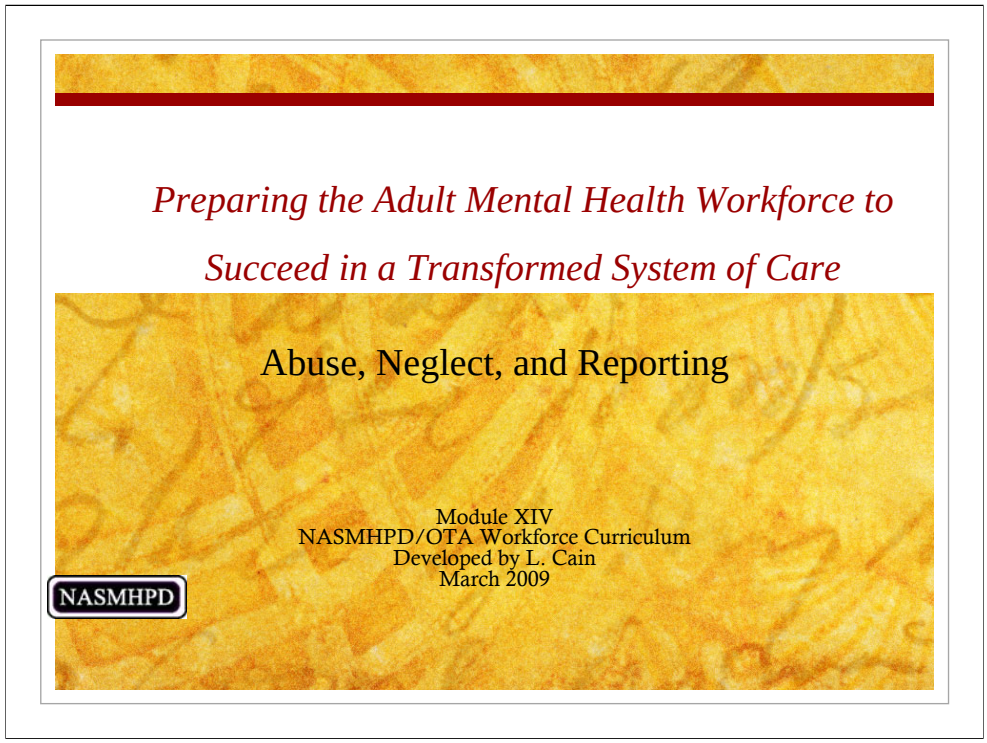


This presentation is designed to provide staff with basic information on abuse and neglect, systems in place to investigate and protect invidviudals diagnosed with a mental illness, including the federal Protection and Advocacy System, and what to do when a staff person witnesses or suspects that someone in their care is being abuse or neglected.

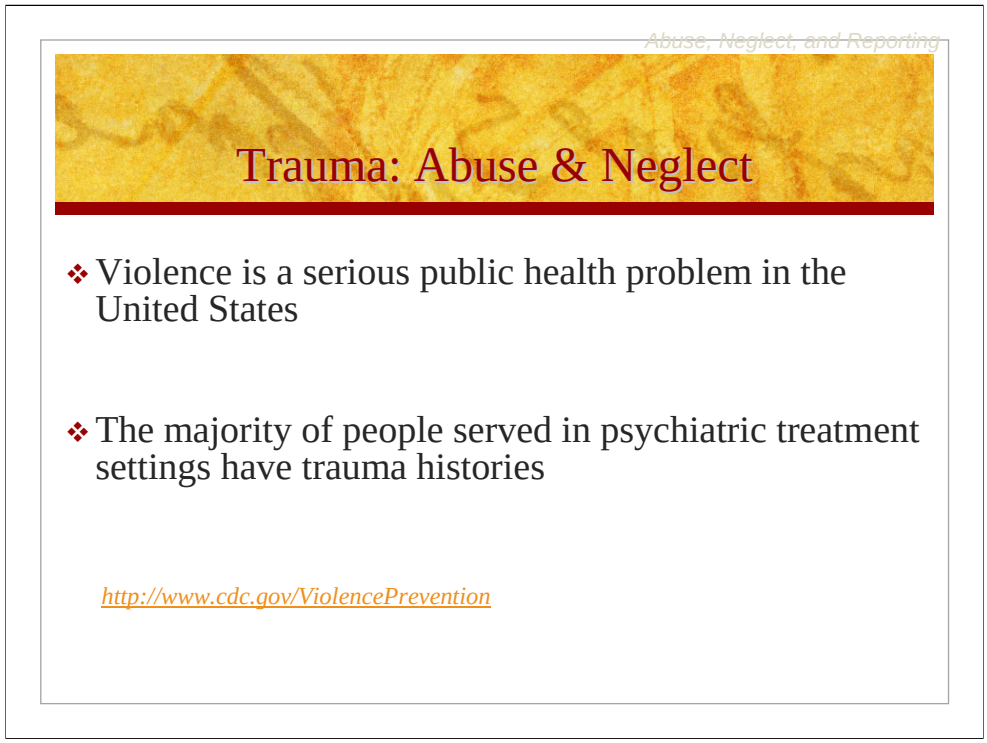
OBJECTIVES

By the end of this training, participants should be able to:

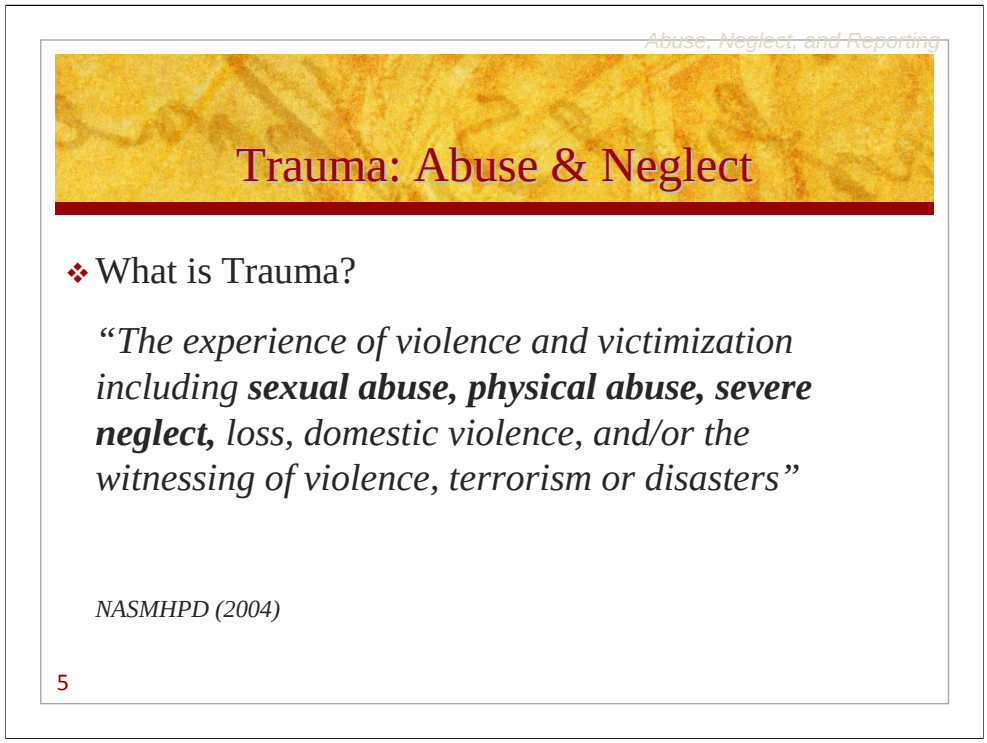
- ✓ Understand what constitutes abuse and neglect
- ✓ Know what protections are in place for individuals diagnosed with a mental illness
- ✓ Know where and how to properly report possible abuse and neglect incidents

OUTLINE

- Trauma, abuse & neglect
- What constitutes abuse and neglect
- Increased risk for abuse and neglect of persons diagnosed with a mental illness
- Protection and Advocacy of Individuals with a Mental Illness
- Staff reporting of abuse and neglect



Reference Mod 13 on TIC: as we've learned, trauma affects the lives of most of the people we serve. It is important to always keep in mind that people are ALREADY trauma victims and take great care to protect them from further abuse or neglect.



Trauma includes acts of abuse and neglect. We shouldn't think of trauma as only something that happened in a person's past, or as necessarily unconnected to the treatment they receive in mental health programs/facilities. It is also important to remember that, because a person may have a prolonged history of abuse/neglect, psychiatric practices, such as restraint and seclusion, will likely be perceived as an act of abuse, even if done lawfully. For example, Jane's mother used to lock her in a closet when she went out to drink with friends, sometimes leaving her locked up for days. Years later, when Jane is put in seclusion, she has flashbacks to her childhood and becomes very frightened and anxious, banging on the door to be let out. Staff perceive this as an escalation of aggression and leave her in seclusion.

What is Abuse?

- Abuse means an act *or failure to act*---knowingly, recklessly or intentionally—which caused, *or may have caused*, injury or death.

42 U.S.C. § 10802(1)

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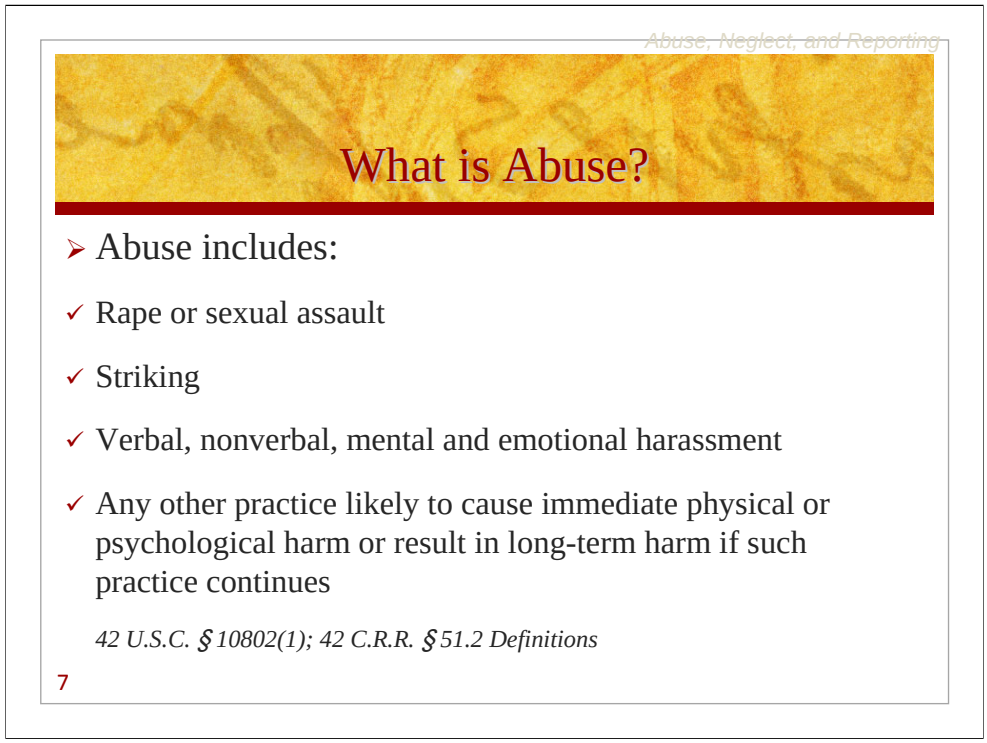
Abuse can be intentional or it can be the result of an act that a reasonable person should have known could cause injury or death. For example, John has temporary muscle paralysis from the medication he has been given and staff lay him down on the floor, on top of a heating grate. The heating system is old and the grate can get very hot. John ends up with severe burns. Whether or not staff intended to harm John, a reasonable person would have known that injury was likely.



In addition to obvious forms of physical or sexual abuse, it is important to be aware of the harm that can be inflicted verbally. Words can hurt and/ or cause fear, especially for people who have been mentally abused as children. Calling a person “stupid” or “lazy” can trigger memories of abuse by a parent or other caretaker. Threatening consumers with loss of freedom or privileges can, depending upon the circumstances, also rise to the level of abuse. For example, Nurse Sharon asks Joe to take a shower, but he wants to wait until the end of the movie he is watching. Nurse Sharon yells at Joe that if he doesn’t get in the shower this minute, she will “make sure that he never breathes fresh air again.” While this is an unlikely threat, if Joe believes it and becomes very distressed, it rises to the level of verbal abuse.

What is Neglect?

- Neglect is an act or omission which caused, *or places an individual at risk for*, injury or death and may include failure to provide:

  Adequate nutrition, clothing or health care

42 U.S.C. § 10802(1)

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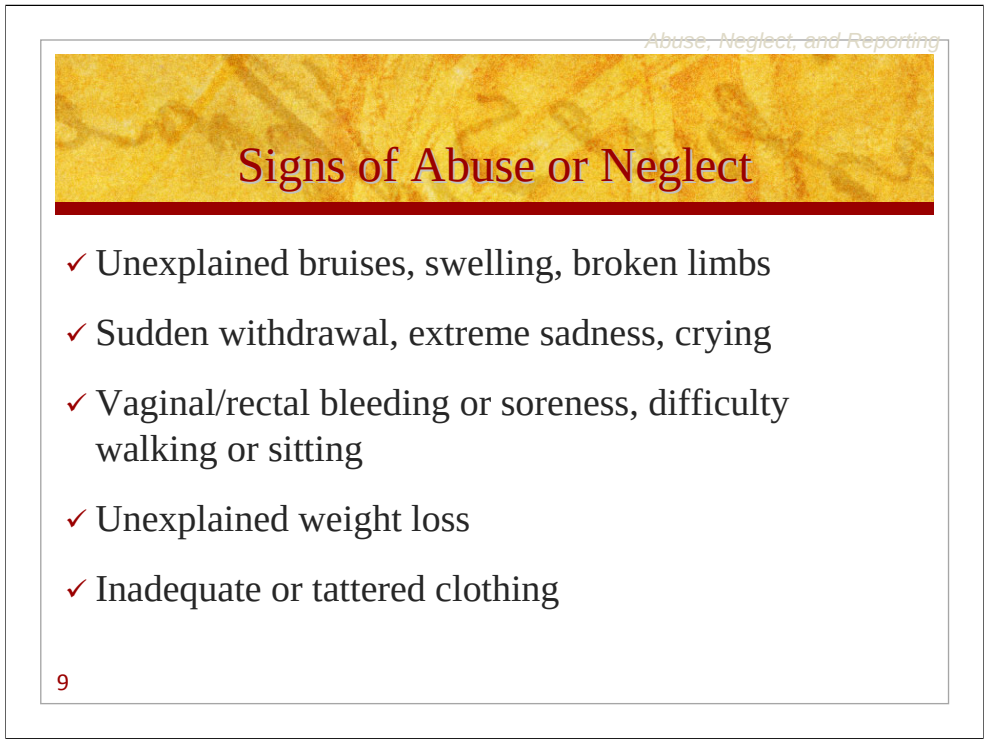
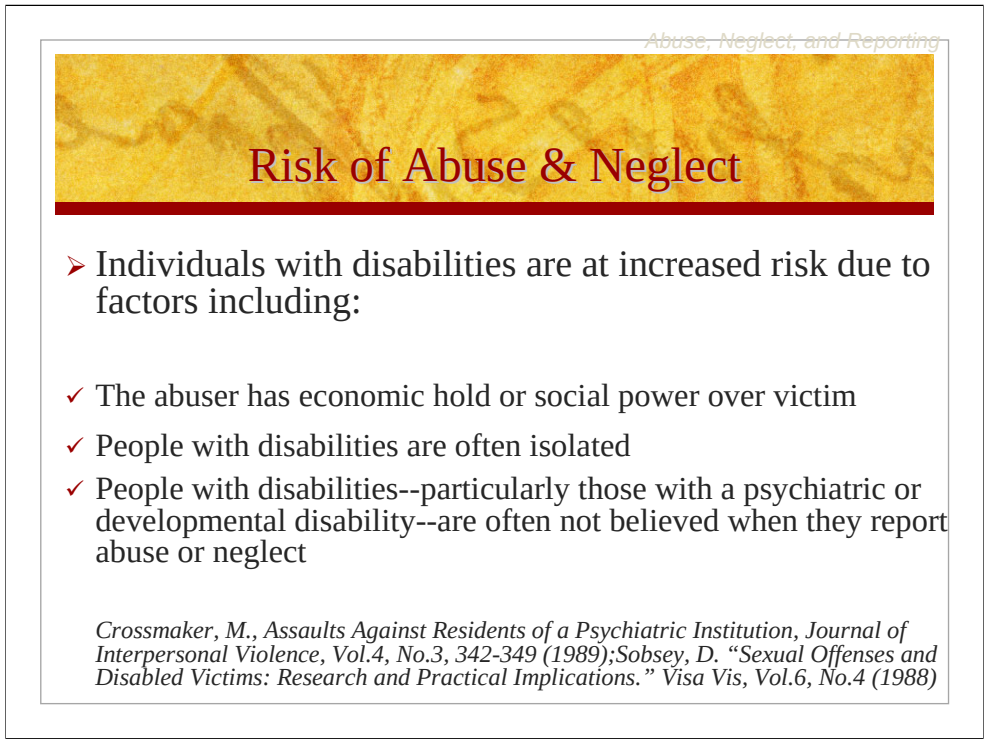
Neglect occurs when we fail to provide for those in our care. Failure to provide timely medical care to a person diagnosed with a mental illness can occur when staff make assumptions about those receiving psychiatric care. For example, “Annie” is known to hospital staff as being “attention seeking.” One day other patients approach the nurses station to report that Annie appears to have trouble breathing. Staff assume that Annie is faking distress to get attention and decide to ignore her to “teach her a lesson.” Several hours later, Annie slumps over and slides to the floor, not breathing. CPR attempts fail and Annie dies. The autopsy reports that Annie had a piece of cake lodge in her esophagus and she very slowly asphyxiated. Unfortunately, the very real medical complaints that a psychiatric patient has is often ignored because we have labeled that person “manipulative” or “attention-seeking,” or because we assume that they are delusional. It is important not to make assumptions when a person complains of pain or other physical symptoms, but rather ensure that he or she is promptly provided with a medical examination and/or care.

It is also important to remember that strict adherence to unit rules can wind up causing abuse or neglect. For example, due to the side-effects of his medication, George has difficulty rousing himself from sleep at mealtimes. The unit “rule” is that a person may not eat if they are more than 5 minutes late to the dining room. Because George is frequently late, he rarely is provided with food and loses a significant percentage of his body weight before an advocate intervenes. Remember, the most important “rule” is “do no harm!”



People are often afraid to report abuse or neglect, so it is important to observe those in your care for signs of possible abuse or neglect. It is also important to take action if someone in your care has unexplained injuries. For example, when Diane arrives at the hospital for her regular morning shift, she finds Janie with a black eye. Janie refuses to talk about what happened. A staff person from the night shift states that Janie "walked into a door." The following week, Diane arrives to work to find Janie with a bruised and swollen lip. Again, Janie refuses to talk about what happened and the same night worker informs Diane that Janie "fell" and hit her lip on the corner of a table. These incidents are signs that someone may be physically abusing Janie and that the night worker is either involved or is covering up his lack of monitoring patient safety. It is not acceptable to ignore these signs of possible abuse.



People with disabilities are extremely vulnerable to abuse or neglect. Due to their disability and/or economic status, they are usually dependent, to varying degrees, upon others financially and/or for housing and care. This not only places them at risk for being abused by those who have some degree of power over them, but also means that they may have a "learned dependence" on others and therefore fear that complaining or making an accusation may cause them to lose something they need to survive. In addition, because people with a psychiatric disability are frequently isolated from the larger community, they may not know where to seek help. Finally, even when a victim complains, he or she is frequently not believed ***because*** of their disability. For example, Ingrid has schizophrenia and is not doing well mentally. She approaches the nurses station and complains of vaginal bleeding. She is taken to the emergency department, where it is determined that she has severe vaginal tearing, requiring numerous stitches. When questioned, Ingrid states that a male patient raped her the previous afternoon. Rather than call the police, staff question the male patient, who states that the sex was "consensual." Staff then re-interview Ingrid and she becomes upset and makes some contradictory statements about the events. Despite the physical evidence of the vaginal tearing, staff conclude that Ingrid consented to the intercourse.

Where Does Abuse/Neglect Happen?

- ✓ private homes
- ✓ schools
- ✓ community programs
- ✓ residential and in-patient settings

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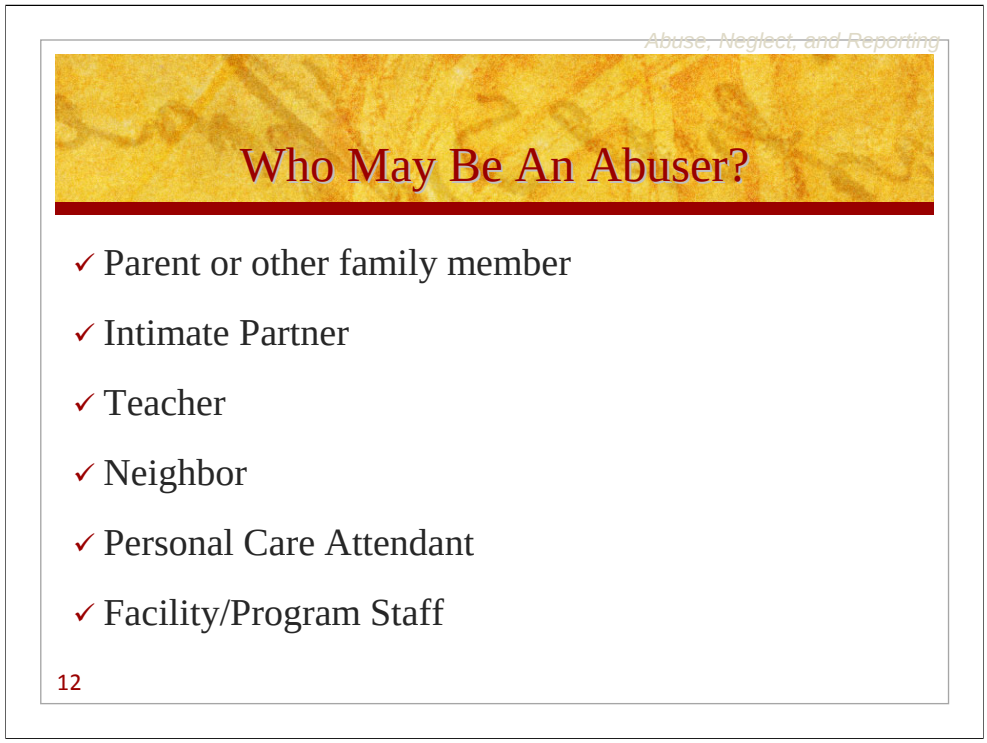
Abuse/Neglect can happen anywhere. Do not make assumptions about where abuse/neglect can and cannot occur. Also, don't make assumptions about . . . Next slide.



Abusers often groom their victims and will therefore be seen as very caring and attentive. While we don't want to assume that everyone IS a potential abuser, do not rule out abuse if you begin to see the signs. Abusers may also seek out positions where they have access and power over victims, including positions such as personal care attendant or facility/program staff.

State laws on mandatory reporting of suspected abuse/neglect vary widely. At a minimum, you need to find out if you are required to report abuse/neglect of the population that you serve. Each state has child and adult protective services that investigate allegations of abuse/neglect of children, the elderly and vulnerable adults (i.e.., those with severe disabilities). Depending on where the alleged abuse/neglect occurs, other entities responsible for ensuring safety and well-being of persons with a psychiatric disability include:

State licensing and oversight agency: If the suspected victim is in a facility or program licensed by the State, the licensing agency is responsible for ensuring that it is in compliance with state and federal laws and can investigate alleged violations. State laws vary, however, as to the circumstances---if any—under which the agency MUST investigate (e.g., they may only investigate complaints of actions or circumstances that are life-threatening.

Center for Medicaid and Medicare Services (CMS): If the facility where the alleged abuse/neglect receives federal Medicaid or Medicare funding, it is required to comply with "conditions of participation," which include safety of residents/patients. CMS will investigate allegations of violations, often in conjunction with the state licensing agency (i.e.., the state licensing agency will conduct the investigation and report its findings to CMS).

Joint Commission on Accreditation of Healthcare Organizations (JCAHO): If a hospital is accredited by JCAHO, it is subject to complying with JCAHO standards on patient care, including abuse and neglect. JCAHO conducts unannounced surveys and may also investigate individual complaints made about a hospital.

Protection and Advocacy of Individuals with a Mental Illness

In 1986, Congress passed the Protection and Advocacy of Individuals with a Mental Illness Act (PAIMI), finding that:

- individuals with a mental illness are vulnerable to abuse, serious injury and neglect; and
- state systems for monitoring compliance with respect to the rights of individuals with a mental illness vary widely and are frequently inadequate

42 U.S.C. § 10801(a)(1)(3),(4) "Congressional findings and statement of purpose"

Because state protection systems vary so widely and are frequently inadequate to protect individuals with a psychiatric disability from harm, Congress passed a statute designed specifically to protect the rights of this vulnerable population.

Protection & Advocacy Systems

- Under the PAIMI Act, States must establish or designate an independent system to investigate abuse and neglect allegations (P&A)
- All 50 states, the District of Columbia and the U.S. Territories, have a P&A

42 U.S.C. § 10801(b)(2)

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Most P&A's are non-profit legal agencies independent from the state. A few, however, are part of state government, but independent of any agency in the state which provides treatment or services to individuals diagnosed with a mental illness.

Protection & Advocacy Systems

- Charged with protecting individuals diagnosed with a mental illness from abuse and neglect
- Must establish an ongoing presence in facilities
- Authority to investigate abuse/neglect allegations
- Access to facilities & patients/residents & medical records
- Monitor facility conditions

42 U.S.C. § 10805(a)(1),(3) &(4); 42 C.F.R. § 51.31(c),(d)(2); § 51.42(a),(b),(c),(d)

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Federal law requires P&A systems to establish, to the extent resources allow, an ongoing presence in all facilities.

P&A systems determine what constitutes “probable cause” to believe that an incident of abuse or neglect has occurred, for purposes of conducting investigations.

In addition to conducting investigations, the P&A has authority to conduct monitoring of facilities to provide information on rights and services, to monitor compliance with respect to rights and safety of residents, and to inspect, view and photograph all areas of the facility which are used by residents or accessible to residents.

Protection & Advocacy Systems

- Authority to enter facilities during reasonable hours or, during emergency, at any hour necessary to conduct an investigation
- During monitoring and investigations, must have reasonable unaccompanied access to all areas used by residents and must be accessible to residents

42 C.F.R. §51.31(c); §51.42(a),(b),(c),(d)

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During investigations, P&A staff have authority to interview any facility service recipient, employee, or other persons, including the person thought to be the victim of abuse or neglect, who might be reasonably believed by the P&A to have knowledge of the incident under investigation. While staff may refuse to speak with the P&A, facilities must make the staff person "available."

Facilities may not insist that a staff person "escort" the P&A during investigations or monitoring activities.

Protection & Advocacy Systems

- Authority to speak ***privately*** with all residents, including minors and adults under legal guardianship
- Authority to provide information and training about rights and P&A services, including name, address, and telephone number of P&A system
- Facilities that receive funds from CMS must furnish written descriptions of legal rights to residents/patients, including a posting of contact information for P&A

42 C.F.R. § 51.31(c); § 51.42(c),(d); 42 C.F.R. § 483.10(b)(7)

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Facilities may not insist that staff be present during an interview with a resident. If there is a security concern, staff may visually monitor from outside the interview room. P&A staff may speak with residents without parental or guardian permission.

PAIMI ACT DEFINITIONS

- Under the PAIMI Act, an "individual with a mental illness" is a person who has a significant mental illness or emotional impairment, as determined by a mental health professional qualified under the laws and regulations of the State, who:
  - ✓ Lives in a community setting, including their own home;
  - ✓ Is an inpatient or resident in a facility rendering care or treatment, or is in the process of being admitted to a facility; or
  - ✓ Is involuntarily confined in a municipal detention facility

42 U.S.C. 10802(4)(A),(B)(i)(I),(II),(III), (ii)

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When the law first passed, it applied only to people who were in an inpatient or residential setting, in the process of being admitted to such facility, or in a municipal detention facility. In 2000, the law was amended to included individuals with a mental illness in any community setting, including their own home. Thus, any person who, by virtue of their diagnosis of a mental illness, is receiving mental health services from your organization or facility, will be covered under the law.

PAIMI ACT DEFINITIONS

- Under the PAIMI Act, facilities include, but are not limited to:
  - ✓ Hospitals
  - ✓ Nursing homes
  - ✓ Community facilities
  - ✓ Board and care homes
  - ✓ Homeless shelters
  - ✓ Jails and prisons

42 U.S.C. 10802(4)(A),(B)(i)(I),(II),(III), (ii)

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This is a list, not exclusive, of the types of places that the P&A has access to for purposes of investigating complaints and monitoring conditions.

Abuse Under PAIMI

- Under the PAIMI Act, abuse ***also*** includes:

- ✓ using "excessive force" when placing an individual . . . In bodily restraints; and
- ✓ use of bodily or chemical restraints not in compliance with Federal and State laws

42 U.S.C. § 10802(1)

Use of restraints places consumers (and staff) at risk of physical and psychological harm and death. Failure to follow the law, including not using excessive force, constitutes abuse. It is important to think about what is "excessive force." It may be having a large number of people involved in the restraint take down or it may be the amount of force used to keep a person down when placing their limbs in mechanical restraints. Certainly, any use of restraint (including emergency medication) on a person who does not pose an immediate threat of harm to self or others---in other words, for staff convenience on a busy unit or as retaliation against the person—is abuse.

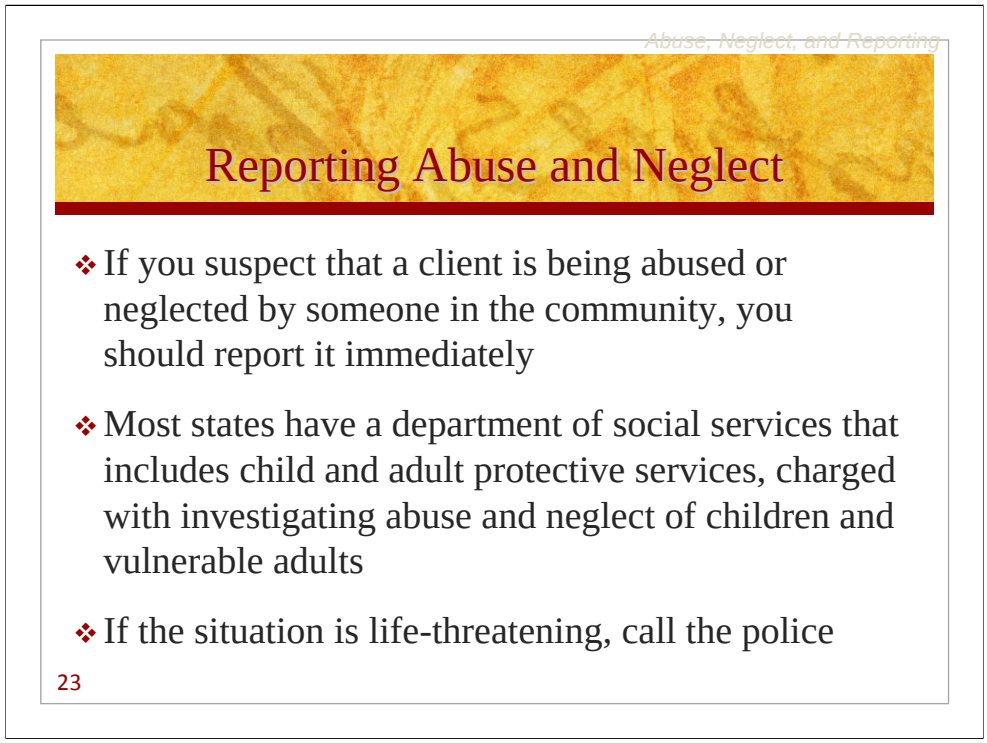
Neglect Under PAIMI

- Under the PAIMI Act, neglect ***also*** includes:

- ✓ Failure to establish or carry out an appropriate individual program plan or treatment plan;
- ✓ Failure to provide a safe environment, including failure to maintain adequate numbers of appropriately trained staff

42 U.S.C. § 10802(5)

People have a right to be safe, and the failure to provide a safe environment, with an adequate number of trained staff, is neglect. A person also has the right to have treatment be individualized to meet their specific needs. Facilities and programs that provide the same, or virtually the same, treatment plan for all patients/consumers are likely failing to address individual needs and may be found to be neglecting the care of patients/consumers.



Even though a consumer may live independently, if he or she receives services from your organization, you should take the proper steps to report suspected abuse or neglect.

Reporting Abuse and Neglect

- All psychiatric residential treatment facilities, private and public, serving individuals 21 years of age or younger, are required to report "serious occurrences" to the P&A
- Some states require reports of deaths of individuals receiving services from the public mental health system to the P&A

42 C.F.R. § 483.374

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A "serious occurrence" is defined as a death, suicide attempt or "serious injury." A "serious injury" is defined as any significant impairment of the resident's physical condition as determined by medical personnel, including burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflected by someone else. These laws were necessary because too many residents continue to be injured or die while in residential care, and this reporting requirement alerts the P&A when potential abuse occurs in an RTC. P&A staff will typically review these incident reports and determine whether there is probable cause to investigate. For example, a report that a child's arm was broken during a restraint should trigger further investigation.

Reporting Abuse and Neglect

- If you suspect that a staff person is abusing or neglecting a client or patient, report it to your supervisor immediately
- Some states also have a "human rights office" or a similar agency to protect individuals in state facilities
- Some states require state employees to immediately report suspected abuse or neglect

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Staff have responsibility to protect mental health consumers from harm. While, as we've learned, there are various protections in place, it is impossible for any one agency or system to adequately monitor all facilities and programs state-wide. As staff, you are "on the ground" and are in the best position to notice if something is going on with a resident/patient/client. Most programs and facilities have protocols for reporting incidents of abuse or neglect. Many states also have internal systems for investigating complaints by or on behalf of residents/patients and some require staff to report abuse or neglect allegations.

If internal or state reporting systems are not responding appropriately to a complaint, you may contact the P&A directly. Staff who fear retaliation for lodging a complaint against a peer, may report confidentially or anonymously. Bear in mind, however, that enough information has to be provided to the P&A to conduct an investigation and find that abuse or neglect has occurred. An investigation may stall if you are unwilling to "go on the record" with what you know or have observed.

Reporting Abuse and Neglect

- If you witness abuse or neglect, document in writing what you observed in as much detail as possible, including:
  - ✓ Parties involved
  - ✓ Date and time
  - ✓ What you observed
  - ✓ Any physical evidence or other corroborating evidence
  - ✓ Other potential witnesses

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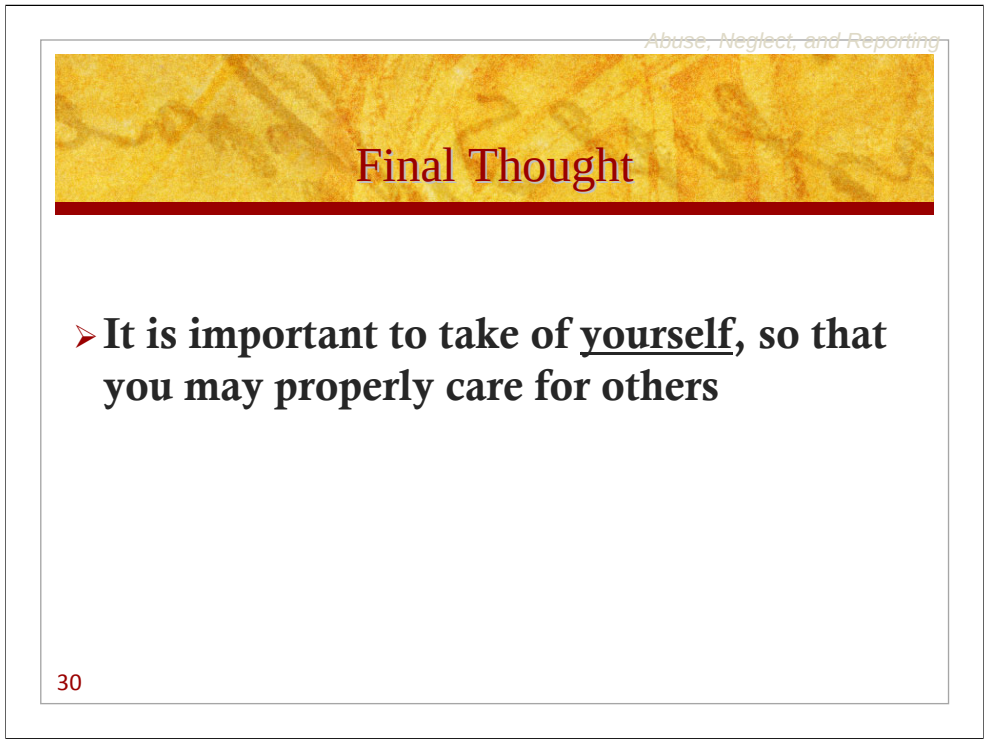
No matter what agency or system you alert or file a formal complaint with, write up the incident or your suspicions and provide as much detail as possible. The more you document, the better the chance that the investigative body will be able to corroborate your allegations as fact.

SUMMARY

- Abuse and Neglect is a significant public health problem
- Majority of people receiving mental health system services have experienced abuse or neglect
- Abuse or neglect can happen in any setting and abusers are frequently people the victims trusted or those who have power over the abused

SUMMARY

- People with disabilities are especially vulnerable to abuse or neglect
- There are systems in place to investigate abuse or neglect of persons with disabilities
- There is a federal law specifically designed to protect persons diagnosed with a mental illness, which grants broad authority to the P&A system to investigate allegations and monitor facility conditions
- It is important to learn where and how to report suspected abuse or neglect



Staff are susceptible to burn-out due to the demands and stress of the job. When tired, mistakes can happen and you may unintentionally contribute to the abuse or neglect of someone in your care. Worse, some staff become angry and lash out against others. You must be sure to take care of your own emotional needs and come to work ready to provide compassionate and quality care.