Institution Abuse and Neglect

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Statistics

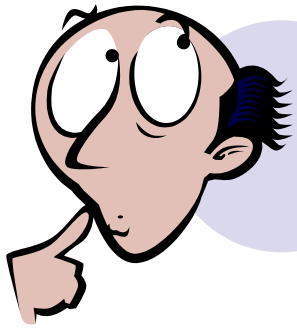
Caveat… little real data; estimates from small studies

- People with disabilities are estimated to be 4-10 times more likely to be victimized.
- People with intellectual impairments at highest risk for victimization.
- People with disabilities are:
  - more likely to experience more severe abuse and abuse of a longer duration,
  - be victims of multiple episodes, and
  - be victims of a larger number of perpetrators.

- People with disabilities 2-10 times more likely to be sexually assaulted.
  - > 90% of persons with developmental disabilities will experience sexual abuse at some point.
  - 80% of people with developmental disabilities sampled were sexually assaulted more than once; 49.6% sexually assaulted 10 or more times.
  - Risk of sexual assault is 2-4 times higher in institutional setting than in the community
    - 90% of ♂ & 80% of ♀ living in institutions have been victims of sexual assault, generally not by staff but other residents

What is Abuse or Neglect?

- Physical abuse – infliction of physical pain or injury
  - Pushing, slapping, hitting
  - Sexual assault
- Misuse of restraint– excessive or inappropriate use; beyond MD order or community standard
  - Mechanical or physical restraint, seclusion, sedating medication
- Verbal or emotional abuse – infliction of mental or emotional suffering
  - Demeaning statements, threats, humiliation, intimidation
  - Harassment
- Physical neglect – disregard for necessities of daily living
  - Failing to provide food, clothing, assistance with bathing
- Medical neglect – lack of care for existing medical problems
  - Not calling MD, ignoring special diet, not taking action on medical problem
- Verbal or emotional neglect – creating situations in which esteem is not fostered
  - Ignoring individual's wishes, restricting contact with outsiders
- Personal property abuse – illegal or improper use of individuals property for another's personal gain
  - Theft

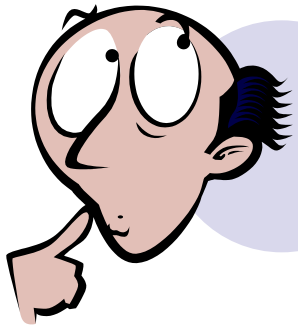


What is difference between

Abuse and Neglect

&

a CRIME?



What is difference between: Abuse and Neglect & CRIME

Mandated Abuse Reporting Act [Welf. & Inst. Code § 15600 *et seq*]

- Physical Abuse
  - Assault [PC § 240]
  - Battery [PC§ 242
  - Sexual assault/battery [PC § 243.4]
  - Rape [PC §§261, 262, 264.1], Incest, Sodomy, Oral Copulation
  - Lewd acts [PC § 288]
- Financial Abuse
- Neglect
- Abandonment, Abduction, Isolation

Crimes Against Elders & Dependent Adults [PC §368]

- Circumstances or conditions likely to produce great bodily harm or death
- Willfully causes or permits unjustifiable pain or suffering
- Care provider willfully causes injury or endangerment

Institutional Abuse & Neglect

Repeat caveat… based on a few studies

- Staff factors: most often perpetrated by direct care staff; younger (> 40 y.o.), male, relatively newer staff, previous incidents of abuse
- Institutional factors: afternoon shift [3-6 p.m.]; in residential areas; during leisure time, personal hygiene, or in transit; staff overtaxed, understaffed, insufficient staffing, fewer licensed staff
- Client factors: more often younger (> 40 y.o.), male, more mobile, with aggressive or maladaptive behaviors, less verbal, more cognitively impaired (severe/profound), previously abused
- Type[+]: physical care and neglect most frequently reported
- Reporting: nearly always by facility staff, then by victim; greater # reporting staff had received inservice training in abuse policies & were newer employees
- Outcome: nearly always administrative/employment consequence (termination, suspension, reprimand)
- Location: (1) residential areas, (2) training areas, (3) grounds

[+]Physical abuse, verbal abuse, behavioral abuse, neglect, exploitation, intimidation, other.

Lisa Russell

48 years old with cerebral palsy and mild mental retardation; used a wheelchair; minimal assistance and supervision; living in large ICF

Incident:

- Seen returning from outside with male nurses aide (CNA) not assigned to her unit
- Blood and mud on back of nightgown and “covered in grass”
- Explanations are inconsistent and don’t make sense
- Lisa hesitantly reported being sexually assaulted the following day
- CNA had left previous facility after c/o of “inappropriate sexual behavigo with male client

Issues:

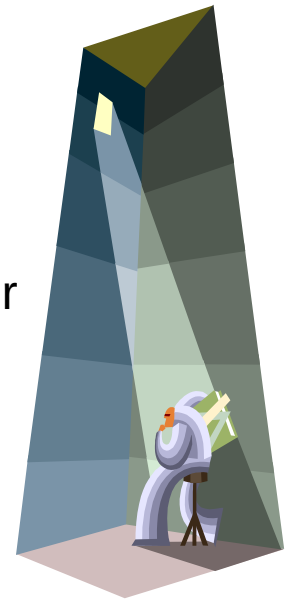
- Staff did not suspect or question at the time of the incident despite her appearance
- Facility administrators did not notify authorities but interviewed Lisa, alone
  - Interviewed by people in power and authority
  - Asked compound and leading questions
  - Concluded encounter was consensual
- Police notified by hospital staff where Lisa was sent for pelvic exam
  - Did not order SART
  - Later concluded CNA committed dependent adult sexual abuse PC §288(c)(2)

Outcome:

- Lisa died 6 weeks from STD before criminal charges were filed
- Licensing cited facility (lowest level) but waived penalty
- CNA fired & license was revoked

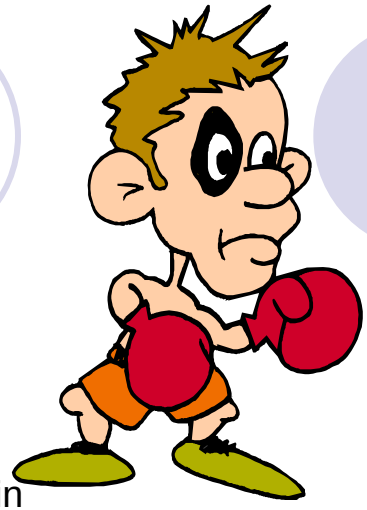
Special Vulnerabilities

- Cognitive deficits:
  - Difficulty recognizing unlawful activity
  - Limited knowledge of their right to safety and protection
  - Impairments impacting ability to execute reporting plan
- Physical disability:
  - Dependence on others for essential care giving
  - Inability to physically escape or defend
- Communication impairment:
  - Limited ability to verbally defend or disclose abuse
- Generally:
  - Stigma
  - Bias about believability
  - Threat of institutionalization

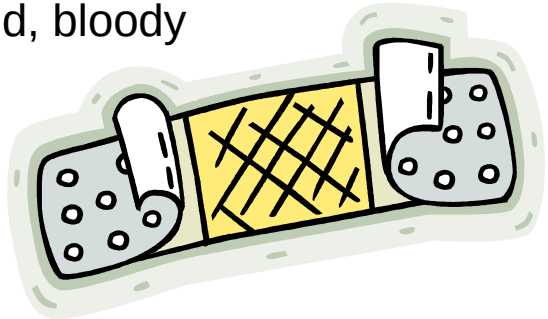


- Situational:
  - Physical isolation
  - Exposure to a large number of care providers
  - Fear of retribution
  - Complex abuse reporting scheme
- Social capacity:
  - Limited social opportunities
  - Lack of training in sex education & limited experience in ‘normal’ sexual relationships
  - Compliance training
  - Lack of experience in self-advocacy

Indications



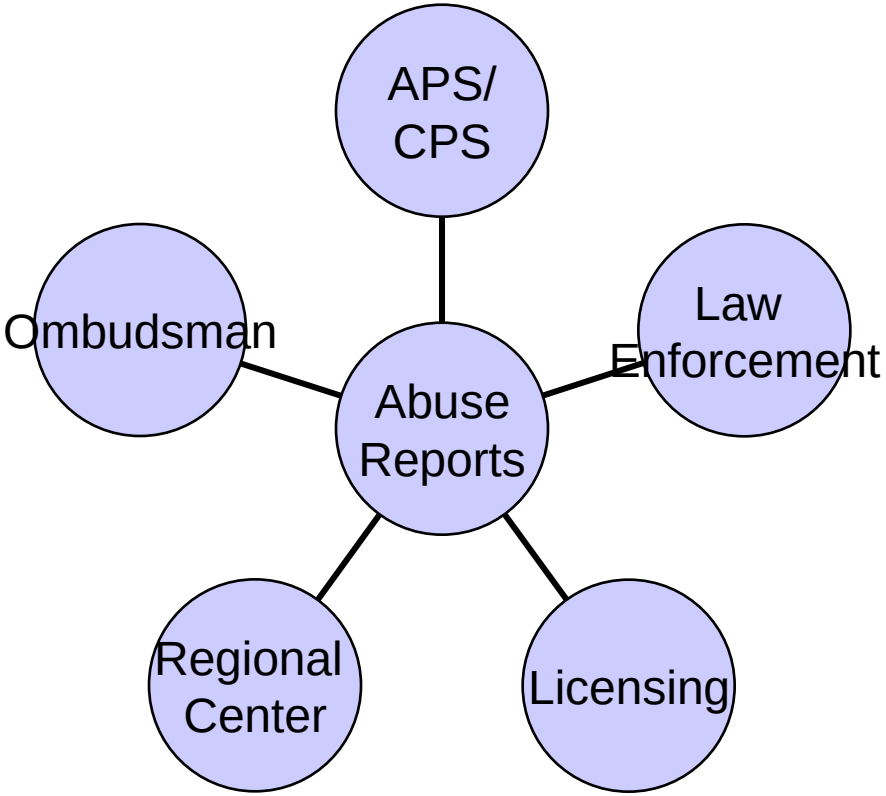
- Physical Abuse:
  - Unexplained bruises, wounds, burns
    - or does not match explanation or history in record
  - Patterns, well-defined shapes, various ages of healing
  - Implausible or contradictory explanations
- Sexual Abuse:
  - Genital/anal pain, itching, bruising, bleeding, cuts
  - STDs
  - Torn, stained, bloody underwear



- Emotional Abuse:
  - Changes in behavior
    - Easily frightened
    - Hesitant to talk openly
    - Aggressive
  - Rocking or sucking (not previously seen)
- Neglect
  - Dehydration, malnutrition, weight loss
  - Poor hygiene, poor oral care
  - Inappropriate dress
  - Unattended physical or medical needs
  - Excoriations
  - Fecal impaction

Abuse Response System

- Adult Protective Services/Child Protective Services = immediate safety of individual(s)
- Law Enforcement = crime investigation
- Ombudsman = complaints from long-term care residents (mostly elderly)
  - Confidentiality restrictions
- Regional Center = provide or coordinate services and supports for individuals with developmental disabilities
- Licensing = oversight of facility & licensed care staff



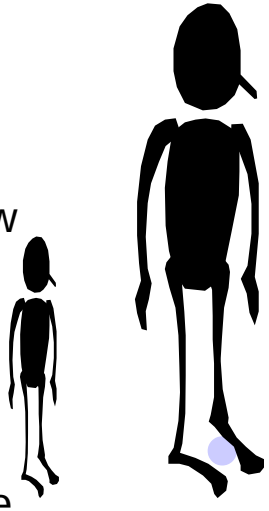
- BMFEA = abuse in LTCF

Gaps/Lapses in Reporting & Response

- Delays in reporting
  - Mandated reporter fails to report
    - Doesn't recognize reportable event
    - Worries of retaliation
  - Internal reporting only
  - Challenges with resident access to reporting system
  - Getting system to "take report"
- Lack of training on investigating or PWD
  - Health facilities staff
  - Victims with disabilities
  - Investigators
  - Judges/DAs
- Ombudsman challenges
  - Confidentiality restriction
  - Funded only for cases involving elders
  - Work force & scope of work
- Not referred to criminal justice system
  - Delayed investigation
  - Not prosecutor's top priority
  - Bias of courts to more egregious cases

Societal Factors Impeding Response

- People with disabilities don't trust system;
  - Unsatisfactory previous contact
  - See police negatively
- Bias & Stigma
  - Unreliable; not credible
  - Won't make good witnesses
  - Take too much time to interview
  - Marginalized, infantilized, invisible
  - Victims don't understand what happened so they suffer less
  - No one would victimize them
  - Care providers care & are more reliable
  - Nothing will happen anyway
- System may lack sensitivity & experience working with people with disabilities



Outcome

- Abuse/neglect handled as administrative/employment issues
- Underreporting of crime
  - 71% of crimes against people with severe mental retardation is underreported
  - 4.5% of serious crimes committed against PWD have been reported (compared with 49% for general population)
  - 80-85% of crime of institution residents is unreported
- Low rates of prosecution
  - 5% of cases involving victim with disability vs. 70% of cases involving victim without disability
- Sentences for crimes against PWD are lighter, particularly sexual assault

Restraint and Seclusion

- **Restraint**

Restrict freedom of movement, physical activity or normal access to one's body

  - Physical force; manual methods
  - Mechanical device, material or equipment

- **Chemical Restraint**

Medication used as a restriction to manage an individual's behavior, generally unplanned and in emergency/ crisis.

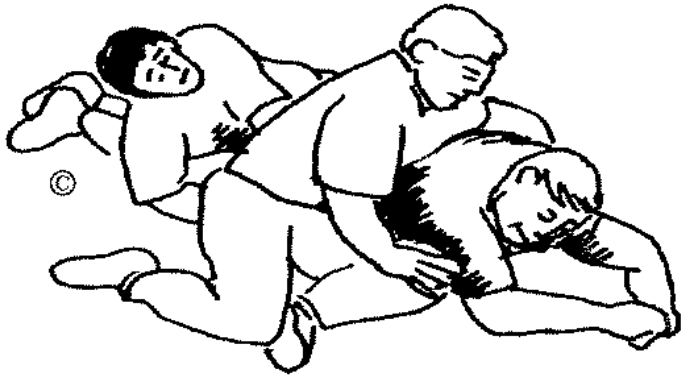
- **Seclusion**

Involuntary confinement alone in a room or an area from which the resident is physically prevented from leaving

- **Time Out**

A behavioral management technique

  - May involve the separation from the group/activity
  - May involve voluntarily restricting the individual in a room or area



Conditions on Use

- Safety measures of last resort; NOT treatment
- To prevent imminent risk of physical harm
  - when other less restrictive alternatives have failed,
  - for the least amount of time necessary, and
  - in least restrictive way.
- Never for coercion, discipline, convenience or retaliation by staff
- Only upon MD order
- For limited period of time

When is it Abuse?

- Inappropriate use
  - For non-imminently dangerous behavior
  - For coercion, discipline, convenience, punishment
  - Beyond MD order
  - By untrained staff
- Excessive use
  - Too long
  - Too much
  - Repeatedly w/out revision of plan/approach
  - Without adequate supervision or monitoring
  - Beyond scope of training

Hazel Jackson

62 y.o. female with severe MR and seizures. Admitted to DC initally 1984 when 36 y.o. ; Briefly transitioned to community in 1991 but returned due to "aggression and agitation."

Problem Behaviors:

1. Harm to others by throwing objects, kicking, pushing.
2. "Agitation" = "hyperactive pacing, crying, screaming, dropping to floor, throwing objects, hitting others, inability to redirect"

IPP: wheelchair restraint with seat belt and lap try @ severity level 2 or higher = "scratch/abrasion, flops down on floor, throws objects that hit someone, scratches self/others, risk of SIB"

Potential Risk of Restraint: "may be stigmatizing."

History: 7 times in restraint in 1 year, some lasting up to 6 hours.

Outcome: found dead ("cold") in wheelchair restraint; she had slid down in chair & restraint belt was at neck/chin area; had been placed in restraint b/c she had been "flailing her arms, yelling," was on floor "resistive to redirection"

Issues:

- Left in wheelchair restraint unsupervised in her room for over 3 hours
- Restraint applied in absence of imminently dangerous behavior
- Boilerplate behavior plan unchanged for years

Lacerations

- Lenny M. 47 years old, IQ 9, nonverbal, requires assistance with ADLs
  - Left unsupervised in shower room for ~ 1 hr
  - In wheelchair with seat belt on, clothed
  - 2 lacerations [“straight fresh cut”] on penis requiring 14 & 1 sutures, 1 around entire circumference
  - Facility staff attributed to unwitnessed fall from wheelchair
  - Reported to investigators the following day

- 7 other incidents in previous 5 years
  - Neal D. 33 years old, IQ 9, nonverbal, needs assistance with zipping & buttoning
    - 1.5 cm laceration on penis, requiring 3 sutures
    - Facility staff attributed to zipper catch
    - Not reported to investigators
  - Roger G. 50 years old, IQ 6, nonverbal, blind, requires assistance with toileting
    - 8 cm L shaped laceration to scrotum, requiring 20 sutures under anesthesia
    - Facility staff attributed to zipper catch (wore elastic waist pants w/o zipper)
    - Reported to investigators 5 days later
  - Sean A. ? Age/adult, nonverbal, requires assistance with ADLs
    - 2 lacerations on underside of penis, requiring 6 sutures
    - Cause unknown
    - Not reported to investigators
  - Alan B. 41 years old, IQ 50, verbal (900 words), blames peer for most incidents
    - 2 cm laceration on scrotum with bruising, requiring 5 sutures
    - Facility staff initially suspect caused by a kick, later dismissed
    - Reported to investigators 2 days later

Conclusions:

- Injuries were highly suspect of abuse
  - Nature, severity, & pattern of injuries is suspicious
  - Not consistent with self-injurious behavior
- Victims should have had sexual assault exams
- Inadequate description of injuries by medical/nursing personnel
- Should have been reported as abuse

Findings:

- Direct care staff failed to see these injuries as suspicious
  - No SARTs, limited description/examination
  - No reported [timely] to investigators
  - Not reported or investigated
- Investigations failed to consider possible abuse or neglect
  - No tracking of staff
  - Appeared to rely upon explanations of care providers
- Trend of injuries not recognized by facility

5 male residents were repeated victimized by 3 CNAs on evening shift

- Taunting residents
- Pinched on nipples & penis; twisted skin on arms
- Forced to eat own feces out of adult briefs
- Given cold showers
- Hit on head w/shampoo bottle
- Paraded naked & soaking wet
- Pinched sutured laceration on eyebrow & asked if it hurt

- Took photographs & videos of abuse on their cell phones
- Witnessed by other staff
- Not reported by facility to law enforcement

DA declined to prosecute "lack of evidence

Roger frail elderly man skin like 'wet tissue paper'

- Sustained large skin tear from armpit to waist then
- Forced into whirlpool bath
- Kept in bath despite cries of pain and pleading

- Not reported by facility but visitor
- Not considered abuse by facility
  - Not reported to law enforcement
  - Not reported to LTCO

Carl Jones

42 y.o. male with autism and severe MR living in large ICF/MR

Problem Behaviors: biting self on forearm; grabbing; biting others; pulling hair

IPP: wrist-waist restraint (110 min max); secure helmet with faceguard (110 min max); arm splint; time out (60 min max) for all problem behaviors

Track Record:

1. IPP unchanged for years
2. Escalating use with at least 24 incidents in 1 year
3. Often all three (restraint with helmet and armguard) used simultaneously
4. Applied in absence of imminently dangerous behavior
5. Often for maximum amount of time

Outcome: barrier to discharge