Memorandum

Date MAY - 3 2001

From Michael F. Mangano
Acting Inspector General

Subject Reporting Abuses of Persons with Disabilities (A-01-00-02502)

To See Addressees Below

Attached are two copies of our final report entitled, "Reporting Abuses of Persons with Disabilities." We are forwarding this report to the Acting Assistant Secretary for Management and Budget for resolution because it contains issues which cut across the responsibilities and interests of the Operating Divisions included at the bottom of this transmittal memorandum.

The objective of our review was to determine the procedures used by State agencies to identify, investigate, and resolve reports of abuse or neglect (incidents) of persons with disabilities. Our review included California, Delaware, District of Columbia (which is referred to as a State for purposes of this report), Massachusetts, New York, North Carolina, and Pennsylvania, and focused on State agencies that oversee or provide residential services to persons with disabilities, especially those diagnosed with mental retardation or mental illness.

We found that Federal requirements for protecting persons with disabilities from abuse or neglect are directed at facility providers rather than State agencies. Some persons with disabilities reside in facilities that are subject to the Health Care Financing Administration's (HCFA) conditions of participation as well as State laws and regulations. However, we estimated that up to 90 percent of persons with disabilities reside in facilities, such as group homes, some residential schools, and supervised apartments, that do not receive HCFA funds or were not part of the Medicaid waiver program and rely solely on various levels of protections that are provided by State laws and regulations.

Also, we found that the Department of Health and Human Services (HHS) is at a disadvantage in identifying systemic problems since it receives incident information from a limited number of sources. Specifically, the protection and advocacy (P&A) program officials submit annual reports to HHS on the number and type of abuse or neglect cases they handled. Information from these reports is compiled and provided to the President, the Congress, and the National Council on Disability. However, these reports reflect only the incidents that were known to the P&As and likely represent only a fraction of the incidents that actually occurred. The HCFA reduced the gap in information when it issued an August 1999 interim regulation which requires hospital facilities to report deaths resulting from the use of restraints or seclusion, (i.e., the confinement of a person in a locked room). However, most restraint and seclusion related deaths occur outside hospital facilities. These reporting requirements were subsequently enacted in legislation passed in 2000.

We recommended that the Health Care Financing Administration, the Administration for Children and Families, the Substance and Mental Health Services Administration, and the Food and Drug Administration work cooperatively to provide information and technical assistance to States that would: (1) improve the reporting of potential abuse or neglect of persons with disabilities; (2) strengthen investigative and resolution processes; (3) facilitate the analysis of incident data to identify trends indicative of systemic problems; and (4) identify the nature and cause of incidents to prevent future abuse.

We would appreciate your views and the status of any further action taken or contemplated on our recommendation within the next 60 days. If you have any questions, please contact me or have your staff contact Donald L. Dille, Assistant Inspector General for Administrations of Children, Family, and Aging Audits, at (202) 619-1175.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5). As such, 2 weeks after the issue date, the final report will be available on the world wide web at http://www.hhs.gov/progorg/oig.

To facilitate identification, please refer to Common Identification Number A-01-00-02502 in all correspondence relating to this report.

Attachments

Addressees:
Dennis Williams, Acting Assistant Secretary for Management and Budget
Diann Dawson, Acting Principal Deputy Assistant Secretary for Children and Families
Bernard Schwetz, Acting Principal Deputy Commissioner of Food and Drugs
Michael McMullan, Acting Principal Deputy Administrator, Health Care Financing Administration
Joseph Autry, III, Acting Administrator, Substance Abuse and Mental Health Services Administration

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REPORTING ABUSES OF PERSONS WITH DISABILITIES

MAY 2001
A-01-00-02502

EXECUTIVE SUMMARY

This report focuses on how States identify, investigate, and resolve abuse or neglect of persons with disabilities, including the misuse of restraints and seclusion. A General Accounting Office (GAO) report dealt with the Health Care Financing Administration's (HCFA) role in providing protections to residents and patients of facilities that receive Medicare and Medicaid funds. However, as we found in our review, many persons with disabilities, are in residential settings that are not subject to HCFA's oversight and rely solely on protections offered by State systems. There were significant differences in the State systems which we detail in this report.

BACKGROUND

At the Federal level, several Department of Health and Human Services (HHS) operating divisions (OPDIVs) fund programs or services that play a role in protecting persons with disabilities from abuse or neglect. The HCFA has established conditions of participation for facilities receiving Medicare or Medicaid funds, including intermediate care facilities for persons with mental retardation (ICFs/MR), nursing homes, and psychiatric facilities that require residents and patients be protected from abuse or neglect. The Administration for Children and Families (ACF), Administration for Developmental Disabilities (ADD) and the Substance Abuse and Mental Health Services Administration (SAMHSA) provide grants to States to establish protection and advocacy (P&A) systems to investigate allegations of abuse or neglect. Finally, the Food and Drug Administration (FDA) oversees the approval of medical devices, including physical restraints, and receives information on deaths occurring during the use of restraints.

OBJECTIVE

The objective of our review was to determine the procedures used by State agencies to identify, investigate, and resolve reports of abuse or neglect (incidents) of persons with disabilities.

SUMMARY OF FINDINGS

The HCFA requirements for protecting persons with disabilities from abuse or neglect are directed at facility providers rather than State agencies. Facilities receiving Medicare or Medicaid funding are subject to HCFA's conditions of participation as well as State laws and regulations. However, many other facilities such as group homes, some residential schools, and supervised apartments do not receive HCFA funds. Residents in these facilities rely solely on protections provided by State laws and regulations. We estimated that up to 90 percent of persons with disabilities resided in facilities that did not receive HCFA funds or that were not part of the Medicaid waiver program, leaving the handling of incidents and protection of residents' rights to laws and regulations which were developed by each State.

Because each State we reviewed independently developed its laws and regulations, we identified a wide range of systems for identifying, investigating, and resolving incidents. The most structured State systems included the following elements:

- an organizational structure which provided for an independent agency to handle incidents and/or oversee investigations performed by other components;

- an automated database for collecting incident information that could be used to identify systemic problems. Such information could be used to identify facilities with large or few numbers of incidents, increasing numbers of incidents, and unexplained or unexpected deaths;

- clear policies and procedures that included standard terms and definitions, specific training requirements, and protocols for handling incidents; and

- individuals and/or committees to assist facility residents in all stages of handling incidents, review the results of investigations and proposed solutions, and disseminate lessons learned to other providers.

Also, we found that HHS is at a disadvantage in identifying systemic problems since it receives incident information from a limited number of sources. Specifically, P&As submit annual reports to HHS on the number and type of abuse or neglect cases they handled. Information from these reports is compiled and provided to the President, the Congress, and the National Council on Disability. However, these reports reflect only the incidents that were known to the P&As and likely represent only a small fraction of the incidents that actually occurred. The HCFA reduced the gap in information when it issued an August 1999 interim regulation which requires hospital facilities to report deaths resulting from the use of restraints or seclusion. However, most restraint and seclusion related deaths occur outside hospital facilities. Reporting requirements for these facilities were subsequently included in legislation enacted in 2000. The HCFA has issued an interim final rule that governs the use of restraints and seclusion that psychiatric facilities must meet to participate in HCFA programs.

RECOMMENDATION

We recommend that HCFA, ACF, SAMHSA, and FDA work cooperatively to provide information and technical assistance to States that would: (1) improve the reporting of potential abuse or neglect of persons with disabilities; (2) strengthen investigative and resolution processes; (3) facilitate the analysis of incident data to identify trends indicative of systemic problems; and (4) identify the nature and cause of incidents to prevent future abuse.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

This report focuses on how States identify, investigate, and resolve abuse or neglect of persons with disabilities, including the misuse of restraints and seclusion. A GAO report dealt with the HCFA role in providing protections to residents and patients of facilities that receive Medicare and Medicaid funds. However, as we found in our review, many persons with disabilities, are in residential settings that are not subject to HCFA's oversight and rely solely on protections offered by State systems. There were significant differences in the State systems which we detail in this report.

At the Federal level, several HHS operating divisions fund programs or services at the State level that play a role in protecting persons with disabilities from abuse or neglect.

- The HCFA pays for residential and medical services under the Medicare or Medicaid programs for people with disabilities at ICFs/MR or in some States, intermediate care facilities for people with developmental disabilities, nursing homes, and psychiatric facilities. The HCFA has established conditions of participation that specifically require that these facilities protect residents and patients from abuse or neglect. The HCFA recently issued conditions of participation focused on psychiatric residential treatment facilities that provide inpatient psychiatric services to individuals under age 21.

- The ACF/ADD and SAMHSA provide grants to States to establish P&A systems to investigate allegations of abuse or neglect. The ACF/ADD administers the Protection and Advocacy Program for People with Developmental Disabilities and SAMHSA administers the Protection and Advocacy for Individuals with Mental Illness program. The P&As provide protection of the rights of persons with disabilities through legal advocacy. The P&A program was established in response to the abuse and neglect of persons with disabilities in institutions.

- The FDA regulates the manufacture and use of medical devices, including devices used to physically restrain people. The Safe Medical Devices Act of 1990 requires all hospitals, nursing homes, and acute care facilities to report deaths related to the use of a medical device to the FDA and the manufacturer within 10 working days. These facilities must also report serious injuries to the manufacturer or to the FDA if the manufacturer is unknown.

While HHS is generally considered to be the Federal agency responsible for the protection of persons with disabilities, the Department of Education (ED) funds educational programs attended by persons with disabilities and the Department of Justice (DOJ) is responsible for assuring the legal rights of persons with disabilities.

States also fund residential facilities for persons with disabilities, such as nursing homes, psychiatric hospitals, acute care hospitals, residential schools, group homes, apartments, and

forensic facilities. These facilities may be State operated, State contracted, or privately operated and, depending on the size of the facility, may or may not be licensed and inspected by the State. They may be operated by nonprofit or profit-making organizations. A list of the types of living arrangements we encountered during our review is included in Appendix A.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our review was to determine the procedures used by State agencies to identify, investigate, and resolve reports of abuse or neglect (incidents) of persons with disabilities.

Scope

Our review was conducted in accordance with generally accepted government auditing standards. Our review included California, Delaware, District of Columbia (which will be referred to as a State for purposes of this report), Massachusetts, New York, North Carolina, and Pennsylvania. We focused on State agencies that oversee or provide residential services to persons with disabilities, especially those with mental retardation or mental illness. Although our audit scope did not include State agencies which do not primarily serve persons with disabilities, some agencies we reviewed also oversaw residential facilities that may serve some people with disabilities, such as nursing homes, or facilities that fall under ED or DOJ, including penal institutions, schools, and foster care facilities. To the extent that the agencies we reviewed oversaw other residential settings such as nursing homes or foster homes, we have included these residential settings in our report. A listing of State agencies reviewed and their general responsibility is included in Appendix B of this report.

In setting the scope of this review, we met with congressional staff, who advised us that they were interested in the availability of data on the use of restraints and seclusion, the extent to which data was collected and used, and the policies and protocols governing the use of restraints and seclusion in psychiatric facilities.

During this review, we kept in contact with evaluators from GAO who performed a closely related review. The GAO issued a report (GAO/HEHS-99-176) entitled, "Mental Health: Improper Restraints or Seclusion Use Places People at Risk" in September 1999. Our Office of Evaluation and Inspections (OEI) has issued a series of reports on hospital quality. Recently issued OEI reports on psychiatric hospitals include "The External Quality Review of Psychiatric Hospitals" (OEI-01-99-00160) and "Restraints and Seclusion: State Policies for Psychiatric Hospitals" (OEI-04-99-00150).

Methodology

We met with State officials responsible for handling reports of abuse or neglect of persons with disabilities to gain an understanding of the policies and procedures their agencies followed when an incident was reported. We also met with officials from P&A systems in each State and with HHS officials from the regional and central offices of HCFA and the ACF/ADD and the central office of SAMHSA. We visited selected residential facilities in each State. We obtained copies of laws, regulations, protocols, reports, and other related documents.

We also reviewed State investigation cases, not to evaluate them for accuracy or compliance, but to reinforce our understanding of the procedures State agencies followed and the documents State agencies used to identify, investigate, and resolve incidents, unexplained deaths, sentinel events, and complaints. Our reviewers encountered four State agencies, all in different States, which would not cooperate with our requests for sample case information, leaving us to rely on written procedures and discussions with State officials. We considered our requests to State agencies for sample cases to be voluntary, because HHS oversight of incident processes is directed to facilities, not to State agencies.

We consulted closely with State officials to ensure that we appropriately represented key attributes of their systems. The charts in this report were developed from these summaries. Because policies and practices varied within a State depending on the agency with program responsibility for different residential settings, we chose the most preponderant conditions for discussion purposes in the body of this report. We have included the complete summaries for all residential settings in Appendix A of this report.

Finally, we referred to an American Association on Mental Retardation publication, "The State of the States in Developmental Disabilities," edited by David Braddock, Ph.D.

Our on-site work was conducted during various periods between January 1999 and March 2000 for the States included in our review. State agencies commented on our summaries of the information related to their incident processes through March 2000.

FINDINGS AND RECOMMENDATION

We found that Federal requirements for protecting persons with disabilities from abuse or neglect are directed at facility providers rather than State agencies. Some persons with disabilities reside in facilities that are subject to HCFA's conditions of participation as well as State laws and regulations. Many others reside in facilities, such as group homes, some residential schools, and supervised apartments, that do not receive HCFA funds and rely solely on protections provided by State laws and regulations. We estimated that up to 90 percent of persons with disabilities

resided in facilities that did not receive HCFA funds or that were not part of the Medicaid waiver program, leaving the handling of incidents and protection of residents' rights to State laws and regulations.

Because each State we reviewed independently developed its laws and regulations, we identified a wide range of procedures and systems for identifying, investigating, and resolving incidents. The most structured State systems included the following elements:

- an organizational structure which provided for an independent agency to handle incidents and/or oversee investigations performed by other components;

- an automated database for collecting incident information that could be used to identify systemic problems. Such information could be used to identify facilities with large or few numbers of incidents, increasing numbers of incidents, and unexplained or unexpected deaths;

- clear policies and procedures that included standard terms and definitions, specific training requirements, and protocols for handling incidents; and

- individuals and/or committees to assist facility residents in all stages of handling incidents, review the results of investigations and proposed solutions, and disseminate lessons learned to other providers.

We also found that HHS is at a disadvantage in identifying systemic problems since it receives limited incident information. Specifically, the P&As submit an annual report to HHS on the number and type of abuse or neglect cases they handled. The Department compiles information from these reports and provides a summary to the President, the Congress and the National Council on Disability. However, the report reflects only the incidents that were known to the P&As and likely represents only a fraction of the incidents that actually occurred. The HCFA reduced the gap in information when it issued an interim regulation in August 1999 which requires hospital facilities to report deaths resulting from the use of restraints or seclusion. However, most restraint or seclusion related deaths occur outside hospital facilities.

Below is a full discussion of our results as they pertain to the Federal role and the incident processing systems we observed at seven States.

FEDERAL ROLE

In some inpatient and residential treatment facilities, such as ICFs /MR, nursing homes, and hospitals, where Medicare and Medicaid provide funding for residential services, HCFA has a strong voice in setting standards and requirements through its conditions of participation. However, we estimated that up to 90 percent of persons with disabilities did not reside in facilities subject to HCFA standards and that no other Federal standards exist to protect persons

with disabilities. They live with their families and friends, in apartments, in group homes, and at residential schools. While some group homes, residential schools, and home settings are covered by HCFA under the Home and Community based waivers, there are other non-Medicare or non-Medicaid facilities which are not subject to HCFA's conditions of participation for setting standards or performing oversight activities. This large number of such residential settings also reduces the likelihood of oversight by State agencies.

Limited Information on Abuse or Neglect Occurrences Received by HHS

The information HHS currently receives is limited in terms of providing sufficient statistical data on restraint or seclusion episodes, serious injuries, and deaths. The lack of such information limits HHS's ability to make informed program decisions or to respond to queries from the White House, Congress, news media, or the public. In August 1999 HCFA issued an interim regulation requiring that hospitals, including State operated hospitals, report all deaths occurring during restraint or seclusion episodes. While this was a significant requirement, the reporting of deaths may not be consistent since States use varying criteria to determine whether a death occurred during a restraint or seclusion episode. (See page 8 and 9 - Identifying and Tracking Incidents). Reporting requirements were subsequently included in legislation enacted in 2000.

The annual performance reports from individual P&As are a primary source of information for HHS on abuse or neglect of persons with disabilities. These reports reflect the incidents that were closed by the P&As during the reporting period and are primarily intended to gauge the accomplishments of the P&A systems. These reports likely represent only a fraction of the incidents that actually occurred because most incidents are entirely processed by State agencies or facilities and the P&As are not usually a part of that process. The Department compiles information from these reports and provides a summary to the President, the Congress, and the National Council on Disability. The compilation provides some useful insights about types of incidents that occurred and how they were handled but the report presents a very limited picture of the volume of incidents.

Finally, State agencies are not required to report any information on incidents of abuse or neglect of persons with disabilities to HHS.

P&As Are Constrained by Limited Funding and Limited Access to Records

The P&A programs administered by ACF/ADD and SAMHSA do not directly set standards for identifying, investigating, and resolving reports of abuse, but their advocacy efforts have a major impact on how States and facilities protect the rights of persons with disabilities. However, these programs are limited by low funding levels and by State agencies that restrict their access to incident information. We found that only two P&As (one a State agency and the other a nonprofit organization) were satisfied with their access to incident and investigation information. We did note, however, that four of the seven P&As were satisfied with their access to information about the resolutions of incidents.

Limited Compliance with FDA Regulations for Restraint Devices

The FDA regulates the manufacture and use of physical restraint devices, e.g., belts, vests, restraint tables and chairs. The Safe Medical Devices Act of 1990 requires that all hospitals, nursing homes, and acute care facilities report deaths related to the use of a medical device to the FDA and the manufacturer within 10 working days. Officials in only three agencies in two of the seven States we reviewed were aware that restraint devices needed FDA approval or that deaths related to the use of these devices must be reported. In the remaining five States, State agency and facility officials we interviewed were not aware of these reporting requirements. We did not determine whether facility operators were complying with the FDA reporting requirements.

STATE AGENCIES

The HHS does not have the authority to establish standards or mandate processes for State agencies to identify, investigate, and resolve incidents involving persons with disabilities. Each of the States we reviewed had developed its own methods for handling incidents, including the misuse of restraints and seclusion. The majority of the States we reviewed assigned responsibility for handling an incident report to the same State agency that arranged for the person's residential or case management services. In six of the seven States we visited, different agencies oversaw facilities serving persons with mental retardation and facilities serving persons with mental illness. Each State agency had its own process for handling incidents. Control over facility operations, including how a facility reports and responds to incidents, also depended on whether the facility was State operated, State contracted, or privately operated, adding to the variations in incident processing within a State. These processes have been summarized in Appendix A.

Two States had established independent agencies to receive and investigate reports of abuse or neglect. Both States created these agencies more than a decade ago in response to concerns about the investigation and resolution of instances of abuse of persons with disabilities. These independent agencies may conduct the incident investigation or monitor the investigation conducted by a State agency. The cases we reviewed and our discussions with State agency officials in both States showed that the independent agencies' investigators generally agreed with State agencies' investigators about what transpired and what corrective action was needed. However, in both States, a State program official could overturn the independent investigator's determination as well as the determination made by its own investigator.

State agencies with incident databases prepared statistical reports that could be used to identify systemic problems, such as facilities with few or large numbers of unexplained injuries. We reviewed statistical reports which showed the number and types of incidents by facility and compared a number of similar facilities using narratives, charts, and graphs. Other reports showed the numbers and durations of restraint and seclusion episodes for various facilities. One State agency used these trend reports to evaluate the need for revised standards and protocols, such as to discontinue the use of certain restraint devices or procedures or to reduce the duration

of a restraint or seclusion episode. In six of the seven States, the majority of the State agencies we contacted advised us that they accessed their automated database incident tracking systems as a routine part of most incident investigations to gather background information about previous investigations involving the facility, the alleged abuser, and the victim.

Conversely, three State agencies in two States advised us that they only had manual tracking systems available. These State agencies could not readily identify incident patterns or trends and could not provide useful statistics on incidents or restraint and seclusion usage. This put these agencies at a distinct disadvantage in terms of the timely identification of facilities with large or few numbers of incidents, increasing numbers of incidents, or questionable deaths.

All States indicated that they would investigate all deaths caused by use of restraints or that occurred while a person was in seclusion. However, only one mental health and two mental retardation agencies advised us they had any deaths related to the use of restraints since January 1, 1995. One State in our review, with the broadest definition of a restraint related death, included any death occurring within 24 hours of a restraint episode. That State reported six restraint related deaths since January 1995. Conversely, six mental health agencies and five mental retardation agencies advised us that they had no restraint or seclusion related deaths during the same period. However, we noted that one mental health agency did not consider two deaths, which occurred when carestaff attempted to apply restraints, to be restraint related deaths because the consumers collapsed before the restraints had been fully engaged. Facility and State agency officials confirmed that facilities in that State were not required to report a death as a restraint related death, even if the sentinel event leading to the death occurred while a restraint or seclusion was being attempted.

INCIDENT PROCESSING SYSTEMS WE OBSERVED AT SEVEN STATES

Each State we reviewed developed its own laws and regulations and we identified a wide range of systems for identifying, investigating, and resolving incidents. The States with the most structured systems:

- Provided facilities with guidelines to identify abusive acts and had developed standard responses for facility and State agency staff to follow when an incident occurs, such as implementing procedures to ensure the timely reporting of incidents to facility management and State executives or the initiation of safety protocols. Some State agencies we reviewed maintained incident systems which provided restraint and seclusion training, required mandatory reporting by specified professionals, and had facilities which provided human rights committees.

- Conducted thorough investigations that relied on the timely gathering of pertinent evidence and the identification of root causes to develop conclusions. This included developing an independent investigation process that provided reasonable assurance that most incidents and complaints were tracked and investigated in accordance with their seriousness.

- Ensured that reported incidents and complaints were satisfactorily resolved by tracking corrective actions. Incident information was also analyzed to assure that systemic problems at one facility may be avoided at other facilities.

Another factor adding to the integrity of the incident process was establishing an independent State agency that either performed or oversaw these functions or conducted a quality control review.

The mental health and mental retardation agencies in the States we reviewed allowed the use of physical force (touching, holding, even martial art techniques, etc.), chemicals (pharmaceuticals), and mechanical restraints (tables with arm and leg restraints, straight jackets, camisole blankets, etc.), but considered use of a restraint or seclusion for any reason other than to protect the consumer or other persons to be an abuse. Some States required facilities to routinely provide information on the use of restraints and seclusion, while others only required reporting of restraints and seclusion if injury or abuse was involved. The HCFA prohibits ICFs/MR, which only serve persons with mental retardation or other related conditions, from using seclusion but does not prohibit these facilities from using time-outs as part of a treatment plan. In many of the case summaries we reviewed, time-outs were voluntary on the part of the consumers. However, State agencies also provided examples of other cases in which time-outs were voluntary because the care workers had ordered the consumers away under either vague or real threats of physical or mental harm. We also noted that HCFA rules do not prohibit persons with mental retardation from being subjected to seclusion if they reside in facilities other than ICFs/MR.

Following are summaries of the key policies and practices we observed in each State we reviewed. For discussion purposes, we have summarized this information on a "Statewide" basis. These summaries may not depict processes used by every State agency and every facility within a given State. In Appendix A, we categorized this information for the seven States according to whether the agency was primarily responsible for residential facilities serving persons with mental illness, mental retardation, or other disabilities.

Identifying and Tracking Incidents

The State agencies which appeared to have had the most assurance that incidents were reported, provided facility operators and other service providers with clear and consistent guidance on how to identify reportable incidents, and had established procedures and time frames for providers and others to follow in reporting incidents. Additionally, these States had disseminated information to facility residents, their guardians, and family members on how to report suspected abuse or neglect and had made a human rights officer available to assist in filing complaints.

The following chart indicates how the seven States we visited approached the process of identifying and tracking incident reports.

CHART 1

IDENTIFYING AND TRACKING INCIDENTS

STATES	1	2	3	4	5	6	7	Total
Facility operators and caregivers were provided agency-specific guidance to identify reportable incidents	X	X	X	X	X	X		6
Facility operators and caregivers were provided Statewide guidance to identify reportable incidents							X	1
Reported incidents were tracked from receipt through investigation and completion of corrective action	X	X		X	X	X	X	6
Centralized, automated database was used for incident tracking	X	X		X	X	X		5
Statistics on deaths, serious injuries, abuse, and restraint/seclusion abuse were maintained	X	X	X	X	X	X		6
Trend analysis was used to identify potential systemic problems	X	X			X	X		4
Mandatory reporting laws for abuse and neglect of persons with disabilities existed	X	X	X	X	X	X	X	7

- All States provided guidance to facilitate the identification of reportable incidents. However, in six States, this guidance was provided in the form of definitions on what is considered an abusive act by the agency with program responsibilities. Only one State provided the same definitions to mental retardation and mental health facilities because the same State agency oversaw both types of facilities. Differences in what is considered an abusive act can affect how an incident is reported and handled. For example:

  - One State classified any death that occurs within 24 hours of a restraint or seclusion episode as a restraint/seclusion death, while another State reserved this designation for deaths that occurred during the use of a restraint or a seclusion.

  - One State differentiated restraints by the terms physical (touching), mechanical (devices), or chemical (pharmaceuticals). A second State, however, referred to the use of mechanical devices as physical restraint and considered all chemical restraints to be abuses, but still allowed the use of restraining or controlling pharmaceuticals as part of a treatment program.

- Six States had standard procedures for tracking abuse cases. State agencies in five States used central automated databases to track investigations. However, two of the five States mainly used their databases to track workloads of investigators, rather than to control the incident process.

- Six States maintained varying statistics on deaths, serious injuries, misuse of restraints or seclusion, and other types of abusive acts at most facilities. Two of these States routinely generated reports on incident information for specified time periods by type of occurrence, type of facility, length of investigation, manner of death, and other criteria.

- Four States collected incident information in automated databases and generated management reports to do trend analysis. For example, these States used information to identify deaths that were potentially caused by the misuse of restraints for investigation. Another example would be the use of incident information to identify facilities with unusually large or few numbers of incidents for follow up.

- All States had mandatory reporting laws, usually as part of their child or adult protective laws. These laws required designated groups of medical, educational, caregiver, and law enforcement professionals to report instances of suspected abuse that they encountered while acting in their official capacity. One independent State investigation agency actively prosecuted criminal cases against those who threatened reporters and had proposed State legislation to allow reporters to seek civil remedies. States that tracked data on the source of incident reports noted that the majority of incidents of abuse or neglect are self-reported by facilities and their care staff.

Investigating Incidents

States used different approaches to investigate incidents. The State agencies that appeared to have the most developed investigation process required a thorough, independent investigation of an incident which included timely gathering of pertinent evidence and testimony, the identification of root causes, and well-supported conclusions. Two States stood out. These States had developed investigation processes which provided reasonable assurance that most incidents and complaints would be investigated in accordance with their seriousness and would be tracked through resolution. The following chart indicates how the seven States we visited approached the process of investigating incidents.

INVESTIGATING INCIDENTS								CHART 2
STATES	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Total**
Employed investigators with backgrounds and experience relevant to incidents and complaints	X	X		X	X			4
Provided clear protocols for when and how to report incidents	X	X			X	X	X	5
Used standardized risk assessment of incoming cases	X	X		X	X			4
Conducted supervisory reviews of screening decisions	X	X						2
Statewide requirement that alleged abusers be suspended or relocated during the investigation	X	X		X				3
Used root cause analysis to focus corrective action	X	X			X	X		4
Investigated all deaths	X	X		X	X	X		5
Some sites had on-site human rights officers or staff to assist patients and representatives in filing complaints	X	X	X	X	X	X		6
Human rights committee reviewed the facility's fact finding and protective and corrective actions	X	X		X	X			4

- Four States hired investigators who had care backgrounds such as medical doctors, doctors of philosophy with differing specialties, forensics practitioners, nurses, and other care workers. These States augmented these care specialists with investigators with law enforcement backgrounds. One State agency hired care workers to perform facility licensing reviews and used the investigator position as a promotion for these employees. The use of qualified investigators not only assists the investigation process, but contributes to assuring that the facility's proposed corrective action plan is appropriate and reasonable. Follow up reviews assure that corrective actions have been fully implemented.

- Five States had clear protocols for when and how to report incidents. Three of them widely disseminated consumer rights protocols, including the reporting of incidents and complaints. We noted that a State without clear protocols could have a single incident administratively investigated by up to six different agencies and criminally investigated by up to three law enforcement agencies with little or no formal communication between those conducting the investigations. The following signature abuse case illustrates the necessity of clear protocols for investigative responsibility:

  > Two facility custodians were convicted of criminal abuse because they had confined two persons with disabilities and had provided them with meager care. Further, they used the residents' government disability checks as one of the custodians main source of income. Since the residents had moved from a bordering State, the first time the State program agency knew of their existence was when the incident was reported to the oversight State agency by a bank loan

officer. The officer became suspicious when the custodians included the disability payments as a source of income on a loan application. Although several State agencies had incident investigation processes, none had clear responsibility for this case, so the handling of the investigation was inadequate. This case resulted in the State revising investigation protocols, improving communications, and eliminating gaps in protections for persons with disabilities.

- Four States used standardized risk assessments of incoming incident reports to determine the level of investigation needed. Since most incidents are self-reported by facility personnel, standardized risk assessment screening, supervisory reviews, and root cause identification provide a level of assurance that incidents are screened and reviewed for abuse or neglect by someone who was not directly involved. They also provide additional assurance to the incident oversight process. For example, both States with independent State investigation agencies showed us sample letters they had sent to facilities and State agencies requiring that they take additional investigative steps prior to closing an investigation.

- Two States required timely supervisory reviews of incident screening decisions initially made by care workers to assure that the proper level of investigation was initiated. Both States demonstrated cases where cursory or low level reviews were upgraded by supervisors.

- Three States suspended or reassigned care staff involved in reported incidents during the fact finding and investigation period.

- Four States routinely tried to identify deficiencies in the service delivery system that led to the incident, commonly called a root cause analysis, as a way of focusing corrective actions to decrease the likelihood of similar incidents in the future.

- Five States investigated all deaths to assure there was no abuse or neglect, yet only two provided this information in management reports showing the numbers of deaths and causes, supported by individual reports on each death investigation. Both States also used mortality committees which, among other duties, confirm or reject causes of deaths reported by doctors and facilities, and decide whether to require additional investigative steps before allowing cases to be closed. Only one State indicated it could require autopsies, though some of the other States indicated they were seeking similar authority.

- In six States, facility staff at State operated facilities assisted consumers and others who submitted incident reports or complaints, but only two States required all facilities to provide assistance to all consumers. A HCFA official stated that this acts as an internal check for surfacing and reporting incidents.

- Four States had independent committees of staff, consumers and the public which review the efforts and decisions of facility fact finders and investigators. The minutes of the committee meetings and the cases we reviewed showed that these committees guide the facilities and investigators during the incident process and contribute to revising protocols.

Resolving Incidents

The State agencies which appeared to have the most control over the resolution process tracked incidents through corrective action and facilitated the review of resolution decisions by outside parties such as community committees and P&As. The following chart indicates how the seven States we visited approached the process of resolving incidents.

CHART 3

RESOLVING INCIDENTS

STATES	1	2	3	4	5	6	7	Total
Standard resolution procedures provided to all State agencies	X				X		X	3
Community committees reviewed investigations and resolutions	X	X		X	X			4
Follow-up or license renewal reviewed and sampled from all cases to uncover unreported incidents	X	X		X	X			4
On-site human rights officers or other staff were available to assist consumers in resolution process	X	X	X	X		X		5
Disseminated results of investigations to all involved parties	X	X		X		X	X	5
Lessons learned were disseminated to other providers	X	X		X				3
Process provided for routine appeals	X	X	X	X	X	X		6
State provided care worker training to State employees	X	X	X	X	X	X	X	7
Provided training in restraints, seclusions, and how to de-escalate potential crisis situations	X	X	X	X	X	X		6
Required all facilities to provide same quality and amount of training								0
Criminal laws for misuse of restraints or seclusion					X			1
State requirement that facility operators perform criminal background checks of prospective employees	X	X	X	X	X	X	X	7
Abuser registry to avoid hiring those involved in abusing persons with disabilities					X		X	2
P&A agency - private, nonprofit agency		X	X	X	X	X		5
P&A agency given access to all incidents and investigations	X					X		2
P&A agency given access to all resolutions	X			X	X		X	4

- Three States had standard resolution procedures for all State agencies providing residential services for persons with disabilities. People with multiple disabilities may receive residential services from any of the agencies covering their disabilities. In these instances, uniform resolution procedures would be beneficial to the consumer and their guardian.

- Four States had groups, such as community committees or human rights committees, that reviewed reported incidents and complaints made by residents and others. Committee membership varied but usually included the facility resident or their representative, someone from the community, advocates, facility staff, and State agency employees. These committees reviewed fact finding or investigative reports, contributed to corrective action plans, and followed up on corrective actions taken by facilities. These States also had State agency staff which followed up on resolutions proposed, either in separate investigations or when they conducted licensing reviews. Two of these States had Statewide committees of physicians, nurses, lawyers, and other professionals which reviewed selected cases involving deaths and sentinel events to assure that investigations were thorough and resolutions were sufficient for the circumstances of the specific incident. Reviews by independent committees and State agencies provide assurance that facilities have actually taken the corrective actions that they planned.

- Five States had on-site human rights officers, committees or other staff who assist consumers and advocates, file complaints, report incidents, provide evidence, and assist in the resolution of the incident. The minutes of the committee meetings and the cases we reviewed showed that these committees guided the facilities and investigators during the incident process and contributed to revising protocols. One example of this was when the investigation of a choking death led a committee to affirm the investigator's determination that the care workers on duty were not at fault because of the lack of a clear protocol to cover the situation. As a result, the committee advised the facility to develop a protocol to prevent such incidents from occurring or to react appropriately, if such incidents should occur. The committee also recommended that the State agency implement a revised protocol for all of its facilities and provide training in the new protocol for all care workers.

- Five States disseminated the results of investigations to all parties of the complaint. Three States made extra effort to evaluate what systems have failed in an incident and used the lessons learned to revise procedures and protocols. For one of those States, the independent investigation oversight State agency had published numerous documents about preventing, identifying, investigating, and resolving incidents, including two booklets full of cases with lessons learned, which they make available to State agencies and facilities throughout the State and throughout the Nation. Confidential information, such as the names of clients, alleged abusers, and facilities, was changed to protect their privacy. This agency had also co-published or contributed to revisions in restraint protocols with the State program agencies it services.

- While all States allowed appeals, six had processes which made appeals routinely available to all the major parties involved in an incident complaint to provide for the fairness of proposed resolutions.

- Although all States established training requirements for care staff in State operated facilities, only six States provided State facility care workers with training programs covering restraints, seclusions, and how to de-escalate situations. None of these six States required that similar training be given to staffs of privately operated facilities. State officials, facility officials, and advocates we interviewed indicated that the training courses given to many carestaff did not include hands on training of restraint techniques. As a result, a caregiver's first attempt to apply a complicated restraint might occur during an emergency. Nearly all of the incident cases we reviewed led investigators to recommend that careworker's be given additional training, even when abuse or neglect was not substantiated.

- Only one State had specific criminal sanctions for abuse or misuse of restraints and seclusion. Others indicated they could use existing criminal laws. All States had the availability of administrative sanctions, such as forfeiture or suspension of program licenses, program participation, and other tools.

- All States required some type of criminal background check of new employees. Some of these States required only local background checks or did not require all facility staff to undergo a check.

- Only two States had registries to keep track of care workers who had abused or neglected persons with disabilities. None of the States had access to registry information from other States.

- In five States, the P&As were nonprofit agencies. The ACF/ADD and SAMHSA encourage States to use a nonprofit agency, rather than a State agency, to run the P&A program to avoid a potential conflict of interest when a lawsuit is brought on behalf of a P&A client. One State-run P&A eliminated potential conflicts by contracting with a private law firm when suing other State agencies.

- Two P&As (one State agency and one nonprofit) were satisfied with their access to incident and investigation information. We did note, however, that four P&As were satisfied with their access to information about the resolutions of incidents.

CONCLUSION

In summary, Federal standards to protect persons with disabilities from abuse or neglect is concentrated in HCFA's conditions of participation, which are directed at providers, not at State agencies which are primarily responsible for administering and licensing residential programs for persons with disabilities. Existing Federal requirements thus apply to facilities serving only a small percentage of people with disabilities.

Absent Federal guidance, each State has developed different methods of collecting incident information. Consequently, the amount and quality of data varied from State to State. Some State agencies used automated databases to collect a significant amount of incident information and used the data to identify and correct systemic problems. Other States treated incidents as unrelated events and collected little information on each occurrence. This latter group is at a disadvantage in terms of identifying facilities with unusually large or few numbers of incidents, facilities with increasing numbers of incidents, or facilities with unexplained or unexpected deaths.

We believe that HHS may be at a similar disadvantage since it does not collect sufficient statistical information on restraint and seclusion episodes, deaths, sentinel events, complaints, investigations, and resolutions in order to make informed program decisions. However, the authority of HHS to require State agencies to provide information on incidents is currently limited. Most State agencies in our review had statistical information available and some offered to develop statistics for our use from their automated databases. State agency officials said they recognized the need of the Federal Government, particularly HHS and HCFA, to collect statistics in order to make informed program decisions and indicated they would be willing to comply with any reasonable Federal request for statistics.

RECOMMENDATION

We recommend that HCFA, ACF, SAMHSA, and FDA work cooperatively to provide information and technical assistance to States that would: (1) improve the reporting of potential abuse or neglect of persons with disabilities; (2) strengthen investigative and resolution processes; (3) facilitate the analysis of incident data to identify trends indicative of systemic problems; and (4) identify the nature and cause of incidents to prevent future abuse.

REPORT COMMENTS

Information on State systems detailed in Appendix A was reviewed with State officials and reflect their comments. Also, during this review we worked closely with OPDIV staff and provided drafts of this report for their review. This report reflects their comments.

APPENDICES

ANALYSIS OF PROCESSES BY STATE AGENCY

AVAILABILITY OF DATA ON ABUSE OR NEGLECT INCIDENTS and USE OF RESTRAINTS/SECLUSION (R/S)

STATE AGENCY CONTROLS BY TYPE OF FACILITY	STD PROCEDURES FOR TRACKING ABUSE	STD PROCEDURES FOR TRACKING R/S	ABUSE DATA ON AUTOMATED DATA BASE	R/S DATA ON AUTOMATED DATA BASE	R/S ABUSE DATA KEPT SEPARATE	STATISTICS AVAILABLE FOR: ABUSE REPORTS	ABUSES BY CAUSE	R/S ABUSES	TOTAL R/S USES BY TYPE	CLIENTS R/S USED ON	SERIOUS INJURIES	DEATHS	DEATHS BY CAUSE
Mental Health													
STATE 1	Y	Y	Y	SOME	Y	Y	Y	Y	Y	Y	Y	Y	Y
STATE 2	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
STATE 3	Y	Y	Y	Y	N	Y	Y	N	SOME	SOME	Y	Y	N
STATE 4	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
STATE 5	Y	Y	N	Y	N	Y	Y	N	Y	N	Y	Y	Y
STATE 6	N	Y	N	N	N	N	N	N	Y	Y	N	N	N
STATE 7	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mental Retardation													
STATE 1	Y	Y	N	N	N	Y	Y	Y	Y	N	Y	Y	Y
STATE 2	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
STATE 3	N	N	SOME	N	N	SOME	N	N	N	N	N	SOME	N
STATE 4	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	N
STATE 5	Y	Y	N	N	N	Y	Y	N	Y	Y	Y	Y	Y
STATE 6	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
STATE 7	Y	Y	Y	Y	Y	N	N	N	Y	Y	N	N	N
Other													
STATE 1	Y	N	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y
STATE 2	Y	Y	Y	SOME	Y	Y	Y	Y	SOME	Y	Y	Y	Y
STATE 3	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
STATE 4	Y	N	Y	N	N	Y	Y	N	N	N	Y	Y	N
STATE 5	Y	N	Y	N	N	Y	Y	N	N	N	Y	Y	Y
STATE 6	Y	N	Y	N	N	Y	Y	N	N	N	Y	Y	Y
STATE 7	Y	N	Y	N	N	Y	N	N	N	N	Y	N	N

LEGEND: "SOME" shows that some facilities administered by a state agency meet the criteria in the column while others do not. "N/A" shows not applicable.

Mental Health facilities include:

STATE HOSPITAL
MENTAL HEALTH CENTER
INTNSVE RES TREATMENT ADOL.
ACUTE CARE MENTAL UNIT
ST. OPERATED GROUP HOME
ST. CONTRACTED GROUP HOME
ST. LICENSED GROUP HOME
PRIVATE MENTAL HOSPITAL
OUT-OF-STATE FACILITIES
ST SCHOOL FOR EMOT DISTURBED
SPECIAL CARE CENTER
MENTAL HEALTH REHAB CENTERS

Mental Retardation facilities include:

ST. OP. LARGE ICFMR
ST. OP. SMALL ICFMR
PRIVATE ICFMR
WAIVER RESIDENCES
ST. OP. GROUP HOME
ST. CONTR GROUP HOME
ST. LIC. GROUP HOME
SUPERVISED APART.
IND. RES. ALTERNATIVES
SUPPORTIVE COM. RES.
SUPERVISED COM. RES.
SPECIALTY HOSPITAL
PRIVATE SCHOOLS
FAMILY CARE
NURSING HOMES
OUT-OF-STATE FACILITIES

Other facilities include:

YOUTH SERVICES
SCHOOL FOR BLIND
SCHOOL FOR DEAF
GROUP HOMES
NURSING HOMES
HOSPITALS
SECURE
RESIDENTIAL SCHOOLS
FORENSIC FACILITIES
TRANSITION/RECEPTION
NON-COM BASED (LIMIT ACCESS)
NON-COM BASED (OPEN ACCESS)
COM BASED (OPEN ACCESS)
FOSTER CARE AGENCIES

ANALYSIS OF PROCESSES BY STATE AGENCY

EXTENT TO WHICH ABUSE OR NEGLECT INCIDENTS OR RESTRAINT/SECLUSION (R/S) USAGE IS REPORTED TO FEDERAL OR STATE AGENCIES

STATE AGENCY CONTROLS BY TYPE OF FACILITY	INCIDENTS OF ABUSE, USES OF RESTRAINTS AND SECLUSION OR DEATHS ARE REPORTED TO:											DATA REQUESTED BY AND USED BY:				
	FACILITY MGMT	H/R OFFICER	H/R COMM	PARENT S/A	S/A DEATH COMM	OTHER S/A 0 TO 18	OTHER S/A 19 TO 59	OTHER S/A 60 OVER	P&A AGENCY	POLICE	DISTRICT ATTORNEY	S/A INVESTIGATIONS	HCFA	SAMHSA	ACF/ADD	DEPT. OF JUSTICE
Mental Health																
STATE 1	Y	N	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N
STATE 2	Y	Y	Y	Y	Y	Y	Y	Y	N	SOME	Y	Y	N	N	N	N
STATE 3	Y	Y	Y	N/A	N	SOME	SOME	SOME	N	SOME	SOME	N	N	N	N	N
STATE 4	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N
STATE 5	Y	N	Y	Y	Y	N	N	N	N	Y	Y	Y	N	N	N	N
STATE 6	Y	Y	Y	Y	N	Y	Y	Y	N	Y	SOME	Y	N	N	N	N
STATE 7	Y	N	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N
Mental Retardation																
STATE 1	Y	N	Y	N	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	N
STATE 2	Y	Y	Y	Y	Y	Y	Y	Y	N	SOME	Y	Y	N	N	N	N
STATE 3	Y	N	Y	SOME	N	SOME	SOME	SOME	N	SOME	SOME	Y	N	N	N	N
STATE 4	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	N
STATE 5	Y	Y	Y	Y	Y	Y	Y	N	Y	N	N	Y	N	N	N	Y
STATE 6	Y	Y	Y	Y	N	Y	Y	Y	N	Y	SOME	Y	Y	Y	Y	Y
STATE 7	Y	N	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N
Other																
STATE 1	Y	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N
STATE 2	N	Y	N	Y	Y	Y	Y	Y	N	SOME	SOME	Y	N	N	N	N
STATE 3	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
STATE 4	N	N	N	N	N	N	Y	Y	N	Y	N	N	N	N	N	N
STATE 5	N	N	N	N	N	N	Y	N	Y	Y	N	N	N	N	N	N
STATE 6	Y	Y	Y	Y	N	Y	Y	Y	N	Y	SOME	Y	Y	N	N	N
STATE 7	Y	N	Y	Y	N	Y	N	N	Y	Y	Y	Y	N	N	N	N

LEGEND:

"SOME" shows that some facilities administered by a state agency meet the criteria in the column while others do not.
"N/A" shows not applicable.
H/R - Human Rights
S/A - State Agency
P/A - Protection & Advocacy

ANALYSIS OF PROCESSES BY STATE AGENCY

POLICIES AND PROTOCOLS GOVERNING REPORTING ABUSE OR NEGLECT INCIDENTS OR RESTRAINT/SECLUSION (R/S) USAGE

STATE AGENCY CONTROLS BY TYPE OF FACILITY	RESTRAINT DEATHS SINCE 01/01	HCFA STDS R/S	STATE STD DEF FOR ABUSE	STATE STD PROCD R/S	PROCD FOR RPTING ABUSE	PROCD FOR RPTING R/S USE	PROCD INVSTG R/S ABUSE	STD TRAINING REQ'D R/S	TIME OUTS	SECLUSION	RESTRAINTS ALLOWED BY STATE: FACE PHYSICAL	FACE DOWN	CHEMICAL	MECHANICAL	ALL MECH RESTR FDA	ALL R/S DEATHS INVESTIGATED	MISUSE OF R/S: ADMINISTRATIVE SANCTIONS	MISUSE OF R/S: CRIMINAL SANCTIONS
Mental Health																		
STATE 1	0	Y	Y	Y	Y	SOME	Y	SOME	N	Y	Y	SOME	Y	Y	N	Y	Y	N
STATE 2	0	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	N
STATE 3	0	Y	Y	N	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	N	Y	N	Y
STATE 4	0	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
STATE 5	0	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
STATE 6	0	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	N
STATE 7	1	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	N
Mental Retardation																		
STATE 1	6	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	N	Y	Y	N	Y	Y	Y
STATE 2	0	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	N	Y	Y	N
STATE 3	0	Y	Y	Some	Y	N	N	N	Y	N	Y	Y	Y	Y	N	Y	Y	Y
STATE 4	3	Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y	Y	N	Y	Y	Y
STATE 5	0	Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y
STATE 6	0	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	N
STATE 7	0	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	N
Other																		
STATE 1	0	N	Y	N	Y	Y	Y	N	Y	Y	Y	N	Y	Y	N	Y	Y	N
STATE 2	3	N	Y	Y	Y	SOME	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	N
STATE 3	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
STATE 4	0	N	Y	N	Y	N	Y	N	N	N	Y	Y	Y	Y	N	Y	N	Y
STATE 5	0	N	Y	N	Y	N	Y	N	N	N	Y	Y	Y	Y	N	Y	N	Y
STATE 6	0	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	N	Y	Y	N
STATE 7	0	Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y	Y	N	Y	Y	N

LEGEND: "SOME" shows that some facilities administered by a state agency meet the criteria in the column while others do not. "N/A" shows not applicable.

STATE AGENCIES REVIEWED

STATES AGENCIES AND FUNCTIONS	DATES OF REVIEW CONTACTS	ON-SITE
California		
Dept. of Developmental Services *Contracts and operates residential services for persons with mental retardation and developmental disabilities*	7/99-1/00	7/99-10/99
Dept. of Health Services *Protect and improve health of citizens including adults and children in psychiatric hospitals, ICFs, ICFs/MR, and SNFs*	7/99-1/00	7/99-10/99
Dept. of Social Services *Administer public welfare programs, license community care - residential care - facilities for adults and children with disabilities*	7/99-1/00	8/99-11/99
Dept. of Mental Health *Ensure availability and accessibility of effective, efficient, and culturally competent mental health services*	7/99-1/00	7/99-11/99
Delaware		
Department of Health and Human Services *Operates psychiatric hospital, ICF/MR, coordinates the mental health system, and provides service for adults with mentay impairments* Division of Alcohol, Drug, Abuse, and Mental Health Division of Mental Retardation Division of Long Term Care Residents Protection Division of Services for Aging and Adults with Physical Disabilities	6/99-9/99	6/99-9/99
Dept. of Services for Children, Youth & Their Families *Services children with mental illness*	6/99-9/99	6/99-9/99
District of Columbia		
Commission on Mental Health Services *Provides services to D.C. residents with mental illnesses in hospitals and other facilities*	7/99-2/00	7/99-12/99
Dept. of Human Services, Mental Retardation & Developmental Disabilities Administration *Provides residential and case management services to person with mental retardation or other developmental disabilities*	6/99-3/00	7/99-12/99

STATE AGENCIES REVIEWED

STATES AGENCIES AND FUNCTIONS	DATES OF REVIEW CONTACTS	ON-SITE
Massachusetts		
Office of Child Care Services *Licenses residential services for children including those with disabilities and those without disabilities*	4/99-1/00	4/99
Dept. of Mental Retardation *Licenses, contracts, and operates residential services for persons with mental retardation or other developmental disabilities*	2/99-1/00	2/99-3/99
Dept. of Mental Health *Licenses, contracts, and administers residential services for persons with mental illness*	3/99-1/00	All in 4/99
Disabled Persons Protection Commission *Oversees and conducts incident investigations*	4/99-9/99	All in 4/99
New York		
Office of Children & Family Services *Licenses residential services for children*	6/99-3/00	6/99
Office of Mental Retardation and Developmental Disabilities *Operates, contracts, and licenses programs and residential services for the persons with mental retardation or developmental disabilities*	5/99-3/00	5/99-7/99
Office of Mental Health, CQC *Operates, contracts, and licenses programs as well as residential services for persons with mental illness*	5/99-3/00	5/99-7/99
Commission on Quality of Care for the Mentally Disabled *Oversees and conducts incident investigations*	4/99-3/00	5/99
North Carolina		
Department of Health and Human Services Division of Mental Health (State Operated) *Administers residential services for the persons with mental illness and developmental disabilities*	9/99-12/99	9/99-12/99
Division of Facility Services *Licenses services for adult care homes, rest homes, family care homes, and group homes for persons with mental illness or mental retardation*	9/99-12/99	9/99-12/99
Pennsylvania		
Dept. of Public Welfare *Licenses care homes, adult day centers, and community living and operates institutions for persons with mental illness or mental retardation* Office of Mental Health and Substance Abuse Office of Mental Retardation	10/99-1/00	All in 10/99
Dept. of Aging *Licenses adult day centers*	10/99-1/00	All in 10/99