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Obstacles to Reducing Patient Abuse in Public Institutions

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Although the abuse of patients in state mental health facilities compromises the patients' therapeutic environment and strongly affects public conceptions of such facilities, there is a lack of reliable research and data on patient abuse. Drawing on his five-year experience as chair of the New York State Commission on Quality of Care for the Mentally Disabled, the author discusses the problems that hinder the reporting, investigation, and prevention of patient abuse in public facilities. He believes that the reporting of minor abusive conduct is precluded by the very working conditions that contribute to its occurrence, but that the reporting of major abusive conduct is precluded by powerful factors in the administrative and disciplinary structures of state institutions. After discussing the problems behind the reporting of patient abuse, the author suggests some preventive measures to decrease the incidence of abuse and to ensure its reporting when it occurs.

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Several years ago, an article in this journal noted the scarcity of literature on the subject of patient abuse (1). A search through periodical indexes today is not much more fruitful. Indeed, existing published materials are more likely to examine the problem of assaults upon staff by patients rather than the converse (2). This ought not to be surprising since most of the available literature has been published by staff of various treatment facilities.

In the absence of a reliable body of research or empirical data on patient abuse, public attitudes toward mental institutions and their staff, particularly public institutions and staff, are influenced and

shaped mainly by periodic exposes reported in the press. Such reporting generally focuses on selected incidents that have been brought to light during class action lawsuits challenging institutional conditions; or through official investigations; reports from institutional staff, visitors, or former patients; or undercover work by journalists. There are few matters that have a more profound impact upon the public perception of state institutions than the issue of patient abuse, yet there are few issues about which less is known (3).

How widespread a problem is patient abuse in state hospitals? Is it as endemic to these institutions as critics believe? Is it as rare as the number of successful disciplinary cases against employees suggests (4,5)?

In 1977 the New York State Legislature created the Commission on Quality of Care for the Mentally Disabled as an independent agency to oversee the services provided in state-operated and state-licensed mental health and mental retardation facilities. One of the commission's functions is to investigate patient deaths and allegations of abuse or mistreatment (6,7).

Several years ago, the commission attempted to determine the number of allegations of patient abuse reported annually. It was believed that such a figure would be readily available since New York State has an elaborate incident reporting and review system, which requires the reporting, investigation, and review of all unusual events occurring in state facilities, including allegations of patient abuse. However, deficiencies in the reporting and investigation of such incidents by state facilities, coupled with the absence of systemic analysis of available incident reports by the State Office of Mental Health, frustrated all the commission's attempts to obtain a figure (8).

Despite the lack of reliable quantifiable data on patient abuse, the commission's inquiry shed a number of interesting insights into the problems of reporting, investigating, and preventing patient abuse. Some of these problems are peculiar to New York State's mental health system, but many emanate from the nature of public institutions and are therefore of more general application.

This article relies on the author's experience over the past five years as chair of the commission for its observations, impressions, hypotheses, and assertions concerning the problem of patient abuse. That experience includes hundreds of investigations into allegations of patient abuse and interviews with scores of people, such as mental health commissioners; facility directors, employees, and personnel officers; labor lawyers; labor arbitrators; patients; families; patient advocates; and legislators. The opinions expressed here, however, are the author's.

Before proceeding with this discussion, we should define patient abuse more specifically. In New York State, "patient abuse and mistreatment" is defined broadly to include actions or inactions that endanger the physical or emotional well-being of a patient. Aside from obvious proscriptions against physical and sexual abuse, the definition also includes "the failure to provide appropriate care and treatment for any patient" and conditions whereby patients "do not receive sufficient, consistent, or appropriate services, treatments, medication, or nutrition to meet their needs" (9).

While this definition embodies the noble aspirations of the mental health system regarding quality of care, from the point of view of realistic enforcement of a standard of care—backed by the threat of discipline for failure to meet the standard—it is quite impractical as applied to state hospitals. Working conditions and staff levels in most state hospitals are such that under this definition, "patient abuse and mistreatment" is a regular and daily occurrence. No one expects to see incident reports filed under such a broad definition of expectations. In this discussion, then, "patient abuse" will be used in its commonly understood sense of physical and sexual abuse.

Even the more specific category of physical and sexual abuse, however, must be further delineated into minor and major patient abuse. The use of these terms is not meant to convey, of course, that any patient abuse is inconsequential, but rather that even though both types of abuse can be caused by similar circumstances, the problems behind their reporting, investigation, and prevention are different. Minor abuse of patients will therefore refer to such actions as verbal abuse, hair pulling, slaps, shoves, and pinches Major abuse will refer to sadistic behavior, sexual exploitation punching, kicking, or other assaultive behavior that causes serious injuries to patients.

From a review of the literature discussions with staff at institutions, and a study of the incident reporting and review system i New York State (8), it is apparently that there is considerable underreporting, misreporting, and nonreporting of both major and mind patient abuse in state hospital (10-12).

Reporting minor patient abuse

Many of the factors that contribute to the occurrence of patient abuse in the first place, particularly minor abuse, also preclude its accurate reporting. What are the factors?

State recruitment, training and supervision. There is limit flexibility in hiring for most state hospital positions, which are p of the civil service merit system Applicants generally qualify employment by taking a competitive civil service test. Typical especially in direct care position the test score is the primary criterion for employment. The background and experience of applicants for direct care positions given only a cursory screening, a potential candidate's temperament is not examined. As a result, persons with low frustration

thresholds and explosive personalities are not screened out. And while state law requires that the criminal records of applicants be checked, no similar statute or authority exists for identifying a previous history of child abuse through the Child Abuse Register, despite the obvious relevance of such a history to positions involving patient care (13).

Compounding the limited discretion of hiring practices is the absence of an adequate employee training program to equip new employees with the skills necessary to cope with certain foreseeable conditions, such as violent behavior by patients. Over the past five years, for example, the commission has investigated a number of deaths of state hospital patients that resulted from violent confrontations with ward staff. In practically every instance, one or more of the staff attempting to restrain the patient had had no training in dealing with violent patient behavior despite often lengthy employment at the hospital (14-17). In the absence of employee training, the use of retaliatory, excessive, and occasionally deadly force has occurred.

The reality of little effective supervision of direct care staff by professionals, particularly after normal business hours, further compounds the problems resulting from inadequate preemployment screening and inservice training. Facility directors and others who have been studying ways of reducing patient abuse have noted that most incidents involving abuse occur during a facility's second shift (3 p.m. to 11 p.m.) while the patients are still awake but most professional supervisors are absent. Even during regular business hours, the most highly trained and highly paid staff are the farthest removed from direct patient contact and are often inaccessible to direct care staff in need of their assistance and guidance.

Working conditions. In many state hospitals, understaffing is a chronic problem that is frequently exacerbated both by overcrowding and by unscheduled absences of direct care staff. It is not uncommon for three or four therapy aides to be primarily responsible for meeting the multiple and conflicting demands of 30 to 40 patients, with little support from their supervisors. Among the aides' duties are helping to bathe, clothe, feed, and sometimes toilet patients; measuring and administering medications several times a day; providing one-to-one supervision for the patients who need it; escorting patients to activities and clinics off the ward; providing activities on the ward; and documenting a variety of important and unimportant occurrences.

Mandatory overtime and double shifts are part of the job when administrators attempt to cope with unanticipated staff absences. The demands on ward staff have been made even more physically and emotionally exhausting by the deinstitutionalization of most of the stabilized patients and the emergence of the actively psychotic young adult chronic schizophrenic patient as a significant segment of the patient population (18).

Under these working conditions, it is altogether understandable that powerless direct care staff, who are at the bottom of the institutional hierarchy, who perform the most difficult work, and who are the lowest paid, experience anger and frustration. Often, the most available outlets for these feelings are the patients, who are probably the only group more powerless than direct care staff and who are also the least capable of retaliation.

Most abuse that occurs in institutions results from acts of frustration and exasperation rather than from sadistic behavior. This minor abuse occurs most frequently during periods of greatest staff-to-patient interaction, such as during the feeding, bathing, and dressing of patients, when the cumulative effects of understaffing, varied job demands, and difficult patients are most acutely felt.

Adverse working conditions are experienced by all direct care staff and most of them therefore understand what motivates minor abusive conduct. Because direct care staff see themselves as victims of a larger system that would be quick to punish them for minor abuses but that is slow to recognize and improve the adverse working conditions that contribute to abusive behavior, at most they will merely caution an abuser not to repeat a behavior. Minor offenses are rarely reported to superiors, except by visitors, trainees, or the patients themselves; by a fellow employee who feels personal animosity to ward the abuser; or by other staff who have become convinced that the abusive behavior is excessive in its frequency or degree and beyond the informal, unarticulated norms that exist among the peer group.

Since minor patient abuse i rarely reported, few staff are eve punished for it. Given that, and the conditions under which staff work there are currently no general of specific deterrents to this type of patient abuse.

Reporting major patient abuse

The so-called code of silence that exists for minor abuse of patient does not generally extend to major abusive behaviors such as sadistical behavior, sexual exploitation, c serious injuries to patients. War staff generally have little sympathy for such behaviors, to some extent at least because the effects are more likely to be apparent.

Because such major abusive be-havior lies outside informal staff norms and is less accepted by staff it is less likely to occur in front (witnesses. But even when such be haviors are witnessed, there are powerful factors at work in the state hospital system to hind< prompt reporting of severe patient abuse by employees as well as by patients. These factors include the facility director's attitude toward employees charged with allege tions of patient abuse; perception of staff about the evenhanded of the disciplinary system as a plied to professional and dire

care staff; and the effectiveness of the disciplinary machinery in punishing alleged abusers.

The director s attitude toward alleged abusers. Several facility directors have stated that no patient abuse is tolerable and that it is their intent to seek dismissal of any employee who is believed to have committed an abusive act. Such an attitude puts the director "on the side of angels" when it comes to dealing with families and patient advocates.

Under New York State law (19), however, the disciplinary process is established through collective bargaining and is embodied in the labor contract (20). The grievance machinery reposes ultimate disciplinary power not in the facility director but in an arbitrator jointly selected by the state and the union from a mutually approved list. The director may propose, but the arbitrator disposes. Thus, the director's decision to seek dismissal (the capital punishment of the workplace) for every transgression, regardless of the employee's prior record or extenuating circumstances, generally has three effects, all of them counterproductive. First, he will be unlikely to prevail in his recommendation in all but the most egregious cases of proven abuse or repeated misconduct. Second, his recommended penalty of termination will soon cease to carry any weight with the arbitrator who will surmise, sometimes correctly, that the director is simply passing him a political hot potato rather than making an honest attempt to find a punishment proportionate to the transgression. Third, the willingness of employees to report instances of abuse will be adversely affected since they recognize that such a report is tantamount to a death sentence for a co-worker.

To the extent that a director is perceived as seeking discipline tailored to the gravity of the offense, he is more likely to impress the arbitrator, prevail in his position, and eliminate an unnecessary barrier to the reporting of abusive incidents.

Staff perceptions of the fairness of the disciplinary process. Closely related to the director's attitude toward ward staff who are charged with patient abuse are the perceptions of staff about the evenhandedness of the disciplinary system in dealing with professional staff. Does the system follow the path of least resistance and target the trainee, the probationary employee, or the lowest level employee to bear the brunt of the responsibility for abusive behavior? Or does the disciplinary process conscientiously attempt to define supervisory responsibility for any lack of training and supervision that may have contributed to the abusive incident?

Direct care staff often have reason to conclude that the former attitude is far more prevalent than the latter. Job descriptions for ward staff are usually far more specific and detailed than those for professional staff, which provide considerable latitude for acceptable behavior and make it more difficult to pin down failures of supervision or training to specific duties. In a legally oriented disciplinary process, ward staff are therefore more susceptible to discipline for breach of a defined duty than are professional staff. Furthermore, when the invocation of a disciplinary sanction appears imminent, most professional staff have considerably greater employment options than ward staff and are assisted in some cases by assurances of a clean letter of reference. If the disciplinary machinery is perceived to grind down the powerless while leaving the more powerful unscathed, direct care staff have no incentive to provide colleagues as fodder for this machine.

Staff perceptions of the effectiveness of the process. Even more important perhaps than the previous two factors is the employee's perception of the effectiveness of the disciplinary system once its operation is triggered. The employee who is an innocent witness to an incident of patient abuse is faced with a terrible choice: he can do nothing about it and become a silent accomplice, subject to disciplinary sanctions himself for failure to report the incident, or he can report the abuse, risk the wrath of and perhaps reprisals from the abuser, and face ostracism by fellow employees who do not approve of his action. The likelihood of discovery in the former instance is not great, but the negative effects of the latter course of action are likely to be real and immediate. Will the disciplinary system be effective in dealing with the abuser or will it fail, leaving the employee who reported the abuse in the uncomfortable and even untenable position of working alongside the abuser?

In New York State, at least, the employee witness confronts a difficult choice between doing the right thing and doing the wrong but prudent thing. The available evidence indicates that only a small percentage of cases of reported abuse ever reach the arbitration stage and, even then, the chances of proving guilt are not great. Moreover, even if the employee is found guilty of an act of patient abuse, there is a substantial probability that he will not be terminated from employment but will eventually resume his patient care duties.

The New York State Office of Mental Health operates 23 adult psychiatric centers with a total inpatient population of approximately 24,000 and a staff of approximately 38,000. Figures from the state Bureau of Employee Relations showed that the total number of notices of discipline alleging patient abuse filed against employees in 1982 was approximately 100, or roughly 10 percent of the total number of notices of discipline filed for all other reasons. No one knows how many allegations of patient abuse made in 1982 simply did not survive to this stage of the disciplinary process because complaints were withdrawn, lacked sufficient evidence, were unfounded, or because the employee resigned.

What is known is that between January 1, 1982, and September 1,

1982, 53 abuse cases in which notices of discipline had been filed were closed. In four of the 53 cases, the notices of discipline were withdrawn. Thirty-four cases were settled prior to arbitration, and in 27 of these cases the penalty was reduced.

Only 15 of the 53 cases went to arbitration, and in only ten of these was a guilty verdict found. Two employees were terminated and three others resigned, two in prearbitration settlements and one when the notice of discipline was withdrawn. The other five employees received lesser penalties. In summary, out of the 53 cases of alleged patient abuse and mistreatment that were closed in an eight-month period, only five employees were, in effect, terminated from employment.

It is easy to blame the poor results of the disciplinary process on arbitrators, who apply standards of proof in arbitration proceedings that approach those used in criminal law proceedings (21). Such standards influence not only the number of cases actually brought to arbitration but also the decision to settle some cases without arbitration.

The single most important reason for the poor results, however, is the ineffectiveness of the disciplinary system in investigating reported allegations of patient abuse. At most facilities, the responsibility for investigations of abuse rests with clinicians or personnel officers who have little or no training in such a task. Although legal rules of evidence are not strictly applied in arbitration proceedings, the failure of personnel officers to appreciate the importance of having witnesses available for cross-examination or of establishing a chain of custody for physical evidence has lost many a case.

The investigators' lack of training is compounded by the inherent difficulty of investigating co-workers with whom one has had prior and possible future working relationships. The investigators may also bear indirect responsibility for some of the conditions that may have contributed to the environment in which the abuse occurred. And underlying those difficulties may be a strongly held view that the investigation itself is likely to be antitherapeutic for the victim and for other patient witnesses.

Like employee witnesses, patient witnesses are placed in the difficult position of having to choose between silence and accusing an employee who is likely to remain on the ward and in a position to retaliate. (Under New York's Civil Service labor contract (22), employees cannot be transferred against their will for disciplinary reasons.) Patients depend daily on employees for their most basic needs. They (and their families) are at the receiving end of a power relationship, and they are deeply fearful of the consequences, real or imagined, of complaining about employees.

If patients do choose to accuse an employee, the ensuing disciplinary proceeding is a mismatch. The employee and his union-supplied attorney (usually a skilled labor lawyer) may confront and cross-examine the accusers, but the case for the facility is typically presented by a personnel officer, and the victim and patient witnesses are entirely without representation. The cross-examination process itself may therefore be a substantial ordeal for patients particularly since, as with most due process proceedings, lengthy delays are inevitable. And, as past arbitration proceedings have shown, confidential clinical records may have to be disclosed to facilitate cross-examination (23).

Finally, the witnesses' very status as patients on psychiatric wards casts a shadow on the competence and credibility of their testimony. This problem is getting more and more serious because the current emphasis on outpatient treatment has raised the level of disability required for the admission of psychiatric inpatients to state facilities. Few disciplinary cases supported solely by the testimony of patients are successful. Given all these factors, it is not surprising that patients have demonstrated little enthusiasm for reporting abusive behavior.

The standards used in disciplinary proceedings and the strains on investigators and patients combine to produce investigations that usually terminate inconclusively. There is reason to suspect, however, that in addition to these very real problems, and perhaps because of them, facility directors have a fairly powerful and probably subconscious inclination to follow the path of least resistance. Barring any outcry by families or patient advocates, many will conclude an investigation with a decision of "allegation unsubstantiated," which avoids the inevitable confrontation with the labor union and its attendant adverse consequences for the facility and the patient. Based on the preliminary data that it collected, the commission estimates that nearly four out of five investigations into allegations of patient abuse in New York State facilities result in such a conclusion.

The poor results of investigations into reports of abuse and the failure of prosecutions when investigations conclude that abuse occurred simply reinforce the message to victims and witnesses of abuse that discretion in reporting may indeed be the better part of valor. The end result at present is that there is little real deterrence to abusive behavior, be it minor or severe.

Preventive strategies

The formidable obstacles to reporting, investigating, and prosecuting allegations of patient abuse heighten the necessity to fortify efforts at prevention. Better preventive efforts, if they successfully reduce abuse through peer pressure and change the attitudes of staff in state institutions, may lift the veil of secrecy from future incidents. The likelihood of such a result will be significantly enhanced if methods are found to protect reporting sources from reprisals, for example, through reassignments of patients or staff, and

if investigations and prosecutions are made more effective through the use of independent professional investigators and attorneys.

The task of prevention really begins, however, with increased attention to the critical role of direct care staff, who have the greatest hands-on contact with patients. Facilities must be allowed to more carefully screen applicants to detect their attitudes toward mentally disabled people and any personal qualities that are relevant to working in the institutional environment.

Once staff are hired, they should be treated as the asset they are. A substantial share of the facility's education and training budget should be devoted to developing direct care employees through training in necessary job skills and in dealing with anger and stress. Emphasis should be placed on dealing with burnout, perhaps through professional conferences with other staff on work-related responsibilities. Employee assistance programs must be available at every institution. Overtime and double shifts should be avoided at all costs because of the toll they take on staff and patient alike.

Equally important, professional staff need to be regularly present and available on the wards beyond normal business hours. To reinforce supervisors' obligations toward preventive efforts, investigations of alleged abuse should closely scrutinize the supervisors' responsibility for conditions that may have caused or contributed to an abusive incident.

A concerted effort must be made to recruit volunteers to assist staff, particularly during times of greatest pressure on staff energies. Finally, careful consideration should be given to the kinds of staff members assigned to particularly troublesome wards, such as intensive treatment units for violent male patients. The assignment of female staff to such units has been reported to have a calming effect on patients.

Some of these measures (such as hiring independent investigators and attorneys) would clearly cost additional money and that is always problematic for public hospitals; the amounts involved here are relatively small, however. Many preventive measures can be achieved without additional funds through a reassessment of internal priorities and changes in management practices. Such changes may provoke substantial resistance because they upset existing power relationships. The failure to make needed changes, however, will guarantee continued ineffectiveness in dealing with the problem of patient abuse. It is evident that our knowledge of patient abuse—a phenomenon that affects not only public attitudes toward institutions but, more important, that pollutes the therapeutic environment—is fragmentary at best. We need more reliable data about the nature and extent of patient abuse and a much greater commitment to dealing forthrightly with this cancer, which has been left unattended for too long. The preventive strategies mentioned here are first steps toward that commitment.

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