REPORT OF THE DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION
AND SUBSTANCE ABUSE ON

The Need for Additional Authority for Criminal Prosecution of Suspected Abuse in Facilities for the Mentally Disabled

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 11

COMMONWEALTH OF VIRGINIA
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STUDY OF THE NEED FOR ADDITIONAL AUTHORITY FOR CRIMINAL PROSECUTION OF SUSPECTED ABUSE IN FACILITIES FOR THE MENTALLY DISABLED

EXECUTIVE SUMMARY

Senate Joint Resolution No. 52 requests that the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) study, in conjunction with other appropriate State Agencies and Associations, the need for additional authority to facilitate the criminal prosecution of those individuals accused of the abuse of patients or residents in facilities for the mentally ill and mentally retarded. A Work Group composed of representatives from seven agencies and associations met to consider the issues and alternatives. The Work Group also held open meetings in five locations around the state to solicit comments from consumers, professionals and families of the mentally disabled.

Findings

The Work Group finds that:

- The clients' vulnerability arises not from the severity of the handicapping condition, but from the clients' dependence on the caretakers who may also be the abusers.

- DMHMRSAS employers must take seriously their duty to report abuse and that reporting must be encouraged.

- The current definition of abuse used by DMHMRSAS is so broad that it may serve as a deterrent to reporting and thus to an effective system of protection.

- The role of the DMHMRSAS Advocates in monitoring the administrative implementation of a program to prevent and/or respond to abuse should be expanded and reinforced.

- Staff must be well trained and must substantially agree that the sanctions for abuse are reasonable given the act committed.

- Staff are discouraged from reporting if personnel actions are not upheld in the appeal process.

- Despite the statutory reference to "written policy" as a basis for upholding termination, a number of circuit courts appear to be unwilling to uphold terminations based solely on the Departmental Instruction.

- The alleged lack of competency of some patients or residents to testify and subject themselves to cross examination, limits the practicality and value of additional criminal legislation.

- The current criminal statutes provide the necessary degree of punishment for those convicted of physically abusing clients.

Recommendations

Acting on the Work Group's recommendations, DMHMRSAS will:

- Adopt a modified definition of abuse.
- Revise the related Departmental Instructions.
- Recommend inclusion of the definition of abuse in the Regulations promulgated under 37.1-84.1 of the Code.
- Update the Interdepartmental Agreement with the Department of Social Services.
- Recommend the addition of specific reference to the right to be free from abuse to 37.1-84.1 of the Code.
- Recommend that no additional Code authority be established for the criminal prosecution of abuse.

SENATE JOINT RESOLUTION NO. 52

Requesting that the Department of Mental Health, Mental Retardation and Substance Abuse Services study the criminal prosecution of individuals who abuse patients or residents of state facilities for the mentally handicapped.

Agreed to by the Senate, February 2, 1988

Agreed to by the House of Delegates, March 9, 1988

WHEREAS, the Department of Mental Health, Mental Retardation and Substance Abuse Services is extremely concerned about the well-being of patients and residents of state mental health facilities and training centers; and

WHEREAS, the mentally handicapped, by virtue of their unique disabilities, are vulnerable to instances of physical and emotional abuse; and

WHEREAS, at present, no statutory authority exists to define patient and resident abuse in the Commonwealth; and

WHEREAS, the state employees' grievance procedure requires that the final decision in cases of patient and resident abuse be determined by the circuit court; and

WHEREAS, the definition of abuse may differ between administrative policies promulgated by the Department, and the definitions utilized by the court in adjudicating cases of patient and resident abuse; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Department of Mental Health, Mental Retardation and Substance Abuse Services is requested to study the need for additional authority to facilitate the criminal prosecution of individuals accused of the abuse of patients and residents in facilities for the mentally ill and mentally retarded.

The Department is requested to conduct the study in cooperation with the Office of the Attorney General of Virginia, the Department for the Rights of the Disabled, the Department of Social Services, the Executive Secretary of the Supreme Court, and the Virginia Association of Commonwealth's Attorneys.

Upon completion of the study, the Department shall report its findings to the Governor and the 1989 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for processing legislative documents.

A Copy, Teste:

J. T. Shropshire

Clerk of the Senate

INTRODUCTION

Senate Joint Resolution No. 52 (SJR 52), agreed to by the 1988 Session of the General Assembly, requests that the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS, also referred to in this report as the Department) study the need for additional authority to facilitate the criminal prosecution of those individuals accused of the abuse of patients or residents in facilities for the mentally ill and mentally retarded. The study was conducted in cooperation with the Office of the Attorney General of Virginia, the Department for the Rights of the Disabled, the Department of Social Services, the Executive Secretary of the Supreme Court, and the Virginia Association of Commonwealth's Attorneys. In addition, the Department invited a representative of the Department of Employee Relations Counselors to participate.

The basis for the study stated in SJR 52, is "the need for additional authority to facilitate the criminal prosecution of individuals accused of the abuse of patients and residents." This statement is premised on the assumption that current authority is insufficient, and that individuals who are accused of abuse can neither be removed from employment nor prosecuted under the law. To

understand the parameters and nature of the problem it is important to recognize that Virginia is not alone in its endeavors to strengthen the protections afforded the mentally ill and the mentally retarded. The Patient Abuse Working Group of the National Association of Attorneys General and the Legislative Committee of the National Association of Medicaid Fraud Control Units jointly published Guidelines for Legislation to Prohibit Patient and Resident Abuse in May,1988. Because of the general relevance to the entire effort of SJR 52, the Guidelines are appended. (See Appendix A) This effort, commissioned in response to a growing national concern, is designed to produce legislative guidelines to address the issue. The guidelines make clear that the constitutional rights and protections of the accused complicate the issue of whether additional legislation would facilitate criminal prosecution.

A recent interagency symposium on abuse and neglect coordinated by the New York State Commission on Quality Care drew nearly 700 people from all across the country. In his address before the group, Clarence J. Sundram, Chairman of the Commission said, "The lack of consistent definitions of what conduct is considered abuse and neglect can leave staff confused and bewildered, particularly since many facilities are covered by more than one set of laws or regulations."

Currently in Virginia there are sixteen facilities operated by the DMHMRSAS serving approximatley 6100 clients daily. Forty Community Services Boards serve an additional 19,000 clients annually in residential programs. Section 37.1-84.1 of the Code of Virginia requires that the State Mental Health, Mental Retardation and Substance Abuse Services Board promulgate rules and regulations to assure the rights of patients and residents in facilities operated, funded or licensed by the Department. Therefore, both community and facility programs are affected by the recommendations of this report.

The Department's relative difficulty in defending its personnel decisions in circuit court appears to arise in part from the absence of a clear definition of abuse in the Code. Definitions of abuse appear in Sections 63.1-55.2 and 63.1-248.2 of the Code. These sections govern adult and child protective services. The current Departmental Instruction defines abuse differently than these Code provisions and has been in use since 1976. (See Appendix B) The courts seem particularly unwilling to affirm termination of long-term employees based solely on the definition of abuse in the Instruction.

Several factors impact upon the ability of the Department to effectively manage the removal or criminal prosecution of an abusive employee. First, the burden of proof, i.e. proof beyond a reasonable doubt, required for

successful criminal prosecution is difficult to carry, particularly given the actual lack or presumed lack of competency of the primary witness (victim). Second, the Grievance Procedure for State Employees, which affords protection to the vast majority of the approximately 11,000 employees who work for DMHMRSAS, places the authority to hear the final appeal by an employee of termination for abuse in the circuit court rather than a three member panel. Not every employee terminated for abuse files a grievance under the Grievance Procedure for State Employees. In instances when a grievance is filed, however, the agency is only successful in having its action upheld in approximately 50% of the cases.

Therefore, the major issues involved in the study are:

1. There is no statutory definition of abuse that specifically governs the abuse of patients and residents in state facilities for the mentally ill or mentally retarded. The problem occurs in the fourth step of a grievance procedure, when the case is heard in circuit court. In such cases, the judge has only the statutory definitions of abuse that are found in the sections of the Code governing protective services for children or adults, Sections 63.1-248.2 and 63.1-55.2 respectively.

2. The prosecution of cases of abuse of clients in a facility operated, funded or licensed by DMHMRSAS is very difficult. In many cases, the only witnesses to the act are the victims themselves or other clients. Their testimony is often challenged and discredited by defense attorneys and is, in fact, frequently of questionable validity. In the absence of other competent witnesses or strong physical evidence, prosecution is often declined by the Commonwealth's Attorney. Recent cases involving the suspected abuse of several profoundly retarded and non-verbal clients were not prosecuted, causing extreme frustration for both families and facility management.

METHODOLOGY

Work Group

A Work Group composed of representatives of the Office of the Attorney General of Virginia, the Department for the Rights of the Disabled, the Department of Social Services, the Executive Secretary of the Supreme Court, the Virginia Association of Commonwealth's Attorneys, the Department of Employee Relations Counselors and the Department of Mental Health, Mental Retardation and Substance Abuse Services met on five occasions to discuss and analyze the issues raised by the Resolution. Drawing upon their own experience and that of their collegues, the task force members carefully reviewed both administrative and legislative actions that would best protect the clients we serve.

The Work Group solicited recommendations from a variety of sources both formally and informally, including staff of the Department, Facility Directors of both mental health and mental retardation facilities, and from the judiciary.

Open Meetings

In order to gather the broadest possible representation and information from a variety of sources, the Work Group chose to have open meetings in five localities around the state. Notice of the meetings was

prominently displayed in the DMHMRSAS Facilities. A letter announcing the meetings was sent to all families of the current patients and residents in every state Facility. Regional representatives of the Department of Social Services and Commonwealth's Attorneys were also invited to participate.

The members of the Work Group who participated at the meetings invited anyone present to comment on the current process for handling cases of abuse. Participants were asked to discuss whether additional authority was needed for criminal prosecution of those charged with abuse. Written comments were also accepted.

FINDINGS

The findings of the study will be described under three main headings. Because of the nature of the issue, a number of topics for consideration will be discussed under more than one heading.

The Goal of Maximum Protection

The ultimate goal of the General Assembly in agreeing to SJR No. 52 is to create an environment that affords maximum protection to the severely mentally disabled persons that the Department serves in both its facilities and in the community. It is recognized that the clients are particularly vulnerable to instances of physical and emotional abuse. **The finding of the Work Group is that the clients' vulnerability arises not from the severity of the handicapping condition, but from the clients' dependence on the caretakers who may also be the abusers.**

In order for the system to work to the advantage of the clients and afford the protection which they deserve, **the Work Group finds that all Departmental employees must take seriously their duty to report abuse and that reporting must be encouraged.** This is, at best, an obvious statement, however, it underscores the need to consider the effect of any recommendation on the willingness and ability of patients, residents, staff

and/or relatives to report circumstances or events which they feel to be potentially abusive.

The Work Group also finds that the current definition of abuse used by the Department is so broad that it may serve as a deterrent to reporting and thus to an effective system of protection. The breadth of the definition is likely to pose particular problems where there is only a single disciplinary sanction for abuse, i.e., anyone found to have abused a client is terminated from employment. The Work Group heard frequently from parents and other relatives during the Open Meetings that they do not perceive all of the actions described by the current definition as equally serious or damaging. In addition, the data which reflects the ability of the Department to successfully prosecute using current criminal statutes and/or remove an employee and sustain a grievance action through the Circuit Court clearly show that some staff actions, e.g., verbal abuse, are not as heavily weighted by the courts.

Administrative Considerations

Two main themes ran through both the Work Group discussions and the comments from the Open Meetings. First, that an effective system of protection must be subject to external review. Second, that the system will only be as strong as the weakest link allows.

The DMHMRSAS Human Rights program has evolved into a sophisticated and dynamic program in the last ten years. **The Work Group finds that the role of the Advocates in monitoring the administrative implementation of a program to prevent and/or respond to abuse should be expanded and reinforced.** In addition, the work, already in progress to redefine the interagency agreement between the Department of Social Services and DMHMRSAS, should be brought to an early conclusion in light of the recommendations of this report.

The second theme was more difficult to define in operational terms. The success of the system in preventing abuse is clearly dependent upon the willingness of the staff, who are the primary "monitors," both to report incidents which appear to be abusive and to cooperate with the investigative process. **The Work Group finds that staff must be well trained and agree that the consequences that flow from any report of abuse are reasonable given the act committed. The second finding is that staff are discouraged from reporting if personnel actions based on such reports are not upheld i.e., if the employee is likely to be restored to duty following action by the court.**

All the material and information gathered by the Work Group leads to the conclusion that the current process is dependent upon the Circuit Court's recognizing the Department's definition of abuse which appears in

Departmental Instruction No. 33. In considering a grievance, in accordance with Section 2.1-116 of the Code, a termination shall be upheld unless shown to have been unwarranted by the facts or contrary to law or written policy. The decision of the court shall be final and binding.

Despite the statutory reference to "written policy" as a basis for upholding termination, a number of circuit courts appear to be unwilling to uphold terminations based solely on the Departmental Instruction. Courts that choose then to turn to the Code for support find the only statute written applies to child or adult protective services, Sections 63.1-248.2 and 63.1-55.2 respectively. These sections define abuse, however, the definitions do not afford adequate protection to mentally disabled individuals in residential care facilities. Thus, when a court looks principally to the Code for guidance, it is frequently forced to acknowledge management's compliance with the Department's Instruction, but yet reverse management's action due to the lack of a specific applicable definition of abuse in the Code. The Work Group recommends that Section 37.1-84.1 of the Code be amended to require the promulgation of regulations defining abuse. This will affirm the basic right to be protected from abuse for individuals residing in facilities operated, or licensed or funded by the Department. It will also provide stronger guidance to the

court, and extend the protection from abuse to both facility and community clients.

Criminal Prosecution

The fundamental difficulty in developing recommendations for legislation which would facilitate the criminal prosecution of individuals accused of abuse is the need to balance the rights of the accused with the need to protect the clients. An accused person retains all of his constitutional due process protections and presumption of innocence in any criminal proceeding. The standard of "beyond a reasonable doubt" requires a high level of proof to convict an accused person of a crime.

It is the adversarial nature of our justice system which highlights the vulnerabilities of our patients or residents who act as accusers when abuse is prosecuted in a criminal setting. **The alleged lack of competency of some patients or residents to testify and subject themselves to cross examination limits the practicality and value of additional criminal legislation.**

The most important persons who protect patients or residents from abuse are the care givers at the facilitites. The caring for and protecting of patients or residents is a very difficult task which requires patience and cooperation. A consistent theme at all the open meetings was that an additional criminal sanction would be counter-productive to the need for reporting and

cooperating with investigations into abuse. **There is a general consensus that the current criminal statutes provide the necessary degree of punishment for those convicted of physically abusing the patients or residents.** However, the more effective means of protecting patients or residents against all abuse is the strengthening of the administrative sanctions against care givers who fail to meet their responsibilities to provide appropriate care.

ADMINISTRATIVE ACTION

Based upon the recommendations of the Work Group, the Department has:

1. Adopted the following modification of the current language as the definition of abuse:

Abuse means:

a. physical acts such as hitting, kicking, scratching, hair pulling, pinching, choking or slapping, or any type of inappropriate striking or touching;

b. coercion, threats or intimidation which are statements or actions that would evoke fear in a reasonable person or that could reasonably be expected to evoke fear in the patient or resident;

c. neglect in care which is the failure to provide treatment, care, goods or services necessary to the health, safety or welfare of a patient or resident;

d. statements or actions which would humiliate, demean or exploit a patient or resident;

e. condoning or permitting the abuse of a patient or resident.

2. Revised Departmental Instruction No. 33 as shown in Appendix B and rescinded Departmental Instruction No. 63. All staff employed by the DMHMRSAS shall receive training at employment and at least biennially thereafter in the prevention and detection of abuse in the context of the Human Rights Program.

3. Recommended inclusion of the definition of abuse as part of the Rules & Regulations To Assure The Rights Of Residents Of Facilities Operated By The Department of Mental Health, Mental Retardation And Substance Abuse Services promulgated under the authority of 37.1-84.1 of the Code. The regulations applicable to facilities operated by DMHMRSAS are currently under revision.

4. Recommended selective revision of the Rules & Regulations To Assure The Rights Of Clients In Community Programs Licensed Or Funded By Department Of Mental Health, Mental Retardation And Substance Abuse Services to incorporate the definition of abuse.

5. Updated the Inter-departmental Agreement with the Department of Social Services.

RECOMMENDATIONS FOR LEGISLATIVE ACTION

Based on the findings of the Work Group, the Department recommends:

1. The addition of the following language to Section 37.1-84.1 of the Code of Virginia (1950), as amended:

> Section 37.1-84.1. Rights of patients and residents. - Each person who is a patient or resident in a hospital or other facility operated, funded, or licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services shall be assured his legal rights and care consistent with basic human dignity insofar as it is within the reasonable capabilities and limitations of the Department or licensee and is consistent with sound therapeutic treatment. Except as may be limited on the basis of legal incompetence as adjudicated by a court of competent jurisdiction, each person admitted to a hospital or other facility operated, funded, or licensed by the Department shall:
>
> 1. Retain his legal rights as provided by the state and federal law;
>
> 2. Receive prompt evaluation and treatment or training about which he is informed insofar as he is capable of understanding;
>
> 3. Be treated with dignity as a human being and be free from abuse;
>
> 4. Not be the subject of experimental or investigational research without his prior written and informed consent or that of his guardian or committee;
>
> 5. Be afforded an opportunity to have access to consultation with a private physician at his own expense and, in the case of hazardous treatment or irreversible surgical procedures, have, upon request, an impartial review prior to implementation, except in case of emergency procedures required for the preservation of his health;
>
> 6. Be treated under the least restrictive conditions consistent with his condition and not be subjected to unnecessary physical restraint and isolation;

7. Be allowed to send and receive sealed letter mail;

8. Have access to his medical and mental records and be assured of their confidentiality but, notwithstanding other provisions of law, such right shall be limited to access consistent with his condition and sound therapeutic treatment; and

9. Have the right to an impartial review of violations of the rights assured under this section and the right of access to legal counsel.

The State Board of Mental Health, Mental Retardation and Substance Abuse Services shall promulgate rules and regulations relative to the implementation of the above after due notice and public hearing as provided for in the Administrative Process Act, Chapter 1.1:1 of Title 9 (Section 9-6.14:1 et seq.) of this Code.

The Board shall also promulgate rules and regulations delineating the rights of patients and residents with respect to nutritionally adequate diet, safe and sanitary housing, participation in nontherapeutic labor, attendance or nonattendance at religious services, use of telephones, suitable clothing, and possession of money and valuables and related matters. Such latter rules and regulations shall be applicable to all hospitals and other facilities operated, funded, or licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services but such hospitals or facilities may be classified as to patient or resident population, size, type of services, or other reasonable classification.

2. No additional Code authority be established for the criminal prosecution of abuse.

APPENDIX A

GUIDELINES FOR LEGISLATION TO PROHIBIT PATIENT AND RESIDENT ABUSE
AND
COMMENTARY

National Association of Medicaid Fraud Control Units
Legislative Committee

and

National Association of Attorneys General
Patient Abuse Working Group

NAAG Working Group:

Honorable Ken Eikenberry, Washington, Chairman
Honorable Linley E. Pearson, Indiana
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Michael Schwartz, Washington

May, 1988

GUIDELINES FOR LEGISLATION TO PROHIBIT PATIENT AND RESIDENT ABUSE AND COMMENTARY

Introduction

Responding to the growing national concern about patient and resident abuse, the Legislative Committee of the National Association of Medicaid Fraud Control Units (NAMFCU) in conjunction with the Patient Abuse Working Group of the National Association of Attorneys General (referred to jointly as "the committee," *infra*), commissioned this effort to produce legislative guidelines to address this important subject. While a number of states have legislated in this area over the last several years, others have not, leaving dependant individuals protected only by traditional criminal laws.

Both the NAAG Working Group and NAMFCU acknowledge the need to formulate special legislation to best protect individuals who must depend on others for their care and well-being. While the majority of those individuals and business entities that provide care to the elderly and the mentally and physically disabled do so in a quality manner, some do not. Meaningful deterrents, sanctions, and remedies for physical abuse and neglect can be accomplished without infringing on the normal and appropriate business and professional practices of those discharging their responsibility for the care of others. With a clear recognition of the critical importance of protecting the elderly and infirm to the full extent of the law, these guidelines are proposed for the consideration, analysis, and adoption by the various states.

Research discloses that the laws of those states who have enacted specific statutes are far from uniform. Some states have adopted comprehensive laws, however, most states have not done so. For example, the laws of several states prohibit intentional assaultive behavior but fail to adequately address criminal neglect. In others, the lack of a proper reporting system for allegations of abuse and neglect prevents, or at least impairs, an appropriate criminal justice response. Conversely, some states have adequate reporting laws but inadequate criminal sanc-

tions. In short, there is substantial variation among the states in the protections provided to patients and residents who are the victims of abuse.

These guidelines are designed to provide to states without relevant laws a framework upon which to base proposed legislation. In states that also have inadequate statues, portions of these guidelines may serve to address existing shortcomings. The guidelines are deliberately broad and encompassing. It is expected that their scope and language will be tailored to meet the specific problem areas existing in each state. Considerable care must be taken to incorporate the proposed provisions with any existing state protections afforded to patients and residents. For example, it is assumed that each state has appropriate statutes for the punishment of major violent crimes (*e.g.* murder, rape, sexual offense, etc.) regardless of the status of the victim. If existing protection is inadequate, or if increased protection is sought for patients and residents of a care facility, a corresponding effort should be made to revise those statutes accordingly.

The guidelines encompass some nine sections: definitions; offenses of patient and resident abuse and exploitation; reporting requirements; collateral consequences (license revocation or suspension); treatment in conformance with right to natural death; treatment based on consent or religious belief; civil cause of action; severability; and, no repeal nor preclusion provisions. The committee has included a separate commentary addressing each section of the guidelines. Again, it should be emphasized that the scope of the guidelines is purposefully broad requiring that attention be focused toward the consideration of individual provisions with the unique circumstances existing in each state considering the enactment of legislation in this area.

Section 1: ***Definitions***

The terms used throughout the Guidelines to Prohibit Patient and Resident Abuse have as their definition the meanings ascribed to them by common usage, except when defined therein. As to the defined terms, the object was to allow each adopting state to integrate this legislation

into its existing criminal code by providing alternative wordings on its specific provisions. For example, the definition of "abuse" provides for adopting states the choice of whether physical "pain", physical "injury" or physical "harm" is to be the standard used to define this term. A state may thus choose the term that best comports with the standards it has already adopted with respect to other criminal acts of an assaultive nature. It is believed that the desired integration will be more readily achieved when the terms selected by a particular state for use in the legislation are terms that have already been defined through the adopting state's statutory or case law. In order to accomplish this, the guidelines provide for alternative word choices in numerous provisions of this legislation. (*E.g. likely to /could*; *recklessly/culpable negligence*; etc.)

The same desire to integrate the guidelines into the existing law of a particular state requires deference to existing law regarding the definitions of several specific terms. The committee believes that many of the terms used in the guidelines have been defined by each state's legislature or judiciary and that adoption of these guidelines as legislation may be more likely if they do not carry definitions foreign to a particular state. For the reason the terms "assault", "knowingly", "physical harm", "psychological harm", "recklessness" or "culpable negligence" and "serious physical harm" were thus left undefined. Each adopting state is encouraged, therefore, to incorporate its definitions of these terms when considering legislation based on these guidelines.

The term "abuse" has been defined to encompass a variety of acts likely to threaten the physical or psychological well-being of patients and residents of care facilities. The definition includes acts which constitute assault and battery under existing state law, as well as acts which constitute the infliction of physical or psychological injury. In some states, assault statutes require that a high degree of physical harm be shown in order to constitute the offense. To avoid excluding from the scope of these guidelines lesser assaults than would satisfy the elements of such statutes, the guidelines include subsection (1)(b) to Section 1. With the inclusion of this subsection, any knowing or reckless/culpably negligent conduct which inflicts harm or which could

inflict harm is within the scope of the prohibitions of the guidelines. As indicated, proper use of the guidelines requires consideration of each state's individual circumstances and needs. In this area, states may choose to include or omit the concepts/language of (1)(a) and/or (1) (b) depending on these particular needs.

Subsections (1)(b) and (1)(c), both address physical conduct that causes, or is likely to cause physical or psychological harm. Through the use of the included qualifying language, health care providers performing their legitimate duties/functions will not be subjected to criminal accountability where such duties/functions may have caused incidental pain or discomfort. An example: insertion of an intravenous tube can be painful; a resident or patient could complain or even demand criminal charges for "conduct which causes physical pain"; under the language of these subsections, however, such a complaint would be unfounded, for the conduct would clearly fall within the exception for "treatment or care. . . in the furtherance of the health and safety of the patient or resident". The conduct which caused the pain, the insertion of an I-V tube, should obviously not be, and under this language could not be, grounds for a criminal complaint.

The term "abuse" also covers, under subsections (1)(d) and (1)(e), conduct which constitutes the failure to provide a patient or resident with sufficient care, including that which is warranted by his condition or the plan of care prescribed by his physician. These provisions encompass conduct which, in some states, is labeled criminal neglect. The object in including these provisions was to make nonfeasance with respect to patients and residents of care facilities a criminal offense. As the elderly or disabled become more dependant on others for their care, it becomes increasingly important for individuals who accept the position of trust as caregivers to the needful to be held accountable for neglecting those in their charge. Failure to provide the care and treatment necessary to maintain the welfare of those who depend on that care is every bit as dangerous and harmful as intentional assaultive behavior. These sections set forth the principle that such acts of neglect be treated accordingly.

Additionally, the term "abuse", in subsection (1)(f), refers to the inappropriate use of a physical or chemical restraint, medication or isolation. The potential for misuse that is presented by the ready availability of physical or chemical restraints and medications in care facility settings is great. Numerous cases have been documented where restraints were used because they were a cheaper method of controlling residents and patients than maintaining adequate levels of trained staff. This conduct must be prohibited. The guidelines do not criminalize the proper use of these items or practices. Rather, they clearly define the situations in which the use of these items and practices shall be deemed criminal-instances where use is dictated by convenience of staff or financial considerations of the facility as opposed to use based on the health and safety of patients and residents.

The definition of the term "care facility" in subsection (2) was drafted to include the widest range of facilities in which persons dependent upon others for their health or resident care needs might be found. The guidelines express the intention that no distinctions with respect to facility size or type should be made regarding the offense of abuse. Any of the forms of harm defined as abuse should be made criminal without regard to the particular settings in which they occurred. Consistency dictates that identical harms should carry the same criminal penalty in a nursing home as in a private home or other care facility. This is especially true with regard to non-institutional settings in light of the fact that there currently exists in many states a policy, directed by quality of life and financial considerations, to provide in-home care for as long as possible and to postpone placing individuals in nursing homes or other institutional settings. As a consequence, many people who would have been in a residential setting, subject to the protections of regulatory and criminal law, are still at home and without such protection. Accordingly, the coverage of the term "care facility" was intentionally made very broad. It includes hospitals and every other type of care facility, even private homes.

An additional reason why states might consider adopting the definition of "care facility" in the broad form in which it appears relates to the impact that excluding certain facilities might

have on the availability of professional staffs. The concern exists that differences in criminal penalties for the same abusive conduct based upon the type of facility in which it occurs might deter nurses or other health care professionals from seeking employment in those facilities to which such higher criminal prohibitions would apply. By including the widest range of care facilities within the definition of "care facility" this potential problem is eliminated. The record clearly supports the fact that patient and resident abuse is not confined to institutions.

Exploitation as proscribed by the guidelines and defined in subsection (3) refers to conduct which is designed to take financial advantage of patients and residents of a care facility. Given the vulnerability of patients and residents of care facilities to financial misdealings by their caregivers, such conduct should be criminalized. The inclusion of the requirement of express voluntary consent on the part of the patients and residents, or their representative if incompetent, to the handling of their assets by caregivers provides protection against coercive or intimidating behavior. Inclusion of a prohibition against exploitive behavior complements the objective of the guidelines to provide maximum and comprehensive protection to persons residing in care facilities.

Subsections (5) and (10) define "patient" and "resident" as one who receives treatment or resides in a care facility respectively.

Subsection (6) defines "person" broadly to include not only any natural person but also any business entity. The guidelines include the concept of vicarious criminal liability. This is particularly the case in abuse prosecutions predicated upon institutional conduct constituting patient or resident neglect.

Section 2: *Offenses of patient or resident abuse and exploitation*

The offense of patient or resident abuse includes both intentional conduct and unintentional acts performed in a reckless or culpably negligent manner. States using these guidelines should look to their own statutory or case law for the term or terms used to describe reckless or crimi-

nally negligent conduct and substitute this language where appropriate. The guidelines are based on the premise that any law which specifically prohibits patient abuse must provide penalties for both intentional and reckless behavior.

Within the area of criminal law, culpability and punishment are often determined by a combination of assessing the perpetrator's state of mind and the amount of harm caused, or which could have been caused, by the perpetrator's actions. The guidelines reflect these traditional considerations through the use of both of these factors in creating the various levels of culpability.

Accordingly, the most severe form of patient or resident abuse is the intentional infliction of "serious physical pain/injury/harm" [Subsection (3)(a)]. This philosophy is consistent with the degree of criminality most commonly ascribed to such behavior and parallels not only enacted patient abuse provisions but also most crimes involving danger to the person. The term "*serious physical* pain/injury/harm" denotes an actual physical injury of a more severe nature or higher degree.

This is distinguishable from "*physical* pain/injury/harm" which is considered a less serious injury resulting in a lesser degree of criminal responsibility. [Subsection (3)(b)]. These terms are borrowed from the statutory language generally encountered in the definitions of assault and homicide and, occasionally, in defenses involving justification or excuse. By far, their most common use is to distinguish degrees of assaultive behavior. Each state should substitute the familiar term of art normally used in such instances.

Subsection (3)(b) also includes the intentional infliction of psychological pain/injury/harm as a punishable offense. Several state patient/resident abuse statutes, either enacted or proposed, contain prohibitions and punishment for psychological harm. Consequently, the guidelines include such a provision. However, in deference to the wide range of definitions and terms of art currently in use in this area, the guidelines do not contain a definition of "psychological

pain/injury/harm". Therefore, it is contemplated that each state will adopt its own definition or objective criteria to accommodate this provision.

Unintentional conduct is punished pursuant to Subsections (3)(c) and (d). Unintentional conduct performed in a criminal, i.e., reckless, criminally negligent, culpably negligent manner which results in serious physical harm is punished to the same degree and to the same extent as the intentional infliction of physical or psychological harm [Subsection (3)(c)]. This is consistent with the aforementioned discussion regarding *mens rea*, the nature of the injury, and the weight each should be accorded in determining the degree of criminal responsibility.

Subsection (3)(d) addresses the unintentional infliction of physical as well as psychological harm. Since this section contemplates criminally negligent or reckless conduct which results in injury of a degree or kind less than that described in Subsection (3)(c) above, the corresponding punishment is also less severe. This section provides for the most lenient punishment of any of the patient abuse activities which result in injury to the victim.

Subsection (3)(e) provides for the punishment of conduct, whether intentional or unintentional, which meets the definition of patient abuse but does not result in any injury to the victim. In this case, there is no distinction made with respect to intent and the focus of culpability is on the act committed. This section embodies the philosophy underlining the guidelines, that people dependant upon others for care and treatment must be protected by the criminal law from abuse arising out of purposeful or neglectful conduct. Under this scheme, it is the conduct of the caregiver that is of critical importance. Regardless of the creation of pain or harm, if the caregiver neglects the health and safety of those who are dependant, he or she must be held accountable. The guidelines contemplate that the punishment in these circumstances be treated as a misdemeanor of the highest grade or degree.

Subsection (4) makes the unpermitted expenditure, diminution, or use of the property or assets of a patient or resident of a care facility a crime. This is in recognition of concerns

expressed that current laws often do not adequately deter unscrupulous care facility operators from converting patient or resident resources to their own benefit and enrichment. Subsection (4)(a) suggests that the punishment for a violation of this subsection be a felony of the same kind or degree as the punishment for the intentional infliction of physical or psychological harm.

Section 3: *Reporting requirements*

Subsection (1): "Person" includes any individual who is directly employed by the facility or any professional who comes into contact with a resident or patient.

The basis for reporting is direct knowledge or "reasonable cause". This language provides for an objective standard which allows for an exercise of discretion in all cases, including those where the allegation originates with the resident. Because the language includes an objective standard, allowing for independent assessment of whether or not "cause" existed that would require a report, individuals or institutions who fail to fulfill their obligations to report will not be able to avoid accountability by claiming ignorance. By the same token, those who decide not to report apparently spurious or obviously false claims will not be subjected to criminal sanctions, as they will be protected by the same objective requirement that "reasonable cause" exist before a report must be made.

The guidelines address the issue of *what* should be reported. The reporting requirement in the guidelines is focused only upon acts that constitute crimes as defined by the abuse law and other existing state laws. The reasoning behind this narrow scope is threefold: (1) an acknowledgment of the professionalism of health care providers and the belief that given proper, understandable guidelines, appropriate choices will be made when considering what to report; (2) a desire to avoid an inundation of reports and the system overload that would follow, a situation that could mean lack of resources to address even the most serious cases; and (3) a desire to increase the quality of referrals and ability to prosecute failures to report by having those referrals based on apparent criminal conduct victimizing a patient or resident.

Subsection (2)(a)(b): The reporting requirement will operate on a two-track approach:

(i) because all reports will involve a belief that a criminal act has occured, police should be notified immediately;

(ii) because all reports involve quality of care issues and the welfare of the resident(s), the department responsible for oversight should also be notified so that they can process the case according to applicable state regulations.

Subsections (2)(b), (2)(c) and (4) require inclusion of specific language describing the appropriate state agency to receive the reports. Factors which may be considered include:

- How the social service department/single state agency is set up;

- Where the regulator function capable of responding to complaints exists within the department;

- Whether or not county or state ombudsman program(s) exist capable of responding to complaints;

- Whether or not a complaint hotline exists;

- Additionally, states may wish to consider formalizing (or establishing) relations between the single state agency and the MFCU by requiring the MFCU to be contacted upon discovery of abuse, etc. Notification of the MFCU could be primary (with police) or secondary (with or from the single state agency), depending on existing decisions of jurisdiction.

Subsection (3): The guidelines require that reports be from identified parties. While anonymous reports may encourage reporting by offering a level of protection to the individual, the actual result expected would be numerous reports of poor quality with limited ability to verify and investigate. The guidelines are based on the expectation that agencies conducting investigations can afford employees protection (at least until charges are filed) by maintaining confidential files, a practice that is currently widespread.

In a related area, the guidelines do protect employees by not requiring that owner/operators be given a copy of employee reports. While concrete proof of "notice" may be helpful in the event that becomes an evidentiary issue in future prosecutions, the guidelines contemplate that "notice" can be sufficiently established by showing that an agency responded to a complaint with an investigation and that this investigation would necessarily have been brought to the attention of the owner/operator. This would be especially true if the complaint were well founded and corrective action ordered as a result. Therefore, with the "notice" issue satisfied

and employee protection an important consideration, requiring the forwarding of a written copy was not included in the guidelines.

Subsection (5)(e): This subsection was written in "generic" form. That is, no distinction was made whether these provisions were to be part of the resolution of a criminal action under (5)(d) if they were to be part of a separate civil action. This determination is, obviously, dependant on state law and whether or not these types of sanctions can be included in a criminal action. Individual states should add whatever additional language is needed to conform this section with existing state law.

Subsection (6): The abrogation of privileged communication and preclusion of orders of incompetency (where state law make certain individuals incompetent because of their confidential relationship with another) is necessary to allow those covered by privilege laws to report their knowledge of abuse, exploitation and other criminal acts.

Also, if applicable, states may wish to specify any established ethical canons that would conflict with the abrogation of privileged communications set forth in this subsection.

Subsection (7) and (8): The guidelines set forth the position that a substantial penalty is appropriate where supervisors or administrators involve themselves and their facilities in blocking the ability or desire of others to report cases of abuse, etc., as required by statute.

Subsection (8)(a)(3): This subsection is not intended to address the issue of manipulation or destruction of internal documents (patient charts, medication orders, pharmacy records, etc.) carried out to avoid detection of improper action in a facility. It is assumed that current state laws regarding obstruction or tampering will adequately address this fact pattern. What this subsection does address is the possibility that a supervisor/institution may allow a subordinate employee to report, but in forwarding the report to the appropriate agency (particularly on behalf of night shift employees) may so alter or manipulate the report as to render it useless.

The reporting requirement plays an important part in protecting patients and residents from the increasing dangers of ongoing abuse, neglect, or exploitation. It is a significant wrong to avoid the duty created by statute to report such cases of abuse, neglect, or exploitation. But it is an extraordinarily unconscionable and unacceptable act for a supervisor or institution to purposefully endanger the safety and health of patients and residents by preventing an employee from making a report that could initiate a needed investigation and intervention by the state. Such acts require a severe response from the criminal law.

Subsection (9): The guidelines include this provision notwithstanding the fact that the definition of "facility" including private homes, may render this section difficult to enforce. The provision, however, is important. While selective enforcement is not advocated, there is an appreciation that professional facilities will be scrutinized for compliance within the context of normal regulation of the industry.

Section 4: ***Collateral consequences of conviction; mandatory revocation or suspension of license.***

Subsection (1) requires the clerk of the convicting court to report the conviction of any licensed or registered professional person or entity for any offense arising under the guidelines (abuse, exploitation, or failure to report such offense or other criminal offense) to the appropriate state board of licensure or registration. A certified copy of such judgment shall constitute sufficient evidence of the conviction. The coverage is intentionally broad and is designed to provide the licensing or registration authority with notice of such conviction so that appropriate action may be timely taken. The terms "professional person or entity" were chosen to insure coverage not only of a licensed professional in the traditional sense (*e.g.* medical doctor, nurse, nursing home administrator, etc.) but also of the entity itself (*e.g.* nursing home or other institution) which holds a license from the state and is the subject of a conviction. In states where nurses' aides are licensed or registered, the provision of this section apply.

Subsection (2) provides that the appropriate state board of licensure or registration retains all authority to discipline its licensure or registrants subject to certain mandatory minimum periods. This approach permits the respective board to suspend or revoke the license or registration for any period, including permanently, in its discretion. However, such discretion is limited by subsection (2)(a) and (2)(b) as the minimum period of revocation or suspension for persons or entities convicted of abuse, exploitation, or failure to report as those offenses are defined in the guidelines. For a conviction of abuse or exploitation, the period of suspension or revocation shall be not less than three (3) years. For a conviction of failure to report under subsection (7)(b) of Section 3 of the guidelines, the period of suspension or revocation shall be not less than six (6) months. For a conviction of failure to report under subsection (8)(b) of Section 3 of the guidelines, the period of suspension or revocation shall be not less than twelve (12) months.

Subsection (3) makes it clear that a conviction of any licensed or registered professional person for any criminal offense where the victim is a resident or patient of a care facility triggers the provisions of Subsections (1) and (2) of this Section. This insures that if a state chooses not to include within its definition of "abuse" under the guidelines an existing criminal offense (*e.g.* rape), such conviction will nonetheless be subject to the same mandatory minimum periods of revocation or suspension.

Section 5: ***Treatment on conformance to right to natural death/and***

Section 6: ***Treatment based on consent or religious belief***

Section 5 and Section 6 both apply to affirmative defenses when a resident, or a person legally authorized to represent a resident, declines treatment. Depending on state law, Section 5 may be superfluous and states may wish to delete it.

The language of the introductory sentence of subsection (6) should be read to clearly convey the intent of the guidelines that sub (c) is required in all events, and that subsections (a) and (b) are alternatives. The choice between sub (a) or (b) depends on the existence of a religious basis with an "informal consent" as allowed for in sub (b).

The language of Section 6 reflects three underlying issues;

(i) The defense is affirmative; the defendant must bear the burden of production and proof of evidence. This system avoids putting the prosecution in the position of having to disprove the existence of facts that would constitute a defense as elements of the crime;

(ii) Subsections (a) and (b) include religious considerations (sub (b)) and a change from the formal 'consent' requirement in sub (a) to 'wishes' in sub (b). [*Note*: If "informed consent" is an applicable term of art in the state, it may be used in place of "written" consent.] The guidelines contemplate that in cases where a third party (most likely a relative) is acting on behalf of the resident and in accord with religious beliefs, it would be inappropriate to require a formal/written consent. The term 'wishes' would also include cases where 'consent' was obtained.

(iii) Whatever action/inaction exists, it must in all cases be consistent with state law. This was left non-specific in recognition of the fact that states have moved forward in the area of 'right to die' by statute and case law or some combination of both. In the face of constant change in this area, it was determined that the best method of addressing this area of law was to leave the language 'generic', thus providing for the automatic inclusion of current and future developments.

The guidelines address "religious" considerations. Though potentially superfluous, if existing state law as depicted in subsection (c) would include religious issues, the guidelines contain specific language on the issue to allay any fears of religious groups.

Section 7: ***Civil cause of action***

The guidelines advocate a specific grant of jurisdiction to state Attorneys General for a civil cause of action or a regulatory action in the quality of care area. This jurisdiction would exist concurrent with, but independent from, any authority within the single state agency or other state regulatory body with jurisdiction over care facilities.

This section is premised on the belief that regulation of the industry is, in many states, inadequate. This inadequacy may exist for a variety of reasons, but appears in the form of too few regulatory actions or fines/penalties too small to have an impact. The expectation

contained with this provision of the guidelines is that independent authority within an Attorney General's office would be exercised without the constraints which may exist within the regulatory agency.

The inclusion of a civil cause of action fits well within the goal of the guidelines: to effectively bring the investigatory powers, punishment, and deterrent values of the criminal law forward to protect patients and residents and to insure their health, safety, and appropriate care. To that end it must be recognized that while a powerful force, the criminal justice system is not omnipotent. There will certainly be occasions when a criminal prosecution cannot be maintained. This may occur as a result of the unavailability of key evidence, the absence of a crucial witness, witness incompetence, or, for other myriad reasons. On occasion, proof meeting the criminal burden of proof beyond a reasonable doubt cannot be obtained. However, the investigation may have developed sufficient evidence to meet the civil preponderance of evidence standard. The guidelines would fall short of their stated goal if an investigation were to reach such a point without providing an alternative remedy.

A civil action could also be useful in situations where immediate relief is needed for the protection of the residents and patients but the investigation has not become ripe for criminal action. Again, the civil jurisdiction would be an extremely useful adjunct to the criminal track.

Civil jurisdiction provides a key element in the overall effort to protect the health and safety of our elderly and dependent population. That element is the ability to utilize a single integrated office with civil, regulatory, and criminal components to address the problem of abuse, neglect, or exploitation of our elderly and dependant population. Inclusion of civil jurisdiction allows for an Attorney General's office to fashion a coordinated approach, and thus provide the best opportunity for insuring the safety and welfare of its citizens.

Other concepts, apart from creating an independent civil cause of action by the Attorney General, were discussed by the committee. One state has enacted an interesting statute which

the committee believes may be of benefit to those states considering legislation in this area. The State of New York has created a private cause of action on behalf of any patient who is subject to a deprivation of any right or benefit by a residential care facility. This cause of action extends to any right or benefit created or established by contract, or arising under any state or federal statute, code, rule or regulation. Compensatory damages are available to any patient injured as a result of such deprivation. Punitive damages may be assessed where the deprivation is found to be willful or in reckless disregard of the patient's rights. The statute also provides for injunctive and declaratory relief, authorizes the bringing of class actions, and for the award of attorneys fees to successful litigants. This action exists independent of any regulatory or other private civil action which may be brought. *See*: New York Public Health Law § 2801-d (McKinney's 1985).

This type of civil action, especially if extended to permit advocacy groups to bring lawsuits on behalf of aggrieved patients and residents, would not only significantly broaden existing protections but would also serve to deter noncompliance by care facilities

Section 8: ***Severability***

The section is self-explanatory.

Section 9: ***No repeal nor preclusion.***

The section is also self-explanatory. Although existing rules of statutory construction in the state may make this section superfluous, out of an abundance of caution, this section is included to make clear that no other existing criminal offenses should be precluded or repealed by the adoption of legislation modeled after these guidelines. This is particularly true with respect to offenses not covered in the guidelines' definition of "abuse" or "exploitation." Obviously, existing laws in conflict with or supplanted by the guidelines should be specifically addressed.

GUIDELINES TO PROHIBIT PATIENT AND RESIDENT ABUSE

Sec. 1: ***Definitions*** -- As used in these guidelines, unless the context clearly indicates otherwise:

(1) "Abuse" means:

(a) Any assault as defined in [reference existing state law];

(b) Conduct which *inflicts/causes* or which is *likely to/could* produce physical *pain/injury/harm* to a patient or resident of a care facility, except where such conduct is a part of the treatment and care, and in furtherance of the health and safety of the patient or resident.

(c) Conduct which *inflicts/causes* or which is *likely to/could* produce psychological *pain/injury/harm* to a patient or resident of a care facility, except where such conduct is a part of the treatment and care, and in furtherance of the health and safety of the patient or resident.

(d) The failure to provide treatment, care, goods or services necessary to the health, safety or welfare of a patient or resident of a care facility.

(e) Failure to carry out a plan of treatment or care prescribed by the physician of a patient or resident of a care facility.

(f) The use of a physical or chemical restraint, medication or isolation as punishment, for staff convenience, as a substitute for treatment, in conflict with a physician's order, or in quantities which *preclude/inhibit* effective care or treatment.

(2) "Care Facility" means: Hospitals; skilled nursing facilities; intermediate care facilities; care facilities for the mentally retarded; psychiatric facilities; rehabilitation facilities; kidney disease treatment centers; home health agencies; ambulatory surgical or out-patient facilities; homes for the aged or disabled; group homes; adult foster care homes; private homes which provide personal care, sheltered care or nursing care for one or more persons; adult day care

centers; and any other health or resident care related facility or home, whether publicly or privately owned.

(3) "Exploit" means: The expenditure, diminution, or use of the property or assets of a patient or resident of a care facility without the express voluntary consent of the patient or resident or the consent of a legally authorized representative of an incompetent patient or resident.

(4) "Knowingly" means: [as defined by existing state law]

(5) "Patient"means: Any person who receives treatment from a care facility.

(6) "Person" means: Any natural person, corporation, partnership, unincorporated association or other business entity.

(7) "Physical *pain/injury/harm*" means: [as defined by existing state law]

(8) "Psychological *pain/injury/harm*" means: [as defined by existing state law]

(9) "*Recklessly/Culpable negligence*" means: [as defined by existing state law]

(10) "Resident" means: Any person who resides in a care facility.

(11) "Serious physical *pain/injury/harm*" means: [as defined by existing state law]

Sec. 2: *Offenses of patient or resident abuse and exploitation*

(1) No person shall knowingly commit abuse of a patient or resident of a care facility.

(2) No person shall *recklessly/through culpable negligence* commit abuse of a patient or resident of a care facility.

(3) Whoever violates subsections (1) or (2) of this section is guilty of the offense of patient or resident abuse.

(a) Violation of subsection (1) of this section which causes any serious physical *pain/injury/harm* is a felony of [set class or degree].

(b) Violation of subsection (1) of this section which causes any physical or psychological *pain/injury/harm* is a felony of [a lesser degree than (a) above].

(c) Violation of subsection (2) of this section which causes any serious physical *pain/injury/harm* is a felony of [the same degree as (b) above].

(d) Violation of subsection (2) of this section which causes physical or psychological *pain/injury/harm* is a felony of [a lesser degree than (b) above].

(e) Violation of subsections (1) or (2) of this Section which does not cause physical or psychological *pain/injury/harm* is a [*serious/aggravated* misdemeanor].

(4) No person shall knowingly exploit any patient or resident of a care facility.

(a) Violation of subsection (4) of this section is a felony [of the same degree as (3)(b) above].

Sec. 3: ***Reporting requirements***

(1) Any person, within the scope of their employment at a care facility or in their professional capacity, who has knowledge of or reasonable cause to believe that any patient or resident of a care facility has been the victim of abuse or exploitation as defined in these guidelines, or any other criminal offense, shall report or cause a report to be made of the abuse, exploitation, or offense.

(2) The reporting of conduct as set forth in subsection (1) shall be:

(a) made immediately upon discovery to the appropriate local law enforcement agency; and,

(b) made orally or telephonically within twenty-four hours of discovery to the [designated agency]; and,

(c) made in writing within two working days of discovery to the [designated agency] with a copy to be retained by the person making the report.

(3) The contents of the reports required by subsections (1) and (2) above shall contain the following information unless the information is unobtainable by the person reporting:

(a) the name, address, telephone number, occupation and employer's address/phone number of the person reporting;

(b) the name and address of the patient or resident who is believed to be the victim of abuse, exploitation or any other criminal offense;

(c) the details, observations, and beliefs concerning the incident;

(d) any statements relating to incident made by the patient or resident;

(e) the date, time and place of the incident;

(f) the name of any individual (s) believed to have knowledge of the incident; and

(g) the name of any individual(s) believed to be responsible for the incident and their connection to the resident.

(4) Any other individual who has knowledge of or reasonable cause to believe that any patient or resident of a care facility has been the victim of abuse or exploitation as defined in these guidelines, or any other criminal offense, may make a report to the appropriate local law enforcement agency, and [the designated agency].

(5) (a) Any individual who, in good faith, makes a report as set forth in this section or who testifies in an official proceeding regarding matters arising out of this section shall be immune from all criminal and civil liability for such reporting or testifying.

(b) No individual shall be terminated from employment, demoted, rejected for promotion or otherwise sanctioned, punished or retaliated against by any person who, in good faith, makes

a report as set forth in this section or testifies in any official proceeding regarding matters arising out of this section.

(c) No patient or resident shall be transfered, discharged, retaliated or discriminated against, or otherwise punished by any person because the patient or resident, in good faith, makes a report as set forth in this section or testifies in any official proceeding regarding matters arising out of this section.

(d) Any person who violates subsection (5)(b) or (5) (c) of this section shall be guilty of a misdemeanor.

(e) In addition to criminal sanctions under subsection (5)(d), the offending party shall be ordered to pay treble damages, costs, and attorneys fees to the offended party.

(f) Subsections (5)(a), (b) and (c) shall not apply to any individual who has engaged in the abuse, exploitation or other criminal conduct against the patient or resident at issue.

(6) Any privilege established by existing state law relating to exclusion of confidential communications and competency of witnesses may not be invoked in any criminal or civil action arising out of a report made pursuant to this chapter.

(7) (a) No person shall knowingly fail to make the report as required by subsections (1), (2) and (3) of this section.

(b) Violation of subsection (7)(a) is a misdemeanor [set class or degree]

(8) (a) No person shall knowingly:

(1) attempt, with or without threats or promises of benefit, to induce another to fail to report an incident of abuse, exploitation or other criminal offense pursuant to subsections (1), (2), and (3) of this section; or

(2) fail to report an incident of abuse, exploitation or other criminal offense after another has indicated a reliance on such reporting pursuant to subsection (1) of this section; or

(3) alter or change without authorization, destroy or render unavailable, a report made by another pursuant to subsections (1), (2), (3) and (4) of this section.

(b) Violation of subsection (8)(a)(1), (2) or (3) is a *misdemeanor/felony* [of a set class or degree higher than 7(b)].

(9) (a) These guidelines shall be posted in a prominent location in all care facilities. In addition, all employees, owners, operators, and health care providers who provide services in care facilities shall be required to sign an affidavit provided by the [designated state agency] attesting to the fact that they have read these guidelines. The care facility shall thereafter retain the signed affidavit.

(b) A facility that fails to comply with the provisions of subsection (9)(a) of this section shall be subject to a civil penalty in an amount not to exceed [appropriate monetary penalty].

Sec. 4: ***Collateral consequences of conviction; mandatory revocation or suspension of license.***

(1) The conviction of any licensed or registered professional person or entity for any offense arising under these guidelines, including failure to report abuse, exploitation or any other criminal offense shall be reported by the clerk of the convicting court to the appropriate state board of licensure or registration. A certified copy of the judgement entered by the sentencing court shall be sufficient evidence of such conviction.

(2) The appropriate state board of licensure or registration shall suspend or revoke the license of the person or entity on account of such conviction for any period, including permanently, in its discretion, subject to the following mandatory minimum periods:

(a) In the case of a person or entity convicted of either the offense of abuse or exploitation as defined in these guidelines, the period of suspension or revocation of licensure shall be not less than three (3) years.

(b) In the case of a person convicted of failure to report as defined in these guidelines, the period of suspension or revocation shall be not less than six (6) months for a conviction in violation of subsection (7)(b) of Section 3 of these guidelines and shall be not less than twelve (12) months for a conviction in violation of subsection (8)(b) of section 3 of these guidelines.

(3) The mandatory suspension or revocation periods set forth in subsection (2) above shall also apply to any conviction of any licensed or registered professional person or entity for any offense not arising under these guidelines where the victim thereof is a resident or patient of a care facility.

Sec. 5: *Treatment in conformance to right to natural death.*

Any affirmative defense which may arise under [citation to "right to natural death" civil and criminal liability provision] pursuant to compliance with [citation to "right to natural death" procedures] shall be fully applicable to any prosecution initiated under these guidelines.

Sec. 6: *Treatment based on consent or religious belief*

To establish an affirmative defense under these guidelines, the defendant must prove either (a) and (c) or (b) and (c) below:

(a) That the act or failure to act was committed in accordance with the *written/informed* consent of the patient or resident or a person authorized to consent on behalf of the patient or resident,

(b) That the act or failure to act was committed in accordance with the wishes of the patient or resident or a person authorized to consent on behalf of the patient or resident, and was in accord with the tenets and practices of a recognized church or religious denomination;

(c) That the act or failure to act was in accord with existing state legal standards.

Sec. 7: ***Civil cause of action***

(a) Notwithstanding any regulatory or administrative penalty and in addition to any private civil cause of action, the Attorney General is authorized to institute a civil cause of action against any person who fails to exercise reasonable care in the hiring, training, supervision, staffing or operation of any care facility when said failure results in the commission of abuse, exploitation, or any other crime against any patient or resident of a care facility.

(b) If the State establishes a failure by such person to exercise reasonable care as set forth in subsection (a) of this section, a penalty of not less than $10,000.00 shall be assessed by the court.

Sec. 8: ***Severability***

The provisions of these guidelines are severable, and if any phrase, clause, sentence or provision of these guidelines, or the application of such phrase, clause, sentence or provision shall be held invalid, the remainder of these guidelines shall not be affected thereby.

Sec. 9: ***No repeal nor preclusion***

Nothing contained in these guidelines shall be deemed to preclude prosecution under any other titles [of the State's criminal code] nor shall these sections be deemed to repeal any other sections [of the State's criminal code].

APPENDIX B

COMMONWEALTH of VIRGINIA

DEPARTMENT OF

Mental Health, Mental Retardation and Substance Abuse Services

HOWARD M. CULLUM
COMMISSIONER

MAILING ADDRESS
P.O. BOX 1797
RICHMOND, VA 23214
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DEPARTMENTAL INSTRUCTION NO. 33

SUBJECT: **Policy on Reporting of Abuse of Patients or Residents**

1. Purpose

To establish policies, procedures and responsibilities for reporting and responding to abuse of patients or residents in state mental health and mental retardation facilities.

2. Definitions

Abuse means:

a. physical acts such as hitting, kicking, scratching, pinching, hair pulling, choking or slapping, or any type of inappropriate striking or touching, including sexual abuse;

b. coercion, threats or intimidation which are statements or actions that would evoke fear in a reasonable person or that could reasonably be expected to evoke fear in the patient or resident;

c. neglect in care which is the failure to provide treatment, care, goods or services necessay tothe health, safety or welfare of a patient or resident;

d. statements or actions which would humiliate, demean or exploit a patient or resident;

e. condoning or permitting the abuse of a patient or resident.

3. Procedure:

A. Any employee, volunteer, contract employee, consultant or relative who has knowledge or

reason to believe that a resident may have been subjected to abuse or other inappropriate behavior shall report such information immediately to the Facility Director. The report of the alleged abuse shall describe the incident as fully as possible giving the names of the persons involved, the time, date and location of the incident, and the names of the witnesses if any.

The Director shall immediately notify the Advocate of the allegation and shall provide to the Advocate all the information obtained from the report. The Director shall also initiate the necessary actions to protect any physical evidence and to protect the safety and welfare of the resident.

B. Normally within 24 hours of the report of the allegation the Director shall confer with the Advocate and shall determine whether there is reason to suspect that abuse has occurred.

C. If there is reason to suspect that abuse has occurred:

1. The Director shall immediately notify the local Department of Social Services in accordance with Section 63.1-55.3 & 63.1-248.3 of the Code and also in accordance with the Interdepartmental Agreement between the Department of Social Services and DMHMRSAS, and

2. If an employee has been identified as the suspected abuser, the employee shall be charged with abuse and shall immediately be suspended by the Director pending final disposition of the case. The Director shall inform the employee of the charges and shall require the employee to cooperate with the administrative investigator(s). Suspensions shall be in accordance with the Employee Standards of Conduct.

D. The Director shall order an administrative investigation to be conducted in accordance with the Department Guidelines for Investigation.

E. Immediately upon determining that abuse has occurred, the Director shall meet with the employee and inform the employee of his

findings, issuing a Group III Standards of Conduct Notice. Such notice shall normally result in termination. However, the Director retains the discretion to mitigate the disciplinary action under the Employee Standards of Conduct to an appropriate sanction other than termination. If at any time, the Director believes that an act is of such a serious nature as to constitute a criminal act, he shall immediately report the act to the proper law enforcement authorities.

F. The Director shall also take administrative action under the Employee Standards of Conduct for any other inappropriate acts which are determined during the investigation.

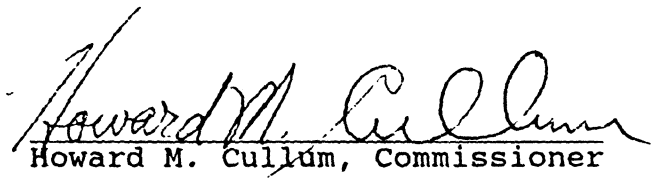
G. The Director shall notify the resident, his legally authorized representative and the Advocate of the results of the investigation and the Director's determination and action.

H. The Director shall report to the Commissioner and to the State Human Rights Director, all allegations made under this instruction, and the results of the subsequent investigation, his determination and action. This report shall be made in a format prescribed by the Commissioner.

I. The Advocate shall monitor all investigative procedures, may review the written investigative report, and/or may conduct an independent investigation. The Advocate shall submit a report of his findings to the Director for his review and consideration in making his determination of the disposition of the case. The Advocate shall discuss the decision of the Director with the resident and shall advise the resident of his rights to pursue the matter through the Human Rights Review Process and/or through the Department of Social Services, or such other advocacy systems as may be appropriate, if he is dissatisfied with the Director's decision. The Advocate shall consult with the Director concerning the implementation of any recommendations developed as a result of the investigation.

4. Distribution

A copy of this policy shall be given to each employee and to each new employee to be reviewed during the initial orientation so as to insure full understanding.



Howard M. Cullum, Commissioner

5. **Effective Date**: January 3, 1989

Replaces DI #33 dated 3/16/82 as well as DI #63 dated 3/16/82.