PROGRAM AUDIT

DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

REPORTING OF RESIDENT ABUSE AND NEGLECT

November 1992

Performance Audit Division

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WILLIAM G. HOLLAND

To the Legislative Audit Commission, the Speaker and Minority Leader of the House of Representatives, the President and Minority Leader of the Senate, the members of the General Assembly, and the Governor:

This is our report of the Program Audit of the Department of Mental Health and Developmental Disabilities' Reporting of Resident Abuse and Neglect.

We conducted this audit at the direction of Section 3-2 of Public Act 86-1013, effective January 3, 1990. This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

The audit report is transmitted in conformance with Section 3-14 of the Illinois State Auditing Act.

WILLIAM G. HOLLAND
Auditor General

Springfield, Illinois
November 1992

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REPORT DIGEST

Program Audit of the Department of Mental Health and Developmental Disabilities

REPORTING OF RESIDENT ABUSE AND NEGLECT

SYNOPSIS

Within the scope[1] directed by the General Assembly, this audit included the following findings:

o DMHDD facility reporting has generally improved since the Auditor General's May 1990 report of suspected resident abuse and neglect;

o Allegations of resident abuse at DMHDD's 21 residential facilities increased 56 percent (610 to 954) and reported resident injuries (those injuries that are not alleged to have resulted from abuse) increased 1,498 percent (416 to 6,647) from Fiscal Years 1988 through 1991. Changes in DMHDD reporting guidelines which expanded reporting requirements to include minor resident injuries and increased emphasis by DMHDD on reporting may account for the increases in both of these categories;

o Facility compliance with reporting policies has improved, but still needs attention. Our sample of 630 resident files disclosed 18 incidents that should have been reported but were not. However, none of these unreported incidents involved alleged abuse; and

o Timeliness of incident reporting has also improved. In Fiscal Year 1991, 65 percent of all incidents were reported within 24 hours versus 42 percent in our 1990 audit.

[1]Public Act 86-1013 directed the Auditor General to conduct an examination of the records of each DMHDD facility concerning reports of suspected abuse or neglect of facility residents. The scope of this audit does not include an examination of the percentage of reports of suspected abuse or neglect of facility residents that are later determined to be substantiated. A program audit of the Office of the Inspector General, to be completed by May 1, 1993, will examine the issue of substantiated reports.

INTRODUCTION

Section 3-2 of Public Act 86-1013, effective January 3, 1990, directed the Auditor General to conduct a program audit simultaneously with the biennial financial audit of the Department of Mental Health and Developmental Disabilities (DMHDD). The program audit is to report trends or patterns of suspected resident abuse and neglect (referred to collectively as "abuse" in this report) of DMHDD facility residents. It should be noted that this audit deals with reports of "suspected" resident abuse, and not with "substantiated" cases of abuse. There are many allegations of abuse that are not substantiated by subsequent investigation.

This audit uses data from the our first report conducted pursuant to this Act (May 1990) as a base for monitoring reported resident abuse trends and patterns. (Page 1)

REPORT CONCLUSIONS

DMHDD facilities reported an increasing number of incidents from Fiscal Year 1988 through 1991. Although the total population at DMHDD's 21 residential facilities decreased 4 percent during this period, allegations of resident abuse increased 56 percent (610 to 954) and the number of reported resident injuries increased 1,498 percent (416 to 6,647). Changes in DMHDD reporting guidelines may account for reporting increases during Fiscal Years 1990 and 1991.

Timeliness of incident reporting to the Inspector General has improved since the Auditor General's May 1990 program audit. Our 1990 audit recommended that the Inspector General monitor facility incident reporting timeliness and recommend corrective action if necessary. In Fiscal Year 1991, 65 percent of sampled cases were reported within 24 hours after the incident occurred, whereas in our 1990 audit only 42 percent of the sampled incidents were reported within 24 hours.

Compliance with reporting policies has also improved. Our 1990 audit recommended that the Director of DMHDD ensure individual DMHDD facilities conform with Department-wide abuse reporting policies. We sampled resident files from all 21 residential facilities for the two years ended June 30, 1991, to test for underreporting and found a total of 18 incidents that should have been reported but were not, compared with 13 unreported incidents from one facility in the last audit. We did not identify any unreported incidents that involved allegations of abuse.

The rate of abuse allegations at mental health facilities has remained consistently twice as high as in developmental facilities; injury and death rates have remained similar for residents in these two types of facilities. There also continues to be wide variations in the number of incidents reported by DMHDD facilities. (Pages 1-2)

BACKGROUND

The Department of Mental Health and Developmental Disabilities operates 21 residential facilities for the mentally ill or developmentally disabled. Facility directors are required to report a variety of incidents and abuse allegations to the DMHDD Office of the Inspector General. The Inspector General reviews reported incidents, conducts investigations, and refers potential criminal cases to the State Police. This report addresses only incident reporting and not investigations. Public Act 87-1158 directs the Auditor General to conduct separate program audits of the Inspector General and release an initial report by May 1, 1993, and a subsequent report by January 1, 1995. (Pages 1-5)

PATTERNS IN TOTAL INCIDENT REPORTING

The following table shows that the number of reported incidents, including resident abuse allegations, increased since Fiscal Year 1988. During that same period, the total resident population at DMHDD facilities decreased from 8,057 to 7,722.

Digest Table 1

INCIDENTS REPORTED TO THE INSPECTOR GENERAL
(Fiscal Years 1988 through 1991)

	ALLEGED ABUSE	INJURIES	DEATHS	OTHER INCIDENTS	TOTAL
FY 1988	610	416	69	535	1630
FY 1989	826	1180	99	1328	3433
FY 1990	857	3947	114	1364	6282
FY 1991	954	6647	101	1485	9187
% CHANGE					
FY88-FY89	35%	184%	43%	148%	111%
FY89-FY90	4%	234%	15%	3%	83%
FY90-FY91	11%	68%	-11%	9%	46%
FY88-FY91	56%	1498%	46%	178%	464%

Source: OAG analysis of DMHDD/OIG data

Changes in reporting guidelines may account for some of the increases during Fiscal Years 1990 and 1991. DMHDD officials also stated the Department increased its emphasis on incident reporting following our 1990 audit, which contained a recommendation concerning underreporting. (Pages 11-13)

DMHDD Comment:

The Department asserts that the dramatic increase in reported injuries is clearly a result of changes the Department made in injury reporting requirements in 1990. In an effort to gather additional information about care and treatment in Department facilities, the Department significantly expanded the definition of "reportable injury" in January of 1990. The new definition redefined "serious" injuries and required that facilities begin reporting minor injuries (i.e., slight red marks, scratches, and redness), even if no first aid is needed. Many trivial injuries which were formerly not reported to the OIG are now being reported.

PATTERNS IN INCIDENT REPORTING AT FACILITIES

There were wide variations in the number and rate of incidents reported by the 21 DMHDD facilities. These variances may be attributable to the number of facility residents, the type of patient served, individual facility reporting practices, or the number of unsubstantiated allegations reported by facility residents.

The abuse allegation rate for mental health facilities was twice that of developmental facilities (.43 versus .20 allegations per 1000 resident days). Injury rates for these two types of facilities were similar. These patterns for incident reporting by facility type are consistent with the findings of our 1990 audit of abuse and neglect reporting. (Pages 15-17)

DMHDD Comment:

The Department believes that the rate of allegations is a less instructive measure of care and treatment than is the rate of substantiated cases of abuse and neglect. Nonetheless, if abuse allegations are reviewed, it is important to note that 17,208 people were served in mental health and dual purpose facilities, while only 4,135 were served in developmental centers in FY 90.

UNDERREPORTING OF INCIDENTS

This audit and our 1990 audit concluded that DMHDD facilities did not report all incidents as required by DMHDD policies and procedures. In this audit we examined 30 resident files at each of the 21 residential facilities for a total of 630 files to test for

underreporting. Our sample disclosed a total of 18 instances of underreporting at nine facilities (Chester, Chicago-Read, Howe, ISPI, Kiley, Madden, Shapiro, Singer, and Zeller). The unreported incidents included non-accidental injuries inflicted by other residents, inappropriate sexual conduct by residents, and unexcused absence from facility premises. Our sample revealed no allegations of abuse that were unreported. (Page 19)

DMHDD Comment:

The Department is also pleased that the audit demonstrated a significant reduction in instances of incident underreporting. The fact that the Auditor General did not find a single instance of underreporting of abuse allegations is indicative of the priority placed on such reporting by the Department.

OTHER ISSUES

The report disclosed other issues related to resident abuse. These issues include: the reporting of incidents occurring at community-based settings, the reporting of resident-to-employee incidents, and the effectiveness of the Inspector General in investigating and substantiating reported incidents. Public Act 87-1158 directs the Auditor General to conduct program audits of the Inspector General and release an initial report by May 1, 1993, and a subsequent report by January 1, 1995. (Pages 21-22)

RECOMMENDATIONS

This audit contains two recommendations related to the prompt reporting of all reportable incidents by DMHDD facilities. The Department concurred with both recommendations. See Appendix D for the Department's complete response.

WILLIAM G. HOLLAND
Auditor General

JK
November 1992

TABLE OF CONTENTS

TABLES

EXHIBITS

APPENDICES

GLOSSARY

ABUSE and NEGLECT	Abuse is any physical injury, sexual abuse, or mental injury inflicted on a resident other than by accidental means. Neglect is a failure to provide adequate care or maintenance to a resident which results in physical or mental injury, or physical or mental deterioration (Ill. Rev. Stat. 1991, ch. 111½, par. 4163(d-e)). We refer to abuse and neglect collectively as "abuse" in this report.
DEVELOPMENTAL DISABILITY	A disability attributable to: (a) mental retardation, cerebral palsy, epilepsy or autism; or to (b) any other condition which results in impairment similar to that caused by mental retardation and which requires services similar to those required by mentally retarded persons. Such disability must originate before the age of 18 years, be expected to continue indefinitely, and constitute a substantial handicap (Ill. Rev. Stat. 1991, ch. 91½, par. 1-106).
DEVELOPMENTAL DISABILITY FACILITY	A facility or a section thereof licensed or operated by or under contract with the State or a political subdivision thereof and which admits developmentally disabled persons for residential and habilitation services (Ill. Rev. Stat. 1991, ch. 91½, par. 1-107).
MENTAL HEALTH FACILITY	Any licensed private hospital, institution, or facility or section thereof, and any facility, or section thereof, operated by the State or a political subdivision thereof for the treatment of persons who are mentally ill (Ill. Rev. Stat. 1991, ch. 91½, par. 1-114).
MENTAL RETARDATION	Significantly sub-average general intellectual functioning which exists concurrently with impairment in adaptive behavior and which originates before the age of 18 years (Ill. Rev. Stat. 1991, ch. 91½, par. 1-116).
RESIDENT	A person residing in and receiving personal care from a long term care facility, or residing in a mental health facility or developmental disability facility (Ill. Rev. Stat. 1991, ch. 111½, par. 4163(b) as amended by Public Act 86-1013).

CHAPTER 1

INTRODUCTION

Section 3-2 of Public Act 86-1013, effective January 3, 1990, directed the Auditor General to conduct a program audit simultaneously with the biennial financial audit of the Department of Mental Health and Developmental Disabilities (DMHDD) (Appendix A). The program audit is to report trends or patterns of suspected resident abuse and neglect (referred to collectively as "abuse" in this report) of DMHDD facility residents. It should be noted that this audit deals with reports of "suspected" resident abuse, and not with "substantiated" cases of abuse. There are many allegations of abuse that are not substantiated by subsequent investigation.

This report uses Fiscal Year 1988 and 1989 data contained in the Auditor General's May 1990 Program Audit of DMHDD Reporting and Investigation of Resident Abuse and Neglect as a base for monitoring trends and patterns of reported resident abuse. This audit differs from our 1990 audit. In this audit the Auditor General was directed to examine the records of suspected abuse of residents at each facility and report the findings of the audit, including findings on trends and patterns of abuse. In the 1990 audit the Auditor General was also to conduct an audit of the Inspector General's effectiveness in investigating reports of suspected abuse. Public Act 87-1158 directs the Auditor General to conduct separate program audits of the Inspector General and release an initial report by May 1, 1993, and a subsequent report by January 1, 1995.

REPORT CONCLUSIONS

DMHDD facilities have reported an increasing number of incidents from Fiscal Year 1988 through 1991. Although the total population at DMHDD's 21 residential facilities decreased 4 percent during this period, allegations of resident abuse increased 56 percent (610 to 954) and the number of reported resident injuries increased 1,498 percent (416 to 6,647). Changes in DMHDD reporting guidelines may account for reporting increases during Fiscal Years 1990 and 1991.

Timeliness of incident reporting to the Inspector General has improved since the Auditor General's May 1990 program audit. Our 1990 audit recommended that the Inspector General monitor facility incident reporting timeliness and recommend corrective action if necessary. In Fiscal Year 1991, 65 percent of sampled cases were reported within 24 hours after the incident occurred, whereas in our 1990 audit only 42 percent of the sampled incidents were reported within 24 hours.

Compliance with reporting policies has also improved. Our 1990 audit recommended that the Director of DMHDD ensure individual DMHDD facilities conform with Department-wide abuse reporting policies. We sampled 30 resident files from each of the 21 residential facilities for the two years ended June 30, 1991, to test for underreporting and found a total of 18 incidents that should have been reported but were not, compared with 13 unreported incidents from one facility in the last audit. We did not identify any unreported incidents that involved allegations of abuse.

The rate of abuse allegations at mental health facilities has remained consistently twice as high as in developmental facilities; injury and death rates have remained similar for residents in these two types of facilities. There also continues to be wide variations in the number of incidents reported by DMHDD facilities.

The Department provided several explanatory comments to this report in an effort to lend perspective to selected findings. These comments are for the most part included within the text and the digest of the report. See Appendix D for full Departmental responses.

BACKGROUND

The Department of Mental Health and Developmental Disabilities provides care and treatment to Illinois citizens who are mentally ill or developmentally disabled. As of June 30, 1991, there were approximately 7,700 residents in the 21 residential facilities. The total resident population at DMHDD facilities decreased 4 percent from Fiscal Year 1988 through 1991 (Table 1-1).

Nine State-operated residential facilities serve the developmentally disabled, eight facilities serve the mentally ill, and four facilities serve both groups. Exhibit 1-1 shows the location of DMHDD's 21 residential facilities.

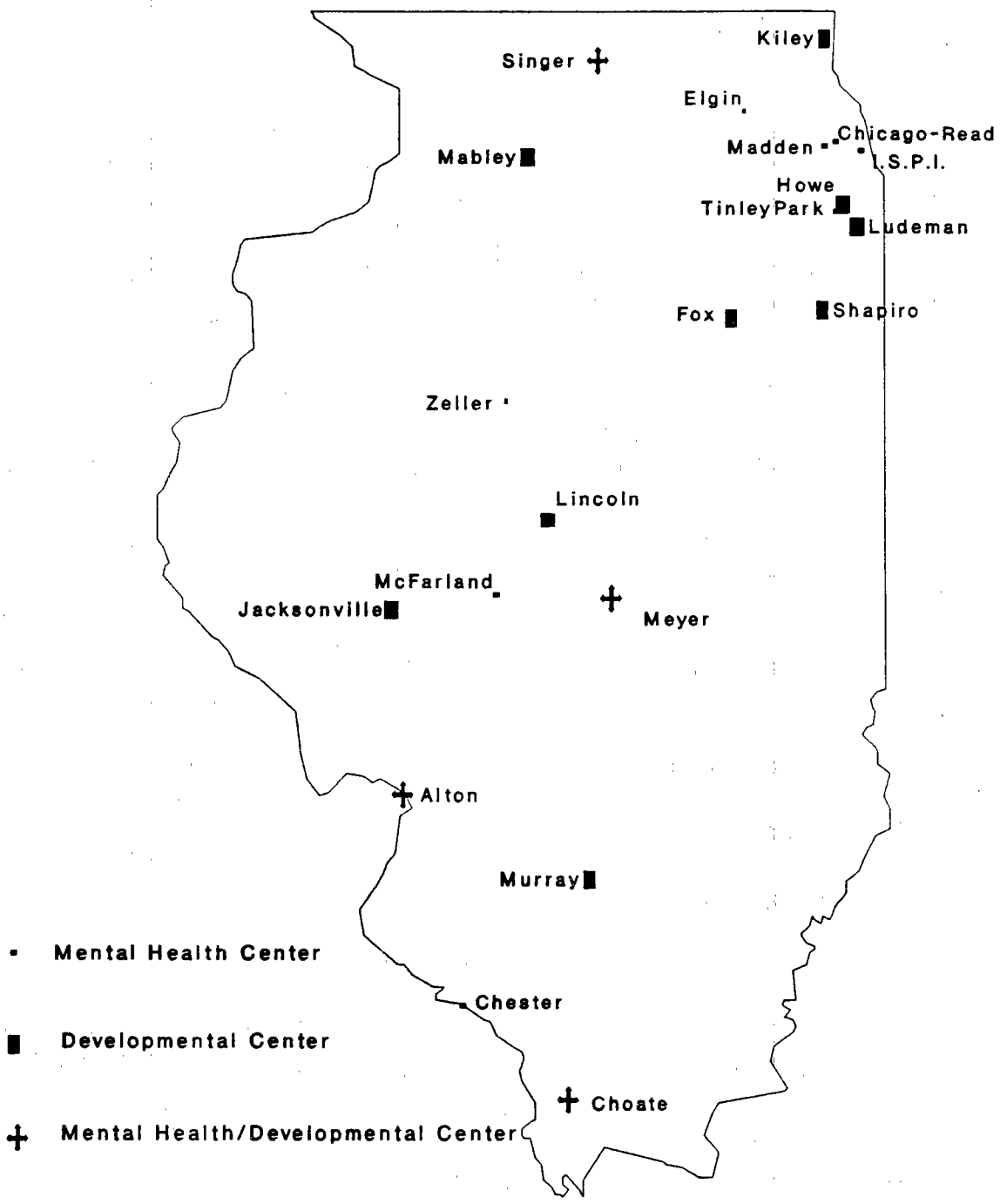
Table 1-1
DMHDD Facility Population

Fiscal Year	Pop.
1988	8057
1989	8097
1990	7961
1991	7722

Source: DMHDD Annual Reports

EXHIBIT 1-1

DMHDD RESIDENT FACILITIES



Source: OAG Analysis

INVESTIGATION AND REPORTING PROCESS

The General Assembly established the Office of the Inspector General (OIG) within DMHDD (Public Act 85-223, effective August 26, 1987) to investigate alleged incidents of abuse at DMHDD-operated facilities. The Inspector General is appointed by the Governor and confirmed by the Senate for a four-year term.

Facility directors are required to report a variety of incidents and abuse allegations to the DMHDD Office of the Inspector General. Prior to January 15, 1990, facilities were also required to report incidents and allegations to the Department of State Police. Exhibit 1-2 summarizes the types of incidents that are reportable to the Office of the Inspector General. Resident abuse (1a-1e) involves only mistreatment of residents by employees and not resident-to-resident incidents.

Exhibit 1-2

TYPES OF INCIDENTS REPORTABLE TO THE INSPECTOR GENERAL

1. Mistreatment of Residents by Employees: a. Physical abuse requiring medical treatment b. Other physical abuse c. Sexual abuse d. Verbal/psychological abuse e. Neglect f. Other improper employee conduct	2. Resident Death 3. (a) Injuries requiring emergency medical treatment or (b) non-accidental injuries inflicted by another person 4. Unauthorized resident absence from a facility 5. Certain sexual incidents between residents 6. Theft of resident property 7. Employee misconduct, malfeasance, misfeasance or other conduct serious enough to warrant reporting

Source: DMHDD Policy and Procedures Directive 01.05.06.03

The Office of the Inspector General establishes criteria for reportable incidents, investigates allegations of abuse and neglect, monitors investigations conducted by facilities, and reviews facility compliance with abuse policies and procedures. The Inspector General reviews reported incidents and refers potential criminal cases to the State Police for investigation. The Inspector General may recommend sanctions to the Department of Public Health or DMHDD. These sanctions, which may be imposed to protect the residents, include the appointment of on-site monitors or receivers, the transfer or relocation of residents, and the closure of units.

SCOPE AND METHODOLOGY

This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

Incident reporting information was collected during our financial and compliance audits of each DMHDD facility for the two years ended June 30, 1991. Internal controls over facility procedures were assessed in connection with these financial and compliance audits.

We collected and analyzed resident abuse data from the Office of the Inspector General and DMHDD facilities to determine trends and patterns of resident abuse. The data presented in our program audit of DMHDD Reporting and Investigation of Resident Abuse and Neglect (May 1990) serves as a base for assessing agency performance.

We reviewed DMHDD policies and procedures related to reporting and investigating resident abuse. We also sampled resident records to determine the effectiveness of reporting incidents at DMHDD facilities. (See Appendix C for sampling methodology.)

REPORT ORGANIZATION

CHAPTER TWO details DMHDD facility requirements and practices regarding incident reporting. It also examines general incident reporting patterns and trends.

CHAPTER THREE examines incident reporting patterns and trends at each DMHDD facility.

CHAPTER FOUR addresses the underreporting of incidents.

CHAPTER FIVE discusses other issues related to incident reporting.

CHAPTER 2

INCIDENT REPORTING POLICIES AND PRACTICES

The number of reported incidents, including resident abuse allegations, has been increasing, although the number of facility residents is decreasing. Changes in DMHDD reporting guidelines may account for reporting increases during Fiscal Years 1990 and 1991.

In Fiscal Year 1991, 35 percent of incidents sampled were reported to the Inspector General after more than 24 hours. Our 1990 program audit found that 58 percent of incidents sampled were not reported within 24 hours. The 24 hour reporting period is not a statutory or DMHDD requirement; it is used for consistency in tracking trends from the 1990 audit period to this audit period.

INTRODUCTION

Section 3.2 of Public Act 86-1013 requires the Auditor General to examine the records of each DMHDD facility concerning reports of suspected abuse of any resident of the facility. This examination was conducted in conjunction with the biennial financial and compliance audits of the Department of Mental Health and Developmental Disabilities' facilities. The financial and compliance audits of 21 facilities for the two-year period ending June 30, 1991, reported the following results related to resident abuse:

- Chicago-Read Mental Health Center: Records of investigations were not properly maintained, and such incidents were not reported to the appropriate levels by Center personnel in a timely manner. Documentation indicating that proper authorities were notified on a timely basis was missing from 10 of the 50 files tested.

- Chester Mental Health Center: Extended restraint/seclusion orders were not properly approved by the facility director. Of 283 extended restraint/seclusion orders reviewed, 10 were not signed and 37 were signed late.

- Lincoln Developmental Center: Of 50 case files reviewed, the reports for 15 incidents were mailed to the Inspector General between 8 and 46 days after discovery.

- Madden Mental Health Center: The facility director did not contact the Inspector General in 7 of 25 cases reviewed. Also, there was insufficient documentation to determine whether corrective action was taken in 10 of 25 cases reviewed.

- Nine facilities (Chester, Chicago-Read, Howe, ISPI, Kiley, Madden, Shapiro, Singer, and Zeller) did not report all incidents reviewed in our sample in accordance with DMHDD Policy and Procedures Directive 01.05.06.03. Exhibit 1-2 describes the types of reportable incidents. Underreporting is discussed in individual facility compliance audit reports, as well as in Chapter Four of this report.

Timeliness of Facility Reporting

According to DMHDD's most recent Policy and Procedures Directive on incident reporting and investigation (September 24, 1990), DMHDD facility directors are required to report to the Inspector General any incident of abuse, improper employee conduct, or resident death "no later than the end of the next working day after the incident was discovered." Facility directors are required to report other types of incidents to the Inspector General within seven days.

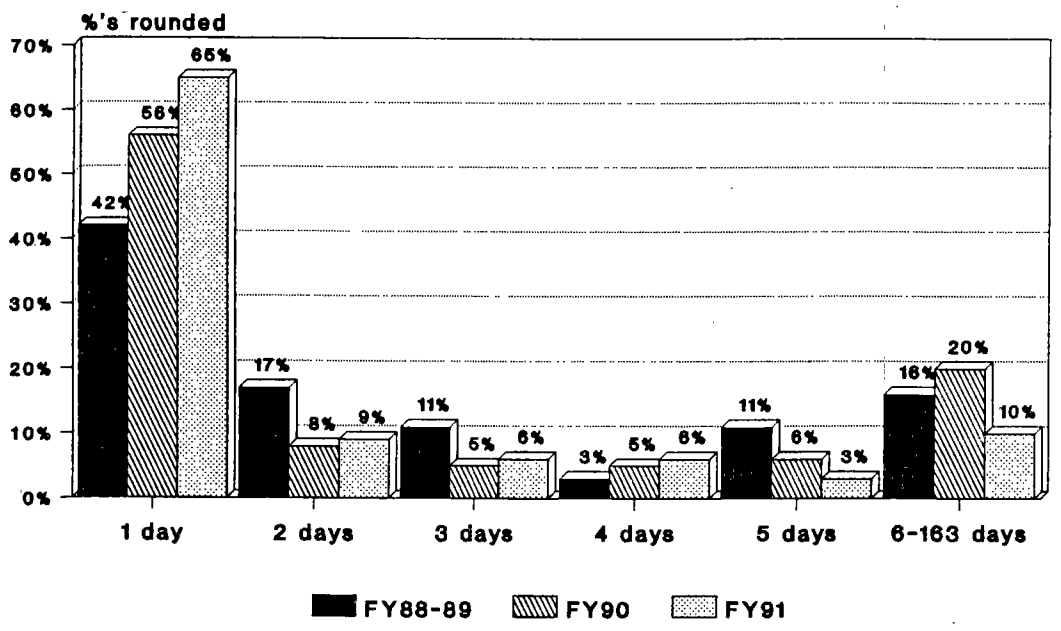
Prior to the recent policy and procedure changes, DMHDD required incidents to be reported promptly to the State Police. We defined "promptly" as within 24 hours in our 1990 program audit. Facility directors are also required to notify the Illinois Department of Public Health Hotline "promptly" upon becoming aware of an incident.

Our 1990 program audit found that 58 percent of incidents sampled were not reported within 24 hours. The audit recommended that the Inspector General monitor facility incident reporting and recommend corrective action when facilities do not report incidents in a timely fashion.

Exhibit 2-1 shows that timeliness of incident reporting by facilities has improved since our 1990 audit. In Fiscal Year 1990, 44 percent of all incidents sampled took longer than 24 hours to report. In Fiscal Year 1991, 35 percent of all incidents sampled were reported to the Inspector General after more than 24 hours. DMHDD officials attributed this improvement to increased emphasis on incident reporting issues following our 1990 audit.

Our 1990 audit reported that in 16 percent of cases sampled, more than 5 days passed before the incident was reported. In Fiscal Year 1990, 20 percent of the cases reviewed took from 6 to 163 days to report, including one case of employee abuse that was reported to the Inspector General 64 days after the alleged incident was discovered. Incidents which required more than 5 days to report decreased to 10 percent in Fiscal Year 1991.

Exhibit 2-1
Reporting Time for All Incidents



Cases sampled FY88&89: 149 FY90: 439 FY91: 569

Source: OAG Analysis of DMHDD records.

Included in our sample for this audit were 148 cases of alleged abuse. Of these cases, 74 (50%) were not reported within 24 hours. Furthermore, 20 (14%) of these 148 abuse cases took from 8 to 64 days to report. While overall timeliness of reporting improved in Fiscal Year 1991 from prior years, further improvement is still needed.

DMHDD Comment:

The Department is pleased that the Auditor General has recognized that the timeliness of facility incident reporting has improved. It is important to note that in the audit's analysis of DMHDD performance in this area, the Auditor General has employed a 24 hour standard for "timeliness" reporting. The statute does not contain any specific time guidelines for facility reporting. While many reports are filed within the 24 hour period analyzed by the Auditor General, the Department's existing policy does not require that reports be filed within this timeframe.

In response to the recommendation of the Auditor General's 1990 audit, Department policy was revised in September of 1990 to include specific time guidelines for reporting to the IDPH Hotline, to the Office of the Inspector General by telephone (for abuse allegations), and by mail for all cases. Since January 1991, the Office of the Inspector General has tracked facility reporting. OIG data indicates that facilities have reported over 90% of incidents to the IDPH Hotline and by telephone to the OIG within the timeframes required by Department policy.

RECOMMENDATION NUMBER 1

The Department of Mental Health and Developmental Disabilities should emphasize that facilities are to report incidents to the Office of the Inspector General in a timely manner.

DMHDD Response:

The Department accepts and will implement this Recommendation. The Department will take additional steps to emphasize that all incidents must be reported to the Office of Inspector General within the appropriate timeframes.

PATTERNS IN ABUSE ALLEGATIONS AT FACILITIES

Public Act 86-1013 required the Auditor General to report on trends relating to abuse of facility residents. From Fiscal Year 1988 through 1991, there has been an increase in the total number of incidents reported and in specific allegations of abuse.

Incidents Reported to the Inspector General

The number of incidents reported to the Inspector General increased significantly from Fiscal Years 1988 through 1991, as shown in Table 2-1. As shown previously in Table 1-1, the total resident population at DMHDD facilities decreased 4 percent during this period.

Table 2-1 shows that the number of reported resident injuries increased most significantly (1,498%) from Fiscal Year 1988 through 1991. There were approximately 2,700 additional cases reported in both Fiscal Years 1990 and 1991. Reports of other types of incidents remained relatively constant during this same period. There are three probable reasons for the significant increase in reported injuries during these years:

1. In June 1988, the Inspector General issued a memorandum to the facilities clarifying the types of incidents that should be reported. This may account for some of the increased reporting in Fiscal Year 1989. Before the Inspector General's memorandum was released, there had been less specific guidelines about what constituted a reportable incident.

2. In January 1990, DMHDD broadened its definition of a reportable injury to include all injuries that "appear to have been inflicted by another person by other than accidental means." Following this change, there was an increase in the number of minor injuries reported. The previous definition required the facility to report the injury only if "the circumstances or nature of the injury indicate possible abuse or neglect by employees."

This change may have affected the number of injuries reported during Fiscal Years 1990 and 1991 . For example, 2,787 (71%) of the 3,947 injuries reported during Fiscal Year 1990 were reported during the six months following the definition change. During the six months prior to the definition change, DMHDD facilities reported 1,160 injuries. The number of reported injuries increased to 3,315 during the first six months of Fiscal Year 1991 and increased only slightly to 3,332 during the final six months of Fiscal Year 1991.

Since facilities are now required to report almost all patient injuries, regardless of severity, and because the number of injury reports leveled off during the final six months of Fiscal Year 1991, we would not expect such significant changes in the future unless there were different reporting requirements, non-compliance with existing requirements, or unless the changes were due to some factor other than reporting, such as increased numbers of patients, decreased numbers of direct care staff, or a decrease in the quality of resident care.

3. DMHDD officials stated that the Department increased its emphasis on incident reporting following our 1990 audit, which contained a recommendation concerning underreporting.

Table 2-1 also shows the number of specific allegations of abuse (i.e. an allegation of physical abuse, sexual abuse, verbal abuse, or neglect resulting from the actions of a staff member) increased by 56 percent from Fiscal Year 1988 through 1991. The number of reported deaths increased by 46 percent during these years. In 1989, DMHDD began including deaths occurring 30 days after discharge in resident death totals, which may account for the increase in reported deaths during that year.

DMHDD Comment:

The Department believes the increases in reported injuries is a positive indication that its changes in reporting policies, increased training activities, and enforcement efforts have been successful. The Department maintains that the increases are clearly and demonstrably related to the changes in reporting requirements.

Table 2-1

INCIDENTS REPORTED TO THE INSPECTOR GENERAL
(Fiscal Years 1988 through 1991)

	ALLEGED ABUSE	INJURIES	DEATHS	OTHER INCIDENTS	TOTAL
FY 1988	610	416	69	535	1630
FY 1989	826	1180	99	1328	3433
FY 1990	857	3947	114	1364	6282
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FY89-FY90	4%	234%	15%	3%	83%
FY90-FY91	11%	68%	-11%	9%	46%
FY88-FY91	56%	1498%	46%	178%	464%

Source: OAG analysis of DMHDD/OIG data

Allegations of Abuse by Demographic Characteristics

We sampled 50 incident reports from each of the 21 DMHDD facilities visited. This total of 1,050 incident reports included all types of reportable incidents and involved 1,367 residents because some incidents involved more than one resident. We analyzed abuse allegations from this sample to identify trends or patterns of alleged abuse in relation to three demographic characteristics of the residents: (1) race only, (2) gender only, and (3) race and gender combined.

The results related to the race and/or gender of residents cannot be generalized to the entire resident population at DMHDD facilities. Inferences based on the sample results refer to a population consisting of all incident reports submitted to the OIG. This population may or may not reflect the characteristics of the general resident population. Further, no firm conclusion regarding abuse incidents can be based on the sample evidence because the incident reports are of alleged abuse and may not be substantiated. (See Appendix C for sampling methodology.)

The results of our sample analysis are as follows:

1. Analysis of the sample by only the race of residents showed that there was a larger proportion of reports of alleged abuse involving black residents than white residents or hispanic residents: 71 of 342 (20.8%) black residents were allegedly abused, while 113 of 929 (12.2%) white residents and 6 of 44 (13.6%) hispanic residents were allegedly abused.

2. Analysis of the sample by only the gender of residents showed no significant differences in the abuse allegation rates.

3. Analysis of the sample by both the race and the gender of residents found that a larger proportion of black females in our sample were allegedly abused: 26 of 122 (21.3%) black female residents were allegedly abused, while 31 of 311 (10.0%) of white female residents were allegedly abused.

These results are in contrast to the sample results reported in our 1990 audit. In that audit, only black male residents were more likely to be allegedly abused. Because our 1990 audit required an audit of the Inspector General's effectiveness in investigating resident abuse, subsequent testing was conducted to substantiate the allegations of abuse involving black males. Of the 17 abuse allegations in our sample involving black male residents, only one was substantiated by the Inspector General. In this audit, the Auditor General did not audit the Inspector General. Consequently, we did not determine the number of substantiated abuse cases involving black females.

DMHDD Comment:

The Department agrees with the Auditor General that the data from their sample cannot be generalized and that no firm conclusion should be drawn from their data. The Department believes that a review of the allegations of abuse which have been substantiated following investigation is a more instructive area of study. The Department has reviewed substantiated abuse cases and found that the substantiated allegations show a pattern of race and gender more closely matching the resident population as a whole.

CHAPTER 3

PATTERNS IN INCIDENT REPORTING BY FACILITIES

Abuse allegation rates at mental health facilities are twice as high as in developmental facilities. The injury rate for residents in these two types of facilities has remained similar. There is also a wide variation in the number and rate of incidents reported by DMHDD facilities.

INCIDENTS REPORTED BY EACH FACILITY

Tables 3-1 through 3-3 summarize trends in facility reporting from Fiscal Year 1988 through 1991. Appendix B also provides detailed information on the number of incidents each facility reported to the Inspector General during these fiscal years.

Tables 3-1 and 3-2 show wide variations in the number and rate of incidents reported by the 21 DMHDD facilities. Table 3-1 shows the number of abuse allegations and Table 3-2 shows the number of reported injuries from Fiscal Year 1988 through 1991. Our sample of resident files from the 21 DMHDD facilities revealed no allegations of abuse that were unreported.

TABLE 3-1

ABUSE ALLEGATIONS
(Number and Rates Per 1000 resident days)

	FY88	FY89	FY90	FY91
ALTON MHDC	35 (.32)	60 (.52)	40 (.34)	86 (.78)
CHESTER MHC	39 (.39)	37 (.35)	84 (.75)	101 (.88)
CHGO-READ MHC	57 (.27)	86 (.39)	103 (.55)	72 (.40)
CHOATE MHDC	34 (.21)	51 (.30)	64 (.41)	100 (.66)
ELGIN MHC	103 (.34)	135 (.46)	150 (.50)	125 (.43)
FOX DC	2 (.03)	0 (0)	0 (0)	2 (.03)
HOWE DC	16 (.06)	43 (.17)	70 (.27)	97 (.41)
ISPI MHC	16 (.25)	23 (.36)	19 (.29)	22 (.35)
JACKSONVILLE DC	44 (.38)	42 (.36)	42 (.35)	42 (.36)
KILEY DC	23 (.13)	32 (.19)	34 (.20)	42 (.24)
LINCOLN DC	29 (.16)	30 (.17)	18 (.10)	17 (.10)
LUDEMAN DC	16 (.09)	8 (.04)	12 (.07)	21 (.12)
MABLEY DC	2 (.05)	6 (.14)	10 (.24)	2 (.05)
MADDEN MHC	37 (.34)	40 (.38)	33 (.35)	32 (.34)
MCFARLAND MHC	8 (.16)	9 (.18)	18 (.34)	9 (.16)
MEYER MHDC	25 (.44)	90 (1.54)	46 (.81)	43 (.75)
MURRAY DC	4 (.03)	9 (.07)	8 (.06)	6 (.05)
SHAPIRO DC	74 (.25)	70 (.24)	39 (.13)	56 (.19)
SINGER MHDC	18 (.23)	7 (.09)	18 (.24)	17 (.25)
TINLEY PARK MHC	26 (.20)	29 (.23)	32 (.24)	30 (.27)
ZELLER MHC	2 (.02)	19 (.22)	17 (.20)	32 (.38)
TOTAL	610 (.21)	826 (.28)	857 (.30)	954 (.34)

NOTES: Rounded rate per 1000 resident days in parentheses.
MHC=Mental Health Center, DC=Developmental Center,
MHDC=Mental Health/Developmental Center.
Appendix C shows facility resident days in FY 1991.

SOURCE: OAG analysis of OIG data

Variances in the number and rate of incidents reported by DMHDD facilities (as shown on Tables 3-1 and 3-2) may be attributable to several factors:

1. The number of residents served by the facility;

2. The characteristics of the resident population or the type of resident served at the facility (Table 3-3);

3. The reporting practices of the facilities; and

4. The number of unsubstantiated or unfounded abuse allegations reported by facility residents.

TABLE 3-2

REPORTED RESIDENT INJURIES

(Number and Rates Per 1000 Resident days)

	FY88	FY89	FY90	FY91
ALTON MHDC	28 (.26)	22 (.19)	252 (2.12)	390 (3.52)
CHESTER MHC	5 (.05)	3 (.03)	77 (.69)	138 (1.20)
CHICAGO-READ MHC	6 (.03)	194 (.87)	163 (.88)	575 (3.19)
CHOATE MHDC	4 (.02)	111 (.64)	329 (2.12)	460 (3.04)
ELGIN MHC	36 (.12)	118 (.40)	448 (1.49)	758 (2.62)
FOX DC	3 (.04)	4 (.06)	9 (.13)	27 (.39)
HOWE DC	17 (.07)	113 (.44)	543 (2.11)	690 (2.95)
ISPI MHC	0 (0)	1 (.02)	27 (.42)	71 (1.14)
JACKSONVILLE DC	16 (.14)	32 (.27)	246 (2.06)	361 (3.10)
KILEY DC	31 (.18)	48 (.28)	277 (1.61)	496 (2.90)
LINCOLN DC	82 (.46)	55 (.30)	132 (.73)	249 (1.40)
LUDEMAN DC	31 (.17)	68 (.37)	301 (1.65)	433 (2.40)
MABLEY DC	7 (.17)	30 (.72)	18 (.42)	179 (4.28)
MADDEN MHC	12 (.11)	17 (.16)	15 (.18)	209 (2.24)
MCFARLAND MHC	1 (.02)	10 (.20)	33 (.63)	69 (1.25)
MEYER MHDC	29 (.52)	119 (2.03)	188 (3.30)	384 (6.66)
MURRAY DC	17 (.13)	18 (.13)	157 (1.17)	103 (.77)
SHAPIRO DC	86 (.29)	162 (.55)	367 (1.25)	336 (1.14)
SINGER MHDC	2 (.03)	2 (.02)	73 (.96)	167 (2.42)
TINLEY PARK MHC	2 (.02)	33 (.26)	227 (1.67)	353 (3.13)
ZELLER MHC	1 (.01)	20 (.23)	65 (.77)	199 (2.39)
TOTAL	416 (.14)	1180 (.40)	3947 (1.37)	6647 (2.37)

NOTES: The definition of a reportable injury as contained in DMHDD's P.P.D. 01.05.06.03. was broadened on 1/15/90. Rounded rate per 1000 resident days in parentheses. MHC=Mental Health Center, DC=Developmental Center, MHDC=Mental Health/ Developmental Center. Appendix C shows number of facility resident days in FY 1991.

SOURCE: OAG analysis of OIG data

These factors must be considered when attempting to compare the reporting rates of various facilities. These factors also underscore the fact that Tables 3-1 and 3-2 show only the numbers and rates of reported incidents and allegations and do not necessarily reflect the actual number and rate of incidents occurring at each facility.

DMHDD Comment:

The Department agrees that there are many factors which may influence the number of reported allegations. However, if abuse allegations are to be reviewed, it is important to note that in FY 90, 17,208 people were served in mental health and dual purpose facilities, while only 4,135 were served in developmental centers.

Because some incidents are unreported by DMHDD facilities (Chapter 4), it is not possible to determine the exact number of incidents that actually occur. The number and percentage of reported cases that are substantiated by the Inspector General is one available measure of abuse and neglect at facilities. However, this measure is also limited because the Inspector General's Office can only investigate allegations it learns of through incident reports. Our 1990 audit reported that 15 percent of abuse allegations sampled were substantiated. Because this audit did not include a review of the Inspector General's effectiveness, substantiation rates were not determined.

INCIDENTS REPORTED BY TYPE OF FACILITY

We also classified the facilities into three types: Mental Health Centers (MHC), Developmental Centers (DC), and combined Mental Health/Developmental Centers (MH/DC). Abuse allegation, injury, and death rates were calculated for each group of facilities. Reporting rates from Fiscal Year 1989 through 1991 are presented in Table 3-3.

Table 3-3 shows the abuse allegation rate for mental health facilities, as a group, was twice that of developmental facilities (.43 versus .20 allegations per 1000 resident days in Fiscal Year 1991). Injury rates and death rates for these two types of facilities are similar. These patterns for incident reporting by facility type are consistent with the findings of our 1990 audit of abuse and neglect reporting.

Table 3-3
INCIDENTS BY FACILITY TYPE
(Number and Rates Per 1000 Resident Days)

FACILITY TYPE	ALLEGED ABUSE Number	Rate	INJURY Number	Rate	DEATH Number	Rate
FY 1991						
MHC	423	.43	2372	2.39	36	.04
DC	285	.20	2874	2.03	47	.03
MH/DC	246	.63	1401	3.60	18	.05
TOTAL	954	.34	6647	2.37	101	.04
FY 1990						
MHC	456	.44	1055	1.02	42	.04
DC	233	.16	2050	1.41	56	.04
MH/DC	168	.41	842	2.07	16	.04
TOTAL	857	.30	3947	1.37	114	.04
FY 1989						
MHC	378	.36	396	.38	32	.03
DC	240	.17	530	.37	53	.04
MH/DC	208	.49	254	.59	14	.03
TOTAL	826	.28	1180	.40	99	.03

Source: OAG Analysis of DMHDD Data. Rates are rounded.

CHAPTER 4

UNDERREPORTING OF INCIDENTS

DMHDD facilities did not report all incidents as required. However, our sample revealed no abuse allegations that were unreported. Also, facility compliance with reporting policies has improved since our 1990 audit.

This audit and our 1990 audit concluded that DMHDD facilities did not report all incidents as required. Proper compliance with reporting guidelines is important in ensuring the completeness of incident reporting figures and the effectiveness of investigations.

In our 1990 audit, we sampled 50 resident files at Fox and 46 files at Singer, two facilities that had reported a small number of incidents, to test for underreporting. Using the incident reporting categories specified in the DMHDD Policy and Procedures Directive, we found 13 incidents at Fox, but no incidents at Singer, that should have been reported but were not. In this audit, we examined 30 resident files at each of the 21 residential facilities for a total of 630 files for the purpose of identifying unreported incidents. Our sample of files during this audit period disclosed no instances of underreporting at the Fox facility. However, our sample disclosed a total of 18 instances of underreporting at nine other facilities (Chester, Chicago-Read, Howe, ISPI, Kiley, Madden, Shapiro, Singer, and Zeller).

Incidents of underreporting disclosed during this audit included non-accidental injuries inflicted by another resident, inappropriate sexual conduct by residents, and unexcused absence from facility premises. Our sample disclosed no unreported abuse allegations.

DMHDD Comment:

The Department is pleased that the audit demonstrated a significant reduction in instances of underreporting (15% in the 96 charts reviewed by the Auditor General in 1990 contained incidents which were not reported, as compared to only 3% in the 630 charts reviewed in the current reporting period). We believe the fact that the Auditor General did not find a single instance of underreporting of abuse allegations is indicative of the priority placed on such reporting by the Department.

RECOMMENDATION NUMBER 2

The Department of Mental Health and Developmental Disabilities should require Department personnel to report incidents as required by DMHDD Policy and Procedures Directive (PPD) 01.05.06.03. The Department should take necessary corrective actions when instances of underreporting are identified.

DMHDD Response:

The Department accepts this recommendation and will strengthen its ongoing efforts to identify instances of underreporting and to take corrective action when underreporting occurs.

CHAPTER 5

OTHER ISSUES

There are additional issues beyond the scope of this audit that help provide a more complete picture of incident reporting at DMHDD. These issues include: the reporting of incidents occurring at community-based settings, the reporting of resident-to-employee incidents, and the effectiveness of the Inspector General in investigating and substantiating reported incidents.

INCIDENT REPORTING IN COMMUNITY SETTINGS

The majority of mentally ill or developmentally disabled persons are served by 425 DMHDD-funded community provider agencies. Through community agencies, DMHDD offers a wide range of residential and support services to nearly 180,000 persons, including approximately 8,000 residents living in community-based residential facilities. As the emphasis on community-based services increased, the resident population in State facilities declined from over 25,000 in the 1960s to approximately 7,700 today. As reported in our 1990 audit, oversight of community-based programs and residential facilities becomes an important issue as their use increases.

RESIDENT-TO-EMPLOYEE INCIDENTS

Resident attacks on employees are a concern in DMHDD facilities. There have been recently published accounts of residents committing physical and sexual assaults on DMHDD facility employees.

It was not within the scope of this audit to determine the number and type of resident-to-employee incidents occurring each year. However, the occurrence of resident-to-employee incidents appears to be a significant part of the total incident reporting picture.

DMHDD Comment:

The Department agrees that resident assaults on employees is a serious concern in DMHDD facilities. While significant efforts have been made to improve employee training, increase staffing levels, and implement programs designed to prevent such recipient behaviors, direct care service remains a challenging occupation. Fortunately, the more violent assaults on employees which have recently received considerable media attention, occur very rarely. Further, the numbers of altercations and assaults where staff have been injured have been decreasing over the past three fiscal years (according to DMHDD Worker's Compensation Program data).

EFFECTIVENESS OF INVESTIGATIONS

Public Act 86-1013 directed the Auditor General to focus only on incident reporting. To do this, we reviewed DMHDD policies and procedures related to reporting and investigating resident abuse and sampled resident records and incident reports to determine the effectiveness of DMHDD facility reporting to the Office of the Inspector General. Trends and patterns of resident abuse reporting were analyzed and compared to information contained in our 1990 audit. However, our 1990 audit also addressed another part of the picture: the Inspector General's effectiveness in investigating reported incidents. This report does not address the Inspector General's effectiveness, but Public Act 87-1158 directs the Auditor General to conduct program audits of the Inspector General and release an initial report by May 1, 1993, and a subsequent report by January 1, 1995.

APPENDICES

APPENDIX A

PUBLIC ACT 86-1013

Public Act 86-1013, Section 3.2
[Effective January 3, 1990]

"Simultaneously with the biannual financial audit of the Department of Mental Health and Developmental Disabilities, the Auditor General shall conduct a program audit of each facility under the jurisdiction of that Department as described in Section 4 of "An Act codifying the powers and duties of the Department of Mental Health and Developmental Disabilities," approved August 2, 1961, as now or hereafter amended. The program audit shall include an examination of the records of each facility concerning reports of suspected abuse or neglect of any patient or resident of the facility. The Auditor General shall report the findings of the program audit to the Governor and the General Assembly, including findings concerning patterns or trends relating to abuse or neglect of facility patients and residents."

Note: The Auditor General's first report pursuant to this Act was issued in May 1990.

APPENDIX B

NUMBER OF INCIDENTS REPORTED TO OIG BY FACILITY AND TYPE OF INCIDENT
Fiscal Years 1988 through 1991

NUMBER OF INCIDENTS REPORTED TO OIG
BY FACILITY AND TYPE OF INCIDENT
FISCAL YEAR 1991

FACILITY	PHYSICAL ABUSE	SEXUAL ABUSE	VERBAL ABUSE	NEGLECT	OTHER CONDUCT	DEATHS	INJURY	SEXUAL ABSENCE	SEXUAL CONDUCT	THEFT	OTHER	TOTAL
ALTON MHDC	71	3	8	4	16	9	390	2	23	1	9	536
CHESTER MHC	81	3	16	1	24	4	138	0	9	0	4	280
CHGO-READ MHC	59	3	7	3	24	3	575	173	42	3	32	924
CHOATE MHDC	82	7	11	0	10	4	460	14	24	0	11	623
ELGIN MHC	82	8	28	7	89	6	758	61	26	9	69	1143
FOX DC	2	0	0	0	1	4	27	0	5	0	2	41
HOWE DC	80	4	9	4	15	10	690	13	10	3	31	869
ISPI MHC	5	11	6	0	6	3	71	8	12	1	6	129
JACKSONVILLE DC	39	0	1	2	5	2	361	3	4	1	12	430
KILEY DC	37	0	3	2	7	3	496	17	61	3	12	641
LINCOLN DC	15	0	2	0	4	7	249	2	5	1	7	292
LUDEMAN DC	16	1	1	3	3	1	433	3	12	0	15	488
MABLEY DC	2	0	0	0	1	1	179	14	17	1	0	215
MADDEN MHC	23	4	4	1	8	2	209	111	14	0	22	398
McFARLAND MHC	3	0	6	0	7	0	69	18	9	0	10	122
MEYER MHDC	27	3	8	5	15	1	384	14	32	0	11	500
MURRAY DC	4	0	1	1	4	2	103	1	0	0	4	120
SHAPIRO DC	51	2	3	0	14	17	336	12	10	2	19	466
SINGER MHDC	8	2	6	1	13	4	167	11	10	1	7	230
TINLEY PARK MHC	18	1	7	4	19	8	353	16	9	2	26	463
ZELLER MHC	17	4	10	1	5	10	199	17	7	0	7	277
TOTAL	722	56	137	39	290	101	6647	510	341	28	316	9187

SOURCE: OAG Analysis of DMHDD/OIG Data

NUMBER OF INCIDENTS REPORTED TO OIG
BY FACILITY AND TYPE OF INCIDENT
FISCAL YEAR 1990

FACILITY	PHYSICAL ABUSE	SEXUAL ABUSE	VERBAL ABUSE	NEGLECT	OTHER CONDUCT	DEATHS	INJURY	SEXUAL ABSENCE	SEXUAL CONDUCT	THEFT	OTHER	TOTAL
ALTON MHDC	26	2	5	7	11	5	252	15	20	0	15	358
CHESTER MHC	66	2	15	1	15	2	77	0	8	0	5	191
CHGO-READ MHC	55	15	22	11	15	12	163	138	29	3	65	528
CHOATE MHDC	51	4	8	1	10	6	329	9	26	1	6	451
ELGIN MHC	69	18	52	11	32	9	448	94	37	9	97	876
FOX DC	0	0	0	0	0	2	9	0	2	0	1	14
HOWE DC	51	2	9	8	2	11	543	12	7	0	45	690
ISPI MHC	6	7	6	0	6	2	27	4	2	1	3	64
JACKSONVILLE DC	29	3	3	7	8	5	246	6	10	1	8	326
KILEY DC	24	1	3	6	1	2	277	5	34	0	11	364
LINCOLN DC	13	0	1	4	2	9	132	1	4	0	7	173
LUDEMAN DC	10	0	0	2	1	4	301	3	5	3	7	336
MABLEY DC	9	0	1	0	0	0	18	5	6	0	3	42
MADDEN MHC	24	4	4	1	1	3	15	99	18	2	13	184
McFARLAND MHC	4	9	0	5	5	1	33	24	20	1	5	107
MEYER MHDC	39	0	6	1	15	1	188	34	29	0	14	327
MURRAY DC	5	1	1	1	3	6	157	1	2	0	7	184
SHAPIRO DC	32	0	3	4	2	17	367	5	13	1	36	480
SINGER MHDC	11	1	6	0	6	4	73	27	5	0	7	140
TINLEY PARK MHC	16	2	7	7	4	3	227	33	3	9	12	323
ZELLER MHC	12	0	3	2	4	10	65	14	4	2	8	124
TOTAL	552	71	155	79	143	114	3947	529	284	33	375	6282

SOURCE: OAG Analysis of DMHDD/OIG Data

NUMBER OF INCIDENTS REPORTED TO OIG
BY FACIITY AND TYPE OF INCIDENT
FISCAL YEAR 1989

FACILITY	PHYSICAL ABUSE	SEXUAL ABUSE	VERBAL ABUSE	NEGLECT	OTHER CONDUCT	DEATHS	INJURY	ABSENCE	SEXUAL CONDUCT	THEFT	OTHER	TOTAL
ALTON MHDC	37	2	6	15	17	2	22	11	30	0	8	150
CHESTER MHC	32	1	4	0	12	2	3	0	9	1	2	66
CHGO-READ MHC	50	4	23	9	21	5	194	199	61	16	67	649
CHOATE MHDC	46	4	1	0	5	3	111	9	17	1	12	209
ELGIN MHC	66	12	35	22	66	12	118	58	34	30	112	565
FOX DC	0	0	0	0	0	4	4	0	0	0	1	9
HOWE DC	31	1	8	3	7	13	113	2	14	0	39	231
ISPI MHC	6	12	2	3	1	0	1	3	3	1	5	37
JACKSONVILLE DC	35	3	3	1	6	4	32	0	7	1	5	97
KILEY DC	21	0	2	9	4	2	48	3	2	2	9	102
LINCOLN DC	21	0	0	9	5	10	55	0	4	4	7	115
LUDEMAN DC	3	0	1	4	1	2	68	6	1	2	3	91
MABLEY DC	3	0	2	1	0	0	30	3	8	0	1	48
MADDEN MHC	27	2	5	6	7	4	17	1	10	2	5	86
McFARLAND MHC	3	4	1	1	2	0	10	17	8	2	9	57
MEYER MHDC	59	8	6	17	12	6	119	44	38	14	54	377
MURRAY DC	5	1	0	3	0	5	18	0	0	1	8	41
SHAPIRO DC	57	4	8	1	4	13	162	8	7	0	28	292
SINGER MHDC	2	4	0	1	1	3	2	1	2	3	6	25
TINLEY PARK MHC	13	3	10	3	14	2	33	4	8	5	14	109
ZELLER MHC	12	0	4	3	2	7	20	12	10	2	5	77
TOTAL	529	65	121	111	187	99	1180	381	273	87	400	3433

SOURCE: OAG Analysis of DMHDD/OIG Data

NUMBER OF INCIDENTS REPORTED TO OIG
BY FACILITY AND TYPE OF INCIDENT
FISCAL YEAR 1988

FACILITY	PHYSICAL ABUSE	SEXUAL ABUSE	VERBAL ABUSE	NEGLECT	OTHER CONDUCT	DEATHS	INJURY	ABSENCE	SEXUAL CONDUCT	THEFT	OTHER	TOTAL
ALTON MHDC	18	5	8	4	2	1	28	2	6	0	15	89
CHESTER MHC	25	0	11	3	4	4	5	0	4	1	5	62
CHGO-READ MHC	39	3	4	11	10	8	6	1	22	0	16	120
CHOATE MHDC	26	4	3	1	5	0	4	0	6	2	9	60
ELGIN MHC	55	12	26	10	38	2	36	9	21	5	39	253
FOX DC	2	0	0	0	1	4	3	0	0	0	0	10
HOWE DC	13	0	2	1	3	9	17	1	1	1	5	53
ISPI MHC	9	5	1	1	8	1	0	0	2	0	2	29
JACKSONVILLE DC	29	1	2	12	4	0	16	1	1	0	4	70
KILEY DC	19	2	1	1	7	2	31	1	0	2	10	76
LINCOLN DC	20	2	3	4	5	10	82	0	4	3	14	147
LUDEMAN DC	13	1	0	2	1	0	31	2	1	0	3	54
MABLEY DC	1	0	1	0	1	0	7	0	3	0	1	14
MADDEN MHC	20	5	7	5	3	1	12	4	17	1	20	95
McFARLAND MHC	4	2	1	1	1	2	1	1	2	2	3	20
MEYER MHDC	21	0	0	4	2	2	29	5	22	7	11	103
MURRAY DC	4	0	0	0	1	4	17	0	0	0	3	29
SHAPIRO DC	65	1	5	3	6	11	86	5	8	0	19	209
SINGER MHDC	10	3	4	1	5	4	2	3	8	1	8	49
TINLEY PARK MHC	11	1	8	6	11	3	2	0	3	14	8	67
ZELLER MHC	0	1	1	0	3	1	1	6	5	0	3	21
							0					
TOTALS	404	48	88	70	121	69	416	41	136	39	198	1630

SOURCE: OAG Analysis of DMHDD/OIG Data

APPENDIX C

SAMPLING AND ANALYTICAL METHODOLOGY

Sampling and Analytical Methodology

We examined the Office of the Inspector General's (OIG) incident report statistics and a random sample of 1050 incident report files for Fiscal Years 1990 and 1991 in order to discern trends or patterns relating to abuse and neglect of DMHDD facility residents.

In Fiscal Year 1990, 6282 incidents were reported to the OIG and in Fiscal Year 1991, 9187 incidents were reported. Files of incidents reported to the OIG are kept at each of 21 DMHDD facilities. Random sampling or systematic random sampling was used to draw a sample of 50 cases for review from the files of incidents reported at each facility. This resulted in 1050 (21 x 50) cases for review and analysis involving 1367 residents. A sample of this size allows for a margin of error no larger than $\pm 2.92\%$ at a 95 percent level of confidence.

The sample data was examined and compared with the resident population statistics, as published by the OIG, to determine if any demographic category was overrepresented. As shown below, the gender ratio of DMHDD's resident population is approximately 36% female and 64% male. The ethnic composition of residents in the DMHDD facilities is 70.1% white, 25.8% black, and 3.4% hispanic. Sample descriptive statistics show that approximately 66% (874) of the residents are males and 34% (442) are females. The ethnic composition of residents in the sample shows that 70.3% (929) are white, 25.9% (343) black, 3.3% (44) hispanic, and 0.4% classified as "other". Discrepancies between the ethnic composition totals and gender totals and the total of 1367 residents is due to processing procedures. Different analytical procedures did not use all available observations where data was missing for some of the relevant variables.

Tests for significant relationships between types of reported incidents and demographic characteristics were performed using the Chi-square test for independence at a 5 percent level of significance.

The Chi-square test measures the difference between the actual and expected frequencies of incidents reported with regard to incident type and demographic attributes. The more the results differ from what would be expected if there was a relationship between the variables, the larger will be the calculated Chi-square number. The Chi-square test is a test of independence between characteristics; it does little to describe to the strength or form of the association between characteristics. The meaning of the level of significance is that due to chance sampling error, the calculated statistic will be exceeded on average by this percentage of Chi-square values calculated from repeated samples drawn from the population where there is not a significant relationship between the incident type and demographic characteristics of the residents involved.

We analyzed the sample for a relationship between the race of the residents and allegations of abuse. The reported Chi-square statistic of 29.51 with a p-value of .0000 is statistically significant at a 5 percent level of significance. The sample provides evidence that black residents were more likely to be involved in incidents of alleged abuse than white or

hispanic residents. Analysis of the sample by both race and gender found no significant relationship between black male residents and allegations of abuse. The reported statistic, 11.3939, means that the difference in likelihood of being abused was marginally significant at a 10 percent level but not meaningful at a 5 percent level. Analysis examining this relationship based on the fiscal year of occurrence was inconclusive. Therefore the sample provided no convincing evidence that black male residents were more likely to be allegedly abused than other male residents. Analysis by gender and race however, showed a significant relationship between black female residents in the sample and allegations of abuse. The reported statistic 25.908 with a significance level of .0002 is significant at a 5 percent level. The sample provides evidence that black females were more likely to be involved in incidents of alleged abuse than white or hispanic females. Due to chance sampling error we would obtain a statistic greater than 25.908 in only 2 of 10000 repeated samples from a population where there is not a significant relationship between the race of the female resident and allegations of abuse.

Tests for significant relationships between the types of incidents reported and facilities were performed using the Chi-square test for independence at a 5 percent level of significance.

To test that facilities reported all reportable incidents in compliance with the OIG's P.P.D. 01.05.06.03, we selected and reviewed a sample of 30 resident files from each facility. The population for the sample consisted of individual case files of all residents at each facility. Random sampling or systematic random sampling was used, thus all resident files for FY90 and FY91 had an equal chance of being selected.

Calculation of Abuse Allegation, Injury, and Death Rates

To adjust for different resident populations and to allow for a more consistent means of analysis of the facilities, an incident per 1000 resident days rate was calculated. A resident day is equal to one patient in residence at a facility for one day. Total resident days service provided during each fiscal year for each facility were divided by 1000. The number of reported incidents, specific allegations of abuse, injuries, and deaths were divided by the facility's respective units of 1000 resident days. In calculating these rates the resident population of each facility as of June 30 of each respective year was used.

Facility population figures and demographic characteristics for Fiscal Year 1991 are shown in the following table.

FISCAL YEAR 1991 DMHDD STAFF/RESIDENT DATA

FACILITY	Population	Resident Days	White	Black	Hispanic	Other	Male*	Female*	Direct Care Staff**	Direct Care Staff/Resident Ratio
ALTON MHDC	305	110872	212	86	4	3	192	112	327	1.07
CHESTER MHC	307	115306	153	142	10	2	316	0	323	1.05
CHGO-READ MHC	527	180076	310	165	44	8	288	206	631	1.20
CHOATE MHDC	426	151171	359	64	2	1	273	141	432	1.01
ELGIN MHC	794	289515	478	264	39	13	560	233	817	1.03
FOX DC	187	69787	146	35	3	3	107	84	181	0.97
HOWE DC	630	234286	434	169	25	2	374	268	859	1.36
ISPI	150	62467	54	73	21	2	95	76	261	1.74
JACKSONVILLE DC	321	116285	281	35	5	0	230	89	332	1.04
KILEY DC	468	171020	380	54	32	2	291	178	577	1.23
LINCOLN DC	491	177448	424	60	3	4	301	185	480	0.98
LUDEMAN DC	494	180769	289	182	19	4	322	173	621	1.26
MABLEY DC	118	41859	97	18	3	0	80	35	134	1.14
MADDEN MHC	222	93489	92	118	10	2	159	97	259	1.17
McFARLAND MHC	161	55182	140	18	1	2	96	55	138	0.86
MEYER MHDC	162	57633	125	36	1	0	104	54	149	0.92
MURRAY DC	369	133136	327	41	0	1	207	158	390	1.06
SHAPIRO DC	817	293958	612	174	28	3	505	300	961	1.18
SINGER MHDC	237	68981	202	27	8	0	121	68	211	0.89
TINLEY PARK MHC	306	112851	89	213	3	1	184	125	363	1.19
ZELLER MHC	230	83275	209	18	2	1	132	96	237	1.03
TOTAL	7722	2799366	5413	1992	263	54	4937	2733	8683	1.13
			70.10%	25.80%	3.40%	0.70%	64.36%	35.63%		

NOTE: FY91 population as of June 30, 1991
* Male, female distribution based on average daily population for Fiscal Year 1991 per DMHDD statistics
** Staff numbers are rounded full time equivalents
SOURCE: DMHDD data

APPENDIX D

AGENCY RESPONSE

Illinois Department of
Mental Health and
Developmental Disabilities

Central Office

October 19, 1992

William G. Holland
Auditor General
509 South Sixth Street
Springfield, Illinois

Dear Mr. Holland:

Thank you for this opportunity to comment on your program audit of reporting of resident abuse and neglect in Department of Mental Health and Developmental Disabilities' facilities. The Department is gratified that your study recognizes the significant progress that has been made since your 1990 audit. The Department is also committed to making further improvements in incident reporting, and in ensuring that all facility residents are free from abuse and neglect. The Department accepts and will implement both recommendations made in the audit report.

While there are no disagreements about the findings of fact, I would appreciate the opportunity to have Department comments inserted directly into the body of the report in an effort to lend perspective to selected findings. Specifically, I would ask that you include the following:

[Please insert following first paragraph of boldface summary - Page 1 of draft]

DMHDD Comment: The Department asserts that the dramatic increase in reported injuries is clearly a result of changes the Department made in injury reporting requirements in 1990. In an effort to gather additional information about care and treatment in Department facilities, the Department significantly expanded the definition of "reportable injury" in January of 1990. The new definition redefined "serious" injuries and required that facilities begin reporting minor injuries (i.e., slight red marks, scratches, and redness), even if no first aid is needed. Many trivial injuries which were formerly not reported to the OIG are now being reported. (see DMHDD Appendix A - Table 1)

[Please insert following second paragraph of boldface summary - Page 1 of draft]

The Department is pleased that the Auditor General has recognized that the timeliness of facility incident reporting has improved. Following the 1990 report, the Department increased its monitoring, training, and enforcement activities in this area, and we agree that significant progress has been made. (see DMHDD Appendix A - Table 2)

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[Please insert following first paragraph of boldface summary - Page 2 of draft]

The Department is also pleased that the audit demonstrated a significant reduction in instances of incident underreporting. The fact that the Auditor General did not find a single instance of underreporting of abuse allegations is indicative of the priority placed on such reporting by the Department. (see DMHDD Appendix C)

[Please insert following second paragraph of boldface summary - Page 2 of draft]

The Department believes that the rate of allegations is a less instructive measure of care and treatment than is the rate of substantiated cases of abuse and neglect. Nonetheless, if abuse allegations are reviewed, it is important to note that 17,208 people were served in mental health and dual purpose facilities, while only 4,135 were served in developmental centers in FY 90. (see DMHDD Appendix B)

[Please insert following boldface summary - Page 7 of draft]

DMHDD Comment: The Department believes the increases in reported injuries is a positive indication that its changes in reporting policies, increased training activities, and enforcement efforts have been successful. The Department maintains that the increases are clearly and demonstrably related to the changes in reporting requirements (see DMHDD Appendix A)

The Department is pleased that the Auditor General has recognized that the timeliness of facility incident reporting has improved. It is important to note that in the audit's analysis of DMHDD performance in this area, the Auditor General has employed a 24 hour standard for "timeliness" reporting. The statute does not contain any specific time guidelines for facility reporting. While many reports are filed within the 24 hour period analyzed by the Auditor General, the Department's existing policy does not require that reports be filed within this timeframe.

In response to the recommendation of the Auditor General's 1990 audit, Department policy was revised in September of 1990 to include specific time guidelines for reporting to the IDPH Hotline, to the Office of the Inspector General by telephone (for abuse allegations), and by mail for all cases. Since January 1991, the office of the Inspector General has tracked facility reporting. OIG data indicates that facilities have reported over 90% of incidents to the IDPH Hotline and by telephone to the OIG within the timeframes required by Department policy. (see DMHDD Appendix A - Table 2)

[Please insert after Recommendation #1 - Page 10 of draft]

DMHDD Comment: The Department accepts and will implement this Recommendation. The Department will take additional steps to emphasize that all incidents must be reported to the Office of Inspector General within the appropriate timeframes.

[Please insert at the end of Chapter 2 - Page 13 of draft]

DMHDD Comment: The Department agrees with the Auditor General that the data from their sample cannot be generalized and that no firm conclusion should be drawn from their data. The Department believes that a review of the allegations of abuse which have been substantiated following investigation, is a more instructive area of study. The Department has reviewed substantiated abuse cases and found that the substantiated allegations show a pattern of race and gender more closely matching the resident population as a whole.

[Please insert after boldface summary - page 14 of draft]

DMHDD Comment: The Department agrees that there are many factors which may influence the number of reported allegations. However, if abuse allegations are to be reviewed, it is important to note that in FY 90, 17,208 people were served in mental health and dual purpose facilities, while only 4,135 were served in developmental centers.

[Please insert after boldface summary - top of page 17 of draft]

DMHDD Comment: The Department is pleased that the audit demonstrated a significant reduction in instances of underreporting (15% in the 96 charts reviewed by the Auditor General in 1990 contained incidents which were not reported, as compared to only 3% in the 630 charts reviewed in the current reporting period). We believe the fact that the Auditor General did not find a single instance of underreporting of abuse allegations is indicative of the priority placed on such reporting by the Department.

[Please insert after Recommendation #2 - bottom of page 17 of draft]

DMHDD Comment: The Department accepts this recommendation and will strengthen its ongoing efforts to identify instances of underreporting and to take corrective action when underreporting occurs.

[Please insert following Resident-To-Employee Incidents Section - bottom of page 18 of draft]

DMHDD Comment: The Department agrees that resident assaults on employees is a serious concern in DMHDD facilities. While significant efforts have been made to improve employee training, increase staffing levels, and implement programs designed to prevent such recipient behaviors, direct care service remains a challenging occupation. Fortunately, the more violent assaults on employees which have recently received considerable media attention, occur very rarely. Further, the numbers of altercations and assaults where staff have been injured have been decreasing over the past three fiscal years (according to DMHDD Worker's Compensation Program data).

The Department appreciates the professionalism and responsiveness demonstrated by the Auditor General staff who conducted this audit.

I hope you find the above information useful.

Sincerely,

Jess McDonald

Jess McDonald
D i r e c t o r

JM:gvf

DMHDD APPENDIX A

Chronology of Policy Changes:

The Department has continually sought to improve the reporting requirements and the expectations regarding incidents. In response to statutory changes, internal reviews, external audits, and inter-agency agreements with related departments, during the time period under audit, the Department has made several revisions to its Departmental policy requirements.

August 15, 1985
This is the revision of the Department's policy that was in effect prior to the creation of the DMHDD Office of the Inspector General in March 1988, pursuant to the passage of Public Act 85-223.

Key Definitions:

Mistreatment of recipients by employees not further defined;
Recipient deaths that occur in the facility or while temporarily transferred elsewhere; and
Serious injury to recipients, not otherwise defined, regardless of circumstances.

Key Reporting Requirements:

If allegation was made against an employee, the incident was to be reported to the Illinois State Police (no time guideline);
All incidents were to be reported to OIG (no time guideline); and
The facility was to investigate and submit a report for review.

June 30, 1988
The memo referred to in this audit was a memo from the new Inspector General, Philip Fisher, who "reiterated and clarified" requirements. It was written in response to the statutory revisions in Public Act 85-223 and it was effective during the entire Fiscal Year 1989.

Key Definitions:

Mistreatment of recipient by employees defined as "physical abuse (two categories), sexual abuse, verbal abuse, neglect, and other improper employee conduct;"
Reportable recipient deaths expanded to include conditional discharges and hospital visit; and
Recipient injuries expanded and subdivided into two categories: those requiring immediate medical attention, and those of unknown and questionable origin.

Key Reporting Requirements

All incidents were to be reported to the Illinois State Police (the statute required the IDPH Hotline to report to the State Police, so Department policy required the facilities to do so also);
If allegation of abuse by employee was made, report was to be made to OIG "by telephone as soon as possible during working hours..." (no time guideline to State Police or OIG); and

OIG Investigators investigated some abuse cases (State Police took a few), all other cases were investigated by the facility with a report submitted to OIG for review.

May 12, 1989, effective July 3, 1989

Public Act 85-223 had specified certain requirements for abuse reporting. It did not include specific time guidelines for this reporting. In response to the reporting requirements, the Department revised its policy. This revision was in effect during the first half of FY 90.

Key Definitions:

The definitions for categories of abuse and neglect by employees were greatly expanded, including actions that were by nature abusive, even if no injury resulted (the statute required an injury);

Recipient death was expanded to include those occurring up to 30 days after discharge;

Serious recipient injuries were further defined to include those "serious enough to require immediate medical treatment by a physician"; and

Other recipient injuries were limited to those that appeared to be caused by abuse or neglect by staff.

Key Reporting Requirements:

All incidents were to be reported to the State Police "promptly" (no other time guideline);

Incidents of abuse allegations, recipient injuries, and sexual assault by another recipient were to be reported "immediately" thereafter to the IDPH Hotline;

Incidents of abuse allegations and deaths were to be reported "promptly" during normal working hours to OIG.

September 20, 1989

In response to the duplication of reporting injuries to the IDPH regional offices while reporting injuries and abuse allegations to the IDPH Hotline, IDPH requested that the Department make some minor revisions. This revision of the policy included some of the changes requested by IDPH. There were no changes to key definitions or to key reporting requirements.

January 15, 1990

Public Act 86-1013 provided that the IDPH Hotline was to report incidents to the OIG, rather than the State Police, all incidents that were received by the Hotline. In addition, the Mental Health Code definition of abuse and neglect was revised to be consistent with the definition in the statute setting up the IDPH Hotline. In response, the Department made significant revisions to its definitions and reporting requirements.

This revision of the Department policy was effective during the second half of FY 90. The definitions have not changed since this revision. The reporting requirements have changed only by the insertion of time guidelines and the internal facility reporting requirements.

Key Definitions:

The definitions of Abuse/neglect and recipient death were left unchanged;

Serious recipient injuries were limited to those requiring emergency medical treatment by a physician; and

The definition of other recipient injuries was greatly expanded to include all injuries that were or appeared to be inflicted by another person by other than accidental means, including simple red marks and slight scratches not requiring first aid.

Key Reporting Requirements:

All incidents involving abuse allegations, recipient injuries, or recipient death were reported to the IDPH Hotline by the facility director "immediately upon becoming aware" of it (no further time guideline);

All incidents involving abuse allegations and recipient death were to be reported to OIG by phone "promptly" (no further time guideline) and OIG investigators accepted all such cases for investigation; and

All incidents were to be mailed to OIG "in a timely manner" (no further time guideline).

Comparing the twelve calendar months prior to the reporting guideline changes to the twelve calendar months after, the number of "serious" injuries reported decreased from 1639 to 214, and the number of other - less serious - reportable injuries increased from 381 to 5721. The number in each category has remained relatively stable since that time, suggesting that the change in definitions alone accounted for the changes in reporting.

The six-month segments also show how the implementation of these changes account for the increases:

Appendix A, Table 1

	FY 89		FY 90		FY 91	
	First half	Last half	First half	Last half	First half	Last half
Serious recip. injuries	399	602	1037	213	168	185
Other recip. injuries	89	91	123	2574	3147	3147

Definition changes -

September 24, 1990

In response to the Auditor General's 1990 report, several changes were made to the Departmental policy. These included the addition of specific time guidelines for reporting. This was in effect during FY 91 and is the current version. Since January 1991, OIG has tracked facility reporting.

Key Definitions:

The definitions of abuse/neglect, recipient death, and recipient injuries were left unchanged.

Key Reporting Requirements:

All incidents involving abuse/neglect, recipient death, and recipient injuries are to be reported to the IDPH Hotline "by the end of the next calendar day" (Heading "A" below);

All incidents involving abuse/neglect and recipient death are to be reported to OIG by phone "by the end of the next working day" (Heading "B"); and

All incidents are to be reported to OIG by mail "within seven calendar days" (Heading "C").

Appendix A, Table 2

Percent of Incident Reported Within Time Guidelines
(See text above for specific requirements)

Last half FY 91 Jan-June 1991			First Half FY 92 July-Dec. 1991			Last Half FY 92 Jan-June 1992		
A	B	C	A	B	C	A	B	C
92%	93%	88%	94%	96%	92%	95%	95%	89%

The Department believes that the rate of allegations is a less instructive measure of care and treatment than is the rate of substantiated cases of abuse and neglect. However, if abuse allegations are reviewed, an additional variable should be taken into consideration. While it is true that on a daily basis, relatively equal numbers of recipients are served in DD and MH facilities, there are significantly more people served in mental health facilities on an annual basis. For example, FY 90 data indicate that a total of 17,208 persons were served in mental health or dual purpose facilities and a total of 4,135 people were served in developmental centers. Utilizing the total number of people served (rather than the "bed-day" calculations used by the Auditor General), the Department's analysis of allegations reveals the following:

	FY88		FY89		FY90		FY91	
	Alleg.	Rate	Alleg.	Rate	Alleg.	Rate	Alleg.	Rate
MI	406	2.1/100	586	3.1/100	624	3.6/100	669	4.2/100
DD	204	4.9/100	240	5.8/100	233	5.6/100	285	4.7/100
TOT	610	.026	826	.036	857	.040	954	.047

DMHDD APPENDIX C

On a formal and regular basis, the Office of Inspector General has conducted reviews of facility records to test for under-reporting. As part of these reviews, five to ten percent of recipient records at each facility are reviewed. The results of these chart reviews show:

Last half FY 91 Jan-June 1991*		First half FY 92 July-Dec 1991		Last half FY 92 Jan-June 1992	
Charts reviewed	Unrep. incidents	Charts reviewed	Unrep. incidents	Charts reviewed	Unrep. incidents
476	26	553	3	489	3

*This time period was done in two separate three-month segments.

DMHDD APPENDIX D

The Department believes that a review of the allegations of abuse which have been substantiated following investigation, is a more instructive area of study. The Department has reviewed substantiated abuse cases and found that the substantiated allegations show a pattern of race and gender more closely matching the resident population as a whole:

Percentage of Substantiated Abuse Allegations in FY 91 by Race/Sex:

	White	Black	Hispanic
Male	42.3	16.1	2.9
Female	25.6	13.1	0.0
Totals	67.9	29.2	2.9

Unduplicated residents in DMHDD facilities in FY 91 in percent:

	White	Black	Hispanic
Male	37.0	22.4	3.2
Female	23.2	12.7	1.5
Totals	60.2	35.2	4.7

Percentage of Substantiated Abuse Allegations in FY 92 by Race/Sex:

	White	Black	Hispanic
Male	43.7	14.0	1.6
Female	26.6	12.5	1.6
Totals	70.3	26.5	3.2

Unduplicated residents in DMHDD facilities in FY 92 in percent:

	White	Black	Hispanic
Male	37.1	22.8	3.0
Female	22.6	13.0	1.5
Totals	59.7	35.9	4.5

As of the end of FY 91, the Department's facility staff composition was as follows: 64.1% White, 30.3% Black, 1.7% Hispanic, and 3.9% Other; and 33.3% Male and and 66.7% Female.