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OFFICE OF THE AUDITOR GENERAL

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. The audit was conducted pursuant to 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
June 1994

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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 found:

- The timeliness of facilities' reporting of suspected abuse improved. We found that 95 percent (543 of 570) of abuse allegations sampled were reported as required within 1 day, a marked improvement over the 50 percent rate (74 of 148) reported in our 1992 audit.

- Allegations of resident abuse reported by Department of Mental Health and Developmental Disabilities (DMHDD) facilities decreased 7 percent, from 954 in Fiscal Year 1991 to 891 in Fiscal Year 1993. The total number of incidents reported decreased 12 percent, from 9,187 in Fiscal Year 1991 to 8,063 in Fiscal Year 1993. Total population at DMHDD's residential facilities declined 11.5 percent over the same period.

- DMHDD facilities were not reporting all incidents as required. Our sample of 630 resident files disclosed 23 incidents that should have been reported but were not. Two of the unreported incidents involved alleged abuse.

This is our third audit of patterns or trends in incident reporting at DMHDD facilities. We also conduct separate audits of the Office of Inspector General's investigation of alleged abuse. The General Assembly may wish to consider eliminating the requirement for the Office of the Auditor General's biennial audit of facility reporting patterns or trends of suspected resident abuse.

[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. Our program audits of the Office of Inspector General examine the issue of substantiated reports.

INTRODUCTION

Since January 3, 1990, the Illinois State Auditing Act (30 ILCS 5/3-2) has required the Auditor General to conduct a program audit, simultaneously with the biennial financial audit of the Department of Mental Health and Developmental Disabilities (DMHDD), to report trends or patterns of suspected resident abuse and neglect of DMHDD residents. This audit deals only with reports of "alleged" resident abuse, not with "substantiated" abuse cases. Data from two audits completed in May 1990 and November 1992 pursuant to this requirement are used as a base for measuring agency performance.

DMHDD operates 21 residential facilities for the mentally ill and/or developmentally disabled. Facility directors are required to report a variety of incidents, including 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.

REPORT CONCLUSIONS

From Fiscal Year 1991 through Fiscal Year 1993, the total number of incidents reported by facilities to the Office of the Inspector General (OIG) decreased 12 percent (9,187 to 8,063), and the number of abuse allegations decreased 7 percent (954 to 891). During the same period, the total population at DMHDD residential facilities decreased 11.5 percent (7,722 to 6,832).

The number and rate of abuse allegations reported by facilities varied widely. Abuse allegation rates at mental health centers (MHC) remained at least twice that of developmental centers (DC). Dual facilities (MHDC) had the highest abuse allegation rates over the past three years.

Facilities' timeliness of reporting abuse allegations to the OIG has improved. In this audit, 95 percent of alleged abuse cases sampled (543 of 570) were reported within one day as required, compared to only 50 percent (74 of 148) in our 1992 audit. The overall timeliness of reporting all types of incidents within the required seven days improved from 94 percent in Fiscal Year 1991 to 96 percent in Fiscal Years 1992 and 1993.

DMHDD facilities are still not reporting all incidents as required. Our 1992 audit found 18 unreported incidents in 630 resident files; this audit found 23 unreported incidents in the same number of files. Two of the 23 unreported incidents involved allegations of abuse. We recommended that the Department take steps necessary to ensure all incidents are reported as required.

PATTERNS IN NUMBER OF INCIDENTS REPORTED

Digest Exhibit 1 shows that the total incidents and injuries reported by facilities increased significantly from Fiscal Year 1989 through Fiscal Year 1991, but declined during Fiscal Years 1992 and 1993. Abuse allegations increased through Fiscal Year 1992 and declined in Fiscal Year 1993.

Digest Exhibit 1
INCIDENTS REPORTED TO THE OFFICE OF THE INSPECTOR GENERAL
Fiscal Years 1989-1993

	Abuse*	Injury	Other	Total
FY89	826	1180	1427	3433
FY90	857	3947	1478	6282
FY91	954	6647	1586	9187
FY92	1079	6427	1531	9037
FY93	891	5887	1285	8063

* = Alleged Abuse and Neglect
Source: OAG analysis of DMHDD/OIG data.

OIG officials expressed concern that underreporting by facilities might account for part of the decrease in incidents reported. Declining resident populations also might have been a factor in the lower number of incidents reported. From Fiscal Year 1991 through Fiscal Year 1993, the resident population at DMHDD's 21 residential facilities decreased 11.5 percent, from 7,722 to 6,832. (Pages 10-13)

PATTERNS IN INCIDENT REPORTING BY FACILITY TYPE

The number and rate of abuse allegations continued to vary considerably among the three facility types: mental health, developmental, and combined mental health and developmental. From Fiscal Year 1989 through Fiscal Year 1993, abuse allegation rates per 1,000 resident days remained at least twice as high at mental health facilities (.36 to .60) than at developmental facilities (.16 to .20). The highest abuse allegation rates per 1,000 resident days generally occurred at combined mental health and developmental centers (.41 to .63).

Injury rates were generally the lowest at developmental facilities. The highest injury rates occurred at combined mental health and developmental facilities. (Pages 15-18)

UNDERREPORTING OF INCIDENTS

This audit and our two prior audits found that DMHDD facilities did not report all incidents as required by DMHDD policy. Proper compliance with reporting guidelines is important to help ensure resident safety, complete incident reporting figures, and effective investigations.

This audit found 23 unreported incidents in 630 resident files sampled; two of the unreported incidents involved alleged abuse. In our 1992 audit, we sampled 630 resident files and found 18 unreported incidents, none of which involved alleged abuse. We recommended that the DMHDD adopt stronger measures to ensure that facility personnel report incidents as required by DMHDD policy and implement procedures to monitor facilities for underreporting. (Pages 19-21)

OTHER ISSUES

This report disclosed other issues related to resident abuse. These issues included the reporting of incidents occurring at community-based settings and the reporting of resident-to-staff incidents.

The General Assembly may wish to consider eliminating the statutory requirement for future biennial audits of patterns or trends in abuse allegation reporting at DMHDD facilities. This has been our third statutorily required audit of facility abuse and neglect reporting. The Office of the Auditor General also conducts statutorily required audits of the Office of the Inspector General's effectiveness in investigating reports of suspected abuse or neglect at DMHDD facilities (210 ILCS 30/6.8). The Office of the Inspector General also provides information on incident trends and patterns in its annual report to the General Assembly. Finally, several other entities (DMHDD's Quality Care Board, Equipped for Equality Incorporated, Citizens Assembly, Guardianship and Advocacy Commission, the Department of Public Health, the Department of Children and Family Services, and the Illinois State Police) have oversight or investigative roles regarding incidents at DMHDD facilities. (Pages 23-25)

MATTER FOR CONSIDERATION BY THE GENERAL ASSEMBLY

The General Assembly may wish to consider eliminating the Office of the Auditor General's biennial audit of patterns or trends in abuse allegation reporting at DMHDD facilities (30 ILCS 5/3-2).

RECOMMENDATIONS

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

WILLIAM G. HOLLAND
Auditor General

WGH\JK
June 1994

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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 (210 ILCS 30/3). 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 (405 ILCS 5/1-106).
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 (405 ILCS 5/1-107).
DUAL FACILITY	A facility that serves both individuals with mental illness and individuals with developmental disabilities.
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 (405 ILCS 5/1-114).
MENTAL ILLNESS	Mental disease to such extent that a person so afflicted requires care and treatment for his own welfare, or the welfare of others, or of the community (45 ILCS 40/1).
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 (210 ILCS 30/3).

CHAPTER ONE
INTRODUCTION

The Illinois State Auditing Act requires the Auditor General to conduct a program audit simultaneously with the biennial financial audit of the Department of Mental Health and Developmental Disabilities (DMHDD). This audit requirement was added by Public Act 86-1013 (30 ILCS 5/3-2), effective January 3, 1990 (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 "alleged" resident abuse, and not with "substantiated" cases of abuse. There are many allegations of abuse that are not substantiated by subsequent investigation.

Two prior program audits reporting on resident abuse have been completed by the Office of the Auditor General. In May 1990, the Auditor General released a program audit on the reporting and investigation of resident abuse and assessed the Office of the Inspector General's effectiveness in investigating reports of suspected abuse. In November 1992, a second program audit reported on trends and patterns of alleged abuse.

This report uses data contained in the Auditor General's May 1990 and November 1992 Program Audits of DMHDD Reporting and Investigation of Resident Abuse and Neglect as a base for monitoring trends and patterns of alleged abuse. This audit is similar to our November 1992 audit, in which we reported on trends and patterns of alleged abuse. In this audit, however, we have expanded the scope of our review of incident reports at each facility.

REPORT CONCLUSIONS

The total number of incidents reported to the Office of the Inspector General (OIG) by DMHDD facilities decreased by 12 percent, from 9,187 in Fiscal Year 1991 to 8,063 in Fiscal Year 1993. During the same period, the total population at DMHDD's 21 residential facilities decreased 11.5 percent, from 7,722 to 6,832.

Abuse allegations decreased 7 percent from Fiscal Year 1991 to Fiscal Year 1993. There were 954 allegations of resident abuse in Fiscal Year 1991. The number of abuse allegations rose to 1,079 in Fiscal Year 1992, and then decreased to 891 in Fiscal Year 1993.

There was a wide variation in the number and rate of abuse allegations reported by DMHDD facilities. Abuse allegation rates at mental health facilities continued to run at least twice as high as at developmental facilities. Facilities serving both the mentally ill and developmentally disabled (i.e., dual facilities) had the highest abuse allegation rates over the past three years.

We found that the timeliness of facilities' reporting of abuse allegations to the OIG improved since our November 1992 audit, although further improvement is needed. In our 1992 audit, 50 percent (74 of 148) of abuse allegations were reported within the required one-day period. In this audit, the number reported within one day increased to 95 percent (543 of 570). In addition, the overall timeliness of the reporting of all incidents within the required seven days improved from 94 percent in Fiscal Year 1991, to 96 percent in both Fiscal Years 1992 and 1993.

Facilities' compliance with the requirement to report all incidents to the Inspector General did not improve since our last audit. In our 1992 audit, we found 18 reportable incidents in 630 resident files reviewed which were not reported to the OIG. In this audit, the number of unreported incidents grew to 23 in 630 resident files reviewed. Two of the unreported incidents involved allegations of abuse. We recommended that the Department take the necessary steps to ensure facilities report all incidents as required by policy.

BACKGROUND

The Department of Mental Health and Developmental Disabilities (DMHDD) provides care and treatment to mentally ill or developmentally disabled citizens of Illinois. Exhibit 1-1 shows that the total resident population at DMHDD's 21 residential facilities decreased from 7,722 residents in Fiscal Year 1991 to 6,832 residents in Fiscal Year 1993.

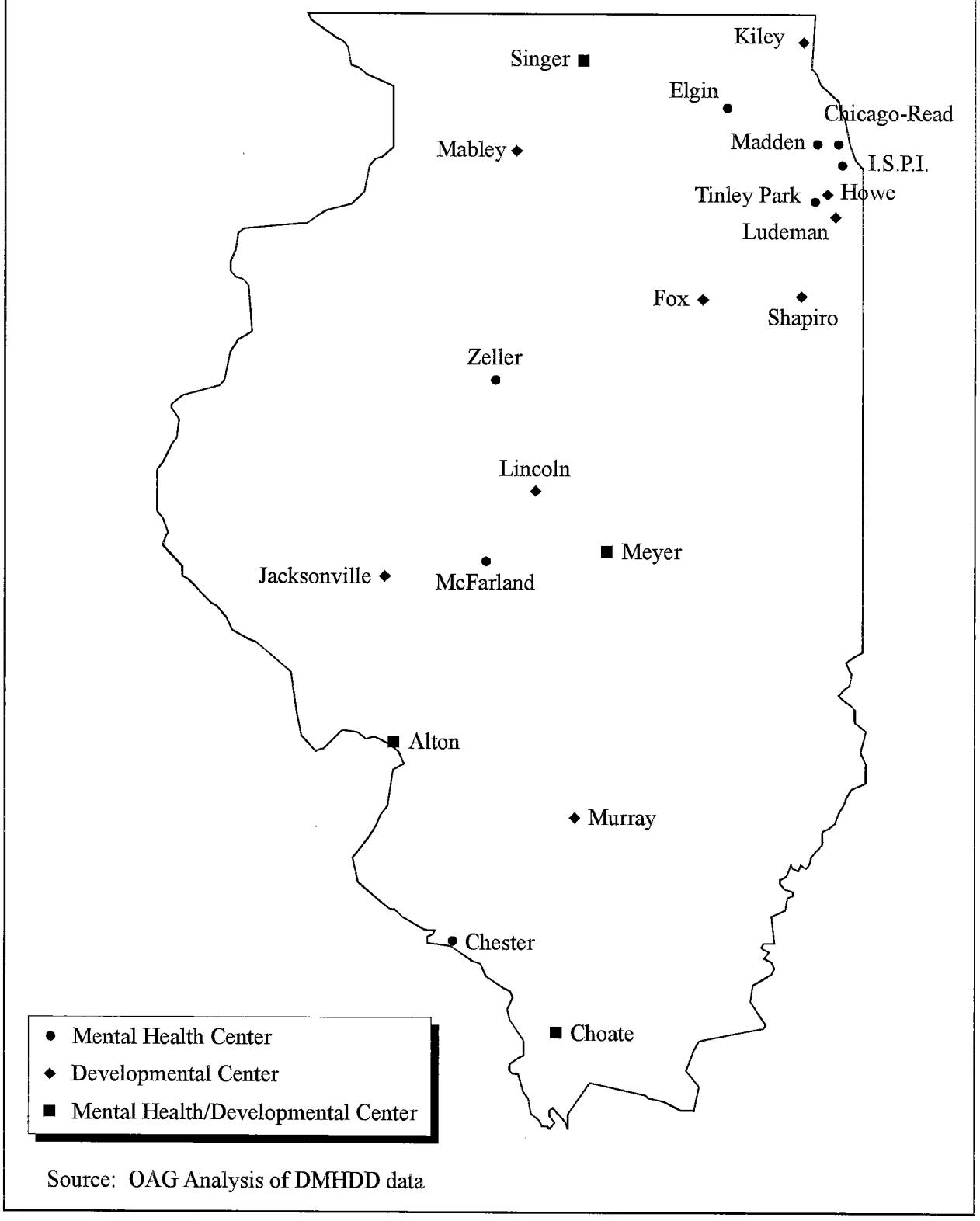
In Fiscal Years 1992 and 1993, nine State-operated residential facilities served the developmentally disabled, eight facilities served the mentally ill, and four facilities served both groups. Exhibit 1-2 shows the location of DMHDD's 21 residential facilities.

Exhibit 1-1
DMHDD
FACILITY
POPULATION

Fiscal Year	Pop.
1988	8,057
1989	8,097
1990	7,961
1991	7,722
1992	7,642
1993	6,832

Source: DMHDD Annual Reports

Exhibit 1-2
DMHDD RESIDENTIAL FACILITIES



Source: OAG Analysis of DMHDD data

INCIDENT REPORTING PROCESS

DMHDD policy requires facility directors to report various incidents and allegations to the DMHDD Office of the Inspector General (OIG). Prior to January 15, 1990, facilities were also required to report incidents and allegations to the Department of State Police. However, a January 1990 policy revision required facilities to notify the OIG of all reportable incidents. Facility directors or their designees are now required to notify the State Police when any incident involving criminal sexual assault or homicide is discovered after normal working hours and requires immediate investigation. Exhibit 1-3 lists the types of incidents reportable to the OIG.

Exhibit 1-3
TYPES OF INCIDENTS REPORTABLE TO THE INSPECTOR GENERAL

ABUSE AND NEGLECT	OTHER REPORTABLE INCIDENTS
1. Mistreatment of Residents by Employees: a. Physical abuse requiring emergency medical treatment. b. Other physical abuse c. Sexual abuse d. Verbal/psychological abuse e. Neglect	1f. 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. All other allegations of misconduct, malfeasance, misfeasance or other conduct serious enough to warrant reporting

Source: DMHDD Policy and Procedures Directive 01.05.06.03

Exhibit 1-3 (1a-e) shows that abuse, which is the focus of this audit, includes any occurrence or allegation of mistreatment of residents by an employee, including physical abuse requiring emergency medical treatment by a physician, other physical abuse, sexual abuse, and verbal/psychological abuse. Neglect includes but is not limited to an act or

omission by an employee that places at risk the recipient's physical or psychological health. Exhibit 1-3 also lists other reportable incidents, including injuries not associated with abuse.

The OIG reviews reported incidents and refers potential criminal cases to the State Police for investigation. The OIG notifies State Police of the incidents involving abuse and neglect, improper employee conduct, criminal sexual assault, death or homicide and incidents of malfeasance, misfeasance, misconduct, and other incidents of a similar nature.

This report addresses trends in the reporting of abuse allegations by DMHDD facilities. A program audit of the OIG, scheduled for release in early 1995, will address allegation substantiation rates and the effectiveness of OIG investigations.

In addition to reporting to the OIG, the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/1-16) requires that long term care facilities, including mental health facilities and developmental facilities, report all allegations of abuse and neglect to the Illinois Department of Public Health (IDPH). DMHDD policy requires facility directors to report to the IDPH Long-Term Care/Nursing Home Hotline regarding all incidents of resident abuse, resident injury, and theft or misappropriation of resident property. Facility directors are also required to notify IDPH whether any of the residents involved in incidents of alleged sexual abuse have been adjudicated incompetent or are under 18 years of age. IDPH is required to transmit copies of reports of alleged resident abuse to the Director of the Guardianship and Advocacy Commission and to Equipped for Equality, Incorporated (formerly Protection and Advocacy, Inc.). IDPH is required to maintain a central register of all cases of suspected long term care facility resident abuse or neglect. IDPH may also investigate abuse allegations occurring at DMHDD facilities.

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, 1993. 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 abuse allegations. We compiled data from samples drawn from the files of incidents reported at each facility. We analyzed the data collected from 4,985 incident report files.

The data presented in our program audits of DMHDD Reporting and Investigation of Resident Abuse and Neglect (May 1990, November 1992) serve as a base for measuring agency performance. Although some data from the May 1990 audit is included in this report, most of our analysis of reporting trends and patterns focuses on data collected for the November 1992 audit (Fiscal Years 1990 and 1991) and this audit (Fiscal Years 1992 and 1993).

We reviewed DMHDD policies and procedures related to reporting and investigating resident abuse allegations to assess facility compliance with these policies. We also sampled resident records at each facility to determine the effectiveness of reporting incidents. See Appendix B for additional information on our audit methodology.

REPORT ORGANIZATION

Chapter Two details DMHDD facility requirements and practices regarding incident reporting. It reviews findings of the biennial financial and compliance audits of the Department of Mental Health and Developmental Disabilities facilities. It also examines system-wide incident reporting patterns and trends.

Chapter Three examines incident reporting patterns and trends at each DMHDD facility.

Chapter Four reviews underreporting of incidents by facilities.

Chapter Five discusses issues related to incident reporting and a Matter for Consideration by the General Assembly.

CHAPTER TWO
INCIDENT REPORTING POLICIES AND PRACTICES

The number of abuse allegations reported to the Office of the Inspector General (OIG) fluctuated between Fiscal Years 1991-1993, from 954 in Fiscal Year 1991, to 1,079 in Fiscal Year 1992, and 891 in Fiscal Year 1993. From Fiscal Year 1991 to Fiscal Year 1993, the total DMHDD facility resident population decreased by 11.5 percent.

We found that the timeliness of facilities' reporting of abuse allegations to the OIG improved since our November 1992 audit, although further improvement is needed. In our 1992 audit, 50 percent of abuse allegations reviewed were not reported within the required one-day period. In this audit, the number reported within one day increased to 95 percent. In addition, the overall timeliness of the reporting of all incidents within the required seven days improved from 94 percent in Fiscal Year 1991 to 96 percent in both Fiscal Years 1992 and 1993.

INTRODUCTION

Public Act 86-1013 (30 ILCS 5/3-2) 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 concurrently with the biennial financial and compliance audits of the Department of Mental Health and Developmental Disabilities' facilities. Audit work conducted during the financial and compliance audits of 21 facilities for the two-year period ending June 30, 1993, found the following results related to abuse allegation and incident reporting:

- Chester Mental Health Center: Six instances of improperly completed reports and three instances of not notifying the OIG within the required time period were found in the examination of 222 incident files.

- Kiley Developmental Center: Incidents and allegations were not properly reported as required by the Department's policy and procedures directive (PPD) 01.05.06.03. Twelve incidents involved late reporting to the Office of the Inspector General. Forty-eight incidents were not reported to the facility director in a timely manner.

- McFarland Mental Health Center: Ten incidents in 167 files reviewed were not reported within the time limits specified by DMHDD policy.

- Singer Mental Health and Developmental Center: Three incidents in 222 incident files reviewed were not reported to the OIG in accordance with DMHDD policy.

- Zeller Mental Health Center: Of the 192 incident files examined, 34 incidents were not reported timely or properly documented.

- Six facilities (Elgin, Jacksonville, Kiley, Lincoln, Mabley and Tinley Park) did not report all incidents reviewed in our sample in accordance with DMHDD policy. Underreporting is also discussed in Chapter Four of this report.

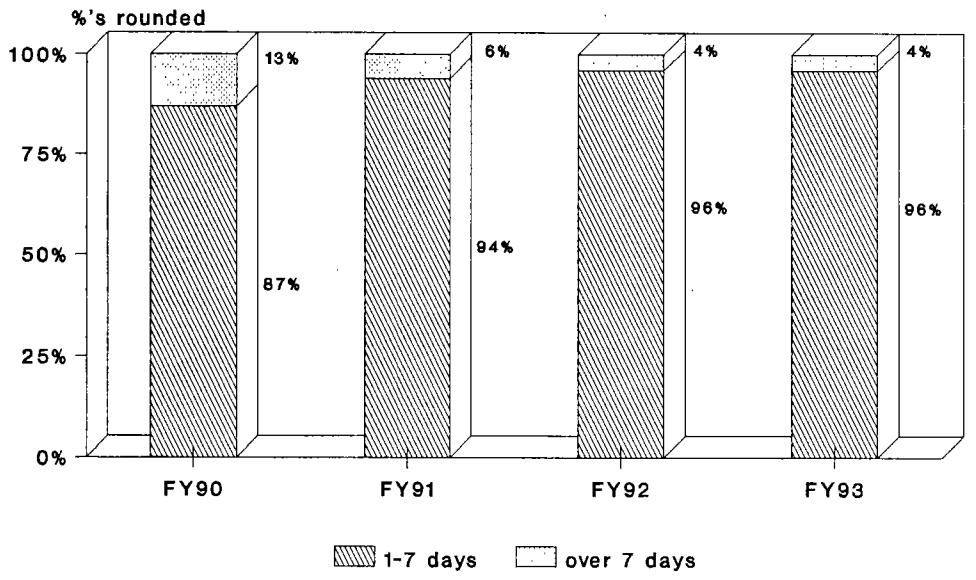
Timeliness of Facility Reporting

DMHDD policy requires that facilities report all allegations of abuse by telephone to the OIG by the end of the next working day; all incidents must be reported by mail within seven days. The timeliness of incident reporting can be an important aspect of the OIG investigation process. Prompt reporting can help preserve the quality of evidence and witness testimonies that can be used to substantiate abuse allegations. We calculated reporting times by determining the day on which the OIG was first notified by either mail, telephone, or facsimile. According to OIG personnel, notification by facsimile satisfies both mail and telephone notification requirements.

Of the 570 cases of alleged abuse sampled for this audit, 543 (95 percent) were reported by the end of the next working day as required by DMHDD policy. Twelve of the remaining 27 cases took over five days to report by telephone. This is a marked improvement from our November 1992 audit, which found that 50 percent of the abuse allegations sampled (74 of 148) were reported to the OIG within one day and 86 percent (128 of 148) were reported to the OIG within seven days.

Exhibit 2-1 shows that the overall timeliness in reporting all incidents improved slightly since Fiscal Year 1990. In Fiscal Year 1990, 87 percent of cases sampled were reported within seven days; this increased to 96 percent in Fiscal Years 1992 and 1993.

Exhibit 2-1
Reporting Time for All Incidents



Valid cases sampled FY90: 439 FY91: 569 FY92: 2658 FY93: 2321

Source: OAG Analysis of DMHDD records.

Although the timeliness of abuse allegation and incident reporting by facilities improved since our November 1992 audit, further improvement is needed to ensure compliance with DMHDD policies that require all abuse allegations to be reported within one working day and all incidents within seven days.

RECOMMENDATION NUMBER 1

The Department of Mental Health and Developmental Disabilities should continue its efforts to further improve the timeliness of facilities' reporting of incidents to the Office of the Inspector General.

Department of Mental Health and Developmental Disabilities Response:

We accept this Recommendation. We are pleased that the auditors found that over 95% were reported in a timely fashion. We will continue to strive for improvement where needed.

PATTERNS IN ABUSE ALLEGATIONS AT FACILITIES

Since Fiscal Year 1991, the total number of reported incidents decreased. Alleged abuse, however, increased in Fiscal Year 1992 but declined in Fiscal Year 1993.

Incidents Reported to the Inspector General

The number of incidents reported to the OIG decreased from 9,187 in Fiscal Year 1991 to 8,063 in Fiscal Year 1993, as shown in Exhibit 2-2. Exhibit 1-1 showed that the total resident population at DMHDD facilities decreased from 7,722 residents in Fiscal Year 1991 to 6,832 residents in Fiscal Year 1993. OIG officials expressed concern that underreporting by facilities might account for at least a part of the decrease in incidents reported (Chapter Four addresses underreporting). The decrease in resident population might also have been a factor in the reduction in incidents reported.

Exhibit 2-2 shows that abuse allegations decreased from 954 to 891 or 7 percent from Fiscal Year 1991 to Fiscal Year 1993. We will analyze these figures in Chapter Three. Reported resident injuries (not associated with abuse) declined from 6,647 in Fiscal Year 1991 to 5,887 in Fiscal Year 1993. All other incidents declined 19 percent, from 1,586 in Fiscal Year 1991 to 1,285 in Fiscal Year 1993.

Exhibit 2-2
INCIDENTS REPORTED TO THE OFFICE OF THE INSPECTOR GENERAL
Fiscal Years 1989 through 1993

	ALLEGED ABUSE AND NEGLECT	INJURIES	OTHER INCIDENTS	TOTAL
FY89	826	1180	1427	3433
FY90	857	3947	1478	6282
FY91	954	6647	1586	9187
FY92	1079	6427	1531	9037
FY93	891	5887	1285	8063
% CHANGE				
FY89-FY90	4%	234%	4%	83%
FY90-FY91	11%	68%	7%	46%
FY91-FY92	13%	-3%	-3%	-2%
FY92-FY93	-17%	-8%	-16%	-11%

Source: OAG analysis of DMHDD/OIG data.

Allegations of Abuse by Demographic Characteristics

We reviewed literature on the subject of patient abuse in institutional settings. A study by New York State's Commission on Quality Care for the Mentally Disabled examined factors related to patient abuse. While the report focused on New York State's mental health system, many of the findings may have a general application. The study found that abuse most frequently occurs during times of greatest staff/resident interaction, at times beyond normal working hours during a facility's second shift (3 p.m. to 11 p.m.), and when there is little effective supervision of direct care staff. Although these were not cited as causal factors of abuse, they contributed to the likelihood of abuse occurring.

To allow us to gather additional information on the demographic characteristics of Illinois abuse allegations, we drew a statistically valid sample, based on incidents reported by each of DMHDD's 21 facilities. The total sample of 4,985 incidents included all types of reportable incidents and contained complete gender and race information for 5,764 residents because some incidents involved more than one resident. In addition, we collected information on the day of occurrence, time and/or shift when the incident occurred, location within the facility where the incident occurred, and staff information. We analyzed abuse allegations from the sample to identify trends or patterns of alleged abuse in relation to three demographic characteristics of residents: (1) race only, (2) gender only, and (3) race and gender combined. We analyzed the data for trends, patterns, or relationships among variables such as where the incident occurred, day it occurred, and time and shift when it occurred.

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 incidents reported to the OIG. This population may or may not reflect the characteristics of the general resident population. Further, no firm conclusion regarding abuse can be based on the sample evidence because the incident reports are of alleged abuse and may or may not be substantiated. (See Appendix B for sampling methodology.)

We identified and collected information on 19 locations where incidents occurred at facilities. Exhibit 2-3 shows that abuse allegedly occurred most frequently in a bedroom (20.6%), dayroom (12.6%), seclusion (8.5%), hallway (6.2%), or nurses station (4.7%). Case examinations revealed that of the 150 cases occurring in bedrooms or seclusion, 38 (25.3%) were situations in which residents were in restraints or staff were attempting to place a resident in restraints.

As shown in Exhibit 2-4, alleged abuse occurred slightly more often from between 7am - 3pm (45.8%) than from 3pm - 11pm (43.8%). Few alleged incidents were reported from between 11pm - 7am (10.4%).

Exhibit 2-3
ABUSE ALLEGATIONS/INJURIES
(By Top Five Locations)

ABUSE ALLEGATIONS		INJURIES	
LOCATION	NUMBER	LOCATION	NUMBER
BEDROOM	106 (20.6%)	DAYROOM	1003 (29%)
DAYROOM	65 (12.6%)	BEDROOM	458 (13.3%)
SECLUSION	44 (8.5%)	HALLWAY	324 (9.4%)
HALLWAY	32 (6.2%)	DINING AREA	219 (6.3%)
STATION	24 (4.7%)	BATHROOM	159 (4.6%)

NOTE: Total Abuse Allegations = 515
Total Injuries = 3,453

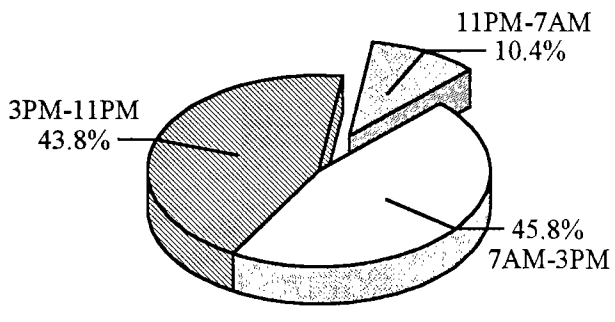
SOURCE: OAG analysis of sample data.

Sample frequency analysis disclosed that recipient injuries were reported to have occurred most often in the dayroom (29%), bedroom (13.3%), hallway (9.4%), dining area (6.3%), or bathroom (4.6%), as summarized in Exhibit 2-3.

Analysis of the global sample by demographic characteristics of the residents involved in the 4,985 incidents reviewed yielded the following results:

1. A significant association existed between black residents and incidents of alleged abuse. A larger proportion of black residents were allegedly abused than white or hispanic residents: 154 of 1,358 (11.3%) black residents, 390 of 4,144 (9.4%) white residents, and 17 of 224 (7.6%) hispanic residents.

Exhibit 2-4
TIME OF ALLEGED ABUSE



Source: OAG analysis of sample data.

2. A significant association existed between females and allegations of abuse. A larger proportion of females (208 of 2,041, 10.2%) than males (283 of 3,810, 7.4%) were involved in alleged abuse incidents.

3. Analysis of the sample by both the race and the gender of residents revealed no significant relationships.

In our May 1990 program audit, we reported that of the population of incidents reported to the OIG, black male residents were more likely to be involved in alleged abuse incidents. The November 1992 program audit reported that in our sample of incident files, black residents in general and black female residents were more likely to be involved in incidents of alleged abuse. In this audit, we found that female residents with no regard to race and black residents with no regard to gender were more likely to be involved in incidents in which abuse was alleged.

The demographic testing over the three audits did not find any gender specific patterns or trends. In our sample of incident files in the two most recent audits, we found that black residents were more likely than any other ethnic group to be the subject of reported abuse allegations. However, the results related to the race of residents involved in the sampled incidents cannot be generalized to entire resident population at DMHDD facilities nor can inference be made regarding substantiated abuse cases. Consequently, we draw no conclusions based on the sample to the overall DMHDD resident population.

Department of Mental Health and Developmental Disabilities Comment:

During FY93, OIG began a new and expanded database to assess trends in all incidents reported and in those that were substantiated. The first trend analysis (cf. Volume II of the OIG's FY93 State of Care Report) found somewhat different results than the results in this audit sample.

Auditor's Comment:

As of May 31, 1994, Volume II of the OIG's FY93 State of Care Report had not been released.

CHAPTER THREE
PATTERNS IN INCIDENT REPORTING BY FACILITIES

There was a wide variation in the number and rate of abuse allegations reported by DMHDD facilities. Abuse allegation rates at mental health facilities continued to run at least twice as high as at developmental facilities. Facilities serving both the mentally ill and developmentally disabled (i.e., dual facilities) have had the highest abuse allegation rates over the past three years.

INCIDENTS REPORTED BY TYPE OF FACILITY

We collected data on reportable incidents from information provided by the OIG and our samples selected at the DMHDD residential facilities. Exhibits 3-1 through 3-3 summarize trends in facility reporting. Appendix C also provides detailed information on the number of incidents each facility reported to the Inspector General.

We classified the facilities into three types: Mental Health Centers (MHC), Developmental Centers (DC), and combined Mental Health/Developmental Centers (MHDC). Abuse allegation and injury rates were calculated for each group of facilities. Reporting rates from Fiscal Year 1989 through 1993 are presented in Exhibit 3-1.

As shown on Exhibit 3-1, over the past five years, abuse allegations have been at least twice as high per 1,000 resident days at mental health facilities than they have been at developmental facilities. Over the past three years, facilities serving both the mentally ill and developmentally disabled (i.e., dual facilities) have had the highest abuse allegation rates. These rates were .63 per 1,000 resident days in Fiscal Year 1991, .62 in Fiscal Year 1992, and .61 in Fiscal Year 1993.

From Fiscal Year 1991 through Fiscal Year 1992, the abuse allegation rate at mental health facilities increased substantially. In Fiscal Year 1991, there were .43 abuse allegations per 1,000 resident days at mental health facilities; this rate increased to .60 in Fiscal Year 1992. We could not identify any single factor that could explain this increase. However, in Fiscal Year 1993, the rate dropped to .44, which was close to the Fiscal Year 1991 level. Throughout the five years presented in Exhibit 3-1, the rate of abuse allegations per 1,000 resident days in developmental facilities remained stable, ranging from a low of .16 in Fiscal Year 1990 to .20 in Fiscal Years 1991 and 1993.

As shown in Exhibit 3-1, the injury rates at mental health, developmental, and dual facilities have all declined over the Fiscal Years 1991 through 1993 period. Injury rates were generally lower at developmental facilities than at mental health or dual facilities.

INCIDENTS REPORTED BY FACILITIES

The number and rate of abuse allegations reported by the 21 DMHDD facilities varied considerably, as shown in Exhibit 3-2. The overall rate of abuse allegations per 1,000 resident days increased from .34 in Fiscal Year 1991 to .39 in Fiscal Year 1992. However, in Fiscal Year 1993, the rate declined back to its Fiscal Year 1991 level, at .34 incidents per 1,000 resident days.

Exhibit 3-2 shows that from Fiscal Year 1991 to 1992, abuse allegation rates increased at 12 of the 21 facilities. Six mental health facilities (ISPI, Elgin, Tinley Park, McFarland, Chester, and Chicago-Read) were responsible for 50 percent (535 of 1,079) of the abuse allegations reported in Fiscal Year 1992. These facilities, however, housed only 29 percent of the resident population during this period. From Fiscal Year 1992 to 1993, abuse allegation rates fell at 12 of the 21 facilities.

Many factors must be considered when comparing the reporting rates of various facilities. These factors include the number of residents served by the facility, the characteristics of the resident population, the reporting practices of the facility, and the number of unsubstantiated or unfounded abuse allegations reported by facility residents. In Fiscal Year 1992, DMHDD reported that budgetary cutbacks resulted in an inability to fill staff vacancies. This may, in part, account for some of the increase in alleged abuse reported in Fiscal Year 1992. The population of DMHDD facilities decreased by 10.6 percent, from 7,642 in Fiscal Year 1992 to 6,832 in Fiscal Year 1993. This decrease in resident population likely contributed to the decline in abuse allegations during Fiscal Year 1993. However, as shown in Exhibit 3-2, the

Exhibit 3-1
INCIDENTS BY FACILITY TYPE
(Rate Per 1,000 Resident Days)

FACILITY TYPE	ALLEGED ABUSE/NEGLECT Number	Rate	INJURY Number	Rate
		FY93		
MHC	392	.44	2090	2.36
DC	272	.20	2543	1.85
MHDC	227	.61	1254	3.37
TOTAL	891	.34	5887	2.24
		FY92		
MHC	576	.60	2267	2.38
DC	258	.18	2737	1.95
MHDC	245	.62	1423	3.59
TOTAL	1079	.39	6427	2.34
		FY91		
MHC	423	.43	2372	2.39
DC	285	.20	2874	2.03
MHDC	246	.63	1401	3.60
TOTAL	954	.34	6647	2.37
		FY90		
MHC	456	.44	1055	1.02
DC	233	.16	2050	1.41
MHDC	168	.41	842	2.07
TOTAL	857	.30	3947	1.37
		FY89		
MHC	378	.36	396	.38
DC	240	.17	530	.37
MHDC	208	.49	254	.59
TOTAL	826	.28	1180	.40

NOTE: MHC=Mental Health Center, DC=Developmental Center, MHDC=Mental Health/Developmental Center.
SOURCE: OAG analysis of OIG data. Rates are rounded.

abuse allegation rate per 1,000 resident days (which would control for increases or decreases in resident population) also decreased from Fiscal Year 1992 to 1993. Consequently, the decrease in resident population levels in DMHDD facilities would not likely be responsible for all of the decline in the number of reported abuse allegations in Fiscal Year 1993.

As shown in Exhibit 3-3, the number and rate of injuries (not associated with abuse) reported by facilities decreased from Fiscal Year 1991 through Fiscal Year 1993. Total injuries reported decreased from 6,647 in Fiscal Year 1991 to 5,887 in Fiscal Year 1993. Fifteen facilities had fewer injuries reported in Fiscal Year 1993, as compared to Fiscal Year 1991.

Exhibit 3-2
ABUSE ALLEGATIONS
(Rates Per 1,000 Resident Days)

	FY91	FY92	FY93
ALTON MHDC	86 (.78)	93 (.85)	70 (.72)
CHESTER MHC	101 (.88)	111 (.97)	92 (.78)
CHICAGO-READ MHC	72 (.40)	136 (.70)	88 (.52)
CHOATE MHDC	100 (.66)	80 (.52)	83 (.55)
ELGIN MHC	125 (.43)	185 (.67)	105 (.42)
FOX DC	2 (.03)	3 (.04)	3 (.05)
HOWE DC	97 (.41)	77 (.34)	75 (.36)
ISPI MHC	22 (.35)	29 (.57)	18 (.32)
JACKSONVILLE DC	42 (.36)	27 (.23)	50 (.43)
KILEY DC	42 (.25)	52 (.31)	43 (.26)
LINCOLN DC	17 (.10)	18 (.10)	26 (.15)
LUDEMAN DC	21 (.12)	26 (.14)	15 (.09)
MABLEY DC	2 (.05)	2 (.05)	2 (.05)
MADDEN MHC	32 (.34)	19 (.26)	12 (.18)
MCFARLAND MHC	9 (.16)	25 (.47)	29 (.57)
MEYER MHDC	43 (.75)	51 (.88)	56 (1.07)
MURRAY DC	6 (.05)	4 (.03)	3 (.02)
SHAPIRO DC	56 (.19)	49 (.17)	55 (.19)
SINGER MHDC	17 (.25)	21 (.28)	18 (.25)
TINLEY PARK MHC	30 (.27)	49 (.44)	28 (.25)
ZELLER MHC	32 (.38)	22 (.29)	20 (.33)
TOTAL	954 (.34)	1079 (.39)	891 (.34)

NOTE: Rounded rate per 1,000 resident days in parentheses.
MHC=Mental Health Center, DC=Developmental Center,
MHDC=Mental Health/Developmental Center.

SOURCE: OAG analysis of OIG data

INDIVIDUAL FACILITY REPORTING

Exhibit 3-2 shows that several facilities, including ISPI, Elgin, Tinley Park, McFarland, Meyer, Chester and Chicago-Read, experienced notable increases in the number and rate of abuse allegations reported in Fiscal Year 1992. Analysis of data published by the DMHDD revealed that, except for Meyer and McFarland, the proportion of black residents in these facilities was higher than the proportion found in the general resident population. We were concerned the disproportionate number of black residents in these facilities might have influenced the results of our overall analysis, in which we found black residents were more likely to be involved in alleged abuse. However, our analysis of data from ISPI, Elgin, Tinley Park, Chester, and Chicago-Read did not show a significant association between the race of the resident and type of incident. Therefore, a higher proportion of black residents at certain facilities was not responsible for our overall conclusion that black residents were more likely than other ethnic groups to be involved in alleged abuse.

We reviewed a sample of incidents reported at each facility and generally found that the results of our analysis regarding the location of alleged abuse incidents and the time of day they occurred were consistent with the global sample results. Our review of the individual facilities disclosed only one facility whose results significantly differed from the global results. Analysis of the sample from Singer found that 38.5 percent of alleged abuse incidents occurred during the night shift. Analysis of the global sample revealed that approximately 10 percent of alleged abuse incidents occurred during the night shift. We could not identify anything that could explain the disproportionate number of alleged abuse incidents occurring at night at this facility.

Exhibit 3-3
RESIDENT INJURIES
(Rates Per 1,000 Resident Days)

	FY91	FY92	FY93
ALTON MHDC	390 (3.52)	498 (4.53)	340 (3.48)
CHESTER MHC	138 (1.20)	95 (0.83)	145 (1.23)
CHICAGO-READ MHC	575 (3.19)	650 (3.35)	625 (3.70)
CHOATE MHDC	460 (3.04)	489 (3.17)	457 (3.03)
ELGIN MHC	758 (2.62)	783 (2.82)	559 (2.23)
FOX DC	27 (0.39)	36 (0.53)	26 (0.40)
HOWE DC	690 (2.95)	609 (2.66)	512 (2.47)
ISPI MHC	71 (1.14)	80 (1.57)	138 (2.45)
JACKSONVILLE DC	361 (3.10)	429 (3.68)	397 (3.38)
KILEY DC	496 (2.90)	389 (2.32)	405 (2.45)
LINCOLN DC	249 (1.40)	282 (1.58)	245 (1.40)
LUDEMAN DC	433 (2.40)	486 (2.70)	407 (2.31)
MABLEY DC	179 (4.28)	137 (3.52)	163 (4.06)
MADDEN MHC	209 (2.24)	161 (2.19)	152 (2.28)
MCFARLAND MHC	69 (1.25)	73 (1.36)	68 (1.35)
MEYER MHDC	384 (6.66)	270 (4.68)	234 (4.45)
MURRAY DC	103 (0.77)	124 (0.94)	169 (1.27)
SHAPIRO DC	336 (1.14)	245 (0.84)	219 (0.75)
SINGER MHDC	167 (2.42)	166 (2.23)	223 (3.13)
TINLEY PARK MHC	353 (3.13)	286 (2.55)	278 (2.45)
ZELLER MHC	199 (2.39)	139 (1.83)	125 (2.08)
TOTAL	6647 (2.37)	6427 (2.34)	5887 (2.24)

NOTE: Rounded rate per 1,000 resident days in parentheses.
MHC=Mental Health Center, DC=Developmental Center,
MHDC=Mental Health/Developmental Center.

SOURCE: OAG analysis of OIG data.

CHAPTER FOUR
UNDERREPORTING OF INCIDENTS

DMHDD facilities did not report all incidents as required. In our review of 630 resident files, we identified a total of 23 incidents, including two allegations of abuse, that were not reported. Compliance with reporting policies has not improved since our 1992 audit.

FACILITY UNDERREPORTING

This audit, as well as our May 1990 and November 1992 audits, found that DMHDD facilities did not report all incidents as required. Proper compliance with reporting guidelines is important to help ensure resident safety, complete incident reporting figures, and effective investigations.

In our 1990 audit, we did limited testing for underreporting; we visited two facilities. At one of these facilities we found 13 incidents that should have been reported but were not and at the other facility we found no such instances. In our November 1992 audit, our sample of 630 resident files from the 21 facilities found a total of 18 instances of underreporting. Incidents of underreporting disclosed in the November 1992 audit included no allegations of abuse. We recommended that the Department take necessary corrective actions when instances of underreporting are identified and ensure that facilities comply with DMHDD reporting policy.

In this audit, we again sampled 630 resident files and found more unreported incidents than we did in our 1992 audit. The sample of 630 resident files contained 623 reportable incidents. In our review, we found 23 instances of underreporting at 6 facilities (Elgin, Jacksonville, Kiley, Lincoln, Mabley and Tinley Park). As shown in Exhibit 4-1, our review disclosed 8 unreported incidents at Lincoln and 4 unreported incidents at Jacksonville, including one allegation of sexual abuse and one allegation of psychological abuse.

Department of Mental Health and Developmental Disabilities Comment:

The two abuse allegations were reported by the direct care staff, but were then apparently misplaced by the facility administration, most likely by the former facility liaison to OIG. While a few of the 23 cited do not meet the definition of what is reportable, 23 of 623 is less than 4%. **(* see Auditor's Comment below)** Nonetheless, we have increased our efforts at finding unreported incidents.

Auditor's Comment:

During the exit process, we reviewed documentation provided by DMHDD regarding the 23 unreported incidents in Exhibit 4-1. We concluded that the 23 incidents were reportable under the Department's reporting guidelines.

Exhibit 4-1

UNREPORTED INCIDENTS

FACILITY	UNREPORTED INCIDENTS	NUMBER AND TYPE OF UNREPORTED INCIDENT
Lincoln DC	8*	8 Resident on resident injuries
Kiley DC	5	5 Resident on resident injuries
Mabley DC	4	4 Injuries requiring emergency treatment
Jacksonville DC	4	1 Allegation of sexual abuse 1 Allegation of psychological abuse 1 Injury requiring emergency treatment 1 Unexcused absence
Elgin MHC	1	1 Resident on resident injury
Tinley Park MHC	1	1 Resident on resident injury
Total	23	

Note: * The OAG Financial and Compliance Audit of Lincoln Developmental Center for the two years ending June 30, 1993 reported 13 unreported incidents. However, based on subsequent documentation provided by DMHDD, the number of unreported incidents has been reduced to 8.
Source: OAG sample of 630 resident files.

In a meeting with the Inspector General and staff, the Inspector General expressed concern for underreporting by facilities. We noted a 12 percent drop in incidents reported from Fiscal Year 1991 through Fiscal Year 1993. The Inspector General stated that her office would expand its testing for underreporting by facilities.

RECOMMENDATION NUMBER 2

The Department of Mental Health and Developmental Disabilities should adopt stronger measures to ensure that facility personnel report incidents as required by DMHDD Policy and Procedures Directive 01.05.06.03. The Department should implement procedures to monitor facilities for underreporting.

Department of Mental Health and Developmental Disabilities Response:

We accept this Recommendation. We have increased our sampling of records to test for under-reporting from 5% to 10%, and we have made this sampling a permanent part of the formal survey process conducted annually by OIG at each facility.

CHAPTER FIVE
OTHER ISSUES

There are additional issues beyond the scope of this audit related to incident reporting at DMHDD. These include issues reported in our November 1992 program audit which bear repeating. These are the reporting of incidents occurring at community-based settings and the reporting of resident-to-employee incidents. In addition, we offer to the General Assembly for consideration, a revision of the Office of the Auditor General's performance audit requirements of DMHDD.

INCIDENT REPORTING IN COMMUNITY SETTINGS

DMHDD's policy to place some facility residents in a less restrictive therapeutic environment will result in more Illinois citizens receiving services from agency funded community-based providers. Our 1992 audit noted that 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. The resident population in State facilities has declined from over 25,000 in the 1960's to 6,832 in Fiscal Year 1993. Oversight of community-based programs and residential facilities becomes an important issue as their use increases.

Department of Mental Health and Developmental Disabilities Comment:

We agree that we have some responsibility to those individuals living in community based residential facilities. We have drafted and supported legislation to authorize OIG to investigate allegations of abuse and neglect we receive regarding these facilities. To date, this legislation has not been signed into law, but the Director has designated OIG as the entity responsible for investigating these complaints, and the Governor and General Assembly have allocated appropriate funding to support staffing levels which allow OIG to fulfill this responsibility.

Auditor's Comment:

As of May 31, 1994, House Bill 3875, which would authorize the OIG to investigate allegations of abuse and neglect in community based residential facilities, was on second reading in the House.

RESIDENT-TO-STAFF INCIDENTS

DMHDD's Risk Management Section reported 2,495 resident-to-staff incidents in Fiscal Year 1990, 2,288 in Fiscal Year 1991, 1,990 in Fiscal Year 1992, and 1,704 incidents in Fiscal Year 1993. Although the number of resident-to-staff incidents has declined, the occurrence of resident to staff incidents remains a concern in DMHDD facilities. The deinstitutionalization of higher functioning individuals to community-based service providers suggests a significant segment of the remaining patient population are individuals that require a more intensive level of care and treatment. Demands upon facility staff may increase because of the likelihood these individuals may exhibit more aggressive and violent behavior.

Department of Mental Health and Developmental Disabilities Comment:

We agree that individual-to-staff incidents are a serious concern in our facilities. While we have made significant efforts to improve employee training, staffing levels, and treatment/behavior plans, the provision of direct service to individuals with mental illnesses or developmental disabilities remains a challenging occupation.

AUDITING REQUIREMENTS

Presently, the Office of the Auditor General conducts two statutorily required audits of abuse reporting and investigation at DMHDD facilities. The Illinois State Auditing Act (30 ILCS 5/3-2) requires a program audit of each facility, performed in conjunction with the biennial financial audit of DMHDD (Public Act 86-1013, effective January 3, 1990). The program audit is required to examine the records of each facility concerning reports of suspected abuse or neglect of any patient or resident and to disclose any findings of patterns or trends relating to abuse or neglect. Statutes also require the Office of the Auditor General to conduct a program audit of the Office of Inspector General, including the Inspector General's effectiveness in investigating reports of suspected abuse or neglect at DMHDD facilities (210 ILCS 30/6.8).

The General Assembly may wish to consider eliminating the biennial audit of facility abuse allegation reporting. This change may be desirable for several reasons. This report represents the third audit of patterns and trends concerning reports of suspected abuse and neglect since 1990. Also, the Office of the Inspector General examines patterns and trends in facility reporting and is required to include this information in its annual report to the General Assembly. The Office of the Inspector General also reports on timeliness of facility reporting and tests for facility underreporting.

In addition to the Office of the Inspector General, there are several other entities that have oversight functions regarding the reporting and investigation functions within DMHDD:

a Quality Care Board monitors the functions of the Office of the Inspector General; Equipped for Equality, Incorporated (formerly Protection and Advocacy, Incorporated), is an advocate for the State's mentally ill and developmentally disabled; the Citizens Assembly is authorized to review DMHDD operations (25 ILCS 130/11A-7); and the Guardianship and Advocacy Commission is authorized to monitor issues concerning the developmentally disabled (20 ILCS 3955/1). The Department of Public Health receives reports and may conduct investigations regarding abuse allegations occurring in DMHDD facilities, the Department of Children and Family Services is to receive reports of abuse allegations involving minors, and the State Police receives reports and investigates allegations of criminal misconduct in DMHDD facilities.

MATTER FOR CONSIDERATION BY THE GENERAL ASSEMBLY

The General Assembly may wish to consider eliminating the biennial audit of patterns and trends in abuse allegation reporting at DMHDD facilities (30 ILCS 5/3-2).

Department of Mental Health and Developmental Disabilities Comment:

We respectfully support the Auditor General's proposal. We note that the Auditor General is currently engaged in a program audit of the investigating of abuse and neglect. We believe that the two audits could appropriately be encompassed within one audit, as was done by the Auditor General in 1990.

APPENDICES

APPENDIX A

30 ILCS 5/3-2

30 ILCS 5/3-2
(Public Act 86-1013, Section 1)
Effective January 3, 1990

Simultaneously with the biennial 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 has issued two reports pursuant to this Act. The first was issued in May 1990 and the second was issued in November 1992.

APPENDIX B

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 4,985 incident reports from Fiscal Years 1992 and 1993 in order to discern trends or patterns relating to abuse and neglect of DMHDD facility residents.

In Fiscal Year 1992, 9,037 incidents were reported to the OIG and in Fiscal Year 1993, 8,063 incidents were reported. Files of incidents reported to the OIG are kept at each of 21 DMHDD facilities. Based on the number of incidents reported at each facility during the audit period, we computed the proper sample size for each facility that would permit valid statistical inferences. For sampling purposes we selected a tolerable error level of 5% and a confidence level of 95%. Random sampling or systematic random sampling was used to draw a sample of 4,985 cases for review and analysis involving 5,764 residents. The actual sample provided (4,985) was slightly smaller than the initial sample requested (5,014) because some of the data collection forms contained incomplete information and were not used in our analysis. Tolerable error levels were recalculated for each facility based on the actual sample size to determine if valid inferences were still possible at the stated 5% level. The calculated error levels rounded to 5% and, therefore, we were able to make valid inferences as planned.

After the survey data was entered in Data-Ease, the Data-Ease file was converted into three different files including a general information file, a staff information file, and a victim information file. To validate these files, we checked them for invalid, inconsistent, and incorrect data. This validation included checking for correct identification number, discovery date, date incident occurred, incident type, incident location, and computation of fiscal year for each case. We also verified each physical abuse allegation to make sure such cases qualified.

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. In Fiscal Year 1993 the gender ratio of DMHDD's resident population was approximately 34.3% female and 65.7% male. The ethnic composition of residents in the DMHDD facilities was 69.1% white, 26.1% black, and 3.9% hispanic. In Fiscal Year 1992 no significant differences existed in demographic data. Sample descriptive statistics show that approximately 66.5% (3,835) of the residents were males and 33.5% (1,929) were females. The ethnic composition of residents in the sample shows that 71.9% (4,144) were white, 23.6% (1,362) were black, 3.9% (226) were hispanic, and 0.6% (32) were classified as "other".

Frequency examinations were completed to determine when and where incidents most frequently occur. 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. Chester MHC was excluded from gender related analysis because it is an all male facility.

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 the strength or form of the association between characteristics.

We did frequency exams and Chi-square tests from both global and facility specific perspectives. Our analysis of the global data indicated that black residents with no regard to gender and female residents with no regard to race were more likely to allege abuse than any other sector of the population. We did Chi-square tests excluding "other" from type of incident if large residual values were present in this category to insure that they were not biasing our results.

We examined the OIG aggregate data in order to discern any trends in the number and type of incidents occurring. We also assessed staff to resident ratios in conjunction with number of reportable incidents to assist us in making a determination on the effects of staffing levels on the number of incidents reported.

In examining the OIG aggregate data we calculated rates for all incidents reported, abuse and neglect allegations, and incidents involving injury. These rates were calculated for developmental disability facilities, mental health facilities, and dual facilities. The rates we calculated were based on the number of incidents occurring per 1,000 resident days. For example, one resident spending one day at a facility is considered one resident day. Therefore 500 residents spending five days at a facility constitutes 2,500 resident days. Rates per 1,000 resident days normalize the population dynamics of the facilities and allow for facility comparison of incident rates.

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 resident files at each facility had an equal chance of being selected for Fiscal Year 1992 and Fiscal Year 1993.

Facility	Incidents Reported FY92	FY93	Total	Requested Sample size	Actual Sample Provided
Alton	668	488	1156	289	288
Chester	243	280	523	222	219
Chicago-Read	1061	898	1959	321	321
Choate	622	596	1218	292	291
Elgin	1241	823	2064	323	322
Fox	51	33	84	70	69
Howe	771	648	1419	302	302
ISPI	150	264	414	198	204
Jacksonville	487	483	970	275	275
Kiley	511	540	1051	280	283
Lincoln	327	283	610	232	232
Ludeman	534	452	986	276	277
Mabley	155	193	348	182	175
Madden	330	249	579	231	229
McFarland	155	149	304	170	167
Meyer	415	376	791	258	258
Murray	136	184	320	175	172
Shapiro	347	319	666	243	243
Singer	247	301	548	230	222
Tinley Park	371	335	706	248	245
Zeller	215	169	384	197	192
Total	9037	8063	17100	5014	4986

APPENDIX C

NUMBER OF INCIDENTS REPORTED TO OIG
BY FACILITY AND TYPE OF INCIDENT
Fiscal Years 1988 through 1993

NUMBER OF INCIDENTS REPORTED TO OIG
BY FACILITY AND TYPE OF INCIDENT
FISCAL YEAR 1993

FACILITY	PHYSICAL ABUSE	SEXUAL ABUSE	VERBAL ABUSE	OTHER NEGLECT	OTHER CONDUCT	DEATHS	INJURY	ABSENCE	SEXUAL CONDUCT	THEFT	OTHER	TOTAL
ALTON MHDC	53	10	6	1	29	3	340	7	32	1	6	488
CHESTER MHC	75	3	14	0	23	5	145	2	9	0	4	280
CHGO-READ MHC	65	11	10	2	34	4	625	113	17	4	13	898
CHOATE MHDC	67	2	12	2	9	4	457	8	23	0	12	596
ELGIN MHC	59	9	31	6	51	8	559	24	20	2	54	823
FOX DC	2	0	1	0	0	2	26	0	0	1	1	33
HOWE DC	57	1	10	7	13	15	512	2	14	3	14	648
ISPI	11	3	2	2	41	3	138	12	17	1	34	264
JACKSONVILLE DC	41	1	7	1	4	4	397	9	10	1	8	483
KILEY DC	38	0	4	1	14	3	405	21	31	1	22	540
LINCOLN DC	22	0	2	2	2	6	245	1	0	0	3	283
LUDEMAN DC	14	1	0	0	1	4	407	16	5	0	4	452
MABLEY DC	1	0	1	0	3	4	163	9	10	0	2	193
MADDEN MHC	8	2	1	1	4	3	152	56	14	3	5	249
McFARLAND MHC	14	5	9	1	12	1	68	8	23	1	7	149
MEYER MHDC	36	3	12	5	21	2	234	31	16	1	15	376
MURRAY DC	3	0	0	0	0	6	169	2	1	1	2	184
SHAPIRO DC	52	2	0	1	3	23	219	3	11	1	4	319
SINGER MHDC	8	3	5	2	12	12	223	13	17	1	5	301
TINLEY PARK MHC	20	0	5	3	6	6	278	8	7	0	2	335
ZELLER MHC	13	1	5	1	5	6	125	6	2	0	5	169
TOTALS	659	57	137	38	287	124	5887	351	279	22	222	8063

Source: OAG Analysis of DMHDD/OIG Data

NUMBER OF INCIDENTS REPORTED TO OIG
BY FACILITY AND TYPE OF INCIDENT
FISCAL YEAR 1992

FACILITY	PHYSICAL ABUSE	SEXUAL ABUSE	VERBAL ABUSE	NEGLECT	OTHER CONDUCT	DEATHS	INJURY	ABSENCE	SEXUAL CONDUCT	THEFT	OTHER	TOTAL
ALTON MHDC	67	7	17	2	24	1	498	8	39	0	5	668
CHESTER MHC	99	3	9	0	18	1	95	0	9	0	9	243
CHGO-READ MHC	83	15	32	6	22	8	650	193	30	2	20	1061
CHOATE MHDC	65	8	6	1	9	6	489	9	21	0	8	622
ELGIN MHC	112	24	40	9	97	6	783	34	41	8	87	1241
FOX DC	3	0	0	0	6	4	36	0	0	0	2	51
HOWE DC	58	1	10	8	15	11	609	10	20	1	28	771
ISPI	13	5	9	2	15	3	80	5	11	0	7	150
JACKSONVILLE DC	23	0	4	0	8	4	429	4	11	0	4	487
KILEY DC	40	3	6	3	10	0	389	9	39	1	11	511
LINCOLN DC	15	1	2	0	6	11	282	2	6	0	2	327
LUDEMAN DC	24	0	0	2	4	0	486	12	2	0	4	534
MABLEY DC	2	0	0	0	1	0	137	8	7	0	0	155
MADDEN MHC	9	4	4	2	8	1	161	114	13	0	14	330
McFARLAND MHC	9	4	9	3	5	3	73	27	12	1	9	155
MEYER MHDC	42	4	4	1	15	2	270	30	38	1	8	415
MURRAY DC	4	0	0	0	0	5	124	1	0	0	2	136
SHAPIRO DC	44	2	3	0	6	12	245	8	17	0	10	347
SINGER MHDC	10	2	6	3	10	9	166	24	11	1	5	247
TINLEY PARK MHC	29	6	10	4	7	5	286	10	4	2	8	371
ZELLER MHC	17	1	3	1	12	7	139	13	14	0	8	215
TOTALS	768	90	174	47	298	99	6427	521	345	17	251	9037

Source: OAG Analysis of DMHDD/OIG Data

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	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	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
TOTALS	404	48	88	70	121	69	416	41	136	39	198	1630

SOURCE: OAG Analysis of DMHDD/OIG Data

ALLEGED ABUSE RATES PER 1000 RESIDENT DAYS

	FY88	FY89	FY90	FY91	FY92	FY93
ALTON MHDC	0.322	0.516	0.337	0.776	0.845	0.717
CHESTER MHC	0.385	0.346	0.750	0.876	0.970	0.782
CHGO-READ MHC	0.267	0.386	0.555	0.400	0.700	0.521
CHOATE MHDC	0.211	0.296	0.413	0.662	0.518	0.551
ELGIN MHC	0.343	0.460	0.498	0.432	0.666	0.418
FOX DC	0.029	0.000	0.000	0.029	0.045	0.046
HOWE DC	0.061	0.168	0.272	0.414	0.337	0.362
ISPI	0.245	0.363	0.294	0.352	0.570	0.320
JACKSONVILLE DC	0.376	0.356	0.352	0.361	0.231	0.426
KILEY DC	0.134	0.186	0.198	0.246	0.310	0.260
LINCOLN DC	0.164	0.165	0.100	0.096	0.101	0.148
LUDEMAN DC	0.088	0.044	0.066	0.116	0.145	0.085
MABLEY DC	0.049	0.144	0.236	0.048	0.051	0.050
MADDEN MHC	0.340	0.382	0.347	0.342	0.259	0.180
McFARLAND MHC	0.156	0.177	0.341	0.163	0.467	0.574
MEYER MHDC	0.445	1.537	0.809	0.746	0.884	1.065
MURRAY DC	0.030	0.067	0.060	0.045	0.030	0.023
SHAPIRO DC	0.253	0.240	0.133	0.191	0.167	0.188
SINGER MHDC	0.233	0.086	0.236	0.246	0.282	0.253
TINLEY PARK MHC	0.197	0.231	0.235	0.266	0.436	0.247
ZELLER MHC	0.021	0.220	0.202	0.384	0.289	0.332
TOTALS	0.209	0.282	0.297	0.341	0.392	0.339

INJURY RATES PER 1000 RESIDENTS DAYS

	FY88	FY89	FY90	FY91	FY92	FY93
ALTON MHDC	0.257	0.189	2.124	3.518	4.526	3.481
CHESTER MHC	0.049	0.028	0.687	1.197	0.830	1.233
CHGO-READ MHC	0.028	0.871	0.878	3.193	3.347	3.702
CHOATE MHDC	0.025	0.644	2.125	3.043	3.167	3.031
ELGIN MHC	0.120	0.402	1.486	2.618	2.818	2.228
FOX DC	0.044	0.057	0.128	0.387	0.534	0.401
HOWE DC	0.065	0.440	2.111	2.945	2.662	2.472
ISPI	0.000	0.016	0.418	1.137	1.573	2.453
JACKSONVILLE DC	0.137	0.271	2.064	3.104	3.677	3.379
KILEY DC	0.180	0.280	1.614	2.900	2.316	2.452
LINCOLN DC	0.464	0.303	0.733	1.403	1.582	1.396
LUDEMAN DC	0.171	0.374	1.655	2.395	2.705	2.307
MABLEY DC	0.171	0.719	0.425	4.276	3.522	4.055
MADDEN MHC	0.110	0.162	0.158	2.236	2.193	2.283
McFARLAND MHC	0.020	0.197	0.625	1.250	1.363	1.346
MEYER MHDC	0.516	2.033	3.305	6.663	4.677	4.451
MURRAY DC	0.127	0.135	1.175	0.774	0.940	1.272
SHAPIRO DC	0.294	0.554	1.250	1.143	0.835	0.748
SINGER MHDC	0.026	0.025	0.956	2.421	2.229	3.129
TINLEY PARK MHC	0.015	0.263	1.669	3.128	2.547	2.451
ZELLER MHC	0.011	0.232	0.771	2.390	1.828	2.078
TOTALS	0.143	0.403	1.366	2.374	2.335	2.239

APPENDIX D

AGENCY RESPONSE

NOTE: Following the Agency Response are two Auditor's Comments. Numbers for comments are in margins of agency responses.

OFFICE OF THE INSPECTOR GENERAL
Illinois Department of Mental Health and Developmental Disabilities

Jim Edgar
Governor

CJ Dombrowski
Inspector General

May 27, 1994

William G. Holland
Illinois Auditor General
509 South Sixth Street, Floor 1
Springfield, IL 62701

Dear Mr. Holland:

Thank you for an opportunity to read the draft report of your audit of the reporting of incidents from the Department's facilities. We are pleased that your audit found at least 95% compliance with all reporting and timeliness requirements.

We also appreciate the opportunity to provide comments and responses to your audit and thank you for your willingness to include these within the text of your report. Please find our comments and responses listed below.

On page 2, after the third paragraph:

Department Comment:
We have added this to the regular surveys conducted annually by OIG at each of the facilities, and we continue to routinely take disciplinary action against employees who have failed to report incidents in a complete and timely manner.

On page 9, after Recommendation 1:

Department Response:
We accept this Recommendation. We are pleased that the auditors found that over 95% were reported in a timely fashion. We will continue to strive for improvement where needed.

Mailing address: 401 William Stratton Building, Springfield, Illinois 62765
Phone 217-786-6865 FAX 217-786-6921 Quality Care Line 1-800-843-6154

On page 13, after the second paragraph:

Department Comment:
During FY93, OIG began a new and expanded database to assess trends in all incidents reported and in those that were substantiated. The first trend analysis (cf. Volume II of the OIG's FY93 State of Care Report) found somewhat different results than the results in this audit sample.

1

On page 18, after the third paragraph:

Department Comment:
The two abuse allegations were reported by the direct care staff, but were then apparently misplaced by the facility administration, most likely by the former facility liaison to OIG. While a few of the 23 cited do not meet the definition of what is reportable, 23 of 623 is less than 4%. Nonetheless, we have increased our efforts at finding unreported incidents.

2

On page 19, after Recommendation 2:

Department Response:
We accept this Recommendation. We have increased our sampling of records to test for under-reporting from 5% to 10%, and we have made this sampling a permanent part of the formal survey process conducted annually by OIG at each facility.

On page 20, after the second paragraph:

Department Comment:
We agree that we have some responsibility to those individuals living in community based residential facilities. We have drafted and supported legislation to authorize OIG to investigate allegations of abuse and neglect we receive regarding these facilities. To date, this legislation has not been signed into law, but the Director has designated OIG as the entity responsible for investigating these complaints, and the Governor and General Assembly have allocated appropriate funding to support staffing levels which allow OIG to fulfill this responsibility.

3

On page 20, after the third paragraph:

Department Comment:
We agree that individual-to-staff incidents are a serious concern in our facilities. While we have made significant efforts to improve employee training, staffing levels, and treatment/behavior plans, the provision of direct service to individuals with mental illnesses or developmental disabilities remains a challenging occupation.

On page 21, after the last paragraph:

Department Comment:
We respectfully support the Auditor General's proposal. We note that the Auditor General is currently engaged in a program audit of the investigating of abuse and neglect. We believe that the two audits could appropriately be encompassed within one audit, as was done by the Auditor General in 1990.

In conclusion, we wish to thank you for the courtesy and professionalism of your audit staff, especially Jim Kincaid and Mike Ingram. We look forward to continuing to work with you to improve the services we provide.

Sincerely,

Jess McDonald
DMHDD Director

CJ Dombrowski
Inspector General

cc: Leonard Beck
Jo Warfield
Patrick Baikauskas
Glenn Grzonka
Candace Keller
File

AUDITOR'S COMMENTS

1. As of May 31, 1994, Volume II of the OIG's FY93 State of Care Report had not been released.

2. During the exit process, we reviewed documentation provided by DMHDD regarding the 23 unreported incidents in Exhibit 4-1. We concluded that the 23 incidents were reportable under the Department's reporting guidelines.

3. As of May 31, 1994, House Bill 3875, which would authorize the OIG to investigate allegations of abuse and neglect in community based residential facilities, was on second reading in the House.