Patient Abuse and Mistreatment in Psychiatric Centers:

A Policy for Reporting Apparent Crimes To and Response By Law Enforcement Agencies

NYS Commission on
QUALITY OF CARE
for the Mentally Disabled

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PROPOSED POLICY FOR REPORTING CRIMES INVOLVING PATIENT ABUSE OR MISTREATMENT TO LAW ENFORCEMENT AUTHORITIES

Introduction

A recent controversy over the lack of a timely report by a psychiatric center to local law enforcement agencies of an act of sodomy between two male patients has focused attention on the responsibility of a psychiatric center director to report apparently criminal behavior to appropriate law enforcement authorities.

The Governor's Office requested the Commission to study this issue and to recommend any changes in the laws or policies that are necessary or apropriate to fulfill the state's obligation to protect patients in its custody from abuse or mistreatment.* In responding to this request, the Commission convened a working

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*The Commission's efforts deal only with conduct that constitutes patient abuse or mistreatment whether committed by employees, fellow patients or others. We recognize that there may be a broader statutory obligation on the part of facility directors to report apparently criminal behavior that is unrelated to patient care, see 1975 Op. Atty. Gen. [Inf.] 210; People v. Klein 96 M. 2d 692, 410 N.Y.S. 2d 12, 15 (Sup. Ct., Suff. Co. 1978), aff'd on other grounds, 76 A.D. 2d 913, 429 N.Y.S. 2d 29 (2d Dept. 1980); see also, OMH Policy Manual §7700, subd. II, para. D [issued 7/16/79]. However, it is beyond the scope of this paper to address the broader issues.

group of individuals representing various facets of the criminal justice and mental health systems (Appendix A is a list of the individuals invited). The purpose of this working group was to assist the Commission in gaining a fuller understanding of the nature and dimension of the problem, and a better appreciation of the perspectives of the various segments of both systems as to what changes in law, policy or practice may be desirable.

In addition to the convening of the work group, the Commission undertook an investigation of the circumstances surrounding the act of sodomy and the lack of timely reporting to law enforcement agencies. The Commission also obtained and analyzed relevant OMH Policy and Procedures, as well as all incident reports of assaults from three psychiatric centers for the month of April 1985. We also reviewed the specific policies at these three facilities dealing with the reporting of possible crimes to law enforcement agencies.

The members of the working group were generous with their time and advice and greatly assisted the Commission in undertaking this effort. While we believe that the analysis and recommendations which follow represent a consensus of opinion of the working group, the Commission takes sole responsibility for the statements herein.

Statement of the Problem

The Mental Hygiene Law provides that the director of a psychiatric center:

> shall have the responsibility of seeing that there is humane treatment of the patients at his facility and shall investigate every case of alleged patient abuse or mistreatment. The director shall notify immediately, and in any event within three working days, the board of visitors of the facility and the mental health information service located in the same judicial department as the hospital, school, or institution of every complaint of patient abuse or mistreatment and shall inform the board and the mental health information service of the results of his investigation. If it appears that a crime may have been committed, the director shall give notice thereof to the district attorney or other appropriate law enforcement official as soon as possible, and in any event within three working days. (MHL section 7.21, subd. (b), emphasis added.)

The Mental Hygiene Law contains no further explanation of how the facility director's obligation to investigate is to be coordinated with an investigation into a possible crime by law enforcement officials, nor does it provide a standard by which a judgment that it "appears" that a crime may have been committed is to be made. Similarly, OMH policy and procedures do not assist in filling the void left by statute by providing guidelines for staff of psychiatric centers in determining when and what to report to law enforcement authorities (see, OMH Policy Manual §§7650, 7700).

In fact, these policies add to the confusion since they contain inexplicable omissions. For example, the policies define "Assaults," which are required to be reported immediately, in terms which are largely consistent with penal law definitions. But this term appears to only include conduct between patients.

"Patient Abuse" appears to cover conduct by staff against patients including physical abuse and sexual activity, but the policy does not require that such conduct be reported to law enforcement agencies. Neither definition specifically includes sex crimes, and thus the policy is silent on the reporting of such crimes to law enforcement agencies.

These factors contribute to the widespread noncompliance with the literal requirements of the law (see, Appendix B - Review of OMH Policies and Practices of Three Psychiatric Centers in Reporting of Assault Incidents, April 1985). This noncompliance results both from a substantive problem of facility directors determining "if it appears that a crime may have been committed," as well as a perceived practical problem of inundating district attorneys and law enforcement officials with a variety of conduct which is, strictly speaking, criminal, yet which is not perceived to be serious or worth prosecutorial resources. It is feared that the routine reporting of all such apparent crimes would result in a lack of police and prosecutorial response to more serious reports which warrant their attention. (See discussion infra, pp. 9-10.)

Some aspects of the legal responsibility to report are apparently clear to facility staff based on a common sense application of the law -- e.g., unambiguous evidence of a serious crime against a patient by a staff person should be reported. Other areas are apparently less clear. Where the conduct involved is less serious (e.g., simple assault), and/or a patient is the actor, facilities seem to have greater difficulty in

determining their legal obligations to report apparent crimes and have less inclination to report. For example, two patients may have been involved in a scuffle and one suffers a bloody nose. The act may be criminal assault or justified self defense. There may be a question of the legal competence of the assailant. Such possibilities present problems to facility directors in discharging their duty to report apparently criminal behavior to law enforcement authorities, at least partly because of confusion as to what role they play in making determinations over criminal responsibility or culpability for the crime, including the mental competence of the actor.

Perhaps the most difficult area for facility directors in carrying out their legal responsibilities to report apparent crimes is in the area of sexual behavior of adult patients. Unlike an assault, where the criminal act exists independent from the question of the criminal responsibility of the individual committing the act, the mental competence of the participants is critical to determining whether sexual conduct between adults constitutes a crime in the first place or is non-criminal consensual behavior.

To some extent at least, each of these situations calls for the application of judgment as to whether a specific set of facts rises to the level of a crime. Where there is a need for such judgment, there is not only room for differences of opinion and differing conclusions but a requirement for a fairly sophisticated knowledge of criminal law, criminal procedure and mental competency. This is particularly true in the environment

of a psychiatric center where the question of competence and mental capacity of the patients, who are either potential defendants in a criminal proceeding, or possible victims or witnesses, is inherently an issue. Determining the functional competence, e.g., to testify, to consent, to accurately report facts, etc., of individuals is among the most difficult and contested questions in both mental health facilities and in the criminal justice system.

As is clear from this statement of the problem, there may be a number of difficult questions to be confronted in determining if a crime has been committed. Indeed, the variety of fact patterns that may be encountered and questions about the competence of assailants, victims and witnesses, where relevant, could prove a veritable minefield, even for a skilled lawyer. At present, facility directors make these determinations about whether it "appears" that a crime may have been committed in the absence of clear guidelines or policy, or readily available legal advice, as best they can, influenced on occasion by the expressed wishes of patient-victims and/or concerns over the clinical condition of patients who may be witnesses, victims or defendants. In the process, they subject themselves to the constant risk of being second-guessed by victims, relatives, mental health professionals, law enforcement agencies, advocates and the media, should they make an erroneous judgment about what is in the patient's best interest or about what ought to have been reported.

The backdrop against which this problem of underreporting of apparent crime to district attorneys and local law enforcement authorities arises bears mentioning. The Commission has detected a strong undercurrent of frustration on the part of mental health professionals with the criminal justice system . A common perception of facility directors, supported to some extent by reports of actual experiences, is that when reports of serious criminal conduct are made to the police, often there is not a sufficiently timely and/or vigorous response in investigating the crime. If the police do conduct an investigation and forward the complaint to the district attorney, the cases are often given a low priority by the district attorney's office and may not be prosecuted altogether because of concerns over the competence and credibility of patient-witnesses or the competence of the patient-defendants. If the district attorney decides to prosecute such a case, frequently a patient-defendant is found unfit to stand trial and returned to the facility, essentially offering the facility no practical change in circumstances as a result of the reporting of the criminal behavior.

In the community of mental health professionals, dramatic instances of failures to prosecute serious crime have been widely disseminated, helping to engender attitudes that have down-played the importance of the statutory duty to report apparent crime.

This backdrop helps to explain, not excuse, the failure to report apparent crimes to appropriate law enforcement authorities.

Discussion

There is a need for a statewide policy on the reporting of apparent crime that is clear and explicit for facility personnel to understand and apply, and that is sensitive to the need and capability of facility personnel to conduct internal investigations. However, to address the responsibility of facility directors to report apparent crime without concomitantly addressing what happens as a result of such reports is to leave the problem only half solved. Accordingly, the statewide policy should also encourage a close working relationship between the facility director and local law enforcement agencies while recognizing the constitutional and statutory responsibilities of law enforcement officials, and also leaving room for accommodation to the differing criminal justice policies and resource levels of various political subdivisions in which psychiatric centers are located.

It is therefore essential that the statewide policy permit both the mental health and criminal justice systems to discharge their respective legal duties in closer harmony, with a recognition and understanding of the essential differences in the roles of the respective officials.

Currently, under the literal terms of the Mental Hygiene Law, a facility director is given no discretion to decide not to report conduct which appears to be a crime. Such a literal interpretation finds support in an Attorney General's Opinion:

> The director must report <u>any</u> evidence of a crime to an appropriate law enforcement official since it is for the law enforcement official to determine whether or not sufficient evidence exists to warrant prosecution or to conduct his own investigation in order to obtain additional evidence. (1975 Op. Att. Gen. [Inf.] 210, 211 (emphasis added))

The police and the district attorney, on the other hand, possess considerable discretion in the use of their investigative and prosecutorial powers following the reporting of an apparent crime by a facility director.

Thus, factors which a facility director believes ought to influence the decision of whether to pursue the investigation and prosecution of conduct in a psychiatric center, which appears to be criminal, should be called to the attention of the law enforcement officials who possess the power to exercise such discretion.

It readily becomes obvious that a close working relationship should be fostered to facilitate not only a more appropriate level of reporting of apparent crime, but more importantly, to elicit appropriate responses to such reports which take into consideration the objectives of both the mental hygiene and criminal justice systems. For example, input from the mental hygiene system may result in a higher priority being given to the vigorous investigation and/or prosecution of serious crime in psychiatric centers which victimize patients. At the same time, a fuller understanding by law enforcement officials of the realities of life in congregate care settings may cause them to view patient behavior, which may technically violate the penal

law, with the same discretion they would apply to such conduct occurring elsewhere in the community.

What Should Be Reported

Defining a precise line which separates the criminal conduct which victimizes patients from undesirable non-criminal behavior by staff, patients or others in a psychiatric center environment is not always easy. From the review of incident reporting practices at three psychiatric centers, it appears that facility directors err, if at all, on the side of not reporting behavior which may be criminal, partly out of a concern that strict adherence to a policy of reporting any apparent crime to local law enforcement authorities could lead to inundation of district attorneys and police in the localities in which psychiatric centers are located. In part, recognition of this practical problem has in the past resulted in the under-reporting of possible criminal conduct, particularly where the conduct does not involve serious physical harm to patients. Part of the reasoning for the lack of reporting of such "minor" criminal conduct is that such behavior is generally not reported when it occurs outside a psychiatric hospital; if reported, it is unlikely to provoke any response from the officials to whom it is reported; the time and resources devoted to such complaints would probably be disproportionate to any beneficial result that could be obtained; and entanglement in the criminal justice system for petty criminal conduct may be traumatic to patients without any realistic possibility of prosecution or other offsetting benefits. Perhaps most importantly, there is a concern that

reporting a large volume of minor criminal conduct may make it unlikely to get a prompt and vigorous law enforcement response when one is needed.

Care must be taken to retain a pragmatic approach to the relationships between the state psychiatric centers and the multitude of district attorneys and other state and local law enforcement officials who comprise the criminal justice system. Since the elements that enter into the exercise of police and prosecutorial discretion vary from jurisdiction to jurisdiction, based on local resources and policies, no single, uniform rule about the differential handling of serious and minor crime can be prescribed on a statewide basis although a framework for developing locally acceptable solutions can be suggested.

The policy that is formulated and applied should reflect the clear intent of the mental hygiene law, which expressly requires that the facility director must have every complaint of patient abuse or mistreatment investigated. If, in the course of such an investigation, there is "some credible evidence" that a crime may have been committed, the director should notify the district attorney or other appropriate law enforcement official. This threshold, which is consistent with the Attorney General's opinion cited earlier, should help separate the patently frivolous reports or allegations which cannot be substantiated from those where there is some evidence, upon which a reasonably prudent person can rely, to indicate that a crime may have been committed. In our view, it is thus necessary, in determining if it "appears that a crime may have been committed," to be able to

point to evidence which is credible to support such a threshold determination. This essentially means that, if in the course of an investigation, such a state of facts is established as would lead a person of ordinary care and prudence to conscientiously entertain belief that a crime may have been committed, the director should report it to local law enforcement agencies.

This policy has the virtue of discharging the State's constitutional obligations to protect residents of a psychiatric center from harm, c.f., Youngberg v. Romeo, 457 U.S. 307 (1982), as well as the duty of care for persons within the state's custody as imposed by the civil law of torts. By notifying appropriate local law enforcement authorities of possible criminal activity, the facility meets one of its legal obligations to residents by invoking whatever protections may be available to them through the application of the penal laws to behavior which may endanger their safety.

When to Report

From a reading of the Mental Hygiene Law, it seems clear that the Legislature contemplated that a facility director would immediately investigate every case of alleged patient abuse or mistreatment. Thus, the director bears a responsibility to conduct an investigation into every such allegation, although the conduct alleged may constitute a crime as well. However, if at any point in the investigation there is credible evidence to believe that a crime may have been committed, based on evidence that is then available, immediate notification to appropriate law enforcement officials is required. It should be noted that

by reiterating a facility director's obligation to investigate, we are not suggesting or envisioning prolonged delays in reporting. Rather the facility investigation will determine, as a threshold matter, whether a complaint is frivolous or entirely unsubstantiated, or is in fact supported by evidence which lends credibility to the complaint. In most cases, the "some credible evidence" standard could be met by statements of witnesses or physical evidence, or both. There may be infrequent instances in which the type of investigation required is more appropriately performed by a law enforcement agency in the first instance, either because of the seriousness of the allegation (e.g. homicide) or because of other factors that make immediate reporting necessary and appropriate even before a threshold determination is made. Where the conduct at issue is less serious, the facility investigation may proceed in greater depth before a determination is made of whether there is "some credible evidence" that a crime may have been committed.

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It should be made clear that the reporting of possible crimes to local law enforcement officials does not absolve the facility from further action. Unless specifically requested by law enforcement officials to defer its investigation, the facility should continue its investigation into the incident in order to take whatever preventive, corrective or disciplinary action as may be warranted. If, as a result of this further investigation the facility later concludes that the alleged perpetrator lacks the requisite competence to form a criminal

intent, or that participants in an apparent and reported sexual crime were in fact competent and consenting adults, this information should be promptly communicated to appropriate law enforcement authorities for their consideration. However, the decision as to what weight should be given to any evidence gathered by facility staff or to their professional opinions, is initially one to be made by law enforcement authorities and not mental health professionals. Should a district attorney decide to prosecute the case despite the additional information provided by the facility, the judicial system will be the ultimate arbiter of these issues.

Similarly, if the facility clinicians believe that involvement in the criminal justice system -- as a witness, a defendant or complainant-victim -- poses a serious risk to a patient's well-being, this opinion should also be communicated to appropriate law enforcement authorities for their consideration but should not be used as a justification for not making a report in the first place. It is simply not the role of the mental health system to make conclusive and binding judgments about criminal responsibility, the validity of defenses to possible criminal charges (e.g., self-defense, insanity, etc.) or the relative social value of prosecuting a particular crime. While prosecutorial decisions regarding these issues may well be guided by the advice and opinions of mental health professionals who are familiar with the clinical history of a patient, the responsibility for making such decisions lies within the criminal

justice system. Wayte v. United States, 105 S. Ct. 1524, 1531 (March 19, 1985).

The special difficulties posed by sexual conduct within an institution serving people with mental disabilities warrant recognition. Competent adults in open society, as well as in institutions, do not violate the penal laws by engaging in sexual relations. Where adult patients are found to have engaged in sexual relations, a facility should exercise particular care in ascertaining whether both parties were competent and consenting. If there is any reason to question the competence of either patient, the director should require that such patient be examined by a qualified psychiatrist, preferably one not employed by the facility, for the purpose of making such a determination, to assist the director in ascertaining if "some credible evidence" exists that a crime may have been committed. If there is no question as to the competence of both patients and both are found to have freely consented, a director can conclude that there is no reason to believe that a crime was committed and thus that no report to law enforcement agencies is necessary. However, such a decision and the reasons therefor should be appropriately recorded. If, on the other hand, following such an examination there is any doubt as to the competence of a patient to consent to sexual relations or that consent was freely given, and thus there is some credible evidence that the sexual conduct may be a crime, a report to law enforcement agencies would be required.

We recognize that in many instances the facts may not be completely clear as a result of a facility's investigation, and issues concerning patients' competence and the manifestation of the consent may present an unclear picture to a facility director. It is precisely because we recognize this inescapable reality that we deem it essential that a facility director have ready access to timely legal advice as to the course of action that ought to be followed given the specific information available as a result of the preliminary investigation. Such practical legal advice should be provided by OMH Counsel's Office. We recognize that, although contemplated by current OMH policy on Administrative Investigation of Major Incidents, the regular performance of such a function by OMH Counsel could increase its workload significantly, necessitating either an increase in resources or a reordering of priorities.

We also believe that close working relationships, based on mutual respect and trust, between police, district attorneys and facility directors would promote the easy exchange of information and the solicitation of informal consultations on the appropriate disposition of difficult cases.

We therefore suggest that OMH policies and procedures direct facility directors to meet with local district attorneys and police chiefs to develop working guidelines on the reporting of apparent criminal activity within psychiatric centers to satisfy both legal requirements and yet adapt to the practicalities of limited law enforcement resources. On the basis of discussions held during meetings of the working group between representatives

of the law enforcement community and mental health officials, we believe that district attorneys and local law enforcement officials would welcome such an opportunity and recognize the value of such a dialogue with an important segment of their community. What is contemplated is that working relationships will be developed at the local level between facility directors and local law enforcement authorities with a goal of fulfilling mutual responsibilities. While mental health professionals would keep their obligation to report possible criminal activity to law enforcement authorities, in the exercise of police and prosecutorial discretion, differential handling of major and minor crimes could be established. This might require, for example, that minor crimes (to be defined jointly) be routinely reported by forwarding copies of incident reports, with the facility to retain primary responsibility for investigation/ correction of the problem, while serious offenses (again, to be defined jointly) would be promptly reported by telephone to the law enforcement agencies to exercise a right of first refusal over the investigation. In this working relationship, the issue of whether reports are made to the police, the district attorney, or other law enforcement agency could also be addressed, based on local preferences or established roles.

The development of such a working relationship would also help to clarify the reasonable expectations that a facility can have when serious crimes are reported to law enforcement authorities. Of particular importance in making this relationship work are assurances of a prompt law enforcement

response to a request for an investigation; sensitive handling of the investigation to minimize disruption of the facility routine, to avoid needless anxiety on the part of patients and staff, or adverse effects on staff morale; respect for clinical considerations regarding patients' status; and vigorous prosecution of crime within facilities when warranted.

The value of leaving to the police and prosecutors the primary responsibility for dealing with criminal activity that occurs within mental hospitals has recently been articulated by mental health professionals:

> Several factors may make the prosecution of the mentally ill assailant morally acceptable and at times morally preferable. First, filing a complaint makes the fact that a violent act has occurred part of the public record. Second, initiating prosecution allows a judge or jury to attribute responsibility for the violent act (an area outside the strict purview of professionals).
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> Third, a policy of initiating prosecution should tend to diminish violent acts by patients who may be able to control themselves. Fourth, since judges and juries appropriately are inclined to sentence recidivists more harshly than first-time offenders, making the information about previous assaults available will tend to cause violent individuals to be sequestered from society longer than they otherwise might be. That may make society somewhat safer.
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> In summary, we believe that professionals may have a duty to initiate charges in cases where a serious assault has occurred. That is true even when the assailant has an intercurrent and serious psychiatric illness.
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> Phelan, Mills & Ryan, Prosecuting Psychiatric Patients for Assault, 36 Hosp. & Comm. Psych. 581, 582 (June 1985).

RECOMMENDATIONS

We recommend that:

(1) OMH should establish and promulgate specific Policies for Reporting Crimes Involving Patient Abuse or Mistreatment to Law Enforcement Authorities. These policies should clearly specify the duty, as set forth herein, of a facility director to report behavior where there is some credible evidence that a crime involving patient abuse or mistreatment may have been committed whether by patients, employees or others. In this connection, OMH should provide facility personnel with guidelines assisting them in the investigation of possible criminal behavior and in differentiating criminal from non-criminal behavior as it relates to the most commonly encountered problem behaviors. The Policies should specifically address the particular problems encountered in dealing with sexual conduct between adult patients in a psychiatric hospital. OMH should also provide facilities and special investigators with further elaboration and such training as needed to understand the application of the law and policy on the reporting of crime to law enforcement agencies.

(2) The OMH should encourage facility directors or their designees to solicit legal advice from OMH Counsel's Office in determining their duty to report specific behaviors that may constitute a crime. OMH Counsel should provide specific advice on a course of action to be followed in the