

TURNING A BLIND EYE

How Breakdowns in State Hospital Oversight Leave
Patients Vulnerable to Physician Abuse and Professional Misconduct

DISABILITY RIGHTS TEXAS
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DISABILITY RIGHTS TEXAS

WHO WE ARE

Disability Rights Texas is the federally mandated legal protection and advocacy (P&A) agency for people with disabilities in Texas. Our mission is to help people with disabilities understand and exercise their rights under the law, ensuring their full and equal participation in society.

One of our statutorily mandated responsibilities is to investigate allegations of abuse, neglect or exploitation of people with disabilities. Other responsibilities of DRTx attorneys and advocates in fulfilling its mission are, among other things:

- Providing direct legal assistance to people with disabilities whose rights are threatened or violated through the courts;
- Advocating informally for people with disabilities to receive the appropriate supports and services in the least restrictive setting;
- Advancing laws and public policies that protect and promote the rights of people with disabilities;
- Informing people with disabilities and their family members about their rights; and
- Referring people with disabilities to appropriate programs and services.

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EXECUTIVE SUMMARY

INTRODUCTION

In 2011, news broke that a child psychiatrist at a Department of State Health Services (DSHS)-operated state psychiatric hospital was alleged to have sexually abused an adolescent patient in his care. The reporting revealed that the physician continued to work with children even while investigators were launching their seventh and eighth investigations into allegations of sexual abuse of children he had treated. A series of articles further disclosed that, despite repeated outcries of abuse over a 20-year period and numerous investigations, this physician is suspected of abusing at least 8 of his young patients during his employment with the State of Texas. Additional media reports exposed other psychiatrists who continued to be employed and practice at state hospitals despite histories of confirmed abuse and/or ethical misconduct.

INVESTIGATION

In response to media reports of alleged abuse by physicians at state psychiatric hospitals, Disability Rights Texas (DRTx), an independent, private non-profit agency mandated by federal law to investigate allegations of abuse and neglect of people with disabilities, launched a comprehensive investigation into the allegations identified in the press. To determine which factors led to repeated allegations of abuse, DRTx reviewed thousands of documents, including court records, Texas Medical Board (TMB) records, physician personnel files, credentialing files and agency investigations, as well as existing agency policies, rules and statutes governing physician misconduct and abuse and neglect at state hospitals. DRTx also requested information from staff at DSHS, the agency responsible for oversight and operation of the state hospitals, and the Department of Family and Protective Services (DFPS), the agency responsible for investigating allegations of abuse, neglect and exploitation at state hospitals and community mental health centers. Additionally, DRTx designed and conducted a statewide survey of state hospital patients to assess their ability to recognize and report abuse, neglect and exploitation to DFPS.

As a result of its investigation, DRTx recommends improvements to the existing hiring, retention, supervision and discipline policies and practices of DSHS, tracking and trending of abuse and neglect in DSHS facilities, and improved monitoring of the state hospital system's responsiveness when a patient makes an abuse allegation. DRTx also recommends ways to improve the effectiveness of DSHS oversight of state hospitals. In addition to reviewing DSHS practices for improvement opportunities, DRTx recommends improving the adequacy of investigations conducted by DFPS in light of the shared role between DSHS and DFPS in protecting patients.

Finally, DRTx reviewed ways in which increased oversight and assistance from the Texas Health and Human Services Commission (HHSC) could improve patient safety. HHSC is the state agency that oversees all health and human services departments, including DSHS and DFPS. The investigation identified opportunities for HHSC to increase collaboration between DSHS and DFPS to increase patient safety.

While investigating the multiple allegations of sexual abuse by the child psychiatrist, the press identified four other physicians with documented histories of professional violations prior to or during employment at a state hospital. Each of these physicians was the subject of confirmed findings for violations of the Medical Practices Act, resulting in adverse action by TMB. TMB's confirmed findings included exploitive sexual relationships with patients, sexual abuse and criminal indecency

with a child. In each of the cases, DRTx found that the state hospitals had either hired or continued to employ these physicians with full knowledge of their past or ongoing problems, without regard for patient safety. Although each physician's credentialing file documented serious abuses and performance concerns, the separately maintained personnel files of each of these physicians reflected positive evaluations and failed to effectively address concerns or deficiencies noted in DFPS investigative reports or TMB findings.

FINDINGS

DRTx's investigation revealed serious breakdowns in policies, procedures and safeguards at DSHS, DFPS and TMB, the entities responsible for ensuring patient safety and investigating allegations of abuse in the state hospitals.

The Department of State Health Services

The analysis by DRTx of DSHS policies, procedures and practices related to hiring and retention of physicians revealed serious deficiencies resulting in a failure to maintain a safe patient environment that ensures protection from abuse, neglect and exploitation. DSHS also currently lacks a credible process to hire, supervise and discipline physicians. Even when DSHS received concerns from credible sources regarding physician behavior, DSHS frequently failed to investigate or act on those concerns. This failure has resulted in a broken system of accountability that unduly shields physicians when they mistreat or abuse their patients.

Additionally, the DRTx investigation identified that DSHS did not track prior allegations of abuse and neglect to help evaluate subsequent allegations or ensure that previous recommendations documented by DFPS investigators in investigative reports were properly implemented. Through conducting a patient survey, DRTx also uncovered an alarming lack of knowledge by patients regarding how to protect themselves against abuse and neglect. Survey results indicate that a majority of patients are unable to properly identify and report abuse or neglect to DFPS.

Breakdowns in the Department of State Health Services and the State Hospitals' Oversight of Clinical Staff:

- State hospital leadership failed to maintain internally consistent physician performance records and files which resulted in misleading physician personnel records.
- DSHS hired and continued to employ physicians despite reports of abuse and neglect, restricted medical licenses and criminal convictions.
- DSHS leadership and clinical supervisors at state hospitals failed to hold physicians accountable for unprofessional, unethical or criminal conduct.
- DSHS failed to provide any documentation indicating that the DSHS medical director complied with the requirement to report allegations of unprofessional conduct, unethical behavior, and abuse and medical neglect made against physicians to the Texas Medical Board or determine the need for a DSHS internal investigation.
- State hospital superintendents failed to remove physicians from patient care responsibility or restrict access to patients when an allegation of serious abuse was made.
- DSHS failed to track and trend previous abuse, neglect, exploitation and rights allegations to identify patterns of behavior or actions by alleged perpetrators.

- DSHS failed to ensure that state hospital credentialing committees track and trend peer review findings and adverse findings in credentialing files and utilize the information when reviewing physicians for appointment or reappointment to the medical staff.
- DSHS and state hospital leadership failed to address DFPS's documented concerns and recommendations related to quality of care and patient protection.
- The DSHS medical director and the clinical supervisors at the state hospitals failed to conduct peer reviews on physicians when there were complaints raised regarding physician conduct or clinical care or when a regulatory body recommended peer review.
- DSHS failed to regulate and monitor state hospital performance.
- DSHS failed to adequately educate patients to identify and report abuse, neglect and exploitation to DFPS or to make complaints to TMB.

The Department of Family and Protective Services

The DRTx review of DFPS investigations of the allegations against the five physicians highlighted in this report as well as agency policies, procedures and practices revealed that DFPS failed to competently interview alleged victims or obtain and analyze necessary evidence. Additionally, DFPS investigators routinely discounted the credibility of the alleged victims. It appears that the victims in these cases were not perceived as credible due to their mental illness and behaviors. The minimization of the alleged victims' accounts of abuse in these cases resulted in unreliable findings. These failures potentially contributed to additional victimization and have further fostered an institutional bias that protects physicians accused of abuse.

Inadequacies in Department of Family and Protective Services Abuse and Neglect Investigations:

- DFPS investigators failed to review previous allegations to identify patterns of behavior or actions by alleged perpetrators.
- DFPS investigators failed to review personnel and credentialing information to assess the physicians' history and credibility.
- DFPS failed to conduct unbiased investigations by unjustifiably favoring the alleged perpetrators' credibility.
- DFPS failed to train its investigators about mental illness and victim behavior, often resulting in unjustified doubts about victim credibility.
- DFPS failed to train investigators to conduct competent investigations of child sexual abuse.

RECOMMENDATIONS

DSHS must demonstrate a zero tolerance policy for all physicians who pose a risk to DSHS clients.

- DSHS must require state hospitals to utilize the existing centralized HHSC Human Resources Division to prescreen and approve physicians for hire.
- Physicians with a history of TMB or other disciplinary action for abuse, neglect or exploitation must not be eligible for hire or continued employment at any DSHS state hospital.

- DSHS must adopt policy and practices that ensure physician personnel and credentialing files are maintained in a consistent manner.
- Physicians and other licensed professionals must be included in the Employee Misconduct Registry.

DSHS and state hospital leadership must be held accountable for appropriate supervision and discipline of physicians.

- DSHS must ensure that all incidences of unprofessional, unethical or abusive conduct by physicians are reflected in their performance evaluations and appropriate disciplinary action is taken.
- DSHS must ensure that state hospitals routinely conduct and document peer review when allegations of a clinical nature, including allegations of abuse, neglect or exploitation, are made against physicians.
- DSHS must report all allegations of abuse, neglect and exploitation against licensed professional staff to appropriate professional boards.
- DSHS must adopt regulations that require state hospitals to remove alleged perpetrators from patient care.

DSHS must effectively monitor, manage and access all relevant abuse, neglect, rights and clinical practice information.

- DSHS must track and trend previous abuse, neglect, exploitation and rights allegations to identify patterns of behavior or actions by alleged perpetrators.
- DSHS must institute policies to ensure that state hospital credentialing committees track and trend peer review findings and adverse findings in credentialing files and utilize the information when reviewing physicians for appointment or reappointment to the medical staff.
- DSHS must ensure that state hospitals implement documented recommendations in DFPS investigative reports, including reports with unconfirmed or inconclusive findings.
- DSHS must provide greater support to the Hospital Services Section so that it, in turn, can exercise appropriate oversight responsibilities and monitor patient safety and quality of care at the state hospitals.

DSHS must better educate state hospital patients to recognize abuse and neglect and report allegations to DFPS.

- DSHS must develop and implement a simpler, more effective process that will improve patient education and reporting on abuse, neglect and exploitation.

DFPS must conduct competent, unbiased investigations of abuse and neglect allegations at state hospitals.

- DFPS must require investigators to trend previous complaints to identify patterns of behavior or actions by alleged perpetrators.

- DFPS must adopt a policy requiring investigators to review all alleged perpetrators' personnel and credentialing files as part of their investigation and include it in collected evidence to ensure a more comprehensive and reliable investigation.
- DFPS must improve investigators' training on assessing the veracity and credibility of alleged perpetrators.
- DFPS must improve investigator self-awareness of stigma and its effect on assessing the credibility of victims.
- DFPS should contract with licensed medical professionals who can provide expert consultation on investigations that require expertise outside the scope of the investigators' education and knowledge.
- DFPS investigators must collaborate with child advocacy centers, utilizing local experts and existing county and local resources where available, to investigate allegations of child sexual abuse.

Entities accountable for patient safety must coordinate with each other to ensure comprehensive investigations of allegations of abuse, neglect and exploitation.

- HHSC must ensure improved coordination and information-sharing between DFPS, DSHS, individual state hospitals, licensing boards and law enforcement, including allowing broad access to records.

CONCLUSION

DSHS and DFPS share an important responsibility to ensure a safe, therapeutic environment for patients at state hospitals. This environment should foster healing and recovery and affirm the dignity of its patients and citizens who depend on state hospital services and deserve protection from abuse, neglect and exploitation while receiving inpatient care and treatment. In order to prevent future occurrences, DSHS and DFPS must act quickly to implement the recommended changes and develop credible and transparent processes to fulfill these responsibilities.

Many of the recommendations in this report require legislative action to ensure their adoption and implementation. DRTx hopes that the Texas Legislature and HHSC will work with DSHS and DFPS to foster the collaboration that is needed to protect Texans with mental illness.

INTRODUCTION

In 2011, the press widely reported that a child psychiatrist at a DSHS-operated state psychiatric hospital was accused of having sexually abused adolescent male patients in his care over a number of years. In response to the news reports, Disability Rights Texas (DRTx), the federally mandated protection and advocacy agency for Texans with disabilities, initiated an investigation to evaluate the State's efforts to protect patients from abuse and neglect by physicians at state hospitals.

In the course of its investigation, DRTx found a pattern of flawed investigations, failure to share information across agencies and an insufficient process to identify and monitor physicians with a history of multiple allegations of abuse and neglect. Shockingly, these failures stretched back over 20 years. The investigation also revealed similar deficiencies with hiring, supervising and disciplining physicians throughout the state hospital system. These breakdowns, which the State has yet to remedy, created an environment in which physicians continued to practice despite repeated allegations of patient rights violations, abuse and neglect.

The findings of this investigation illustrate the failure of the Texas mental health system to ensure the safety of Texans with mental illness receiving institutional care and treatment in the state hospital system. Having identified the circumstances that permitted these breakdowns to occur, DRTx hopes the report will create the impetus for improved policies and practices necessary to protect individuals with mental illness served by the state hospital system.

OVERVIEW OF AGENCIES, FACILITIES AND PROCEDURES

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

The Health and Human Services Commission (HHSC) oversees the Texas health and human services delivery system, including the Department of State Health Services and the Department of Family and Protective Services. The HHSC Executive Commissioner, who is appointed by the Governor, appoints the commissioners of the departments it oversees.

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

The Texas Department of Mental Health and Mental Retardation (TXMHMR) was responsible for operations and oversight of the state-operated inpatient psychiatric hospitals and the state supported living centers. In 2004, TXMHMR was divided into two agencies, the Department of Aging and Disability Services (DADS) and the Department of State Health Services (DSHS). DADS took over responsibility for the state supported living centers and other long term care facilities. DSHS became solely responsible for operations and oversight of the ten state-operated inpatient psychiatric hospitals, including a residential treatment facility for adolescents, the Waco Center for Youth.¹ These facilities, located throughout the state of Texas, provide inpatient mental health services to children, adolescents and adults.

DSHS, as part of its oversight responsibility, is to ensure that reports of allegations of abuse and neglect by clinicians are, when required by law, reported to the licensing authority for the discipline under review, i.e., the Texas Medical Board for physicians, the State Board of Dental Examiners for dentists, the Texas State Board of Pharmacy for pharmacists, the Board of Nurse Examiners for the State of Texas for registered nurses, or the Board of Vocational Nurse Examiners for licensed vocational nurses.

TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

The Department of Protective and Regulatory Services is the predecessor agency to the Department of Family and Protective Services (DFPS). The change was in name alone.² DFPS also operates under the oversight of the Health and Human Services Commission. Adult Protective Services (APS), a division of DFPS, is responsible for receiving reports of and investigating abuse, neglect and exploitation of individuals receiving services in state hospitals and community mental health centers.

If a report of abuse or neglect involves clinical practice, APS refers the allegation back to the head of the facility, who immediately refers the allegation to the facility medical/dental/nursing/pharmacy director, as appropriate to the discipline involved, for possible peer review.

Employees of state hospitals are required to report to DFPS if they know or suspect that a person served is being or has been abused, neglected or exploited.

¹ To avoid confusion, citation will be to DSHS, as both agencies were responsible for the operation and oversight of the state-operated inpatient psychiatric hospitals.

² To avoid confusion, citation will be to DFPS.

TEXAS MEDICAL BOARD

The Texas Medical Board (TMB) is the state agency that licenses, regulates and disciplines physicians, physician assistants and acupuncturists. It is mandated to determine a physician's eligibility for licensure. It also investigates complaints against physicians who are alleged to have violated the Medical Practices Act, which includes acting in a manner inconsistent with public health and welfare – including failure to meet standards of care, inappropriate prescribing, incorrect diagnosis, or a medical error that may or may not have resulted in an injury to a patient. Upon finding a violation of the Medical Practices Act, TMB has the authority to cancel, revoke, restrict, suspend or otherwise limit the license of any physician. The current status of a physician's license, as well as any actions taken against a physician's license by TMB, can be viewed by any member of the public through the database available on TMB's website.

EMPLOYEE MISCONDUCT REGISTRY AND NURSE AID REGISTRY

The Employee Misconduct Registry (EMR) and the Nurse Aid Registry (NAR) are searchable databases maintained by the Department of Aging and Disability Services (DADS) that include the names of nurse aids and individuals (other than doctors and nurses) who have been:

- Convicted of a criminal offense that would bar employment at DSHS or DADS facilities under the Texas Health and Safety Code;³ or had
- Confirmed allegations of abuse, neglect, sexual abuse, or financial exploitation of an individual receiving services from DADS or DSHS.⁴

A person whose name is recorded in these registries is prohibited by law from working for certain facilities or agencies, including the state hospitals.⁵

Licensed professionals, including doctors and nurses, are not included in either registry.

CLIENT ABUSE AND NEGLECT REPORTING SYSTEM

The Client Abuse and Neglect Reporting System (CANRS) contains confirmed cases of abuse and neglect by both licensed and unlicensed state hospitals employees, state supported living center employees, and community mental health/mental retardation center employees. Information stored in CANRS includes the perpetrator's name and any disciplinary action taken in response to the abuse and neglect.

Confirmed cases of abuse and neglect must be entered into CANRS within 30 calendar days of the final finding.⁶

³ TEX. HEALTH & SAFETY CODE § 250.006

⁴ 40 TEX. ADMIN. CODE § 711.1407; TEX. HEALTH & SAFETY CODE § 250; TEX. HEALTH & SAFETY CODE § 253

⁵ TEX. HEALTH & SAFETY CODE § 250.001(3)(G); TEX. HEALTH & SAFETY CODE § 250.003(c).

⁶ 25 TEX. ADMIN. CODE § 417.510(i).

THE INVESTIGATION

METHODOLOGY

DRTx began its review of a single hospital psychiatrist's alleged abuse of multiple children. DRTx then expanded its investigation by cross referencing all currently employed psychiatrists at DSHS-operated facilities with TMB confirmed licensure violations for sexual abuse. This investigation included a review of:

- current DSHS and state hospital policies and practices related to hiring, retention, supervision and discipline of physicians;
- current DSHS and state hospital investigation policies, procedures and practices;
- personnel records, credentialing files and investigative reports of five psychiatrists employed at state hospitals with confirmed findings by TMB of sexual abuse;
- current DFPS investigation policies, procedures and practices;
- current HHSC oversight functions of DSHS and DFPS;
- current statutes and rules governing DSHS and DFPS oversight, operations and practices at state hospitals; and
- the quality of DFPS investigations of abuse and neglect at state hospitals.

Between December 2011 and May 2012, DRTx advocates also conducted a statewide survey of 237 patients at seven state hospitals designed to gauge their understanding of how to recognize and report abuse and neglect. Respondents included youth and adults. In order to identify individuals interested in participating, DRTx advocates approached individuals at random in unit common areas and invited them to participate voluntarily after explaining the survey. DRTx only included patients who were willing to participate in the survey.

FACTS

Dr. A⁷

Dr. A, a board-certified child psychiatrist, began his career at DSHS over 20 years ago as clinical director and attending psychiatrist at a DSHS-operated residential treatment center (RTC) for adolescent boys and girls ranging from 12 to 17 years of age. Around the same time, Dr. A accepted a dual employment arrangement as an attending child psychiatrist at another DSHS facility. The records obtained by DRTx reveal that Dr. A was repeatedly investigated for alleged sexual abuse of children until he was terminated 21 years later.

Dr. A's performance reviews, despite multiple sexual abuse allegations, a grand jury hearing and a TMB investigation, found Dr. A met or exceeded expectation in all areas. The performance evaluations did not discuss or assess the frequency of allegations of abuse by patients he treated. In fact, the same year he was investigated by the grand jury, Dr. A received another all positive performance evaluation and was described as a "great role model."

⁷ To protect the physicians' privacy, DRTx assigned a pseudonym to each physician.

- A male resident of the DSHS-operated RTC accused Dr. A of sexual abuse. Although DFPS did not confirm the sexual abuse, the investigator made recommendations. There is no evidence that the RTC acted on the recommendations.
- Dr. A resigned from the RTC. However, he remained employed at the state hospital where he worked exclusively with children and adolescents.
- Nine years after Dr. A's resignation from the RTC, a second youth accused Dr. A of sexually abusing him at the state hospital where the doctor remained employed. DFPS did not confirm the allegation.
- That same month, Dr. A was described in his performance evaluation as "exemplary" and "attending of the year."
- One month later, a third youth accused Dr. A of sexually abusing him while a patient in Dr. A's care. DFPS did not confirm the allegation.
- Early the following year, the Austin Police Department investigated Dr. A for sexual assault of an unnamed child, and prosecutors took his case before the grand jury. He was not indicted.
- The same year he was investigated by the grand jury, Dr. A received another all positive performance evaluation and was described as a "great role model."
- The following year, a fourth patient accused Dr. A of sexual abuse at the state hospital. DFPS did not confirm the allegation.
- In Dr. A's performance evaluation that year, he was described as "commendable, ethical and dedicated."
- The following year, a fifth youth accused Dr. A of sexually abusing him while a patient at the state hospital. The allegation was not confirmed, but once again DFPS made recommendations. There is nothing in Dr. A's personnel file that indicates any action was taken by the state hospital to address the recommendations.
- The following year, the TMB opened an investigation into a sixth youth accusing Dr. A of sexually abusing him while a patient at the state hospital but did not issue any findings or take any action. DFPS investigated but did not confirm the allegation. DFPS again made recommendations. Once again, there is no evidence that the recommendations were followed up on by the state hospital.
- After a seventh and eighth youth from the state hospital accused Dr. A of sexual abuse, the hospital superintendent finally notified Dr. A that he had to inform the superintendent's office immediately of any allegations of sexual abuse against him. In addition, he could not:
 - close his door while seeing patients;
 - take patients off of the unit;
 - provide therapy outside of regular business hours; or
 - touch patients.
- DFPS confirmed both allegations of sexual abuse against the seventh and eighth youth.
- After reviewing the confirmed DFPS report, the state hospital clinical director determined that Dr. A's clinical work was not in question and that a peer review investigation was not warranted.
- Later that year, DSHS placed Dr. A on paid administrative leave after DFPS confirmed the two most recent sexual abuse allegations.

- The following month, DSHS terminated Dr. A's employment at the state hospital.
- At Dr. A's TMB license suspension hearing, concerns were raised that throughout the 20 years of allegations of Dr. A, he repeatedly received the benefit of the doubt over the alleged victims.
- The same month Dr. A was terminated from employment at the state hospital, TMB suspended Dr. A's medical license.
- As a result of the confirmed allegations and a criminal investigation, a grand jury indicted Dr. A on two counts of sexual assault, nine counts of sexual assault of a child, seven counts of indecency with a child by contact, and five counts of indecency with a child by exposure. Dr. A is currently awaiting trial.

Dr. B

Dr. B was first employed 25 years ago as a staff psychiatrist at a state hospital. He was assigned to work with both adults and children. Less than a year before his employment began, Dr. B was indicted for indecency with a child under age 17 for touching genitals with intent to arouse/gratify.

- Two years later, Dr. B entered a plea of nolo contendere (no contest), was convicted of indecency with a child, and sentenced to eight years of probation and a \$3,000 fine.
- Two years after his conviction, TMB restricted Dr. B's medical license with terms and conditions that allowed him to only practice at the state hospital where he was currently employed and not treat patients under 18 years of age for an 18-month time period.
- Two years and six months into Dr. B's eight-year probation, members of the administration and medical staff at the state hospital successfully advocated on Dr. B's behalf that the criminal court set aside his conviction and end his probation.
- Shortly after his conviction was set aside, Dr. B entered the state hospital psychiatric residency program to complete his residency requirements. Dr. B completed his residency and was rehired by the state hospital as a staff psychiatrist. Dr. B continued his employment for five years until he resigned to accept an appointment as a child psychiatrist at a local mental health authority.⁸

Dr. C

Dr. C was hired as a psychiatrist at a state hospital where he was employed for nine years until his resignation from the hospital. Dr. C was later employed as a part-time contract provider for the same facility. Since that time he was once again hired as a full-time staff psychiatrist at the state hospital. Prior to working at the state hospital, TMB had disciplined Dr. C.

- While employed at a private psychiatric hospital, the mother of a current patient accused Dr. C of kissing her and fondling her breasts while meeting to discuss her son's care and treatment.
- As a result of the allegation, TMB suspended Dr. C's medical license for three years due to "unprofessional and/or dishonorable conduct likely to deceive, defraud, or otherwise injure the public." TMB stayed the suspension and placed Dr. C on probation with terms and conditions

⁸ Dr. B has had no further criminal charges, medical board action or allegations of misconduct since 1984. His case is offered in this white paper solely to demonstrate the significant concerns raised by TMB's and the state hospital's willingness to allow the hiring, retention and advocacy for reduced court supervision of someone convicted of felony sexual indecency.

that he take 10 additional hours of Continuing Medical Education-approved ethics courses for a three-year period and that he receive a psychiatric evaluation and treatment from a TMB-approved psychiatrist.

- Two years later, TMB ended Dr. C's probation and cleared his status.
- DFPS received several complaints alleging Dr. C's emotional and verbal abuse towards patients, but it appears as though the cases were not confirmed due to the unquestioned reliance on the doctor's credibility as well as concerns over the patients' credibility. DFPS did make recommendations in several of the cases, but the records contain no evidence that the recommendations were followed up on by the state hospital.

Dr. D

Dr. D was hired as a staff psychiatrist despite numerous problems. At the time he was hired, Dr. D was on probation with the TMB and another state medical board for sexual misconduct and professional misconduct with patients. Both medical boards had previously suspended Dr. D's medical license and twice had placed him on probation for separate incidents of sexual and professional misconduct with patients. Dr. D had a history of non-compliance with probation. Dr. D, according to media reports, was involved in ongoing litigation related to sexual misconduct with a patient. Despite the suspension of Dr. D's license, his state employment application did not indicate a gap in his employment, adverse personnel action by previous employers, or legal actions against him. Dr. D. exhibited other unprofessional conduct throughout his employment at the state hospital.

- Prior to being hired at the state hospital, Dr. D was placed on three years of probation by an out-of-state medical board for unprofessional conduct due to his sexual relationship with a patient. Two years after being placed on probation, TMB reinstated his license without limitation.
- An out-of-state medical board suspended Dr. D's license again for sexual relationships with patients and prescribing a dangerous controlled substance to a family member for personal use.
- TMB suspended Dr. D's license based on the other state medical board's action.
- Shortly after Dr. D's suspension, the order was modified to five years probation with terms and conditions that included receiving psychiatric evaluation and treatment, as well as limiting his practice to group and hospital settings. TMB took reciprocal action.
- Two years after being placed on probation, a former patient filed a medical malpractice lawsuit against Dr. D alleging improper sexual relations with her.
- The year after the malpractice lawsuit was filed, Dr. D applied for employment at a DSHS hospital. On his application he indicated that both an out-of-state medical board and TMB suspended his license but did not disclose that he was currently on probation with both medical boards. He also failed to disclose the pending medical malpractice lawsuit.
- Although DSHS could easily have obtained information regarding Dr. D's previous license suspensions for sexual abuse and unprofessional behavior, they still hired and continued to employ him.
- State hospital leadership warned and counseled Dr. D multiple times for rudeness to staff, verbal abuse of patients, confirmed rights violations, and failure to provide appropriate medical care.

- After multiple warnings by state hospital leadership, Dr. D received a confirmed finding by DFPS for verbal and emotional abuse of a patient. DFPS found that Dr. D spoke to the patient in a cruel and demeaning manner, escalating the patient to the point of violence. This escalation resulted in a staff member breaking his arm while attempting to physically restrain the patient. Dr. D received three days of suspension by the state hospital as a result of the finding.
- Despite all of these concerns, the records reveal that no change was made to Dr. D's level of supervision or ability to practice medicine at the state hospital.
- Recently, Dr. D resigned his position in lieu of termination for being intoxicated at the hospital while on duty.

Dr. E

Dr. E was employed and left employment at Texas state hospitals three times. The last time he was terminated. During his absences from the state hospitals he was employed at several community mental health centers, all components of the DSHS system, where he was either forced to resign or was terminated.

- Dr. E was previously terminated by a community services division of the DSHS where he was employed as a psychiatrist. Following his termination, Dr. E filed a whistleblower suit and entered into a settlement agreement with DSHS in which he agreed never again to apply for a job with DSHS or any program funded by DSHS.
- Dr. E began employment at another community center and resigned after a DFPS investigation confirmed Class I abuse for having an inappropriate sexual relationship with a 23-year-old patient.
- Based on the incident, TMB issued an agreed order finding that Dr. E had been “personally involved in an inappropriate manner” with his patient and ordered Dr. E to enroll in a “Maintaining Proper Sexual Boundaries” course and pay a \$2,000 penalty. A year later, TMB cleared Dr. E's status.
- Dr. E then applied for a position as a psychiatrist at a state hospital. A review of Dr. E's employment history revealed that one of his listed employers was the community center where Dr. E resigned after a DFPS confirmation of Class I abuse. Additionally, there were several gaps in his employment history.
- Despite all of this negative information, the state hospital hired Dr. E as a staff psychiatrist.
- On multiple occasions over several years while employed at the state hospital, Dr. E was determined by the state hospital to need improvement in the areas of identification of target symptoms, inadequate psychiatric evaluations, and inadequate progress notes. No further action was taken.
- After the media reported about Dr. E's problems, DSHS legal services discovered Dr. E's settlement agreement with DSHS in which he agreed to never again apply for a job with DSHS or any program funded by DSHS. The state hospital terminated Dr. E's employment for failing to disclose the settlement and violating the terms of the agreement.

FINDINGS

BREAKDOWNS IN THE DEPARTMENT OF STATE HEALTH SERVICES AND THE STATE HOSPITALS' OVERSIGHT OF CLINICAL STAFF

State hospital leadership failed to maintain internally consistent physician personnel and credentialing files which resulted in misleading physician personnel records.

Unlike the other subdivisions of DSHS, the state hospitals do not use the centralized HHSC Human Resources Division to prescreen and approve physicians for hire. Instead, with the exception of a cursory screening of the application by HHSC, each state hospital handles all elements of its own hiring process for physicians. The state hospitals keep two separate files related to physician qualifications, performance, supervision and discipline. These files are identified as the personnel and credentialing files. The personnel files should contain the employee's application for employment, relevant hiring documentation, performance evaluations, employee development notes and any discipline or termination notices. The credentialing file should contain all documents related to professional licensure, privileging, peer review and clinical performance issues. DSHS considers the credentialing file to be confidential and shielded from disclosure under the Texas Public Information Act. Each state hospital maintains paper credentialing files for each physician it employs.

For each of the five physicians discussed in this report, DRTx reviewed the state hospitals' personnel and credentialing files only to discover significant inconsistency around file maintenance. Although some personnel files contained previous DFPS allegations, some of the hospitals kept this information in the credentialing file. Some of the personnel files contained resumes, but one hospital kept resumes in the credentialing file. Much of the documentation appeared to be haphazard.

Although each physician's credentialing file contained troubling information about previous or current conduct⁹ and performance problems, the personnel files often did not contain similar information.

DSHS hired and continued to employ physicians despite reports of abuse and neglect, restricted medical licenses and criminal convictions.

Four out of five physicians identified in DRTx's investigation had action taken by TMB against their licenses for inappropriate behavior before they were hired. Dr. B had felony charges pending for indecency with a child at the time he was offered state hospital employment; he pled no contest and was convicted during his employment at Austin State Hospital. Dr. C's medical license was suspended due to "unprofessional and/or dishonorable conduct likely to deceive, defraud, or otherwise injure the public." Dr. D previously had his license suspended and was on probation with TMB for the second time when Rusk State Hospital hired him. Finally, Dr. E was ineligible for hire by any DSHS agency, including a state hospital, due to a confirmed finding of Class I abuse while employed at a community mental health center which requires a bar to state employment.¹⁰

The decision by the state hospitals to hire these physicians was not the result of insufficient information. In each case, the state hospital extended an offer of state employment despite full

⁹ DRTx reviewed each physician's credentialing file. However, due to the confidentiality of these files, DRTx is unable to reproduce the concerns identified in these files.

¹⁰ See 25 TEX. ADMIN. CODE § 417.514 ("former employees with confirmed Class I abuse...are not eligible for reemployment at any facility.").

knowledge of documented ethical and professional misconduct or criminal charges. However, Texas regulations only bar employment at a state hospital if an applicant has been confirmed for Class I abuse by DFPS; whereas at a facility for persons with intellectual disabilities, the regulations do not allow hiring of an applicant who has any confirmed case of abuse or neglect, not just Class I. Class I abuse is limited to physical abuse which caused serious physical injury or sexual abuse. As a result, state hospitals are able to hire employees who, despite not causing serious injury to clients, have physically harmed clients, neglected clients, or verbally and emotionally abused clients. Residents at both types of facilities are psychologically and physically vulnerable and equally dependent on facility employees to meet their physical and emotional needs, creating a strong power difference between employees and residents. Additionally, it is often difficult for a resident to avoid contact with an abuser, particularly when the individual is unable to leave the facility or the facility is a permanent living arrangement. As well, because residents are served by multiple caretakers, there is a greater risk for mistreatment as well as more difficulty identifying the perpetrator. Given these factors, there is no logical reason for the differences in hiring policies between the two types of facilities.

DSHS leadership and clinical supervisors at state hospitals failed to hold physicians accountable for unprofessional, unethical or criminal conduct.

Although all but one of the physicians identified in this report had documented findings during their employment by DSHS, ranging from poor clinical care to rights violations, abuse and neglect, and criminal convictions, there is an absence of documentation indicating that the state hospitals' clinical leadership ever restricted their privileges or monitored them more closely. Despite the numerous concerns documented in peer reviews, supervisory notes and credentialing files, each of these physicians received satisfactory overall performance evaluations and consistently had their privileges renewed by the credentialing committee.

Dr. A represents the most egregious example of this systemic failure. For over 20 years, Dr. A was the subject of at least eight allegations of sexual abuse of a minor, two of which were confirmed. Although the majority of these allegations were not confirmed by DFPS, they resulted in repeated concerns by the DFPS investigators. Despite the repeated allegations of sexual abuse, a grand jury investigation, and a TMB investigation, the leadership at the facility allowed Dr. A to practice without additional supervision. In fact, Dr. A was promoted to senior psychiatrist on the child and adolescent unit and supervised other physicians and students. After at least four allegations of sexual abuse or misconduct, he was recognized and rewarded by the facility superintendent for excellent performance.

At the time DSHS hired Dr. B, he faced criminal charges for felony indecency of a child. When Dr. B was charged, he was enrolled in a university residency program and was providing care to children at the facility. Even though Dr. B had criminal charges pending, the facility medical director hired Dr. B as a staff psychiatrist. After his hire, the medical director wrote a letter to the judge presiding over Dr. B's case stating that he knew of the pending charges at the time of Dr. B's employment. Less than three years into Dr. B's eight-year probated sentence, rather than provide extra supervision, the medical director, Dr. B's direct supervisor, and the supervisor of the unit where Dr. B practiced wrote letters of reference to the court supporting Dr. B's request that his sentence be set aside and his probation terminated. Dr. B's personnel file and credentialing file do not contain any documentation that facility leadership considered the potential risk to patients either at the time of his hire or after his felony conviction.

Dr. C received numerous complaints against him for verbal and emotional abuse. Despite DFPS and unit staff concerns, the records contain no evidence that supervisory staff noted these concerns in

performance evaluations or supervisory notes. Similarly, the records do not document that any peer review occurred related to patient care complaints.

Dr. D was the subject of numerous supervisory notes that raised serious concerns about Dr. D's temperament and conduct with patients, but this yielded no safeguards to protect patients or increased clinical supervision besides performance counseling and written reprimands. Even after DFPS confirmed an allegation against Dr. D of verbal and emotional abuse, the hospital only imposed a three-day suspension.

DSHS failed to provide any documentation indicating that the DSHS medical director complied with the requirement to report allegations of unprofessional conduct, unethical behavior, and abuse and medical neglect made against physicians to the TMB or determine the need for a DSHS internal investigation.

State regulations require that the state hospitals and community mental health centers report all instances of physician misconduct or malpractice to the DSHS medical director.¹¹ The DSHS medical director, in turn, has a duty to report the allegation to TMB, regardless of whether someone previously reported it.¹² More specifically, state law requires that if a patient alleges sexual exploitation by a mental health services provider during the course of treatment, the employer must report the alleged conduct to the prosecuting attorney in the county in which the alleged sexual exploitation occurred and any state licensing board that has responsibility for the mental health services provider's licensing.¹³

Although all of the physicians identified in this report had at least one allegation of abuse against them during their employment in the state hospital system, the records contain no evidence that the DSHS medical director ever reported the allegations to TMB as required. There is no evidence that all of the allegations reported against the doctors while employed at a state hospital were reported by the state hospital to the DSHS medical director. Additionally, although Dr. D had multiple incidents of confirmed unprofessional and abusive behavior, records contain no documentation that the hospital ever reported the incidents to TMB or DSHS. Even after the facility terminated Dr. D for being impaired by alcohol while on duty at the hospital and notified DSHS of the incident, no report was made to TMB.

State hospital superintendents failed to remove physicians from patient care responsibility or restrict access to patients when an allegation of serious abuse was made.

In the simplest terms, state hospital superintendents are charged with protecting patients in the state hospitals' care. DRTx's investigation revealed that while physicians were being investigated for abusive treatment, poor medical care and rights violations, the state hospitals made little to no effort to assess the risk of allowing these physicians to have unsupervised access to patients and management of patient care. For example, an email written by the superintendent of the facility indicated that Dr. A continued to work on the unit with children even while under investigation for his seventh and eighth allegations of sexual abuse with children. Even when DFPS confirmed two sexual abuse allegations against Dr. A, and the facility medical director sent Dr. A an email restricting his off-unit activities and directing him not to lock doors or see patients after hours, it is not clear that Dr. A was monitored for compliance with these requirements.

¹¹ 25 TEX. ADMIN. CODE § 417.509(c).

¹² 25 TEX. ADMIN. CODE § 417.509(e).

¹³ TEX. CIVIL PRAC. & REM. CODE § 81.006.

Similarly, Dr. B was permitted to treat children while under criminal indictment for indecency with a child and was only restricted from working with children and adolescents after his conviction and subsequent condition of probation restricting his practice to treating adults. After DFPS confirmed verbal and emotional abuse of a patient, Dr. D received a three-day suspension and was then allowed to return to his previous unit and treat patients without limitation or restriction. In each of these cases, state hospital leadership allowed the physicians to continue their patient care activities with little or no additional supervision while an investigation was pending.

DSHS failed to track and trend previous abuse, neglect, exploitation and rights allegations to identify patterns of behavior or actions by alleged perpetrators.

Three of the physicians reviewed in this investigation had multiple similar complaints of abuse, neglect or rights violations. If DSHS had actively tracked and monitored abuse, neglect and rights allegations, there would have been an opportunity for clinical supervision or quality management efforts to address the frequency of complaints about a certain provider. At minimum, the number and nature of the complaints could have triggered alarm bells and led to proactive action by the state hospitals to reduce the complaints or investigate the employee's behaviors alleged in the complaints for corrective action.

DSHS failed to ensure that state hospital credentialing committees track and trend peer review findings and adverse findings in credentialing files and utilize the information when reviewing physicians for appointment or reappointment to the medical staff.

Although the credentialing committees at the state hospitals consistently reviewed each of these physicians at prescribed times for reappointment, there is no documentation in the credentialing files that indicates a process was used to determine, based on previous information from peer reviews and external investigations, whether to recommend appointment.

DSHS and state hospital leadership failed to address DFPS's documented concerns and recommendations related to quality of care and patient protection.

In several of the investigative reports conducted by DFPS into allegations against Dr. A. and Dr. C, investigators noted concerns and made recommendations to mitigate risk and try and prevent the future allegations of abuse. The extensive records DRTx reviewed as part of its investigation did not contain a single instance in which state hospital leadership noted, considered or implemented DFPS's recommendations.

The DSHS medical director and the clinical supervisors at the state hospitals failed to conduct peer reviews on physicians when there were complaints raised regarding physician conduct or clinical care or when a regulatory body recommended peer review.

Even though peer review serves as a valuable tool to assess physician performance in a constructive, conscientious manner, the records suggest that DSHS and the state hospitals consistently underutilize it. This is likely due to the fact that Texas regulations make the peer review process permissible but not mandatory.¹⁴ Although there is no way to determine whether a peer review would have deterred future abuse, DSHS certainly missed an opportunity to evaluate risk and implement potential corrective action. And the state hospitals appear to continue to miss these opportunities for improvement. According to data received by the *Austin American-Statesman*, state hospitals rarely conduct peer

¹⁴ 25 TEX. ADMIN. CODE § 417.509.

reviews when they receive complaints regarding physician conduct or clinical care. Between 2009 and 2011, DFPS referred 396 complaints back to the state hospitals as clinical issues involving licensed staff. During that same time period, the state hospitals conducted a mere 31 peer reviews of all licensed professionals.¹⁵

DSHS failed to regulate and monitor state hospital performance.

DRTx's investigation exposed DSHS's insufficient monitoring of state hospital performance and clinical practice issues. DSHS relies too much on the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) process as evidence of quality at the state hospitals. The DSHS Hospital Services Section has an employee who is responsible for monitoring JCAHO accreditation but does not have a single position dedicated to quality management. Instead, DSHS has delegated the majority of its quality management functions to the state hospitals, leaving them largely self-monitored. This violates the principle of authority/provider separation, an organizing principle of DSHS itself that a services provider should not be responsible for monitoring its own compliance. This has resulted in the Hospital Services Section being largely unaware of current state hospital performance issues and unable to take a proactive role in correcting deficiencies. Quality management of state hospitals at DSHS has devolved into a process of reactive crisis management when the agency learns of problems from external sources.

State agency rules also vest the Consumer Services and Rights Protection (CSRP) unit with responsibility for investigating rights violations and monitoring abuse and neglect in state hospitals, but DSHS has delegated the CSRP's abuse and neglect monitoring responsibilities to the Hospital Services Section. The DSHS Mental Health and Substance Abuse Division (DSHS-MHSA) has further weakened the CSRP by unilaterally overturning CSRP investigators' findings. CSRP findings are subject to being overturned by DSHS-MHSA administration, again violating the principle of authority/provider separation.

DSHS failed to adequately educate patients to identify and report abuse, neglect and exploitation to DFPS and to make complaints to TMB.

State regulations require the state hospitals to provide each patient, at the time of admission, education on abuse and neglect and how to report an allegation to DFPS. Additionally, hospitals are required to post this information on each unit and in client living areas. As noted previously, DRTx conducted a state hospital patient survey to determine the effectiveness of current efforts to ensure that patients are aware of how to report abuse and neglect to DFPS.

Although 54 percent of the patients who participated in DRTx's survey said the hospital explained how to report abuse, neglect or exploitation at some point in time, only 46 percent of those surveyed had heard of DFPS. Fifty-seven percent of patients surveyed could not demonstrate the necessary knowledge and skills to successfully report allegations of abuse and neglect to DFPS.

For example, when asked who to make reports of abuse to, answers ranged from the hospitals' clients' rights officers to family and friends. The lack of knowledge on the part of patients is likely due to the fact that the majority of state hospitals rely on hospital admissions staff to educate patients about this information at the time of admission. The information is often inconsistent or incomplete depending on the staff member providing the information. Additionally, many patients do not retain all of the

¹⁵ This number is inclusive of *all* peer reviews conducted for any reason.

information they receive at admission as they are provided with an overabundance of information, introduced into a stressful environment, and many are experiencing an acute psychiatric crisis.

INADEQUACIES IN DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES ABUSE AND NEGLECT INVESTIGATIONS

DFPS investigators failed to review previous allegations to identify patterns of behavior or actions by alleged perpetrators.

Much attention has been given to the need for DFPS investigators to look for patterns as part of their investigation protocol by reviewing previous cases of alleged abuse, neglect and exploitation. A Settlement Agreement between the State of Texas and the Department of Justice¹⁶ requires the tracking and trending of all abuse, neglect and exploitation in state supported living centers (SSLCs). The tracking and trending at SSLCs have contributed to an increase in the number of abuse and neglect confirmations. This is not a requirement, however, for abuse, neglect and exploitation at state hospitals. The lack of trending at state hospitals is problematic because past allegations are a window into the behavior of the alleged perpetrator. Past investigations can assist the investigator in determining whether the alleged victims fit a certain profile and whether multiple victim statements over time show a similar pattern of abuse, neglect or exploitation. At a minimum, these cases can assist in determining whether risk management issues exist and require redress. Additionally, investigator turnover, multiple investigators in a region and state, and hospital staff mobility inhibit continuity in investigations. When conducting a new investigation, investigators lack of familiarity with the details of previous investigations of the alleged perpetrator also inhibits the ability to see patterns of alleged abuse and neglect.

Dr. A highlights the need for this type of analysis. Dr. A was accused multiple times over a 20-year period of sexually abusing adolescent males in his care. Despite similarities in the allegations and the multiple victims' profiles, DFPS assessed each case on its own merit, and in most instances without a review of the previous investigative reports. Eventually, DFPS's review of all of the investigations led to the confirmation of abuse, but many years passed without this analysis and possibly contributed to an increased number of victims.

DFPS investigators failed to review personnel and credentialing information to assess the physicians' history and credibility.

As previously explained, the state hospitals keep two separate files related to physician qualifications, performance, supervision and discipline. These files are identified as the personnel and credentialing files. The personnel files contain the employee's application for employment, relevant hiring documentation, performance evaluations, employee development notes, and any discipline or termination notices. The credentialing file contains all documents related to professional licensure, privileging, peer review and clinical performance issues.

A review of the DFPS investigation files revealed that none of the DFPS investigations of the doctors included a review of the alleged perpetrator's personnel or credentialing files, meaning the investigators never requested such records as part of their investigations. While credentialing files may not be subject to the Texas Public Information Act, there is nothing that prohibits their release to DFPS

¹⁶ *United States of America v. State of Texas*, Cause No. A09CA-490SS, in the United States District Court for the Western District of Texas, June 26, 2009

investigators. Yet a review of past performance and practice issues is critical in many cases to evaluate the credibility of the alleged perpetrator. DFPS indicated that review of physician personnel and credentialing files is not a routine part of a DFPS investigation even when there are issues related to credibility of the alleged perpetrator. However, a review of the alleged victim's medical record is generally part of the investigation.

The importance of reviewing the alleged perpetrator's files is evidenced by Dr. A's case. Had DFPS looked at Dr. A's personnel file, investigators would have learned of the previous grand jury investigation and the TMB investigation into similar allegations.

Whether a review of these records would have assisted the investigator in his or her investigation or changed the outcomes is unknown. However, a number of cases that were not confirmed seemed to rest on the assignment of greater credibility to the alleged perpetrator. A review of the alleged perpetrator's personnel and credentialing files would, at a minimum, have provided a more complete, and likely more balanced, view of the individual under investigation.

DFPS failed to conduct unbiased investigations by unjustifiably favoring the alleged perpetrators' credibility.

It is our concern that many of the allegations against the physicians were not confirmed due in part to the fact that DFPS investigators gave greater weight to the credibility of the alleged perpetrators than the victims. It did not appear as though the DFPS investigators made a meaningful assessment of the alleged perpetrator's credibility. For example, despite the frequency of reports of sexual abuse against Dr. A over a 20 year period only by adolescent males, it appears as though DFPS investigators often perceived Dr. A as being more credible than the victim.

In DRTx's review of all the records, it seems as if the reasons for the lack of confirmation by DFPS is the unquestioned reliance upon the credibility of the doctors. This institutional bias inadvertently creates an environment that shields physicians from accountability for unprofessional conduct.

DFPS failed to train its investigators about mental illness and victim behavior, often resulting in unjustified doubts about victim credibility.

Based on our analysis of the DFPS investigations into physician abuse of patients, the DFPS investigators relied heavily on opinions about the patient's behavior and psychiatric history to discount the victim's credibility, even in the absence of evidence that the victim was not to be believed such as providing inconsistent or conflicting statements of abuse or false outcries. Many of the determinations could have been based on the investigators' faulty assumptions about mental illness and victim behavior.

The truth is that children with a disability are more than twice as likely as the general population to be physically abused and almost twice as likely to be sexually abused.¹⁷ In addition, rates of rape and sexual assault are 12.3 times higher for people with mental illness than for individuals without.¹⁸ The Department of Justice has found that "virtually half, 48.1 percent, of the perpetrators of sexual abuse

¹⁷ Department of Justice (DOJ) (US), Office of Justice Programs, Office for Victims of Crime. Working with victims of crime and disabilities. Washington (DC): Government Printing Office; 1998. OVC Bulletin No.:1. p. 4

¹⁸ Teplin, Linda A., Gary M. McClelland, Karen M. Abram, and Dana A. Wiener. "Crime Victimization in Adults with Severe Mental Illness." Arch Gen Psychiatry 62 (2005): 911.

against people with disabilities had gained access to their victims through disability services.”¹⁹ Children with disabilities are at elevated risk of abuse particularly in cases where the disability impairs their perceived credibility.²⁰

It is our concern that DFPS’s investigators may lack knowledge of child abuse victim behavior when determining the credibility of the victims. Child and adolescent sexual abuse victims often exhibit sexualized behavior, including perpetrator behaviors, destructive behavior, substance abuse, somatization, school/learning problems, and a ten times greater likelihood of further victimization.²¹ Based on media reports about Dr. A., it appears that although several issues were raised regarding Dr. A.’s credibility and behaviors, the victims’ previous sex abuse histories and psychiatric histories were key elements in discrediting or calling into question their credibility.

DFPS failed to train investigators to conduct competent investigations of child sexual abuse.

DRTx’s review of the DFPS investigations of Dr. A raises numerous concerns about the adequacy of DFPS investigators’ knowledge, skills and abilities related to child sexual abuse. It is not evident that DFPS investigators used current best practices for conducting forensic interviews or that child abuse specialists were used to elicit information from Dr. A’s young victims. Although Dr. A’s victims shared a similar profile of having previous trauma histories and a history of sexual acting out, DFPS made no effort to profile the victims or their accounts of Dr. A’s alleged behavior. Each of the victims who made outcries was an adolescent male, but interviews and investigative techniques were not tailored to their ages and histories.

When an allegation of child sexual abuse is made in the community, a referral is made to a local Child Advocacy Center (CAC). However, this resource is not utilized to investigate allegations of child sexual abuse that occur in state hospitals. The methodology and practices used to interview child sex abuse victims has evolved greatly. The CAC is at the forefront of nationally recognized practices for investigating child sexual abuse and coordinates the activities of child protection workers, police investigators, prosecutors and child behavioral specialists. Many cities in Texas have a CAC model that utilizes a team approach that includes specialists in victim and perpetrator behavior. The forensic interview is conducted in a supportive, safe and non-leading manner by a professional trained in the NCAC Forensic Interview model. Interviews are remotely observed by representatives of the agencies involved in the investigation (such as law enforcement and child protective services). Although Austin and Travis County agencies responsible for investigating child abuse have taken great steps to improve abuse investigations involving child victims, neither the hospital nor DFPS capitalized on these existing resources to investigate the allegations of child sexual abuse made against Dr. A.

¹⁹ Department of Justice (DOJ) (US), Office of Justice Programs, Office for Victims of Crime. Working with victims of crime and disabilities. Washington (DC): Government Printing Office; 1998. OVC Bulletin No.:1. p. 8

²⁰ See American Psychological Association website <http://www.apa.org/pi/families/resources/child-sexual-abuse.aspx>

²¹ *Id.*

RECOMMENDATIONS

DSHS must demonstrate a zero tolerance policy for all physicians who pose a risk to DSHS clients.

- **DSHS must require state hospitals to utilize the existing centralized HHSC Human Resources Division to prescreen and approve physicians for hire.**

Much attention and concern has been given to the fact that all but one of the physicians identified in this report had professional or criminal histories that should have precluded them from employment or raised serious questions regarding their employability. Although state hospitals are facing enormous challenges hiring an adequate number of physicians to effectively operate and provide acceptable standards of care in its facilities, this pressure should not allow for questionable or risky hiring decisions to be made.

In order to ensure that hospitals do not hire abusive or unethical physicians to fill staffing vacancies, DSHS must require state hospitals to utilize the existing centralized HHSC Human Resources Division to prescreen and approve physicians for hire and must not allow them to hire physicians that HHSC has determined do not meet hiring standards. Additionally, HHSC must have access to all DSHS, DFPS, Department of Public Safety (DPS), TMB and individual hospital records to make these determinations. HHSC must develop a centralized database for these records that is accessible to HHSC hiring specialists.

- **Physicians with a history of TMB or other disciplinary action for abuse, neglect or exploitation must not be eligible for hire or continued employment at any DSHS state hospital.**

In order to ensure that state hospital patients and clients of community mental health clinics are not put at risk of abuse or neglect, the state's bar to employment must be expanded beyond confirmed Class I abuse. If TMB, another state medical board, DSHS licensure or a previous employer confirms that a physician engaged in behavior that would meet the definition of abuse, neglect or exploitation, this finding should constitute a bar from DSHS employment.

- **DSHS must maintain internally consistent personnel and credentialing files**

DSHS must adopt policies and procedures that ensure that when performance issues are identified, all deliberations related to the performance issues are documented in the credentialing file. If the deliberation related to the performance issue results in a confirmed finding the finding must also be documented in the personnel file. This would alleviate the disparity between performance evaluations which are placed in the personnel file, which might indicate good performance, and credentialing files, which might indicate serious performance concerns.

- **Physicians and other licensed professionals must be included in the Employee Misconduct Registry.**

In order to prevent state hospitals from hiring physicians and other licensed professionals that DFPS has confirmed for abuse or neglect, licensed professionals must be included in the Employee Misconduct Registry. Chapter 253 of the Texas Health and Safety Code currently

requires unlicensed individuals to be listed on the registry if they have a confirmed allegation of abuse or neglect, including abuse or neglect that causes or may cause death or harm to a resident or consumer of a facility; sexual abuse of a resident or consumer of a facility; financial exploitation of a resident or consumer of a facility in an amount of \$25 or more; and emotional, verbal or psychological abuse that causes harm to a resident or consumer of a facility. State law does not currently require licensed professionals, including physicians, to be included in the Employee Misconduct Registry. The registry should be expanded to include licensed professionals to ensure that the state does not put patients at risk of being victimized by confirmed abusers who happen to be licensed professionals.

DSHS and state hospital leadership must be held accountable for appropriate supervision and discipline of physicians.

- **DSHS must ensure that all incidences of unprofessional, unethical or abusive conduct by a physician are reflected in their performance evaluations and appropriate disciplinary action is taken.**

Although each of the physicians had some serious practice problems and performance issues, these problems were rarely documented in their performance evaluations. The state hospital must adopt policies and practices to ensure that summaries of incidences of unprofessional, unethical or abusive conduct by a physician are reflected in the performance evaluations along with any corresponding corrective action and expectations.

HHSC uses the Positive Performance Program (PPP) for supervising, counseling and disciplining staff. This process ensures adequate documentation of performance issues and prescribes a process for employee communication and corrective action. DSHS should regularly use the PPP when addressing physician conduct and performance. This would help ensure that incidences of unprofessional conduct are appropriately documented in employee personnel files.

- **DSHS must ensure that the state hospitals routinely conduct and document peer review when allegations of a clinical nature, including allegations of abuse, neglect or exploitation, are made against physicians.**

Peer review is an essential quality improvement process used to evaluate clinical practice issues. Peer review can be used to assess clinical practice or concerns about a particular physician. To ensure that peer review is thorough and yields the necessary feedback and quality improvement, the results of peer review are confidential under state law. Both the Centers for Medicare and Medicaid Services (CMS) and JCAHO require hospitals to maintain a functional peer review process.

Although each of these cases involved physicians accused of unprofessional, unethical or abusive conduct, the records contain no evidence that the state hospitals used peer review consistently to investigate and/or resolve performance issues. Adoption of regulations that provide mandatory requirements for peer review will help ensure strong physician accountability for compliance with accepted conduct and practice guidelines.

- **DSHS must comply with requirements to report allegations of abuse, neglect and exploitation against licensed staff to appropriate professional boards.**

Clinical supervisors must be held accountable for compliance with state law and regulatory provisions that require reporting to the appropriate medical boards and prosecutors, not only because it is legally required, but because these provisions are meant to protect state hospital patients. To ensure this happens, HHSC should expand the role of the current Department of Aging and Disability Services (DADS) State Supported Living Center Ombudsman to include monitoring state hospitals compliance with reporting to appropriate medical boards and prosecutors.

Additionally, a law should be passed making failure to report to appropriate licensing boards a Class A misdemeanor. A similar law already exists for failure to report abuse and neglect to DFPS.

- **DSHS must adopt regulations that require state hospitals to remove alleged perpetrators from patient care.**

To protect patients during an abuse and neglect investigation DSHS must adopt regulations and practices for assessing known risks to the alleged victim and other patients and taking protective action consistent with the risk assessment findings. These practices should include removal from patient care responsibility or increased supervision of the alleged perpetrator during the investigation.

DSHS must effectively monitor, manage and access all relevant abuse, neglect, rights and clinical practice information.

- **DSHS must track and trend previous abuse, neglect, exploitation and rights allegations to identify patterns of behavior or actions by alleged perpetrators.**

There is currently not a reliable process to centrally track abuse, neglect and rights violations by individual staff member. Although the Client Abuse and Neglect Reporting System (CANRS) is used to track DFPS abuse cases, and DSHS has a process to track rights complaints, there is no simple process to identify rights and abuse and neglect complaints by employee or to cross-reference DFPS abuse and neglect cases with DSHS rights violations. The system should also be able to trend confirmed peer review findings related to clinical practice or findings by other regulatory agencies, including TMB and Medicare.

DSHS is in the process of developing a tool to track and trend, by individual staff member, past abuse, neglect and rights complaints, but much more collaboration needs to occur with HHSC and partner agencies to ensure that clinical findings and external regulatory findings are incorporated into the database. Additionally, regulations need to be adopted to ensure that this process continues. This information needs to be accessible to clinical supervisors at state hospitals, regulatory agencies including DFPS, and state hospital credentialing committees. This information should also be routinely utilized by state hospitals prior to hiring or rehiring employees and as part of the regular performance evaluation in the personnel file.

- **DSHS must institute policies to ensure that state hospital credentialing committees track and trend peer review findings and adverse findings in credentialing files and utilize the information when reviewing physicians for appointment or reappointment to the medical staff.**

Hospital credentialing and peer review committees are instrumental in ensuring that physicians privileged to practice at state hospitals provide therapeutic treatment in a humane manner that benefits their patients. When clinical or professional conduct issues are identified by the peer review or credentialing committee, there should be evidence of a credible process to ensure that any identified performance issues are monitored on an ongoing basis and considered when determining whether a physician should be credentialed.

Although each of the physicians in this report had identified performance issues or concerns regarding unprofessional conduct, there is no evidence that identified issues were considered in the credentialing process or monitored more closely. DSHS must adopt policies and practices that require ongoing trending and tracking of practice issues and action by peer review and credentialing committees in order to ensure that state hospitals maintain the highest standards for physicians practicing at state hospitals.

- **DSHS must ensure that state hospitals implement documented recommendations in DFPS investigative reports, including reports with unconfirmed or inconclusive findings.**

Although DFPS commonly notes concerns and makes recommendations to improve client safety and shared important concerns in its investigative reports, there is no evidence in these cases that the state hospitals considered or acted on the recommendations. HHSC could ensure follow-up by expanding the role of the current Department of Aging and Disability Services (DADS) State Supported Living Center Ombudsman to include monitoring state hospitals for implementation of DFPS recommendations.

- **DSHS must provide greater support to the Hospital Services Section so that it, in turn, can exercise appropriate oversight responsibilities and monitor patient safety and quality of care at the state hospitals.**

DSHS needs to evaluate the adequacy of the staffing and resources available to the Hospital Services Section to adequately monitor quality and regulate performance at the state hospitals. The Hospital Services Section is responsible for overseeing all 10 state hospital campuses, yet the resources committed to this division are woefully inadequate.

Given existing pressures on DSHS's budget, DSHS should utilize resources in other DSHS divisions, including the Mental Health and Substance Abuse (MHSA) Division, to improve the Hospital Services Section's oversight of the state hospitals. For example, the DSHS Hospital Licensure Unit employs licensed medical professionals who are currently responsible for surveying private hospitals and Medicare units at state hospitals. These surveyors have the requisite skills to evaluate the adequacy of medical services, including performance of licensed individuals. This division could be an enormous asset in investigating medical and psychiatric treatment issues related to clinical care.

The Quality Management Division of DSHS-MHSA is tasked with providing quality oversight activities for local mental health authorities and community contractors. DSHS should expand the Quality Management Division's current scope and resources to include monitoring the quality of care at state hospitals. This would also strengthen DSHS's overall ability to monitor continuity of care services and overutilization of state hospitals. It would also streamline and merge functions of the MHSA Division, creating efficiencies and cost-savings both as a result of fewer layers of bureaucracy and improved quality.

To ensure that the agency complies with its own rules and to alleviate pressure on the Hospital Services Section, DSHS must restore the abuse and neglect monitoring function to the CSRP, provide it sufficient funding to be successful, and create an internal expectation that the CSRP's findings and decisions are to be respected. Additionally, the DSHS-Consumer Services and Rights Protection (CSRP) unit should be given expanded autonomy and authority, as well as increased resources, to monitor reports of rights violations and abuse and neglect. The DADS State Supported Living Center Ombudsman role should be expanded to address the review or appeals of CSRP findings.

DSHS must better educate state hospital patients to recognize abuse and neglect and report allegations to DFPS.

- **DSHS must develop and implement a simpler, more effective process that will improve patient education and reporting on abuse, neglect and exploitation.**

Currently, DSHS staff are required to educate state hospital patients about rights, abuse and neglect, and procedures for reporting violations. This practice is ineffective at best, given that 57 percent of patients could not demonstrate the knowledge and skills necessary to independently report abuse and neglect to DFPS. This education process would be greatly improved and more effective if DSHS, with advocate and stakeholder input, developed a video that all the state hospitals use uniformly to educate patients on their rights and how to report abuse and neglect as well as rights violations. If such a video were available, patients could be exposed to the video multiple times, and the video could be used as a teaching tool by and for hospital staff and advocacy groups. This training should also be done separate and apart from any other trainings or information that is provided to patients.

Due to the often lengthy wait times, time limits on patient phone calls, and restrictive hospital phone policies, it is sometimes difficult and frustrating for patients to report abuse and neglect complaints to DFPS. This problem could be alleviated by allowing patient access to the internet for the purpose of reporting abuse and neglect complaints online. Currently, state hospital and DSHS staff are able to use an online process to report abuse and neglect allegations to DFPS. This has greatly shortened the time it takes to make a complaint. Additionally, hospital units need dedicated phones with direct access to DFPS to make abuse and neglect complaints. This would alleviate the pressure for patients to restrict their time on the phone and would allow access to DFPS during non-phone times.

DFPS must conduct competent, unbiased investigations of abuse and neglect allegations at state hospitals.

- **DFPS must require investigators to trend previous complaints to identify patterns of behavior or actions by alleged perpetrators.**

DFPS should expand the requirement contained in the Settlement Agreement between the State of Texas and the Department of Justice that requires DFPS to have a system that allows the tracking and trending of investigation results. Trends should be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation. In order to review prior allegations for patterns of abuse, DFPS must retain complete records of investigations, including witness statements and other evidence collected. This affects the future ability of investigators to adequately investigate cases of alleged perpetrators with multiple reports of abuse or neglect.

Although DFPS has expressed its intention to change its policy to track, trend and preserve investigations, this requirement should be codified to ensure ongoing compliance and prevent future policy reversals.

- **DFPS must adopt a policy requiring investigators to review all alleged perpetrator's personnel and credentialing files as part of their investigation and include it in the investigations collected evidence to ensure a more comprehensive and reliable investigation.**
- **DFPS must improve investigators' training on assessing the veracity and credibility of alleged perpetrators.**

DFPS must provide specific training on credibility assessment during orientation and create mentoring opportunities for new and less experienced investigators. Additionally, DFPS should track and trend investigators reports and ensure that supervisors conduct regular case reviews to identify problems and determine which existing staff need more training and mentoring.

- **DFPS must improve investigator self-awareness of stigma and its effect on assessing the credibility of victims.**

DFPS must train its investigators on mental health stigma and its effect on investigators' perception of individuals with mental illness. DFPS should utilize mental health consumer advocacy groups to conduct this training. Additionally, DFPS should develop an internal review process that incorporates periodic review of completed investigations by mental health consumer advocates as a way of ferreting out intentional or unintentional investigator bias.

- **DFPS should contract with licensed medical professionals who can provide expert consultation on investigations that require expertise outside the scope of the investigators' education and knowledge.**

- **DFPS investigators must collaborate with child advocacy centers (CACs), utilizing local experts and existing county and local resources where available, to investigate child sexual abuse.**

DFPS should consider referring all child sexual abuse cases to the local CAC for forensic interviews. DFPS should also provide all of its investigators with the training provided by CAC, which offers free online training on forensic interviewing and victim advocacy. Collaborating with available resources within DFPS and the local community avoids duplication of effort and protects already scarce DFPS resources.

HHSC RECOMMENDATIONS

Entities accountable for patient safety must coordinate with each other to ensure comprehensive investigations of allegations of abuse, neglect and exploitation.

- **HHSC must ensure improved coordination and information-sharing between DFPS, DSHS, individual state hospitals, licensing boards and law enforcement, including broad access to records.**

Currently, there is no consistent process for DSHS and DFPS to coordinate on specific cases and access records from multiple agencies. Also, there is no defined process for these agencies to collaborate and share information with law enforcement and regulatory bodies. This results in multiple, inadequate investigations by different entities. Greater collaboration cannot be accomplished without leadership from HHSC. Additionally, HHSC could be instrumental in developing a centralized, shared database of all rights complaints, abuse and neglect allegations, law enforcement action, and TMB actions.

CONCLUSION

Citizens in Texas who depend on state hospital services deserve protection from abuse, neglect and exploitation while receiving inpatient care and treatment. DSHS and DFPS share an important responsibility to ensure a safe, therapeutic environment that fosters healing and recovery while affirming the dignity of its patients. DSHS and DFPS must act quickly to implement the recommendations in this report and develop credible processes to fulfill this responsibility. It has become all too easy and familiar to blame insufficient mental health funding for problems in the state hospital system. While the challenge of limited resources is indisputable, it cannot be an excuse for the State's failure to protect patients charged with their care. In most of the cases investigated here, inadequate funding played no role in the state hospital and oversight agencies' failures. Although much media and public attention has focused recently on lapses in state hospital patient protection, these issues do not represent new challenges; the problems identified in this report are longstanding and largely unrelated to fiscal concerns.

Much of the State's work to correct deficiencies since the child sexual abuse news broke in November 2011 has focused on increased scrutiny of staff and additional regulatory requirements. Although DSHS and DFPS have drafted new rules and ordered a number of internal changes, the agencies have done little to address the structural deficiencies that led to the abuses described in this investigation. Current agency rules and policies, as well as state hospital guidelines, already prohibit abuse and neglect. Myriad reporting requirements exist to multiple agencies responsible for investigating these infractions.

Despite all of this, the regulatory safeguards in place failed to detect and hold physicians accountable for providing competent care and protecting patients from harm. DSHS and state hospital leadership did not use, and in some cases completely ignored, existing tools for ensuring responsible hiring and supervision. For each of the individual physicians identified in this report, the state hospital hired or continued to employ them in spite of obvious risk factors. In each case, the risk could have been minimized or prevented by appropriate hiring and supervisory decisions and with proper regulatory oversight. The many changes needed now demand a sustained effort to transform a culture of state hospital independence with minimal regulatory oversight.

The responsible state agencies must also demonstrate a commitment to investigating allegations of patient abuse without bias and holding professional staff accountable when appropriate.

Many of the recommendations in this report require legislative action to ensure their adoption and implementation. DRTx hopes that the legislature and HHSC will work with DSHS and DFPS to ensure the collaboration necessary to improve the State's care of Texans with mental illness.