

ABUSE AND NEGLECT OF ADULTS WITH DISABILITIES: WHY EXISTING LAWS AND SYSTEMS IN PENNSYLVANIA ARE NOT ENOUGH TO PROTECT ADULTS AGES 18-59

Just as we need protective services systems for children and older adults because the existing laws and systems are otherwise inadequate to protect them, we need a law and a system for vulnerable people between the ages of 18 and 59. In fact, the Office of Children Families and Youth receives calls about individuals over the age of 18 who are victims of abuse and neglect, and the Older Adult Protective Services system receives reports of abuse and neglect concerning persons under the age of 60, but neither has the responsibility to investigate these reports, the authority to enter a private house or to force the removal of the at-risk individual or the perpetrator. As a result, many of these complaints go uninvestigated.

Below we explain some of the holes in the safety net, including examples of cases dealt with by the Disability Rights Network of PA (DRN), Pennsylvania's federally mandated advocacy system.

Police

Police are legally unable, and often unwilling, to demand entry into a private house to investigate even when an abuse or neglect report is filed with them about an adult between the ages of 18 and 59. This happens because: the abuse may not have resulted in obvious injury (especially emotional or psychological abuse and exploitation); the individual may be unable to talk and report what has happened to them or to be a credible witness; or the victim may be afraid and unwilling to press charges. For example:

- *DRN has a case where a young woman over 18, who is still in school, told her teacher she is being kicked at home. It was reported to police. At first police said they were too busy to follow up. They viewed it as a low priority domestic dispute. Our advocate called police and convinced them to accompany her to the home. A family member confirmed that the person had been kicked, but called it an accident. When the police interviewed the person she refused to say what had happened. She was afraid what would happen to her when the police left. There was a second incident of kicking and sexual assault. When DRN called the police they said that if they go out to interview her and she doesn't tell them what happened, they will charge her with obstruction of justice. They are not able to offer her safe haven, services, etc. Even if they arrest the perpetrator, that person could be out on bail and back home with her within a few days, maybe even hours. DRN has no authority, nor does the county have the authority to remove her from the home unless she asks for that help. She is afraid to ask for help because once before when she did ask to leave and was placed in respite, the family found her and took her home.*

The proposed legislation will give the protective services system the ability and responsibility to work with the police to gain access to adults ages 18 to 59 who live in private homes and other non-regulated

residences. Protective services workers will have a mandatory obligation to report to law enforcement officials when they have reasonable cause to suspect that a person is the victim of sexual abuse, serious physical injury, or serious bodily injury, or a suspicious death. They will bring an understanding of disabilities to the over burdened police and a safety net of support to victims.

Private Homes and Unlicensed Settings

The Neglect of Care Dependent Persons Act makes it a crime for a professional caretaker or a person who has an obligation to provide care for monetary consideration to intentionally or recklessly harm a person in their care. This criminal law has no bearing on abuse and neglect by family or other persons who are not paid caregivers. Additionally this Act requires there to be serious bodily harm before action can be taken to protect the individual.

The proposed legislation will grant authority to the protective services system to investigate abuse and neglect reports, involving paid and non-paid caregivers, before the abuse or neglect reaches the serious bodily harm standard.

People with disabilities living in private homes or unregulated settings are often most vulnerable because there is no entity in Pennsylvania which has authority to access that home without the permission of the homeowner or overt signs of criminal activity. Often people live with their caregivers in these homes and either can't speak for themselves or are afraid to speak for themselves. The victim may be totally dependent on the caregiver who is abusing or neglecting them. After an allegation of abuse/neglect is made and a social service agency attempts to visit the person to confirm the allegation, it is not unusual for the caregiver to terminate the person's services, completely isolating them from the outside world.

Social service agency staff does not have legal authority to enter a person's private home without being invited in, even when the person had been actively receiving services. Staff cannot require a victim of abuse or neglect, or the caregiver of a person about whom an abuse or neglect report has been filed, to either accept or continue receiving needed services. People are left to remain in abusive and/or neglectful situations because we have no system in place that, grants legal authority to access the person to conduct assessment of the person's need for protective services, to relocate the person, if needed, and to provide for the needed supports and services to eliminate the harm.

- *DRN received a report about a young adult with development disabilities who told a staff person at her day activity program that that her stepfather had sexually abused her. The stepfather is a sex offender listed on Megan's List. The woman was taken to the police station to file an abuse report and was sent home and not taken to the hospital for a rape kit to be performed. The police did not go out to the house to investigate. When her mother found out that the woman had told the police and others about the abuse, the woman's mother stopped the woman from attending the day activity program and refused to allow human services workers access to the woman.*

No agency can now gain access to this woman, nor does she have anyone who can take her to get help from a sexual assault program.

The proposed legislation would protect adults who live in private houses and other non-regulated residences and provide them the protection, assistance and services that they need in order to prevent further harm. The law would also provide for development of a service plan and delivery of needed services by those with knowledge and experience working with people with disabilities.

Quality Control in Regulated Settings

Existing quality controls in regulated settings don't always work for a variety of reasons, leaving people in these settings at risk and in need of the intervention by an independent protective services system. An example of this is the incident reporting and investigation systems that providers are to follow to protect individuals receiving services in settings regulated by the Office of Developmental Programs (ODP) and the Office of Mental Health and Substance Abuse Services (OMHSAS). These systems require providers to self-report and investigate themselves. For example, when an allegation is made the ODP provider is supposed to suspend the target staff from working in all programs until the investigation is complete. Obviously, this can put a strain on a provider who is already understaffed and can lead to under-reporting. In some cases, findings are manipulated. In theory, ODP reviews all incident reports as a quality control mechanism, but that can take months and in some cases years.

- *DRN has received a number of calls where staff will say they have reported abuse or neglect but it is never entered into the HCSIS computer reporting system, never investigated, or if investigated, eyewitnesses and the individual who was abused were never interviewed. They have found incident reports that were misclassified and an investigation never completed.*

Similar concerns exist for the provider incident reporting system required by OMHSAS. Only providers that operate two specific residential models (Community Residential Rehabilitations programs and Long Term Structured Residences) are required to use the system; those in other settings have no reporting system. This system also requires that providers investigate themselves.

The proposed legislation will grant access to and oversight of provider incident reports by the protection services system. The system will have the responsibility and authority to review the quality of investigation as needed and to request that the court order the provision of needed services and supports to protect the person.