

**DRC Policy Paper & Report to the Governor's Council on ANE:
Observations on Potential Focal Points for Systems Change
Opportunities or Gaps in the System for Council Review of the Current
ANE Investigation System:**

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General Acknowledgments of the Overall ANE Investigative System:

- Each agency involved does incredibly important and difficult work. Each agency (Aging, KDHE, SRS, AG, law enforcement) plays a vital role. The recent example with the abuse allegations at KNI and how important the state's response can be with ANE. We have seen how state agencies stepped up their efforts and responses with the KNI example. This shows how important this system is, and how the system can and does do incredibly important work.
- The system has an awesome responsibility and by most accounts it is not provided enough funding to accomplish the tasks.
- The ANE Unit established in Senate Sub for HB 2105 was a difficult process, but it helped spur discussion and was an impetus helped lead us to discussing this issue today. The Unit is also helping to increase the focus on holding perpetrators accountable and obtaining justice for victims through victim-driven legal services.
- The ANE Unit plays a unique role in focusing on the perpetrators of ANE and getting justice for victims - but that does not take away from the important role that SRS, Aging or KDHE play. In fact, some of these opportunities and ideas suggest that each agency in the system might be able to play a more important and bigger role in holding perpetrators accountable and helping to obtain justice for victims.
- The fact that much of SRS, Aging and KDHE's efforts focus on holding providers accountable through rule and regulation enforcement, administrative sanctions and licensure is not meant to downgrade the significance of their work.
- Though we must as a Council look at the system with a critical eye toward changes and reforms, as a Council we must also remember that our goal is to improve the system and make recommendations for systemic change that will help prevent ANE.
- DRC is offering suggestions or potential systems changes, but DRC also wants advice and input on how we can improve our services and our role in the system. How can DRC improve as the Protection and Advocacy system (P&A) in investigating ANE?
- **Upwards of 50% of Reports are "Screen Out" & Never Investigated – Indication that the System is Under Funded and Overworked? By What Process are they Screened Out?** – These are FY 2005 numbers and only for SRS Adult Protective Services (APS), but of the roughly 10,000 reports of ANE annually to APS, about 5,000 are "screened out" as not being appropriate to investigate. Does this indicate that the system is dramatically under funded and greater state appropriations are needed for the state-run ANE investigations? For these allegations that are screened out, what is the process to determine

if a call is screened out? How objective is this process? Some of the complaints and allegations against the Kaufman house were screened out.

- **Of the Reports Not Screened Out, the State Focuses 50% of its Investigations on Protecting People With Disabilities “From Themselves” – Shouldn’t the Focus be Protection from Perpetrators?** – Upwards of 50% of all the reports of ANE investigated by state are for “self neglect” (Ex: FY 2005, of the 5116 reports of ANE investigated by SRS/APS, 2710 – over 50% - were allegations of “self neglect”). Also, 75% of the *confirmed* cases are self neglect. Many in the disability community would argue that protecting people from themselves has the potential to cross over the line from protection to paternalism. Shouldn’t the focus be on promoting self-determination and independence? People with disabilities that are independent and engaged in self-determination are less likely to be abused. When the number one area of investigation borders on paternalism and “protecting people from themselves,” the system can’t focus on getting the real bad guys – the perpetrators of ANE. Is this the right focus (protecting people from themselves)? What is the standard by which the state decides to intervene in a self neglect case? [ex: When a person’s actions or their living environment may pose a potential threat of harm to self (low standard)? Or, when a person’s actions pose an imminent threat of life-threatening bodily harm to self (high standard)? Kansas law has the same standard for self neglect and perpetrator neglect]
- **It should not matter where the person with a disability resides – they should get the same quality investigation, akin to child abuse investigations** – The type, intensity and protocols of the investigation vary by the agency doing the investigation (KDOA, KDHE, SRS). So, not only is there a difference between the level of investigation into ANE against a child and ANE against an adult with a disability, there is also a difference between the investigation depending on where the person with a disability happens to live (ICFMR, Nursing Facility, Group Home, etc.). In some settings the provider may do the initial investigation (ex: Nursing Facilities). The state must close the gap between child abuse investigations and adult abuse investigations. The standard should be that adults get the same coordinated, intensive-type of ANE investigations as children receive. Then, that standard of a quality investigation should be the same regardless of where the individual with a disability lives.
- **Are Licenses Pulled? Is it an Empty Threat? Are the current options of Administrative Sanctions Sufficient?** – When a provider is responsible for the actions of ANE or the actions of their employees, most of the remedies afforded to the state-run Investigative system (Aging, SRS, KDHE) center around the threat of pulling the providers license. How often are licenses pulled? If the numbers show that licenses are not pulled that often, then what other remedies and enforcement tools do these agencies need to hold bad providers accountable? Does the way in which the licensure system is setup systematically make licenses less likely to be pulled?

- **Very Few Referrals to Law Enforcement** – The ANE Unit is already addressing this in a systemic manner, but in FY 2005, of the 10,000 reports SRS APS received on ANE, only 154 were ever referred to law enforcement.
- **State Abuse Registries Don't Seem to Talk to Each Other, So Abusers Continue to Be Hired** – The different state investigative agencies (KDHE, SRS, KDOA, etc.) seem to keep separate registries of employees of group homes, NFs, etc., who have abused or neglected people. Those registries/databases do not appear to be integrated. You can be put on the KDOA registry, and go to work for a CDDO licensed by SRS, and you may not appear on the SRS registry. So, the known abuser gets hired and recycled. DRC pointed this out in its 2005 White Paper "A Proposal to Improve the ANE of Kansans with Disabilities Protection System," but our understanding is that no change has occurred. Also, as an employer who does background checks, we found it difficult to obtain this information (no single point of entry, have to know about all the abuse registries, contact multiple sub-agencies).
- **Investigative Agencies Don't Know IF the Person Has a Guardian, or Who the person's Guardian is, or Which Guardians have Conflicts of Interest, etc.** – APS can't conduct an investigation if the Guardian refuses or if consenting adults don't want to be investigated. There is no centralized registry available to investigative agencies of Guardianships and Conservatorships to track all this. This was a huge problem in the Kaufman house case, because SRS was told by Mr. Kaufman that the people there were consenting adults and that they didn't have guardians. That was not true. At different points more than half had Guardians. In fact, Mr. Kaufman WAS the guardian for at least one resident (clear conflict of interest but is unfortunately allowed under law – this must change). There was no guardian/conservator registry for investigative agencies to check this out (SRS, Aging, KDHE, AG, DRC, law enforcement, etc.). The Kansas Supreme Court could operate such a registry.
- **Lack of Secondary Investigation or Quality Control** – Some states have "secondary investigations" conducted as a check of the thoroughness and quality assurance of the work product of the primary investigation. This process of secondary investigations acts as a quality control on the investigation, accountability, etc. What states do an effective job with this? How can Kansas learn from them and implement this? Who should do the secondary investigation? Perhaps not a peer agency (problems with the three state agencies watching each other), but maybe an agency external of the State investigative system and maybe an agency with a law enforcement background (KBI, etc.).
- **The Unit has Increased the Focus on Holding the Perpetrators Accountable and Increasing Justice for Victims through Victim-Controlled Legal Services – But more Must be Done to Make the System more Victim-Driven and Focused on Justice** – Until the ANE Unit was created, there was no real systemic state focus on the needs of the victim and having the victim direct their form of justice. When you look at the state ANE Investigation System as a whole it is still tilted to focus on licensure, administrative

sanctions, rules & regulations, etc. The Unit is only partially funded. Full funding was \$1.2 million (provided with \$350,000). Also, as many of the systemic issues show, changes can be made to make the system more focused on holding perpetrators accountable through victim-driven justice.

- **Does the State-Run Investigative System Need More Funding, a Different Focus, Both?** – The current investigative system clearly has strengths and improvements that can be made. Is one needed improvement an increase in funding for SRS, Aging and KDHE to investigate all the complaints that come in (ex: 50% of allegations reported to SRS/APS are “screened out” and never investigated)? Is more funding needed? Or, is the problem that the current focus on “protecting people from themselves” (50% of investigations fit this “self neglect” category) needs to be changed to focus on perpetrators and free up capacity within existing resources? Or, are both additional funding and new focus needed?

Additional Ideas for Potential Council Support of Bills and Legislation:

Support Passage of Bill to Eliminate Conflicts of interests with Guardians/Conservators – Kansas law is flawed in that it allows guardians and conservators (G/C) to have conflicts of interest over their wards (people with disabilities). The G/C can be the service provider, and the service provider is often the abuser. The G/C can stop the State Agencies investigation by not consenting to it.

- This Council could endorse 2005 SB 240 version that was developed by DRC with input from the Kansas Guardianship Program and disability community. This would prevent conflicts of interests with G/C over their wards.

Support Passage of a Bill to allow prosecutors to criminally prosecute providers and administrators if they are willfully or grossly negligent of the abuse – Want to make providers take notice and stop abuse before it starts? Give prosecutors the ability to criminally prosecute administrators for abuse when they are grossly negligent. Some states do this.

Fully Fund the ANE Unit and Provide Dollars for Children’s Abuse (like Wichita Case) and Increase funding for State Investigative System (SRS, Aging, KDHE) –

The current \$350,000 in funding was only the first year of a multi-year program. Also, it only provides enough money to help some persons with disabilities. The \$350,000 first-year funding never contemplated children who are abused (like the recent Wichita example) and the Unit is still not fully funded.

- Council could endorse fully funding or increasing funding to the ANE Unit program (currently funded at \$350,000 - \$122,000 in FY 06 rolled over into 07 and \$228,000 in FY 07 – the total program without kids was \$1.2 million total funding). Phase the total cost in over the out years.
- The State Investigative System is obviously overburdened and under funded. This council could endorse funding increases for this system (SRS, Aging and KDHE)

Council Endorse the State Board of Education or Legislature to Pass Enforceable Seclusion/Restraint in Schools Standards –

How does SRS Child Protective Services (CPS) can effectively investigate allegations of improper use of seclusion and restraint when the tactic causes harm to the student with a disability if there are no established enforceable standards through rule and reg or law?