BANGOR DAILY NEWS (http://bangordailynews.com/)

Investigations into the abuse of disabled adults in Maine have slowed, without explanation (http://bangordailynews.com/2017/02/12/news/state/investigations-into-the-abuse-of-disabled-adults-in-maine-have-slowed-without-explanation/)

Ashley L. Conti | BDN

Geneva Belden looks down the hallway at her home in Bangor on Jan. 19. Belden fell on two occasions under the watch of service provider Branches. While those injuries were not necessarily caused by abuse or neglect, the state should have investigated those cases but never did.

By Danielle McLean (http://bangordailynews.com/author/dmclean/), BDN staff
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BANGOR, Maine — During the past four years, Geneva Belden has fallen twice. The first fall, in May 2013, broke her nose. The second, in October 2016, broke her thumb, according to the home care agency Branches, which assists her in the Bangor group home where she lives.

Belden is intellectually disabled, and while she can converse with others and care for herself, she has trouble with critical thinking and long-term planning.

After the first fall, Branches staff didn't take her to the hospital for two days until they noticed her black eyes. When Branches administrators learned of this, they reported these incidents to the Office of Aging and Disability Services, as required by state regulations (https://www.google.com/url?q=https://docs.google.com/document/d/1lgwptnlFbF8scSv1F7H1MpudsXROYbyg6M4pglFN9GI/edit&sa=D&ust=1486935991702000&usg=AFQjCNGUP said Brian Noble, the owner of Branches (https://www.google.com/url?q=https://www.facebook.com/Branches-LLC-212640922086654/&sa=D&ust=1486935991709000&usg=AFQjCNFAF15LbBjdjG_SswNFb8hXZgWMGg). They did the same after the second fall.

State regulations specify those who care for people with intellectual disabilities must report all potentially dangerous situations within a day of learning of them — and the most pressing situations immediately — even if actual harm or injury did not occur.

It's expected that these reports would trigger an independent investigation by state regulators with Adult Protective Services (https://www.google.com/url?q=http://www.maine.gov/dhhs/oads/aps-guardianship/&sa=D&ust=1486935991713000&usg=AFQjCNHHD4czJWnxsL23U9yohN1u1TbICA), a division of the Maine Department of Health and Human Services, which is required to investigate abuse and neglect — which can range from sexual assault to group home staff members falling asleep on the clock — of people with intellectual disabilities such as Down syndrome or autism.

But to date, neither Belden nor Noble say they've heard from the state regarding these reports.

According to several providers who have came forward to the Bangor Daily News to share concerns about the state's system for investigating suspected abuse and neglect, this silence has become increasingly common.

Five health care service providers in York, Penobscot, Androscoggin and Kennebec counties shared their referral numbers with the BDN. Combined, they had reported 555 allegations of possible abuse, neglect or exploitation between 2011 and 2015. Adult Protective Services had produced final reports for just 40 of them.

What's not known is whether the state is declining to investigate allegations, if the investigation reports are being shielded, perhaps because of privacy concerns, or if there has been a policy shift away from what health care service providers believe should occur.

"Agencies don't receive reports any more. So what happens is an agency files a reportable event as they are required to and doesn't necessarily ever hear anything again," said Charlene Kinnelly, a recently retired lobbyist for the Maine Association for Community Service Providers, which represents residential or day-program providers' interests.

The Maine Developmental Services Oversight and Advisory Board, which provides independent oversight of services for adults with intellectual disabilities or autism, also has expressed grave concern over the state's lack of responsiveness.

"When staff of the [advisory board] contacted, or tried to contact the investigator or the supervisor to find out the status of the investigations, no calls were returned," the board wrote in comments to the state in August 2016.

It continued, saying it "believes that what has happened is that the [Adult Protective Services] unit has indeed been overwhelmed and that it cannot function effectively to protect the persons it is mandated to protect."

'Not keeping the promise'

The current problems have their origins in a legal battle dating back to 1975 when a class action lawsuit was filed on behalf of people involuntarily admitted to the Pineland Center, a state-run mental health institution in New Gloucester.

Conditions at the facility were poor, with residents spending much of their time in large, open rooms, half-dressed, with, in many cases, no individualized treatment.

"There might be 30 to 40 people standing in a room and one staff person. And the staff person's job was to clean up urine and feces on the floor. That's how it was," said Richard Estabrook, who was the chief advocate in the Office of Advocacy from 1985 to 2012, monitoring people with intellectual disabilities and autism served by Maine DHHS.

Estabrook worked at Pineland as an advocate for patients and later became a member of the Maine Developmental Services Oversight Advisory Board (https://www.google.com/url?q=http://mainedsoab.org/&sa=D&ust=1486935991786000&usg=AFQjCNFRHf96ujy1qSNPJVv-OUVB5iHBLA), the group charged with overseeing the state's care of people with developmental and intellectual disabilities.

A judge first ordered a consent decree in 1978 to force the state to improve conditions. The move prompted the state to phase out the facility and attempt to better care for people in the community. In 1994, a new decree sought to better support people's health and safety in their community environment.

It was this consent decree that U.S. District Court Judge George Singal lifted in 2010 (https://www.google.com/url?q=https://drive.google.com/file/d/0B0ouQC_0FoyhVjFmZXFaVEVVWlk/view?usp%3Dsharing&sa=D&ust=1486935991789000&usg=AFQjCNF2q1JhPIVgsXhugCvwuPxGHUYeMw) because, as he ruled, the state had "made a substantial and sustained good faith and largely successful effort to achieve compliance." Maine Attorney General Janet Mills argued in favor (https://www.google.com/url?q=http://www.maine.gov/ag/news/article.shtml?id%3D93905&sa=D&ust=1486935991814000&usg=AFQjCNHpUmoYjaW08ES_sKb6fcMooMrY2w) of lifting it.

Maine had mechanisms in place to prevent the state from slipping on its obligation to protect vulnerable people, including the work of Adult Protective Services and the Consumer Advisory Board, Singal wrote in his order.

He said he understood people's concerns that the state could regress, especially given financial pressures. "The fear that history may repeat itself will always be present," he wrote, requiring those who advocate for people with disabilities "to be forever vigilant."

The Maine Developmental Services Oversight Advisory Board — the successor to the Consumer Advisory Board — has been paying attention. But though state regulations spell out that it will receive final reports of Adult Protective Services investigations, it hasn't received one since it formed in 2011, its chairman, Cullen Ryan, said.

Without information, the 10-member board can't oversee the state's work — or even determine how much of the required work it's doing.

"We have not seen the department be responsive to requests for information, and we are looking for that information so we can help ensure that the department is doing what it's responsible to do to meet the needs of folks with intellectual disabilities," Ryan said.

Maine DHHS is legally required to prepare a report for the Legislature every two years about its services for people with intellectual disabilities and autism. Those reports state it is choosing few cases to investigate: It "accepted" 428 cases (https://www.google.com/url?q=https://drive.google.com/file/d/0B0ouQC_0FoyhMUJMRFBIYnJxTWs/view?usp%3Dsharing&sa=D&ust=1486935991832000&usg=AFQjCNFWKGE-6SX2QbUp4tu47hGGoUBlag) out of 1,293 referrals in fiscal year 2015; 428 cases (https://www.google.com/url?q=https://drive.google.com/file/d/0B0ouQC_0FoyhV0c3NlY1UFRRekk/view?

usp%3Dsharing&sa=D&ust=1486935991833000&usg=AFQjCNGsUpc5YAmjFLVfTaWEblzFPgwJyg) out of 1,377 referrals in fiscal year 2014; and 159 cases (https://www.google.com/url?q=https://www1.maine.gov/dhhs/reports/biennial-plan-for-adults-with-ID-autism.pdf&sa=D&ust=1486935991834000&usg=AFQjCNErEePnYTX3GxRDuJSHjM1XOVUmmA) out of 1,311 referrals in fiscal year 2012.

FISCAL YEAR 2015 APS REFERRALS (p. 7) (https://www.documentcloud.org/documents/3405065-OADS-2017-2018.html#document/p7/a335341)

View entire document on **DocumentCloud** (https://www.documentcloud.org/documents/3405065-OADS-2017-2018.html#document/p7/a335341)

UNTITLED NOTE (p. 8) (https://www.documentcloud.org/documents/3405213-OADS-Biennial-Plan-2015-Adults-With-ID-or-Autism.html#document/p8/a335531)

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The state's reports say the cases involved "Developmental Services only." It's not clear from the reports whether the department is tracking data related to complaints involving people with intellectual disabilities.

Mental health professionals questioned the state's published numbers, given their knowledge of how many reports of potential harm each of Maine's more than 200 caretaker agencies are likely to make per year.

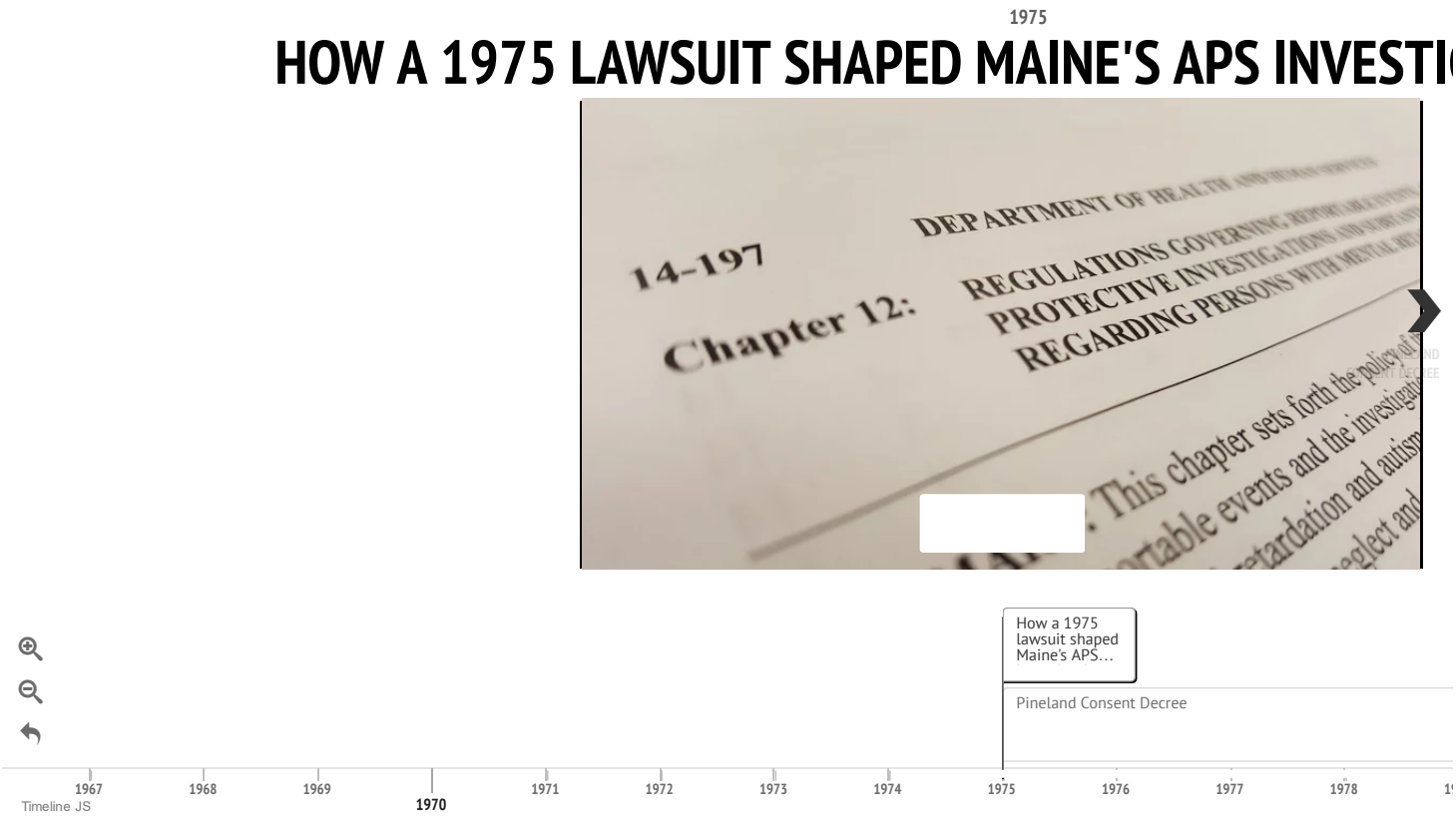
"There's no way that's credible," Estabrook, the oversight advisory board member, said.

They also questioned why the state was choosing to accept various cases, when they understand, based on the state's regulations, that it must look into every one.

"You do not want to send the message to the people out doing direct care or any kind of treatment ... that you're going to be heavily triaging these allegations before they're even investigated," Estabrook said. That's because it could discourage them from reporting potential harm in the first place.

Kinnelly, with the Maine Association for Community Service Providers, served as the superintendent of Pineland after the original consent decree in the 1970s.

"It's heartbreaking," she said. "We're just not keeping the promise."



'We call them jumpers'

When cases are not resolved by the state, it means the employees who potentially put clients in harm's way are never entered into a state database that tracks misconduct, allowing them to find a new job at another agency.

"We call them jumpers," Noble said. "They jump to another agency, and there is no tracking this because there was never an investigation. Therefore it cannot be released to another agency."

It may also expose agencies to liability.

Peter Kowalski, CEO of John F. Murphy Homes in Auburn, said larger agencies with investigators on staff like his will look into allegations themselves if they don't hear back from the state. Otherwise, he said, the agency could be exposed to a lawsuit if it were to fire an employee without investigating.

For example: John F. Murphy Homes was asked by Adult Protective Services to investigate more than 30 allegations of abuse, neglect or exploitation it reported in 2014 and 2015. The state can delegate these investigations to an agency, but it is still required to issue a report outlining their findings.

The state accepted the agency's findings over the phone and never produced a final report, according to John F. Murphy Homes Chief Operating Officer Laurie Crane-Turton.

It's not ideal for an agency to look into abuse allegations without oversight from the state, said Frances Cartier of ISC for ME, a case-management company based in Bangor, which works with Belden.

"If there is an agency that looks at the reportable event as a personal insult, then it doesn't work," Cartier said. "I question the wisdom of the fox watching the hen house because if you are only doing investigations for your own agency, what is the result going to be?"

Her organization reported 58 allegations of possible abuse, neglect or exploitation between 2014 and 2016. She has seldom received calls from investigators following up, she said, and she hasn't seen a single final investigation report for any of the cases.

"If it were me not following the law, I probably would be put in jail and put out of business," said Cartier.

'I feel bad for them'

The federal Office of the Inspector General within the U.S. Department of Health and Human Services confirmed in January it is investigating the state of Maine's oversight of adults with intellectual and developmental disabilities.

The Office of the Inspector General did this recently in Massachusetts, (https://www.google.com/url?q=https://oig.hhs.gov/oas/reports/region1/11400008.pdf&sa=D&ust=1486935991875000&usg=AFQjCNFlQGSJ7bcbuIteNYPXxwnGr-TsDQ) where it found shortcomings in that state's system for reporting and addressing incidents of suspected abuse and neglect. But the office said it could not describe the nature of the Maine investigation until it was complete.

The state's position on the concerns about adult protective services is not clear.

Maine DHHS spokeswoman Samantha Edwards did not respond to five requests for comment.

Maine attorney general spokesman Timothy Feeley said the office is “unaware of any complaints about [Adult Protective Services] compliance or non-compliance with the regulation.”

But multiple providers and the developmental services oversight board say they rarely hear from Adult Protective Services about whether it even investigates, let alone when cases are closed. Caretakers assert the state is violating rules put in place after three decades of court orders meant to protect often-powerless residents.

“It was always the state’s responsibility, and remains to this day the state’s responsibility, to do all these adult protective investigations,” said Estabrook. “Nobody knows if they have been investigated at all.”

It is important for those running group homes or overseeing caseworkers to know the results of an investigation, so they can remove people from possible danger, and prevent neglectful or abusive employees from continuing to work with vulnerable clients.

Like Geneva Belden.

Over the last couple months, an aide who was supposed to look after Belden fell asleep, according to Noble.

Then a family member tried to convince Belden to live with her. It didn’t sit right with Noble, who did a background check and became suspicious that the family member was trying to trick Belden into paying the rent.

Belden’s case manager from ISC for ME, which oversees her personal care and finances, and Noble from Branches both said they also reported these incidents involving Belden to the Office of Aging and Disability Services (https://www.google.com/url?q=https://www.maine.gov/dhhs/oads/&sa=D&ust=1486935991887000&usg=AFQjCNF3Kb-wKbs_876Xmjp5f7ywW0WDSQ) office in Bangor.

Again, nobody from Branches heard back, they say. Neither did ISC for ME, said Cartier.

For her part, Belden feels protected. But she’s concerned others are at risk.

“There’s a lot of people out there who need help, and they aren’t getting it,” Belden said. “And I feel bad for them. I think the state should do their job.”

CORRECTION:

An earlier version of this report should have noted that Charlene Kinnelly, who worked as lobbyist for the Maine Association for Community Service Providers, retired from that position earlier this year.