

# **ABUSE AND NEGLECT PREVENTION PLAN**

**for people with disabilities**

**Approved by the Olmstead Subcabinet  
on September 28, 2016**

## Contents

<b>Purpose of this Document</b> .....	3
<b>Why This Topic Is Important</b> .....	4
<b>Recommendations for a Comprehensive Abuse and Neglect Prevention Plan</b> .....	7
<b>1. Appoint Leadership Team</b> .....	7
<b>2. Review Minnesota and Other States for Best Practices</b> .....	7
<b>3. Involve People with Disabilities</b> .....	7
<b>4. Build on Current Initiatives and Commit to Improvement</b> .....	8
<b>5. Information Management and Data Systems</b> .....	9
<b>Next Steps</b> .....	9
<b>Detailed Information Supporting Recommendations:</b> .....	10
<b>Minnesota Adult Abuse Reporting Center (MAARC) Public Awareness Campaign</b> .....	10
<b>Governor’s Task Force on the Protection of Children - Final Report and Recommendations</b> .....	11
<b>Maltreatment Report: Vulnerable Adults &amp; Minors Served by Minnesota Licensed Providers</b> .....	12
<b>Existing Prevention Strategies Across Multiple Agencies</b> .....	13
<b>Other State’s Experiences</b> .....	14
<b>Department of Health and Human Services Office of Inspector General (OIG) Reports</b> .....	15

## Purpose of this Document

The purpose of this document is to present recommendations to the Subcabinet on the components of a comprehensive abuse and neglect prevention plan. This document is based upon the current goal contained in the June 1, 2016 Olmstead Plan as described below.

The Olmstead Subcabinet directed an interdepartmental workgroup to convene to develop recommendations of the components of a comprehensive abuse and neglect prevention plan. A workgroup of Subcabinet members and agency staff examined each of the six components of the goal. Based on this work, the group is proposing 11 recommendations including the establishment of a Specialty Committee structure that will be responsible for continuing the work of putting the components of the prevention plan in place.

### **OLMSTEAD PLAN**

The June 1, 2016 Olmstead Plan included the following goal on page 100:

**Preventing Abuse and Neglect Goal One: By September 30, 2016, the Olmstead Subcabinet will approve a comprehensive abuse and neglect prevention plan, designed to educate people with disabilities and their families and guardians, all mandated reporters, and the general public on how to identify, report and prevent abuse of people with disabilities, and which includes at least the following elements:**

- A comprehensive information and training program on the use of the Minnesota Adult Abuse Reporting Center (MAARC).
- Recommendations regarding the feasibility and estimated cost of a major “Stop Abuse” campaign, including an element for teaching people with disabilities their rights and how to identify if they are being abused.
- Recommendations regarding the feasibility and cost of creating a system for reporting abuse of children which is similar to MAARC.
- Utilizing existing data collected by MDE, DHS, and MDH on maltreatment, complete an analysis by type, type of disability and other demographic factors such as age and gender on at least an annual basis. Based upon this analysis, agencies will develop informational materials for public awareness campaigns and mitigation strategies targeting prevention activities.
- A timetable for the implementation of each element of the abuse prevention plan.
- Recommendations for the development of common definitions and metrics related to maltreatment across state agencies and other mandated reporters.

Annual goals will be established based on the timetable set forth in the abuse prevention plan.

## Why This Topic Is Important

A great deal of progress has been made over the last 50 years to advance the rights of people with disabilities, including the passage of the Americans with Disabilities Act; the 1999 Supreme Court ruling in *Olmstead v. L.C.*; and greater integration in education, employment, health, community living, and community engagement.

Despite this progress, people with disabilities experience abuse, neglect, and maltreatment at a much higher rate than people without disabilities.<sup>1</sup> People with disabilities have the right to be free from abuse and neglect. To address these issues, it is necessary that Minnesota adopt a comprehensive abuse and neglect prevention plan. To accomplish this, collaboration between people with disabilities and their families, advocates, and public and private entities will be required.

### PREVALENCE OF ABUSE AND VIOLENCE

In Minnesota like all other states, people with disabilities still experience high risk and prevalence of abuse, neglect, and maltreatment.

#### Minnesota Data

In Minnesota in 2014, more than 10 percent of the population (580,494 people) was identified as having a disability.<sup>2</sup>

- In Minnesota, children with disabilities experience abuse and neglect at much higher rates than their peers without disabilities. Although kids with disabilities are 4% of the under-18 population, they experience 25% of the cases of physical abuse, 15% of neglect, 20% of sexual abuse, and 45% of medical neglect.<sup>3</sup>
- According to the 2013 Minnesota Student Survey, students with disabilities reported that they were 50% more likely to experience sexual, physical, or emotional abuse at home.<sup>4</sup>
- In 2014, there were 35,877 reports of maltreatment of vulnerable adults in Minnesota.<sup>5</sup> Of these reports, the breakdown by type included 46.9% caregiver neglect; 23.3% self-neglect; 17.1% financial exploitation; 10.3% physical abuse; 10% emotional/mental abuse; and 3.2% sexual abuse.

#### National Data

According to the Department of Justice May 2015 report,<sup>6</sup> persons with disabilities experienced about 1.3 million violent victimizations in 2013. People with cognitive disabilities were targeted most

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<sup>1</sup> As defined in Minnesota Statutes 626.556, 626.557, and 626.5572. Abuse may include: physical, verbal, emotional or sexual abuse or financial exploitation. Neglect may include: failure to provide with necessary food, shelter, supervision, health, medical or other care required for the individual's physical or mental health.

<sup>2</sup> Minnesota Compass, Reports on Disability, 2014.

<sup>3</sup> Minnesota Department of Human Services, "Minnesota's Child Welfare Report 2014" (December 2015).

<sup>4</sup> Minnesota Department of Education, "Minnesota Student Survey 2013".

<sup>5</sup> Minnesota Department of Human Services, "Adult protection in Minnesota: Preventing Maltreatment of Vulnerable People over 18" (June 2015).

<sup>6</sup> U.S. Department of Justice, Bureau of Justice Statistics, "Crime Against Persons with Disabilities, 2009-2013 Statistical Tables" (May 2015).

frequently, and nearly a quarter of victims believed that they were targeted on account of their disability. Only half of these crimes against people with disabilities were reported to police, and the most common barrier to reporting to law enforcement was because it was “dealt with another way” (i.e. reported to a different official, dealt with internally, etc.). Forty-one percent of crimes against people with disabilities were committed by a casual acquaintance or someone they knew well.

- In 2012, the age-adjusted rate of violent victimization for persons with disabilities (60 per 1,000 persons with disabilities) was nearly three times the rate among persons without disabilities (22 per 1,000 persons without disabilities).<sup>7</sup>
- In 2013, people with disabilities made up 12% (37 million people) of people in the United States,<sup>8</sup> but accounted for 21% of all crime victims in the United States.<sup>9</sup>
- In the 2012 Survey on Abuse of People with Disabilities, from the Disability Abuse Project, more than 70% of people with disabilities who took the survey reported they had been victims of abuse.<sup>10</sup>
- Studies show that children with any type of disability are 3.5 times more likely to be a victim of abuse compared to children without disabilities.<sup>11</sup>
- It is estimated that approximately 5 million crimes are committed against people with developmental disabilities in the US every single year.<sup>12</sup>
- Due to the lack of available national data to show the scope of the problem of abuse and neglect of people with disabilities, the creation of systemic solutions through research, innovation, or policy has proven difficult for decades.<sup>13</sup>

## **PUBLIC COMMENTS**

The public also weighed in on the importance of this topic to the Olmstead Plan. Public comments were solicited from July 19 – August 14, 2016 on what should be included in Minnesota’s Abuse and Neglect Prevention Plan. Comments were received from eleven individuals and summarized below:

- There is concern about the disincentives and barriers of people with disabilities and their families to report incidents of abuse and neglect.
- There is a need for training for people with disabilities and their families on: the right to be free of abuse and neglect; what is abuse and neglect; how to report abuse and neglect; and risk factors.
- A lack of integrated health care with social services results in poor quality of care for people with disabilities.

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<sup>7</sup>U.S. Department of Justice, Bureau of Justice Statistics, “Crime Against Persons with Disabilities, 2009-2013 Statistical Tables” (May 2015).

<sup>8</sup> American Community Survey, 2015.

<sup>9</sup> 2013 Crime Victims with Disabilities Survey, Bureau of Justice Statistics.

<sup>10</sup> 2012 Disability Abuse Survey, Disability Abuse Project.

<sup>11</sup> Sullivan, P. M., & Knutson, J. F. (2000). Maltreatment and disabilities: A population-based epidemiological study. *Child abuse & neglect*, 24(10), 1257-1273.

<sup>12</sup> Petersilia, Joan. (2000). When Justice Sleeps: Violence and Abuse Against the Developmentally Disabled. Conference Presentation.

<sup>13</sup> Horner-Johnson, W., & Drum, C. E. (2006). Prevalence of maltreatment of people with intellectual disabilities: A review of recently published research. *Mental retardation and developmental disabilities research reviews*, 12(1), 57-69.

- There is a need to train law enforcement and other first responders on how to deal with suspected abuse and neglect of people with disabilities.
- There is concern about reporting of suspected abuse or neglect by a caregiver who the individual is dependent on for daily care and support.
- There is concern about individuals who seek hospital treatment for injuries suspected to be the result of abuse or neglect whose only choice is to return to the place where the suspected perpetrator lives or works.

Additional public comments were solicited from September 2 – September 11, 2016 on the draft report. Comments were received from three individuals and the comments are summarized below:

- There is concern about citing studies that are old. Reference studies that are more current.
- There is a correlation between mental illnesses, sexual abuse, and trafficking. The report should reference human trafficking.
- There is concern that families with a loved one with a mental illness may not have a place to seek support when their loved one may be in a vulnerable or unsafe situation.
- There were a number of comments on how to improve the Minnesota Adult Abuse Reporting Center (MAARC) or the child abuse reporting process. These were forwarded to DHS as they seemed pertinent to work being done at the agency level.
- There is additional concern about the need for people with disabilities and families to be educated to identify abuse and neglect, recognize the signs, and know what to do.

## Recommendations for a Comprehensive Abuse and Neglect Prevention Plan

### 1. Appoint Leadership Team

- A. The Subcabinet will appoint a Specialty Committee to oversee the Abuse and Neglect Prevention Plan. The composition is expected to include Subcabinet agencies and other state agencies. Other members may include individuals with disabilities and their families, university researchers, and representatives from non-profit agencies and law enforcement. The Chair of the Subcabinet will appoint all members and the appointees will have experience, responsibility or authority in this topic area or experience in leading or participating in prevention campaigns. The Subcabinet will approve the establishment of the Specialty Committee and a charter outlining the tasks to be completed.

As part of the Olmstead Plan amendment process, beginning in December 2016, the Specialty Committee will propose the timeline for establishing baselines and measurable goals and key strategies.

### 2. Review Minnesota and Other States for Best Practices

- A. Review existing prevention campaigns currently underway. Consider specifically including messaging on disabilities in those campaigns.
- B. Minnesota should examine the Office of Inspector General (OIG) reports from three states to identify lessons learned and determine if risk factors exist in Minnesota's system of reporting, investigating and taking corrective action.
- C. Review other states' prevention campaigns and prevention models currently underway to determine which ones are effective and could be adopted by Minnesota.

### 3. Involve People with Disabilities

- A. Create ongoing channels for gathering input and feedback from people with disabilities and their families, on the topic of abuse and to identify disincentives and barriers to reporting abuse/neglect and plans to remediate. Conduct surveys of other states to find best practices in involving people with disabilities.
- B. Establish a comprehensive public awareness campaign on the prevention of abuse and neglect to educate people with disabilities and their families. The topics could include education about their rights, how to identify if they are being abused, how to report abuse and how to get help if they are abused. Education could also include risk factors and preventative strategies. This campaign could be done in cooperation with public and private entities.

- C. Additional efforts should include expanding the person centered planning initiatives to include education on rights, how to identify if they are being abused, how to report abuse and how to get help if they are abused. Education could also include risk factors and preventative strategies.

#### 4. Build on Current Initiatives and Commit to Improvement

- A. Develop a public awareness campaign that includes:
- Target audience of people with disabilities and their families; state agencies and employees; advocacy organizations; providers; general public
  - Identification of risk factors and associated protective strategies
  - Information on prevalence of violence against people with disabilities as compared to the general population
  - Multiple communication channels such as:
    - Direct mail or other ways to reach people with disabilities and their families)
    - Agency Bulletins or other formal communication tools
    - Newsletters/events
    - Social media
    - Media (newspaper, television, radio, etc.)
  - Key messages that can be customized for the target audience and communication channel
  - Metrics to judge effectiveness of the campaign to determine if we are reaching the targeted audience and whether it changed people's behavior.
  - A cost projection for implementation of the campaign
  - Elements that ensure the campaign will be sustainable over time
- B. Examine existing prevention strategies to see which ones could be enhanced by specifically targeting people with disabilities.
- C. Begin discussion with state agencies (Minnesota Departments of Health, Human Services, Education, Corrections, and Public Safety), Minnesota Chiefs of Police Association, Minnesota Sheriffs Association, County Attorney Association and the state court system regarding establishing a multidisciplinary approach to address violence committed against persons with disabilities. The goal is to provide protection, treatment and continuity of care for persons with disabilities who are victims of a crime, to increase awareness of crimes being committed against persons with disabilities, to increase communication and cooperation between law enforcement, professionals, and agencies providing services to people with disabilities and to ensure that crimes committed against people with disabilities are reported promptly, investigated by trained law enforcement personnel and prosecuted.
- D. The Olmstead Subcabinet will monitor a work group convened by DHS to address the recommendations of the Governor's Task Force on the Protection of Children regarding consideration of centralizing a statewide child abuse and neglect reporting system in Minnesota. Consideration will include feasibility (recognizing federal requirements for timeliness of reporting) and cost.

## 5. Information Management and Data Systems

- A. Complete an annual analysis of existing reports of maltreatment from Minnesota Department of Education, Department of Human Services, and the Minnesota Department of Health and the Ombudsman for Mental Health and Developmental Disabilities. The analysis should identify trends of maltreatment that can be targeted for prevention activities such as advisory bulletins.

### Next Steps

As part of the Olmstead Plan amendment process, beginning in December 2016, the Specialty Committee will propose the timeline for establishing baselines and measurable goals and key strategies. The associated workplans will be developed within 60 days of the submission of the Olmstead Plan amendment to the Court. Each workplan will include specific activities to be completed, expected outcomes, responsible agencies, and timelines for completion.

For the components of the comprehensive abuse and neglect prevention plan that may require additional resources, the Specialty Committee will provide feasibility and cost projections to the Subcabinet.

In considering the recommendations on feasibility and cost projections, the Subcabinet will rely on:

- The Governor's Executive Order 15-03 which states "The Sub-Cabinet shall allocate such resources as are reasonably necessary, including retention of expert consultant(s) and consult with other entities and State agencies, when appropriate, to carry out its work" and
- The "Cross Agency Coordination of Legislative and Funding Strategies" section on page 115 of the June 1, 2016 Olmstead Plan which reads "Within each of the Topic Areas in this Olmstead Plan, there are activities described that are essential to the accomplishment of the outcomes described in the measurable goals. Each of these activities is subject to funding and policy directives that are the result of State or Federal appropriations and legislative and regulatory actions. In order for certain changes in activity to occur, it may be necessary for State agencies to propose and pursue statutory changes or regulatory waivers. It may also be necessary for State agencies to request authorization to redirect funding or to request additional funding in order to accomplish certain outcomes. The need for such statutory, regulatory and funding requests may become apparent as more and better data is available to analyze the outcome of the activities anticipated by the Plan.

The subcabinet will work to ensure the needs for statutory, regulatory, or funding changes that arise as a result of implementing the Olmstead Plan are fully considered as part of the biennial budget and legislative planning process."

## Detailed Information Supporting Recommendations:

Several items were reviewed in the development of this report to assist in the development of recommendations. The following includes a summary of the items reviewed, findings, and recommendations. The recommendations included below are grouped into categories and included in the recommendations section on pages 7 – 8.

### Minnesota Adult Abuse Reporting Center (MAARC) Public Awareness Campaign

- As of July 1, 2015, Minnesota moved to a single reporting system for reporting suspected maltreatment of adults by mandated reporters and by the general public. This consolidated system will make reporting more consistent and will allow for better data analysis and tracking trends of abuse and neglect. The single reporting system operated under DHS is called the Minnesota Adult Abuse Reporting Center (MAARC). MAARC includes a 24/7, 365 days a year, toll free phone number and a web application for mandated reporters.
- A Statewide videoconference training was held for health care and human services professionals, including mandated reporters on the use of the MAARC.
- A MAARC public awareness campaign began June 15, 2016 and included:
  - Dissemination of printed materials targeted to the public;
  - A videoconference for health care and human services professionals, including mandated reporters; and
  - Ongoing communication and dissemination of materials with key stakeholders, people with disabilities, families, and advocates.
- The public awareness campaign took 26 months to plan and implement.
- The estimated cost of the campaign was \$150,000 and was designed in cooperation with a private sector marketing company.

### Findings

The MAARC public awareness campaign was focused on implementation of the MAARC system and how to report, using the new system. The campaign was not designed to be a comprehensive public awareness campaign to educate people with disabilities and their families on the definition of abuse and neglect, their rights, risk factors, and protective strategies.

### Recommendation

- Establish a comprehensive public awareness campaign on the prevention of abuse and neglect to educate people with disabilities and their families. The topics could include education about rights, how to identify if they are being abused, how to report abuse and how to get help if they are abused. Education could also include risk factors and preventative strategies. This campaign could be done in cooperation with public and private agencies.

## Governor's Task Force on the Protection of Children - Final Report and Recommendations<sup>14</sup>

On September 22, 2014, Governor Mark Dayton issued Executive Order 14-15 establishing the Governor's Task Force on the Protection of Children. In March 2015, the Task Force provided the following recommendation regarding consideration of centralizing a statewide child abuse and neglect reporting system in Minnesota:

*DHS should work with counties, tribes and other stakeholders and experts to examine the possible development of a statewide child abuse and neglect reporting system creating one number with a system to route calls to the appropriate local child welfare agency. Local county and tribal child welfare agencies would be permitted to maintain practices for accepting reports of suspected maltreatment and the decision making authority on how to handle the reports would remain with counties. The statewide system should be able to route calls 24 hours per day, seven days per week, necessitating counties to have designees in place to accept calls outside of normal business hours. In designing this new system, the following items should be considered:*

- a) Creation of a steering committee composed of state, county, and community stakeholders as well as individuals with telephone experience.*
- b) Review of New York's and Colorado's statewide systems and outcomes to see if they have created greater quality in intake and screening leading to increased child safety.*
- c) Promotion of one 24/7 statewide child abuse reporting hotline with calls routed to the appropriate county or tribe.*
- d) Review for impact recording may have on a reporter's willingness to freely share critical information regarding a child and a family*
- e) Exploration of a "cloud" system for interactive voice response, call data, call recording, and consideration for data practices implications.*
- f) Accommodations for callers who do not speak English and accessibility for people who are deaf or have hearing impairments.*
- g) A public awareness campaign to promote the statewide hotline and reporting of suspected child maltreatment.*
- h) Central record-keeping and tracking of both "reports" and "inquiries".*
- i) Process by which counties can opt to have DHS or another county to receive reports and inquiries on their behalf.*
- j) Standardized training and certification for all staff prior to taking reports and inquiries.*
- k) Consistency in information gathering.*
- l) Adequate staffing and resources for counties and the state to implement the hotline, especially with anticipated increased reports with the visibility of a single state-wide number.*
- m) Continuous quality improvement: listening to audio taped calls and providing training, feedback, coaching to workers and supervisors.*
- n) System-side data collection.*
- o) State hotline administration/unit, help desk functions and escape features from automated system to talk to a live person.*

### **Findings**

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<sup>14</sup> <https://edocs.dhs.state.mn.us/lfsrver/Public/DHS-7057A-ENG>

It's important to note that a statewide child abuse and neglect reporting system is not a prevention strategy for abuse and neglect. Prevention of child abuse and neglect is an established field of study and practice consisting of efforts to promote child and family well-being, public awareness, creating supportive communities, and a cadre of evidence based best practices such as; home visiting, early childhood services, parent education, respite care, family resource centers, etc.

### **Recommendation**

- DHS will convene a work group to address the recommendations of the Governor's Task Force on the Protection of Children regarding consideration of centralizing a statewide child abuse and neglect reporting system in Minnesota. Consideration will include feasibility (recognizing federal requirements for timeliness of reporting) and cost. The Olmstead Subcabinet will monitor the progress of this workgroup.

## **Maltreatment Report: Vulnerable Adults & Minors Served by Minnesota Licensed Providers** <sup>15</sup>

The March 24, 2016 Legislative Report from Minnesota Department of Health (MDH) and the Minnesota Department of Human Services (DHS) presented findings about alleged maltreatment involving providers licensed by each agency. In addition, an interagency workgroup of MDH, DHS, the Minnesota Department of Education (MDE), Child Protection and the Ombudsman for Mental Health and Developmental Disabilities (OMHDD), met in 2015 regarding the tracking of maltreatment reporting.

### **Findings**

This interagency workgroup determined that the definitions for abuse, neglect and financial exploitation are similar based on Minnesota law. However, there are differences in how the agencies count the allegations of maltreatment and the outcomes of investigations. In addition, the information tracked includes the larger population of vulnerable adults in Minnesota, not just persons with disabilities.

### **Recommendation**

- Complete an annual analysis of existing reports of maltreatment from the Minnesota Department of Education, Department of Human Services, and the Minnesota Department of Health. The analysis should identify trends of maltreatment that can be targeted for prevention activities such as advisory bulletins.

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<sup>15</sup>[https://mn.gov/dhs/assets/Maltreatment%20Report%20%20Final%20With%20Plain%20Language%20and%20Access\\_tcm1053-202704.pdf](https://mn.gov/dhs/assets/Maltreatment%20Report%20%20Final%20With%20Plain%20Language%20and%20Access_tcm1053-202704.pdf)

## Existing Prevention Strategies Across Multiple Agencies

Minnesota already has many existing statewide initiatives for preventing violence, abuse, neglect, and injury. These initiatives, with sufficient resources, can be built upon for preventing abuse and neglect of people with disabilities. Examples of such initiatives include:

- The Minnesota Department of Health currently operates public health awareness programs to prevent injury and violence, and sexual violence.
- The Department of Human Services is currently engaged in a number of child maltreatment prevention efforts. Examples include the Parent Support Outreach Program which provides early intervention supports and services to children and their families who are at risk of child abuse and neglect and the Childcare Mental Health Consultation System which works to increase early learning staff awareness and competence in trauma, adversity, and early childhood and family mental health conditions
- The Minnesota Department of Education works to promote bullying prevention in all schools throughout the state.
- The Minnesota Department of Public Safety - Office of Justice Programs coordinates statewide programs for assisting victims of crime.
- The Ombudsman for Mental Health and Developmental Disabilities also works to track and investigate alleged cases of abuse and neglect of people with disabilities throughout the state.

### Findings

People with disabilities are not specifically identified as a target population in many prevention strategies sponsored by state agencies. Several local organizations have been working to build awareness of abuse and neglect and strengthen prevention programs throughout the state.

### Recommendation

- Review existing prevention campaigns currently underway. Consider specifically including messaging on disabilities in those campaigns. By embedding messaging about the intersection of disability and abuse into these existing campaigns, our state can work to build awareness around the existence of abuse of people with disabilities and be a catalyst for greater reporting and prevention of abuse and neglect.

## Other State's Experiences

- Massachusetts Disabled Persons Protection Commission Website<sup>16</sup>
- New York Justice Center for the Protection of People with Special Needs<sup>17</sup>

Two states have adopted comprehensive and integrated systems for preventing abuse and neglect of people with disabilities and they are Massachusetts and New York.

The state of New York administers its Justice Center for the Protection of People with Special Needs with the mission of "supporting and protecting the health, safety, and dignity of all people with special needs and disabilities." The Justice Center operates a 24 hour hotline for reporting abuse, wrongful deaths, or financial misconduct, and then conducts full investigations into reports of abuse, in collaboration with law enforcement.

In Massachusetts, Disabled Persons Protection Commission (DPPC), an independent state agency, has worked to investigate and remediate cases of abuse and neglect of people with disabilities since 1987. The DPPC operates seven interwoven units for reporting, education, outreach, and prevention:

- Hotline Unit (receives initial reports)
- Investigations Unit (investigates reports and develops protection plans for alleged victims)
- Oversight Unit (assesses risk levels, puts protective services in place, and reports and tracks abuse data)
- Legal Unit (provides legal guidance for DPPC staff and obtains protective orders for victims who are at immediate risk of harm)
- IT Unit (maintains the DPPC Abuse Database)
- Abuse Prevention Unit (provides training, education, and consultation to agencies and providers, and analyzes DPPC's abuse data for trends)
- State Police Detective Unit (responds to criminal complaints of abuse and neglect against people with disabilities; trains law enforcement)

### Findings

Massachusetts has:

- A single place to provide education and outreach to people with disabilities and their families on the issues of abuse and neglect and financial exploitation.
- Systematic tracking and reporting on the occurrence of abuse and neglect, and data analysis to target prevention efforts.
- Formal agreements between state agencies, law enforcement and county attorneys specifying each agency's role in a comprehensive abuse and neglect prevention strategy.

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<sup>16</sup> <http://www.mass.gov/dppc/>

<sup>17</sup> <https://www.justicecenter.ny.gov/abuse-prevention-resources>

## Recommendations

- Establish a comprehensive public awareness campaign on the prevention of abuse and neglect to educate people with disabilities and their families. The topics could include education about rights, how to identify if they are being abused, how to report abuse, and how to get help if they've been abused. Education could also include risk factors and preventative strategies. This campaign could be done in cooperation with public and private entities.
- Establish formal agreements between state agencies, Minnesota Chiefs of Police Association, Minnesota Sheriffs Association, County Attorney Association and state court system to utilize a multidisciplinary approach to address violence committed against persons with disabilities and identifies the specific role of the parties involved.
- Review other states' prevention campaigns and prevention models currently underway to determine which ones are effective and could be adopted in Minnesota.

## Department of Health and Human Services Office of Inspector General (OIG) Reports

The US Department of Health and Human Services Office of Inspector General began investigating Medicaid claims in hospitals due to abuse. They drew samples in three states and analyzed whether reporting abuse occurred according to federal regulations. The three states included:

- Massachusetts, July 2016 OIG Report<sup>18</sup>
- Connecticut, May 2016 OIG Report<sup>19</sup>
- New York, September 2015 OIG Report<sup>20</sup>

## Findings

The OIG found that both Massachusetts and Connecticut did not meet standards for reporting, investigating and taking corrective action when abuse occurred. For example, the state agencies did not meet the requirements for reporting and monitoring critical incidents because providers lacked adequate training. No exceptions were found in the New York report.

## Recommendation

The Minnesota Department of Health plans to launch a similar study of Emergency Room visits. Minnesota should examine the OIG reports from these three states to identify lessons learned and determine if risk factors exist in Minnesota's system of reporting, investigating and taking corrective action.

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<sup>18</sup> <https://oig.hhs.gov/oas/reports/region1/11400008.pdf>

<sup>19</sup> <https://oig.hhs.gov/oas/reports/region1/11400002.pdf>

<sup>20</sup> <https://oig.hhs.gov/oas/reports/region2/21401011.pdf>