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Testimony before the Senate Committee on Human Services, Children and Families
Senator André Jacque
October 14, 2021

Committee Members,

Adults with disabilities are 7 times more likely to be the victims of abuse, neglect, or exploitation. Senate Bill 395 will make a simple change to increase protections for adults with disabilities ages 18-59, whose abuse and neglect get reported to Adult Protective Services (APS).

Current state law requires investigation into any reports of abuse made to APS for Elder Adults (ages 60+). However, current statutes allow APS to decide not to investigate reports about adults with disabilities (adults-at-risk ages 18-59). This has led to complaints of abuse or neglect for adults at risk that don't get the review and attention they require and vulnerable people left without knowing if anyone will follow-up.

Senate Bill 395 will make the investigation requirements for adults-at-risk reports the same as the requirements for elder adult reports. SB 395 requires an adult-at-risk agency that receives a report, or has a reason to believe an adult-at-risk is a subject of abuse, financial exploitation, neglect, or self-neglect to respond by conducting an investigation. This investigation must take at least one action already specified in the law or refer the report to another agency for investigation.

Senate Bill 395 are supported by the Wisconsin Board for People with Developmental Disabilities, The Arc, and the Wisconsin Counties Association.

Thank you for your consideration of Senate Bill 395.

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Testimony before the Senate Human Services, Children, and Families Committee

SB 395

October 14, 2021

Thank you Chair Jacque, Vice-Chair Ballweg, and members of the Senate Human Services, Children, and Families Committee for holding this hearing on SB 395, relating to responses to reports relating to elder adults at risk (those persons age 60 and older) and adults at risk (those persons age 18-59). As explained in the analysis by the Legislative Reference Bureau, when a report is made where there is suspected abuse, financial exploitation, neglect, or self-neglect regarding elder adults at risk, the state statutes require an investigation to determine if the report has validity, and may determine whether the elder adult is in need of protective services.

Currently, when a report of abuse, financial exploitation, neglect, or self-neglect is made regarding adults at risk, the law states that an investigation "may" be done and the investigation is not required. People with disabilities are falling through the cracks. SB 395, a bill with bipartisan support, replaces the word "may" with the word "shall", which then requires an investigation of the report made regarding adults at risk, to include at least one of the actions specified in the current law, which are the same actions described for investigations related to elder adults at risk.

Over the last 7 years, the reports of abuse and neglect for people with disabilities have risen by 38%, and reports of abuse for elder adults have increased by 235%. Others will testify about specific incidences where reports were made, but not investigated, leading to frustration and confusion as well as continued abuse. With the moral fabric of society disintegrating and individuals having more and more difficulty using good judgement and recognizing right from wrong, it is even more important to codify the protection of vulnerable individuals, such as adults at risk. SB 395 creates parity with adults at risk and elder adults at risk. It creates one system for mandatory investigations of abuse, financial exploitation, neglect, or self-neglect.

You may notice this technical fix is being requested without additional funding. Many county Human Services Departments across Wisconsin already take reports regarding adults at risk seriously and investigate them. They do this without additional funding because they care about these individuals and do their due diligence to protect them. The departments fit this into their

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Adult Protective Services budget, adding county tax levy to APS dollars from DHS which have been inadequate for many years. The last increase in funding for APS was in 2006.

This technical change in the state statute plans for the future. Others will speak regarding possible funding for the immediate future, but plans are for a request for additional APS funding in the next biennial budget to support investigations due to the increased percentages of reports. The second reason for requesting this technical change is to show adults at risk and their families that these reports are taken seriously. In the counties where these reports are not investigated, by demonstrating the seriousness of the reports with codifying the requirement, there is hope that these departments will begin investigating reports of abuse, financial exploitation, neglect, or self-neglect against people with disabilities and will not neglect to do so.

SB 395 begins the investment in the State's Abuse and Neglect reporting system that protects Wisconsinites with disabilities. Future investments will occur with an increase in funding for Adult Protective Services.

Thank you for your kind attention, and for your support of this technical change in the Statute.

LIVING WELL
Healthy, Safe and Connected

A PROJECT OF
Wisconsin BPDD
WISCONSIN BOARD FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

To: Senate Committee on Human Services, Children and Families

From: Sally Flaschberger, BPDD-Wisconsin Living Well Project

RE: SB 395

My name is Sally Flaschberger and I am the lead for the Wisconsin Living Well project with the Board for People with Developmental Disabilities. The Wisconsin Living Well project supports SB 395. We are extremely grateful for holding a hearing and to Senator Jacque for being a lead on this bill.

Wisconsin is one of eight states to get a five-year federal grant to improve community monitoring and prevent abuse, neglect, and exploitation. Disability advocates--including the Waisman Center, Disability Rights Wisconsin, and The Arc Wisconsin—are working with Wisconsin Long-Term Care organizations, service providers, and the state to prevent abuse and neglect while also improving the response.

We have seen that incidents of abuse, neglect, and exploitation of people with disabilities are often unseen, unreported, and unaddressed. Even recognizing that many cases go unreported, in 2020, the Wisconsin Department of Health Services reported 52% of abuse or neglect cases involved people with I/DD or physical disabilities.[1] Nationally, people with intellectual and developmental disabilities (I/DD) are up to 7 times more likely than people without disabilities to be victims of abuse[2]. People with I/DD are more reliant on paid staff and family members to help get basic needs met. They also often cannot communicate as effectively about things that have happened to them, and are less likely to be listened to. During COVID, increased risk for abuse and neglect includes higher levels of social isolation, lack of privacy, increased staff stress and overall shortages of staff available.

During the last year, the Wisconsin Living Well team worked with state agencies, experts in Wisconsin's Adult Protective Services system, professionals in our long-term care system, as well as families and people with disabilities. As part of that work, we learned there is inequity in the statutes that require investigation of claims of abuse, neglect, and financial exploitation. Currently, County APS must investigate ALL claims of abuse for people over 60. But for people with disabilities, known as Adults at Risk, County APS has discretion whether to investigate similar reports. In 2020, DHS reported statewide, 316 cases or 14% of reports adults at risk were not accepted for investigation. The data on why these investigations are not accepted is not available in the annual reporting but raise concerns that some cases that should be investigated may be denied. This bill makes a simple change to the

[1] Wisconsin's Annual Report on Abuse, Neglect, and Financial Exploitation of Adults at Risk: 2020. https://www.dhs.wisconsin.gov/publications/p00123-20.pdf

[2] National Core Indicators

statute to treat both vulnerable populations equally in the statutes and in turn provide greater protections for people with disabilities in Wisconsin.

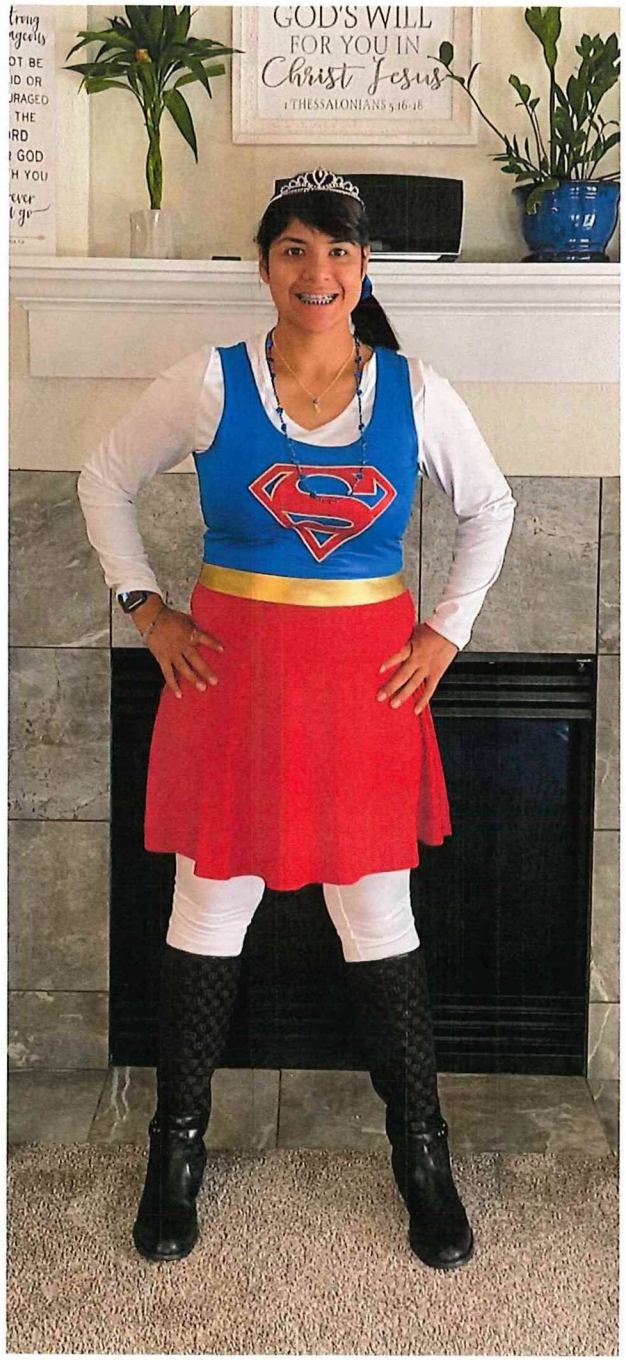
Why is this small change so significant? Our Living Well team frequently interacts with self-advocates, families, service providers, and long-term care organizations and they report concerns and examples about abuse report not being investigated. Self-advocates and families report contacting county APS and no action was taken. In many situations, a determination that the intervention of a family member, guardian, or service provider to provide immediate safety is deemed sufficient and so further investigation is not pursued. Without investigating each report, it becomes difficult to identify repeat offenders as well as prevent additional abuse of a person who has experienced trauma and has not seen the system respond.

The legislative fiscal bureau provided data that current state funding for County APS is $7 million of the $30 million needed to operate the system. Despite a 38-percent increase in reports of abuse and neglect for people with disabilities in the past 7 years, APS has had no increase in funding since the original statute was put in place over 15 years ago. Many APS units report they investigate all reports of abuse they receive, but the current funding is wholly inadequate to address the increasing numbers.

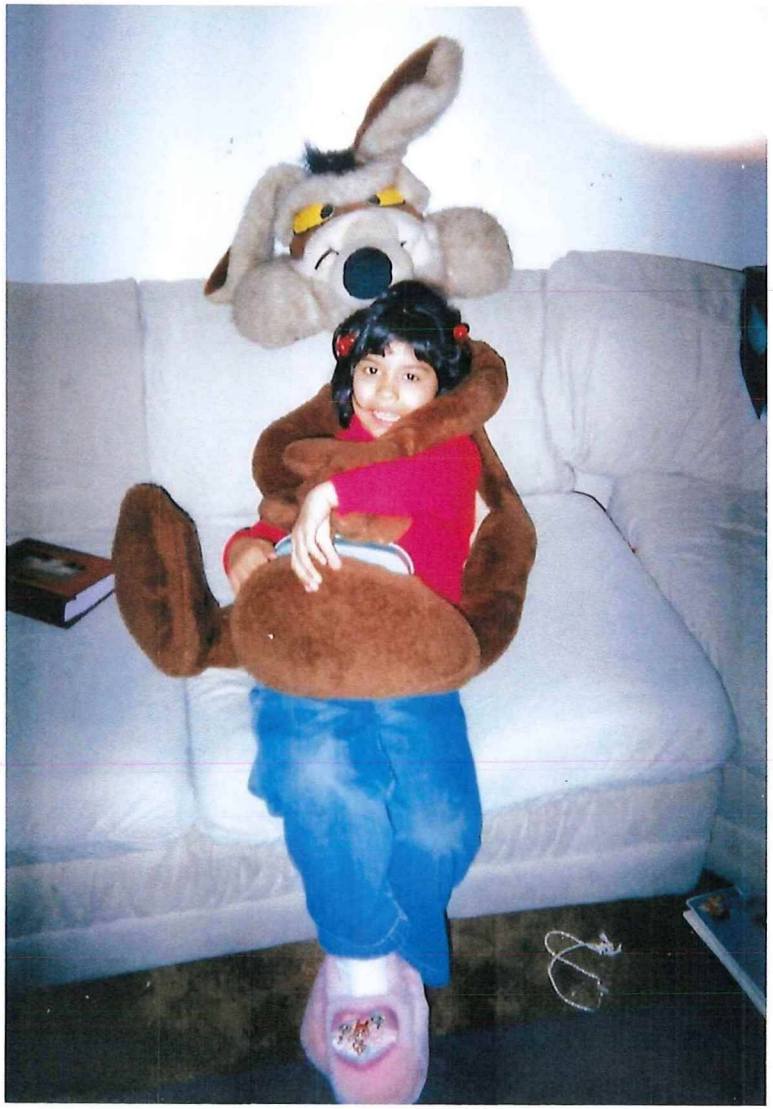
During the state budget process, legislators, people with disabilities, and other advocates requested an additional $1.9 each year of the biennium to cover the 38% increase in reports of abuse against people with disabilities. Ultimately, this budget motion request was not included.

While significant investments in the current APS system are greatly needed, especially in light of the increased risks created by the pandemic, the changes identified in this bill are a first step. The language change would ensure that people with intellectual and developmental disabilities are assured the same response and investigation as older adults when a report is made and creates equity between the requirements for the Adult Protective Services for Adults at Risk and Elder adults.

Thank you.



Alex 26 years old



Alex at 8 Years Old

Hello,

My name is Sandra Lomeli. I am here to share my daughter's story of abuse and our experience with Adult Protective Services. We hope that by sharing our story you will see why it is imperative to pass AB400 and change the verbiage from 'may' investigate to 'must' investigate.

This is a picture of my daughter Alex. She is 26 years old. According to several neurologists at ProHealth care and the Waisman center, Alex is cognitively 8 years old. Although her body will age. Her mind will forever remain a child.

On July 12, 2020, at 9:15 Alex disclosed to me that she was being sexually assaulted by my then husband. Her stepfather. The man who helped me raise her for 13 years. The man she called dad.

We were on our way to church at the time. I immediately met with the Senior Pastor at church he along with his wife questioned Alex and believed her story to be true. He helped to have my husband removed from our home. Within days I took both my adult disabled children and moved from our home in Milwaukee to Waukesha where my family and natural supports live. I didn't want her to further suffer and relive the nightmare by sleeping in the same room for the abuse occurred.

Only July 17, 2020, after reaching out to my daughters IRIS team, I called Adult Protective Services in Waukesha, where a recording advised me to leave my name and number someone would call back within 24 hrs. Two days later I received a call back only to be advised that they could not help us. As the abuse occurred in Milwaukee, I would need to call Milwaukee APS. I called APS Milwaukee and left a voicemail. When I finally received a call back from Milwaukee APS, I was advised that they could not help me as I no longer reside in their county. This volley of phone calls continued more than 8 times between July 20, 2020, and August 8, 2020.

On August 12, I received a call from an agent with Milwaukee APS. The call quickly turned into interrogation on me. The agent proceeded to question my character as a mother and as a human being. Scolding me for contacting them and not law enforcement. She advised that it was not their job to look into this. That is for the police to do. As I pleaded my daughters case reminding the agent of my daughter's cognitive level, I was reminded it's not APS job. All they do is make sure she is not in harm's way. Please keep in mind this was the first call where someone spoke with me more than 1min. And at no time did anyone ask of my daughter's well-being. Let alone even ask to speak with her directly. The agent took only the verbal information that we were not currently residing in the same house as my daughter's abuser. That information was as enough for Milwaukee APS to determine that no action was needed on their part. When I inquired as to what department with the police I should call. I was told 'you do know how to dial 911 don't you?'

In parallel to my many attempts to work with APS, my daughter's new IRIS nurse, her case manager and the case managers supervisor sent several referrals over to Milwaukee APS. After finally escalating to Madison, I received another call from Milwaukee APS. A different agent this time. She took our information and advised that most likely nothing will be done. That APS relies solely on law

enforcement to investigate and if they find anything and report back to APS. Then and only then will APS step in to assist.

Prior to my filing for a restraining order. My ex-husband was opening 'confessing' his sin to several people. His family, friends, the Senior Pastor at our church as well as multiple men's recovery groups. All individuals that have strong viewpoints and believe that social services should be the front line in the community. Not law enforcement.

Between July 20 and September 30, 2020, I reached out to APS in Madison, Milwaukee, and Waukesha more than 18 times. It wasn't until my last call in September of 2020 that I learned that a case was opened and closed on the same day. August 18, 2020. Noting no further action was needed.

If a person in the community such as her physician, his therapist, or group counselor did try to reach out to APS to provide them information about my daughter's case, awareness of his confession, anything. The information would never be recorded as the case was closed. Therefore, leaving nothing for law enforcement to use if they needed.

In reaching out to a fellow advocate I learned about Milwaukee Sensitive Crimes. Their team actively embraced my daughter and did everything they could to support her case. Sadly, like many developmentally disabled victims. Her abuser was never prosecuted. He is actively out in the community. Free to do as he pleases with no record of what he has done.

I wholeheartedly believe, that if APS would have pursued an investigation from a social perspective, they too would have clearly seen that the abuse occurred. They would have been able to gain key information from those in her environment (family, friends, neighbors, the church) that would have been given the judicial system what was needed to pursue charges that could have resulted prosecution.

According to Wisconsin's Annual Report on Abuse, Neglect, and Financial Exploitation of Adults at Risk: 2020 the majority of the incidents 'reported', I put 'reported' in quotes as I know in our case it took multiple calls, escalations from several people before APS even entered our case into the 'incident reporting system'. The majority of cases reported are of individuals with developmental disabilities between the ages of 18 and 40 that reported to have been sexually assaulted by someone they know. That of those cases more than 50 % had previously reported the abuse multiple times. Yet according to the report, NO action was taken. No services provided.

My daughter's case was one of the few that made it into APS reporting system. Like the other cases, my daughter's case was deemed as not warranting an investigation. She didn't even warrant a direct conversation to see if she was ok. Physically, emotionally, psychologically. To date. APS has never communicated with her.

Alex was once a vibrant, social butterfly that was going to school and had hopes of living on her own with community supports. She was a role model participant in Project Search at ProHealth care and

was awarded one of the top individuals of the program. She was on track to achieve her goal to be 'independent' by summer of 2022.

It has been over a year since my daughter disclosed of the abuse that she had been enduring for more than 4 months. The once happy go lucky extrovert is now reserved, anxious, fearful. She has panic attacks several times a day. She is in therapy several times a week and still has trouble sleeping at night. We have a home security system and several cameras so she can see if someone comes near her room. A panic button within reach next to her bed that will set off the alarm and immediately notify local police. We have an on-going active relationship with our local law enforcement who have come by on several occasions to re-enforce that she is safe and that they will protect her should anyone try to harm her. Yesterday we went to the bowling alley for Special Olympics. We have to get there when they first open up so no one is there. The entire time she looks around in panic, fear that he will show up. Things that once were carefree and full of joy and laughter. Now are done in haste, forced smiles with a sprinkle of giggles in between. She is most comfortable when we leave the state. Then and only then does she have a bit of sense of 'safety'. Her dream of being on her own, well, it's still a dream.

She wants to have a life. She wants to live. But for now, it's a life in the shadow of fear. We are working on independence and safety skills. But the trauma is deep, and the healing will take a lifetime. Afterall, who can we trust? Who can SHE trust?

The man who swore to love, honor and protect that has violated my daughter and betrayed our family.

The pastor who stands up at the pulpit every Sunday preaching the Word of God, who later refused to disclose that he was present during my ex-husband's confession to police.

The agency that's very title is Adult PROTECTIVE Services. The same agency that is widely promoted and encouraged as a KEY resource for help. Didn't even ask to hear her voice to see if existed let alone if she was 'okay'.

People with developmental disabilities long to live in the community and be an active member in society. My daughter is no exception. Agencies like Adult Protective Services were created to help a person like my daughter. When harm happens, they are supposed to help. To provide protection or at minimum verify that the individual is not being harmed. The reality is, they are not even recording incidents unless they receive a dozen phone calls.

Adult Protective Services should not be given an option. If a person calls reporting abuse, an investigation MUST be conducted. For the sake of the individual at risk, as well as for the safety of the community.

I pray that you will move forward to pass AB400
Thank you

Wisconsin BPDD

WISCONSIN BOARD FOR PEOPLE
WITH DEVELOPMENTAL DISABILITIES

October 14, 2021

Senate Committee on Human Services, Children and Families
Sen. Jacque, Chair
Wisconsin State Capitol, Rm 7S
Madison, WI 53707

Dear Sen. Jacque and members of the committee:

The Wisconsin Board for People with Disabilities (BPDD) supports SB 395, which makes a technical change to make sure reports of abuse are equally investigated regardless of a person's age. Current law required Adult Protective Services (APS) to investigate reports of abuse for adults 60 and over but allows counties discretion on whether to investigate reports of abuse for people ages 18-59 living with disabilities, known as Adults at Risk. SB 395 requires equal investigation of abuse and neglect reports.

Wisconsin is one of eight states that has received a federal grant to test evidence-based approaches and make policy recommendations to decrease the risk of abuse, neglect, and exploitation. My colleague Sally Flaschberger manages the Living Well grant and here to talk about some of the early findings. The bill in front of you today is one initial policy recommendation.

During BPDD's work we have heard many people with disabilities, family members, and concerned providers recount incidents of abuse and neglect of individuals; many times, they have gone unreported or unaddressed by our systems.

Many people with disabilities experience power and control dynamics that are an integral part of abuse and neglect. Unequal power dynamics may occur between people with disabilities and paid providers and caregivers, medical professionals, and family members. Fear of losing the supports they rely on is a powerful motivation for people with disabilities to stay silent if there is threatening or abusive behavior, including restriction choices about their own lives, opportunities to make decisions, access to finances, access to communication devices, delay or failure to provide daily cares, etc.

The reasons why people with disabilities are at an increased risk for abuse and neglect are known--social isolation (lack of relationships beyond paid staff), social stigma, lack of privacy, staff stress and lack of training, lack of control/decision making in their lives, significant dependence on others, lack of community participation, and ignorance of their rights—are predictive of abuse[1], and are all too common in many people with disabilities' daily lives.

Attitudes and expectations of people with disabilities contribute to a lack of recognition when abuse is occurring (including the victim not identifying when they are being mistreated), underreporting, and a lack of tools that can help social service, victim service, and law enforcement, and the general public effectively respond to and stop abuse.

[1] National Core Indicators.

Wisconsin Board for People with Developmental Disabilities
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BPDD stresses this needed legislation is one of many steps that Wisconsin must take to better prevent and respond to abuse and neglect of people with disabilities. The Living Well grant has identified initial recommendations including the following, and we anticipate there is much more to be done in this arena:

- New incident management system in DHS that would include Adult Protective Services (APS), Division of Quality Assurance (DQA), and Division of Medicaid Services (DMS) that would provide real-time tracking and trending
- Greater oversight of 1-2 bed Adult Family Homes (AHF's)
- Expansion of the caregiver misconduct registry
- A hotline for people to report abuse and neglect
- Public awareness campaign on reporting abuse and neglect
- Education and training for self-advocates, families and guardians, and professionals on recognizing abuse and neglect and how to report.
- Ensuring people with disabilities understand their rights and have a mechanism to appeal when rights are denied
- Increasing the capacity for APS to investigate reports

BPDD is charged under the federal Developmental Disabilities Assistance and Bill of Rights Act with advocacy, capacity building, and systems change to improve self-determination, independence, productivity, and integration and inclusion in all facets of community life for people with developmental disabilities[2].

Thank you for your consideration,

Beth Swedeen

Beth Swedeen, Executive Director,
Wisconsin Board for People with Developmental Disabilities

[2] More about BPDD https://wi-bpdd.org/wp-content/uploads/2018/08/Legislative_Overview_BPDD.pdf .

To: Senate Human Services, Children and Families Committee

From: Karyn VanRyzin, Parent/Guardian

Thank you to the committee for holding a hearing on this important issue.

My name is Karyn VanRyzin. In my professional life I am the Director of a non-profit group child care center. In my personal life my husband and I are parents of four. At 32 years old, David is our oldest. David joined our family through the foster care system when he was 8 years old. David has Down syndrome and autism in his list of diagnoses. These result in cognitive, medical, and mental health challenges. David also has a history of early childhood trauma which continues to impact him in adulthood. While David is very talkative and loves silly talk and comedic routines, as a result of his cognitive disability and his autism, he is not able to relay information in a way that is easily understood.

David lives in an adult family home with one other man. The program has one on one staffing for each resident for the daytime and an awake staff person during the night time hours. The provider is a well-known and well regarded provider by managed care organizations and other providers. The placement was a result of his previous provider's decision to close the day and residential program that served David. David sees no one outside of employees of the provider on a daily basis. As with all providers they have struggled with staffing prior to and throughout the pandemic. David and our family had no choice in his living arrangement or house mate, this was the only bed open when his previous program gave 30 day notice.

The reason I am here today is to speak about our personal experiences with abuse and the reporting of possible abuse and/or neglect for an individual with David's challenges, his age, and the living arrangement he is in.

On a Friday at our home in the summer of 2020 I discovered a hand print on David's back. David wasn't able to tell me what had happened. I assumed it was caused by his housemate and worked to follow up on reporting and management of aggression in the home. On Monday morning, before I addressed the hand print, I was informed by a supervisor of the program that a casual call staff, someone who was filling in at the program, had reported what she felt was abusive behavior toward David on the part of a co-worker. The information provided to me was that the 6 foot tall man told my 5 foot tall, 120 pound son to "sit his ass down" when he approached the kitchen for a snack. When David urinated in his pants (a stress response by David) the staff person approached him while crushing a water bottle in his hands in a threatening manner. While mopping up following the urination, the staff person then shoved the wet mop into our son's lap in a mopping motion. The reporting staff did nothing to stop the abusive staff actions, rather reported the observations after the shift was complete. Rather than agreeing to be interviewed about the incident the accused employee quit on the spot and that was the end of the investigation. The program's supervisor notified me that their investigation determined that emotional and verbal abuse had occurred. This information was also

reported to the managed care organization that is responsible for David's case management and oversight of the program.

The hand print on David's back was never investigated. While no one had seen any aggression between the two residents that would account for the bruising, there was no investigation within or outside of the program. The program did agree to start doing daily body checks on David during his daily personal care routines.

Approximately a month later we got another call. This time it was the supervisor reporting that David had a scrape on his leg and a hand print on his buttocks. They reported that David stated a specific staff person's name in relation to the injuries. After the program supervisor determined that physical abuse had occurred and whom the abuser was, the police were called and a report was filed. The police were unable to effectively interview David due to his disability and his trauma from the incident. The staff person that it is believed abused David worked alone with David and his non-verbal house mate for over a year.

To my knowledge David was never interviewed or had these incidents investigated by people trained in abuse or neglect. Adult protective services was never contacted by the residential provider, managed care organization, or the police. The only consequence to the perpetrators is that one abuser is on probation for 2 years of disorderly conduct and then his record will be cleared. No one doing due diligence will ever be able to find out about these incidents. Due to privacy rules I have no idea of any possible abuse of other program residents nor would the managed care organization unless it was one of their clients. We don't know if this was the only abuse that occurred in this program or if there was a climate of abuse occurring.

In my field of early education and care we are required to notify child protective services at the first sign of abuse or neglect. We are taught that only those trained in the field of protective services should be interviewing potential victims and determining if abuse has occurred. We are trained that questioning possible victims can taint the case moving forward. In child care we are considered mandated reporters. Reporting suspected abuse to a supervisor is not considered sufficient reporting to be in compliance with the law. Our son was not given the protections that we give children and the elderly. Please pass this legislation and provide sufficient funding so that our son and others can have the same protections as others.

Thank you for your time.

HO-CHUNK NATION LEGISLATURE
Governing Body of the Ho-Chunk Nation

Written Comments
SB Bills 395, 402, 491, 601
Wisconsin State Senate
Committee on Human Services, Children and Families
October 14, 2021

Thank you, Senator Jacque and the Committee on Human Services, Children and Families, for accepting these written comments from the Ho-Chunk Nation Legislature on a set of bills that will have an impact on tribes, tribal children, and tribal families.

> *"The fundamental constitutional right to family integrity extends to all family members, both parents and children." O'Donnell v. Brown, 335 F.Supp.2d 787, 820 (W.D. Mich. 2004), citing Wallis v. Spencer, 202 F.3d 1126, 1136 (9th Cir. 2000). The "right of a child to be raised and nurtured by his parents" is "fundamental. . ." Brokaw v. Mercer County, 235 F.3d 1000, 1019 (7th Cir. 2000).*

SB 395 – Responses to reports relating to adults-at-risk and elders

- **Support Bill**

For years, staff at the Ho-Chunk Nation could not understand why the requirement of investigating reports of neglect, abuse, and exploitation of adults-at-risk and elders was never mandatory, as it is for children. Ho-Chunk pays tremendous respect and reverence to our elders. They are proof that even through the most traumatic experiences, we will be resilient and continue the traditions and culture on to future generations.

As such, changing the requirement to complete an investigation after receiving an intake from a "may" to a "shall" is greatly supported by the Ho-Chunk Nation. This is an important step towards ensuring that that tribal elders and adults-at-risk are better protected.

SB 402– Creating foster parent bill of rights

- **Oppose Bill**

The ambiguity of SB-402 presents opportunities for foster parents to be errantly raised to the level of party status and on the same footing as a biological parent. The purpose of foster care is to provide a temporary home to ensure a child's safety while biological parents are provided support and services to develop the necessary protective parenting capacity needed to ensure their children's safety. Foster parents play an important role in providing this safety, but the primary goal is and should always be – except in those very rare and statutorily expressed egregious circumstances –

reunification. To lose sight of this creates imbalance that will circumvent a biological parent's constitutionally protected fundamental right to parent and a child's constitutionally protected fundamental right to be with their parent.

Tribal attorneys are in a unique situation in that many have participated in contested hearings/trials in states where foster parents are granted party status. They have experienced firsthand how this imbalance negatively affects biological parents, but it also creates an imbalance as it pertains to the rights of Indian Tribes and Indian children established by the federal and Wisconsin Indian Child Welfare Act (ICWA/WICWA). For Tribes that do not have the financial ability to fight the cases themselves or find local counsel in states where pro hac vice is too difficult or denied, it creates an insurmountable barrier to protecting their actual party status rights when facing legal attacks by foster parents.

Further, there is serious concern with language that proposes to create a preferred placement upon reentry. This is in direct conflict with ICWA placement preferences (unless the family was initially a preferred ICWA placement- but ICWA placement preferences already provide that potential protection if the family is still available and willing to take placement). ICWA/WICWA's placement preferences apply at reentry, just as they did when the first case opened/first removal occurred. A county social services agency has an ongoing duty up until the date of reunification/closure or termination of parental rights to provide active efforts, which includes seeking family members for placement and/or support. *Again, an ongoing obligation to continually seek out placements that meet ICWA/WICWA's statutory placement preferences through the entirety of the case, and every case thereafter.*

One of the most important parts of ICWA/WICWA is the establishment of standards that require that Indian children be placed in foster care, pre-adoptive, or adoptive placements that reflect the unique values of the Indian child's tribal culture. It is not enough that a non-Indian couple takes a child to a pow wow. Pow wows are, often, simply intertribal social gatherings. They are not necessarily a place in which to fully learn a particular tribe's culture- principally language and tribal roles. These types of learnings are only established through placement within one's tribal family, clan, or other tribal family.

It should never be forgotten when addressing the placement of Indian children, that Wisconsin unanimously voted to create a best interests of an Indian child standard. Wis. Stat. § 48.01(2) clearly sets forth that the best interests of an Indian child is to be placed "in a placement that reflects the unique values of the Indian child's tribal culture and that is best able to assist the Indian child in establishing, developing, and maintaining a political, cultural, and social relationship with the Indian child's tribe and tribal community."

Lastly, there are built in protections within ICWA and WICWA that allow for an adoption to be overturned if it is found that a parent consented to a termination of parental rights, but did so through fraud or duress. This can happen up to two (2) years later. Further, a case can be invalidated if the minimum standards set forth in ICWA are not complied with. That is why Tribes always push for ICWA/WICWA compliance. Simply put, do it right from the beginning and you will not have to redo the whole thing causing additional trauma to a family.

Sometimes other parties think we "don't care about children" because we push for compliance that can result in changes in placement or invalidation of cases. In fact, we love our children that much, which is why we push for compliance. Our children deserve a chance to be

reunified with their parents. In order for our families to have a chance, the minimum standards must always be complied with.

It is not the Tribes that cause changes of placement and invalidation of cases through ICWA. Failing to comply with ICWA standards is what leads to invalidation of cases.

SB 491 - Subsidized Guardianship Payments

- **Support Bill**

  As to the Amendment, the Nation is less concerned with who makes the payments, and more concerned with the need for increased appropriations and infrastructure for these valuable forms of permanency to be utilized more often across the state.

The reason we submit our support for this bill is that by removing the Subsidized Guardianship language from the beginning section, it should free up some money for tribal high-cost pool needs. It is our understanding that the subsidized guardianship monies are skimmed off the top first by the counties. By removing subsidized guardianship from this section, it should return the high-cost pool to what it was meant to be- just a high-cost pool.

However, we would like to take this opportunity to stress the importance of subsidized guardianships, particularly for the Ho-Chunk Nation that has an expansive traditional kinship system. Many Tribes prefer guardianship as the primary permanency option, as opposed to adoption. This is particularly true for the Ho-Chunk Nation. The Ho-Chunk Nation does not support the permanent severance of parental ties, and as such explicitly bans the use of termination of parental rights in tribal court and likewise does not support such in state courts.

Guardianship ensures parents' rights are not severed and leaves the door open for parents to come back once they get back on their feet. This is important because addiction typically prevents reunification within the 15-to-22-month timeframe set forth by the Adoption and Safe Families Act (ASFA). Therefore, this is a helpful tool to support families in reunifying once a parent can overcome their addiction. Due to the historical trauma inflicted upon tribal peoples, there is unfortunately a high rate of addiction within our communities. However, extended family members or tribal members can at times step in and provide the safety, love, and support to not only the children, but to their parents as well. Thus, nurturing the traditionally communal system of raising of a child through extended familial and clan relationships.

Some counties have pushed back on subsidized guardianships because some of those funds come from the county's coffers. Therefore, some of the smaller and poorer counties have claimed in the past to not have the funding to utilize subsidized guardianships when they are needed and appropriate. Whether the funding comes directly from DCF or through appropriations to the counties from DCF, does not matter as much as the need for more funding for these important forms of permanency. This aligns with the goals of the Family First Prevention Services Act, that being to increase and promote familial placements when a child cannot remain safely within their home after preventative services are exhausted.

While one of the main goals of the 2018 federal Family First Prevention Services Act is to ensure children can remain safely in their homes and avoid unnecessary removals, it recognizes that there will at times be a need for necessary removal. In that event, the counties should be looking

towards identifying kinship/relative caregivers instead of foster homes to which the children have no relation to. If children are appropriately placed with kin in the event of removal, and a case needs to progress to permanency, then subsidized guardianship is the ideal form of permanency.

SB 601 – Duty to participate in an appeal of order terminating parental rights

- **Neutral**

While the Ho-Chunk Nation does not support termination of parental rights, this bill makes sense on its face. We have not seen or heard of this being an actual issue. As such, it certainly does not seem to be a widespread issue that requires any sweeping change. However, while we never support termination of parental rights, we stand mute and will not actively oppose this bill.

Conclusion

We say it every time we present comments, but it is because it holds that much truth and meaning to tribal peoples. As such, our final words are as they should always be:

There is nothing more important to a tribe than its children.
They are our future,
and they will ultimately be the links to our past.

And because we have the added topic of adults-at-risk and elders, we would be remiss to not mention again the reverence we have for our elders.

Equally important to a tribe are its elders.
They bring us the knowledge of our past,
and they will ultimately be what continues to make us resilient into the future.

Thank you for taking the time to listen to how these bills will impact our tribal community. We would be happy to meet with any legislator to answer questions or elaborate on any information provided herein.

People First Wisconsin

See Our ~~dis~~Ability

10/14/2021

To: Senate Committee on Human Services, Children and Families

From Cynthia Bentley, Executive Director, People First Wisconsin

My name is Cynthia Bentley and I am the Executive Director of People First Wisconsin. People First Wisconsin is a statewide advocacy organization. We advocate for the rights of people with disabilities and without disabilities. We do not believe in segregated places and we support people living and working in their communities.

I lived and was abused at the State institution so I know what it is like to be abused. I also have friends who have been abused. Abuse happens to people with disabilities. When we talk about abuse, it is not just sexual assault but is also neglect and financial abuse. More people with disabilities are abused or neglected and you might not realize how many.

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I have helped people with disabilities who have been abused or neglected. Our office got a call from a person and I reached out to Milwaukee County Adult Protective Services and gave them all the information. It was reported and another advocate went to the person's house to check on the person. The person said there were bars on the window and the person wasn't allowed to use the phone. The county was not able to tell People First whether they had followed up with the person. It was a life-threatening situation. I also called the police to report the situation. The person was threatening to kill herself or staff. No one was listening to her. The experience with the county was not very helpful and because of that experience I would not recommend people call there for help.

It is very difficult for people with disabilities to report abuse. The system needs to be easier for people to report. People who can't talk can have difficulty telling people what happened to them. Adult Protective Services needs to investigate even when people have a hard time telling them what happened. They need to be held accountable and these are people's lives. They need to investigate all calls until they get the facts until it is solved. My experience has made me not want to call them again or recommend someone call them.

disabilityrights WISCONSIN
Protection and advocacy for people with disabilities.

Written Testimony in Support of SB 395
Senate Committee on Human Services, Children & Families
October 14, 2021
Mitchell Hagopian, Attorney

Disability Rights Wisconsin is the designated Protection and Advocacy System for people with disabilities in Wisconsin. A major part of our charge is to protect our constituencies from abuse and neglect. DRW also houses a Victim Advocacy Program that works directly with survivors of crime with disabilities across the state. In that work we regularly work with adult protective service agencies and law enforcement agencies when our clients experience abuse or neglect. We strongly support SB 395 because it will ensure that all allegations of abuse and neglect of at-risk-adults will be investigated. Current law permits adult protective service agencies to decide on a case-by-case basis whether an investigation will occur. Of necessity, this means that some reports do not get investigated.

Our experience with abuse and neglect of at-risk-adults is, sadly, significant. We do our own investigations of abuse and neglect when we learn of incidents where we do not believe the service system (APS, CPS, DHS, DCF and/or Family Care MCOs) has responded effectively. In addition, our victim advocacy program regularly engages with law enforcement in support of victims of abuse and neglect.

We regularly monitor the Department of Health Services' Division of Quality Assurance's monthly release of "statements of deficiency" for the community-based facilities it regulates. [1] Many of these deficiencies are instances of abuse, neglect or serious rights violations of at-risk adults. Unfortunately, the sheer volume of these deficiencies has risen dramatically since the DQA has resumed in-person surveys following the initial wave of COVID. For example. In December of 2020 (when DQA had suspended regular surveys of facilities) DQA reported 67 statements of deficiency related to 59 facilities. In June of 2021 those numbers were 316 and 209, respectively. Based on our preliminary review of the June data, at least 8 facilities were cited for serious abuse or neglect of their residents. These results show that if you don't investigate abuse and neglect you don't find it. That doesn't mean it isn't happening.

And the type of abuse or neglect that is occurring is highly disturbing. Here are two examples from DQA's June release:

[1] DQA regulates community-based facilities with more than 2 beds. Facilities with 1-2 beds are overseen by the managed care organizations that serve the Family Care long term care program. MCOs do not have any formal regulatory powers.

- A person with mental illness in the care of a 4-bed adult family home died under circumstances indicating medical neglect. The person missed medical appointments prior to their death and was found to be severely underweight and to have pressure injuries postmortem. The facility failed to notify the guardian or treating physician of the person's rapid physical decline.
- A person with schizoaffective disorder, borderline intellectual functioning and a history of falling was left unattended (despite having 1 to 1 staffing requirement) and fell off of a couch while staff was cleaning. About two hours later, incoming staff noticed resident appeared to have suffered a stroke." Management directed staff to transport the resident to hospital in a private vehicle rather than calling 911. On the way to the hospital, the resident lost consciousness and turned blue. At hospital, they were revived and discovered to have broken their spine. The resident died in hospital 4 days later.

Equally alarming is the rate at which Wisconsin is losing its community-based facilities—community based residential facilities and adult family homes. There are currently at least 16 CBRFs in the process of closing. We are aware of at least one hundred 3-4 bed AFH closures so far in calendar year 2021, thirty-two in the month of July alone. Inability to hire/retain staff is the main reason they cite for closing. No agency keeps track of what is happening among the 1-2 bed AFHs, but our anecdotal experience is that they too are unable to maintain staffing.

The dwindling supply of residential placement opportunities means that people are being placed farther from their home communities and farther from the friends and loved ones whose eyes provide one of the most effective abuse and neglect prevention weapons in our arsenal.

Because of the workforce crisis we are experiencing in Wisconsin, more facilities are likely to close, and the remaining ones are likely to be short-staffed on a more frequent basis. Family members caring for loved ones at home are becoming more stressed due to COVID and fewer opportunities for respite. Under these circumstances more people are likely to experience abuse and neglect. We are on a downward spiral in Wisconsin that requires shifts in many policies. SB 395 is one such small shift. A qualified person must look at every complaint of abuse or neglect of an adult-at-risk. Without such a mandate the numbers of complaints that will not be investigated is likely to grow.

Others have appropriately pointed out that this bill simply makes the adult-at-risk reporting system equivalent to the elder abuse reporting system, which has always required that all allegations of abuse or neglect be responded to. Obviously, younger adults with disabilities are no less valued members of society and are deserving of the same protection as our vulnerable elders.

One serious deficiency in SB 395 (and its Assembly counterpart) is its failure to include additional funding to county adult protective services agencies to support this critical work. Quality investigations take time and expertise, and county protective services agencies are already stretched very thin. We can afford this. Wisconsin is expected to run a nearly $2-billion-dollar surplus in FY 2021.[2] A small part of the current surplus would fund the support counties need to respond to abuse and neglect of some the most vulnerable people in our state. We urge members to amend this bill to include an appropriation sufficient to fund the costs of implementing it.

Thank you for the opportunity to comment in support of this important bill.

[2] "The final estimate of 2020-21 tax collections (projected on June 8) was $19,253.8 million. Actual collections were $319.0 million, or 1.7%, above the estimated amount." Legislative Fiscal Bureau, Sept. 2, 2021.

WISCONSIN COUNTIES ASSOCIATION

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MEMORANDUM

TO: Honorable Members of the Senate Committee on Human Services, Children and Families

FROM: Sarah Diedrick-Kasdorf, Deputy Director of Government Affairs

DATE: October 14, 2021

SUBJECT: Support for Senate Bill 395 – Responses to Reports Relating to Elder Adults at Risk and Adults at Risk

The Wisconsin Counties Association (WCA) supports Senate Bill 395 that requires adult at risk agencies to respond to reports of adults at risk in the same manner that they respond to reports of elders at risk.

In Wisconsin, the adult protective services (APS) system is county-based. State statutes impose duties on counties relative to elder adults at risk, adults at risk, and the adult protective services system. Each county is required to identify a lead elder-adults-at-risk agency for adults ages 60 and over and an adults-at-risk agency for adults 18-59 to take primary responsibility for receiving and responding to allegations of abuse, financial exploitation, neglect, and self-neglect. Most counties combine these into a single agency. Each county is required to designate an APS agency responsible for providing protective services and protective placements to all individuals at risk, regardless of age.

The number of elder abuse reports and adults at risk incident reports has steadily risen over the years.

Year	Elder Adult at Risk Incident Reports	Adults at Risk Incident Reports
2013	6,331	2,167
2014	6,972	2,269
2015	7,323	2,322
2016	8,031	2,468
2017	8,500	2,370
2018	8,803	2,563
2019	10,033	2,974
2020	10,429	2,842

Earlier this year, our counties started to have discussions around the increasing number of reports coming in to county APS agencies related to elders and adults at risk, along with the amount of funding provided by the state for adult protective services. Around that same time WCA received a request for a meeting from The Arc Wisconsin and the Board for People with Developmental Disabilities to discuss a modification to state statutes related to requiring county APS agencies to investigate reports of adults at risk. Following those discussions, we decided to combine our efforts and work toward a statutory change to require county APS agencies to investigate adult at risk reports, while at the same time work on a budget amendment for increased APS funding. While no funding was provided in the 2021-23 state biennial budget, Senate Bill 395 was introduced.

Although increased APS funding was not included in the budget, the Wisconsin Counties Association still supports Senate Bill 395. Not only is it the right thing to do, but most, if not all, counties were unaware of the "may" versus "shall" language included in the statutes and were investigating adult at risk reports anyway. Of course, WCA will be making a request for increased APS funding in the 2023-25 state biennial budget. The last GPR funding increase was in 2006 with the change in law extending county APS responsibility to those age 18-59.

WCA respectfully requests your support for Senate Bill 395. Thank you for considering our comments.

The Arc Wisconsin

October 14, 2021

To: Senator Jacque, Chair

Members, Senate Committee on Human Services, Children and Families

From: Lisa Pugh, Executive Director; The Arc Wisconsin

Re: Senate Bill 395 Relating to: responses to reports relating to elder adults at risk and adults at risk.

The Arc is the largest national community-based organization advocating for and serving people with intellectual and developmental disabilities (IDD) and their families. In Wisconsin we have 14 local chapters. Our mission is to improve access to the community for people with IDD and to ensure they are free from abuse and neglect.

Available research indicates that people with disabilities are 4 to 10 times more likely to be a victim of a crime or abuse than people without disabilities. In Wisconsin alone there has been a 38% increase in reporting of abuse/neglect in our Adult Protective Services system for adults at risk (those ages 18-59) from 2005-2019.

Nationally, and in Wisconsin the COVID-19 pandemic and the direct care workforce crisis have made things worse. People are frequently going without care or being supported by poorly trained, low-wage workers - increasing their risk of abuse or neglect. Several states have been under court order to make reporting system improvements after vulnerable people have been violently assaulted or died.

Wisconsin's system for responding to reports of abuse and neglect of people with disabilities is fragmented. People with disabilities say they are confused about who to contact, are sometimes not believed or never hear back about the results of a report. In addition, the system lacks funding; the APS system supporting vulnerable adults has not had an increase since 2006.

Recently The Arc Wisconsin took a call from a mother of a 26-year-old son who uses a wheelchair and came home from his day program with unexplained scrapes and bruises. There was no note about what happened, and her son cannot speak. She took him to the emergency room and helped him recover at home. The day program indicated they had no idea how the injuries occurred and instead blamed Mom. This mother had no idea who to call or how to make a report.

Examples of states that are doing better than Wisconsin include New York where they have developed a central repository for all reports of allegations of abuse, neglect - tracking all reported cases to resolution and ensuring all allegations are fully investigated. A special Individual and Family Support Unit provides guidance, information, and support to victims and their families throughout the process.

In Massachusetts an independent state agency receives and screens reports of suspected abuse, neglect, and deaths through a 24-Hour Hotline, conducts investigations, ensures that the appropriate protective services are provided and offers training and education for service providers, law enforcement personnel and the public.

Tennessee's Abuse Registry is part of their holistic "Protection from Harm" system and is user friendly. All incidents are logged into a database and reviewed by the central office team weekly for trends.

The Arc Wisconsin believes our state's Adult Protective Services system needs updating and new funding. SB 395 addresses a small but important part of Wisconsin's APS system by aligning the Vulnerable Adult and Elder Adult at-Risk statutes.

Current state law requires investigation into any reports of abuse made to Adult Protective Services (APS) for Elder- Adults at Risk (ages 60+). However, current statutes give APS the option to investigate reports about adults with disabilities (Adults at Risk age 18-59). This legislation will align investigation requirements ensuring that an adult-at-risk agency that receives a report or has a reason to believe an adult-at-risk is a subject of abuse, financial exploitation, neglect, or self-neglect will respond by taking at least one investigatory action which is already specified in the law or by referring the report to another agency for investigation.

Regardless of someone's age, the way in which an investigation into an abuse claim is made should not differ. Making this simple language change will keep people safer and create more awareness about the risks vulnerable people are facing. We hope the legislature will consider adequately funding the APS system in the future.