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NJ must find the will to stop abuse and neglect in our I/DD group homes | Opinion

4-minute read

Paul Aronsohn Special to the USA TODAY Network

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Key Points AI-assisted summary

- Abuse and neglect in New Jersey group homes for individuals with intellectual or developmental disabilities is a pervasive issue.
- Underpaid, undertrained, and overworked staffs contribute to the problem, necessitating a living wage, better training, and enforced staff-to-resident ratios.
- Investigations of abuse and neglect need improvement, with a recommendation to consider an independent third-party organization like New York's Justice Center.
- Holding providers accountable through civil penalties and increased transparency, such as video cameras and better communication between families, is crucial.

Regarding "The group home system in NJ is flawed. See our yearlong investigation," NorthJersey.com, May 2025:

In October 2018, one of the leaders in New Jersey's disability provider community referred to instances of abuse and neglect as "uncommon events." Although only a few months in my current position, I was confused by the statement, because my experience was already telling me otherwise — that abuse and neglect were seemingly common and pervasive. Fast-forward a couple of years, and the situation seemed so dire that I felt compelled to include a thorough discussion in our office's 2020 annual report — one that stated emphatically, "People may disagree about the prevalence of abuse or neglect, but there is absolutely no denying it exists."

Since then, abuse and neglect have been a central topic in each of my office's annual reports. Why? Because abuse and neglect have been — and continue to be — a central focus of our day-to-day work. Physical abuse. Emotional abuse. Sexual abuse. Improper medicine administration. Improper food practices. Questionable visitation policies. Questionable house practices. Unexplained injuries. Unexplained deaths. Not a single day goes by without someone

contacting us about an allegation of abuse and neglect. Sometimes it is about a new, terrible experience. Often it is about an ongoing situation.

As just one indicator of this deplorable reality, last year, our office website's "How to Report Abuse & Neglect" section had 2,313 unique visitors — those visiting the section for the first time. In fact, during the 11 months last year that we tracked such metrics, at least one new person per day visited our site's section on abuse and neglect.

Without question, abuse and neglect in state-licensed residential settings — for children as well as adults — have been one of the most concerning and most persistent challenges brought to our attention over the years. And one of the most heartbreaking and infuriating truths about this shameful reality is that relatively few people — working within the system — seem willing to acknowledge it, much less talk about it.

Granted, I fully recognize that providing supports and services for individuals with intellectual or developmental disabilities is not easy. Whether you are sitting in a government office making policy or working in a group home providing direct care, the responsibilities are challenging. The demands are great. Mistakes are sometimes made.

But let's be clear: None of this is rocket science. Preventing abuse and neglect is not hard. We know the causes. We know the solutions. We just need the collective will to take the necessary steps and make the necessary changes.

Going forward, at a minimum, I offer the following three sets of recommendations:

We know that abuse and neglect occur in group homes that are understaffed. We know that abuse and neglect occur in group homes where staff members are underpaid and undertrained. We know that there is high turnover and high vacancy rates of direct care staff in group homes, because the workers are underpaid, undertrained and overworked. We therefore know that our approach to group home staffing is not working.

And despite claims to the contrary and small annual wage increases, the undeniable fact remains: Direct support professionals in New Jersey are still paid only a little more than minimum wage on average and only a little more than starting salaries at supermarkets — far less than the demands of the job would suggest.

As such, I recommend a more reality-based approach to direct care staffing — one rooted in common sense. Real simple: If we want good outcomes, we need to pay good salaries, provide good training and require good performance. More specifically, I recommend that direct care staffers be paid a living wage (indexed annually) and trained appropriately and that staff-to-resident ratios be established and enforced.

Importantly, this can and should be done without the state having to put more money into the system. After all, many provider agencies are already paid between $250,000 and $500,000 per year, per resident.

NJ must do more to investigate abuse and neglect in group homes

We know abuse and neglect are underreported. We know there are serious questions about the quality of the investigations, the process as well as substance. We know most investigations are conducted by the provider agencies themselves and that, in the end, most allegations against them are “unsubstantiated.” We know deaths in group homes are not automatically investigated by the state, even when they are unexpected or otherwise suspicious. We know final investigation reports are rarely shared with anyone, even the individual or guardian.

And we also know none of this makes sense.

Simply stated, when it comes to investigations of abuse and neglect, the status quo is clearly not working.

Most notably, allowing provider agencies to investigate themselves is just bad policy. At the most basic level, it undermines trust in the provider agencies and the system of care as a whole. The process is suspect. The final report is suspect. And no finding of “unsubstantiated” will ever be believed. Moreover, not investigating all deaths in state-licensed residences is bad policy, too. This is particularly true with respect to the nearly 70% of deaths considered “unexpected.”

Therefore, for everyone's sake, we should explore the possibility of having a third-party, independent organization responsible for investigations. To this end, I recommend that we look to New York's Justice Center for the Protection of People with Special Needs as a model for us to consider here in New Jersey.

Whatever the answer, we need to get this right. Investigations have to be real if we are to stop the abuse.

We must hold all NJ providers accountable

We know there are good provider agencies led by good, mission-driven people and staffed by good, caring, hardworking professionals. But we also know the opposite is true — that there are some agencies that are not so good, agencies that have organizational cultures seemingly not aligned with the interests of the people they are charged to serve. We know that there are minimal incentives to keep the bad actors from acting badly. Indeed, we know that there are no civil financial penalties for agencies that violate state policies, understaff group homes, or allow abuse and neglect to happen.

As such, I recommend holding provider agencies accountable by following the lead of the New Jersey Department of Health, which long ago established a schedule of civil monetary penalties to punish hospitals, nursing homes and assisted living residences for misconduct. (The department even publishes its enforcement letters to providers on its website.) Specifically, I recommend that the New Jersey Department of Children and Families and the New Jersey Department of Human Services adopt and impose similar monetary penalties as a way to incentivize even the poorest performers to do the right thing and to do it in the right way.

With the threat of such penalties, otherwise underperforming provider agencies may be more inclined to ensure their residences are properly staffed and to take other preventive and corrective actions, as needed.

I also recommend that video cameras be more readily available in state-licensed settings, because we know that many people living in group homes are among our state's most vulnerable people. We know many have an intellectual disability. We know many have a communication disability, including many who cannot speak. We know many of them and their families fear retribution from provider agencies if they express a concern or if they question a policy or practice.

We know that most, if not all, families want video cameras in the common areas of group homes. We know that most, if not all, provider agencies that use video cameras swear by them as an invaluable tool for protecting residents, protecting staff and educating all involved in particular situations.

Finally, I also recommend that the Stephen Komninos' Law be extended to the New Jersey Department of Children and Families. It has never made sense to me why this important law — which aims to ensure the safety and well-being of people with disabilities living in state-licensed settings — applies only to adults over the age of 21.

Moreover, the Department of Human Services should begin enforcing a key provision of the law, which has been largely overlooked or disregarded until now — the provision that requires residential provider agencies to inform parents/guardians that (with permission) they will share their contact information with other parents/guardians of the residents in the residence "in order to provide an opportunity for parents and guardians to share experiences about the individuals."

Paul Aronsohn currently serves as New Jersey's Ombudsman for Individuals with Intellectual or Developmental Disabilities and Their Families – a position to which he was appointed by Gov. Phil Murphy in 2018.

Provided By Paul Aronsohn

This is critically important and was put into the 2017 law for a reason: When families communicate with each other, less abuse and neglect is likely to occur. They can share observations. They can share concerns. They can work together if abuse and neglect are suspected.

Taken together, there is much we can and should do to prevent abuse and neglect in state-licensed group homes for people with intellectual or developmental disabilities. We have the knowledge and understanding. We have the resources. We just need to have the will to do the right thing.

As my mother would (often) remind all of her kids, “Where there’s a will, there’s a way.”

Paul Aronsohn, a former mayor of Ridgewood, is New Jersey’s ombudsman for individuals with intellectual or developmental disabilities and their families. His older sister, Patti, had developmental disabilities.