

2017 OTIS

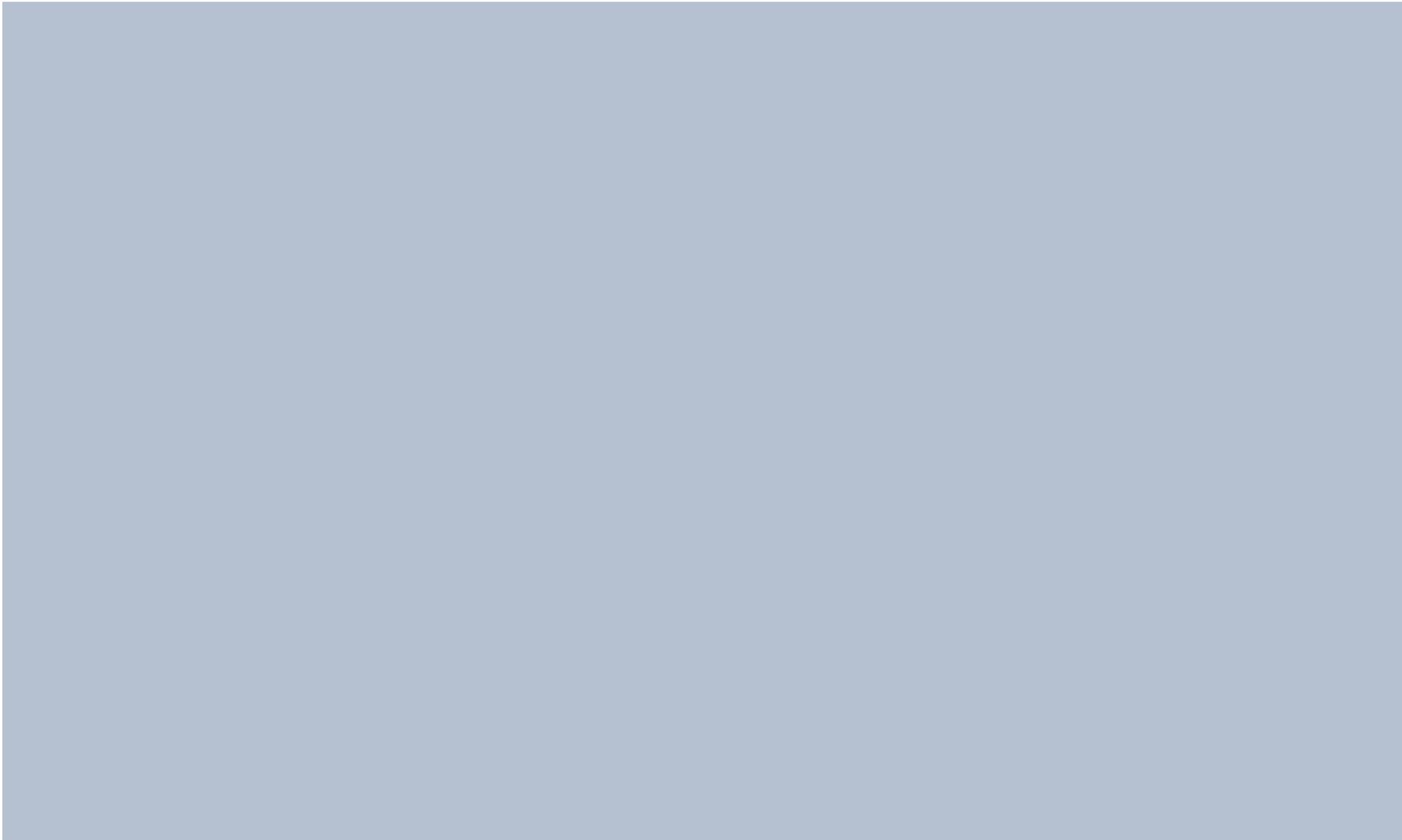
Office of Training,
Investigations and Safety

DATA BOOK

OTIS is a Shared
Service of DHS & OHA

The 2017 Data Book was
produced in collaboration
with OTIS's partners

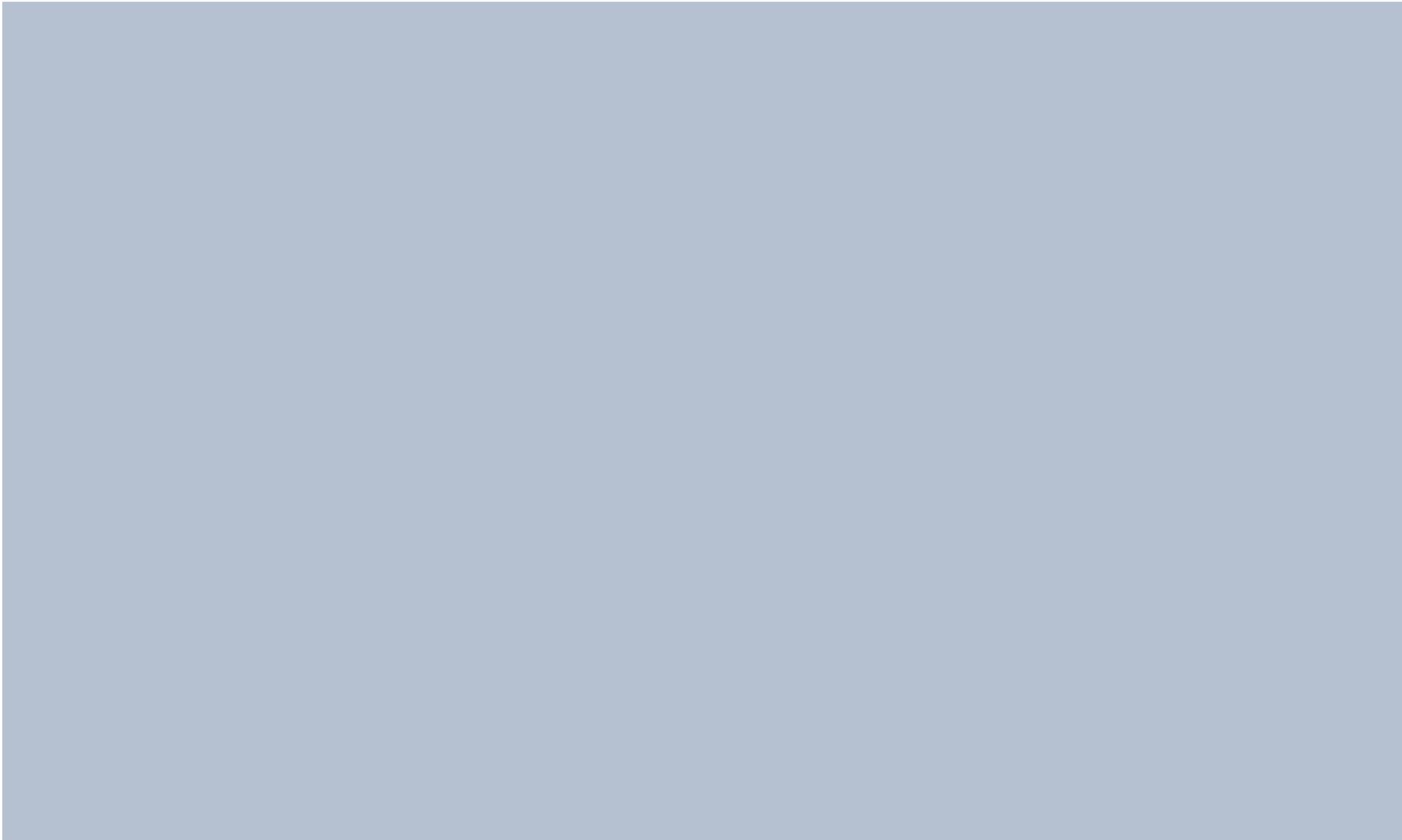
The Office of Training,
Investigations and Safety
(OTIS) was formerly known as
the Office of Adult Abuse
Prevention and Investigations
(OAAPI)



2017 OTIS/OAAPI Data Book

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Executive Summary

This is the story of the protective service assessments during 2017 that were performed or overseen by OTIS/OAAPI. In 2018, the program formerly known as OAAPI (Office of Adult Abuse Prevention and Investigation) was renamed to better reflect our work and became known as OTIS (Office of Training, Investigations and Safety). Because the program is known as OTIS at the time of writing and was known as OAAPI during the period of this report, it will be referred to by both names in this report.

OTIS/OAAPI is a Department of Human Services (DHS) and the Oregon Health Authority (OHA) shared service and supports programs within both DHS and the OHA.

Along with our partner agencies, OTIS/OAAPI strives to ensure vulnerable Oregonians are safe.

As mandated by Oregon Revised Statute (ORS), vulnerable individuals are assured that protective services will be assessed if the need arises. Protected people range from children- and youth-in-care to adults with intellectual and developmental disabilities or those who are living with mental illness and enrolled in services. Some protected people reside at the Oregon State Hospital or other state operated mental health treatment facilities. Protected people live in all parts of Oregon - along the Pacific Coast and in the high deserts of Eastern Oregon, in the Columbia Gorge and Willamette Valley, in the urban density of Portland and the vast open ranges of Harney County.



Executive Summary

Investigators with OTIS/OAAPI are responsible for investigations of possible abuse or neglect in: licensed child-caring agencies, the Oregon State Hospital (OSH), and OHA-operated residential treatment facilities for people with mental illness. They also investigate at homes for people with developmental disabilities operated by the state Developmental Disabilities Services Program (I/DD) as the Stabilization and Crisis Units (SACU), and at I/DD residential homes for children. Analysts at OTIS/OAAPI provide technical assistance and oversight to local investigators throughout the state who investigate the majority of allegations of abuse and neglect for people enrolled in I/DD or mental health services.

In 2017, analysts for the Adult Protective Service of Aging and People with

Disabilities (APD) returned to APD after several years being a part of OTIS/OAAPI. APD has chosen to present their data independent of this report.

In 2017, partnering with staff at the Department of Justice (DOJ) and stakeholders, OTIS/OAAPI identified some gaps in statute that affected investigations in both community mental health settings and the Oregon State Hospital. OTIS/OAAPI's policy unit, leadership, and stakeholders joined with members of the Oregon Legislature, and in 2018, legislation was passed to extend protective services to all people enrolled in mental health services. The impact of this on both the Oregon State Hospital investigations and community mental health investigations is discussed further later in this report.



Executive Summary

Investigations result in findings of substantiated, inconclusive and not/unsubstantiated. In adult programs, these findings are based on the preponderance of evidence. If the investigator determines that the allegation is more probably true than not, s/he will substantiate the allegation.

For investigations involving children, the standard of proof to substantiate an investigation is reasonable cause to believe. This standard relies on the investigator gathering clear and specific facts. After those facts are gathered, the investigator determines whether there is reasonable cause to believe the child has been abused and whether there is reasonable cause to believe a specific person was responsible for that abuse. If the investigator can conclude yes to both of those conditions, the allegation will be substantiated. If there is some evidence but not enough to support

a substantiation, the allegation will be inconclusive.

In all investigations the needs of the person reported to have been victimized are paramount. First and foremost these are protective service and abuse investigations. The investigator approaches each investigation with a trauma-informed approach, which begins with understanding the impact of trauma on the individual, the family system and the community. It recognizes the signs and symptoms of trauma. Knowledge about trauma and its impact is integrated into policies, procedures and training. Most importantly, it actively seeks to avoid re-traumatizing the individual.



Executive Summary

The investigator is trained to respect the victim's right to self-determination while assessing the protective measures offered in order to keep the victim safe and to address the needs rising from the reported abuse or neglect. All services are voluntary; the victim or the victim's guardian have the right to decline any or all offered services.

In regulated settings, the investigative report is shared with agencies that license care facilities or certify service providers. These

reports support their actions. Those actions taken by our partner agencies help to ensure the safety of the reported victim and others. The

investigator will also make recommendations to the care facility or provider. Through the protective services offered to the victim and recommendations to the service provider, the investigator is seeking to prevent further abuse or neglect.

Despite similarities in the investigation process, each program is evaluated individually due to factors such as distinctions between eligible populations, varying abuse rules based on their intended population, and living situation. As will become apparent, the size of the eligible population varies dramatically, which also makes comparison across programs problematic. Because of the differences between programs it is inappropriate to aggregate numbers for abuse across programs.



2017 Data Book Overview

Intellectual/Developmental Disabilities - Adults	<ul style="list-style-type: none"> In 2017, of the 1,651 allegations of abuse investigated, 772 were substantiated 1,133 people were alleged to be victims, and 611 individuals were found to have been abused
Stabilization and Crisis Unit	<ul style="list-style-type: none"> In 2017, of the 206 allegations of abuse investigated, 34 were substantiated 131 people, both children and adults, were alleged to be victims, and 23 individuals were found to have been abused
Intellectual/Developmental Disabilities - Children's Residential	<ul style="list-style-type: none"> In 2017, of the 24 allegations of abuse investigated, 3 were substantiated 20 people were alleged to be victims, and 3 individuals were found to have been abused
Child Caring Agencies	<ul style="list-style-type: none"> In 2017, of the 387 allegations of abuse investigated, 43 were substantiated 299 children were alleged to be victims, and 40 individuals were found to have been abused
Mental Health Programs	<ul style="list-style-type: none"> In 2017, of the 339 allegations of abuse investigated, 132 were substantiated 280 adults were alleged to be victims, and 112 individuals were found to have been abused
Oregon State Hospital and Oregon Health Authority Operated Residential Facilities	<ul style="list-style-type: none"> In 2017, of the 69 allegations of abuse investigated, 7 were substantiated 51 people were alleged to be victims, and 7 individuals were found to have been abused

Reabuse Rates by Program

I/DD total	7.04%
I/DD licensed settings	8.39%
I/DD non-licensed settings	4.92%
Stabilization and Crisis Unit	4.35%
Children's 24-hour Residential Programs	0.00%
Child Caring Agencies incl CCP	2.50%
Mental Health Programs total	3.57%
Mental Health Programs licensed settings	0.00%
Mental Health Programs non-licensed settings	4.76%
Oregon State Hospital and OHA-Operated Residential Treatment Facilities	0.00%

Reabuse Definition

Victims Reabused: are people identified as the victim in two or more substantiated investigations within the same year.

Victims: are people with at least one substantiation in their case.

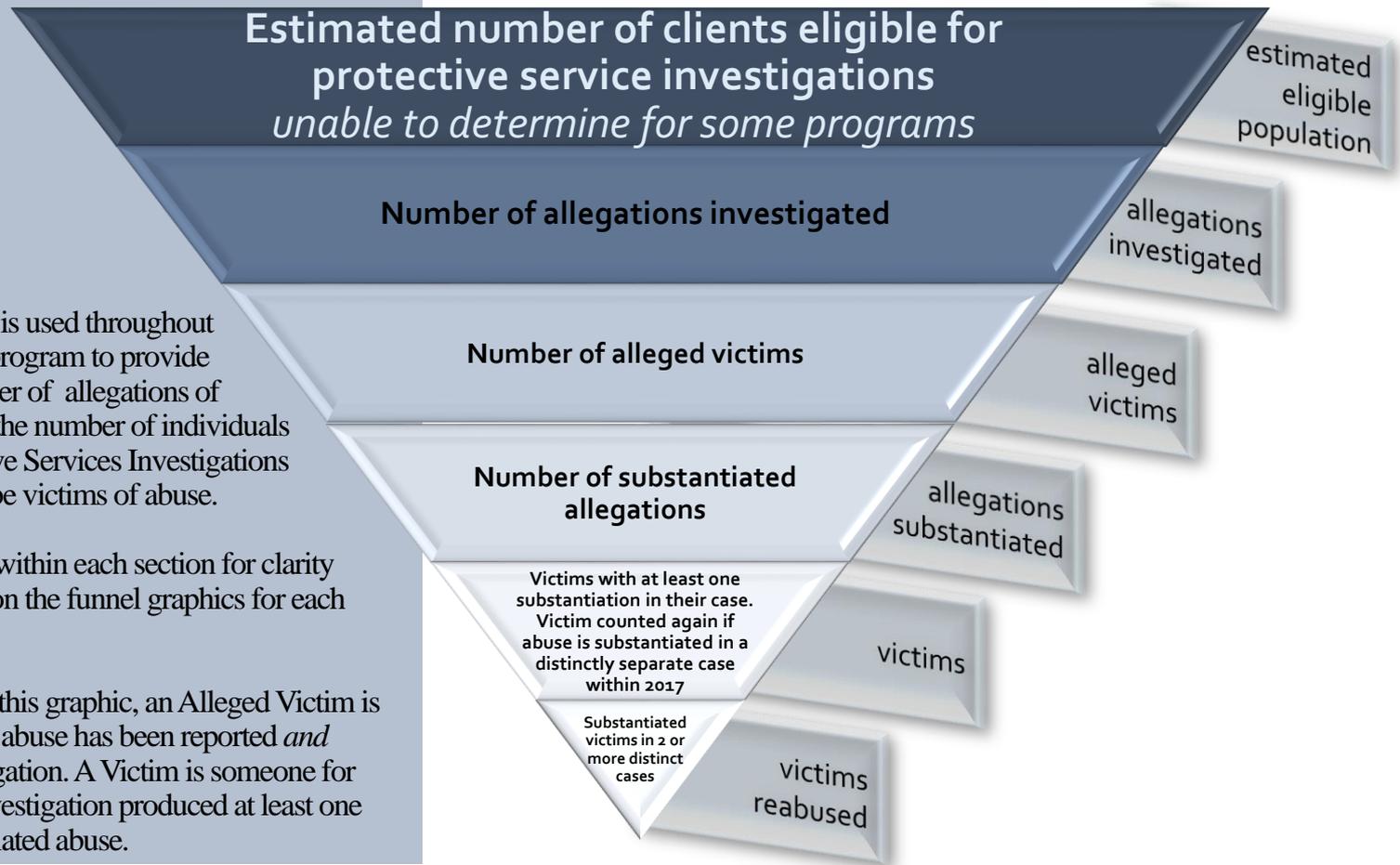
The Reabuse Rate is calculated as the **victims reabused** divided by the number of **victims**.

There are more allegations than investigations because an individual can experience multiple types of abuse in a single incident, or an investigation can contain multiple alleged victims or alleged perpetrators.



Reader's Guide

Definitions: Population, Allegations, & Victims Funnel



This funnel graphic is used throughout the report for each program to provide context to the number of allegations of abuse in relation to the number of individuals eligible for Protective Services Investigations and those found to be victims of abuse.

Review definitions within each section for clarity about the numbers on the funnel graphics for each program.

For the purposes of this graphic, an Alleged Victim is someone for whom abuse has been reported *and* assigned for investigation. A Victim is someone for whom the abuse investigation produced at least one instance of substantiated abuse.

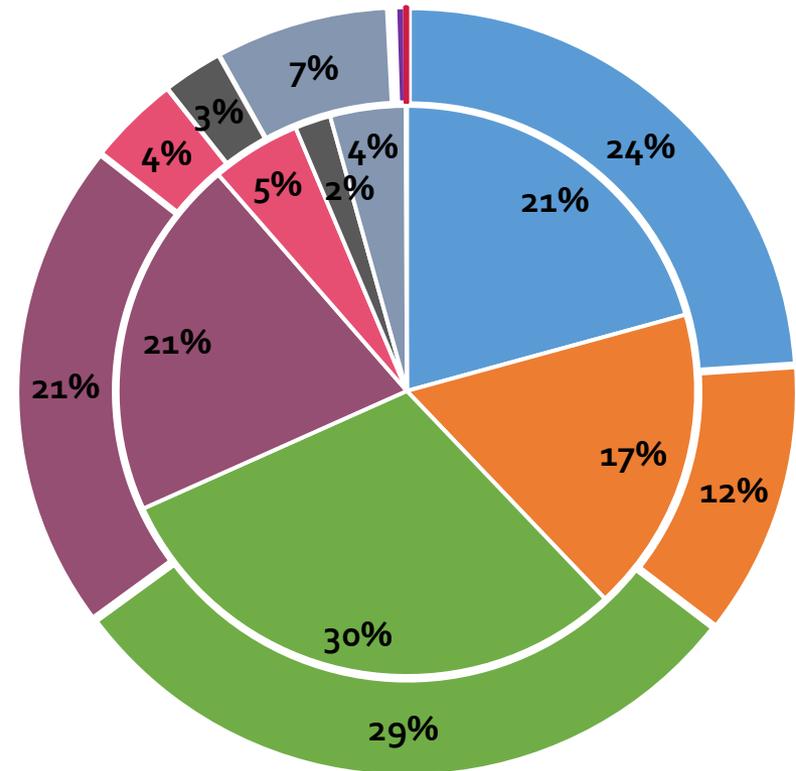
Definitions: Visualizations Data Sheet

Outer Circle: Types of Abuse Investigated
Inner Pie: Types of Abuse Substantiated

These nested pie charts compare abuse types *investigated* and abuse types *substantiated* for investigations which concluded in 2017.

- The Outer Circle distributes allegations investigated by Abuse Type.
- The Inner Pie distributes Substantiated allegations by Abuse Type. The percentage of each abuse type is based on total substantiations.

For this sample data, neglect comprised 29% of allegations investigated, and substantiated neglect comprised 30% of all substantiated allegations.



- | | | |
|--|--|---|
| ■ Physical | ■ Financial | ■ Neglect |
| ■ Verbal | ■ Restraint | ■ Seclusion |
| ■ Sexual | ■ Abandonment | ■ Mental Injury |
| ■ Threat of Harm | ■ Maltreatment | ■ Mistreatment--Physical |
| ■ Mistreatment--Neglect | ■ Mistreatment--Verbal | |



Office of Developmental Disabilities Services

ODDS Adult Program Summary

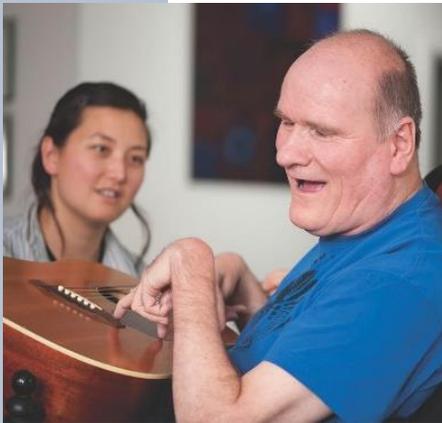
Developmental disability is an umbrella term that includes intellectual and other disabilities. Some developmental disabilities occur largely due to medical conditions or brain injury that affect a person's development and may or may not include limitations in cognition, such as cerebral palsy or epilepsy. Some individuals may have a condition that occurs genetically or during gestation that affects physical and intellectual development such as Down syndrome or

Fetal Alcohol syndrome. People with such disabilities may also have significant medical or mental health needs and frequently face challenges related to aging.

Intellectual disability is characterized by below-average mental capacity

(reasoning, learning, problem solving) and significant limitations in adaptive behavior skills (social, conceptual, practical). Adult Intellectual / Developmental Disabilities (I/DD) programs and its partners provide supports and services to adults who meet eligibility criteria. In 2017 more than 19,000 adults were enrolled in I/DD services.

Services to adults range from supports to assist an individual to live in their own home or with family or friends to 24-hour comprehensive services depending on the individual's need. An Individual Support Plan is established with each adult to identify supports based upon their health and safety needs, interests, choices and goals. Each plan uses a person-centered planning process.



See the full definition of Intellectual / Developmental Disability in OAR 411-320-0020

ODDS Adult Program Summary



People who are enrolled in I/DD programs can choose to receive case management services through Brokerages or through a Community Developmental Disability Program (CDDP). These community programs operate in specific geographic areas, usually encompassing a county or several counties.

When abuse is reported, the investigator will work with the person's case manager to ensure that protective services are offered to the person. (If the person is case managed by a brokerage, they have a personal agent. If the person receives services from a CDDP, they have a services coordinator.)

The majority of allegations of abuse or neglect are investigated by CDDP investigators. If an investigation is particularly complex, encompasses several CDDP jurisdictions, or involves a conflict of interest, it is referred to OTIS/OAAPI for investigation.

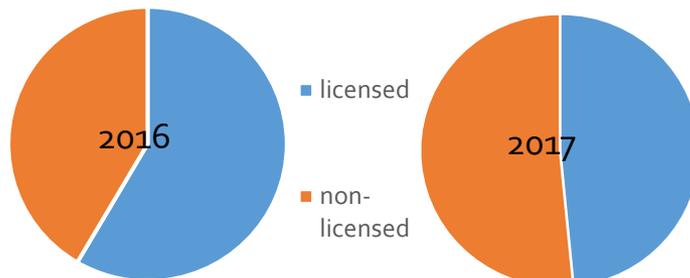
Investigations can be conducted in licensed, endorsed, or community settings. Licensed settings include 24-hour residential programs such as group homes and adult foster homes. Endorsed settings include supported living programs and employment and day support programs. Community settings include locations where case management services are received as well as locations where people receive community supports to enable them to live in their own home or their family home.

Before March 2017 a trust relationship was required to exist between the alleged victim and the alleged perpetrator before a community investigation could be assigned. As a result, a majority of allegations assigned in 2016 were in licensed settings. After the change in practice the majority of assigned allegations are in non-licensed settings. For more detail into how the change in practice increased safety for people enrolled in I/DD services, please see page 27.

ODDS Adult Program Summary

In 2017, 1,651 allegations were assigned for investigation by CDDP investigators or OTIS/OAAPI staff. This is an 18 percent increase over the number of allegations assigned in 2016. Of these allegations 851 were in non-licensed settings; this is an almost 47 percent increase over the number of allegations assigned in non-licensed settings in 2016. Allegations assigned in licensed settings declined 2 percent with 800 allegations assigned in 2017.

Allegations Assigned each Year by Setting



As the graphs on page 20 show, neglect continued to be the most frequently investigated abuse type followed by verbal/emotional abuse. This follows a pattern we see across programs; any program that includes licensed settings is likely to see neglect as the most prevalent allegation. A care home, which is a licensed setting, assumes broad responsibility for the residents in its care which creates conditions for a higher incidence of neglect of care than would occur in non-licensed settings.

ODDS Adult Program Summary

Verbal/emotional abuse also has high incidences in licensed settings. This is most likely because all employees of these programs are mandatory reporters, which means that the verbal abuse that occurs is more likely to be reported than that which occurs in the community. Employees of licensed and endorsed programs are trained in what constitutes abuse, and are more likely to recognize potential verbal/emotional abuse than members of the general public.

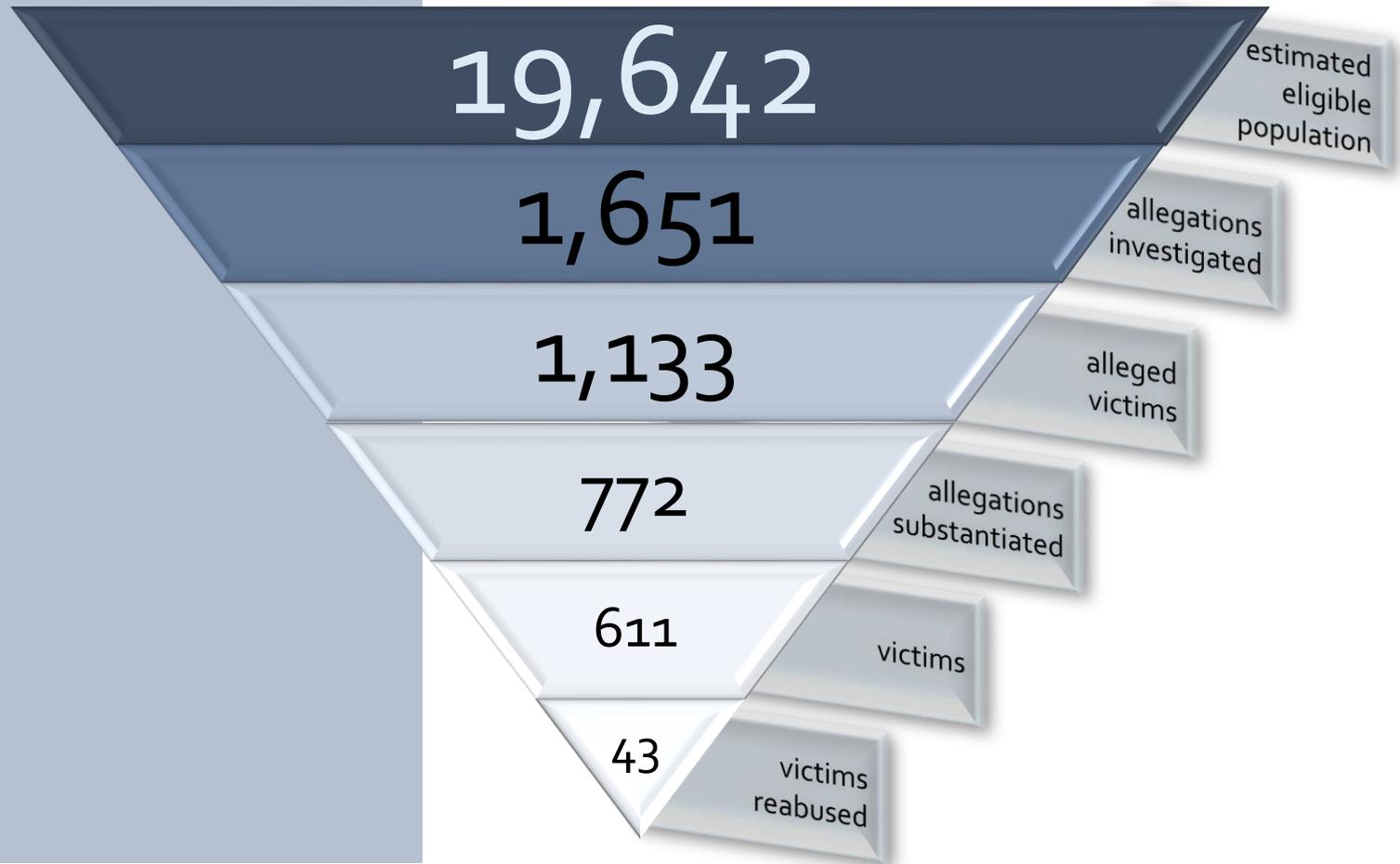
One of the interesting dynamics of investigations in licensed settings is that an investigation can have multiple victims. As an example, allegations of wrongful restraint increased by 15 compared to 2016; however, the number of investigations for wrongful restraint only

increased by one. This is because two investigations contained 14 allegations. In licensed care settings, multiple people can be victimized in the same incident; this happens much more rarely in community settings. Overall, allegations in licensed settings decreased slightly, 2 percent in 2017 as compared to 2016.



Find out more at <https://www.oregon.gov/DHS/SENIORS-DISABILITIES/DD/Pages/county-programs.aspx>

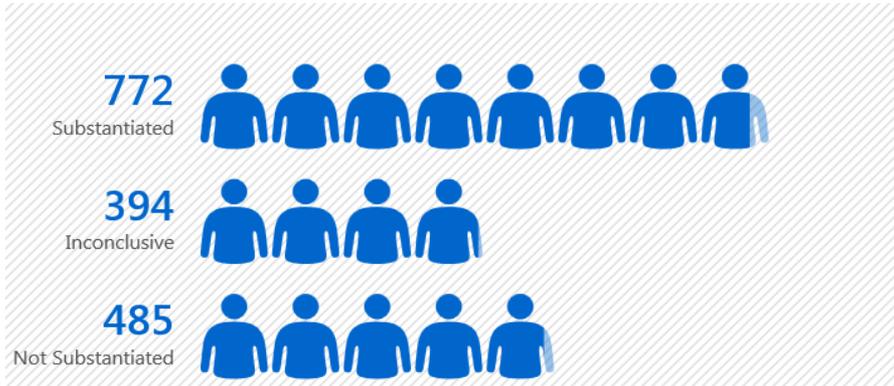
2017 I/DD Adult Population, Allegations, & Victims



2017 I/DD Adult

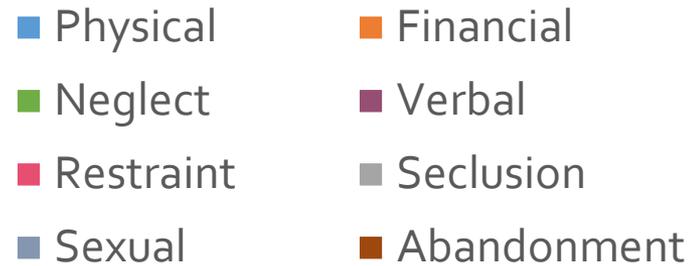
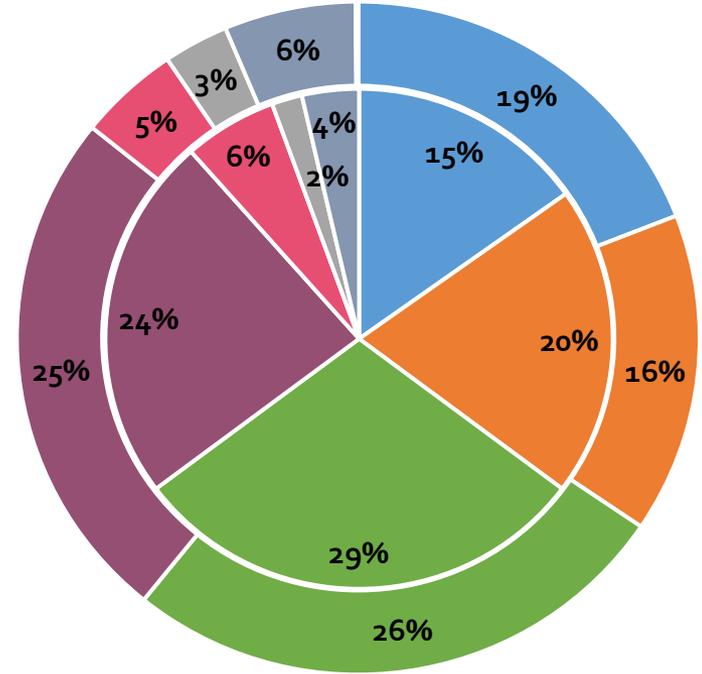
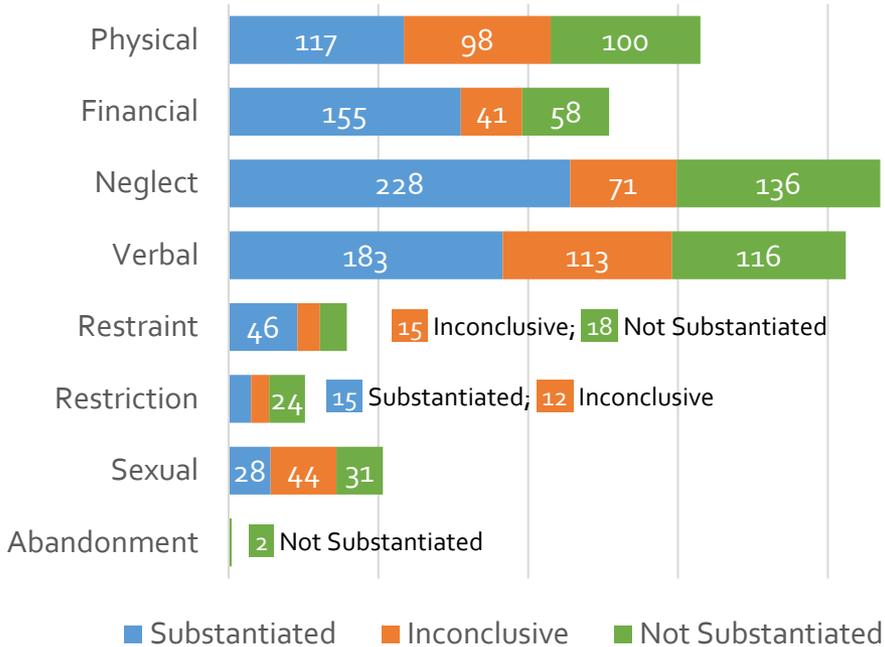
Allegation Results

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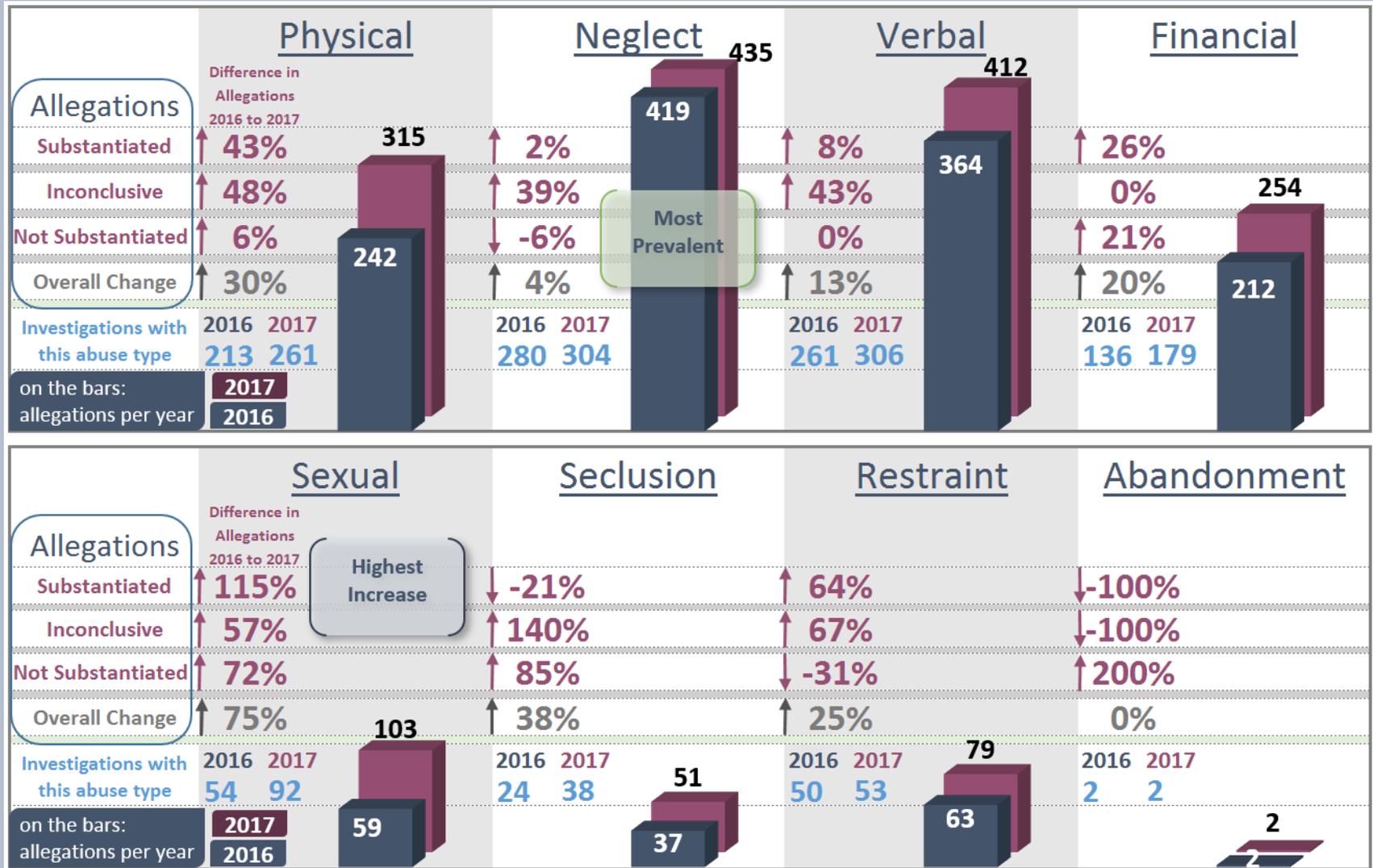


Outer Circle: Types of Abuse Investigated
Inner Pie: Types of Abuse Substantiated

Results of Abuse Investigations

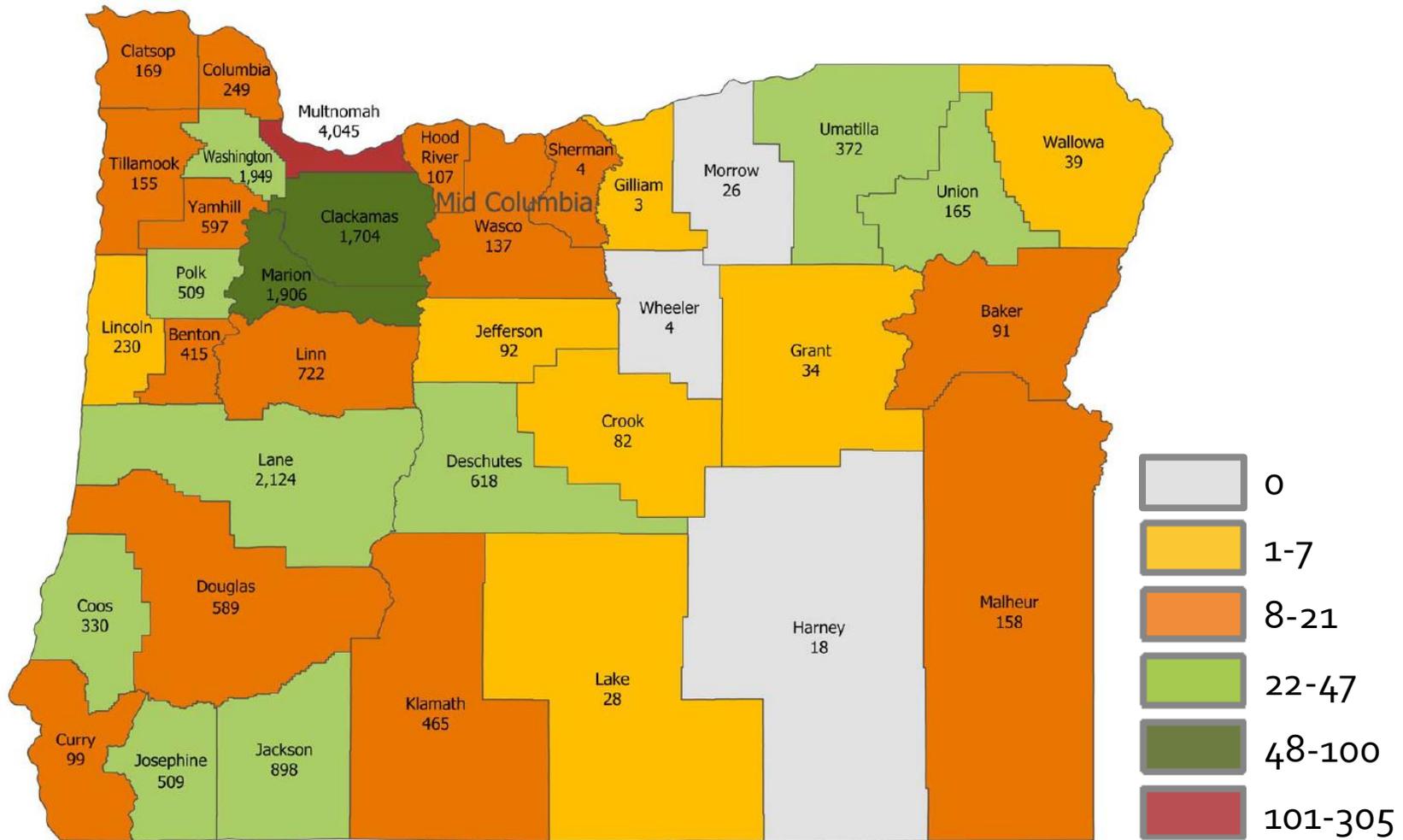


I/DD Adult - Comparison of 2016 and 2017 Allegations



There are more allegations than investigations because an individual can experience multiple types of abuse in a single incident, or an investigation can contain multiple alleged victims or alleged perpetrators.

I/DD Adult Investigations Closed in 2017 by County

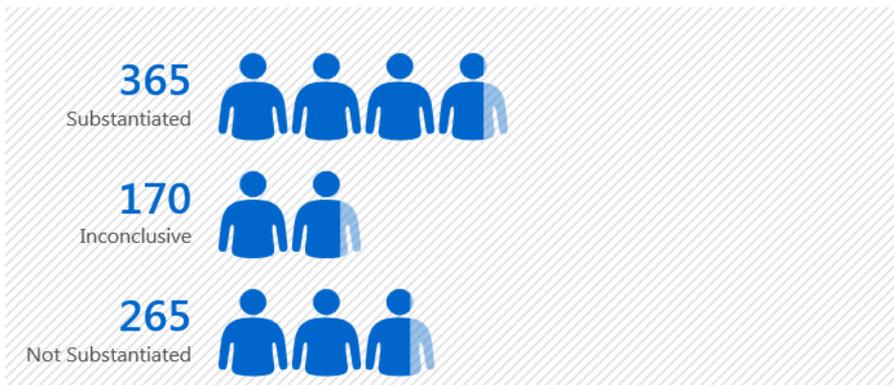


The numbers under each county name represent the number of people residing in that county in 2017 who were eligible for protective service investigations based on their status as enrolled in I/DD services.

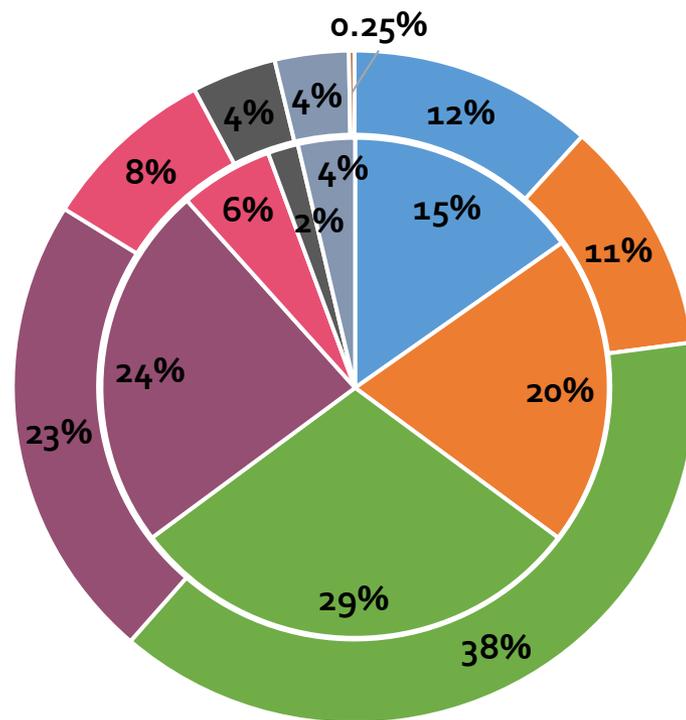
2017 I/DD Adult - Licensed Settings

Allegation Results

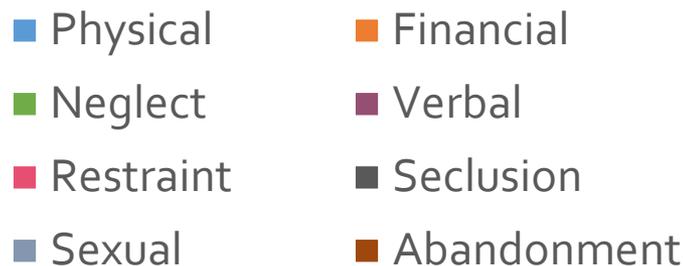
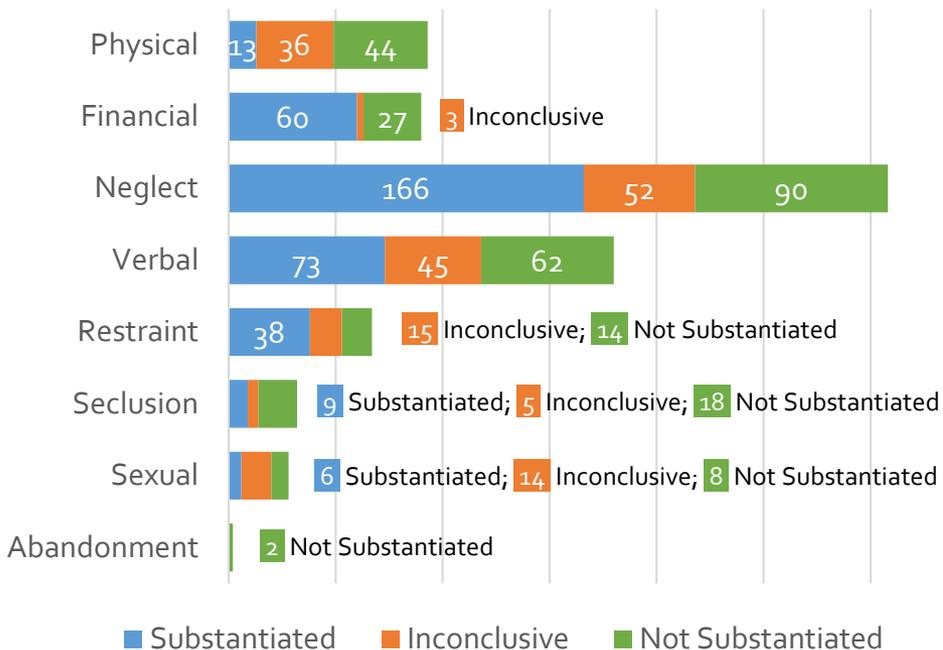
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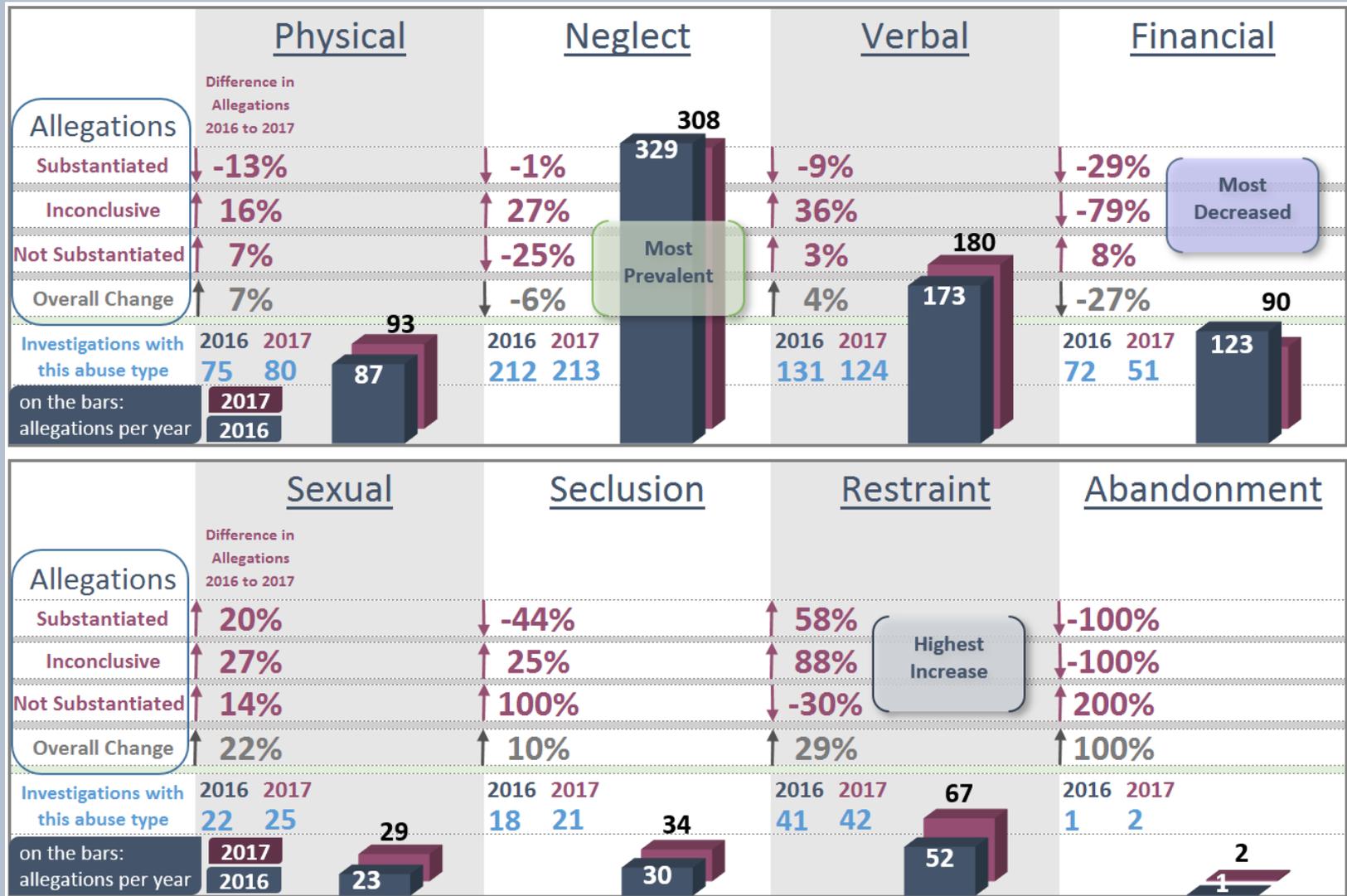
Outer Circle: Types of Abuse Investigated
Inner Pie: Types of Abuse Substantiated



Results of Abuse Investigations

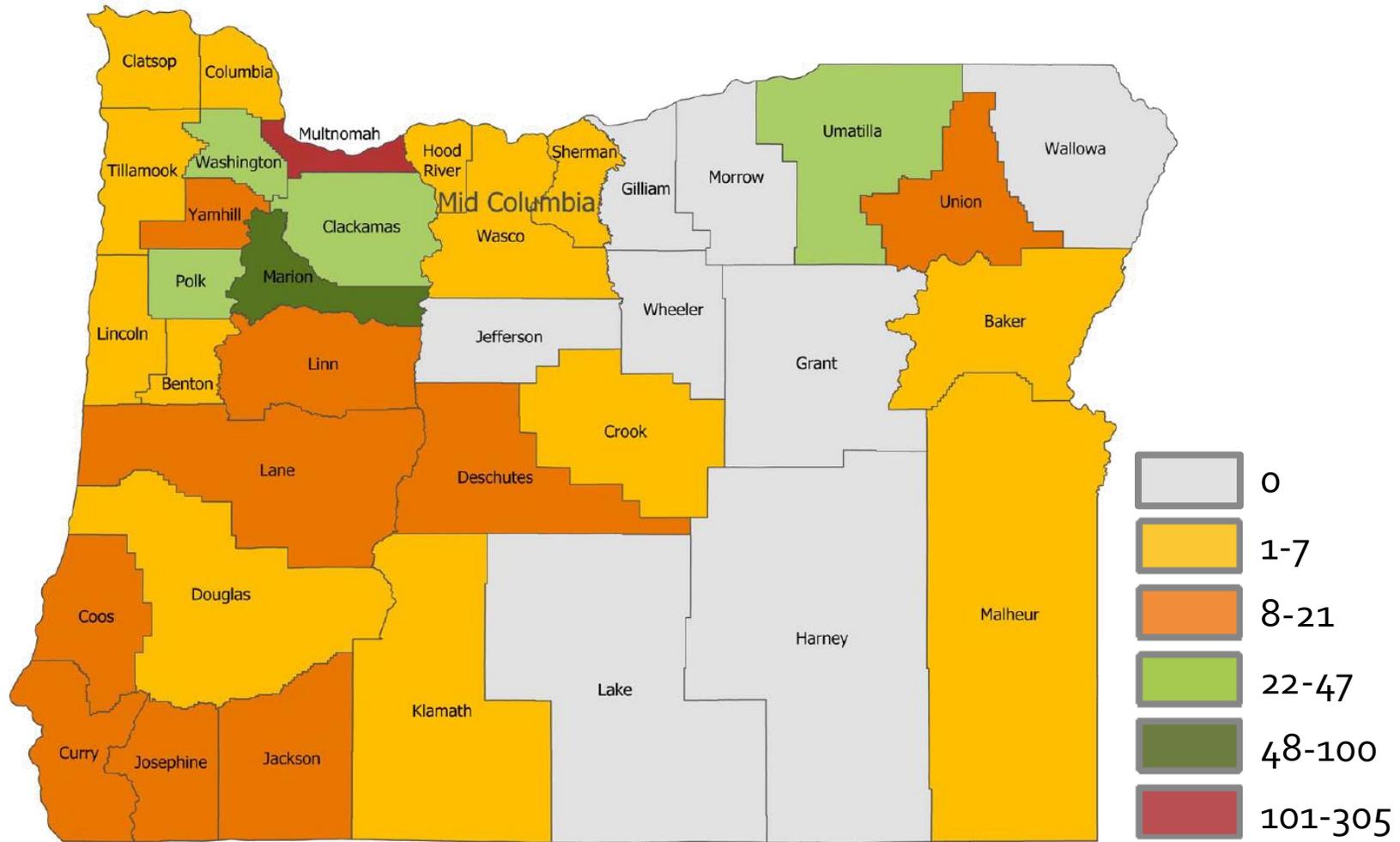


I/DD Adult - Comparison of 2016 and 2017 Allegations in Licensed Settings



There are more allegations than investigations because an individual can experience multiple types of abuse in a single incident, or an investigation can contain multiple alleged victims or alleged perpetrators.

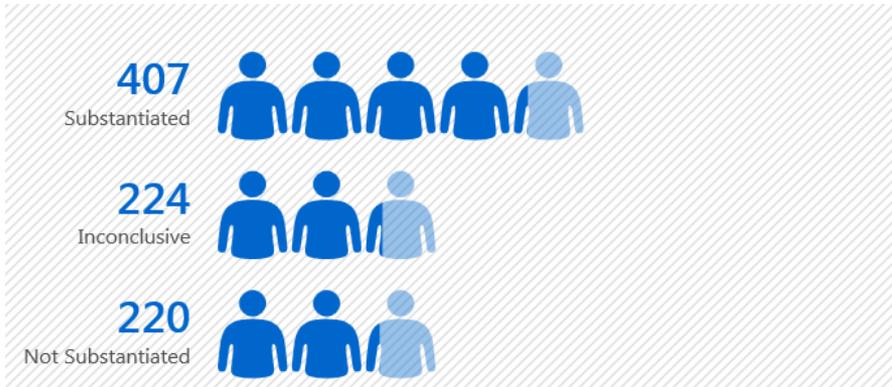
I/DD Adult Investigations Closed in 2017 by County in Licensed Settings



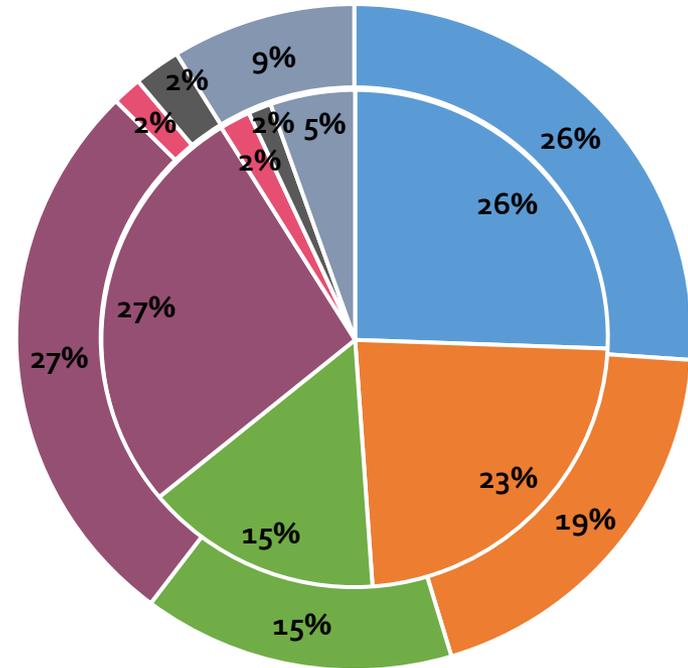
2017 I/DD Adult - Non-Licensed Settings

Allegation Results

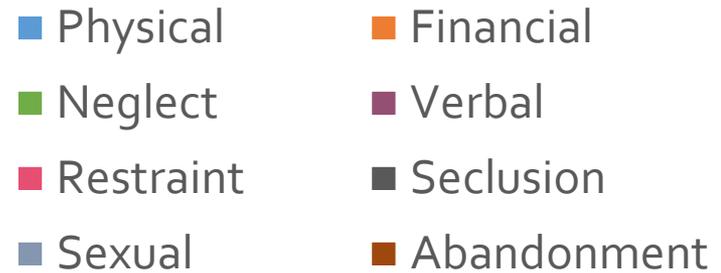
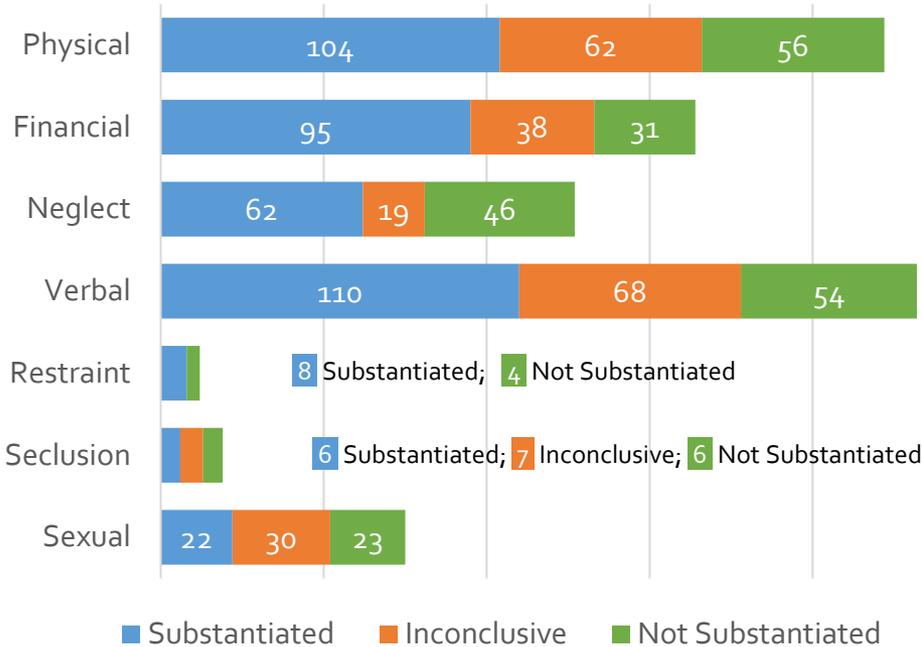
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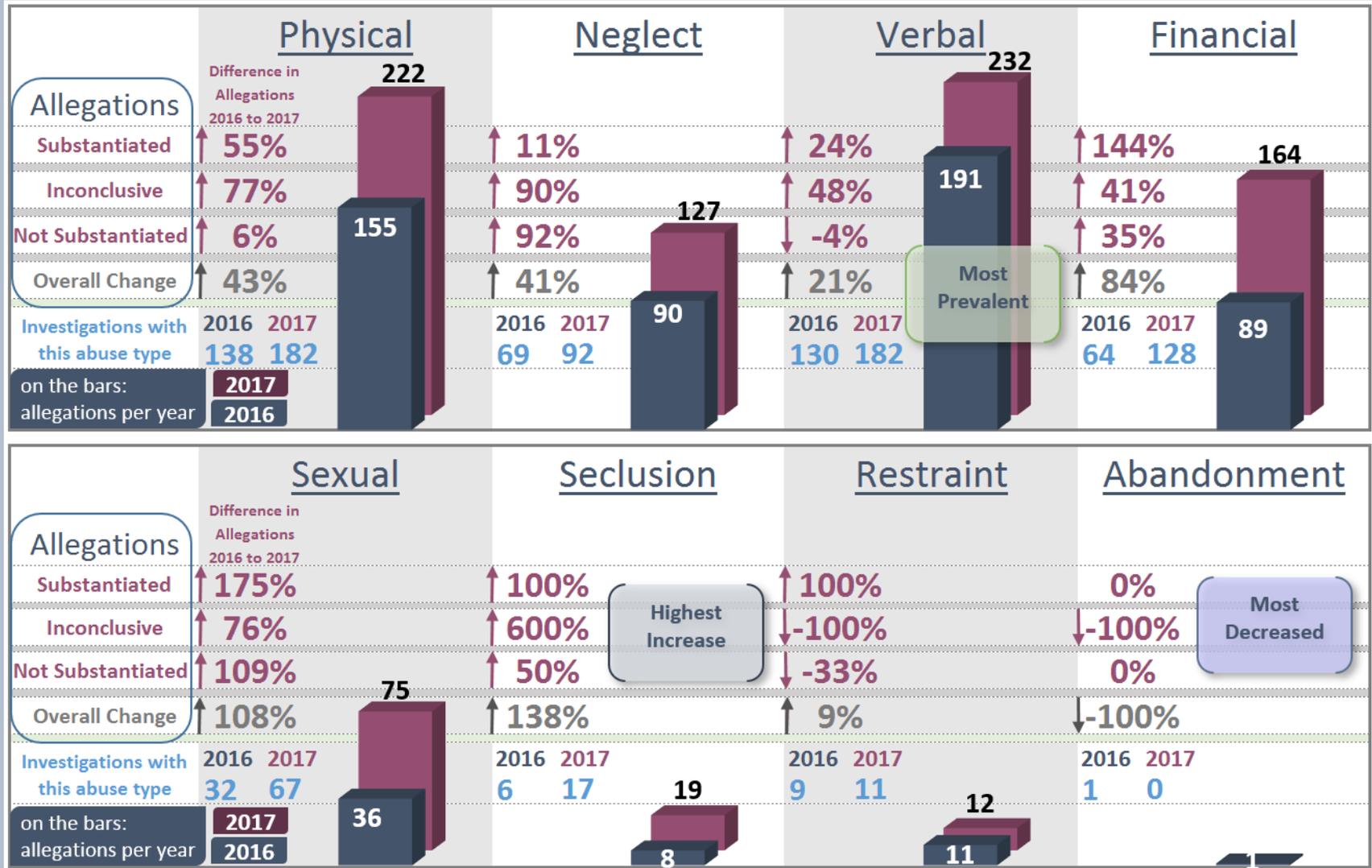
Outer Circle: Types of Abuse Investigated
Inner Pie: Types of Abuse Substantiated



Results of Abuse Investigations

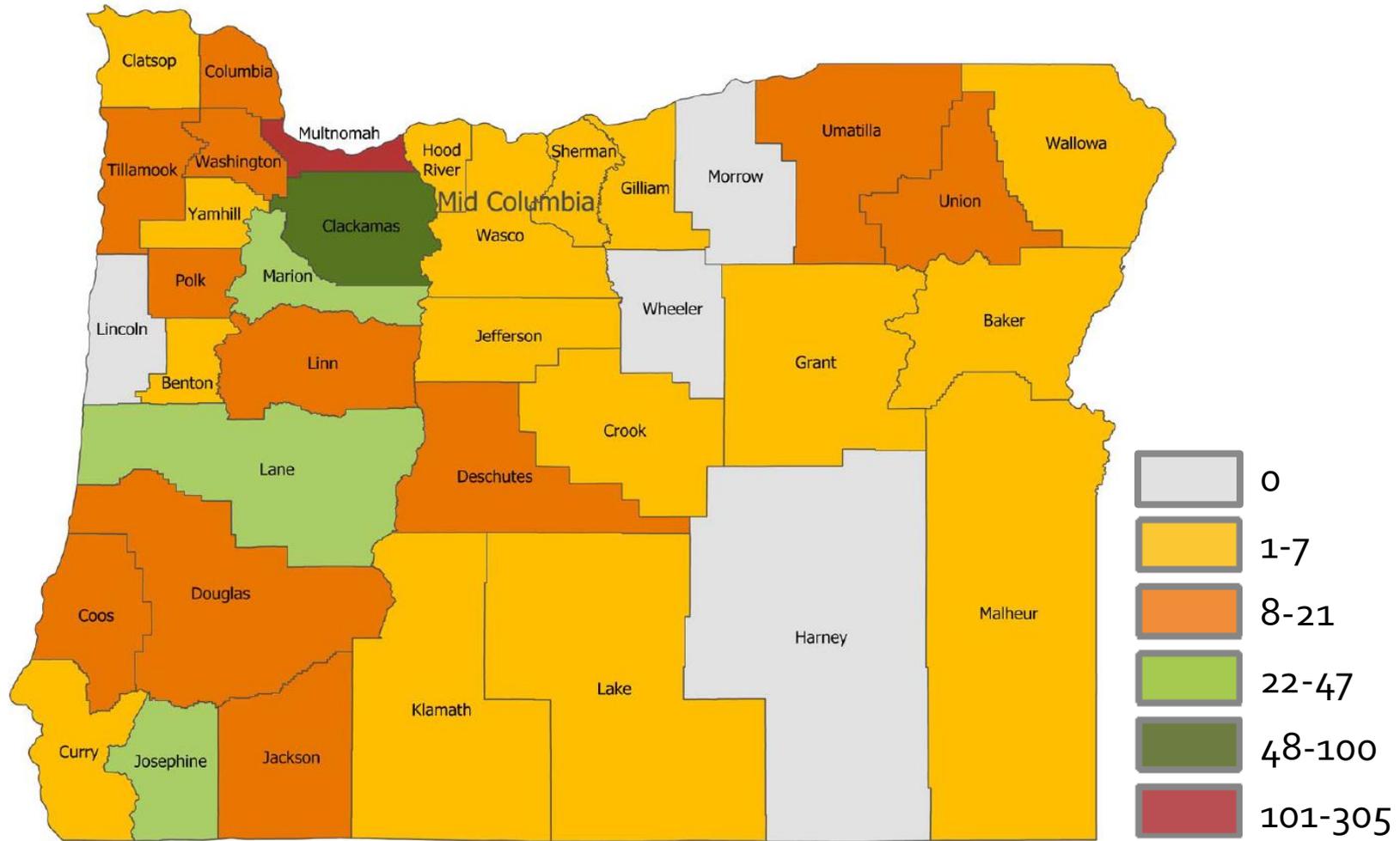


I/DD Adult - Comparison of 2016 and 2017 Allegations in Non-Licensed Settings



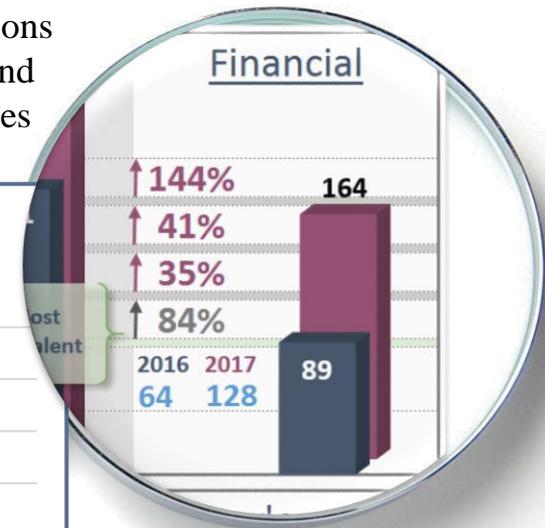
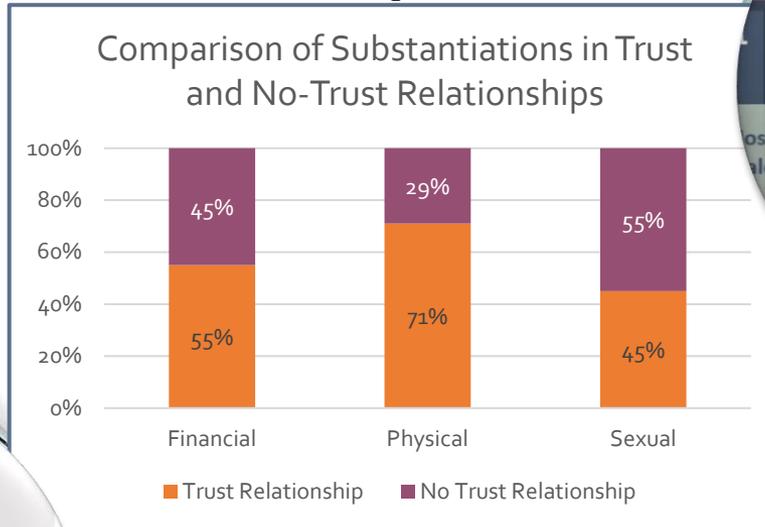
There are more allegations than investigations because an individual can experience multiple types of abuse in a single incident, or an investigation can contain multiple alleged victims or alleged perpetrators.

I/DD Adult Investigations Closed in 2017 by County in Non-Licensed Settings



Safety Increased by Process Change

In 2017, we saw some startling and dramatic increases in the number of allegations of sexual and financial abuse. Allegations of sexual abuse more than doubled, and allegations of financial abuse almost doubled. Substantiations of both abuse types more than doubled. Clearly this is due to the end of the requirement of a trust relationship between the victim and alleged perpetrator. Of the substantiated sexual abuse allegations, 55 percent had no trust relationship. For financial abuse allegations, 45 percent had no trust relationship.



We know several things about these investigations:

- Protective services were offered to the victim.
- Law enforcement was notified if the abuse was potentially criminal.
- The victim's case manager was informed of the allegation and able to engage with the victim to offer services and adjust the person's service plan to increase his/her safety.
- If the perpetrator was identified, that person is flagged in future background checks.

Stabilization and Crisis Unit Program Summary

The Stabilization and Crisis Unit (SACU) is a specialized program of the I/DD program. SACU provides 24-hour residential care and supervision to children and adults who have multiple needs and are at higher risk. SACU is a safety-net resource for Oregonians with I/DD with no other option for a residential bed due to significant I/DD and mental health challenges. SACU supports people to stabilize and then to transition to community settings.

In 2017, OTIS/OAAPI conducted investigations in the children's homes for just a few months. Investigative authority was then transferred to DHS Child Welfare. Data for those investigations is held by them and not reflected in the data book.



The SACU residential group homes are located along the I-5 corridor from Portland to Eugene. Even though there are separate homes for children and adults, for the purposes of this report the data is considered as a whole.

SACU Program Summary

Allegations of abuse and neglect are investigated by OTIS/OAAPI. In 2017, a total of 206 allegations were investigated. This is a 14 percent decrease from the number of allegations investigated in 2016 and is directly due to quality improvement actions initiated in 2017. The 206 allegations involved 131 SACU residents of whom seven were children.

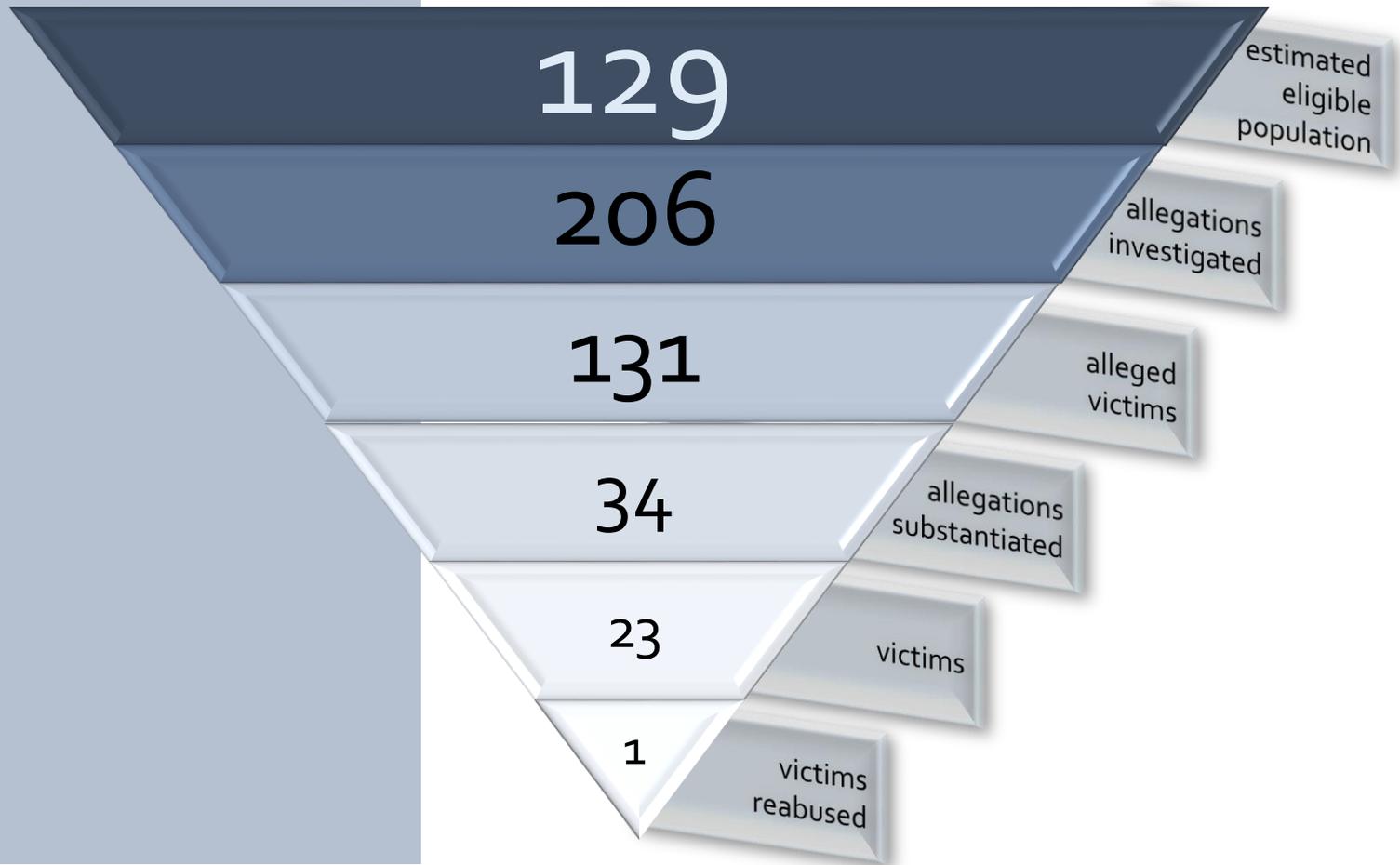
As was true in 2016, the majority of allegations were for neglect; neglect was also the most frequently substantiated allegation. As is true of all care settings, SACU assumes broad responsibility for its residents resulting in neglect being the most frequent allegation of abuse. Verbal abuse was, again, the second most substantiated type of abuse. However, even though the number of allegations increased by almost 20 percent, the number of allegations substantiated dropped. Financial abuse, last year's most

substantiated allegation, decreased both in prevalence and in substantiation rate this year. Allegations of involuntary seclusion more than tripled (from 2 to 7), but none were substantiated.

There are many indicators that the quality improvement steps taken by the SACU were highly successful, but perhaps the most significant is the number of residents who were reabused in 2017. Only one resident was the victim of abuse two or more times in the calendar year. This is a 92 percent decrease from 2016.



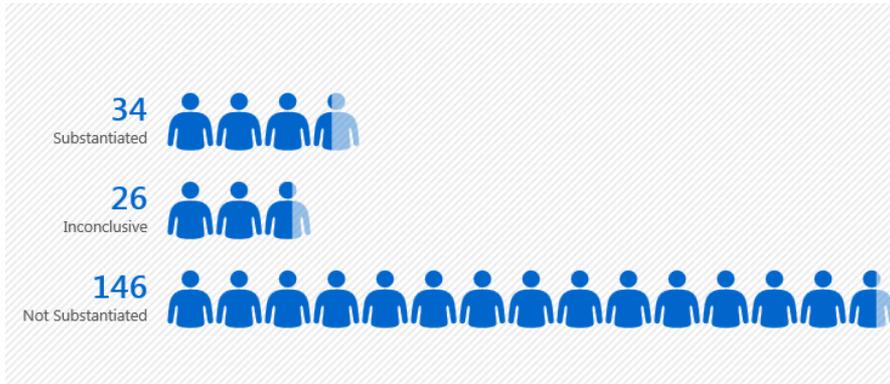
2017 SACU Population, Allegations, & Victims



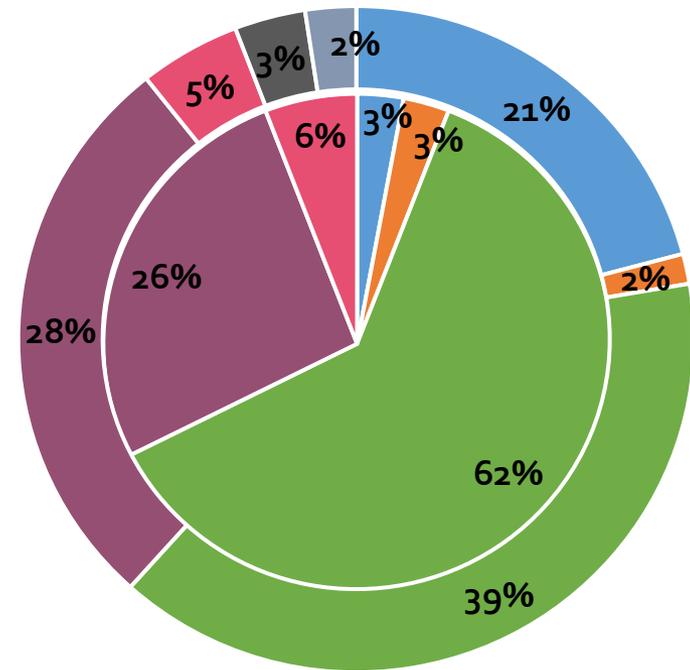
2017 Stabilization and Crisis Unit

Allegation Results

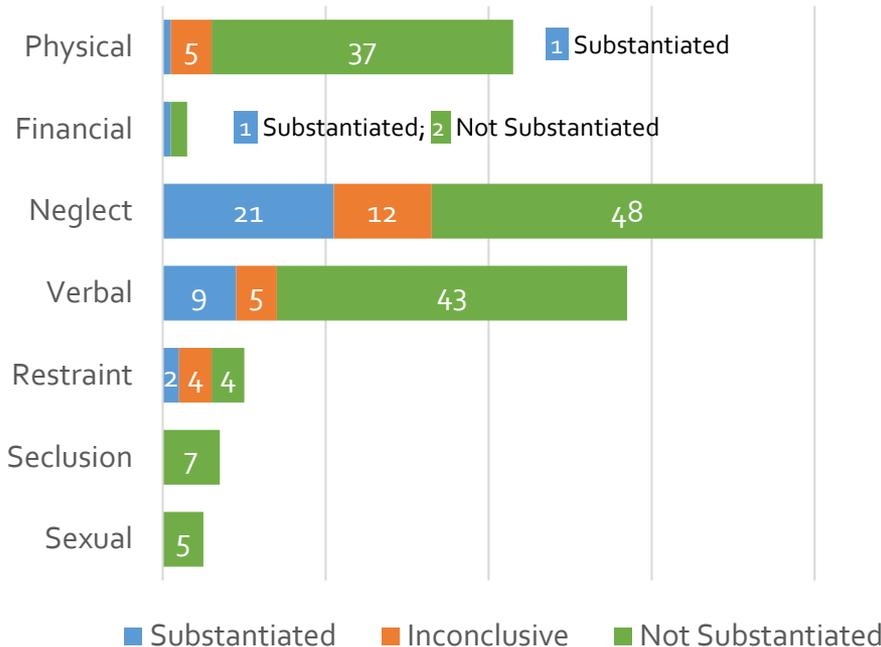
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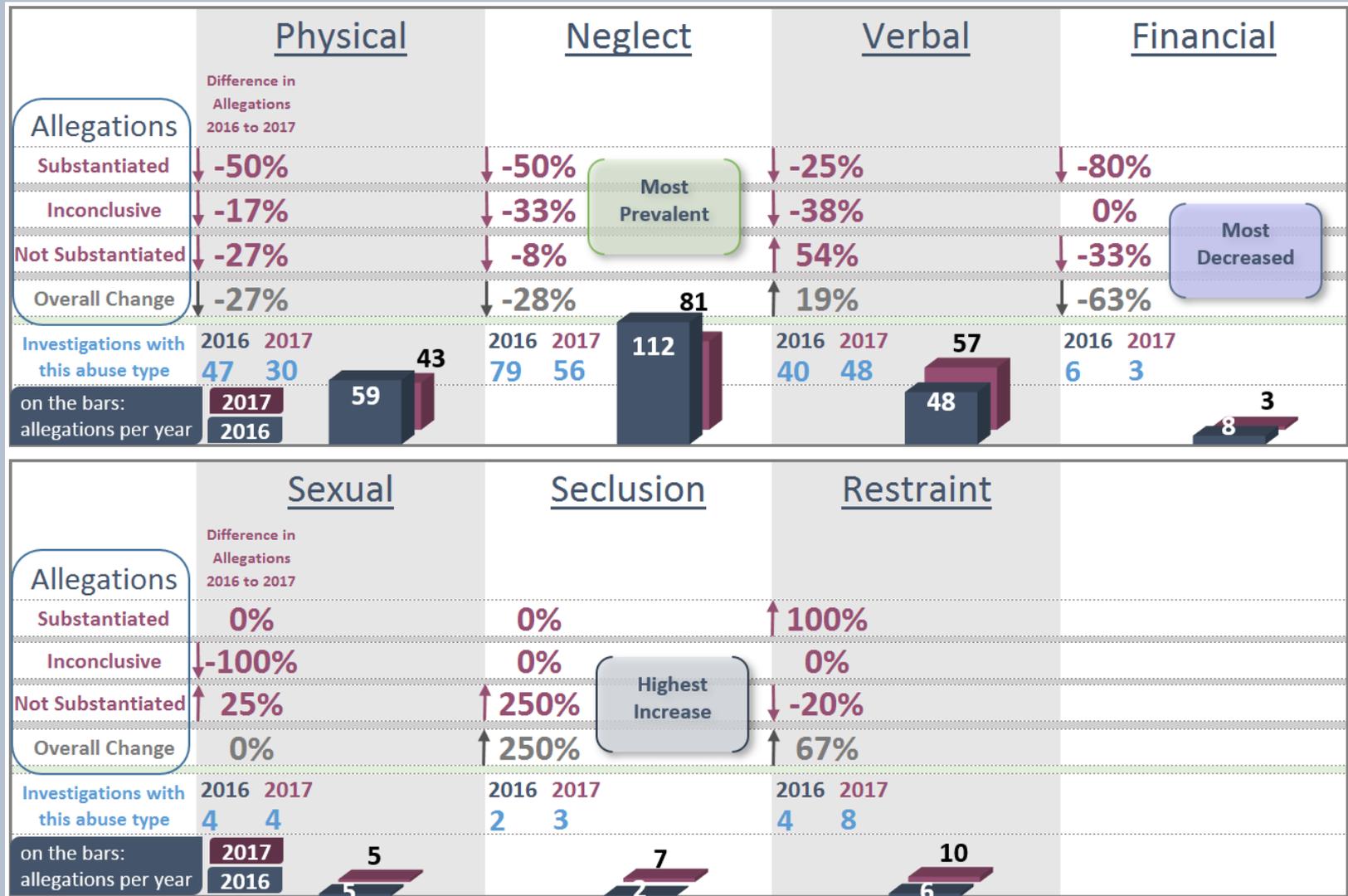
Outer Circle: Types of Abuse Investigated
Inner Pie: Types of Abuse Substantiated



Results of Abuse Investigations



SACU - Comparison of 2016 and 2017 Allegations



There are more allegations than investigations because an individual can experience multiple types of abuse in a single incident, or an investigation can contain multiple alleged victims or alleged perpetrators.

Intellectual/Developmental Disabilities Children's Residential Program Summary

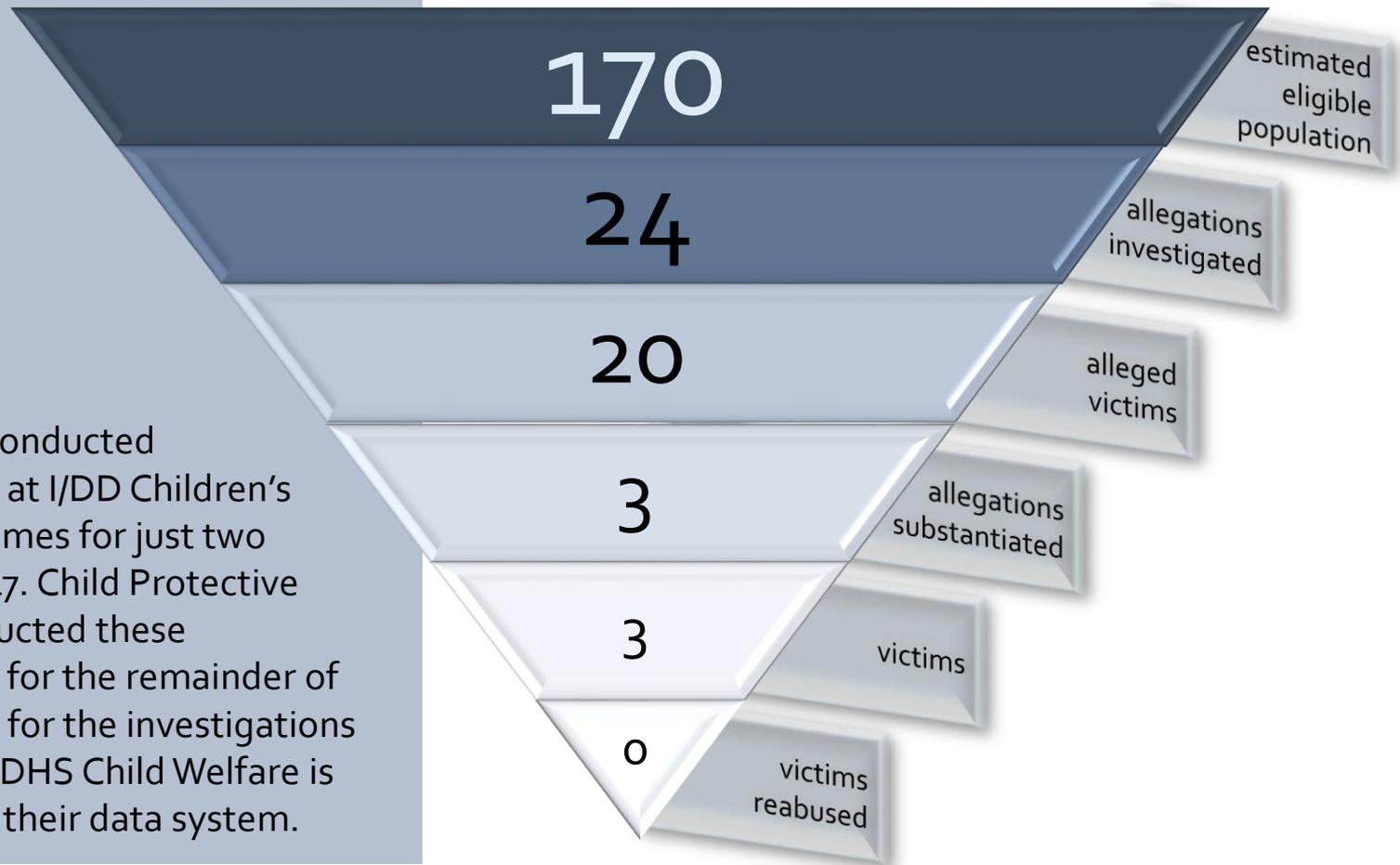
Children's I/DD 24-hour residential group homes specialize in meeting the needs of children who have intellectual / developmental disabilities and are intended to provide care that the child would normally receive in his/her family home. The children who live in these homes are enrolled in I/DD services. They may have families who are no longer able to provide the necessary level of care, supervision, and/or support to keep the child safe and to support the child's development. It is important to note that this population includes children who are in a specific type of state-licensed residential care setting. This does not include children in state care who are in foster homes nor does it include children in SACU settings.

In 2017, these investigations were transferred to investigators with the Child Welfare Program. Investigators from

OTIS/OAAPI were responsible for conducting abuse investigations in these licensed facilities for only two months. In 2018, it was decided to return these investigations to OTIS/OAAPI. As is frequently seen in residential programs, the two most frequent allegations were neglect and verbal abuse. Neglect was substantiated once, and verbal abuse was not substantiated.



2017 I/DD Children's Residential Allegations & Victims



OTIS/OAAPI conducted investigations at I/DD Children's Residential homes for just two months of 2017. Child Protective Services conducted these investigations for the remainder of the year. Data for the investigations conducted by DHS Child Welfare is maintained in their data system.

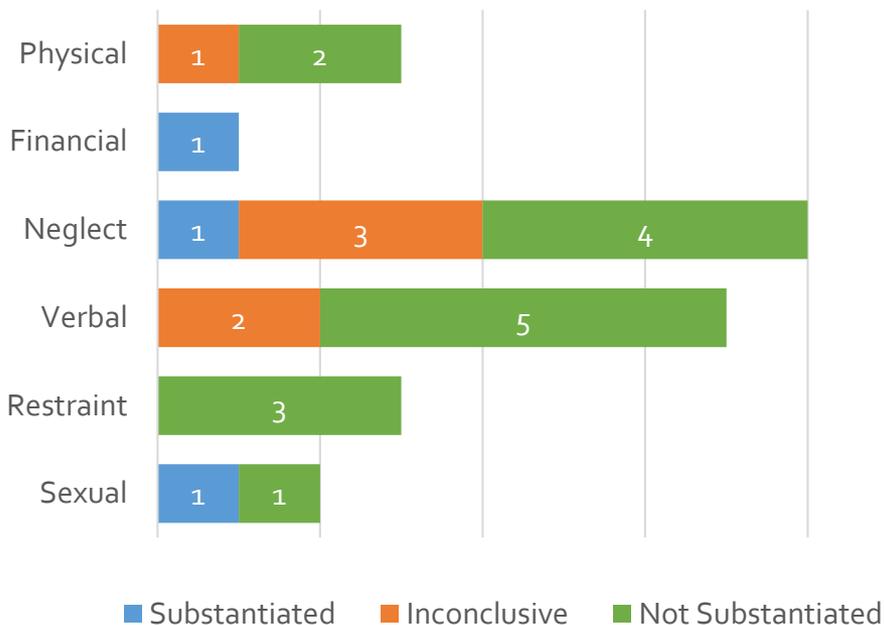
2017 I/DD Children's Residential

Allegation Results

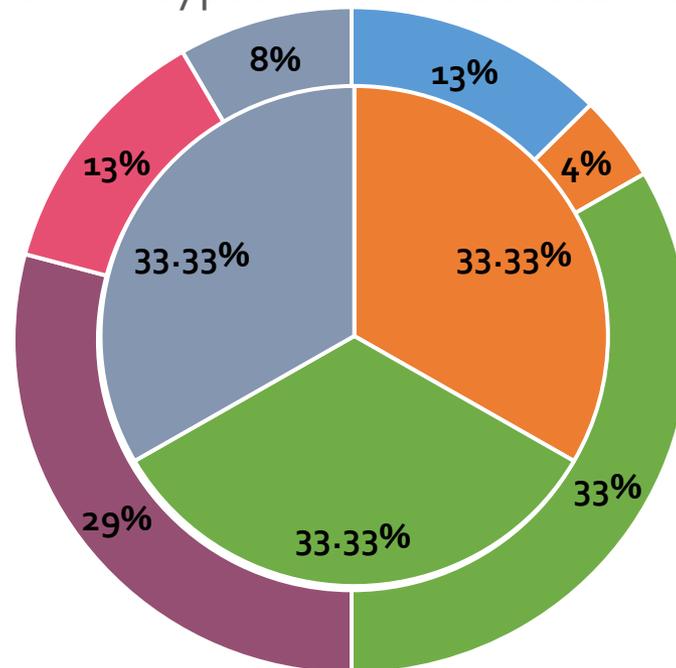
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Results of Abuse Investigations



Outer Circle: Types of Abuse Investigated
Inner Pie: Types of Abuse Substantiated



- Physical
- Financial
- Neglect
- Verbal
- Restraint
- Sexual

OTIS/OAAPI conducted investigations at I/DD Children's Residential homes for just two months of 2017. Child Protective Services conducted these investigations for the remainder of the year. Data for the investigations conducted by DHS Child Welfare is maintained in their data system.



Child Caring Agencies and Child Caring Programs

Child Caring Agencies & Child Caring Programs Program Summary

Statute related to Child-Caring Agencies (CCA) changed significantly on July 1, 2016. With the implementation of The Abuse of a Child-in-Care statute (SB 1515), two sets of statute and rule apply to these agencies—one to allegations that occurred before July 1, 2016 and one to those that occurred on or after that date. Each set of regulation identifies different abuse types; they also apply to somewhat different populations. The Abuse of a Child-in-Care statute applies to young people under age 21 who are served by a Child-Caring Agency; the older statute and rule applies only to young people up to age 18; OTIS/OAAPI identifies these as a Child-Caring Program or CCP.

Whether known as a CCA or a CCP, they provide therapeutic care to children and youth with emotional disturbances or behavioral health needs; the care may be either day-treatment, residential, or

therapeutic foster care. OTIS/OAAPI's Investigation Unit is responsible for conducting the protective service investigations at these facilities. Because the two different statutes and rules affect essentially the same eligible population, we consider the two programs together.

Comparing 2017 to 2016 is difficult for these programs. Use of the CCP statute and rule is dependent on the alleged abuse occurring before July 1, 2016. As more time passes, the number of investigations assigned under this statute dwindles. The change in statute occurred mid-year in 2016, so CCAs have only six months of data for 2016. In addition, OTIS/OAAPI worked with DOJ, program partners and providers well into the fall of 2016 to operationalize the new statute and rule. As clarity about the definition of abuse developed, the number of allegations assigned decreased.



CCA & CCP Program Summary

In 2017, OTIS/OAAPI investigators closed a combined total of 215 investigations using both the CCA and CCP rules that involved 48 different providers. Those investigations contained 387 allegations and involved almost 300 different children and young people. Just over 10 percent of the allegations investigated were substantiated. Only one child or young adult was the substantiated victim of abuse more than once in the calendar year.

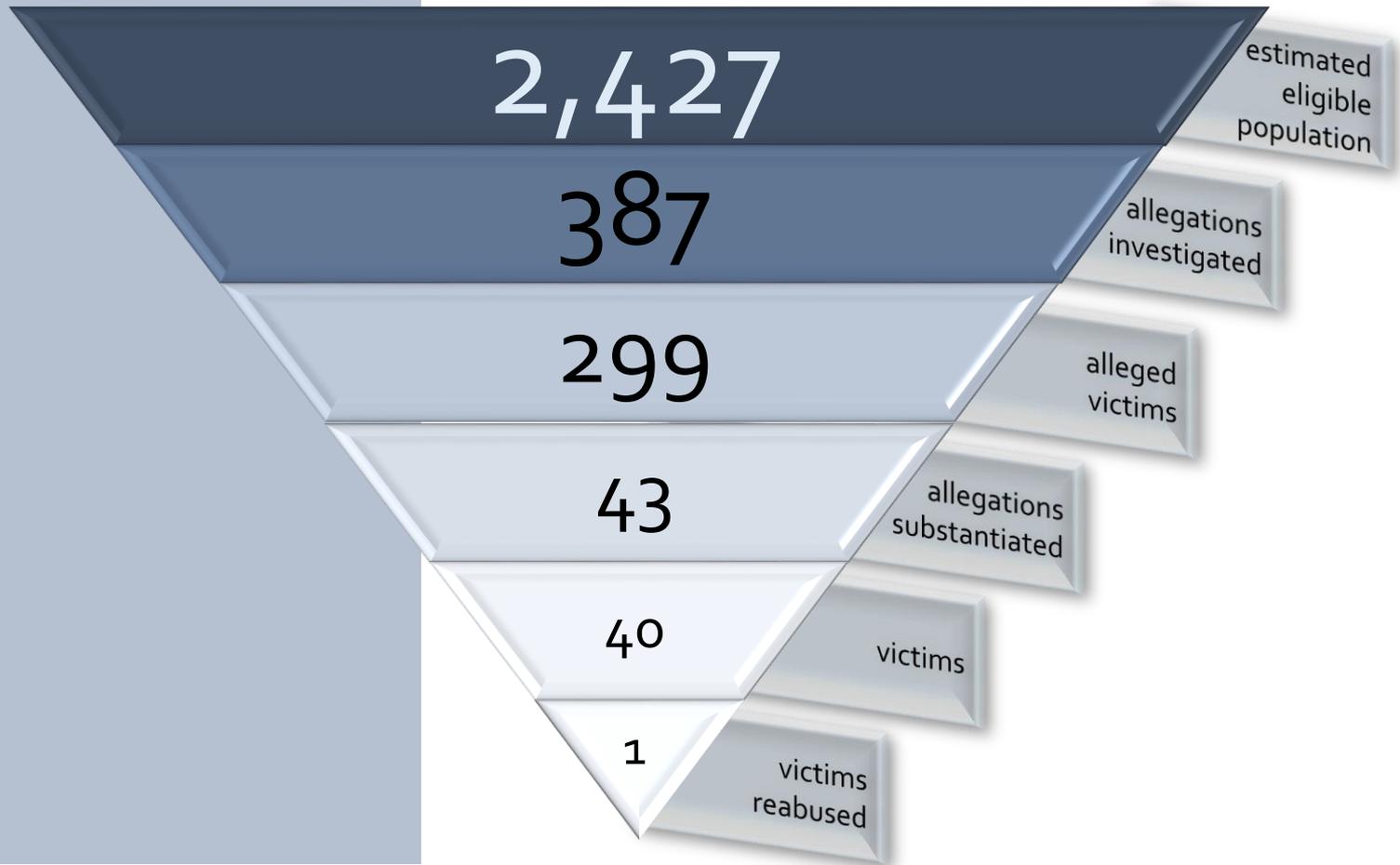
For those allegations investigated under the CCP rules, negligent treatment was the only abuse type that was substantiated; it was 70 percent of all of the allegations investigated. Neglect, an abuse type introduced by SB1515 that is similar to negligent treatment but more specific, comprised 55 percent of the allegations investigated under the CCA rule. This was the most frequently substantiated abuse

type. The next most frequently substantiated abuse type under this rule was sexual abuse, which had five substantiated allegations; four of those allegations were investigated in one case and involved the same staff person.

Next year, the data set will be sufficiently large to perform a year-to-year comparison. It will be informative to see how the understanding of abuse continues to evolve.



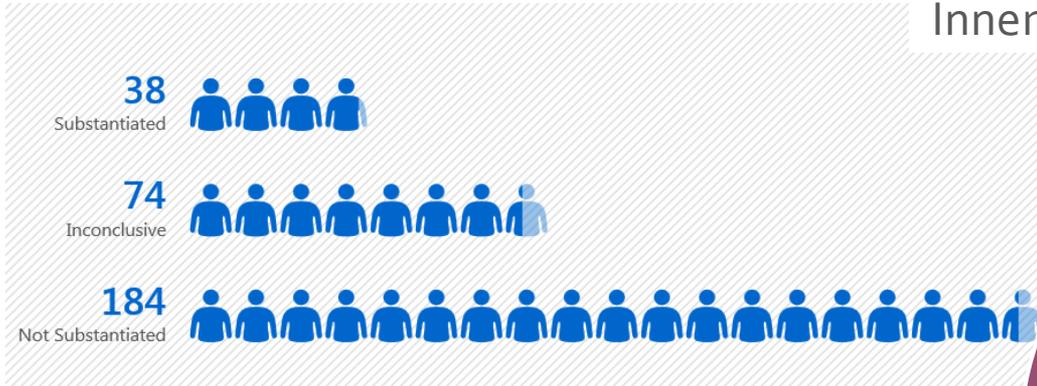
2017 CCA & CCP Population, Allegations, & Victims



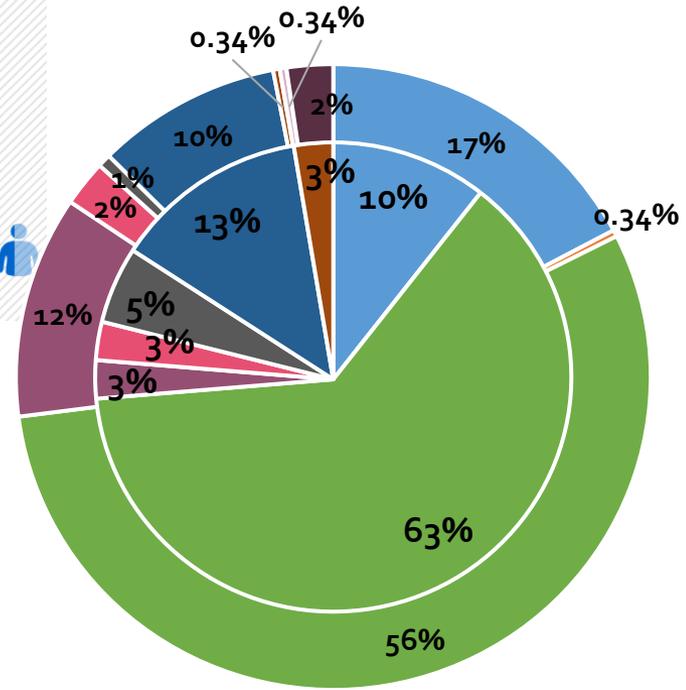
2017 Child Caring Agencies

Allegation Results

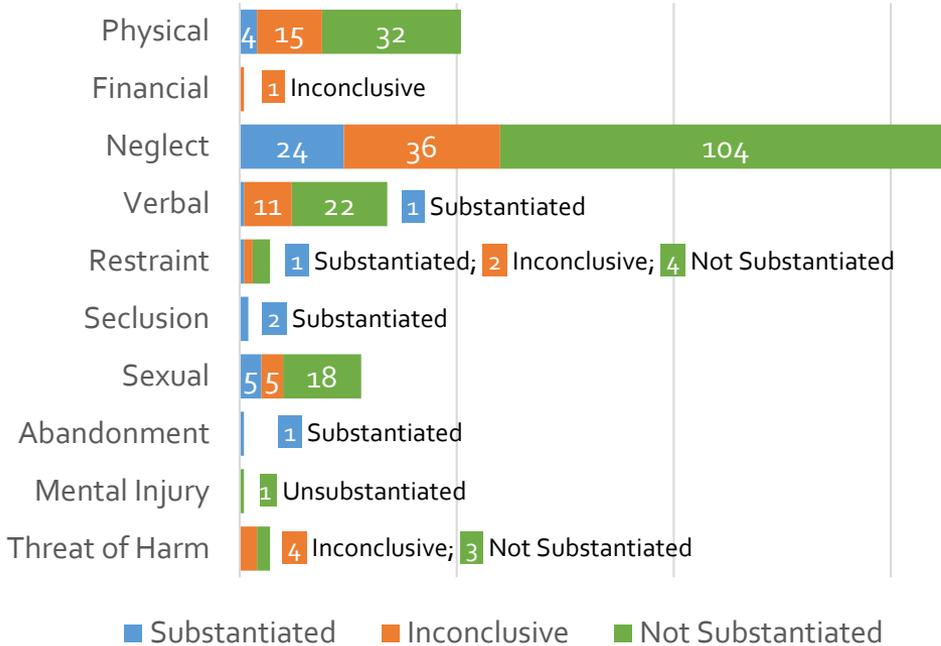
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Outer Circle: Types of Abuse Investigated
Inner Pie: Types of Abuse Substantiated



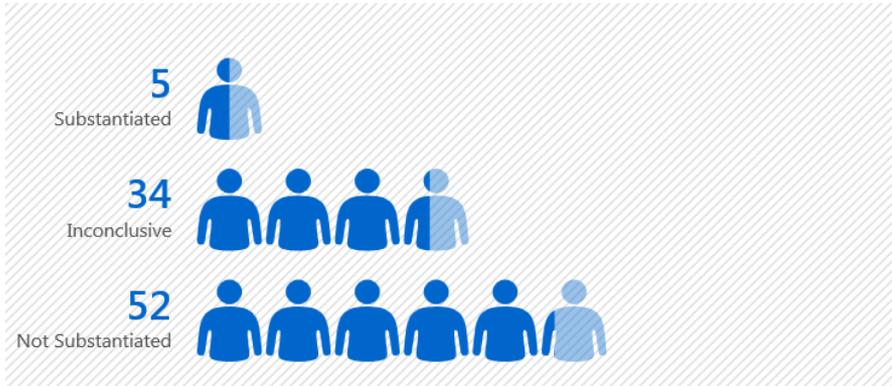
Results of Abuse Investigations



2017 Child Caring Programs

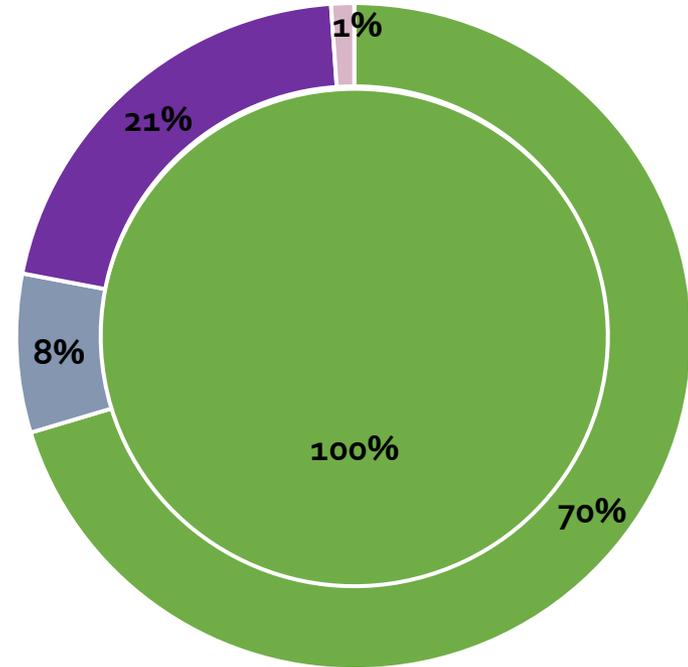
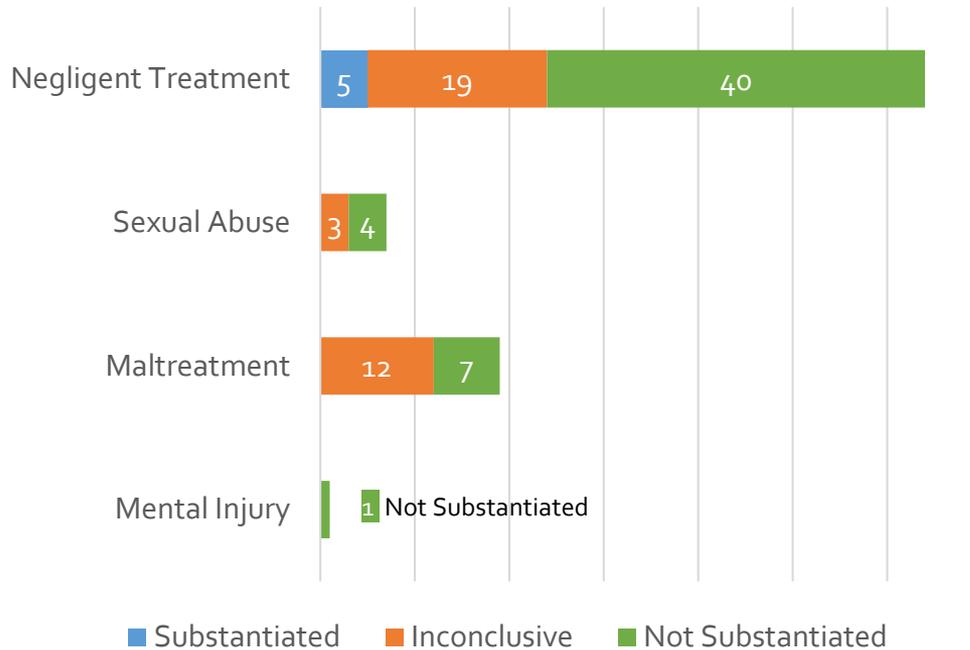
Allegation Results

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Outer Circle: Types of Abuse Investigated
Inner Pie: Types of Abuse Substantiated

Results of Abuse Investigations



- Negligent Treatment
- Sexual Abuse
- Maltreatment
- Mental Injury



Oregon Health Authority Programs

Community Mental Health Programs

Program Summary

Within the diverse population of individuals with a mental illness, there is a broad range of abilities and vulnerabilities. The need for services by people living with mental illness exists on a continuum, and people can move along that continuum at different times in their lives. Some people live independently and require minimal services such as medication management, case management and outpatient services. Others need significant assistance including service enriched housing, money management and intensive and on-going case management to remain independent in the community. Some people are unable to live independently and require the supports of licensed residential programs or commitment to a psychiatric facility to assure their health and safety.



The Oregon Health Authority (OHA) Health Systems division provides supports

and services to adults at all points on the continuum who are receiving mental health services through a Community Mental Health Program (CMHP) or through an entity that contracts with or is certified by the state or a CMHP. Support and services are also provided to individuals receiving care in a psychiatric placement in a hospital.

As a person with a mental illness moves along the continuum of service needs, his/her need for protective services will fluctuate. When a person with a mental illness is experiencing symptoms that impact his/her functioning, s/he may be more vulnerable to abuse and exploitation by others. A person's difficulty managing challenging symptoms or communicating needs can contribute to increased vulnerability. It is at these times that protective service investigations become particularly important to ensure the health and safety of the person.

CMHP Program Summary

Discrimination and stigmatization may further exacerbate the difficulties faced by adults with a mental illness and increase their risk of abuse. Most protective service investigations are conducted by the CMHP. Extremely complex investigations or investigations that involve a conflict of interest are referred to investigators with OTIS/OAAPI.

In 2017, OTIS/OAAPI, working in conjunction with the Department of Justice (DOJ) conducted an evaluation of statute. This evaluation resulted in a determination that authority for conducting an abuse investigation was more narrow than previously applied. It was discovered that allegations of abuse of certain populations fell outside of the scope of investigative authority. Following this discovery, OTIS/OAAPI, together with stakeholders and Legislators worked to rectify this. New statute was written,

passed by the Legislature and signed into law in 2018 that clarified the scope of investigations. This resulted in greater safety for people receiving mental health services.

This discovery resulted in 65 investigations and death reviews being closed without findings because it was determined they should not have been assigned. It also complicates the presentation of data for these programs. Statute and rule for these programs distinguished between abuse and mistreatment. For many years, this nuance was overlooked and all allegations were captured as abuse. As a result, the rate of abuse in these programs are likely overstated in 2017 as they have been historically.



CMHP Program Summary

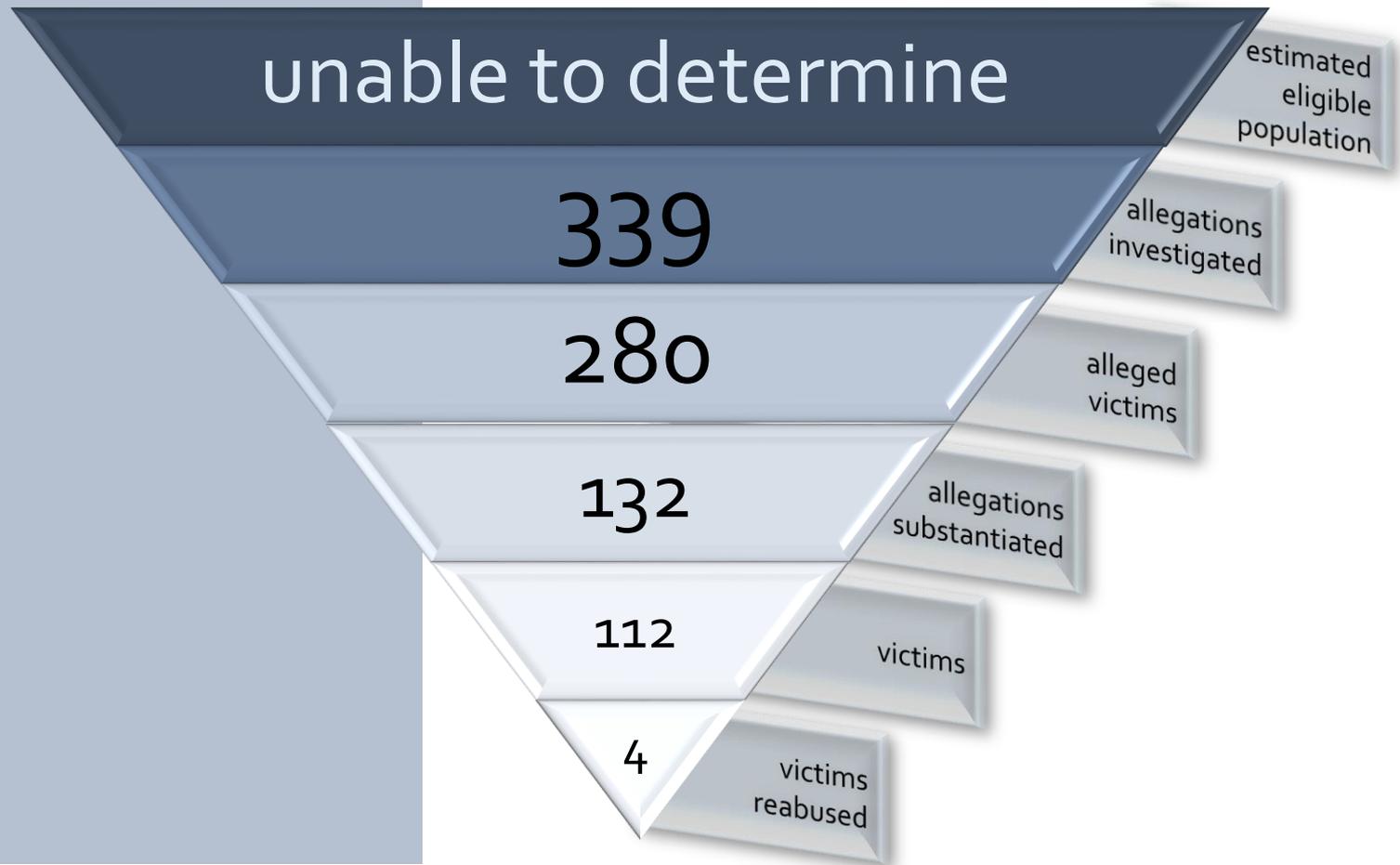
Comparison between 2016 and 2017 is also complicated by this discovery. As you'll see from the graphs on page 44, the number of sexual abuse allegations in non-licensed settings decreased. This is undoubtedly due to issues with the scope of authority to investigate. More than likely, the slight decrease in physical abuse investigations is due to the same reason. This same dynamic is in play with the increase in neglect allegations; individuals in community settings who have caregivers are most likely to fall within the scope of authority to investigate. Because the caregiver is paid to provide care or knowingly assumed the role, neglect of care is a frequently investigated allegation for all populations with caregivers.

The prevalence of neglect is also apparent in licensed settings; it is not only the most prevalent abuse type in licensed

residential mental health settings in 2017, it also shows the highest increase in reports. As in other programs, this is due to the responsibility the facility takes for the person residing in it. The decreases in verbal abuse, financial abuse, restriction, and restraint are likely due to the narrowing of the scope of authority.



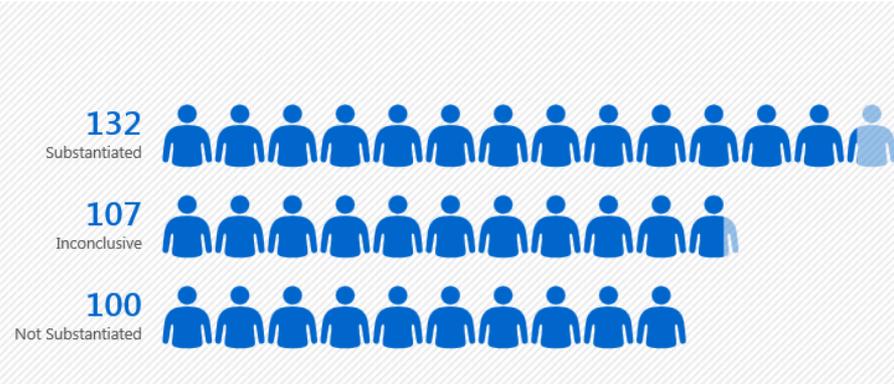
Community Mental Health Programs Allegations & Victims



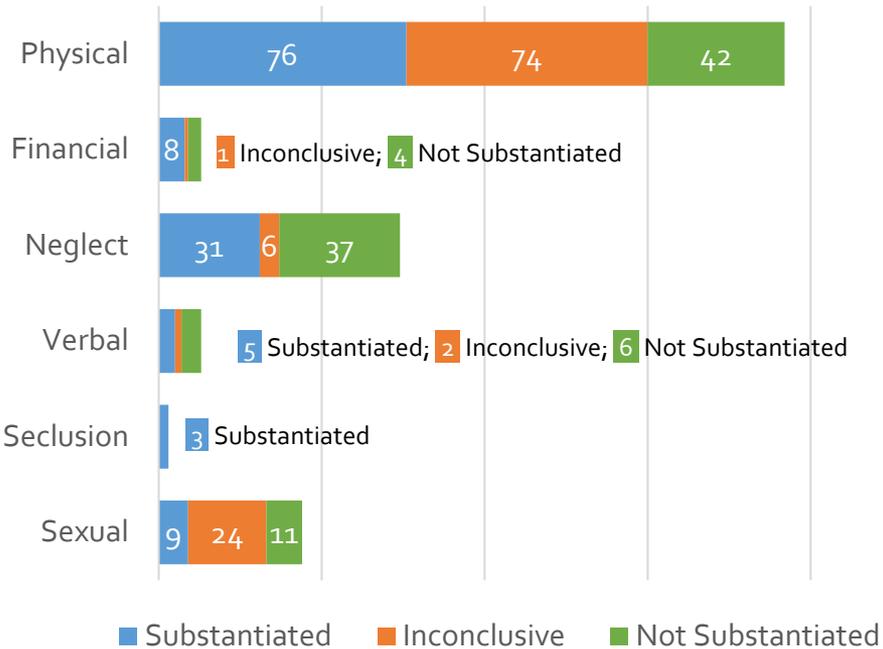
2017 Community Mental Health Programs

Allegation Results

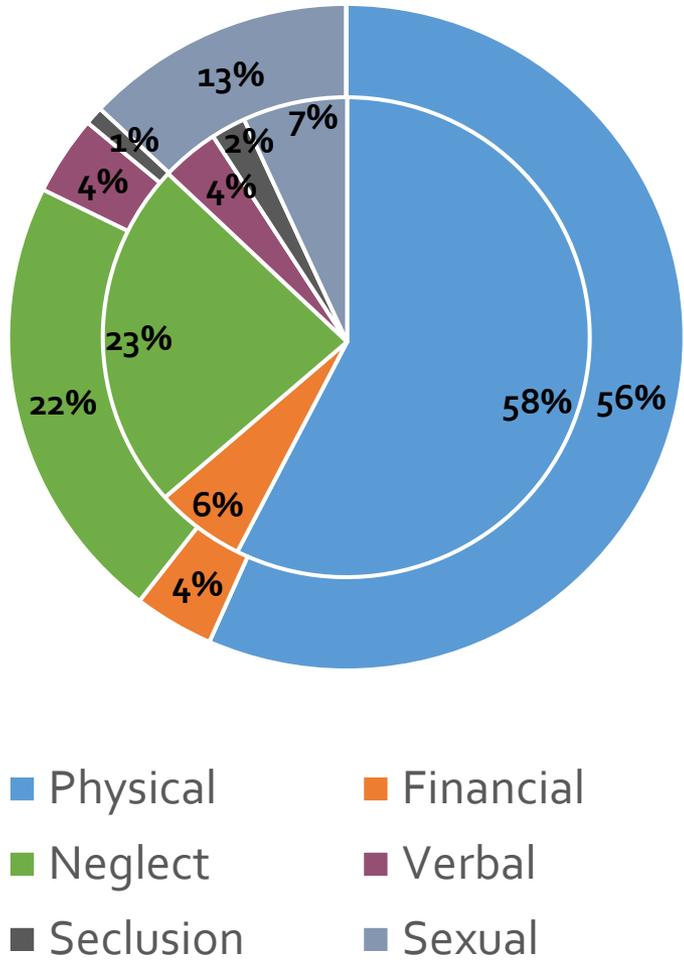
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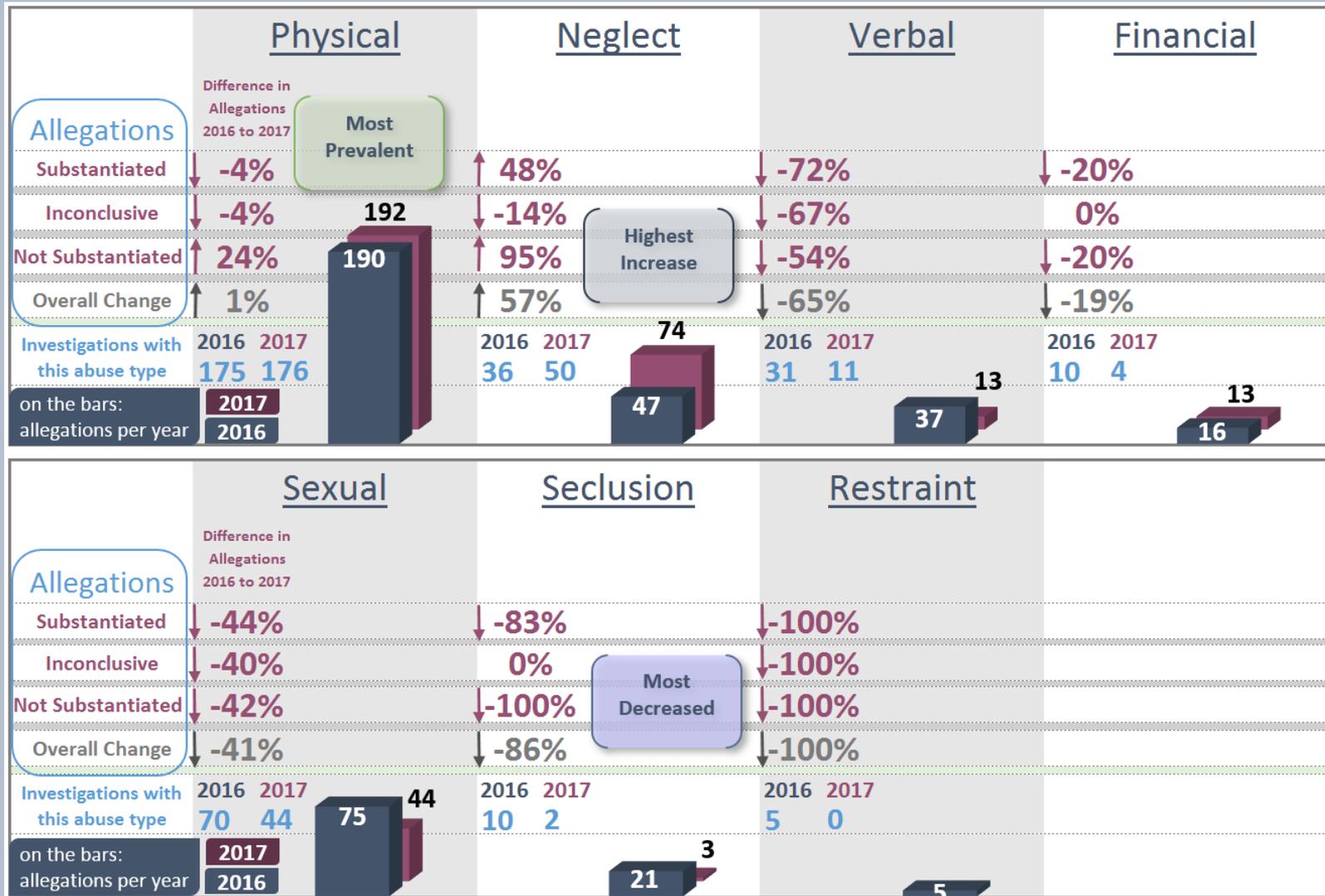
Results of Abuse Investigations



Outer Circle: Types of Abuse Investigated
Inner Pie: Types of Abuse Substantiated



CMHP - Comparison of 2016 and 2017 Allegations

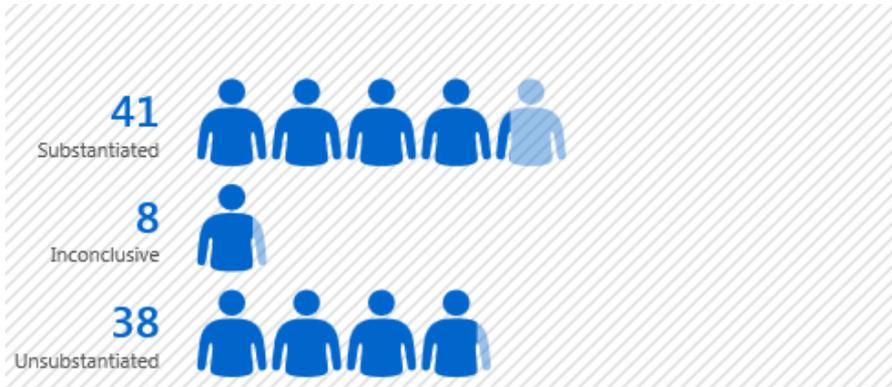


There are more allegations than investigations because an individual can experience multiple types of abuse in a single incident, or an investigation can contain multiple alleged victims or alleged perpetrators.

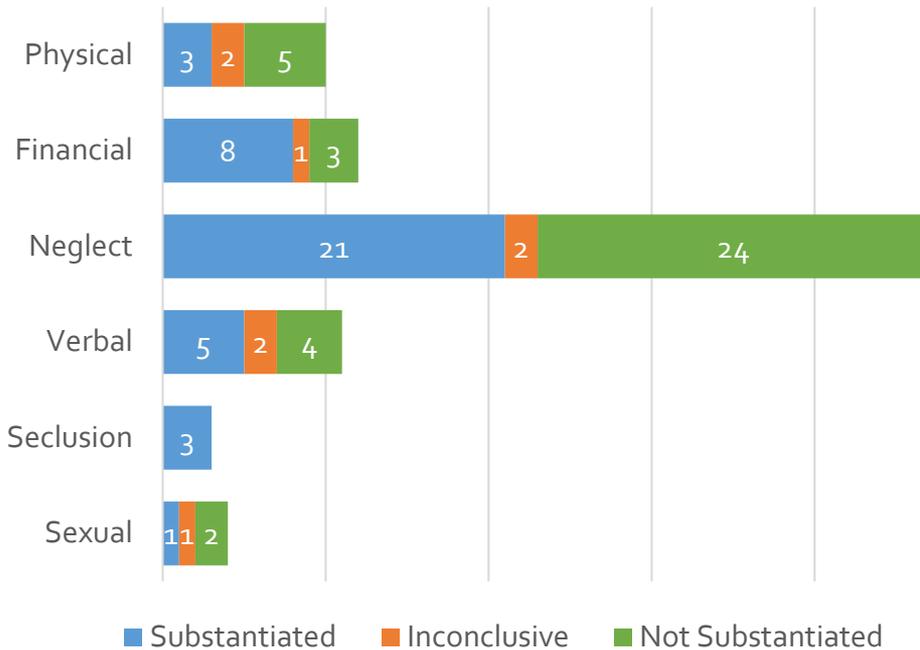
2017 CMHP - Licensed Settings

Allegation Results

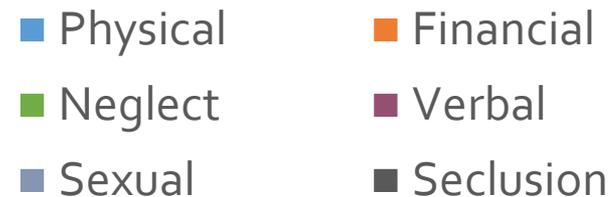
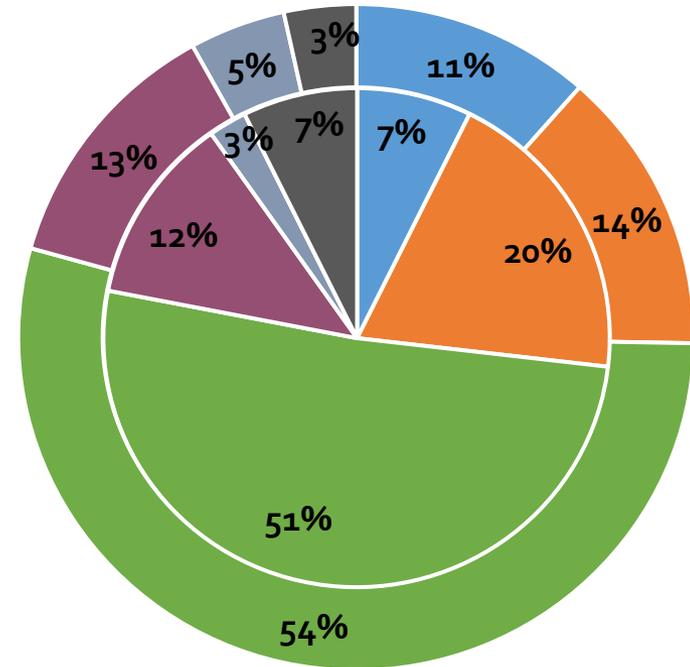
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Results of Abuse Investigations



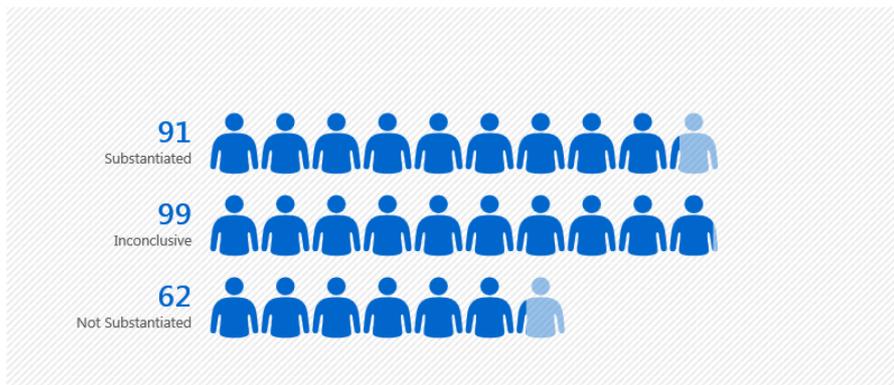
Outer Circle: Types of Abuse Investigated
Inner Pie: Types of Abuse Substantiated



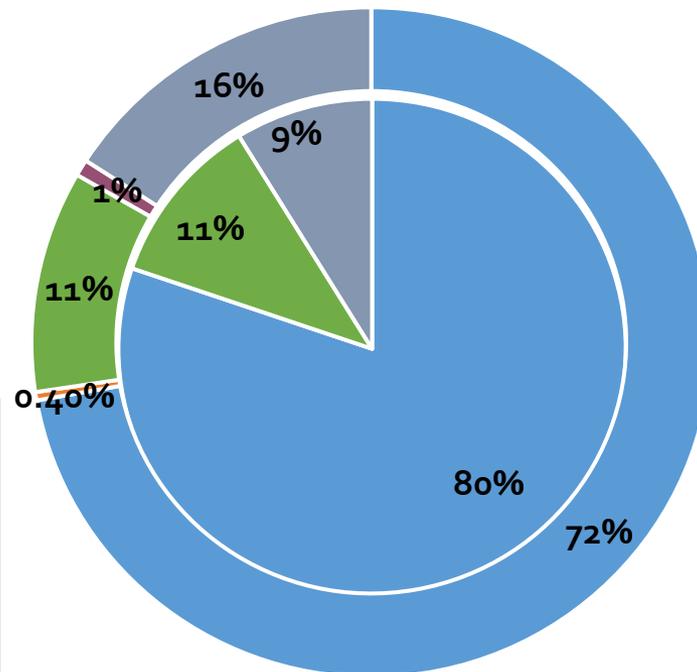
2017 CMHP - Non-Licensed Settings

Allegation Results

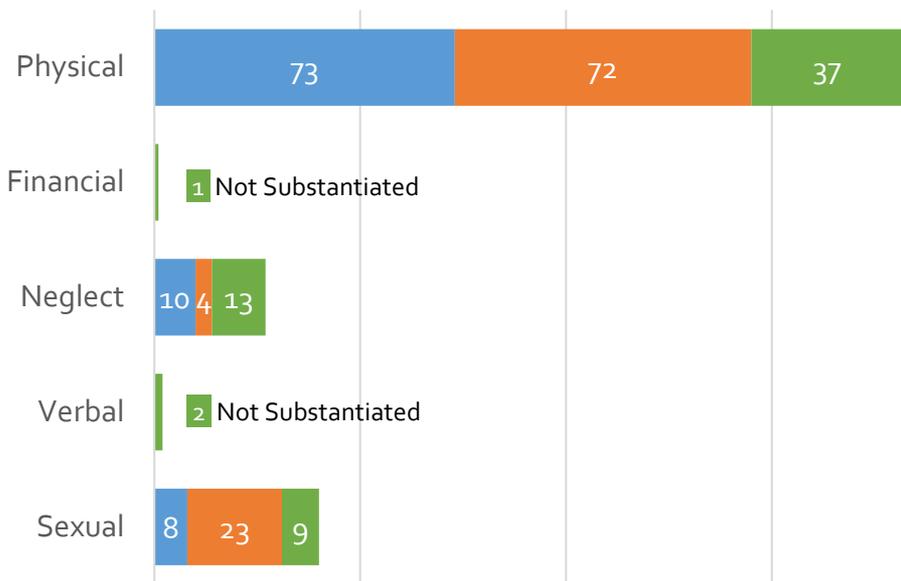
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Outer Circle: Types of Abuse Investigated
Inner Pie: Types of Abuse Substantiated



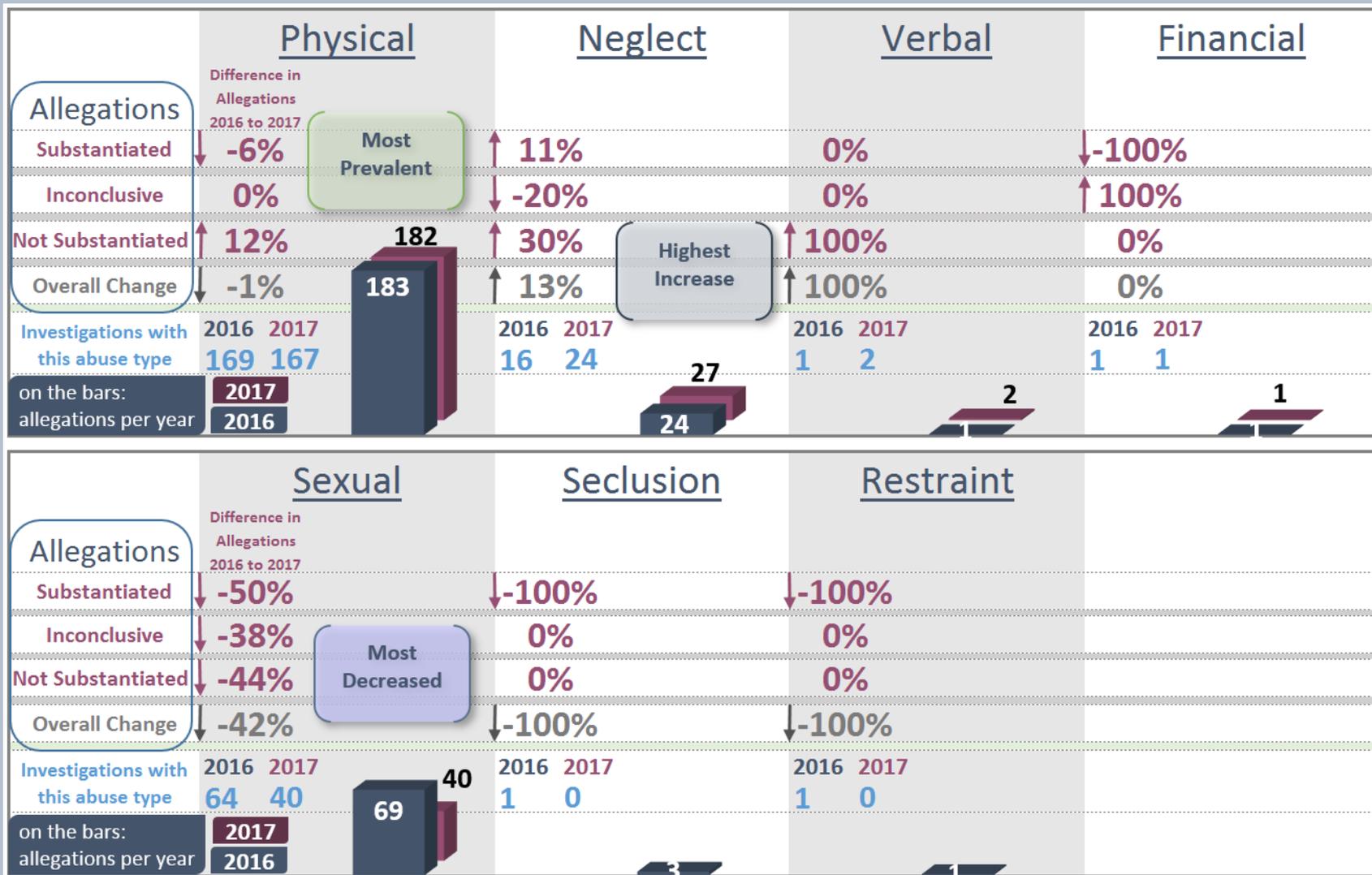
Results of Abuse Investigations



- Physical
- Financial
- Neglect
- Verbal
- Sexual

■ Substantiated ■ Inconclusive ■ Not Substantiated

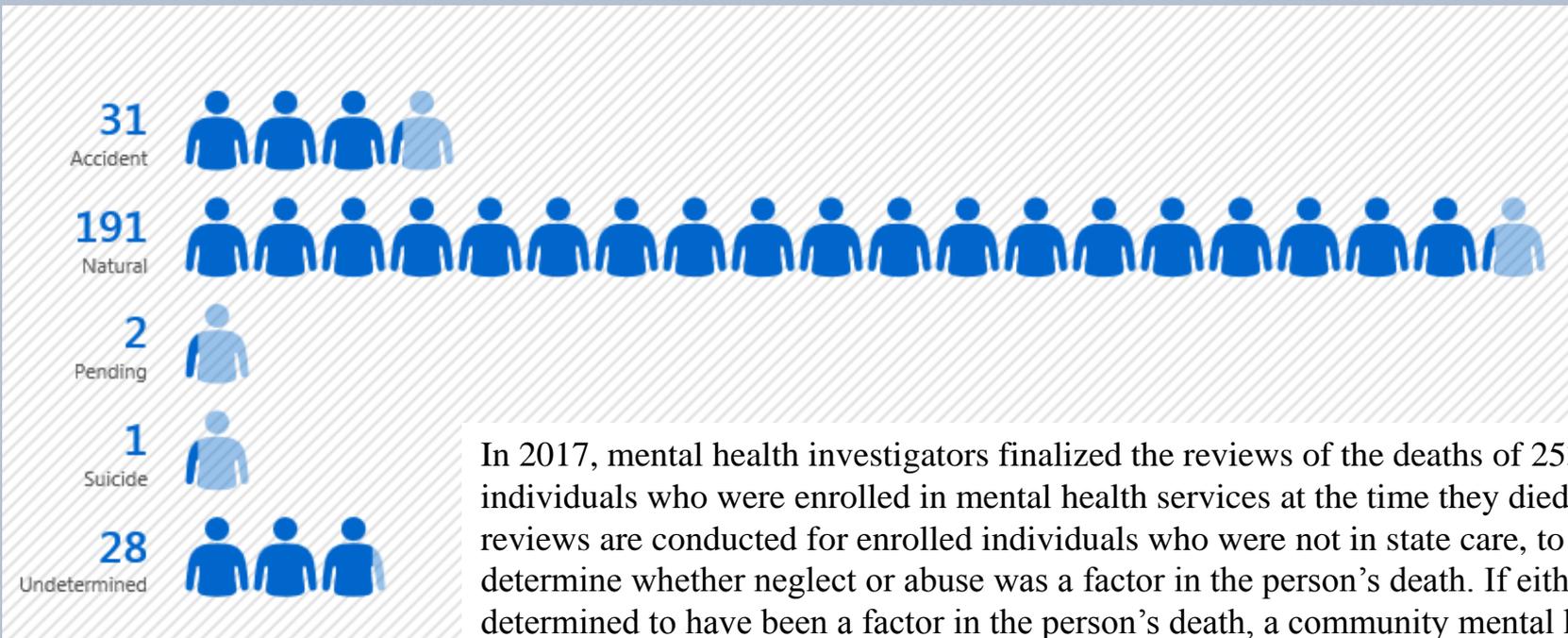
CMHP - Comparison of 2016 and 2017 Allegations in Non-Licensed Settings



There are more allegations than investigations because an individual can experience multiple types of abuse in a single incident, or an investigation can contain multiple alleged victims or alleged perpetrators.

2017 Reviews of Deaths of Adults with Mental Illness

 = 10



In 2017, mental health investigators finalized the reviews of the deaths of 253 individuals who were enrolled in mental health services at the time they died. These reviews are conducted for enrolled individuals who were not in state care, to determine whether neglect or abuse was a factor in the person's death. If either is determined to have been a factor in the person's death, a community mental health investigation will be opened.

Natural causes were responsible for 75 percent of the deaths investigated during the time period. Cancer, heart disease, renal failure, and pneumonia were the most frequently cited reasons. Accidental death occurred in 12 percent of these reviews, and 56 percent of accidental deaths were caused by drug misuse or overdose.

Oregon State Hospital and Oregon Health Authority Operated Residential Facilities Program Summary

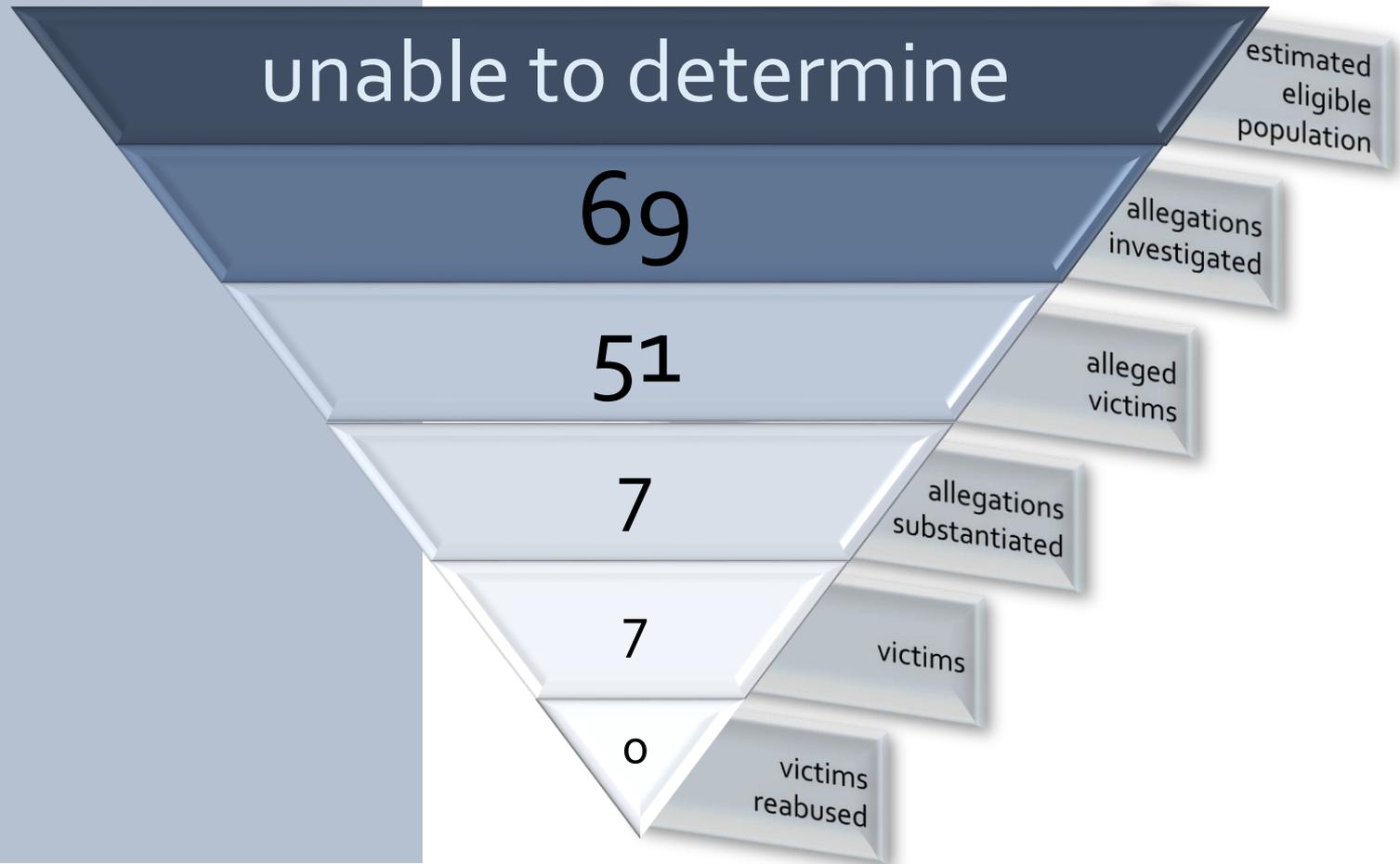
Investigators from OTIS/OAAPI's Investigation Unit are responsible for investigating allegations of abuse and neglect at Oregon State Hospital (OSH) and at Oregon Health Authority (OHA) operated residential treatment facilities such as the Cottages in Pendleton, which offer a less restrictive care setting than the state hospital. As with the community mental health programs, staff from partnering programs along with stakeholders from DOJ and OSH reviewed statute and determined that investigative authority was narrower than had been previously thought. Working with stakeholders and Legislators, OTIS/OAAPI sought new legislation to provide necessary protections to patients at the State Hospital. While that was in process, at the request of OSH leadership,



investigators from OTIS/OAAPI began conducting investigations for the State Hospital's Human Resources department. These investigations were for allegations of mistreatment rather than abuse.

As a result of these changes to investigative scope, investigations at the State Hospital and OHA Operated Residential Treatment Facilities decreased by 50 percent from 2016. Along with a decrease in the number of investigations, the number of substantiated allegations also decreased markedly. Those investigations that were conducted at the State Hospital relied solely on statute rather than applying both statute and rule; the more narrow definitions present in statute contributed to the decrease in substantiated allegations.

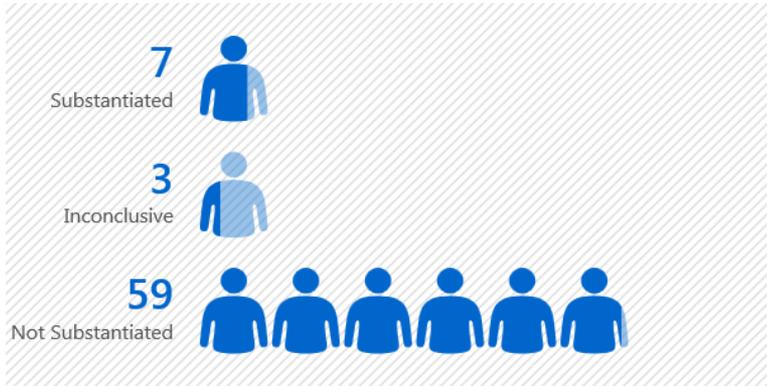
2017 OSH & OHA Operated Residential Facilities Allegations & Victims



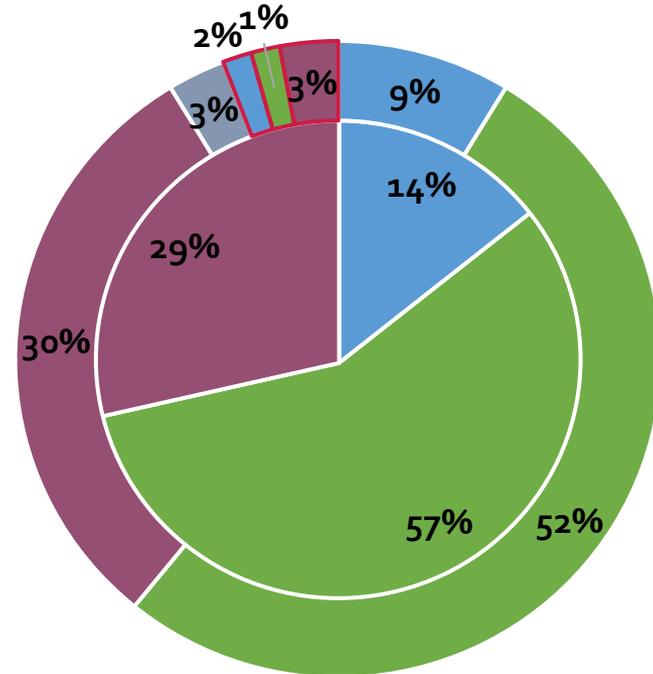
2017 OSH & OHA Operated Residential Facilities Data Sheet

Allegation Results

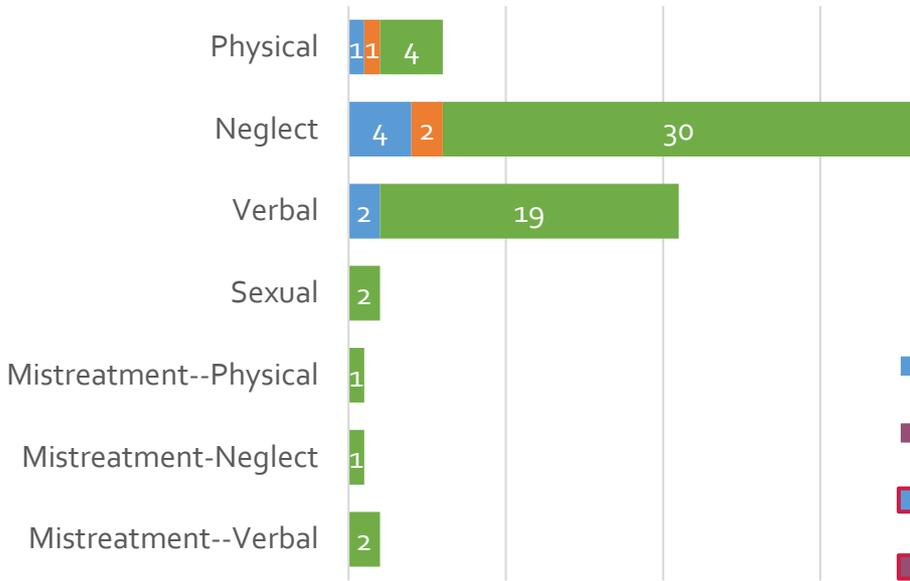
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Outer Circle: Types of Abuse Investigated
Inner Pie: Types of Abuse Substantiated

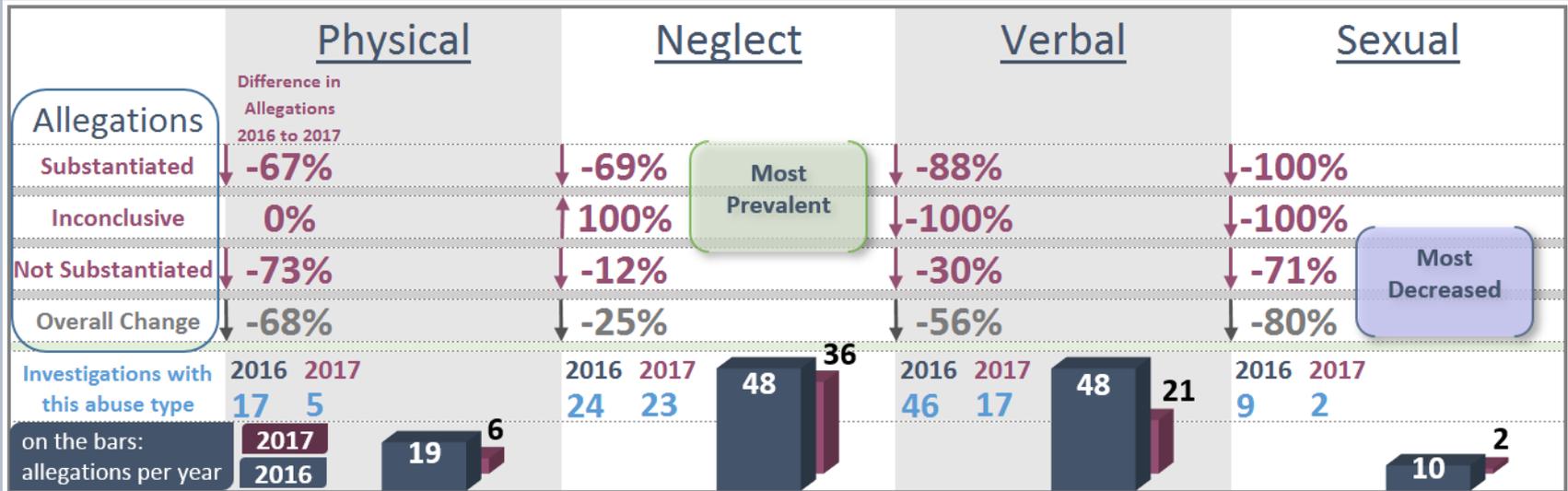


Results of Abuse Investigations



 Substantiated  Inconclusive  Not Substantiated

OSH & OHA Operated Residential Facilities Comparison of 2016 and 2017 Allegations



Mistreatment

There are no comparison data available for mistreatment allegations. In February 2017, as explained further on page 51, OTIS/OAAPI began conducting investigations for the OSH Human Resources Department. These resulted in mistreatment allegations.

Allegations	<u>Physical</u>	<u>Neglect</u>	<u>Verbal</u>
Substantiated	1	0	0
Inconclusive	0	0	0
Not Substantiated	1	1	2
Total Allegations	1	1	2
Investigations with this mistreatment type	2017	2017	2017
	1	1	2

There are more allegations than investigations because an individual can experience multiple types of abuse in a single incident, or an investigation can contain multiple alleged victims or alleged perpetrators.



Thank you to our
partners for
contributions to this
book

OTIS/OAAPI partners with other
offices and agencies to protect
Oregonians who may be at risk of
abuse. We coordinate and
conduct abuse investigations. We
provide trainings and regulatory
oversight for providers. The use of
data helps to inform and guide all
of our work.

To report abuse:
1-855-503-SAFE (7233)

Follow us on Facebook:
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More information: <https://www.oregon.gov/DHS/seniors-disabilities/adult-abuse/Pages/index.aspx>