

OAAPI

Office of Adult Abuse Prevention and Investigations

2016 DATA BOOK



Oregon
Health
Authority



DHS | Oregon Department
of Human Services

OAAPI is a Shared
Service of DHS & OHA

The 2016 Data Book was
produced in collaboration
with OAAPI's partners

2016 OAAPI Data Book

Table of Contents

Table of Contents	Slide Number
OAAPI Report	3
Reabuse Rates by Program	6
2016 Data Book Overview	7
Reader's Guide:	8
<ul style="list-style-type: none"> • Quick Facts Funnel Graphic • Visualizations Data Sheet – Nested Pie Charts • Nested Pie Charts with Breakdown of "Other" 	
2016 Facility APS	13
<ul style="list-style-type: none"> • Quick Facts Funnel • Visualizations • Program Summary 	
2016 Community APS	17
<p><i>Excluding Self-Neglect</i></p> <ul style="list-style-type: none"> • Quick Facts Funnel • Visualizations <p><i>Including Self-Neglect</i></p> <ul style="list-style-type: none"> • Quick Facts Funnel • Visualizations • Program Summary 	
2016 Intellectual / Developmental Disabilities – Adults	27
<ul style="list-style-type: none"> • Quick Facts Funnel • Visualizations <ul style="list-style-type: none"> ♦ All I/DD Adults ♦ I/DD Adults in Licensed Settings ♦ I/DD Adults in Non-Licensed Settings • Program Summary 	

	Slide Number
2016 Stabilization And Crisis Unit	34
<ul style="list-style-type: none"> • Quick Facts Funnel • Visualizations • Program Summary 	
2016 Intellectual / Developmental Disabilities – Children's Residential	38
<ul style="list-style-type: none"> • Quick Facts Funnel • Visualizations • Program Summary 	
2016 Child Caring Agencies	42
<ul style="list-style-type: none"> • Quick Facts Funnel • CCA Visualizations • CCP Visualizations • Program Summary 	
2016 Mental Health Programs	50
<ul style="list-style-type: none"> • Quick Facts Funnel • Visualizations <ul style="list-style-type: none"> ♦ All MH Adults ♦ MH Adults in Licensed Settings ♦ MH Adults in Non-Licensed Settings • Program Summary 	
2016 Oregon State Hospital and Oregon Health Authority Operated Residential Facilities	56
<ul style="list-style-type: none"> • Quick Facts Funnel • Visualizations • Program Summary 	
2016 Reviews of Deaths of Adults with Mental Illness	59

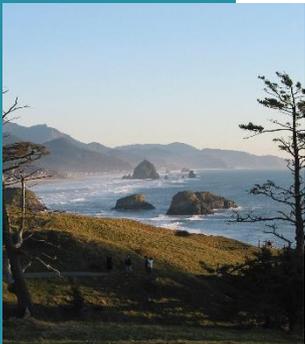


OAAPI Summary

OAAPI Report

The 2016 Data Book focuses on the people the State of Oregon has a responsibility to protect – they range from children and youth in care to elders and physically disabled adults. They are adults with intellectual and developmental disabilities or living with mental illnesses who are enrolled for services. Some of the protected people reside at the Oregon State Hospital or at another state operated mental health treatment facility.

Protected people live along the Pacific Coast or in the high deserts of Eastern Oregon, in the Columbia Gorge or the Willamette Valley, in the urban density of Portland or the vast open ranges of Harney County. What every vulnerable person has in common is the assurance protective services are assessed as mandated to them by Oregon Revised Statute (ORS). This is



the story of those protective service assessments during 2016.

OAAPI is part of the Department of Human Services (DHS) Shared Services and supports programs within both DHS and the Oregon Health Authority (OHA). Along with our partner agencies, OAAPI strives to ensure that vulnerable Oregonians are safe—wherever they live. OAAPI investigators are responsible for investigations of possible abuse or neglect in licensed child-caring agencies, the Oregon State Hospital (OSH), OHA-operated residential treatment facilities for people with mental illness, and residential training homes for people with developmental disabilities operated by the state Developmental Disabilities Services Program (I/DD) as the Stabilization and Crisis Units (SACU).

OAAPI Summary

OAAPI Report

Analysts at 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 and people 65 years and older and people with physical disabilities.

Oregon Revised Statute (ORS) and the Oregon Administrative Rules (OAR) are living documents that change over time, and 2016 was a time of significant change for one protected population. On July 1, 2016, Senate Bill 1515 took effect. With it, a new set of abuse definitions specifically for “children in care” that applied across programs (DHS, OHA, and Oregon Youth Authority) took effect. This legislation also changed the age range of those people protected. Young people up



to the age of 21 in these agencies are now protected; formerly the upper age limit of protection was 18. The standard for substantiating an abuse allegation also changed from preponderance of evidence to reasonable cause.

DHS/OHA staff and many providers who work with protected populations are mandatory reporters of abuse, and OAAPI’s training team works with them to help them recognize signs of abuse and neglect. Abuse is less frequently reported in community settings; a recent study of elder abuse showed that for every case reported, 24 instances went unreported.¹ Victims may be reluctant to self-report because of fear of retaliation, lack of ability to report, or desire not to get the abuser in trouble.

¹ Lifespan of Greater Rochester, Inc., Weill Cornell Medical Center of Cornell University, & New York City Department for the Aging. (2011). [Under the Radar: New York State Elder Abuse Prevalence Study \(PDF\)](#).

OAAPI Summary

OAAPI Report

An investigation results in findings of substantiated, not substantiated/unsubstantiated, or inconclusive. In all programs except CCAs, these findings are based on the preponderance of evidence—more than 50% of the evidence points one way or the other. If the investigator cannot determine which way the preponderance of evidence leans, or is unable to contact a vital witness or to obtain essential evidence s/he may reach a conclusion of 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 that respects self-determination, asking what protective services are necessary to keep the victim safe and to address any needs the victim has that arise 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 form the basis of 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.



OAAPI Summary

OAAPI Report

Through these protective services and recommendations, the investigator is seeking to prevent further abuse or neglect. We define reabuse as occurring when a person is identified as the victim in two or more substantiated investigations within the same year. The reabuse rate is determined based on the number of reabused victims divided by the number of unduplicated substantiated victims.

Program	Reabuse Rate
Facility APS	6.1%
Community APS <i>excluding self-neglect</i>	5.2%
Community APS <i>including self-neglect</i>	5.4%
I/DD total	6.3%
I/DD licensed settings	8.0%
I/DD non-licensed settings	3.8%
Stabilization and Crisis Center	34.3%
Children's 24-hour Residential Programs	17.1%
Mental Health Programs total	3.6%
Mental Health Programs <i>licensed settings</i>	6.5%
Mental Health Programs <i>non-licensed settings</i>	1.0%
Oregon State Hospital and OHA-Operated Residential Treatment Facilities	4.0%
CCA/CCP	6.7%

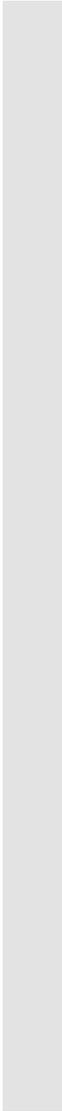
Despite similarities in the investigation process, each program is evaluated individually due to factors like distinct eligible populations per program, varying abuse rules based on their intended population, and the eligible person's living situation. As will become apparent, the size of the eligible population varies dramatically which also makes comparison across programs problematic. Because of the profound differences between programs, no aggregate numbers for abuse across the state will be included in the data book.



2016 Data Book Overview

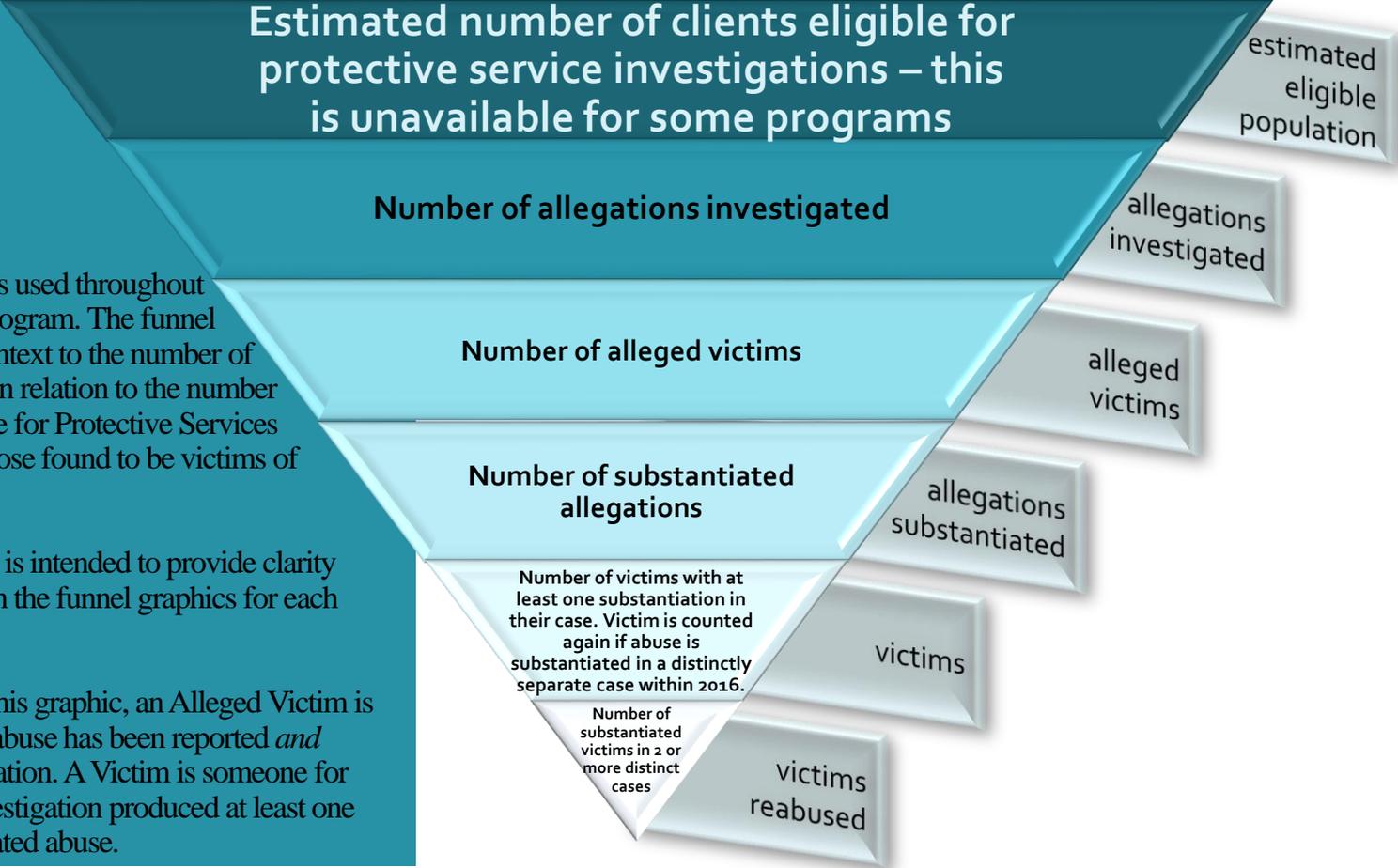
Facility APS	<ul style="list-style-type: none"> • In 2016, of the 7,114 allegations of abuse investigated, 1,267 were substantiated • 5,832 people were alleged to be victims, and 1,074 individuals were found to have been abused
Community APS	<ul style="list-style-type: none"> • In 2016, of the 14,737 allegations of abuse and self-neglect investigated, 4,185 were substantiated • 10,990 people were alleged to be victims, and 3,195 individuals were found to have been abused or self-neglecting • Notably, without Self Neglect, there were 12,270 allegations of abuse investigated and of those, 3,634 were substantiated • Without Self Neglect, 8,701 people were alleged to be victims, and 2,678 individuals were found to have been abused
Intellectual/Developmental Disabilities - Adults	<ul style="list-style-type: none"> • In 2016, of the 1,399 allegations of abuse investigated, 660 were substantiated • 997 people were alleged to be victims, and 546 individuals were found to have been abused
Stabilization And Crisis Unit	<ul style="list-style-type: none"> • In 2016, of the 240 allegations of abuse investigated, 62 were substantiated • 181 people, both children and adults were alleged to be victims, and 54 individuals were found to have been abused
Intellectual/Developmental Disabilities -Children Residential	<ul style="list-style-type: none"> • In 2016, of the 181 allegations of abuse investigated, 47 were substantiated • 133 people were alleged to be victims, and 35 individuals were found to have been abused
Child Caring Agencies	<ul style="list-style-type: none"> • In 2016, of the 623 allegations of abuse investigated, 129 were substantiated • 476 people were alleged to be victims, and 91 individuals were found to have been abused
Mental Health Programs	<ul style="list-style-type: none"> • In 2016, of the 391 allegations of abuse investigated, 164 were substantiated • 304 adults were alleged to be victims, and 144 individuals were found to have been abused
Oregon State Hospital and Oregon Health Authority Operated Residential Facilities	<ul style="list-style-type: none"> • In 2016, of the 125 allegations of abuse investigated, 34 were substantiated • 99 people were alleged to be victims, and 26 individuals were found to have been abused





Reader's Guide

Definitions: Population, Allegations, & Victims Funnel



This funnel graphic is used throughout the report for each program. The funnel endeavors to give 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.

This definitions slide is intended to provide clarity about the numbers on the funnel graphics for each program.

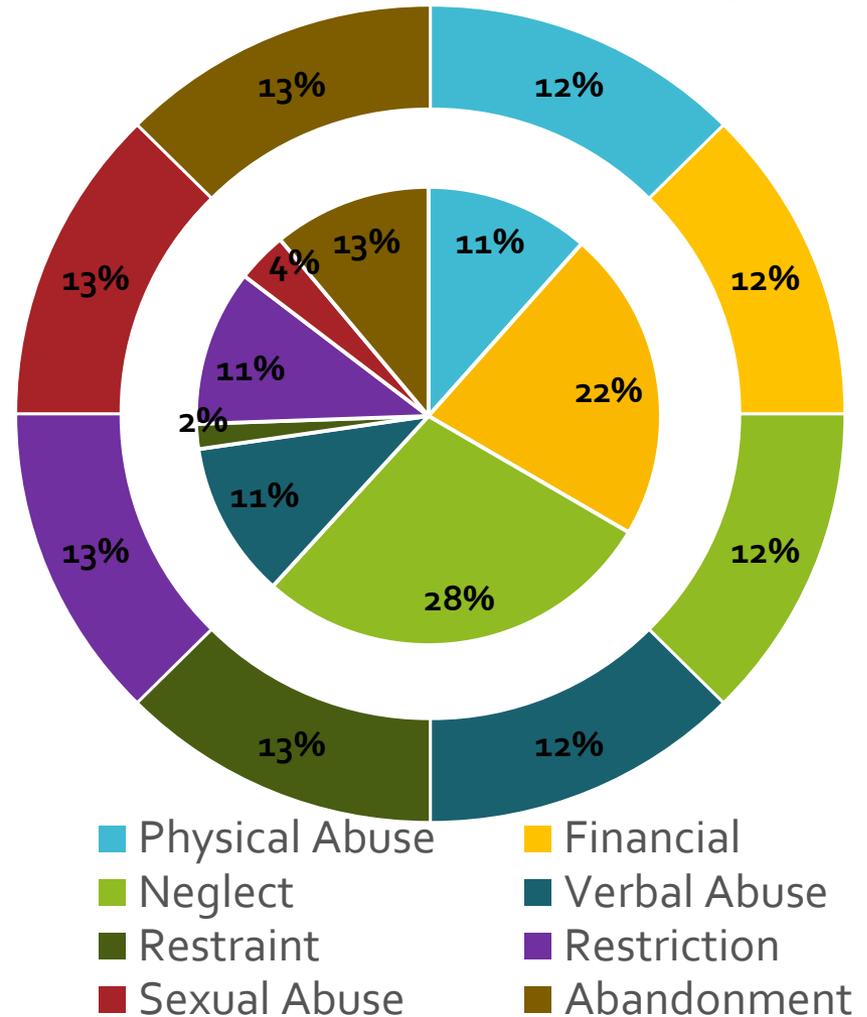
For the purposes of this graphic, an Alleged Victim is someone for whom abuse has been reported *and* assigned for investigation. A Victim is someone for whom the abuse investigation produced at least one instance of substantiated abuse.

Definitions: Visualizations Data Sheet

Nested pie charts allow for a seamless and effective comparison of the difference between the abuse types investigated and the abuse types that are actually substantiated.

- The Outer Circle shows the distribution of Abuse Types that were investigated. All allegations in investigations which concluded in 2016 are represented here.
- The Inner Circle shows the distribution of Abuse Types that were substantiated. Only substantiated abuse is represented here, and the percentage of each abuse type is based on total substantiations, not total allegations.
- For this sample data, allegations of neglect comprised 12% of allegations investigated, and 28% of all allegations substantiated.

Outer Circle: Types of Abuse Investigated
Inner Circle: Percentage of All Substantiated Allegations by Abuse Type

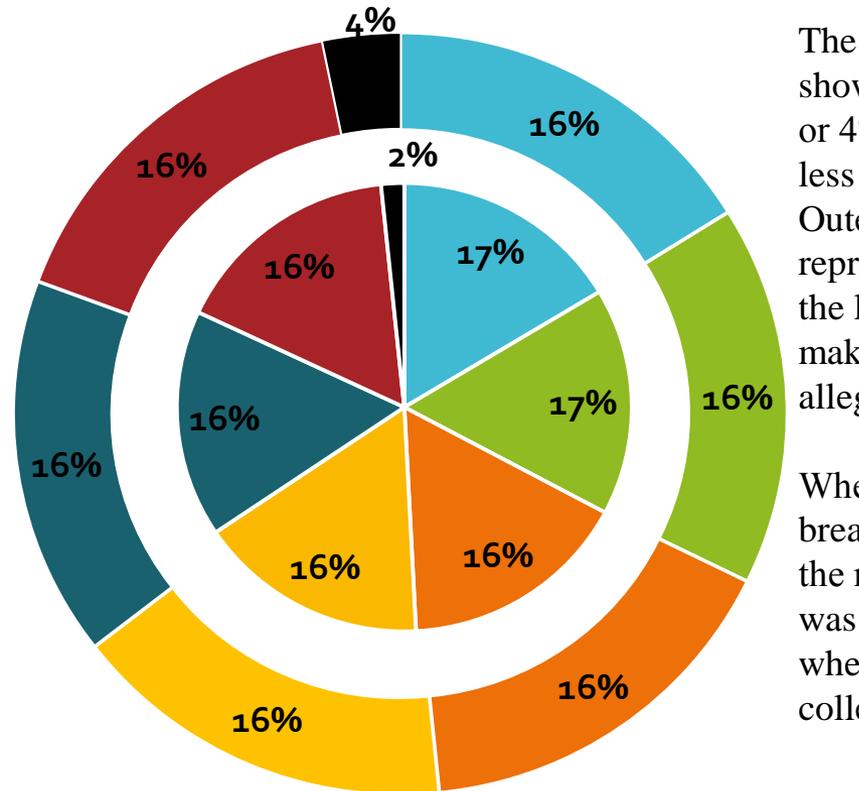


Definitions: Nested Pie Charts when Breakdown of "Other" is Used

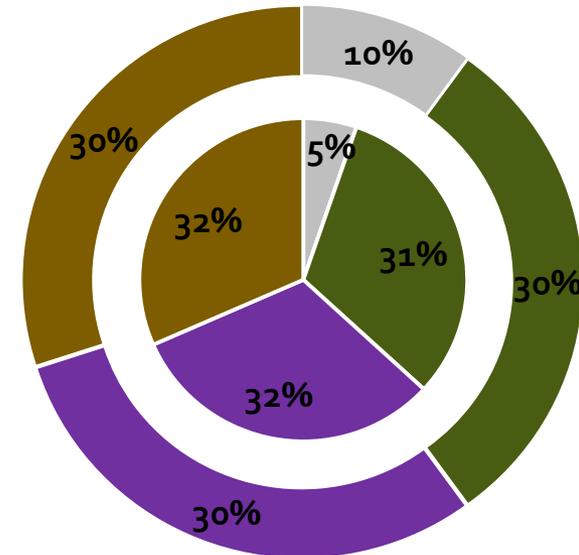
In some programs, some abuse types produce pie chart slivers too small to see clearly when they're next to the more prevalent abuse types. The left set of graphs captures five abuse types plus "Other".

The Breakdown of "Other" graphs show what percentage of that 2% or 4% of "Other" belongs to the less prevalent abuse types. On the Outer Circle, Abandonment represents 30% of the 4% Other in the larger nested pie charts. That makes Abandonment 1.3% of all allegations investigated.

When "Other" appears in the breakdown (the set of graphs on the right), it means that "Other" was selected as the Abuse Type when the investigation data was collected.



Breakdown of "Other"



- Other
- Wrongful Restraint
- Involuntary Seclusion
- Abandonment

- Physical Abuse
- Neglect
- Self Neglect
- Financial Exploitation
- Verbal/Emotional
- Sexual Abuse
- Other

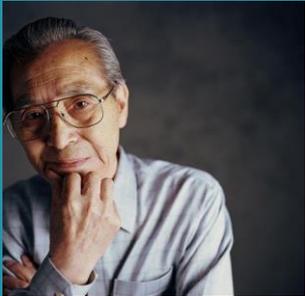
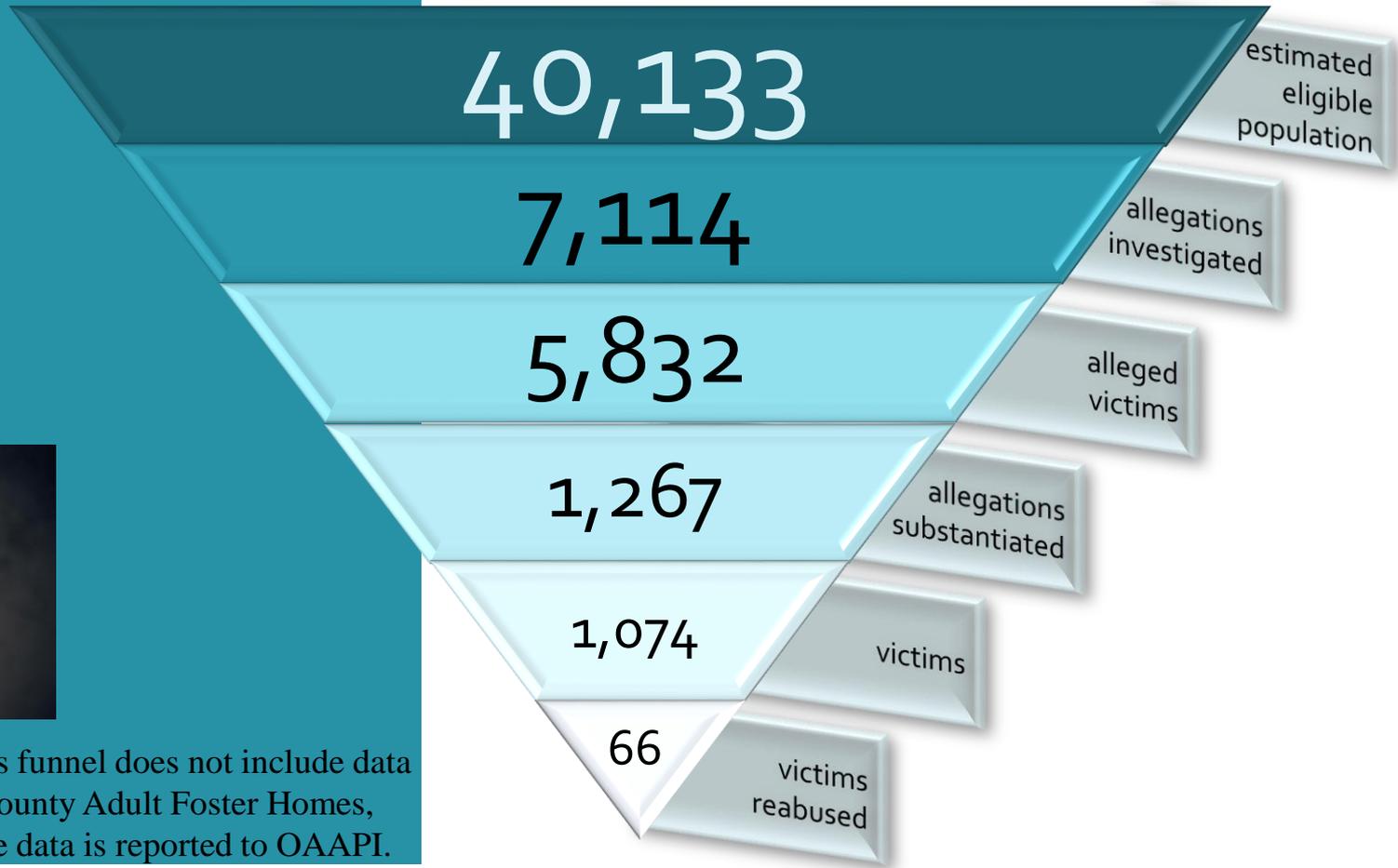




Aging and People with Disabilities Programs

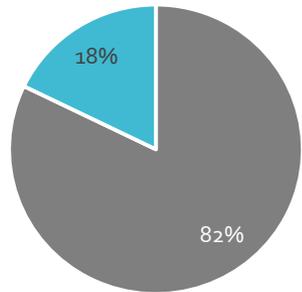


2016 Facility APS



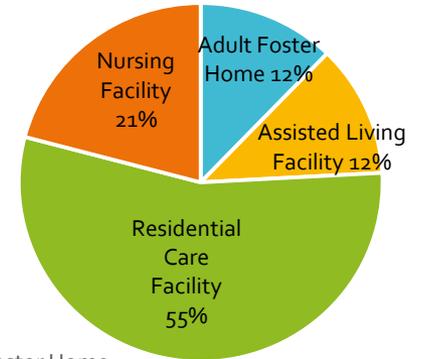
Victim data in this funnel does not include data for Multnomah County Adult Foster Homes, due to the way the data is reported to OAAPL.

2016 Facility APS Data Sheet

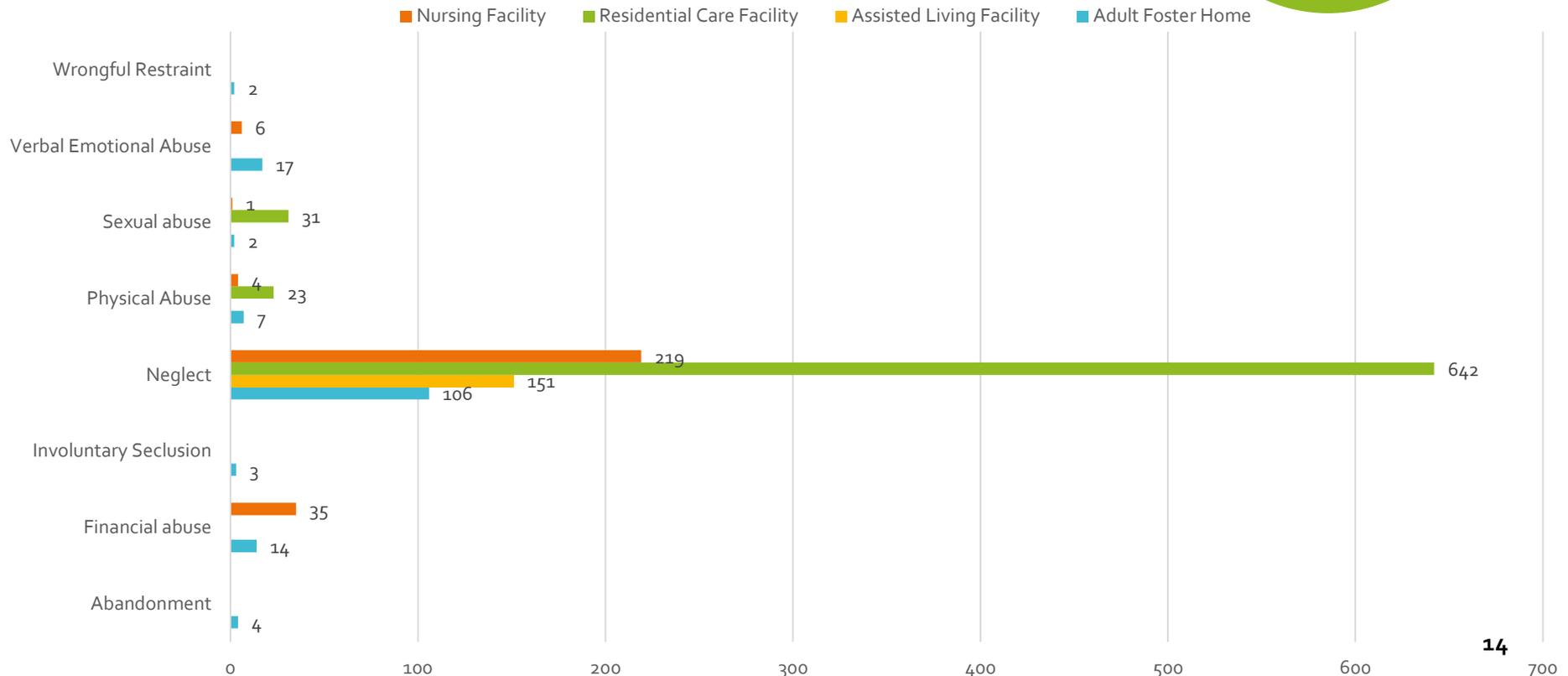


7,114 Allegations Investigated
1,267 Allegations Substantiated

Distribution of Substantiated Allegations by Facility Type



Substantiated Abuse by Facility Type



Program Summary

Facility APS

Protective services investigations for adults over 65 years of age and people with disabilities are broadly divided into either community or facility investigations—depending on where the person identified as the victim lives. All people who live in care facilities are eligible for protective service investigations regardless of their age. The estimated eligible population is based on the number of occupied licensed beds¹ at all types of facilities—nursing homes, assisted living facilities, residential care facilities, and adult foster homes multiplied by the occupancy rate for that type of facility.



In 2016, Adult Protective Service (APS) investigators and surveyors from the Nursing Facility Survey Unit (NFSU) investigated 7,114 allegations of abuse or neglect at facilities throughout Oregon. The majority of these investigations were conducted by APS, however NFSU has jurisdiction over some types of allegations at nursing facilities.

These allegations involved 5,832 reported victims; some people were reported to have been the victim of more than one type of abuse in an investigation.

¹ Portland State University Institute on Aging, Oregon State University College of Public Health and Human Sciences, Oregon Department of Human Services (2016). *Comparison of Long-Term Care Settings in Oregon, 2016*. Retrieved from <http://www.oregon.gov/DHS/SENIORS-DISABILITIES/pages/publications.aspx>

Program Summary

Of those people identified as possible victims, a little over 75% were sixty-five (65) years of age or over. Due to missing data on victims' ages, it's possible this percentage is higher. For those whose age was known, the average age of a reported victim was eighty-two (82).

In 2016, 1,267 allegations of abuse or neglect were substantiated in Oregon facilities. An overwhelming number of these substantiated allegations were for neglect. Because a care facility assumes broad responsibility for the resident, neglect of care is the most common complaint made that involves residents of care facilities.



The 1,267 substantiated allegations involved 1,074 victims. The difference between the number of victims and substantiated allegations could mean a person was the victim of two or more different types of abuse and/or neglect or that multiple people perpetrated against the victim.

Sixty-six (66) people experienced re-abuse in a facility setting. As we are defining it, re-abuse occurs when a person who was found to be a victim in one investigation is found to be a victim in a different, subsequent investigation.

2016 Community APS

Excluding Self-Neglect

500,000+

estimated
eligible
population

12,270

allegations
investigated

8,701

alleged
victims

3,634

allegations
substantiated

2,678

victims

132

victims
reabused

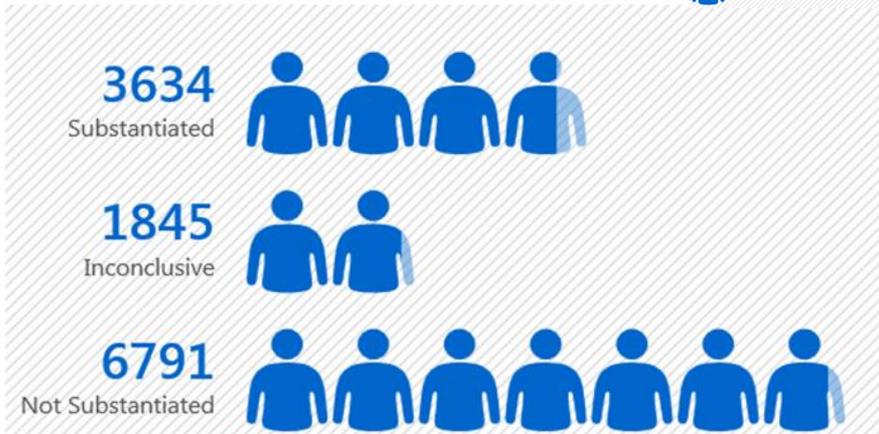


Self-Neglect is a unique abuse type because there is no alleged perpetrator. There is value in seeing what happens to the data excluding Self-Neglect and including it (slide 20).

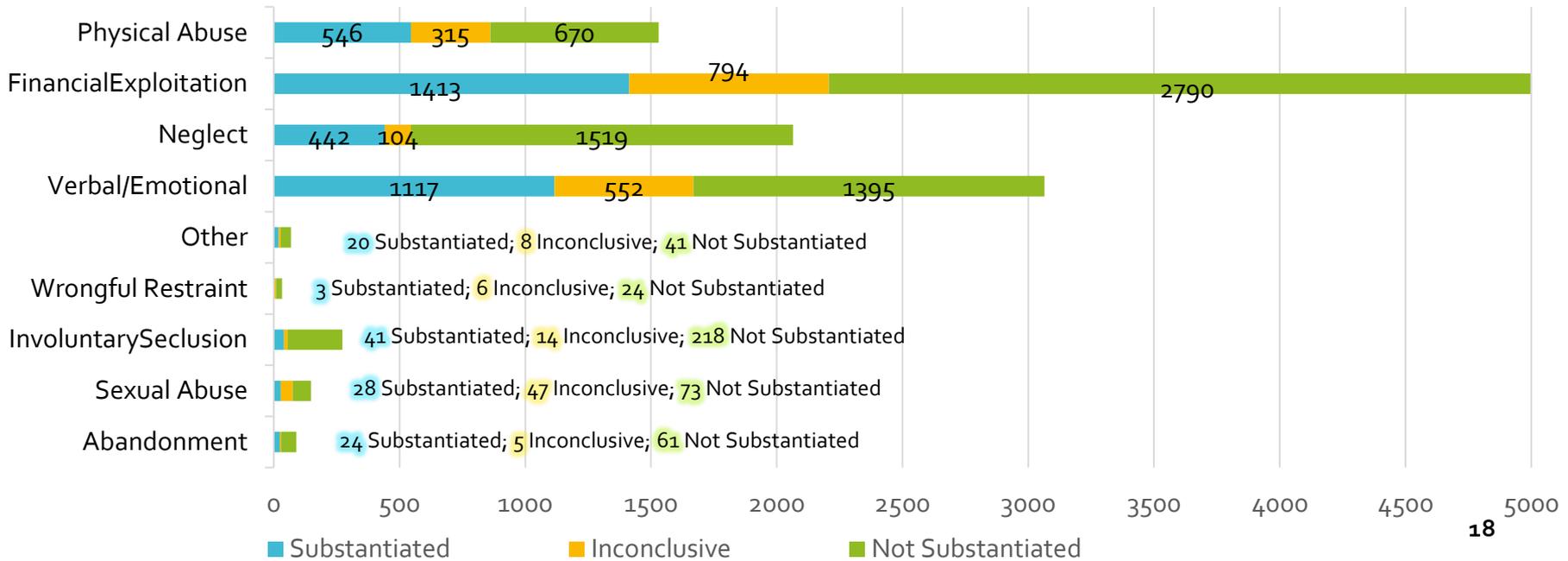
2016 Community APS excluding Self Neglect

Allegation Results

 = 1000

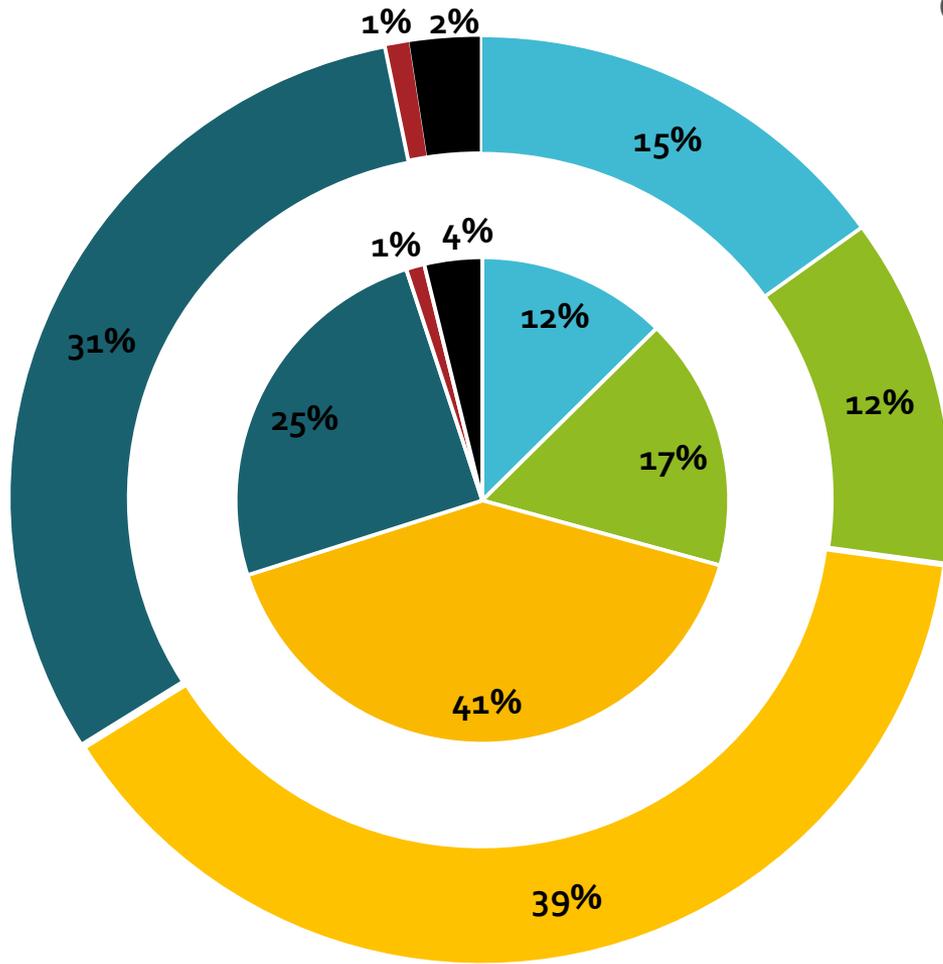


Results of Abuse Investigations



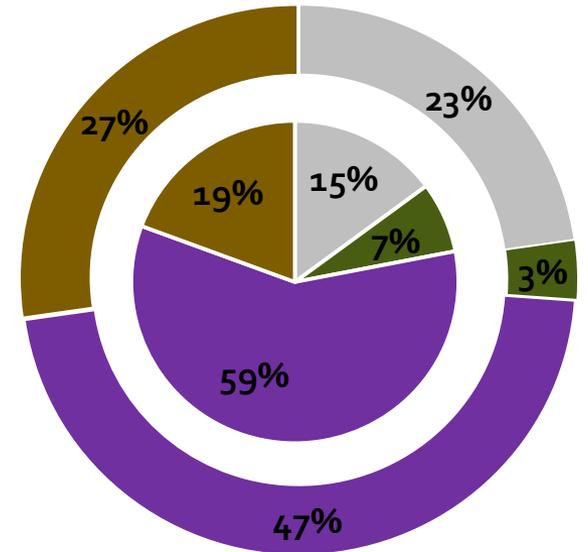
2016 Community APS excluding Self Neglect

Outer Circle: Types of Abuse Investigated
 Inner Circle: Percentage of All Substantiated Allegations by Abuse Type



- Physical Abuse
- Financial Exploitation
- Sexual Abuse
- Neglect
- Verbal/Emotional
- Other

Breakdown of "Other"



- Other
- Wrongful Restraint
- Involuntary Seclusion
- Abandonment



2016 Community APS

Including Self-Neglect

500,000+

estimated
eligible
population

14,737

allegations
investigated

10,990

alleged
victims

4,185

allegations
substantiated

3,195

victims

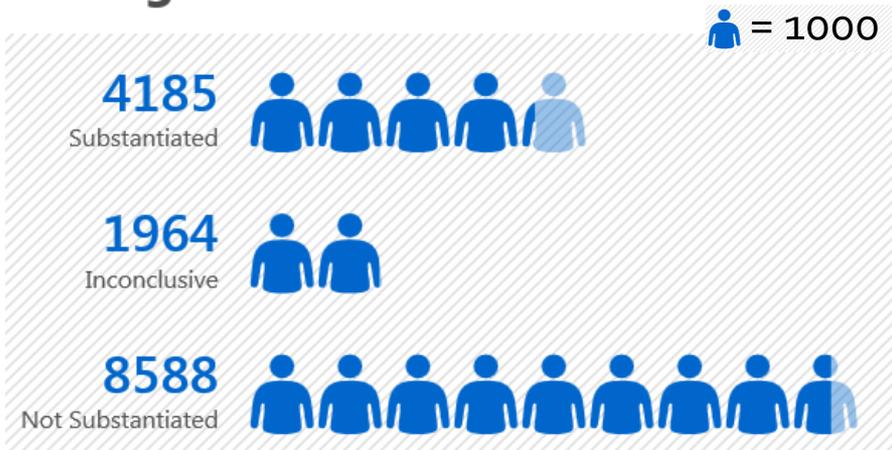
163

victims
reabused

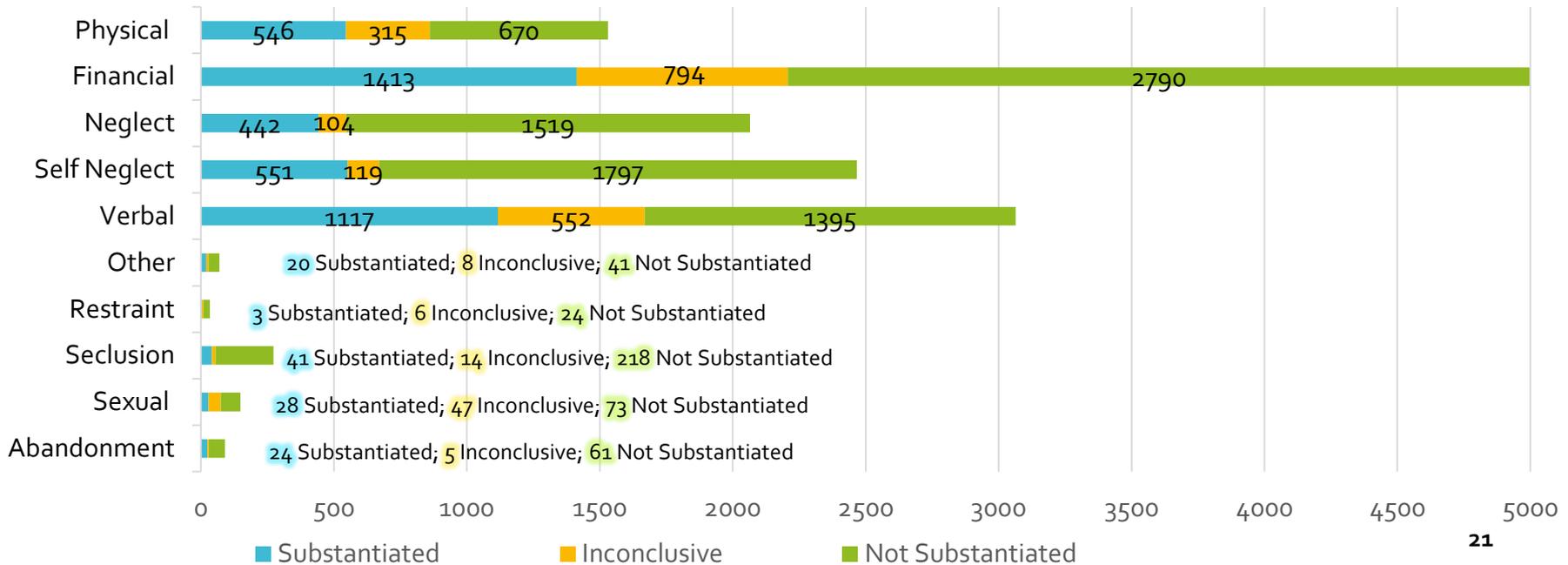


2016 Community APS including Self Neglect

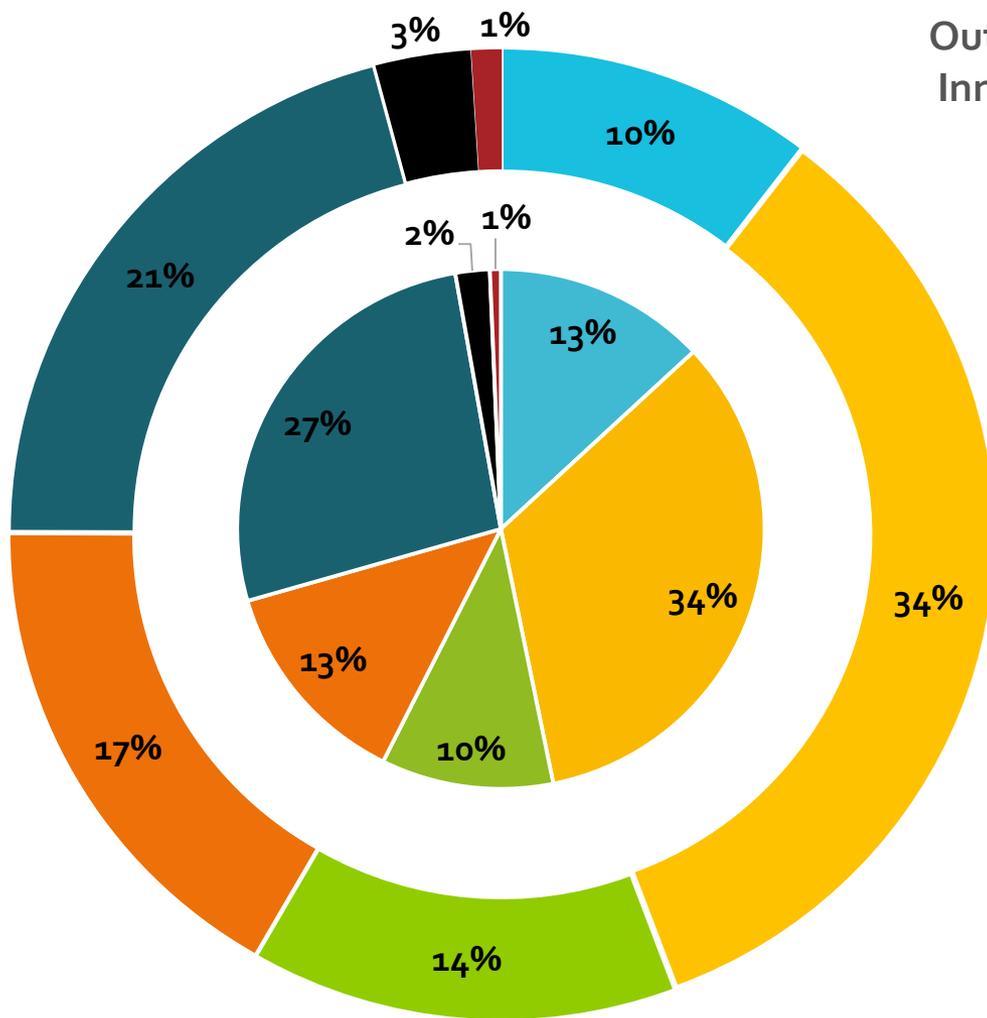
Allegation Results



Results of Abuse Investigations



2016 Community APS including Self Neglect

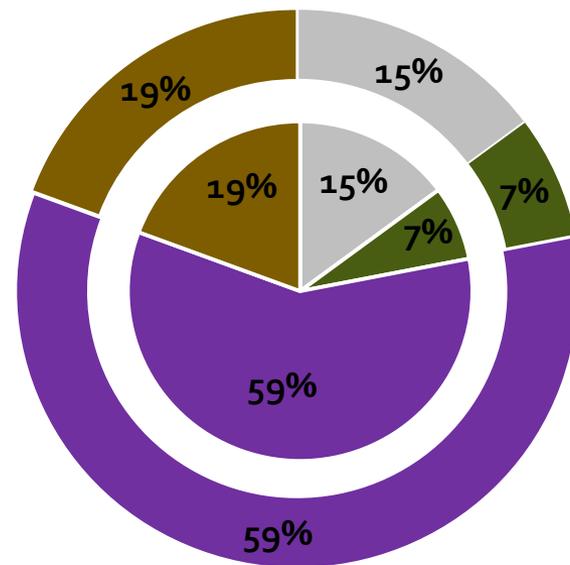


- Physical Abuse
- Neglect
- Verbal/Emotional
- Sexual Abuse

- Financial Exploitation
- Self Neglect
- Other

Outer Circle: Types of Abuse Investigated
 Inner Circle: Percentage of All Substantiated Allegations by Abuse Type

Breakdown of "Other"



- Other
- Wrongful Restraint
- Involuntary Seclusion
- Abandonment



Program Summary

APS Specialists investigated 12,270 allegations of abuse involving an alleged perpetrator in community settings in 2016. These APS investigations had 8,701 reported victims; as with facility investigations, in some cases, a victim was identified in multiple allegations in the same investigation. Vulnerable Oregonians over age 65 or any adult with a physical disability are eligible for community APS investigations. Conservative estimates of this eligible population identify over 500,000 people across the state as meeting this criteria.

Of the 12,270 allegations, 3,634 allegations were substantiated. This is just shy of 30% of all allegations received. Financial exploitation was both the most frequent type of allegation received and the most frequently substantiated type of

abuse. The number of reports of financial abuse is due, in part, to the extraordinary outreach conducted by the Elder Abuse unit of the Department of Justice, OAAPI's financial abuse specialist, the Oregon Bankers' Association, and dedicated teams of APS specialists and local law enforcement. Their trainings have raised awareness of elder financial abuse both among the public and banks and other financial service agencies. Financial exploitation together with verbal/emotional abuse accounted for 70% of all substantiated allegations.

The 3,634 substantiated allegations contained 2,678 identified victims. Of the identified victims, 132 people were reabused during 2016.



Program Summary

We are defining reabuse as a person who is found to be the victim in two different investigations within the calendar year. It is important to keep in mind that the victim has the right to self-determination. Often, especially when the perpetrator is a relative, the victim may want or believe that they have to maintain a relationship with the perpetrator.

Community APS is unique from all other adult abuse investigations, that along with allegations of abuse or neglect perpetrated by another person, investigators will also investigate allegations of self-neglect. Oregon Administrative Rule defines self-neglect as, “the inability of an adult to understand the consequences of his or her actions or inaction when that inability leads to or may lead to harm or endangerment to self or other.”¹



The most important determination in a self-neglect investigation is the individual’s ability to understand the consequences of his or her actions. An adult citizen has the right to self-determine; that includes the right to folly. If a person can make an informed choice about his/her actions, self-neglect will not be substantiated. It is only when individuals are unable to understand the consequences of the harm to themselves that self-neglect can be substantiated.

When self-neglect allegations are included, the total number of allegations investigated increases by 20% to 14,737. The number of reported victims increases by a similar percentage to 10,990 persons. Self-neglect was one of the least substantiated allegation types with only 22% of allegations being substantiated.

¹ Oregon Administrative Rule, 411-020-0002 (38)

Program Summary

Comparatively, financial exploitation, physical abuse, verbal/emotional abuse, and abandonment were all substantiated at higher rates than self-neglect. Because relatively few self-neglect allegations were substantiated, substantiated allegations increased only by 15% to 4,185 when self-neglect is included in the data.

Interestingly, when we add self-neglect to the total cases, we see the number of victims who were reabused increase by 23%--from 132 to 163. A higher percentage of reabuse for self-neglect is expected and an indication of the complexity of self-neglect investigations. In all abuse and self-neglect investigations, the investigator is working to identify protective services that would mitigate or ameliorate those concerns.

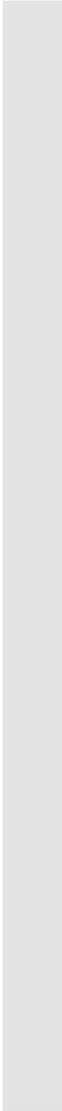


Even though the APS specialist will offer services, the reported victim has the right to accept or decline any or all of the services offered. Thus accepting protective services is voluntary.

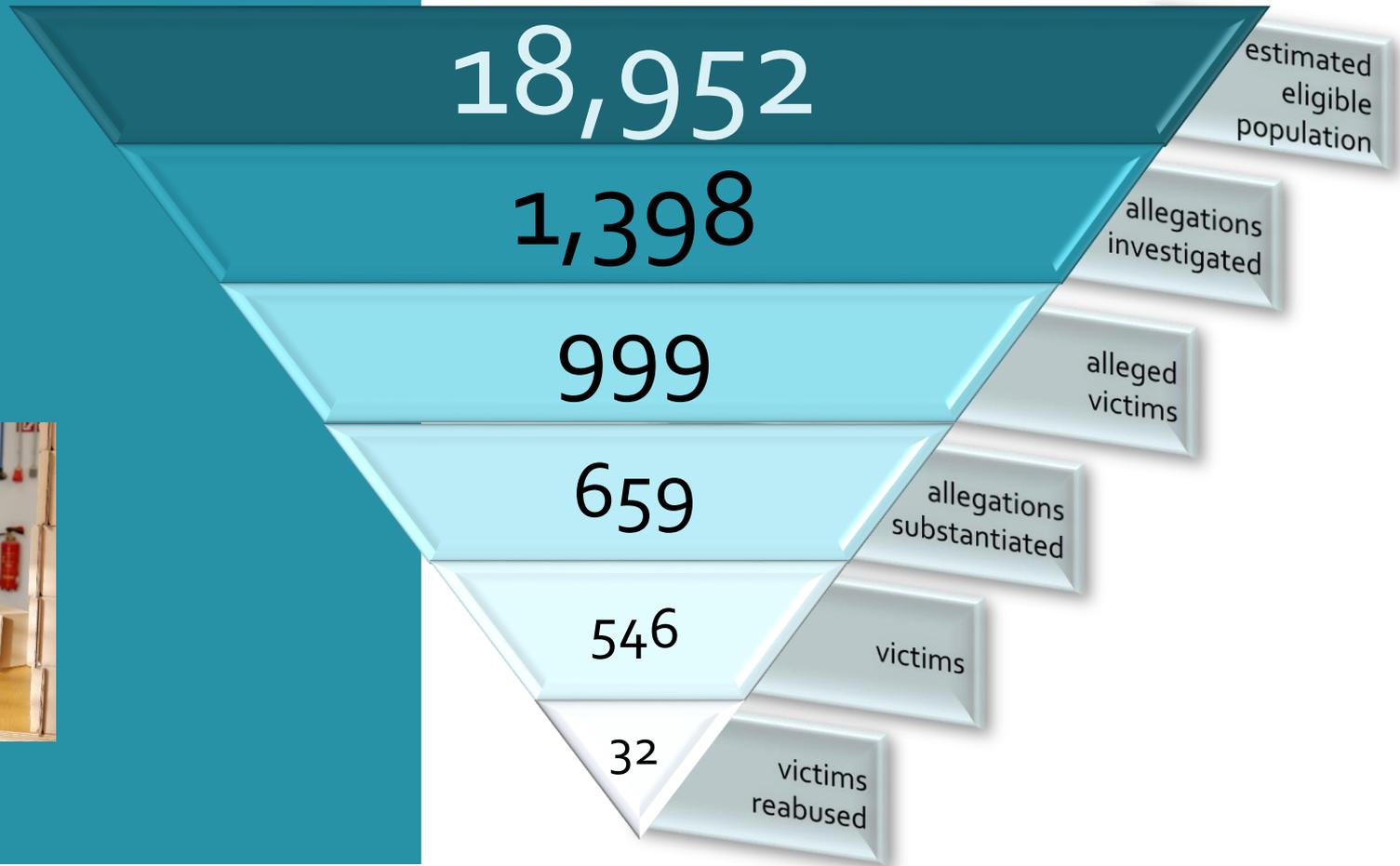
In Oregon, the State cannot move an adult to a safer placement nor make an adult comply with services without a court order. Thus, APS specialists do not take action without the reported victim's support and cooperation—or in imminent and serious circumstances, a court order for protective care. Consequently, APS specialists regularly go out on more than one self-neglect allegation with the same victim before the reported victim accepts services or it is appropriate for a court to legally intervene.



Office of Developmental Disabilities Services Programs



2016 I/DD Adults



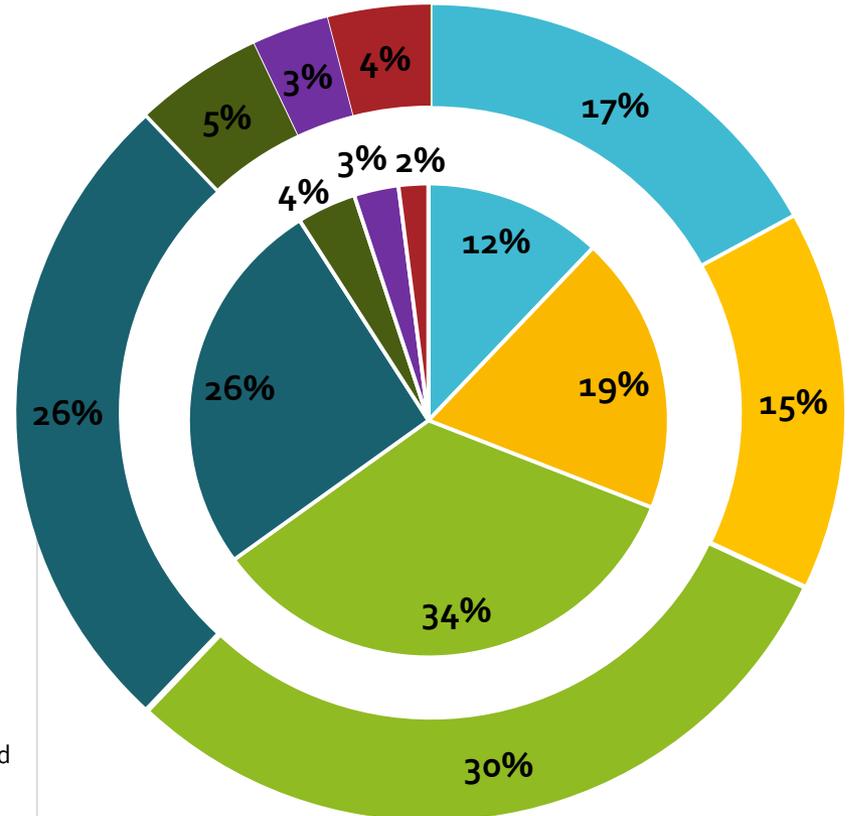
2016 I/DD Adults Data Sheet

Allegation Results

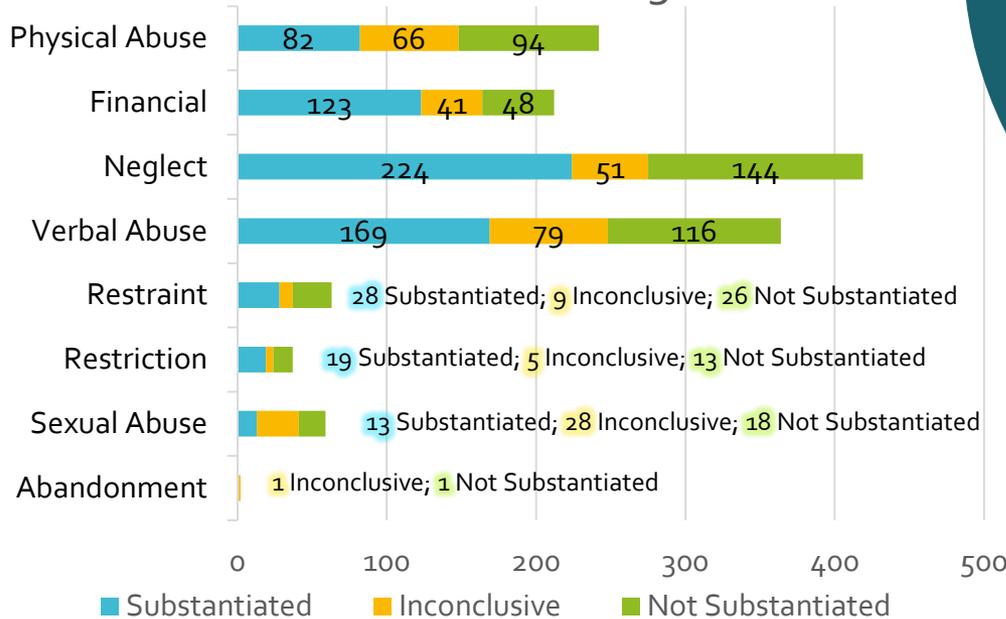
 = 100



Outer Circle: Types of Abuse Investigated
Inner Circle: Percentage of All Substantiated Allegations by Abuse Type



Results of Abuse Investigations

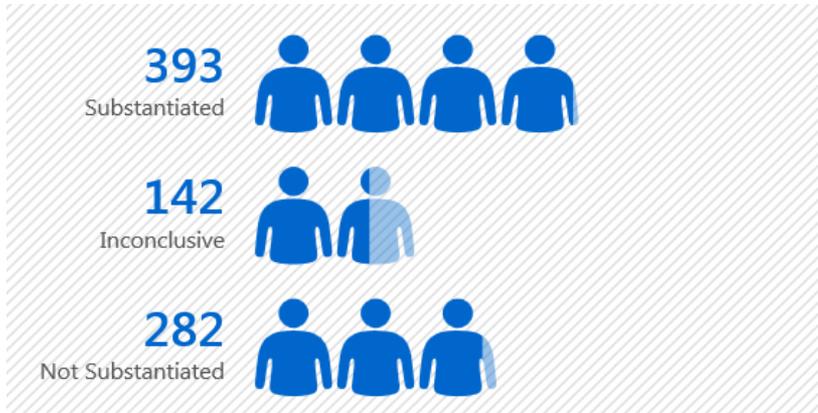


- Physical Abuse
- Financial
- Neglect
- Verbal Abuse
- Restraint
- Restriction
- Sexual Abuse
- Abandonment

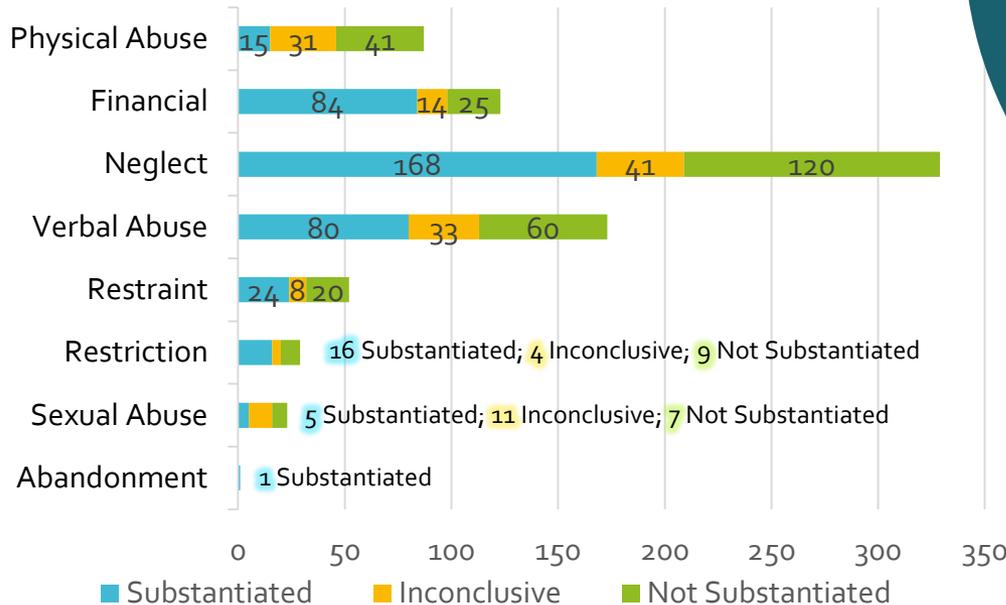
2016 I/DD Adults in Licensed Settings Data Sheet

Allegation Results

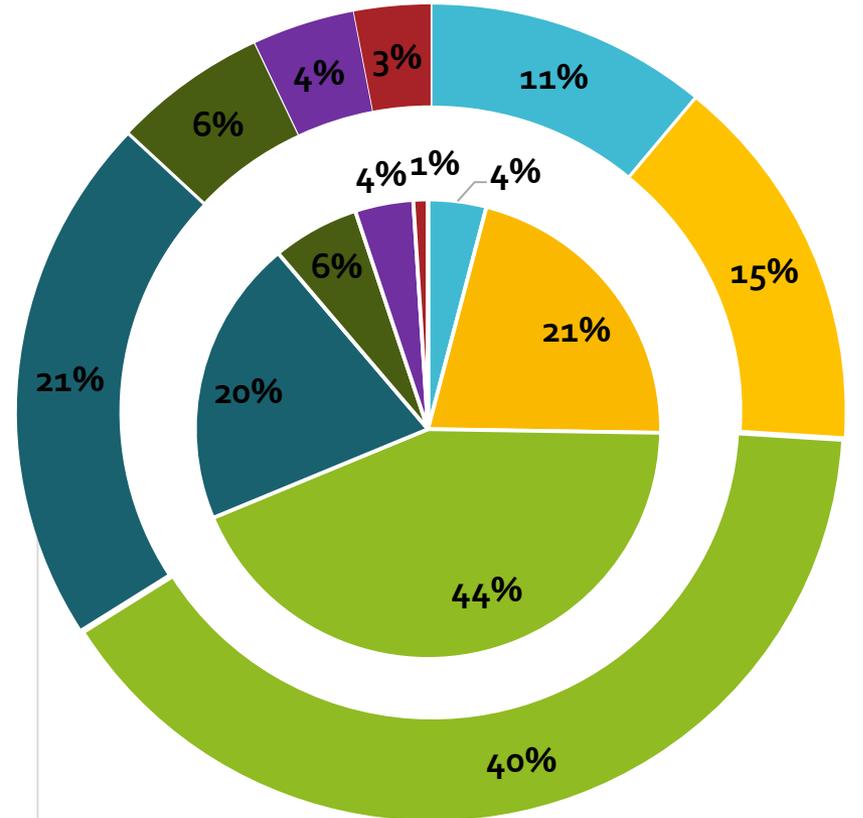
 = 100



Results of Abuse Investigations



Outer Circle: Types of Abuse Investigated
Inner Circle: Percentage of All Substantiated Allegations by Abuse Type

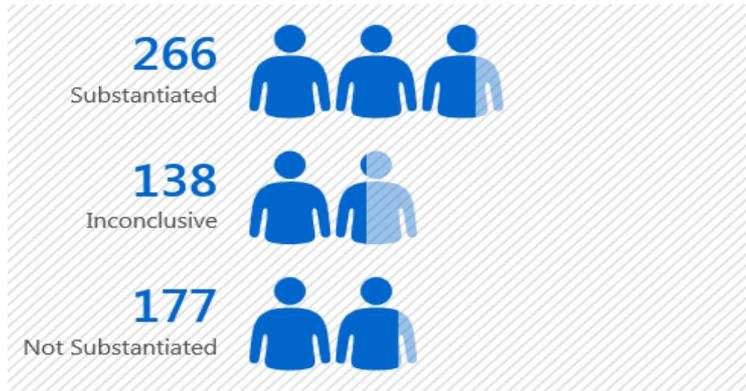


- Physical Abuse
- Neglect
- Verbal Abuse
- Restraint
- Sexual Abuse
- Abandonment
- Financial
- Restriction

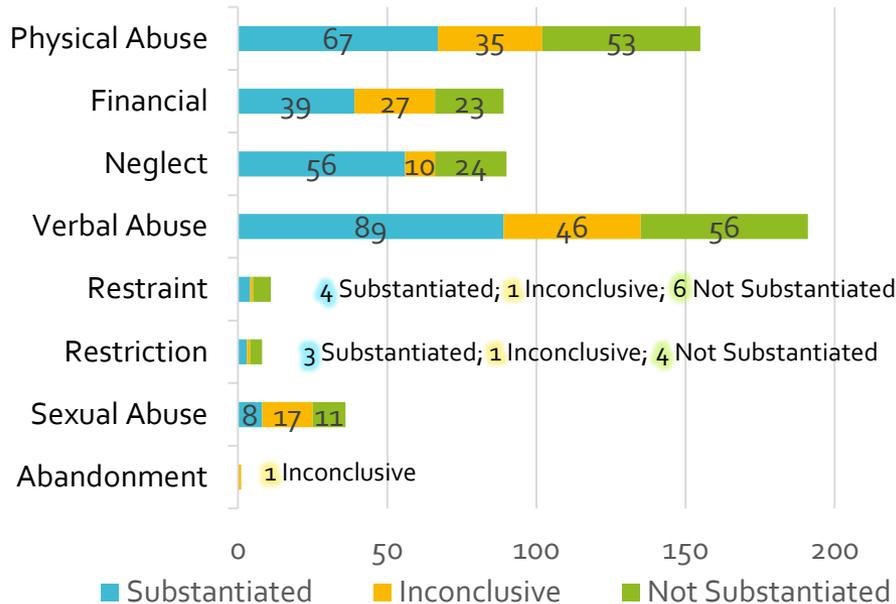
2016 I/DD Adults in Non-Licensed Settings Data Sheet

Allegation Results

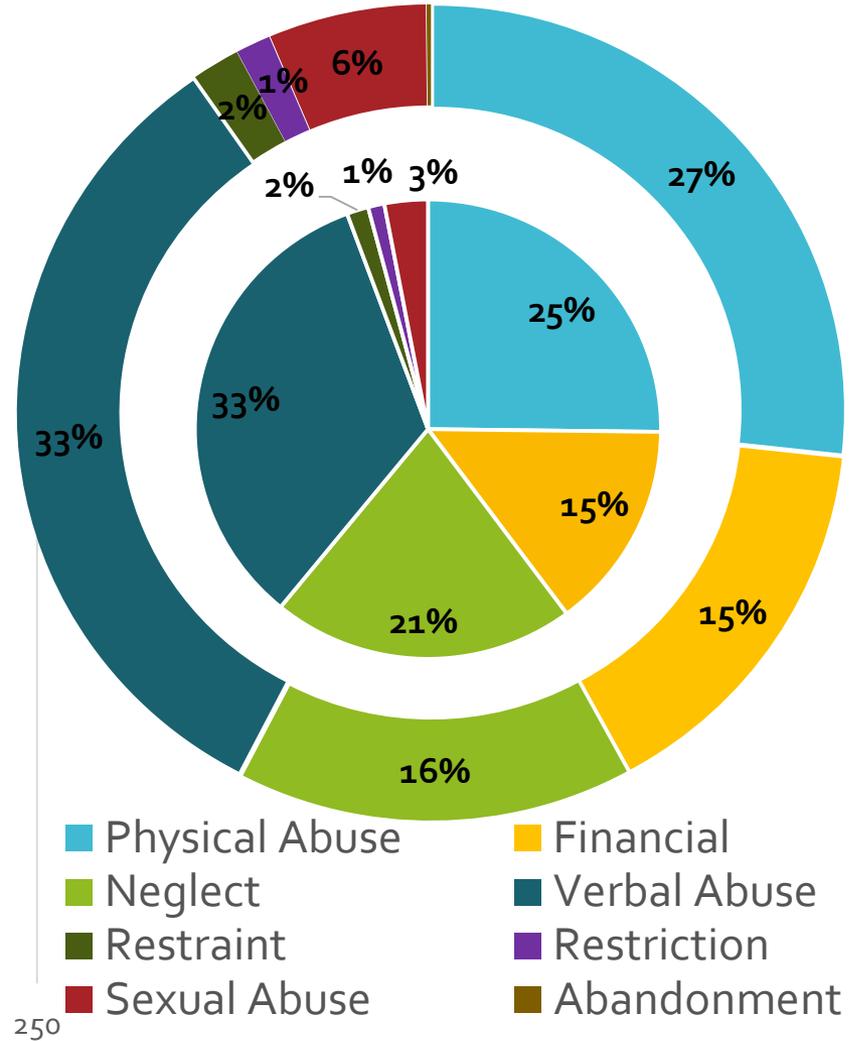
 = 100



Results of Abuse Investigations



Outer Circle: Types of Abuse Investigated
Inner Circle: Percentage of All Substantiated Allegations by Abuse Type



Program Summary

Adult Intellectual/Developmental Disabilities (I/DD) programs and its partners provide supports and services to adults who meet eligibility criteria. In 2016, almost 19,000 adults were enrolled in I/DD services. Intellectual disability is characterized by below-average mental capacity (reasoning, learning, problem solving) and significant limitations in adaptive behavior skills (social, conceptual, practical). Developmental disability is an umbrella term that includes intellectual disability but also includes 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.

People enrolled in I/DD programs receive protective service assessments through Community Developmental Disability Programs (CDDP). CDDPs operate in specific geographic areas, usually encompassing a county or several counties. 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 OAAPI for investigation.

Program Summary

Investigations can be conducted in licensed, certified, endorsed, or community settings. Licensed facilities include 24-hour residential facilities such as group homes and adult foster homes. Certified settings include child foster care homes; endorsed settings include supported living programs and employment and day support programs. Community settings included locations where case management services are

received as well as locations where people who receive community supports to enable them to live in their own home or their family home.



In 2016, 1,399 allegations were investigated by CDDP investigators or by OAAPI staff. Of these allegations, 817 occurred in licensed facilities. In licensed settings the most common abuse types were neglect and verbal abuse. In non-licensed settings, verbal and physical abuse were the most common allegations. In part this is due to the responsibility a licensed setting has to provide care; neglect is the most frequent allegation in facilities across programs. In both licensed and non-licensed settings these allegations resulted in 997 reported victims.

Of the 660 substantiated allegations, 267 occurred in non-licensed settings and 393 were in licensed settings.

Program Summary

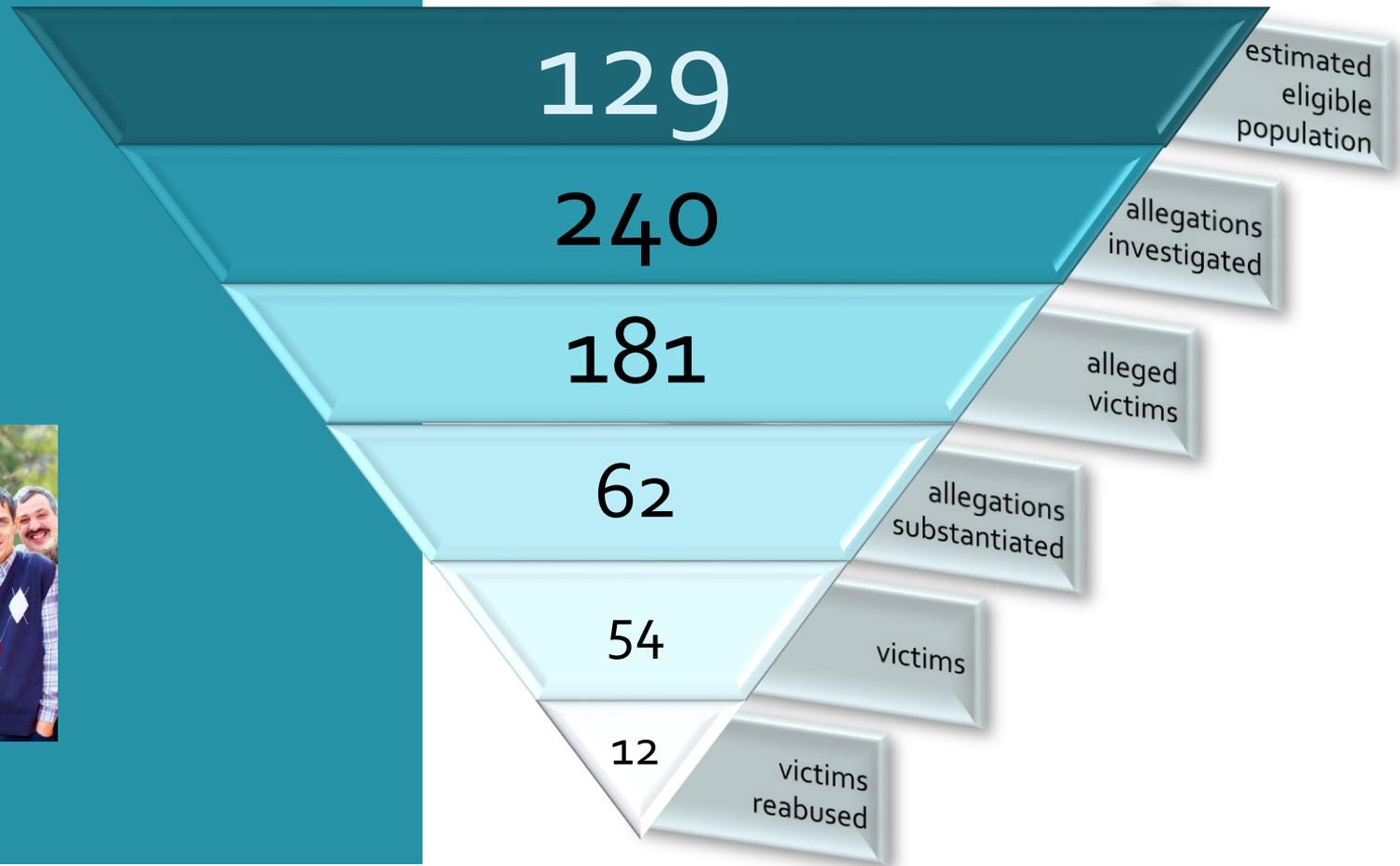
In licensed settings, neglect was the most frequently substantiated abuse type followed by financial and verbal abuse; between the three, they account for 85% of all substantiated allegations in licensed settings. In non-licensed settings, verbal abuse was the most frequently substantiated allegation type; however, it was only substantiated in one-third of the allegations made. Physical abuse was the next most frequently substantiated allegation in non-licensed settings; one-quarter of the allegations made were substantiated. Together they account for only 58% of the substantiated

allegations. Of the distinct 546 victims of the substantiated allegations, 217 were in non-licensed settings and 329 were in licensed settings.

Of the people who were reabused, eight were in non-licensed settings and 25 were in licensed settings.

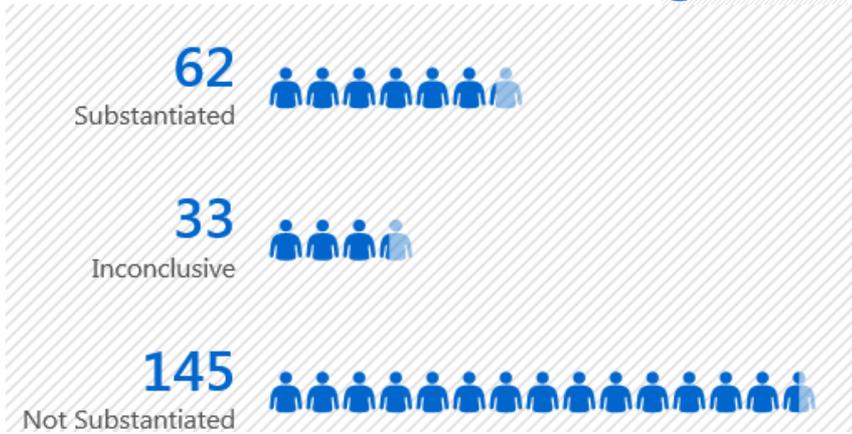


2016 Stabilization and Crisis Unit

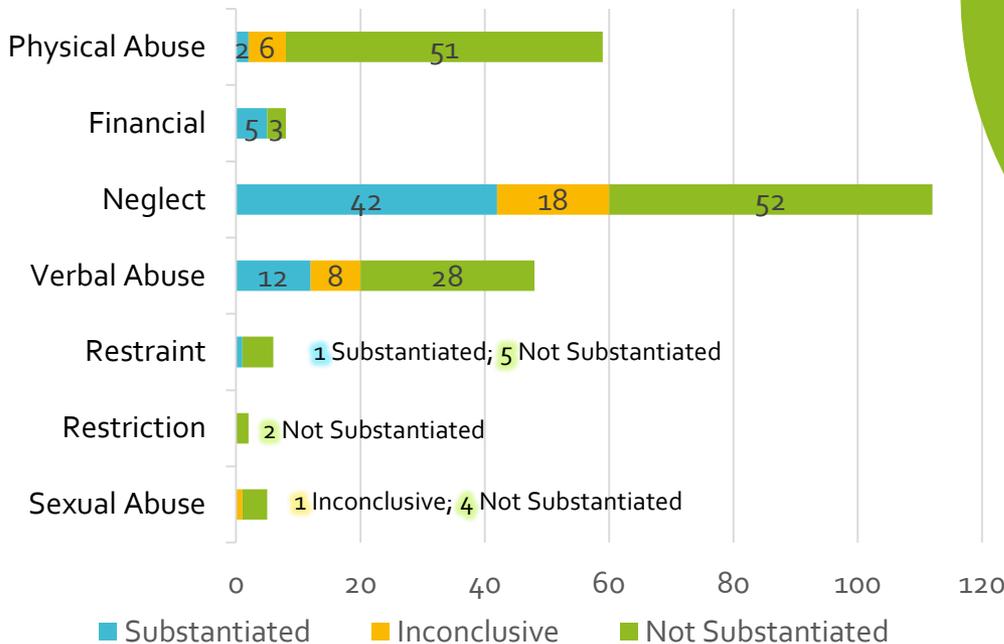


Allegation Results

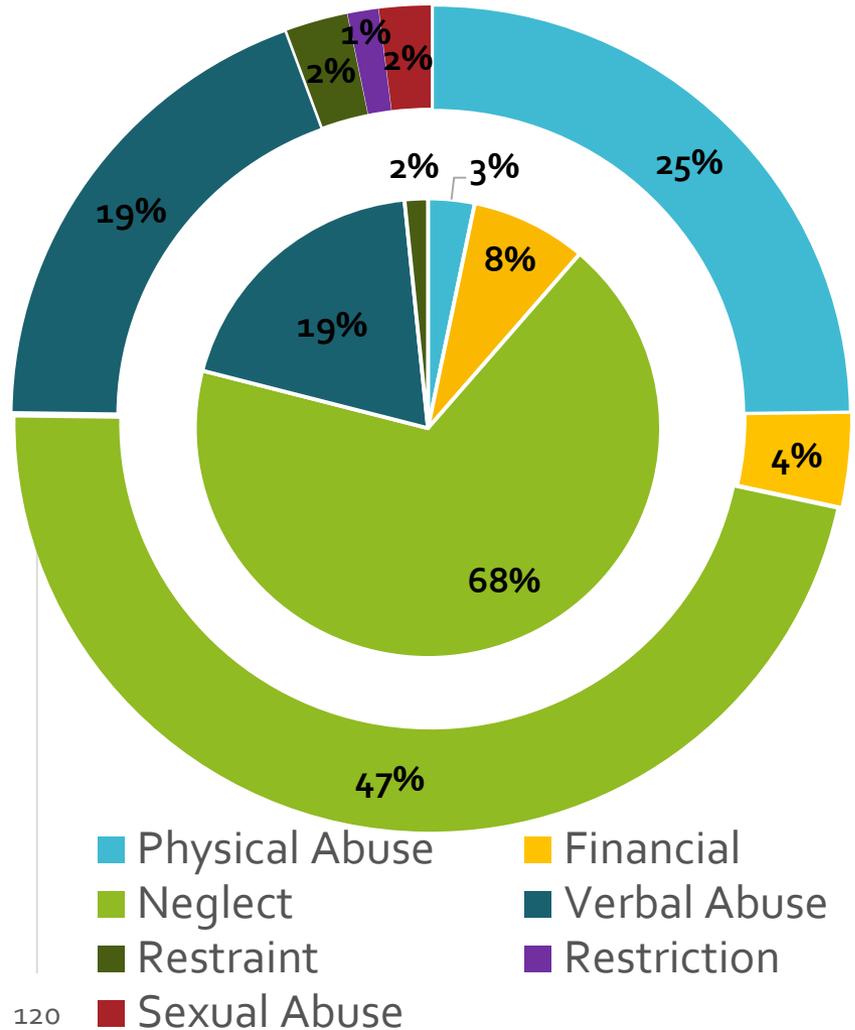
 = 10



Results of Abuse Investigations



Outer Circle: Types of Abuse Investigated
 Inner Circle: Percentage of All Substantiated Allegations by Abuse Type



Program Summary

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. Provision of high levels of staff support allow the residents a great deal of support to be successful in their lives and community. Along with residential care in a group home, residents receive medical supports, behavioral supports, psychological services, and personal care.



All enrolled individuals of the I/DD program are eligible for SACU services if they should need them, however, there are only a limited number of placements available.

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

Allegations of abuse and neglect are investigated by OAAPI's Investigation Unit. In 2016, they investigated 240 allegations. The majority of the allegations (47%) were for neglect; physical and verbal abuse were the next most frequent allegations. Together, they comprised 91% of all of the allegations investigated. There were 181 people identified as victims in these allegations, 11 of whom were children.

Program Summary

Sixty-two allegations were substantiated, and neglect accounted for over two-thirds of the number of substantiations. It was substantiated in 37.5% of the allegations made. Verbal abuse was substantiated in 25% of the allegations made, and with neglect, accounts for 87% of all substantiated cases.

Even though a larger number of neglect and verbal abuse allegations were made, a majority of financial abuse allegations were substantiated. Only eight allegations of financial abuse were made, and five of them were substantiated. For all abuse types, a total of 54 people were substantiated as victims; this number includes three children.

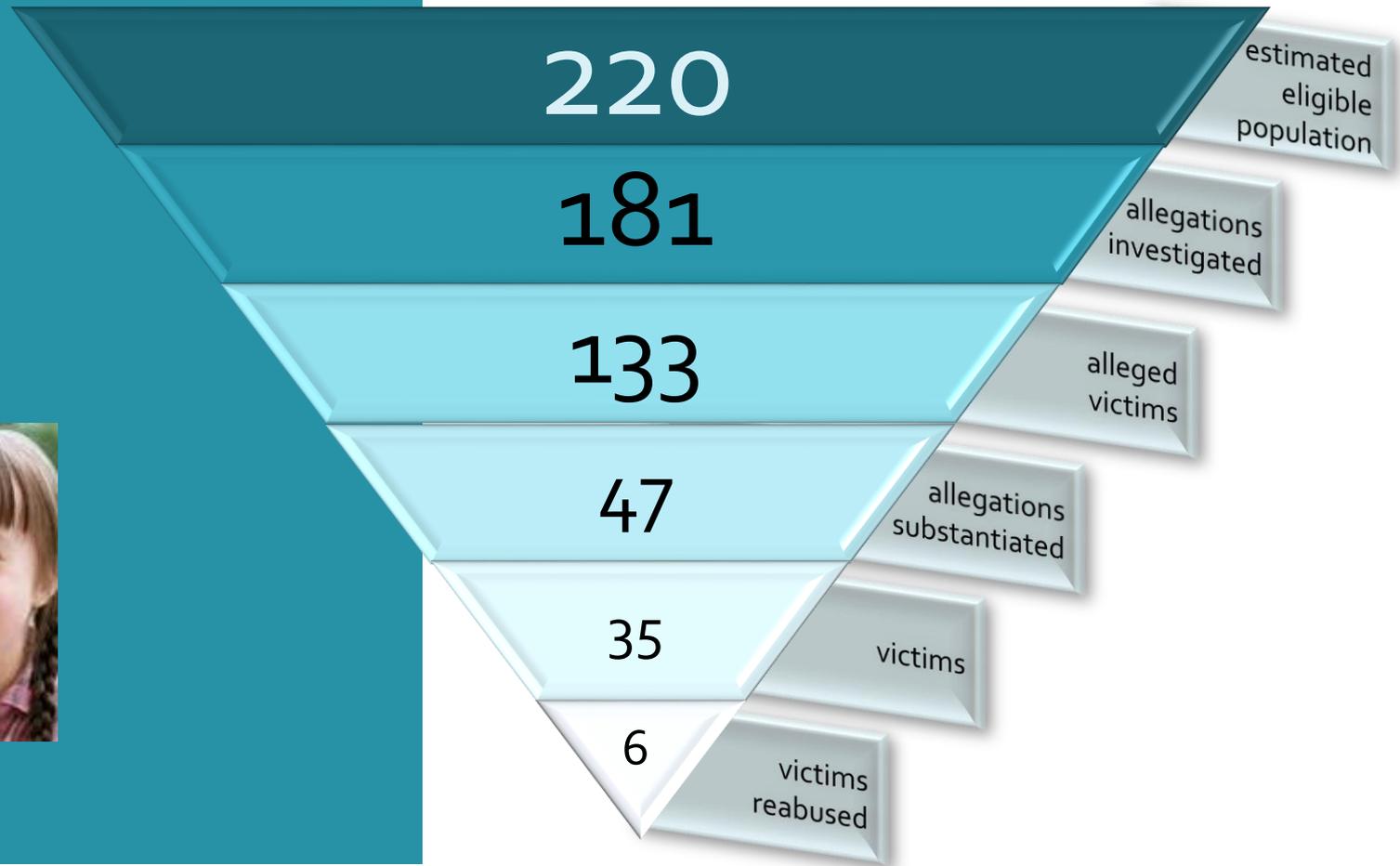


Twelve identified victims accounted for 31 different investigations; no children are included in this number. Fully two-thirds of the reabuse was neglect; verbal abuse was responsible for 20% of the reabuse.



SACU operates residential group homes along the I-5 corridor from Portland to Eugene.

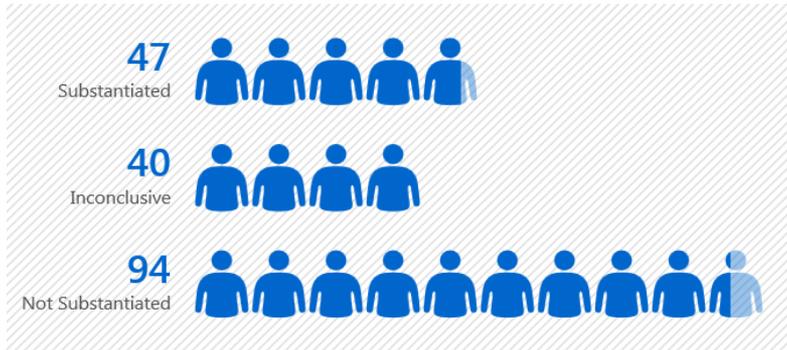
2016 Children's I/DD 24-Hour Residential Facilities



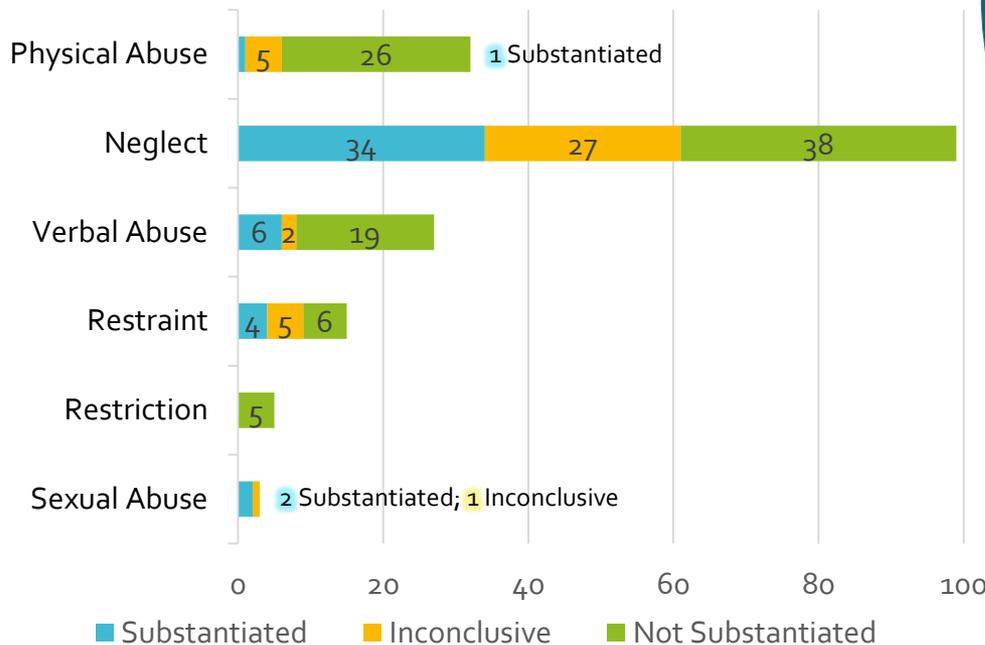
2016 Children's I/DD 24-Hour Residential Facilities Data Sheet

Allegation Results

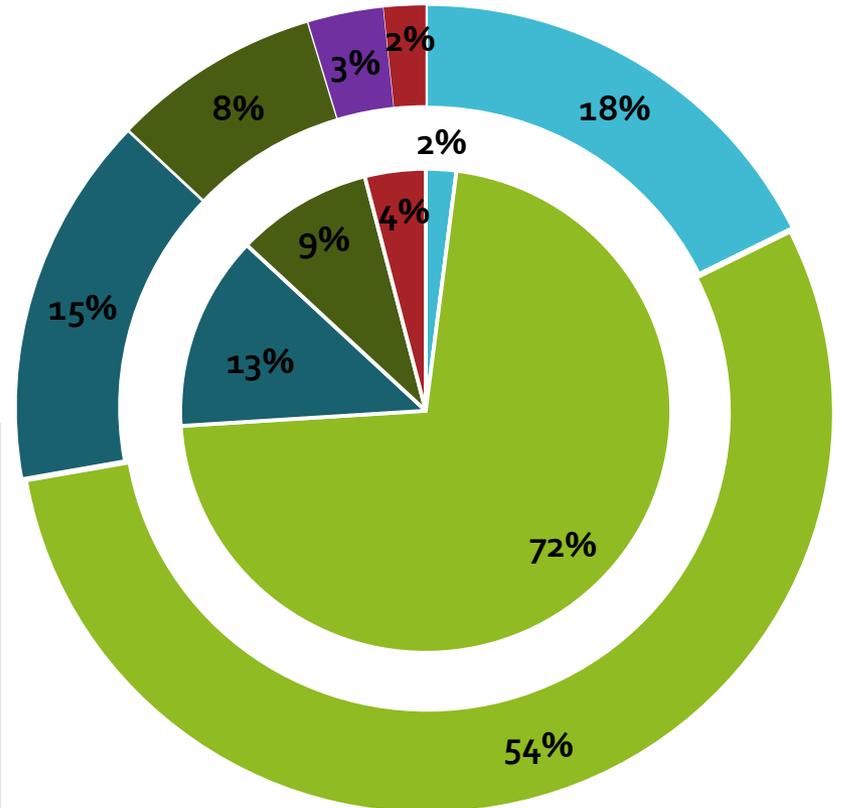
 = 10



Results of Abuse Investigations



Outer Circle: Types of Abuse Investigated
Inner Circle: Percentage of All Substantiated Allegations by Abuse Type



-  Physical Abuse
-  Neglect
-  Verbal Abuse
-  Restraint
-  Restriction
- Sexual Abuse

Program Summary

Investigators from OAAPI's Investigation Unit are responsible for conducting abuse investigations in licensed 24-hour residential settings for children enrolled in I/DD services. These children 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. The children served in these programs live in a

residential care program; these 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.



In 2016, there were a total of 220 unique individuals served in children's 24-hour residential settings. Each of these children was eligible for investigatory services.



It is important to note that this 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.

Program Summary

In 2016, 181 allegations were investigated in these settings. As with most residential settings, the most frequent allegation was neglect; it accounted for 54% of the allegations. Verbal and physical abuse were the next most frequently received allegations. All of the allegations received involved 133 children.



Of the 181 allegations received, 47 (26%) were substantiated. Neglect accounted for 72% of the substantiated allegations; however, only one-third of the total neglect allegations received were substantiated. Sexual abuse had the highest substantiation rate with two of the three allegations being

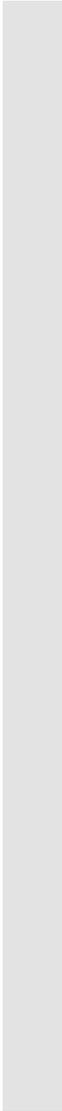
substantiated. Even though sexual abuse has a high substantiation rate, because so few allegations were received, sexual abuse accounts for just 3% of all allegations substantiated.



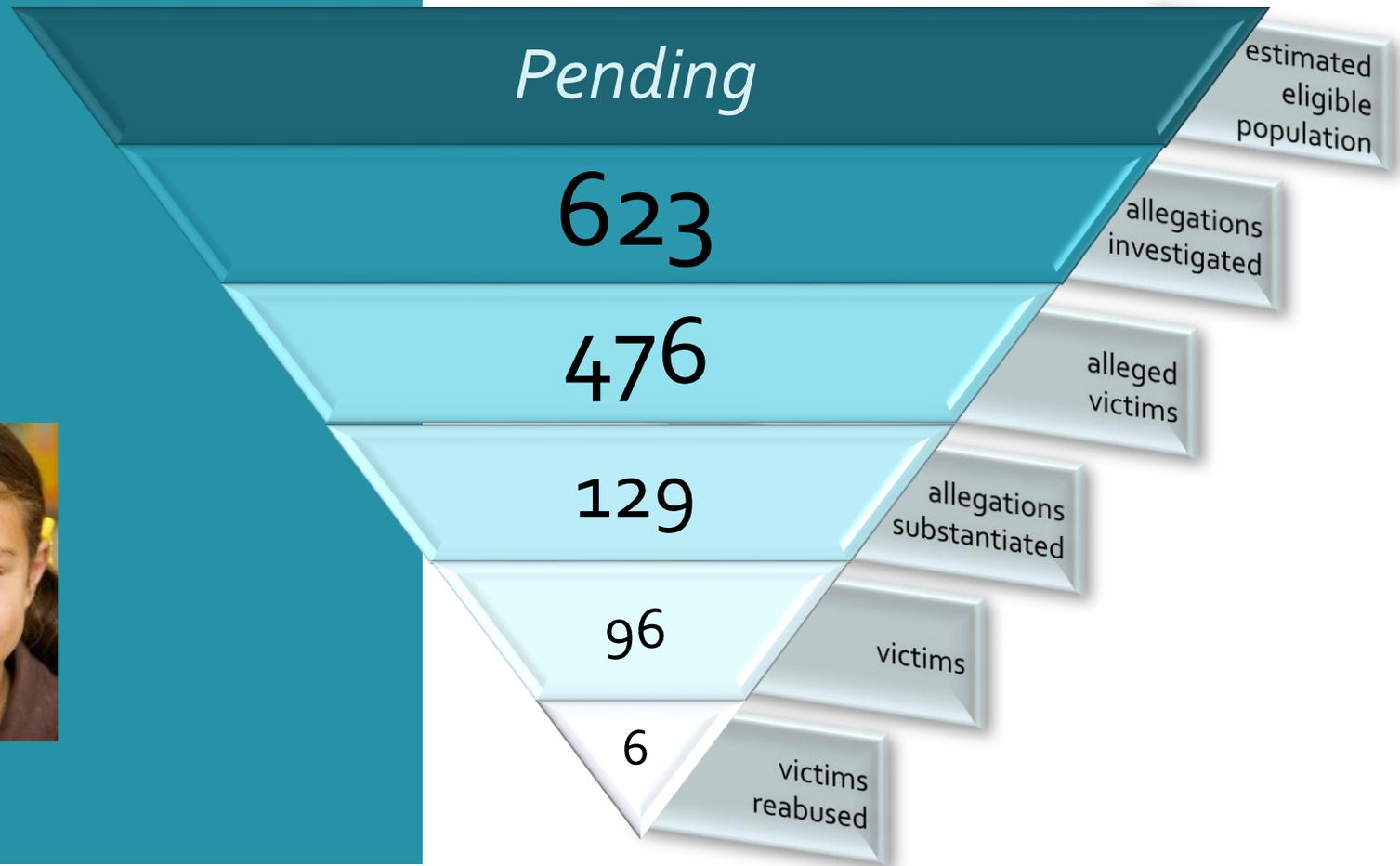
The 47 substantiated allegations had 35 victims; six children were reabused. Most of the cases of reabuse involved neglect. Verbal abuse and restraint were also identified in these cases.



Child Caring Agencies



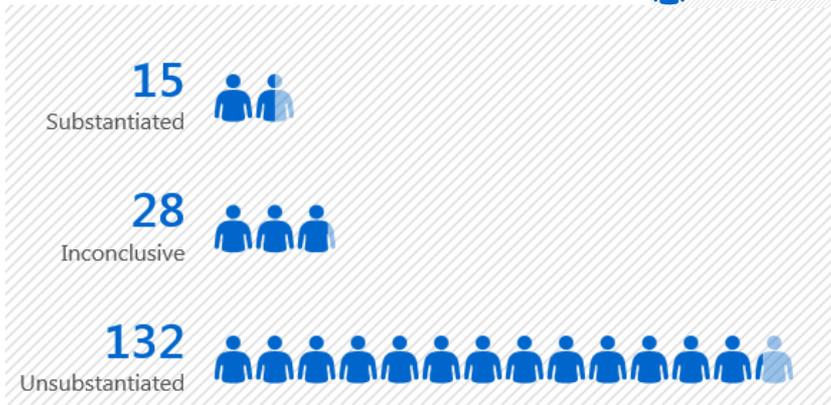
2016 CCA & CCP



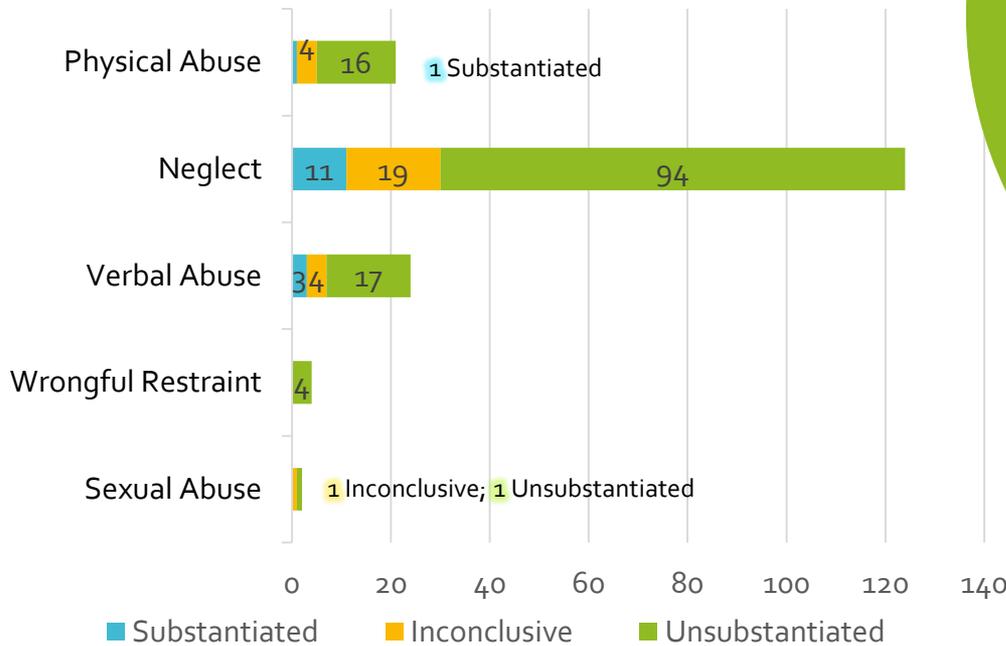
2016 CCA Data Sheet

Allegation Results

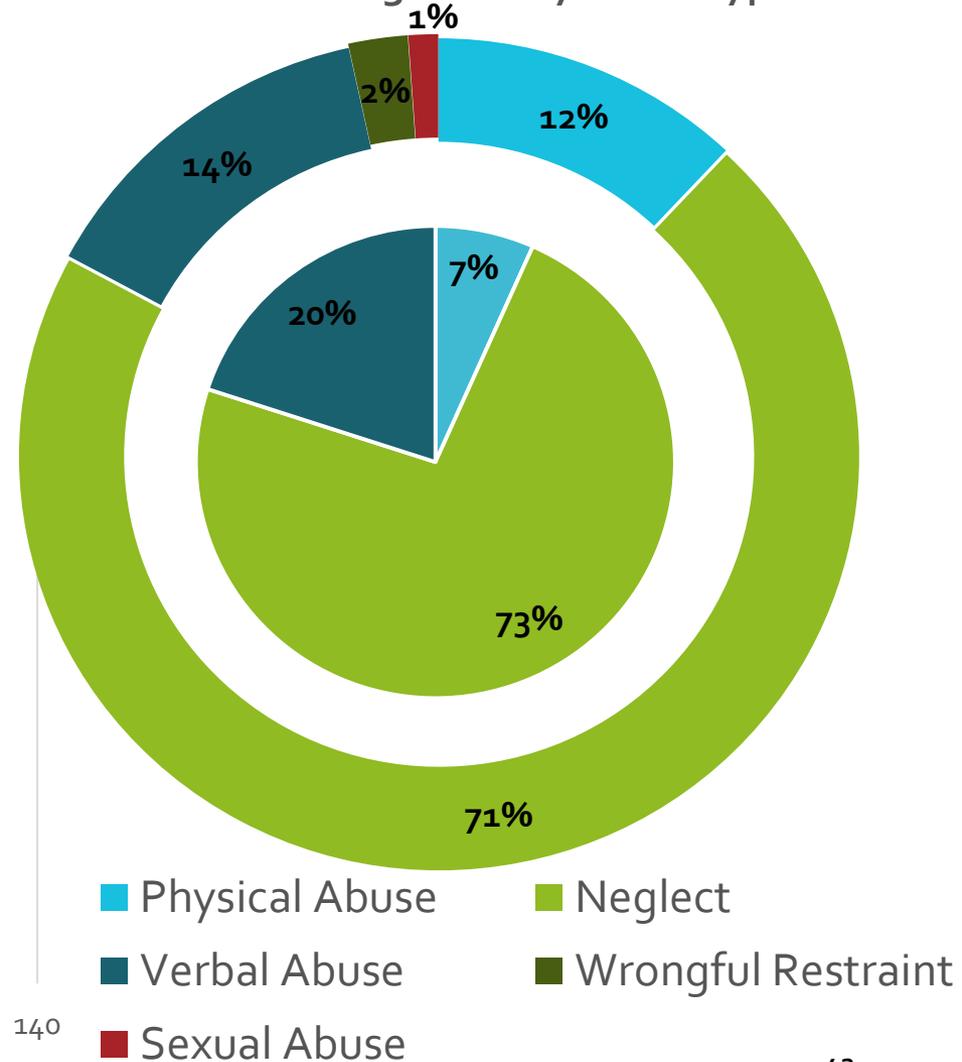
 = 10



Results of Abuse Investigations



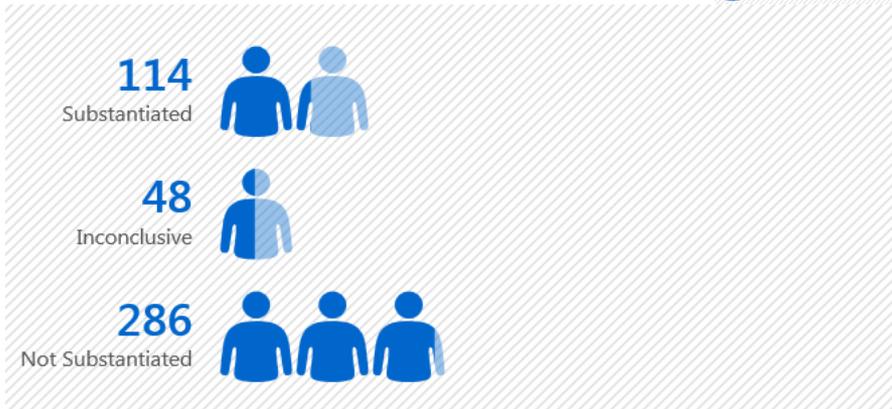
Outer Circle: Types of Abuse Investigated
 Inner Circle: Percentage of All Substantiated Allegations by Abuse Type



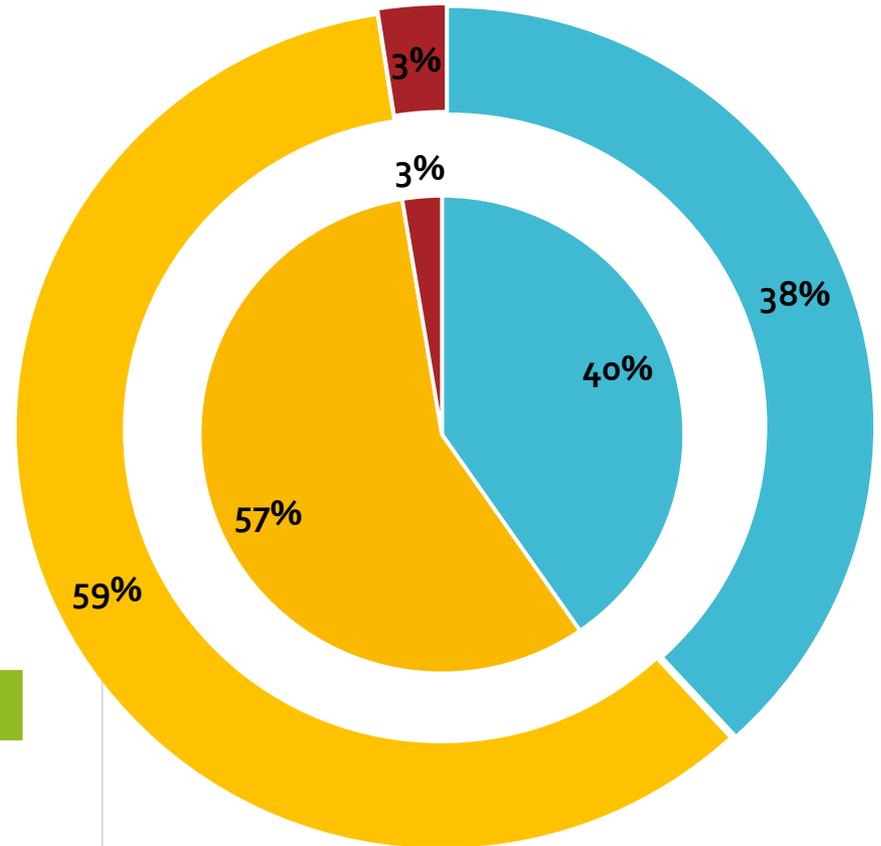
2016 CCP Data Sheet

Allegation Results

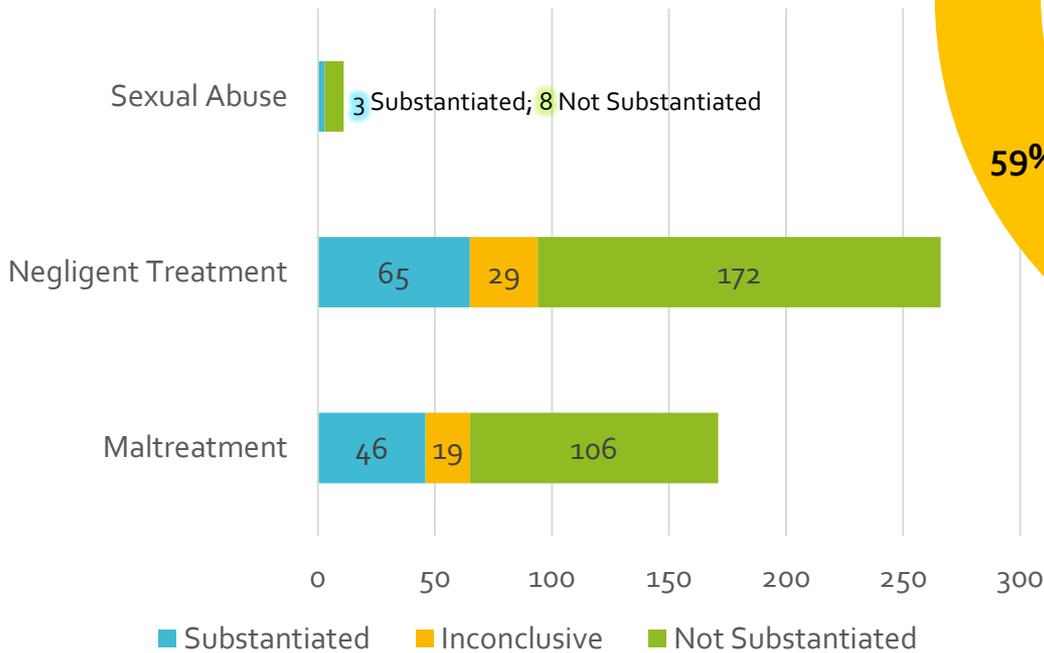
 = 100



Outer Circle: Types of Abuse Investigated
 Inner Circle: Percentage of All Substantiated Allegations by Abuse Type



Results of Abuse Investigations



 Maltreatment
 Negligent Treatment
 Sexual Abuse

Program Summary

Senate Bill 1515¹ became law on July 1, 2016. The implementation of this law profoundly changed statute and rule related to Child-Caring Agencies (CCA). Previously, these programs had been known to OAAPI as Child-Caring Programs (CCP). Due to the changes to statute and rule, two different sets of regulation govern investigations at these



programs; the date the abuse is alleged to have happened governs the regulation applied. 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.

Whether the program is referred to 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. OAAPI's Investigation Unit is responsible for conducting the protective service investigations at these facilities.

¹<http://www.oregon.gov/DHS/CHILDREN/Pages/sb1515.aspx>

Program Summary

The evolution in statute affected essentially the same eligible population, so we are considering the two programs in tandem. Investigations under the CCP rule were assigned during the entire calendar year, so 12 months of data were collected for CCP allegations. Investigations under the CCA rule were only assigned for 6 months of 2016; as a result, the data looks

somewhat lopsided when the two are considered side-by-side. It's also important to state that OAAPI was still operationalizing the new CCA statute and rule well into the fall of 2016. Working with DOJ, program partners, and providers, OAAPI provided leadership to clarify

interpretation and definitions of abuse.

In 2016, investigations at CCA and CCP programs combined included 623 allegations—175 in CCAs and 448 in CCPs, that had 476 children and youth reported as victims. In CCPs, 60% of those allegations involved negligent treatment. For CCAs, 72% of the allegations involved neglect.

Even though there are some subtle shadings of difference between negligent treatment and neglect, they are more similar than they are different. The most significant difference is that maltreatment ceased to be an abuse type with the change in statute and the differing types of maltreatment were clearly defined as abuse in the CCA rule.



Program Summary

Child Caring Agencies

Thus, with the implementation of the Abuse of a Child-in-Care Statute, we see allegations of physical and verbal abuse as well as wrongful restraint where with the previous rule we saw those allegations being subsumed as maltreatment.

A total of 129 allegations were substantiated. In CCAs, 8.6% of the allegations received were substantiated; in CCPs the substantiation rate was 25.4%.

In early 2016, OAAPI received a large number of allegations involving several troubled providers. As those were closed over the course of the year, the influx of allegations decreased. The substantiated allegations had 91 victims; as with other programs, a victim could

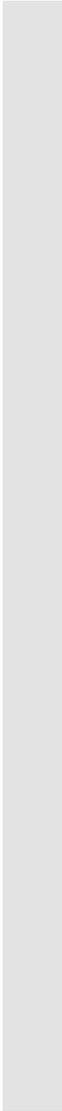


have experienced multiple types of abuse or had multiple perpetrators investigated in the same investigation. Six young people were identified as reabused in the same calendar year and while in a program OAAPI has jurisdiction for investigating.

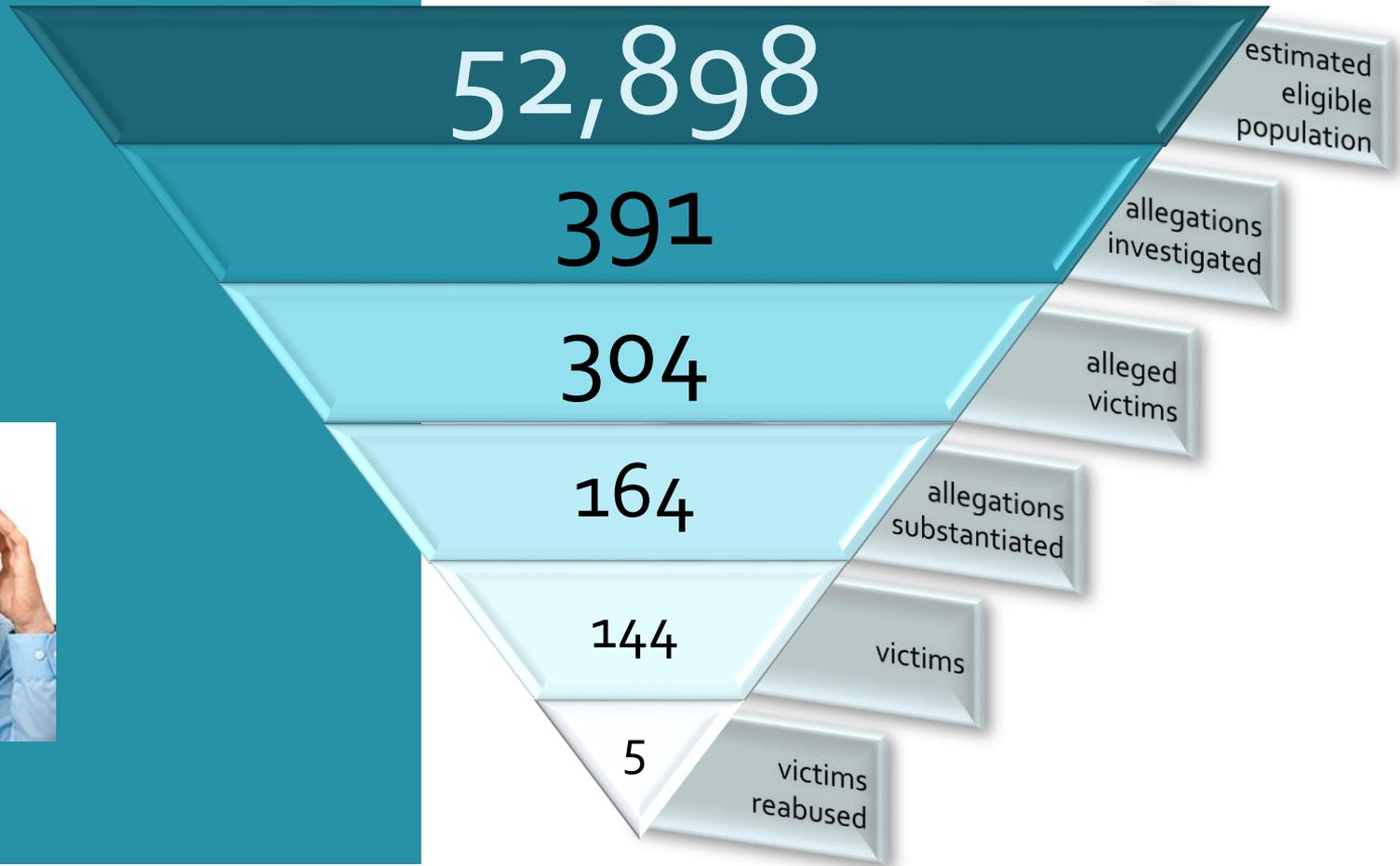




Oregon Health Authority Programs



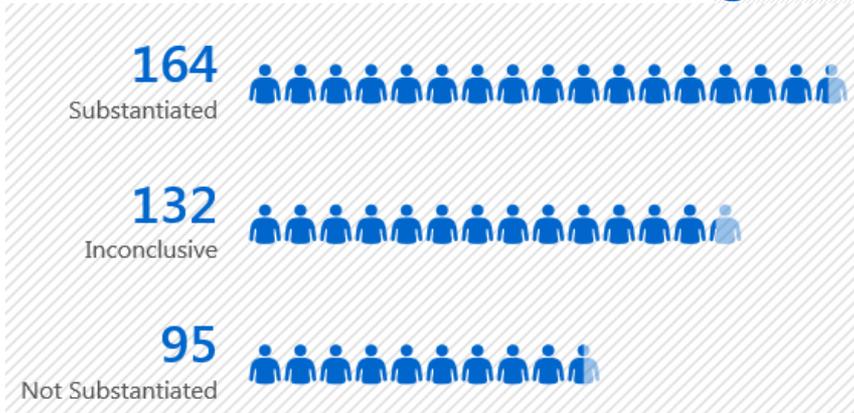
2016 Community Mental Health



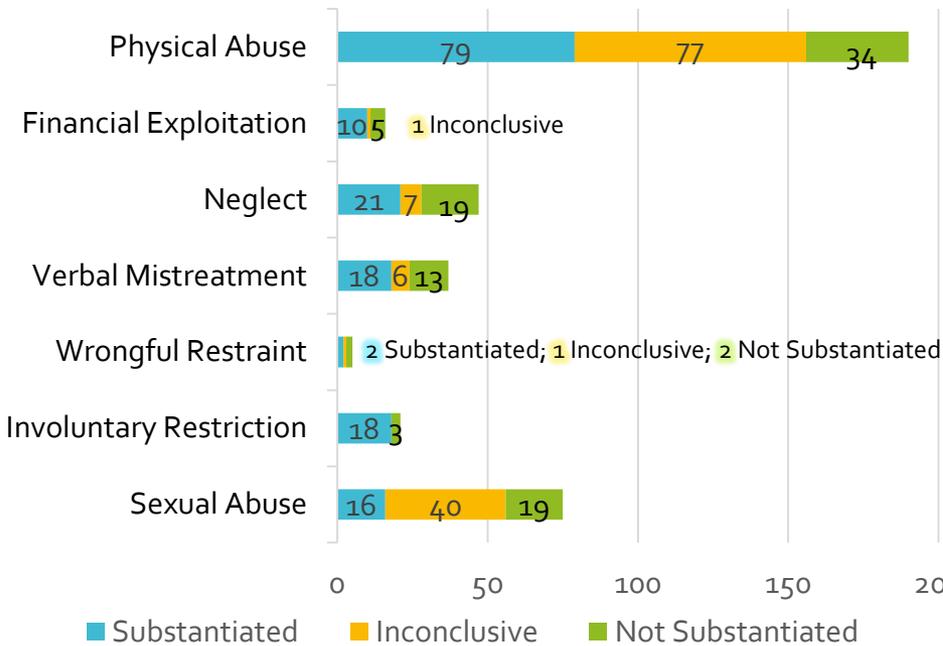
2016 Community Mental Health Data Sheet

Allegation Results

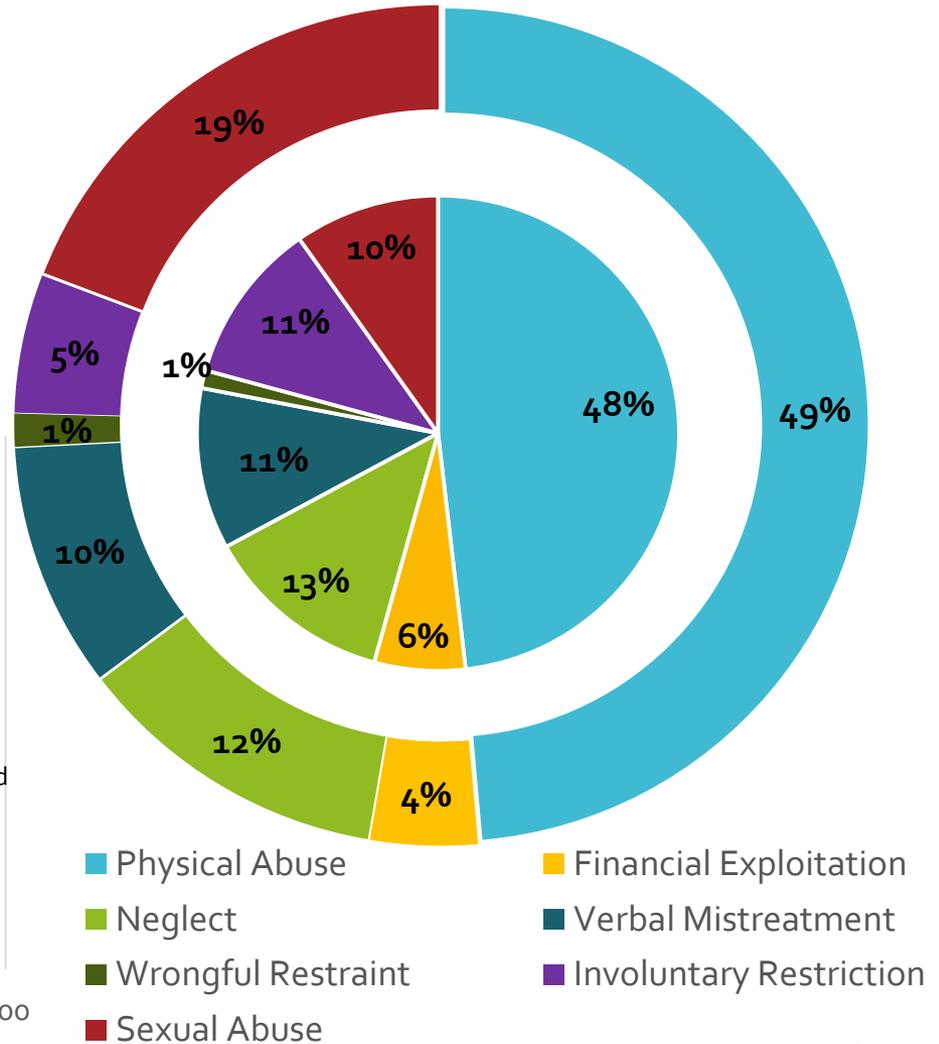
 = 10



Results of Abuse Investigations



Outer Circle: Types of Abuse Investigated
Inner Circle: Percentage of All Substantiated Allegations by Abuse Type

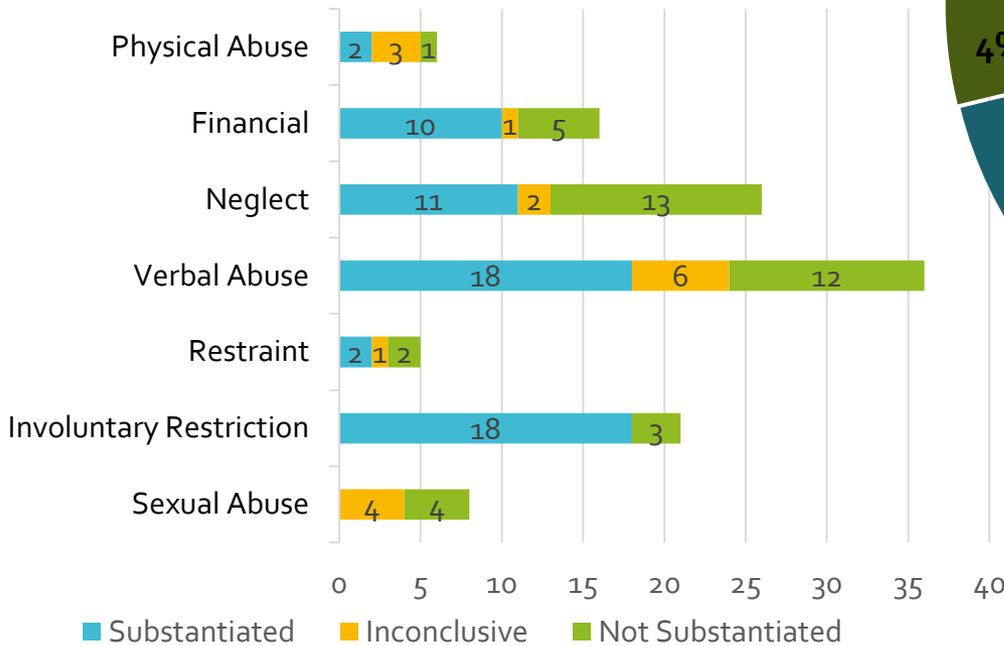


2016 Community Mental Health Licensed Settings Data Sheet

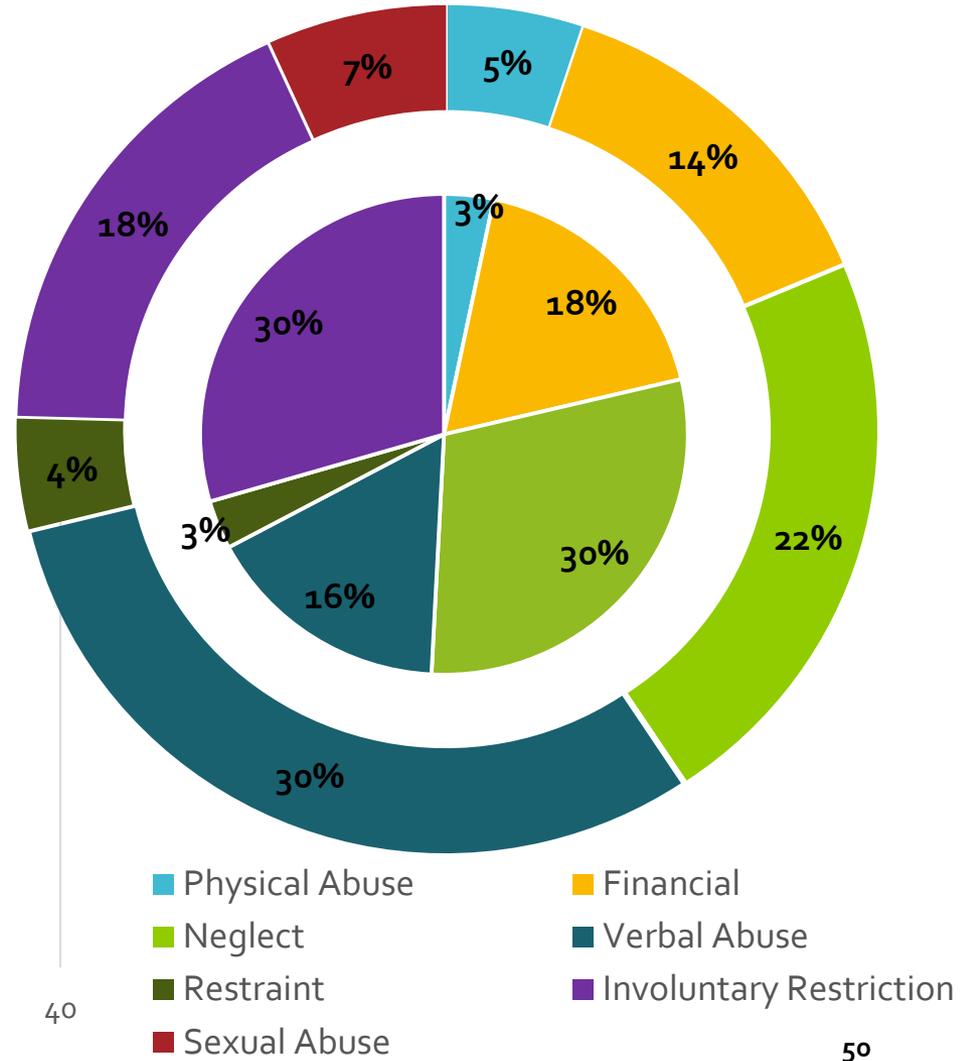
Allegation Results



Results of Abuse Investigations

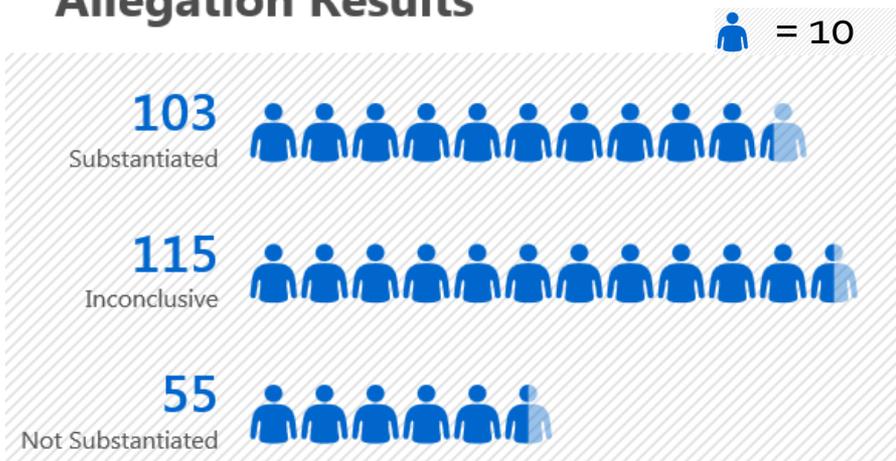


Outer Circle: Types of Abuse Investigated
Inner Circle: Percentage of All Substantiated Allegations by Abuse Type

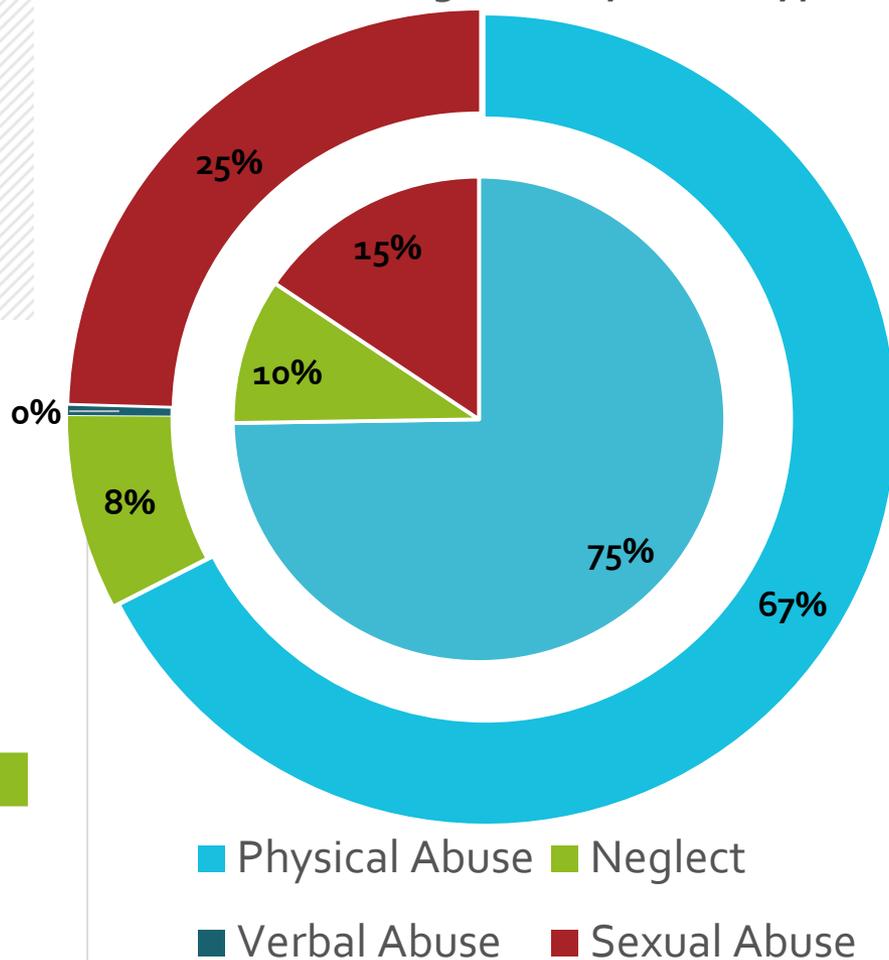


2016 Community Mental Health Non-Licensed Settings Data Sheet

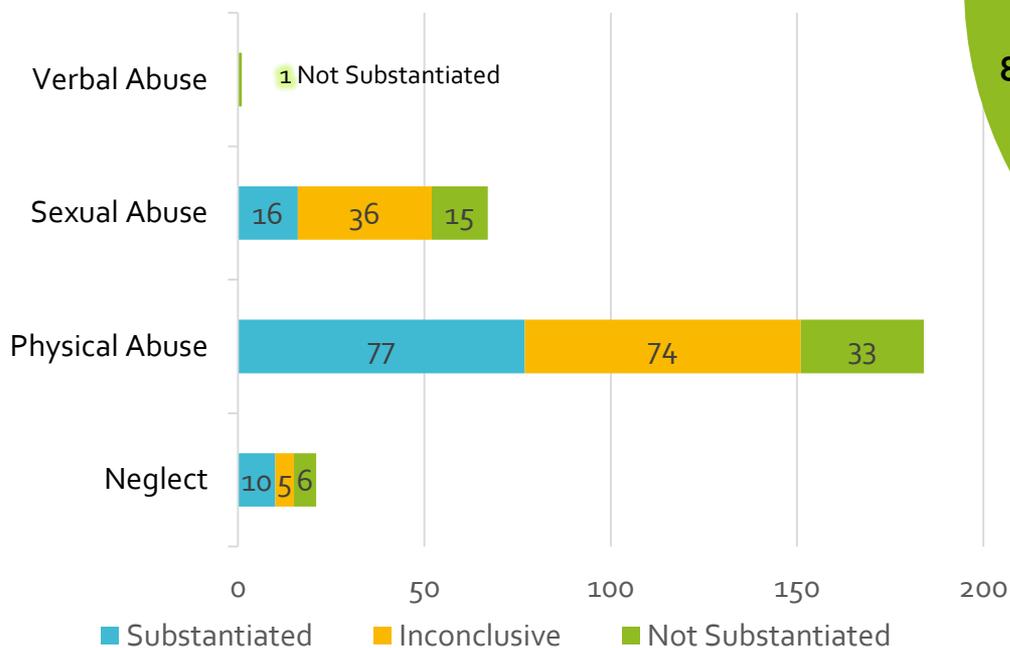
Allegation Results



Outer Circle: Types of Abuse Investigated
Inner Circle: Percentage of All Substantiated Allegations by Abuse Type



Results of Abuse Investigations



Program Summary

OHA Health Systems division provides supports and services to adults enrolled in mental health services through a Community Mental Health Program (CMHP) or with an entity that contracts with or is certified by the state or a CMHP. Support and services are also provided to individuals receiving acute care in a psychiatric placement in a hospital.

Within the diverse population of individuals with a mental illness, there is a broad range of abilities and vulnerabilities. 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 ongoing 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.

When an individual with a mental illness is experiencing symptoms that impact his/her functioning, s/he may be more vulnerable to the abusive and exploitative behavior of others. In addition, a person's difficulty managing challenging symptoms or communicating needs contributes to increased vulnerability.

Program Summary

Discrimination and stigmatization may further exacerbate the difficulties faced by adults with a mental illness and increase their risk of abuse.

In 2016, 391 total allegations were investigated; investigations can be said to occur in either a licensed or non-licensed setting, depending on where the victim is living at the time the abuse occurred. Almost three-quarters (73%) of all investigations took place in non-licensed

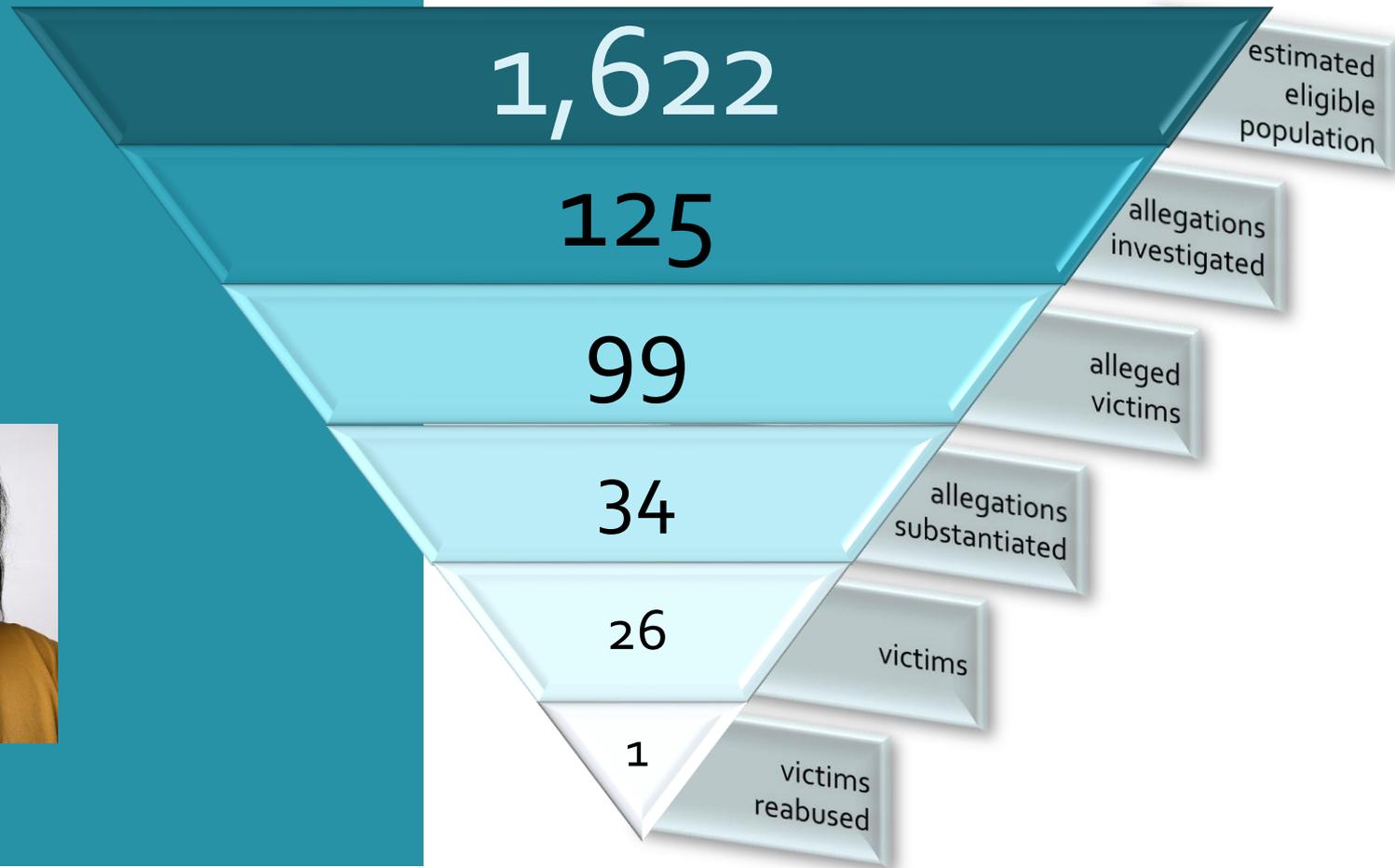
settings. Some abuse types, such as financial abuse or involuntary restriction, can only be investigated in licensed settings. There were 304 adults who received an investigation.

Of the 164 allegations substantiated, 66% or two-thirds, of those allegations were in non-licensed settings. The vast majority of the substantiated allegations (74%) in non-licensed settings were for physical abuse. In many cases this abuse is perpetrated by a family member or intimate partner. In licensed settings, 60% of all substantiated allegations were for either involuntary restriction, placing limits on an individual's freedom of movement, or verbal mistreatment.

The substantiated allegations resulted in 144 people being identified as victims of abuse. Of these, five adults were the victims in two or more investigations.



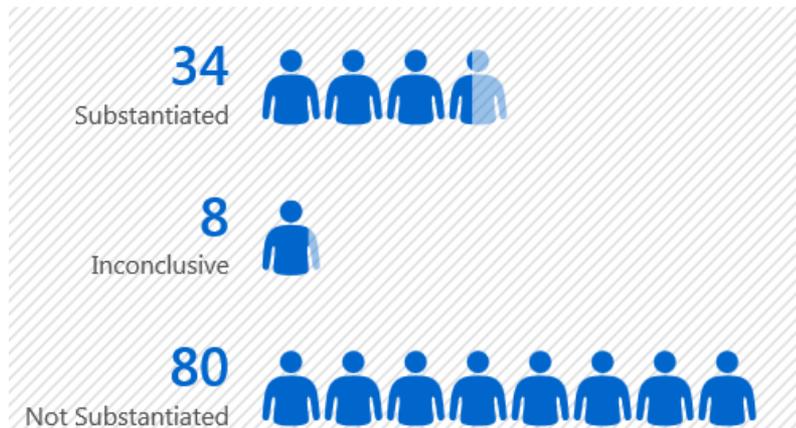
2016 Oregon State Hospital and Authority-Operated Residential Treatment Facilities



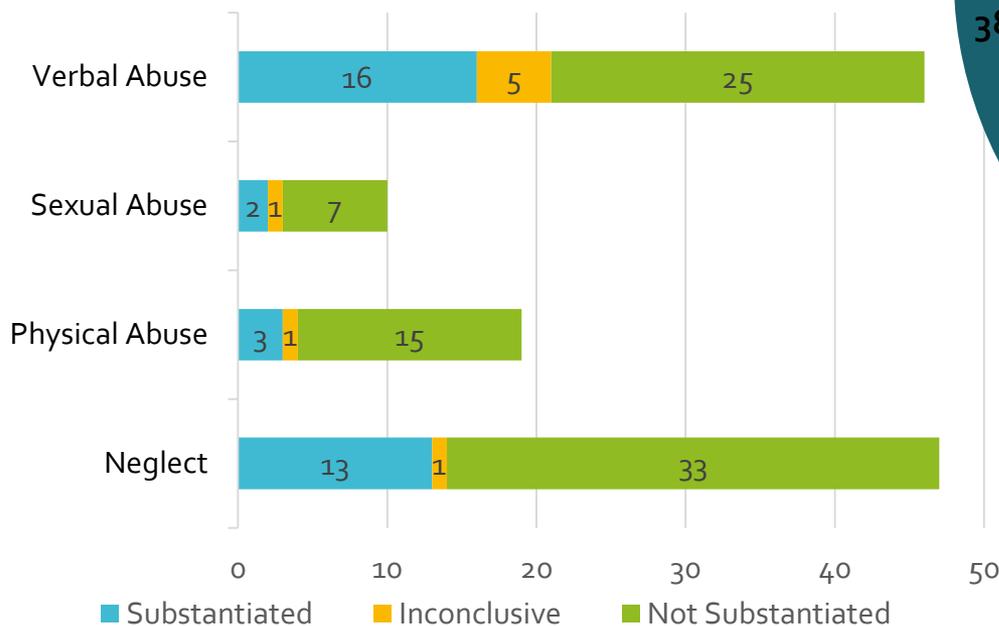
2016 OSH & Authority-Operated Residential Treatment Facilities Data Sheet

Allegation Results

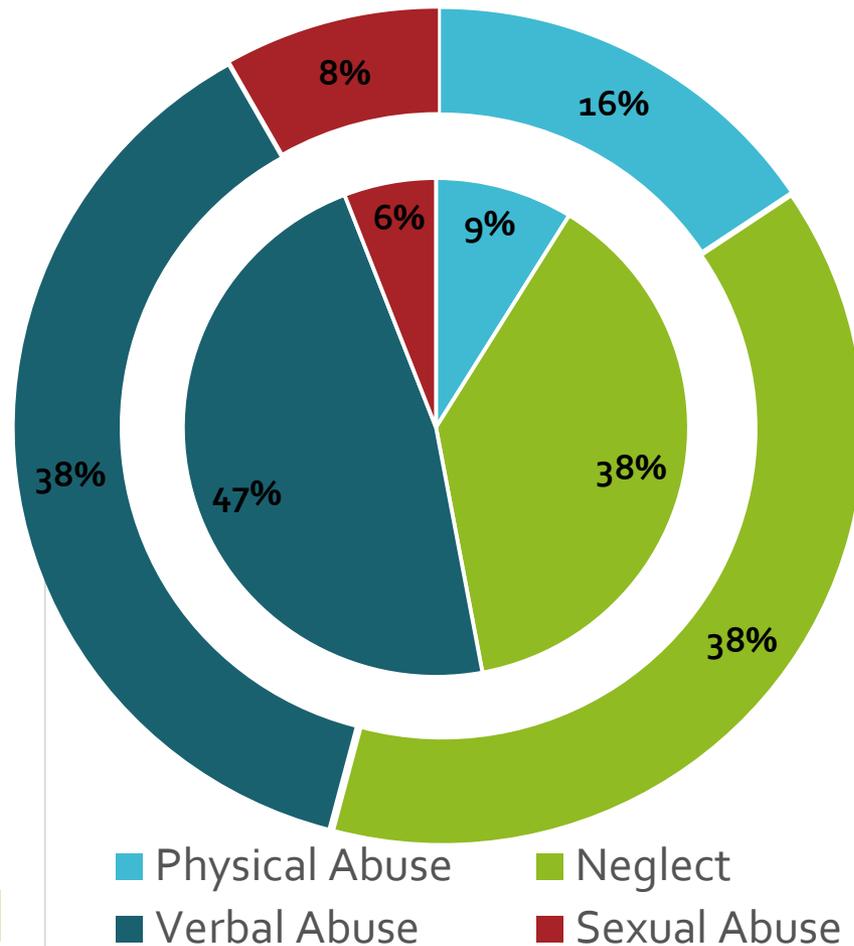
 = 10



Results of Abuse Investigations



Outer Circle: Types of Abuse Investigated
Inner Circle: Percentage of All Substantiated Allegations by Abuse Type



Program Summary

Investigators from OAAPI's Investigation Unit are responsible for investigating allegations of abuse and neglect at Oregon State Hospital (OSH) and at Authority-operated residential treatment facilities such as the Cottages in Pendleton, which offer a less restrictive care setting than the state hospital. A total of 125 allegations were investigated, all except three occurred at either OSH's Salem or Junction City campus.

verbal abuse accounted for over 75% of all allegations. Interestingly, even though both types of abuse were reported at the same rate, 23% more allegations of verbal abuse were substantiated—making verbal abuse the most frequent abuse type.

As with other programs, the number of substantiated allegations is greater than the number of unduplicated victims. This is due to people being identified as the victim of multiple abuse types or having multiple perpetrators of abuse or neglect in the same investigation. One person was identified as being reabused. This is due, in part, to the transitional nature of the state hospital. Very few people stay for an extended period of time; the goal is to help people stabilize and move on to a more appropriate and less restrictive living situation.

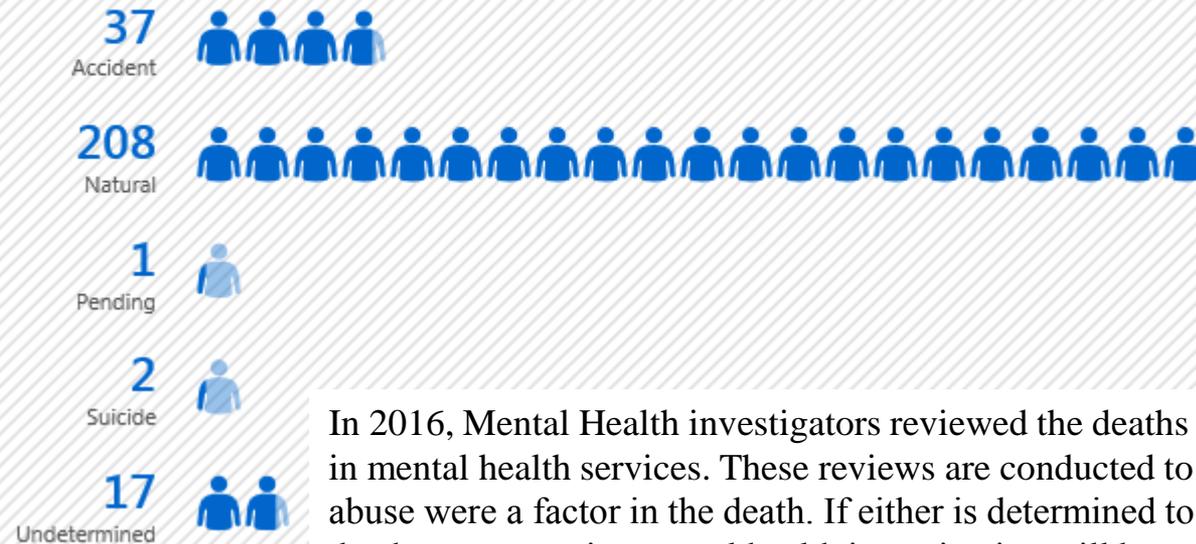


The allegations investigated by OAAPI involved 99 identified victims and resulted in 34 substantiated allegations. All reports, regardless of outcome, are forwarded to administrative staff at OSH for review. Allegations of neglect and

Reviews of Deaths of Adults with Mental Illness

Cause of Death

 = 10



In 2016, Mental Health investigators reviewed the deaths of 265 individuals enrolled in mental health services. These reviews are conducted to determine if neglect or abuse were a factor in the death. If either is determined to be a factor in the person's death, a community mental health investigation will be opened.

Natural causes were responsible for 78% 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 14% of these reviews. A significant majority (60%) of these were caused by drug misuse or overdose.