

2018 OTIS Data Book

Office of Training, Investigations and Safety

OTIS is a Shared Service
of DHS & OHA.

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

The 2018 Data Book was
produced in collaboration
with OTIS's partners.

SAFE Line

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



Executive summary

We invite you to review the 2018 OTIS Data Book. This book pulls together data for all populations that the Office of Training, Investigations and Safety (OTIS) serves, including:

- Adults with intellectual or developmental disabilities (I/DD)
- Children and youth with I/DD who reside in 24-hour residential settings
- Children and youth who are served by child-caring agencies (CCAs)
- Adults who have a mental illness and
- Patients at the Oregon State Hospital.

OTIS ensures that vulnerable Oregonians in these populations are safe where they live, work and play. When people are free from abuse, their need for medical and psychological treatments declines and their quality of life improves.



As you read this report, remember that the statute and rules governing the abuse investigations that OTIS does or oversees changed in 2018. These changes include:

Mental health

- Authority for investigations at the Oregon State Hospital transferred to OTIS.
- The definition of an adult with mental illness who is considered vulnerable expanded.
- Statutory definitions of abuse were expanded for people with mental illnesses.

I/DD

- Authority for investigations for children and youth in 24-hour residential settings transferred to OTIS.
- The scope of investigations was clarified.

CCAs

- Limitations on OTIS's authority to investigate certain types of CCA licenses were removed.

The 2018 OTIS Data Book details the impact of these rule changes.

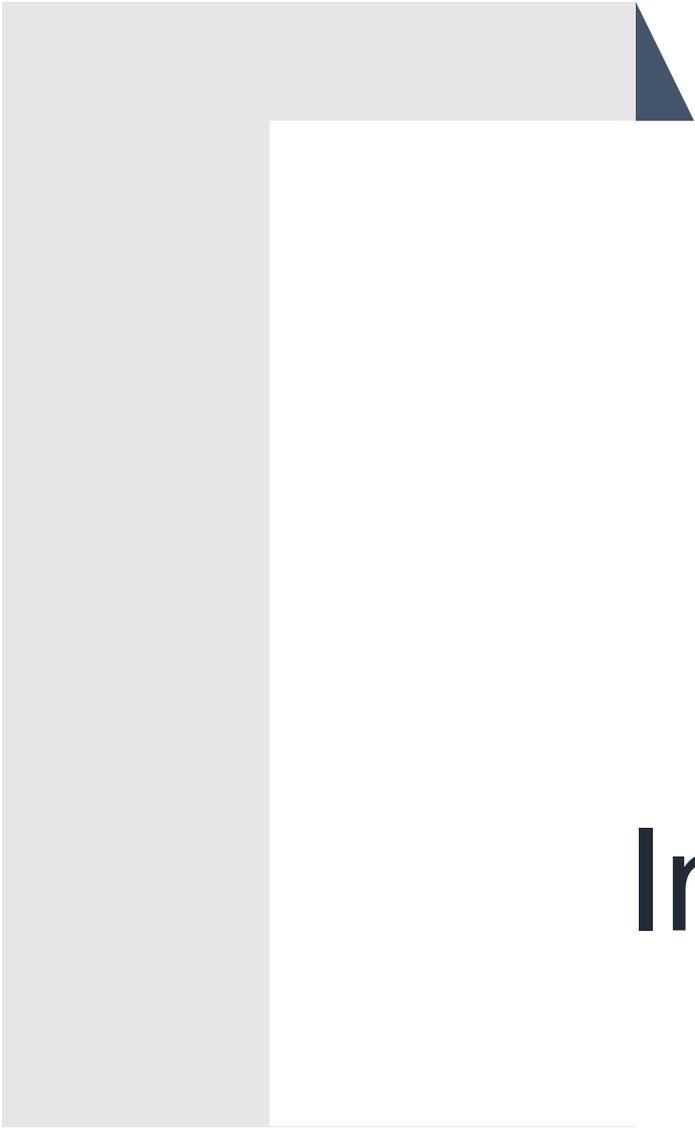
Executive summary

Intellectual/developmental disabilities — adults	<ul style="list-style-type: none"> • In 2018, of the 1,176 allegations of abuse investigated, 449 were substantiated. • 691 people were alleged to be victims, and 327 individuals were found to have been abused.
Stabilization And Crisis Unit — adults	<ul style="list-style-type: none"> • In 2018, of the 109 allegations of abuse investigated, 13 were substantiated. • 42 people were alleged to be victims, and 12 individuals were found to have been abused.
Stabilization and Crisis Unit — children	<ul style="list-style-type: none"> • In 2018, of the 25 allegations of abuse investigated, 5 were substantiated. • 11 children were alleged to be victims, and 5 individuals were found to have been abused.
Intellectual/developmental disabilities — children's residential	<ul style="list-style-type: none"> • In 2018, of the 309 allegations of abuse investigated, 49 were substantiated. • 99 children were alleged to be victims, and 24 individuals were found to have been abused.
Child-caring agencies	<ul style="list-style-type: none"> • In 2018, of the 571 allegations of abuse investigated, 83 were substantiated. • 356 children were alleged to be victims, and 61 individuals were found to have been abused.
Mental health programs	<ul style="list-style-type: none"> • In 2018, of the 147 allegations of abuse investigated, 45 were substantiated. • 112 adults were alleged to be victims, and 41 individuals were found to have been abused.
Oregon State Hospital — abuse	<ul style="list-style-type: none"> • In 2018, of the 42 allegations of abuse investigated, 8 were substantiated. • 32 people were alleged to be victims, and 6 individuals were found to have been abused.
Oregon State Hospital — mistreatment	<ul style="list-style-type: none"> • In 2018, of the 27 allegations of mistreatment investigated, 4 were substantiated. • 18 people were alleged to be victims, and 4 individuals were found to have been mistreated.

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.

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Introduction and reader's guide

2018 data book introduction

Oregon Revised Statute (ORS) mandates that reports of abuse to protected people be investigated to ensure the person's well-being. Protected people range from children and youth in care to adults with intellectual and developmental disabilities or those living with a severe and persistent mental illness. Some protected people reside at the Oregon State Hospital or another state-operated mental health treatment facility. Protected people live in all parts of Oregon.

This is the summary of the protective service assessments and abuse investigations during 2018 that the Office of Training, Investigations and Safety (OTIS) performed or oversaw. OTIS is a Department of Human Services (DHS) and Oregon Health Authority (OHA) shared service. It supports programs within both DHS and OHA. OTIS investigators are responsible for investigating possible abuse or neglect in:

- Licensed child-caring agencies (CCAs)
- The Oregon State Hospital (OSH)
- OHA-operated residential treatment facilities for people with mental illness

- Stabilization and Crisis Units (SACU) and
- I/DD licensed residential group homes for children.

OTIS investigation coordinators provide technical assistance and oversight to local investigators throughout the state who investigate most allegations of abuse and neglect for people enrolled in I/DD or mental health services.

The alleged victim's needs are paramount in all investigations. The investigator uses a trauma-informed approach for each investigation. This approach 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, OTIS actively seeks to avoid re-traumatizing the individual.

The investigator is trained to respect the victim's right to self-determination while assessing the protective measures needed to keep the victim safe and to address well-being. All services are voluntary. The victim or the victim's guardian has the right to decline any or all offered services.

2018 data book introduction

In regulated settings, the investigator shares the report with agencies that license care facilities or certify service providers. These reports support their actions. The actions taken by our partner agencies help 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.

Investigations involving adults result in findings of “substantiated,” “closed without abuse determination” and “not substantiated.” These findings are based on the preponderance of evidence (more likely than not). If the investigator determines the allegation is more likely true than not, they will substantiate the allegation. Until March 2018, a finding of “inconclusive” was also possible. However, a statute change removed “inconclusive” as a finding and introduced “closed without abuse determination.”



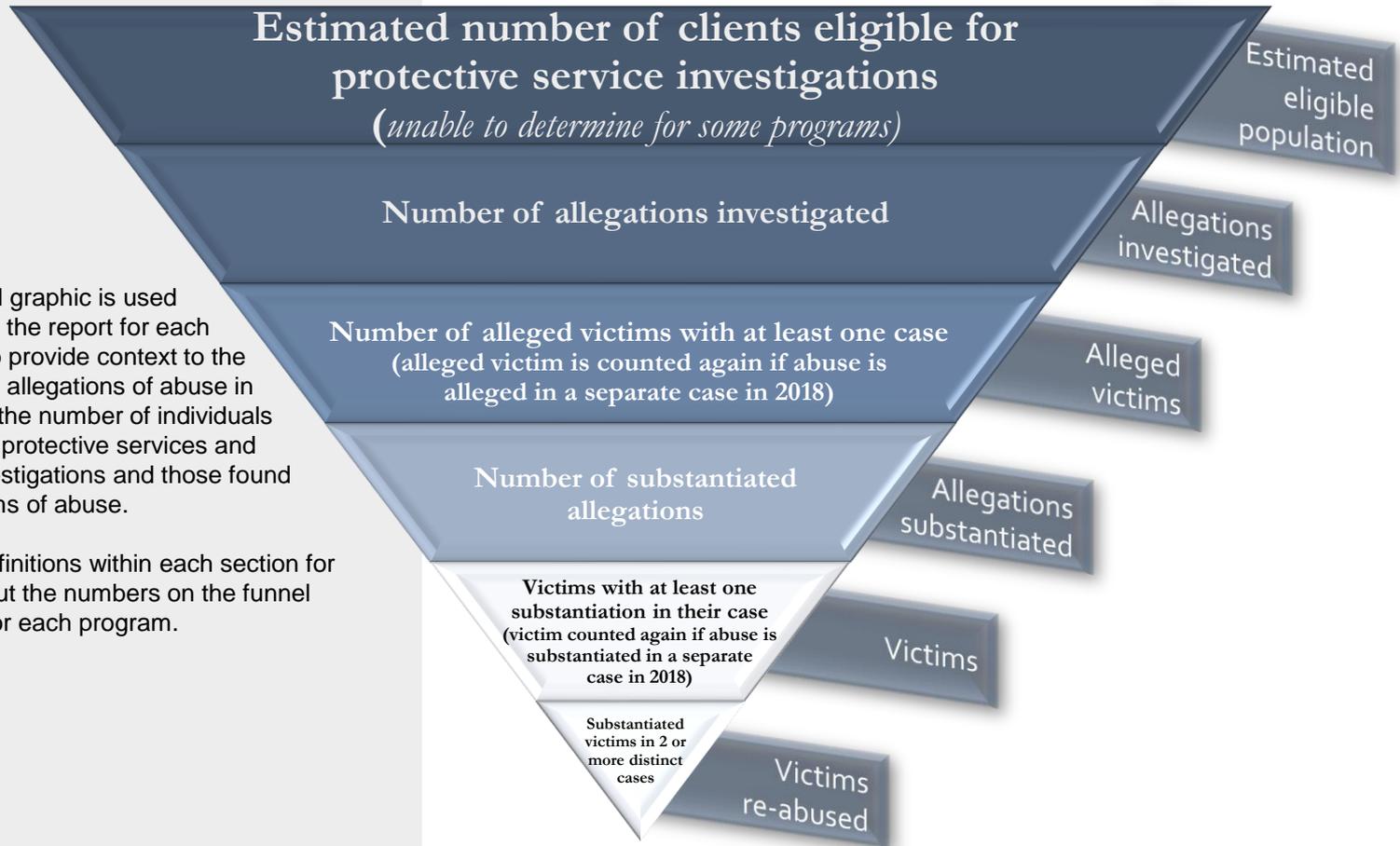
For investigations involving children, the possible findings are “substantiated,” “inconclusive” and “unsubstantiated.” The standard of proof to substantiate an investigation is reasonable cause to believe. This standard relies on the investigator gathering clear and specific facts. After gathering those facts, 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.

Program funnel graphic

Population, allegations and victims



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 and abuse 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.

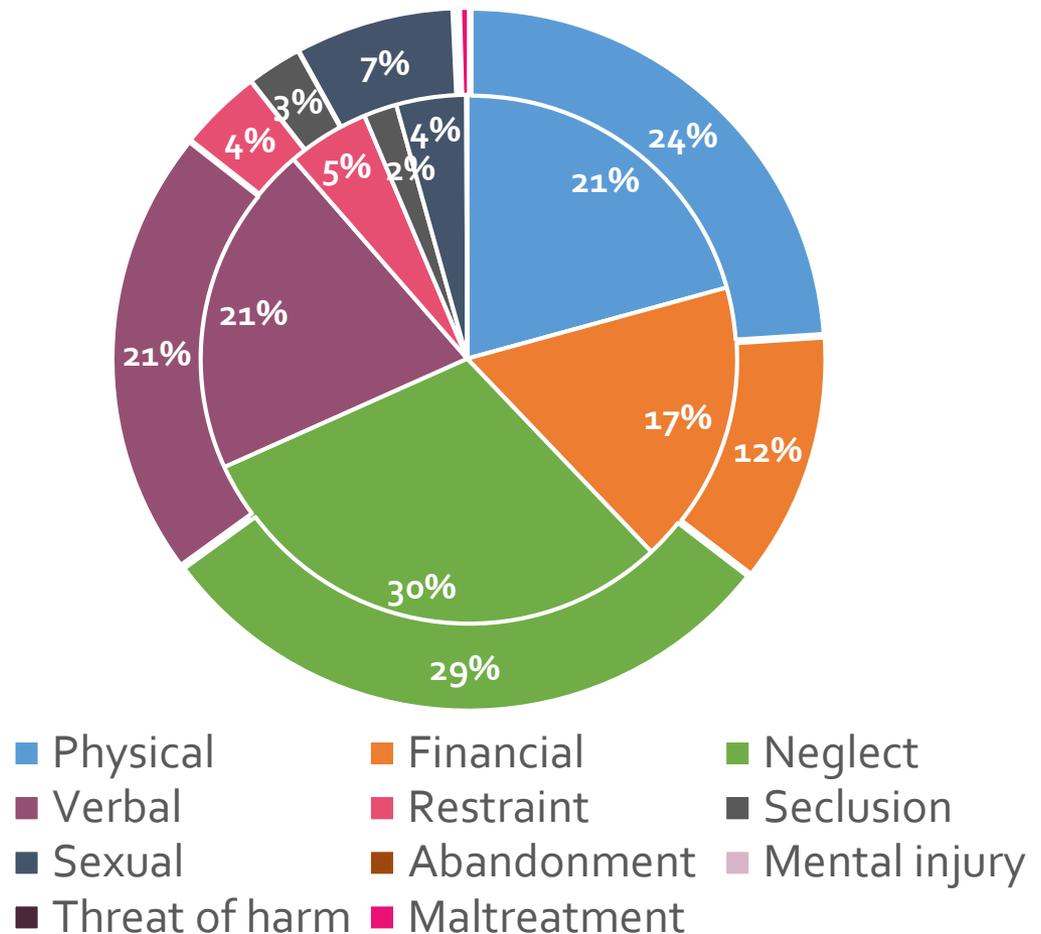
Program-specific data sheets

These nested pie charts compare abuse types *investigated* and abuse types *substantiated* for investigations that concluded in 2018.

- 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.

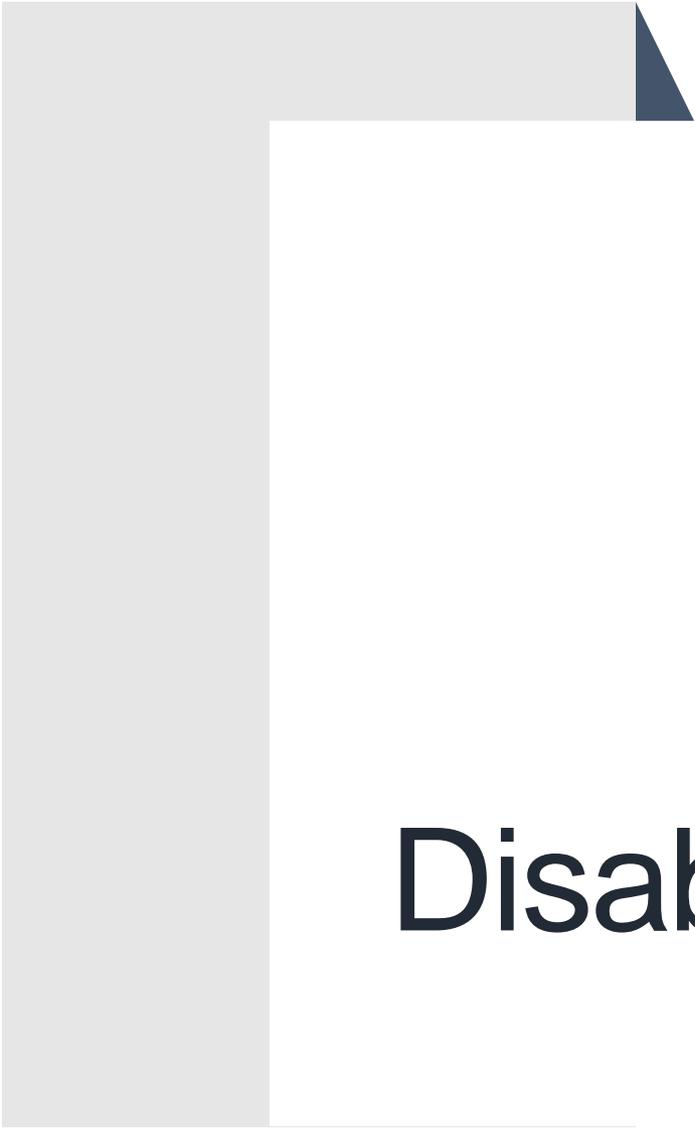
For this sample data, neglect comprised 29% of allegations investigated (outer circle), and substantiated neglect comprised 30% of all substantiated allegations (inner pie).

Outer circle: types of abuse investigated
Inner pie: types of abuse substantiated



Glossary

CCA	Child-caring agency	ODDS	Office of Developmental Disabilities Services
CCLP	Children's Care Licensing Program	OHA	Oregon Health Authority
CCP	Child-caring program	ORS	Oregon Revised Statute
CDDP	Community Developmental Disability Programs	OSH	Oregon State Hospital
CMHP	Community mental health programs	OTIS	Office of Training, Investigations and Safety
CPS	Collaborative Problem Solving	SACU	Stabilization and Crisis Units
DHS	Oregon Department of Human Services	SB	Senate Bill
DOJ	Oregon Department of Justice	SRTF	State-operated residential treatment facilities
HR	Human Resources		
I/DD	Intellectual or developmental disabilities		
OAR	Oregon Administrative Rule		



Office of Developmental Disabilities Services programs

I/DD adults summary

“Developmental disability” is a term that includes intellectual and other disabilities. Some developmental disabilities occur largely due to medical conditions or brain injury that affects a person’s development. Some people may have a genetic condition such as Down syndrome that affects physical and intellectual development. People with these disabilities may also have medical or mental health needs.

Intellectual disability is characterized by below-average mental capacity that affects reasoning, learning and/or problem solving. People with intellectual disabilities may also have limitations in behavior skills. The Office of Developmental Disabilities (ODDS) and its partner adult intellectual/developmental disabilities (I/DD) programs provide supports and services to adults who meet eligibility criteria. In 2018 more than 20,000 Oregon adults were enrolled in I/DD services.

Operation of the state’s I/DD system is a partnership. ODDS issues rules and provides technical assistance and oversight. Brokerages and Community Developmental Disability Programs (CDDPs) provide local services.

These community programs operate in specific geographic areas, usually a county or several counties. People enrolled in I/DD programs can choose to receive case management services

through brokerages or through a CDDP.

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

CDDP investigators investigate most abuse and neglect cases. If an investigation is particularly complex, encompasses several CDDP jurisdictions or involves a conflict of interest, it is referred to OTIS 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 people receive case management services as well as locations where people get community supports to enable them to live in their own home or their family home.



I/DD adults summary

Several trends in the abuse investigation data for 2018 occurred. The total number of abuse allegations decreased from 2017. OTIS, ODDS and their partner agencies' staff reviewed Oregon Revised Statute (ORS) and Oregon Administrative Rule (OAR) as part of a continuous process improvement, which led to changes in practice. As a result, a temporary spike occurred in allegations investigated in 2017. This significantly increased workload resulted in OTIS's clarification of statute and increased technical assistance.

The number of people identified as victims in substantiated allegations decreased in 2018. The number of people who were re-abused also decreased. Both of these are the effects of a decreased number of substantiated allegations. In 2018, 38 percent of all allegations were substantiated compared to 47 percent in 2017. This decrease is due to how

investigations are conducted and the way outcomes are determined. Another significant change from 2017 is the prevalence of neglect among the substantiated allegations in licensed settings. Neglect allegations were almost 40 percent of all allegations investigated in 2017 and 2018. This is not unusual. Because licensed care settings are paid to give care to the person, they assume a higher level of responsibility for the people who live in them. Neglect is

the most frequently investigated allegation in all care settings. However, in 2018 neglect accounted for 42 percent of the substantiated allegations in I/DD licensed settings — a much higher percentage than in 2017 when it was 29 percent of all substantiated allegations. This is, in part, because of two very large investigations that involved multiple allegations.



I/DD adults summary

The other two frequently substantiated allegations were verbal abuse and financial exploitation. Along with neglect, they are more than 75 percent of all substantiated allegations in licensed settings.

In non-licensed settings, almost two-thirds of all substantiated allegations are either verbal or physical abuse. Research shows the accused person is either a relative or a partner of the victim in 40 percent of allegations. Note that this data may be incomplete. The database is only able to capture one relationship between the victim and the accused person. For example, if the accused person is both a relative and a paid caregiver, only one relationship will be identified. The accused person appears to be unknown to the victim in 30 percent of the allegations.

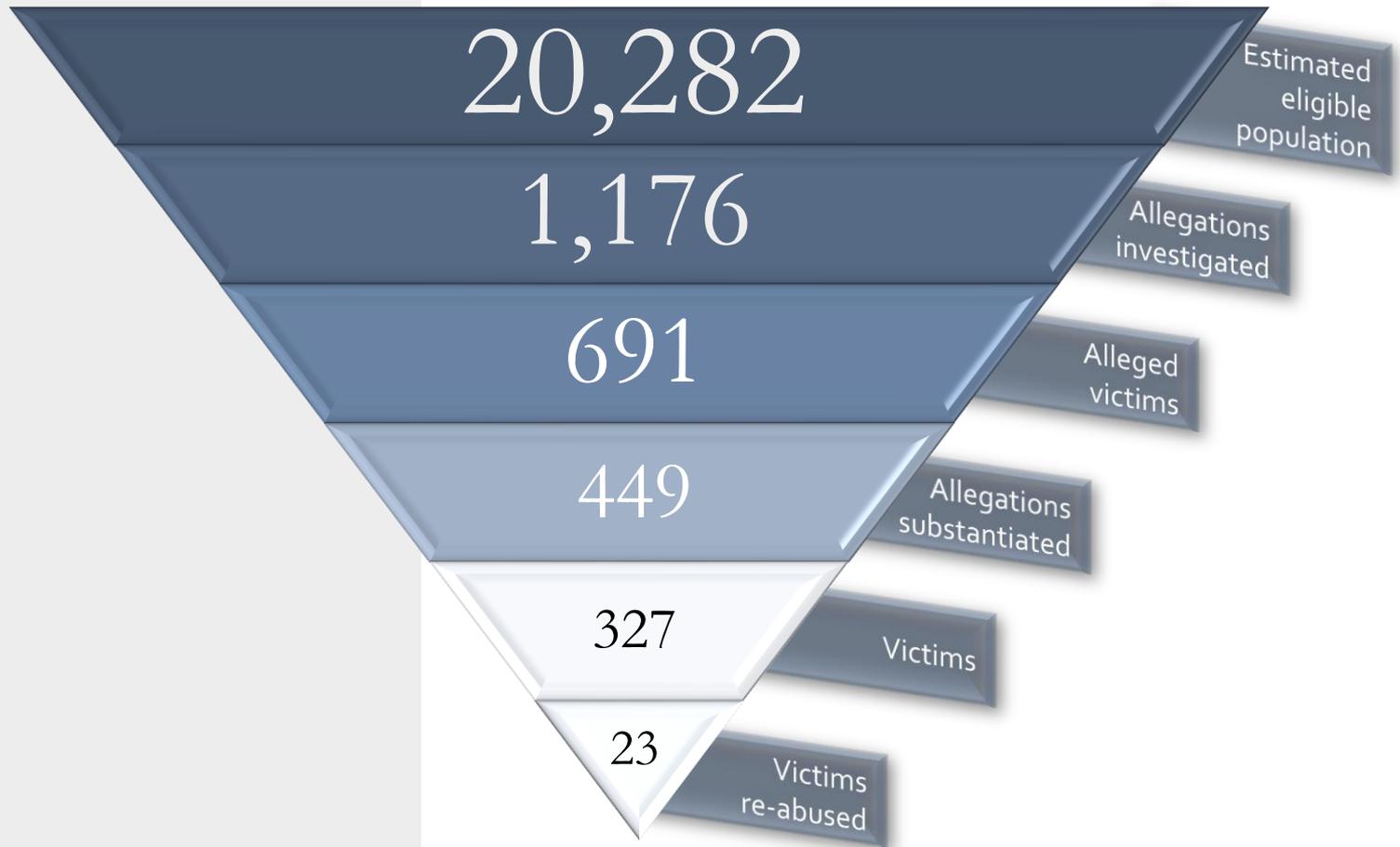


All abuse exists in a mild to severe range. Neglect can range from placing a vulnerable person at risk of harm to not providing basic care that results in hospitalization or death. Physical abuse can range from a scratch, cut or bruise that causes mild discomfort to broken bones and head injuries that require immediate medical attention. Sexual abuse can range from unwanted sexual advances or unwanted exposure to sexual material to physical sexual assault.

Victims of abuse and neglect experience seen and unseen effects. Trauma effects can vary based on the severity and duration of the abuse as well as the individual's vulnerabilities. This data does not and cannot capture the range of severity of the substantiated abuse. It also cannot portray the impacts or trauma of abuse on victims.

2018 I/DD adults

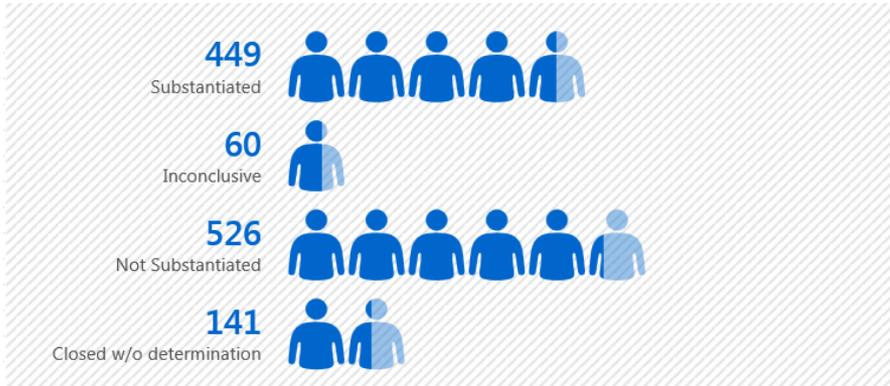
Population, allegations and victims



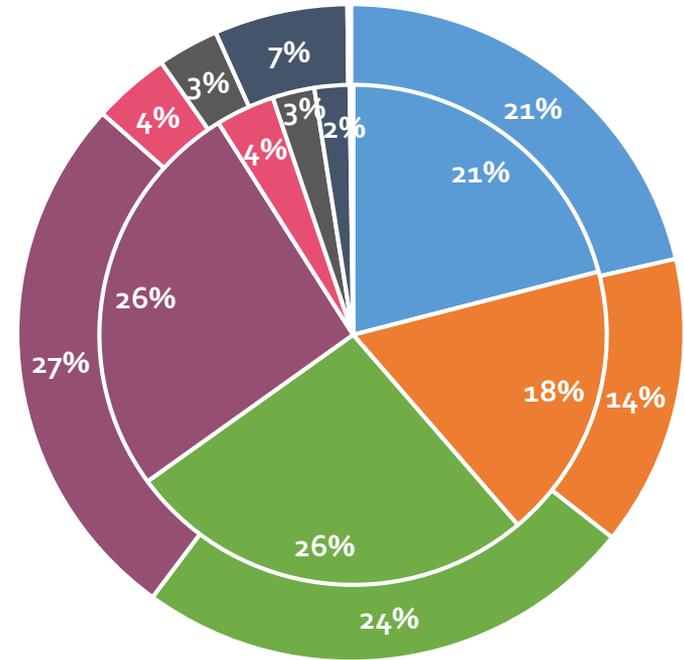
2018 I/DD adults

Allegation results

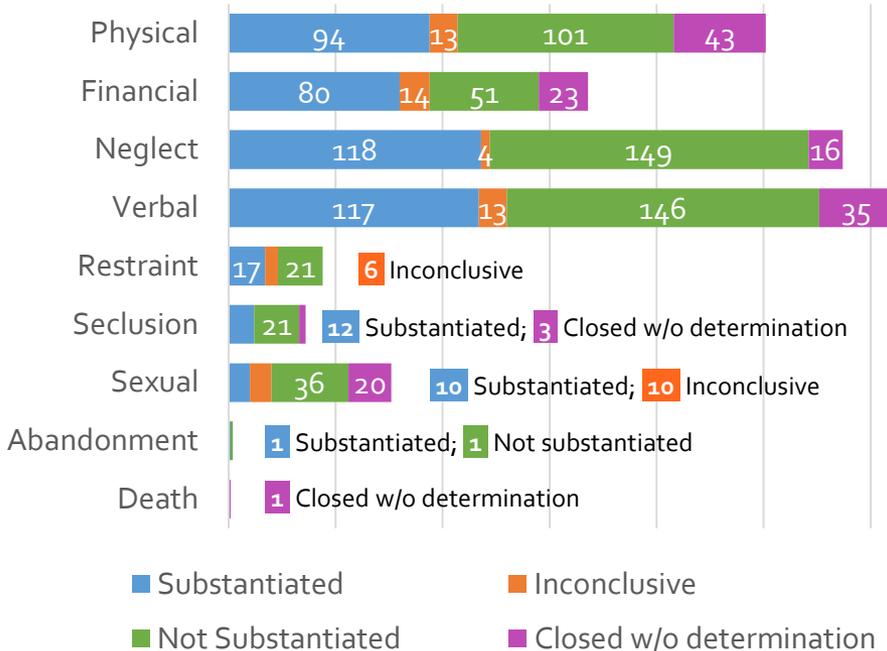
1 person icon = 100



Outer circle: types of abuse investigated
Inner pie: types of abuse substantiated

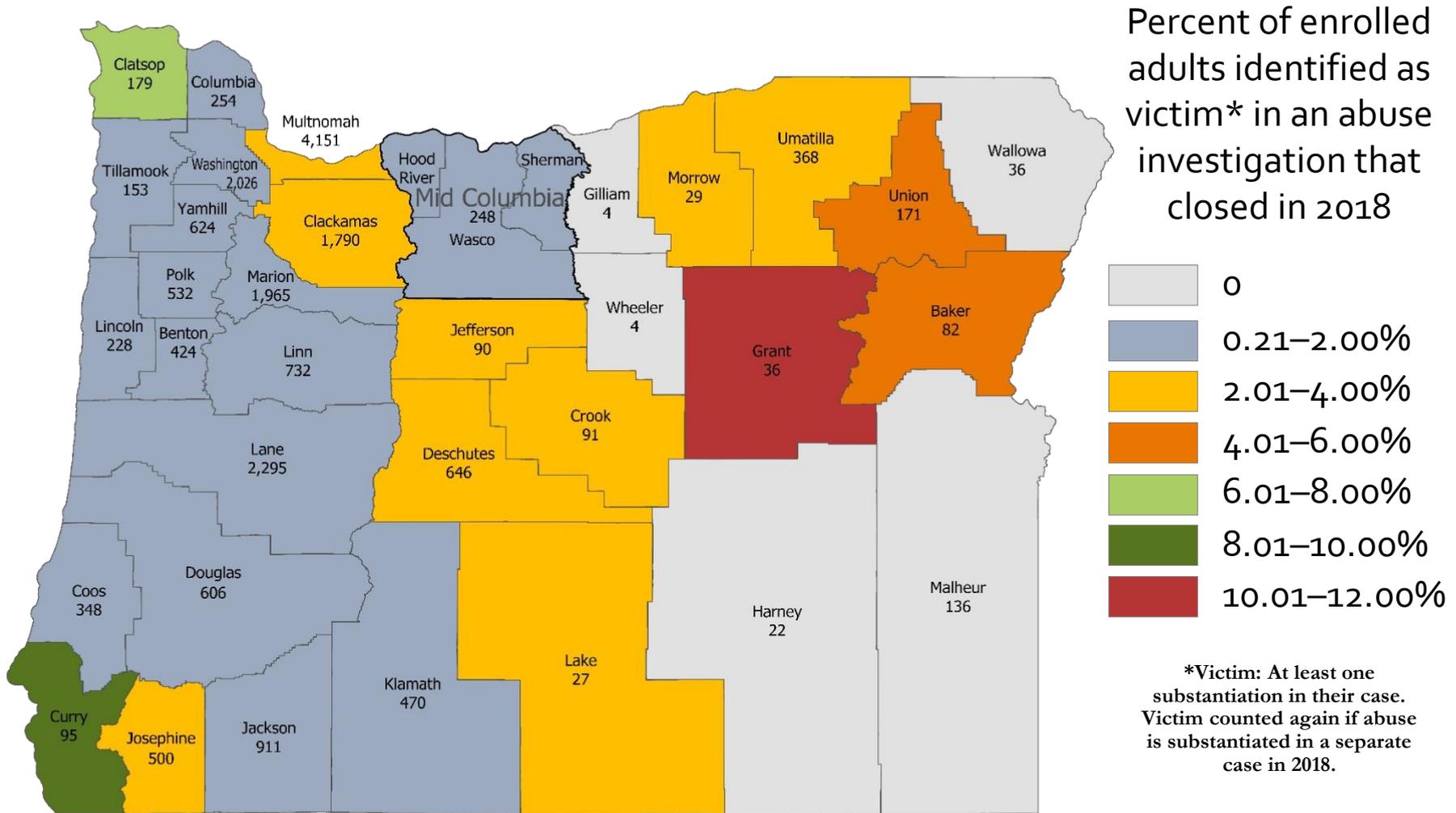


Results of abuse investigations



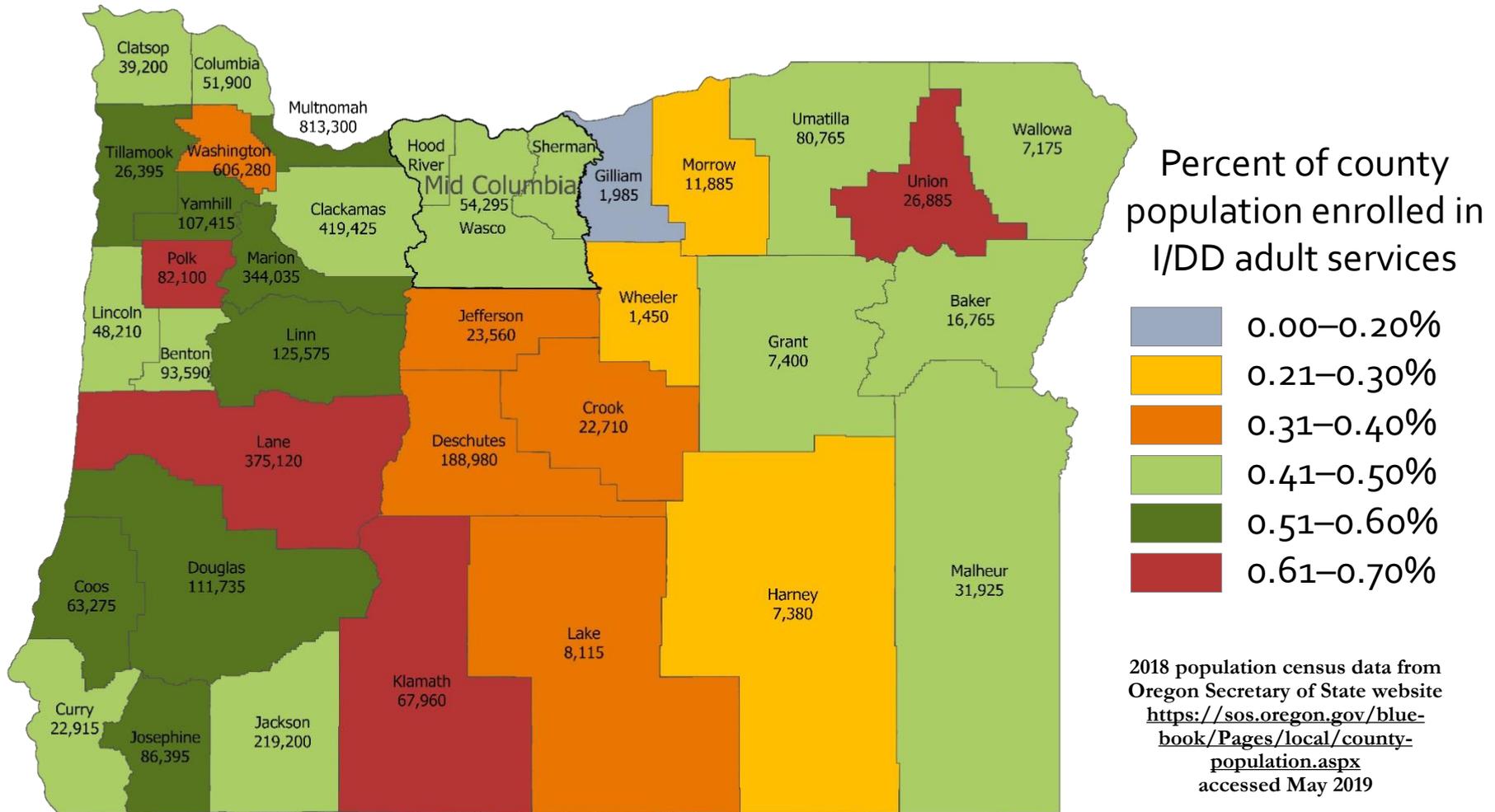
- Physical
- Financial
- Neglect
- Verbal
- Restraint
- Sexual
- Seclusion
- Abandonment

2018 I/DD adults



The numbers under each county name represent the population of adults enrolled in ODDS services, and therefore the number of individuals eligible for a protective services investigation. Mid-Columbia's population of eligible individuals is a total from the three counties in its jurisdiction.

2018 I/DD adults

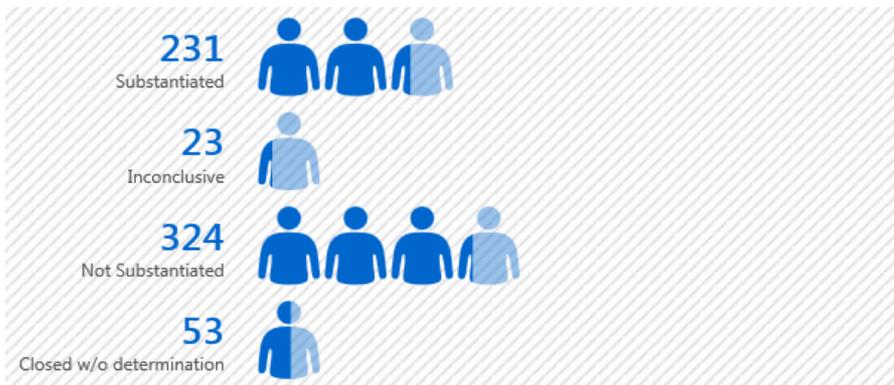


The numbers under each county name represent the 2018 Census population of that county. Mid-Columbia’s population is a total from the three counties in its jurisdiction.

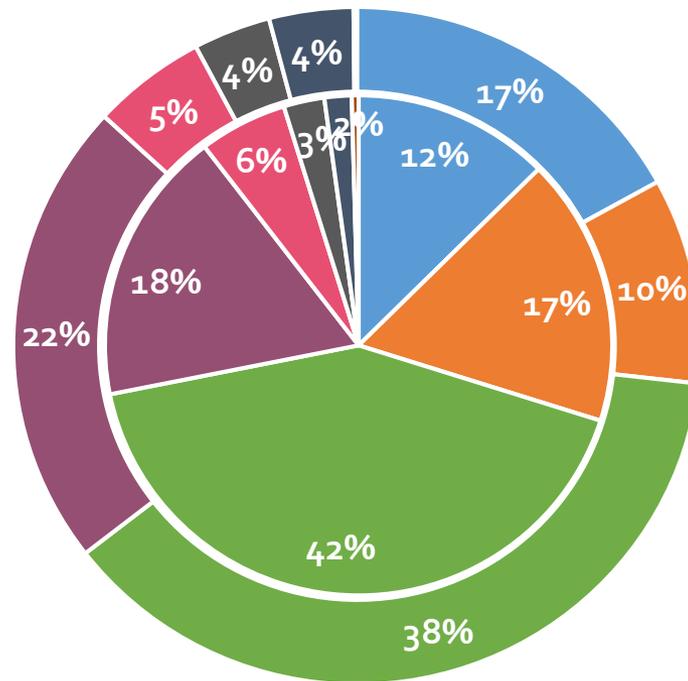
2018 I/DD adults in licensed settings

Allegation results

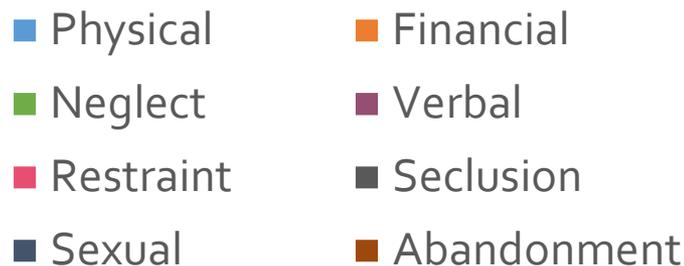
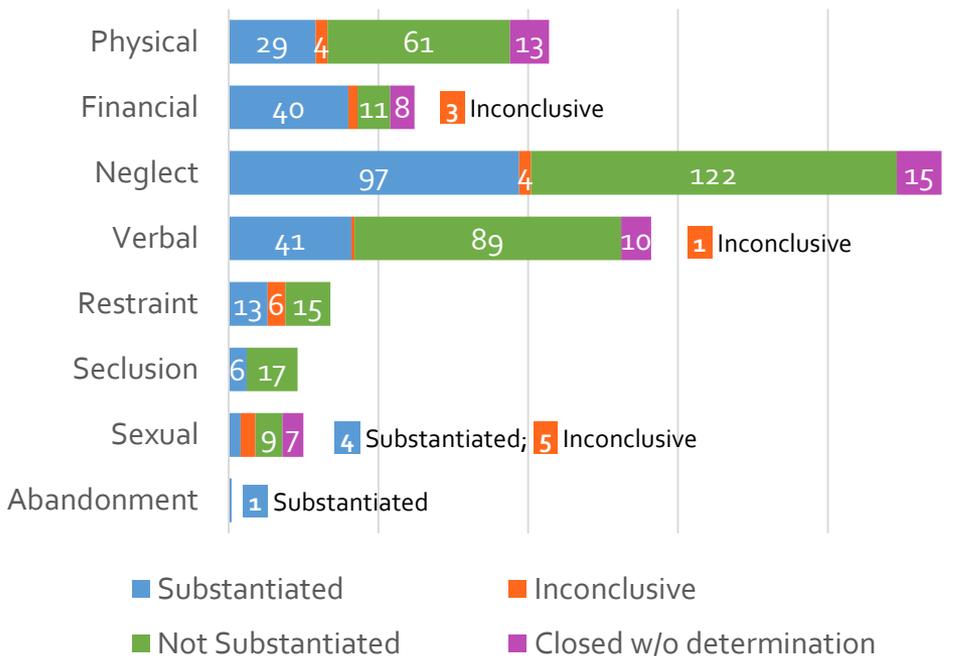
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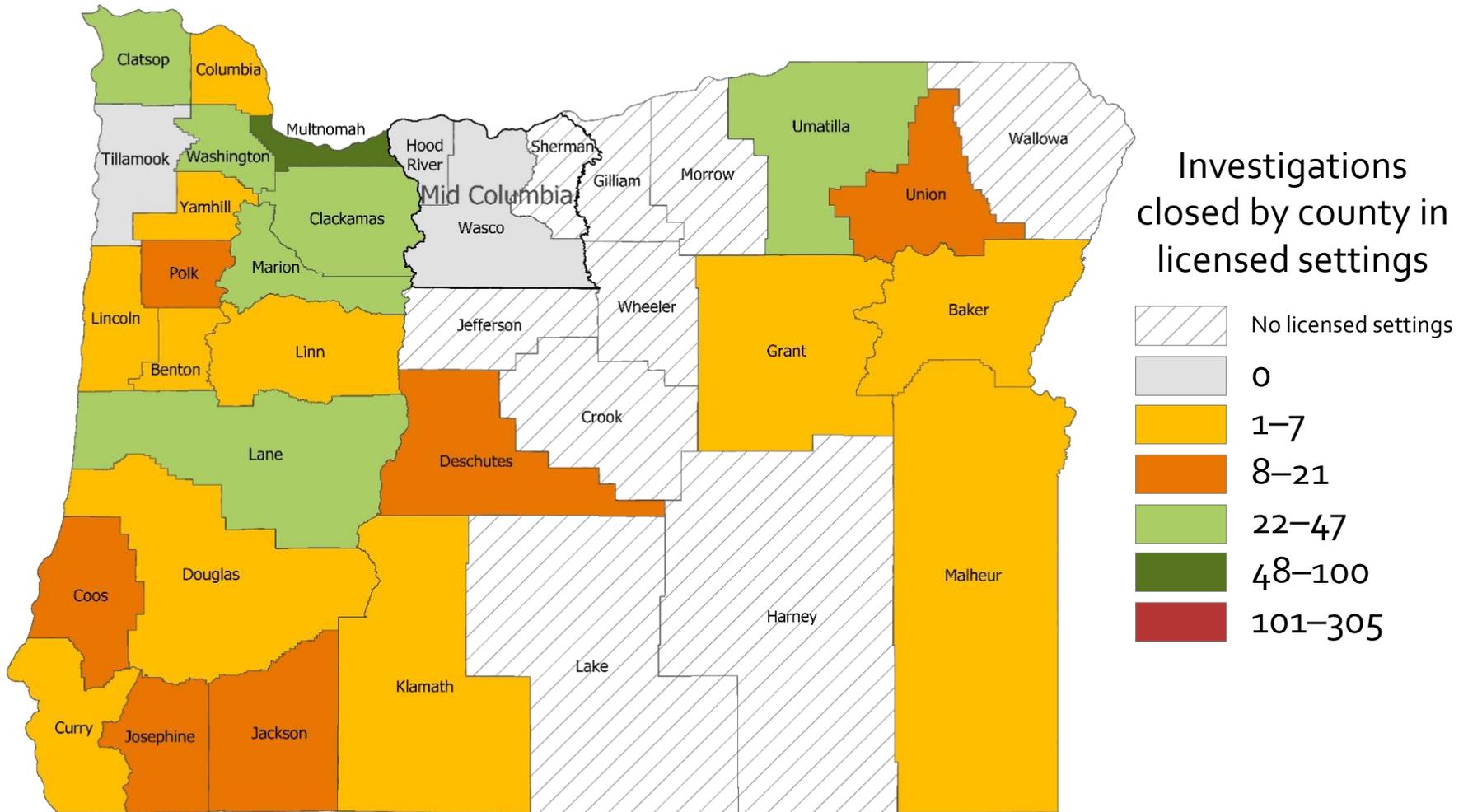
Outer circle: types of abuse investigated
Inner pie: types of abuse substantiated



Results of abuse investigations



2018 I/DD adults in licensed settings

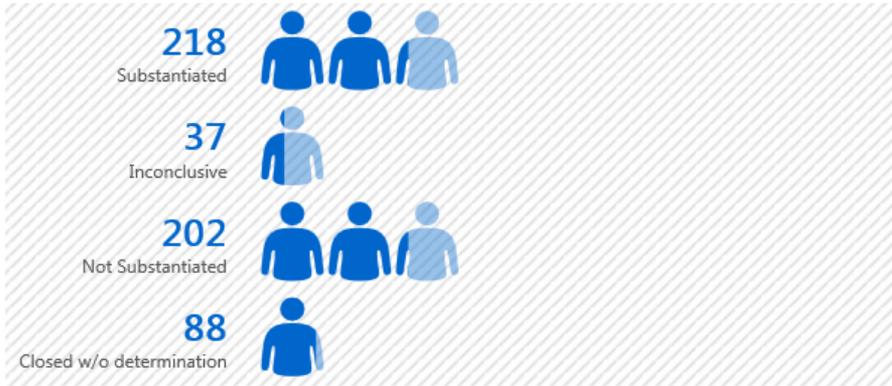


Mid-Columbia has three counties in its jurisdiction.

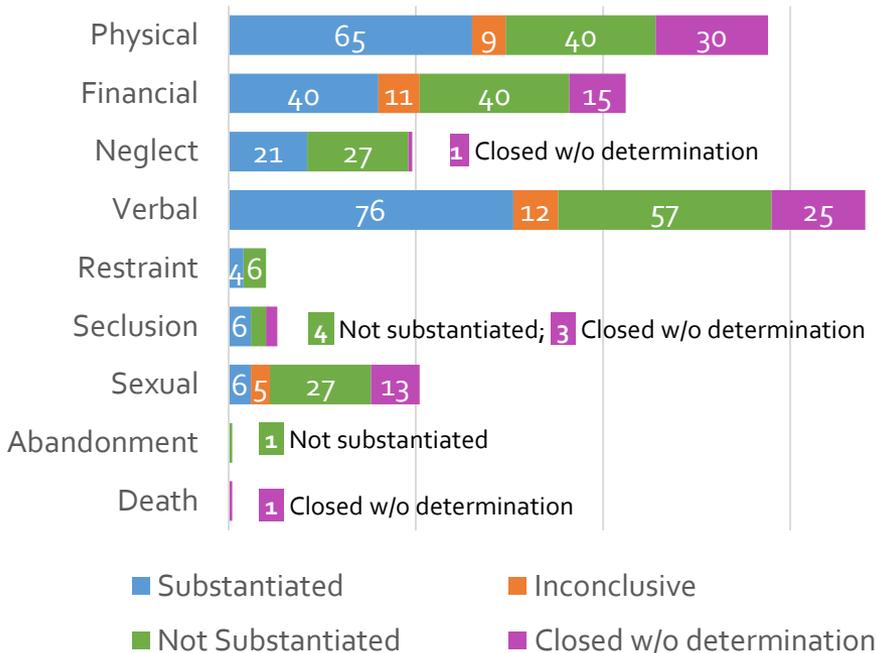
2018 I/DD adults in non-licensed settings

Allegation results

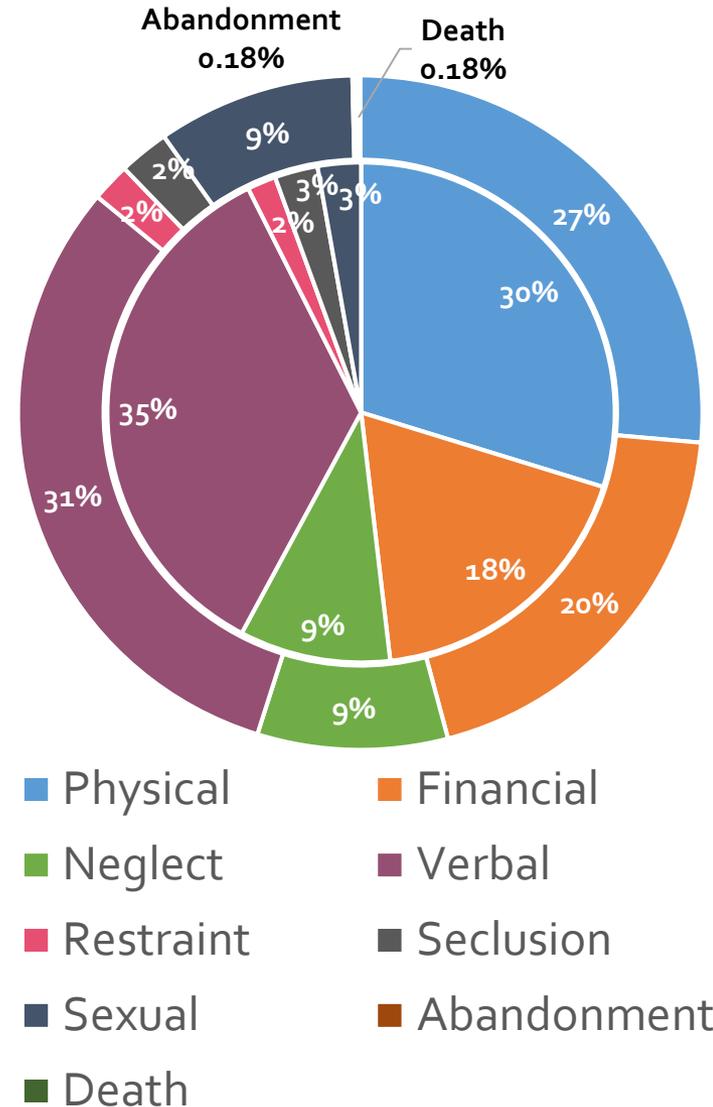
1 person icon = 100



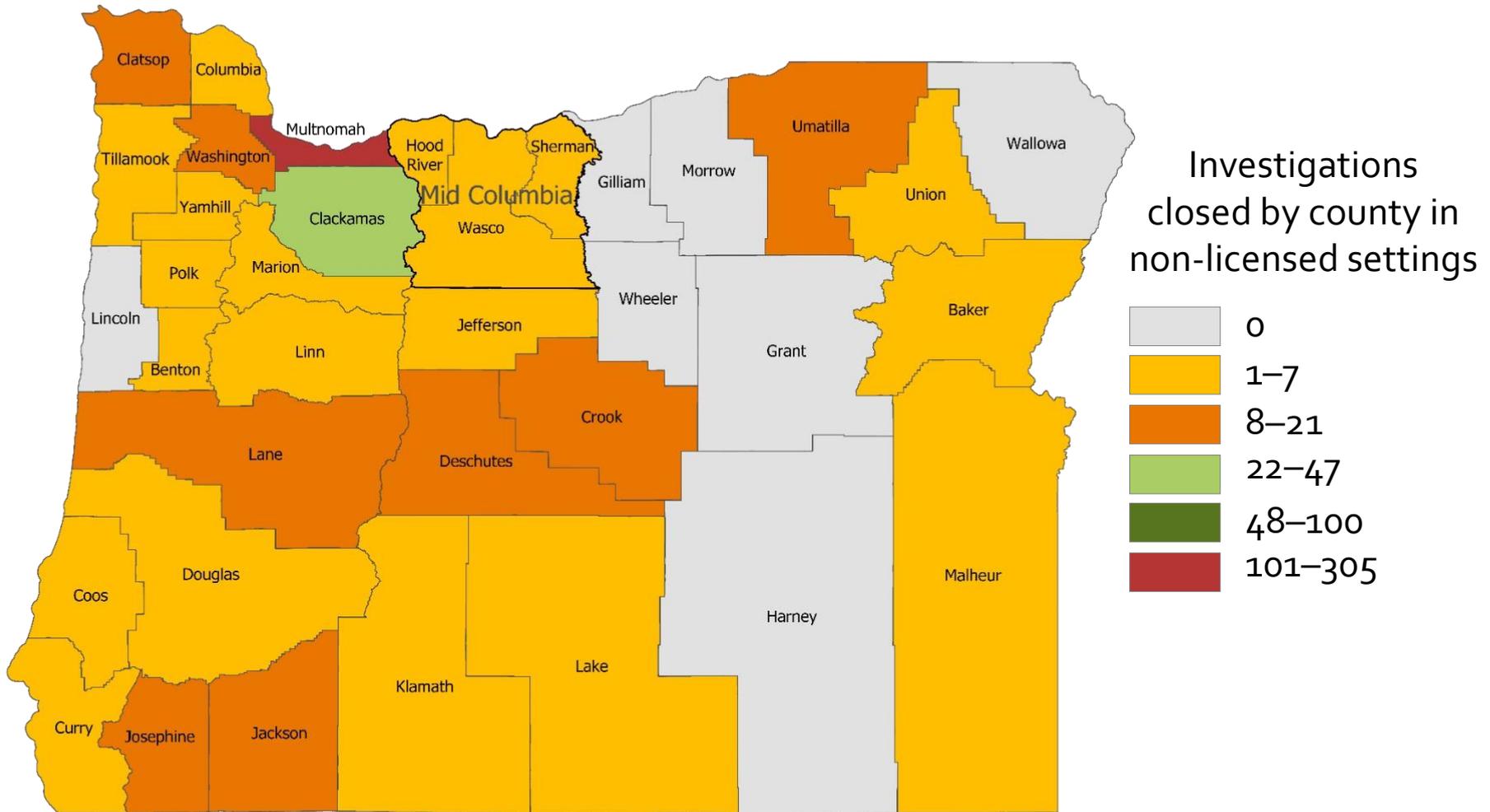
Results of abuse investigations



Outer circle: types of abuse investigated
Inner pie: types of abuse substantiated



2018 I/DD adults in non-licensed settings



Mid-Columbia has three counties in its jurisdiction.

SACU adults summary

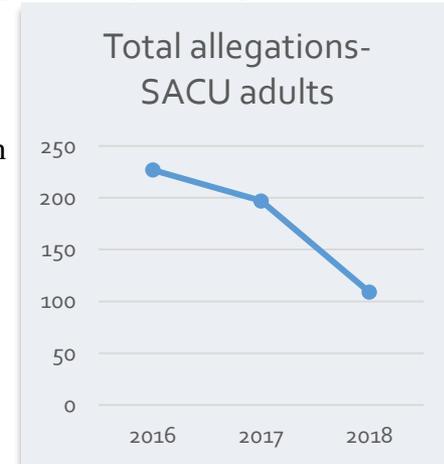
SACU is an ODDS specialized program that provides 24-hour residential care and supervision to children and adults who have multiple needs and need stabilization. It is a safety-net resource for Oregonians with I/DD who have no other option for a residential bed due to significant I/DD and mental health challenges. SACU supports people to stabilize and then transition into community settings.



SACU residential group homes are located along the I-5 corridor from Portland to Eugene. There are 18 homes for adults and three homes for children. OTIS conducts abuse investigations in SACU homes.

Adults living in SACU homes

In 2018 investigators investigated 109 allegations in SACU adult homes. As the graph shows, this is a decrease in the number of allegations from both 2016 and 2017. Allegations dropped by more than half between 2016 and 2018. Creating and implementing a Compliance Team contributed to this. The team reviewed the Oregon Revised Statute and the Oregon Administrative Rules that apply to SACU. They trained staff on these and on documentation of events that happen in the homes.

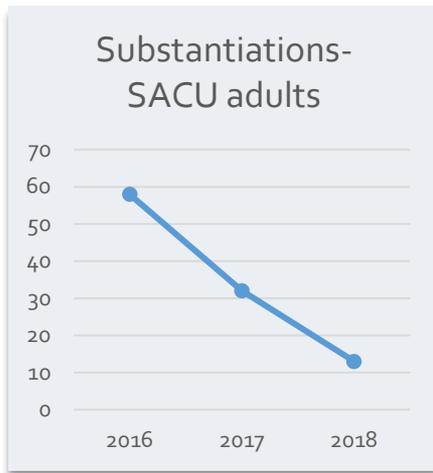


A new position, regional training manager, was established. The manager onboards and trains new managers on policy and procedure. SACU also updated policies and procedures and trained staff on these new processes. In 2017 SACU also began providing Collaborative Problem Solving (CPS) training for every employee in the program.

SACU adults summary

OTIS has a recurring scheduled segment in SACU's New Employee Orientation training to educate new program staff about how they can help ensure Oregon's most vulnerable I/DD population remains healthy and safe. All of these steps have had a substantial impact.

The number of adult substantiations decreased significantly – by 77 percent – between 2016 and 2018.



Neglect was the most frequently investigated allegation in 2018. It accounted for almost half of all allegations investigated. This is true in all residential care settings.

Because group homes and other

residential care settings are paid to provide care, they

assume broad responsibility for their residents. In SACU adult residences, 11 of the 13 substantiated allegations were for neglect.

All abuse exists in a mild to severe range. Neglect can range from placing a vulnerable person at risk of harm to not providing basic care that results in hospitalization or death. Physical abuse can range from a scratch, cut or bruise that causes mild discomfort to broken bones and head injuries that require immediate medical attention. Sexual abuse can range from unwanted sexual advances or unwanted exposure to sexual material to physical sexual assault.

Victims of abuse and neglect experience seen and unseen effects. Trauma effects can vary based on the severity and duration of the abuse as well as the individual's vulnerabilities. This data does not and cannot capture the range of severity of the substantiated abuse. It also cannot portray the impacts or trauma of abuse on victims.

2018 SACU adults

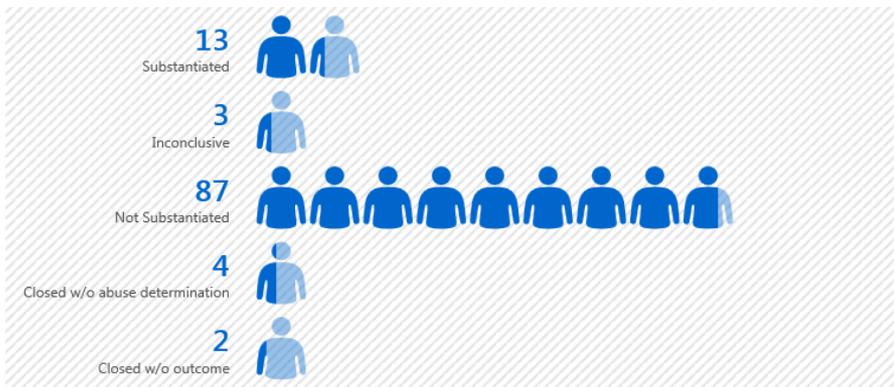
Population, allegations and victims



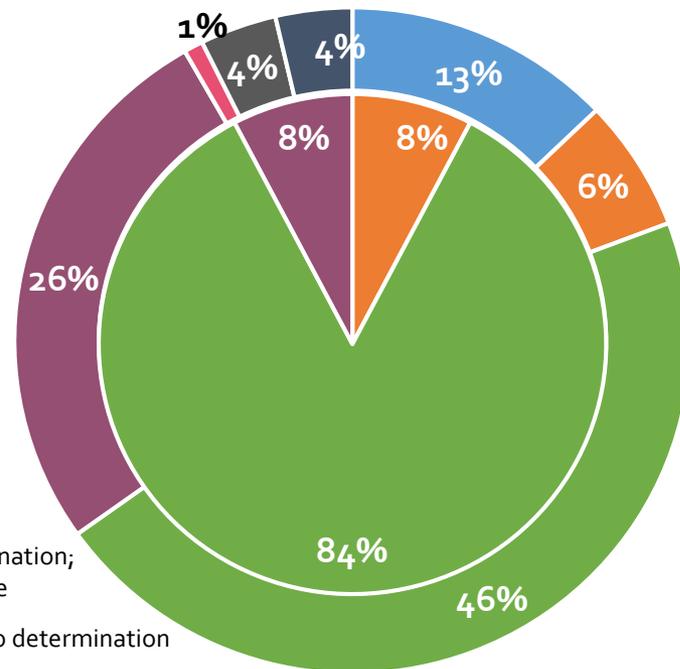
2018 SACU adults

Allegation results

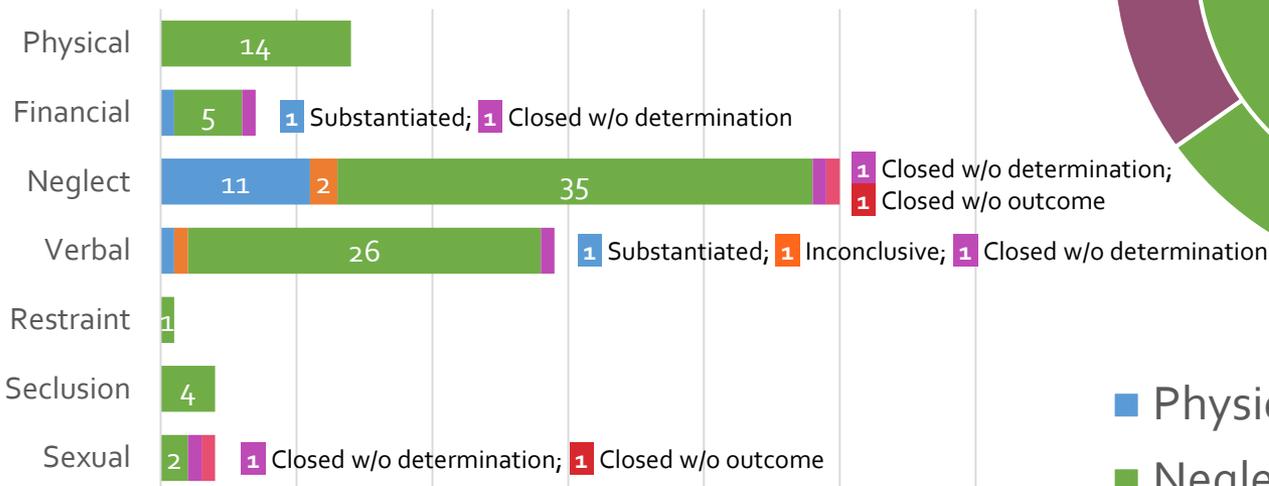
1 icon = 10



Outer circle: types of abuse investigated
Inner pie: types of abuse substantiated



Results of abuse investigations



SACU children summary

SACU children

In 2018 OTIS investigated 25 allegations of abuse at the three SACU group homes for children. The two most prevalent allegations were neglect and physical abuse. They totaled almost two-thirds of all allegations investigated. Neglect is usually the most frequently investigated and substantiated allegation in residential care settings because the group home is paid to provide care to its residents. Physical abuse is frequently reported if a child is placed in a protective physical intervention and expresses pain. No physical abuse allegations were substantiated.

Of the 25 allegations investigated, five were substantiated. The substantiated allegations were spread over five different abuse types — with one substantiated allegation each of neglect, verbal abuse, wrongful restraint, mental injury and sexual abuse.

An investigator sometimes discovers the alleged abuse occurred before

the child was living at the SACU home or while the child was outside the SACU's care (e.g., on a home visit). In these circumstances the investigation will be referred to another agency.

All abuse exists in a mild to severe range. Neglect can range from placing a vulnerable person at risk of harm to not providing basic care that results in hospitalization or death. Physical abuse can range from a scratch, cut or bruise that causes mild discomfort to broken bones and head injuries that require immediate medical attention. Sexual abuse can range from unwanted sexual advances or unwanted exposure to sexual material to physical sexual assault.

Victims of abuse and neglect experience seen and unseen effects. Trauma effects can vary based on the severity and duration of the abuse as well as the individual's vulnerabilities. This data does not and cannot capture the range of severity of the substantiated abuse. It also cannot portray the impacts or trauma of abuse on victims.



In 2017, OTIS conducted investigations in the children's homes for just a few months. Investigative authority was then transferred to DHS Child Welfare Program investigators. These investigations returned to OTIS in 2018. Because Child Welfare holds the data for those 2017 investigations, we are unable to compare 2018 data to previous years.

2018 SACU children

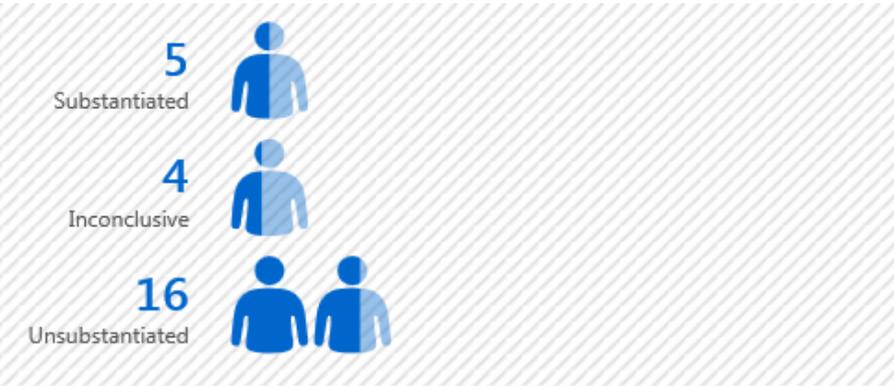
Population, allegations and victims



2018 SACU children

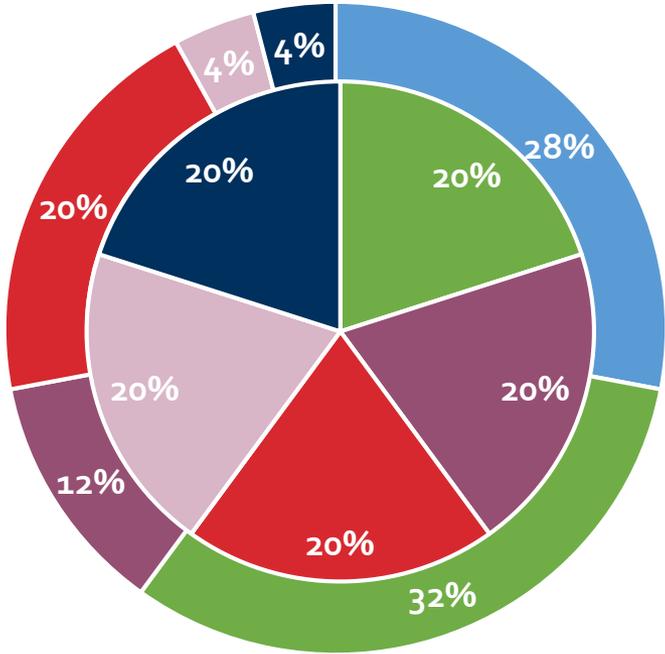
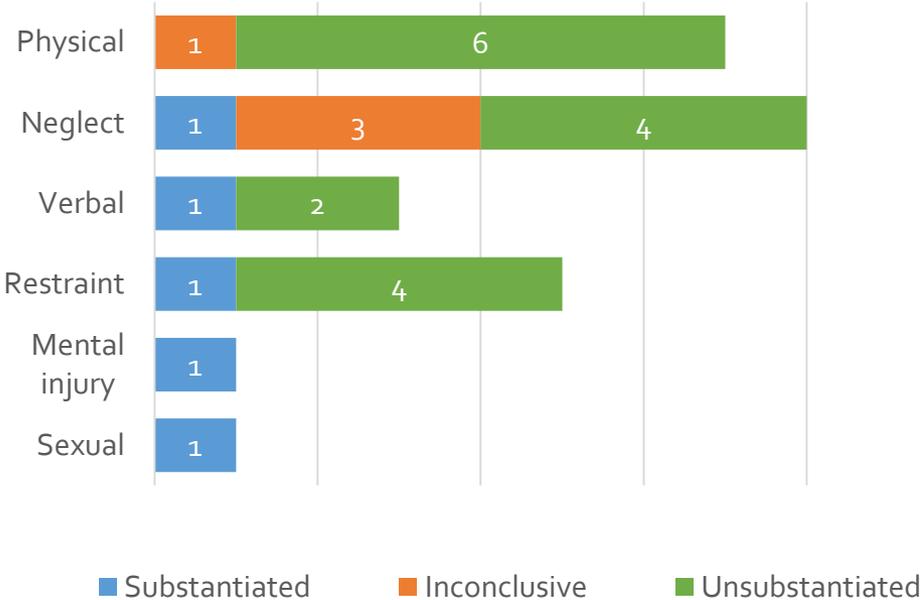
Allegation results

1 icon = 10



Outer circle: types of abuse investigated
Inner pie: types of abuse substantiated

Results of abuse investigations



- Physical
- Neglect
- Verbal
- Restraint
- Mental injury
- Sexual

I/DD children's residential summary

Children's I/DD 24-hour residential group homes specialize in meeting the needs of children who have intellectual/developmental disabilities (I/DD). They 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. 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 or in SACU settings. For information about children in SACU homes, please turn to [page 28](#) of the data book.

In 2018, OTIS investigated 309 abuse allegations. Neglect and physical abuse allegations were most frequently investigated, totaling 67 percent or two-thirds of all allegations. Neglect is the most frequent type of allegation in residential care. Physical abuse allegations often occur when a child is placed into a physical intervention and expresses pain or reports an injury.

All abuse exists in a mild to severe range. Neglect can range from placing a vulnerable person at risk of harm to not providing basic care that results in hospitalization or death. Physical abuse can range from a scratch, cut or bruise that causes mild discomfort to broken bones and head injuries that require immediate medical attention. Sexual abuse can range from unwanted sexual advances or unwanted exposure to sexual material to physical sexual assault.

Victims of abuse and neglect experience seen and unseen effects. Trauma effects can vary based on the severity and duration of the abuse as well as the individual's vulnerabilities. This data does not and cannot capture the range of severity of the substantiated abuse. It also cannot portray the impacts or trauma of abuse on victims.



I/DD children's residential summary

Of the 49 substantiated allegations, more than half were for neglect. The second most frequently substantiated abuse type was wrongful restraint. Wrongful restraint is identified in rule as the “wrongful use of a physical or chemical restraint.”* Physical restraint is defined as, “restricting a child or young adult's voluntary movement as an emergency measure in order to manage and protect the child or young adult or others from injury when no alternate actions are sufficient to manage the child or young adult's behavior.”+ Preventing a child or youth from moving between places in a non-emergency situation is an example of wrongful restraint. It can also include using medications that are not prescribed for the child to manage uncontrollable behavior. For example, preventing a child from running into traffic would not be wrongful restraint.

Wrongful restraint accounted for 21 percent of all substantiated allegations. Investigations will often begin with an allegation of physical abuse because a child

indicates pain or injury caused by physical intervention. The investigator may discover the statutory definition of physical abuse is not met, but the child's individual support plan did not recommend physical intervention or the intervention was not performed according to licensing protocols. The investigator will then open and investigate an allegation of wrongful restraint to determine if the restraint was necessary and/or appropriate. Combined, neglect and wrongful restraint are more than three-quarters of the substantiated allegations. Physical abuse accounted for just 10 percent of all substantiated allegations in 2018.

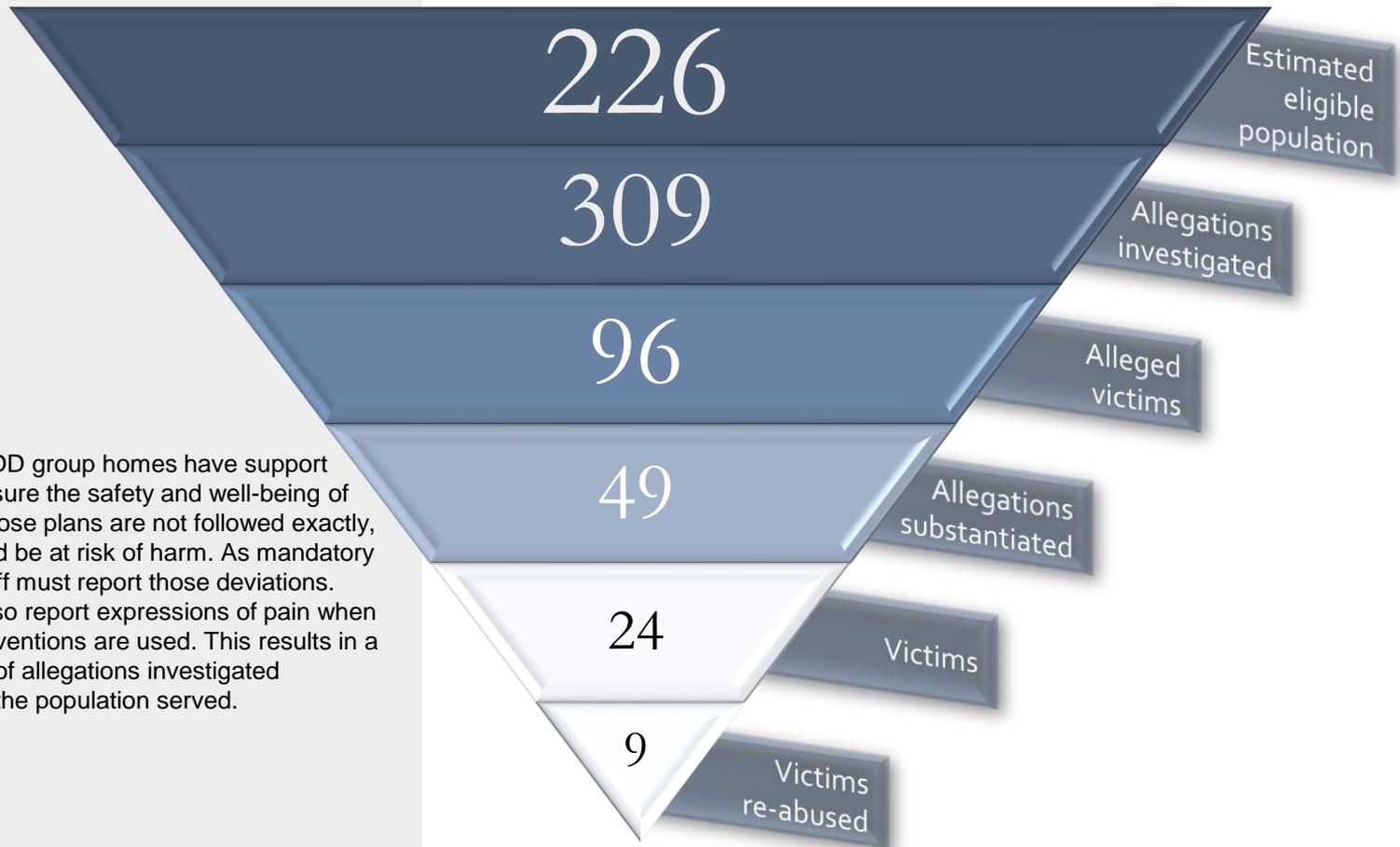
In 2017, OTIS investigators conducted abuse investigations in these licensed settings for only two months before these investigations were transferred to investigators with the Child Welfare Program. These investigations returned to OTIS in 2018. Because Child Welfare holds most of the data for 2017, comparisons between 2018 and previous years are not possible.

* OAR 407-045-0887(3)(h)

+ OAR 407-045-0887(3)(h)(A)

2018 I/DD children's residential

Population, allegations and victims

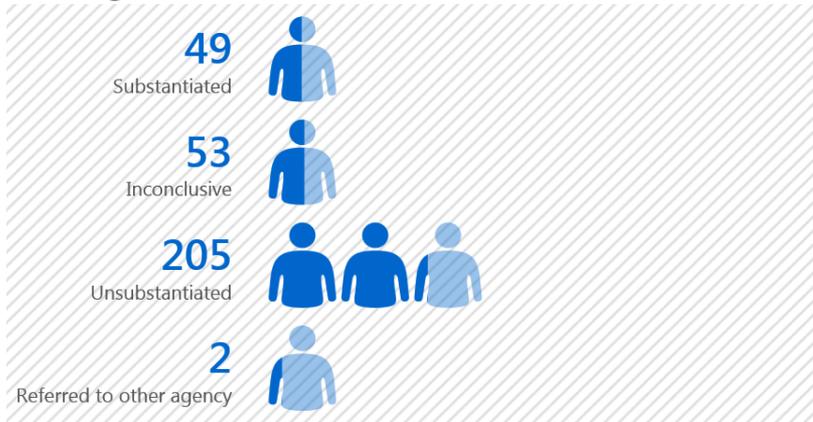


Children in I/DD group homes have support plans that ensure the safety and well-being of the child. If those plans are not followed exactly, the child could be at risk of harm. As mandatory reporters, staff must report those deviations. They must also report expressions of pain when physical interventions are used. This results in a high number of allegations investigated compared to the population served.

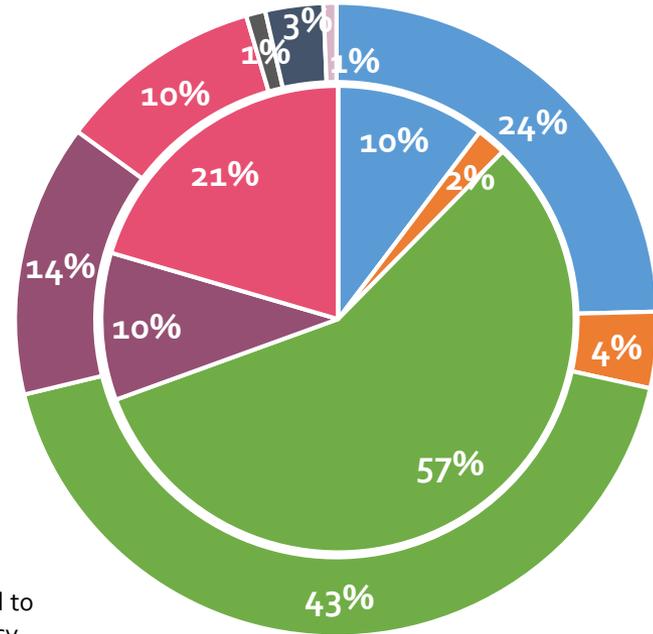
2018 I/DD children's residential

Allegation results

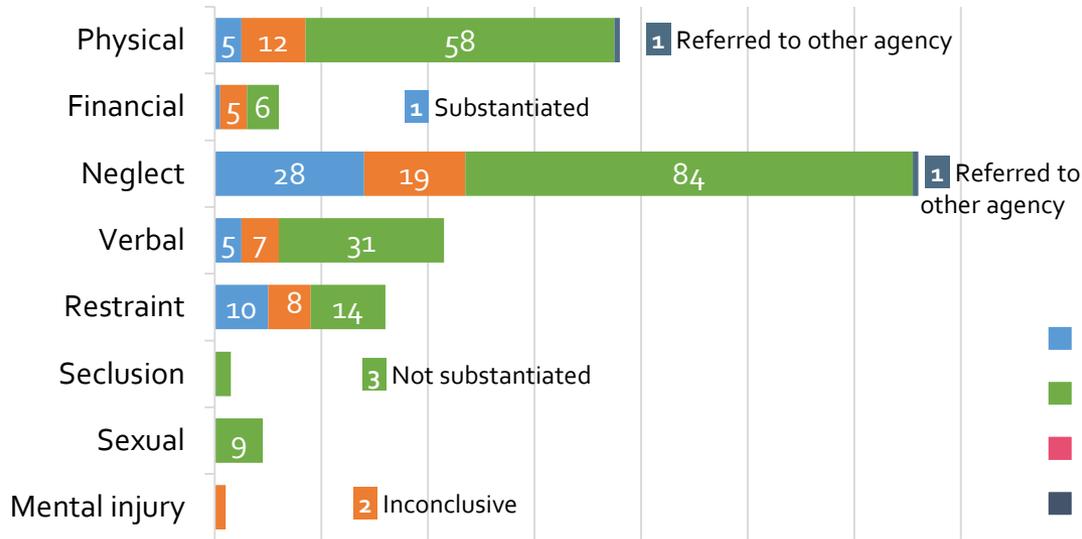
1 person icon = 100



Outer circle: types of abuse investigated
Inner pie: types of abuse substantiated

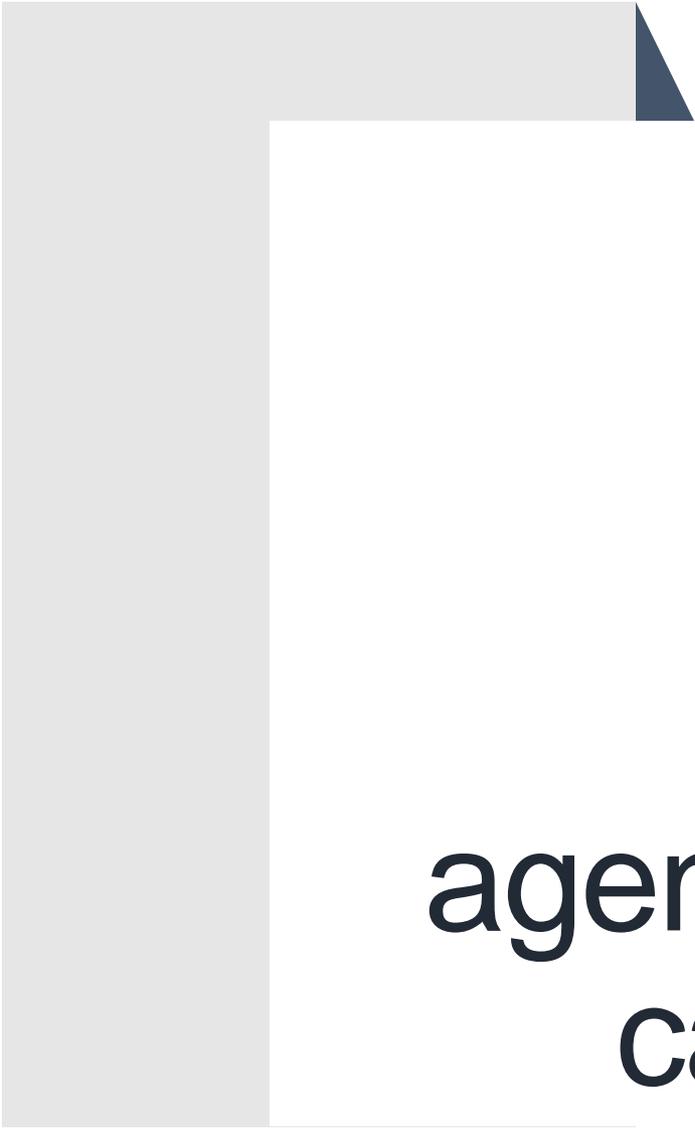


Results of abuse investigations



■ Substantiated ■ Inconclusive
■ Unsubstantiated ■ Referred to other agency

■ Physical ■ Financial
■ Neglect ■ Verbal
■ Restraint ■ Seclusion
■ Sexual ■ Mental injury



Child-caring agencies and child- caring programs

CCA and CCP summary

Child-caring agencies provide out-of-home care and other services to children. These agencies include:

- Residential treatment facilities that offer therapeutic care to children and youth with emotional disturbances or behavioral health needs
- Day treatment centers for children with emotional disturbances or behavioral health needs
- Adoption agencies
- Shelters for homeless or runaway youth
- Therapeutic foster care
- Residential programs for youth transitioning to independence
- Therapeutic outdoor programs for youth
- Academic boarding schools.

The OTIS Children's Care Licensing Program (CCLP) provides regulatory oversight of these agencies. The OTIS Investigation Unit investigates allegations of abuse at any of these agencies.

Statute related to CCAs changed significantly on July 1, 2016. With the implementation of SB 1515, two sets of statute and rule apply to these agencies. Each regulation set identifies different abuse types and somewhat different populations:

- The newer statute, SB 1515, applies to young people under

age 21 served by a CCA who experienced abuse after July 1, 2016.

- The older statute and rule applies only to young people up to age 18 who experienced abuse before July 1, 2016. OTIS identifies these as occurring in child-caring programs or CCPs.

Because the two different statutes and rules affect essentially the same eligible population, we combined both programs in the funnel.

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 number of these investigations decreased by almost two-thirds between 2017 and 2018. There were three substantiated allegations of sexual abuse in 2018. All three allegations were at the same agency and involved the same staff person. They were revealed in 2018 but occurred in 2014. The program no longer employs the staff person involved.



CCA and CCP summary

We are also seeing a large number of inconclusive findings in these programs. Inconclusive findings increased from 37 percent of all outcomes in 2017 to 47 percent of all outcomes in 2018. As time passes from the incident, it becomes difficult to meet the standard of proof to substantiate an allegation. The investigator may be able to conclude that something happened but not be able to find sufficient proof to substantiate the allegation.

In 2018 a total of 586 allegations were investigated under both rules sets — 32 were investigated using the CCP regulations; the other 554 were investigated using the new statute. Neglect was the most frequent allegation investigated in CCAs. Of the 554 allegations investigated, 341 (almost two-thirds) were for neglect. No other abuse type was as

All abuse exists in a mild to severe range. Neglect can range from placing a vulnerable person at risk of harm to not providing basic care that results in hospitalization or death. Physical abuse can range from a scratch, cut or bruise that causes mild discomfort to broken bones and head injuries that require immediate medical attention. Sexual abuse can range from unwanted sexual advances or unwanted exposure to sexual material to physical sexual assault.

Victims of abuse and neglect experience seen and unseen effects. Trauma effects can vary based on the severity and duration of the abuse as well as the individual's vulnerabilities. This data does not and cannot capture the range of severity of the substantiated abuse. It also cannot portray the impacts or trauma of abuse on victims.

frequently reported or as frequently substantiated.

Licensed care settings assume a lot of responsibility for the people they care for. This results in many allegations of neglect in these settings.

Physical abuse was the second most frequently investigated allegation. These allegations often occur when a child is placed into a physical intervention and

expresses pain or reports an injury. Employees of a CCA are mandatory reporters, so they must report the child's expression of pain to the Oregon Child Abuse Hotline.



CCA and CCP summary

The statutory definition of physical abuse identifies it as, “any physical injury to a child which has been caused by other than accidental means.”* Pain or injury caused by a physical intervention seldom meets this standard. As a result, physical abuse was one of the least substantiated allegations. The investigator may discover the statutory definition of physical abuse is not met, but the physical intervention was not necessary and/or appropriate. If this is the case, the investigator will open and investigate an allegation of wrongful restraint.

The second most frequently substantiated abuse type in CCAs was sexual abuse. Twelve of the 45 allegations investigated were substantiated. Six of these allegations involved the same event. A staff person at a program was sharing sexually explicit material on their phone with youth at the program. Protective services were put into place for the young people involved.

Comparing 2018 to 2017, it’s clear it’s been a busy year. 2018 saw almost double the number of allegations

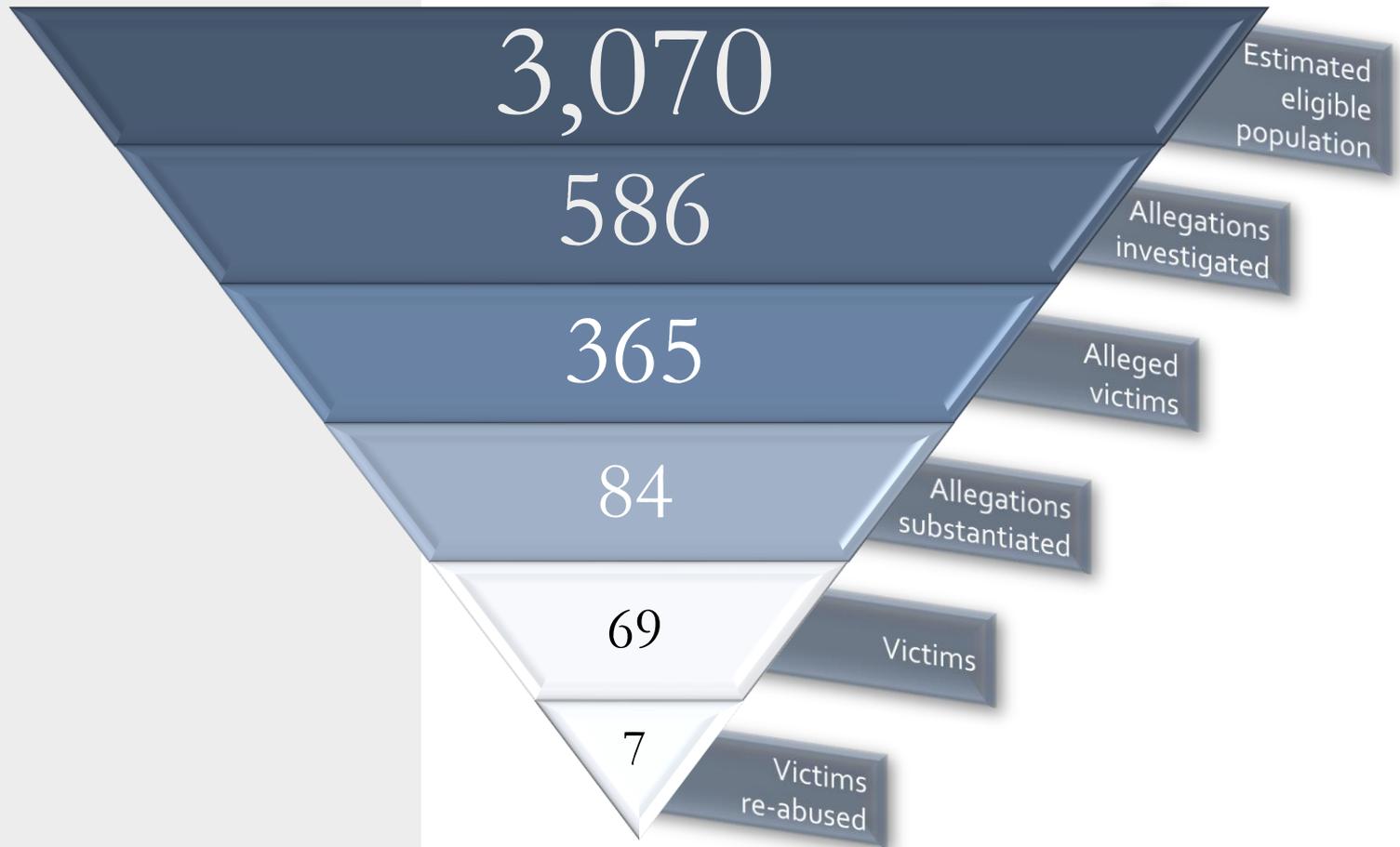
assigned for investigation than the previous year. One-third of those allegations came from just three programs. One of those three programs was over-reporting concerns. Licensors from the CCLP provided training and worked with that program to clarify statute and rule. Another of the programs was troubled and has since been closed. The third agency had a program with problems. That agency retained its license and closed the troubled program. For a deeper look at how the CCLP works with agencies, please turn to [page 42](#).

The data shows a significant increase in the percentage of allegations substantiated in 2018 as compared to 2017. Many of those substantiations occurred at a single program — one that has been closed. The program was responsible for all of the substantiated allegations of involuntary seclusion and more than half of the substantiations of wrongful restraint. That program also contributed 12 percent of the substantiated neglect allegations.

*Oregon Revised Statute 419B.005 (1)(a)(A)

2018 CCA & CCP

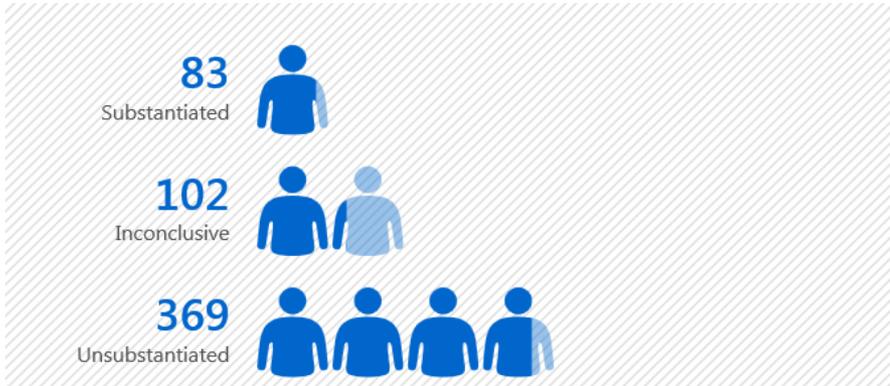
Population, allegations and victims



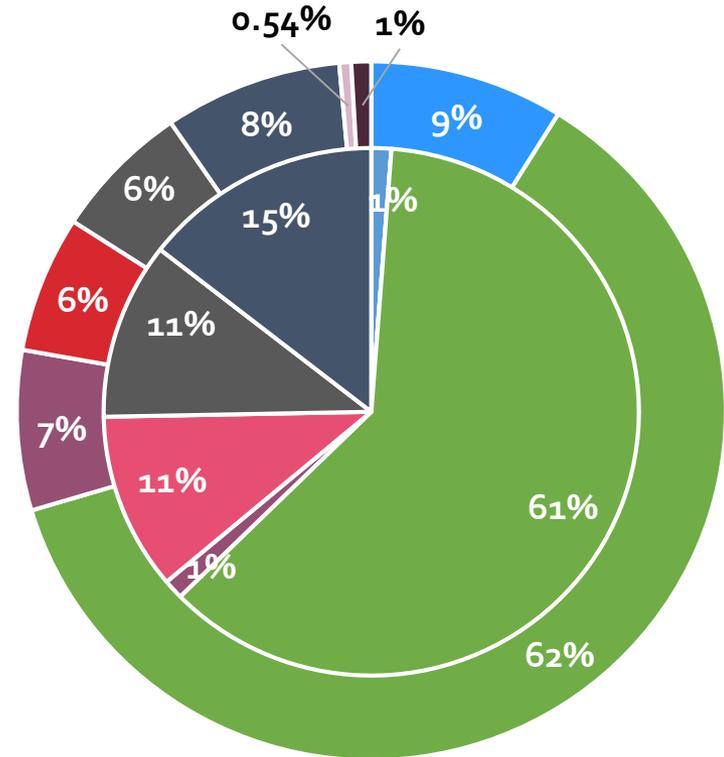
2018 Child-caring agencies

Allegation results

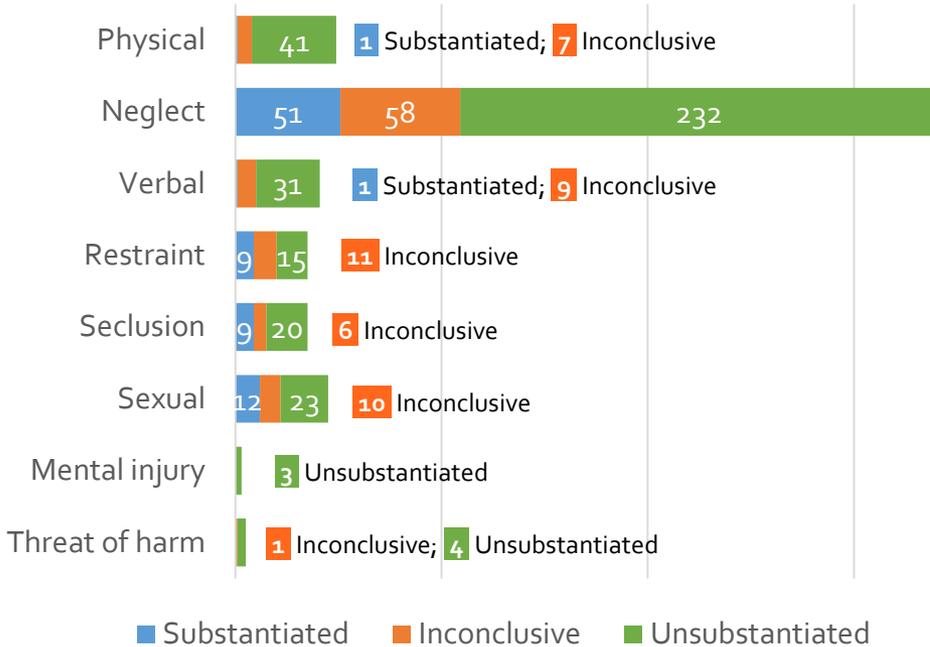
1 person icon = 100



Outer circle: types of abuse investigated
Inner pie: types of abuse substantiated



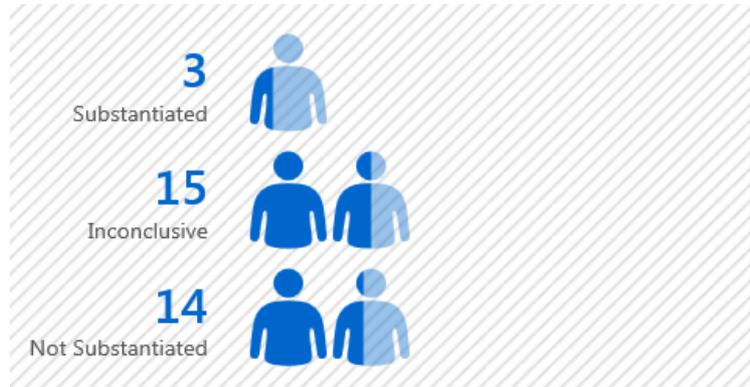
Results of abuse investigations



2018 Child-caring programs

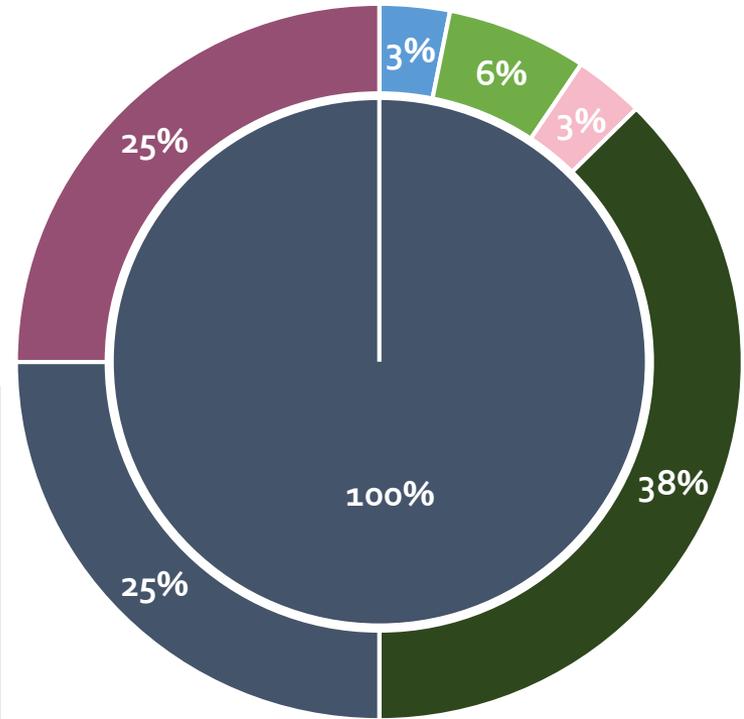
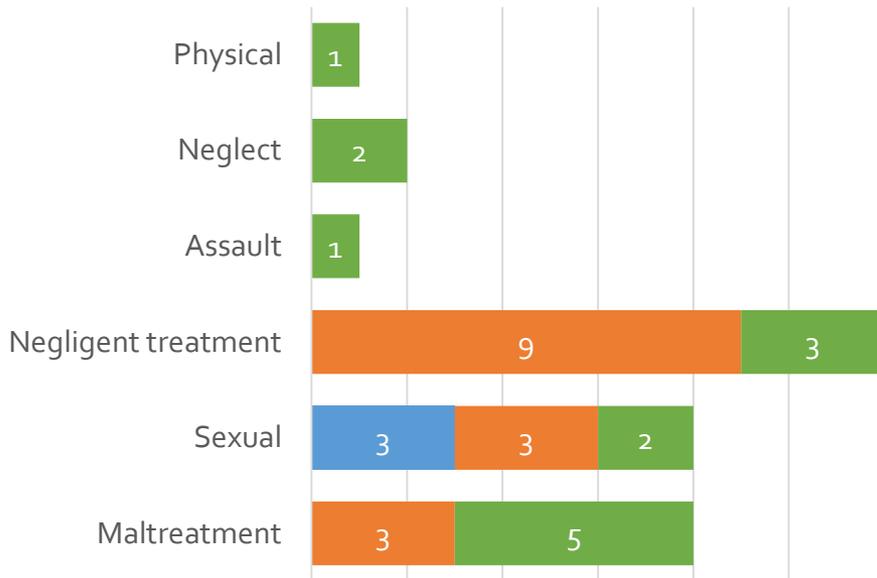
Allegation results

👤 = 10



Outer circle: types of abuse investigated
Inner pie: types of abuse substantiated

Results of abuse investigations



■ Substantiated ■ Inconclusive ■ Not Substantiated

CCLP summary

The Children's Care Licensing Program (CCLP) licenses agencies that provide out-of-home care and other services to children and youth. These agencies include:

- Residential treatment facilities that offer therapeutic care to children and youth with emotional disturbances or behavioral health needs
- Day treatment centers for children with emotional disturbances or behavioral health needs
- Adoption agencies
- Shelters for homeless or runaway youth
- Therapeutic foster care
- Residential programs for youth transitioning to independence
- Therapeutic outdoor programs for youth
- Academic boarding schools.

A corporation that provides these services must be licensed by the state. A child-caring agency (CCA) may have multiple programs and/or multiple types of programs, and each program must be licensed. For example, a CCA may have a program that provides residential treatment and another program that provides day treatment, or it may

have several residential treatment programs that each serve children or youth with different types of needs.

Licensors make routine annual inspection visits to each program. They may also make unannounced visits. A licensing violation is not necessarily abuse, but it can put children and youth in danger. As an example, having unrepaired broken windows for several weeks isn't abuse, but it could be a licensing violation.

Licensors with the CCLP ensure that agencies comply with regulation. They also provide technical assistance to the agencies. In 2018 when OTIS investigators identified that some programs were over reporting possible abuse, licensors with the CCLP reached out to the programs and provided training to help clarify statute and rule. These trainings helped decrease the amount of over reporting.

Licensors also take action when a pattern of abuse is discovered. Two programs were closed in 2018 for this reason. The CCLP has the option of issuing conditions to agencies to bring the program into compliance. If the agency is unable or unwilling to meet those conditions, the license to operate will be terminated and the program will be closed.



Oregon Health Authority programs

Community mental health program summary

The population of individuals with a mental illness is highly diverse and includes people with a broad range of abilities and vulnerabilities. The need for services is on a continuum. 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 help to remain independent including service enriched housing, money management and intensive and ongoing case management. 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. Because of people's differing needs and their ability to move along the continuum of need, it is virtually impossible to determine the number of people eligible for abuse investigations.

The Oregon Health Authority (OHA) Health Systems Division provides supports and services to adults receiving

mental health services through a community mental health program (CMHP) or through an entity that the state or a CMHP contracts with or certifies. OHA Health Systems provides these services and supports to people at all points on the continuum of service needs. Individuals receiving care in a psychiatric placement in a hospital also receive support and services.

Discrimination and stigmatization may further exacerbate the difficulties faced by adults with a mental illness and increase their risk of abuse. As a person with a mental illness moves along the continuum of service needs, his/her need for protective services will fluctuate. When people with a mental illness experience symptoms that affect their functioning, they 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 abuse investigations become particularly important to ensure the health and safety of the person.

CMHP summary

CMHPs conduct most protective service investigations. Extremely complex investigations or investigations that involve a conflict of interest are referred to OTIS investigators. In 2018 a new statute was written, passed by the Legislature and signed into law that affected these investigations. Previously, OTIS and the Department of Justice (DOJ) conducted an evaluation of statute. This evaluation resulted in a determination that authority for conducting an abuse investigation was narrower than previously applied. The reviewers discovered that allegations of abuse of certain populations fell outside the scope of investigative authority.

Following this discovery, OTIS, stakeholders and legislators worked to rectify this. The new statute expands abuse protections and mandatory reporting responsibilities to all parts of Oregon's current mental health delivery system, including coordinated care organizations, community mental health programs, residential facilities and individual treatment providers.

New definitions of abuse were included and existing definitions were expanded. All of these changes resulted in greater safety for people receiving mental health services.



This change to statute and the change to rule that resulted mean that data from 2018 can't be compared to previous years.

CMHP summary

Most striking about the 2018 data is the very high rate of physical abuse allegations. Neglect and sexual abuse were also frequently reported. The three abuse types combined account for 89 percent of allegations for community mental health programs. When the allegations are considered based on setting, it becomes clear that neglect is the most frequent allegation in licensed settings.

Physical and sexual abuse are most frequently alleged in non-licensed settings.

The prevalence of neglect allegations in licensed settings is common across all programs. As in other programs, this is due to the responsibility the facility takes because it is paid to provide care for the person residing in it. Neglect was substantiated at almost twice the rate of all other abuse types combined in these licensed

mental health settings.

Physical and sexual abuse combined accounted for 82 percent of all allegations investigated in non-licensed settings, and physical abuse was the most frequently substantiated allegation. It was substantiated two-and-a-half times more than all other abuse types combined.

More than half of the substantiated allegations involved

either a family member or intimate partner. Two of the three victims who were re-abused were victims of domestic violence.

All abuse exists in a mild to severe range. Neglect can range from placing a vulnerable person at risk of harm to not providing basic care that results in hospitalization or death. Physical abuse can range from a scratch, cut or bruise that causes mild discomfort to broken bones and head injuries that require immediate medical attention. Sexual abuse can range from unwanted sexual advances or unwanted exposure to sexual material to physical sexual assault.

Victims of abuse and neglect experience seen and unseen effects. Trauma effects can vary based on the severity and duration of the abuse as well as the individual's vulnerabilities. This data does not and cannot capture the range of severity of the substantiated abuse. It also cannot portray the impacts or trauma of abuse on victims.



2018 Community mental health programs

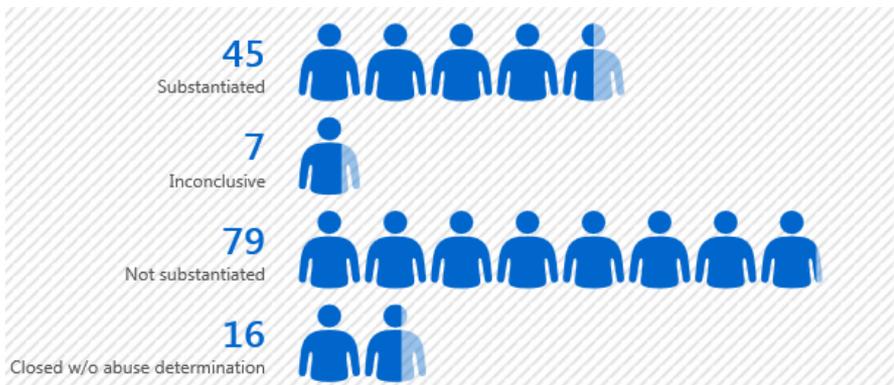
Population, allegations and victims



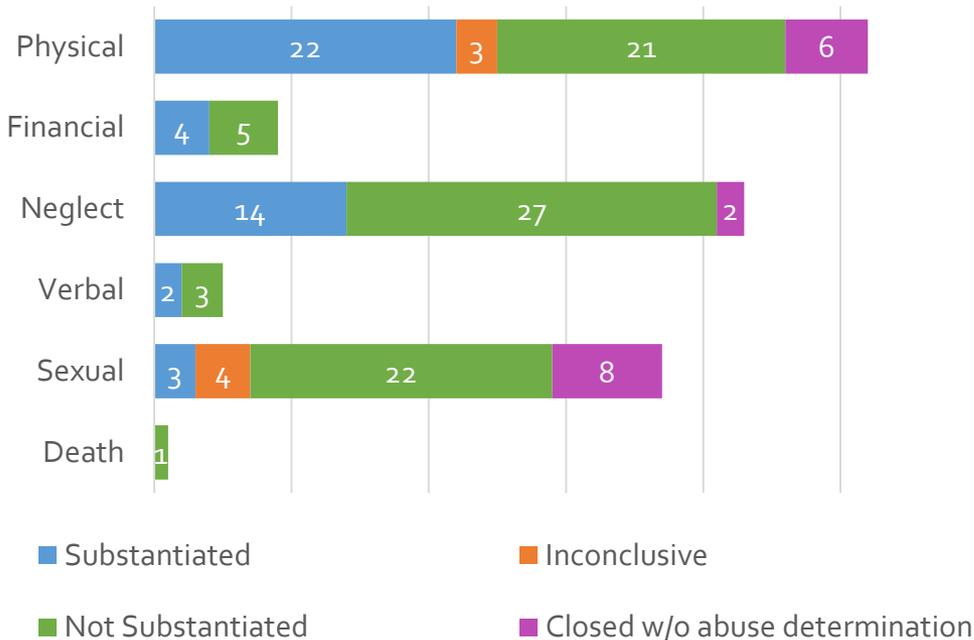
2018 Community mental health programs

Allegation results

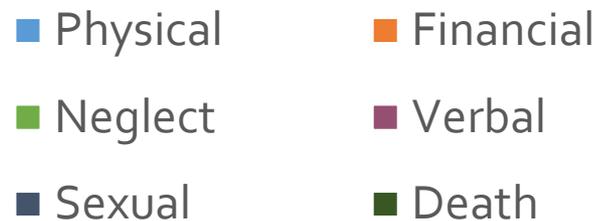
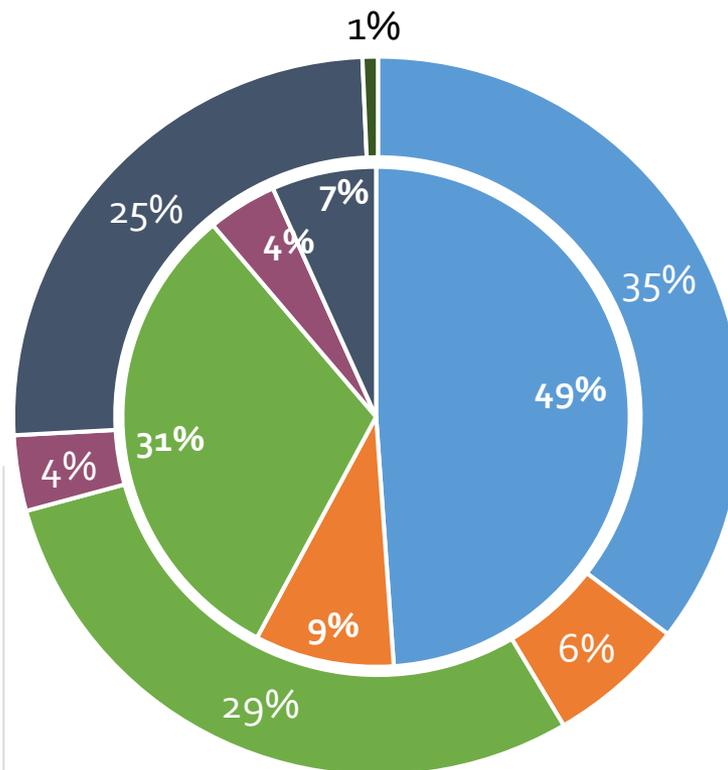
👤 = 10



Results of abuse investigations



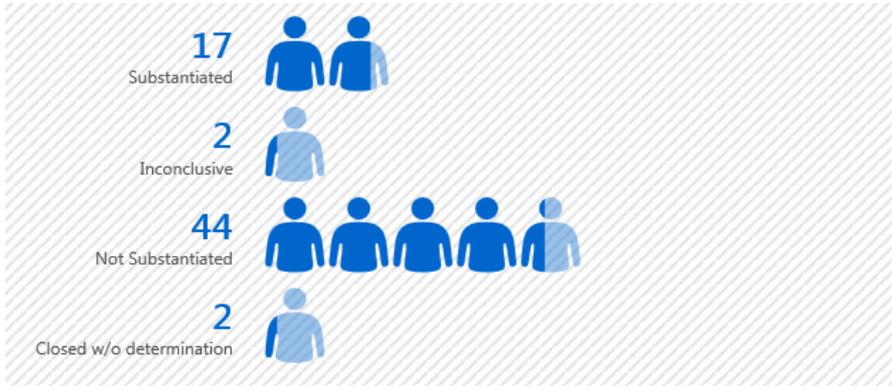
Outer circle: types of abuse investigated
Inner pie: types of abuse substantiated



2018 CMHP in licensed settings

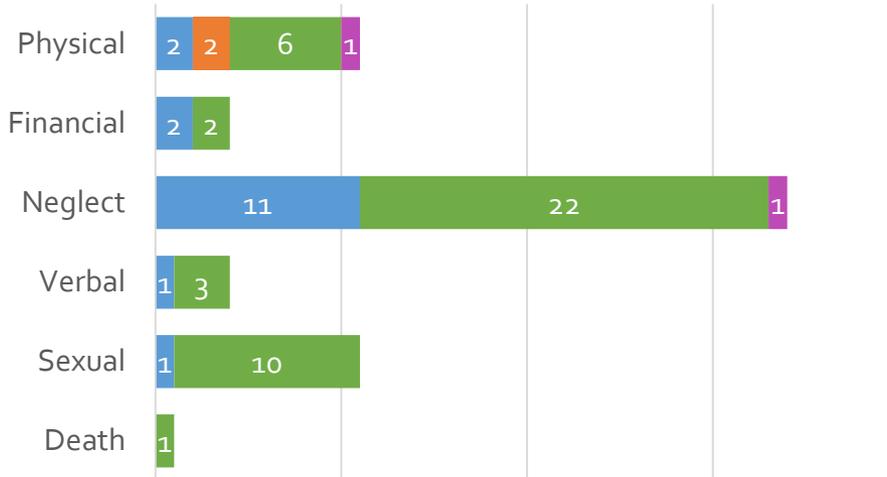
Allegation results

1 icon = 10

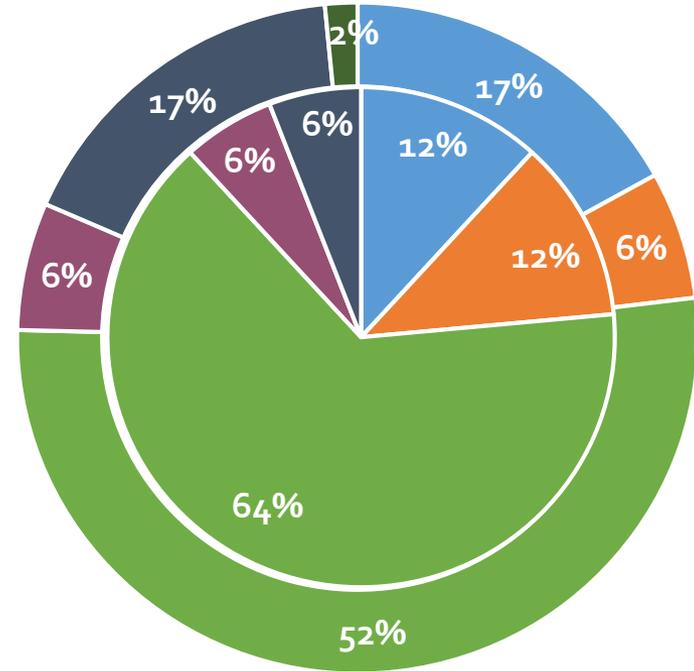


Outer circle: types of abuse investigated
Inner pie: types of abuse substantiated

Results of abuse investigations



■ Substantiated ■ Inconclusive
■ Not Substantiated ■ Closed w/o abuse determination

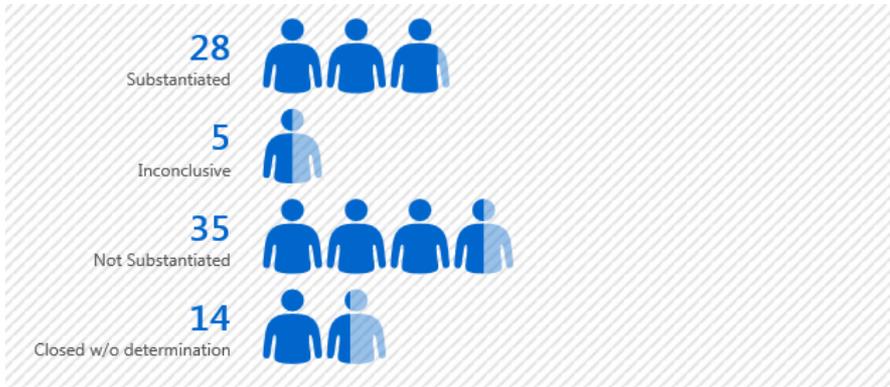


■ Physical ■ Financial
■ Neglect ■ Verbal
■ Sexual ■ Death

2018 CMHP in non-licensed settings

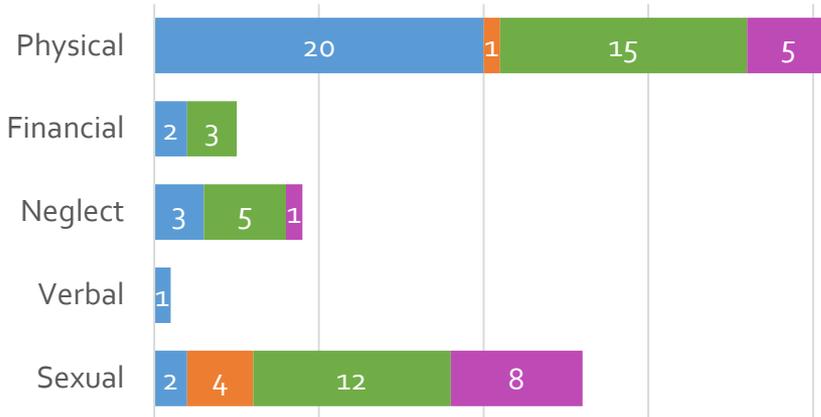
Allegation results

👤 = 10

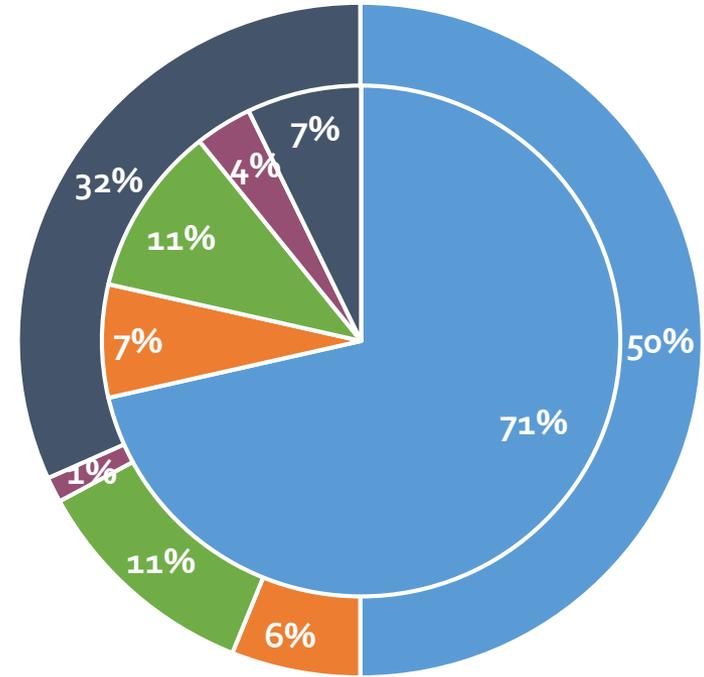


Outer circle: types of abuse investigated
Inner pie: types of abuse substantiated

Results of abuse investigations

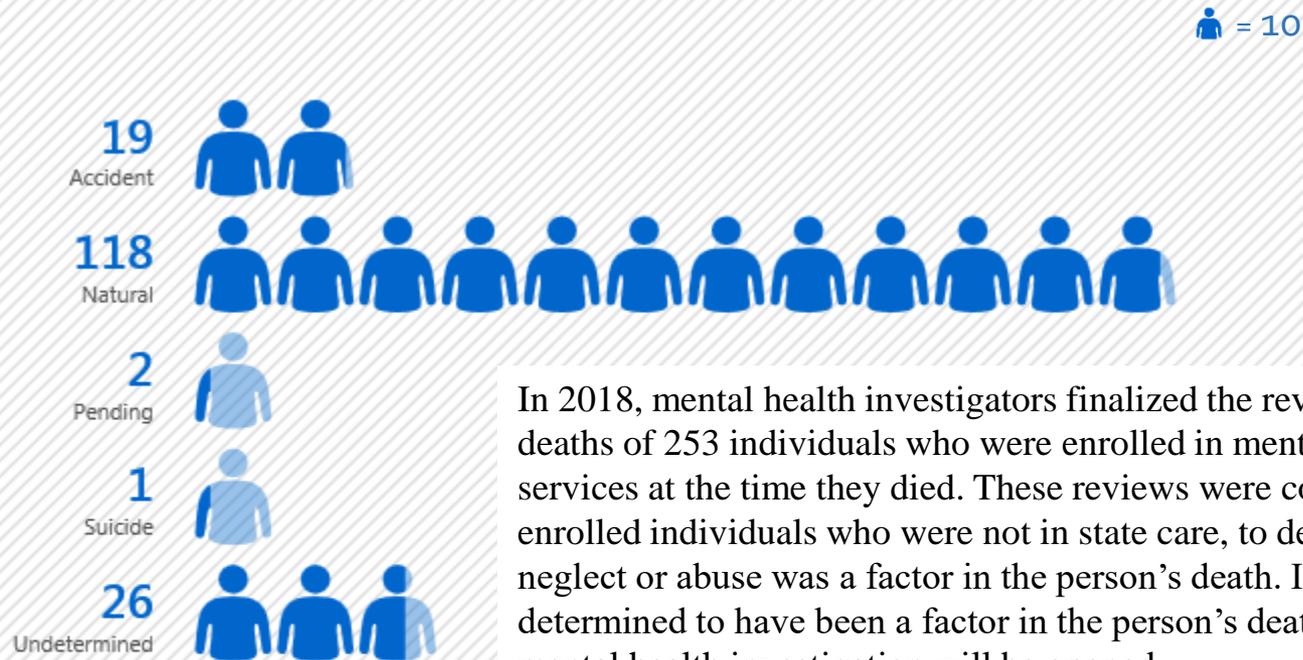


■ Substantiated
■ Inconclusive
■ Not Substantiated
■ Closed w/o abuse determination



■ Physical
■ Financial
■ Neglect
■ Verbal
■ Sexual

Death reviews



In 2018, 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 were 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 71 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 11 percent of these reviews, and 63 percent of accidental deaths were caused by drug or substance misuse or overdose. 21 percent of accidental deaths were related to injuries incurred from motor vehicle accidents.

OSH summary

Abuse and neglect allegations at the Oregon State Hospital (OSH) are investigated by the OTIS Investigations Unit. 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 sought new legislation to provide necessary protections to patients at OSH. That new legislation was written, passed by the Legislature and

signed into law during 2018. Because of the change to statute, it isn't possible to compare 2018 data to previous years.

Before that legislation was enacted, statutory authority did not exist to classify certain actions as abuse. However, those actions violated OSH policy. OSH leadership and its Human Resources (HR) department asked OTIS investigators to conduct mistreatment investigations before the new legislation took effect. This enabled continued protection of vulnerable people.



OSH summary



All abuse exists in a mild to severe range. Neglect can range from placing a vulnerable person at risk of harm to not providing basic care that results in hospitalization or death. Physical abuse can range from a scratch, cut or bruise that causes mild discomfort to broken bones and head injuries that require immediate medical attention. Sexual abuse can range from unwanted sexual advances or unwanted exposure to sexual material to physical sexual assault.

Victims of abuse and neglect experience seen and unseen effects. Trauma effects can vary based on the severity and duration of the abuse as well as the individual's vulnerabilities. This data does not and cannot capture the range of severity of the substantiated abuse. It also cannot portray the impacts or trauma of abuse on victims.

In total, 27 allegations of mistreatment were investigated at OSH before the new legislation took effect. Mistreatment-neglect (neglecting to provide reasonable and necessary care) and verbal mistreatment account for 85 percent of the 27 mistreatment allegations. Verbal mistreatment was substantiated at a three-to-one ratio to mistreatment-neglect. None of the other types of mistreatment was substantiated.

As we see in other formal care settings, neglect is the most frequent allegation. After statutory authority was established, OTIS investigated 28 allegations of neglect, which is two-thirds of the total abuse allegations investigated at OSH. Allegations of neglect were double the number of all



other allegations combined.

Allegations of neglect accounted for 75 percent of all substantiations. It should be noted that this is a relatively small number of allegations — only six allegations of neglect were substantiated. One allegation each of physical abuse and sexual abuse were also substantiated.

2018 Oregon State Hospital

Population, allegations and victims

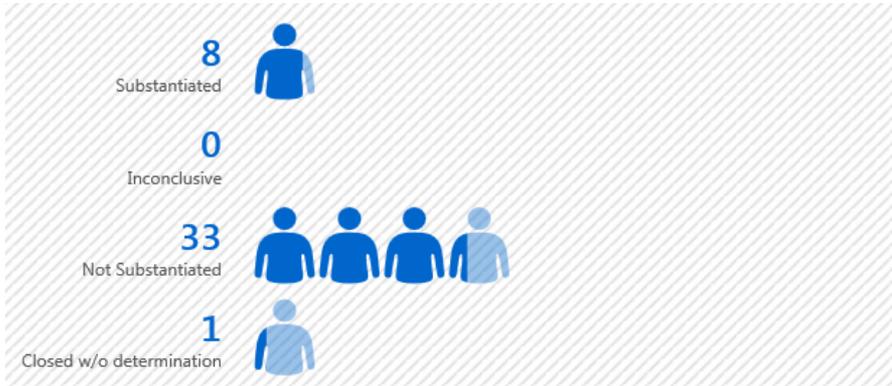


This graphic combines both abuse and mistreatment allegations to represent all of the investigations that took place during the year at the Oregon State Hospital.

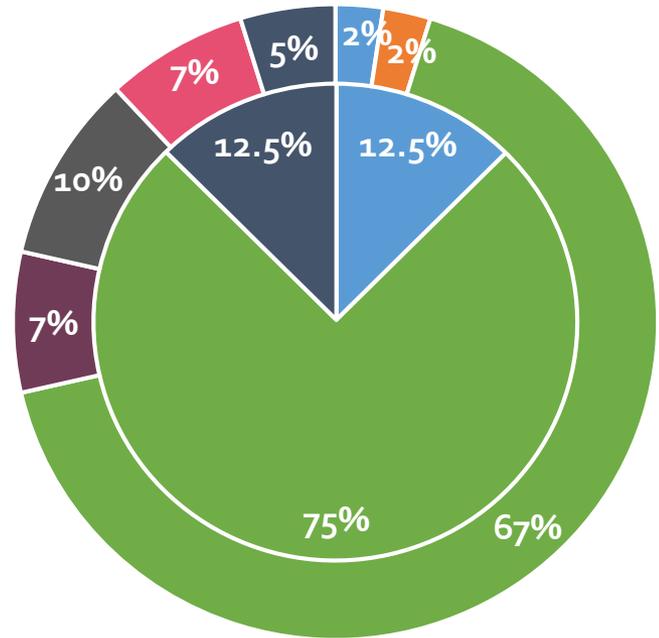
2018 Oregon State Hospital abuse

Allegation results

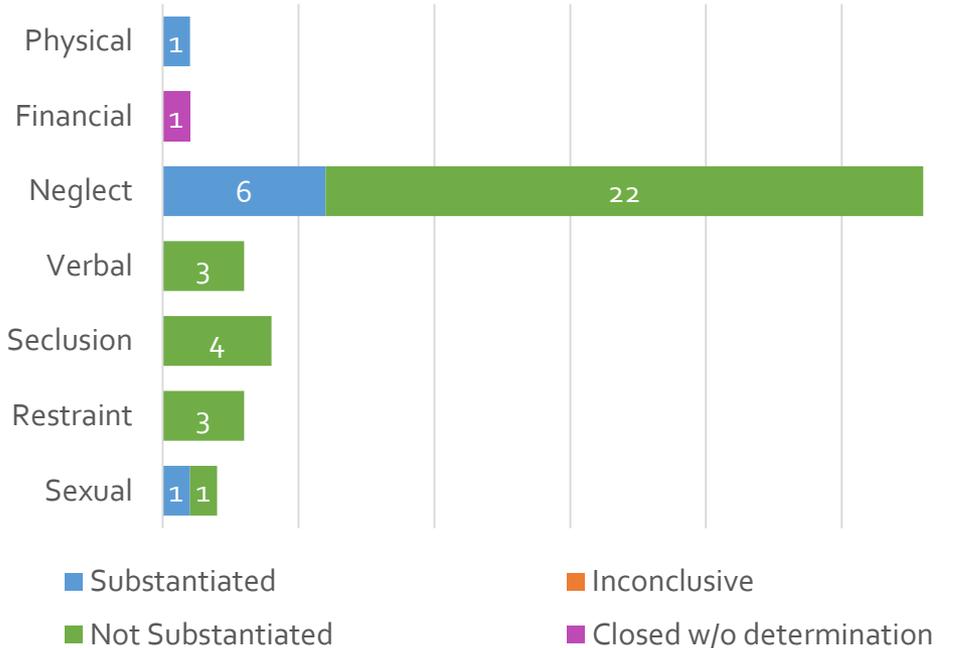
👤 = 10



Outer circle: types of abuse investigated
Inner pie: types of abuse substantiated



Results of abuse investigations

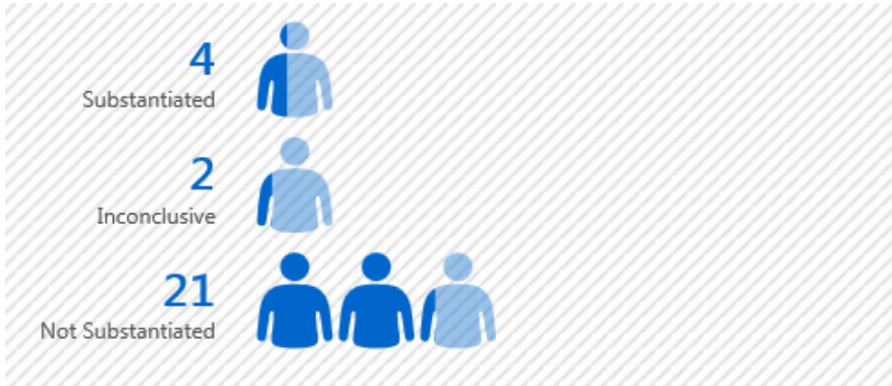


- Physical
- Neglect
- Seclusion
- Sexual
- Financial
- Verbal
- Restraint

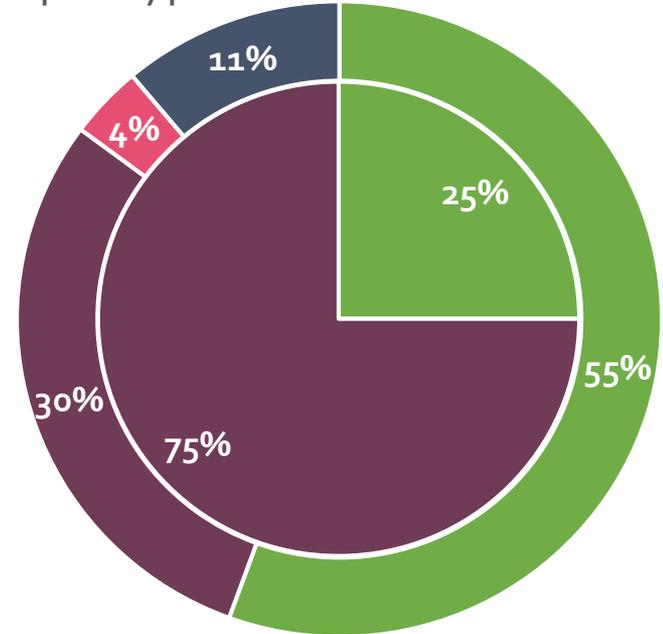
2018 Oregon State Hospital mistreatment

Allegation results

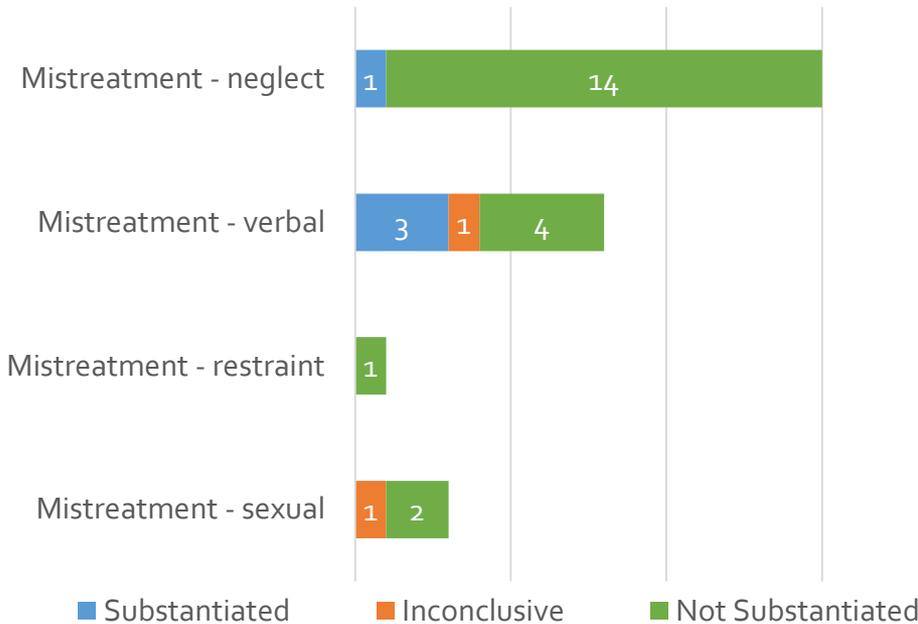
👤 = 10



Outer circle: types of abuse investigated
Inner pie: types of abuse substantiated



Results of abuse investigations



- Mistreatment - neglect
- Mistreatment - verbal
- Mistreatment - restraint
- Mistreatment - sexual



You can get this document in other languages, large print, braille or other accessible format. Contact the Office of Training, Investigations and Safety at 1-866-406-4287. We accept all relay calls or you can dial 711.

Acknowledgements

Thank you to our partners for contributions to this book.

OTIS 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.

SAFE Line

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

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MSC 9685 (6/2019)