MEMORANDUM

To: Marissa Madrigal, Chief Operating Officer

From: Peggy J. Brey, DCHS Department Director
Mohammad Bader, DCHS Department Deputy Director

Date: October 26, 2018

RE: Multnomah County Mental Health Adult Protective Services Review

The following is the outcome of the Department of County Human Services (DCHS) review of the Mental Health Adult Protective Services (APS) process from January 2017- August 2018.

Executive Summary

In August of 2018, Multnomah County Attorney's office and the County Chief Operating Officer requested an internal review of the County's Mental Health Adult protective Services processes between January 2017 - August 2018. The purpose of this review was to gain clarity on the County's authority, processes, and responsibility in responding to reports of abuse and neglect of mental health patients and/or community members and to conduct a retrospective chart review of records.

The Department of County Human Services (DCHS) was requested to conduct this review due to adult protective services expertise both from the Aging, Disability and Veterans Services Division (ADVSD) and the Intellectual and Developmental Disabilities Division (I/DD). In addition these two divisions have over 25 years of working within the APS field and interfacing with the Mental Health Adult Protective Services system. The team of reviewers were led by Mohammad Bader, Deputy Director for DCHS.

The team conducted a retrospective chart review of nearly 1300 "screened out" records. Screened out records indicate that the APS screener (Mental Health staff) received a referral with a complaint related to abuse and/or neglect and did not assign it for an abuse investigation. The team reviewed whether the reports of abuse were handled in compliance with State rules and, in particular, looked at referrals for protective services (referrals to other County departments, State offices, and community based organizations that could provide services, safety plans and related supports) and referral to law enforcement when there was question of a crime. Eighteen of the records were associated with Unity Behavioral Health.

Background

In July of 2017, the Oregon Department of Human Services provided guidance to the Mental Health Adult Protective Services field throughout the State that there would be new limitations on mental

health abuse investigations. This set of temporary rules were enacted on September 1, 2017 (OAR 407-045-0120 et al to replace OAR 943).

The following excerpt is from meeting notes of a State Quarterly meeting held on July 26, 2017 in which guidance was provided:

> *"Making sure investigators are operating within the limitations in statute...Governed by 430.745:*
> *a) Person with mental illness some receiving services from a licensed facility or receiving services from a community mental health program 430.610 and 430.695.*
> *b) Investigations will be limited to persons only in these two groups"*
> (Source: Justin Hopkins/Karla Kerstner July 26, 2017 Quarterly Meeting Notes)

As can be seen on Chart G in the attached document, there was a decrease in "screened in" reports (cases assigned for a full abuse investigation). It is also important to note that the State continued to expect the County to assess and assure protective services were offered to prevent further abuse and that in cases where there was a question of a crime that there was a referral to law enforcement.

In August of 2018, a new administrative rule was adopted to align with ORS 430.632. This amendment broadened the county authority for abuse investigations. Consistent with the 2017 rules there continues to be the expectation that protective services and law enforcement referrals occur as needed.

Findings
We conducted a retrospective chart review to gain clarity on the actions taken by the Mental Health program with regard to Adult Protective Services complaints that were screened out between January 2017 and August 2018. The attached report describes the retrospective review process, findings and recommendations, see link . The following highlights some of the key findings:

- Total Charts reviewed: 1338
- 169 referrals were screened out for investigation and were assigned a protective services assessment (PSA).
    - 17 were not referred to law enforcement. The reviewers determined 9 of these cases should have been referred to law enforcement.*
- 1169 referrals were screened out with no protective services assessment.
    - 613 had an abuse type listed. The remaining 556 did not have a documented abuse type.
    - The reviewers indicated that 94 of these referrals should have been assigned for an abuse investigation.*

1010 were not referred to law enforcement.he reviewers determined that 136 of these cases should have been referred to law enforcement.*

- 210 cases should have received protective services.*
  ***Note**: The review team is currently working with law enforcement and with the Mental Health leadership to follow up of the items with an asterisk.*

Mitigation Measures
To ensure current safe and appropriate practice for consumers and the community Mental Health interim leadership conducted the following:

- Ensured that all the Adult Protective Services staff (screener and investigators) were trained by the State on the new process.
- Appointed a senior manager and temporary supervisor to work with the team and provide ongoing consultation. (Ongoing)
- Conducted 100% review of all new referrals by the senior manager and temporary supervisor.(Ongoing)
- Provided the staff with specific instructions on providing protective service referrals.
- Provided the staff with specific instructions on ensuring law enforcement referrals are made.
- Moved the screening data to a secure system as the prior system was reported as losing data periodically.
- Instructed staff to use a new template each time a screening is conducted as prior practice revealed inaccuracies in the data.

Next Steps/Preliminary Recommendations

The next steps once law enforcement completes their review will be to conduct a system analysis of the 2018 Adult Protective Services processes. DCHS will assist Mental Health by facilitating the analysis following continuous quality improvement methods and tools (CQI). This will result in an action plan with metrics, timelines and ongoing monitoring until the system change is considered stable. Additionally, this report includes some preliminary recommendations that will be considered as the CQI process analysis ensues:

- Develop standard protocol for screening documentation to include type of abuse, sources of information, citation of rules and clear justification for decision.
- Develop standard protocols and expectations regarding contact with an alleged victim (AV) during a protective services assessment (PSA). Consider supervisor approval for deviation from the protocols.
- Develop standard protocols and expectations when a PSA is assigned. Consider supervisor approval for deviation from the protocols.
- Develop a standard series of questions and expected collateral contacts to obtain as much relevant information as possible when initial referral is unclear.
- Develop a decision tree to support the justification for each screening decision.
- Develop protocol to require objective documentation and cross reporting. Do not assume the reported abuse did not happen because the AV is actively symptomatic.
- When screening facility referrals, the screener requests and reviews care plans, incident reports or other documents to determine outcome of screening.
- Request County Counsel to review and provide guidance for interpretation of neglect definitions within statute ORS 430.735(10)(c) to allow for investigation of resident to resident incidents.
- Develop standard protocol for warm transfers to other Protective Services or Law Enforcement agencies to ensure reports are made to appropriate entity.
- Develop standard protocol for documenting details of safety plans.

- Develop standard protocol for screening documentation to include follow up actions by Supervisor, Quality Management and Residential Specialist.
- Develop protocols and expectations for responding to these cases: staffing with supervisor, contacting Domestic Violence advocates, bringing cases to law enforcement staffing.
- Ensure State licensing bodies are notified of reports and screening decisions.
- Clarify the expectation of referring abuse reports to CCOs, as indicated in the Behavioral Health Investigations Update document.
- Develop a protocol to ensure police reports are always filed when a crime has occurred. Screener should consider utilizing the PPB online reporting system to expedite this process.

Once the CQI process is completed and improvements are implemented a report of outcomes will be provided to county executive leadership.

Thank you for this opportunity. We welcome your comments and questions.