



Agenda

FAMILY AND HUMAN SERVICES COMMITTEE

July 20, 2009

1:00 P.M.

651 Pine Street, Room 101, Martinez

Supervisor Federal D. Glover, District V, Chair

Supervisor Gayle B. Uilkema, Vice Chair

Agenda Items:

Items may be taken out of order based on the business of the day and preference of the Committee

1. Introductions
2. Public comment on any item under the jurisdiction of the Committee and not on this agenda (speakers may be limited to three minutes).
3. Referral #98 – Mental Health Pavilion – A Review of Program Services to Be Provided
Presenters: Donna Wigand, Mental Health Director
Pat Godley, Chief Financial Officer
4. Referral #45 – Elder Abuse – Annual Update
Presenter: John Cottrell, Bureau Director

1. *The Family and Human Services Committee will provide reasonable accommodations for persons with disabilities planning to attend Committee meetings. Contact the staff person listed below at least 72 hours before the meeting.*

 *Any disclosable public records related to an open session item on a regular meeting agenda and distributed by the County to a majority of members of the Family and Human Services Committee less than 96 hours prior to that meeting are available for public inspection at 651 Pine Street, 10th floor, during normal business hours.*

 *Public comment may be submitted via electronic mail on agenda items at least one full work day prior to the published meeting time.*

For Additional Information Contact:

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Glossary of Acronyms, Abbreviations, and other Terms (in alphabetical order):

Contra Costa County has a policy of making limited use of acronyms, abbreviations, and industry-specific language in its Board of Supervisors meetings and written materials. Following is a list of commonly used language that may appear in oral presentations and written materials associated with Board meetings:

AB	Assembly Bill	HCD	(State Dept of) Housing & Community Development
ABAG	Association of Bay Area Governments	HHS	Department of Health and Human Services
ACA	Assembly Constitutional Amendment	HIPAA	Health Insurance Portability and Accountability Act
ADA	Americans with Disabilities Act of 1990	HIV	Human Immunodeficiency Syndrome
AFSCME	American Federation of State County and Municipal Employees	HOV	High Occupancy Vehicle
AICP	American Institute of Certified Planners	HR	Human Resources
AIDS	Acquired Immunodeficiency Syndrome	HUD	United States Department of Housing and Urban Development
ALUC	Airport Land Use Commission	Inc.	Incorporated
AOD	Alcohol and Other Drugs	IOC	Internal Operations Committee
BAAQMD	Bay Area Air Quality Management District	ISO	Industrial Safety Ordinance
BART	Bay Area Rapid Transit District	JPA	Joint (exercise of) Powers Authority or Agreement
BCDC	Bay Conservation & Development Commission	Lamorinda	Lafayette-Moraga-Orinda Area
BGO	Better Government Ordinance	LAFCo	Local Agency Formation Commission
BOS	Board of Supervisors	LLC	Limited Liability Company
CALTRANS	California Department of Transportation	LLP	Limited Liability Partnership
CalWIN	California Works Information Network	Local 1	Public Employees Union Local 1
CalWORKS	California Work Opportunity and Responsibility to Kids	LVN	Licensed Vocational Nurse
CAER	Community Awareness Emergency Response	MAC	Municipal Advisory Council
CAO	County Administrative Officer or Office	MBE	Minority Business Enterprise
CCHP	Contra Costa Health Plan	M.D.	Medical Doctor
CCTA	Contra Costa Transportation Authority	M.F.T.	Marriage and Family Therapist
CDBG	Community Development Block Grant	MIS	Management Information System
CEQA	California Environmental Quality Act	MOE	Maintenance of Effort
CIO	Chief Information Officer	MOU	Memorandum of Understanding
COLA	Cost of living adjustment	MTC	Metropolitan Transportation Commission
ConFire	Contra Costa Consolidated Fire District	NACo	National Association of Counties
CPA	Certified Public Accountant	OB-GYN	Obstetrics and Gynecology
CPI	Consumer Price Index	O.D.	Doctor of Optometry
CSA	County Service Area	OES-EOC	Office of Emergency Services-Emergency Operations Center
CSAC	California State Association of Counties	OSHA	Occupational Safety and Health Administration
CTC	California Transportation Commission	Psy.D.	Doctor of Psychology
dba	doing business as	RDA	Redevelopment Agency
EBMUD	East Bay Municipal Utility District	RFI	Request For Information
EIR	Environmental Impact Report	RFP	Request For Proposal
EIS	Environmental Impact Statement	RFQ	Request For Qualifications
EMCC	Emergency Medical Care Committee	RN	Registered Nurse
EMS	Emergency Medical Services	SB	Senate Bill
EPSDT	State Early Periodic Screening, Diagnosis and treatment Program (Mental Health)	SBE	Small Business Enterprise
et al.	et ali (and others)	SWAT	Southwest Area Transportation Committee
FAA	Federal Aviation Administration	TRANSPAC	Transportation Partnership & Cooperation (Central)
FEMA	Federal Emergency Management Agency	TRANSPLAN	Transportation Planning Committee (East County)
F&HS	Family and Human Services Committee	TRE or TTE	Trustee
First 5	First Five Children and Families Commission (Proposition 10)	TWIC	Transportation, Water and Infrastructure Committee
FTE	Full Time Equivalent	VA	Department of Veterans Affairs
FY	Fiscal Year	vs.	versus (against)
GHAD	Geologic Hazard Abatement District	WAN	Wide Area Network
GIS	Geographic Information System	WBE	Women Business Enterprise
		WCCTAC	West Contra Costa Transportation Advisory Committee

Schedule of Upcoming BOS Meetings

July 21, 2009
 August 4, 2009
 August 11, 2009

August 18, 2009
 August 25, 2009

WILLIAM B. WALKER, M.D.
Health Services Director
DONNA M. WIGAND, L.C.S.W.
Mental Health Director



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CCHS – Development of Multi-Program Psychiatric Campus

Presentation to the Financial Services Committee and the Family and Human Services
Committee of the Contra Costa County Board of Supervisors

July 20, 2009

The process for CCHS planning and developing a proposed Multi-Program Psychiatric Campus has continued since March 2008. The recommendation from CCHS for a Multi-Program Psychiatric Campus evolved out of departmental and county discussions around proposed budget reductions early in 2008. CCHS recommended to the Board of Supervisors the proposed concept based upon achieved efficiencies and cost savings by shifting from a more restrictive and intensively staffed setting to less costly settings which would provide a continuum of care for mental health clients, as well as be modeled around mental health wellness and recovery concepts.

We have included the following information with an overview and timeline of the evolving proposal in order that the Board of Supervisors might have an opportunity to review the ongoing progress around the project.

Description of Proposed New Programs:

The three mental health treatment programs that are proposed are:

- Assessment and Recovery Center (ARC)
- Psychiatric Health Facility (PHF)
- Crisis Residential Facility (CRF)

- Assessment and Recovery Center: Currently, Crisis Stabilization Services (CSS) are provided in a designated area of the Emergency Department(ED) of Contra Costa Regional Medical Center. This configuration requires that all requirements of Title 22 related to hospital outpatient emergency services be met. Title 22 requires the physical presence of a psychiatrist at all times and nursing staff that meet required nurse/patient ratios. The physician must perform a face to face assessment of all consumers and direct and order all required care. Nursing staff provide adjunctive nursing services as ordered by the physician. Non-medical staff (mental health clinicians, social workers, etc.) may participate in assisting with placement and discharge planning but cannot perform independent assessments or independently recommend a course of treatment. This is understandable within the context of an ED intended primarily to provide physical health care: physical health care must be directed and provided by a physician and other licensed medical professionals. It is the location of CSS within the ED of CCRMC that mandates compliance with Title 22. It is not in regulation that CSS be located in an ED,



nor that it be in compliance with Title 22 when not located in an ED. CSS by regulation is intended to be an outpatient specialty mental health service operated under Title 9.

Additionally, the current configuration of Crisis Stabilization Services within the Emergency Department(ED) requires that the majority of consumers seeking only outpatient mental health interventions must first be registered for physical health care in the general ED, wait for assessment of physical health needs and then be moved to the mental health area of the department, where they are then registered for mental health services and triaged for mental health care. There has been an accommodation made for mental health consumers arriving at the ED on a 5150 W&I Code transportation order via ambulance to be taken directly to the designated mental health area, but this is the minority of consumers seeking service at the ED. Less than 25% of mental health consumers arriving at the ED require psychiatric hospitalization. The great majority of the individuals are seeking crisis intervention, medication services and referral to outpatient services and do not need ED-level care.

Also, the current structure does not allow for the provision or reimbursement of the full array of outpatient mental health services allowed under Title 9. Current structure allows only for Crisis Stabilization Services (a bundled service) and does not accommodate claiming for crisis intervention, medication evaluation, individual therapy, family therapy, etc as discrete services.

The new ARC will provide a different model of service. The service will operate under Title 9 of the Welfare and Institutions Code. The major differences between Title 22 and Title 9 are:

- The proposed Assessment and Recovery Center would operate under Title 9 as an outpatient mental health program rather than a component of a hospital-based outpatient emergency department operated under Title 22.
- Regulations for CSS under Title 9 require a multi-disciplinary team of a variety of mental health professionals, inclusive of physicians and nurses, but not at the staffing levels required by Title 22 and not exclusive of non-medical personnel.
- A psychiatrist must be available to perform functions specific to a physician (e.g. medication evaluation and prescribing, order laboratory studies and other medical interventions, etc.), but need not assess every consumer seeking mental health services. This is consistent with operations of all other community outpatient mental health programs regulated by Title 9.
- Qualified licensed mental health professionals (as defined in Title 9 and inclusive of licensed psychologists, licensed clinical social workers, licensed marriage and family therapists) can, within their scope of practice,

independently conduct mental health assessments, assign diagnoses and develop treatment plans.

- Unlicensed mental health staff can provide adjunctive services as allowed in regulation and county policy which provide further support of consumers.
- In general, services provided under Title 9 allow a more flexible, wellness and recovery approach to mental health care that ensures safeguards to physical health but without the constraints of a physical health care model.

The proposed model of structuring the Assessment and Recovery Center as two programs (Crisis Stabilization Services and Urgent Care Services) within one building operating under Title 9 allows for the full range of outpatient mental health services to be provided and reimbursed.

The Crisis Stabilization Service will provide assessment, stabilization or referral for consumers thought to need psychiatric hospitalization and will serve as the receiving center for consumers transported via ambulance on involuntary mental health holds. These services, coded as crisis stabilization, will be claimed under Title 9 as a bundled service lasting up to 24 hours.

The Urgent Care Service would be available to consumers voluntarily seeking some level of mental health care, inclusive of crisis intervention, medication assessment, referral to residential or outpatient services, and hospitalization if indicated. These services will be claimed as discrete units of care and reimbursed accordingly.

This dual model facilitates each consumer receiving the appropriate level of care at the time of arrival to the Center. Operating under Title 9, a full array of mental health professionals and specialists will be able to provide a variety of outpatient mental health services. Further, direct access to the Assessment and Recovery Center would not require the double registration and transfer of care from physical health professionals to mental health professionals as required in the current structure.

- **Psychiatric Health Facility:** The Psychiatric Health Facility (PHF) will be a 16 bed locked facility. Unlike psychiatric hospitals and psychiatric inpatient units which operate under Title 22, the PHF will operate under Title 9 regulations, as described above in the ARC section, so there will be considerably more flexibility in staffing and programming than hospital based care. The PHF will serve mental health consumers voluntarily and involuntarily (pursuant to Sec 5150 W&I Code) who require acute care within a safe, confined setting. Each consumer in the PHF will be assessed and treated by a psychiatrist on a daily basis and will participate in wellness and recovery activities facilitated by a multidisciplinary team comprised of doctors, nurses, licensed mental health clinicians and other adjunctive staff. Family involvement and support will be

encouraged to the extent allowed by the adult residents of the facility. The intent of the PHF will be to provide short term (average length of stay less than 10 days) acute care focused on comprehensive assessment and stabilization with appropriate discharge planning for after-care in the community. This facility is intended primarily for Medi-Cal beneficiaries and uninsured mental health consumers who do not have high physical health needs requiring specialized medical services.

- Crisis Residential Facility: The Crisis Residential Facility (CRF) will be an unlocked, but highly structured and supervised 16 bed residential program intended to assist mental health consumers achieve stabilization during a period of crisis and thereby avoid hospitalization. It also will serve to assist consumers discharging from hospital and long-term locked facilities that need a gradual step-down from institutional care to successfully transition back into community living. This program will operate under Title 9 regulations and employ a multi-disciplinary treatment team skilled at working with consumers requiring assistance with medication compliance, symptom identification and management, and establishment of a structured community discharge plan inclusive of living arrangements, health and financial benefits and outpatient mental health services. Consumers can reside in the CRT for up to 30 days, as allowed for in Title 9 regulations. Consumers residing in the CRF do not need locked inpatient care but do need a high level of mental health services during a crisis period. This facility will assist in diversion from hospitalization and in reduction of hospital days. It will serve as the mid-point in the continuum of care: more structured and supervised than outpatient mental health treatment but less restrictive than hospital or psychiatric health facility (PHF) care.

Description of Timeline, and Conclusions:

In conclusion, CCHS has continued with the planning process for the proposed multi-program psychiatric campus commensurate with the Board of Supervisors direction to Dr. Walker on April 8, 2008. The concept of including crisis residential care on the campus, as well as the need for availability of 24/7 urgent care, was born out of the MHSA public planning process started in 2005. The concept of including a PHF was a result of the outcome of possible budgetary reductions planned in the spring of 2008.

In order to document the ongoing community planning process, the following timeline is also presented for clarification.

- 2005-2007 – through multiple MHSA public planning processes involving 1100 + community members (through community forums, focus groups, surveys), the need for crisis residential care was identified in CCMH’s Community Services and Supports Plan proposal to State DMH, but the effort was not funded.
- March 18, 2008 – State Department of Mental Health issues Capital Facilities and Technological Needs Component Guidelines for MHSA funds. Capital Facilities funds may be used for only those portions of land and building where MHSA programs,

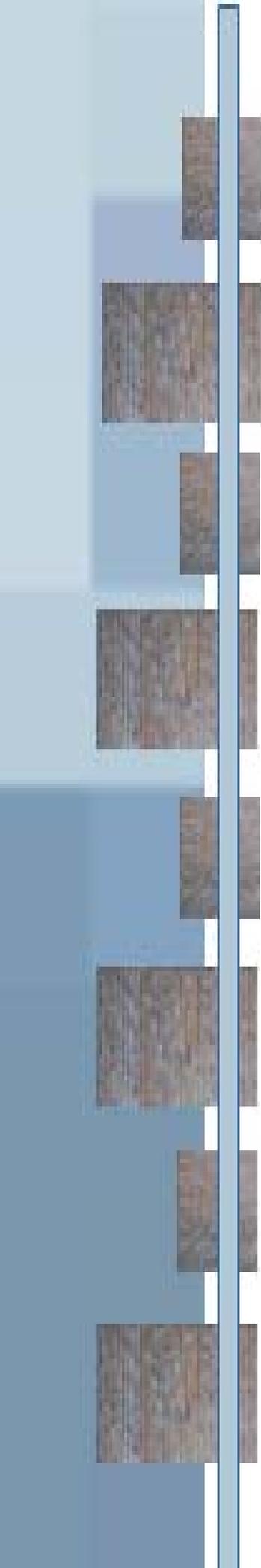
services and administrative supports are provided. The guidelines state that capital facilities funds may not be used “for facilities where the purpose of the building is to provide housing”. In general, also states that capital facilities funds shall be used for buildings that serve clients in less restrictive settings (there are rare exceptions to this, however).

- April 8, 2008 – Contra Costa County Board of Supervisors – during discussion by the Board members about the proposed PHF, Dr. Walker was asked to sum up his direction from the Board. "To move forward with the acquisition of land near the hospital where we could undertake bids for construction for a PHF, look at how that integrates into the Mental Health Division, and work with the Mental Health Commission on this issue regarding their views of continuity and quality of how we deliver mental health services, particularly as I heard from at least one member of the Commission today, moving back toward more of a community mental health model rather than a medical model, and that certainly would be our intention."
- April 17, 2008 – Special Mental Health Commission Meeting – called to review and make recommendations regarding establishing a separate psychiatric site (and other matters).
- April 22, 2008 – Letter to Contra Costa County Board of Supervisors from Mental Health Commission Co-Chairs (see attached) – with recommendations regarding Health Services Department proposal to develop a new multi-program psychiatric campus.
- April 22, 2008 – Contra Costa County Board of Supervisors approved moving forward with financial feasibility stage of the project, approval included: 1) obtaining option to buy 20 Allen St property, 2) performing a building evaluation of site, 3) issuing RFP for CBO to run the program, and 4) closing or downsizing the inpatient unit at CCRMC.
- April 24, 2008 – Mental Health Commission – Mental Health Director reports that a Planning group around the separate psychiatric unit issue will be put together for the purpose of crafting a vision for the future.
- May 8, 2008 – Letter to Contra Costa County Board of Supervisors from Dr. William A. Walker and Patrick Godley, Subject: Acquisition of 20 Allen Street, for New Psychiatric Facility – prepared for closed Session on May 13, 2008.
- May 13, 2008 – Closed Session – Contra Costa County Board of Supervisors re: Conference
- 2007-2008 Annual Report: MH Commission -2008 MH Commission Annual Report to the Board of Supervisors:
 - Item #I-8.: Participated on a PHF Workgroup with Mental Health Administration.
 - Item #V: For 2009 Work plan: Participate in the development of the sites set aside for PHF and other services and programs.
- July 22, 2008 – Contra Costa County Board of Supervisors approves Option to Purchase Agreement for 20 Allen Street, Martinez area, District II, Project No. 5955-6X5024

- October 23, 2008 – Report to MH Commission with update on all MHSA components, including Capital Facility and Technology Need Component Proposal to be posted for public comment within the next few weeks.
- November 7, 2008 – Proposed new Psychiatric Health Facility feasibility report
- November 13, 2008 – MHSA Stakeholder Workgroup meeting – Capital/Technology Plan – Capital Section – 3 Mental Health Commissioners attended, 2 staff
- November 24, 2008 – MHSA Stakeholder Workgroup meeting – Capital/Technology Plan – Capital Section – 2 Mental Health Commissioners attended, 2 staff
- December 9, 2008 through January 22, 2009 - Public Comment Period opened on MHSA Capital Facilities and Technology Needs Component Proposal – 2 comments received during 30+ day public comment period 1 for more housing, 1 positive commending the plan.
- December 15, 2008 – MHSA Stakeholder Workgroup meeting – Capital/Technology Plan – Capital Section - 1 Local One Rep, 4 Mental Health Commissioners, 2 Staff
- December 29, 2008 – MHSA Stakeholder Workgroup meeting – Capital/Technology Plan – Capital Section - 1 Local One Rep, 3 Mental Health Commissioners, 1 Staff
- December 2008 – Feasibility Report for proposed new Mental Health Recovery Services – Final Report.
- January 2009 – Feasibility Study, Including Building Evaluation of Property, Completed
- January 12, 2009 – MHSA Stakeholder Workgroup meeting – Capital/Technology Plan – Capital Section - 1 Local One Rep, 2 Mental Health Commissioners, 2 Staff
- January 22, 2009 – Contra Costa Mental Health Commission convenes Public Hearing regarding the CCMH Capital Facility and Technology Need Component Proposal
- February 5, 2009, State Department of Mental Health approves Contra Costa Mental Health Capital Facility and Technology Needs Component Proposal
- February 12, 2009 – MHSA Stakeholder Workgroup meeting – Capital/Technology Plan – Capital Section - 4 Mental Health Commissioners, 2 Staff
- February 25, 2009 – MHSA Stakeholder Workgroup meeting – Capital/Technology Plan – Capital Section - 4 Mental Health Commissioners, 1 Staff
- March 3, 2009 – Campus Master Plan Update for the Contra Costa Regional Center to address 20 Allen parking issues.
- March 20, 2009 – CCHS issued Request for Proposals for Freestanding Psychiatric Campus – Facility and Services
- April 1, 2009 – Contra Costa County Board of Supervisors – Finance Committee Meeting – Letter from Patrick Godley and Donna M. Wigand, LCSW, Mental Health Director, re: Mental Health Facility Feasibility Study – Status Report
- April 6, 2009 – Mandatory Bidder’s Conference for CCHS Freestanding Psychiatric Campus – Facility and Services
- May 1, 2009 – Vendor Response Deadline for CCHS Freestanding Psychiatric Campus – Facility and Services

- May 28, 2009 – Focus Group – Capital Facilities - Central County Mental Health Consumers (7 consumers, 1 Mental Health Commissioner, 2 observers)
- June 12, 2009 – Focus Group – Capital Facilities – West County Mental Health Consumers (8 consumers, 1 Mental Health Commissioner, 1 observer)
- June 2, 2009 - MHSA Community Input Meeting – Ambrose Center, Bay Point
- June 17, 2009 – MHSA Community Input Meeting – Maple Hall, San Pablo
- June 18, 2009 – East County Mental Health Consumers (7 consumers, 1 Mental Health Commissioner)
- June 20, 2009 – MHSA Community Input Meeting – Pleasant Hill Community Center
- June 22, 2009 – Central County Family Members (12 family members, includes 3 Mental Health Commissioners)
- June 23, 2009 – West County Family Members (7 family members, includes 1 Mental Health Commissioner, 1 Board and Care Operator)
- June 30, 2009 – East County Family Members (3 MHCC Staff, 1 Consumer, 1 Mental Health Commissioner, 1 Room and Board Operator)

Thank you for your time and attention.



ADULT PROTECTIVE SERVICES

Adult Protective Services:

A Report to the Family and Human Services Committee of the Contra Costa County Board of Supervisors

July 2009

Introduction

The last report on APS to the Family and Human Services Committee was in 2006. In 2007 APS chose to report on conservatorship services as an integral component of a range of tools available to respond to protecting elders. There was no report in 2008.

Approach

The main strategy of the APS program is to make available to the at-risk individual a variety of health and social programs to ameliorate or eliminate the risk of abuse, neglect, or exploitation. At this point in time APS is unable to implement the full range of intervention (case management) in place to protect these individuals. This can result in premature institutionalization or repeated reports of abuse coming into the program. Previous reports to this committee have outlined the deficits to the program and the need for adequate staffing. The rapid economic collapse and resultant contraction of pre-existing minimal services has put the current APS program in a precarious position. APS is the public's first responder to allegations of abuse and neglect against the elderly and dependent adults and the ability to fulfill this obligation has been compromised.

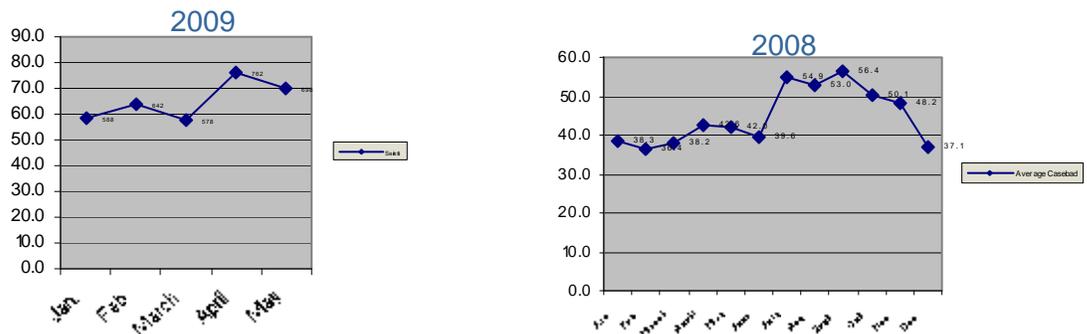
Staffing

This year is the first year of operation for APS following severe staffing reductions and an overall environment of fewer resources to draw upon both internally in the county and in community-based services. Aging and Adult Services Bureau of EHSD has given up the in-house case management programs of the Multi-purpose Senior Services Program (MSSP), a Medi-Cal waiver program, and Linkages, funded through the Older Californians Act. Both programs were transitioned to a community-based organization; however, both are in danger of being eliminated altogether or significantly cut because of the State's financial problems. APS refers to both programs for longer-term case management services.

APS practitioners statewide generally have agreed that the best practice caseload is to receive 15 new abuse reports and to carry over another ten from the previous month for a total of 25 cases per month. In 2004 caseload size averaged 23.75 cases per month per worker. In 2005 caseload sizes increased by over 33% to 31.8 cases. In 2006 average caseload size ran about 35 cases per worker, with eleven social casework specialists and one mental health clinical specialist (outstationed from HSD) who carried cases. In 2007 average caseload size was 37, although there were dramatic changes on a month-to-month basis. For the first four months of 2009 case load size ran on average 64 per worker per month.

At its fullest staffing, APS had 18 social casework specialists, a mental health clinical specialist and two public health nurses in the first half of 2002. In the second half of 2002 it lost a unit's worth of staff. That unit specialized in self-neglect cases. Self-neglect cases are often those which require the longest interventions to realize lasting changes and prevent further deterioration. The program further experienced a 75% reduction in December of 2008. APS lost its multi-disciplinary capacity with the elimination of a mental health clinical specialist and its remaining public health nurse. Today it is running on one supervisor and seven social casework specialists. There are staffing difficulties to cover for illness and vacations. Adequate coverage has been challenging.

2008 & 2009 APS CASELOAD AVERAGES



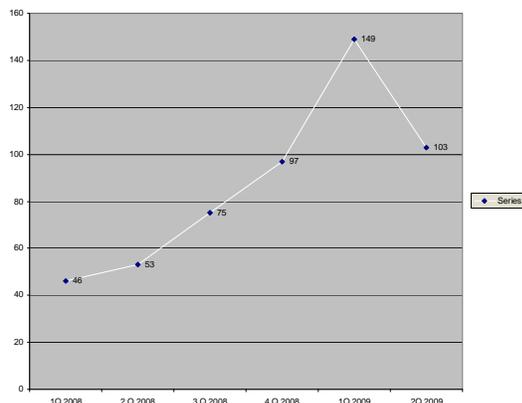
The following is a short table comparing APS staffing levels for comparable counties averaging 500-700 active cases per month.

County	Staffing Level	Comments
Alameda	1 FTE manager, 2 FTE supervisors, 17 social workers	No PHN or mental health specialist. Relies on county's mental health crisis team or law enforcement for 5150 authority. Manager is also director of the Public Guardian-Conservator office.
Fresno	1 FTE manager, 2 FTE supervisors, 15 social workers	Has collaborative field team support of 3 mental health therapists with 5150 authority and 2 PHNs on call as needed to APS.
Santa Clara	1 manager, 3 supervisors, 24 social workers	No 5150 authority, uses PHNs from IHSS. Lost one SW in Oct., 2008
Stanislaus	1 manager with responsibility for 2 other programs, 1 supervisor, 8 social workers, 1 PHN	Lost 3 social workers since 10/07 and had funded a co-located DA Investigator. Lost other contracts for restraining orders and time for community outreach and education.
CONTRA COSTA	.5 FTE manager, 1 supervisor, 7 social workers	Lost 1 FTE case management division manager, 1 mental health specialist with 5150 authority, 2 PHNs and 5 SWs

The following is a synopsis of how APS in Contra Costa County must work differently because of insufficient staffing:

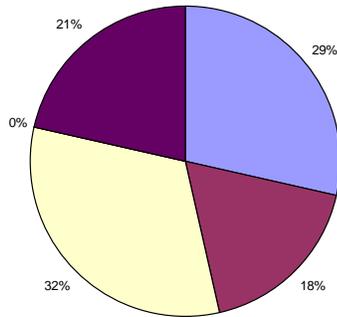
- Higher utilization of NIFFI (No initial face-to-face investigation), a provision under the Welfare and Institutions Code (§15763 (b)(2)); what used to be used infrequently is now used in over 50% of the reports received. If a case is known to APS and is determined not to be in imminent risk, an APS worker gets the case as a “NIFFI” case. The worker will make calls to the victim or to third parties to gather information and try to arrange resources and services from the office. If the case is new, the case gets assigned to an Information and Assistance social worker who makes various collateral calls and tries to arrange services.
- Direct referral to law enforcement in financial abuse cases; the problem with this is that police and sheriff departments must use their resources for higher crimes, such as homicides. There may be less prosecution of elder financial abuse cases because law enforcement doesn’t have the time to investigate and gather information for the District Attorney’s office in the way that APS did. This shift around responding to financial abuse cases is doubly unfortunate because the senior community is becoming more aware of financial exploitation and reports of financial abuse from financial institutions are increasing.
- Self-neglect cases get assigned as NIFFI cases unless the incoming report is explicit enough about imminent risk to the person; one example of how neglect can be life-threatening occurs when someone is immobile for a prolonged period of time, experiences skin breakdown, which leads to systemic infection. APS has received such reports, actually from caregiver neglect, and the victims died from infection, a totally preventable death. The public health nurse in APS was able to evaluate the severity of such situations and is sorely missed.
- Greater use of the Information and Assistance unit in screening and investigating NIFFI reports. For the first time, I&A workers are being assigned APS NIFFI cases in order to manage the caseload.

NIFFI CASES – First Half 2009

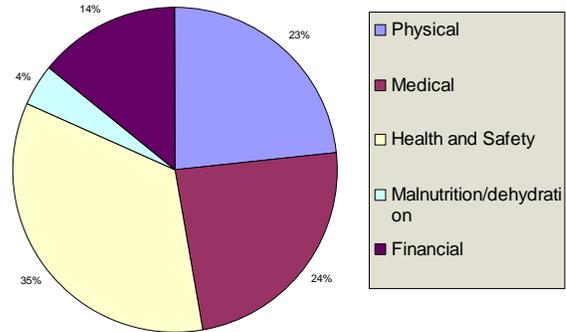


2008-09 CONFIRMED SELF-NEGLECT

Confirmed Self-Neglect 1Q 2009



Confirmed Self-Neglect 1Q 2008



The following is a short list of components of the elder abuse response network that have been missing as of 2006:

- Insufficient caseworkers to intervene in financial abuse cases.
- Lack of district attorney investigators and attorneys to pursue criminal investigation and prosecution of alleged perpetrators.
- Multi-Disciplinary Team meetings, bringing knowledgeable professionals in to consult on APS cases has been difficult (required under WIC §15763 (f)¹).
- No multi-disciplinary Financial Abuse Specialist Team capable of responding on short notice to protect financial assets of vulnerable adults or even a consultation panel.

¹15763(f) Each county shall designate an adult protective services agency to establish and maintain multidisciplinary teams including, but not limited to, adult protective services, law enforcement, probation departments, home health care agencies, hospitals, adult protective services staff, the public guardian, private community service agencies, public health agencies, and mental health agencies for the purpose of providing interagency treatment strategies.

- Limited probate conservatorship services to protect the assets of many more vulnerable adults on a long-term basis.

These limitations are now combined with APS' own reduced capacity in staffing and in contracting for emergency services. Tangible services may be provided by APS.² In the past APS has contracted for emergency shelter in a licensed board and care facility or a skilled nursing facility; for home care services on a short-term basis to bridge a gap; for minor home modifications, such as grab bar installation or construction of ramps; for mental health capacity evaluations to create documentation necessary for conservatorship; and for other services. APS no longer has contracting capacity.

Grand Jury Findings

In March of 2009 the Grand Jury issued report # 0904, "The Lost Generation: The Elderly Citizens of Contra Costa County." This report issued findings pertaining to Adult Protective Services, with many of which EHSD agreed or partially agreed.

The Grand jury report highlighted the issue of elder financial abuse in particular, where protection of financial assets is paramount. Prior reports to the FHS committee have discussed elder financial abuse (2006 report) and the varied resources needed for response. We will reiterate the Grand Jury finding that the primary target for financial abuse in Contra Costa County is elderly individuals. Without a dedicated elder abuse prosecuting attorney in the District Attorney's office, the Public Guardian's ability to react immediately to freeze assets, adequate APS staffing, and a higher priority among law enforcement agencies, elder financial abuse will continue to receive inadequate response.

At this point in time prevention of elder financial abuse is the most proactive step to take and a consortium of community-based organizations, elder advocates and a member of the AAA's Advisory Council on Aging have formed CASE, Communities Against Senior Exploitation, a public awareness campaign with a speaker's bureau to speak to senior groups and the general public about elder financial abuse. A couple of the cooperating agencies in this effort include the elder law clinic of John F. Kennedy University and the Elder Financial Protection Network.

The Grand Jury report made a number of recommendations, including:

- Develop realistic long term solutions to determine which services could be enhanced with restructuring.

EHSD response: "The recommendation requires further analysis. The pooling of available department-wide Social Casework Specialist resources to enhance APS will be explored and a report on the availability of these resources will be prepared for discussion by October 1, 2009."

One SCS has been added back into APS bringing the total from six to seven. Aging and Adult Services also continues to utilize the Information and Assistance (I&A) social workers and Area Agency on Aging staff as backup resources for APS. I&A social workers are performing APS intake and carrying some NIFFIS (no face to face interview) cases.

- Restore the essential staff positions, such as the Public Health Nurse, the Mental Health Specialist and at least four of the social workers to APS that were lost as of January 1, 2009.

EHSD response: "The recommendation requires further analysis. EHSD will continue to explore the resources available for the addition of four Social Casework Specialists, a Public Health Nurse and the Mental Health Specialist that were lost as of Jan. 1, 2009. At this time, there currently exist no additional

county funds to add capacity in APS. A report on the progress will be developed by October 1, 2009.”

Ongoing conversations with Health Services are occurring to explore options to coordinate and restore resources to APS, such as consultations with the Public Health nurse and a Mental Health specialist.

² WIC§15760. Adult protective services shall include investigations, needs assessments, remedial and preventive social work activities; the necessary tangible resources such as food, transportation, emergency shelter, and in-home protective care; the use of multidisciplinary teams; and a system in which reporting of abuse can occur on a 24-hour basis.

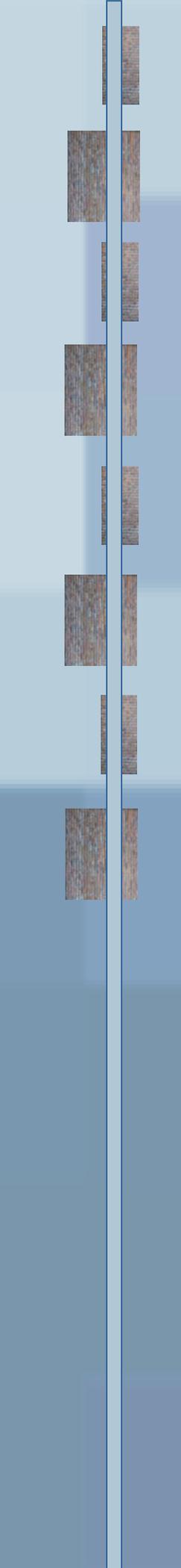
15763 (e) To the extent resources are available; each county shall provide emergency shelter in the form of a safe haven or in-home protection for victims. Shelter and care appropriate to the needs of the victim shall be provided for frail and disabled victims who are in need of assistance with activities of daily living.

(g) Each county shall provide tangible support services, to the extent resources are available, which may include, but not be limited to, emergency food, clothing, repair or replacement of essential appliances, plumbing and electrical repair, blankets, linens, and other household goods, advocacy with utility companies, and emergency response units.

Government Role in Protection of Vulnerable Citizens

The State Legislature recognizes that government has a responsibility to protect people subjected to abuse, neglect, or abandonment. As stated by the Welfare and Institutions Code §15763 (b) (1) “A county shall respond immediately to any report of imminent danger to an elder or dependent adult residing in other than a long-term care facility, as defined in Section 9701 of the Welfare and Institutions Code, or a residential facility, as defined in Section 1502 of the Health and Safety Code. For reports involving persons residing in a long-term care facility or a residential care facility, the county shall report to the local long-term care ombudsman program. Adult protective services staff shall consult, coordinate, and support efforts of the ombudsman program to protect vulnerable residents. Except as specified in paragraph (2), the county shall respond to all other reports of danger to an elder or dependent adult in other than a long-term care facility or residential care facility within 10 calendar days or as soon as practicably possible.”

The Ombudsman program, to which the WIC section referred, investigates allegations of abuse and neglect in skilled nursing facilities and licensed residential care facilities for the elderly (sometimes called assisted living facilities). Its volunteers go into institutional settings to do what APS workers do in community-based settings. The Ombudsman program experienced a 49% budget reduction last year and had to layoff and reduce staff hours. This program was already “bare bones.” While APS and Ombudsman have enjoyed close collegial relations, the cuts to the two main investigative bodies for elderly persons have made a safety net concept against elder abuse unrealistic.



Conclusion

Even though the Contra Costa County Adult Protective Services Program has been reduced to a level that has compromised our ability to protect the most vulnerable elderly and citizens with disabilities, Aging & Adult Services Bureau is currently working on a plan that incorporates all available and appropriate resources (Area Agency on Aging, Information & Assistance, In Home Supportive Services and Adult Protective Services) to continue to fulfill the mandates of the program and provide the minimal necessary services and protections.

To date, In Home Supportive Services (IHSS) intake has been transferred from the Information and Assistance (I&A) program to In Home Supportive Services (IHSS). This allows the I&A social workers to act as backup resource for APS. The Area Agency on Aging is also providing staff assistance with backup for planned absences for APS staff. All available and appropriate resources are being deployed to assist in the operation of APS and to meet required mandates.

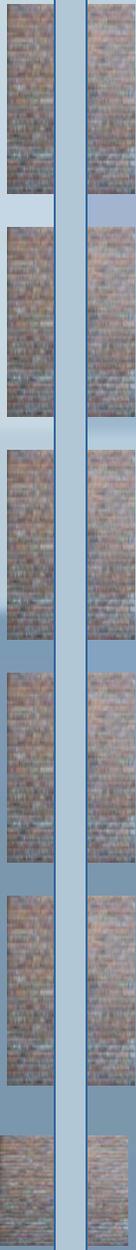


Adult Protective Services

**A Report to the Family and Human
Services Committee
of the Contra Costa County
Board of Supervisors**

INTRODUCTION

The last report on Adult Protective Services to the Family and Human Services Committee was in 2006.



Approach

The main strategy of the APS program is to make available to the at-risk individual a variety of health and social programs to ameliorate or eliminate the risk of abuse, neglect, or exploitation.

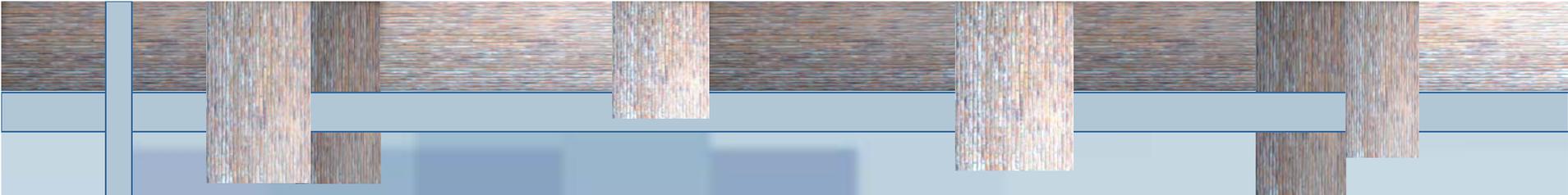
At this point in time APS is unable to implement the full range of intervention (case management) to protect these individuals. This can result in premature institutionalization or repeated reports of abuse coming into the program.

Approach

APS is the public's first responder to allegations of abuse and neglect against dependent adults and the elderly and the ability to fulfill this obligation has been compromised.

Staffing

This year is the first year of operation for APS following severe staffing reductions and an overall environment of fewer resources to draw upon both inside the county and for community-based services.



Caseloads

APS practitioners statewide generally have agreed that the best practice caseload is to receive 15 new abuse reports and to carry over another ten from the previous month for a total of 25 cases per month.

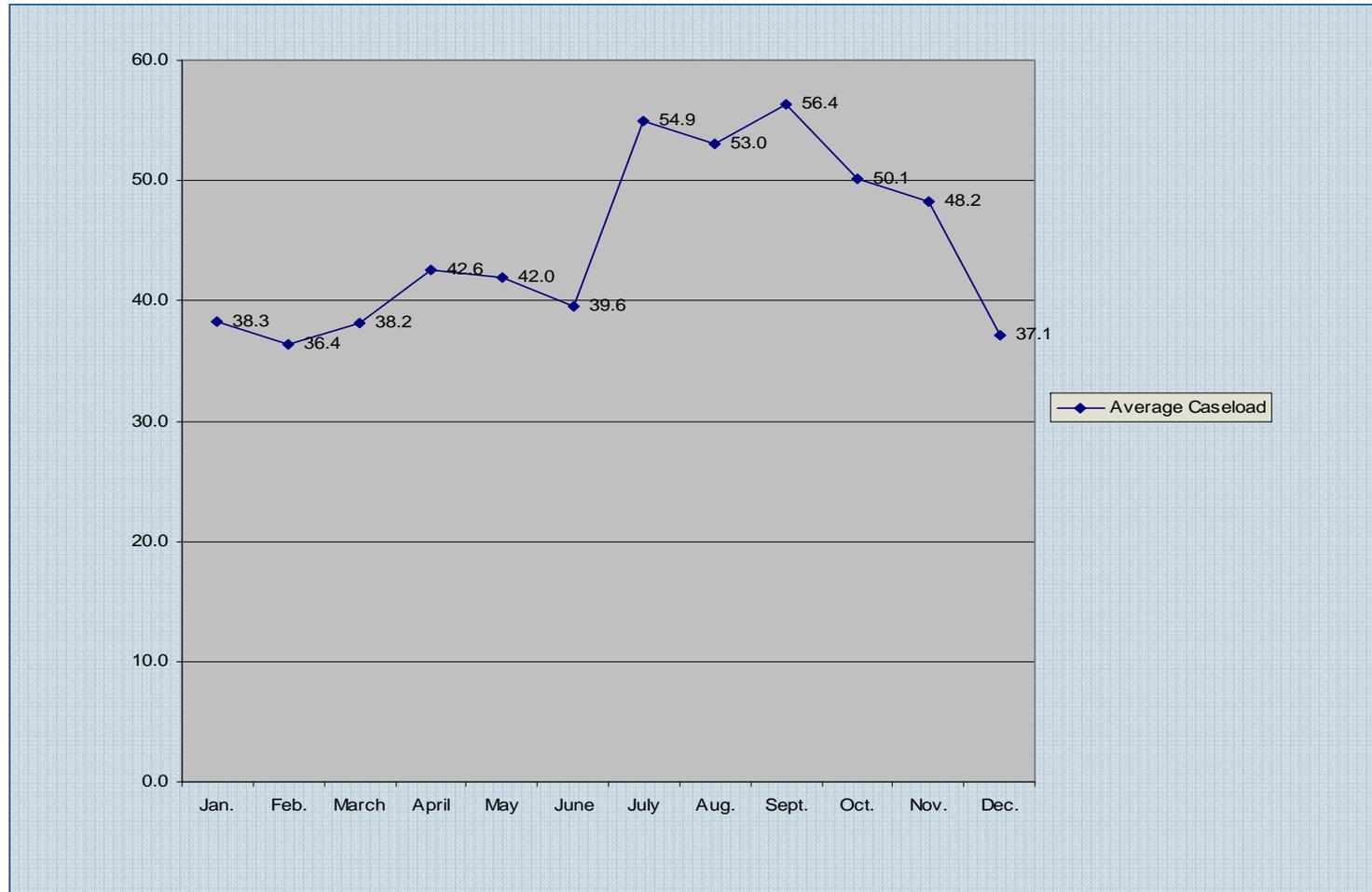
Caseloads

Year	Caseload size/per Worker/per Month
2004	23.75
2005	31.8 (increase of 33%)
2006	35
2007	37
2008	44.73
2009	64

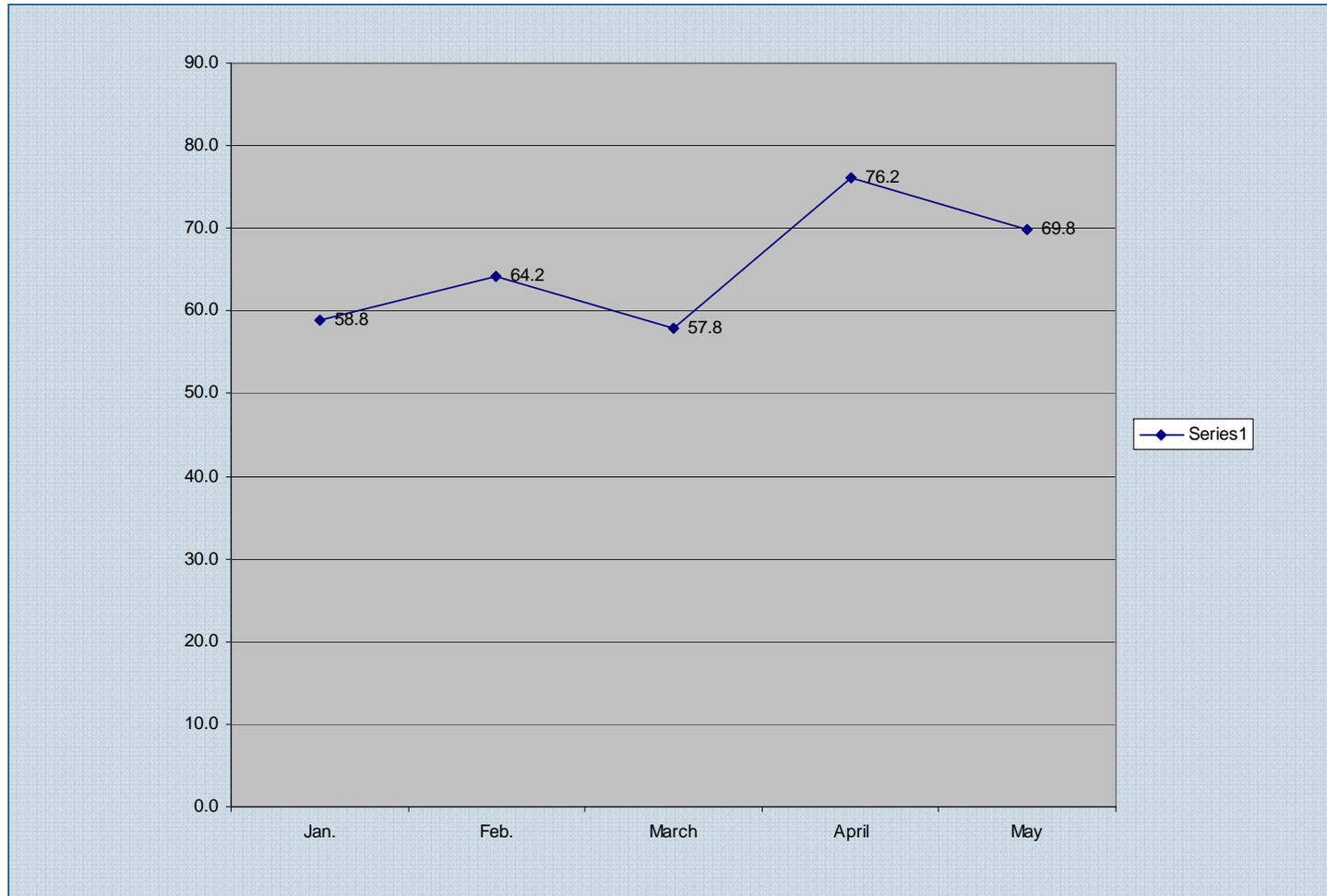
Caseloads

- In the first half of 2002, APS had 18 social casework specialists, a mental health clinical specialist and two public health nurses.
- In the second half of 2002, it lost a unit's worth of staff.
- December of 2008, experienced a 75% reduction.
- Today, there is one supervisor and seven social casework specialists.

2008 APS CASELOAD AVERAGES



2009 APS CASELOAD AVERAGES



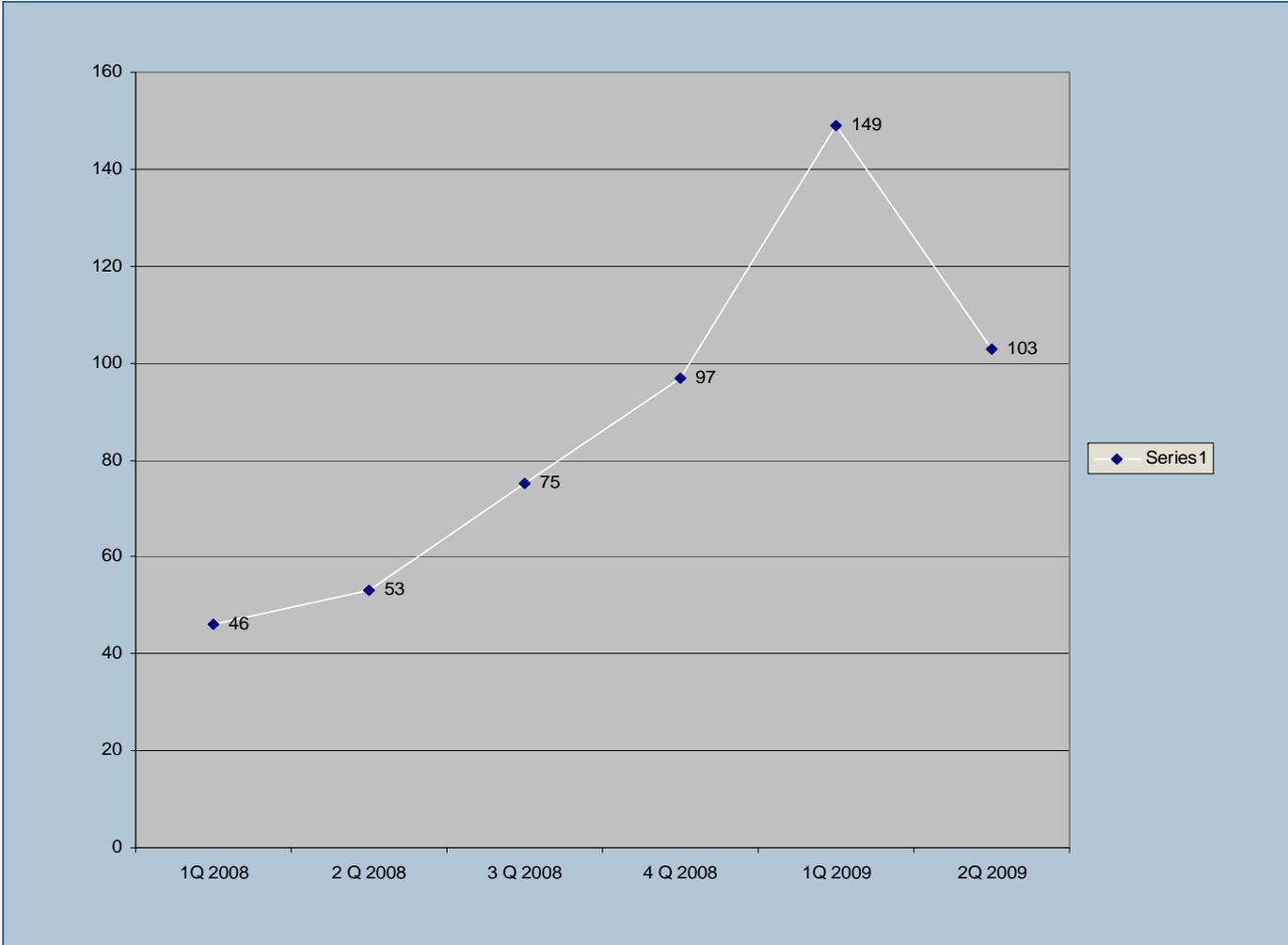
COUNTY	STAFFING LEVEL	COMMENTS
Alameda	1 FTE manager, 2 FTE supervisors, 17 social workers	No PHN or mental health specialist. Relies on county's mental health crisis team or law enforcement for 5150 authority. Manager is also director of the Public Guardian-Conservator office.
Fresno	1 FTE manager, 2 FTE supervisors, 15 social workers	Has collaborative field team support of 3 mental health therapists with 5150 authority and 2 PHNs on call as needed to APS.
Santa Clara	1 manager, 3 supervisors, 24 social workers	No 5150 authority, uses PHNs from IHSS. Lost one SW in October 2008
Stanislaus	1 manager with responsibility for 2 other programs, 1 supervisor, 8 social workers, 1 PHN	Lost 3 social workers since 10/07 and had funded a co-located DA Investigator. Lost other contracts for restraining orders and time for community outreach and education.
CONTRA COSTA	.5 FTE manager, 1 supervisor, 7 social workers	Lost 1 FTE case management division manager, 1 mental health specialist with 5150 authority, 2 PHNs and 5 SWs

APS Practices Resulting from Reduced Staffing

- Higher utilization of “NIFFI” (no face-to-face investigation.) What used to be used infrequently is now used in over 50% of the reports received.
- Direct referral to law enforcement in financial abuse cases. Law enforcement hasn’t the time to investigate and gather information for the District Attorney’s Office. The senior community is becoming more aware of financial exploitation and reports of financial abuse from financial institutions have increased.
- Self-neglect cases get assigned as NIFFI cases unless the incoming report is explicit enough about imminent risk to the person. Neglect can be life-threatening when someone is immobile for a prolonged period of time, experiences skin breakdown, which leads to systemic infection. APS has had such reports where victims died from infection, a totally preventable death.
- Greater use of the Information and Assistance unit in screening and investigating NIFFI reports. For the first time, I&A workers are being assigned APS NIFFI cases in order to manage the caseload.

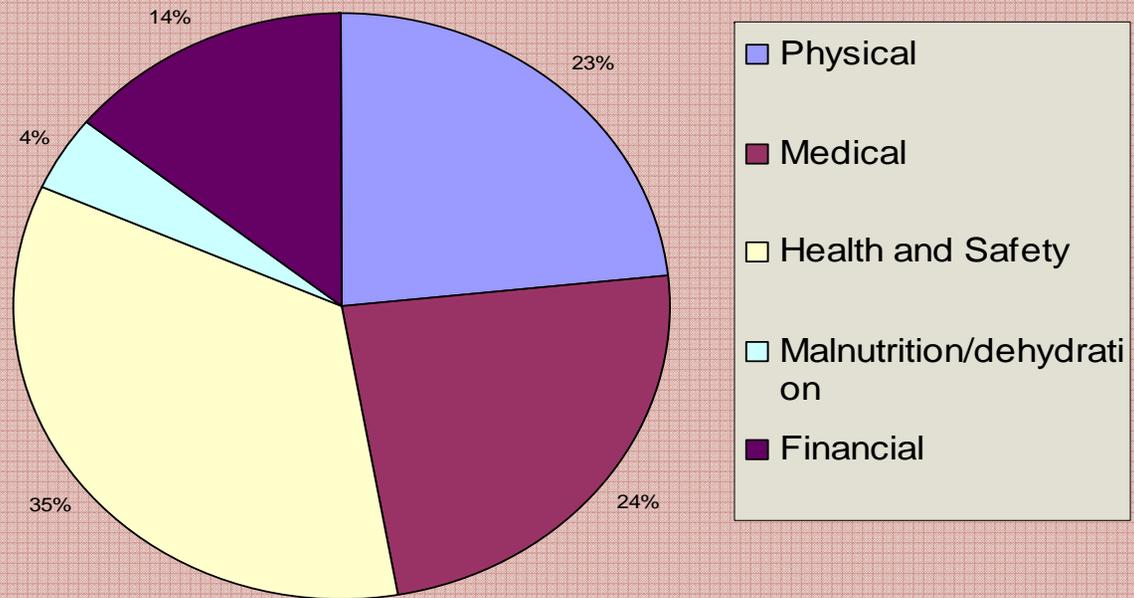
NIFFI CASES

2008 & First half of 2009



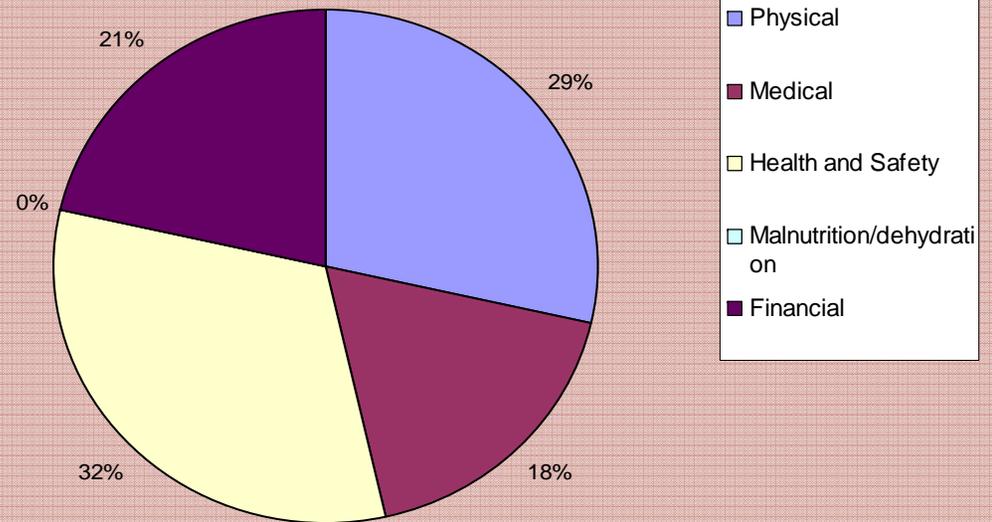
2008 CONFIRMED SELF-NEGLECT

Confirmed Self-Neglect 1Q 2008



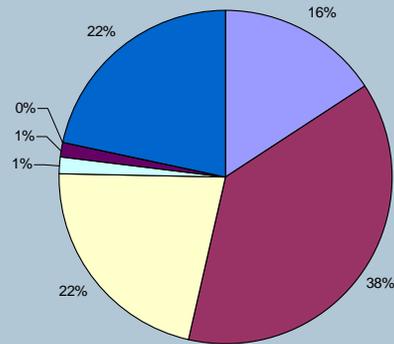
2009 CONFIRMED SELF-NEGLECT

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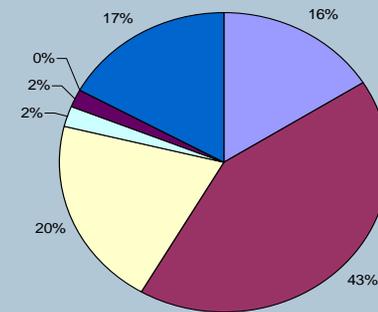


2008 CONFIRMED PERPETRATOR ABUSE

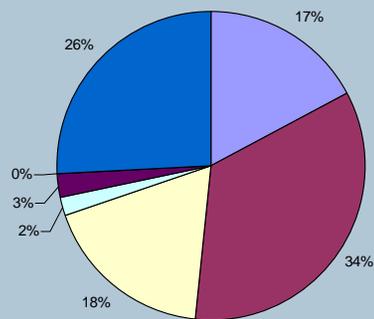
Confirmed Perpetrator Abuse 4Q 2008



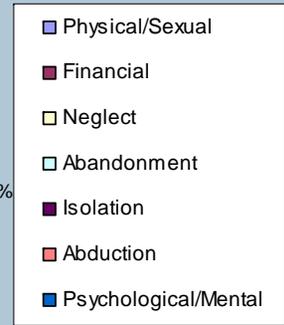
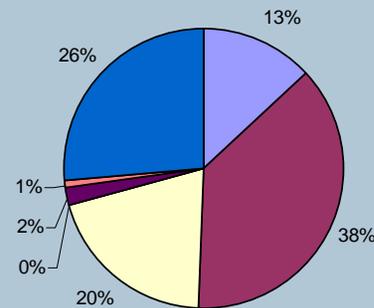
Confirmed Perpetrator Abuse 3Q 2008



Confirmed Perpetrator Abuse - 1Q 2008

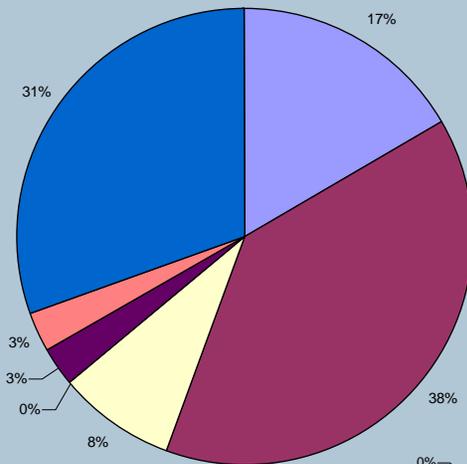


Confirmed Perp Abuse - 2008 2Q

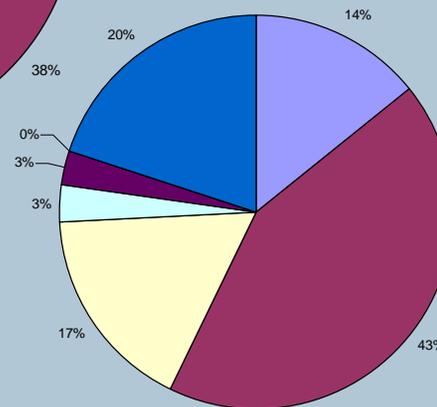


2009 CONFIRMED PERPETRATOR ABUSE

Confirmed Perpetrator Abuse - 1Q 2009



Confirmed Perpetrator Abuse 2Q 2009



- Physical/Sexual
- Financial
- Neglect
- Abandonment
- Isolation
- Abduction
- Psychological/Mental

Components of the Elder Abuse Response Network Missing Since 2006

- Insufficient caseworkers to intervene in financial abuse cases.
 - Lack of district attorney investigators and attorneys to pursue criminal investigation and prosecution of alleged perpetrators.
 - Limited Multi-Disciplinary Team meetings, bringing knowledgeable professionals in to consult on APS cases.
(Required under WIC §15763 (f)1)
 - No multi-disciplinary Financial Abuse Specialist Team capable of responding on short notice to protect financial assets of vulnerable adults or even a consultation panel.
- 

Missing Components of the Elder Abuse Response Network

■ These limitations are now combined with APS' own reduced capacity in staffing and in contracting for emergency services.

■ In the past APS has contracted for emergency shelter in a licensed board and care facility or a skilled nursing facility; other contracting included:

- home care services on a short-term basis to bridge a gap
- minor home modifications such as grab bar installation or construction of ramps
- mental health capacity evaluations to create documentation necessary for conservatorship; and for other services

■ **APS no longer has contracting capacity.**

Grand Jury Findings

We will reiterate the Grand Jury finding that the primary target for financial abuse in Contra Costa County is elderly individual.

- a consortium of community-based organizations, elder advocates and a member of the AAA's Advisory Council on Aging have formed **CASE = Communities Against Senior Exploitation**
- **CASE is a public awareness campaign with a speaker's bureau to speak to senior groups and the general public about elder financial abuse**
- **A couple of cooperating agencies in this effort include the elder law clinic of John F. Kennedy University and the Elder Financial Protection Network.**

Grand Jury Recommendations

- Develop realistic long term solutions to determine which services could be enhanced with restructuring.
- Restore essential staff positions, such as the Public Health Nurse, the Mental Health Specialist and at least four of the social workers to APS that were lost as of January 1, 2009.

Protection of Vulnerable Citizens

The State Legislature recognizes that government has a responsibility to protect people subjected to abuse, neglect, or abandonment. As stated by the Welfare and Institutions Code §15763(b) (1) “A county shall respond immediately to any report of imminent danger to an elder or dependent adult residing in other than a long-term care facility, as defined in Section 9701 of the Welfare and Institutions Code, or a residential facility, as defined in Section 1502... **within 10 calendar days or as soon as practicably possible.**”

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Conclusion

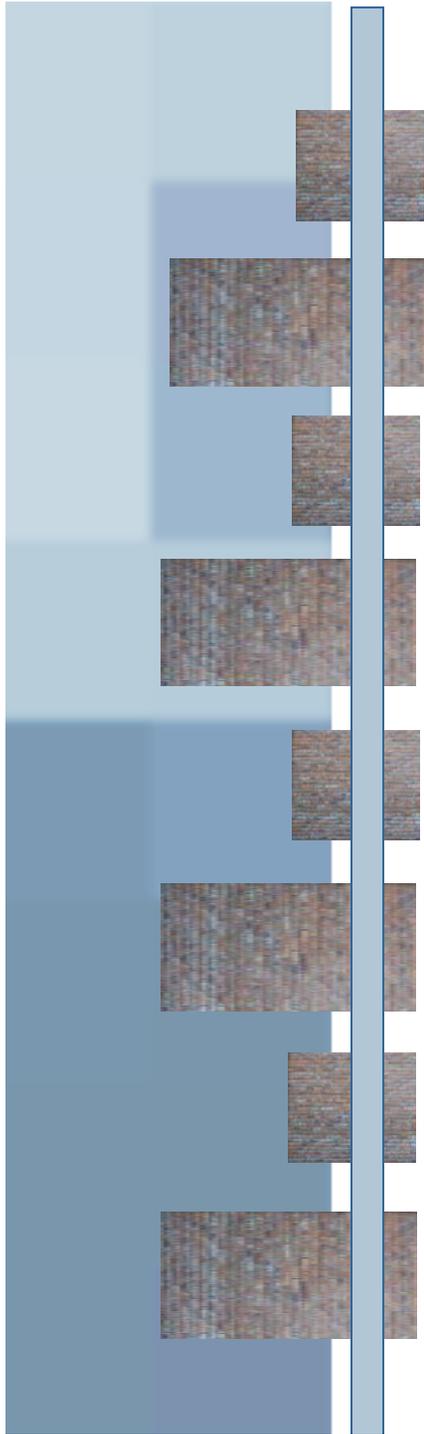
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To date, In Home Supportive Services (IHSS) intake has been transferred from the Information and Assistance (I&A) program to In Home Supportive Services (IHSS). This allows the I&A social workers to act as backup resource for APS. The Area Agency on Aging is also providing staff assistance with backup for planned absences for APS staff. In the short term, available and appropriate resources are being deployed to assist in the operation of APS and to meet required mandates.

Conclusion

In the long range, with the increase in financial abuse referrals, coupled with the inevitable increase in the vulnerable adult population, the current staffing model for APS would be inadequate to meet the required mandates.



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