BOARD OF SUPERVISORS - COUNTY OF MARIPOSA

RESOLUTION NO. 74-105

BE IT HEREBY RESOLVED that the Board of Supervisors of the County of Mariposa, State of California, does approve the proposed use of the new and expanded Continuing Care Program Funding resulting from the passage of AB 4513 (Lanterman) which was submitted by the Mariposa Mental Health Services on this date, and

BE IT FURTHER RESOLVED that the Board of Supervisors approves an additional $10,000 for the Mariposa Mental Health Services Budget.

PASSED AND ADOPTED by the Board of Supervisors of the County of Mariposa this 25th day of October, 1974, by the following vote:

AYES: Hurlbert, Moffitt, Long, Richardson

NOES: None

ABSENT: Davis

NOT VOTING: None

TOM R. RICHARDSON, Chairman Pro Tem
Board of Supervisors

ATTEST:

ELLEN P. RITTER, County Clerk and Ex-Officio Clerk of the Board
In response to the new and expanded Continuing Care Program Funding as a result of the passage of Assembly Bill Number 4513 (Lanterman), the following is Mariposa County's proposal for the use of part of these funds.
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A. SYSTEM NEED:

In Mariposa County, there is a population of mentally ill patients who are in consistent need of mental health services. These patients are generally described as being chronically mentally ill and usually fall into three diagnostic categories. The "chronic schizophrenic", the "inadequate personality", and the "chronic alcoholic". What is known about these patients is that they generally do not, and have not, responded satisfactorily to various modes of psychotherapy. Generally, because of repeated hospitalizations and nonresponse to psychotherapy, these patients become dependent on public services for their livelihood.

The local mental health clinic provides an important link in maintaining these individuals in the community. Previous to the development of the local mental health facility and licensed out-of-home care facilities to house these individuals, they were sent to large state hospitals. These same individuals have now returned to the local communities and without mental health intervention, many would be returned to large locked facilities. In Mariposa County, there are approximately 45-50 persons who meet the aforementioned criteria and who are in need of services.

B. GOALS OF CONTINUING CARE:

1. To prevent unnecessary hospitalization of mentally handicapped persons.

2. To affect a return to the community of mentally handicapped individuals who are no longer in need of psychiatric hospitalization.

3. To assist mentally handicapped individuals in maintaining their adjustment to community living by helping the patients to identify, mobilize and facilitate the most complete, effective use of community resources available to them.
C. PROGRAM DESIGNED TO MEET THE GOALS:

For the chronically mentally ill patient, the major program to meet their needs is the Continuing Care Program. This is a county-wide program staffed by one psychiatric social worker who can devote only one day a week to the program due to fiscal limitations.

D. OBJECTIVES OF CONTINUING CARE:

1. Identifying, evaluation and formulation treatment plans for the chronically mentally ill patient.

2. Finding and supervision of out-of-home placement with patients following long-term or acute psychiatric hospitalization.

3. Daily, weekly, monthly administration of medication for the maintenance of patients, both in the clinic and in the field.

4. Community follow-up with continued stabilization to include taking on an advocate role for the patient in relating to the myriad of services required for his stabilization.

5. Providing weekly, bi-weekly, monthly socialization activities in the local community for the patient.

6. The provision of consultative services to residential care facilities to insure proper treatment of patients in those facilities.

7. The provision of consultative services to community agencies concerned with this patient population.

8. The provision of training to residential care facilities regarding the care of these patients.

9. Insuring adequate documentation of services provided.

10. Monitoring services provided to insure that they are adequate, appropriate and indeed needed.

11. Insuring that patients rights are protected as provided in the W & I Code Section 5325.
E. ACTIVITIES DESIGNED TO MEET THE STATED OBJECTIVES:

1. As patients are referred from continuing care from various sources including the Merced inpatient facility, the local welfare department, other county agencies and private referrals, a determination is made to admit to continuing care or refer to another resource. The evaluation done on each patient on his entrance to the continuing care program includes the following:

a. Identifying information: Name, age, sex, marital status, referral source, medication and funding.

b. Chief complaint: The statement of complaint and duration of onset.

c. History of present illness, onset and precipitation factors, description of symptoms, previous treatment for this, etc...

d. Current living situation: Makeup of home, description of relationships, financial situation, leisure time interests and their relationships.

e. Past history: 1. Family members and their relationships. 2. School, sexual and marital history. 3. Employment history. 4. Conflict with the law; use of drugs and/or alcohol. 5. Medical history. 6. History of psychiatric hospitalization and contact.


g. Diagnostic impression:

h. Recommendations: 1. Type of treatment. 2. Medication. 3. Long-range goals. 4. Short-term goals. 5. Plans to carry out goals.
2. Placements are facilitated by frequent contacts with those most directly concerned with the placement. For instance, timely visits are made with the board and care operators, and ongoing relationships have been established with the welfare department and the public conservator office. This is designed to insure swift placement and continuous supervision of the patient in the home.

A current listing of available placements in the various facilities are maintained by the department of health licensing agency and the welfare department licensing unit. The continuing care psychiatric social worker remains aware of the vacancies in these facilities. He also knows what each facility is capable of providing and the type of patients the facility is capable of handling.

3. Medication needs are monitored through a medication clinic held weekly at the Mental Health Services for Mariposa County in the Health and Welfare Building in Mariposa.

4. Follow-up services are provided by the continuing care psychiatric social worker. In his absence, the program manager is available to provide needed services. In the event of an emergency either staff member will be available depending on proximity to the patients.

Due to the spread of distance between various points in this county and the mountainous road conditions, the largest segment of time and mileage expenditure are generated in follow-up and emergency services to the continuing care population.

There are several activities involved in follow-up services available to clients. Calls from the care home operator and/or the patients, are responded to in an effort to forestall potential crisis situations or
resolve a current crisis. This entails the social worker spending the necessary amount of time it takes to help the operator and/or patient resolve the situation. Also, regularly scheduled meetings are held with the patient, the family, or the respective home operator to enable the patient to reach his or her optimum level of self-realization. Individual counseling and/or psychotherapy is available to those patients who can benefit from it.

5. Consultation to the out-of-home providers is primarily the responsibility of the continuing care psychiatric social worker. He is assisted, as needed, for specialized situations, by the program manager and the staff psychiatrist. Other "experts", e.g., public health nurse, vocational rehabilitation counselor, regional center personel, etc., are called upon to assist when necessary.

6. Consultation to larger systems, e.g., welfare department, regional center, etc., is the primary responsibility of the program manager. These larger systems are appraised on a periodic basis of the availability of the consultation concerning their relationship with continuing care patients.

7. Each continuing care patient has a case record. The required recording addresses itself to the number and nature of contacts made towards the completion of the case plan. It particularly relates to the progress made towards the realization of both long-term and short-term goals. The recording is reviewed and countersigned by the program manager. It is also reviewed on a regular basis by an outside medical records specialist. Weekly staff meetings are held to further monitor the activities of the continuing care psychiatric social worker.

8. Each continuing care patient involuntarily held is made aware of his rights and documentation to that affect is recorded in the patient's record.

9. Through supervision, required recording and record reviews, the need for services is constantly re-evaluated. It must, however, be made clear that by the severity and chronicity of their illnesses, continuing care patients
are not usually short-term patients.

10. The case closure comes about when the individual reaches a level of functioning which would require only services such as outpatient visits, day treatment, legal services only, economic aid only, etc... As long as the individual is in need of and can benefit from the following services he would usually remain as a continuing care patient: a. vocational services, b. ongoing management of medication, c. social rehabilitative services, d. out-of-home placement services and follow-up, e. activity programs, f. mental health services included in the county plan plus involvement in the continuing care function, g. referral and advocacy services.

Referrals for services to continuing care patients that are not provided by the Continuing Care Program are referred to the appropriate agency and closely monitored to insure that adequate receipt of service is provided. In many cases, the social worker actually accompanies the patient on a referral to insure adequate transfer and receipt of services.
Section B

A. SYSTEM NEED:

While the Continuing Care Program in Mariposa County is functional and reasonably strong in certain areas, there remains a definite need in four areas. They are presented here in their order of priority:

1. Budgetary constraints vs. the demand for services hinders the program in these areas:
   a. Case finding;
   b. Effective and adequate monitoring of case plans, placements and use of medication; and
   c. Development of a complete and more adequate socialization program.

2. The out-of-home care operators have expressed a felt need for additional and more in-depth training.

3. Present allocations will allow for only limited use of the newly developed community-based Day Activities Center by mentally ill persons. It is contemplated that additional use of the Center by continuing care clients will be needed.

B. GOALS OF NEW AND EXPANDED PROGRAM:

1. To prevent unnecessary hospitalization of potential chronically mentally ill persons and those who already have been identified as chronically mentally ill, including persons under the age of 18.

2. To assist mentally handicapped individuals in maintaining their adjustments to community living by helping patients identify, mobilize and facilitate the most complete and effective use of all community resources available to them.

3. To assist out-of-home care operators in the development of their maximum personal and facility's potential.
C. PROGRAMS DESIGNED TO MEET THE GOALS:

Additional funding will enable the Mental Health Services for Mariposa County to allocate additional staff time for case finding, monitoring, socialization programs, and training of out-of-home care operators. There will be no loss of existing services, only the development of new and expanded services under the current framework.

D. OBJECTIVES OF THE EXPANSION OF CONTINUING CARE:

1. Identify, evaluate and effect a treatment plan for persons not presently included in the Continuing Care Program.

2. Increase staff time in order to maintain and further enhance our present system of monitoring case plans, placements and use of medication.

3. Increase staff time to further develop a socialization program for continuing care patients.

4. Provide more in-depth training programs for out-of-home care operators.

5. Identify, evaluate, refer and fund more patients who can make effective use of the local Day Activities Center.

E. ACTIVITIES DESIGNED TO MEET THE STATED OBJECTIVES:

Allocating one and one/half more days per week, for a total of not less than two and one/half days per week, of the psychiatric social worker's time to the Continuing Care Program. At present, other components of the mental health program, e.g., Outpatient Services, Medication Clinic, Community Services, etc., have identified potential continuing care patients. These have not been included in the Continuing Care Program on a timely basis because of the lack to staff time to contact, evaluate and develop a treatment plan for these persons. More of the social worker's time would be devoted to this aspect of the program. It is felt that this will curtail potential hospitalizations in the county. Also, it possibly will allow for intervention by the mental
health system previous to the development of "chronicity" in certain mentally ill persons.

Additional staff time will also concomitantly increase the amount of time that can be spent in monitoring case plans, placements and use of medication. The social worker will be able to be in closer touch with the patient's needs from the point of placement to the attainment of the patient's goals. He will be able to go into the hospital prior to a placement and provide expertise in discharge planning, as well as serve as a transitional force from the hospital to the out-of-home care placement. With the distances in the county and time involved in traveling these distances, it is often necessary to refer persons to the inpatient facility for evaluation when a crisis occurs. Additional staff time will allow for a quicker reaction to crises and more on-site evaluations of crises, particularly "medication crises".

2. The continuing care social worker will expend more time in the development and facilitation of socialization programs in the out-of-care homes where the population is large enough to demand an on-site socialization program. For the smaller homes, all of which happen to be within a ten mile radius of the town of Mariposa, a socialization program will be developed and function out of clinic offices.

3. The continuing care social worker and program manager will develop a more in-depth training program that will include both in-house and out-of-house training opportunities for the out-of-home care operators.

4. A community-based Day Activities Center ran a pilot project this past summer to test out the efficacy and need for this type of program in the community. Six persons were referred to the Center from the mental health program. An evaluation of each person was done at the completion of the pilot program, as well as, an evaluation of the overall program and how well it met its stated objectives. The results of that evaluation indicated
that it was of significant help to our clients in the areas of increased proficiency in social skills and potential for employment. The Center group is presently securing the needed funds to begin full time operation in the Winter of 1974/75. Already they have secured financial support from several private funding resources; the local County Board of Supervisors, the Department of Vocational Rehabilitation and the Regional Center. Our program is presently budgeted to accommodate six slots in the Center when it begins operation.

With expanded case finding and closer monitoring of patient's needs, it is reasonable to expect that additional mentally ill persons will qualify for participation in the Center's program. Although difficult to project because of the soft data at hand, it is contemplated that five additional slots will be needed. These daily slots will be distributed, it is expected, over ten persons who will attend the Center on a part-time basis.

All referrals will be brought to the attention of the program manager by the continuing care social worker. A joint review of the individual's needs and potential for effective use of the Center program will be made prior to the referral to the Center by the social worker. The patient will be interviewed by the Center Director to inform the patient of the services available at the Center and to clarify individual patient goals. Monthly reports will be provided by the Center staff to the continuing care social worker. Periodic review by the social worker and the program manager will be made in collaboration with the Center staff to determine the patient's progress in the program and determine when termination in the program is appropriate. These reports by the Center staff will be filed in the patient's continuing care case record, as well as, the content of the periodic reviews.
BUDGET INFORMATION:

1. -- $6,059 -- Salary and benefits for psychiatric social worker.

2. -- $3,941 -- Day Activity Center slots.
Attachment A

JOB DESCRIPTION:

I. Title: Continuing care psychiatric social worker

II. Definition:

1. Responsibility is to the program manager.
2. Works with emotionally disturbed individuals, with families, and groups.
3. Tasks may be within the mental health clinic, the inpatient unit, the board and care home or with the community.

III. Requirement:

1. Masters degree from an accredited school of social work.
2. Basic knowledge requirements must include the following areas:
   a. Knowledge of the use of psychotropic medication:
   b. Knowledge of the use of community resources:
   c. Knowledge of welfare laws:
   d. Knowledge of the treatment of chronically mentally ill persons.
3. Must possess a valid California Driver's License.

IV. Responsibilities:

1. Provides screening and evaluation services on both a routine and emergency basis.
2. Assists in developing and reaching case goals.
3. Provides individual, group and family therapy, as well as working to facilitate the social milieu of the care home.
4. Monitors the health and psychiatric needs of the patients.
5. Provides placement services.
6. Participates in community organization, gathers resources for program development and takes on active role in evolving them into action.
7. Provides referral and resource information to the patients and/or care operators.
3. Provides training and consultation to the care operators in developing and maintaining their programs.

9. Maintains clear, accurate patient records and prepares reports and correspondence.

10. Maintains involvement with other members of the mental health services.

11. Any other duties as assigned by the program manager.
Instructions:

(A) Under population or problem groups, identify those requiring continuing care, e.g., chronic mentally ill; patients discharged from local or state hospitals; persons in out-of-home care facilities, etc.

(B) For each of the identified population or problem groups, indicate the name(s) of the provider who will provide continuing care services.

(C) For each provider, indicate the number of entries for the F.Y. i.e., how many persons are admitted to each provider service during the F.Y. (entries, NOT unduplicated persons count).

(D) For each provider, indicate in column form the Services To Be Provided for the number of entries identified in the previous column. Please indicate what services are rendered, NOT modes of services, e.g. (residential treatment and aftercare).

The CR/DC budget serves as backup to this part of the summary.

(E) For each provider, serving an identified population or problem group, indicate the Gross Short-Doyle Costs for the services provided to the number of entries.

(E) Enter the Total Gross Short-Doyle Costs. This total should equal Gross Cost Line on the CR/DC budget Form HAS 1559.
# Patient Services Fiscal Summary

## Continuing Care Services

<table>
<thead>
<tr>
<th>Population or Problem Group</th>
<th>Name of Provider</th>
<th># of Entries/FY</th>
<th>Services To Be Provided</th>
<th>Short/Doyle Gross Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronically ill persons in out-of-home facilities</td>
<td>2203-00</td>
<td></td>
<td>Salaries and Benefits-M.S.W.</td>
<td>$6,059</td>
</tr>
<tr>
<td>Chronically ill persons in out-of-home facilities.</td>
<td>2203-00</td>
<td></td>
<td>Day Activity Center Slots</td>
<td>3,941</td>
</tr>
</tbody>
</table>

*Total Gross Costs Should Equal Gross Cost Line on Form HAS 1559.

Total Gross Costs* $10,000
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