CHAPTER 3
ASSESSMENT STANDARDS & AUTHORIZED SERVICES

ASSESSMENT OF NEED FOR PROTECTIVE SUPERVISION

Introduction
This section provides information on:

- Defining protective supervision.
- Determining when a recipient needs protective supervision.
- Assessing an applicant’s need for protective supervision.
- Situations that do not require protective supervision.
- Sample protective supervision scenarios and computation.

Protective Supervision Defined
Protective supervision consists of observing recipient behavior in order to safeguard the recipient against injury, hazard, or accident. The service is available for monitoring the behavior of non-self-directing, confused, mentally impaired, or mentally ill persons, whose physical functioning is such that they are able to and do put themselves at risk if not supervised. The following exceptions apply:

- Protective supervision does not include friendly visiting or other social activities.
- Supervision is not available when the need is caused by a medical condition and the form of supervision required is medical.
- Supervision is not available in anticipation of a medical emergency.
- Supervision is not available to prevent or control anti-social or aggressive recipient behavior.
- Protective supervision is not an alternative to psychiatric commitment described in Welfare and Institutions Code sections 5150. Therefore, protective supervision is not available to prevent potential suicide or other self-destructive behavior.

When Does A Recipient Need Protective Supervision?
Draft MPP section 30-757.17 et seq. specifies that protective supervision is available, only when all the following conditions exist:

- Recipient is non-self-directing, confused, or mentally impaired;
- Service is necessary to safeguard against injury, hazard, or accident;
- Service is not a friendly visit or social activity;
- Need is not caused solely by a medical condition or in anticipation of a medical emergency;
- Service is not to prevent anti-social or aggressive behavior (e.g., destruction of property, suicide, substance abuse);
- 24-hour need exists;
- Service will allow recipient to remain at home safely; and
- Entire 24-hour need can be met (please see Appendix F for Voluntary Services requirements);
- All preventive interventions have been undertaken, and the risk of injury, hazard or accident remains;
Assessment of the need for Protective supervision is based on consideration of current behavioral history;
Recipient is physically able to put him/herself at risk of injury, hazard or accident.

Assessment
NOTE: The suggestions given here are by no means mandates, but rather guidelines to assist the Social Worker in making an accurate assessment. Some may find these suggestions too technical, and may not be comfortable using them. Some may find that the recipients become threatened by some questioning techniques. Use these guidelines as a tool to help you develop your own assessment strategy, one that is natural to you. As long as you keep the “questions for the Social Worker to consider” in mind, you will be on your way to an accurate assessment.

Self-Direction
Self-direction has to do with the recipient’s ability to make decisions for him/herself. A recipient may follow the direction of others, but it is the recipient’s independent ability to make decisions that must be assessed. The recipient may be physically unable to act on those decisions but retain the mental ability to decide.

Questions For The Social Worker To Consider
1. What would the recipient do when confronted with danger, crisis, or hazard? Does the recipient know how to act in a way that is appropriate to the situation?
2. What decisions is the recipient making in daily life? Is he/she able, for example, to choose his/her own clothes? What he/she will eat? Whether or not to go to sleep? What TV shows to watch?

It is important, when possible, to obtain information regarding the recipient’s mental functioning directly from the recipient. This may be done by asking questions directly to the recipient (for example, “What did/do you want for lunch” or “What TV show do you like to watch at this time”). If it is not possible to obtain information by observing or engaging with the recipient, try to obtain the information from a neutral party, or ask neutral questions to the interested party so that the answer will elicit information rather than bias.

Confusion
Confusion has to do with the recipient’s orientation, concrete thinking and, abstract thinking. It is important to consider these three areas within the context of the need for protective supervision (i.e., is the recipient’s confusion putting him/her at risk of injury or accident?).

Orientation consists of three areas:
- Person
- Place
- Time

Ordinarily orientation is assessed by asking the recipient about his/her address, phone number, birth date, or age; about today’s date and day of the week; and the names of current and past presidents. But these questions yield only limited information in terms of risk of injury or accident.
Concrete thinking is usually assessed by examining the recipient’s ability to recognize objects and their physical properties. In contrast, abstract thinking is the ability to understand the meaning of things or the relationship between things (e.g., fire means danger, an open flame can burn me), and to make sense of concepts (e.g., joy, political science). Abstract thinking can be easily assessed by asking the meaning of a common maxim or adage. If the recipient states, for example that “people in glass houses shouldn’t throw stones,” means “a rock can break glass,” he/she is thinking concretely, not abstractly. Typically, abstract thinking is lost long before concrete thinking (e.g., the recipient can still recognize a broken glass but not understand that it can cut).

Questions for the Social Worker to consider:
1. How does the recipient’s confusion put him/her at risk?
2. Can the recipient recognize danger?
3. How alert is the recipient?

If, during the home visit the recipient’s cognitive abilities come into question, be sure to assess person, place, and time orientation.

Mana Hobson, M.D., of Sonoma County Community Hospital tells us that one simple test can detect 93% of all dementias: You simply ask the recipient to spell the word “world” backwards. This challenges the recipient’s cognitive process to turn “world” into letters (“w,” “o,” “r,” “l,” and “d”), then to conceptualize these letters in reverse order, and finally to hold all this in short-term memory before and during recitation. It also eliminates much of the anxiety the recipient may experience.

The most important consideration (as mentioned earlier) is how does the recipient’s confusion (or memory loss) put him/her at risk? If the recipient becomes lost in his/her home, or expects to find a deceased spouse in the living room, he/she may still not be in danger of injury or accident. It is only when the recipient’s confusion leads directly to injurious behavior that Protective supervision should be considered.

Mental Impairment
Mental impairment is described as diminished function in mental ability, measured usually by lowered social or occupational functioning. Mental impairment can affect reasoning, thinking, learning, and memory. This term is usually used when describing brain injuries, organic changes to the brain, or mental retardation. Many developmentally disabled individuals have some degree of mental impairment (often measured by I.Q.), but may have good dexterity and mobility, thus putting the recipient at risk. Remember that current behavioral history is more important than diagnosis alone. Many times it can be difficult to distinguish mental impairment from confusion without formal testing. For purposes of assessing the need for Protective supervision, follow the processes already used to determine self-direction and confusion.

Questions for the Social Worker to consider:
1. If the recipient is mentally retarded or brain-injured, what is his/her level of intellectual functioning?
2. How has the impairment affected the recipient’s ability to avoid danger?
3. What is the recipient’s capacity to learn to keep him/her safe?

**Mental Illness**

Mental illness is best diagnosed by a licensed professional. However, several features of mental illness are relatively easy to observe (but observing any of these does not necessarily mean that the recipient is mentally ill):

- Bizarre thoughts (e.g., “my neighbor’s dog speaks to me through the toaster”).
- Bizarre behaviors (e.g., speaking to someone who is not in the room).
- Hallucinations (e.g., FBI on the roof).
- Flat affects (i.e., no expression of emotion).
- Inappropriate expression of emotion (e.g., seems not to care that the cat just died.)

**Questions for the Social Worker to consider:**

1. How does the recipient’s mental illness affect her/his ability to recognize and avoid danger or injury?
2. What is the recipient’s ability to keep him/herself safe?

**Other Factors**

**Injury, Hazard, Or Accident**

Does the fact that the recipient is non-self-directing; has confusion, mental impairment, or mental illness directly cause injury, hazard, or accident? Often, there is a fine line between the prevention of accident and the anticipation of accident. One good way to distinguish is to obtain information on the recipient’s history of injury or accident. This will clarify whether the client is at risk or might be.

**Antisocial Behavior**

The intent of protective supervision is to keep the qualifying recipient from unintentional harm. IHSS is not intended to be a form of behavior control or a program to prevent self-destructive behavior (e.g., suicide, substance abuse, or self-mutilation). However, a previous history of antisocial behavior does not preclude IHSS need or eligibility, if medication or other factors control this behavior.

**Recipient’s Ability To Put Him/Herself At Risk**

In some cases, protective supervision may not be necessary because the recipient does not, or is unable to, harm him/herself (e.g., a “benignly demented” recipient who may be confused but does not endanger him/herself, or a bed-bound recipient who is unable to wander). But, some bed-bound or wheelchair recipients can endanger themselves, despite mobility impairments. In cases like these, the Social Worker must evaluate more than mental functioning.

**Preventive Interventions**

Many times a simple instrumental or structural change in the recipient’s environment can remove the need for costly services (e.g., a bedside commode, which would eliminate the need for a provider to walk the recipient down the hallway to the bathroom). This principle holds true for protective supervision as well. Preventive measures should be used first, before considering
protective supervision. If the knobs can be removed or the gas valve closed to the stove, for example, then the recipient’s safety can be ensured without expending the cost for protective supervision. If knives or other sharp objects can be locked in a cabinet, then the recipient’s risk of injury is dramatically reduced at no cost to IHSS. This principle has been used as a common-sense approach to child rearing for many years.

**Minors**

Although it is our policy to evaluate cases individually, some general rules do apply. State law recognizes that the parent is responsible to supervise all minor children. However, some children, especially older ones, with an extraordinary care need, may be at special risk of injury or accident because of non-self-direction, confusion, mental impairment, or mental illness.

**Degree Of Risk**

CDSS Division 30-757.172(a) states that Protective supervision must be able to keep “the recipient … at home safely if … provided.” In some cases, the recipient remains at high risk even with Protective supervision. In such cases, the need for other arrangements (such as placement) should be addressed.

**Paying For Protective Supervision When Recipient Is Left Unmonitored**

State regulations require that the recipient be receiving 24-hour monitoring before paying for Protective supervision can be justified. Should the Social Worker find that, in fact, the recipient is not monitored for significant periods of time and seems not to be at risk, the need for this service should be questioned.

**Documentation**

The importance of thorough and accurate documentation cannot be overly stressed, especially regarding the assessment of the need for protective supervision. Good narrative documentation specifying the Social Worker’s findings, and the sources of those findings, is a key element in the assessment process. In addition, a documentation check-list or flow chart will assist the Social Worker in making the decision:

1. Is the recipient confused, mentally impaired, non-self-directing, or mentally ill?
2. How did I obtain this information?
3. From whom?
4. On what basis did I make my determination?
5. To what degree do these factors put the recipient at risk of injury, hazard, or accident?
6. What steps have been taken to prevent or reduce the recipient’s risk without incurring the cost of protective supervision?

**Summary Of Questions For The Social Worker To Consider**

**Self-Direction**

1. What would the recipient do when confronted with danger, crisis, or hazard? Does the recipient know how to act in a way that is appropriate to the situation?
2. What decisions is the recipient making in daily life? Is he/she able, for example, to choose his/her own clothes? What he/she will eat? Whether or not to go to sleep? What TV shows to watch?
CHAPTER 3 Assessment Standards & Authorized Services

Confusion
1. How does the recipient’s confusion put him/her at risk?
2. Can the recipient recognize danger?
3. How alert is the recipient?

Mental Impairment
1. If the recipient is mentally retarded or brain-injured, what is his/her level of intellectual functioning?
2. How has the impairment affected the recipient’s ability to avoid danger?
3. What is the recipient’s capacity to learn to keep him/herself safe?

Mental Illness
1. How does the recipient’s mental illness affect his/her ability to recognize and avoid danger or injury?
2. What is the recipient’s ability to keep him/herself safe?

Protective Supervision And PCSP
CDSS regulations have different statutory maximums for IHSS recipients receiving services from both the residual and the PCSP IHSS Program from those recipients who receive services only from the residual program.

Non-severely impaired individuals who are PCSP eligible and receive IHSS from a PCSP-enrolled provider cannot be limited to the IHSS Residual Program statutory maximum of 195 hours monthly for non-severely impaired recipients. Any recipient who is PCSP eligible can receive up to 283 hours monthly, if needed.

Most PCSP eligible non-severely impaired individuals receiving IHSS from a PCSP-enrolled provider will require less than 195 monthly hours to meet his/her assessed needs. However, any PCSP eligible non-severely impaired individual receiving IHSS from a PCSP-enrolled provider and also assessed as needing Protective supervision is eligible for a maximum of 195 hours of Protective supervision as part of the IHSS Residual Program. The recipient’s domestic, related and personal care services would be authorized as part of the PCSP. The recipient is therefore eligible for up to a maximum of 283 hours when domestic, related and personal care services are combined with his or her authorization for IHSS Residual Protective supervision.

- Hours for domestic, related, and personal care services will be calculated first.
- Hours for residual protective supervision will be calculated next, up to a combined maximum of 283 hours. In no case should the Protective supervision authorization exceed 195 hours.

PCSP Guidelines
- There are no impairment levels in PCSP – everyone has a maximum of 283 hours.
- NSI Residual/PCSP – 195 hours monthly (45.03 weekly) for PS plus all other hours to a maximum of 283 hours monthly.
- SI Residual/PCSP – 283 hours monthly (65.36 weekly) but no more than 195 hours monthly (45.03) can be PS.
PCSP Reminders

- The recipient must be PCSP-eligible and have an enrolled provider for the case to be considered PCSP.
- Being PCSP-eligible and receiving services in excess of 195 hours per month does not alter impairment status.
- Impairment levels are not a factor for a PCSP recipient.

The PCSP program has only a single maximum of 283 hours per month. This contrasts with the IHSS-R and IPW that have a limit of 195 service hours per month for non-severely impaired individuals, and 283 hours per month for severely impaired individuals. (30-765.111)

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<tr>
<th>Maximum Hours of Service</th>
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<tbody>
<tr>
<td>PCSP recipient</td>
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<tr>
<td>283 hours monthly</td>
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<tr>
<td>(65.36 hrs. weekly)</td>
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<tr>
<td>IPW recipient - Severely impaired</td>
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<tr>
<td>283 hours monthly</td>
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<tr>
<td>(65.36 hrs. weekly)</td>
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<tr>
<td>IPW recipient – Non-severely impaired</td>
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<tr>
<td>195 hours monthly</td>
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AB 1862, signed into law in August 1999, eliminated unmet need for all IHSS Residual recipients.
# Guidelines For Assessing Recipient’s Need For Protective Supervision

The charts on the next two pages provides Protective supervision information, including California Department of Social Services Manual of Policies & Procedures, Division 30 citation numbers, an interpretation of that reference, and indicators to consider when evaluating the need for Protective supervision.

## Assessing Protective Supervision

Protective supervision (PS) consists of observing recipient behavior in order to safeguard the recipient against injury, hazard, or accident.

<table>
<thead>
<tr>
<th>POLICY</th>
<th>REFERENCE</th>
<th>INTERPRETATION</th>
<th>INDICATION</th>
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<tbody>
<tr>
<td>Protective supervision is available for monitoring the behavior of non-self-directing, confused, mentally impaired, or mentally ill persons.</td>
<td>30-757.171</td>
<td>Client must be both mentally impaired and physically capable of taking action that puts self at risk if left alone.</td>
<td>Sum of mental functioning scores is at least 7 and rank for mobility inside is not 5.</td>
</tr>
<tr>
<td>Client must be mentally confused, mentally impaired or mentally ill.</td>
<td>30-757.171</td>
<td>Diagnosis alone does not establish need; functioning does.</td>
<td>Medical report might assist worker understand behavior and determine.</td>
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<td>Protective supervision does not included friendly visiting or other social activities.</td>
<td>30-757.171 a</td>
<td>There must be a foreseeable risk of danger to the client that the behavior poses.</td>
<td>Determine the behavior that creates the risk. Evaluate whether risk can be eliminated by change to the environment in lieu of PS.</td>
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<td>Supervision is not available when the need is caused by a medical condition and the form of supervision required is medical.</td>
<td>30-757.171 b</td>
<td>The form of the disability must be psychological/mental in nature.</td>
<td>PS is not appropriate for one who might need assistance with a ventilator or who has an uncontrollable seizure disorder.</td>
</tr>
<tr>
<td>Supervision is not available in anticipation of a medical emergency.</td>
<td>30-757.171 c</td>
<td>PS cannot be authorized in case a frail client might fall or in case the house catches on fire.</td>
<td>Look for mental impairment and hx of behavior that puts client at risk.</td>
</tr>
<tr>
<td>Supervision is not available to prevent or control antisocial or aggressive recipient behavior.</td>
<td>30-757.171 d</td>
<td>Client's action must put self at risk.</td>
<td>No PS for combative Recipients or those who rub feces on wall or destroy property.</td>
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<tr>
<td>POLICY</td>
<td>REFERENCE</td>
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<td>The Social Worker has determined that a 24-hour need exists.</td>
<td>30-757.172 a</td>
<td>Yes, recipients are eligible if they sleep, but they are not eligible if they have become disoriented only at twilight as with early stages of Alzheimer’s Disease.</td>
<td>Is the client at risk during waking hours? Does client occasionally wander during hours of sleep?</td>
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<tr>
<td>The Social Worker has determined that the recipient can remain at home if PS is provided.</td>
<td>30-757.172 a</td>
<td>If provider is incapable of safeguarding client, PS cannot be provided.</td>
<td>If the IP is a stranger to the client, the risk of abuse may be great.</td>
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<tr>
<td>The Social Worker has discussed with the recipient or recipient’s guardian or conservator, the appropriateness of out-of-home care as an alternative to protective supervision.</td>
<td>30-757.173</td>
<td>Deinstitutionalization may not be the best alternative for the client. The client may be at increased risk of abuse because of burdened caretaker stress.</td>
<td>Send “at risk” letter to significant people in the client’s life to express concern about client’s well being.</td>
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<tr>
<td>When the recipient is a minor, protective supervision is limited to that needed because of the functional limitations of the recipient. Routine childcare cannot be authorized.</td>
<td>30-763.245(d)(5)</td>
<td>If the client is under the age of 14, evaluate the extraordinary behavior of the child that is potentially self-destructive. If the parent is unable to control the child, perhaps another resource can teach the parent limit setting and behavior control.</td>
<td>If the recipient is over the age of 14, evaluate as for an adult.</td>
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