**VETERANS AND SENIORS COMMITTEE**

**OF THE**

**SUFFOLK COUNTY LEGISLATURE**

**MINUTES**

A meeting of the Veterans and Seniors Committee of the Suffolk County Legislature was held in the Rose Y. Caracappa Legislative Auditorium of the William H. Rogers Legislature Building, 725 Veterans Memorial Highway, Smithtown, New York, on June 9, 2014.

**Members Present:**
Legislator Stern - Chairman
Legislator Anker - Vice-Chair
Legislator Barraga
Legislator Krupski
Legislator Muratore

**Also In Attendance:**
Legislator Gregory – Presiding Officer
Lora Gellerstein - Chief Deputy Clerk
George Nolan - Counsel to the Legislature
Michael Pitcher - Aide to Presiding Officer Lindsay
Paul Perillie - Aide to Legislator Gregory
Kevin LaValle - Aide to Legislator Muratore
Tom Ronayne - Director of Veteran's Services
Holly Rhodes-Teague - Director of Office for the Aging
Sergeant Nancie Byrne – Suffolk County Police Department
Timothy Ferguson – Suffolk County Adult Protective Services
Rick Brand - Newsday
All Other Interested Parties

**Minutes Taken and Transcribed By:**
Gabrielle Severs - Court Stenographer

***(*The meeting was called to order at 12:34 p.m.*)***

**CHAIRMAN STERN:**
Good afternoon, everyone. Welcome to the committee on Veterans and Seniors. I'm going to ask everybody to please rise and join us in the pledge led by Legislator Muratore.

(*Salutation*)

Please remain standing and join us in a moment of silence as we keep all of the individuals involved in the senseless tragedy in Las Vegas as well as all of the brave men and women fighting for our freedoms in our thoughts and prayers. Thank you.

(*Moment of Silence Observed*)

We do have a special guest with us today and looking forward to their presentations. Before we go to the presentations today, first let's have Director Ronayne.

**DIRECTOR RONAYNE:**
Good morning, Mr. Chairman, Members. Good morning. Good afternoon. Thank you again, as always, for the invitation, and I actually have very little to report other than some of the activities that we have been engaged in since our last committee. We've been fairly busy working with and planning various events related to both Memorial Day and the 70th anniversary of D-Day. So while we've had, certainly, a lot happening within the agency, a lot of it has been also focused around those two significant holidays.

In addition to the Memorial Day and anniversary of D-Day, we also held this past Saturday, and I would just like to report on the first, what we would hope to be the annual, day of -- First Annual Day of Family Wellness for the Joseph Dwyer Program. It was a day that we have been planning for some time and we did not, quite honestly, we did not allow ourselves to have expectations in terms of the scale or the proportions that the events would take on. We marketed, if you'll indulge that word -- I'm not a big fan of using that word, but for purposes of this discussion, we marketed the event not so much to our veteran population as to the family members and loved ones, folks who have relationships or connections or associations with veterans, and the intent was, obviously, to deliver information and accesses to services and programs that would benefit both our veterans and the family members and loved ones. But it was also very, very intentionally-focused on providing access to nontraditional services, and by the nontraditional services, you know, we've had so many discussions about the plight of our veterans when they return, whether they are high-functioning or experiencing difficulty accessing different services that best allow them to resume their normal civilian life and move on from their service effectively. What this program allowed was access to things such as reiki, yoga, meditative breathing, massage, yoga, all sorts of disciplines that are not traditionally embraced at least by the veterans community. And as much, generally, as we like to think of ourselves as the adapt, improvise, and overcome types, we tend to be sort of in-the-box thinkers, and when it comes to treatment protocols, we very often default to what has historically been available to us, which is primary medicine, primary mental health care, and lots and lots and lots of meds.

This event, this effort was focused on providing access to disciplines that have zero reliance on the meds, and it's been very well-received. We've been expanding our reach into these communities for several months now at least, and honestly I've been very pleasantly surprised by the response. The veterans and the family members alike have embraced it certainly in numbers larger than I anticipated. I thought it would be a tougher sell than it has turned out to actually be, and we've got some wonderful partners in the community who have agreed certainly, at least for the time being, to

meet with and provide service or access to services for our demographic at no cost. So the focus here is not on providing billable services or billable hours. The focus is on identifying these resources to the individuals that we're hoping will consider them as an option and at least make an effort to better understand them.

We also had some of our animal therapy folks present. We had activities for the children and just, all in all, I was very pleasantly surprised. I can tell you that one gentleman who has been actively involved in our program from, really, from nearly the beginning, Dennis DeMars (ph). Dr. DeMars is a Vietnam veteran. Dennis actually worked in a forward medical evacuation base in Vietnam and, remarkably enough, his assignment in Vietnam in 1969 to 1970 was specifically to work with the veterans who had been injured or wounded and evacuated from the line, and beyond the normal reluctance or resistance or desire to not return to the line, providing, really, essentially what at the time would probably hold other things but providing peer services, peer support at that time. So Dennis has been doing this for a very long time, and yesterday, having had about 24 hours to digest the events of Saturday's program, Dennis sent me an e-mail that I thought was just very, very interesting, and I thought it was very telling coming from a gentleman who is a combat veteran, a Ph.D., and somebody who has devoted his life to providing services to veterans, and his sense, coming out of this program on Saturday, is that we are experiencing a paradigm shift in how services are being received and delivered by veterans on Long Island. We're seeing successes that we just could not have anticipated if we had to forecast what our saturation rate into this community was and what the effect of -- positive response would have been, I don't think any of us would have imagined that it would have been at the level that we're seemingly finding, so I'm very optimistic. I'm enthusiastic over -- about the results and we've got some follow-up meetings and discussions scheduled for tomorrow. I'll certainly be able to provide you a more clinical report on this at our next committee. In fact, I'm going to ask that I ask Dr. DeMars to join me and participate in the presentation because I think this is important.

Once again, I'm delighted as a taxpayer to report to you that this entire program was produced, hosted, and executed at zero cost to the Suffolk County taxpayer. We had a lot of support from our community up to and including being fully catered by the Texas Roadhouse restaurant over on Deer Park Avenue, so we've been meeting with great success both within our demographic and within the larger community, and I think that this is really proving at this point to be an eye opener. It's something going forward that I have very high hopes for. It's certainly an evolution of th Dwyer Program. If we had had this conversation two and a half years ago, I probably would have not embraced a lot of what I'm sitting here discussing with you today, but I think the results speak for themselves, and I'm very, very pleased with it.

**CHAIRMAN STERN:**
Good. Legislator Anker.

**LEG. ANKER:**
Again, as always, thank you for your work that you do for our servicemen and -women. And again, I think what's interesting, too, is that it seems, and in the form of a question, it seems that -- or would you agree that we tend to be focusing on the emotional and the mental issues as well as the physical where prior it had not been focused on before? I don't know if you want to elaborate on that.

**DIRECTOR RONAYNE:**
I think largely our focus as a community has primarily been on the physical pain, the physical injuries, the recovery of physical wounds of war. Only in this past number of years have we begun to better recognize and, I think, better understand the invisible wounds of war and one thing, not to use a catch phrase, but we've been using it more and more in our discussions, and I think rightfully so is the effect of moral injury. Very rarely up until the past year or so and certainly within our

circles have I heard a lot of discussion about the specifics of moral injury, and I think that's very important because as an area of mental health that has not been ventured into in any significant way for veterans, this is something -- you know, we've all had the stories about Uncle Harry or dad or grandpa came home from World War II or Korea, even Vietnam, and never discussed their experiences and there's a -- and I'm not demeaning anybody's service, and I certainly would never do that, but there's a significant difference in terms of nature of service and the service of an individual who serves during a time of war in many of the critical support capacities that are absolutely vital to the support and success of our missions: the war fighters, the trigger pullers, the guys who are out there in the grass.

The moral injury that is experienced when you encounter another person when you effectively deal with another human being one on one and the results, the outcomes of many of those encounters are tragic, but they affect us psychologically and emotionally in ways that have been very difficult for veterans to articulate and it's been accepted that it's best to simply not suck it up, take the uniform off, put on some fresh clothes, go out there, get to work and move on with life. And I think now that we're, as a culture, as a society, we're beginning to embrace that this is a very real part of the dynamic behind what is effecting these service members, we're doing a better job of acknowledging it, and the moral injury piece is unconventional. It's not something that -- you know, you can't easily define what the effect is because each individual is affected in his own unique way. So I think that this is really the beginning of a door opening for us in ways that -- again, I won't speak for anybody outside of Suffolk County, but I can say that we are excited, we are seeing results, and some of the guys who, you know, historically we have had some difficulty and -- when we reach out and touch someone, we've had some difficulty, we're breaking down barriers. We're accessing folks that we probably would not have been able to successfully or effectively access just not too long ago.

**LEG. ANKER:**
I also wanted to comment, too, you know, the tide of mental health is basically coming down on us and that waive is intense. I mean, not only do we have our veterans, we have our seniors. People are living longer, so now we have dementia and Alzheimer's. Not only do we have issues with our children just in general, now we have a rise in autism and also addiction, so there's so much regarding mental health that I really feel the programs that you're working on will give proof that we need to do something, that we are doing something, and hopefully we can take from that and create more programs, but thank you, Tom.

**DIRECTOR RONAYNE:**
Thank you. And I would say I should have mentioned this earlier. We do have one audience member who was present working with us on the program through his affiliation with the Dwyer Program, and that is John Rago from the EOC of Suffolk County SSVF programs, so I didn't know if John had anything that he wanted to add or if I've kind of covered it.

**MR. RAGO:**
Just that it was a great event and a great success.

**DIRECTOR RONAYNE:**
And another ancillary benefit to having a lot of veterans, another benefit to having a lot of veterans with certain types of trainings in groups or assembled together is we had a medical emergency and somebody was able to employ the Heimlich maneuver, and we had a save at the event too, so all other things being equal, we came out of the day with a save. That's a good day.

**CHAIRMAN STERN:**
Legislator Krupski.

**LEG. KRUPSKI:**
I'd just like to compliment you. You talked about treatment in an alternative to medication, and I think that's really important, and I just want to say that that's the sort of thing -- you're being very progressive, and I'm very impressed with that. Thank you.

**CHAIRMAN STERN:**
Presiding Officer.

**P.O. GREGORY:**
I also wanted to compliment you for all the programs that you do, and this is a difficult subject area where it's not just as simple as having people come forward who feel that they have some physical or mental illness. You know, military people are generally -- you know, it takes a certain type of person to face danger and put yourselves in harm's way, and when you're damaged physically or emotionally, it's difficult for that person to feel vulnerable, and that's exactly what we're kind of asking them to do, to identify their vulnerabilities, which is not something that, you know, their first inclination to do, so you have the break down that military culture of being tough and nothing can hurt you, you're the protector, the great defender, and it's difficult for people to ask for help and they feel that -- and it's, you know, for many it's viewed as a sign of weakness if you don't project strength coming from the military, and I know it's a very difficult challenge, and I applaud you and all those that are involved in this effort to reach out to those people and creative ways to implore them to get the help that they need, and the country admires their efforts, and we're just here to help them to survive the aftereffects, I guess, if you will, of their sacrifice for their country. So thank you for all that you do.

**DIRECTOR RONAYNE:**
Thank you very much.

**CHAIRMAN STERN:**
Legislator Barraga.

**LEG. BARRAGA:**
I think you make a good point, Tom, because I've known so many veterans who, after World War II or the Korean War or Vietnam, they really don't discuss anything that happened during those wars because those memories are so close to the surface. They find it very, very difficult to even express what happened to them many, many years ago. What I normally run into is as someone gets older, for whatever reason, those memories seem to come back more and more. I think what happens when they come home, as you point out, they put on a different uniform, they go out, they have their jobs, their families, everybody is growing, the years go by, and then when they get to around 65 or 70 years of age, they start thinking more and more of what happened in that war and what happened to those people who didn't come home, and it's like a PTSD but latent, and it's very, very difficult to get these folks to come forward and express themselves, so I applaud in terms of what you're doing.

In an unrelated subject, there has been a great deal of discussion in the media for the last four or five weeks at least with reference to the V.A. system and General Shinseki -- he was like the lightening rod in this particular case -- he has resigned. I think his deputy is now taking over. But the number of hospitals that apparently have had this issue with reference to delaying appointments for veterans in some cases at tremendous cost because x amount of veterans have lost their lives waiting for appointments seems to be growing, and I just wanted to get your input.

My sense with the V.A. Northport, certainly that hospital isn't in that group. They have a lot of positive programs. Would it pay for the Veterans Committee here to invite some of the key people from V.A. Northport to come down and tell us about some of their programs, if nothing else just to

give reassurance to the veterans of Suffolk County and the people of Suffolk County that they do have a first-rate V.A. hospital in Northport? Because my sense would be that if we did that, the media would cover it; you know, the Newsdays and whatnot, they'd be interested in some of the testimony before a committee. It would not be a grilling but just to get input so that a million five hundred thousand people in Suffolk and those in Nassau who use the system out here would feel a lot more comfortable that, you know, we've got a great V.A. hospital here in Suffolk County.

**DIRECTOR RONAYNE:**
I would be happy to pass that invitation along to Director Moschitta.

**LEG. BARRAGA:**
With all due respect, you have to speak to the chairman. I haven't even discussed this with him. It just seems like with everything that's been in the papers, it would be a natural kind of evolution if they would come down and just tell us about the programs, tell us about, you know, how the hospital operates, all the good things that sort of want to hear at this point because we've seen all the negatives in so many other V.A. hospitals around the country.

**DIRECTOR RONAYNE:**
I would absolutely agree, and with the Chairman's indulgence, through you to the legislator, with your permission, I would be happy to extend that invitation to the senior management, to the director, and his associate, I would invite, I suppose, the number one, two, and three man to visit at your convenience and provide a report on the medical center, the activities, the patient load, the soup-to-nuts view.

**LEG. BARRAGA:**
What concerns me at the national level, yes, it's Mr. Shinseki is now gone -- I think his deputy is going to take his place -- but the problems are endemic. They're not going to go away, and what appears to be apparent to me is that the organizational structure around Shinseki was weak, and he has to take responsibility for that because he headed that organization. He should have had good people, organization- and division-wise around him so that input was coming back free flow. For whatever reason, it didn't, and he was, for the most part, completely unaware of some of the problems, serious problems in those hospitals, and that really is unacceptable.

**DIRECTOR RONAYNE:**
I agree, and I don't know that this is even relevant, but I like to believe on some level that there's as piece, a connection here. Shortly before the secretary did resign, he appointed a career V.A. executive to go to Phoenix and assume command of that medical center and really get to the bottom of this mess, and I would tell you Steve Jones -- I'm sorry, Steve Young. Steven Young is his name. I've known Steve for a number of years, and as a part of the progression of Steve's career, Steve had served about five years ago for just about one year as the acting director of the Northport Medical Center right here on Long Island. So the talent that the administration believed was necessary to put into that facility in Phoenix has been a part of our organization here in Northport, and I think that's, if nothing else, a strong endorsement of the quality of the folks that have led that organization. But again, I will divert to the chairman, and if you would like me to coordinate such a visit, I'd be happy to do so.

**CHAIRMAN STERN:**
I recall a few years ago, we had led a committee, a group to -- we had held one of our meetings at the V.A. and we were able to meet with administrative staff and take the tour, and perhaps with the change in lineup among committee members and especially in light of what, unfortunately, we are learning more and more about on a daily basis, it is time to lead that kind of a meeting once again; so, Director, anything that you can do to help coordinate that, we certainly would be appreciative.

**DIRECTOR RONAYNE:**
Would it be your preference to have the senior management invited here to testify, or would you prefer to have an offsite meeting at V.A.? I could arrange for transportation and coordinate the logistics of that?

**CHAIRMAN STERN:**
I think ultimately whatever is best for members of the committee; although I do recall very clearly that having a meeting of committee members at the facility, I thought, was a good experience for anybody that had not been to the Northport V.A. before so they can get to learn the layout, the services offered, meet with some of the very dedicated staff there and several members of the administration. I know that those of us who took that tour at that time and had the opportunity after the tour to really sit down and have, you know, face-to-face and ongoing conversation got a lot out of it, so perhaps that would be the first choice.

**DIRECTOR RONAYNE:**
Well, if it's okay with you, then, maybe I will -- if we'll wait 24 hours, I'll give you time to confer with the committee members and whatever your instruction to me is tomorrow in terms of how you would like me to go forward with that, I'm happy to proceed however you would like.

**LEG. BARRAGA:**
I think, Steve, it's a good idea, say, if we could have a regular committee meeting at the V.A. Northport in which they came down, spoke to us, testify, and afterwards a tour of the facility. That would work out well for most members. That would work out well, I think, for most members. I haven't been there in years. I haven't been there since the Vietnam War.

**DIRECTOR RONAYNE:**
Are you enrolled? We could accomplish that while you visit.

**LEG. BARRAGA:**
I'll just take the tour.

**CHAIRMAN STERN:**
Okay. So we'll discuss and see how we can best coordinate. Anybody else for the director? All right. Director, as always, thank you. Thank you to you, of course, for being here, for all of your important work on the program that has been such an ongoing and even growing success for leaders like you, and, John, thank you for being here as well. That's great news, and, again, as that program, the expansion of the program and the services offered continues to be a model, a model for us here in Suffolk County and all of New York State.

**DIRECTOR RONAYNE:**
Thank you very much.

**CHAIRMAN STERN:**
Okay. Holly.

**MS. RHODES-TEAGUE:**
Good afternoon, everybody. I thought I would highlight one of the services in our offices today. I think it touches everyone who sits here and the other legislators as our information and assistance that we provided in our office. You know, it sounds like it's just something that you do every day, and we do do it every day, and we do do it every day, but it's a little involved. We have information and assistance in our office. We do approximately 900 calls per month in the office. We have four staff members who field phone calls. Phone calls come in to the clericals. If it's something very quick, they want a program and services guide, they just put it in the mail. If it's anything more

lengthy than that, it goes to one of the four staff members who are on the phones, and the people on the phones rotate every day. It's caseworkers and advocates that are on those phones. We have found that the calls, the numbers stay around 9, 950, maybe 900 in a month, but the calls are becoming more intensive. I mean, the people who are calling have more needs or more confusing needs, I guess, and so what we find is that we spend a fair amount of time with each phone call. The calls that come in, health insurance is by far the number one issue that we find. People are very confused about Medicare, Medicaid, how they can be served, what they are covered for, so we do spend a lot of time on that.

And then we also have the health insurance information counselling line, which does Medicare calls, and that's a separate part of our office, so some calls come into the hotline on the hi-cap and some calls come into our office. But on our regular 853-8200 number, health insurance calls, home care people are looking for, and also housing is a huge issue. People are looking for safe, affordable housing in Suffolk County, so those are the calls that we get. We get calls from older residents themselves or their family members, and we have to be very careful sometimes. Sometimes we have residents who call and they aren't really supposed to speak for the older resident that they may be calling on, so we have to make sure that they are able to call for them.

We also have, as part of our information and assistance, our advocates go out to approximately 50 sites in the county a month. They're at libraries, senior centers, housing complexes, and they see about a 175 to 200 people each month at these sites, and some of them are regulars. They come and they like to chat the same person up when they come when they're at a senior. They like to just check in with them. And then we have others who come in and they come with a stack of paper that they say, We don't know what to do with this. Our office tries to go through and explain to them. We do a lot of entitlement forms. We do food stamps. We assist people with HEAP application and also with assistance to pay with some of their medical cost. There's a lot that happens with staff in the office, but they are becoming more intense with the calls.

And your offices, a lot of times, will call us and say, I have somebody who needs assistance, and quite frequently we might say, Well, if they're going to be near the library where an advocate is, it's easier to go to that library if it's on the schedule, and I believe all the offices get copies of where our schedule will be each month, so it's -- we're happy to take the referrals from your office, and obviously if it's an emergency, we're always very happy to try and get somebody to reach out right away. The 853-8200 number is the key number for our office, and I just wanted to let everybody know that information and assistance is alive and well in Suffolk County Office for the Aging.

**CHAIRMAN STERN:**
And, Holly, that's what we try to do in our office is to help promote the dates and the places when you're going to have representatives out in the libraries and the other locations in the community to deal with people one on one. At this point, how does that best get promoted from your office? I assume that you're in touch with the libraries, and the libraries are going to put the word out. Are there any other ways that you might get the word out?

**MS. RHODES-TEAGUE:**
Our schedules are out to all our partners in the aging network. They go to the libraries. They go to all their legislators. They go to some of the state legislators. We get them out any way we can. I'm trying to think if there's -- and, again, phone calls to our office, because we're very frequently the very first place someone calls when they just don't know what to do; you know, if they need to look for a nursing home placement, assisted living, they need the housing, they don't know how to get to from point A to point B, nutrition, meals, congregate sites. So they hear about things, and they call and say, We've heard about you, What do we do? And that's when, a lot of times, we tell them where we're going be located because for some people, they want the one-on-one. They want to sit with somebody face to face, hand them all their papers, and go, I don't know what to do with

this. For other people, the phone call is sufficient, especially for a family member if they're just looking for a quick answer.

Our office gets walk-ins but not as many as you would think. It's not easy to get all the way to Hauppauge if you live in another part of the county, so I really believe that our -- being at the libraries and the senior centers are really helpful.

We also do a lot of training and providing information to the senior centers in the county so that when somebody comes in with some basic questions, they can also assist and they know to send somebody to us when it becomes more than what they know, so we're pretty fortunate that way. That network with the 10 townships is really invaluable in Suffolk County, and I always tell people in other parts of the state we're very fortunate to have that because it really -- we get a lot of bang for the buck because everybody's got a piece to providing services to older residents; very fortunate in that way. Any questions?

**CHAIRMAN STERN:**
Questions for Holly? Legislator Barraga.

**LEG. BARRAGA:**
How do you deal with the issue with reference to someone calling when it's usually a son or a daughter with reference to getting their parent or parents into a nursing home? Do you -- I know with Medicaid, for example, there's a 50-mile radius that usually can be imposed for placement where the family doesn't have much of an option. You may live in Suffolk County, but mom may wind up in Queens if there's a bed available. Do you make any suggestions or recommendations, or do you just give them general guidelines?

**MS. RHODES-TEAGUE:**
We generally will tell people -- first, when people call, first we find out if they've done the PRI, which is the document they needed or to find out if somebody is eligible for nursing home placement because sometimes they may not need the nursing home placement, but they don't know that; they just know that something has to happen. So very frequently, what will happen is we'll say, Maybe home care might be the answer for you. Maybe they don't need the nursing home placement yet. So depending on the situation, we try to, you know, fan out from them what really is happening in the household, and if we can we try to offer recommendations for other services prior to a nursing home placement because in all the years I'm in this business, I've never heard anybody say, Pick me for the nursing home, I can't wait to get there. Everybody wants to be home, so we always try to assist them with trying to see what the options are. We do a lot of options counseling with people, and then if there really is a nursing home placement that they need, then we try to explain to them what they should be looking for in the nursing home, and it really is a feel that people get when they go to a facility because somebody will say, Oh, God, I love this place, and somebody else walks in and goes, I don't want any part of it. They have to feel that it's right for their loved one, so we tell them what they should be looking for. We also give them a list of the nursing homes that are available. There's also, on the Department of Health's website for the state, it gives you reviews of the nursing homes.

So there's a lot of things they should look at before somebody gets placed, and I understand what you're saying about the 50-mile radius because it happened to my grandmother many years ago that she was placed in Far Rockaway, and then we had to work to get her back out of there, and I don't know how often that's happening now, if that's still the case. I haven't heard much about that in recent years.

And then the other piece to it is that how people are on Medicaid with Medicaid managed care companies. There's pieces and parts to that are changing as we speak and that if somebody is in a

Medicaid managed care plan and they haven't been in a nursing home yet, they will have to go in a nursing home that's part of that plan, so there are other things that are going to come into play over the next several months.

**LEG. BARRAGA:**
Yeah, because I've had phone calls over the years from, you know, family members indicating, My mom and dad has to go into a nursing home, can you help me out, can you get her placed within 10 or 20 miles instead of 40 or 50 miles. You know, at times we've been able to be of assistance, frankly, because, you know, I may know the head of a nursing home somewhere or locally or we make some phone calls, but it's usually a major concern to the son or the daughter trying to place the parent relatively close to where they live so they're not traveling long distance to visit.

**MS. RHODES-TEAGUE:**
Well, there is quite a bit of homework that needs to be done of somebody if they have the opportunity. If they're being placed from a hospital, then there's usually tight timeframes, but they need to go look because you cannot tell by just reading a review or by hearing from someone else that this is the nursing home for your loved one because everybody's got a different thought as to what they want, so we do try to tell people that when they call. But again, before they get to that, we try to go through all the options that might be out there.

**LEG. BARRAGA:**
Because on this particular case, their abilities and such and the evaluations have been done, and they definitely need a nursing home.

**MS. RHODES-TEAGUE:**
Right.

**LEG. BARRAGA:**
I wouldn't, you know -- just trying to get an idea of how you folks handle that. We never tell anybody to pick a particular nursing home. We can't do that, so we always give them a list and tell them what they should look for.

**LEG. BARRAGA:**
Okay. Thank you.

**CHAIRMAN STERN:**
Legislator Anker.

**LEG. ANKER:**
Again, thank you, Holly, for your work that you're doing with our county's issues, and I know we had been in conversation, you know, dealing with my own mother who needed -- falling between a senior who's independent and someone who needs medical assistance, there's very places for those folks and, you know, instead of the $6,000 a month I would have to pay for my mother, I found a place in South Carolina for $800 a month. Again, is there anything like that? I know this is off-topic that we could talk more about, but what do we do? What do the Long Island residents do?

**MS. RHODES-TEAGUE:**
It's very difficult. If you're below nursing home placement and then you look at assisted livings or adult homes, there's very few that take Medicaid, so it's self-pay for the assisted livings and they are very expensive. You talk six or eight thousand dollars a month, which it's a high cost for people, so there isn't a lot out there in terms of assistive type of housing that is covered by Medicaid. There's only a few that I know of in Suffolk.

**LEG. ANKER:**
Do you think Long Island will ever be able to get to a point where we, you know, where that type of housing can be found?

**MS. RHODES-TEAGUE:**
I can't really answer that. That's a tough one. I know if somebody has Medicaid and they can stay home that the push is becoming more and more that you try to provide services within the community for people, you know, so that they can stay home. That is a push nationally and also statewide. You know, they don't want to put people in nursing homes. It's prohibitively expensive. People could stay home, maybe, with an aide for several hours a day, and then if family members are available at night, they can stay home much cheaper, so there is a push to keep people home, but that's not always the case for somebody who's on their own, either.

**LEG. ANKER:**
Say a person doesn't have a family, they don't have the other options, so there's a lot of work to do, it sounds like, but thank you.

**MS. RHODES-TEAGUE:**
There is a lot of work to do, but there is, on the state and national level, there's a recognition that we need to try to find different types of assistive housing and also to have people age in the community where they have lived and worked all their lives rather than put them in facilities.

**LEG. ANKER:**
Right, and when I was looking, you actually had to go on a list, and that list was -- there was so much -- what is it? A waiting list, hundreds and hundreds.

**MS. RHODES-TEAGUE:**
A waiting list. There's a waiting list for subsidized housing.

**LEG. ANKER:**
Hundreds and hundreds, right.

**MS. RHODES-TEAGUE:**
Some of the list, they don't even open to add more people to the list for several years.

**LEG. ANKER:**
Thank you.

**CHAIRMAN STERN:**
Tom.

**LEG. BARRAGA:**
In conjunction with what Sarah is saying, what we have to do in this country, and we haven't done it so far, is to convince people to take out long-term care insurance because, you know, New York State is one of the very, very few states that really offers the New York State Partnership for Long-Term Care so that, you know, whether you need nursing home care or at-home care, if you have a partnership policy, the first three years are basically covered, for the most part, by the insurance company; and then after that, you automatically qualify for Medicaid. They cannot touch any of your assets: your stocks, your bonds, your home, nothing. And what we have in the state right now is a lot of people who don't have the policies that should have the policies because you wait too long. When someone is 70, 75, 80 years old, it's too late to get the policy because the premium is too expensive, but these people that should be getting these policies, from a marketing perspective, should be those 40, 45 years of age where the premiums are next to nothing, and it's

just a good investment.

The other thing that bothers me too in this state, you could be a millionaire and if your father goes into a nursing home, you don't have to pay for him. You can do spousal refusal, and Medicaid will come in and pick it up because you refuse to pay. We saw that -- you know, it's immoral but people do it, and they go off the Florida, they live like millionaires. When Suozzi was in office a couple of years ago, they went after about a dozen of these peoples, but there are hundreds out there who do that. You know, you and I are married, and I go into a nursing home, you turn around and say, Hey, he's on his own, I'm not paying a nickel for him; spousal refusal, and they get away with it. It's amazing, right?

**MS. RHODES-TEAGUE:**
It is amazing. The long-term care insurance, several years ago, they had done a big push on the state level to try to get people to purchase it, and then the recession hit, and I think the -- it's very costly, even if you're younger, for a lot of people.

**LEG. BARRAGA:**
Well, not really.

**MS. RHODES-TEAGUE:**
Well, people look at it as insurance. Insurance in general --

**LEG. BARRAGA:**
You have to spend 5,000 --

**MS. RHODES-TEAGUE:**
I have it, so I agree with you.

**LEG. BARRAGA:**
-- you could spend $1,000 on a premium annually to safeguard all of the assets that you've generated for your entire life. Why should you have to give those assets away to a nursing home at $180,000 a year?

**MS. RHODES-TEAGUE:**
Personally, I do not disagree with you because I already have my policy.

**LEG. BARRAGA:**
So do I.

**MS. RHODES-TEAGUE:**
I got it at exactly 50 years of age. But for a lot of people, at the time that the recession hit, they were dropping it because they have to pay it for life and they feel they can't afford it. We heard a lot of people, and they just -- nobody wants to think about tomorrow. In New York State when we did it, the premiums are very reasonable and they're tax deductible at the state level. Whatever the premium is, it's tax deductible. But, unfortunately, Sarah, what happened was they went out and marketed it to a bunch of 70-year-olds or go to senior clubs and all they want is a piece of cake and a cup of coffee. They don't have the capability, frankly, of absorbing the intricacies associated with the policy. They should have gone to people like you, younger people, with the premiums like $1,000, and then by the time you need the policy if you ever need it, and probably you will, because you're not going to die and sleep in bed -- they're going to keep you alive for a long time -- the policy pays for itself.

**MS. RHODES-TEAGUE:**
Quite honestly, when they did the push several years ago, we had had a small grant from the state to do outreach, and we had given it to Cornell Cooperative and they went and the numbers were dismal, and when I checked around the state, they were dismal everywhere. They just did not have a big success trying to push the plan, and I don't know why honestly because I thought it was a great way to make sure that your future was going to be a little more secure, but they did not have a great success statewide.

**LEG. BARRAGA:**
Yeah, it's really a shame, but that's what's really needed: inexpensive, New York State long-term care policy that, you know, so at the end of your life, whatever you've generated, you can at least give to your children if you choose to as opposed to spending four, five years in a nursing home at 180,000 a year.

**CHAIRMAN STERN:**
Okay. All right. Very good. Holly, thank you.

Okay. It is a pleasure to welcome our guests today, Timothy Ferguson, who is the bureau director of the Suffolk County Adult Protective Services, and Sergeant Nancie Byrne, commander of the Domestic Violence and Elder Abuse Bureau of the Suffolk County Police Department. Great having you both with us today and particularly today because this month is Elder Abuse Awareness Month. So here to talk about an important issue that affects so many of our older adults throughout Suffolk County, so it's really great to be able to welcome you both today. Thank you. Let's see. Sergeant Byrne.

**SGT. BYRNE:**
Thank you again for inviting me here today. Am I on? Thank you again for the invitation. I can't believe a year has passed already. And like you had said, sir, it is Elder Abuse Awareness Month, and I think that awareness really is the key when we talk about this important issue; awareness for the general public so that they themselves don't become victims of elder abuse and also awareness so that they may be able to recognize the signs of other people who may be being victimized. So what I was hoping to do here today was to go over -- maybe define the problem and then discuss what the police department's role is in preventing and investigating elder abuse issues.

So just to go over a few brief definitions. Elder abuse, as you can see on the screen there, they talk about intentional actions that cause harm or create a serious risk of harm to a vulnerable elder. The question there is what is an elder, what is the definition of an elder. Nationwide, no one really has been able to come to terms as to one specific definition as to what an elder is. With some of the programs here locally, VIBS has a great elder abuse program, and the age limit that they use in their program is 50 years of age or older if certain specifics are present, and when you talk about the penal law, New York State Penal Law, we use the age of 60, and there's also a local senior citizens law program that Touro runs and they also use the age of 60 plus, and this does create a little bit of an issue when you start talking about statistics, when you start trying to look at what the national picture is with elder abuse because everyone is using different definitions.

What I would like to just show you are two definitions, and I believe I brought these two statistics with me last year, but I just think that they're important and worth revisiting. The one study that was done showed that the vast majority of abusers are family members, and when they said "vast majority," they looked at a number of approximately 90 percent. So in most of the cases that we're dealing with, this is what we're seeing. Most of the time, it's that cross between domestic violence and also elder abuse.

The other statistic I found important and what we're seeing more and more of is they found that family members who abuse drugs or alcohol or have some type of mental illness and they're caring for a vulnerable adult or elder, that they feel -- when they start to feel burdened that the abuse rates are much higher in those situations, and what we're seeing here, at least in Suffolk County, what I'm seeing, is that we're seeing more and more of that where we're seeing adult children who are caring for their elderly parents and those children have these dependencies or mental illness issues, and that's concerning only because when you do look at this study, they're saying that the abuse is at a higher rate in those types of scenarios.

Elder abuse can affect all people. We see it. There's no specific community that this is happening in. Basically, it crosses all lines: Racial lines, ethnic lines, financial lines as far as even social status and both men and woman are affected.

So one term that I'm sure you'll hear Tim Ferguson also discuss is the definition of "vulnerable adult." And, really, when we look at -- and I'll get into a little bit of what it is that my unit does for the police department, but this is really the category of people that we are looking at. They're vulnerable adults, so they're not necessarily elderly. We're not looking at an age limit of 60 or 50. We're actually looking at when CPS stops assisting children and they hit that 18 years of age, 18 years or older is actually the age group that we're looking at, and if they can't care for themselves due to a physical limitation or a mental impairment, that's what we consider a vulnerable adult.

So what is it that our unit does? My unit consists of four plainclothes officers and myself, and the two main roles that we have are vulnerable adult abuse investigations and then also domestic violence outreaches, and I think it works out well. The domestic violence unit started back in, I believe it was 1989, and then several years later -- I want to say maybe about 10 years lather -- is when the vulnerable adult abuse investigations were kind of brought into our unit. Again, I think that's because of the big crossover between the two issues. A lot of times with the vulnerable adult abuse investigations, we're looking at domestic violence issues as well.

But we're also, you know, we're a liaison to the general public. We get a lot of phone calls from the public in my office just trying to direct people in the right direction as far as resources are concerned. Domestic violence investigations are not done at our level. Unfortunately, the numbers are just way too high for four police officers to handle. I think last year, we were looking at about 34,000 domestic accident reports, so four people obviously would not be able to handle that, so the domestic violence investigations are handled at the precinct level.

So the majority of the cases that my unit deals with are referrals from Adult Protective Services, and years back before my unit got those duties as far as doing these types of investigations, Adult Protective Services' caseworkers would have to go through the 911 system to try to get an officer to come with them on a case if there was any type of allegation of any kind of criminal behavior. It just didn't make sense. It wasn't an efficient use of county services. It may take -- Tim could probably say, because there are times they still have to go through and patrol it -- it may take quite some time to get an officer free to go to some things such as like a check on the welfare because of the priority level, so it works out really well.

What happens when Adult Protective Services gets a case where it looks as though there's some type of criminal element to it, they fax that information over to my office, and my officers who are in plainclothes go out jointly with the caseworker unannounced to the home. So, like I said, it's a much more efficient way of handling these types of situations. Any kind of felony investigations are handled by the precinct detective bureau or the white dollar crime unit in the DA's office.

Types of abuse, very similar again to domestic violence cases except for maybe the addition of the neglect and the financial exploitation, but when we talk about physical abuse, there are some added

things that we need to look at. The first thing that we need to look at -- and what I'm going to do here is just go through a little bit, each type of abuse, just the types of scenarios that we are running into and the things that we really have to address.

Is the person competent or incompetent? If we have a competent victim, maybe they're physically disabled, but they have mental capacity to make their own decisions, then it's almost as though we handle it like any other type of case. Yes, they're more vulnerable, but they can make their own decisions. They can tell us what's been happening.

I have "harassment" up there with a question mark. If it was a situation where it was a pushing, shoving, kicking incident, that would be determined to be a harassment situation. If we have a competent victim, then it's easy to pursue that harassment charge. If, in fact, we're dealing with somebody who is incompetent, we no longer have that avenue because we don't technically have a victim who can pursue charges and who can tell us what's happening. So in these types of cases, they're very evidence-based. We're looking at things that just witnesses -- we're looking at the story that's being told, if we have injuries. If they're saying that he or she fell; well, is that plausible? If the person even mobile? Age of bruising, does the story make sense? Are we looking at old bruises that they're saying occurred just yesterday? The shape of injury. Are we looking at marks on, say, the lower arms or upper legs where it might look like restraint was used. So it's really, again, evidence-based more so than it is just asking the victim what occurred. I put medications on there because medications do, in fact, play a big role when we're dealing with the elderly population. If they're on blood thinners, something like Coumadin, you know, that could cause bruising to happen very easily. I've seen people where their body is covered in bruises and you would automatically think, Oh, my God, there's something bad going on here, but it's because of the medications that that's happening, so that's something that we have to take into account. And as we age, you know, our skin gets thinner, and we're more susceptible to that injury.

So a lot of times, a lot of the cases that we're going out on, sometimes the best case scenario for us is just to get the victim out of the situation. If we can't prove a criminal case, at least we can try to assist along with Adult Protective Services and some other advocacy groups out there to try to get the person out of the situation. Sometimes that's the best we can do.

And when we talk about a competent victim, the other thing that we have to look at is reasons why someone in that position may be uncooperative if there's someone who has physical limitations or they're an Alzheimer's or dementia patient. Well, I shouldn't say Alzheimer's because we're talking about somebody right now who is competent. The victim may be dependent upon the abuser for all of their daily needs. You know, is this a situation where the caregiver says to the victim, Well, if you call the police because of what's happening, I'm not going to change your diaper for the next week and you're just going to have to sit there and lay in it? They really are completely dependent upon the person that's being the abuser. The nursing home, like Holly said, it's very rare that we run into anyone who says, Yeah, I'm in, I want to get into that nursing home, please sign me up, especially when they have someone who may be an abuser and is telling them how horrendous these places are. They would much rather stay in the abusive situation then end up in one of these horrible nursing facilities. Family members they don't want to alienate their caregiver, retaliation, and isolation; the victim may be isolated due to the medical or physical condition.

When we talk about neglect, again competency plays a large role. If we have a situation where the person lacks competency and we go to a home and the home, we run into a lot, like, a hoarding situation where it's just deplorable living conditions, and there are other family members, let's just say adult children, living in that home with them. Now we have to look at this situation and say, okay, is this the way they've always lived? Is this the way the parent always lived? And is this the environment that that child grew up in? Or is this a situation where the home is immaculate, but the elder is in a back bedroom that's completely deplorable, no food, urine and feces on the floor?

That's a completely different scenario. So when we look at that type of situation as far as home environment, we have to take those things into consideration.

Poor caretaker skills versus knowingly endangering someone. As I mentioned before, we have a lot of situations that we're running into where we have these adult children with drug or alcohol addiction or mental illness issues. They can't even care for themselves, much less care for the elder, and some of them have always lived at home and it's always been that way, and now they're burdened with something that they just don't know what to do with. So again we have to look at that: Is this a knowingly neglectful situation, or is this somebody who needs more skills or more assistance in the home?

Nutritional neglect; again, we have to look at lacking ability to pay versus intentional withholding of food. Medical neglect, we've run into that -- we've run into that on occasion, not so much. You see that more with children where maybe a parent just doesn't believe that that's the right thing for that child as far as getting the medical that maybe a doctor thinks that they need. You do see that sometimes with adult children saying, You know what, I don't want my mother or father -- I don't think that that's the right thing for them, so that's when we usually get medical personnel involved to try to determine what's best for that elder.

And other types of abuse, emotional abuse, that may not be criminal behavior, emotional abuse. It's still a form of abuse, and there still is intervention that needs to happen, but it may not necessarily be criminal behavior. Sexual abuse is any nonconsensual sexual contact, so if someone does not have capacity, then that would be considered nonconsensual sexual contact. And then financial exploitation, this is where, at least in my opinion, a lot of -- the financial part of it is normally the basis for other forms of abuse. It usually starts with a money situation and kind of escalates from there.

So when you look at indicators of financial exploitation, if we start seeing sudden changes in power of attorney or maybe a change in the will, you know, is it because someone is speaking in this person's ear and forcibly trying to get them to change these items? Unusual pattern of financial interactions. Sometimes what we see, especially with the elder community, most elders don't use ATMs. They still like going into the bank if they're able to get into the bank, so if you all of a sudden start seeing ATM transactions and you know that that elder doesn't even know how to use an ATM machine, that's something to look at.

And just a brief description of what a power of attorney is, it's a powerful tool and it's something that's a good tool and very useful but it can be abused. They have made some changes as far as legislation over the last five years or so to try to make it harder to have that happen as far as the abuse, but it's something that doesn't have to be handled by an attorney. You can have the abuser go right down to Staples and fill out the form and have the elder sign it or the vulnerable adult, so it's easily gotten which, again, is a good thing, as long as it's not being abused. The person has to have mental capacity. Now if it's a situation where the abuser goes into Staples to get the piece of paper and has the person sign it, how do we know at that point -- now we're talking about medical records to try to determine whether or not the person had mental capacity at the time it was signed. And it can be revoked, that's where APS a lot of times will come in and assist with the elder if it's a situation where power of attorney is being refused. It can be revoked. And it just should be known that power of attornies have nothing to do with healthcare decisions; that's all just financial matters.

And, you know, in the news just to spotlight, this is a very common situation, what you see with Casey Kasem in the news. The two grown daughters from his first marriage don't feel as though he's getting the care that he should be getting from his wife of 33 years, and the wife of 33 years believes that the children are out for his $80-million estate. So who's right and who's wrong? It's up to the courts to decide at this point, but just to give you an example, this is a very -- it's atypical

as far as the dollar amount, but typical type of situation as someone starts to age and different family members get involved trying to determine who's doing the right thing.

I just wanted to take a minute to talk about undue influence because under the right set of circumstances, I think that anyone, including anyone in this room, could be subject to what we call "undue influence," and basically, as you see here, it's one person using their role and power to exploit the other person, and it parallels a lot to domestic violence. So there was one study done, and I thought that this really put it in good light as far as how these things progress, these situations. And basically what normally happens, the first step is isolation so the that when you have an abuser -- let's just say it's an adult child or a family member -- and they decide -- maybe it's a situation, like I mentioned before, where it's someone who has been living home their whole life. They needs mom and dad's Social Security money. They need that home. They can't have him go into a nursing home, so in order to get that parent or those parents to do what it is that they want, the first step is isolation. So basically, it's keeping others away. Sometimes the isolation happens strictly because the elder is already immobile; and then the second step is creation of the siege mentality, which we see a lot, and that's basically where the suspect says to the victim, you know, Everyone else wants to hurt you, everyone else wants to steal your money, I'm here to protect you; so they kind of become the savior.

The next step is dependency, and that's really through steps one and two that the dependency happens, and I would say that I hope that at least by stage three that some -- either an advocacy group, a neighbor, APS, or the police department, that someone gets in there before it gets to stage four, and that's really our hope, and that's why we -- awareness is so important because once you start talking about steps four, five, and six. By step four, the victim already feels powerless, is fearful, and the suspect at this point has complete control, which makes the victim compliant to pretty much anything that that abuser wants to have happen. So it's just critical that the services get in there before that happens.

And if we have time, I know I'm taking a little bit of time -- if we have time, I had a short video or we can just save it for another day. I would say it's about three minutes. This is actually something that transpired in Virginia, but I think it's important because it does talk about what I was just describing.

(*Video is played*)

I thought that was important, that story, because it just highlights the mental illness piece, the financial piece and the fact that mom doesn't blame her daughter for what occurred, and when you look at her face, it's just hard to imagine. So again, it just highlighted the few things that I had been discussing as far as what we see most often.

And I will end it here just with the fact that there have been some changes recently that I think were done for the elder population, which I think are positive. When you're dealing with orders of protection, if you're dealing with a family member, they now added three new family offenses to the family offense list. So now you can go to family court -- you don't have to pursue criminal charges -- if you're a family member for the listed larcenies -- larceny and coercion; so identify theft, grand larceny, and coercion were added, and I believe this was done for exactly the situations that I described before, so I think that's a positive step forward. And I thank you for your time, and if there are any questions, I would be happy to answer.

**CHAIRMAN STERN:**
Sergeant Byrne, first of all, thank you for being with us, and I see that there are some members of your team here with us today. Thank you, all of you, for being with us as well.

I was interested to know how you see the numbers recently, say, compared to last year, the year before. Are there trends that we need to be aware of and concerned about? Are numbers holding steady, going up, going down? What are you seeing in your office?

**SGT. BYRNE:**
I would say the numbers are holding steady. We're seeing more and more domestic incidents where we're dealing with the children, the adult children who are still at home and starting to influence power and control, and I don't know if part of that is because of the economy and the way it is. But I have to say as far as our numbers, holding steady, but I could see a problem going forward.

**CHAIRMAN STERN:**
Legislator Anker.

**LEG. ANKER:**
And again, we continue to talk about the issue of mental illness, you know, but what are we doing about it? Again, it's very frustrating because, again, like this young woman who attacked her own mother, now we got to talk about also drug addiction, you know, and it's not even just with our kids that are becoming addicted, acting out, but our seniors are addicted to so many pharmaceutical products that they've been taking. Where can we go with this? You know, you mentioned awareness is one of the most important elements in trying to address this issue. Can you give us some ideas of what we can do? I have one of the largest senior communities in my district. Do you take this presentation to those communities and talk about it? And if you do, what other options do we have to get the awareness out there?

**SGT. BYRNE:**
Yeah, we absolutely do, and what we try to do is to tailor the presentation based on who the audience is, but we certainly do go around and we try to do as many lectures as possible. I think one of the most important things that I'll mention is just the advocacy groups that we deal with that do tremendous work. VIBS just stands out in my mind when we talk about the elder abuse issues. They have several adult abuse and elder abuse programs, so keeping agencies like that funded, I think, is very important; and of course our partners, Adult Protective Services. They're caseworkers, and I know they have quite a caseload, so ensuring that that remains available as far as options, I think that's important.

**CHAIRMAN STERN:**
Legislator Barraga.

**LEG. BARRAGA:**
My experience has been even when there's no abuse involved, being a caregiver is extremely difficult because you're dealing with people, maybe a mother or father in late 80s. Often their cognitive abilities are not what they should be. They're extremely demanding, and it's a very hard stressful situation for that son or daughter who is trying to take care of that parent, and often they're doing it because maybe the elderly parent has assets and they don't want to go into a nursing home. They know the expense associated with it. And, you know, the inevitability, as you pointed out, sooner or later the caregiver seeks power of attorney because if there are two or three children and she's the one taking care of the parent and the other two are in Cincinnati and Texas, you know, they're living their lives and all of a sudden, they want the power of attorney because they feel that, you know, they should control the finances. I've had situations where I had someone come into me a number of years ago complaining to me that his sister had the power of attorney. He lived in Manhattan, and she was writing checks once a month equal to what the nursing home was going to charge if their mother was in a nursing home. And, you know, she had every right to do that. I mean, it's not illegal, and he was complaining about it. The reality, he was doing

absolutely nothing.

Let me ask you a quick question. The reports, when they come in, so many of these situations are within the confines of a family unit. How does one become aware of abuse, when it's just, say, an elderly parent and the son or daughter, you're depending on somebody in the family -- I mean, for example, I cannot see elderly people picking up the phone and calling the police. They just don't do it. They just don't do it, all right. So I sense from your discussion, you know, you're waiting for a third party to report them or someone goes into the house, but in many cases, that's not the case. No one goes near them, so they just live day to day, so there's a lot of abuse out there, bottom line, that you and are I are just not aware of, but it does exist, and we're not going to be aware of because nobody is going to report it.

**SGT. BYRNE:**
You are correct. In those situations, it normally takes that person -- that victim may be ending up in a hospital situation, something like that, then we get involved; but you're right, there is a lot going on out there that we really just don't even know about.

**CHAIRMAN STERN:**
Tim.

**SGT. BYRNE:**
Thank you.

**MR. FERGUSON:**
Thank you for inviting me. Sergeant Byrne and I do work together quite a bit at various forums like this. I wasn't quite sure what was being asked of me. I do a training on a regular basis during the year, which is quite a lengthy training. You've got the handouts from it. I'm going to try to squeeze the hour training into about 10 or so minutes for you, and then I can say certainly entertain some questions. You know, I'm going to start and kind of diverge a little bit to Mr. Barraga. Did I --

**LEG. BARRAGA:**
That's good enough.

**MR. FERGUSON:**
Your question about where do we hear about these people. In APS, it's really a variety of sources. A lot of times, we hear about people simply from other parts of our agency. They're coming in to Medicaid or to public assistance and an examiner will be working with them and they're confused, you know, and they'll make a referral to us. That's a common source. I'll get some from the police as we will send some to the police. We do get some from hospitals, people who are coming in for emergency procedures or just emergency checkups in the hospitals; we will get calls from them. We get a lot of calls from the individuals themselves. About 15 percent or so of our calls -- between 10 and 15 percent, given different years, are actually coming from the individuals themselves calling in. Often, it's just for some simple little information, I'm confused about this form, I'm confused about what phone number I need to follow up for Medicaid or public assistance or HEAP benefits or whatever. They're really -- neighbors are often calling in. We get anonymous calls. We will encourage people to share who they so that we can follow up with them. We do protect the name of any person that calls that is confidential, just to address your question.

But to present this to you, I'm going to kind of focus on a couple of things. First of all, Adult Protective Services by definition is voluntary services, so unlike Child Protective Services for children, our clients, we can go out there and they can say, I don't want you here. Now as the director I can assure you that if somebody says I don't want you here, we discuss different ways of

engaging them, and they're going to have to say that a number of times before we're going to really act on an "I don't want you here." People in this community in this country have a right to live where they want to with whom they want to and how they want to as long as, number one, they aren't impacting on somebody else. Obviously, you can't do that. You can't take your car and park it in your neighbor's front lawn. You can't do things like, and the police get involved in those, but if people are making decisions on their behalf, and they aren't mentally competent and they aren't making wise decisions, that's the most common time that APS will get involved.

Now, I know this is the elder committee and the Veterans Committee, but I have to say, APS, we do have cases from 18 years old and we've had some clients over 100, and I don't have the exact statistics for the last year, but I know over the years, it's been somewhere around 60 percent are over 60, which means we have a lot of clients that are under 60 years of age, and those are primary individuals who are developmentally disabled or mentally ill. We have -- those are some of the really most challenging cases are the mentally ill clients that we're working with.

We also have to do a lot of financial management work with them people who basically cannot maintain their funds. Of our open cases, approximately 30 percent were representative payees on and that's why we're there. They can't handle -- we are managing their Social Security or their railroad retirement benefit funds, and I have a couple of cases that we have been payee on since the middle 1980s. We've been doing this for all of these years. We have some payee cases that are in their 20s. They're physically healthy, but mentally they're challenged or they're emotionally disturbed. They can't handle that money, and -- I don't know -- we could have that case 30 years from now, 40 years from now, even, because we do maintain some of them that long.

I do need to spend a little bit of time about what makes an Adult Protective Services case, because by regulation we have requirements, and to be accepted as an Adult Protective Service case, you have to meet three criteria. The first criteria is there must be some type of an impairment, a mental or physical impairment, so not just any person out in the community that needs a little bit of help with housing or whatever. It doesn't qualify. There must be a mental or physical impairment that we can identify.

Secondly, there must be a risk, some kind of a risky situation they're in. We are not a preventive service, and we end up doing a lot of preventive services after we, let's say, address that risk, deal with it, and see other needs that we get very much involved in, addressing those others' needs.

And the last section of this that must be met, and you must meet all three criteria, not one of three, the last one is there has to be no one able or willing to assist that client including active case managers, including other family members. I have a staff of 23 case workers that cover all of Suffolk County, and it would be -- it's quite challenging with our caseloads to do that, and I don't know -- these aren't my rules that you have to have all three of these criteria; these are the state's rules. And that last one is really -- would convey the following: If they have an active manager, that's not an APS case. If they're in a nursing home, that's not an APS case. If they are in assisted living where there's caseworkers involved there, there's people to work with them, that's not an APS case. So you have to meet all three of those particular requirements.

Now I always encourage people when I do this training, I said I don't want -- I spend a lot of time on those requirements. I'm touching them in a minute to you. That's usually about 20 minutes in my training. There's people struggle with those requirements. I tell everybody when I train them, I'm not here to turn you into APS caseworkers. I'm telling you this so you have an understanding. If you are concerned, I want you to call our intake unit. We get somewhere around 300 calls a month in intake. Of those, that usually turns into about somewhere between 95 and 120, 125 cases that actually will go to a caseworker that goes out in the field. Now what about those other 200 cases? Many of those phone calls are really informational and referral-type things. In fact,

this year -- I'm sorry, over the last year, I've gotten two letters from individuals simply telling me how grateful they were for APS and the case never got through the first person that picked up the phone call and spent, you know, 15, 20 minutes with the individual trying to help work them through, give them the proper referrals, give them some encouragement and be a good listening ear.

Of those hundred cases, what will happen is when that case comes in, when that intake comes in, when our intake screens that case and they spend a lot of time screening it and they'll even do some phone calls after that before it gets to the caseworker that goes out in the field, they'll check to see if there's mental health services, the person that is addressing those; they'll check to see if there's a public assistance case open, if there's active Medicaid, those types of things. We're trying to do that right upfront so that when our worker goes out in the field, they have an idea what this case is about. When it comes out of intake, they make a decision of whether it's an emergency or, in essence, we need to get somebody out within 24 hours or if it's something that we can wait towards the state-mandated 72-hour contact. I would have to say most of the cases are of the 72-hour nature because many, many of these referrals have to do with entitlements and need for that support to get that Medicaid, that -- housing issues. We do not have housing resources, but we certainly help connect people with housing and (indiscernible), and we'll help them go through applications for Section 8 and those types of things. We do a lot of advocacy work.

Our worker will go out. They will see that person, and within 60 days, we have to make a decision. The decision is whether or not we will open the case. That 60 days exists in Child Protective Services, but it's a completely different decision that's made there. Child Protective Services, they're looking to see if there's some credible evidence to support the allegation. We are not doing that. During that 60 days, we are trying to make a decision whether we'll open that case. Now during that 60 days, we do an awful lot of casework, and many, many times in that 60 days, we do enough work. We address that problem, and we can help them resolve it within finding community resources in most situations, and we do not actually open the case. We do what we call "resolve" it. You resolve the problem, and that case, we maintain a record on it so if something comes up in the future, we can go back to deal with that. If the case is open, it's open subject to six-month recertification period. If it gets recertified two times -- so now we've been working with the family for 60 days plus 6 months plus another 6 months, so it's a year and two months. If they want to recertify it again, that means a meeting not -- with the supervisor, the caseworker, and myself as the director, because we have to be able to move these cases along. We have quite an intake, and when I became director about four years ago, I noticed that there were some cases that just seemed to go on and on. Caseworkers did some wonderful work at the beginning, but, you know, the client wanted the visits and we just -- we can't afford to just continue visiting. We have more cases. So if we can identify work that we're doing, we identify needs that the clients have that we're addressing directly, of course we're going to keep those cases open. But that is one of my challenges: To try and keep moving these cases along so that we can meet these people's needs.

Just one or two quick things that are on your sheets here that I'm going to touch on. Family-type adult homes. That is a state program. It's somewhat like -- it's almost like foster care for adults. These are individuals that will live in a family setting. They participate in the family activities. They do have to go to a day program during the day, so you're not going to qualify if you're not going to go to a day program and participate in that. So sometimes people that have emotional disturbance or mental health issues, they don't always work well in family-type of day programs. This is a state program, but basically the state leaves it to Suffolk County APS to certify it, to recertify it, and oversee it. Most of the patients there are not made by us. They are people that are coming out of a hospital, so if somebody goes into the hospital, their medicals needs are met. Hospital social workers have to find a placement sometimes for them. They can't go home, and often the hospital social workers will actually make the direct placement in family-type adult homes. I only have one caseworker that handles those adult homes -- family-type adult homes in Suffolk

County. There's about -- I think there's 37 or 38 of them now and about 65 to 70 individuals living in them. They can have up to four individuals placed there, but not too many have the full placement.

I mentioned here financial management services. That is one of the services we give that goes beyond simply rep/payee and maintaining their Social Security and railroad retirement. This would be for any funds that come in, and my caseworkers will literally go out once a month and they'll sit with them, and if I don't bring the checkbook out and bring all the bills out, and they'll help them fill that out and they'll explain, and they'll help them budget, and these would be for clients that are functioning pretty well on other levels. We'll go in, we'll find a refrigerator full of food. You know, the house will be clean. They can tell us who their doctor was. They can tell us when the last appointment was and when the next one is coming, but when it comes to filling out and taking care of that budget and remembering to put money aside so you pay those taxes in six months, that's where their greatest challenge is. This would be more for the clients that we have that have dementia, challenges. That would be -- but some are also emotionally disturbed or have mental illness and some have both. We do provide that service, and those are some of those cases that can go on for quite some time. Sometimes we're fortunate, we find somebody in the community that will take over and give that assistance.

I do mention guardianship here, and I'm going to end with this for the purpose of time. Guardianship is the ultimate step we would take. In guardianship, we're basically saying -- we're saying you can't make decisions for yourself, and that's something I take very seriously as a director. Nobody even gets to pursue that without a meeting with myself, and we look at that. We have one worker who has been working in a guardianship unit for about the last six or seven years, has tremendous expertise in that she is our guardianship unit, the one individual, and we always have her go out. We just take that very, very seriously, of course. If you get a guardianship, everyone's different because there's about 30, 35 powers or so, and the judges will give -- well say, On this case, I'm going to give you powers one through six, but you're not getting seven through eight, you're getting nine, you're not getting ten through fifteen and so forth, so on. To make it very, very brief and quick, there's powers that can be given that have to do with property, and there's power that have to do with the person. Most of time when we're going for guardianships, it's for financial exploitations. We have too many of those cases, and they seem to be on the increase.

My last statement I would make is also our referrals, our direct referrals to the district attorney have gone up significantly over the last year and a half. I've sent more cases to the district attorney on financial exploitation last year than we did in the last two and a half years total prior to that, and we're on pace for about the same this year.

Thank you. That's an hour tried to condense into 10, 15 minutes for all of you.

**CHAIRMAN STERN:**
Thank you. So what I'm hearing, then, is if it's a case of someone not being able to manage their assets -- they cannot pay the bills or write the checks -- then those are services that your staff will provide. It's only on those cases where there is financial exploitation then that perhaps you are considering referring over to a guardianship proceeding. Is that --

**MR. FERGUSON:**
It could go guardianship or it could be a direct referral to the district attorney and given how that plays out, it could go guardianship. We have both tools, and you make a judgment.

**CHAIRMAN STERN:**
But in the -- I just remember that in the past that if there was someone who was in a position that

was not able to manage their finances, maybe there was no criminal activity, but someone was just incapable of being able to do that, then even those matters might have otherwise been sent over for the appointment of a guardian. But what you're saying is that it might not be necessary to go that route; that's a service that you and your staff can provide.

**MR. FERGUSON:**
We can provide that financial management service. Now, again, that would be for somebody that was in other elements of their life fairly competent. As I said, that was the person who the house is clean, they had food in the refrigerator, they can tell you who their doctor is, et cetera. Now if we have somebody that has problems with financial management and we're seeing some of these other issues, that would lead us more toward the guardianship. It's very hard to generalize because every case is so unique.

**CHAIRMAN STERN:**
Sure. How many people on your staff do you have providing that type of financial management?

**MR. FERGUSON:**
Well, that would be one of the services that those 23 individuals that are going out. Nobody -- I mean, they're all doing everything.

**CHAIRMAN STERN:**
I see.

**MR. FERGUSON:**
So the person that does some of the financial management is also going to be going out and dealing with the housing or dealing with the entitlement issues or dealing with the referrals. We do a lot of our work is to mental health agencies, if need be, or for Section 8, for all those types of things, that's an awful lot of our work there. A lot of our work is -- sometimes we do a lot of picking people up and transporting them and taking them to the doctors and sitting through that. You know, if they have some challenges, they can still live at home, but they need a little bit of help. I have staff that'll pick somebody up, spend all afternoon, take them to the doctor, pick up the prescription on the way home, go to the pharmacy, get the prescription filled out, and bring it back to them. We do a lot of work also in terms of home care, a lot of times helping people make connections to get visiting nurses and home care services into the homes.

**CHAIRMAN STERN:**
So if financial management is a need in any of the case that any of your caseworkers are handling, then they would provide those service.

**MR. FERGUSON:**
Correct, if it was so identified.

**CHAIRMAN STERN:**
Okay. Presiding Officer.

**CHAIRMAN GREGORY:**
Yes. Thank you, Mr. Chair. I have a question. These three criteria that you referred to, is that a self-imposed, or is that some type of state statutory --

**MR. FERGUSON:**
That's the state regulations.

**P.O. GREGORY:**
Okay; because I -- we had a situation where someone in my office that visited my office -- not even just my particular office but the district office for years. She was a rape victim, and she received a TBI as a result of the rape and slowly deteriorated over time. She was a hoarder. She had a bunch of cats. There was feces all over her. She lived in a trailer, trailer park that's being redeveloped right now. And, you know, we had referred her for services, but she didn't meet, according to your staff, the three criteria, and if you talk to her for five minutes, she'd seem like everything was okay, but that ten minutes, it's like everything was off the -- I mean, that's what happened. She was literally in her office, and someone was talking -- we called CPEP. They came out with their mobile unit. I mean, she was talking to the radio. And at first, we said, No, you've got to sit with her, and at first, they sat with her and said, Oh, no, she's fine; and when that eight-, ten-minute mark came, she was like, Do you hear that? And that's what they started cluing in, and eventually she ended up being placed somewhere. She had the other signs. She would mail out her bills. She would sign a piece of paper, I'm paying my light bill; you know, obviously it would come back and it wouldn't be paid, but she needed help, and because of the criteria, we weren't able to help her and she just really deteriorated.

So it's difficult to see that happen and because of this criteria, I imagine she's not the only person that falls into that realm. And, actually, she didn't have family, but she had some neighbors that were helping her, and they were actually coming out of their pocket to pay for things, and they ended up being investigated because she was collecting Social Security and somehow there was a wife and a husband, they were able to get onto there because they would go to the bank and they would withdraw monies to help her pay for things, but they thought they were abusing her or taking advantage of her. It was a whole thing, and it wasn't. They were very caring, giving people, and we were trying to get them services but we couldn't, so I was hoping what you could say is that this is some type of criteria that we self-imposed --

**MR. FERGUSON:**
That is the state criteria. What you're describing is very familiar. We have lots of cases of that nature. I mean, I would have to -- you would have to maybe call me directly and obviously we can't discuss it here, but I would certainly be willing to look into that. Have a staff member give me a call.

**CHAIRMAN STERN:**
Legislator Anker.

**LEG. ANKER:**
Again, I want to thank you for the work that you've been doing. You provide a safety net for those people here in our county that desperately need it. Just a couple quick questions. Do you work with social workers that are interns at our colleges? I was just wondering.

**MR. FERGUSON:**
I will tell you this: The last two years, I have given this training up to the hour to social work students at Adelphi, so twice I have done that.

**LEG. ANKER:**
So do they come in and they work with you? Because I just can't imagine doing all this work with 23 people in your department. It's amazing what you can accomplish.

**MR. FERGUSON:**
We have -- they have interns in Department of Social Services, more in the children's services areas. In fact, when I was in children's services, I spent many years there. I actually oversaw those units. I think there was some discussion of possibly getting somebody for APS. That would be new.

That's not on the table at this moment.

**LEG. ANKER:**
Okay. Well, if you do want some help with that, I'd be more than happy to assist you. The other question would be dealing with not-for-profits. Do you work with not-for-profits, churches, you know, other organizations that provide help?

**MR. FERGUSON:**
Okay. The way I'd like to answer that is just to tell you very briefly about myself. I'm hitting my 40th year with Social Services July 1st; 35 of them were children's services, so I'm only APS for five. What I would like to say to you is that the APS staff, by nature of the job, has to be so cognizant of the community; you know, much more so than children's services, we're so focused on court orders and acting according to what the court is asking them, so our staff is -- we do tremendous work in the communities. We do a lot with VIBS. VIBS, for instance, just has brand new program that basically they and we developed together. For the first time, we have a program in domestic violence that is there to help not only the victim but to help those that want to help the victim. You get family members that say, I'd like to help, they make a report, I'd like to do my part, but there's nobody there for them. We've developed that program. We've also developed a program with VIBS for early-onset dementia that did not exist in the past. That's brand new this year, so we're kind of excited about -- we have some programs we didn't have in the past.

**LEG. ANKER:**
Okay. And, again, just to remind you, if there are programs and organization that you feel truly benefit Suffolk County, it'd be good for us to know because we decide on the money allocated to those organization, and at times we really don't know what is the connection, you know, what do they do for the county. So we've heard a lot of wonderful things about VIBS and some of the organizations, and we thank you greatly.

**MR. FERGUSON:**
You're welcome.

**LEG. BARRAGA:**
Certainly I can see how your organization is a tremendous benefit to someone who is elderly and living alone who need assistance, especially from a financial perspective. But in my experience, in most cases where there's a caretaker involved, they are often the ones paying the bills for their elderly parents. Sometimes they have power of attorney, and sometimes, frankly, they don't; but they get involved heavily in the financial end of the business. Has that has that been your experience?

**MR. FERGUSON:**
The cases that would come to us, again, the third criteria is there's nobody able and willing to assist.
**LEG. BARRAGA:**
I understand that.

**MR. FERGUSON:**
Now that criteria is very -- it's very flexible.

**LEG. BARRAGA:**
I think there's a large number of people out there that wouldn't qualify for all three criteria because they're already taking care of it, whether it's totally legal or not, but they're taking care of it.

**MR. FERGUSON:**
Well, we certainly get those situations where it's questionable. Now a lot of the financial

exploitation cases, we were involved in a study that the state did, and I sent about 20 cases up to them for review last year, and it was all on financial exploitation because there's a tremendous amount of concern about that. And sometimes it's caring people that start to help out and then unfortunately see an opportunity and take it, so we'll get involved in those.

In terms of involvement when another party is stepping in, I'm sure there's some; I don't think there's a lot, because somebody is providing and that's the rules that we have. But there sometimes will be involved particularly if that individual that's helping with the finances is out of the county. I've had situations where a daughter in New Hampshire is monitoring that, but there's still other needs, and we've been involved in some of those other needs.

**LEG. BARRAGA:**
One final quick question. We can prove this abuse on part of the caretaker in terms of the elderly person that they're supposedly taking care of from a legal perspective, and charges, I assume, can be brought against the caretaker. Now if that's the case, what happens to the elderly person that they're supposed to be taking care of? If the abuser can no longer be in the same household, what happens to that elderly person? I've run into some problems with that in the past where the elderly person puts up with the abuse because they just don't want to leave their home, they don't want to go to a nursing home. What is the outcome of a situation like that?

**MR. FERGUSON:**
Every one of them is really hard, and every one of them -- I wish I could give you -- I can't give you a general answer because every one of them is so unique. I mean, one of the things that we're mandated to do is to see if we could find somebody else to help. If I could share just one quick example with you where we had a scenario somewhat like that, and the elderly person was in the hospital for medical needs, and my worker went there and we knew the situation at home, it's really something that we could not bring her back to. And again, Sergeant Byrne mentioned it, sometimes we find out when they are at the doctor's office or they're in the hospital, and the social workers are saying, Okay, you're ready to go home, tell us about your home, and all of a sudden, it's an issue.

In this situation, my worker went there and the client asked her if she could go to her house to pick up her pocketbook, and she gave her permission to go there, and somebody got the door. She picked up the pocketbook, and when she picked up the pocketbook, there was a little piece of paper on it and a first name. Nobody -- we knew nothing about this person. We went, asked the client, and she said, Oh, that's my daughter, I haven't talked to her in 15 years. Well, my worker got on the phone, called the daughter and found out that our client had early-onset dementia and found out that our daughter -- that daughter had been trying to maintain contact with the client and sometime they came apart. Well, she needed a nursing home placement, and the daughter happened to work as a nurse in a nursing home upstate and said, I'd be glad to facilitate this. So sometimes we have happy outcomes like that. We're certainly going to try those things. It's very, very difficult. It's very difficult, and often they have to end up with -- we try to get the PRIs so we know the level of care that we approach. Resources are challenging.

**LEG. BARRAGA:**
I've had situations where the outcome is not as happy as that --

**MR. FERGUSON:**
I'm sure there are.

**LEG. BARRAGA:**
-- where the elderly person still wants to go back and, in essence, putting up with what I would classify as abuse just to avoid going to a nursing home, just to avoid leaving their home that they've

been in for, like, 50 or 60 years. It's a real rough road. That's okay because we have to go --

**MR. FERGUSON:**
But that's an appropriate -- see, when they go back, that would be an appropriate case to send to us. We'll look at that.

**LEG. BARRAGA:**
All right. Thank you.

**CHAIRMAN STERN:**
Okay. Thank you to the both of you for being with us today. An ongoing, critically important issue. We talk about all the challenges, but at the same time, I think it's important to note that because of your efforts in Suffolk County is well-known and well-recognized throughout New York State as having some outstanding individuals and, of course, an outstanding program to deal with these many issues; which of course, Sergeant Byrne, I agree with you, that we can do as best we can but just based on the sheer numbers and an aging population all the other challenges that go along with a family situation particularly these days, it will be a problem on the rise. So I thank you both for being with us today and all of your efforts.

We do have an item on the agenda.

It is **IR 1506, Establishing December 15th as "Silver Star Medal Day" in Suffolk County. (Muratore)** Legislator Muratore.

**LEG. MURATORE:**
Motion.

**CHAIRMAN STERN:**
Motion to approve by Legislator Muratore. Second by Legislator Anker. All in favor? Any opposed? Any abstentions? IR 1506 is **approved. (VOTE: 6-0-0-0)**.

There being no other business before the committee, we are adjourned. Thank you.

***(*The meeting was adjourned at 2:17 p.m.*)***