NATIONAL ADULT PROTECTIVE SERVICES ASSOCIATION
THE NATIONAL APS RESOURCE CENTER

Technical Assistance Brief

Working with Cases Involving Mental Illness

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The National Adult Protective Services Resource Center (NAPSRC) provides monthly Technical Assistance (TA) calls on subjects requested by the field. Our team of adult protective services (APS) experts provides this national TA to state APS administrators. This brief summarizes the information provided during the April 2015 call.

Introduction

In response to a Technical Assistance (TA) request, the NAPSRC has undertaken steps to assist adult protective services (APS) programs in understanding and addressing cases involving alleged victims or perpetrators displaying symptoms of mental illness. State APS administrators were surveyed regarding their programs' experiences with mental health cases. Results were compiled, analyzed, and distributed. Our April 2015 TA call was devoted to this topic. This TA Brief addresses issues involved in APS program planning and service delivery.

Mental health Cases Challenge APS Practice in Multiple Ways

Practice reveals that cases involving mental illness are routinely reported to and handled by APS. Mental health problems experienced by victims as well as perpetrators can influence and complicate both investigation and intervention methods.

When Victims Suffer Mental Health Conditions

Situations commonly encountered in APS include alleged victims with either long-term or recent onset mental illness. The increased vulnerability of people with psychiatric illness to victimization is illustrated by findings from a National Institute on Aging-funded study (Ramsey-Klawsnik, Teaster, and Mendiondo, 2008). Among 412 alleged victims of sexual abuse residing in care facilities who were reported to APS and state regulatory agencies over a six-month period, 41% had a diagnosed psychiatric disability. While certain diagnoses such as Delusional Disorder are associated with irrational thinking and ungrounded beliefs, investigators must avoid assuming that abuse disclosures are the result of illness-induced misperceptions. Would-be perpetrators perceive people with psychiatric diagnoses as "easy victims" and the lack of credibility generally afforded to people with mental

About the National Adult Protective Services Resource Center (NAPSRC)

The National Adult Protective Services Resource Center (NAPSRC) is a project (No. 90ER0003) of the Administration for Community Living, U.S. Administration on Aging, U.S. Department of Health and Human Services (DHHS), administered by the National Adult Protective Services Association (NAPSA). Grantees carrying out projects under government sponsorship are encouraged to express freely their findings and conclusions. Therefore, points of view or opinions do not necessarily represent official Administration on Aging or DHHS policy.

health problems increases their vulnerability to abuse. Careful forensic attention is required to distinguish valid disclosures from those resulting from a psychotic thought process.

Cases in which alleged victims display psychiatric symptoms but have no formal diagnosis and have not been clinically evaluated can be even more complex than those in which a mental health diagnosis exists. Intense fear of being psychiatrically labeled and treated, often accompanied by the conviction that there is nothing wrong with their thinking processes, can cause these individuals to be unwilling to undergo clinical evaluation. Additionally, stigma causes many who suffer mental illness and their families to conceal problems and avoid seeking help.

Mental health factors also impact APS practice in the following way: Sustaining abuse can result in multi-faceted, extensive, long-lasting psycho-social trauma. Some victims who were free of mental health symptoms prior to abuse qualify for a mental health diagnosis as an abuse consequence. To illustrate, The MetLife Mature Market study (2011) found that some financial exploitation victims developed depression post-abuse. Burgess, Ramsey-Klawsnik, and Gregorian (2008) demonstrated that older victims of sexual and related abuses experienced the onset of symptoms of Post-Traumatic Stress Disorder including sleep disturbances, incontinence, increased anxiety, crying spells, withdrawal, depressive symptoms, startle reflex, agitation, restlessness, decreased enjoyment in activities, and intrusive memories.

Illustrative Case - Mrs. T., age 79, was reported to APS for self-neglect because she made numerous 911 calls seeking police protection from "invaders" whom she believed had taken over the attic of her home. Officers described her as "harmless but deranged." They found no evidence of "the little people" that Mrs. T. claimed had designed a siphoning system to steal the natural gas used to heat her home. Mrs. T.'s delusion (false belief) resulted in her refusal to pay the gas bill, termination of gas service, and no heat in her home in the frigid New England winter. The APS investigation revealed that despite evidence to the contrary, Mrs. T. was convinced that she was being victimized. She was unwilling to consent to an evaluation and dismissed the notion that she could be in need of treatment (adapted from Ramsey-Klawsnik, 2008).

When Perpetrators are Mentally Ill

Psychiatric problems displayed by perpetrators may represent long-term diagnosed or undiagnosed conditions or recent onset accompanied by significant behavior changes. Assisting victims who love, are loyal to, and want to protect an ill but dangerous family member who abuses them is particularly fraught with challenges. These victims often experience a combination of strong emotional attachment to, and perceived duty to protect and care for, mentally ill kin. Some victims find ways to minimize the danger their disturbed family member creates while others have few if any viable options for self-protection.

Crises are Common in the Lives of People who are Mentally Ill

Like physical illness, mental illness contributes to high stress in the lives of those afflicted and their significant others. Simultaneously, many forms of mental illness reduce effective coping and problem-solving strategies. Crises are normal in the lives of people who are psychiatrically ill, and particularly so for those with serious mental illness (SMI) such as Schizophrenia and other psychotic disorders, Bipolar disorders, and Major Depressive Disorders. SMI results in serious functional impairment that substantially interferes with or limits one or more major life activity such as earning a living, managing a home and money, and getting along with others. Long-term and specialized services (such as medication and case management and housing support) are typically required to help people with SMI remain stable and effectively meet basic and interpersonal

Illustrative Case - Mrs. Evelyn W. has been referred to APS on several occasions by family members concerned about her safety due to the presence of her son, Lester, age 56, in her home. He is chronically unemployed, has no income or home of his own, and no friends. He is addicted to alcohol, clinically depressed and exhibits temper outbursts and behavioral problems. Over the years, he has received brief periods of psychiatric treatment. Evelyn tolerates Lester living with her but is distressed by his drinking and bizarre behavior including covering the walls of his bedroom with sexualized drawings. When drinking he becomes sexually offensive and frightening. It was easier for Evelyn to get by on her limited income during the months when Lester wasn't living with her - eating her food and demanding money for alcohol and cigarettes. APS previously helped Evelyn to evict Lester but she is reluctant to again take this step fearing that he will die on the streets or be incarcerated (adapted from Ramsey-Klawsnik, 2006).

needs. Personal and family crises are more frequent and severe without specialized and ongoing support and treatment. When there are no services in place, mental health crises are often referred to APS, especially if self-neglect or dangerous acting out towards other vulnerable adults occurs.

Challenges Faced by APS

Herein lies a major problem: APS programs and their staff are not typically trained or equipped to deal with mental illness. APS is not designed or funded as a mental health emergency service. It not only lacks the resources, it lacks the legal authority to coerce public or private care systems to take responsibility for people in crisis requiring psychiatric and related services. Additionally and significantly, APS staff cannot coerce clients into submitting to psychiatric services. Involuntary mental health commitment can be obtained only in very limited circumstances and by specified personnel, typically police officers and mental health professionals. Evidence of clear and present danger to self or identified others must be demonstrated and civil rights are protected by a number of requirements, including legal representation for the individual and court review. The purpose of commitment is short-term stabilization to prevent suicide and imminent danger to identified others.

A further APS complication is that dual diagnoses or problem situations are common, including mental illness coupled with developmental or other disabilities, dementia, substance abuse, or hoarding. The more layers of disability and illness present, the more frequent the crises tend to be and the more complex the needed intervention.

Mental Health Treatment Limitations

While therapy services can and do help many people, psychotherapy cannot reverse or heal aberrations in brain functioning believed to be present in SMI. Psychotropic medication can often help to control troubling symptoms but causes side effects for many. Additionally, there are psychiatric conditions that are not amenable to chemical control. Often a "cure" is not possible and the best outcome is helping the individual learn to manage the illness and function to highest level possible. Building in ongoing support services for the diagnosed individual to avert and respond to crises is essential. Additionally, family members and others who live with and provide assistance to the diagnosed individual need support.

Let us know what you think of this brief. Please take a quick six question survey.

NAPSRC Mental Health Survey Findings

APS programs and their staff are not typically trained or equipped to deal with mental illness. APS is not designed or funded as a mental health emergency service.

Our brief nationwide survey of APS administrators produced a response rate of 54%. The most common challenges reported in managing cases involving mental illness were: insufficient resources (lack of client housing, placements, in-patient care, and mental health services); clients refusing services; lack of staff training and expertise regarding mental illness; and need for better collaboration with the mental health and related agencies.

Only 26% of the respondents have mental health consultation available to their staff statewide while another 11% have this only in limited areas. Three states have contractual arrangements with clinicians to consult on complex cases. Other states (5) have informal arrangements with clinicians in limited areas. Among the programs that have mental health consultation, 75% have found it helpful.

Most of the respondents (78%) have one or more multi-disciplinary teams operating but only half have a participating mental health clinician.

Only one-quarter of the respondents track mental health data. Among the four states that provided this data, on average 31% of victims had a mental illness. Only three states provided data regarding perpetrators displaying mental illness yielding a mean of 13%.

APS System-Level Suggestions

Data is essential for demonstrating the existence of a social problem and the need for resources to address it. It is significant that presently only one-quarter of the statewide APS programs that responded to the NAPSRC Mental Health Survey collect and analyze data regarding cases involving mental illness. Practice reveals that APS frequently handles mental health cases and that many are difficult to resolve. Therefore, the careful collection and analysis of data regarding APS victims and perpetrators demonstrating mental illness is warranted. The National Adult Maltreatment Reporting System (NAMRS) is a voluntary national APS data collection system being developed with funding from the Department of Health and Human Services. Up to 60 case-level data elements will be collected from states able to submit some or all of those elements. Information on victims, perpetrators, types of abuse, and services provided will be collected, including mental health elements regarding both victims and perpetrators. This data will likely prove useful in justifying needed resources, collaborations, and program planning to effectively manage mental health cases confronting APS.

In recent years, APS programs have expanded their use of consultants as subject matter experts to help staff analyze and intervene in highly complex cases. Many programs now have access to specialists such as nurses, forensic accountants, and clinicians skilled in conducting cognitive capacity evaluations. Our survey revealed that few states have clinicians to consult on complex mental health cases but that most programs with this consultation have found it helpful. Obtaining consultation from qualified mental health clinicians within APS programs is highly recommended. Clinicians can be educated to understand APS program goals, challenges, and limitations and can then advise on policies relative to handling mental health cases, problem-

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solve especially complex cases with supervisors and workers, serve as liaisons between APS programs and mental health services, train staff regarding diagnoses and medications and treatment/case management approaches, and assist staff to assess client and worker safety and dangerousness.

Casework and Supervisory Strategies

When handling challenging cases involving people who have mental illnesses, it is helpful to remember that no one choses to become psychiatrically ill. People who have a mental illness and their families suffer tremendously. We can forget this when dealing with the challenging behaviors that can accompany mental illness. Behaving in a trustworthy manner, treating people with respect, and honoring right to self-determination is essential to building rapport, the first step in providing assistance. Offer options and choices and expect fear-based behaviors that may not make sense to observers. Do not belittle symptoms or suffering and provide encouragement that things can improve. Assess client needs, worries, problems, and goals and offer possible solutions that may be tolerable to the client. Practitioners may find it helpful to review the video: "A Mother Never Gives Up Hope" (Terra Nova Films, 2009) when working with victims like Mrs. W. who was mistreated by her mentally ill adult son.

When working with clients who display delusional thinking (as in the example of Mrs. T.) refrain from either challenging or appearing to join in false belief(s). Express concern for the impact of the belief on the client and attempt to problem-solve with the client and involved caring others. Express concern for the client's anxiety, fear, upset, and worries. Ask clients if there are people whom they trust that you may contact. Try to connect them with sources of help they can tolerate (MD, clergy, senior center, neighbor, family member). In Mrs. T.'s case, expressing concern for the upset and worry that plagued her (instead of either telling her that she was mistaken or appearing to believe her account) led to Mrs. T. cooperating with APS services. Mrs. T.'s adult daughters, physician, and local senior center were involved in the intervention plan. The daughters increased their social support to Mrs. T. and the physician arranged for a psychiatric nurse practitioner to evaluate and prescribe anti-psychotic medication. Both interventions were helpful, along with APS negotiating (with Mrs. T.'s consent) to restore gas service. Mrs. T. also was referred to and joined a group that met regularly at the senior center to further reduce her social isolation and thereby facilitate remaining stable and oriented.

Expect that workers struggling with mental health cases will require careful and perhaps intensive supervision. It can be very challenging to build casework relationships and successfully intervene with clients demonstrating certain diagnoses, such as Personality Disorders or Major Depression, and symptoms such as delusional thinking. Increased support and guidance from a skillful supervisor is invaluable in helping workers to create and implement effective casework boundaries and intervention strategies.

APS Role in Mental Health

There are key steps that we can all take to maximize our mental and physical health. Critically important are good nutrition, having a safe living environment, enjoying social interactions and support, exercising regularly, and otherwise engaging in a healthy life style. When our basic needs are met, both physical and mental health is optimized. APS programs are hard at work every day helping their clients achieve these steps and in this way contributing to the optimal mental health and functioning of their clients.

Citations

Burgess, A., Ramsey-Klawsnik, H., & Gregorian, S. (2008). Comparing routes of reporting in elder sexual abuse cases. *Journal of Elder Abuse and Neglect, 20*, 336–352.

MetLife Mature Market Institute. (2011). The MetLife study of elder financial abuse: Crimes of occasion, desperation, and predation against America's elders. Report for MetLife Mature Market Institute.

Ramsey-Klawsnik, H. (2008). Late onset mental illness. *Victimization of the Elderly and Disabled, 10*(6), 81, 94 – 96.

Ramsey-Klawsnik, H. (2006). Victimization of elders by offspring. *Victimization of the Elderly and Disabled, 9*(4), 51 – 52, 64.

Ramsey-Klawsnik, H., Teaster, P. & Mendiondo, M. (2008). Researching clinical practice: Findings from the study of sexual abuse in care facilities. *Victimization of the Elderly and Disabled, 11*(2), 17 – 18, 24, 28, 31.

About the Author

Dr. Holly Ramsey-Klawsnik is a sociologist researcher, Licensed Marriage & Family Therapist, and Licensed Certified Social Worker. She has provided secondary prevention services to older adults and adults with disabilities and conducted forensic evaluations and investigations for APS and court systems. She has presented continuing education programs for Adult Protective Services systems, regulatory and law enforcement agencies, health care providers, the judiciary, and domestic violence and sexual assault coalitions. Her research and practice have focused on investigating alleged abuse, interviewing skills, casework intervention and supervision, mental health and mental capacity, self-neglect, domestic violence and sexual assault in later life, and victimization in facilities. Employing quantitative and qualitative methods, she has researched APS case handling procedures and outcomes. She has authored journal articles, book chapters, training curricula, technical assistance materials, and professional reports and has also developed caseworker and supervisory training manuals for multiple APS systems. Holly has served as a contracted trainer and consultant for APS and regulatory systems nationwide.