

Clinical Mental Health Outreach to Older Adults:

Serving the Hard-to-Serve

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Abstract

Psychologically impaired older adults face significant barriers to accessing services. Those who are suspicious of outside intervention are particularly difficult to serve but are at risk of elder abuse, homelessness, premature institutionalization, and decreased quality of life. This article describes a project in which trained clinicians provide relationship-based mental health assistance to hard-to-serve older adults, including: 1) victims of elder abuse in long standing, interdependent relationships who are hesitant to set limits on abusive family members and 2) older adults who are delusional and suspicious, and often refuse services due to their fearfulness.

Key words: older adults, outreach, clinical, mental health

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Providing older adults adequate mental health services continues to be challenging. Approximately three percent of older adults have a diagnosable depression, twenty percent have clinically significant depressive symptoms, six percent have an anxiety disorder; and 5 to 7 percent have a dementia, often complicated by mood disorder, psychotic symptoms and/or behavioral disorder (APA, 2004). Over the past 3 decades, mental health advocates for older adults have begun to address the shortage of services. Medicare, the primary health insurance for older adults, now reimburses for licensed psychologists and licensed clinical social workers providing mental health care. Gero-psychological continuing education training is now a licensure requirement for many mental health professionals.

However, while approximately twenty percent of older adults suffer from significant symptoms of mental illness, as many as two-thirds are untreated (Rabins, 1996; Report of the Surgeon General, 1999). Barriers to service include lack of information, physical frailty and lack of mobility, lack of finances, lack of lingual and cultural appropriateness of services, as well as cognitive, emotional and attitudinal issues (Report of the Surgeon General, 1999; Yang & Jackson, 1998). Some particularly difficult barriers are: 1) entrenched, emotionally dependent relationships in which elders feel unwilling to set limits on abusive behavior; and 2) suspicious or paranoid thinking, rendering the elder frightened of receiving services. An example of the former is L.B., a 76 year old post-stroke woman who lived with her 47 year old son. A Vietnam Vet with PTSD, he hit her intermittently her. Although her daughter asked her to come live with her, LB would not do so, saying her son “couldn’t help himself” and she worried about who

would take care of him if she did move in with her daughter. Four to six percent of older adults are victims of elder abuse (Wolf, 2000), and approximately 2% - 4 % suffer psychotic delusions or paranoid symptoms (Rabins, 1992). This article will describe a project conducted by The Center for Aging Resources in Pasadena, California, that targets mental health outreach to these particularly underserved older adults.

The Center's Mental Health Outreach Project developed out of more than 20 years of collaboration with the local police department in which mental health clinicians provided counseling to older adult crime victims. Victims of familial abuse and elders experiencing delusional and suspicious thinking were especially hard to serve with traditional mental health approaches. Elder abuse victims were often reluctant to separate from abusive but loved family members, due to mixed feelings of fear and love, concern over having "no one else" to take care of them, feelings of guilt, etc. Delusional, suspicious older adults often complained that a crime had been committed against them, but the police could not substantiate the complaint. For example, Mr. X. called the police department on the average of once a week, complaining that people had broken into his home through the air conditioning system, and stolen money, magazines and heirloom jewelry. The police could find no evidence of robbery, and did find his home piled high with various belongings. These delusional seniors were often socially isolated, in early stages of memory decline, and had a hearing or vision impairment. They had multiple practical, as well as emotional and social needs, and concurrently, were extremely reluctant to accept services.

While difficult to serve, these two subgroups of older adults are also in great need. They are at risk of eviction, homelessness, premature institutionalization, premature guardianship, elder abuse including self-neglect and decreased quality of life. They may be capable of

remaining safely in the community if provided the appropriate support, but frequently refuse help due to their mental illness and/or entrenched family relationships. Under traditional service delivery approaches, when offered “counseling” or “psychotherapy” these individuals refuse. However, they are often open to establishing a relationship, when the clinician comes to the older adult at a slower pace and in a non-threatening manner. The clinician may initially be refused access into the home, but the older adult will often talk with the clinician “through the screen door.” The Center formalized this approach and developed its Mental Health Outreach Project.

The Intervention

This project provides ongoing, long-term clinically sensitive outreach and intervention. Given that the barrier targeted by the project is one of hesitancy, fear and ambivalence the key to diffusing this barrier lies in the interpersonal relationship between the older adult and the clinician. By slowly and gently developing trusting relationships, clinicians help seniors toward gradual stepwise change. While the concept for the program initiated out of a police contract, generous financial support from the Archstone Foundation enabled the Center to develop and implement a protocol for clinical mental health outreach, and additional funds from the S. Mark Taper Foundation have enabled the Center to continue this outreach.

Clinician Recruitment:

Well-intentioned community workers who are not equipped with mental health expertise often conduct outreach to severely mentally ill clients. Engaging and providing consistent, ongoing services to these reluctant elders requires a highly clinically trained interpersonal approach, and an ability to conceptualize and plan intervention from a mental health perspective. Clients with “major access barriers” need clinicians with “highly developed clinical skills”

(Trejo, 2000). Project clinicians must have significant prior experience with psychiatrically ill persons, be able and willing to work in a nontraditional manner, and have the personal maturity to be persistent in the face of rejection. Over the first several contacts, the older adult may give very mixed messages to the clinician. For example, on the first phone call, Mr. W. agreed to a visit “anytime,” but when the clinician arrived, Mr. W. got angry, said he had been sleeping and slammed the door. The project hires masters’ and doctoral level mental health clinicians with several years of graduate education and clinical experience.

Outreach and Participant Recruitment:

Through networking meetings and one-on-one contacts, project staff actively introduce the program to professionals and paraprofessionals in the community who work with at-risk, isolated, abused and delusional elders. This includes law enforcement, Adult Protective Service workers, case managers, postal carriers, physicians, apartment managers, senior center staff, clergy, hospital discharge planners, paramedics, local code-enforcement personnel, etc. These “gatekeepers” (Florio & Rauchko, 1998) are encouraged to call the Project Director when they learn of at-risk elders who need but refuse help.

Initial Outreach Contacts with Elders:

Third-party referrals precede initial contact since these individuals seldom self-refer. The project’s Director gathers information from the referring party and attempts telephone contact with the referred individual to initiate a relationship and gain the individual’s verbal consent to a visit by the clinician. The Director further evaluates the needs of the individual and then assigns a clinician. The clinician approaches the older adult, either by phone or in person, after consultation with the Director. The clinician proceeds only if the elder gives consent for a second visit or telephone call. When the relationship between the elder and the referring party is

one of trust, the clinician will highlight to the elder that the referring party suggested the clinician visit or include the referring party in the first meeting.

Initiating contact with the identified elder is a critical and sensitive aspect of successful intervention. The individual's hesitancy to accept outside intervention may relate to: fear of professionals trying to remove him, her or a loved one from the home, fear of being placed in a "nursing home," having sought help from the professional system and being disappointed in the past, previous experiences of victimization by authority figures, for example child abuse, organic or environmentally induced paranoia. Beginning with the initial contact, clinicians are alert and sensitive to the individual's wishes, concerns and fears, particularly about who the identity of the clinician. Clinicians state the Center's name, offer a business card or picture identification and tell the individual the type of services the Center provides. Clinicians allow the elders time to process the information and then inquire about their thoughts. Clinicians listen and follow the elder's lead as to how to proceed.

Project clinicians initiate contact in an informal, friendly, non-threatening manner. Significant time is spent carefully and gently drawing out the elder, developing an in-depth understanding of why the elder has been reluctant to receive help in the past. Clinicians troubleshoot threats to developing trust, thoughtfully responding to the older adult's questions. The elder may question the clinician's intent, such as whether the clinician was sent by a son or daughter of whom the elder is distrustful, or whether the clinician wishes to put the elder into "a home." The elder may question the clinician's beliefs about the delusions. For example, the older adult may challenge the clinician as to whether the clinician believes there really are "rabbits in the attic" or "ghosts poisoning the food." The project emphasizes validating the elder's affect, while neither challenging nor affirming the content of the delusion. This could

take the form of affirming the elder's perception of the rabbits and empathizing with the threat and aggravation related to the rabbits, while not directly engaging whether or not the rabbits are real.

On the first visit, the clinician informally evaluates the older adult for multiple needs, including: medical, nutritional, social, mental health and housing, as well as emergent needs such as suicidality, elder abuse and potential violence towards others. (e.g., Gelman & Pederson, 1993). The clinician defuses any imminent crisis and determines practical services needed.

As the clinician begins to establish a relational context for continued outreach and service, he/she assesses the elder's receptivity to continued contact. Offering more contact or services than the elder is open to may overwhelm the elder, while offering too little may lead to disappointment and withdrawal. The clinician proposes to follow-up with the elder in person or by telephone, depending on the senior's level of receptivity. Initial outreach contacts generally require several hours per week over the first 3 to 4 weeks. In the case of Mr. W., mentioned above, after Mr. W. slammed the door, the clinician called again some days later and rather than encourage a face to face visit, suggested a follow up phone call for the following week. Weekly check-in phone calls were conducted for 3 more weeks before another visit was suggested.

Ongoing Clinical Interventions:

If the individual is receptive to further contact, clinical interventions are conducted with the goals of defusing current crises and resolving problems that interfere with ongoing safety, independence and quality of life. The clinician develops a specific treatment approach in consultation with the supervising psychologist and outreach team. Interventions begin with careful, non-reactive listening and patient relationship building. As the elder's demonstrated interest in clinical mental health outreach increases, the clinician works with the elder to forge a

successful link to needed services (for example legal help, in-home supportive services, meals, emergency cash, friendly visitors, medical attention (including tools such as vision and hearing aids), social opportunities, etc.). The developing working alliance of the elder and the clinician allows the clinician to begin to form a bridge to other service providers. At this time, prior to introducing another agency, the clinician will request consent to make the referral, either verbally or in writing. For example, Mrs. A. had become isolated from neighbors and relatives due to her paranoid thinking. She had stopped going to medical appointments and had difficulty walking to the grocery store and paying her bills. As an outreach clinician approached her, Mrs. A.'s fear of relational contact was so severe that during the first several months of contact, the elder permitted only semimonthly contact, and only talked with the clinician on the phone or the porch. After six months, the elder engaged in weekly visits and allowed the clinician inside her home. After one year, the clinician facilitated the older adult's acceptance of a case manager to oversee the elder's practical needs and a driver to take her to the doctor and grocery store.

When possible, clinicians refer concrete needs to case management agencies that specialize in case management for frail elders. However, when referral to another agency is likely to rupture the fragile working alliance between elders and clinicians, project clinicians apply their psychological expertise to provide case management directly. Meetings with family members and/or alternate significant others are pursued when expected to be helpful and permitted by the elder. Contacts are arranged in whatever manner maximizes the older adult's comfort (e.g., in-home, at their doctor's office, in a community center, on the street corner, etc).

One project goal is to encourage the elder to consider traditional psychotherapy. If the elder is willing, he/she is engaged in psychotherapy by the clinical outreach clinician. A disruptive transfer to a new mental health professional is avoided. Continuity of relationship is

critical to retain and build upon the trust developed between elder and clinician. When non-mental health professionals have been employed as outreach workers, elders often declined further services when contacted by the new therapist, feeling injured by the loss of the relationship with the trusted outreach worker and fearful of a new relationship.

Clinician Training and Supervision:

Clinicians meet weekly with the supervising psychologist to discuss clinical approaches and interventions. Weekly clinical staff meetings provide emotional support and brainstorming to generate additional clinical suggestions. These needy yet reluctant elders often provoke anxiety in, and can be demoralizing and emotionally taxing to the clinicians.

Community Consultation:

Project clinicians also facilitate service provision by providing emotional support and psychological education to other professionals who serve older adults, thus maximizing the possibility of elders' acceptance of needed services. For example, in the case of Mrs. A., the clinician helped the social worker tolerate the elder's repeated refusals to accept help and the elder's verbalized perception that the social worker was "evil." Without this team approach, the social worker would have more likely terminated services and/or acted defensively with the hard-to-serve elder, thereby solidifying the elder's refusal of services.

Aspects of a several other mental health projects were incorporated into this one including: 1) use of nontraditional community members to identify and refer older adults like the Gatekeeper Case Finding Model, in Spokane, Washington (Florio & Rauschko, 1998); 2) active interagency collaboration to identify cases and coordinate care such as that found in the Midlands Older Adult Access Program in Lexington County, South Carolina and The Masters Program of Valley Mental Health in Salt Lake City, Utah (WICHE, 2005); and 3) relationship-

building techniques similar to those used in the Outreach to At-Risk Seniors (OARS) program in Manchester, New Hampshire (WICHE, 2005). The Little Tokyo Service Center, Los Angeles, California also incorporates many of these aspects in their outreach program (Kywata, 2000).

Outcomes

In 24 months the project received 566 referrals, served a total number of 508 elders, with 304 of them receiving long-term clinical outreach or psychotherapeutic services. The project provided 4475 hours of ongoing psychological services.

As shown in Table 1, the positive changes in elders' circumstances included: 54 received practical services previously refused (e.g., in-home meals, transportation, phone service); 34 avoided eviction or movement to a higher level of care; 25 decreased inappropriate, harassing contact with outside agencies (e.g., city employees, law enforcement) or decreased the need for involvement by APS or local code enforcement; 29 reduced the intensity and frequency of delusional material; 41 decreased isolation and increased contact with friends, family, and/or neighbors; and 8 began to set limits in abusive relationships.

Table 1

Positive Changes in Circumstances of Elders Served

54	Received supportive services
41	Decreased isolation
34	Decreased risk of homelessness or premature higher level of care
29	Decreased psychotic symptoms
25	Decreased contact with governmental agencies
8	Increased limit-setting behaviors

The need in the community to aid these hard-to-serve elders was very high, as indicated by the significant increase in referrals over time (i.e., a 389% increase from first to fourth quarter). The project received 27 new referrals during the first quarter, 46 during the second quarter, 109 during the third, and 132 new referrals in the fourth quarter of operation.

Despite the presence of the aforementioned programs which include some aspects similar to this program, such as interagency collaboration and relationship-based services, comparison data detailing outcomes is sparse. Using Florio et. al's (1998) Gatekeeper Case Finding Model, isolated, at-risk elders were identified by non-traditional case finders, such as meter readers, postal workers, etc. Florio et al found that these elders had greater initial service needs, but that after one year of interdisciplinary in-home clinical case management, these older adults did not use a greater number of services than a comparison. Data from a similar type of intervention with younger adults (Burns et al, 2001) indicate that compared with mentally ill patients who received standard psychiatric treatment, those who received regular visits at home by clinicians providing care for health and social issues, reduced future hospitalization days. No literature was found describing or evaluating the efficacy of in-home, mental health outreach to older adults.

Ongoing Issues

One of the difficult issues facing project staff is the slow progress hard-to-serve elders make, in comparison with speedier progress of older adults in more traditional psychotherapy. Clinicians must be patient and learn to identify small evidences of progress, for example, events such as the elder letting the clinician in the home, the elder's improved affect as judged by facial expressions and the older adult's willingness to call the clinician. Burn-out prevention among clinicians and community partners who serve hard-to- reach elders is addressed through: 1) emotional support, 2) case load distribution (assigning at most half of a full-time clinician to outreach cases), 3) regular, short breaks from the work, and 4) education about adjusted expectations.

The slower progress associated with nontraditional clinical mental health outreach

impacts the cost of the work. Similarly, the high level of psychological expertise required to accomplish the work affects the cost. For example, although hard-to-serve elders often require a high level of case management, especially in the early phase of the work when almost all supportive services have been refused, to be effective the case management assistance must be introduced with a high level of psychological sophistication because the elders' primary barrier to service is a mental health difficulty. Consequently, the cost of all clinical mental health outreach services is estimated at competitive psychological assessment and psychotherapy rates. The Center has partnered with private and public sources to develop and maintain its clinical mental health outreach services. However, no long-term funding relationships have been established to date.

Adhering to the ethical guideline of informed consent requires nontraditional methods. These elders need help to live safely and independently in the community but due to mental illness often refuse supportive services. Traditional approaches to obtaining written informed consent would result in these individuals refusing needed help. In the absence of traditional written informed consent, project clinicians follow a stepwise consent procedure that matches the elder's expressed interest in available services. If an older adult indicates interest in talking with the clinician, the clinician continues, explaining that she/he will be helping "through talk." If an older adult clearly tells the clinician to leave and not return, the clinician respects his/her request and ends services. When the older adult verbalizes concurrent requests for the clinician to stay and to leave, the clinician consults with his/her supervisor to assess the older adult's stronger intent. The clinician documents the manner in which consent is obtained.

EXAMPLES: Ms. Q. was an unmarried woman with mild memory impairment and estranged from her only relative, a niece. She began calling the local police department several times a week, reporting that various neighbors broke into her home, and stole keys and medications. Given the lack of corroboration of criminal activity, the excessive calls irritated

police officers, and interfered with their ability to respond to actual crimes. A mental health outreach clinician gradually developed a relationship with Ms. Q., helped her reconnect with her niece and an old friend, helped her express feelings of anger and helped with memory aids. Over time her quality of life improved and her calls to the police department decreased dramatically, enabling police officers to focus their energy on actual crimes and to be more amenable to responding in the future, when and if she actually needed them.

Mrs. K. was an older woman who had long-term dependency needs, exacerbated in late life by medical problems, including a stroke. She was widowed and was emotionally and physically dependent on her son, who was addicted to alcohol and cocaine. Although her son abused her financially, and at times physically, she was unwilling to seek or accept help, because she received some loving attention from him, and she did not want to “be abandoned.” Although Mrs. K. initially refused regular clinician visits, over time she agreed to weekly visits. After nine months of nontraditional clinical mental health outreach, Mrs. K. became willing to seek a restraining order against her son and explore other options for her own care.

Conclusion

While most older adults prefer to live in their own homes in an independent and healthy manner, some fail to access needed services to the full extent possible, and thus endanger themselves and their independence. While a number of barriers interfere with such access, this project addresses psychological factors such as fear, emotional dependency, suspiciousness, mistrust and shame. The Center for Aging Resources’ “Mental Health Outreach to Older Adults” extends relationship-based mental health assistance beyond the usual limits of psychotherapy by trained clinicians who are adept at developing trusting relationships and using their psychological skill to gradually introduce needed help to troubled older adults (Yang & Jackson, 1998; Stolee, Kessler, LeClair, 1996). While this approach requires time-intensive and highly skilled intervention, it shows promise to help maintain recalcitrant individuals in the community in a more healthy and stable manner.

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