Protocol for Quality Care of At-risk Adults with Mental Illness

2001

Adult Protective Services
Mental Health Services

State of Colorado
Department of Human Services

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Adult Protective Services and Mental Health Services

May 2001

PURPOSE

The purpose of this protocol is to provide guidance to adult protection and mental health professionals as they work together throughout the state providing collaborative services to at-risk adults with suspected or known mental health needs. The protocol will also be used for cross training of mental health and adult protection workers, law enforcement agencies, and professionals who provide services to at-risk adults. The expectation is that there will be a spirit of cooperation, creativity, and respect between the local professional agencies involved in assisting at-risk adults with mental health issues.

I. POPULATION DEFINITIONS

MENTAL HEALTH

A "mentally ill person" means a person with a substantial disorder of the cognitive, volitional, or emotional process that grossly impairs judgment or capacity to recognize reality or to control behavior; mental retardation is insufficient to either justify or exclude a finding of mental illness. (CRS 27-10-102[7])

ADULT PROTECTIVE SERVICES

An "at-risk adult" is an individual eighteen years of age or older who is susceptible to mistreatment or self-neglect because the individual is unable to perform or obtain services necessary for the individual's health, safety, or welfare or because the individual lacks sufficient understanding or capacity to make or communicate responsible decisions concerning the individual's person or affairs. (CRS 26-3.1-101[1])

II. ELIGIBILITY ASSESSMENT

MENTAL HEALTH - Those eligible for mental health services include the following:

A. **Medicaid**:

All adults with Medicaid coverage are entitled to a full range of mental health services. The Mental Health Assessment and Service Agency (MHASA) shall provide all necessary mental health services to all Medicaid recipients with a covered diagnosis enrolled in the Mental Health Capitation and Managed Care Program. For consumers who have both a covered mental health diagnosis and a non-covered diagnosis under the Program, the MHASA shall provide all necessary services (including psychiatric services) to treat the covered diagnosis whether the diagnosis is the primary diagnosis or a secondary diagnosis. For example, a person with a covered mental health diagnosis of depression and the

non-covered diagnosis of dementia will be provided mental health services that address the depression.

B. **Non-Medicaid**:
State funding is limited and non-Medicaid consumers are prioritized according to their psychiatric condition. Adults are eligible on the basis of those most in need of mental health services and are defined as:

- Adults and older adults with serious and persistent mental illness (SPMI).
  Persons who have a mental illness which seriously impairs their ability to be self-sufficient, and who have been persistently ill for over a year or have been hospitalized for intensive mental health treatment.

- Adults and older adults with serious mental illness (SMI).
  Persons who are diagnosed with serious mental illness such as schizophrenia or severe affective disorders but who may not meet the definition of "persistent" because of the duration of their illness, the intensity of treatment they have received formerly, or the level of their dysfunction.

C. **Other**:
Mental health services may be available to individuals with Medicare, other private insurance and private pay sources.

ADULT PROTECTIVE SERVICES: Those eligible for Adult Protective Services include the following:

A. At-risk adults 18 years of age and older who are unable to protect their own interests, and who are:
   - In need of assessment for protection or in need of short term services due to a report of actual or potential neglect, abuse, or exploitation and/or
   - In need of ongoing protection as the result of documented evidence of neglect, abuse, or exploitation and who agree to accept the services of adult protection. Such at-risk adults receive protective services for as long as the possibility of abuse, exploitation and/or neglect continues.

B. At-risk adults for whom the county department has guardianship or conservatorship.

C. At-risk adults for whom the county department is the representative payee.

D. Residents of long term care facilities (nursing homes) who must be relocated due to the closure of the facility, according to Colorado Department of Human Services Staff Manual Volume 7-7.100, "Program For The Protection Of At-Risk Adults Unable To Protect Their Own Interests," 7.103.

E. All at-risk adults in Colorado are eligible for adult protection services regardless of income.

III. CONSUMER SERVICES

MENTAL HEALTH

A. **Required Consumer Services**

The basic core services provided for non-Medicaid adult consumers include:

- Assessment;
- Clinical treatment;
- Case management;
- Rehabilitation services for adults and older adults;
- Residential services for adults and older adults;
- Vocational services for adults;
- Emergency services;
- Psychiatric services;
- Interagency consultation;
- Public education;
- Consumer advocacy and family support.

B. **Medicaid recipients** must receive all necessary mental health services that at a minimum include all core services plus hospitalization.

C. **Response Times**

Emergency Response:	15 minute phone response, 24 hours a day, 7 days a week (911 is always an appropriate response in emergency situations)
Urgent Response:	Same/next business day
Routine Response:	Within 5 days for Medicaid recipients; as available for non-Medicaid

ADULT PROTECTIVE SERVICES

A. **Adult protective services include**:

- Receiving and investigating reports of abuse, neglect, exploitation;
- Providing non-clinical* assessment;
- Providing non-clinical* counseling;
- Enlisting law enforcement intervention as appropriate;
- Seeking legal assistance as appropriate;
- Initiating probate court actions as appropriate including guardianships, conservatorships, civil restraining orders, powers of attorney, etc.;
- Developing service plans;
- Arranging for services designed to reduce client risk of further abuse, neglect and exploitation;

- Evaluating the effectiveness of the service plan.

* *Non-clinical* indicates that the assessment and counseling services provided are separate from clinical treatment services.

B. **Response Times**

Emergency Response:	Same day response during business hours. After hours: If emergency exists, 911 or the after hours procedure set up for local department of human services response should be used.
Urgent Response:	24 hours response: If report indicates the possibility of physical harm to the victim.
Routine:	3 working days response: All other reported adult protection situations.

IV. SERVICE COORDINATION

MENTAL HEALTH

Referrals to Mental Health Services are appropriate when the adult is experiencing one or a combination of the following:

- A danger/threat to self or others;
- "Gravely disabled" according to CRS 27-10-102;
- Experiencing a life crisis with mental illness symptoms;
- In need of and agrees to a mental health assessment and treatment.

ADULT PROTECTIVE SERVICES

Referrals to Adult Protective Services are appropriate when any or all of these conditions exist:

- It is suspected or known that the adult is being mistreated through exploitation, neglect and/or abuse;
- It is suspected or known that the adult is self-neglecting;
- It is suspected or known that the adult no longer has caregiver services or that the adult is unable to care for self and is at risk of abuse, neglect and/or exploitation.

V. CASE COLLABORATION

A. Confidentiality

Mental health and adult protection professionals will follow confidentiality guidelines as set forth in statute or policy. Permission for non-emergency referrals will be secured from the mental health consumer, at-risk adult or court appointed guardian prior to referral.

B. Emergency/Crisis Situations

There will be instances when individuals receiving services primarily from Adult Protective Services or primarily from Mental Health Services will experience a crisis situation that will require intervention from the other service systems. Law enforcement or other emergency services may be required in any crisis situation. Examples of emergency situations may include:

Example:
A person with a mental illness receiving services through a community mental health center requires immediate intervention from Adult Protection when imminent danger exists in his/her current environment that renders him/her vulnerable to mistreatment or self-neglect. Adult Protection will respond to the request for intervention and will collaborate with Mental Health to determine the most appropriate disposition.

Example
An at-risk adult receiving services through Adult Protection requires immediate intervention from Mental Health when imminent danger to self or others or grave disability is suspected and may be associated with a mental illness. Mental Health will respond to the request from Adult Protection and conduct an assessment to establish the most appropriate mental health intervention, working collaboratively with Adult Protection to determine the most suitable disposition.

C. Urgent Response/24 Hour Face-To-Face Response

There will be instances when persons known to Mental Health or Adult Protection demonstrate the need for services from the other system yet the service intervention does not require an emergency response. Mental Health will set an intake/assessment appointment time for the same day or the next business day or as negotiated with Adult Protection in the person's county of residence. Adult Protection will respond to a request from Mental Health within 24 hours or as negotiated with Mental Health for an investigation of the possibility of imminent danger due to mistreatment or self-neglect.

D. Routine Response/3 Working Days Response

There will be instances when persons known to Mental Health or Adult Protection demonstrate the need for services from the other system yet the services are not emergent or urgent in nature. Mental Health will respond to requests from Adult Protection for routine mental health services by scheduling

an intake/assessment within 5 working days if the consumer is a Medicaid recipient and may place other consumers on a waiting list, if necessary. All efforts will be made to prioritize at-risk adults for services within the public mental health system. Adult Protection will respond to requests for investigations of at-risk adults in routine situations within 3 working days. Both systems will be kept informed of the results of the assessment/investigation. Resources from each system will be used to ensure appropriate service planning.

DEFINITIONS

CASE MANAGEMENT

For the purposes of this protocol, the term "case management" includes but is not limited to the following:

- **Advocacy**
  Activities undertaken on behalf of a specific consumer or family for the purpose of accessing needed services.

- **Crisis Intervention**
  Activities undertaken on behalf of a consumer to meet emergency needs.

- **Linkage**
  Working with consumer and family and/or service providers to secure access to services.

- **Monitoring/Follow-up**
  Contacting the consumer/family or others to ensure a consumer is following an agreed upon service plan and monitoring the progress and impact of the plan.

- **Outreach**
  The provision of all necessary services, including assessment, to consumers in their homes or communities in order to engage and maintain in treatment. It is also a process that provides an opportunity to develop mutually beneficial relationships with other community organizations to enhance the service delivery system for consumers. Outreach should include education, (joint) service planning, and ongoing follow-up.

- **Referral**
  Arranging for initial appointments for consumers or families with service providers or informing consumers of services available, addresses and telephone numbers of agencies providing services.

CERTIFICATION (Involuntary Mental Health Treatment-Emergency Procedures)

A. **Definition**
"Certification" is the process by which an individual is legally ordered to involuntary mental health treatment for a specified period of time and with specific conditions (CRS 27-10-107).

B. **Who May Be Certified?**
Any person who has been detained for a 72-hour evaluation and treatment under

the CRS 27-10 emergency procedure or by court order may be certified for treatment under the following conditions:

- The professional staff of the facility providing the 72-hour treatment and evaluation has analyzed the person's condition and has found the person to have a mental illness, and as a result of mental illness, the person is a danger to self or others or gravely disabled (see definition for "gravely disabled" below).

- The person has been advised of the availability of, but has not accepted, voluntary treatment. If reasonable grounds exist to believe that the person will not remain in a voluntary treatment program, his/her acceptance of voluntary treatment shall not preclude certification.

CONTINUITY OF CARE

A. Definition

For the purpose of this protocol, "continuity of care" is defined as the coordination and provision of appropriate services between and among agencies and professionals providing services to at-risk adults and persons with mental illnesses.

B. **Continuity of Care** encompasses, but is not limited to, the following areas of responsibility:

- Emergency response;
- Ongoing services;
- Transportation and transportation costs;
- Transfer of care and aftercare;
- Discharge planning for consumers who are involved with more than one agency upon discharge from and into facilities;
- Transfer and handling of court actions, i.e., certifications, guardianships, conservatorships, etc.;
- Medical issues involving transfers of care or assessment;
- Interstate compacts;
- Conflict resolution;
- Issues of special populations and multiple co-occurring disorders;
- Paperwork transfers;
- Confidentiality issues.

CONSERVATORSHIPS

A. **Definition**

"Conservator" means an individual twenty-one years of age or older (resident or non-resident), a trust company, or a bank with general power to serve as trustee, who/that is appointed by a court to manage the estate of a protected person. A prioritized list of

individuals/entities eligible for consideration of conservator status can be found in CRS 15-14-410.

B. **When Appropriate/Scope**

Colorado Revised Statute (CRS 15-14-401): "Appointment of a conservator . . . may be necessary in relation to the size of the estate of a person if the court determines that the person is unable to manage his property and affairs effectively because of:

- Mental illness;
- Mental deficiency;
- Physical illness or disability;
- Chronic use of drugs;
- Chronic intoxication;
- Confinement, detention by a foreign power;
- Disappearance;
- The person has property which will be wasted or dissipated unless proper management is provided;
- Funds are needed for the support, care, and welfare of the person or those entitled to be supported by him;
- Protection is necessary or desirable to obtain or provide funds."

DEMENTIA

Multiple cognitive deficits (including memory impairment) due to direct physiological effects of a general medical condition and/or persisting effects of substances, or multiple etiologies.

DELIRIUM

A disturbance of consciousness and change in cognition that develops over a short period of time.

EMERGENCY (27-10) PROCEDURES - See **"MENTAL HEALTH SERVICES"**

GRAVELY DISABLED

"Gravely disabled" means:

A condition in which a person, as a result of mental illness is in danger of serious physical harm due to his inability or failure to provide himself the essential human needs of food, clothing, shelter, and medical care, OR lacks judgment in the management of his resources and in the conduct of his social relations to the extent that his health or safety is significantly endangered and lacks the capacity to understand that this is so.

OR

A person who, because of care provided by a family member or by an individual with a similar relationship to the person, is not in danger of serious physical harm or is not significantly endangered may be deemed "gravely disabled" if there is notice given that the support given by the family member or other individual who has a similar relationship to the person is to be terminated and the mentally ill individual is diagnosed by a professional person as suffering from

any one of the following: chronic schizophrenia; a chronic major affective disorder; a chronic delusional disorder; or other chronic mental disorder with psychotic features AND has been certified pursuant to this article for treatment of such disorder or has been admitted as an inpatient to a treatment facility for treatment of such disorder at least twice during the last thirty-six months with a period of at least thirty days between certifications or admissions AND is exhibiting a deteriorating symptomatic course leading toward danger to self or toward others and is not receiving treatment that is essential for his health or safety. (CRS 27-10-102)

GUARDIAN

A. **Full/Permanent Guardian**
means an individual at least twenty-one years of age, resident or non-resident, who has qualified as a guardian of an incapacitated person pursuant to appointment by a parent or by the court. The term includes a limited, emergency, and temporary substitute guardian, not a guardian ad litem. (CRS 15-14-102)

B. **Emergency Guardian**
(1) …the court…may appoint an emergency guardian whose authority may not exceed sixty days and who may exercise only the powers specified in the order. Immediately upon appointment of an emergency guardian, the court shall appoint a lawyer to represent the respondent throughout the emergency guardianship. . . (R)easonable notice of the time and place of a hearing on the petition must be given to the respondent and any other persons as the court directs.
(2) An emergency guardian may be appointed without notice to the respondent and the respondent's lawyer only if the court finds from testimony that the respondent will be substantially harmed if the appointment is delayed. If not present at the hearing, the respondent must be given notice of the appointment within forty-eight hours after the appointment. . .
(3) Appointment of an emergency guardian, with or without notice, is not a determination of the respondent's incapacity.
(4) The court may remove an emergency guardian or modify the powers granted at any time. An emergency guardian shall make any report the court requires . . .
(CRS 15-14-312)

C. **Limited Guardianship**
A limited guardianship is a guardianship appointment by the court that limits the duties, powers, and/or duration of the guardianship as determined by that court. In Colorado the terms "conservatorship" and "limited guardianship" do not appear to be interchangeable, though there may be limited guardianship appointments that do function in much the same way as conservatorships.

D. **Temporary Substitute Guardian**
(1) If the court finds that a guardian is not effectively performing the guardian's duties and that the welfare of the ward requires immediate action, it may appoint a temporary substitute guardian for the ward for a specified period not exceeding six months. Except as otherwise ordered by the court, a temporary substitute guardian so appointed has the

powers set forth in the previous order of appointment. The authority of any unlimited or limited guardian previously appointed by the court is suspended as long as a temporary substitute guardian has authority . . .

(2) The court may remove a temporary substitute guardian or modify the powers granted at any time. A temporary substitute guardian shall make any report the court requires . . .

INCAPACITATED PERSON

"Incapacitated person" means an individual, other than a minor, who is unable to effectively receive or evaluate information or both or make or communicate decisions to such an extent that the individual lacks the ability to satisfy essential requirements for physical health, safety, or self-care, even with appropriate and reasonably available technological assistance. (CRS 15-14-102) A licensed physician, psychologist, psychiatrist, or psychiatric nurse must declare the person incapacitated.

MEDICAL CLEARANCE

"Medical clearance" is a procedure performed by medical personnel to determine whether the presenting problem of an individual is due to a medical, substance abuse, or other issue(s).

MENTAL HEALTH SERVICES

A. **Emergency Mental Health Procedures under CRS 27-10-105**

Emergency procedures may be invoked under either one of the following two conditions as defined in CRS 27-10-105:

- A peace officer or other "intervening professional" as listed in 27-10-105, determines that a person appears to be mentally ill and as a result of such mental illness appears to be in imminent danger to others, or to himself or herself, or appears to be gravely disabled, the person may be taken into custody and placed in a facility . . . for a seventy-two hour treatment and evaluation.
- A court establishes that a person appears to be mentally ill and as a result of such mental illness appears to be in imminent danger to others, or to himself or herself, or appears to be gravely disabled, and orders the person to be taken into custody and placed in a facility . . . for a seventy-two hour treatment and evaluation.

B. **Urgent Mental Health Services**

Urgent services shall be provided to a consumer who is experiencing a life crisis, or when there is an indication of a deteriorating course of symptoms, as evidenced by one or more of the following:

- The consumer is in need of a prescription and has run out of medication that is necessary to stabilize a mental health disorder.
- The consumer is exhibiting mild/moderate symptoms of a deteriorating course.
- The consumer's mental illness is exacerbated thereby affecting his/her ability to perform activities of daily living.
- The consumer presents without a support system.
- An assessment indicates that an intervention scheduled the same day or the next day meets the needs of the consumer.

C. **Routine Mental Health Services**

Routine services shall be provided to consumers when ongoing mental health treatment is requested in a non-emergency situation and:

- The consumer agrees to treatment.
- There is no suicidal ideation, plan, or recent gestures. History of past attempts should be considered.
- The prospective consumer indicates no hallucinations or delusions that are interfering in his or her ability to function, and appears to be oriented to time, person and place.
- The consumer is able to care for self (and others in his/her charge) in a reasonable, adaptive manner.

ORGANIC MENTAL DISORDER

The term "organic mental disorder" has been replaced by the term "mental disorder due to general medical condition." The new term distinguishes this condition from (primary) "mental disorders." A "mental disorder" is defined as a clinically significant behavioral or psychological syndrome or pattern that is associated with distress or disability or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

ADULT PROTECTION

DEFINING THE POPULATION OF "AT-RISK ADULTS"

II

Section II – APS Population

- "At-risk Adults" according to state statute
- Mistreatment categories
- Self-neglect
- APS Eligibility
- Reporting to APS
- Confidentiality/Liability of Reporter
- APS Referral Information
- APS Response

Definition by Law

"At-risk Adult" means an individual **18 years of age or older** who:

- is susceptible to **mistreatment** or **self-neglect** because the individual is unable to perform or obtain services necessary for the individual's health, safety, or welfare
- or **lacks sufficient understanding** or capacity to make or communicate responsible decisions concerning the individual's person or affairs. (CRS 26-3.1-101[1])

Mistreatment

An act or omission of an act that threatens the health, safety, or welfare of an at-risk adults or that exposes the adult to a situation or condition that poses an imminent risk of death, serious bodily injury, or bodily injury to the adult. (CRS 26-3.1-101[4])

Mistreatment includes:

- ABUSE
- CARETAKER NEGLECT
- EXPLOITATION

ABUSE

- Infliction of physical pain or injury, such as substantial or multiple skin bruising, bleeding, malnutrition, dehydration, burns, bone fractures, poisoning, subdural hematoma, soft tissue swelling, or suffocation.
- Unreasonable confinement or restraint
- Subjection to nonconsensual sexual contact or conduct

CARETAKER NEGLECT occurs when:

Adequate food, clothing, shelter, psychological care, physical care, medical care, or supervision is not secured for the at-risk adult or is not provided by a caretaker in a timely manner and with the degree of care that a reasonable person in the same situation would exercise…

EXPLOITATION means:

The illegal or improper use of an at-risk adult or the adult's resources for another person's profit or advantage.

Self-neglect

An act or failure to act whereby an at-risk adult substantially endangers the adult's health, safety, welfare, or life by not seeking or obtaining services necessary to meet the adult's essential human needs.

NOTE: Choice of lifestyle or living arrangements is not, by itself, evidence of self-neglect.

UNDERSTANDING or CAPACITY

to make or communicate Responsible Decisions may be effected by:

- Acquired Brain Injury
- Dementia
- Developmental Disability
- **Mental Illness**
- Physical Impairment
- Substance Abuse
- Medication mismanagement

APS ELIGIBILITY

Age or **Disability** alone do not define the population served by APS. The adult must . . .

- **Be unable to perform or obtain necessary services**
- **Lack sufficient understanding or capacity to make or communicate responsible decisions**

. . . in order to be considered "at-risk."

No financial criteria are used in determining client eligibility for adult protection.

APS Regulatory Definition:

- At risk adults 18 years of age and older who are unable to protect their own interests and who are in need of:
  - assessment for protection or short-term services due to a report of neglect, abuse, or exploitation,
  - ongoing protection due to documented evidence of neglect, abuse, or exploitation.
- At risk adults for whom the county department has guardianship or conservatorship or representative payee
- Residents of long-term care facilities who must be relocated due to the closure of the facility.

** Colorado Department of Social Services Staff Manual, Volume VII*

Reporting to Adult Protection

Call your County Adult Protective Services intake worker with reports or suspicions of abuse, neglect or exploitation of an at-risk adult.

Confidentiality and Liability of Reporter

- The identity of the **reporting party is confidential** (CRS 26-3.1,102 [7a]), with the exception of a court order.
- All reporters are **immune from any civil or criminal liability** when the report is made in good faith (CRS 26-3.1,102 [5]).

APS Referral Information

Include the following information in your report when possible.

1. At-risk Adult's:
   Name:
   Address:
   Phone:
   Age/DOB:
   Social Security #, if known
2. Caretaker's:
   Name:
   Address
   Phone:

APS Referral Information (continued)

3. Perpetrator
   Name:
   Address
   Phone:
   Relationship to Client:
   Age:
4. Family members, Physician(s), interested parties
   Names, addresses, phone numbers on each

APS Referral Information (continued)

5. Injuries (if any)
   Nature of . . .
   Extent of . . .
6. Mental Status at time of referral
7. Conditions and Circumstances that contribute to mistreatment/self-neglect.
8. Worker Safety Issues, such as contaminated environment, weapons in home, volatility of client/perpetrator, watch dogs, etc.
9. Other information you feel may be pertinent.

APS Response to Report

Information provided in a report to APS is reviewed by the APS Supervisor who determines if it is possible, within Colorado Law, to pursue the case.

APS Response to Report (continued)

Client Autonomy

It is important to understand that even in cases where situations of actual or potential abuse, neglect, or exploitation exist, if the client is competent to make rational decisions and refuses protective services, no APS services can be provided.

Section II Summary

- At-risk Adults according to state statute
- Mistreatment categories
- Self-neglect
- APS Eligibility
- Reporting to APS
- Confidentiality/Liability of Reporter
- APS Referral Information
- APS Response

MENTAL HEALTH

III

DEFINING THE POPULATION
of PEOPLE WITH MENTAL ILLNESS

Section III – MHS Defining the Population

- "Mentally Ill Person" according to state statute
- "Mental Disorder" according to DSM-IV
- Appropriate referrals
  - **Including Signs & Symptoms**
- Reporting to MHS
- MHS Referral Information
- Confidentiality
- Mental Health Response

Definition by Law

A "mentally ill person" means a person with a substantial disorder of the cognitive, volitional, or emotional process that grossly impairs judgment or capacity to recognize reality or to control behavior; mental retardation is insufficient to either justify or exclude a finding of mental illness. (CRS 27-10-102 [1])

MENTAL ILLNESS (DISORDER)

- "Each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress, disability, or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. It must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual."

DSM IV- 4th Edition

CO-OCCURRING DISORDERS:

- **Substance Related Disorders & Mental Illness**
- **Developmental Disability & Mental Illness**

When co-occurring conditions exist, it is best to contact/collaborate with local service system(s) that are in place to assist with each condition.

APPROPRIATE REFERRALS

to mental health services are referrals of adults who:

- **Have a <u>diagnosis</u> of a mental illness and**
- **Are on a <u>psychiatric medication</u> and/or**
- **<u>Display signs & symptoms</u>*of mental illness.**

*All possible causes for exhibited symptoms, including organic and neurological causes, should be considered.

SIGNS & SYMPTOMS

OF AFFECTIVE OR MOOD DISORDERS

Symptoms of Depressed Mood

- Persistent sad, anxious or "empty" mood
- Sleeping too little, or sleeping too much
- Decreased appetite and weight loss, or increased appetite and weight gain
- Loss of interest or pleasure in activities once enjoyed
- Restlessness or irritability
- Persistent physical symptoms that don't respond to treatment (such as headaches, pain, digestive problems)
- Difficulty concentrating, remembering or making decisions
- Loss of energy, persistent tiredness
- Feeling guilty, hopeless or worthless
- Thoughts of death or suicide

Symptoms of Manic State

- Elevated mood, euphoria, unceasing enthusiasm or expansiveness, or irritable mood. Mood can shift from up to down or euphoric to irritable.
- Inflated self-esteem or expressions of grandiosity sometimes to the extent of delusions.
- Decreased need for sleep
- Pressured or forced speech
- Flight of ideas, or ideas jumping all over the place
- Increased involvement in goal-directed activity or increased productivity or psychomotor activity
- Excessive involvement in pleasurable activity, i.e., spending money and/or sex, with negative outcome

Symptoms of Anxiety

- Common Symptoms:
  - Apprehension
  - Fear
  - Dread
  - Pounding Heart
  - Dizziness
  - Nausea
  - Sweating
  - Repetitive Behaviors

Please understand when making referrals to mental health that:

Symptoms of Depression, Mania, and Anxiety are not always indicators of a Major Mental Illness . . .

but referrals for mental health services can still be made when such symptoms are experienced by the person.

Psychotic Symptoms

- Loose thought associations; disorganized speech/thinking; flight of ideas
- Delusions - erroneous beliefs, misinterpretations of perceptions or experiences
- Hallucinations (auditory, visual, olfactory, tactile)
- Disorganized/catatonic behavior; odd/bizarre behavior; childlike silliness; agitation; immobility
- Paranoia – suspicious; feelings of persecution
- Withdrawal/isolation; flat affect; poverty of thought and speech

Same Symptoms . . .
Different Reasons

Psychiatric symptoms
may be caused by
organic or neurological **conditions.**

COMMON PSYCHIATRIC SYMPTOMS

that may be caused by
ORGANIC/NEUROLOGICAL CONDITIONS

- **Paranoia**
- **Short attention span**
- **Mood swings/lability**
- **Euphoria**
- **Depression**
- **Sleep disturbance**
- **Poor impulse control**
- **Impaired memory**
- **Anxiety/agitation**
- **Apathy**
- **Aggression**
- **Changes in personality**

ORGANIC/NEUROLOGICAL CONDITIONS
that may cause
PSYCHIATRIC SYMPTOMS

- **Dementia**
- **Delirium**
- **Degenerative brain disease**
- **Traumatic brain injury**
- **Metabolic disease/diabetes**
- **Creutzfeldt-Jakob disease**
- **Major organ malfunction**
- **Epilepsy/seizure disorder**
- **Hypothyroidism**
- **HIV disease**
- **Huntington's disease**
- **Parkinson's disease**
- **Pick's disease**
- **Multiple sclerosis**
- **Substance abuse**

Let's take a closer look at …..

Dementia & Delirium

- These two conditions are often seen in older clients. (33 - 50% of hospitalized elderly experience delirium at some time.)
- Neither dementia nor delirium is a mental illness.
- Both conditions produce symptoms that are also seen in people with mental illness.

Dementia
is a mental (**neurological) disorder**

- Clients with a primary diagnosis of dementia benefit most from **medication therapy**.
- Medication therapy for people with dementia is best provided by a **private psychiatrist or PCP**. Mental health centers generally do not provide medication therapy for people with dementia.
- Mental health may assist with emergency hospitalization of a client with dementia, but do not customarily screen or provide ongoing services to them.

Dementia Symptoms

- Affect change
  - Labile - early stages
  - Apathy - later stages
  - Vegetative signs - later stages
- Personality changes
- Language disturbances, aphasia
- If person is aware of their dementia process, they may become anxious and depressed.
- Psychotic symptoms may also be associated with dementia such as hallucinations, delusions, and paranoia.

Delirium

is often the **physiological consequence** of:

- a medical condition,
- substance intake,
- withdrawal from medication or
- toxicity from medication.

A medical evaluation for delirium should be done prior to completion of mental health screen.

Delirium exhibits:

- Sudden Onset:
  - hours to days
  - may fluctuate during the day
- Clouded state of consciousness
- Disturbance in cognition.

Delirium Symptoms

- Disturbance in psychomotor activity
- Reduced level of consciousness
- Reduced level of awareness of environment
- Attention wanders
- Perceptual disturbance
- Can be vulnerable to self-destructive acts
- Change in cognition, memory, orientation, language

Reporting to Mental Health Centers

Call your local Mental Health Center on-call/emergency intake worker to refer individuals you believe to have a mental illness or psychiatric related emergency.

(Remember that mental health centers do mental health evaluations, **NOT** competency evaluations.)

Include the following information in your report when possible:

MH Referral Information

1. At-risk Adult's:
   - Name, Address, Phone:
   - Age/DOB:
   - Social Security #, if known:
   - MI Diagnosis:
   - Presenting Problem:
   - Prescription Medication:
   - Physician's Name/Phone:
   - Psychiatrist's Name/Phone:
   - Street drug use/currently intoxicated(?):
   - Type of insurance:
   - Family members names, etc.:
   - Other pertinent information:
2. Is he/she a current mental health center client?

MH Referral Information

3. Is the client aware that the referral is being made?
4. Indicate whether the client is willing and able to visit the MHC for an evaluation.

   Is this a safe option?
5. Be aware that either MH or APS may call law enforcement for a welfare check.

Confidentiality in Colorado

Common Principles

- ***"Informed" Consent*** –Elements listed in ADAD rules
- ***Need to know*** – only information that is directly related to the purpose of the disclosure should be released.
- ***Re-disclosure*** – Common consent forms have been developed as a result of the need for the sharing of information in collaborative service provision.
- ***Other sources of information*** – eg. Family, friends members

Client Autonomy

If a mental health professional goes to the home of the client, the evaluation will not be done if the person refuses to allow them to enter the home for an interview.

In some cases, the police may be called to do welfare check.

Section Summary

- "Mentally Ill Person" according to state statute
- "Mental Disorder" according to DSM-IV
- Appropriate referrals
  - **Including Signs & Symptoms**
- Reporting to MHS
- MHS Referral Information
- Confidentiality
- Mental Health Response

APS ASSESSMENT

IV

Section IV – APS Assessments

- Assessment Explained
- Assessment & Investigation
  - Physical
  - Financial
  - Medical
  - Mental
  - Environment
  - Support System
- Evaluating Capacity/competency

APS ASSESSMENT

The APS social worker assigned to a case will make an assessment of various aspects of the alleged victim's living and health situations.

Should the adult be determined to be at-risk, an investigation of the abuse, neglect, and/or exploitation is initiated.

APS Assessment Process

- Assessment of current situation/ presenting problem
- Determination of at-risk status
- Review of case history, previous referrals, etc.
- Investigation of allegations of mistreatment or self neglect

Self-Determination

Throughout initial contact, assessment and investigation, the client retains the right to self-determination.

At any time during the process, the client may decide to refuse or reject adult protective services and recommendations.

Assessment & Investigation

At any point during the assessment, the credibility of the allegations may be confirmed. Such a confirmation serves to justify the initiation of the APS investigative process along with or in addition to the completion of the assessment process.

Criminal cases will usually require an extensive investigative process that will include the services of law enforcement.

An investigation includes such factors as:

- Physical status - **assessment of indicators of physical or sexual abuse**
- Financial status - **assessment of ability to manage income**
- Medical status - **assessment of ability to manage care for self.**
- Mental status - **ability to make decisions concerning self**
- Environmental - **safety concerns**
- Support system - **family, friends, services**

Physical Status

The client's physical status is assessed on the basis of the activities that the person is able to perform; what type of assistance with activities the person does or does not require; whether or not there are any indicators of physical (sexual) abuse to the person.

Physical status assessment considers:

- Physical injury such as bruises, broken bones, cuts, burns and dislocations.
- Multiple injuries in different stages of healing.
- Over/under medicated state.
- Bilateral skin markings.
- Repeated ER or hospital admissions
- Hospital/ER/Doctor hopping.

Physical status assessment considers:
(continued)

- Explanation of injury not consistent with medical findings.
- Unexplained sexually transmitted disease.
- Reported sexual assault.

Financial Status

The client's financial status is assessed on the basis of the assets possessed by the person, such as bank accounts, home ownership, credit status, and whether or not there are any indicators of financial exploitation of the person.

Financial status assessment considers:

- **Review of sources of income and resources**
- **Existence of Representative Payee, Power of Attorney, Conservatorship designations /appointments**
- **Payment status of monthly bills, especially mortgage and utility bills**
- **Monthly income checks status (cashed/uncashed)**
- **Bounced checks**
- **Amount of food in home**
- **Ability to obtain/buy food**
- **Ability to complete applications for entitlement programs.**

Financial status assessment considers:
(continued)

- Ability to comprehend financial situation
- Names on bank accounts/property titles
- Income/assets used by another
- Questionable transfer of assets/property.
- Quality of actions taken by existing rep payee/POA/guardian/conservator

Medical Status

Medical status significantly impacts how the client:

- Presents during the assessment*
- Reacts to daily stressors
- Responds to service intervention

* **Poor medical status may negatively impact emotional & mental well-being.**

Medical Status Process:

APS professional social workers:

- Assess a client's general medical condition;
- Observe signs & symptoms of existing or suspected medical problems;
- Document signs & symptoms, other concerns
- Document known medical proxy, DNR, etc. information;
- Provide results of observations to medical and psychiatric professionals, when appropriate;
- Function as trained observers, not diagnosticians.

Medical status assessment considers:

- Known diagnoses/suspected conditions
- Health insurance coverage/benefits
- Names of doctors/other health care providers
- Circumstances/dates of recent medical care
- Existence of untreated medical conditions
- Current medications being taken
- Non-compliance/inability to adhere to medical regimen

Medical status assessment considers:
(continued)

- Apparent care needs in areas of bathing, hygiene, dressing, meal preparation, toileting, transfers, housekeeping, shopping, laundry and medication administration.
- Caregiver information: identification, contact information, hours, qualifications, relationship, etc.
- Inability of caregiver to provide adequate care.

Medical status assessment considers:
(continued)

- Evidence of self/caregiver neglect including:
  - unkempt, dirty appearance
  - bedsores
  - signs of malnourishment
  - signs of dehydration
  - incontinency with lack of appropriate care
  - mismanaged medication
  - frequent falls
  - inadequate or inappropriate diet

Environmental Status:

The environment in which the client lives impacts his/her level of risk for mistreatment, exploitation, and neglect. For example, many older adults raise multiple pets. As a result, the older adult may be unable to provide adequate food, shelter, sanitation or medical care for him/herself and the animals. The adult lives (and often prefers to remain) in the filthy and unhealthy environment.

Environmental Status Assessment considers:

- Inappropriate/inadequate clothing for the weather
- Functioning of heating, plumbing, electrical systems
- Sanitary conditions within home, e.g. animal/rodent feces in house
- Hoarding behavior
- Homelessness with inability to obtain shelter.
- Verbal threats/intimidation/abuse in the home

Mental/Behavioral Status

The mental/behavioral status of the adult also significantly impacts his/her level of risk for mistreatment, exploitation, and neglect. ***APS workers observe, document, and report symptoms and behaviors.*** APS reports this information to the mental/behavioral health workers. The mental health workers use this information in the mental health intake and/or evaluation process.
APS workers do not diagnose. ***They observe, document, & report symptoms and behaviors.***

Mental/behavioral status assessment considers:

- Wandering/getting lost
- History of fires/burns from smoking, cooking, heating
- Confusion/disorientation
- Memory impairment
- Incoherence/inability to follow conversation
- Inability to follow simple directions, plan or problem solve.
- Inability to perceive normal risks

Mental/behavioral status assessment considers: (continued)

- Use of faulty judgment/reasoning skills
- Problems with impulse control
- Inability to receive or communicate information regarding one's needs
- Inability to understand and comply with medical and nutritional recommendation of medical providers
- Inability to advocate for self
- Inability to report own history or contacts

Support System Status

Support systems for the client may include personal, social, professional, and community contacts that have an interest in or concern for the individual.

Support System Status

- Names and phone numbers of family
- Names of medical providers, agencies and hospitals used by client
- Community agencies that have served the client
- Names of guardian, conservator, representative payee, powers of attorney (definitions in handouts)
- Names of friends, neighbors and other informal supports

What APS workers look for during investigations

To get a more complete picture of what APS workers look for when assessing for and investigating allegations of mistreatment, please refer to Handout titled:
"Abuse Indicators & Assessment Tools."

Evaluating Capacity/Competency

- Please note that other instruments may be used for an informal assessment of capacity.
- Professional capacity evaluations are traditionally completed by medical doctors and psychiatrists.

Section IV Summary

- This section listed and discussed various types of assessment areas done by APS.
- The roles of medical and psychiatric professionals in making diagnoses of suspected conditions were emphasized.
- Details in the investigation of alleged abuse, neglect, exploitation & capacity may be found in the referenced handouts.

MH ASSESSMENT

V

Section V – MH Assessment

- Areas/Issues considered
  - **Mental Status**
  - **Violence Risk**
  - **Suicide Risk**
  - **Homicide Risk**
  - **Level of Impairment/Diagnoses**
  - **Level of Care/Scope of Services Required**

MENTAL HEALTH ASSESSMENT

A comprehensive mental health assessment takes into consideration:

- Presenting Problem
- Psychiatric History
- Medical Issues
- Current Medications
- Mental Status
- Violence Risk
- Suicide Risk
- Homicide Risk

MENTAL HEALTH ASSESSMENT (cont.) A comprehensive MH assessment also determines/considers:

- Gravely Disabled criteria
- Certification criteria
- Medical Clearance
- Strengths, include support system
- Cultural/Age Issues
- Substance Abuse
- Level of Impairment/Level of Services

MENTAL STATUS ASSESSMENT

- Mental Health professionals are qualified to make a psychiatric diagnosis on the basis of observed symptomology, psychiatric history, and a mental status assessment

MENTAL STATUS ASSESSMENT
INCLUDES AN EVALUATION OF:

- Presentation
  - **Affect**
  - **Posture**
  - **Appearance**
  - **Speech**
  - **Mood**
- Orientation
  - **Memory**
  - **Concentration**
  - **Focus**
  - **Organization**

MENTAL STATUS ASSESSMENT (cont.)
INCLUDES AN EVALUATION OF:

- Thought process- psychosis/thought
- Intellectual level
- Functioning-insight
- Judgment
- Understand variables
- Ability to develop coping strategies

VIOLENCE RISK ASSESSMENT

- Assessment of the individual's potential for violent behaviors towards self or others.

SUICIDE RISK ASSESSMENT

- Suicidal Ideation
- Plan/Means/Opportunity
- Impulsivity
- Prior Attempts
- Family History
- Willingness to Contract for Safety
- Substance Abuse

HOMICIDAL RISK ASSESSMENT

- Homicidal Ideation
- Threats
- History of Violence
- Access to Weapon
- Paranoia
- Target
- Substance Abuse

ASSESSMENT RESULTS

The the mental health assessment results in a determination of whether an individual is suffering from a mental illness. If so, a determination is further made as to the level of services the individual might need to maintain optimal mental health.

Level of Impairment
determines
Level of Care

- Outpatient services
- Intensive Outpatient services
- Case Management services
- Residential services
- Inpatient services

INTENSIVE OUTPATIENT SERVICES

- Usually 4 or more hours of service daily
- Adults who need a more structured environment
- Adults needing intensive maintenance treatment
- Adults requiring crisis stabilization to avert hospitalization
- Multidisciplinary approach; physician services, medication monitoring, groups, individual counseling, residential, vocational services, outreach case management

CASE MANAGEMENT

- Advocacy
- Crisis Intervention
- Linkage
- Monitoring/Follow-up
- Outreach
- Referral
- Service Planning

POSSIBLE DIAGNOSES

Upon completion of the comprehensive mental health assessment, it is possible that one of the following Major Mental Illness Diagnoses will be made.

Major Mental Illness Diagnoses

- MAJOR DEPRESSIVE DISORDER
- DYSTHYMIC DISORDER
- BIPOLAR DISORDER
- SCHIZOPHRENIA
- SCHIZOAFFECTIVE DISORDER
- Axis II – including "Personality Disorder"

MAJOR DEPRESSIVE DISORDER

A depressed mood and at least five other signs and symptoms of depression (covered earlier) that have been present for a significant length of time and is a significant change from the person's typical functioning level.

DYSTHYMIC DISORDER

- A low grade depression including a depressed mood that has existed for over two years.

BIPOLAR DISORDER

- Occurrence of one or more manic episodes and at least one major depressive episode.
- Bipolar disorders impair social and/or occupational functioning, can include psychotic features and can lead to hospitalization.

Schizophrenia

A thought disorder notable for significant delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, and/or a flat affect.

Schizoaffective Disorder

- A mood disorder that occurs together with symptoms of schizophrenia.

Section V Summary

- In this section, the types of information used in assessing whether or not a person has a diagnosable psychiatric condition were outlined.
- In addition, common symptomology for each of the major mental illness diagnoses were provided.

ADULT PROTECTION EMERGENCY & ON-GOING CASE MANAGEMENT SERVICES
VI

Section VI – APS Services

This section will review:

- APS emergency services
- Response times to APS referrals
- Guardianship processes
- APS ongoing monitoring of
  - **Legal issues**
  - **Medical issues**
  - **Nutrition issues**
  - **Home Health issues**
  - **Social issues**
  - **Housing issues**
  - **Financial issues**

APS Emergency/ Crisis Intervention Services

During crisis intervention APS may:

*Refer client to law enforcement, mental health, medical services, shelters, emergency food programs,etc.

*Assist client with applications for entitlement programs, housing, long term care programs, etc.

*Contact family, friends, etc.

APS Crisis Intervention (continued)

*Assist client with the placement process.

*Refer client for mental status evaluation, neuro-psychological evaluation or mental competency evaluations.

*Assist client in obtaining restraining orders, legal services, powers of attorney, living wills.

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APS Crisis Intervention (continued)

*Remove client from home or other unsafe environment

*Request assistance from law enforcement for reporting crimes, protecting client and/or the caseworker, gaining access to the client

*Assist client with revoking a POA

*Assist client with closing or changing bank accounts to protect them from perpetrator(s)

APS Crisis Intervention (continued)

*Petition the Court for:
- court ordered alcohol commitments
- legal imposition of disability
- emergency guardianship/conservatorship

* Seek M-1's via mental health or law enforcement

*Collaboration with other agencies as needed to meet client needs

Response Time Parameters

There are 3 levels of Response Times for APS program staff. Borrowing the Response level terminology from Mental Health Services, response levels may be classified as:

1. Emergency: Immediate (same day) Response
2. Urgent: 24 hours Response
3. Routine: 72 hours Response

Immediate (Emergency) Response

If report/referral indicates imminent danger to an at-risk adult, the APS worker will contact law enforcement and make a face-to-face contact with the client immediately.

24 hour (Urgent) Response

If the report/referral indicates that there is the possibility of physical harm to the victim, the APS worker will make a face to face contact with the client within 24 hours of the report/referral.

72 hour (Routine) Response

When a referral is made of an at-risk adult who appears to be in no immediate danger with no indication of the possibility of physical harm, the APS worker will make a face-to-face contact within 3 working days of the referral.

APS Role as Facilitator

- Many of the clients APS workers serve are in need of supports that will involve court proceedings to implement. If such appointments as conservatorships or guardianships are not be assumed by the county agency, APS workers will assist others (concerned family members) in the legal process of obtaining such appointments.
- Examples of processes APS will facilitate follow.

Processes Facilitated by APS

Restraining Orders – facilitate application process through legal systems to avoid contact with perpetrators
Representative Payeeship - search or referral to a private Rep Payee to receive/oversee Social Security benefits
VA fiduciary services - facilitate application process
Power of Attorney, Medical Proxy, Guardian, Conservator - search for relative/friend having or willing to accept such roles
Private/public guardian – Refer client to or arrange for assessment of client's need for guardian.

County APS programs interpret the following statute in accordance with traditions/policies of their county agencies.

C.R.S. 26-3.1-104

If an incapacitated adult is being mistreated or self-neglectful and does not consent to the receipt of protective services, and no other appropriate person is willing or able to do so, APS may petition the court for an order authorizing protective services and/or the appointment of a guardian. Such services must always be the least restrictive intervention possible to maintain the safety of the individual.

If APS accepts guardianships, the process will include:

1. **Collaboration with physician, neuro-psychologist, etc. in order to provide:**
   - Letter of evaluation
   - Diagnosis
   - Prognosis
   - Details of incapacitating condition
   - Recommendation for guardianship

APS & Guardianships (continued)

2. **Letter to the court including:**
   - Brief social history
   - Statement regarding the current level of risk of client
   - Statement regarding the need for a guardian

APS & Guardianships (continued)

3. **<u>APS has an added burden of proof</u>** to demonstrate that the respondent is an *at risk adult* requiring protection from neglect, abuse or exploitation. (A family member would not be required to meet this standard.)

APS & Guardianships (continued)

If APS <u>does</u> <u>not</u> accept guardianships, etc. the APS worker **may facilitate the process** for an interested party.

Types of Guardianships

- Emergency (temporary) Guardianships
- Permanent Guardianships
- Limited Guardianships

Emergency Guardianships

- **A petition is submitted to the court by family or other concerned party, requesting a hearing.**
- **The initial hearing date is set.**
- **The hearing is held, at which the APS caseworker must testify.**
- **The court appoints an attorney to represent the respondent.**
- **A court visitor may be appointed.**
- **The emergency guardian is appointed for 60 days only.**

Emergency Guardianships (continued)

- **At the end of the 60 days emergency guardianship the court will**
  - **appoint a permanent guardian**
  - **OR appoint a limited guardianship, with limited authority to areas/time frames specified by the court**
  - **OR assure that necessary changes have been made in respondent's living situation, such as service coordination, designation of POA or conservator, etc., and allow respondent to be released from the court's oversight**

APPEAL Of Emergency Guardianships

- **Respondent may appeal an emergency guardianship**
- **Appeal hearings must be set within 10 days**
- **Respondent must appear (if possible) at the appeal hearing and will be represented by attorney**
- **The court determines the respondent's competency status**
- **The court may:**
  - **continue the emergency guardianship for the remainder of the 60 days,**
  - **appoint a permanent guardian,**
  - **or terminate the emergency guardianship.**

Permanent Guardianships

- **A petition is submitted to the court, requesting a hearing.**
- **The hearing date is set.**
- **A court visitor is appointed.**
- **The court visitor interviews the respondent, the prospective guardian, the physician and others. The visitor's report is submitted to the court.**
- **An attorney is appointed to represent the respondent if one is requested.**

Permanent Guardianships (continued)

- **The respondent appears in court. Testimony may be taken from both the petitioner and respondent.**
- **The court determines respondent's competency status and may appoint a guardian.**

Limited Guardianship

A guardian may also petition and be appointed as/to a *limited guardianship.*

As the name implies, limited guardianships have authority that is limited to certain aspects of the ward's life (such as housing issues) as specified by the court.

Ongoing APS Services

- **Ongoing services involve reducing or preventing further mistreatment, self-neglect or exploitation.**
- **APS caseworkers help clients accomplish specific goals toward these ends by addressing the client's needs/issues in a number of areas critical to the client's safety and life quality.**

Ongoing APS Services address the following Issues:

- **Legal**
- **Medical**
- **Nutrition**
- **Home Health**
- **Social**
- **Housing**
- **Financial**

LEGAL

- Assist client, client's family or friend with obtaining:
  - **Restraining Orders**
  - **Powers of Attorney**
  - **Designation of Representative Payee**
  - **Conservatorship**
  - **Guardianship**
- Refer case to the Police or District Attorney if criminal conduct is involved/suspected **(example: financial exploitation)**

MEDICAL

- Refer to/help finding:
  - **Doctor**
  - **Transportation to medical appointments**
  - **State for an alcohol hold/commitment**
  - **Mental health for evaluation, treatment, hold, or commitment**
  - **Neuro-psychological evaluation**
  - **Hospital**
- Immediate call to 911 if client appears to be in imminent danger

MEDICAL (continued):

- Referral to/help arrange
  - **Home health care**
  - **Hospice care, in-home or inpatient**
- Application for Medicaid

MEDICAL (continued):

- Resolving problems with prescriptions
  - **Obtaining needed medications**
  - **Appropriate intake of medications**
  - **Payment for medications**
  - **Ask doctor to evaluate medications**
  - **Ask doctor to evaluate for medication addiction and overdose**

MEDICAL (continued):

- Assistance to obtain:
  - **durable medical equipment**
  - **dental care**
  - **vision care**
  - **hearing care**
  - **podiatry care**

NUTRITION

- **Obtaining emergency groceries**
- **Arranging for Meals on Wheels**
- **Referring to nutrition sites at Senior Centers**
- **Assisting with Food Stamp application**

HOME HEALTH

- Referral to/for:
  - **Homemaker services**
  - **Home modifications (for disrepair or safety reasons)**
  - **Electronic monitoring**
  - **Options for Long Term Care**
  - **Respite care**
  - **Private pay home care**
  - **Transportation**
  - **Handyman services**
  - **Weatherization services**

SOCIAL

- **Referral to telephone assurance programs**
- **Arranging for a friendly visitor or senior companion**
- **Referral to a senior center for social programs**
- **Assistance in locating and transportation to an adult day care program**

HOUSING

- **Locating appropriate housing or apartments for independent living**
- **Referrals to shelter**
- **Assistance in locating, visiting, moving into personal care boarding home, adult foster care, alternative care facilities, assisted living or nursing home**

FINANCIAL

- Application assistance for benefits such as:
  - **Social Security retirement**
  - **Social Security survivor benefits**
  - **Old Age Pension**
  - **Aid to the Needy Disabled**
  - **Medicaid**
  - **Veterans benefits**
  - **Low income energy assistance**
  - **General assistance from Dept. of Human Services**
- Help in finding a money manager

Section VI Summary

- **APS Emergency (Crisis Intervention) and On-Going Services include a wide variety of quality of life issues.**
- **Legal proceedings, such as emergency, limited and permanent guardianship hearings, may be necessary in order to reduce risk for client.**
- **Reduction of risk and prevention of future neglect, exploitation and abuse are primary objectives of services for clients implemented by APS workers.**

MENTAL HEALTH EMERGENCY & ONGOING SERVICES

VII

Section VII – MH Services

In this section, the following ***emergency response issues*** are reviewed including:

- **27-10 Hold and Treats (a.k.a. M-1's)**
- **"Gravely Disabled"**
- **Medical Clearance**
- **Certification**

Urgent & Routine responses are also discussed.

Finally, an ***overview of Mental Health Services*** available in many regions is provided.

Mental Health Services address a wide range of consumer needs and issues. Adult protection and mental health are most often brought together to deal with consumers who have or appear to have a mental illness and are in emergency situations. A description of these mental health services follows.

MENTAL HEALTH 27 – 10

HOLD & TREATMENT

The Colorado Regulatory Statutes (C.R.S.) Section 27 – 10, 105 defines the steps to be taken to place a person on a 72 hour mental health hold.

Mental Health Holds issues:

- **WHO may initiate a mental health hold**
- **Criteria used in determining *imminence***
- **Questions to assess *imminence***
- **Statutory definition of "Gravely Disabled"**
- **Medical Clearance**
- **Certification**

MENTAL HEALTH HOLDS (continued)

- Persons authorized to sign a mental health hold include:
- Certified Peace Officers
- Licensed Physicians
- Licensed Psychologists
- Licensed Clinical Social Workers
- Licensed Professional Counselors
- Licensed Marriage & Family Therapists
- Psychiatric Nurse Specialists

MENTAL HEALTH HOLDS (continued)

One of the following criteria must be met ***in order to detain a person against his or her will***:

- **Any person who appears to have a mental illness and, as a result of such illness, appears to be an *imminent** danger to self.**
- **Any person who appears to have a mental illness and, as a result of such illness, appears to be an *imminent* danger to other.**
- **Any person who appears to have a mental illness and as a result of mental illness appears to be gravely disabled.**

MENTAL HEALTH HOLDS (continued)

* ***Imminent*** is the key word in this context.

NOTE: CRS 27 – 10 does not define ***imminent*** nor has it been defined clearly in case law.

Questions to ask to assess ***imminence***:

The best indicator of homicidal risk (violence towards others) or suicidal risk is past acts of violence and suicide attempts.

- **Does the person have a history of violence toward others?**
- **Does the person have a history of suicide attempts?**

Questions to ask to assess ***imminence***: (continued)

- **Has the person made specific suicidal or homicidal statements recently?**
- **Has the person developed a plan which is feasible and do they have the means to carry out the plan?**
- **Do they have access to weapons?**
- **If they are homicidal, do they have access to the person they are making threats against?**

Gravely Disabled

- ***Gravely Disabled*** is defined as being in danger of serious physical harm due to an inability or failure to provide for himself/ herself the essential human needs; lacking in judgment in managing his/her resources; and conduct of relations to the extent his/her health or safety is significantly endangered; and, lacks the capacity to understand that this is so. **(CRS 27-10-102, [5],[a],[I-II])**

Gravely Disabled (continued)

- Loss of support by caregivers and family and the possible consequences of the withdrawal of this support is related to whether the person is gravely disabled.
  (CRS 27-10-102, [5],[b])

Gravely Disabled (continued)

Gravely Disabled can be applied when a person has had withdrawal of support by family and friends, and

- the person has Schizophrenia, a chronic major affective disorder, a chronic delusional disorder with psychotic features, and

Gravely Disabled (continued)

- the person has been certified and admitted to an inpatient psychiatric facility at least twice in the last three years, with a period of at least 30 days between the admissions, and
- the person is exhibiting a deteriorating course which could lead to danger to self or others,and
- the person is not receiving treatment which is essential for their health and safety.

(CRS 27-10-102, [5],[b],[I-IV])

Medical Clearance

Medical clearance:

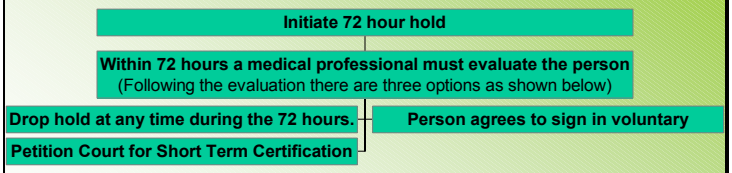
- is the determination and documentation by a physician that a consumer's vital signs and medical condition do not require medical care in the medical unit within a hospital.
- must be determined prior to evaluation for treatment within the psychiatric unit of the hospital.

Medical Clearance

Medical clearance should be obtained if a consumer:

- **is in need of a mental health evaluation and possible psychiatric hospitalization, and**
- **may have some medical condition that would impact their health, and**
- **would need a medical professional to determine if he/she is able to be safely transferred to an inpatient psychiatric facility**

Mental Health Hold & Treatment (27-10) Process



Certification

- Certification may be imposed if a mental health professional determines a person:
  1. **Is a danger to self or others and/or gravely disabled and needs further assessment and/or treatment beyond 72 hours**
  2. **The person has been advised of availability of, but not accepted voluntary treatment and there is reasonable belief that a person will not accept voluntary treatment**.

Certification (continued)

- Any person detained under a mental health hold may be certified.
- Once certified, a person may be detained under a **short term certification** for three (3) months and a **long term certification** for six (6) months.

Certification (continued)

- Certifications can be transferred to a mental health center in the community and the person treated on an outpatient basis.
- If the person does not cooperate with treatment and a mental health professional believes that the person needs to be hospitalized in order to prevent decompensation, the MH professional may transfer the person to an inpatient psychiatric facility by authorizing a ***Transfer of Certification*** from the mental health center to the hospital.

MH Responses to Requests for Mental Health Evaluations

There are three levels of response by mental health center staff:

1. Emergency Response
2. Urgent Response
3. Routine Response

Emergency Response

Emergency response is needed when there is reason to believe that a person may be a danger to self, others, and/or gravely disabled

Emergency Response

An Emergency Response includes:

- A phone response to an emergency within 15 minutes by a trained clinician;
- A face to face evaluation within one hour;
- Medical clearance in an emergency room (may be requested) before a client is evaluated.

Urgent Response

An Urgent Response is appropriate when:

- The person does not appear to be dangerous to self or others
- However, the person may be at risk of becoming a danger or
- The person's mental health condition could quickly deteriorate

Urgent Response

An Urgent Response involves a mental health evaluation that can be conducted within 24 hours.

Routine Response

A Routine Response is appropriate when there is no indication that the person is a danger to self or others or is at risk of becoming a danger to self or others

Routine Response

Evaluation for services occurs within 5 business days for Medicaid clients or as available for non- Medicaid clients.

Contacting Mental Health for Services

All mental health centers have 24-hour, 7 days a week emergency response systems.

Contact your local mental health center for the number to call.

Overview of MH System

The following is a brief overview of the structure of the Mental Health Service System in Colorado. . .

Overview - MHS System

MHASA

(Mental Health and Assessment Service Agency)

- Monitor/authorize payment of Medicaid for mental health treatment.
- Authorize payment for inpatient costs for Medicaid clients
- Mental Health Centers may act as agents of the MHASA to authorize treatment.

Overview MHS System (continued)

Private Insurance or Medicare Coverage

Clients admitted for inpatient treatment, through private insurance and Medicare, are not authorized for payment by the MHASA or mental health center.

Indigent Clients

Clients who are indigent are often referred to the State Mental Health Institutes at Ft. Logan and Pueblo, if beds are available.

Overview MHS System (continued)

CAPACITY

Colorado State Mental Health Institutes

FT LOGAN

55 Beds - Children & Adolescents (20 residential)
132 Beds - Adults (25 beds for Geriatric Patients)

PUEBLO

30 Beds - Children & Adolescents
96 Beds - Adults/Geriatrics

Overview - MHS System (continued)

- **Admissions from a hospital Emergency Room are the responsibility of the ER physician.**
- **The Evaluator from the Mental Health Center serves as a consultant to the ER physician and may authorize payment for Medicaid recipients**.

Overview – MHS System (continued)

Disaster Response Plans

All Mental Health Centers have Disaster Response Plans that outline and are used to implement mental health service responses to local, regional and state wide disasters.

COLORADO STATUTES

- **CRS 13-21-117** — **Duty to Warn**
- **CRS 27-10-125** — **Imposition of Legal Disability**
- **CRS 27-10.5-110** — **Imposition of Legal Disability Developmental Disabilities**
- **CRS 27-10-106 [2]** — **Court Ordered Mental Health Evaluations**

Duty to Warn

CRS 13-21 117 ***protects the mental health professional*** **who receives a communication from a client indicating a "serious threat of imminent physical violence against a specific person or persons" and (the professional) warns the individual(s) of the threat. A mental health professional's** ***failure to provide this warning*** **allows he/she to be liable for damages in civil court.**

Imposition of Legal Disability

CRS 27-10-125 states that *any interested person may petition the court* for an *imposition of legal disability* or deprivation of a legal right. Designation of legal disability must be reviewed by the court in six months from original determination and may be reaffirmed at that time to justify continuance of the disability or deprivation.

Imposition of Legal Disability (continued)

CRS 27-10.5-110 states that any interested person may petition the court for an imposition of legal disability or deprivation of a legal right from a *person with a developmental disability*. (For details, please refer to this and the previous statute in your handout materials.)

Court Ordered Mental Health Evaluations

CRS 27-10-106 (2) ***Any individual may petition the court*** **in the county in which the respondent resides or is physically present alleging that there is a person who appears to be mentally ill and, as a result of such mental illness, appears to be a danger to others or to himself or appears to be gravely disabled and** ***requesting that an evaluation of the person's condition be made.***

Other Mental Health Services

- **Rehabilitation**
- **Residential**
- **Vocational**
- **Case Management**
- **Clinical Treatment**
- **W.R.A.P.** (**W**ellness **R**ecovery **A**ction **P**lan)

Rehabilitation Services

- **Psycho-educational Groups**
- **Aftercare Program**
- **Drop-in Programs**
- **Peer Counseling**
- **Home and Community Based Services (HCBS)**
- **Substance Abuse**

Rehabilitation Services (continued)

- **Wrap Around Services**
- **Skills Training**
- **Recreation Therapy**
- **Day Treatment**
- **Family Support and Education**

Residential Services

- **Group Homes**
- **Alternative Care Facility(s) (ACF)**
- **Transitional Apartment**
- **Independent Apartments / Section 8**
- **Referral services**
  - To Nursing Homes
  - To Alternative Care Facilities
  - To Assisted Living Facilities
  - To Adult Foster Care Facilities

Vocational Services

- **Pre-vocational Services**
- **Job Development**
- **Job Shadowing**
- **Job Coaching**
- **Employment Assistance**
- **Job Placement**
- **Skills Training**
- **Retraining Services**
- **On-site Employee Support**

CASE MANAGEMENT

- **Advocacy**
- **Crisis Intervention**
- **Linkage**
- **Monitoring/Follow-up**
- **Outreach**
- **Referral**
- **Service Planning**

Case Management:

ADVOCACY

Activities designed to assist a consumer or family to access needed services.

Case Management:

CRISIS INTERVENTION

Activities performed on behalf of a client which help alleviate or ameliorate a crisis situation or meet the client's emergency needs

Case Management:

LINKAGE

- **Working with clients and/or services providers to secure access to services.**
- **May include phone calls to agencies for appointments or services**
- **Taking clients to agencies for services and appointments**

Case Management:

MONITORING/FOLLOW-UP

- **Contacting the consumer/family or others to ensure a consumer is following an agreed upon service plan**
- **Monitoring the progress and the impact of the service plan**

Case Management:

OUTREACH

- **Providing all necessary services to consumers in their homes or in the community to engage and maintain in treatment**
- **Provides mutually beneficial relationships with community organizations**
- **Includes education, joint service planning, ongoing follow-up**

Case management

REFERRAL

- **Arranging initial appointments for consumers or families with service providers**
- **Informing consumers of services available**
- **Maintaining addresses and phone numbers of agencies providing services**

Case Management:

SERVICE PLANNING

- **Comprehensive plan of care for a consumer**
- **Documents all activities, treatment and supportive services**
- **Includes mental health treatment plan and all other plans of care provided by other agencies**

CLINICAL TREATMENT

- Individual, group, families, couples
- Wherever the person lives
- Outpatient
- Intensive services
- Inpatient
- WRAP

WRAP: WELLNESS RECOVERY ACTION PLAN

- System for monitoring, reducing and eliminating uncomfortable or dangerous physical symptoms and emotional feelings
- Developed jointly by client and therapist

WRAP (continued)

WRAP development includes:

- **Daily maintenance list**
- **Triggers**
- **Early warning signs**
- **Crisis plan**
- **Medications**
- **Help from others**
- **Community plan**

Section VII Summary

- **Emergency Services**
- **Response Levels**
- **Overview of MHS System**
- **Other Mental Health Services**

COLLABORATION
VIII

Section VIII - Collaboration

Common Goal

Improved consumer services **is the common and motivating goal of collaboration between mental health & adult protection professionals.**

To that end this section reviews some advantages and methods used in effective collaborative work to best serve our common consumers.

Collaboration . . .
Needed Now, More Than Ever Before:

- **Shrinking resources**
- **Overlapping/duplicating services**
- **Filling the gaps in services**
- **Serving a complex population**
  - **More people with multiple disabilities**
  - **More older adults**
  - **More cultural diversity**

Benefits of Collaboration

Inter-agency staff work together to:

- ***gain understanding of each system***
- ***form respectful relationships***
- ***build mutual trust***
- ***provide best possible continuum of care to consumer***

Benefits (continued)

How to Understand other system(s):

- Develop some basic knowledge about the regulations, statutes and policies by which the collaborating system operates.
  - **Do your own *research* first (or not).**
  - ***Ask non-challenging questions* about specifics, local history, etc. to an agency staff person or administrator during an informal meeting or over coffee.**
  - **Discuss mutual service options using old or *hypothetical case scenarios* to learn more about available services and resources.**

Benefits (continued)

How to form respectful relationships:

Professionals are more likely to share information about their service agency & system in a collaborative environment that . . . ***communicates respect & support.***

Such information can be critical to gaining a better understanding of service availability, eligibility criteria and resource limitations.

Benefits (continued)

How to build mutual trust:

Build mutual trust between agency staff by

- ***modeling professional accountability*** for service contributions without chastisement, non-constructive criticism or "axe grinding."
- ***Support/commend attempts to serve consumers***, whether or not they are successful, e.g. going to consumer's home to do an assessment and being denied entry.
- ***Share the frustrations*** of those service workers who are prohibited from providing needed services due to time/funding limitations and/or lack of system supports.

Benefits (continued)

How to provide the best possible continuum of care:

- ***Collaboratively developed Service Plans***
- ***Inter-agency staff discussions/reviews*** of
  - what happened
  - how the systems responded
  - how well it worked
  - what could be done differently next time

Working Together

Collaborative relationships develop in various ways and under differing conditions/political situations. Be open to meeting and developing relationships with agency staff people in many different settings.

- **CONSUMER CRISIS**
- **COMMITTEE/COMMUNITY ACTIVITIES**
- **INFORMATION & REFERRAL CONTACTS**
- **EDUCATIONAL/TRAINING EVENTS**
- **COMMON CASES**

Consumer Crisis

APS and MH professionals often first meet when consumers are in crisis. Crisis situations increase the need for speedy responses to service requests. As a result, in a crisis situation:

- **the referring agency feels pressure to address and resolve the consumer's crisis**
- **the agency receiving the referral is pressured to determine the appropriateness of the referral in a short time-frame.**

Committee/Community Activities

Common membership on professional and civic groups **can often lay the ground work for improving relationships** between professionals from APS and MH service systems. Take advantage of these opportunities to get to know your colleagues outside the office/business setting.

Information and Referral Contacts

Take advantage of non-crisis opportunities for I & R calls to your colleagues. Learn what their favorite/least favorite types of cases/diagnoses are and why. Ask their opinions on past case scenarios or some worst case scenarios. "This is what we did in this case. How would your agency respond to such a situation?" or "What would you do if you had a client in this situation?"

Educational/Training Events

Be an active participant in training opportunities in the areas of service provision that you share with your colleagues. Introduce yourself to agency representatives. Discuss class content with them. Go to coffee/lunch with them. Find out more about the services each agency offers at the local level.

Common Cases

Often, we connect because of cases with which both systems are working. They are often long term (chronic) cases. Releases are signed. Communication is not complicated within the parameters set by the release forms.
Use such low stress situations to better acquaint one another with service/agency parameters.

Challenges to Collaboration

- INTAKE PROCESS
- STAFF TURNOVER/RE-ASSIGNMENT
- CONFIDENTIALITY ISSUES
- EMERGENCY/CRISIS SITUATIONS

Challenges/Intake (continued)

INTAKE PROCESS

- Before referring consumer determine services you will request, such as an evaluation, assessment, or investigation.
- Avoid dictating services that are needed but for which the client may not qualify.
- Find out & use the agency protocol for Crisis and Routine Intakes
- Or find out who you need to talk to and ask for the person by name.

Challenges/Intake (continued)

INTAKE PROCESS

- The intake process can be stifled by misunderstanding professional jargon/terms
  (e.g.,"mental health" evaluation is not a "competency" evaluation)
- Intake staff are encouraged to ask specific questions about what has lead to the referral
- Determination needs to be made whether or not the referral is a crisis or routine service request

Challenges/Staff Turnover (continued)

STAFF TURNOVER/RE-ASSIGNMENT

Staff turnover and staff re-assignment make it difficult to maintain/develop effective collaborative relationships.

Challenges/Confidentiality (continued)

CONFIDENTIALITY

- ***Sharing information on a need to know basis*** is appropriate when:
  - APS is involved in an investigation of a crisis situation
  - MH is involved in a consumer crisis

Challenges/Confidentiality (continued)

CONFIDENTIALITY

- ***Ongoing communication*** between agencies requires ***signed release forms***.

Challenges/Confidentiality (continued)

CONFIDENTIALITY

- **It is *always acceptable to receive information* from a concerned agency or individual even without a release.**

Challenges/Confidentiality (continued)

CONFIDENTIALITY

- ***Third party records*** cannot be released.

Challenges/Emergency Cases (continued)

EMERGENCY/CRISIS CASES

- Discuss acceptable plans for crisis situations
- Review/improve process in previous crises
- High advocacy/therapeutic needs
- Share "need to know" information
- Regroup/debrief following crisis to analyze process and adjust process

Collaboration with other agencies:

ADAD	-	Dual diagnosis with Substance Abuse (**A**lcohol & **D**rug **A**buse **D**ivision)
HCBS	-	"**H**ome & **C**ommunity **B**ased **S**ervices"
	-	Supported Living Services
OBRA/ PASARR	-	Persons in nursing homes who require MHS
POLICE/ SHERIFF	-	Unsafe, crisis situations, suspicions of criminal activities

HOSPITALS & FAITH COMMUNITIES

EXAMPLES OF COLLABORATION

Evaluations for Mental Health (M-1or 27/10) Hold:

- Strong signs and symptoms of grave disability
- Consumer refuses to leave home to obtain evaluation
- Neither home environment nor consumer pose a safety risk for any responder
- APS worker is willing to accompany MH worker to consumer's home

Other Examples of Successful Collaboration

Section VIII Summary

- Benefits of Collaboration
- Challenges of Collaboration
- Examples of Collaboration

Scenarios - Suggested Collaborative Process (Group/Representative Notes)

1. Define the client's needs.

2. Identify the resources available to meet those needs.

3. Obtain releases from the client, if possible, to exchange relevant information with needed resource service providers.

4. Staff case together with (client, if possible, and) other service providers.

5. Develop integrated Service Plan/Proposal (with client input, if possible) pooling all appropriate resources.

6. Confirmation of who will be responsible for what in regards to the client and the Service Plan.

7. Develop a time line/coordination of plan/sequence of events according to Service Plan.

8. Establish a follow-up meeting(s) schedule.

9. Determine the necessary frequency of ongoing communication between the various group members/service providers.

10. Was the "tone" of the referral (letter) respectful of the receiving professional's expertise?

11. If not, what gives you that impression and how could the "tone" be improved?

12. Any other general recommendations regarding the "tone" and content of any referral document/scenario description between the two systems (APS & MH)?

SCENARIO #1

MH REFERRAL TO APS - **MRS. ATWATER**

Referral Information

APS receives a call from a mental health worker in the Substance Abuse Recovery program of the local Mental Health Center. MH is referring Mrs. Atwater who is 60 years old. She is diagnosed with a psychotic disorder and abuses alcohol. She was recently hospitalized and certified for treatment at Ft. Logan. Following her discharge from Ft. Logan, Mrs. Atwater was offered and accepted placement at an Alternative Care Facility (ACF). She has stabilized during her stay there and has been doing well.

The concern is that Mrs. Atwater's daughter paid an unexpected visit, after her mother's Social Security check arrived. The daughter took her home. Prior to Mrs. Atwater's hospitalization, she had signed over a Quick Claim Deed for her house to the daughter. When talking to her therapist at a later date, Mrs. Atwater stated, "Well, my daughter is having a difficult time. Her husband is not working and she just needs some help. I just gave her my birthday money and some additional money."

The consumer would not disclose the amount of money that she gave the daughter. In describing Mrs. Atwater, the mental health worker stated that she is alert and oriented, and claims to have given the money voluntarily without coercion, threat, or undue influence.

Scenario #2 MH MAKES A REFERRAL TO APS - **MRS. WHITAKER**

Referral Letter

Dear Adult Protective Services Representative:

We are writing out of concern for Mrs. Whitaker. She has a developmental disability and multiple major mental illnesses, including Major Depression, with psychotic features, Post-Traumatic Stress Disorder, and Poly-substance Abuse.

First, we are concerned about self-neglect. Mrs. Whitaker continually puts herself at risk by avoiding mental health treatment. She doesn't take her medications, gets depressed and takes non-prescribed drugs. She has history of overdosing. Over the past two years, she has been admitted to inpatient hospitalization every 3 months for drug overdose, suicide attempts and/or threats to commit suicide. When not in residential or inpatient treatment, she lives with her daughters and a sister. We believe she is at risk when living at home with her family. Family has been unable to provide the support that she needs. There is evidence that her choices improve when she is living in a structured, supportive setting, such as a residential treatment facility.

Second, we believe that family members are exploiting her financially. In the past, her sister, as rep payee, has refused to buy her a bus pass in the past. The pass would make it easier for her to receive treatment, etc. Without it, she has to rely on friends and family members, who have shown they are not reliable to provide transportation when needed. Mrs. Whitaker receives a monthly SSI check. She has been receiving inpatient treatment at Ft. Logan for the past two months. During that time, Social Security has not been notified and her sister has been using the SSI checks to make rent, phone, and cable payments for herself and her daughters. Because of this the client doesn't have money to pay for her prescription medications.

We are very concerned for Mrs. Whitaker's safety. We believe that unless a change is made in her representative payee designation, she will continue to be exploited. This Mental Health Center served as representative payee for Mrs. Whitaker in the past, but had to discontinue the service because it significantly interfered with her therapeutic process.

We request that Adult Protective Services take action in this case. We expect to hear from APS regarding what can be done about this situation.

Sincerely,

Treating Therapist

Scenario #3 APS MAKES REFERRAL TO MH - **MRS. WHITE**

An APS worker calls the local mental health center and requests assistance in evaluating and creating a plan for services for Mrs. White, a resident of a senior housing complex.

Referral Information

APS received a report from a subsidized senior housing complex for independent living. Mrs. White is 66 years old. She has been accusing other residents and maintenance staff of entering her apartment and stealing, moving, or taking things from her apartment. The accusations have caused enough conflict among the other residents of the complex that "something must be done." All investigation by management has produced no evidence that there is actually any such (theft) activity occurring. The police have been involved on more than one occasion and found no credible basis for the reports. Mrs. White continues to call the managers with complaints, write extensive letters of complaint to the corporate office, and confront other residents. Management at the facility is at the point that they will present her with an eviction notice if her behaviors persist.

On her home visit with Mrs. White, the APS worker found her to be an active, independent woman. She correctly answered all questions on the Folstein Mini Mental Status Exam. Her apartment and person were very neat and clean. She manages her finances responsibly. She also manages her insulin dependent diabetes independently. She has insomnia and arthritis, for which she takes prescribed medications appropriately.

Mrs. White's adult son assists her with grocery shopping and with making copies of the letters, etc. she creates when reporting the alleged "violations." Her letters are clearly written, and complete with dates and time-of-day.

Mrs. White has a history of inpatient psychiatric treatment at Fitzsimmons Hospital in 1989 for 11 days. She reports one suicide attempt in the past during which she overdosed. She called her pastor following that overdose. He went to her apartment, found her and called the ambulance. She saw a psychiatrist a year and a half ago. The doctor put her on Prozac. She did not like the effects of the medication and took herself off of it.

At this time, Mrs. White does not believe she has any mental health needs and will not go to a mental health center for services. When presented with the possibility that she may be evicted and that this would compromise her access to future subsidized apartments, she does not present any solutions or alternatives.

Scenario #4 APS MAKES REFERRAL TO MH - **MR. SMITH**

APS calls MH requesting an evaluation for an M-1 to have Mr. Smith taken in for assessment and treatment.

Referral Information

The APS caseworker has made 2 visits with Mr. Smith following a report of self-neglect made by his landlord. Mr. Smith is 72 years old. He had a stroke two years ago. He has right-sided weakness but does walk with the assistance of a 4-prong cane. He seems very unsteady, due to either the after effects of the stroke or to weakness. He has multiple bruises of varying color on the exposed skin of his arms and on his forehead and cheeks. His lower pant is stuck to his left leg, as if there is an open wound that has drained onto the pants. He will not let the worker see his leg uncovered.

This gentleman refuses to go to the doctor with the worker. Following a recent fall, he refused to go with the ambulance despite the paramedic's expressed concern about the condition of his leg. He minimizes the wound to his leg although it has an extremely foul odor.

There are animal feces throughout the small apartment from Mr. Smith's aged dog. According to the landlord, Mr. Smith has lost quite a bit of weight over the past months. The only food in the home is what the caseworker provided following the first visit. It does not appear that any of that food has been touched; yet Mr. Smith insists that he has eaten "a little." He looks dehydrated and there is no evidence that he has used any glasses since the previous visit earlier in the week.

Mr. Smith talks slowly in a whisper. He communicates both expressively and receptively. He can tell the worker his address, date of birth, and social security number, but does not know the date, season, president, or how much money he gets every month. He does not know if his social security check is delivered to his home or deposited directly into his bank. There are unopened bills piled on the table. The landlord complains that Mr. Smith's significant other quit visiting a year ago and that he has to ask repeatedly for the rent. The landlord also states that while Mr. Smith wrote checks on his own during the year following his stroke, the landlord currently has to help write the rent checks to get his payment. The landlord does not know of any family. No one else has visited Mr. Smith.

The worker has offered medical care, home services, meals on wheels, and assisted living. Mr. Smith has refused all help saying he will be okay. He is not able, however, to explain how he will take care of himself.

The caseworker believes that Mr. Smith is suffering from depression. His condition is making it impossible for him to make informed decisions or to care for himself.

Abuse of At-risk Adults
Indicators and Assessment Tools

Manifestations of Abuse or Neglect

- Recurring or unexplained injuries
- Non-treatment of medical problems
- Poor hygiene
- Malnutrition; dehydration
- Depressions, withdrawal or fearfulness
- Over-sedation or misuse of medication
- Threat of punishment by friend, family member or caregiver
- Inconsistency of information by family member or caregiver

Conditions associated with high risk of abuse or suggesting potential for abuse:

- Severe cognitive impairment; depression
- Severe physical impairment requiring heavy care
- Family norm of violence
- Social or physical isolation of the elder and/or the caregiver
- Refusal of outside services
- Control of elder's financial affairs or assets by another

In situations of physical abuse of the elderly, victims and abusers usually live together. When abuse is by spouses, it may continue from earlier in life, or it may begin in old age. In cases of abuse by offspring, the abuser is likely to have mental health or substance abuse problems. Victims are often dependent on their abusers for care. Abusive offspring are often dependent on victims for money or a place to live.

In investigating physical abuse, it is often difficult to distinguish between injuries that were inflicted and those that were the result of an accident, health condition, or medication. For this reason, it is important to explore and evaluate explanations and interpretations of physical indicators. The behaviors of victims and suspects, as well as the interactions between the two, can provide valuable clues in investigating physical abuse.

Indicators of Physical Abuse

1. Unexplained or recurring bruises and welts:
   a. on face, lips, mouth, torso, back, buttocks, thighs
   b. bruising in various stages of healing as follows:

00-02 days:	swollen, tender	07-10 days:	yellow
00-05 days:	red-blue	10-14 days:	brown
05-07 days:	green	02-04 weeks:	clear

   c. clustered or forming regular pattern
   d. reflecting the shape of the article used to inflict abuse (e.g., electric cord, belt, buckle)
   e. appearing on different surface areas
   f. appearing routinely after unexpected absences, weekend or vacations away from the facility (after the elder goes home for a visit)
   g. periodic bruising and bruising around the jaw caused by slapping: thumping marks to the ear; hemorrhaging of the cartilage of the ear caused by twisting.

2. Unexplained burns:
   a. cigar, cigarette burns, especially on soles, palms, back or buttocks
   b. immersion burns (bi-lateral, sock-like, glove-like, doughnut-shaped, on buttocks or genitals)
   c. patterned like electric burner, iron, etc.
   d. rope burns on arms, legs, neck or torso

3. Unexplained lacerations or abrasions:
   a. to mouth, lips, gums, eyes, ears
   b. to external genitalia

4. Unexplained fractures
   a. to skull, nose, ear (cauliflower ear), facial structure
   b. in various stages of healing
   c. multiple or spiral fractures
   d. facial injuries
   e. poorly set bones
   f. history of previous fractures

5. Unexplained hair loss:
   a. hemorrhaging beneath scalp
   b. possible hair pulling, by self or other
   c. possible evidence of underlying severe head injury (subdural hematoma)

6. Human bite marks

7. Signs of confinement:
   rope burns on wrists, ankles, neck, torso

8. Evidence of past injuries, old and new injuries that have not properly healed:
   a. deformities - skull, nose and ears, cauliflower ear, hands (twisting reflex)
   b. contracture resulting from restraint and delay in seeking treatment
   c. dislocation (may be due to incorrect lifting), pain, tenderness and swelling

Behavioral Indicators of Abuse

The Victim:

- Has change in activity level
- Shows lack of interest
- Is easily frightened or fearful
- Exhibits unjustified fear
- Exhibits denial of the situation
- Is agitated or trembling
- Is hesitant to talk openly
- Offers implausible stories
- Makes contradictory statements
- Exhibits recent or sudden changes in behavior, i.e. depression
- Displays unwarranted suspicion; is unwilling to communicate

The Suspected Perpetrator:

- Conceals the victim's injuries, brings the victim to a different medical facility for treatment each time there is an injury (doctor-hopping)
- Use emergency rooms frequently
- Offers inconsistent or implausible explanations for the victim's injuries
- Is obstructive to investigation: speaks for the older person, dominate the interview, refuses to allow the older person to be interviewed alone, tries to divert the interviewer from the subject, or acts defensively
- Handles the older person roughly or in a manner that is threatening, manipulative, sexually suggestive, or insulting
- Is unreasonably critical of and/or dissatisfied with social and health care providers and frequently changes providers.

Sexual Abuse

A number of cases of sexual abuse come to light each year, often only after some other form of abuse has been reported. It is important to keep the possibility of sexual abuse in mind when investigating other forms of abuse.

Indicators of Sexual Abuse

1. Difficulty in walking or sitting
2. Torn, stained or bloody underclothing
3. Pain or itching in genital area
4. Bruises or bleeding of external genitalia, vaginal or anal areas: vaginal discharge
5. Unexpected and unreported reluctance to cooperate with toileting and physical examination of genitalia.

Referral to a hematologist with unexplained bruising, families going to their PCP (primary care physician) with vague symptoms, requesting tranquilizers or placement in residential care may also be indicators of sexual abuse.

The clients themselves may try to indicate the problem with frequent presentation to general practitioners of vague aches and pains. However, the elder may be labeled as neurotic or senile, even paranoid, if they make accusations of sexual abuse against the alleged perpetrator.

Indicators of Neglect

- ✓ Inadequate or inappropriate clothing
- ✓ Absence of eyeglasses, hearing aids, dentures, assistance devices; dirty eyeglasses, hearing aids that don't work
- ✓ Decubitus ulcers (bedsores)
- ✓ Excessive dirt or odor
- ✓ Decreased alertness, responsiveness
- ✓ Sudden, unexplained loss of weight
- ✓ Dehydration
- ✓ Malnutrition
- ✓ Unused or spoiled food
- ✓ Cold, sparsely furnished room; locked room with no access to toilet facilities; room out of keeping with rest of household
- ✓ Elder confined to only one room of the house

Possible Indicators of Financial Abuse

1. Unusual activity in bank accounts. Activity in bank accounts that is inappropriate to the older adult, i.e., withdrawal from automatic banking machines when the person cannot walk or get to the bank.

2. A power of attorney is appointed by the older adult at a time when she/he is unable to comprehend his or her own financial situation nor is capable of comprehending the significance of the appointment.

3. Unusual interest on the part of a caregiver or family member that in the amount of money being expended for the care of the older person, concern that too much is being spent.

4. A conservator's refusal to spend money on the care of the conservatee.

5. Numerous unpaid bills or overdue rent when someone has been designated or authorized to pay such bills.

6. Recent acquaintances expressing gushy, undying affection for a wealthy older person.

7. Recent change of title of older person's home in favor of a friend, when the older person is clearly incapable of understanding the nature of the transaction.

8. A Will dated and signed at a time when the older person is clearly incapable of comprehending the meaning of the actions/changes in the Will.

9. Caretaker/family member asks only financial questions, does not ask care questions.

10. Lack of amenities, i.e., TV, personal grooming items, appropriate clothing, when the elder could easily afford such items.

11. Personal belongings such as art, silverware or jewelry are missing.

12. A friend or housekeeper tries to isolate the older adult from friends or family. Tells the elder that the other friends/family don't want to see him/her. The older person then becomes isolated and alienated from those who care for him/her. The older person begins to totally rely upon the housekeeper, who has total control.

13. Where promises of life long care in exchange for a will or deeding all property and bank accounts to the caretaker have been made.

14. Watch for signatures on checks, etc., that do not resemble the older person's signature or when you know the older person cannot write.

15. When the older person complains that he/she used to have money and they don't anymore.

16. Eviction notice arrives when the older person thought they owned the house.

17. When the older person says he/she has been signing papers and doesn't know what they have been signing.

18. A caretaker is evasive about financial arrangements.

19. Implausible stories about the finances by both the caretaker and/or the older person.

20. People involved with the older person should become very cautious when they hear about antiques missing or favorite objects missing.

Other Possible Indicators of Abuse

1. Undue anxiety or aggression displayed by the older person.
2. Depression, helplessness, hopelessness
3. Excessive fearfulness, ("What are you going to do to me?"), or fear of being left alone.
4. Ribbons in hair, toys, baby talk; inappropriate or inadequate dress.
5. Cowering
6. Expression of ambivalent feeling towards family
7. Unusual interest being shown by other in the elderly person's possessions, especially money.
8. Necessities not being provided by caregivers (money for soap, sweets, newspapers), despite holding the pension/bank books
9. Unexplained genital infections
10. Soiled bed linen or clothing
11. Unexplained or unexpected deterioration in health
12. Absence of glasses, hearing aid and/or dentures
13. Forcing an older person to have a bowel movement in his/her diaper rather than toileting or leaving the person on a bedpan for an extended period of time
14. Threatening punishment if the older person does not behave
15. Talking to the older person as if he/she is a child
16. Talking about the older person as if he/she was not there
17. Yelling or screaming, using demeaning language or ridicule
18. Unnecessary confinement, prohibiting free choice, not allowing participation in activities.
19. Using silence to punish and/or isolate the older person/ignoring his/her questions and comments.
20. Older person is experiencing:
    - ✓ chronic insomnia/sleep deprivation
    - ✓ needs excessive sleep.
    - ✓ unexplained weight loss or gain
    - ✓ change in appetite

- ✓ unexplained paranoia
- ✓ low self-esteem
- ✓ ambivalence
- ✓ resignation
- ✓ tearfulness
- ✓ confusion
- ✓ agitation

ACTIONS FOR PROFESSIONALS TO HELP PREVENT ABUSE

1. Be knowledgeable about factors that cause stress and lead to abuse.

2. Instigate medical investigation and treatment at early stages of illnesses that could lead to risk conditions.

3. Give all the information about the medical condition, its prognosis (even when time limits cannot be given), the effects of treatment, particularly side-effects of medication. The physician should be prepared to discuss alternative treatments.

4. Ensure that the older person and the caregiver feel that they have each been heard, understood and that they feel the advise/suggestions given to them are things they can do.

5. Ensure the caregiver's own health needs are considered.

6. Use the appropriate skills of other primary health care workers.

7. Always refer to social services/social work departments, giving comprehensive information including family structure and inform the older person and caregiver or your actions.

8. Ensure that the older person and caregiver know of the self-help groups and other organizations that can provide support to them. Refer and ask those organizations to contact the individuals if those involved agree.

9. Help caregiver to accept their right to a life of their own and to have their own needs met. Do not reinforce the feelings that lead to isolation and stress.

10. Take regular opportunities to see the elderly person and the caregiver separately or refer to a senior center resource specialist.

How to Avoid Being Victimized

1. Plan for the possibility of disability by seeking out an attorney who can advise you about powers of attorney, guardianships and conservatorships, natural death acts and "living wills."

2. Consider nominating co-conservators or co-guardians so that more than one person knows your affairs and can take action if something goes amiss in the administration of your assets or personal care.

3. Make a will and review it annually, but do not revise it lightly.

4. Be wary about deeding or willing your house or other asset to anyone who promises to "keep you out of a nursing home" or take care of you at home if you become disabled.

5. Be careful when asked to sign anything. Go the extra step and have someone you trust review the document.

6. Be sure you are thoroughly familiar with your financial status and know how to handle your assets.

7. Arrange for direct deposit of your Social Security check or other regular payments.

8. Do not rely solely on family for your social life or for care if you have any health problems. Continually cultivate friends of all ages so there are always people around who are concerned about you.

9. If an adult child, particularly one who has led a troubled life, wants to return home to live with you, think it over carefully. Be especially careful if your family has a history of violent behavior or drug/alcohol abuse. Instead, consider supporting the child in his or her own apartment.

10. If there has been alienation from family or friends, make peace to the extent possible - not only because it is a healing thing to do, but because it creates a climate of concern for you and your well-being.

MISCELLANEOUS HANDOUTS

The checklists and tools in this section of the handbook appeared in Suggested Protocols for Victims of Spousal and Elder Abuse, A Task Force Reference Document for Colorado Hospitals. It was published by the Colorado Department of Health and reprinted with permission.

ASSESSMENT CHECKLIST
FOR VICTIMS OF DOMESTIC VIOLENCE

DOMESTIC VIOLENCE

(Interview should be conducted with victim separated from spouse/boyfriend/alleged perpetrator.)

RISK FACTORS
(check those that apply)

_____ Financial problems, unemployment
_____ Divorce or separation especially during pregnancy
_____ Drug or alcohol abuse by victim or alleged perpetrator
_____ Victim or alleged perpetrator physically abused as a child
_____ Overly protective or controlling alleged perpetrator (refuses to leave room during exam/treatment)
_____ Suicide attempts by victim or alleged perpetrator
_____ Mental illness of victim or perpetrator

SIGNS OF PHYSICAL ABUSE: (check those that apply)

_____ Self-induced or attempted abortions, multiple therapeutic abortions, miscarriages
_____ Abdominal or pelvic injuries, back or spine injuries (no fall or MVA)
_____ Injuries to face, neck, throat, chest, breasts
_____ Injuries during pregnancy
_____Increased drug/alcohol abuse during pregnancy
_____ Multiple injuries in various stages of healing
_____ Injury inconsistent with history
_____ Delay between injury and medical treatment
_____ Woman minimized frequency or seriousness of injuries
_____ Repeated ER visits with multiple somatic complaints, or injuries of increasing severity.
_____ Sexual assault by partner
_____ Suicide attempt
_____ Single car accident
_____ Fractures in various stages of healing
_____ Burns (cigarette, friction, splash, chemical)
_____ Head injuries
_____ Low self-esteem, sense of apprehension or hopelessness, depression of victim (laughing inappropriately, crying, no eye contact, angry, defensive)

_____ HOMICIDAL RISK

- ✓ Presence of gun in home
- ✓ Alleged perpetrator threatened to kill victim
- ✓ Victim believes that alleged perpetrator may kill her
- ✓ Overly jealous perpetrator
- ✓ Violent behavior by perpetrator towards non-family members
- ✓ Use of alcohol or drugs by perpetrator
- ✓ Increasing severity of injuries
- ✓ Perpetrator has killed pets
- ✓ Perpetrator objectifies victim (calls names, body parts, animals)

PHYSICAL ABUSE SCALE

The following is a listing of types of physical abuse, presented in the order of less to more sever. By locating a particular given incident of abuse on this scale, a person may more effectively assess two things:
(1) The level of dangerousness of the assailant
(2) The need for protection of the victim

Most ongoing abuse escalate in more or less this order so that the presence of an action identified as #5 or #6 on the scale is indicative of probable past abuse having occurred even if there has been no prior police or system involvement.

#1 Throwing things, punching the wall
#2 pushing, shoving, grabbing, throwing things at victim
#3 Slapping with an open hand
#4 Kicking, biting
#5 Hitting with closed fists
#6 Attempted strangulation
#7 Beating up (pinned to wall/floor, repeated kicks, punches)
#8 Threatening with weapon
#9 Assault with weapon

Sexual abuse is often present in physically abusive relationships, and verbal/emotional abuse is always present. It is crucial for anyone using this scale to help assess a situation to include the victim's opinion about the dangerousness of the situation for her. If the victim is telling you that her situation is more dangerous than the scale would indicate . . . believe HER. The scale is only a tool.

Adapted by Project Safeguard from Straus, M.A>, Geller, R.J., and Steinmetz, S.K., Behind Closed Doors - Violence in the American Family, New York: Anchor/Doubleday, 1980.

Used with permission by Mile High United Way Special Report Criminal Justice System's Response to Domestic Violence - Metro Denver, May 1989.

QUESTIONS TO ASK AT RISK ADULTS - HOW TO ENCOURAGE DISCLOSURE

When interviewing the person, the use of adaptive devices or interpreter may be necessary. An independent interpreter should be utilized at the time of the examination.

A. It is important and helpful to ask questions when you suspect abuse. Victims may not respond immediately, but you have begun the process of establishing trust. Consider incorporating questions about at risk adult abuse in other patient/consumer questionnaires.

B. Ask about suspected abuse in different ways. Not all victims will respond to the same kinds of questions. Studies show that the percentage of people who admit they are abuse victims increases with the number of different questions asked because victims' perceptions of what has happened differ.

C. Abuse is a difficult situation, and you may have to give these patients more time than you may allocate for others.

D. Maintain eye contact (when culturally correct).

E. Most abuse victims are filled with fear and shame. The most helpful "feeling" response to a patient's revelation of abuse is empathic concern. Most will be inhibited by a show of horror, anger, disbelief or demonstrative sympathy. Some people may fear nursing home placement, or other losses of independence as a result of their disclosure.

F. Assume that any older patient can be a victim of abuse and that batterers can come from any family or economic background.

G. It is important for the physician to recognize that victims are more than objects of abuse. Although abuse does affect their responses and perceptions, they are survivors..

H. The following questions may help the person reveal abuse:

1.Relationships between adults are sometimes violent, even among family members. I am here to listen and I may have some suggestions for what you can do about it. What happens when there is an argument at your house?

2. I noticed that you have a number of bruises. How did they happen? If the explanation sounds improbable, continue to probe. It is better to pose a direct question like, "Did someone slap you, hit you, push you or rough you up?" than to let an improbably explanation pass without saying anything.

3. Do you need any assistance in bathing, dressing, eating, etc? If so, who helps you? How often does he/she help you? How did this person decide to help you?
Has there ever been a time when this person has not helped, that you thought he/she should? How often has that happened? Have you been left for long periods of time?

4. Does anyone assist you in anyway with handling your money or assets? (i.e., paying rent, buying groceries, cashing checks, etc.?) Is this a legal or formal agreement? How does this person keep you informed of your financial status?
Have you ever mistrusted the way this person has handled your money?

PHYSICAL ABUSE SCALE & LETHALITY

(Michael Lindsey, Arapahoe Psychotherapy Collective)

Regarding Lethality . . .

All battering relationship should be considered potentially lethal, in the sense that any battering episode can end in death.

Also, batterers who are actively contemplating suicide or homicide tend to function in specific ways. *Homicidal thinking is a transient state that batterers can enter into and exit from again and again.*

- The "Lethality Checklist" is a tool to assess how many of those characteristics are present at any given time. It is a checklist, not a scale. It can be useful to those persons monitoring the level of functioning of a batterer in terms of when to give feedback to the victim to ensure her safety.

- Although the "physical Abuse Scale" can serve a useful function in helping police correctly identify an ongoing violent relationship when there is denial from the batterer (sometimes the victim), it is not a safe predictor of lethality.

- Severity of past violence is one indicator of dangerousness, but it does not always predict homicide. It can be more useful when assessed in conjunction with the lethality checklist.

- When using either of these tools, it is critical to obtain information from the victim, as well as the alleged perpetrator.

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DANGER ASSESSMENT

Jacquelyn Campbell, Ph.D. R.N., Copyright, 1985, 1988

Several risk factors have been associated with homicides (murders) of both batterers and battered women in research that has been conducted after the killings have taken place. We cannot predict what will happen in your case, but we would like you to be aware of the danger of homicide in situations of severe battering and for you to see how many of the risk factors apply to your situation. (The "he" in the questions refers to your husband, partner, ex-husband, ex-partner or whoever is currently physically hurting you.)

Using the calendar, please mark the appropriate dates during the past year when you were beaten by your husband or partner. Write on the date, how long each incident lasted in approximate hours and rate the incident according to the following scale.

1. Slapping, pushing - no injuries and/or lasting pain
2. Punching, kicking - bruises, cuts and/or continuing pain
3. "Beating up" - sever contusions, burns, broken bones
4. Threat to use weapon - head injury, internal injury, permanent injury
5. Use of weapon - wounds from weapon

_____1. Has the physical violence increased in frequency over the past year?
_____2. Has the physical violence increased in severity over the past year and/or has a weapon or threat with weapon been used?
_____3. Does he ever try to choke you?
_____4. Is there a gun in the house?
_____5. Has he ever forced you into sex when you did not wish to do so?
_____6. Does he use drugs? By drugs, I mean "uppers" or amphetamines, speed, angel dust, cocaine, "crack," street drugs, heroin or mixtures.
_____7. Does he threaten to kill you and/or do you believe he is capable of killing you?
_____8. Is he drunk every day or almost every day? (In terms of quantity of alcohol.)
_____9. Does he control most of all your daily activities? For instance, does he tell you who you can be friends with, how much money you can take with you shopping, or when you can take the car? (If he tries, but you do not let him, check here _____.)
_____10. Have you ever been beaten by him while you were pregnant? (If never pregnant by him, check here ___.)
_____11. Is he violently and constantly jealous of you? (For instance, does he say, "If I can't have you, no one can.")
_____12. Have you ever threatened or tried to commit suicide?
_____13. Has he ever threatened or tried to commit suicide?
_____14. Is he violent toward your children?
_____15. Is he violent outside of the home?

_____ Total "Yes" answers.

THANK YOU. PLEASE TALK TO YOUR NURSE, ADVOCATE OR COUNSELOR ABOUT WHAT THE DANGER ASSESSMENT MEANS IN TERMS OF YOUR SITUATION.

Nurses and other health care professionals or battered women's advocates are invited to use the Danger Assessment with battered women with whom they come in contact. The woman will need to discuss her answers with someone after she fills out the assessment, so that it is not appropriate to use as a take home or mail out questionnaire. If anyone wishes to use the instrument in a clinical or shelter setting or for research, they may make copies as needed. However, please write to Jacquelyn Campbell, Ph.D. R.B. at Wayne State University College of Nursing, Detroit, MI 48202, to let her know you are using it. The instrument is being used with permission: Jacquelyn Campbell, Ph.D., R.N.