CLINICAL COMMENTS

Clinical Mental Health Outreach to Older Adults: Serving the Hard-to-Serve

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ABSTRACT. Older adults with severe and persistent psychological difficulties can have trouble taking care of their basic needs, protecting themselves, and maintaining adequate housing. Traditional community mental health interventions, as well as almost all supportive services, are refused by this subgroup of elders. The project described in this article expands mental health services to older adults who, because of the severe nature of their psychological difficulties, are at risk of eviction, homelessness, premature institutionalization, premature guardianship, elder abuse including self-neglect, and decreased quality of life. The project utilizes psychological skills in personalized, flexible, time-intensive interventions that are delivered in community settings. Foundational to the interventions are careful clinician recruitment and established working relationships with community gatekeepers. Initial

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contacts include informal needs assessment and often require several hours per week. Ongoing clinical interventions are stepwise and may expand to include case management and traditional psychotherapy. Community consultation supports sustained interdisciplinary assistance to hard-to-serve elders. Outcomes included 508 persons served, of which 304 received long-term assistance. Positive changes included elders receiving services previously refused, decreasing isolation, avoiding eviction, reducing need for emergent services, decreasing delusional material, and setting limits in relationships. Ongoing issues such as burnout prevention and informed consent are addressed.

KEYWORDS. Older adults, outreach, clinical, mental health

While approximately 20% of older adults suffer from significant symptoms of mental illness (American Psychological Association, 2004), as many as two-thirds are untreated (Rabins, 1996; U.S. Department of Health and Human Services, 1999). Service barriers include lack of information, physical frailty, poverty, lack of lingual and cultural services, and psychological issues (Report of the Surgeon General, 1999; Yang & Jackson, 1998). Some particularly difficult barriers are (1) entrenched, dependent relationships in which elders feel unwilling to set limits on abusive behavior, and (2) suspicious, paranoid thinking, rendering the elder frightened of receiving services. Four to 6% of older adults are elder abuse victims (Wolf, 2000) and approximately 2%-4% suffer psychotic delusions or paranoid symptoms (Rabins, 1992).

This article describes The Center for Aging Resources' Mental Health Outreach Project. Developing out of referrals from the local police department, victims of familial abuse and elders experiencing delusional and suspicious thinking were especially hard to serve. Elder abuse victims were often reluctant to separate from abusive but loved family members, often due to mixed feelings of fear, love, guilt, and so forth. Delusional, suspicious older adults often complained that a crime had been committed against them, but the police could not substantiate the complaints. These seniors had multiple practical, as well as emotional and social needs, and concurrently, were extremely reluctant to accept services. For example, Mr. X. called the police department

several times a week, complaining that people had broken into his home and stolen items, although the police found no evidence of robbery.

Older adults are at risk of eviction, homelessness, premature institutionalization, premature guardianship, elder abuse including self-neglect, and decreased quality of life. They may be capable of remaining safely in the community if provided the appropriate support. Under traditional service delivery approaches, when offered "counseling" or "psychotherapy" these individuals often refuse. However, they may be open to establishing a relationship when a clinician approaches the older adult in a nonthreatening manner.

THE INTERVENTION

This project provides clinically sensitive mental health outreach. The barrier targeted is hesitancy, fear, and ambivalence, and the key to diffusing this barrier is the interpersonal relationship between older adult and clinician. By gently developing trusting relationships, clinicians help seniors toward gradual stepwise change. Generous funds from the Archstone Foundation and the S. Mark Taper Foundation enabled implementation of this outreach.

Clinician Recruitment

Providing consistent, ongoing services to reluctant elders requires a highly clinically trained approach and an ability to conceptualize an intervention from a mental health perspective. Project clinicians must have significant experience with psychiatrically ill persons, be able and willing to work in a nontraditional manner, and have the personal maturity to persist in the face of rejection. Over the first several contacts, the older adult may give mixed messages to the clinician. For example, on the first phone call, Mr. W. agreed to a visit "anytime," but when the clinician arrived, Mr. W. got angry and slammed the door.

Outreach and Participant Recruitment

Project staff introduce the program to professionals in the community who work with at-risk, isolated, abused, and delusional elders. These "gatekeepers" (Florio & Rauschko, 1998) include law enforcement, Adult Protective Service, case managers, postal carriers, physicians,

apartment managers, senior center staff, clergy, paramedics, code-enforcement personnel, and so forth.

Initial Outreach Contacts with Elders

Third-party referrals usually precede initial contact. The project Director gathers information from the referring party, and attempts telephone contact with the elder to initiate a relationship and gain consent to a clinician visit. The Director assigns a clinician, who approaches the older adult, by phone or in person. The clinician proceeds only if the elder agrees to further contact. When the relationship of the elder and the referring party is one of trust, the clinician highlights the referring party's role, and may include the referring party in the first meeting.

Care and sensitivity at the initial contact is critical. The individual's hesitancy to accept outside intervention may relate to fear of professionals trying to remove him/her or a loved one from the home, fear of being institutionalized, previous disappointment by the system, prior experiences of victimization, organic, or environmentally induced paranoia. Clinicians state the Center's name, offer identification, and tell the individual of services the Center provides.

An informal, nonthreatening manner is used. Significant time is spent drawing out the elder, developing an in-depth understanding of why the elder has been reluctant to receive help. Clinicians troubleshoot threats to developing trust. The elder may question the clinician's intent, such as whether the clinician was sent by a distrusted relative or authority. The elder may challenge the clinician as to whether the clinician believes the delusions. The project emphasizes validating the elder's affect, while neither challenging nor affirming the delusion's content.

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

The clinician assesses the elder's receptivity to continued contact. Offering more contact than the elder wants may overwhelm the elder, while offering too little may lead to disappointment and withdrawal. Initial outreach contacts generally require several hours per week over the first few weeks. In the case of Mr. W., after he slammed the door, the clinician called again some days later and suggested a follow-up phone

call rather than a face-to-face visit. Weekly check-in calls were conducted for three weeks before another visit was suggested.

Ongoing Clinical Interventions

The clinician develops a specific treatment approach in consultation with the supervising psychologist and outreach team. Interventions begin with careful, nonreactive listening. As the elder's interest in services increases, the clinician works with the elder to forge successful links to needed services (e.g., legal help, in-home supportive services, meals, emergency cash, friendly visitors, medical attention, social opportunities, etc.). For example, Mrs. A. had become isolated due to paranoia. She had stopped going to medical appointments and rarely went to the grocery store or paid her bills. Initially, her fear was so severe that she permitted only semimonthly phone contact. After six months, Mrs. A. engaged in weekly visits and after one year, she accepted a case manager and a driver to take her to the doctor and grocery store.

When possible, clinicians refer concrete needs to agencies specializing in case management. When a referral is likely to rupture the alliance, clinicians provide case management directly. Meetings with family members and/or important others are pursued when expected to be helpful and permitted by the elder. Contacts are arranged in whatever manner maximizes the older adult's comfort (e.g., in-home, at their doctor's office, in a church, at the street corner). Clinicians meet weekly with the supervising psychologist. Weekly staff meetings provide brainstorming to generate clinical suggestions and emotional support. Work with these elders can be demoralizing and emotionally taxing.

One project goal is to encourage the elder to consider traditional psychotherapy. If the elder agrees, he/she is engaged in psychotherapy by the same outreach clinician, thus maintaining continuity and avoiding disruptive transfer. When nonprofessional community workers conduct outreach, elders often decline services when contacted by a new professional, feeling injured by the loss of the relationship with the trusted outreach worker and fearful of a new relationship.

Community Consultation

Project clinicians also facilitate service provision by providing support and psychoeducation to other professionals who serve older adults. For example, in the case of Mrs. A., the clinician helped the social

worker tolerate the elder's repeated refusals to accept help and her verbalized perception that the social worker was "evil." Without this support, the social worker may have terminated services and/or acted defensively with the hard-to-serve elder, thereby solidifying the elder's refusal of services.

Aspects of other mental health projects were incorporated including (1) use of nontraditional community members to identify cases (Florio & Rauschko, 1998); (2) interagency collaboration to identify cases and coordinate care such as those in the Midlands Older Adult Access Program and The Masters Program of Valley Mental Health (Western Interstate Commission for Higher Education: WICHE, 2005); and (3) relationship-building techniques similar to the Outreach to At-Risk Seniors (WICHE, 2005).

OUTCOMES

In 24 months the project received 566 referrals, served 508 elders, 304 of them received long-term clinical outreach or psychotherapeutic services. The project provided 4,475 hours of ongoing psychological services. Positive changes (Table 1) included receiving services previously refused, decreased isolation, avoiding eviction or movement to higher level of care, decreased harassing contact with outside agencies (e.g., city employees, law enforcement) and decreased need for involvement by APS or code enforcement, reduced delusional material, and setting limits in abusive relationships.

The increase in referrals over time (i.e., a 389% increase from the first to fourth quarter) indicates the high need to aid these elders. The

TABLE 1. Positive Changes in Circumstances of Elders Served

Number of Elders	Positive Changes
54	Received supportive services (e.g., in-home meals, transportation, phone service)
41	Decreased isolation; increased contact with family, friends or others
34	Decreased risk of homelessness or premature higher level of care
29	Decreased psychotic symptoms
25	Decreased contact with governmental agencies
8	Increased limit-setting behaviors

project received 27 new referrals in the first quarter, 46 during the second quarter, 109 during the third quarter, and 132 in the fourth quarter.

Despite the aforementioned similar programs, comparison data are sparse. Using Florio and Rauschko's (1998) Gatekeeper Case Finding Model, isolated, at-risk elders were identified by nontraditional case finders. The authors found these elders had greater initial service needs, but that after one year of interdisciplinary in-home clinical case management, these older adults did not use a greater number of services than a comparison. Data from a similar type of intervention with younger adults (Burns et al., 2001) indicate that compared with mentally ill patients who received standard psychiatric treatment, those who received regular home visits by clinicians providing care for health and social issues reduced future hospitalization days. No literature was found describing or evaluating the efficacy of in-home, mental health outreach to older adults.

ONGOING ISSUES

One of the difficult issues facing project staff is the slow progress hard-to-serve elders make. Clinicians must be patient and identify small evidence of progress (e.g., the elder's improved affect as judged by facial expression; the older adult's willingness to call the clinician, etc.) (Table 2). Burn-out prevention is addressed through (1) emotional

TABLE 2. Case Examples

Examples
Ms. Q. was an unmarried woman with mild memory impairment and estranged from her only relative, a niece. She began calling the police several times a week, reporting that neighbors broke into her home and stole keys and medications. Given the lack of corroborated criminal activity, the excessive calls irritated police, and interfered with their ability to respond to actual crimes. A mental health outreach clinician gradually developed a relationship with Ms. Q., helped her reconnect with her niece, and helped with memory aids. Over time, her quality of life improved and her calls to the police decreased.
Mrs. K. was an older woman who had long-term dependency needs, exacerbated by medical problems. She was widowed and was emotionally and physically dependent on her son, who was addicted to alcohol and cocaine. Although her son abused her financially and at times physically, she was unwilling to accept help because she received some loving attention from him, and did not want to "be abandoned." Although Mrs. K. initially refused regular clinician visits, over time she agreed to weekly visits. After nine months of nontraditional mental health outreach, Mrs. K. sought a restraining order against her son and considered other options for her own care.

support, (2) case load distribution (assigning at most half of a full-time clinician to outreach cases), (3) regular, short breaks, and (4) education about adjusted expectations.

Adhering to the ethical guideline of informed consent requires non-traditional methods. Traditional approaches to obtaining written informed consent would likely result in refusal of help. In the absence of traditional written informed consent, project clinicians follow a stepwise consent procedure that matches the elder's expressed interest in available services. If an elder indicates interest in talking with the clinician, the clinician continues, explaining that she/he will help "through talk." If an older adult clearly tells the clinician to leave and not return, the clinician ends services. When the older adult verbalizes concurrent requests for the clinician to stay and to leave, the clinician consults with his/her supervisor to assess the older adult's stronger intent. The clinician documents the manner in which consent is obtained (Table 2).

CONCLUSION

While almost all older adults prefer to live independently, some endanger themselves by failing to access needed services. While many barriers interfere with access, this project addresses psychological factors such as fear, dependency, suspiciousness, and mistrust. This project extends relationship-based mental health assistance beyond the usual limits of psychotherapy, by trained clinicians who develop trusting relationships and use psychological skill to gradually introduce help to troubled older adults. While this approach requires time-intensive, highly skilled intervention, it promises to help maintain recalcitrant individuals in the community in a more healthy and stable manner.

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