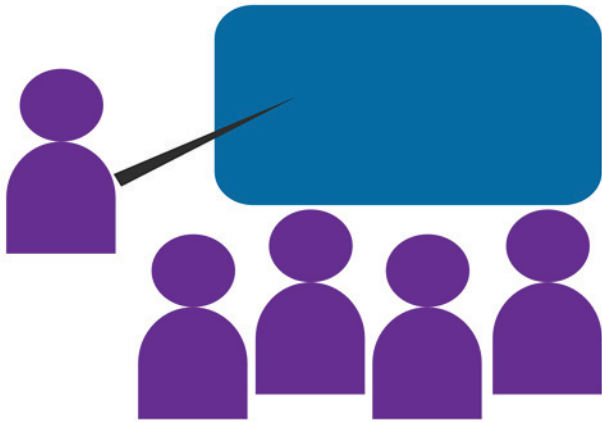


Safely Responding to Mental Health Crises in Adult Protective Services



Introduction

According to the National Adult Maltreatment Reporting System (NAMRS), [2019 Adult Maltreatment Report](#), “nearly 30% of clients have cognitive difficulties (including mental problems)” (McGee & Urban, 2020). Clients with mental health conditions can be challenging for adult protective services (APS) programs and staff. APS workers occasionally deal with individuals with mental health concerns in emotionally charged situations. Clients can become disoriented and confused, evoking a hostile response. We all recognize the Thomas Jefferson adage, previously attributed to Sir Francis Bacon, that knowledge is power. “With knowledge and/or education, one’s potential or ability to succeed in the pursuit of one’s objectives will certainly increase” (Definitions.net, 2021). This principle is not unfamiliar and applies to APS cases. With increased knowledge, APS workers can better protect themselves from potentially dangerous situations while also keeping their clients safe.

This brief focuses on identifying clients experiencing mental health conditions, minimizing risk to workers, and de-escalating client behavior. It addresses the intersection of, and parallels between, APS and mental health services. The brief provides insight into how to recognize and de-escalate individuals experiencing mental health symptoms with whom APS workers may interact. Based on discussions with Oregon, this brief also highlights promising practices they have implemented, including specific protocols for interacting with those experiencing mental health symptoms. Their consultation is much appreciated and will undoubtedly be helpful for those states who are currently developing policies and procedures to strengthen this area of the APS program.

What is Mental Health?

According to the Centers for Disease Control and Prevention (CDC), “mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices” (Centers for Disease Control and Prevention, 2021). In times of crisis, we all may have poor or strained mental health. This includes our clients. Stress and anxiety can trigger emotion and affect the way individuals react to the APS investigation. Mental health is “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (World Health Organization, 2021). An APS investigation can be a difficult time for many. Fear, uncertainty, and

anger can exacerbate the situation, thus evoking an emotional response. Clients with mental health concerns can have a heightened response to these circumstances and decreased coping mechanisms during this stressful time.

What is De-escalation?

To de-escalate is “to decrease in extent, volume, or scope” (Merriam-Webster, n.d.). For the purposes of this brief, this definition will apply to the APS worker’s response to individuals who are experiencing mental health concerns during an APS investigation. This may include the victim, the alleged perpetrator, family members, etc. In times where an individual’s response is severe, (yelling, swearing, etc.) the APS worker must rely on their training to decrease the client’s response or de-escalate the situation.

Safety and Risk

Worker safety is a priority for all APS programs. Understanding and balancing risk is something that every professional who interacts with clients should prioritize. APS workers should always have a safety plan and anticipate danger. Each situation an APS worker approaches has the potential to be plagued with hostility, emotion, and threat. Paying attention to a client’s tone and body language can help APS workers recognize potential adverse reactions. If this is witnessed during an interview, the focus of the meeting should shift to reducing anxiety. Workers should be calm, sensitive, and supportive, acknowledging frustrations with empathy. Calm reactions can help defuse the situation. A person in the midst of a mental health crisis cannot always clearly communicate their thoughts, feelings or emotions. They may find it difficult to understand what others are saying. It is important to emphasize and connect with the person’s feelings, stay calm and try to de-escalate the crisis. If these strategies do not work, seek outside resources or help.

According to the National Alliance on Mental Illness (NAMI) Minnesota, “a crisis is any situation in which a person’s behaviors puts them at risk of hurting themselves or others and/or when they are not able to resolve the situation with the skills and resources available” (Minnesota, 2018). NAMI MN produced a [crisis planning guide](#), excerpted in Figure 1, that has many helpful tips including advice on de-escalation. APS workers should be familiar with these techniques.

Figure 1 – De-escalation Techniques

De-escalation techniques that may help resolve a crisis:

- ✓ Keep your voice calm
- ✓ Avoid overreacting
- ✓ Listen to the person
- ✓ Don’t make judgmental comments
- ✓ Don’t argue or try to reason with the person
- ✓ Express support and concern
- ✓ Avoid continuous eye contact
- ✓ Ask how you can help
- ✓ Keep stimulation level low
- ✓ Move slowly
- ✓ Offer options instead of trying to take control
- ✓ Avoid touching the person unless you ask permission
- ✓ Be patient
- ✓ Gently announce actions before initiating them
- ✓ Give them space, don’t make them feel trapped

Source: Excerpt from [National Alliance on Mental Illness Minnesota: Mental Health Crisis Planning for Adults](#)

Planning for a safe interaction is based on the background information that is gathered before commencing the investigation. Thorough preparation for each case can be a key to increasing confidence

and reducing the overwhelming stress that can be felt during the investigative process, thus increasing safety for all parties. Ensuring that staff are well-trained on safety procedures will assist them in situations where background information about the client's mental health is not known prior to a visit.

Ideally, APS programs would have robust training, policies and procedures identifying steps in the investigative process, including de-escalation techniques. Training should outline programmatic best practices regarding the agency approach in dealing with individuals with mental health symptoms and referral resources to help support their staff.

The [Voluntary Consensus Guidelines for State APS Systems](#) and the [National Adult Protective Services Association \(NAPSA\) Code of Ethics](#) both provide guidance regarding client rights that may assist with positive engagement. Interactions with clients should be client-centered, involve the client to the greatest extent possible, and respect the client's right to self-determination and ability to refuse services. Treating clients with respect will increase their level of engagement in the investigation, reduce anxiety that may lead to a heightened emotional response and assist APS workers in building the rapport necessary to gather the important facts of the investigation.

A Collaborative Approach: What Can We Learn from Other Partners

APS workers should coordinate with stakeholders during the investigative process to gain an in-depth overview of the totality of circumstances related to the APS client. APS workers do not have all the tools in their toolbox to process these cases effectively and independently alone. "Since the earliest days of the field of elder mistreatment, it has been widely recognized that no one agency or discipline alone could successfully intervene." (National Center on Elder Abuse, 2021) Collaboration with others, such as

law enforcement and mental health, in a multidisciplinary approach will benefit all involved. One such approach is the use of crisis intervention teams. "Crisis Intervention Team (CIT) programs are being implemented by police agencies across the United States to improve police response to persons with mental illness. The goals of CIT programs include improving safety in encounters between police and persons with mental illnesses, diverting persons with mental illnesses away from the criminal justice system, and increasing access to mental health services" (Watson, 2011).

APS workers do not have a badge or a gun, but often interact with the same potentially unstable clients as law enforcement. For years, disciplines such as law enforcement have been trained on de-escalation techniques. The use of these techniques can mitigate the need for the use of force. "Basic de-escalation skills training, such as that included in CIT training curriculum, is a law enforcement training experience designed to equip police officers with knowledge and skills that enable them to initiate specific actions to de-escalate a crisis situation" (Olivia, 2010). Though APS does not use force like law enforcement, APS workers must be trained on de-escalation. Situations have to be approached cautiously, with empathy and respect. There are times where APS workers cannot approach the situation safely. In these instances, it is better to discontinue the interview and try again at another time.

Involving mental health professionals early in the investigation can be a tremendous asset. Natalie Kean, a published author and staff attorney at Justice in Aging, mentions the importance of considering mental health in the geriatric community, stating that a plethora of "older adults need behavioral health services. One in five adults aged 55 and older and nearly half of individuals dually eligible for Medicare and Medicaid have at least one mental or behavioral health condition. Many older adults have both mental and substance use disorders, along with

physical health conditions” (Kean, 2019). Mental health professionals have specialized training and expertise to evaluate this population. Consistency from state to state varies regarding consultation with mental health professionals in APS investigations. The 2020 updated Voluntary Consensus Guidelines for State Adult Protective Services Systems recommend that APS systems establish:

- expert consultation to programs regarding mental health disorders (p. 20),
- inclusion of mental health status and behavioral issues in needs and risk assessments (p.41),
- protocols to work in tandem with mental health clinicians and to offer mental health services (p. 47), and
- core competency training and supervised fieldwork to include mental health disorders (p. 57)

How Can APS Leaders Help?

State APS administrators can empower APS workers by providing appropriate support in addition to the training already mentioned in this brief. Support for staff can be shown in many ways, and staff will need varying levels of support depending on case specifics and tenure. Having an open-door policy and making time to discuss cases with APS workers will strengthen relationships and foster communication. Additionally, utilizing other more experienced staff as mentors will create a culture of collaboration.

Identifying the before, during, and after support for APS investigations will create the transparency necessary to allow APS workers to anticipate the next steps in the investigative process.

Figure 2 – Before, During, and After Support for APS Investigations Involving Mental Health Crises



Before

Develop a thorough training curriculum to take the guesswork out of how to deal with uncertainty in APS investigations. Start with gathering as much information as possible during the intake process. This includes the demeanor of all the parties and any safety concerns.

Thoroughly review any past cases and conduct a web search to determine if there have been law enforcement charges related to mental health concerns. Consult with law enforcement to gather key information needed to make decisions about whether to request a law enforcement escort or have an additional staff member attend the visit.



During

Encourage the discussion of concerns with a supervisor and ensure APS workers share their schedules with leadership. Supervisors should know where APS workers are going and a timeframe for their return. This enhances APS worker safety and allows the supervisor to assist if issues should arise.



After

Administrators can assist by debriefing with APS workers as the investigation concludes. This allows APS workers to discuss any issues and emotions brought on by the investigation. It also provides additional support to the APS worker in cases where there are traumatic events that occurred during the investigation.

Leaders can also do a variety of things to increase communication and program transparency. Many leaders find the most effective way of doing this is through newsletters to report program changes, accomplishments and give kudos. Wellness activities, team events and celebrations bring staff together and facilitate team bonding.

COVID-19 Pandemic Concerns

The COVID-19 pandemic crisis had an immense national impact. APS programs were forced to shift the way they did business in a matter of days. For some states, gone (temporarily) were the days of in-person contact to protect both staff and clients. What did not change was APS' duty to be the safety net for vulnerable adults who were maltreated. When other service providers closed their doors, APS

continued to serve clients, even if in an often-virtual capacity. For many APS jurisdictions the volume of reports initially decreased. APS had limited observations and there were fewer professional eyes on clients. Conversely, clients had decreased social interactions and attempted to limit contact with others for fear of contracting the virus. This left the clients socially isolated and at an increased risk for falling prey to maltreatment.



Promising Practices - Oregon

Interview via telephone with Traci Robertson, Complex Case Specialist, Central Office Adult Protective Service Team, Oregon Department of Human Services (ODHS), April 5, 2021

Question: What challenges do APS programs currently have identifying and serving clients with mental health concerns?

Answer: Some specific challenges for coordinating with mental and behavioral health services include:

- Eligibility for behavioral health services is determined by a separate process and a different program structure than services for older adults and physical disabilities who need assistance due to physical or cognitive impairment. APS clients must be directed to a completely different agency to seek services.
- Unless the person is in immediate, life-threatening crisis, the process of seeking and enrolling for behavioral health services is a voluntary one. APS workers can refer adults to programs, but ultimately their participation and enrollment is voluntary in all but the most severe situations.
- Behavioral health services are administered and delivered by county-based Community Mental Health Programs, and a person may lose their county services when they are found to be eligible for Medicaid services under the state Aging & People with Disabilities program, on the assumption that the Medicaid system will meet the behavioral health needs of the person. This creates, at a minimum, continuity of care challenges and, in some instances, a loss of effective behavioral health services altogether.
- Petitions for Civil Commitment in crisis situations are generally initiated by county mental health staff, via a petition in the county Circuit Court. Oregon's Civil Commitment statute is interpreted conservatively in some jurisdictions, meaning that APS workers may not succeed in getting a county program to file a petition or, if filed, may see the petition fail.
- APS programs often receive referrals of adults who do not meet APS age criteria and whose issues are primarily the result of behavioral or emotional disorders, rather than physical disability or cognitive impairment. APS is often expected to respond to these referrals and is perceived as "not responding" to the reported situations, even when the appropriate avenue for referral is through the county mental health programs and referrals to those programs or crisis responders are made.

Question: How do investigators typically prepare for these cases? Is there specific training on de-escalation techniques or policy related to approaching individuals displaying mental health symptoms?

Answer: All State of Oregon Adult Protective Service Investigators receive training early in their career, referred to as Fundamentals of Adult Protective Services (APS). While we do not train investigators to specifically work with mental health consumers, we provide training for interviewing and working with individuals who experience diminished or impaired cognition. The appearance of mental/behavioral health events can be due to ongoing medical conditions, medications, substance abuse, dehydration, UTI, grief or many other factors. APS investigators make initial contact with the reporting parties, inquire as to the history of the victim through community partners, coordinate with law enforcement or resources available in the area. The new screening system for APS, Centralized Abuse Management (CAM) now houses basic enrollment for mental health consumers. Our training program has adapted, due to the pandemic, to offer an interactive virtual training that includes highly qualified trainers.

Question: Can you describe any innovative approaches Oregon APS has with regard to this population?

Answer: Oregon APS utilizes the cooperative efforts of active multidisciplinary team meetings, the high-risk team approach in two of Oregon's cities, Eugene and Springfield, and the use of [Whitebird Clinic](#). For over 50 years, they have offered 24/7, free crisis intervention service and immediate, short-term support to those in need.

I reached out to our office in that area and spoke to Suzie Cole, Supervisor and Nicole Newall, Medicaid Case Manager. Both have worked with Whitebird Clinic and CAHOOTS throughout their careers. CAHOOTS staffs 24/7 "vans" that are on-call and include the services of a mental health professional and EMT. When APS responds to an allegation of abuse or neglect with a potential mental or behavioral health component CAHOOTS is a resource that can offer onsite professional mental health evaluation and stabilization. Other communities and states are looking to create this safety net within their areas. Whitebird Clinic offers outreach and training and most recently provided a de-escalation training that was very well received and described as, "robust" by attendees.

Question: Has anything changed in the past year with the onset of the coronavirus/COVID-19 pandemic about how to approach these cases? Has the volume changed?

Answer: The onset of COVID-19 has had two significant impacts on the ability of APS staff to respond to alleged victims of abuse who may have behavioral health challenges.

- The reduction of social contact in general has meant fewer "eyes on" for vulnerable adults who may be living with behavioral or emotional challenges, and who often get referred to APS for self-neglect.
- Concerns about the risk of transmission have led to a reduction in face-to-face visits, making it more difficult for APS to assess the challenges and needs of alleged victims of abuse or self-neglect. In some cases, assessment must occur by telephone, which removes the ability for visual observation of the person and their surroundings and makes it more difficult to screen for behavioral or emotional disorders.

There are two ways that we can measure the intersection of behavioral health and APS in our Central Abuse Management System.

- Marking any one of four characteristic boxes in the person record would indicate some presence of behavioral health indicators. The characteristic fields utilized not just behavioral health, but of those that were populated in 2019, 9.6% had some behavioral health indicator marked. In 2020, the percentage was an identical 9.6%.
- Indications of services, interventions, referrals, etc. that are created at intake or during the investigation also measure this intersection. In 2019, 12.8% of the cases with referrals or protective services sought some sort of behavioral health services or interventions for the victim. In 2020 this rose to 13.3%. This was not a

significant increase and possibly attributed to the field getting better at recording the referrals and protective services.

Question: Any other thoughts related to the intersection of APS programs and mental health?

Answer: The intersection between Mental Health and APS is increasing as the population demographics shift. Elderly Oregonians do not cease to require Mental Health support at 65 but rather, require Mental Health support along with physical care support, offered by APS. In the future, instead of using “intersect” to describe the relationship between APS and Mental Health, that is to “cross paths” and continue in different directions, I am hopeful that it can become a parallel relationship, working side by side, understanding the scope of each separate program, but both moving toward the ultimate goal. We need to communicate and build partnerships to offer the support needed by our consumers. This will require a shift in how things have historically been done; no longer will mental health stop and APS start. Currently, Oregon legislation (HB 2822) is bringing this needed cooperative approach between Behavioral Health and the APS program to light. The complex cases I work through, with APS and Medicaid Case Managers, exemplify the need for continued Mental and Behavioral Health resources ongoing and cooperatively to meet our consumer’s needs.

Conclusion

APS workers often interact with clients experiencing mental health symptoms. These interactions, if strategically planned, can go smoothly enabling APS workers to gather the important details to assist clients and complete the investigative process. A collaborative approach to APS cases enables stakeholders to better support clients during the investigative process. Parallel cooperative efforts among disciplines can allow APS workers to gather important facts they would not necessarily have access to independently, remediate gaps in service planning during the APS investigative process and build strong community partnerships to address client needs.

Other Mental Health Resources From the APS TARC

- Toolkit: [Mental Health Educational Toolkit](#)
- Blog: [Adult Protective Services & Mental Health: Practices and Policies](#)
- Webinar: [Behavioral Health Link - APS and Mental Health Working Together](#)
- Webinar: [Self-Care for APS Workers](#)
- Webinar: [Trauma Informed Care Approach to Elder Abuse](#)
- Brief: [Trauma Informed Approach for APS](#)



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