Deciding Who Gets Treated and How: Assessment of Problem Behaviours and Risks in the Elderly

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Learning Objectives

1. Understanding some reasons why community mental health services for the elderly are utilized inefficiently;

2. Exploring a Service Delivery Model based on assessment of problem behaviours and their associated risks;

3. Applying qualitative research to validate alternate approaches to delivery of mental health services.

outline

- background
- the Mental Health 60+ Team at CLSC René-Cassin
- historical perspective
- clinical cases
- why assess behaviours?
- problem behaviours and associated risks
- service delivery model - Mental Health 60+ Team
- description of study
- conclusions

Background

- CLSCs are mandated to provide front-line health and social services, including to those with a loss of autonomy, to help individuals remain in the community
- a significant proportion of elderly clients suffer from mental health problems
    - many are unable or unwilling to obtain mental health services from existing resources
- to meet their needs, CLSC René-Cassin set up a specialized team

the Mental Health 60+ Team at CLSC René-Cassin

- An interdisciplinary team: social workers, nurses, family support workers, psychiatrist
- Responds to psychosocial and health needs of people 60 and over with severe and persistent mental health problems
- Clients may, or may not, have a psychiatric diagnosis
- Clients may, or may not, be followed in psychiatry

Historical Perspective - 1

- A number of referrals were inappropriate:
  - diagnosis of mental illness
  - stable condition
  - adequately connected with existing mental health resources
- Some clients seemed to be continually in crisis, consumed a lot of time and energy, but with no improvement in their situation

Historical Perspective - 2

- Clients who benefited most had clearly identifiable problem behaviours, with or without psychiatric diagnoses
- Some clients refused intervention:
  - how to determine when to intervene against a client's wishes

The law in Québec

- Must always respect refusal of a competent patient
- for incompetent patients, refusal can be overridden only if:
  - immediate life-threatening emergency (no consent required)
  - cases of hygiene
  - ordered by a court
- Thus, assessment of risks determines whether one intervenes against a client's wishes

Task for the Mental Health 60+ Team

- Develop a service delivery model to guide intervenors in:
  - assessing clients
  - planning interventions
  - assessing the results
- base the model on identification of problem behaviours and associated risks

The use of problem behaviours as a criterion for service delivery dates back to my days at Douglas Hospital, during a strategic planning exercise. It was clear that when the only criteria for deciding which clinical programme a patient belonged to was their age or where they lived, serious inequities in meeting patient needs resulted. For example, mentally retarded patients under 18 received at least 3x as much in therapeutic services as the same patients would get as soon as they turned 18 and were transferred to a different program. I therefore proposed a model based on patient needs, rather than age or place of residence; it turned out that needs identification had to do with problem behaviours, rather than diagnosis or even symptom profile. For example, a patient with dementia who runs away and gets lost, may need a locked unit, whether age 50 or 80, or whether the running away is due to akathisia or command hallucinations.

Barriers to Service Delivery

- Use of diagnosis as a ticket for entry
  - Insufficient rationale when clients are stable
  - May exclude the sickest individuals

Patients who are stable and already well connected to adequate mental health resources, such as the Psychogeriatrics Clinic, do not need the team's services.

On the other hand, many individuals with mental health problems are paranoid and refuse to be seen by psychiatry or sometimes by any physician, and thus will not have a diagnosis of psychiatric illness. Should they not get services?

Barriers to Service Delivery - 2

- Some patients and families demand inappropriate or excessive levels of services
  - leads to staff burnout and anger
  - gives rise to official complaints against staff

For example, a patient with multiple medical problems related to her diabetes, insisted on having hours of home care, paid for by the CLSC, because of mobility problems. She called her CLSC case worker multiple times daily; when she didn't get immediate responses, she would leave abusive messages, call the Director of Professional Services to complain, and call the police, the fire department, and urgences santé, insisting that she was in danger because she was unable to walk. She convinced the home care worker to take a key to her apartment, because she couldn't walk to the apartment door to let her in. Some time later, she accused the home care worker of stealing from her, citing the fact that the worker was in possession of a key. Other CLSC workers reported seeing her in Cavendish Mall, apparently able to walk.

Barriers to Service Delivery - 3

- Age limits
- Exclusion of organic disorders, eg dementia

Many services are structured to work only with certain age groups. Children's services often have a cutoff at age 18, whereas geriatric programs may refuse people under 65. These limits make a great deal of sense in many ways, for example, adults under 65 may be on welfare whereas those over 65 receive pensions, and staff become specialized in dealing with one system or the other.
On the other hand, a 50 year old with Alzheimer's and behaviour problems may be more appropriately treated in a psychogeriatric setting. Also, a child with a pervasive developmental disorder may suddenly see the services he or she receives cut by two thirds when turning 18, because of differences in the funding levels for the two age groups.
Another barrier is the exclusion of certain diagnostic categories, for example, psychiatry inpatient services often exclude patients with dementia, even though the staff on such a unit may be much better equipped to deal with behaviour problems than staff on neurology or family medicine units.

Alternative ways of including or excluding patients

- geographic (ie place of residence)
- language
- religious affiliation
- willingness to pay
- political beliefs
-

All of these ways of defining or limiting one's caseload have been used at one time or another. And they all make sense, but only if alternate services, of the same quality, are available for people with needs who are otherwise excluded because of language, and so on.

Alternative ways of including or excluding patients

- geographic (ie place of residence)
- language
- religious affiliation
- willingness to pay
- political beliefs
- problem behaviours

The problem behaviours criterion, being needs-based, does not exclude people with real needs.

Clinical Case - Miss U.

- 84-y-o single woman, living alone; living with her sister until 1991 when the sister died
- subsequently maintained by a nephew and other family who shop, bring food, visit weekly
- Maintien à domicile involved since 1991 until 1998 ice storm
- client was agoraphobic, wouldn't leave apartment, even though no electricity and no heat during ice storm

Clinical Case - Mrs. T.

- 77 y-o widow, on a pension, living alone
- diagnoses of anxiety and depression
- problems: treatment noncompliance, abused medication, refused assessment, verbal abuse
- referred by hospital social worker
- the patient interpreted her anxiety as a heart attack and would go the the ER frequently

Clinical Case - Mrs. S.

- 73-y-o widow, lives with a common-law partner in a house
- chronic depression, currently stable, on medication
- has been hospitalized in the past for alcoholism
- previously known to CLSC for financial abuse by her son
- partner has severe OCD, won't leave the house, won't take medication, sleeps all day
- came to CLSC requesting counselling re relationship with partner

Clinical Case - Mr. O.

- 80 year old widower, lives alone in a rented, furnished apartment
- alcoholic profile, but no psychiatric diagnosis
- referred by the JGH where he stayed in the shelter during the ice storm
- problem behaviours:
  - failure to provide self with necessities of life
  - refused evaluation by health care professional
  - refusal of interventions
  - sabotage of interventions

why assess behaviours?

- The majority of patients are brought to psychiatric care by others (family members, friends, caregivers, police, etc.)
- because of behaviours which are a problem for the person bringing the patient
- our job is to satisfy the customer by “fixing” the patient

Behaviours are things that people do or say, as opposed to what people think or feel. For example, if I’m angry at my boss, and I punch him in the nose, I’m likely to lose my job, not for being angry, but for my angry behaviour.

When a patient is brought to us, the person bringing the patient is our real customer, not the patient. It’s a bit like being a car mechanic: the car owner brings us the car to fix, and we work on the car, but not to make the car happy; our goal is to satisfy our customer. Similarly, patients are brought to us because of problem behaviours which affect others; our job is to deal with the problem behaviours so the person bothered by it no longer sees it as such a big problem.

Review of the Literature

- No literature!

Actually, there is a fair amount of research on problem behaviours: either in children, or in dementia patients. It's not really applicable, as it deals mainly with treatment approaches. Also, much of it has been published only in the last couple of years, after this project was completed.

types of problem behaviours

- behaviours dangerous to oneself
- behaviours dangerous to others
- behaviours disturbing to others
- disturbing behaviours towards the patient

Problem behaviours can be classified into four categories:

behaviours dangerous to oneself

- Failure to provide self with life necessities: food and water (including facilities for cooking and refrigeration)
- Failure to provide self with life necessities: adequate clothing (including provisions for laundering)
- Failure to provide self with life necessities: heat and light
- Forgetfulness resulting in danger to self
- Inappropriate risk-taking, where own welfare is at risk

behaviours dangerous to oneself - 2

- Neglect of a serious medical condition
- Self-mutilation
- Suicidal behaviour
- Refusal of essential services
- Refusal of life necessities: adequate clothing (including provisions for laundering)
- Refusal of life necessities: food and water (including facilities for cooking and refrigeration)
- Refusal of life necessities: heat and light

behaviours dangerous to others

- Forgetfulness resulting in danger to others
- Physical aggression against family member/caregiver
- Physical aggression against worker
- Taking inappropriate risks with others' welfare
- Threats of physical violence to family member/caregiver
- Threats of physical violence to worker

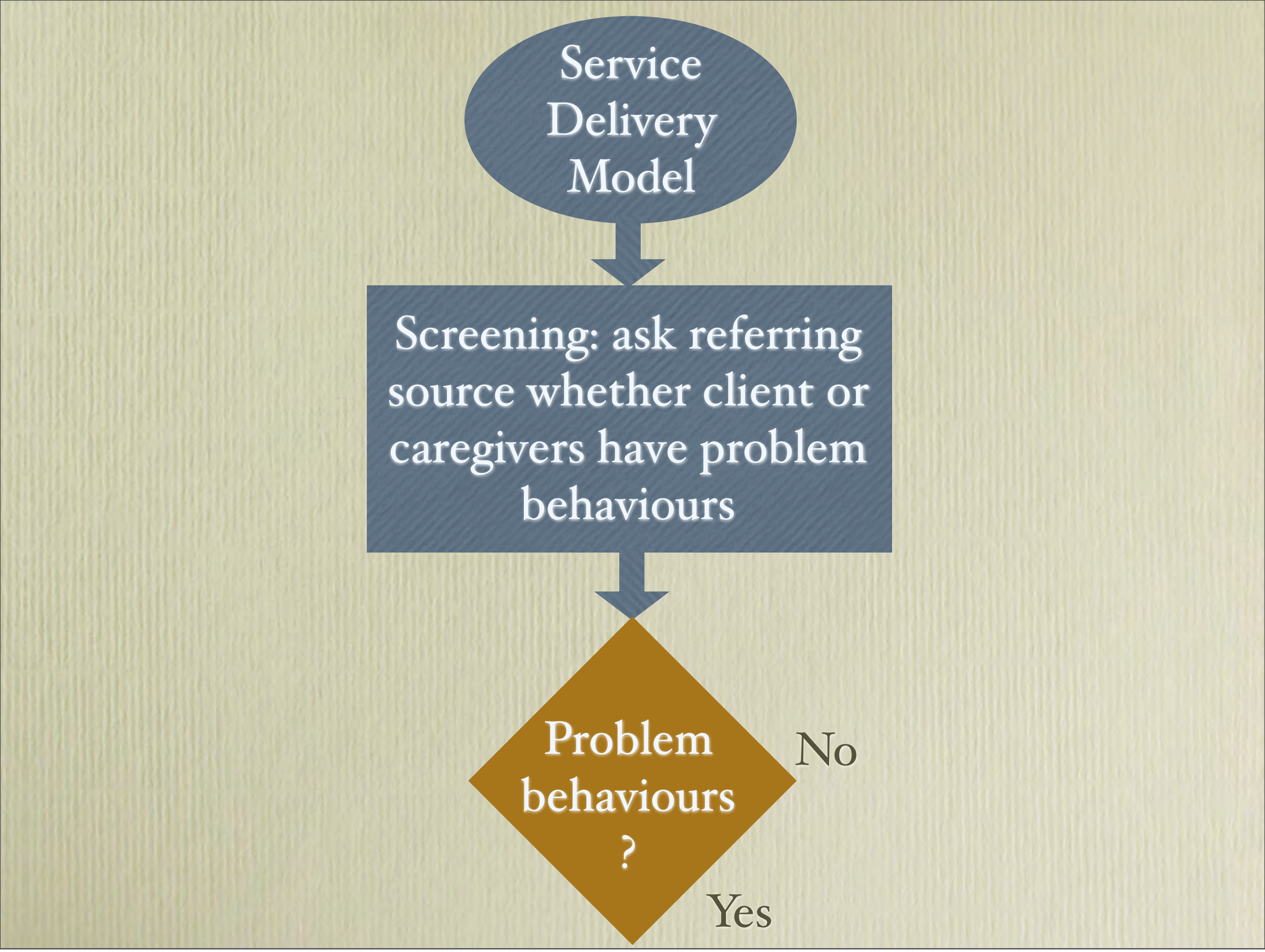
behaviours disturbing to others

- Excessive charity
- Covert non-compliance or poor compliance with treatment interventions
- Excessive spending
- Inadequate personal hygiene
- Living in filth
- Refusal to be evaluated by a health care professional
- Refusal of intervention by a health care professional
- Sabotage of evaluation or intervention
- Unjustified complaints against worker
- Verbal aggression against worker
- Suicidal threats

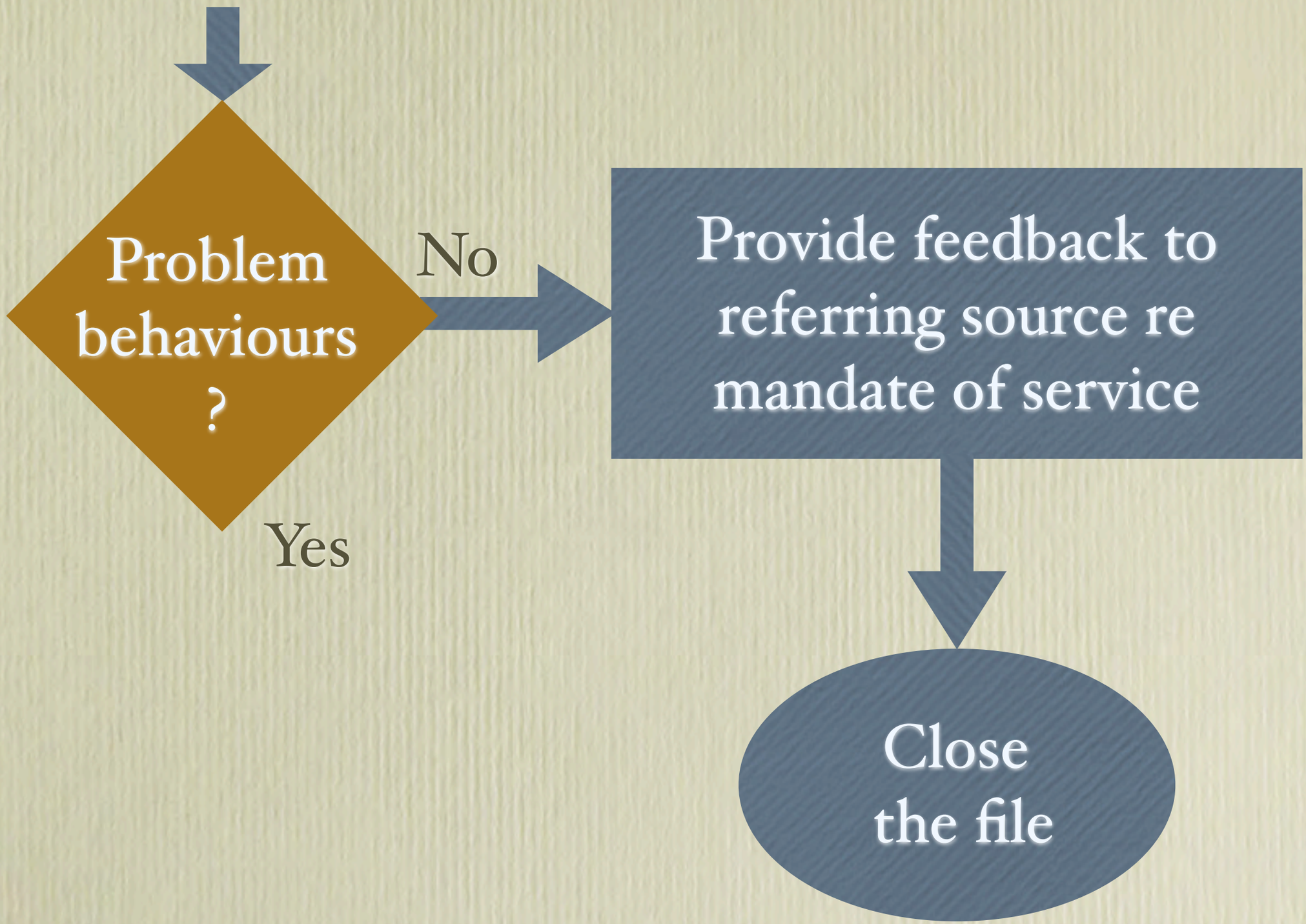
disturbing behaviours towards the patient

- Failure to provide appropriate medical care for client
- Failure to provide life necessities for client
- Financial abuse of client
- Financial neglect of client
- Physical abuse of client
- Psychological abuse of client
- Psychological or emotional neglect of client
- Social neglect of client
- Verbal abuse of client

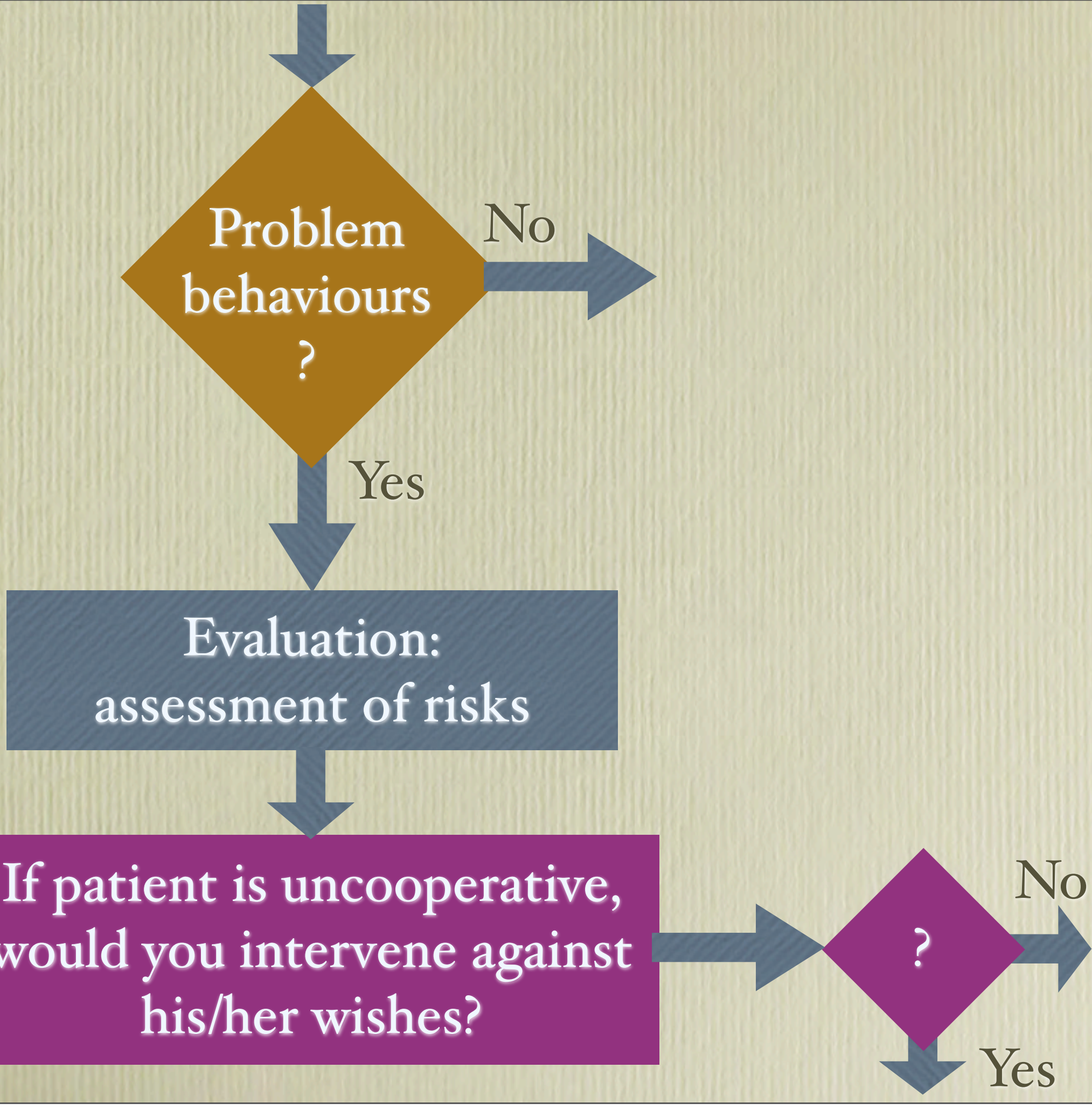
While these behaviours do not appear at first glance to be patient behaviours, in fact they result from a passivity about defending oneself or an inability to look after one's own interests.



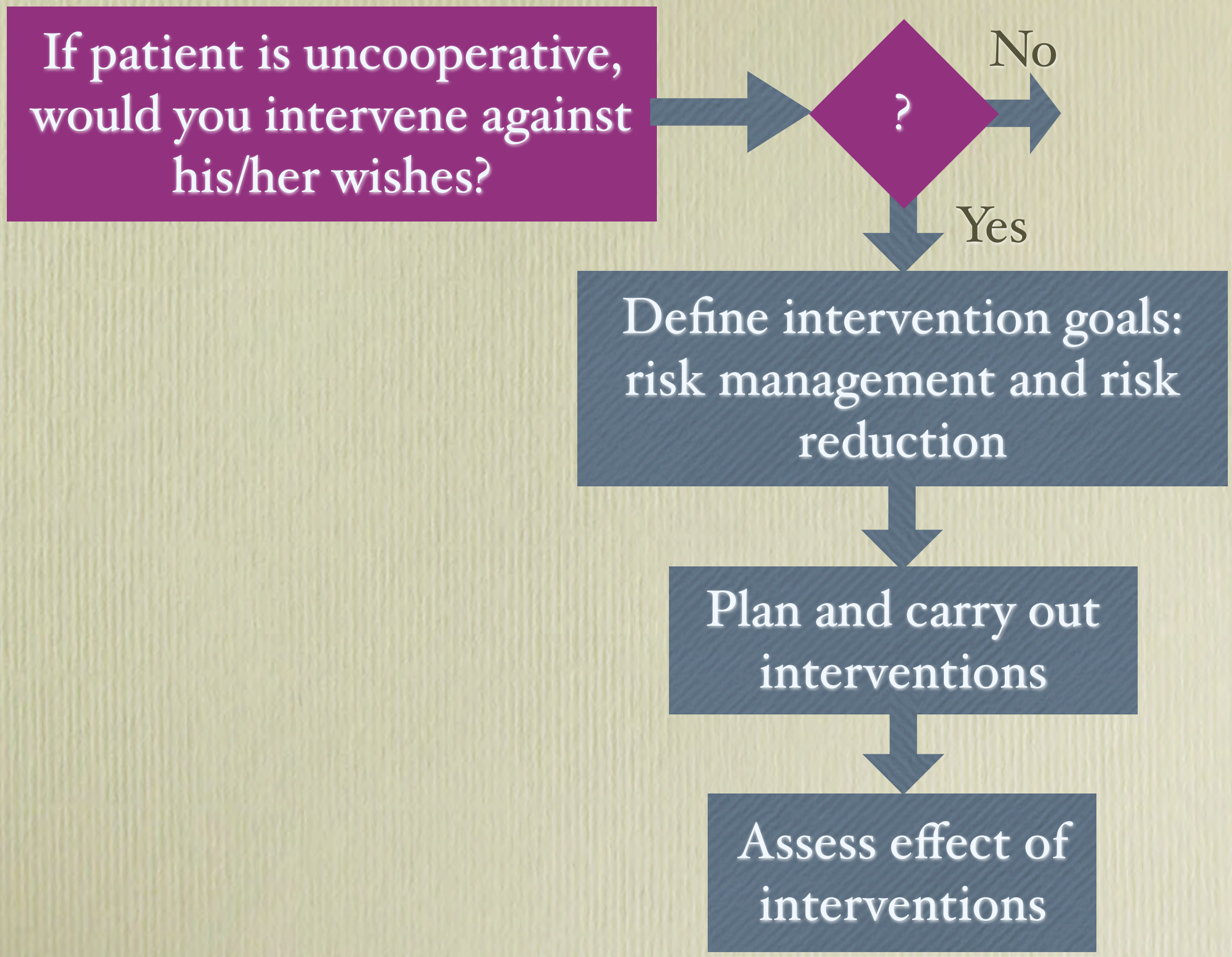
The Service Delivery Model that was developed is shown here in a flowchart. Members of the Mental Health 60+ team work with both clients and “customers”. Customers include caregivers, family members, other services within the CLSC such as Maintien à domicile, and outside agencies such as hospitals, the police, Jewish Family Services, and foster home proprietors.
When a request for services is received, a screening takes place where the client or the referring source is asked about problem behaviours, as I listed earlier.



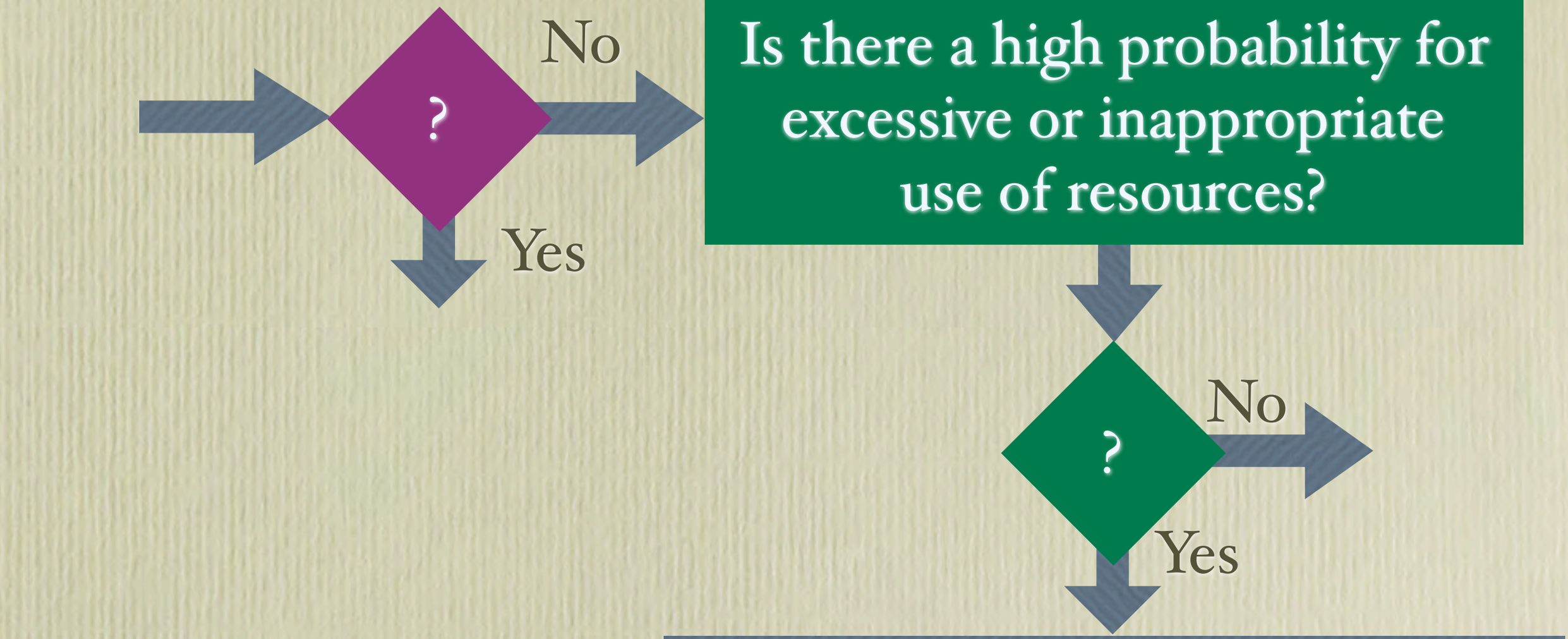
If there are no problem behaviours, the case is sent back to the referring source and the file is closed.



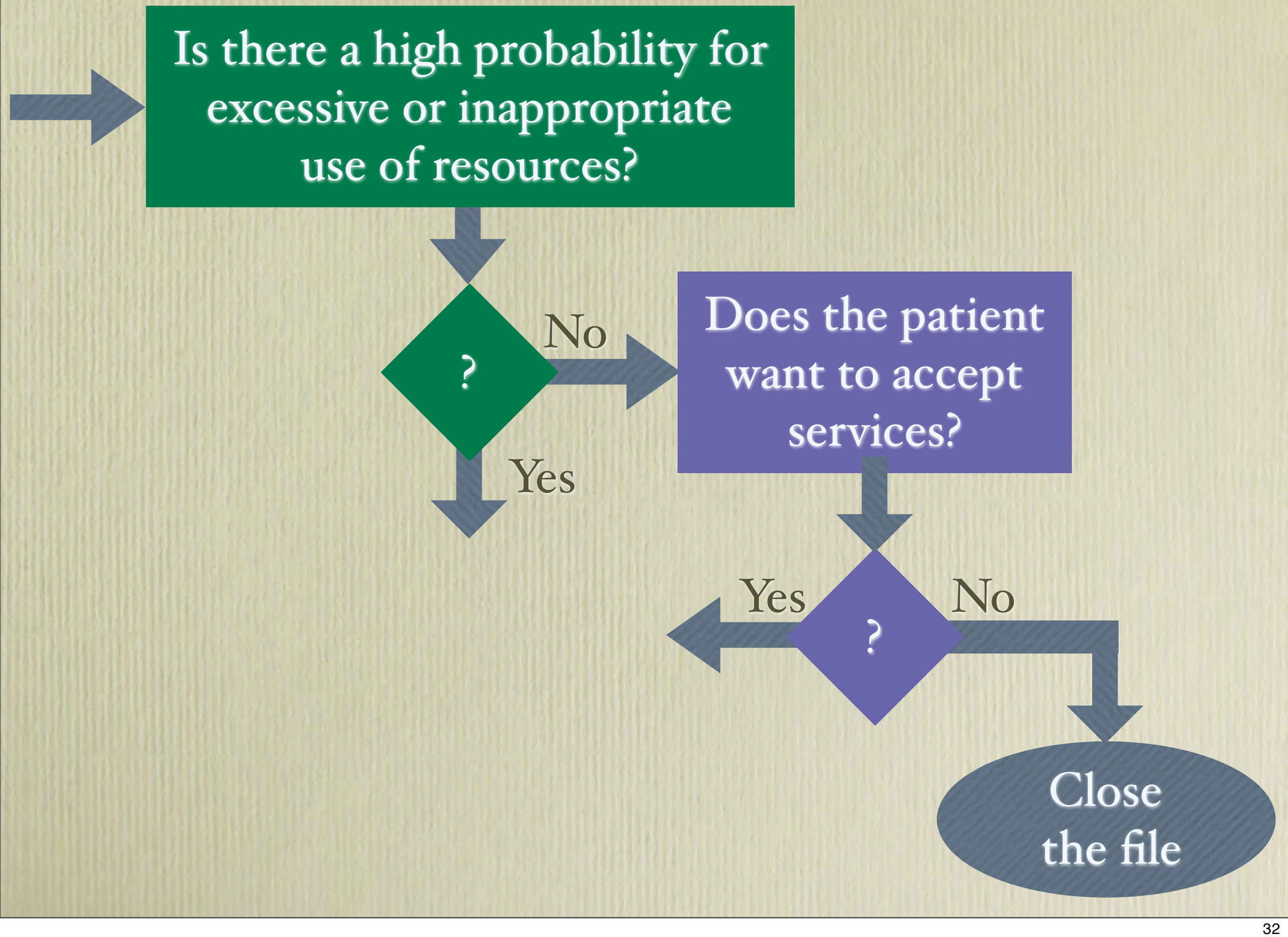
However, if one or more problem behaviours are present, an assessment or evaluation is made. The case manager with the help of other team members as necessary, collects information and evaluates the risk, either to the client or to others, of these problem behaviours.
If the risks are severe, for example danger to the life or health of someone, it is necessary to make a decision about whether one would intervene even against the client's wishes.



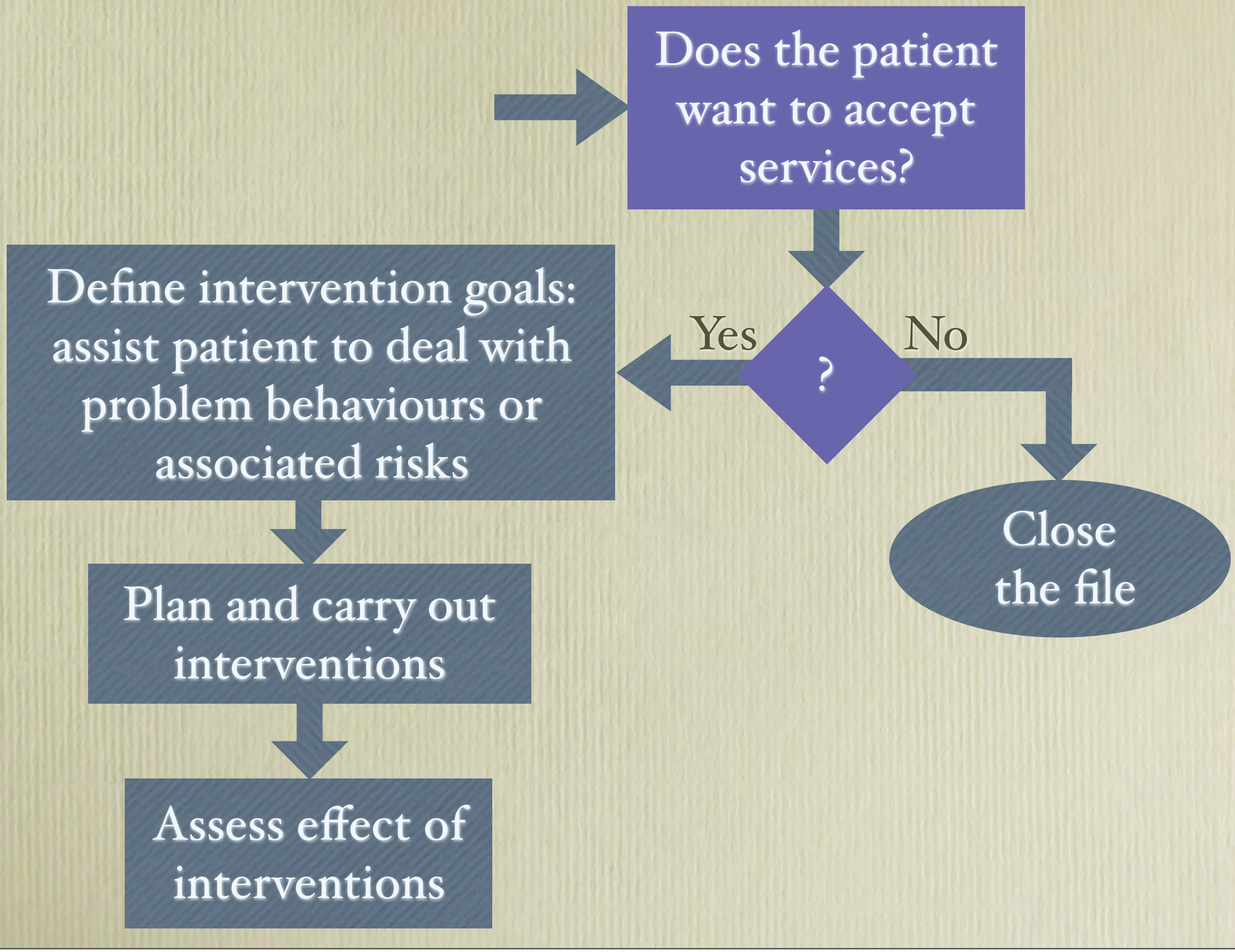
If the risks are severe enough to warrant intervention even against the client's wishes, the next step is to define the purpose of any intervention: basically, to lessen and manage the risk of dangerousness. With this goal in mind, interventions can be planned and carried out, and the effect of these interventions can then be evaluated.



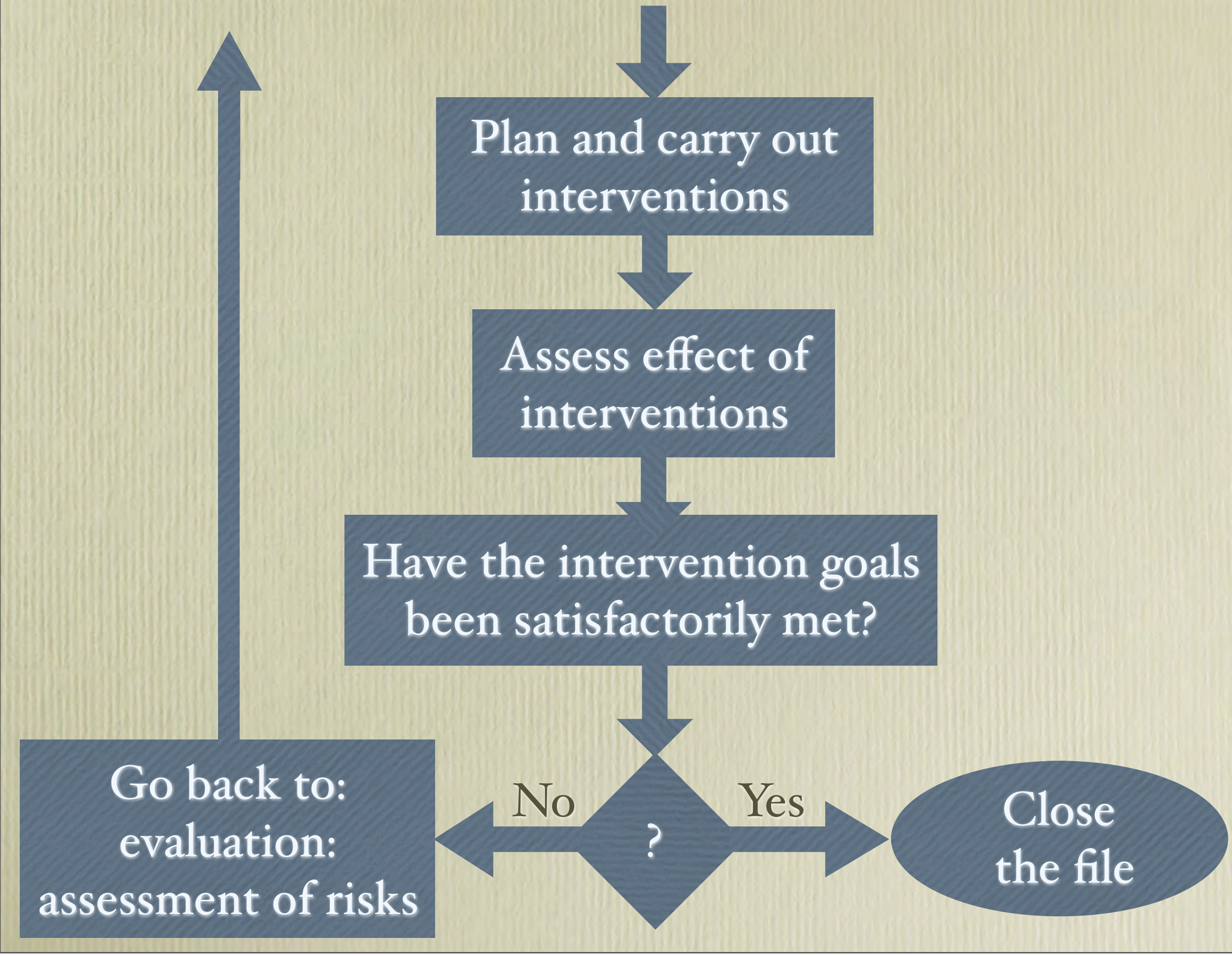
If the risk is not sufficiently high to consider acting against the client's wishes, then it is necessary to consider whether there is the likelihood of an excessive or inappropriate use of resources, including resources of the CLSC, hospitals, or other agencies. If an overuse is suspected, the intervention goals would be decrease the use or shift to a more appropriate usage.



If there is not a high probability for inappropriate or excessive use of resources, and the client or caregiver is unwilling to accept services from the team, the file is closed.



If the client or caregiver is willing to have services, intervention goals of assisting the client to deal with the problem behaviours and the associated risks are established.



Finally, after interventions have been planned and carried out, the result of the interventions needs to be assessed. If the intervention goals have been satisfactorily met, the file can be closed. If not, we go back up to the beginning and start the whole process over again by reassessing the risks.

Study hypotheses

- following the service delivery model predicts a successful outcome
- the specialised services of the Mental Health 60+ Team are best utilised for cases with identified behaviour problems
- objective criteria for successful outcome can be used instead of subjective assessments of outcome by workers
- when clients refuse interventions, and risks are not high, then continuing to provide services predicts lack of success

Study - method

- population: active cases, coded as chronic and/or severe and persistent mental health problems
  - excluded: elder abuse cases
- 109 cases: 25 cases randomly selected
- involved intervenors were individually interviewed using a semi-structured questionnaire format
  - interviews were audiotaped & transcribed

cases which involved research team members were excluded

intervenors were 5 social workers, 2 nurses, 2 homecare workers.

Method - 2

- Case transcripts were summarized into tables
- Qualitative review by Research Team:
  - was the intervention successful?

Research team: 3 social workers, 2 researchers, myself

Criteria for success - research team

- the problem behaviour(s) has been eliminated or reduced
- the risks associated with the problem behaviour(s) have been eliminated or reduced
- the needs expressed in the request for intervention have been satisfactorily addressed
- the resource utilization has been appropriate to the results obtained

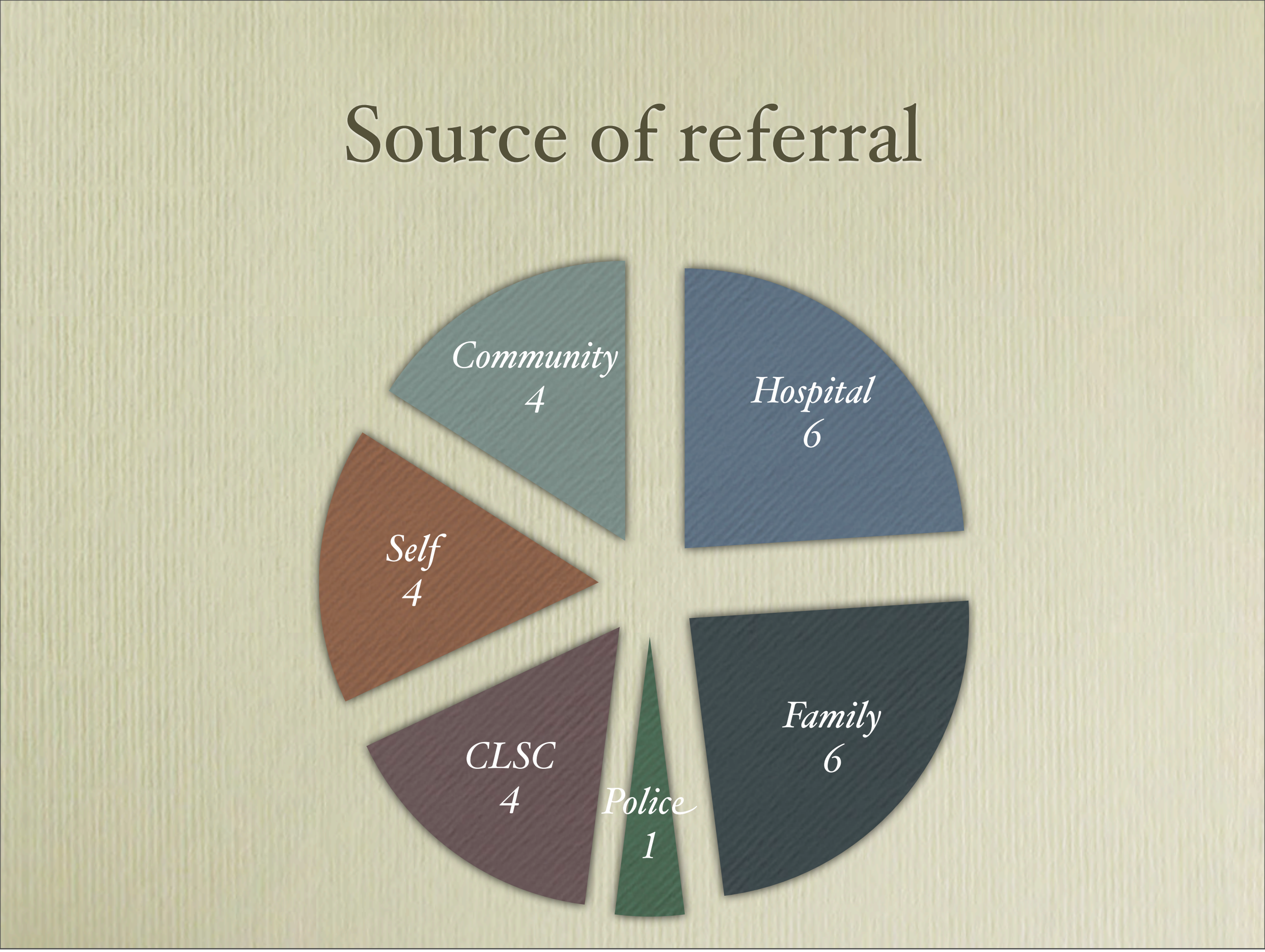
Assessment of case evolution

- was the Service Delivery Model followed?
  - if not: at what point was there digression?
    - screening
    - assessment
    - goal setting / intervention planning / intervention

Case workers were not aware of the service delivery model at the time of the interview or at any during during their prior interventions with cases.

Results

Source of referral



About a quarter of the sample was referred by a hospital, and another quarter by family.
There were four clients referred by other programs within the CLSC, another four by community agencies, and four were self-referred.
Only one client was referred by the police.

Client Demographics (n=25)

- Age 61-87, mean 74.8
- 21 (84%) women; 4 (16%) men
- Marital status:

widowed	12	48%
single	6	24%
married	5	20%
divorced or separated	2	8%

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Client Demographics (n=25)

- Living situation:

living alone	15	60%
with spouse or friend	9	36%
in a residence	4	16%

Medication monitoring

3

Nat[illegible] of service request

In 10 of the cases, or 40%, the request was for counselling. Help with daily living, evaluation, assessment for relocation, and medication monitoring were other types of services requested.

Problem Behaviours

Problem behaviours	Cases	%
5 - 10	6	24%
3 - 4	5	20%
1 - 2	9	36%
0	5	20%

The research team concluded that the services of the Community Mental Health 60+ team had not been required for the 5 cases where no problem behaviours were identified.

Total of 79 problem behaviours

refusal of psychiatric interventions	22%
poor medication compliance	16%
caregiver neglect	14%
poor hygiene	14%
isolation	14%
poor nutrition	8%
financial abuse	5%
falls	5%
overt suicidal behaviour	2%

Risks due to problem behaviours

Risk to own health or safety	17	68%
Risk to family	1	4%
No risk identified	7	28%
Seriousness of risk would warrant intervention against the client's wishes	7 /17	41%

Workers and Roles

Social workers	Nurses	Home Care workers
• counselling • case management • advocacy • support to family or other caregivers • monitoring • evaluation • referrals • crisis intervention • placement	• medication monitoring • dressing changes • on site case management • evaluations • referrals • treatment of skin problems	• bathing • medication monitoring • hygiene monitoring • nutrition monitoring • behaviour monitoring • taking clients to doctors' appointments • providing emotional support

There were 51 workers at the CLSC involved in the 25 cases, although not all at the same time. This included physicians, social workers, nurses, home care workers, recreational therapists, occupational therapists, and physiotherapists.
36% of the cases involved only a social worker.

Initial Goals of Interventions

- counselling
- placement
- decreasing isolation
- psychiatric evaluation
- bathing & hygiene
- support and monitoring
- caregiver respite
- reduction of anxiety
- arranging medical followup
- monitoring nutrition
- arranging help with finances
- support to family
- bereavement counselling

Criteria for Success

Workers' Point of View	**Research Team's Point of View**
• client is satisfied	• problem behaviour(s) eliminated or reduced
• client is stable	• associated risks eliminated or reduced
• client's needs are being met	• needs expressed in the request for intervention have been satisfactorily addressed
• risk reduced or eliminated	• resource utilisation was appropriate to the results obtained
• appropriate resources have been made available	
• client is safe and functioning better	

Clinical Case - Mrs. T.

- 77 y-o widow, on a pension, living alone
- diagnoses of anxiety and depression
- problems: treatment noncompliance, abused medication, refused assessment, verbal abuse
- referred by hospital social worker
- the patient interpreted her anxiety as a heart attack and would go the the ER frequently
- patient had a psychiatric assessment
- agreed to weekly home worker visits for bathing, monitoring, medication monitoring

In the case of Mrs. T., the client was first seen by the nurse, whose goal was to get the patient to a psychiatric evaluation. This was accomplished, and the psychiatric assessment has been helpful in that the ER has a better understanding of how to deal with the patient when she comes with the belief she is having a heart attack. The home care worker also began going in weekly, to monitor the patient's status and her medication compliance.

Mrs. T. - results

Worker's opinion	Research Team's opinion	Model followed?
success	success	yes

There were risks to the client's health and safety, sufficiently severe to warrant intervening against the client's wishes. Intervention goals were to reduce risk and reduce an excessive use of resources.
Although risk has been reduced, and in that sense the case is considered a success, the home care worker pointed out that the patient continued to frequent the ER, convinced that her symptoms of anxiety were really a heart attack.

Clinical Case - Miss U.

- 84-y-o single woman, living alone; living with her sister until 1991 when the sister died
- subsequently maintained by a nephew and other family who shop, bring food, visit weekly
- Maintien à domicile involved since 1991 until 1998 ice storm
- client was agoraphobic, wouldn't leave apartment, even though no electricity and no heat during ice storm
- CLSC relocated her to an assisted living residence
- home care worker visits, walks with her, gets her out of the apartment, helps her to overcome her fears

In the case of Miss. U., the CLSC relocated her, against her will, out of her cold, dark apartment during the ice storm, into an assisted living residence.
After the storm, the home care worker would visit the client, take her out for walks, and work with her to overcome her fears.

Miss U. - results

Worker's opinion	Research Team's opinion	Model followed?
success	success	yes

In this case, there were risks to the client's health and safety, sufficiently severe to warrant intervening against the client's wishes.

Both the worker and the research team concluded that the case had been successful, and the research team judged that the service delivery model had been adequately followed.

clinical case- Mrs. S.

- 73-y-o widow, lives with a common-law partner in a house
- chronic depression, currently stable, on medication
- has been hospitalized in the past for alcoholism
- previously known to CLSC for financial abuse by her son
- partner has severe OCD, won't leave the house, won't take medication, sleeps all day
- came to CLSC requesting counselling re relationship with partner
- worker has just begun counselling with client

This is the case of Mrs. S. She had come requesting counselling, and at the time of the interview with the social worker, counselling had just begun.

Mrs. S. - results

Worker's opinion	Research Team's opinion	Model followed?
indeterminate	indeterminate	no

Screening?	Assessment?	Goal Setting/ Intervention?
inadequate	?	?

The worker felt it was too soon to tell whether the case was successful or not; the research team couldn't judge because its criteria for success could not be applied. The team felt that there was not an identified problem behaviour, that this was not screened for, and that therefore the model was not followed.

Clinical Case - Mr. O.

- 80 year old widower, lives alone in a rented, furnished apartment
- alcoholic profile, but no psychiatric diagnosis
- referred by the JGH where he stayed in the shelter during the ice storm
- problem behaviours:
  - failure to provide self with necessities of life
  - refused evaluation by health care professional
  - refusal of interventions
  - sabotage of interventions

Clinical Case - Mr. O.

- Worker's initial goals:
  - arrange for medical treatment and followup
  - arrange for Meals on Wheels
  - arrange to have his apartment cleaned

- Mr. O. refused all services
- The worker would not intervene against the client's wishes

Mr. O. - results

Worker's opinion	Research Team's opinion	Model followed?
failure	failure	no

Screening?	Assessment?	Goal Setting/ Intervention?
adequate	inadequate	inadequate

The research team felt that the goals which were set were unrealistic, as the client did not want services.

According to Workers

According to Research Team

	Success	Indeter-minate	Failure	Totals
Success	10	4	0	14
Indeter-minate	0	4	1	5
Failure	0	2	4	6
Totals	10	10	5	25

Here's a summary of the success or failure status, in a cross-tabulation between opinions of the case workers, and the judgments of the research team according to their criteria.
If you add up the numbers on the diagonal, you see that workers agreed with the research team in 18 cases, or 72%. This gives a Kappa coefficient of 0.568, significant with a $P < 0.0005$. None of the cases were felt to be a success by one group and a failure by the other.

Utilisation of the Service Delivery Model

According to Research Team

	model followed	model not followed	total
success	8	2	10
indeter-minate	1	9	10
failure	0	5	5
total	9	16	25

The research team concluded that the service delivery model had been followed in 9 cases, almost all of which were judged successful. In contrast, for the 16 cases in which the service delivery model was not followed, almost all were either indeterminate or considered failures.
The statistic that was applied was
Kendall's tau = 0.678, $P < 0.0001$

Reasons why model was not followed

	indeterminate cases (n=9)	**failure cases (n=5)**
inadequate screening	5	3
inadequate assessment	2	3
inadequate goal setting & interventions	5	2
inadequate reassessment of interventions	1	

Conclusions from the study

- following the service delivery model predicts a successful outcome
- specialized services are unnecessary when no problem behaviours are identified
- objective criteria for success are useful and agree with subjective assessments of outcome by workers
- continuing to provide services against client wishes in low-risk cases predicts failure

What can we conclude from this project?

- Assessment of problem behaviours and associated risks can be useful for screening clients and planning treatment goals in the community geriatric mental health setting.
- Does this approach offer anything for other treatment settings?
  - inpatient units
  - general psychiatry outpatient clinics
  - specialized clinics