# An Adult Protective Services View of Collaborative Efforts With Mental Health Services

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# Executive Summary

## Introduction

Mental Health Services (MHS) are charged with meeting the mental health needs of older adults through active, outpatient, community-based care. These needs are not minimal. It is estimated, for example, that up to 25% of people 65 and over experience some sort of mental illness, with depression dominant among the various mental disorders. Like MHS, Adult Protective Services (APS) has long been involved with the highly nuanced needs of older adults who have mental disability and mental illness.

APS and MHS staff are likely to work together when they respond to the needs of victims and those adults at risk for abuse, neglect, self-neglect, and exploitation. APS personnel may receive referrals from MHS, or they may refer clients to MHS, including psychiatric and cognitive assessments or interventions to reduce the risk of abuse and treat its effects. Victims' families as well as perpetrators may also benefit from MHS.
Increasingly complex needs of clients with mental health problems living in the community, together with severe cutbacks in fiscal allocation for services, create both a fertile ground and a critical need for collaborative efforts between APS and MHS.

The intent of this study was to achieve a national perspective by soliciting input from members of both networks to shed light on key elements and prerequisites of effective collaborations. It examines such features as leadership, organizational culture, administration, and resources in predicting success. It contributes to current knowledge about existing collaborative relationships, explores the benefits and challenges of these relationships, and identifies elements of effective collaborations. The study objectives were to: identify situations where APS and MHS interface; determine common elements for successful collaboration between APS and MHS; discover impediments to collaboration for both APS and MHS and determine remedies for those impediments; and to provide guidance to APS and MHS professionals for developing collaborative services.

## Methods

A survey was pilot tested and then sent via e-mail to the National Association of Adult Protective Services Administrators (NAAPSA), an organization comprising about 125 members and to the American Society on Aging Mental Health Special Interest Group, an interest group comprising approximately 4,000 professionals from a vast array of professions such as practitioners, educators, administrators, policymakers, business people, researchers, and students. Raw data were entered into computer software that allows data manipulation by a doctoral level graduate assistant (GA) in the Ph.D. Program in Gerontology at the University of Kentucky who cross-checked it for accuracy with the assistance of another doctoral level GA. Data were analyzed using descriptive statistics.

## Roles in the Collaboration

Survey data revealed that the roles of both APS and MHS in the collaborative effort overwhelmingly concerned direct service provision. The bulk of services included consultation on cases, assessment, and client visits. More than half of the collaborations had direct contact with clients.

## Preservation of Confidentiality/Working Arrangements

Confidentiality was typically maintained through the use of client consent forms. Relationships between APS and MHS seemed to be the most important factor in assuring that confidentiality was maintained while balancing a critical "need to know."

Most APS-MHS working arrangements were informal, usually involving information sharing and joint participation in meetings involving case review. Most respondents said that a formal collaboration between APS and MHS was relatively new. Emergency situations, "cases gone wrong," and the need to avoid duplication of services precipitated the formation of many of these collaborations.

## Challenges Collaborations Face

Differing definitions of emergency situations created strife in the collaboration as do administrative priorities, treatment modalities, and acceptance of, and attention to clients. Frustrations were readily apparent, with the implementation of new laws adding to an already challenging situation (e.g., *Olmstead,* HIPAA). Conceptual misunderstandings about agency/program goals and methods and resource constraints appear to underlie problems with collaboration.

Although both APS and MHS have strong commitments to protecting clients' rights and autonomy, there appear to be differences between the two with regard to implementation. This is particularly apparent in cases involving clients with diminished mental capacity who are at imminent risk, but who refuse help. Some APS workers felt that MHS thresholds for incapacity and danger were too high and that MHS did not intervene soon enough to prevent crises. Differences in perspective were cited as impediments to collaboration.

## Strengths of Collaborations

Strengths of the collaboration were improved communication and better service for at-risk clients. Some were strengthened when programs confronted constraints faced by agency laws and regulations.

## Conclusions

- Successful APS-MHS collaborations depend on the relationships and commitment of the individuals involved in the collaboration.
- Collaborations flourish when an understanding of agency roles and relationships are fostered at upper levels of administration. APS-MHS collaborations can provide a structure for resolving difficult situations.
- Documentation of client services is necessary to demonstrate accountability and effectiveness of the collaboration and contribute to an overall knowledge of client needs.
- Funds should be earmarked to develop and sustain collaborations between APS and MHS.

# Collaborative Efforts Between Adult Protective Services and Mental Health Services

## *Introduction*

Mental Health Services (MHS) are charged with meeting the mental health needs of older adults through active, outpatient, community-based care. These needs are not minimal. It is estimated, for example, that up to 25% of people 65 and over experience some sort of mental illness, with depression dominating among the various mental disorders (Achieving the Promise, 2003; Buckwalter, Smith, & Caston, 1994; Dyer, Pavlik, Murphy & Hyman, 2000; National Survey on Drug Use, 2002). Many elders deal with chronic mental illness in their daily lives, and more succumb to mental illness as an outcome of other life changes, including physical declines and loss of function, financial pressures caused by limited income and growing health costs, or an increasing sense of isolation brought about by mobility limitations (Achieving the Promise, 2003; Barker, Manderscheid, Hendershot, Jack, Schoenborn & Goldstrom, 1992; Wacker, Roberto, & Piper, 1998). In general, mental illness negatively affects life quality; it also increases the chances for abuse, neglect, and exploitation.

Like MHS, Adult Protective Services (APS) has long been involved with the highly nuanced needs of older adults who have mental disability and mental illness. For example, symptoms of mental illness underpin many of the needs for care often found within self-neglect cases (Dyer et al., 1991; Fabian & Rathbone-McCuan, 1992; Vinton, 1992), while in abuse cases, perpetrators often have some form of mental illness (Wolf, Godkin, & Pillemer, 1986; Johnson, 1995).

APS and MHS staff are likely to work together when they respond to the needs of victims and those adults at risk for abuse, neglect, self-neglect, and exploitation. APS personnel may receive referrals from MHS, or they may refer clients to MHS agencies for services including psychiatric and cognitive assessments or interventions to reduce the risk of abuse and treat its effects. Victims' families as well as perpetrators may also benefit from MHS.

Increasingly complex needs of clients with mental health problems living in the community, together with severe cutbacks in fiscal allocation for services, create both fertile ground and a critical need for collaborative efforts between APS and MHS.

Because of the projected increases in the population of older adults and concomitant projected increases in the number of older adults who experience mistreatment or who are self-neglecting, collaborations between APS and MHS are developing. The combined efforts of these systems are not without challenges, however, as the two programs, while similar in their missions – addressing the needs of vulnerable older adults – differ in culture, policies and procedures. Critical issues, such as parameters surrounding confidentiality requirements, criteria for addressing "crisis" situations, and resource limitations, can cause friction and frustration between APS and MHS professionals. Failure to understand or address these programmatic differences is likely to lead to poor service coordination, duplicative or fragmented services, inefficiency, animosity between agencies, and ultimately, detrimental effects on clients. Thus, it is necessary and timely to understand the nature of APS-MHS collaborations.

To date, the only descriptions of APS and MHS collaborations have concerned a single case or description (Office of Services to the Aging, 1983; Dayton, Anetzberger, & Matthey, 1997; Nerenberg, 2000). A gap in knowledge exists, particularly on a systematic and empirical level, regarding how collaborative efforts have developed nationwide, how they function and the number that exist. The intent of this study was to achieve a national perspective by soliciting input from members of both networks to shed light on key elements and prerequisites of effective collaborations. The study examines features such as leadership, organizational culture, administration, and resources in predicting success. It contributes to current knowledge of existing collaborative relationships, explores the benefits and challenges of these relationships, and identifies elements of effective collaborations. A nascent attempt to understand collaborative efforts between APS and MHS, the study objectives were to: identify situations where APS and MHS interface; determine common elements for successful collaboration between APS and MHS; discover impediments to collaboration for both APS and MHS and determine remedies for those impediments; and to provide guidance to APS and MHS professionals for developing future collaborative services.

## Background

### *The Goals of APS*

*"*APS refers to publicly funded programs that investigate and intervene in reports of abuse, neglect, and exploitation of adults who are mentally or physically impaired and unable to protect themselves from harm" (Mixson, 1995, p. 69). Because APS programs were relatively unfettered by federal regulation or funding, each jurisdiction developed independently, and thus, addresses issues of the abuse of older adults using a wide variety of approaches (Byers & Hendricks, 1993; Wolf, 1988). A distinguishing characteristic of APS is that state law mandates it must accept and investigate reports of elder/adult abuse and neglect as its singular mission.

Certain common goals for its clientele distinguish APS from other services for older adults. APS practices are predicated on a social work model and include an individualized, client focus emphasizing problem solving over legal solutions, presuming client competence, including clients' participation in decision making where possible, allowing clients refusal of services (with the exception of when an individual is judged incompetent), and providing services in the least restrictive manner (Mixson, 1995). At its core, the fundamental goal of APS is to protect clients while respecting their right to autonomy.

### *The Goals of MHS*

Although MHS can play an important role in addressing elder abuse and neglect (Marin, Fugal, Hawkins, Duffy, & Rupp, 1995), limited resources have forced MHS to adhere to the detailed criteria for providing services to mentally ill people of all ages. Because MHS generally provides services to persons of all ages with serious mental illness, its service responsibilities are much broader than those of APS. The scope of MHS service responsibilities is much narrower than APS in regards to the type of disabling conditions that are addressed.

Like APS, the MHS service structure for older adults differs from state to state. Older adults are recognized and uniquely responded to within MHS as an underserved population. Some states have established and maintained special older adult out-patient treatment programs, while other states are more limited in their ability to serve them. Community mental health (CMH) centers traditionally provide services that include out-

patient counseling, strictly proscribed crisis intervention, case management, group therapy, case consultation, and day treatment (Mosher-Ashley & Allard, 1993). MHS differ from APS in its response to symptoms of dementia that occur within the older population, because a distinction is drawn between symptoms caused by neurological illness and those caused by mental illness.

MHS are sometimes available to family caregivers, who may experience mental health problems because of the stress-related physical and emotional demands of caregiving. According to George (1992), caregivers of older adults often report problems with depression and high use of psychotropic drugs. In the main, a mental health approach to clinical care operates within a medical model. Treatments are realized through biomedical interventions (e.g., psychotropic drugs or electroconvulsive therapy), interpersonal and other psychological interventions (e.g., individual or family therapy), and socio-environmental interventions (e.g., arrangements for in-home services, protective services evaluations, legal consultation, evaluation) (Marin, Booth, Lidz, Moryzc, & Wettstein, 1995). MHS assistance to at-risk older adults with clinical symptoms, especially assistance within the homes of older adults and their caregivers, is an ideal response that few MHS systems are able to provide.

*Elder Abuse and the Nexus of APS and MHS*

As stated earlier, elder abuse and self-neglect cases often involve instances of mental illnesses of the victim and the perpetrator (Teaster & Colleagues, 2003). APS staff is likely to receive referrals from MHS or refer a client to MHS who might benefit from services (e.g., psychiatric and cognitive assessments, interventions to reduce risk, and treatment for victims, their families, and in some cases, perpetrators). MHS may become involved with abuse victims who are in need of assessment services, including determining the need for involuntary placements, protective custody, or guardianship; identifying clients who would benefit from cognitive and psychiatric assessments or gatekeeper programs; and measuring incapacity to build civil or criminal cases. MHS can reduce the risk of abuse occurring or recurring by treating conditions associated with elder abuse, neglect, or exploitation (e.g., depression, substance abuse, reversible dementias, and obsessive-compulsive disorders); providing counseling and support to overcome dysfunctional relationships; reducing the impact of abuse (e.g., crisis

intervention to diffuse long-term trauma); and benefiting abusers or those at risk of abusing (e.g., involuntary assessment or placement of those who present a danger to themselves or others due to mental illness, psychotropic or behavioral treatment for offenders with personality disorders, mental illness, or other mental health problems that create the potential for abuse).

## Methods

### *Sample*

Because no national list of APS-MHS collaborations was available, the research team requested the help of voluntary participants solicited from an e-mail request by the Executive Director of the National Association of Adult Protective Services Administrators (NAAPSA), an organization comprising about 125 members. Also, an e-mail request was made via the American Society on Aging Mental Health Special Interest Group, an interest group comprising approximately 4,000 professionals from a vast array of professions such as practitioners, educators, administrators, policymakers, business people, researchers, and students The researchers presumed that the study was applicable to only a small number of participants, even though the membership in both groups is relatively substantial.

### *Procedure*

The survey instrument was developed by the research team, which drew upon a questionnaire from an earlier study begun by the late Dr. Rosalie Wolf, Director of the Institute on Aging at University of Massachusetts Memorial Health Care, Worcester. The questionnaire elicited information on the features of collaborative arrangements, including key or "defining" features of collaborative efforts, program characteristics, funding sources, characteristics of the collaboration, roles in the collaboration, barriers, strengths, and approaches or best practices for overcoming problems.

After approval by the University of Kentucky's Institutional Review Board, the survey was pilot tested with two persons involved in APS-MHS collaborations. Their suggestions were incorporated in the final email survey that was ultimately sent to respondents. The communication to respondents included an invitation to participate, explanation of the purpose and procedure of the study, instructions for completing the survey, and the survey itself. The survey could be returned by e-mail, fax, or

conventional mail. The Executive Director of NAAPSA sent out a second request in order to garner more data. Follow-up e-mail messages and telephone calls were also made to solicit participation by the original participants in the study begun by Dr. Wolf.

Raw data from the surveys were entered into SPSS and Excel, computer software that allow data manipulation. A doctoral level graduate assistant (GA) in the Ph.D. Program in Gerontology at the University of Kentucky entered the data and cross-checked it for accuracy with the assistance of another doctoral level GA. The GA contacted respondents for clarification when questions arose regarding information provided on the survey. Data were analyzed using descriptive statistics.

From the surveys sent to all members in ASA and NAAPSA, the research team received 24 completed surveys from self-identified participants. Some non-completers advised the GA that they could not complete the survey due to time constraints. All respondents had an agency affiliation with APS and were from various locations around the country. Of those respondents, 41.7% were at the county level and 50.0% were at the state level of administration. Respondents' programs ranged from those serving clients informally on a case-by-case basis to those serving them on a statewide coverage basis.

## Program Characteristics

Programs (all respondents were from APS) were asked to indicate which services (related to elder/vulnerable adult abuse only) they provide (Table 1). Because a primary function of APS programs is assessment, programs were asked to specify what types of assessments they perform. Three-fourths of programs reported that they performed one or more of the following: assessments for abuse, neglect, self-neglect, or exploitation (100%); need for/eligibility for protective services (95.8%); need for guardianship (91.7%); and need for protective custody (79.2%). Other functions of agencies included needs for other benefit program services (e.g., food stamps, Medicaid, state financial assistance, community services); needs for elderly and disabled waiver services and mental health commitments; and investigations and interventions.

Table 1: Assessment Services

| Assessment | n | % |
|---|---|---|
| Assessment for abuse, neglect, self-neglect, exploitation | 24 | 100 |
| Need for/eligibility for protective services | 23 | 95.8 |
| Need for guardianship | 22 | 91.7 |
| Need for protective custody | 19 | 79.2 |
| Danger to self and/or others as a result of mental illness | 15 | 62.5 |
| Dementia | 14 | 58.3 |
| Need for mental health treatment | 6 | 25.0 |
| Eligibility for other MHS | 4 | 16.7 |
| Other | 2 | 8.3 |

Note: Multiple responses

Respondents also gave information on other services (Table 2). Over three-fourths provided consultation to other agencies/professionals (95.8%), crisis intervention (91.7%), professional training (e.g., cross-training) and public education (both, 83.3%), and case management with the victim (79.2%). Two programs indicated other APS services: petitioning for guardianship when no one else is available to do so, providing emergency services (e.g., chore services, emergency support, respite care), and engaging in legal interventions.

Table 2: APS Services

| Services | n | % |
|---|---|---|
| Consultation to other agencies/professionals | 23 | 95.8 |
| Crisis intervention | 22 | 91.7 |
| Professional training (e.g. cross training) | 20 | 83.3 |
| Public education | 20 | 83.3 |
| Case management with the victim | 19 | 79.2 |
| Emergency Shelter/Placement | 16 | 66.7 |
| Routine monitoring | 16 | 66.7 |
| Family support services | 9 | 37.5 |
| Residential care | 7 | 29.2 |
| Advocacy | 7 | 29.2 |
| Counseling/partial hospitalization | 7 | 29.2 |
| Psychiatric services for elderly | 6 | 25.0 |
| Psychiatric services for non-elderly | 6 | 25.0 |
| Clinical treatment of perpetrator | 2 | 8.3 |
| Other | 1 | 4.2 |

Note: Multiple responses

Service delivery options included home visits (95.8%), care planning and staffing (75.0%), routine check-ins to monitor the case (70.8%), and routine check-ins after case closure to determine the case outcome/disposition (8.3%). Other options (20.8%) included adult in-home services via inclusion in the adult in-home program; case management for individuals enrolled in the Title XIX Waiver Program (i.e., Home and Community Based Care for the Elderly and Chronically Ill); recommendations to families and other agencies for clients' least restrictive environment; guardianship assessments; and investigations of reports of abuse, neglect, exploitation of at-risk adults, including plans to remediate confirmed cases.

*Working Arrangement Between APS and MHS*

Respondents were asked to categorize and describe the nature of the working relationship between APS and MHS (Table 3). By far, the most common arrangement was an informal one (70.8%). Informal arrangements were characterized by sharing of cases on a "need-to-know" basis, allowing individual APS offices to make individual arrangements with MHS agencies to collaborate on a specific case, making expedited referrals for services, and participating in community meetings with other community agencies as members of a "wrap-a-round team" (i.e., pooling community resources and forging collaborative service plans in dealing with mutual clients with problems that cross program and division lines). Other informal arrangements included referrals to MHS by an APS nurse, protocols for gaining assistance from MHS facilities, and crisis teams for victims of abuse or neglect.

Table 3: Working Arrangement between APS and MHS

| Working Arrangements | n | % |
|---|---|---|
| Informal Arrangements | 17 | 70.8 |
| Information Sharing | 11 | 45.8 |
| Memorandum of understanding | 8 | 33.3 |
| Other arrangements | 8 | 33.3 |

Information sharing, indicated by nearly half of the respondents (45.8%), was provided on a need-to-know basis and under an APS law that permits request and receipt of all information from any source that furthers an investigation, and release of information for devising or implementing a service plan. In one instance, MHS has representation on an APS advisory committee where cases are staffed for problem solving.

A third of respondents (33.3%) indicated that they had a memorandum of understanding (MOU) between APS and MHS. According to the survey results, MOU agreements are traditional in nature. Descriptions of MOUs included those that

established criteria and processes for such areas as intake, investigation, data collection and reports, confidentiality, appeal or review of decisions, professional training, consumer safety, and quality assurance. Structurally, some MOUs extend beyond APS and MHS to include agreements with other local service entities such as law enforcement, prosecutors, Medicaid, and other service programs. One MOU established a statewide APS review team (that included MHS) with statewide, rather than local, criteria and expectations. A few respondents described unique aspects of their MOU documents (collaborative arrangement). For example, one MOU stipulated that APS investigations of complaints involving older people with mental illness who reside in mental health institutes be carried out by "complaint investigators" within the MHS state institution system. Another MOU required collaborative investigations that adhered exclusively to APS rules and policies.

None of the collaborative arrangements reported having legal contracts, although a third (33.3%) used other formal arrangements. Those included statutory mandates requiring APS investigations in MHS settings, commitments to work together for cross-training and to develop written protocols, mandatory reporting, and MHS case managers who conduct home visits at APS requests and vice-versa.

*Other Agencies/Programs in the Collaboration*

Collaborations are not always limited to APS and MHS programs; other agencies may also be involved. Agencies involved in the APS-MHS collaboration identified by approximately half of the respondents included police/sheriffs (54.2%), district attorney's offices (50%) departments of human/social services (50.0%), and aging services staff (41.7%) (Table 4). To a lesser degree, other programs were involved, including staff from departments of child and family services, domestic violence, and health departments. Other members (37.5%) were from local and county offices, local hospitals, nursing homes and assisted living facilities, Office of Regulatory Services, long-term care licensing and health care/private care providers, financial institutions, local long-term care ombudsman, geriatricians and other physicians, agencies addressing developmental disabilities, Catholic Charities, and the Social Security Administration.

Table 4: Other Agencies in the Collaboration

| Agencies | n | % |
|---|---|---|
| Police/Sheriffs | 13 | 54.2 |
| District Attorney's Offices | 12 | 50.0 |
| Departments of Human/Social Services | 12 | 50.0 |
| Aging Services | 10 | 41.7 |
| Departments of Children and Family Services | 8 | 33.3 |
| Local Health Departments | 6 | 25.0 |
| Domestic Violence Program/Shelter | 6 | 25.0 |
| Other | 9 | 37.5 |

*Program/Agency History*

Because all the respondents were from APS, agencies tended to have long histories, with 15 having been in existence for more than 20 years, three for more than 10 years, three for more than five years, and one for approximately two years. Seventeen respondents provided information on the history of their collaborative arrangement: most arose from a clear need to develop a working relationship to better address the needs of clients, families, and, in some cases, perpetrators, with mental health problems. Descriptions of the working relationship ranged from extremely positive to those indicating that it was nonexistent. Below are highlights of the responses provided.

- There is a long history of sharing information between agencies. We have no formal agreements but share with and refer to each other's programs in the normal course of doing day-to-day services for clients.
- In the past (and only for a very short period of time-18-24 months) there was a mental health APS collaboration, but this was dissolved by mental health policy makers.

- At the state level there have been few opportunities to do meaningful collaboration: usually the "coming together" has been in times of a crisis or media attention of a "problem." About 5 years ago state legislation was passed to make the local/regional [mental health] system providers privatized and under contract to the state through Regional Boards. Since then, there have been vast problems working together. Also, *Olmstead*, with its emphasis on moving clients into the community, has introduced new challenges for already strained relationships. (Note: *Olmstead* is a Supreme Court case brought by two Georgia women who were living in state-run institutions even though professionals had determined that they could be appropriately served in community settings. The plaintiffs charged that continued institutionalization was a violation of their rights under the Americans with Disabilities Act (ADA). The court ruled in their favor, affirming that unjustified isolation constitutes discrimination based on disability. In response, the Department of Health and Human Services directed states to increase their efforts to enable people with disabilities to live in the community and provide them with more opportunities to exercise informed choice).

- In the 1980s, we entered an agreement for foster home recruitment and placement of MHS clients in APS recruited homes when space permitted. That has not been active in some time due to cutbacks in APS staffing. We currently request the county department to work with local mental illness and mental retardation contacts. However, state office coordination is sometimes required to facilitate services to individuals in crisis situations.

- A “rocky road" best describes it! Collaboration has depended in large part upon how well individual APS and MHS providers work together.

- In 2001, APS invited MHS to an adult task force with the objective of improving our working relationship and developing protocols for collaborative interventions and information sharing to best serve clients.

- Local MHS has been invited to participate in monthly community collaboration meetings and monthly Adult Protective Services Review team meeting for several years. However, MHS participation has never been consistent, citing confidentiality even though this has been addressed in collaboration by-laws and the MOU. HIPAA has closed more doors for any further collaboration or information sharing between APS and MHS. (The "Health Insurance Portability and Accountability Act of 1996" provides for easier entry into employee-sponsored group health plans for employees with preexisting conditions. In 2001 guidelines were published to clarify HIPAA’s provisions for protecting patients’ medical privacy. The guidelines have raised widespread concerns by service providers [including APS and CMH] about what agencies and types of information are covered.)

- MHS staff has participated on our multidisciplinary team since 1996.

*Development of the Collaborative Relationship*

Collaborations were prompted for various reasons, the most frequent reason being "case gone wrong" (i.e., cases that had negative outcomes) (41.7%), followed by client emergency (45.8%), needs assessment (37.5%), and political environment/politics (25.0%). Some respondents provided additional explanatory information. Under the category of *client emergency*, respondents said that collaborations were formed to address a disagreement between APS and MHS as to whether an involuntary psychiatric placement or a guardianship was the appropriate course of action in a specific case; to act on emergencies of common clients; to close down a group home and relocate clients; to assist clients who were abandoned; or when there was a breakdown in the caregiving systems; and to seek an emergency detention order.

For *case gone wrong*, the collaboration was instituted to reduce duplication of services; share information to evaluate vulnerability and develop protective plans; address differences in opinion regarding client eligibility for APS and MHS services; reconcile funding issues, access, and availability of services; and better serve APS clients with untreated/under diagnosed mental illness. Under the category of *needs assessment*, one APS-MHS collaboration was instituted to address needs for divisions to work better together (e.g., APS workers requested specific placement services but learned MHS might provide in-home services that might salvage a situation). In some instances, collaboration was prompted by *changes in the political environment*, such as lawsuits, state-level oversight investigations, priorities from the Governor's and Commissioner's offices, and disparities in funding of APS and MHS. *Other reasons* collaborative efforts were developed included consolidating resources for effective client service, passing a human services levy to garner additional revenue, verifying involvement of either agency with the victim, facilitating involuntary civil commitment, finding placements for assisted living clients, addressing guardianship issues, ensuring staff safety, and streamlining client referrals.

*Maintenance of Confidentiality*

More than half of the respondents used a client consent form to maintain confidentiality (54.2%), 25% had an MOU, and 16.7% used a specifically designed confidentiality or non-disclosure form. Over half of collaborations (62.5%) used other

mechanisms, such as inter-agency agreements and general professional efforts to obtain consent wherever possible. Some said they shared information outside rigid guidelines for confidentiality, when a close professional relationship existed between MHS and APS workers.

*Roles in the Collaborative Arrangement*

According to participants in this study, APS roles in the collaboration included direct service provision (83.3%), training (62.5%), and administrative/supervisory (50.0%). Other roles of APS (41.7%) in the collaboration were case consultation and troubleshooting, leadership when relocations occur, advocacy, intake and referrals to MHS, sharing assessment/care planning information, and locating resources.

With regard to the role of MHS in the collaboration, respondents reported direct services provision (75.0%), administrative/supervisory (37.5%), and training (33.3%). Other roles (29.2%) of MHS were case consultation, intake and referral functions, and participation on an APS community advisory committee.

*Services Provided in the Collaborative Arrangement*

Specific services provided by the collaboration (Table 5) were interagency consultation (58.3%), client visits (54.2%), assessments (50.0%), referrals (50.0%), and investigations (41.7%). One collaboration initiates commitment petitions. Collaborations were also invited to provide additional information about specific services provided. Comments on services included joint filing of guardianship/conservatorship petitions and coordination and delivery of in-home services. Two respondents emphasized that all services and funding are inconsistent across their state.

Table 5: Services Provided in Collaborative Arrangement between APS and MHS

| Services | n | % |
|---|---|---|
| Interagency consultation | 14 | 58.3 |
| Client visits | 13 | 54.2 |
| Assessment | 12 | 50.0 |
| Referrals | 12 | 50.0 |
| Investigations | 10 | 41.7 |

*Clients Served*

Respondents were asked about the clients they served through their collaborative activities. This question only pertained to programs that provide direct services to clients as opposed to programs that engaged in such activities as collaborative training. Fourteen collaborative programs provided direct client contact (58.3%). Of those programs providing direct client contact, only five keep some information on clients served through the collaborative agreement.

*Program Costs*

No program received special funding for the collaboration, although 62.5% received in-kind contributions. In-kind contributions included staff time spent at MHS meetings; staff work via phone or meeting in program offices; administrative petitions for commitment; consultation and coordination; staffing cases; policy development; staff time and assistance in facilitating community collaboration; at-risk APS cases or MHS cases requiring consultation services and advice of emergency crisis staff on cases as needed. Other in-kind contributions included providing food, meeting rooms, brochures, and travel reimbursement for training.

## Challenges and Strengths of Collaboration

*Challenges*

Collaborative programs were asked to identify challenges of the relationship (Table 6). Roughly half indicated challenges concerning emergency situations (e.g., agency disagreements about what constitutes an emergency) (58.3%), administrative

priorities (54.2%), intervention and treatment from APS or MHS regarding behavior/symptoms (e.g., dementia versus depression) (50.0%); and confidentiality, funding, lack of understanding of agency roles, mandates, policies, and procedures, provision of on-site services at client's residents (e.g., APS requests that MHS conduct in-home visits/assessments, which MHS may not be able to conduct) (all, 45.8%). Two collaborative efforts indicated that HIPAA created roadblocks to information sharing. Other challenges included severe fiscal cutbacks in MHS, non-compliant clients/consumers being terminated from services, lack of interest on the part of agency directors to provide any type of collaborative services for clients with MHS needs, dissolution of arrangements by policy makers, provision of services by contractors who sometimes "pick and choose" less difficult clients, narrow focus of MHS on voluntary clients (with the exception of civil commitments), few follow-up services by community mental health centers regarding mutual clients, and little MHS initiative to creatively encourage clients of questionable mental capacity to comply with treatment protocols.

Table 6: Challenges of Collaboration

| Challenges | n | % |
|---|---|---|
| Emergency situations | 14 | 58.3 |
| Administrative priorities | 13 | 54.2 |
| Intervention and treatment from APS or MHS | 12 | 50.0 |
| Confidentiality | 11 | 45.8 |
| Funding | 11 | 45.8 |
| Lack of understanding of agency service provisions | 11 | 45.8 |
| Provision of on-site services at client's home | 11 | 45.8 |

*Strengths*

For over half of respondents, strengths of the collaboration (Table 7) included improved communication and improved relationships between/among agencies serving at-risk adults (79.2% each), clarification of roles (70.8%), improved case coordination,

access to resources of other agencies (62.5% each), and increased services provided to at-risk adults with mental illness (58.3%). Other strengths cited were equality of workload between APS and MHS and improved relations when APS became more knowledgeable about MHS service provision limitations. One collaboration reported that a benefit has been the presence of a behavioral nurse on APS staff. The nurse performs in-home assessments and makes referrals to physicians, hospitals, and MHS.

Table 7: Strengths of the Collaboration

| Strengths | n | % |
|---|---|---|
| Improved communication | 19 | 79.2 |
| Improve relationships between/among agencies | 19 | 79.2 |
| Clarification of roles | 17 | 70.8 |
| Improved case coordination | 15 | 62.5 |
| Access to resources of other agencies | 15 | 62.5 |
| Increased services provided to at-risk adults with mental illness | 14 | 58.3 |

*Factors Contributing to Success*

From the list of response options, participants identified factors that contribute to the success of their collaboration (Table 8). The greatest factor was cross-training (41.7%), followed by compatible individual working styles (20.8%). In some cases, programs elaborated on the categories. For example, under the category *Expectations from higher ups that you will make it work,* programs identified legislative expectations, collaboration between department commissioners, and the commitment by MHS to report and share information. Under *Programs located in close proximity,* one program indicated that state offices are housed almost directly across the street from each other, while only one respondent indicated that the programs were administered within the same department. Regarding *Worker latitude in decision-making,* one respondent commented on APS skill in accessing services of other departments and support of staff in their decision-making in the field. Another collaboration mentioned the importance of cross-

training with law enforcement and with APS and MHS alone. Referring to "Compatible individual working styles," two programs emphasized that collaborative efforts vary depending on personalities involved as well as agency protocols.

Table 8: Contributions to Success

| Contributions | n | % |
|---|---|---|
| Cross-training | 10 | 41.7 |
| Compatible individual working styles | 5 | 20.8 |
| Expectation from "higher ups" that you will make it work | 4 | 16.7 |
| Programs located in close physical proximity | 3 | 12.5 |
| Workers with latitude in decision making | 3 | 12.5 |
| Programs administered within the same department | 1 | 4.2 |

Fourteen respondents provided additional factors contributing to the success of the collaboration. These included understanding of program limitations and jurisdictional boundaries, APS not being governed by HIPAA regulations (i.e., it can obtain information more readily), knowledge that APS must have 24-hour coverage for mental health care, mutual commitment to work together by leadership, regarding older adults as a priority population, and commitment of staff in both APS and MHS to work well together for the victim/client.

Lack of financial resources for both APS and MHS has led to improved collaboration in some instances (e.g., departments agree to fund a part of the case plan in order to provide client services). Other factors leading to successful collaborations were the importance of personality and commitment and involvement of upper management, maintenance of a good relationship with MHS, awareness that more individuals with mental illnesses are being funneled to APS for lack of a better option, willingness of the community to accept APS as a consultant on cases and not always expecting that APS can or will open a case, and passion of those involved.

## Future Plans for Collaborations

Though three respondents indicated that they had no future plans for collaboration, 15 respondents provided information about future plans. These included the following:

- Coping with a pending reorganization of MHS that drastically changes its structure,
- Conducting more cross-training,
- Providing additional face-to-face staffing on difficult cases at the local level,
- Developing written protocol,
- Exploring a collaborative waiver for clients with mental retardation,
- Continuing ongoing regular meetings, establishing relationships with contract mental health facilities, including meeting the point person assigned to work community issues and developing a process for APS workers to use when facing a MHS situation,
- Creating similar MOUs with other regional mental health offices,
- Securing services for clients on waiting lists,
- Locating providers with expertise in the various areas of at-risk adult issues,
- Fostering closer working relations with the Attorney General's office, and
- Filling a vacant MHS position on a multidisciplinary team.

### *Recommendations for Forming or Maintaining an APS/MHS Collaboration*

Fifteen respondents provided recommendations for forming or maintaining an APS-MHS collaboration.

- Transferring abuse and neglect investigations from MHS to APS has helped us comply with HIPAA confidentiality provisions because APS is not a covered entity,

- Raise critical questions in a spirit of problem-solving, not blaming,

- Establish a working relationship with the local MHS with training and education about your program and services offered, and receive the same in return,

- There has to be a true commitment on the part of administrators (and not just lip service) to the value of collaboration. Social workers, case managers, and therapists are more than willing to work together on providing collaborative services to the [individual] client/patient, which makes for a much more successful intervention,

- Develop a sense of "we" rather than "you" and "I;" put the focus on serving the public/clients rather than on political aspects. Have a willingness to come together and put the past in the past for a renewed commitment to try and begin anew,

- Define terminology. Common terms in APS had a different meaning to MHS (e.g. abuse and neglect),
- Put agreements in writing, clearly delineating each agency's responsibilities, and make sure that the agreement is supported from the top down in each agency. Work together to try to understand each other's systems and services, and honestly and openly discuss the limitations,
- Have a clear understanding of MHS internal policies and procedures regarding participation in collaborative efforts. Confidentiality is a critical issue for all professionals. There should be an understanding among the collaborative agencies that some information must be shared in the provision of services to the client beyond obtaining the client's signed release. In some cases, we are unable to obtain releases due to trauma, crisis, or incapacity,
- Become familiar with key people in the other agency. Begin exposing them to APS, common clients, and common issues. Respond to their requests for assistance and continue to educate, educate, educate. Invite them to multi-disciplinary teams. Use the multidisciplinary team as a vehicle for formalizing the relationship,
- Have constant interaction, especially regarding elders 60+,
- Meet regularly,
- Develop trust,
- Share success and failures with other APS units, and
- Allow creativity in problem-solving.

## Discussion and Conclusions

This study was a first effort to shed light on collaborative arrangements between APS and MHS across the nation. From the perspective of APS only, it provides information on structures and services, explores benefits, and provides insight into the challenges these collaborative efforts face.

The roles of both APS and MHS in the collaborative effort overwhelmingly concerned direct services provision. Intake and referral was also an important role for both. The bulk of services included consultation on cases, assessment, and client visits. More than half of the collaborations had direct contact with clients. Although a third indicated that they kept track of clients in the collaborative arrangement, they provided little information with regard to number of male and/or female clients over or under 60

years of age. Documentation of client services is necessary to demonstrate accountability and effectiveness of the collaboration and contribute to an overall knowledge of client needs.

Confidentiality was most typically maintained through the use of client consent forms. Relationships between APS and MHS seemed to be the most important factor in assuring that confidentiality was maintained while balancing a critical "need to know."

Other entities played an important role in the APS-MHS collaboration, most notably law enforcement and social services. Clearly, these arrangements are often well-informed by a multidisciplinary perspective (see Teaster, Nerenberg, & Stansbury, under review) that can lend perspective (and services) to the complex needs of challenging cases.

Most APS-MHS working arrangements are informal, usually involving information sharing and joint participation in meetings involving case review. More formal arrangements may emerge over time, or alternately, they may be deemed an unnecessary impediment to creative problem solving. According to most of our respondents, formal collaboration between APS and MHS was relatively new, while a few had informal arrangements. Emergency situations, "cases gone wrong," and the need to avoid duplication of services precipitated the formation of many collaborations.

Some collaborations encountered significant challenges. Differing definitions of emergency situations appear to create strife in the collaboration as do administrative priorities, treatment modalities, and acceptance of and attention to clients. Frustrations with efforts to work together were readily apparent, with the implementation of new laws adding to an already challenging situation (e.g., *Olmstead,* HIPAA). Conceptual misunderstandings about agency/program goals and methods and resource constraints appear to underlie problems with collaboration.

Although both APS and MHS have strong commitments to protecting clients' rights and autonomy, there appear to be differences between the two with regard to implementation. This is particularly apparent in cases involving clients with diminished mental capacity who are at imminent risk, but who refuse help. Some APS workers felt that MHS thresholds for incapacity and danger were too high and that MHS did not

intervene soon enough to prevent crises. Differences in perspective were cited as impediments to collaboration.

It is disturbing that no programs indicated receiving earmarked funding for the collaborations and that only in-kind services are provided for them. Fiscal allocation signals priorities, and a lack of such support may complicate efforts to work together as well as to sustain efforts over time.

Strengths of the collaboration were improved communication and better service for at-risk clients. Some collaborations were strengthened when programs confronted constraints faced by agency laws and regulations. It is curious that training was seen as a factor for success for less than half of respondents. None of the factors for success cited by respondents were rated as particularly significant, and respondents' "other" perceptions were inconsistent. Three collaborations indicated that they had no future, which may suggest intractable problems with the arrangement.

This study, small in size, is limited by responses from the APS perspective only. Our strategy for capturing MHS may not have been an appropriate one; future studies of this kind need a specifically identified key informant from MHS to garner data. That MHS did not complete any surveys may be due to a lack of time as well as fiscal constraint. Severe cuts in MHS funding have necessitated increased case loads, permitting less time for administrative activity, thus limiting opportunities to complete a survey of this nature. An additional limitation is the small number of MHS programs that deal specifically with older people (Wacker, Roberto, & Piper, 1998) Certainly, it is necessary to find other approaches to capture the MHS perspective in the collaboration.

Successful APS-MHS collaborations depend on the relationships and commitment of the individuals involved in the collaboration. Collaborations flourish when an understanding of agency roles and relationships are fostered at upper levels of administration. The number of older adults who may be mistreated, due to their own mental illness or that of a caregiver, may well rise. Increases are attributable to such factors as an aging population generally and varying family structures that significantly affect caregiving for family members as well as friends in the community. APS-MHS collaborations can provide a structure for resolving difficult situations.

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