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Mental and behavioral health conditions among older adults: implications for the home care workforce

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Abstract

Objectives—The shift towards home and community-based care, coupled with the growing prevalence of mental and behavioral health conditions, increases the demand for skilled home care workers. However, little is known about the experiences of home care aides who provide care to clients with mental and behavioral health diagnoses. The purpose of this study was to identify challenges aides face in providing care to this particular group of clients, as well as the strategies and support they utilize to complete their job responsibilities.

Methods—Data from five focus groups with home care workers ($N = 49$) throughout Massachusetts were used to examine the experiences of home care workers providing services to adults with mental or behavioral health needs. A constant comparative method was used during analysis of the focus group transcripts.

Results—Aides described a lack of prior-knowledge of challenging client behaviors, leaving them unprepared to deal with disruptions to care delivery. Aides feel unsafe or unsure providing care to someone with complex needs, made worse by a perceived lack of training and support from the broader care team. Aides develop unique strategies for accomplishing their work.

Conclusion—This analysis of the aide's perspective contributes valuable, and often unheard, insight to inform what we know about providing reliable, quality and safe home care to this growing group of vulnerable adults. Implications of this convergence are discussed relative to aides.

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Keywords

home health aides; long-term care; mental health; behavioral health; direct care workforce

Introduction

Providing the highest quality care at the lowest cost remains a high priority within the United States' health care system. With the advent of accountable care organizations and patient-centered medical homes, reaching this goal means delivering care in the community instead of hospitals or long-term care facilities. This shift to home and community-based health care includes people with mental or behavioral health conditions, many of whom are rapidly aging into systems that are not fully prepared to meet their needs (Mechanic, 2012).

The prevalence of mental health disorders in the United States is staggering, nearly half of the population is expected to develop a mental illness in their lifetime (Kessler et al., 2005). In 2006, medical expenses for those with mental disorders cost 57.5 billion, making it the fifth most costly condition (Soni, 2009). On average, the length of stay among older adults who have been hospitalized for mental illness has declined over the last decade (Hoover et al., 2008). These adults are discharged home, many times to be cared for by home care workers who are not traditionally prepared to provide care to individuals with mental or behavioral health conditions (CMS Conditions of Participation, 2001).

Direct care workers provide the majority of the paid community-based care required by individuals with physical, developmental and mental disabilities. Home health occupations will increase by 48% between 2012 and 2022, making it the third fastest growing employment sector in the country (PHI, 2014). Though this expanding workforce continues to bear the burden of home care for individuals with mental illness, they are rarely heard from in either policy or practice. Thus, examining their perspective on how the mental and behavioral health of clients affects their ability to maintain high quality care and safety for their clients is an important task for research.

Under federal regulations, home health aides (HHAs) are required to receive 75 hours of initial training and 12 hours of in-service training per year (CMS, 2001). Within these regulations there are no explicit requirements for training on mental health diagnoses (CMS, 2001). Massachusetts is unique in that HHAs have the opportunity to receive 12 hours of additional training to become an advanced aide, called a Supportive Home Care Aide (SHCA) in one of the two areas: Alzheimer's disease or mental health (EOEA, 2014). The SHCA is considered an advanced HHA service and is reimbursed at an enhanced rate by the network. As a result, SHCAs are paid a higher wage, work more closely with clinical staff, and experience higher retention rates than traditional home care aides. Even still, with turnover rates of HHAs between 35% and 65% per year and demand outpacing supply, recruiting and retaining a qualified workforce is of immediate concern (Dill & Cagle, 2010). Further, this SHCA training has not been updated in 20 years; and it does not reflect current recommendations for working with and providing care to individuals who are experiencing mental illness. Currently, there are no required, or even suggested, guidelines for what should be included in the mental health training for SHCAs (EOEA, 2014).

In a system that is increasingly reliant on the least trained, lowest paid workforce to keep the country's sickest individuals safe in the community, one task addressed by this study is to understand how this workforce can be best supported relative to mental and behavioral health. From the perspective of the home care aide, the primary aim of this paper is to describe the aspects of mental or behavioral health conditions that pose challenges for aides in conducting their daily work, as well as the implications of these conditions for the safety and quality of the home care provided. A discussion of how this workforce can be better supported as they provide home care to a growing population of adults with mental or behavioral health needs is included.

Methods

Five focus groups were conducted throughout the state of Massachusetts between May and July 2014. The focus group moderator used a semi-structured focus-group protocol to engage HHAs in discussion about the types of mental illness and behavioral health conditions (i.e., substance abuse, hoarding and other addicting behaviors) that aides most commonly encounter, and how they provide care to this population of older adults with complex needs. Participants were paid for their time. Each focus group was audio recorded and these recordings were transcribed verbatim. In addition, one member of the research team, a doctoral candidate in gerontology with training in qualitative methods, took notes regarding the contextual nature of the conversations. The focus group facilitator is an expert in both mixed method research and issues of long-term care related to older adults and people with disabilities. All study protocol and associated materials were approved by the Institutional Review Board at the University of Massachusetts Boston.

Sample and recruitment

Participants were recruited through their agency of employment. The research team distributed flyers and email requests to member agencies of the Home Care Aide Council (the trade association for home care agencies); and participants voluntarily contacted the research staff. Two focus groups consisted of aides who reported receiving any SHCA training and three focus groups included participants who had not.

In total, 49 home care aides attended the focus groups; 15 were SHCAs, 30 were HHAs, and 4 were personal care homemakers, homemakers, or personal care attendants (see Table 1). Nearly all (96%) of the aides were female and their years of experience in the field ranged from less than 1 to 40 years. Efforts were made to recruit participants from urban and rural areas of the state to ensure that results accurately reflect the varying conditions of home care. Ultimately, our focus groups took place in five communities (two rural; one urban and two suburban), but because we wanted to protect the confidentiality of the HHAs we did not record demographic characteristics or information about their specific agencies within these communities, such as whether agencies were proprietary or non-profit.

Analysis

Focus group transcripts were scrutinized and emerging themes were identified and labeled with primary codes. The constant comparison method was used to delineate similarities and

differences between the primary codes and to develop categories and subcategories (see Table 2), which were verified and refined as the analysis proceeded to ensure conceptual consistency (Glaser, 1965). This constant comparative approach is considered a systematic way of analyzing qualitative interview data and places emphasis on the frequent and purposive comparison between researchers and across interviews to develop themes (Boeije, 2002). Coding was performed by two trained members of the research team. Inter-rater reliability was quantified as the degree to which both coders agreed with the codes that were independently assigned (Miles & Huberman, 1994). As discrepancies were found, the research team came to an agreement about how to resolve the discrepancy until the reliability among coders was 90% or higher for each code.

Results

Out of all mental and behavioral health conditions mentioned by HHAs, hoarding (39%), substance abuse (27%) and depression (20%) were the most frequent. Other conditions HHAs encountered with clients included: schizophrenia, dual diagnosis of a mental health condition and dementia, bipolar, or suicide ideation (see Figure 1). Regardless of diagnosis, aides highlighted that one major barrier to assisting clients with mental illness were behaviors that limited the HHA's ability to meet the requirements of their job. These behaviors, reported by HHAs, were grouped into three categories: aggressive, disruptive and psychotic (see Table 3). In addition to these behaviors, aides described three domains that affected their ability to perform their work, both positively and negatively: communication, coping strategies, and formal external support.

Communication

Oftentimes, aides developed their own strategies to manage the delivery of home care for their clients. All strategies they described revolved around communication, both verbal and nonverbal. Aides gave examples of using negotiation skills, active listening, and voicing empathy to work effectively with clients who have mental or behavioral health conditions.

Verbal communication—Using empathy to communicate with clients was a common way aides described being effective at their job. One aide reported her use of compassion and positive feedback in working with a client, who hoards:

I always ask her to follow me and ask her where to put things. 'Where do you want to put this?' And I let her pick a place. And she feels really good the next time I see her she said, 'See. I had the house re-organized for you.' ... I give her praises. She tried, you know?

Nonverbal communication—Other aides described the power of silence in communicating with clients who suffer from mental illness. For example, one aide observed that by letting her client vent, she was able to avoid conflict:

But [if] that person's yelling? ... when you're quiet they realize they're arguing with themselves ... And then they end up apologizing.

When verbal communication was seemingly impossible for aides, they described ways in which they communicated with their client using nonverbal communication tactics like body language and redirection of the conversation:

What I find helpful to do when I find clients that are sort of difficult to be with sometimes? If they give me such a hard time, I'll leave them alone and I'll step back. And then tell them I'll go [something else] and I'll be back and then try to re-direct it in a different sort of way.

Interpersonal relationship building—Part of communicating with clients is building a strong relationship based on trust and mutual respect. HHAs spoke about the ways that they develop relationships with their clients and by doing so were able to learn their triggers and better manage their difficult behavior. For example,

... You have to really, really talk to them and unwrap them like a gift, slowly ... to find out more about them before you start cleaning up. And that's what I did. I just talked to her, and listened to her mostly and [by] doing so we got rid of a lot of stuff.

By getting to know each other, aides are able to limit the power differential in their provider-patient relationship. For example, one aide advised, based on her success with this client population in the past:

Make them like you. ... you walk into their house and you know, you don't see the mess. You just [say] 'How are you? Let's go take a shower.' And then sit with her. They have feelings. They're just like us.

Finally, negotiation was reported as being another way that aides can effectively communicate with clients. One aide described a useful strategy for accomplishing her tasks:

I can't get her in the shower. The phone rang. I answered ... it was a telemarketer. I'm like ... 'Oh, [client's name]. The phone's for you. She's like 'Can you give it to me?' I said, 'it doesn't reach, you're going to have to get up.' ... So she got up ... and answered the phone. And I'm like, 'how about we go into the bathroom and change your brief?' From that day on I've never had a hard time ever. I have the kids call every day ... She goes in the bathroom. It's like a miracle.

Coping resources

Just as individual client characteristics contributed to the ability of HHAs to cope with the stress of their job, aides developed their own individual strategies for being successful at work. These internal strategies included managing their own personal and emotional response to challenging client behaviors, managing the aide-client relationship by setting boundaries and by focusing on positive affect of accomplishing tasks, no matter how small. Attempting to control their own response to the work demands, particularly when faced with a difficult behavior, led some aides to struggle:

I ... help do anything for my client, but at times I felt like I was going to burn out ... I had one client for 11 years and saw her every day. When she died I had to take

a year and a half off because I could just not look at anybody in that age group without ... crying. And there was no support at all.

Emotional response—Coping with their own emotional response to client's behavior was a major challenge for aides. For example, home care aides may have taken the behavior personally because they have built relationships with their clients:

... a few weeks ago she [client] had a really bad day. And was saying I was doing my laundry at her house ... because she found pillow cases that she didn't recognize. And I was explaining to her over and over ... those belong to your son ... she didn't believe it ... I was upset that day. It like hurt me in a way because I've been with her for four years.

Though building interpersonal relationships with clients is a strategy for managing challenging behaviors related to mental or behavioral health, aides reported difficulty in not responding emotionally to the behavior.

Setting boundaries—Aides provided examples of their struggle to establish and maintain boundaries with clients. Building strong relationships with clients was considered an important aspect of the HHA's job, but this presents a challenge in preserving the line between getting too personally invested and remaining professional. Additionally, aides reported feeling manipulated by clients who took advantage of their willingness to help. One aide describes:

I did personal care ... I'm not there to clean ... but it needs cleaning. So I would do stuff that is not even really my job. And [client's] clothes would get dirty ... am I going to leave him naked? He didn't have any clothes. So one time ... I bought all these clothes.

Active response—Action may also be needed when the aide or the client's safety is at risk. Aides sometimes chose to leave the client's home to protect themselves or call their supervisor or other authorities for further support. HHAs are often put into situations where they are forced to take action. Aides learned, often on the job, strategies to manage client's difficult behavior:

If you're not safe and you have to leave then that patient's not safe because you're not there. So what's the plan? It's 911 right now, which is sad.

Another aide talked about drawing on external support to manage a difficult situation with a client suffering from addiction:

It's hard because sometimes I couldn't get my client to wake up because she was passed out [from drugs]. And I'd have to call the office and then watch her breathing or call a family member that was on a contact list. And eventually she passed away from that. And she was only in her 50's. Near my age.

Sense of accomplishment—Despite the struggle that HHAs encountered, many described instances where they were successful in their response and approach or felt positive about the work they were doing. In these occasions, aides were able to feel a small

sense of accomplishment, relative to the circumstances. For instance, when providing home making care to individuals with hoarding behavior, aides reported finding ways to make progress:

“I cleaned a bad house like that I got paid extra because it was like so filthy. ... I was like scrubbing the walls and stuff for like two day, six hours a day. It was just like grease everywhere. ... And after I did it like you can actually see white, is was actually kind of cool.”

Another aide talks about how the positive impact she had on the life of her client keeps her motivated to stay in the field of homecare:

... there's been times when I wanted to quit. And I'm like, 'Maybe I'm in the wrong field.' I think, you know, this is not for me. Like one time I was really negative and I went to see a client and I put on this smile. And I was doing something and the client just encouraged me all day. And I was just like, 'I needed that.'

External support

Home care aides described both positive and negative experiences working with their direct supervisor and the larger agency. Their relationship and overall interpretation of the level of support they receive shaped their broader work experience on the job. For those who voiced having a positive experience, they spoke of the support they receive and how they feel they are part of the larger team. Those aides who did not have that experience expressed concerns about the lack of support, particularly feeling like the supervisor and the agency did not understand the realities of the challenges that they face daily. Additionally, not having anyone to call for help or receiving appropriate or correct information about clients was brought up as a major frustration that often left aides feeling isolated.

Information—Frequently, HHAs were unaware of a specific mental health diagnosis either because the client had an undiagnosed condition or the information about the diagnosis had not been provided to the aide:

I just walked out the door and called my manager and said, 'I think you're going to be getting a phone call.' And that's when I found out oh yeah she's got all these issues and she's fired us before. And I said, 'Oh my God. Why didn't you tell me that?' Because it was a very stressful visit. If I had some background when I was going in to it I think I could have been more successful.

Aides did not feel that they received enough information from the agency to perform their job successfully and when passing information to the agency, did not think it was taken seriously. Aides described passing up clients who were informally known as having challenging behaviors related to mental or behavioral health conditions as a way of communicating the need for agency support:

... many times I've turned down a case ... so that it would be passed to someone else. And the more it's passed, the more the case manager has to pay attention to it and it becomes a priority.

Agency support—Beyond the transfer of information, many aides voiced lack of support from their direct supervisor and from the larger agency:

If I can get a hold of my supervisor, or if I can get a hold of anyone, then I've got the support. But if I end up jumping through hoops to try and find somebody, I feel pretty much let down.

Even when making particular requests for help, HHAs stated that they often were not heard or ignored:

A lady [client] took a knife on me and I called the agency right away. And they kept [me with] the client after that like about a month. And I didn't feel comfortable after that happened. And I feel like I was forgotten by the company.

Not only was the agency support network unreliable, aides perceived a lack of understanding by the agency for the difficult work they do with mental or behavioral health clients:

They will send you but they have no idea ... where you're going into. All they think about is the hours. 'You're going to get 60 hours. It's good pay.' ... I don't care about the 60 hours. I want to be comfortable.

Although unexpected, participating aides described that the act of engaging in this focus group discussion with a group of their professional peers provided a great sense of relief to them. Aides discussed the power of peer support; and that simply by knowing that others face the same challenges related to providing home care for older adults with mental and behavioral health conditions was comforting to them. In addition, they were able to share in strategies of managing these clients as well as their own personal response.

Training—Home care aides desire more training to give them the skills and tools to perform their job better:

They're sending us in with health aide degrees. It's just as important for us to be prepared and protected, if not more, than somebody that's counseling them [client] once a week ... you should be able to get more than a certificate ... if that's what they want us to deal with? ... it can be very dangerous ...

Most aides within the focus groups reported never receiving any training on mental illness or behavioral health:

... you can't really mentally prepare yourself to deal with any issues that might arise if you have no idea of what you're walking into, you know? And then it's all slammed on you. And there's no real formal training of any kind [about] ... what steps you should do to like help that behavior.

Limited training led aides to feel unprepared to manage behaviors presented by clients with mental illness. The two groups of currently trained SHCAs were the exception to this particular finding. Aides with previous training as SHCAs focused on the strength of their agency support as being crucial to their success in providing care. As one aide described, the regularly scheduled meetings required under the SHCA program were an important avenue for continued support:

We have a good support system at work ... we have a counselor that is head of SHCA aides. He is used to mental health issues and someone to vent with. Plus we ... have the weekly meeting ...

Client's family involvement—According to aides in this sample, clients with mental or behavioral health challenges often have difficult family dynamics; either the client is isolated from family and friends or they have tenuous family relationships. Managing the client's behavior in addition to the family dynamics could put pressure on home care aides:

She [client] doesn't have relative[s], no life. So she thinks I am everything for her—her sister, her mother, her daughter ...”

Abuse or neglect can also be present within households, forcing aides to determine how to manage the situation and whom to call to report it. Additionally, aides described situations where the client's safety was jeopardized by their family member who also suffered from a mental or behavioral health condition like substance abuse. One aide described:

I had to call the cops on a family member ... they would continuously show up to my patient's house at 2 in the morning ... drugged out of their mind ... and my patient could not deal. She had a heart condition.

Discussion

This study examined the experience of providing care to adults with mental or behavioral health conditions from the perspective of HHAs in Massachusetts and the study results yielded three main insights. Although the most prevailing client conditions that aides report were depression, hoarding, and substance abuse, they emphasized the importance of recognizing warning signs and responding to behavior (as opposed to the diagnosis). In particular, aides highlighted their difficulty in managing aggressive behavior, behavior that limits their ability to complete their job, and psychotic or irrational behavior. Second, aides developed their own strategies to handle unsafe or crisis situations and to manage difficult behaviors to execute their job duties. These strategies were only mildly successful. Third, a lack of external support (from agency or client's family) and inadequate information about client's behavioral status put aides in unexpectedly precarious situations and left them feeling unsupported.

Management of challenging client behaviors seemingly played a role in the length of care–aide relationships such that working with an individual with difficult mental or behavioral health challenges contributes to shorter care relationships. Moreover, an aide's ability to respond constructively to challenging behaviors may affect their ability to cope and decrease the likelihood they will burnout (Mitchell & Hastings, 2001). A consistent worker who is committed to their job is critical to building and maintaining the client–aide relationship, a component of care that is important for both the aide's satisfaction and the client's quality of life (Bishop et al., 2008; Eustis & Fischer, 1991). The ability to manage these challenging behaviors is moderated by support and information provided by the agency or client's family. With support and information, an aide is likely more capable of coping with the challenges of their job, affecting their decision to remain in the field. Indeed, results from

this study support an argument for worker consistency or the intentional matching of aides to clients with mental illness.

In times of acute crisis related to mental or behavioral health behaviors, aides were required to activate additional supports (i.e., from agency or police). These situations often consumed large amounts of time and energy from the aide, the home health agency and other members of the health care team. Having the skills and training to quickly react in these situations is critical to not only the client, but also the success of care in the community. The problem-solving process required of aides in times of high stress requires an understanding of complex risks; attending to the immediate needs of the client while maintaining their autonomy and individual choice (Taylor, 2006). These behaviors can be seriously disruptive to the care plan and leave aides feeling unaccomplished if they are not adequately prepared to deal with crisis situations. In this study SHCAs reported far more supervisory and agency support. This is likely because the SHCA track includes quarterly meetings between aides and supervisors. This supportive aide service is unique to Massachusetts and warrants replication in other states.

In addition, communication among different providers, and between supervisors and aides, were cited as key areas for improving care for clients. Supported by findings from this study, HHAs serve as key agents in managing the healthcare of adults with mental or behavioral health needs. They can act as the ‘eyes and ears’ for the healthcare team, thus including them in communication across providers should be used as a strategy for managing a client’s care plan (Stone, Sutton, Bryant, Adams, & Squillace, 2013). One unexpected by-product of these focus groups with HHAs was the emphasis placed on peer-support. The opportunity to share stories and exchange strategies during these focus group conversations was identified as a valuable use of time to validate one another’s struggles and successes with this client population. These contextual findings exemplify the need for continued training and professional development for this increasingly essential workforce.

Finally, it is important to acknowledge the limitations of this study. First, this qualitative study took place entirely in the state of Massachusetts and therefore is not generalizable to the national population of HHAs. There is also potential selection bias because participants volunteered to participate in these focus group discussions. In addition, limited demographic information and home care agency characteristics were collected from focus group participants, restricting the researcher’s ability to examine the impact of these factors on the HHA’s response to client behavior. Though this was a limitation, protecting the HHA’s confidentiality outweighed the potential gain from the collection of this information; allowing the HHAs to feel comfortable and speak honestly about their experiences, without fear of retaliation. Including a large proportion of low-wage, female minorities, as well as foreign-born individuals, many of whom have limited English language proficiency (Seavey & Marquand, 2011) the HHA workforce is made up of relatively vulnerable individuals. This is a point researchers need to remain particularly sensitive to when conducting research with this population. Despite this challenge, expanding research to include direct care workers is critical to hearing their voice and understanding their role in the evolution of home healthcare.

Conclusion

Insights from this study reiterate that HHAs have extremely challenging jobs, made even more demanding by the difficult behaviors presented by clients with mental and behavioral health diagnoses. With the anticipated demand for HHAs expected to increase by 50% between 2012 and 2018, determining ways to improve their capacity to provide care to increasingly complex clients is critical (Seavey & Marquand, 2011). This study illustrates that HHAs need assistance developing the coping skills to work with clients with mental or behavioral health conditions. Many aides rely on strategies they have learned on-the-job; approaches that could be leveraged through additional training and mentoring. Additionally, enhanced supervisory and peer support may be ways to improve HHAs' ability to cope.

The study has policy implications as well, including potential changes to regulations to encourage HHAs active participation in care planning, as well as enhancing training requirements. These changes may also lead to the construction of professional infrastructure by which aides can advance, such as through enhanced roles to serve more complex clients (Eldercare Workforce Alliance, 2014; Mitchell & Hastings, 2001). Taken together, the training, support, and promotion of HHAs who provide care to this population may have a positive influence on worker retention. With turnover rates reported as high as 44%–65%, it is an important consideration for future work (Seavey & Marquand, 2011).

More research examining the organizational dynamic between HHAs, their agency and the broader care team is needed. Aides are poised to serve an even greater role within the healthcare team in the next decade. Investments should be made to provide them with the skills and tools to support older adults to remain in the community.

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Figure 1.

Prevalence of mental health conditions reported by aides ($N = 64$).

*Other diagnoses include: unspecified mental health conditions, autism, or multiple sclerosis.

Table 1Descriptive results-home care aides. ($N = 49$).

	<i>N</i>
Job title	
Supportive home care aide (SHCA)	15 *
Home health aide	30
Home health aide only (HHA)	16
Home health aide & certified nursing aide (CNA)	10
Hospice home health aide	4
Personal care homemaker/homemaker	2
Personal care assistant (PCA)	2
Female	47
Years of experience <i>M</i> (range)	9.3 (<1–40)

* The specialization of 2 SHCAs is unknown.

Source. Author's analysis.

Table 2

Qualitative coding scheme.

Primary theme	Secondary theme
Communication	Verbal communication
	Nonverbal communication
	Interpersonal relationship building
Coping Resources	Emotional response
	Setting boundaries
	Active response
	Sense of accomplishment
	External support
Information	Agency support
	Training
	Client family involvement

Table 3

Types of behaviors reported by aides caring for clients with mental or behavioral health needs.

	Representative quotes
Aggressive	<p>“There’s been times where ... I see him balling up his fist. His face is turning red and he’s bigger than me. I don’t want him to hit me. So I just say listen. I gotta go. I see him three times a week”</p> <p>“Wow, this house is beautiful ... and then you step into the little living room and it’s like hell broke loose. She [client] is like ‘Who the hell are you? F*** you, you B****’ ... we went to the bathroom and she was like ‘Don’t touch me. You’re ugly,’ she would curse me out because I was Spanish ... it was very uncomfortable.”</p>
Disruptive	<p>“So my hands are tied.... All I can do is every time I go in there is suggest to her, ” Don’t get mad. You wash up. Do you want help with the shower? If you want to take a shower, I’m here.” I tried every avenue with her. I tried to get her to wash up. Nothing works. She doesn’t mind me doing housekeeping. But as far as personal care? No. She’s adamant about that.”</p> <p>“She wouldn’t drink [alcohol] in front of me, but she would hide it ... sometimes if I got there early she had already started. She would say ‘you can do the usual but I am not going to eat.’ So she would never eat. I would try ... you had to talk her into it. It wasn’t easy. It was tough.”</p>
Psychotic	<p>“I had this client who ... wouldn’t let anyone into her home. And she [thought] everyone was after her. It got to the point ... she was urinating and yelling just in the main room. Like she opened the door and I got the smell of urine ..., the poor woman ... said she couldn’t go to the bathroom because that was how they were coming into her now was if she went to the bathroom they were going to get her there.”</p> <p>“I mean you have to be very careful that, you know, everything’s in its place and that if the patient is already paranoid and saying stuff’s missing? You know, I had one guy who said the hippies were coming and stealing his sugar. That was kind of silly ... but people have valuable things and if it’s just moved, then it’s gone.”</p> <p>“She [client] thought everybody was out to get her and ... so she kept saying ‘I know my kids don’t bother with me because they’re trying to kill me.’ And every time he would give her a tea or coffee she said there’s poison in it so I’m not going to drink it ... she wouldn’t take anything ...”</p>

Source. Author’s analysis.