Community Mental Health

Assisted Living Facility Training for Limited Mental Health Licensure

Department of Mental Health Law and Policy
Louis de la Parte Florida Mental Health Institute
University of South Florida

June 2012
These materials were produced by the Department of Mental Health Law & Policy, de la Parte Florida Mental Health Institute, University of South Florida in collaboration with and under contract to the Florida Department of Children and Families (contract #LH232, Annette Christy, Ph.D., Principal Investigator, Associate Professor).

Acknowledgments

Jackie Beck, MSW, Section Chief, Mental Health Services, Department of Children and Families

Peter E. Gamache, Ph.D., System of Care Educator assisted with editing manual text.

We would like to acknowledge the following individuals for their review of manual materials and suggestions for their improvement.

Central Florida Behavioral Health Network:
David Clapp, Community Manager
Neal Dwyer, Community Manager
Marcia Monroe, Vice President of Provider Services

South Florida Behavioral Health Network:
Joanna Cardwell, Risk and Compliance Coordinator
Adilen Cruz, Adult System of Care Manager

Department of Children and Families:
Carmen Gomez, Operations Review Specialist
Laura Menendez, Adult Mental Health & Quality Improvement Coordinator
Mario Ramirez, Human Services Program Specialist

Laura M. Naredo, Director Behavioral Health Services, South Florida Behavior Health Network and Neil Dwyer, Community Manager, Central Florida Behavioral Health Network also assisted to coordinate the review sessions for draft manual materials.

Project Staff at the University of Florida include:

Deborah E. Heller, Assistant Director
Joyce Lessard, Publications Designer

For more information

Electronic copies of documents and additional information may be found at http://www.BakerActTraining.org/.
Training Agenda

8:00 a.m. Welcome and Introduction

8:15 a.m. Major Diagnosis of Mental Disorders
What is mental illness?
- Diagnoses, symptoms, behavior
- Stigma/discrimination (including myths of MI)
- Co-occurring substance abuse and mental illnesses
- What is meant by “recovery?”

9:45 a.m. Break

10:00 a.m. Common Psychotropic Medications and Side Effects
Treatment for MI (medications, side effects, therapies, support services, etc.)

11:00 p.m. Legal and Ethical Issues
Consumer Rights (right to self-determination, and rights listed in (394)
- Cooperative agreements, community living support plans, etc. (all aspects of s. 394.4574 requirements)
- Resident Care Standards
- Confidentiality/Informed consent
- Prevention of elopement / whether facilities may detain individuals against their will
- Advance directives
- Abuse/Neglect and how to report
- Ombudsman role

12:30 p.m. Working Lunch - Question and Answer Session (optional)

1:30 p.m. Basic Behavior Management Techniques
- Development and implementation of behavior plans
- Behavioral issues, how to avert escalation, and interventions (including overview of Personal Safety Plan document found in Baker Act book)

3:00 p.m. Break
- Communicating effectively with residents
- Reality Orientation

4:00 p.m. Crisis Intervention Techniques
- How to access emergency mental health services
- Baker Act overview and appropriate use
- Suicide prevention

4:30 p.m. Trauma
- SAMSHA
- Understanding Traumatic Triggers
- Types
- Treatments

4:50 p.m. Summary – Q&A

5:00 p.m. Adjourn
# Table of Contents

## Introduction
- Overall ................................................................................................................... 1
- Slides/Handout Materials ......................................................................................... 8

## Chapter 1
- Diagnosis of Mental Illness ............................................................................. 13
- Slides/Handout Materials ......................................................................................... 44

## Chapter 2
- Common Psychiatric Medications and Side Effects ......................................... 57
- Slides/Handout Materials ......................................................................................... 83

## Chapter 3
- Legal and Ethical Issues ....................................................................................... 101
- Slides/Handout Materials ......................................................................................... 129

## Chapter 4
- Behavior Support ..................................................................................................... 147
- Slides/Handout Materials ......................................................................................... 176

## Chapter 5
- Crisis Intervention Techniques ............................................................................. 187
- Slides/Handout Materials ......................................................................................... 210

## Chapter 6
- Trauma Informed Care ........................................................................................... 219
- Slides/Handout Materials ......................................................................................... 228

## Appendix A
- Advanced Directives for Mental Health Treatment ............................................. 235

## Appendix B
- Behavioral Analysis Form ....................................................................................... 243

## Appendix C
- Personal Safety Plan ............................................................................................... 245

## Appendix D
- Residents’ Rights ..................................................................................................... 249

## Appendix E
- Cooperative Agreement ........................................................................................... 253

## Appendix F
- Community Living Support Plan ............................................................................ 257
**Basic Manual Instructions**

The purpose of this manual is to provide materials to train personnel who have direct contact with residents at assisted living facilities. Each chapter contains text and Power Point presentations to go along with the text. Power Point presentations are available electronically at www.BakerActTraining.org. The chapters are designed to be presented in the order they are included in this manual. If chapters cannot be presented in order (for example, to accommodate multiple speakers schedules), then the Introduction should be presented before the content from other chapters.

At the start of each training session, introduce yourself and have participants introduce themselves. Use a warm-up exercise, if desired, and allow time for questions during and after each session.

The training time for each chapter depends on the person presenting the materials and if there is a guest speaker. A few chapters suggest asking the assistance of an expert such as a psychiatric nurse or attorney to explain technical or medical jargon or to provide examples. We recommend that you provide examples that are relevant to your community mental health system and use exercises that will encourage staff participation.

**Technical Information**

This manual is available online in PDF (portable document file) format. The document can be viewed and/or printed with “Acrobat Reader” software, which is available at no charge from the Adobe company and can be downloaded from a variety of websites. The following link is one of the Internet locations where this software can be downloaded:

http://www.adobe.com/prodindex/acrobat/readstep.html

The heading text is in Frutiger LT Std, and the body text is in Adobe Garamond Pro. These fonts are universal and should be adaptable with all printers and computers. The information in this manual is copyrighted. You may make copies, but should not change the information. If you use this material appropriate credit should be given to the authors.

(Note to the trainer: We highly recommend that you include a 15 minute presentation from a person who has a mental illness. Have them speak after you complete the language portion of the introduction. There are specific guidelines for the person to use that are written on the page where the language portion of the presentation ends).

I want to welcome each of you to this training that has been designed to meet the training requirements for obtaining a Florida limited mental health license. Obtaining a limited mental health license means that you
have or will have people living in your facility who have a mental illness. The goal of this training is to give you an understanding of mental illnesses, their affect on the people who live with them, the ways that they are treated, and legal issues that you should be aware of.

Most importantly, we want to provide information that helps you understand what a mental illness is and what it is not.

**Stigma**

First of all, a mental illness can strike anyone. It can affect someone who is rich, poor, educated, uneducated, White, Black, Christian, Jewish, young or old. There is no typical person who develops a mental illness. More than 48 million Americans will be affected by one or more mental illnesses during a one year period.

It is sometimes easy to forget that our brain, like all our other organs, is vulnerable to disease. Unfortunately, because people with a mental illnesses often experience symptoms that are behavioral, they are sometimes thought of differently than people with physical ailments. Instead of receiving compassion and support, these people may experience unsympathetic, unfair or hostile responses.

Most of the intolerance can be attributed to the stigma that accompanies mental illnesses. People who have a mental illness are frequently depicted as strange, scary, or even dangerous. These misconceptions frequently result in blatant discrimination. In fact, when people with mental illnesses are asked to identify the biggest problem they face, most say it is simply lack of acceptance.

For example, diabetes is a disorder that is treatable but not usually curable. It is a chronic condition that many people have to manage throughout their lives. We do not blame people for having diabetes, or for that matter heart disease, asthma or a number of other chronic health conditions. The same needs to be true for mental illnesses. There should not be blame for living with schizophrenia, bipolar illness, manic depression or any other mental illnesses. Rather, it should be viewed as a something that needs to be managed just as any other chronic condition.

**Exercise**

*(To the Trainer: Ask participants to close their eyes and listen to a story you are going to read to them. Read this story with a short pause between each line and then ask participants the following questions.)*

1. What thoughts and feelings did you experience while I was reading this?
2. Do you think the situation was reason enough for people to react so differently toward you?

3. Did you know that this scenario happens to thousands of Americans who have been diagnosed with a mental illness?)

**A Story & Case History**

1. You are a person who has left your job as a publications manager due to a mental illness.

2. You needed temporary hospitalization and medication to stabilize your condition.

3. You were told that if you were faithful to your medication, then your symptoms would be controllable.

4. You were relieved to know what your condition was and how to control it.

5. You wanted your old job back but were told it had been eliminated.

6. You tried to talk to a friend about your experience, but your friend was cold and uncomfortable speaking with you.

7. You thought the experiences with your former employer and friend were merely flukes until you started to experience the same sort of treatment everywhere you turned.

8. Your landlord opted not to renew your lease.

9. All of your friends seemed distant and uncomfortable around you.

10. Job opportunities vanished whenever you mentioned your condition.

11. You felt worthless, hopeless, and confused.

**Discrimination**

Discrimination occurs when people do not know the truth about mental illness, and separating fact from myth is difficult in the face of images presented in the media. Unfortunately, while many people believe that it is wrong to discriminate against someone with a physical illness, they think it is acceptable to discriminate against someone who has a mental illness. In a 1996 survey, 41% of the respondents thought it was acceptable for a landlord to discriminate on the basis of mental illnesses. This discrimina-
tion robs people of the emotional support they need, as well as employment and housing opportunities to restore their lives.

Unfortunately, most of the attitudes and misconceptions we hold regarding people with mental illnesses come from the media. Newspapers often stress a history of mental illness in the backgrounds of people who commit violent crimes, and television news programs frequently sensationalize crimes where persons with a mental illness are involved. Comedians make fun of people with mental illnesses by using their disabilities as a punchline for humor. Even national advertisers present stigmatizing images as promotional gimmicks to sell products.

**Let’s separate myth from fact.**

**Myth**  
A mental illness is different from a physical illness because it is just “in the head” of the person.

**Fact**  
While many psychiatric illnesses cannot be detected through simple blood tests or biopsies, studies have linked these diseases to physical, biological origins.

**Myth**  
A person diagnosed with a mental illness can never really be normal.

**Fact**  
While only 40-50% of people with heart disease will recover, 80% of people diagnosed with depression will recover and 60% of people diagnosed with schizophrenia will recover.

Many of our great works of art, music, and literature were produced by persons diagnosed with a mental illness, and a surprising number of high level jobs are filled by people who have experienced a mental illness.

**Myth**  
Everyone faces trouble in their lives and copes adequately, so people with a mental illness must be weaker in character than the rest of us.

**Fact**  
A person’s character has nothing to do with whether they develop a mental illness. It strikes people with all kinds of temperaments, beliefs, morals, and backgrounds.
**Myth**
A person diagnosed with a mental illness is unpredictable and dangerous.

**Fact**
Violence among people with a mental illness is not common. In fact, people with a mental illness are more often victims of violence than perpetrators. In cases where violence does occur, the incidence typically results from the same reasons as anyone else, such as feeling threatened or the excessive use of alcohol and/or drugs.

**Language**
Language is very powerful. It shapes our perception of the world in ways that we are not aware. Language also conveys subtle meanings. Most of our interactions are based on language, written or spoken. The language we use can convey our respect, our sincere interest, and our love, or it can convey our distrust, disapproval, or hatred. Language can hurt, and words such as “crazy,” “nuts,” “psycho,” “lunatic,” “wacko,” and “loony” are dehumanizing affronts to people experiencing symptoms from a mental illness.

Another way that language shapes our perceptions of people with mental illnesses are words like “schizophrenic,” “Manic Depressive,” and “Borderline.” These are examples of words used to refer to a person by their diagnosis. Using this language to speak about a person makes them invisible. You do not think of the person; instead, you think of their symptoms or whatever you believe is associated with that term. A person may have schizophrenia or manic depression, but they are always a person first.

What we all have in common when we communicate with each other is that we are people. Our different experiences, and challenges are many, but we are always people. The statement, “those of us who have a mental illness” magnifies a fact that is not apparent with the language generally used to talk about anyone with a mental illness. That is, a person diagnosed with a mental illness is included in “us” rather than perceived as “them” that implies “not us.”

Becoming aware of how we use language means being more deliberate about the words we choose to communicate. So, when you speak to people living in your facility, be thoughtful and responsible for the intent of your communication. They will know, even if they do not put it into words, that you are either interested and care about their well-being or are uninterested and bothered by them.

*(Note to the trainer: Introduce the person who will give the 15 minute presentation from their own personal experiences. Ask them to share the least and most helpful ways people working in the mental health system have related to them).*
The ALF is a home.

When someone arrives at your facility, it will become their home. This is easily forgotten in the daily routine of running or working at an ALF. It becomes a job, and the people living there may become the object of that job. But, from time to time, give yourself the opportunity to remember it is their home by reflecting on the characteristics that make a home.

(To the Trainer: Ask the participants for their ideas of the characteristics that make a home and what characteristics of the people in a home make a home. List the following examples if the participants do not identify them:

- Feeling safe;
- Feeling accepted;
- Privacy;
- Feeling respected;
- Feeling cared about by others;
- Available support;
- Encouragement;
- Feeling needed;
- Feeling valued;
- Sharing the space with other living things like plants, pets; and
- Feeling of family.)

Then review the following strategies to convey the message that the facility is a home to many people:

- Receive each person into your facility as an adult. Do not try to be a parent to them. Treat each person in the way you would wish to be treated by another adult.
- Accept each person’s unique personality and challenges.
- Encourage each person to be themselves.
- Accept that people will make mistakes and recognize that mistakes are a vital part of learning rather than an act of failure, not only
for the person who is making a home at your ALF but for yourself as well.

• Respect the differences between people.

• Honor each person’s need and/or desire for privacy.

• Attend to each person with respect and dignity even when your feelings and thoughts toward them are in disagreement. Over time, respect can bridge the gap between people and promote trust.

• Be honest when you communicate without being hurtful or controlling.

• Engage in two-way dialogue about ongoing needs and ways for residents to feel comfortable.

(To the trainer: Ask the participants if there is anything they would like to add to the list).

Now, let’s talk about some of the different mental illnesses, their symptoms, and some of the treatments used to eliminate or reduce their disabling effects.
Introduction

Assisted Living Facility Training for Limited Mental Health Licensure

In collaboration with
Department of Mental Health Law and Policy
Louis de la Parte Florida Mental Health Institute
University of South Florida

Housekeeping

Please remember to silence your cell phones, and please refrain from texting or checking your phone excessively.

Agenda

[Welcome]
Major Diagnosis of Mental Illnesses
[Break]
Psychotropic Medications and Side Effects
[Lunch]
Legal and Ethical Issues
Basic Behavior Management Techniques
[Break]
Communicating Effectively with Residents
Crisis Intervention Techniques
Trauma Informed Care
**Stigma**

A mental illness can strike anyone. Our brains are also vulnerable to disease.

Stigma is the cause of most intolerance towards people who have a mental illness.

People with a mental illnesses say lack of acceptance is the biggest problem they face.

---

**Story and Case History**

What thoughts and feelings did you experience while I read this case?

Do you think the illness was reason enough for people to react so differently toward you?

Did you know that this scenario happens to thousands of Americans who have been diagnosed with a mental illness?

---

**Discrimination**

Many people believe it is wrong to discriminate against someone with a physical illness, but think it is OK to discriminate against someone with a mental illness.

Discrimination robs people of emotional and economical support, such as the jobs and housing needed to restore their lives.

The media is the most common source of misconceptions and negative attitudes.
### Myth vs. Fact

A mental illness is different from a physical illness because it is just "in the head" of the person.

While many psychiatric disorders cannot be detected through simple blood tests or biopsies, these diseases have been linked in studies to biological origins.

### Myth vs. Fact

A person with a mental illness can never really be normal.

While only 40-50% of people with heart disease will recover, 80% will recover from depression and 60% will recover from schizophrenia with proper treatment.

### Myth vs. Fact

Everyone faces trouble in their lives and copes adequately, so people with a mental illness must be weaker in character than the rest of us.

A person’s character has nothing to do with whether they develop a mental illness. It strikes people with all kinds of temperaments, beliefs, morals, and backgrounds.
Introduction

An ALF is a Home

- Receive each person into your facility as an adult. Do not try to be a parent to them. Treat each person how you would wish to be treated by another adult.
- Accept each person’s unique personality and challenges.
- Encourage each person to be themselves.
- Accept that people will make mistakes and recognize that mistakes are a vital part of learning rather than an act of failure, not only for the person who is making a home at your ALF, but for yourself as well.

Language

- Language shapes our perception of the world.
- Language conveys our respect, our sincere interest, our love or our distrust, our disapproval, our hatred.
- Words like “crazy,” “nuts,” “psycho,” “lunatic,” “wacko,” and “loony” are dehumanizing.
- Words like “schizophrenic,” “borderline,” and “manic depressive” refer to the person by their diagnosis. They are a person first and not their diagnosis.
- Be deliberate and thoughtful with the words you use.

Myth vs. Fact

A person with a mental illness is unpredictable and dangerous.

Violence among people with a mental illness is not common. In fact, people with a mental illness are more often victims of violence than perpetrators. In cases where violence does occur, the incidence typically results from the same reasons as with everyone else, such as feeling threatened or the excessive use of alcohol and/or drugs.
An ALF is a Home

- Respect the differences between people.
- Honor each person’s need and/or desire for privacy.
- Attend to each person with respect and dignity even when your feelings and thoughts toward them are in disagreement. Over time, respect can bridge the gap between people and promote trust.
- Be honest in your communication without being hurtful or controlling.
- Engage in two-way dialogue about ongoing needs and ways for residents to feel comfortable.
Diagnosis of Mental Disorders

Assisted Living Facility Training for Limited Mental Health Licensure

Chapter 1

Amber M. Gum, Ph.D.
Associate Professor

Timothy L. Boaz, Ph.D.
Associate Professor

Peter E. Gamache, Ph.D.
System of Care Educator

Department of Mental Health Law and Policy
Louis de la Parte Florida Mental Health Institute
University of South Florida
Chapter 1

Chapter Directions

Be sure to read the Introduction at the beginning of the manual before proceeding with the chapter presentations. A PowerPoint presentation for this chapter is available at www.BakerActTraining.org and is also printed at the end of this chapter.

Chapter Description

Mental disorders are conditions involving emotions, behaviors, or thoughts that produce significant problems for the person experiencing them or that interfere with the person's ability to function in their work, home, or personal relationships.

This training module is intended to be used for a 40 to 60 minute training session for employees of Assisted Living Facilities. The content is concerned with the diagnosis of selected mental disorders that may be found among persons living within these facilities.

Learning Objectives

Participants should be able to:

1. Identify three reasons why diagnoses are made;

2. Recognize the major symptoms of the diagnoses discussed; and

3. Describe their role in identifying symptoms of mental disorders.

Time Frame

90 minutes

Materials

LCD Projector/PowerPoint Slides
Handouts
# Outline

## I. Introduction

## II. Schizophrenia/Psychotic Disorders

- A. Delusions
- B. Hallucination
- C. Disorganized Speech
- D. Disorganized Behavior
- E. Negative Symptoms

## III. Mood Disorders

- A. Bipolar Disorders
- B. Depressive Disorders

## IV. Anxiety Disorders

- A. Panic Disorders
- B. Phobic Disorders
- C. Obsessive Compulsive Disorder
- D. Posttraumatic Stress Disorder
- E. Generalized Anxiety Disorder

## V. Personality Disorders

- A. Antisocial Personality Disorder
- B. Borderline Personality Disorder
- C. Histrionic Personality Disorder
- D. Narcissistic Personality Disorder
- E. Avoidant Personality Disorder
- F. Dependent Personality Disorder
- G. Obsessive Compulsive Personality Disorder
- H. Paranoid Personality Disorder
- I. Schizoid Personality Disorder

## VI. Cognitive Disorders

- A. Delirium
- B. Dementia

## VII. Substance Related Disorders

- A. Substance Use Disorders
- B. Substance Induced Disorders

## VIII. Comorbidity of Mental Disorders

## IX. Recovery

## X. Stigma and Myths

## XI. Summary
Chapter 1

I. INTRODUCTION

Mental illnesses are conditions involving emotions, behaviors, or thoughts. All mental illnesses have serious effects for the individual. To be diagnosed with a mental disorder, the condition must:

a) produce significant distress for the person experiencing the condition; and/or

b) interfere with the person’s ability to function in his or her work, at home, or in relationships with others.

A variety of mental illnesses are common among residents of Assisted Living Facilities (ALFs). It is important for those who work with people who have been diagnosed with a mental illness to have an adequate knowledge and understanding of the major types of mental illnesses. The worker does not need to be able to make a diagnosis; however, the ability to identify the primary symptoms and behaviors associated with the various types of mental illnesses is required for several reasons.

It is important that ALF employees become familiar with common mental illnesses for at least three reasons:

1. To understand the behavior of a person diagnosed with a mental illness and to know what to expect from him/her;

2. To determine if a consultation with a mental health professional is needed or to make other appropriate referrals; and

3. To communicate to mental health professionals about observations of whether a resident’s symptoms worsen or improve. This information helps them determine the best course of treatment.

Often a lay person’s ideas about mental illness are based on images portrayed in the popular media. These images tend to show only the most dramatic and frightening aspects of mental illness. It is important to keep in mind that people with mental illness experience these acute episodes with severe symptoms only part of the time, if at all. Perhaps the most disturbing aspect of mental illness is the unpredictability of behaviors or moods. It is natural for the worker to be concerned about this; however, one should also remember that the actual likelihood of violence by people who have a mental illness is very low.

Labeling a person as mentally ill can stigmatize that person and result in others making unwarranted assumptions about their motives, behaviors, and abilities. Therefore, it is important to understand why mental health professionals need to make an accurate diagnosis. First, making a proper
Chapter 1

Diagnosis of Mental Illnesses

Diagnosis is necessary in order to develop an effective treatment plan. Simply put, different mental illnesses require different treatment approaches. Second, accurate diagnosis allows one to more accurately predict the person's behavior and the course of his or her prognosis.

For this section, six major categories of mental illness are presented. The following categories represent the most common that workers will contact:

1. Schizophrenia / Psychotic disorders;
2. Mood disorders;
3. Anxiety disorders;
4. Personality disorders;
5. Cognitive disorders; and
6. Substance related disorders.

Each section is organized the same way: overview, symptoms, prevalence, risk factors and progression, and treatment approaches.

This chapter is NOT a diagnostic manual. It is only an overview of some of the mental illnesses a worker is most likely to encounter. For more complete information (and information on other disorders), one should refer to the Diagnostic and Statistical Manual of Mental Disorders-IV-Text Revision (DSM-IV-TR) which was published in 2000. The DSM-IV contains a more extensive discussion of these categories, as well as numerous other classifications of disorders. The DSM-IV provides a systematic description of the essential features of the disorder, associated features, age of onset, course of the disorder, level of impairment, complications, predisposing factors, prevalence, sex ratio, and familial patterns. The DSM-IV should be relied upon as the definitive reference for mental illnesses.

It should be noted that the DSM-IV is currently being revised. The DSM-5 is expected to be published in May 2013. The following website provides updates: www.dsm5.org. This chapter is based on the DSM-IV, as it is unknown how the DSM-5 will be different in its final form. The main categories of illnesses reviewed in this chapter are not expected to change dramatically, however.

II. SCHIZOPHRENIA/PSYCHOTIC DISORDERS

Overview

For many people, schizophrenia is the illness that most frequently comes to mind when they think of mental illness. Schizophrenia is one of the “psychotic” disorders; broadly speaking, psychosis means being out of
touch with reality. Schizophrenia lasts six months or longer (usually much longer), and often seriously effects a person’s ability to work and care for him or herself. It affects approximately 1% of the adult population.

**Symptoms**

Individuals diagnosed with schizophrenia exhibit one or more of these symptoms. The person must have been experiencing some change in behavior for at least six months or more, and this change may be gradual or sudden. For at least one month during this time, the person must show two or more symptoms of psychosis. The five symptoms of psychosis are as follows:

- Delusions;
- Hallucinations;
- Disorganized speech;
- Disorganized or catatonic behavior; and
- Negative symptoms.

**A. Delusions**

A **delusion** is a false belief that an individual maintains in spite of compelling evidence to the contrary that can’t be explained by the person’s culture. Some examples of types of delusions are as follows:

- **Delusion of Grandeur** – This is perhaps the most famous of the delusions. Examples include a person believing that he is the President of the United States or is God.

- **Somatic Delusion** – Belief that one has a horrible sickness such as cancer with no supporting medical evidence. This delusion is often bizarre, and contrary medical evidence does not change the person’s mind.

- **Delusion of Persecution** – Belief that one is being plotted against, threatened, or mistreated by others.

- **Delusion of Reference** – Belief that other people are talking about him/her, such as portraying his/her life in movies or on television.

**Question and Answer:** Ask participants for examples (but not to include names or other identifying information for the person described). Then discuss these examples.
B. Hallucination

A hallucination is a false sensory perception. It is a perception of seeing, hearing, feeling, smelling, or tasting something that other people do not experience and that has no real world stimulus to cause it. Auditory hallucinations (that is, hearing things that are not there) are by far the most common type of hallucination in schizophrenia. A person may hear voices telling him or her to do something (called command hallucinations) or commenting on his or her behavior or personal worth. Visual hallucinations occur in about 10 - 20% of cases. Hallucinations involving other senses such as smell, taste, or touch are rare in schizophrenia.

Question and Answer: Ask participants for examples (but not to include names or other identifying information for the person described). Then discuss these examples.

C. Disorganized Speech

Disorganized speech may include the use of made-up words, inappropriate use of rhyming or repetition of phases, frequent tangents, or communicating in other incoherent ways. The person is usually not aware that his or her speech is not understandable, since it makes sense to him or her.

Question and Answer: Ask participants for examples (but not to include names or other identifying information for the person described). Then discuss these examples.

D. Disorganized Behavior

Disorganized behaviors may include difficulties when carrying out activities of daily living. For example, they may appear disheveled or may have difficulties taking care of their living quarters. They may dress in an odd manner or they may evidence bizarre behaviors such as odd movements, gestures, or postures. They may also display prolonged silence, silly giggling, or repetitive, meaningless motions.

There are two exceptions to the requirement of having at least two of the symptoms just described. First, only one symptom is required if the delusions are bizarre or highly unlikely to occur (e.g., being controlled by a computer chip implanted by aliens, the target of lightning strikes). Second, only one symptom is required if the hallucinations involve two or more voices conversing or a voice keeping a commentary on the person’s behavior or thoughts.

Question and Answer: Ask participants for examples (but not to include names or other identifying information for the person described). Then discuss these examples.
E. Negative Symptoms

The symptoms just described are called “positive” symptoms because when they occur they suggest the presence of the disorder. Some other symptoms of schizophrenia are called “negative” symptoms. These are symptoms that consist of the lack of certain desirable behaviors. For example, people with schizophrenia may avoid social contact. They may display very little emotion, their speech may be very limited, or they may show very little initiative. They also may neglect their personal hygiene.

Question and Answer: Ask participants for examples (but not to include names or other identifying information for the person described). Then discuss these examples.

Course

Schizophrenia usually first shows up in adolescence or early adulthood for males and in the late 20s for women. It usually starts with a gradual decline in functioning (called the “prodromal phase”). This decline may include symptoms such as social awkwardness, shyness, peculiar behavior, lack of initiative, or difficulty in work or school. Eventually, the person experiences a psychotic episode (called the “active phase”) in which the person meets the full diagnostic criteria for schizophrenia.

Often, the symptoms of schizophrenia will come and go over the course of a person’s life. The episodes of psychosis may be separated by prolonged periods with fewer symptoms (called “residual phases”). Over time, a third of people with schizophrenia will get better, and they may be able to return to a relatively normal level of functioning. However, for another one-third of persons with schizophrenia, their symptoms will get more and more severe over time, and their lives will be very severely disrupted. The rest will continue to experience symptoms of schizophrenia, but their symptoms will stay about the same in terms of severity. People with schizophrenia may lack family supports because of the impact their behavior has had on those relationships.

Causes and Risk Factors

We do not know what causes schizophrenia, although it appears to be a combination of genetic and environmental factors. There is a genetic or biological basis to the disease, according to studies of twins and families. A variety of environmental factors increase risk as well, however, such as severe stress or trauma, or even prenatal factors such as a mother’s folic acid deficiency.

Treatment Approaches

There is no cure for schizophrenia. Treatment for schizophrenia usually
Involves “antipsychotic” medication (also called major tranquilizers or neuroleptics). These medications are more effective at controlling the positive symptoms (that is, hallucinations, delusions, and disorganized speech and behavior) than the negative symptoms of schizophrenia. Medications used for mental illnesses are discussed more in Chapter 2 of this training.

Behavioral interventions also play an important role in the treatment of schizophrenia, as discussed in Chapter 4 of this manual. People with schizophrenia function better when they receive coping skills training in life skills, such as managing finances or transportation, compared to only using antipsychotic medication. Assertive Community Treatment (ACT) is a comprehensive case management approach that works very well with people with schizophrenia. In Florida, whereby ACT is called FACT for Florida Assertive Community Treatment, a case manager works closely with an individual to help the person manage medical appointments, medications, housing, financial matters, and coping skills. “FACT Teams” may come into the ALF to provide services for residents. Finally, the behavior management principles discussed in Chapter 4 can benefit individuals with schizophrenia, such as identifying antecedents and consequences of behaviors.

People with schizophrenia can benefit from:

- Structure;
- Repetition;
- Participating in productive daily activity;
- Safe and secure environment; and
- Peer support services.

Other related psychotic disorders include:

- **Schizoaffective Disorder** is a disorder in which the person has a combination of symptoms of both Schizophrenia and a Mood Disorder (which we will discuss next).

- **Delusional Disorder** is a disorder in which the person experiences delusions, but does not meet the other criteria for schizophrenia.

- **Physiological and organic conditions.** Symptoms of psychosis can occur in persons with various medical diseases (e.g., thyroid disease, encephalitis, vitamin deficiency, AIDS) or during drug or alcohol intoxication or withdrawal.
III. MOOD DISORDERS

Mood disorders involve two abnormalities of mood: depression and mania. Mood disorders that involve the occurrence of episodes of mania symptoms (usually also with episodes of depression) are referred to as Bipolar Disorders. Conversely, Depressive Disorders involve the occurrence of episodes of depression, but no episodes of mania.

A. Bipolar Disorders

Overview

In bipolar disorder, the person experiences episodes of manic symptoms and usually also episodes of depression. Bipolar disorder used to be called “manic depression.” Bipolar disorder is often a severe and persistent mental disorder. The extreme mood states make it hard for most people to maintain relationships and jobs, and at times the illness makes it difficult for someone to take care of him or herself.

Symptoms

To be diagnosed with Bipolar I Disorder, a person must have experienced at least one manic episode or mixed mood episode at some time in their life (a mixed mood episode is one in which the person meets criteria for episodes of both depression and mania during the same time period). A person with Bipolar I Disorder may or may not have also experienced episodes of depression. See the section on depressive disorders within this chapter for symptoms of depressive episodes.

Mania Symptoms

A manic episode is a distinct period lasting at least one week (or less, if the mood change is so severe the person must be hospitalized). The person’s mood is abnormally and persistently elevated, expansive, or irritable. This mood change is severe enough to cause marked impairment in occupational or social functioning. During a manic episode, the person’s mood may change rapidly among these moods, such as alternating between euphoria and irritability. In general, the mood can be described as being so unnaturally energetic or active that harmful consequences occur. Manic episodes usually begin suddenly, with a rapid escalation of symptoms over a few days. Manic episodes last from a few days to months.

A manic episode is characterized by the simultaneous occurrence of expansive mood that is usually described as cheerful or enthusiastic (although occasionally the mood will be irritable, especially when limits are placed on the person’s behavior), and at least three of the following symptoms:
- **Inflated self esteem:** This may range from uncritical self-confidence to frank grandiosity (delusional beliefs about one’s own worth or abilities, such as believing one is invincible or has supernatural powers).

- **Decreased need for sleep:** This is almost invariably present and can range from being able to get by on only a few hours sleep to going days without sleep, without any apparent decrease in energy level.

- **Pressured speech:** Pressured speech is loud, rapid, and difficult to interrupt.

- **Flight of ideas:** This is evidenced by a nearly continuous flow of rapid speech, with abrupt changes from topic to topic. When severe, speech may be disorganized and incoherent.

- **Distractibility:** This common symptom is indicated by a tendency to respond to irrelevant external stimuli, which results in rapid changes in speech or activity.

- **Increased activity level:** The person begins or plans to begin multiple activities. Activities are usually accompanied by unwarranted optimism of success.

- **Excessive involvement in risky behaviors:** Lack of judgment along with increased activity level may lead to activities such as giving away money, spending or gambling sprees, indiscriminant sexual behavior, or reckless driving.

**Course**

Bipolar disorder usually begins in the early 20s, although it can begin in adolescence or after age 50. Over the course of the person’s illness, they may have multiple episodes of mania and depression. Often (50-60% of the time), the person will have a depressive episode right before or right after a manic episode. In some cases, the person alternates rapidly between episodes of mania and episodes of depression. There is some evidence that the episodes of mania and depression become less severe as people age, although it varies for each individual.

**Causes and Risk Factors**

Like schizophrenia, the causes of bipolar disorder are not fully known, although it is likely caused by genetic and environmental factors. Genetic factors are implicated, because family members of someone with bipolar disorder are more likely to have the illness than the general public. Even if one identical twin has bipolar disorder, the other twin often does not, so
other non-genetic causes must be involved. These may involve stressful life events or life disruptions that trigger manic or depressive episodes. Also, if a person with bipolar disorder takes an antidepressant medication, then this can trigger a manic episode in some cases.

**Treatment Approaches**

Similar to schizophrenia, the ideal treatment for Bipolar I Disorder involves a combination of medication and behavioral intervention. The type of medications that are usually used to treat bipolar disorder are called “mood stabilizers,” such as lithium or valproic acid. Some of the newer “atypical” antipsychotic medications used to treat schizophrenia also have been found to benefit people with bipolar disorder.

Also similar to schizophrenia, behavioral interventions such as coping skills training, ACT, and behavior management are beneficial. When someone is very manic, the recommended approach is medication to stabilize mood and modification of the environment to ensure the person’s safety and reduce triggers of irritability or other undesired behaviors (see chapter 2). During a manic phase, a person may say or do something that seems rude; nonetheless, it is critical to remain patient and professional at all times.

When the person’s mood has been stabilized to some degree, it is valuable to engage in coping skills training. At this time, the individual is often able to identify effective coping strategies, such as taking medication regularly, keeping a regular routine, and dealing with other problems such as finances and housing. There is some evidence that keeping a regular routine may help prevent manic episodes, such as waking and sleeping at usual times, eating meals at usual times, and other consistent daily activities. It is also beneficial to help the person identify “red flags” or signs that he or she may be becoming manic or depressed and develop a plan of how to address those signs.

**Other related disorders include:**

- **Bipolar II Disorder** is similar to Bipolar I except that the person experiences hypomanic episodes, but not manic episodes. Hypomanic episodes involve the same symptoms as mania, but they are less severe. People with Bipolar II Disorder have major depressive episodes (see section below on depressive disorders).

- **Cyclothymia** involves less severe episodes of mania and depression than Bipolar I or II disorders.
B. Depressive Disorders

Overview

Major Depressive Disorder (also called major depression) is evidenced by episodes of major depression with no manic, mixed, or hypomanic episodes. Many people with major depression are able to remain in the community and benefit from outpatient treatment. For some people, however, depression is so severe that they need the supervision and support of an ALF to care for them and prevent them from attempting suicide. It is critical to connect these individuals to helplines and other supports so that they have options to reach out for help.

Symptoms

To meet criteria for an episode of major depressive disorder, the person must have five of more of the following symptoms. The five symptoms must last for most of the day, nearly every day, for at least two weeks. At least one of the five symptoms must be depressed mood or loss of the ability to feel pleasure. This means a person can be depressed without feeling sad or down.

- **Depressed mood**: Depressed mood involves feeling sad, down, or blue. The person may cry more often than usual.

- **Loss of ability to feel pleasure** (also called anhedonia): The person no longer enjoys activities he or she normally enjoys. This person is not interested in engaging in activities she or he would normally be interested in doing.

- **Change in appetite**: Change in appetite can move in two directions. The person may no longer eat meals with the same enjoyment, have an aversion to eating, and even lose weight. Or the opposite may occur, where the person has a compulsion for eating, eats more than usual, and gains weight.

- **Sleep disturbance**: Similar to appetite, change in sleep can move in two directions. The person may have difficulty going to sleep, staying asleep, or may wake up earlier than usual. Sleep is not restful. Or the opposite may occur, where the person may sleep a lot more than usual.

- **Psychomotor agitation or retardation**: Again, this change can move in opposite directions. The person with psychomotor agitation is visibly agitated, moves around more than usual, and is perhaps described as “jittery.” Psychomotor retardation is the opposite and involves moving or speaking much more slowly than usual.
• **Fatigue or loss of energy:** The person tires more easily than usual or feels a lack of energy.

• **Feelings of worthlessness or excessive or inappropriate guilt:** The person feels worthless most of the time and may feel excessively guilty about things done or not done. The person is likely to focus selectively on “errors” or “mistakes.”

• **Difficulty thinking, concentrating, or making decisions:** This person has a difficult time thinking or concentrating on daily activities, such as reading or watching television. Decision making is slowed. The person may see him or herself as incapable of making decisions.

• **Recurrence thoughts of death, suicidal ideation, or a suicide attempt or specific plan:** The person may be preoccupied with thoughts of death, may not care whether she or he lives or dies, or may actually wish to die. The person may have a specific plan for committing suicide or may even attempt suicide.

**Course**

Depression can begin at any time in a person’s life (including childhood). Across people, there is a lot of variability in terms of how severe the symptoms are, how long an episode can last, or how many episodes people have over their lifetime. Most people have their first episode earlier in their life, such as in childhood, adolescence, or early adulthood (e.g., before age 50).

**Causes and Risk Factors**

Similar to other disorders, Major Depressive Disorder has a complex mix of biological and environmental causes. There is a genetic component, in addition to neurochemical changes in the brain. Conversely, there is also very strong evidence that stressful life events can cause depressive episodes, such as the death of a loved one, divorce or separation, a job loss or other financial problems, health problems, or a traumatic event. It is normal to have a period of distress or mourning when these events occur. Depression is diagnosed when the reaction to stressful life events is severe or prolonged. Some people are able to “bounce back,” whereas other people remain “stuck” and become depressed. The “stress-diathesis” theory suggests that some people are vulnerable to becoming depressed after a stressful life event because of their genetics, brain chemistry, personality, limited social support, and limited problem solving and coping skills.
Treatment Approaches

For most people (70-80%), depression is effectively treated with antidepressant medications or psychotherapy. There are several categories of antidepressant medications that work well, including tricyclic (older) and selective serotonin reuptake inhibitors (SSRIs with common commercial names such as Prozac or Paxil). Several forms of psychotherapy work just as well as medication in many cases, including cognitive-behavioral therapy, interpersonal therapy, and problem-solving therapy. In general, medications and therapy work equally well. If someone is very severely depressed, then combining medication and therapy is recommended. If someone is very severely depressed and medication or therapy has not worked, then electro-convulsive therapy (ECT) can be effective.

For a depressed person living in an ALF, use behavior management strategies (chapter 4) to try to increase the person’s involvement in pleasant activities and exercise. Research shows that exercise and staying active can help alleviate symptoms of depression.

Other related disorders

Dysthymia is evidenced by episodes of symptoms that are less severe than major depression and are chronic. To be diagnosed with dysthymia, the episode of depressive symptoms must last most of the time for two years or longer. No episodes of mania or hypomania are observed.

IV. ANXIETY DISORDERS

Overview

Anxiety disorders involve the presence of symptoms of anxiety and/or avoidance behavior. The main differences across the different anxiety disorders are determined by what is feared and how the person tries to avoid it. Although there are several specific diagnoses, anxiety disorders can be grouped in five categories, as listed below. Instead of listing all symptoms for each disorder, the five categories are briefly summarized.

1. Panic Disorder
2. Phobic Disorders
3. Obsessive Compulsive Disorder
4. Post Traumatic Stress Disorder
5. Generalized Anxiety Disorder
Chapter 1

A. Panic Disorder

Panic disorder involves recurrent panic attacks. A panic attack is an abrupt episode of intense fear with associated intense “autonomic arousal” (e.g., shortness of breath, dizziness, rapid heart rate, trembling, sweating, choking, nausea, chest pain). These attacks are usually unexpected and last for several minutes (rarely hours). In the beginning, they are not associated with any particular stressful situation. They are followed by persistent concern about the attacks (for at least one month). Over time, the person fears having additional panic attacks, which can lead him or her to avoid situations where they had panic attacks in the past. Panic disorder can lead to agoraphobia, which may include becoming unable to leave a confined, safe setting.

B. Phobic Disorders

Phobic disorders involve experiencing intense (excessive or unreasonable) fear associated with a particular situation or stimulus. Common types of phobic disorders include:

- **Agoraphobia**: fear of situations in which escape is difficult or embarrassing, generally because of fear of having a panic attack;

- **Social phobia**: fear of certain interpersonal or social situations (e.g., public speaking, large social gatherings, dates, eating in public); and

- **Specific phobia**: fear of a specific situation or object (e.g., heights, flying, or snakes).

Phobic disorders also involve avoidance behavior. That is, the person tries to avoid feared objects or situations. To be diagnosed with a phobic disorder, the avoidance must be distressing or result in significant impairment in the person’s social and occupational functioning. For example, a person with social phobia may have difficulty keeping a job or developing close relationships. A person with a phobia of heights may have difficulty going to many places, which severely limits their mobility.

C. Obsessive Compulsive Disorder (OCD)

This disorder involves obsessions or compulsions that are distressing or interfere with the person’s social and occupational functioning. **Obsessions** are recurrent, unwanted thoughts that are usually experienced (at least initially) as intrusive or senseless. Among the most common obsessions are recurrent thoughts of contamination (e.g., by germs, dirt, or chemicals) or fears of losing control (such as acting on an impulse to hurt oneself or
Compulsions are repetitive, intentional behaviors that are performed to avoid the obsession and decrease anxiety. This could include, for example, repetitive hand washing to the point of skin breakdown in response to obsessions about contamination. When the person attempts to resist a compulsion, he or she experiences increasing anxiety, which is promptly relieved by carrying out the compulsion – for a short time, until the obsession returns and the cycle repeats.

D. Posttraumatic Stress Disorder

Posttraumatic stress disorder (PTSD) has received considerable attention because of its prevalence among veterans. PTSD develops after an extreme traumatic stressor, such as combat, a serious automobile accident, or a violent crime. Such an event would be distressing to anyone and is usually experienced with intense fear and helplessness. Therefore, PTSD is diagnosed when the reaction to the traumatic event is severe and prolonged. (See chapter 6 for additional information about trauma).

The major symptoms of PTSD involve reexperiencing the event (flashbacks and recurrent nightmares about the event), avoidance of stimuli or situations associated with the event, and increased arousal. This includes difficulty falling asleep or staying asleep, recurrent nightmares about the event, hypervigilance, and exaggerated startle response.

E. Generalized Anxiety Disorder

Generalized anxiety disorder involves excessive anxiety and worry that occurs more days than not over a period of six months or longer. The person must worry about multiple life domains (e.g., finances, health, relationships, family members’ well being) and have difficulty controlling these presents worries.

Course

Anxiety disorders are some of the more common psychiatric illnesses, affecting approximately 25-30% of adults. Anxiety disorders often begin in adolescence or early adulthood. Left untreated, anxiety disorders tend to last for years for many people. People with anxiety disorders commonly have major depression as well; in these cases, the anxiety usually begins before the depression.

Causes and Risk Factors

As with all other disorders, anxiety disorders appear to be caused by a combination of biological (genetic, neurotransmitters in the brain, sensitivity of the nervous system), psychological (personality, coping styles), and environmental factors (stressful or traumatic life events, daily stressors).
Chapter 1

Most anxiety disorders (except OCD) are more common among women. Certain fears (e.g., of social situations, animals, etc.) may be learned from one's family or others, such as authority figures.

Treatment Approaches

Anxiety disorders are commonly treated with medication. Antidepressant medications are also effective for some anxiety disorders, and anxiolytic medication (e.g., alprazolam) are often used during times of acute anxiety (such as a panic attack). Evidence suggests, however, that psychotherapy is more effective in the long run for treating an anxiety disorder. The form of psychotherapy with the strongest evidence for improving or addressing anxiety disorders is “cognitive-behavioral therapy,” in which the therapist teaches the person relaxation skills and helps the person to gradually stop avoiding and confront feared stimuli. Behavior management (chapter 4) can be a valuable approach for ALF staff to reward someone with anxiety when she or he confronts or tolerates anxiety-provoking situations.

V. PERSONALITY DISORDERS

Personality disorders begin to develop early in life. They involve long-lasting patterns of perceiving, relating to and thinking about the environment, oneself, and other people. People with this illness exhibit problems in interpersonal relationships.

Personality disorders are briefly described in this chapter, because individuals with personality disorders can create challenges for staff and other residents in ALFs. The major manifestations of the various personality disorders include the following:

A. Antisocial Personality Disorder

Also called sociopathic and psychopathic personality disorder, people with antisocial personality disorder are often in trouble. Their behavior includes criminality, assaultiveness, impulsivity, stealing, lying, promiscuity, unreliability, and severe drug and alcohol use. Although they are adept at social interaction, they often fail at jobs, are abusive to family members, and cannot maintain close relationships. The behavior seems to peak in late adolescence and young adulthood and is more common in males than females. Family histories often include neglect and abuse, rejection, poverty, parental (intergenerational) criminality and substance abuse.

B. Borderline Personality Disorder

Borderline Personality Disorder (BPD) is complicated. Usually people with BPD are socially functional, but they can become transiently psy-
chotic and/or depressed. Common clinical characteristics include intense and highly variable emotions (especially anger), anxiety, chronic loneliness, boredom, a sense of emptiness, volatile interpersonal relationships, and impulsivity. Persons with BPD tend to alienate staff and may play staff members against one another. Suicidal threats and gestures are common.

C. Histrionic Personality Disorder

Persons with histrionic personality disorder are characterized by excessive emotionality and attention seeking. They often appear on the surface as likeable, charming, and seductive, though they often have difficulty maintaining close personal relationships. Frequent complaints of poor health are common among these individuals.

D. Narcissistic Personality Disorder

A pervasive pattern of grandiosity, hypersensitivity to the evaluation of others, and lack of empathy are the essential characteristics of this disorder. Chronic dissatisfaction due to a constant need for admiration and unrealistic self expectations, ideas of omnipotence (being all powerful and knowing), and superficial and exploitive interpersonal relationships are common with people who have this disorder. They also frequently become depressed.

E. Avoidant Personality Disorder

The person with avoidant personality disorder is a shy, lonely, hypersensitive person with low self esteem and a seeming willingness to go to any length to avoid disapproval from others. This person wants social involvement, but is inhibited from pursuing relationships because of their fear of rejection.

F. Dependent Personality Disorder

This disorder involves excessive passivity, uncertainty, and isolation combined with excessive, controlling, possessive dependency on one or just a few people. These people are often unable to make everyday decisions without an excessive amount of advice and reassurance from others. Such people are easily hurt by criticism and are often devastated at the end of a relationship.

G. Obsessive Compulsive Personality Disorder

This disorder involves extreme perfectionism that usually interferes with the ability to carry out a task. Obsessive compulsiveness involves an ad-
justment that is inhibited, perfectionistic, judgmental, rigid, continuously anxious, detached from intimacy, cold, and demanding of oneself.

H. Paranoid Personality Disorder

The major characteristic of this disorder is a pervasive and unwarranted tendency to interpret the actions of others as deliberately demeaning or threatening. They often perceive that people are “out to get them.” People with this disorder present as emotionally cold, suspicious, “touchy” about slights, rigid, contentious, and litigious. Their own suspicions and mistrust are barriers to their seeking or accepting treatment.

I. Schizoid Personality Disorder

Persons with this disorder evidence a pervasive pattern of indifference to social relationships and a restricted range of emotional experience and expression. They do not desire or enjoy close relationships. People with these characteristics who also evidence eccentricities of communication or behavior are said to have Schizotypal Personality Disorder.

Treatment Approaches

Personality disorders are very difficult to change and treat, although psychiatric medications and psychotherapy can be beneficial. For ALF residents with personality disorders, use behavior management strategies (chapter 4) to identify triggers of problematic behavior and to reward desired behaviors. The person may be critical of you or others, overly flattering to you, or may vacillate back and forth. Simply remain patient and professional at all times, and interact with the person just as you would with any other resident.

VI. COGNITIVE DISORDERS

Overview

Cognitive disorders refer to a category of disorders that cause deficits to memory and/or other aspects of cognitive functioning (e.g., attention, processing speed, language). Two common categories of cognitive disorders are delirium and dementia. These are not specific medical diseases, but syndromes (a set of symptoms) that can have various underlying medical causes.
A. Delirium

Symptoms
Delirium is syndrome (a set of symptoms) characterized by a reduced level of consciousness, sensory misperceptions, disturbance of the sleep-wake cycle, disorientation, and memory impairment. This syndrome also involves a reduced ability to maintain or to appropriately shift attention and disorganized thinking as manifested by rambling or incoherent speech.

Course
Onset of delirium is usually rapid, and the duration is brief if it is treated properly. Symptoms typically fluctuate in intensity. Depending on the underlying cause, delirium can cause death or irreversible brain damage if it is not treated in a timely manner.

Causes and Risk Factors
A variety of underlying physical conditions (e.g., severe infection, stroke or other head trauma, severe electrolyte imbalance, alcohol withdrawal) can cause delirium. Young children and older adults, particularly people with physical health problems, are at a heightened risk for delirium.

Treatment Approaches
Delirium represents a medical emergency. Persons with delirium should be seen by a physician right away. The physician should identify and treat the underlying cause of the delirium.

B. Dementia

Symptoms
Symptoms of dementia involve multiple cognitive deficits that impair a person’s functioning and is a decline from previous functioning. Dementia impairs memory (including the ability to remember new information and the ability to recall information previously learned). Dementia also impairs at least one other area of cognitive functioning: language, ability to carry out motor activities (despite intact motor functioning), failure to identify objects, or “executive dysfunction” (e.g., reasoning, judgment, planning, organizing).

Course
The principal differences between dementia and delirium are that dementia typically has a slower onset, more stable symptoms, and much longer...
duration. Further, the person with dementia is alert. The exact course of dementia depends on the underlying physical condition causing the dementia. Dementia may worsen, remain the same, or improve, depending on the underlying cause and treatment. Most of the time dementia is either stable or worsens. As dementia progresses behavioral problems may occur, such as wandering or agitation. People with severe dementia become disoriented, not knowing who they are, where they are, or the date. They will also often lose the ability to recognize loved ones or others with whom they have a close relationship. For example, ALF staff they see every day may become unknown to them.

Causes and Risk Factors
Like delirium, dementia is a syndrome (a set of symptoms), not a disease. Dementia is caused by several different physical diseases. Alzheimer’s disease is the most common cause of dementia, accounting for over half of the cases of dementia, although there are other causes of dementia as well (Please see the following).

Causes of Dementia
- Alzheimer's Type Dementia (early or late onset)
- Atherosclerosis (also called hardening of the arteries)
- Vascular Dementia
- Dementia due to other medical conditions:
  - HIV
  - Head trauma
  - Parkinson's Disease
  - Huntington's Disease
  - Pick's Disease
  - Creutzfeldt-Jacob Disease
  - Substance-induced

The primary risk factor for dementia is age, becoming much more common in later life. It is estimated that 2-4% of adults aged 65 or older have Alzheimer’s disease, but this prevalence increases to almost 50% by age 85. Other risk factors for dementia include genes, a family history of dementia, low education, and alcohol or substance abuse. Healthy habits (e.g., nutrition, exercise, limited alcohol intake, not smoking) also appear to protect against some causes of dementia.
Treatment Approaches

The medical treatment approach depends on the cause of the dementia. Therefore, if dementia is suspected, it is critical that the person receive a complete medical evaluation. For Alzheimer’s disease several medications can be used to treat cognitive impairment, such as donepezil (Aricept). These medications do not cure or reverse Alzheimer’s disease, but seem to slow down the progression of the disease.

Behavior management (chapter 4) is very effective at managing a variety of problematic behaviors seen in ALF residents with dementia, including wandering, agitation, or withdrawal. In cases of agitation, usually the person is being under-stimulated (sitting around with nothing to do – by making noise, someone attends to them, which is rewarding) or over-stimulated (too much activity or noise, receiving complicated instructions). Use the behavioral management principles in chapter 4 to identify and eliminate triggers, keep the person engaged in enjoyable activities, and reward desired behaviors.

VII. SUBSTANCE-RELATED DISORDERS

Overview

Substance-related disorders include disorders related to abusing drugs, experiencing side effects of medications, and being exposed to toxins. DSM-IV identifies 11 classes of substances that can be involved in substance-related disorders.

Classes of Substances Involved in Substance-Related Disorders

- Alcohol
- Cannabis
- Hallucinogens
- Nicotine
- Sedatives
- Anxiolytics
- Amphetamines or similarly acting sympathomimetics
- Caffeine
- Cocaine
- Inhalants
- Opioids
- Hypnotics
- Phencyclidine (PCP)

There are two broad types of disorders within the Substance-Related Disorders category, specifically Substance Use Disorders (which include Substance Abuse and Substance Dependence) and Substance Induced Disorders (which include Intoxication, Withdrawal, and Substance Induced Mental Disorders).
Chapter 1

Symptoms

A. Substance Use Disorders

Substance Abuse and Substance Dependence both involve maladaptive patterns of substance use, which lead to significant impairment or distress. These may involve negative consequences related to work, social relationships, legal status, and physical and psychological health. In addition to the harmful consequences associated with repeated use, Substance Dependence also involves the experience of tolerance (the need for increasing amounts of the drug to achieve the desired effect), withdrawal (symptoms experienced when the use of the drug is discontinued), compulsive use (taking more of the drug or taking the drug more often than intended), or the persistent desire or unsuccessful efforts to cut down on usage. The occurrence of tolerance or withdrawal symptoms indicates that the person has a physiological dependence on the drug.

B. Substance Induced Disorders

A variety of mental illnesses can be “induced” by the use of substances. For example, a person could evidence symptoms of depression that are caused by the person’s use or abuse of a drug. In this case, the person could be diagnosed as having a “substance-induced mood disorder.” Disorders described in the DSM-IV that can be “substance-induced” include mood disorder, anxiety disorder, psychotic disorder, persisting dementia, and delirium (among others). Since these disorders were described previously, we will not discuss them further here except to note that, as this discussion implies, the use of substances can cause or make worse various symptoms of other mental disorders.

In addition to the previously described substance-induced disorders, there are two other substance-induced disorders (intoxication and withdrawal). Substance intoxication is the condition that occurs as a result of taking a drug. Withdrawal is a set of symptoms that occur when a person who is dependent on a substance discontinues the use of that substance. It is important to keep in mind that substance intoxication (particularly when the person takes an “overdose”) and withdrawal can be potentially life-threatening circumstances and should be taken seriously. If a person who has been abusing substances begins to evidence symptoms such as extreme lethargy, disorientation, hallucinations, or convulsions, they are in need of immediate medical attention.

Course

The course varies depending on the substance and severity of symptoms. For example, many young adults abuse alcohol, and then go on to moder-
ate their alcohol use throughout the rest of their lives after leaving certain environments such as college. Depending on severity, substance abuse or dependence can have devastating effects for individuals, including criminal behavior, job loss, relationship loss, and other risky behavior to obtain the substance. Individuals with long-term substance abuse or dependence will usually experience other serious physical and cognitive disorders later in life.

Causes and Risk Factors
As with all other mental illnesses, the causes are not fully understood, although there are a mix of biological, psychological, and environmental risk factors. A person’s genetics and biological functioning can make him or her vulnerable to substance abuse or dependence. Exposure to substances, stressful life events, and other mental illnesses also increase the risk of substance abuse or dependence.

Treatment Approaches
Treatment depends on the substances that are abused, in addition to the degree of dependence and severity. It may be necessary to hospitalize someone during detoxification. Outpatient treatment varies from self-help groups (e.g., Alcoholics Anonymous) to formal mental health treatment (e.g., inpatient settings). Mental health treatment can involve medications that reduce cravings or other psychiatric symptoms (e.g., depression, anxiety), as well as psychotherapy to examine causes and triggers of substance abuse and improve coping skills to manage problems associated with substance misuse (e.g., job loss, interpersonal conflict). Behavior management principles (chapter 4) can be useful to help identify antecedents of substance abuse and reward desired behaviors.

VIII. COMORBIDITY
Mental illnesses do not occur in isolation. Often, an individual may be diagnosed with two or more disorders, which is called “comorbidity.” Another phrase is “co-occurring disorders,” which generally refers to the comorbidity of a mental illness and a substance use disorder (e.g., major depressive disorder and alcohol dependence). Comorbidity can occur at the same time or at different times (e.g., PTSD at one age, major depression at a later age). There are several reasons why people often have two or more diagnoses: the same risk factors can cause multiple disorders (e.g., a trauma can cause PTSD and depression), one disorder can cause another disorder (e.g., alcohol abuse can cause depression; depression may cause Alzheimer’s disease), or the person may have two diagnoses by coincidence.
Comorbidity of major depressive disorder and the anxiety disorders is very common. Substance misuse is also very common in most of the other mental disorders, including schizophrenia, bipolar disorder, depression, anxiety disorders, and personality disorders. Substance misuse can lead to delirium or dementia.

Finally, mental and substance use disorders are often comorbid with other physical illnesses as well. There is some evidence that these relationships are bidirectional: physical illnesses can cause mental illnesses, and mental illnesses also appear to lead to physical illness.

Comorbidity can complicate treatment. It is important that ALF staff know about all of the person's symptoms and illnesses. It is also important that medical personnel be involved in the individual’s treatment to evaluate and manage other physical illnesses. The same behavior management principles (chapter 4) are valuable with people who have comorbid conditions.

IX. RECOVERY

A new working definition of recovery from mental illnesses and substance use disorders is being announced by the Substance Abuse and Mental Health Services Administration (SAMHSA). The definition is the product of a year-long effort by SAMHSA and a wide range of partners in the behavioral health care community and other fields to develop a working definition of recovery that captures the essential, common experiences of those recovering from mental illnesses and substance use disorders, along with major guiding principles that support the recovery definition. SAMHSA led this effort as part of its Recovery Support Strategic Initiative.

The new working definition of Recovery from Mental Disorders and Substance Use Disorders is as follows:

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

“Over the years it has become increasingly apparent that a practical, comprehensive working definition of recovery would enable policy makers, providers, and others to better design, deliver, and measure integrated and holistic services to those in need,” said SAMHSA Administrator Pamela S. Hyde. “By working with all elements of the behavioral health community and others to develop this definition, I believe SAMHSA has achieved a significant milestone in promoting greater public awareness and appreciation for the importance of recovery, and widespread support for the services that can make it a reality for millions of Americans.”

In August 2011, SAMHSA posted the working definition and principles...
that resulted from this process on the SAMHSA blog and invited comments from the public via SAMHSA Feedback Forums. The blog post received 259 comments, and the forums had over 1,000 participants, nearly 500 ideas, and over 1,200 comments on the ideas. Many of the comments have been incorporated into the current working definition and principles.

Through the Recovery Support Strategic Initiative, SAMHSA also delineates four major dimensions that support a life in recovery:

1. **Health**: overcoming or managing one’s disease(s) as well as living in a physically and emotionally healthy way;

2. **Home**: a stable and safe place to live;

3. **Purpose**: meaningful daily activities, such as a job, school, volunteering, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and

4. **Community**: relationships and social networks that provide support, friendship, love, and hope.

**Guiding Principles of Recovery**

*Recovery emerges from hope*: The belief that recovery is real provides the essential and motivating message of a better future – that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them. Hope is internalized and can be fostered by peers, families, providers, allies, and others. Hope is the catalyst of the recovery process.

*Recovery is person-driven*: Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals. Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience. In so doing, they are empowered and provided the resources to make informed decisions, initiate recovery, build on their strengths, and gain or regain control over their lives.

*Recovery occurs via many pathways*: Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds including trauma experiences that affect and determine their pathway(s) to recovery. Recovery is built on the multiple capacities, strengths, talents, coping abilities, resources, and inherent value of each individual. Recovery pathways are highly personalized. They may include professional clinical treatment; use of medications; support from families and in schools;
Recovery is non-linear, characterized by continual growth and improved functioning that may involve setbacks. Because setbacks are a natural, though not inevitable, part of the recovery process, it is essential to foster resilience for all individuals and families. Abstinence from the use of alcohol, illicit drugs, and non-prescribed medications is the goal for those with addictions. Use of tobacco and non-prescribed or illicit drugs is not safe for anyone. In some cases, recovery pathways can be enabled by creating a supportive environment.

_Recovery is holistic:_ Recovery encompasses an individual’s whole life, including mind, body, spirit, and community. This includes addressing: self-care practices, family, housing, employment, education, clinical treatment for mental illnesses and substance use disorders, services and supports, primary healthcare, dental care, complementary and alternative services, faith, spirituality, creativity, social networks, transportation, and community participation. The array of services and supports available should be integrated and coordinated.

_Recovery is supported by peers and allies:_ Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Peers encourage and engage other peers and provide each other with a vital sense of belonging, supportive relationships, valued roles, and community. Through helping others and giving back to the community, one helps one’s self. Peer-operated supports and services provide important resources to assist people along their journeys of recovery and wellness. Professionals can also play an important role in the recovery process by providing clinical treatment and other services that support individuals in their chosen recovery paths. While peers and allies play an important role for many in recovery, their role for children and youth may be slightly different. Peer supports for families are very important for children with behavioral health problems and can also play a supportive role for youth in recovery.

_Recovery is supported through relationship and social networks:_ An important factor in the recovery process is the presence and involvement of people who believe in the person’s ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change. Family members, peers, providers, faith groups, community members, and other allies form vital support networks. Through these relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in new roles (e.g., partner, caregiver, friend, student, employee) that lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusion, and community participation.

_Recovery is culturally-based and influenced:_ Culture and cultural back-
ground in all of its diverse representations including values, traditions, and beliefs are keys in determining a person's journey and unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual's unique needs.

**Recovery is supported by addressing trauma:** The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues. Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.

**Recovery involves individual, family, and community strengths and responsibility:** Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. In addition, individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals should be supported in speaking for themselves. Families and significant others have responsibilities to support their loved ones, especially for children and youth in recovery. Communities have responsibilities to provide opportunities and resources to address discrimination and to foster social inclusion and recovery. Individuals in recovery also have a social responsibility and should have the ability to join with peers to speak collectively about their strengths, needs, wants, desires, and aspirations.

**Recovery is based on respect:** Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems – including protecting their rights and eliminating discrimination – are crucial in achieving recovery. There is a need to acknowledge that taking steps towards recovery may require great courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in one's self are particularly important.

**Additional Resources**

For further detailed information about the new working recovery definition or the guiding principles of recovery, please visit: http://www.samhsa.gov/recovery.

SAMHSA is a public health agency within the Department of Health and Human Services. Its mission is to reduce the impact of substance abuse and mental illness on America's communities.

National Alliance on Mental Illness (NAMI) is dedicated to improving the lives of individuals and families affected by mental illness. To learn more about NAMI, please visit: www.nami.org.
X. STIGMA AND MYTHS

Stigma is common for people with mental illnesses. The person may be afraid of what other people think, and other people actually treat the person differently. People often avoid living or socializing with someone with a mental disorder. Professionals may hold inaccurate or prejudiced views about people with mental illnesses or may experience symptoms themselves (secondary stigma, or stigma by association). Some mistaken beliefs that cause stigma are that someone with a mental illness is violent, less intelligent, weak, or just needs to “pull themselves up by their bootstraps,” or just need to “snap out of it.”

Stigma causes people with mental illnesses to hide their symptoms and avoid treatment. Although one in five Americans has a mental disorder, less than half of people with a mental illness seek any treatment. Being isolated or shunned by others can also worsen a disorder.

To address stigma, it is important for all professionals to consider their personal attitudes about mental illnesses, the language they use, how they interact with someone with a mental illness and how others who interact with ALF residents can potentially stigmatize them. It is important to not blame the person; most people are doing the best they can given their situation. On the other hand, it is important to not see the person as helpless or their symptoms as out of their control. They can often learn ways to manage or cope with their symptoms. For example, having arthritis is not someone’s fault, but the person can learn strategies to manage arthritis and pain. Therefore, it is important to be understanding as well as empowering.

Language is also powerful; use “person first” language. A person is not defined by his or her diagnosis, so do not refer to someone as “a schizophrenic;” instead, say “a person with schizophrenia.” Avoid terms like crazy or psycho.

There is little reason to fear someone with a mental disorder. While some symptoms may seem odd, the vast majority of individuals with a mental illness are not violent and do not harm others. Safety considerations should be more on an individual rather than stereotypical basis.

Another myth about people with mental illnesses is that they will always have a mental disorder. With proper treatment and support from other people, many people with mental illnesses recover. Even people who do not fully recover or who have a recurrence still contribute to society and can engage in meaningful relationships and activities, including work, helping others, art, and many others.

Individuals who visit or interact with ALF residents (family members, contractors or vendors) may stigmatize these residents if they do not
understand their condition and, for example, repeat something that they saw from the public media. Remaining mindful of misinformation and its sources and the need to educate individuals who perpetuate this misinformation can help to prevent and address stigma and myths.

XI. SUMMARY

The foregoing chapter provided an overview of some of the major types of mental illnesses that a worker may encounter in an Assisted Living Facility. Mental health professionals use these categories to formulate clinical diagnoses. Based on the diagnosis, a treatment plan is developed. By understanding the diagnoses and symptoms, you can recognize prominent symptom patterns and communicate your observations in a meaningful way to residents’ health care / mental health care providers. You can also use this understanding to empathize with and support the person with a mental disorder, and perhaps to guide your use of behavior management principles (chapter 4).
Chapter 1

1. Schizophrenia/Psychotic Disorders

- General name for a group of disorders
- Persons with schizophrenia experience:
  - Distortions in reality such as hallucinations, delusions, and disorganized speech.
  - Disorganized and fragmented thoughts, perceptions, and emotions.
- Symptoms among people with schizophrenia will vary and may come and go over the course of a person's life.

When someone has a substance related disorder and another mental health disorder (such as depression), they are said to have a "co-occurring disorder."
Slide 4

**Delusions**

Beliefs that continue even with evidence to the contrary

- Do not discount the person’s experience.
- Listen for what may be real.
- Avoid a debate or argument about the delusion which only increases tension in the situation.
- Let them know that you will listen and attend to their concerns.

---

Slide 5

**Hallucinations**

Disturbances of perception such as vision, hearing, smell, taste, and touch. Hearing voices is the most common hallucination.

- Ask for help from the case manager about how best to communicate with the person.
- Inform case manager if this is a new symptom.
- Not all persons who experience delusions and/or hallucinations have schizophrenia and not all persons with schizophrenia experience these symptoms.

---

Slide 6

**Other Psychological Symptoms**

- Disorganized speech
- Disorganized behavior (e.g., sloppy appearance)
- Difficulty initiating or following through on task and may need prompts
- When the person does not present any behavior that requires attention, they can easily be forgotten
Chapter 1

Slide 7

Physical Symptoms

- Vague and/or incoherent speech.
- Engage in conversations with themselves.
- Peculiar gestures, postures or movements.
- They use monotone voice or they may remain silent
- May perform the same task repeatedly

Slide 8

People with Schizophrenia
Can Benefit from:

- Structure
- Routine
- Participating in productive daily activity
- Safe and secure environment
- Peer Support Services

Slide 9

2. Mood Disorders

- Depression
- Bi-Polar Disorder
Bipolar Disorder

Symptoms

- Symptoms of Depression
  - Symptoms of depression are similar to clinical depression, but they alternate with mania.
- Symptoms of Mania
  - The person may get by with only a few hours of sleep or go for days without sleep and lose none of their energy. Speech becomes loud and rapid. They have an inflated self-esteem, and engage in high risk activities. May have outbursts of irritability.

Bipolar Disorder

Treatment

- Medication
  - Lithium is the most common medication to treat the symptoms of bipolar disorder.
- When a person is experiencing the symptoms of mania, be non-confrontive in your speech and body language.
- Avoid placing undue restriction on the person’s behavior unless it is harmful to themselves or others.

Depression

- Situational
  - Is temporary and usually caused by an event such as loss of a loved one. Resolved when situation returns to normal.
- Clinical
  - Is more enduring and/or reoccurring and requires treatment. It is not triggered by external events
Chapter 1

Slide 13

### Depression Symptoms

- Psychological
  - Feelings of sadness, irritability, worthlessness, anxiety, hypercritical of themselves, isolation, difficulty concentrating or making decisions, and suicidal thoughts.
- Physical
  - Fatigue, engages in agitated behavior such as pacing or hand wringing, sleep difficulties, changes in appetite, decreased sex drive.

Slide 14

### Depression Treatment

- Medication
- Behavior Therapy
- Insight Therapy
- Environmental Supports
  - Use of relaxation tapes
  - Structured activities
  - Daily routines

Slide 15

### 3. Anxiety Disorders

An intense, painful experience of anxiety, often accompanied by feelings of guilt or worthlessness.

- Feelings of extreme fear with no apparent reason.
  Physical symptoms such as trouble breathing, bowel distress, stomach upset, headaches, flushes, chills, sweating, sleep problems.
Chapter 1

### Slide 16

**Anxiety Disorder Treatment**

- Medication
  - Minor tranquilizers
- Therapies
  - Behavior and Insight therapies
- Environmental Adaptations
  - Calm, quiet environment
  - Quiet area
  - Relaxation and/or music tapes
  - Daily routines
  - Affirmations or worth

### Slide 17

**4. Personality Disorders**

- Paranoid
- Antisocial
- Schizoid
- Dependent
- Obsessive-Compulsive
- Passive-Aggressive
- Histrionic
- Avoidant
- Narcissistic

### Slide 18

**People usually have problems with:**

- Interpersonal relationships
- Tolerance of rules
- Tolerance with delayed gratification
- Their ability to conduct themselves within social norms
- Coping mechanisms which are rigid and inflexible
- Maladaptive ways of perceiving, thinking or relating
Chapter 1

Slide 19

5. Cognitive Disorders

- Clause deficits to
  - Memory
  - Attention
  - Processing Speed
- Delirium and dementia are two types of cognitive disorders

Slide 20

Delirium

- Reduced level of
  - Consciousness
  - Sensory misperception
  - Disturbance of sleep/wake cycle
  - Disorientation
  - Memory Impairment

Slide 21

Delirium (cont’d.)

- Rapid onset
- Brief duration if treated properly
- Symptoms change intensity

Delirium is a medical emergency. This means that people with delirium should be seen right away by a physician
**Chapter 1**

**Slide 22**

### Dementia

- Impairs at least one other area of cognitive functioning:
  - Language
  - Ability to carry out motor activities
  - Ability to carry out motor activities
  - Executive function
    - Reasoning
    - Judgment
    - Planning
    - Organization

**Slide 23**

### Dementia (cont’d.)

- Symptoms
  - Multiple cognitive deficits that impair a person’s functioning
  - A decline from previous functioning
  - Impairs memory
    - New information
    - Previously learned information

**Slide 24**

### Difference between Delirium & Dementia

- Dementia usually has a:
  - A slower onset
  - More stable symptoms
  - Much longer duration

- People with dementia are usually alert, while people with delirium are NOT alert
Slide 25

**6. Substance Related Disorders**

Maladaptive patterns of substance use which lead to significant impairment or distress for the person.

- Negative Consequences
  - Work
  - Family relationships
  - Social relationships
  - Legal status
  - Physical health
  - Psychological health

Slide 26

**6. Substance Related Disorders (cont’d.)**

- Substance Dependence
  - Need for increasing the amount of the drug to achieve desired effect
  - Withdrawal symptoms
  - Overdoses which are potentially life threatening

Slide 27

**Classes of Substances involved in Substance-Related Disorders**

- Alcohol
- Caffeine
- Cannabis
- Cocaine
- Hallucinogens
- Inhalants
- Nicotine
- Opioids
- Sedatives
- Hypnotics
- Anxiolytics
- PCP
- Amphetamines (includes methamphetamines)
Chapter 1

**Substance-Related Disorders Treatment**

A person should receive immediate medical attention if they have been abusing drugs and experience the following symptoms:

- Lack of Energy
- Disorientation
- Hallucinations
- Convulsions

**Comorbidity**

- Often, individuals are diagnosed with two or more disorders, which is called “comorbidity.”
- The term “co-occurring” is used when referring to individuals with a mental disorder and a substance abuse use disorder such as depressive disorder and alcohol dependence.

**Principles of Recovery & Resiliency**

Recovery includes:

- **Strength-based:** recognize my abilities, talents and skills
- **Holistic:** consider all the aspects of who I am – mind, body, spirit
- **Responsibility:** I have the primary responsibility for my journey to recovery. I can trust myself.
- **Support:** I need help from my peers and mental health staff
Chapter 1

Principles of Recovery & Resiliency (cont’d.)

Choice
- Mental illness does not define who I am
- It’s about “me”
- I have the right to make choices
- Choices are the center of my services
- People respect my choices
- People give me feedback to assist in recovery
- People support me in achieving my goal

Hope
- Is fundamental to human dignity
- Provides me with the belief that life can get better
- Helps me to not give up

Stigma
- Stigma is common for people with mental disorders
- Because of stigma people may avoid those with mental disorders
- Stigma sometimes makes people hide their symptoms and avoid seeking treatment
Stigma

- When assisting people with mental illness staff should:
  - Consider their personal attitudes about mental disorders
  - The language they use
  - How they interact with someone with a mental disorder
  - How others ALF residents interact with persons with mental illness, because other residents may also stigmatize persons with mental disorders

Stigma

- Important not to blame the persons with mental disorders for their disorders
- Important to NOT see the persons with mental disorders as helpless
- Important to understand that persons with mental disorders are not always out of control, often learning ways to manage and cope with their symptoms

Stigma - Language

- Language is powerful
- Use person first language
  - A person is NOT defined by his/her diagnosis
  - Do NOT refer to people as:
    - Schizophrenic
    - Instead say he/she is “a person with schizophrenia
- Avoid terms such as “crazy” “psycho” or “nuts”
Common Psychiatric Medications and Side Effects

Assisted Living Facility Training for Limited Mental Health Licensure

Chapter 2

Beverly Crockett, R.N.

Department of Mental Health Law and Policy
Louis de la Parte Florida Mental Health Institute
University of South Florida
Chapter Directions

Be sure to read the Introduction at the beginning of the manual before proceeding with the chapter presentations. A PowerPoint presentation for this chapter is available at www.BakerActTraining.org and is also printed at the end of this chapter.

It is recommended that you identify a psychiatric nurse or psychiatrist who is willing to be a resource for you when you begin preparing and have questions about the material. Avoid the use of medical jargon unless a term is commonly used, and discuss symptoms by using a behavioral context.

Chapter Description

The content is concerned with common psychiatric medications, side effects, precautions, and basic information regarding their use. The areas covered include: the different types of medications; the names of those medications and the symptoms that they help; the different side effects that can be caused by these medications; what you can do if an emergency arises; and finally, the precautions that should be taken with these medications.

Learning Objectives

Participants should be able to:

1. Identify the names of at least five medications that are commonly used to treat the symptoms of a diagnosed mental disorder;
2. List five common side effects a person might experience as a result of taking a psychiatric medication;
3. Identify two precautions associated with psychiatric medications; and
4. Identify two ingredients in over-the-counter medicines which could possibly be harmful if taken while on a psychiatric medication.

Time Frame

1 hour

Materials

LCD Projector/PowerPoint Slides
Handouts
Outline

I. Introduction .................................................................60

II. Medication Adherence ...................................................60
   A. Factors that Affect Adherence to Medication Treatment ...61
   B. Adverse Results of Not Taking Medication ....................65
   C. Medication Workable Solutions .................................66

III. Medications ....................................................................68
   A. The Difference Between
      Brand Name and Generic Name .................................68
   B. Understanding What We Treat ...................................69
   C. Common Medications ..............................................69

IV. Side Effects ....................................................................72
   A. Common Side Effects ................................................73
   B. Side Effects that Cause Problems
      to the Nervous System ..............................................73
   C. Life Threatening Side Effects ....................................74

V. General Medication Information ....................................75
   A. Precautions .............................................................75
   B. Over-the-Counter Medicines ......................................75
   C. Preparing to See the Doctor ......................................78
   D. Knowing the Residents of Your Facility .......................79
   E. Prevention ...............................................................81
Chapter 2

Slides 1, 2, 3, 4

Common Psychiatric Medications and Side Effects

---

Slide 5

I. INTRODUCTION

We will be introducing some of the more common medications that the residents of your facilities are taking to regulate the symptoms of their disorder and help them live in the community. These medications can help to provide a person with the opportunity to enjoy a quality of life that fits their needs and goals. Several of the areas we will introduce include:

- The different types of medications, the names of those medications and the symptoms that they help;
- The different side effects that can be caused by these medications and what you can do if an emergency arises; and
- The precautions that should be taken with these medications.

II. MEDICATION ADHERENCE

Assisted Living Facilities (ALF) play a vital role in providing support to people who have a psychiatric illness and want to live in the community. The symptoms of a person’s illness can be so disabling that even everyday activities such as personal hygiene, cooking, taking medications, etc. may be difficult. An ALF provides a structure outside the hospital that helps a person with these everyday activities by making it possible for him/her to enjoy a better quality of life. Therefore, before we begin talking about medications, let’s first talk about your role and the resident’s role in taking medication (i.e., medication adherence).

Often the term “medication compliance” is used when discussing how to ensure someone is taking medication as it was prescribed. However, I want to have a new conversation and consider the difference between medication compliance and medication adherence. **Medication adherence** is a partnership between the person and the clinician or the person responsible for resident medication at the ALF, whereas **medication compliance** can be considered a person’s unconditional obedience to take medication as prescribed. The residents of your ALF are adults, and they have choices and responsibilities regarding their medication.

Taking medications as prescribed consistently is important to help regulate symptoms, shorten or prevent relapses of an illness, and to help a person continue to do well over time. If a person does not take medication consistently the way it is meant to be taken, it can have disastrous results including:

- Symptom relapse
- Re-hospitalization
• Loss of living arrangements
• Difficulty restabilizing on medication
• Trauma from re-hospitalization
• Alienation from staff, and
• Loss of community support.

On the other hand, medications are not a cure for a mental disorder and they often come with disadvantages that are in conflict with a person’s experience of recovery and quality of life, such as side effects and stigma. The people working at an ALF are the residents’ support team and play an important role in the residents’ medication adherence by helping residents understand their medication, listening to problems a person may be having with medication, helping them to communicate these problems to their doctor, and increasing the likelihood that a person is taking the correct medication using the correct dose, at the correct time, and through the correct route.

When someone is not adhering to their daily medication schedule, one or more of the following is usually occurring:

• Taking less medication than prescribed;
• Taking more medications than prescribed;
• Altering the pattern of use or correct route prescribed for a medication; and
• Stopping a medication altogether.

This can have very serious consequences that are debilitating and humiliating for the person and frustrating for the staff. Putting practices in place that help the staff to work with residents will go a long way in establishing an environment where residents can discuss their medications and have the support they need to resolve problems they may be having.

A. Factors that Affect Adherence to Medication Treatment

Some of the factors that become barriers to following medication schedules include:

• Having to take medications over an indefinite period of time;
• Onset and persistence of side effects;
• Complex medication schedules;
Common Psychiatric Medications and Side Effects

Chapter 2

- Interruptions in medication taking routines;
- Difficulty with mental processes that help with organization;
- Lack of information about the medications they are taking;
- Lack of trust/confidence in psychiatric professionals; and
- Financial hardships.

Having to take medications over an indefinite period of time

For many people who are diagnosed with a major mental disorder, the process of learning to manage their illness and live their lives with autonomy, quality, and dignity is a lifelong challenge.

Taking medications daily over a lifetime requires that a person has access to reliable, personally useful, and personally understandable information on diagnosis and treatments (including medications and their side effects), financial resources, personal resources, and support from professionals, family, and friends. Disruptions to any of these variables jeopardize the necessary continuity of taking medication over long periods of time.

Onset and persistence of side effects

We take medication in order to feel better. When side effects occur and these side effects are intolerable, frightening, uncomfortable, disabling, or embarrassing, a person is more likely to avoid taking medication. This is especially true when these side effects have not been explained, are unexpected, and have not been given the attention needed to resolve the problem.

When the side effects seem worse than the help a person is getting from a medication, then it is less likely someone will be motivated to take the medication. Some side effects, such as tardive dyskensia (see bottom of p. 73 for description), become permanent if not addressed immediately. Those risks highlight the apprehension faced by anyone who wants the benefits of medication, but also worries about the potential harm.

Effective, well tolerated, and acceptable psychotropic medications may help to overcome one of the major causes of non-adherence with treatment, and thus improve outcomes. However, the therapeutic alliance between a person and a mental health professional will continue to be vital in ensuring that the need for and benefits of treatment are understood, and that those aspects of the illness itself (which can lead someone to stop taking medication) are recognized and addressed.
Complex medication schedules

When a medication schedule is too complex, the chance of someone following it as prescribed is reduced. Some examples of such complexity include the following:

- Inflexible dosing schedules;
- Special instructions such as with food, without food, 1 hour before meals or 2 hours after meals, etc.; and
- Poorly communicated and/or understood instructions.

This can be improved by talking with the doctor and finding out if it is possible to simplify the schedule or alter the route. When this is not possible, work with the person to set schedule for taking medication that is a better match with their regular and predictable daily activities. Also, the use of aids such as containers to prepackage medications for each day or each week can be helpful. Someone with schizophrenia may prefer monthly injections such as Prolixin Decanoate (see bottom of p. 77 for information about injectable medications).

Interruptions in medication-taking routines

A person may actually reduce the amount of medication they are taking or stop altogether when there is an interruption in their medication routine. There are many ways that a medication regimen might be interrupted. Some examples are listed below.

- One or two doses are consecutively missed, which begins a pattern of missing doses each day or several days a week.
- The prescription bottle is empty, and there is no money or transportation to get a refill.
- A new prescription is needed to get a refill, and the appointment for a medication evaluation and prescription renewal has been missed and is rescheduled after the medication runs out.

These are only some examples of how medication routines can be broken and begin a spiraling effect or not taking medications.

Difficulty with mental processes that help with organization

Taking medications consistently as prescribed requires a person to organize, comprehend and follow instructions, and then to plan ahead how medications and correct dosages will be taken.
A person’s ability to think clearly may be already impaired by the symptoms of his/her illness, as well as affected by a medication itself. If a person cannot follow through with routine activities because of disorganized thinking, the chances that medications will be taken as prescribed are even less likely. Also, some side effects of medications can impair memory, thereby resulting in missed doses or double dosing when a dose was already taken but forgotten.

**Lack of information about the medications they are taking**

The literature on medication and/or treatment adherence suggests that a person whose diagnosis and treatment (including potential side effects) have been explained clearly is more likely to follow a medication regimen than someone who does not understand why s/he has been placed on medication.

A lack of information leaves a person unprepared to deal with problems that may arise especially when s/he is expecting to feel better and instead encounters side effects that are more intolerable to him/her than any benefits from the medication.

Though we want and expect prescribers to take the time to clearly explain why a medication has been prescribed, what a person might expect in benefits, potential side effects, and long term use considerations, this is not always the case. Ensuring that the resident’s support team has open, honest communication regarding diagnosis and treatment is very important to increase the chances of a person following through with treatment.

**Lack of trust/confidence in psychiatric professionals**

Being told that you have a major physical or mental disorder is traumatic for most people. From that moment, a person’s life is changed forever and the adjustment to such news can be complex and lengthy. The experiences people have with professionals as they look for and get help has a direct effect on the following:

- The trust they feel when seeking help;
- The confidence they have in receiving help; and
- The motivation or interest in following treatment recommendations.

**Financial hardships**

Even when a person wants or is willing to take medication, if s/he does not have the financial resources to purchase medications, pay for transport-
tion, or cover the cost of food, rent, utilities, and medications, it is more likely that taking medications will be problematic. Helping someone to meet these comprehensive needs may be the best solution to their medication treatment adherence.

**B. Adverse Results of Not Taking Medication**

There are many possible outcomes when a person is not taking medication as it was prescribed. Some of the adverse results that can occur include the following:

- Unwanted symptoms return;
- A loss or interruption to the gains a person may have made (e.g., housing, employment);
- Education and social support from family and friends;
- Hospitalization or re-hospitalization;
- Greater difficulty re-stabilizing on medication;
- Homelessness;
- Encounters with law enforcement; and
- Accidental overmedication or overdose.

Even though there are many adverse effects of not taking one's medication, there are some results that may initially seem appealing. These include the following:

- Initially feeling better and more normal (e.g., thinking more clearly, regaining affect and spontaneity);
- Regaining a sense control over choices/decisions regarding illness and other life issues; and
- Gaining first-hand experience of “off medication vs. on medication;” and
- Eliminating the financial stress of maintaining medication.

Such results can reinforce a person's decision for stopping their medications. However, these “benefits” usually last only a short time and are soon overshadowed by adverse effects.
C. Mediating Workable Solutions

Listen to the resident’s reasons for not wanting to take or not taking their medication

A multinational survey showed that psychiatric medical professionals may underestimate the frequency of extrapyramidal side effects (see p. 73) and hormonal side effects, such as impotence, often associated with the older generation of antipsychotic agents. Patient concerns about movement disorders and sexual dysfunction were common, but many felt that these problems were overlooked by their doctors.

Ignoring or minimizing these communications or assuming that a person is unreliable in his/her perceptions will only further the chances that a person will not remain on medication. Their experience is real in their life, and addressing these issues can only help.

Discuss medications from the perspective of the person’s life

It is important to discuss the use of medications from the perspective of a person’s life. Taking medication must be meaningful in light of what a person wants for the quality of her/his life.

For example, telling someone that taking medication will help them think more clearly and eliminate unwanted voices may be less important to him/her than understanding the medication will allow him/her to participate in an activity that s/he loves, such as reading, because the medications will improve the concentration needed for reading.

Explore solutions that are acceptable to and workable for him/her

When there are problems with a medication or medication schedule, explore solutions that will not only alleviate the problems, but will make sense to the person and will be workable within his/her day-to-day life. Solutions that do not satisfy the personal needs of an individual may only lead to further problems.

If the person wants to take medications, find the resources necessary for him/her to have success in doing so. People that clearly want to take medication because of the benefits they experience should get all the support possible to have that opportunity. Being persistent in helping them obtain the resources they need may be the only barrier to overcome. However, it can be a significant barrier.
Provide available information about their diagnosis and medications

According to the literature, providing people with the information they need to make choices and decisions that work within the context of their life will only increase the chances that they will take medication as prescribed. The concern among some individuals that providing information will lead to a greater problem with adherence because of fear resulting from receiving information has not been substantiated by the research. Actually, more information has generally meant higher rates of treatment adherence.

Use the available supports such as the following:

- Psychoeducational groups in the local community mental health center;
- Collaborative efforts to identify problems and set achievable goals;
- Behavioral modeling and reinforcement with the use of Peer Educators;
- Reliable health care linkages;
- Information sharing that is available and accessible to residents; and
- Collaborative to foster motivation for self-management.

Be accepting of a person’s views regarding their medications, and always leave the door open for discussion

Even when a person has been provided clear explanations and information about her/his diagnosis and treatments, s/he may still view medication negatively. Avoid coercion when a person’s decision regarding medication is definitive. This is true for all of us when we make decisions that we believe are in our best interest. Be respectful and accepting, but offer an invitation to discuss it further if s/he should change his/her mind.

Working with your residents in a way that recognizes their right to choose, providing the information and tools to make these choices, and accepting these choices without withdrawing support will go a long way in facilitating medication adherence.

III. MEDICATIONS

Psychiatric medications are given to people to decrease the symptoms of their mental disorder. Each person diagnosed with a mental disorder has a different set of symptoms, and each medication helps a certain set of symptoms. Elavil, Prozac, Zoloft, and Paxil are some examples of medications that help people who have symptoms of depression. People taking these medications might have symptoms such as poor appetite, difficulty sleeping, thoughts of wanting to die, negative thoughts about themselves, or loss of interest in doing activities that they usually like. These same medications would not help someone experiencing symptoms of psychosis, such as hearing voices that no one else hears or believing that they are being followed by the CIA. Medications prescribed for residents should be reviewed on a periodic basis by a physician. Let’s examine the difference between a brand name and generic name, understanding what we treat and some common medications.

A. The Difference Between Brand Name and Generic Name

When a prescription is filled by a pharmacy, the medication name on the prescription bottle will either be the brand name or the generic name. The brand name is the name the company making the medication gives it, and the generic name is the chemical name given to it when it is developed. Generic medications are usually cheaper.

It is a good idea to know the generic and brand names for a particular medication. The medication’s chemical compositions is basically the same whether it is the generic or the brand name. They will look different, so if a person gets medication that looks different than what they are used to, talk to the pharmacist. The pharmacist will make sure it is the right medication and tell the person whether it is the generic or brand form. Here are some examples of brand names and generic names.

<table>
<thead>
<tr>
<th>Brand name</th>
<th>Generic name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elavil</td>
<td>Amitriptyline</td>
</tr>
<tr>
<td>Norprimin</td>
<td>Desipramine</td>
</tr>
<tr>
<td>Tofranil</td>
<td>Imipramine</td>
</tr>
</tbody>
</table>
B. Understanding What We Treat

There are three primary categories of psychiatric illness: mood disorders, thought disorders, and anxiety disorders. Other categories include attention deficit/hyperactivity disorders, dementing disorders, and substance abuse disorders.

Medications do not cure these disorders, but help reduce or eliminate their symptoms. So, being familiar with the symptoms of a disorder helps you to understand the medication a resident takes for those symptoms.

Another important thing to understand about medications is that people react differently to the medications they take. For example, two people may have similar symptoms and take the same medication. One person feels better and the other does not. One person may have side effects from a medication, and another person taking the same medication will not have side effects.

A person should only take the medication that has been prescribed especially for them by a doctor and should never take someone else’s medication. If a person does not think their medication is helping to reduce their symptoms, or the side effects they are having are too uncomfortable, then they should make an appointment to visit the doctor and discuss these problems.

C. Common Medications

Examples of common medications given to decrease the symptoms of depression (e.g., trouble concentrating, sleeping too much or too little, loss of enjoyment, loss of interest in doing things, thoughts of wishing to die, eating too much or too little) include the following:

<table>
<thead>
<tr>
<th>Brand name</th>
<th>Generic name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prozac</td>
<td>Fluoxetine</td>
</tr>
<tr>
<td>Zoloft</td>
<td>Sertraline</td>
</tr>
<tr>
<td>Paxil</td>
<td>Paroxetine</td>
</tr>
<tr>
<td>Celexa</td>
<td>Citalopram</td>
</tr>
<tr>
<td>Lexapro</td>
<td>Escitalopram</td>
</tr>
<tr>
<td>Wellbutri</td>
<td>Bupropion</td>
</tr>
<tr>
<td>Remeron</td>
<td>Mirtazapine</td>
</tr>
<tr>
<td>Effexor</td>
<td>Venlafaxine</td>
</tr>
<tr>
<td>Pristiq</td>
<td>Desvenlafaxine</td>
</tr>
<tr>
<td>Cymbalta</td>
<td>Duloxetine</td>
</tr>
<tr>
<td>Elavil</td>
<td>Amitriptyline</td>
</tr>
<tr>
<td>Norpramin</td>
<td>Desipramine</td>
</tr>
<tr>
<td>Tofranil</td>
<td>Imipramine</td>
</tr>
<tr>
<td>Pamelor</td>
<td>Nortriptyline</td>
</tr>
<tr>
<td>Sinequan</td>
<td>Doxepin</td>
</tr>
<tr>
<td>Desyrel</td>
<td>Trazodone</td>
</tr>
</tbody>
</table>
Common medications given to decrease symptoms of anxiety (e.g., intense fears, panic, repeating thoughts, stomachaches, fast breathing and heartbeat, tremors) include the following:

<table>
<thead>
<tr>
<th>Brand name</th>
<th>Generic name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valium</td>
<td>Diazepam</td>
</tr>
<tr>
<td>Xanax</td>
<td>Alprazolam</td>
</tr>
<tr>
<td>Ativan</td>
<td>Lorazepam</td>
</tr>
<tr>
<td>Klonopin</td>
<td>Clonazepam</td>
</tr>
<tr>
<td>Librium</td>
<td>Chlordiazepoxide</td>
</tr>
<tr>
<td>Serax</td>
<td>Oxazepam</td>
</tr>
<tr>
<td>Tranxene</td>
<td>Clorazepate</td>
</tr>
<tr>
<td>Centrax</td>
<td>Prochlorperazine</td>
</tr>
<tr>
<td>Vistaril</td>
<td>Hydroxyzine</td>
</tr>
<tr>
<td>Buspar</td>
<td>Buspirone</td>
</tr>
</tbody>
</table>

Common medications given to decrease symptoms of psychosis (e.g., hallucinations, delusions, disorganized thinking) include the following:

<table>
<thead>
<tr>
<th>Brand name</th>
<th>Generic name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risperdal</td>
<td>Risperidone</td>
</tr>
<tr>
<td>Zyprexa</td>
<td>Olanzapine</td>
</tr>
<tr>
<td>Seroquel</td>
<td>Quetiapine</td>
</tr>
<tr>
<td>Geodon</td>
<td>Ziprasidone</td>
</tr>
<tr>
<td>Abilify</td>
<td>Aripiprazole</td>
</tr>
<tr>
<td>Invega</td>
<td>Paliperidone</td>
</tr>
<tr>
<td>Saphris</td>
<td>Asenapine</td>
</tr>
<tr>
<td>Fanapt</td>
<td>Iloperidone</td>
</tr>
<tr>
<td>Clozaril</td>
<td>Clozapine</td>
</tr>
<tr>
<td>Haldol</td>
<td>Haloperidol</td>
</tr>
<tr>
<td>Prolixin</td>
<td>Fluphenazine</td>
</tr>
<tr>
<td>Stelazine</td>
<td>Trifluoperazine</td>
</tr>
<tr>
<td>Thorazine</td>
<td>Chlorpromazine</td>
</tr>
<tr>
<td>Trilafon</td>
<td>Perphenazine</td>
</tr>
<tr>
<td>Navane</td>
<td>Thiothixene</td>
</tr>
<tr>
<td>Loxitane</td>
<td>Loxapine</td>
</tr>
<tr>
<td>Moban</td>
<td>Molindone</td>
</tr>
<tr>
<td>Mellaril</td>
<td>Thioridazine</td>
</tr>
</tbody>
</table>
Common medications given to help stabilize a person’s mania with symptoms (e.g., not sleeping for several nights, frantic highs, drastic lows) include the following:

<table>
<thead>
<tr>
<th>Brand name</th>
<th>Generic name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lithium</td>
<td>Lithobid, Lithium</td>
</tr>
<tr>
<td>Eskalith</td>
<td>Lithium</td>
</tr>
<tr>
<td>Tegretol</td>
<td>Carbamazepine</td>
</tr>
<tr>
<td>Depakote</td>
<td>Divalproex, Valproic Acid</td>
</tr>
</tbody>
</table>

The following medications are used to treat alcohol withdrawal symptoms. Alcohol is the most dangerous of the substance abuse withdrawal syndromes and is the only syndrome that can lead to death. The withdrawal symptoms that are of most concern are delirium tremens, hallucinations, and seizures.

<table>
<thead>
<tr>
<th>Brand name</th>
<th>Generic name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tegretol</td>
<td>Carbamazepine</td>
</tr>
<tr>
<td>Neurontin</td>
<td>Gabapentin</td>
</tr>
<tr>
<td>Serax</td>
<td>Oxazepam</td>
</tr>
<tr>
<td>Ativan</td>
<td>Lorazepam</td>
</tr>
<tr>
<td>Valium</td>
<td>Diazepam</td>
</tr>
</tbody>
</table>

Medications for alcohol abstinence and maintainence include the following:

<table>
<thead>
<tr>
<th>Brand name</th>
<th>Generic name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antabuse</td>
<td>Disulfiram</td>
</tr>
<tr>
<td>ReVia, Vivitrol</td>
<td>Naltrexone</td>
</tr>
<tr>
<td>Campral</td>
<td>Acamprosate</td>
</tr>
</tbody>
</table>

Medications used to treat Heroin and other opiate withdrawal symptoms include the following:

<table>
<thead>
<tr>
<th>Brand name</th>
<th>Generic name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dolophine</td>
<td>Methadone</td>
</tr>
<tr>
<td>ReVia</td>
<td>Naltrexone</td>
</tr>
<tr>
<td>Reves</td>
<td>Naimefene</td>
</tr>
<tr>
<td>Catapres</td>
<td>Clonidine</td>
</tr>
<tr>
<td>Buprenex, Subutex</td>
<td>Buprenorphine</td>
</tr>
</tbody>
</table>
Medications use for Heroin and other opiate abstinence and maintainence include the following:

<table>
<thead>
<tr>
<th>Brand name</th>
<th>Generic name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dolophine</td>
<td>Methadone</td>
</tr>
<tr>
<td>ReVia, Vivitrol</td>
<td>Naltrexone</td>
</tr>
<tr>
<td>ORLAAM</td>
<td>LAAM</td>
</tr>
<tr>
<td>Buprenex, Subutex</td>
<td>Buprenorphine</td>
</tr>
<tr>
<td>Narcan</td>
<td>Naloxone</td>
</tr>
</tbody>
</table>

Medications used for Nicotine withdrawal symptoms and cravings include the following:

- Nicorette
- Habitrol, Nicotrol, Nicoderm-CQ
- Nicotrol Inhaler
- Nicotrol Nasal Spray

Medications used for Nicotine abstinence and maintainence:

<table>
<thead>
<tr>
<th>Brand name</th>
<th>Generic name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zyban</td>
<td>Bupropion</td>
</tr>
<tr>
<td>Chantix</td>
<td>Varenicline</td>
</tr>
</tbody>
</table>

**IV. SIDE EFFECTS**

All medications can have potential side effects. Side effects are the undesirable physical effects from taking a medication. For example, the same medication taken for a stuffy nose and congestion can also cause drowsiness. The drowsiness is a side effect.

Medications for a mental disorder can also have side effects. Dry mouth is a common side effect of these types of medications. In fact, there are actions a person can take to make these side effects more tolerable. Here are some examples:

**Constipation**  
Eat plenty of leafy green vegetables, bran cereals, and fruits daily. Take daily walks or exercise.

**Sun Sensitive Skin**  
Use strong sun block lotion, wear long sleeve shirts, long pants, and hats. This is very important because a person can
develop a second degree burn in 15-20 minutes of sun exposure.

Dry Mouth Suck on hard candy, sip water often.

A. Common Side Effects

Some side effects, known as extrapyramidal side effects, can cause problems to the body’s nervous system, such as the following:

- Muscle spasms;
- Muscle tremors (shaking); and
- Restlessness.

These side effects can often be treated with special medications. The most common medications used to treat these side effects are as follows:

<table>
<thead>
<tr>
<th>Brand name</th>
<th>Generic name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cogentin</td>
<td>Benztropine</td>
</tr>
<tr>
<td>Artane</td>
<td>Trihexyphenidyl</td>
</tr>
<tr>
<td>Symmetrel</td>
<td>Amantadine</td>
</tr>
<tr>
<td>Benadryl</td>
<td>Diphenhydramine</td>
</tr>
</tbody>
</table>

B. Side Effects that Cause Problems to the Nervous System

Other side effects may not be life threatening but are uncomfortable. Examples include nausea, diarrhea, or difficulty with sexual performance. If a person is having very uncomfortable side effects, then they should talk to a doctor to change their medication or dosage.

Some side effects cause problems with a person’s thinking such as confusion or memory problems.

Tardive dyskinesia is another especially concerning side effect. This side effect includes symptoms such as the following:

- Facial tics;
- Eye blinking;
- Tongue thrusting;
- Shuffled gait;
- Moving one’s head to the back or to the side.
What is particularly worrisome about this side effect is that the person cannot control these muscle movements. Also, the side effects can become permanent and lead to breathing problems, difficulty eating because of swallowing problems, mouth sores, and trouble standing or walking. If you notice any of these symptoms, seek immediate medical attention.

C. Life Threatening Side Effects

Some side effects are dangerous and can be life threatening. Most of these side effects are rare, but it is important to know what they are and what to do if someone is having them.

Neuroleptic Malignant Syndrome

The body’s nervous system begins to shut down. This is rare, but can occur anytime while the person is on the medication. It is most often associated with medications that are given for symptoms of psychosis.

If a person is having this side effect, then they would have some or all of the following symptoms:

- Very stiff muscles;
- Fever;
- Fast heartbeat;
- Fast breathing; and/or
- Heavy sweating;
- Confusion.

Agranulocytosis

Agranulocytosis occurs when the body stops making the blood cells that fight infection. This is also rare, but less rare than neuroleptic malignant syndrome. It can also occur anytime while someone is on the medication. The medications that it occurs with most often are Clozaril (generic name Clozapine) and Tegretol (generic name Carbamazepine), though it can occur with any of the medications given for psychosis. If a person is having this side effect, then they would have some or all of the following symptoms:

- High fever;
- Extreme weakness;
- Red and painful inside mouth;
- Sides of neck are swollen; and/or
- Sore throat.

Lithium Toxicity

Lithium toxicity occurs when the body has too much lithium. Although this can happen because the dosage of lithium is too high, lithium toxicity
can also occur when the person taking lithium becomes dehydrated. A person can become dehydrated from diarrhea, too much alcohol, a really bad sunburn, vomiting, or anything that causes the person to lose a lot of body fluids.

If the person is lithium toxic, then they would have some or all of the following symptoms:

- Mental confusion;
- Slurred speech;
- Vomiting;
- Severe diarrhea;
- Severe muscle tremors;
- Severe drowsiness; and/or
- Poor coordination;
- Severe muscle tremors;
- Coma.

All these side effects listed in section C are medical emergencies, and the symptoms should alert you to call the doctor or 911 immediately.

Older adults who have dementia and take antipsychotics such as Zyprexa/olanzapine have an increased chance of death during treatment. They may also have a greater chance of having a stroke or mini-stroke during treatment. The FDA has not approved these medications for behavioral problems in older adults with dementia.

V. GENERAL MEDICATION INFORMATION

A. Precautions

The following precautions are important to know:

- It is dangerous to drink alcohol when taking medications. When alcohol is in the blood, it makes some medications stronger. The body thinks it is getting extra medication, and therefore drinking alcohol when on some of these medications can cause an overdose.

- Medications can be harmful to an unborn child during pregnancy.

- Mixing prescription and nonprescription medications can be dangerous.

B. Over-the-Counter Drugs

- Medicines that can be bought without a prescription can be used for minor ailments and are usually but not always safe and effective.
• They can interact with other medicines and make some conditions worse. In older adults, these negative interactions between medications can occur more quickly and become an emergency.

• When a person uses a medicine bought without a prescription, make sure they have asked their doctor or a pharmacist if the medicine can be taken with the prescription medication they are already taking.

• Over-the-counter medications that you should be especially worried about are the ones that contain the following:
  - Alcohol;
  - Antihistamine (in cold remedies);
  - Aspirin;
  - Decongestant;
  - Potassium;
  - Salt (sodium); and
  - Sugar (sucrose).

• Medicines that contain these ingredients can be harmful if a person is also taking medications for the following:
  - Mental disorders;
  - Arthritis;
  - Diabetes;
  - Glaucoma;
  - Heart condition;
  - High blood pressure;
  - Kidney condition; and
  - Sleep problems.

Encourage people to read the labels of over-the-counter medications they purchase and to check with the pharmacist to make sure there are no dangerous reactions that could occur.

Negative interactions can occur not only between psychiatric medications and over-the-counter drugs, but also between psychiatric medications and prescription drugs, that are taken for medical conditions. It is very important that a person informs their psychiatrist of any other medication they are taking, whether it is over-the-counter or prescribed by a medical doctor for a medical condition. Also, it is best that they inform
their medical doctor of the psychiatric medications they are taking. This will help both the psychiatrist and the medical doctor avoid putting someone on medications that can cause harmful effects when they are taken together. It is helpful to have the psychiatrist indicate in writing what over the counter medications (and their dosages) may be taken for common ailments (such as colds).

**Chewable tablets**

Chewable tablets should *always* be chewed before swallowing and should *never* be swallowed whole. When they are not chewed they simply pass through the intestines without fully dissolving, so the person does not get any benefit from the medication. People who have dentures sometimes don’t like chewable tablets because they interfere with their dentures.

**Tablets and capsules**

These are meant to be swallowed. Some people prefer that they be crushed in food. They can be given this way as long as they are taken immediately after mixing.

**Long acting tablets**

They should *not* be crushed and should *always* be swallowed whole. They are made to let stomach and intestinal digestion slowly release the medication.

**Liquids**

Liquids are difficult to measure. Be sure a measuring instrument specifically designed for measuring medication is available.

**“Fizzy” medicines**

Medicines that fizz are very high in sodium. These medicines will not be good for someone who is on a low salt diet or has high blood pressure. A pharmacist should be asked before using these types of medicines.

**Injectable medicines**

Some people may receive their medications by injection once a week or once every two weeks. The only medications that can be given by injection are Haldol (generic name Haloperidol) and Prolixin (generic name Fluphenazine). These injectable medications are time-released in the body so that they will work during the time between injections. These medications may be required for someone who has difficulty taking medications. Additional considerations include the following:
• Only the doctor should change the dosage. The dosage of medication should never be changed without talking to the doctor first.

• Medication should never be shared with another person. What medication works well for one person may be harmful to another person.

• One person’s dosage of medication should never be used to provide another person’s dosage of medication, even if they are on the same medication. A bottle of medication is only prescribed to last until the next doctor’s appointment. Using anybody’s medication for someone else means they will run out before they can get more. This may set up a situation where their symptoms will return before they can see a doctor.

C. Preparing to See the Doctor

When a person at your facility is going to see the doctor, you can help them to prepare by suggesting that they write the following:

• Anything that is bothering them about the medication or any complaints they may have.

• How long it has been occurring (i.e., when it started).

• A list of all the medications they use, including aspirin, laxatives, vitamins, etc.

• Bring medicine with you to the doctor when you see him/her for any reason.

• A list of any allergies they may have.

• A list of any poor reactions to medications they have taken in the past.

When a person is prescribed a new medication, these are some of the questions they can ask the doctor include the following:

• What is the name of the medication?

• When will the medication begin to help?

• How will I know it is helping?

• Are there any side effects?
• When and how often will it need to be taken?
• How long will the medication have to be taken?
• How much will it cost?
• Is there a good generic at a lower cost?

If you have to supervise people taking their medication or give them their medications, be sure to:

• Keep a list of all the prescription medications each person is taking, including the dosages and the times they are to be taken each day.
• Know when changes have been made to a person’s medications by the doctor.
• Know all the nonprescription and over-the-counter medications a person is taking.
• Whenever possible, encourage each person to have their prescriptions filled by the same pharmacy. This enables the pharmacist to become familiar with the person and the medications they are taking.
• If a person’s physical or mental condition changes, report this to the doctor, nurse or pharmacist immediately since the medications they are taking could be causing the changes.
• If a mistake is made when someone is taking their medication, don’t be afraid to report it to the doctor or a nurse. Some mistakes can be harmful, and they will know what steps to take next. Not reporting a mistake might make it worse.

D. Knowing the Residents In Your Facility

Among your handouts is a Personal Information Sheet that you can use to keep track of medication information on the residents if you don’t already have a method. This sheet is just one example of an easy way to keep track of medication information. Feel free to make copies for your use if you think it will be helpful.

If you are concerned that there is a behavioral or physiological change in someone, try to talk with this person and ask questions such as the following:
• How are you feeling? I have noticed you are spending more time in your room.

• How are you feeling? I have noticed you are sleeping more than usual.

• How are you feeling? Are you hearing voices that are bothering you?

• How are you feeling? I have noticed that you and I are arguing more.

Let them know what you are seeing them do or hearing them say that concerns you, and ask them what they might need that will help them. There are many reasons that a medication might not be helping. For example:

• They are taking the right medication, at the right dose, at the right times, and through the right route but it isn’t helping the symptoms enough.

• They have run out of medications and have missed too many doses.

• They were having side effects that were very upsetting to them, so they stopped taking the medications.

• They look like they are taking their medications, but actually they are keeping it in their mouth and then spitting it out when they are alone.

Report change that is noticeable in a person. Don’t be afraid to call their doctor. The doctor might be irritated, but that’s OK. Call anyway and tell them what you are concerned about and what you have been seeing a person do or hearing a person say. If the doctor is not available, then ask for a nurse.

When families have questions about a person’s medication, give them the name and number of a psychiatric nurse or the person’s psychiatrist that can answer their questions. It is best not to try to give any information that you are not confident in giving.

The more you educate yourself about the medications that people in your facility take and involve them to resolve individual problems with medications that arise, the more manageable the day-to-day responsibilities with medications will be.
E. Prevention

Have a plan for your residents. If residents have a case manager, then the plan can be developed with the case manager. If the resident does NOT have a case manager, then an initial plan can be developed by asking the following:

- “What does it look like when you start having symptoms?”
- “What can you do when you begin to feel your medicine is not working?”

Also materials on advanced directives (pp. 124-125 and Appendix A).
Course Goal

To review practical information about psychotropic medications to help you in your daily interactions with mental health residents

The Challenge

- There are approximately 120 commonly used psychotropic medications
- There are at least that many psychiatric diagnoses
- But less is more—we will condense all of this to a few key points
**Brand Name versus Generic**

- Medications have a 17-20 year patented life span
- Once it becomes generically available, the medication is often referred to by either its brand name or generic name
- Prescription bottles will sometimes **but not always** have the brand name identified

**Medication Adherence**

**Medication Adherence**
- Person-centered
- Collaboration
- Open communication
- Goal: resident self-mastery
- Activities negotiated
- Rules matched to lifestyle by mutual agreement
- Discuss, negotiate, motivate
- Viewing resistance as information to make adaptations

**Medication Compliance**
- Clinician-centered
- Dominance
- Information dictated
- Goal: resident obedience
- Activities dictated
- Rules dictated
- Persuade, coerce
- Resistance is not tolerated

**Medication Non-Adherence**

- Taking less medication than prescribed
- Taking more medications than prescribed
- Altering the pattern of use prescribed for a medication
- Stop taking a medication altogether
Factors that Affect Adherence to Medication Treatment

- Having to take medications over an indefinite period of time
- Onset and persistence of side effects
- Complex medication schedules
- Interruptions in medication taking routines
- Difficulty with mental processes that help with organization
- Lack of information about the medications they are taking
- Lack of trust/confidence in the psychiatric professionals
- Financial hardships

Adverse Results of Not Taking Medication as Prescribed

- Unwanted symptoms return
- A loss or interruption to the gains a person may have made regarding housing, employment, education, etc.
- Education, and social support from family and friends.
- Hospitalization or re-hospitalization
- Greater difficulty re-stabilizing on medication
- Homelessness
- Encounters with law enforcement
- Accidental overmedication or overdose

Adverse Results of Not Taking Medication as Prescribed

- Initially feeling better and more normal (e.g., thinking more clearly, regaining affect and spontaneity)
- Regaining a sense control over choices/decisions regarding illness and other life issues
- Gaining first-hand experience of “off medication vs. on medication”
- Eliminating the financial stress of maintaining medication
Chapter 2

Mediating Workable Solutions

- Listen to the resident’s reasons for not wanting to take or not taking their medication as prescribed
- Discuss medications from the perspective of the person’s life
- Explore solutions that are acceptable to and workable for the resident
- Provide available information about their diagnosis and medications
- Be accepting of a person’s views regarding their medications, and always leave the door open for discussion

Provide Information and Educate

- Psychoeducational groups in the local community mental health center
- Make collaborative efforts to identify problems and set achievable goals
- Provide behavioral modeling and reinforcement with the use of Peer Educators
- Set up reliable health care linkages
- Stress information sharing that is available and accessible to residents
- Use a collaborative process to foster motivation for self-management

Understanding What We Treat

There are three primary categories of psychiatric illness:

- Mood disorders
- Thought disorders
- Anxiety disorders

And…
Chapter 2

Slide 13

Everything Else

- Attention/Hyperactivity disorders (usually children and adolescents)
- Dementing disorders (usually the elderly)
- And NEVER FORGET, Substance Use Disorders

Slide 14

Mood Disorders:
Depression Symptoms

- Trouble concentrating
- Sleeping too much or too little
- Loss of enjoyment
- Loss of interest in doing things
- Thoughts of wishing to die
- Eating too much or too little

Slide 15

Antidepressants:
Newer | Older

<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Brand</th>
<th>Generic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prozac</td>
<td>Fluoxetine</td>
<td>Elavil</td>
<td>Amitriptyline</td>
</tr>
<tr>
<td>Zoloft</td>
<td>Setaline</td>
<td>Norpramin</td>
<td>Desipramine</td>
</tr>
<tr>
<td>Paxil</td>
<td>Paroxetine</td>
<td>Tofranil</td>
<td>Imipramine</td>
</tr>
<tr>
<td>Celexa</td>
<td>Citalopram</td>
<td>Pamela</td>
<td>Nortriptyline</td>
</tr>
<tr>
<td>Lexapro</td>
<td>Escitalopram</td>
<td>Sinequan</td>
<td>Desyrel</td>
</tr>
<tr>
<td>Wellbutri</td>
<td>Bupropion</td>
<td>Bupropion</td>
<td>Trazodone</td>
</tr>
<tr>
<td>Remeron</td>
<td>Mirtazapine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effexor</td>
<td>Venlafaxine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pristiq</td>
<td>Desvenlafaxine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cymbalta</td>
<td>Duloxetine</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Anxiety Disorders

- Strong fears, sometimes sudden and overwhelming
- Nervousness
- Constant repetitive thoughts
- Stomach aches and diarrhea
- Shortness of breath and rapid heartbeat, sweating
- Lightheadedness and dizziness
- Insomnia

### Anti-Anxiety Medications

<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Brand</th>
<th>Generic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valium</td>
<td>Diazepam</td>
<td>Vistaril</td>
<td>Hydroxyzine</td>
</tr>
<tr>
<td>Xanax</td>
<td>Alprazolam</td>
<td>Buspar</td>
<td>Buspirone</td>
</tr>
<tr>
<td>Ativan</td>
<td>Lorazepam</td>
<td>NOT CONTROLLED</td>
<td></td>
</tr>
<tr>
<td>Klonopin</td>
<td>Clonazepam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Librium</td>
<td>Chlordiazepoxide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serax</td>
<td>Oxazepam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tranxene</td>
<td>Clorazepate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Centrax</td>
<td>Prochlorperazine</td>
<td>CONTROLLED</td>
<td></td>
</tr>
</tbody>
</table>

### Thought Disorders: Psychosis

- A loss of touch with reality

- Includes hallucinations such as:
  - Hearing voices that no one else can hear
  - Seeing people or things that no one else can see
Mood Disorders:
Bipolar Disorder

- Frantic highs, drastic lows
- Mania: grandiosity, euphoria, markedly decreased need for sleep, rapid and pressured speech, racing thoughts, increased activity or severe agitation, impulsive with poor judgment—may progress to psychosis.
- Hypomania: talkative, irritable, increased energy and mental productivity, decreased need for sleep, elated, mildly grandiose

Thought Disorders:
Psychosis (cont’d.)

- Delusions: a fixed, false belief, such as:
  - Thinking that there are people who are planning and organizing to harm them in some way
  - Thinking one has special powers, often religious

Common Antipsychotic Medications

<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Brand</th>
<th>Generic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risperdal</td>
<td>Risperidone</td>
<td>Haldol</td>
<td>Haloperidol</td>
</tr>
<tr>
<td>Zyprexa</td>
<td>Olanzapine</td>
<td>Prolinix</td>
<td>Fluphenazine</td>
</tr>
<tr>
<td>Seroquel</td>
<td>Quetiapine</td>
<td>Stelazine</td>
<td>Trifluoperazine</td>
</tr>
<tr>
<td>Geodon</td>
<td>Ziprasidone</td>
<td>Thorazine</td>
<td>Chlorpromazine</td>
</tr>
<tr>
<td>Abilify</td>
<td>Aripiprazole</td>
<td>Trilafon</td>
<td>Perphenazine</td>
</tr>
<tr>
<td>Invega</td>
<td>Paliperidone</td>
<td>Navane</td>
<td>Thiothixene</td>
</tr>
<tr>
<td>Saphris</td>
<td>Asenapine</td>
<td>Loxitane</td>
<td>Loxapine</td>
</tr>
<tr>
<td>Fanapt</td>
<td>Iloperidone</td>
<td>Moban</td>
<td>Molindone</td>
</tr>
<tr>
<td>Clozaril</td>
<td>Clozapine</td>
<td>Mellaril</td>
<td>Thoridazine</td>
</tr>
</tbody>
</table>

2nd GENERATION 1st GENERATION
## Medications to Stabilize Mood

<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lithium, Lithobid, Eskalith</td>
<td>Lithium</td>
</tr>
<tr>
<td>Tegretol, Equetro, Carbatrol</td>
<td>Carbamazepine</td>
</tr>
<tr>
<td>Depakote, Depakene</td>
<td>Valproic acid, Divalproex</td>
</tr>
<tr>
<td>Lamictal</td>
<td>Lamotrigine</td>
</tr>
<tr>
<td>Trileptal</td>
<td>Oxcarbazepine</td>
</tr>
<tr>
<td>Topamax</td>
<td>Topiramate</td>
</tr>
</tbody>
</table>

## Medication to Treat Alcohol Withdrawal

<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tegretol</td>
<td>Carbamazepine</td>
</tr>
<tr>
<td>Neurontin</td>
<td>Gabapentin</td>
</tr>
<tr>
<td>Serax</td>
<td>Oxazepam</td>
</tr>
<tr>
<td>Ativan</td>
<td>Orazepam</td>
</tr>
<tr>
<td>Valium</td>
<td>Diazepam</td>
</tr>
</tbody>
</table>

## Medication for Alcohol Abstinence and Maintenance

<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antabuse</td>
<td>Disulfiram</td>
</tr>
<tr>
<td>ReVia, Vivitrol</td>
<td>Naltrexone</td>
</tr>
<tr>
<td>Campral</td>
<td>Acamprosate</td>
</tr>
</tbody>
</table>
### Medication for Heroin and other Opiate Withdrawal

<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dolophine</td>
<td>Methadone</td>
</tr>
<tr>
<td>ReVia</td>
<td>Naltrexone</td>
</tr>
<tr>
<td>Revox</td>
<td>Naimefene</td>
</tr>
<tr>
<td>Catapres</td>
<td>Clonidine</td>
</tr>
<tr>
<td>Buprenex, Subutex</td>
<td>Buprenorphine</td>
</tr>
</tbody>
</table>

### Medication for Heroin and other Opiate Abstinence & Maintenance

<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dolophine</td>
<td>Methadone</td>
</tr>
<tr>
<td>ReVia, Vivitrol</td>
<td>Naltrexone</td>
</tr>
<tr>
<td>ORLAAM</td>
<td>LAAM</td>
</tr>
<tr>
<td>Buprenex, Subutex</td>
<td>Buprenorphine</td>
</tr>
<tr>
<td>Narcan</td>
<td>Naloxone</td>
</tr>
</tbody>
</table>

### Medications used for Nicotine Withdrawal and Cravings

<table>
<thead>
<tr>
<th>Brand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nicorette</td>
</tr>
<tr>
<td>Habitrol, Nicotrol</td>
</tr>
<tr>
<td>Nicoderm-CQ</td>
</tr>
<tr>
<td>Nicotrol Inhaler</td>
</tr>
<tr>
<td>Nicotrol Nasal Spray</td>
</tr>
</tbody>
</table>
Medications used for Nicotine Abstinence & Maintenance

<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zyban</td>
<td>Bupropion</td>
</tr>
<tr>
<td>Chantix</td>
<td>Varenicline</td>
</tr>
</tbody>
</table>

Common Side Effects

- blurred vision
- weight gain
- dry mouth
- confusion
- constipation
- headaches
- nervousness
- difficulty sleeping
- nausea
- diarrhea
- clumsiness
- sleepiness
- fast heartbeat
- shaking or tremors
- stiff muscles
- muscle spasms
- restlessness
- difficulty urinating

- Sensitive skin that can burn easily in the sun
- Dizziness when going from sitting or lying to standing
- Changes in a woman’s monthly period
- Difficulty having an erection
Chapter 2

Examples of Managing Side Effects

<table>
<thead>
<tr>
<th>Condition</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constipation</td>
<td>Eat plenty of leafy green vegetables, bran cereals, and fruits daily. Drink plenty of fluids and get exercise.</td>
</tr>
<tr>
<td>Sun sensitive skin</td>
<td>Use good sun block lotion, wearing long sleeve shirt, long pants, and hats. This is very important because a person can develop a 2nd degree burn in 15-20 minutes of sun exposure.</td>
</tr>
<tr>
<td>Dry mouth</td>
<td>Suck on sugarless hard candy, chew sugarless gum, sip water often.</td>
</tr>
</tbody>
</table>

Next, More Serious Side Effects

- Tardive dyskinesia: from older antipsychotic medications
- Diabetes: from newer antipsychotic medications, often but not always associated with weight gain

Tardive Dyskinesia

- Facial tics
- Eye blinking
- Tongue thrusting
- Shuffled gait
- Facial grimacing
- Lip smacking
- Foot tapping
- Head nodding

These symptoms can become permanent and lead to:
- Breathing problems
- Mouth sores
- Trouble standing or walking
- Difficulty eating because of swallowing problems
Chapter 2

Diabetes

- Complications of diabetes:
  - cardiovascular disease
  - stroke
  - kidney failure
  - blindness
  - nerve damage
  - coma
  - bacterial/fungal infections
  - amputation

Finally, Life Threatening Side Effects

- Neuroleptic malignant syndrome—from both older and newer antipsychotic medications
- Agranulocytosis—from carbamazepine, clozapine, possibly other medications
- Lithium toxicity—from lithium

Life Threatening Side Effects (cont’d)

Neuroleptic Malignant Syndrome occurs when the body’s nervous system begins to shut down:

rigid muscles, fever, fast heartbeat, fast breathing, heavy sweating, confusion

CALL THE DOCTOR OR 911 IMMEDIATELY
Agranulocytosis occurs when the body stops making the blood cells that fight infection:
- high fever
- sides of neck are swollen
- listlessness
- red and painful inside mouth
- sore throat

CALL THE DOCTOR OR 911 IMMEDIATELY

Lithium Toxicity occurs when the body has too much lithium:
- mental confusion
- slurred speech
- vomiting
- severe diarrhea
- severe muscle tremors
- severe drowsiness
- poor coordination
- coma

CALL THE DOCTOR OR 911 IMMEDIATELY

- No alcohol
- Pregnancy
- Over-the-counter medicines can be harmful
- Check with a pharmacist before using an over-the-counter medicine
- Only the doctor should change the dosage: The dosage of medication should never be changed without talking to the doctor first.
Chapter 2

Common Precautions (cont’d.)

- Be especially concerned about over-the-counter medicines that have the following ingredients:
  - alcohol
  - potassium
  - antihistamine
  - salt (sodium)
  - aspirin
  - sugar
  - decongestant

Tablets/Capsules

- Chewable tablets:
  Chewable tablets should always be chewed before swallowing and should never be swallowed whole.

- Tablets and capsules:
  These are meant to be swallowed. They can be crushed and put in food, as long as they are taken immediately after mixing.

- Long acting tablets:
  They should not be crushed and should always be swallowed whole. They are made to let stomach and intestinal digestion slowly release the medication into the body.

Liquids/Injectable

- Liquids:
  Liquids are difficult to measure. Be sure a measuring spoon specifically designed for measuring medication is available.

- Injectable medications:
  Some people may receive their medications by injection once a week or once every two weeks. The only medications that can be given by injection are Haldol, Prolixin, Risperdal Consta, and Invega Sustenna. These injectable medications are time released in the body so that they will work during the time in between injections. These may be given to someone when they are very unreliable about taking meds.
Never Share Medication

- Medication should never be shared.
  
a) Medication should never be shared with another person. What medication works well for one person may be harmful to another person.
  
b) One person’s dosage of medication should never be used to provide another person’s dosage of medication. A bottle of medication is only prescribed to last until the next doctor’s appointment. Using anybody’s medication for someone else means they will run out before they can get more. This may set up a situation where their symptoms will return before they can see a doctor.

Preparing to See the Doctor

When a person at your facility is going to see the doctor, you can help them prepare by suggesting they write:

- anything that is bothering them about the medication or any complaints they may have.
- how long has it been occurring?
- how did it start?

Preparing to See the Doctor (cont’d.)

- A list of all the medications they use including aspirin, laxatives, vitamins, etc.
- A list of any allergies they may have.
- A list of any poor reactions to medications they have taken in the past.
Questions to Ask:

When a person is prescribed a new medication, these are some of the questions to ask the doctor:

- What is the name of the medication?
- When will the medication begin to help?
- How will I know it is helping?
- Are there any side effects?

Questions to Ask:

- When and how often will it need to be taken?
- How long will the medication have to be taken?
- How much will it cost?
- Is there a good generic at a lower cost?

Important Information to have for each Resident:

- Keep a list of all the prescription medications the resident is taking including the dosages and the times they are to be taken each day.
- Know when changes have been made to the resident’s medications by the doctor.
- Know all the nonprescription and over the counter medications the resident is taking.
Important Information to have for each Resident:

- Encourage a resident to have his/her prescriptions filled by the same pharmacy.
- If a person’s physical or mental condition changes, report this to the doctor or pharmacist immediately since the medications they are taking could be causing the changes.

Mistakes

If a mistake is made when someone is taking their medication, don’t be afraid to report it to the doctor or a nurse. Some mistakes can be harmful and they will know what steps to take next. Not reporting a mistake might make it worse.

Some Reasons a Medication Might Not be Helping:

- They are taking the right medication, right dose, at the right times, but it isn’t helping the symptoms enough.
- They have run out of medications and have missed too many doses.
- They look like they are taking their medications, but actually they are keeping it in their mouth and then spitting it out when they are alone.
- The side effects are too difficult to put up with, so they have stopped taking the medication.
Changes/Concerns – Notify the Doctor

- Report change that is noticeable in a resident.

- Don’t be afraid to call their doctor. Tell them what you are concerned about and what you have been seeing a person do or hearing a person say.

- If the doctor is not available, ask for a nurse or medical assistant.
Legal and Ethical Issues
Assisted Living Facility Training for Limited Mental Health Licensure

Chapter 3

Paul G. Stiles, J.D., Ph.D.  
Associate Professor

Randy K. Otto, Ph.D.  
Associate Professor

Department of Mental Health Law and Policy  
Louis de la Parte Florida Mental Health Institute  
University of South Florida
Chapter Directions

Be sure to read the Introduction at the beginning of the manual before proceeding with the chapter presentations. A PowerPoint presentation for this chapter is available at www.BackerActTraining.org and is also printed at the end of this chapter.

Chapter Description

People working in and managing Florida’s ALFs may encounter a number of legal and ethical issues when providing care for residents who have a mental health disability. This section discusses the following nine issues.

1. Confidentiality;
2. Informed consent;
3. Resident Bill of Rights;
4. Right of Self Determination as it applies to guardianship;
5. Advanced Directives;
6. Mandatory abuse reporting;
7. Elopement
8. The role of the Ombudsman

Learning Objectives

Participants should be able to identify and discuss:

1. Important provisions of Florida Law and Rules regarding the limited mental health license and mental health coordinators in such facilities;

2. Two basic ethical principles (confidentiality and informed consent) and understand their application; and

3. Seven special areas of Florida law that ALF staff members are more likely to encounter as they carry out their caregiving duties.

Time Frame

90 minutes

Materials

LCD Projector/PowerPoint Slides
Handouts
Outline

I. Introduction.................................................................................104

II. Limited Mental Health License
    and Mental Health Coordinators.............................................104
    A. Florida Statutes..................................................................104
    B. Florida Administrative Code.............................................108

III. General Ethical Principles ....................................................113
    A. Confidentiality .................................................................114
    B. Informed Consent...............................................................115

IV. Seven Areas of Law Particularly Important for ALF Staff.....116
    A. Patient Bill of Rights.........................................................116
    B. The Right to Self Determination .......................................122
    C. Advanced Directives..........................................................124
    D. Reporting of Abuse and Neglect of
       Elderly Persons (Florida Statutes 415)..............................125
    E. Elopement .........................................................................127
    F. What is an “Ombudsman?”................................................127
Chapter 3

Slide 1

I. INTRODUCTION

Staff in Florida’s Assisted Living Facilities (ALFs) may encounter a number of legal and ethical issues when providing care for mentally disabled residents. This section first provides a general overview of the Florida Law and Rules governing limited mental health licensure and mental health coordinators, and then discusses five issues that caregivers should be aware of when working in a Florida ALF. The first two are general legal-ethical principles that should be observed while caring for residents and can help guide decision making when dealing with ethical dilemmas (confidentiality and informed consent); the last four are special areas of the law that ALF staff members are more likely to encounter as they carry out their caregiving duties (resident Bill of Rights, self determination/guardianship, elder abuse, and civil commitment).

II. THE LIMITED MENTAL HEALTH LICENSE AND MENTAL HEALTH COORDINATORS

- The “department” referred to below is the Florida Department of Children and Families.
- SSI is an abbreviation you may hear for “social security income.”
- OSS is an abbreviation you may hear for “optional state supplementation.”

A. Florida Statutes

394.4574

Department responsibilities for a mental health resident who resides in an assisted living facility that holds a limited mental health license.

(1) The term “resident with mental illness,” for purposes of this section, means an individual who receives social security disability income due to a mental illness as determined by the Social Security Administration or receives supplemental security income due to a mental illness as determined by the Social Security Administration and receives optional state supplementation.

(2) The department must ensure that:

(a) A resident with mental illness, has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or psychiatric nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted
living facility. The documentation must be provided to the administrator of the facility within 30 days after the resident with mental illness has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident if it was completed within 90 days prior to admission to the facility.

(b) A cooperative agreement, as required in s. 429.075, is developed between the mental health care services provider that serves a resident with mental illness and the administrator of the assisted living facility with a limited mental health license in which the mental health resident is living. Any entity that provides Medicaid prepaid health plan services shall ensure the appropriate coordination of health care services with an assisted living facility in cases where a Medicaid recipient is both a member of the entity’s prepaid health plan and a resident of the assisted living facility. If the entity is at risk for Medicaid targeted case management and behavioral health services, the entity shall inform the assisted living facility of the procedures to follow should an emergent condition arise.

(c) The community living support plan, as defined in s. 429.02, has been prepared by a mental health resident and a mental health case manager of that resident in consultation with the administrator of the facility or the administrator’s designee. The plan must be provided to the administrator of the assisted living facility with a limited mental health license in which the mental health resident lives. The support plan and the agreement may be in one document.

(d) The assisted living facility with a limited mental health license is provided with documentation that the individual meets the definition of a resident with mental illness.

(e) The mental health services provider assigns a case manager to each mental health resident who lives in an assisted living facility with a limited mental health license. The case manager is responsible for coordinating the development of and implementation of the community living support plan defined in s. 429.02. The plan must be updated at least annually.

(3) The Secretary of Children and Family Services, in consultation with the Agency for Health Care Administration, shall annually require each district administrator to develop, with community input, detailed plans that demonstrate how the district will ensure
the provision of state-funded mental health and substance abuse treatment services to residents of assisted living facilities that hold a limited mental health license. These plans must be consistent with the substance abuse and mental health district plan developed pursuant to s. 394.75 and must address case management services; access to consumer-operated drop-in centers; access to services during evenings, weekends, and holidays; supervision of the clinical needs of the residents; and access to emergency psychiatric care.

History.--s. 9, ch. 97-82; s. 23, ch. 98-80; s. 12, ch. 2000-349; s. 18, ch. 2006-197.

429.075 Limited mental health license.

An assisted living facility that serves three or more residents with mental illness must obtain a limited mental health license.

(1) To obtain a limited mental health license, a facility must hold a standard license as an assisted living facility, must not have any current uncorrected deficiencies or violations, and must ensure that, within 6 months after receiving a limited mental health license, the facility administrator and the staff of the facility who are in direct contact with mental health residents must complete training of no less than 6 hours related to their duties. Such designation may be made at the time of initial licensure or relicensure or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with this part, part II of chapter 408, and applicable rules. This training will be provided by or approved by the Department of Children and Family Services.

(2) Facilities licensed to provide services to mental health residents shall provide appropriate supervision and staffing to provide for the health, safety, and welfare of such residents.

(3) A facility that has a limited mental health license must:

(a) Have a copy of each mental health resident’s community living support plan and the cooperative agreement with the mental health care services provider. The support plan and the agreement may be combined.

(b) Have documentation that is provided by the Department of Children and Family Services that each mental health resident has been assessed and determined to be able to live in the community in an assisted living facility with a limited mental health license.
(c) Make the community living support plan available for inspection by the resident, the resident’s legal guardian, the resident’s health care surrogate, and other individuals who have a lawful basis for reviewing this document.

(d) Assist the resident with mental illness in carrying out the activities identified in the individual’s community living support plan.

(4) A facility with a limited mental health license may enter into a cooperative agreement with a private mental health provider. For purposes of the limited mental health license, the private mental health provider may act as the case manager.

History. s. 3, ch. 95-418; s. 37, ch. 96-169; s. 4, ch. 97-82; s. 66, ch. 97-100; s. 4, ch. 98-80; s. 2, ch. 2006-197; s. 140, ch. 2007-230.

Note.— Former s. 400.4075.

409.912

In developing the behavioral health care prepaid plan procurement document, the agency shall ensure that the procurement document requires the contractor to develop and implement a plan to ensure compliance with s. 394.4574 related to services provided to residents of licensed assisted living facilities that hold a limited mental health license.

These statutory provisions are fairly clear in requiring the special license. However, the administrative rules promulgated to implement the statute provide greater detail regarding staffing, training and care. Section 58A-5.029 of the Florida Administrative Code reads as follows:

The above rule (58A-5.029) that details the requirements for a limited mental health license, stipulates in section (4)(a) that “no person who has been determined by a community mental health provider to be eligible for case management services under Rule 65E-15.031(1)(a)-(c)(e)(g), FAC, shall be admitted to a facility unless the facility has applied for and received a limited mental health license...” Rule 65E-15.031 defines priority clients for mental health case management, and sections (1)(a)-(c), (e), and (g) read as follows:

“(1) Persons of all ages with one of the following characteristics are priority clients:

(a) Persons who are being admitted to a state facility or are awaiting admission to a state treatment facility;

(b) Persons who are in a state treatment facility regardless of admission date;
Thus, if an ALF intends to admit any of the above types of clients, under Rule 58A-5.029, the ALF must have a limited mental health license.

**B. Florida Administrative Code**

Florida Administrative Code provides guidance on how to implement statutes. The Resident Care Standards in Florida Administrative Code (58A-5.0182) summarize multiple issues related to how staff care for residents.

**58A-5.0182 Resident Care Standards.**

An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility.

1. **SUPERVISION.** Facilities shall offer personal supervision, as appropriate for each resident, including the following:

   a. Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C.

   b. Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the individual.

   c. General awareness of the resident’s whereabouts. The resident may travel independently in the community.

   d. Contacting the resident’s health care provider and other appropriate party such as the resident’s family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident’s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.

   e. A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses
which resulted in medical attention, major incidents, changes in
the method of medication administration, or other changes which
resulted in the provision of additional services.

(2) SOCIAL AND LEISURE ACTIVITIES. Residents shall be
encouraged to participate in social, recreational, educational and
other activities within the facility and the community.

(a) The facility shall provide an ongoing activities program. The
program shall provide diversified individual and group activities in
keeping with each resident’s needs, abilities, and interests.

(b) The facility shall consult with the residents in selecting, plan-
ning, and scheduling activities. The facility shall demonstrate
residents’ participation through one or more of the following
methods: resident meetings, committees, a resident council, sug-
gestion box, group discussions, questionnaires, or any other form
of communication appropriate to the size of the facility.

(c) Scheduled activities shall be available at least six (6) days a week
for a total of not less than twelve (12) hours per week. Watch-
ing television shall not be considered an activity for the purpose
of meeting the twelve (12) hours per week of scheduled activities
unless the television program is a special one-time event of special
interest to residents of the facility. A facility whose residents choose
to attend day programs conducted at adult day care centers, senior
centers, mental health centers, or other day programs may count
those attendance hours towards the required twelve (12) hours per
week of scheduled activities. An activities calendar shall be posted
in common areas where residents normally congregate.

(d) If residents assist in planning a special activity such as an out-
ing, seasonal festivity, or an excursion, up to three (3) hours may
be counted toward the required activity time.

(3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate
resident access to needed health care, the facility shall, as needed
by each resident:

(a) Assist residents in making appointments and remind residents
about scheduled appointments for medical, dental, nursing, or
mental health services.

(b) Provide transportation to needed medical, dental, nursing or
mental health services, or arrange for transportation through fam-
ily and friends, volunteers, taxi cabs, public buses, and agencies
providing transportation for persons with disabilities.
(c) The facility may not require residents to see a particular health care provider.

(4) ACTIVITIES OF DAILY LIVING. Facilities shall offer supervision of or assistance with activities of daily living as needed by each resident. Residents shall be encouraged to be as independent as possible in performing ADLs.

(5) NURSING SERVICES.

(a) Pursuant to Section 429.255, F.S., the facility may employ or contract with a nurse to:

1. Take or supervise the taking of vital signs;

2. Manage pill-organizers and administer medications as described under Rule 58A-5.0185, F.A.C.;

3. Give prepackaged enemas pursuant to a physician's order; and

4. Maintain nursing progress notes.

(b) Pursuant to Section 464.022, F.S., the nursing services listed in paragraph (a) may also be delivered in the facility by family members or friends of the resident provided the family member or friend does not receive compensation for such services.

(6) RESIDENT RIGHTS AND FACILITY PROCEDURES.

(a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C.

(b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint.

(c) The address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Disabilities Rights
Florida, 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456.

(d) The statewide toll-free telephone number of the Florida Abuse Hotline “1(800)96-ABUSE or 1(800)962-2873” shall be posted in full view in a common area accessible to all residents.

(e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility’s policies with respect to such issues, for example, as resident responsibilities, the facility’s alcohol and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements.

(f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law.

(g) The facility shall provide residents with convenient access to a telephone to facilitate the resident’s right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility shall not prohibit unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there shall be, at a minimum, an accessible telephone on each floor of each building where residents reside.

(h) Pursuant to Section 429.41, F.S., the use of physical restraints shall be limited to half-bed rails, and only upon the written order of the resident’s physician, who shall review the order biannually, and the consent of the resident or the resident’s representative. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be considered a physical restraint.

(7) THIRD PARTY SERVICES. Nothing in this rule chapter is intended to prohibit a resident or the resident’s representative from independently arranging, contracting, and paying for services provided by a third party of the resident’s choice, including a
licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for continued residency and the resident complies with the facility’s policy relating to the delivery of services in the facility by third parties. The facility’s policies may require the third party to coordinate with the facility regarding the resident’s condition and the services being provided pursuant to subsection 58A-5.016(8), F.A.C. Pursuant to subsection (6) of this rule, the facility shall provide the resident with the facility’s policy regarding the provision of services to residents by non-facility staff.

(8) ELOPEMENT STANDARDS.

(a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement shall be identified so staff can be alerted to their needs for support and supervision.

1. As part of its resident elopement response policies and procedures, the facility shall make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility’s name, address, and telephone number. Staff attention shall be directed towards residents assessed at high risk for elopement, with special attention given to those with Alzheimer’s disease and related disorders assessed at high risk.

2. At a minimum, the facility shall have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The photo identification shall be made available for the file within 10 calendar days of admission. In the event a resident is assessed at risk for elopement subsequent to admission, photo identification shall be made available for the file within 10 calendar days after a determination is made that the resident is at risk for elopement. The photo identification may be taken by the facility or provided by the resident or resident’s family/caregiver.

(b) Facility Resident Elopement Response Policies and Procedures. The facility shall develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures shall include:

1. An immediate staff search of the facility and premises;

2. The identification of staff responsible for implementing each
part of the elopement response policies and procedures, including specific duties and responsibilities;

3. The identification of staff responsible for contacting law enforcement, the resident’s family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and

4. The continued care of all residents within the facility in the event of an elopement.

(c) Facility Resident Elopement Drills. The facility shall conduct resident elopement drills pursuant to Sections 429.41(1)(a)3. and 429.41(1)(l), F.S.

(9) OTHER STANDARDS. Additional care standards for residents residing in a facility holding a limited mental health, extended congregate care or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively.


III. GENERAL LEGAL-ETHICAL PRINCIPLES

Ethics are derived from what we as a society believe is morally “right and just.” However, what society believes is right and just in a particular situation is not always crystal clear and can even be quite confusing and contradictory. So, “professional ethics codes” have been developed by a number of professional groups (physicians, psychologists, social workers, nurses, etc.) to clarify the right and just thing to do in a specific situation. Unfortunately, no ethics codes have been developed specific to providing services in ALFs.

Therefore, the best way for you to determine what to do in a difficult situation where you’re not sure what is “ethically right” is to talk about it with your supervisors. Discussing your dilemma will hopefully help you come to some resolution of what you should do. Other opinions are a good indication of what society in general might believe is morally “right and just” to do in a given situation. There are oftentimes no definite right or wrong answers in ethical situations, just different shades of gray. Your supervisor can help you clarify your options in some gray areas.
Although there are no ethics “codes” for staff providing services in ALFs, it is helpful to keep in mind two general ethical principles as you make care decisions: confidentiality and informed consent.

A. Confidentiality

Confidentiality means keeping what is said to you by a resident private or “in confidence.” This also includes the personal information contained in a resident’s ALF record or file. The ethical concept of confidentiality started as a sort of an “anti-gossip” rule – that is, it is not fair or considerate to talk about the problems of someone else. However, decisions by judges to enforce this rule (and hold professional caregivers liable if is broken) essentially legalized it for several professions. Some state legislatures have also recently made laws that require certain professionals to keep confidential what is said to them by clients.

Confidentiality in professional relationships is generally an “absolute right.” This means that the client or resident is presumed to have confidentiality as a right with no conditions. Even though you may not feel that your relationship with an ALF resident is a “professional” one, as a caregiver, you should treat it as one. Respect your residents’ privacy by keeping their conversations with you confidential.

Exceptions

As with all absolute rights, there are exceptions to maintaining confidentiality — that is, when can you talk with someone else about what a resident said or did.

- **Mandated reporting.** If someone is being abused or neglected, you must report it to the State of Florida (see discussion of Elder Abuse below). The State of Florida’s Abuse Hotline number is: 1-800-96ABUSE (962-2873) or see dcf.state.fl.us/programs/abuse/.

  An ALF staff member may tell someone else (such as a case manager or therapist) about this abuse, but this does **not** relieve that person of the obligation to report.

- **Imminent danger to self/others.** If someone is threatening suicide (hurting himself or herself) or homicide (hurting someone else), you should report this to others (physician, supervisor, etc.) so that appropriate action can be taken to prevent the harm from occurring. Related to this exception is when a person tells you about plans for a future criminal behavior. If a person is going to commit a crime, you should report it to others (such as your supervisor).
• **Professional consultation.** Consulting fellow staff members and other professionals about issues concerning a resident is appropriate in order to provide the best care for the individual.

• **Consent of the person.** If the person properly consents to the release of information (which must be very specific and in writing), the confidentiality privilege is waived for the information specified in the consent. Release of information to insurance carriers for purposes of payment typically falls under this exception.

• **Other exceptions.** Other exceptions include actions such as the release of information when the resident sues you (or the ALF), if a court subpoenas information.

The bottom line is, always be aware of the private nature of information that residents may tell you about and only tell others about it if the resident is in danger, or if it directly relates the person’s care.

**B. Informed Consent**

Before caregivers at an ALF can do anything that directly affects the rights or physical integrity of an individual resident (for example, beginning a medical procedure or releasing records) they need to obtain the person’s informed consent. Typically, facilities like ALFs obtain a general consent from residents when they arrive as part of their admission process. This allows the ALF staff to carry out usual care for the individual. If an unusual procedure or action is desired, specific consent for that action should be obtained from the person.

In order for the person’s consent to be valid, the consent must be **knowingly, voluntarily and competently** given:

1. **Knowledgeable:** reasonable and full disclosure of purpose, benefits, risks and consequences of providing consent must be provided. The disclosure must be understood, so use simple words and if the person cannot read, use other modes of communication other than writing.

2. **Voluntary:** persons cannot be manipulated into giving consent. Be careful about pressuring the person to consent. For example, if a family member strongly persuaded the individual to consent, then it may not be voluntary.

3. **Competent:** the person must possess the capacity to receive, comprehend and utilize the information provided to make a decision. If a person seems incoherent or incompetent, then consult a supervisor or other colleagues to find out the procedures you need to follow.
Exceptions

Similar to confidentiality, there are exceptions to having to obtain informed consent - that is, when do you not need to obtain consent to act on a person’s behalf.

- **Emergency Situations.** If a person is in imminent danger because of a medical condition (e.g., heart attack, unconsciousness) or other emergency situation, then no consent is needed for responsible action to help the person. (Also see description of guardianship in chapter 4).

- **Incompetency.** If a court has adjudicated a person to be incompetent to make decisions, then no consent is needed from the individual (by definition, it would be invalid). However, consent is required from a guardian or surrogate (see the following discussion).

  - People who are found incompetent will have a court appointed guardian.
  - It is important to have the name and contact information for guardians.

IV. SEVEN AREAS OF LAW PARTICULARLY IMPORTANT FOR ALF STAFF

A. ALF Residents’ Bill of Rights

Section 429.28 of the Florida Statutes defines a “Resident Bill of Rights” for ALFs, and Section 429.29 defines the power to enforce these rights through a civil court action. This means that a variety of stipulated people can file a civil enforcement lawsuit against the facility and its administration/staff, unlike criminal action, where only the state can file an action. The rights and cause of action are fairly clear in the statute, and both sections are duplicated below:

429.28 Resident bill of rights.—

(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:

(a) Live in a safe and decent living environment, free from abuse and neglect.
(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.

(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.

(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.

(e) Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community.

(f) Manage his or her financial affairs unless the resident or, if applicable, the resident’s representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.

(g) Share a room with his or her spouse if both are residents of the facility.

(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.

(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.

(j) Access to adequate and appropriate health care consistent with established and recognized standards within the community.

(k) At least 45 days’ notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to
a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally incapacitated, the guardian shall be given at least 45 days’ notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.

(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without restraint, interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents’ exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.

(2) The administrator of a facility shall ensure that a written notice of the rights, obligations, and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. This notice shall include the name, address, and telephone numbers of the local ombudsman council and central abuse hotline and, when applicable, the Disability Rights Florida, and the Florida local advocacy council, where complaints may be lodged. The facility must ensure a resident’s access to a telephone to call the local ombudsman council, central abuse hotline, Advocacy Center for Persons with Disabilities, Inc., and the Florida local advocacy council.

(3)(a) The agency shall conduct a survey to determine general compliance with facility standards and compliance with residents’ rights as a prerequisite to initial licensure or licensure renewal.

(b) In order to determine whether the facility is adequately protecting residents’ rights, the biennial survey shall include private informal conversations with a sample of residents and consultation with the ombudsman council in the planning and service area in which the facility is located to discuss residents’ experiences within the facility.

(c) During any calendar year in which no survey is conducted, the agency shall conduct at least one monitoring visit of each facility cited in the previous year for a class I or class II violation, or more than three uncorrected class III violations.
(d) The agency may conduct periodic followup inspections as necessary to monitor the compliance of facilities with a history of any class I, class II, or class III violations that threaten the health, safety, or security of residents.

(e) The agency may conduct complaint investigations as warranted to investigate any allegations of noncompliance with requirements required under this part or rules adopted under this part.

(4) The facility shall not hamper or prevent residents from exercising their rights as specified in this section.

(5) No facility or employee of a facility may serve notice upon a resident to leave the premises or take any other retaliatory action against any person who:

(a) Exercises any right set forth in this section.

(b) Appears as a witness in any hearing, inside or outside the facility.

(c) Files a civil action alleging a violation of the provisions of this part or notifies a state attorney or the Attorney General of a possible violation of such provisions.

(6) Any facility which terminates the residency of an individual who participated in activities specified in subsection (5) shall show good cause in a court of competent jurisdiction.

(7) Any person who submits or reports a complaint concerning a suspected violation of the provisions of this part or concerning services and conditions in facilities, or who testifies in any administrative or judicial proceeding arising from such a complaint, shall have immunity from any civil or criminal liability therefor, unless such person has acted in bad faith or with malicious purpose or the court finds that there was a complete absence of a justiciable issue of either law or fact raised by the losing party.

History.—ss. 12, 31, ch. 80-198; s. 2, ch. 81-318; ss. 55, 75, 79, 83, ch. 83-181; s. 53, ch. 83-218; s. 65, ch. 91-221; s. 19, ch. 91-263; ss. 23, 38, 39, ch. 93-216; s. 778, ch. 95-148; s. 11, ch. 95-418; s. 17, ch. 98-80; s. 20, ch. 2000-263; ss. 76, 143, ch. 2000-349; s. 63, ch. 2000-367; s. 38, ch. 2001-45; ss. 2, 51, ch. 2006-197.

Note.—Former s. 400.428.
429.29 Civil actions to enforce rights.—

(1) Any person or resident whose rights as specified in this part are violated shall have a cause of action. The action may be brought by the resident or his or her guardian, or by a person or organization acting on behalf of a resident with the consent of the resident or his or her guardian, or by the personal representative of the estate of a deceased resident regardless of the cause of death. If the action alleges a claim for the resident’s rights or for negligence that caused the death of the resident, the claimant shall be required to elect either survival damages pursuant to s. 46.021 or wrongful death damages pursuant to s. 768.21. If the action alleges a claim for the resident’s rights or for negligence that did not cause the death of the resident, the personal representative of the estate may recover damages for the negligence that caused injury to the resident. The action may be brought in any court of competent jurisdiction to enforce such rights and to recover actual damages, and punitive damages for violation of the rights of a resident or negligence. Any resident who prevails in seeking injunctive relief or a claim for an administrative remedy is entitled to recover the costs of the action and a reasonable attorney’s fee assessed against the defendant not to exceed $25,000. Fees shall be awarded solely for the injunctive or administrative relief and not for any claim or action for damages whether such claim or action is brought together with a request for an injunction or administrative relief or as a separate action, except as provided under s. 768.79 or the Florida Rules of Civil Procedure. Sections 429.29-429.298 provide the exclusive remedy for a cause of action for recovery of damages for the personal injury or death of a resident arising out of negligence or a violation of rights specified in s. 429.28. This section does not preclude theories of recovery not arising out of negligence or s. 429.28 which are available to a resident or to the agency. The provisions of chapter 766 do not apply to any cause of action brought under ss. 429.29-429.298.

(2) In any claim brought pursuant to this part alleging a violation of resident’s rights or negligence causing injury to or the death of a resident, the claimant shall have the burden of proving, by a preponderance of the evidence, that:

(a) The defendant owed a duty to the resident;

(b) The defendant breached the duty to the resident;

(c) The breach of the duty is a legal cause of loss, injury, death, or damage to the resident; and
(d) The resident sustained loss, injury, death, or damage as a result of the breach.

Nothing in this part shall be interpreted to create strict liability. A violation of the rights set forth in s. 429.28 or in any other standard or guidelines specified in this part or in any applicable administrative standard or guidelines of this state or a federal regulatory agency shall be evidence of negligence but shall not be considered negligence per se.

(3) In any claim brought pursuant to this section, a licensee, person, or entity shall have a duty to exercise reasonable care. Reasonable care is that degree of care which a reasonably careful licensee, person, or entity would use under like circumstances.

(4) In any claim for resident’s rights violation or negligence by a nurse licensed under part I of chapter 464, such nurse shall have the duty to exercise care consistent with the prevailing professional standard of care for a nurse. The prevailing professional standard of care for a nurse shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar nurses.

(5) Discovery of financial information for the purpose of determining the value of punitive damages may not be had unless the plaintiff shows the court by proffer or evidence in the record that a reasonable basis exists to support a claim for punitive damages.

(6) In addition to any other standards for punitive damages, any award of punitive damages must be reasonable in light of the actual harm suffered by the resident and the egregiousness of the conduct that caused the actual harm to the resident.

(7) The resident or the resident’s legal representative shall serve a copy of any complaint alleging in whole or in part a violation of any rights specified in this part to the Agency for Health Care Administration at the time of filing the initial complaint with the clerk of the court for the county in which the action is pursued. The requirement of providing a copy of the complaint to the agency does not impair the resident’s legal rights or ability to seek relief for his or her claim.

Note.—Former s. 400.429.
Chapter 3

**B. The Right to Self Determination**

**Introduction**

Americans’ value of independence, autonomy, and self-reliance is reflected in the law. With only very specific exceptions, all persons have the right and authority to make important life decisions for themselves and without the interference of others.

**Exceptions to the Right**

There are some exceptions to this general rule, because the right to self-determination and the freedom from interference from others assumes that the people have the capacity to make reasoned and informed decisions for themselves. For example, children are presumed incompetent to make important life decisions and their parents or appointed guardians make decisions in their behalf.

The law provides that certain rights can be restricted and sometimes transferred to another person who is responsible for making decisions in the best interests of this person. In cases where an adult, as the result of some kind of physical or mental disability, is unable to make sound and reasoned judgements that are in his or her best interests.

Although many older persons are quite able to exercise their own rights and make decisions for themselves, some older persons, as the result of a physical or mental disorder, are unable to make decisions in their best interests.

**The Importance of Limiting Intrusion, Restrictiveness, and Aversiveness.**

Given the importance and value of self-determination and autonomy, it is important that in cases where one’s abilities to make decisions are impaired and their rights are limited, an ALF resident retain as much independence and autonomy as possible and as many rights as possible.

There are two general clinical-legal principles that govern caretakers’ intervention in such cases:

1. **Principle of Least Restrictive Alternative or Minimal Intrusion:** When interventions of some type have to be imposed without the consent of someone or over someone’s objections, they should be as “minimally restrictive” and “minimally intrusive” as possible.

2. **Principle of Personal Preference and Possible Choice:** When interventions of some type have to be imposed without the con-
sent of someone or over someone's objections, staff should take into account the person's preference and **whenever possible** take the action that is least disliked by, or less offensive to, the person. For example, in a case where an ALF resident is showered over his objections, this resident should be given as much choice as possible (e.g., who will supervise his shower, when it will occur, etc.).

**Applications of Interventions**

There are a number of interventions available for persons whose ability to make decisions in their best interests is limited to some degree. Some of the individuals in your facility may have some of these protections/interventions in place. If such interventions are in place, then it is important that caretakers know about them since decision making about the person and the care he or she receives at the facility may be affected in some important ways. The interventions are presented below in order of restrictiveness.

- **Living Will (Florida Statutes 765)**
  A living will allows people with a terminal illness to anticipate being incapacitated (i.e., unable to make decisions for themselves) and identify life-prolonging procedures that they do not want employed. A living will is typically written and identifies specific techniques that should not be employed in case of terminal illness (e.g., use of a respirator).

- **Health Care Surrogate/Health Care Proxy (Florida Statutes 765)**
  A health care surrogate is an individual identified, in advance, by a person who anticipates becoming incapacitated (i.e., unable to make decisions for him or herself) as the result of some kind of illness. The health care surrogate has the authority to make decisions only about the medical care and treatment the individual will or will not receive only when the individual lacks capacity. As such, the health care surrogate gains or “loses” power in cases as the person loses and regains capacity. A health care surrogate must be identified in writing. In the absence of an advanced directive (e.g., living will) and of prior appointment of a Health Care Surrogate, and when two doctors believe that the person is unable to make medical treatment decisions, health care decisions can be made by a “Health Care Proxy” who, in order of priority comprise a judicially appointed guardian, spouse, adult child or majority of children, parent, adult sibling or majority thereof, adult relative, or close friend.
• **Revocable Living Trust (Florida Statutes 737)**
A person can establish a revocable living trust to identify someone to manage his or her financial affairs. Such a trust can be established when the person is competent and can remain in effect if the person becomes incompetent.

• **Power of Attorney (Florida Statutes 709)**
A person may designate another to handle one’s personal and financial affairs by way of a power of attorney. In the case of power of attorney, both the individual as well as the person appointed power of attorney retain the right to make decisions. Thus, the person is assumed to remain competent and with capacity. A “durable” power of attorney can continue after a person is declared incapacitated, whereas a normal power of attorney terminates after a finding of incapacity.

• **Guardianship (Florida Statutes 744)**
In cases where a person is determined to be incapacitated or incompetent, a guardian can be appointed by a court to make decisions about the person’s legal, medical, financial and personal affairs. Florida law identifies 13 areas or rights that can fall under a guardianship. While some of these rights can be restricted so that the person (i.e., ward) cannot exercise them (e.g., right to marry, right to vote) others are transferred to the guardian so that the guardian can make decisions about them on the ward’s behalf (e.g., consent to medical treatment, enter into a contract). Florida law makes clear that as many rights as possible should remain with the ward, and only those rights that the ward is incapable of exercising should be restricted or transferred. A guardianship can only be employed when there are no less restrictive alternatives available (see above for such alternatives).

• It is essential that the ALF has the name and contact information so that the guardian can be contacted as needed.

**C. Advanced Directives**

Florida law encourages people to make their own decisions about what medical and mental health treatment they want or don’t want while they are capable of making those decisions. Each competent adult should be encouraged to have an “advance directive,” a witnessed, written document in which a person gives instructions about their desires concerning any aspect of their health care. They name a person to act as their health care surrogate if they are ever determined to be incompetent to make decisions for themselves. The health care surrogate can only consent to health care that he or she believes the person would have consented to if they were capable of making such decisions. A health care surrogate cannot consent
for the person’s voluntary admission to a mental facility or for treatment of a person on voluntary status in a mental health facility. They also cannot consent to electroconvulsive therapy, abortion, sterilization psychosurgery, or experimental treatment.

Additional information about psychiatric advance directives can be found at pad.duhs.duke.edu. A template to use to complete a psychiatric advance directive can be found at pad.duhs.duke.edu/templates.html. This template is also included in appendix A.

**Other actions you can take to make advanced preparation include talking with the person about:**

- What steps they want to take or have taken when the symptoms of their mental illness first begin to be noticeable.

- What steps they are willing to take or have taken if or when the symptoms of the mental illness become severe enough to require crisis intervention.

Setting up a plan with the person gives them an opportunity to have control over what happens to them if a crisis occurs and defines clear expectations. Most of us do the best in situations where we know what to expect. Having some control in determining those expectations and participating in advanced planning may influence a person to be more open to receiving help voluntarily if or when it is needed.

It also encourages a trusting and respectful relationship between you and the person when their symptoms are under control.

A partnership between the person and you may not eliminate crisis situations, but it will be the most beneficial step you can take to minimize the need for crisis intervention at your facility.

**D. Reporting of Abuse and Neglect of Elderly Persons (Florida Statutes 415)**

**General Rationale and Requirements**

In order to protect persons who may be unable to protect themselves, Florida requires health care professionals to report suspected abuse or neglect of certain classes of people, including older persons. This mandatory reporting requirement supersedes confidentiality requirements that may apply to health care professionals. Essentially, anyone working in a facility housing older adults is required to make such reports, and a person making a report “in good faith” (i.e., with good intentions and not maliciously)
cannot be subjected to criminal or civil penalties as a result of making the report.

**Definitional Issues**

For the purposes of reporting, **abuse** is defined as:

The nonaccidental infliction of physical or psychological injury or sexual abuse upon a disabled adult or an elderly person by a relative, caregiver, or household member, or an action by any of those persons which could reasonably be expected to result in physical or psychological injury, or sexual abuse of a disabled adult or an elderly person by any person. “Abuse” also means the active encouragement of any person by a relative, caregiver, or household member to commit an act that inflicts or could reasonably be expected to result in physical or psychological injury to a disabled adult or an elderly person.

For purposes of reporting, **neglect** is defined as:

The failure or omission on the part of the caregiver or disabled adult or elderly person to provide the care, supervision, and services necessary to maintain the physical and mental health of the disabled adult or elderly person, including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services, that a prudent person would consider essential for the well-being of a disabled adult or an elderly person. The term “neglect” also means the failure of a caregiver to make a reasonable effort to protect a disabled adult or an elderly person from abuse, neglect, or exploitation by others. “Neglect” is repeated conduct or a single incident of carelessness which produces or could reasonably be expected to result in serious physical or psychological injury or a substantial risk of death.

For the purpose of mandatory reporting, **aged person** is defined as:

“Someone 60 years of age or older who is suffering from infirmities of aging as manifested by organic brain damage, advanced age, or other physical, mental or emotional dysfunctioning to the extent that the person is impaired in his ability to adequately provide for his own care and protection.”

For purposes of mandatory report a **vulnerable adult** is defined as:

“a person 18 years of age or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to a mental, emotional, sensory, long-term physical, or developmental disability or dysfunction, or brain damage, or the infirmities of aging.”

The reasons ALF residents need to reside in ALFs means that they will meet the definition of a **vulnerable adult**.
If abuse or neglect is known or suspected, it should be reported by calling the State of Florida hotline at 1-800-96-ABUSE (962-2873).

E. Elopement

Within 30 days of hiring all ALF staff should receive a copy of Elopement: Facility's Resident Elopement Response Policies & Procedures as per Florida Administrative Code, 58A-5.0191(2)(f).

**Elopement** means an occurrence in which a resident leaves a facility without following facility policy and procedures. (58A-5.0182.13, F.A.C)

*Florida Statutes* (429.42(3)(1)) require “the establishment of specific policies and procedures on resident elopement. Facilities shall conduct a minimum of two resident elopement drills each year. All administrators and direct care staff shall participate in the drills. Facilities shall document the drills.”

*Florida Statutes* (429.41(1)(a)(2)(m)(3) resident elopement requirements state that:

Facilities are required to conduct a minimum of two resident elopement prevention and response drills per year. All administrators and direct care staff must participate in the drills which shall include a review of procedures to address resident elopement. Facilities must document the implementation of the drills and ensure that the drills are conducted in a manner consistent with the facility’s resident elopement policies and procedures.

This means that staff, including anyone attending this training who works at an ALF, should participate in this training and follow procedures as specified in the Elopement Response Policies & Procedures for their facility.

F. What is an “Ombudsman?”

In the state of Florida, a long-term care ombudsman is a volunteer who helps to improve the lives of people who live in long-term care settings like nursing homes, assisted living facilities and adult family care homes.

As older adults in Florida make the transition into long-term care facilities (such as ALFs), a strong support system for each person becomes critical. Unfortunately, many ALF residents do not have anyone to look out for their best interests when it comes to personal health, safety, welfare and rights.

The Long-Term Care Ombudsman Program is made up of more than 300 volunteers who are passionate about improving the quality of life for residents. It takes a special kind of person to commit to such a mission. Ombudsman are proud to be a unique program whose success depends
on the boldness and compassion of volunteers. These special individuals dedicate thousands of unpaid hours each year to ensuring that the voices of Florida’s long-term care facility residents are heard.

**Advocating for Residents’ Rights**

The Ombudsman program consistently empowers residents to know their rights, and often provides a voice for those who may not be able to speak up for themselves. Examples of the rights to know include:

**Responding to Residents’ Concerns**

Ombudsmen personally visit the residents in their facilities to look into their concerns and provide empowerment and assistance in resolving them. Examples of common issues in nursing homes include: discharges and evictions, medication administration and matters of personal hygiene. Common issues in assisted living facilities and adult family-care homes include: menu quality, quantity and variation; medication administration; and general housekeeping or cleanliness.

Ombudsmen work to resolve residents’ concerns to the best of their abilities and within the greatest extent of the law. All services are provided at no charge, and all complaints are confidential.

**History of the Ombudsman Program**

Florida’s Long-Term Care Ombudsman Program was founded in 1975 as a result of the federal Older Americans Act, which grants a special set of residents’ rights to individuals who live in long-term care facilities such as nursing homes, assisted living facilities and adult family care homes. Volunteer ombudsmen seek to ensure the health, safety, welfare and rights of these residents throughout Florida.

**Contacting the Program**

If you would like to learn more about the Long-Term Care Ombudsman Program contact a local ombudsman office in your area.

Ombudsman headquarters office at:
Long-Term Care Ombudsman Program
4040 Esplanade Way, Suite 280
Tallahassee, FL 32399-7000
850-414-2323 or toll-free 1-888-831-0404
Fax: 850-414-2377
e-mail: LTCOPInformer@elderaffairs.org
Chapter 3

Legal and Ethical Issues

Assisted Living Facility
Limited Mental Health Training

Mental Health Resident Definition

• “Mental health resident” means an individual who receives social security disability income due to a mental disorder as determined by the Social Security Administration or receives supplemental security income due to a mental disorder as determined by the Social Security Administration and receives optional state supplementation.

Limited Mental Health Statutes & Administrative Codes

- 429.02(6) - ALF Definition
- 429.02(16) - Mental Health Resident Definition
- 58a-5.0131(20) - Mental Disorder Definition
- 58a-5.0181(1) - Admission Criteria
- 429.075 - Limited Mental Health Licence Requirements
- 58a-5.0191(8) - Training
- 58a-5.029 - Standards
- 429.02(8) - Community Living Support Plan Definition
- 429.02(9) - Cooperative Agreement Definition
- 429.28 - Resident’s Bill Of Rights
- 415 - Adult Protective Services
- 58a-5.0182(6)(d) – 1-800-96-ABUSE

Mental Health Resident Definition
Assisted Living Facility Definition 429.02(6)

“Assisted living facility” means any building or buildings, section or distinct part of a building, private home, boarding home, home for the aged, or other residential facility, whether operated for profit or not, which undertakes through its ownership or management to provide housing, meals, or one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.

Limited Mental Health License 429.075

- An assisted living facility that serves three or more mental health residents must obtain a limited mental health license.

LMH Facilities Must:

(a) Have a copy of each mental health resident’s community living support plan and the cooperative agreement with the mental health care services provider. The support plan and the agreement may be combined.

(b) Have documentation that is provided by the Department of Children and Family Services that each mental health resident has been assessed and determined to be able to live in the community in an assisted living facility with a limited mental health license.
**LMH Facilities Must: (cont’d.)**

(c) Make the community living support plan available for inspection by the resident, the resident’s legal guardian, the resident’s health care surrogate, and other individuals who have a lawful basis for reviewing this document.

(d) Assist the mental health resident in carrying out the activities identified in the individual’s community living support plan.

**Community Living Support Plan Definition – 429.02(8)**

- (8) "Community living support plan" means a written document prepared by a mental health resident and the resident’s mental health case manager in consultation with the administrator of an assisted living facility with a limited mental health license or the administrator’s designee. A copy must be provided to the administrator. The plan must include information about the supports, services, and special needs of the resident which enable the resident to live in the assisted living facility and a method by which facility staff can recognize and respond to the signs and symptoms particular to that resident which indicate the need for professional services.

**Community Living Support Plan (cont’d.)**

- Community Living Support Plan and Cooperative Agreement For
- Assisted Living Facilities with a Limited Mental Health License
- And Mental Health Providers
- Resident Name: ________________________________
- Assisted Living Facility: ________________________________
- Contact Person at the Facility: ________________________________
- ALF Facility Address: ________________________________
- ALF Facility Telephone: ________________________________
- Mental Health Provider: ________________________________
- Mental Health Provider Telephone number: ________________________________
- Mental Health Case Manager/FACT: ________________________________
- Mental Health Provider's 24-hour Emergency Telephone: ________________________________
### Community Living Support Plan (cont’d.)

**Purpose:** To identify the responsibilities of the Mental Health Provider and the Assisted Living Facility to ensure delivery of appropriate community-based services to mental health residents. The agreement specifies directions for accessing emergency and after-hours care for the mental health resident and a method by which the staff of the ALF can recognize and respond to the signs and symptoms particular to that resident and indicate the need for professional services.

- Describe resident’s daily activities:
  - [Blank lines for description]

- List those stressors that agitate the resident and that could initiate changes in mood and/or behavior:
  - [Blank lines for description]

### Community Living Support Plan (cont’d.)

**Describe method(s) to be used by ALF staff to recognize and respond to changes/actions which could indicate the need for professional services to this resident:**

- [Blank lines for description]

**Describe any needs, services, activities, medications or arrangements with which the facility will assist this resident to enable him/her to live in the assisted living facility:**

- [Blank lines for description]

### Community Living Support Plan (cont’d.)

**Describe the case manager’s role in helping the assisted living facility to meet the resident’s needs:**

- [Blank lines for description]

**Person Served Diagnosis – medical and psychiatric (do not use codes):**

- [Blank lines for description]
Cooperative Agreement 429.02(9) - Definition

(9) "Cooperative agreement" means a written statement of understanding between a mental health care provider and the administrator of the assisted living facility with a limited mental health license in which a mental health resident is living. The agreement must specify directions for accessing emergency and after-hours care for the mental health resident. A single cooperative agreement may service all mental health residents who are clients of the same mental health care provider.
Chapter 3

Cooperative Agreement
429.02(9) (cont'd.)

Intent of Cooperative Agreement Between Assisted Living Facilities and Mental Health Providers

- The mental health provider, ____________, shall:
- Initiate referrals to an Assisted Living Facility with a Limited Mental Health License, persons served whose needs can best be met at this ALF.
- Offer case management services to their clients residing in the ALF and give the case manager’s telephone number and location.

Cooperative Agreement
429.02(9) (cont'd.)

- Develop the Community Living Support Plan with each mental health resident who is served by the provider and in consultation with the Facility’s administrator or designee. The plan will be completed within thirty days after the mental health assessment is finished.
- Furnish to the Facility administrator a copy of the Community Living Support Plan for each mental health resident.

Cooperative Agreement
429.02(9) (cont'd.)

- Link the provider clients in the Facility with appropriate community mental health services and other services in accordance with the individual’s community living support plan and mental health service plan.
- Provide services to residents without regard to race, age, sex, religion, economic status, sexual orientation or physical handicap.
Chapter 3

Cooperative Agreement
429.02(9) (cont’d.)

- Case managers will discuss with the Facility administrator or designee issues pertinent to the care, safety and welfare of the residents. This does not preclude the mandatory reporting requirements for reporting to the DCF Abuse Registry in regard to cases of abuse, neglect or exploitation.
- Within available resources, provide technical and clinical information to assist the facility in program and staff development issues.
- Furnish mental health residents served by the Mental Health Agency and the Assisted Living Facility staff with the 24-hour emergency crisis telephone number.

Cooperative Agreement
429.02(9) (cont’d.)

The Assisted Living Facility with a Limited Mental Health License Shall:

- Notify the Mental Health Agency if an Assisted Living Facility resident may qualify as a mental health resident.
- Advise the Mental Health Agency of a resident’s significant behavior or situation change.
- Participate in the development of the mental health resident’s Community Living Support Plan

Cooperative Agreement
429.02(9) (cont’d.)

- Facilitate a mental health resident’s participation in mental health and other appropriate activities.
- Facilitate a mental health resident’s participation in other appropriate activities.
- Facilitate the provision of a resident’s privacy and confidentiality during case manager visits to the ALF.
- Provide support services as indicated in the resident’s Community Living Support Plan.
Chapter 3

Cooperative Agreement
429.02(9) (cont’d.)

- Describe the method(s) to be used by the ALF staff to recognize and respond to changes/actions which could indicate the need for professional services to a mental health resident.
- Acceptance/Refusal of Services: All services provided pursuant to this agreement shall be in accordance with resident rights, including the right of the resident or resident’s guardian, or health care surrogate to accept or refuse clinical mental health services.
- Financial Consideration: There shall be no financial obligation placed on one party by the other party as a result of this agreement.

Termination: This agreement shall continue in force until termination by either party upon receipt of a 45-day advance written notice.

This Agreement is executed when signed and dated below:

Provider (Case Manager, Recovery Support, FACT) Facility (ALF Representative)

_________________________________ _________________________________
Signature Signature
Print Name Print Name
Title Title
Date Date
Resident:

Resident’s Signature Date

Limited Mental Health
58A-5.029

- (2) RECORDS.

(a) A facility with a limited mental health license shall maintain an up-to-date admission and discharge log containing the names and dates of admission and discharge for all mental health residents.

(b) Staff records shall contain documentation that designated staff have completed limited mental health training as required by Rule 58A-5.0191.
Chapter 3

Confidentiality

- Keeping what is said to you private or “in confidence”.
- Confidentiality in professional relationships is generally an “absolute right”.
- Regard your relationship with a resident as professional, respecting privacy and confidentiality.

Confidentiality Exceptions

- Consent of the person
- Mandated reporting
- Imminent danger to self/others
- Professional consultation
- Other exceptions

Informed Consent

- A person, who is legally competent, is voluntarily giving their permission in writing with full knowledge and understanding of what they are agreeing to do or have done to them.
Valid Informed Consent

- **Knowingly:**
  The person must have full understanding of purpose, benefits, risks and consequences when giving consent or permission. A reasonable and full disclosure of purpose, benefits, risks and consequences must be provided in writing and verbally.
- **Voluntarily:**
  A person must give their consent without pressure, coercion, intimidation, manipulation, coacting, or cajoling from anyone.
- **Competently:**
  The person must possess the capacity to receive, comprehend and utilize the information provided to make a decision.

Informed Consent Exceptions

**Emergency Situations**
This refers to situations in which the person is experiencing a life threatening medical condition.

**Incompetency**
This means that a person's judgment is so affected by his or her mental illness that the person lacks the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical or mental health treatment.

Resident Rights

- 429.28 – Bill of Rights
- 429.29 –Civil Actions to Enforce Rights
- 429.34 –Right of Entry and inspection 58A-.0182(6)(a) – (b):
  - Copy of Resident Bill of Rights to be posted in full view in a freely accessible room
  - Grievance Procedures for receiving & responding to resident complaints
  - Information on how to file complaints with the Ombudsman or State Advocacy Council for residents with disability who are less than 60 years of age
Chapter 3

Assisted Living Resident
Bill 429.28, F.S.

No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, the Constitution of the United States, as a resident of a facility. Every resident shall have the right to:

- live in a safe and decent environment, free from abuse and neglect
- be treated with consideration and respect and with due to recognition of personal dignity, individuality, and the need for privacy
- retain clothes and other personal items
- unrestricted private communication including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his/her choice between the hours of 9:00 a.m. and 9:00 p.m., at a minimum

Assisted Living Resident
Bill 429.28, F.S. (cont’d.)

- Manage his/her own financial affairs
- Share a room with a spouse if both are residents of the facility
- Reasonable opportunity to exercise
- Exercise civil and religious liberties, including personal decisions
- Access to adequate and appropriate health care
- Forty-five (45) days notice of relocation or termination of residency
- Present grievances and recommend changes in policies, procedures, and services to the facility without restraint, interference, coercion, discrimination, or reprisal

The Right to Self Determination

All persons have the right and authority to make important decisions for themselves and without interference of others.

Exceptions:
A physical or mental impairment which disables or reduces a person's ability to make decisions in their own best interest.
Chapter 3

Slide 34

Legal Principles Governing a Caretaker’s Intervention

- Principle of least restrictive alternative or minimal intrusion.
- Principle of personal preference and possible choice.

Slide 35

Principle of Least Restrictive Alternative

- Least restrictions in mobility, supervision, etc., that is possible, given the limitations imposed by the physical/mental disability.
- Most autonomy and independence in having choices and making decisions that is possible, given the limitations imposed by the physical/mental disability.

Slide 36

Principle of Personal Preference and Possible Choice

Whenever possible take actions that appeal closest to a person’s preference and choice.

example: A resident requires a shower over their objection, they should be able to choose when it will occur, who will supervise, etc.
Mental Health
Advanced Directive

A legal document in which a person can state their preferences regarding mental health care before a mental health crisis occurs.

Advanced Directives

*Florida law encourages people to make their own decisions about what medical and mental health treatment they want or don't want, while they are capable of making those decisions.*

- An Advanced Directive is a written document that is Witnessed, and includes:
  1. Instructions about a person's desire concerning any aspect of their health care
  2. Name of the person they want to act as their health care surrogate if they are ever determined to be incapable to make these decisions for themselves

Advanced Preparation

- Involve each person in preparing the steps to take if or when the symptoms of their mental disorder first become noticeable
- Involve each person in preparing the steps to take if or when the symptoms of their mental disorder becomes severe enough to require crisis intervention
- A partnership between the person and a mental health recovery support worker may be the most beneficial step a person can take.
Benefits of Advanced Preparation

- Provides the person an opportunity to have some control over how a situation will be handled and defines clear expectations
- Most people do best when they know what to expect in any given situation
- Encourages a trusting, respectful relationship when the person’s symptoms are under control
- A partnership between the resident, the recovery support worker and the ALF may be the most beneficial step you can take to minimizing the need for crisis intervention

Abuse, Neglect, & Exploitation

- 415, F.S. – ADULT PROTECTIVE SERVICE LAW
- 58A-5.0182(6)(d) – 1-800-96-ABUSE posted in full view in a freely accessible room

Abuse

- Non-accidental physical or psychological injury or sexual abuse done by a relative, caregiver, household member, or any person to a person who cannot protect themselves due to a disability or age.
- An action which could result in physical or psychological injury or sexual abuse.
- The active encouragement of any person by a relative, caregiver, or household member to commit an act that can or does result in physical or psychological injury or sexual abuse
Neglect

- The failure or omission to provide care, supervision, and services necessary to maintain resident's physical and mental health.
- Failure to make a reasonable effort to protect a resident from abuse, neglect, or exploitation by others.
- Carelessness that can or does result in physical or psychological injury or sexual abuse.

Exploitation

- Stands in a position of trust and confidence with a vulnerable adult and knowingly, by deception or intimidation, obtain or uses, or endeavors to obtain or use, a vulnerable adult's funds, assets, or property with the intent to temporarily or permanently deprive a disabled adult or an elderly person of the use, benefit, or possession of the funds, assets, or property for the benefit of someone other than the vulnerable adult; or
- Knows or should know that the vulnerable adult lacks the capacity to consent, and obtains or uses, or endeavors to obtain or use, the disabled adult's or elderly person's funds, assets, or property with the intent to temporarily or permanently deprive the vulnerable adult of the use, benefit, or possession of the funds, assets or property for the benefit of someone other than the vulnerable adult.

Exploitation (cont'd.)

Exploitation may include, but is not limited to:
- Breaches of fiduciary relationships, such as the misuse of a power of attorney or the abuse of guardianship duties, resulting in the unauthorized appropriation, sale, or transfer of property:
- Unauthorized taking of personal assets;
- Misappropriation, misuse, or transfer of moneys belonging to a vulnerable adult from personal or joint account;
- Intentional or negligent failure to effectively use a vulnerable adult’s income and assets for the necessities required for that person’s support and maintenance.
Chapter 3

Seclusion and Restraint

Assisted Living Facilities are not permitted to use restraints except
a) half-bed rails, which require a physician’s order or
b) when the resident is on hospice and hospice authorizes the use of restraints.

ALF residents DO have the right to leave the ALF at will whenever they like based on the ALF Resident’s Bill of Rights

Chemical Restraint – Definition

Chemical restraint means a pharmacologic drug that physically limits, restricts, or deprives an individual of movement or mobility, and is used for discipline or convenience and not required for the treatment of medical symptoms.

429.02(6), F.S.

Physical Restraint – Definition

Physical restraint means a device which physically limits, restricts, or deprives an individual of movement or mobility, including, but not limited to, a half-bed rail, a full-bed rail, a geriatric chair, and a posey restraint.

The term “physical restraint” shall also include any device which was not specifically manufactured as a restraint but which has been altered, arranged, or otherwise used for this purpose. The term shall not include bandage material used for the purpose of binding a wound or injury.

429.02(17), F.S.
Elopement - Definition

Elopement means an occurrence in which a resident leaves a facility without following facility policy and procedures.

58A-5.0182.13, F.A.C.

Elopement

Within 30 days of hiring all ALF staff should receive a copy of Elopement: Facility’s Resident Elopement Response Policies & Procedures as per Florida Administrative Code

58A-5.0191(2)(f), F.A.C.

Elopement (cont’d.)

Florida Statutes require “the establishment of specific policies and procedures on resident elopement. Facilities shall conduct a minimum of two resident elopement drills each year. All administrators and direct care staff shall participate in the drills. Facilities shall document the drills.”

58A-5.0191(2)(f), F.A.C.
Chapter 3

Slide 52

**Elopement (cont’d.)**

Facilities are required to conduct a minimum of two resident elopement prevention and response drills per year. All administrators and direct care staff must participate in the drills which shall include a review of procedures to address resident elopement.

58A-5:0191(2)(f), F.A.C.

Slide 53

**What is the Long-Term Care Ombudsman Council?**

- The Long-Term Care Ombudsman Council is a group of concerned citizens whose goal is to improve the quality of life for people who live in long-term care facilities such as nursing homes, assisted living facilities, adult family care homes and long-term care units in hospitals.

Slide 54

**What is an Ombudsman?**

- An ombudsman is a specially trained and certified volunteer who has been appointed by the governor and given authority under Florida law to investigate and resolve complaints made by, or on behalf of, long-term care facility residents.
Behavior Management Techniques and Development and Implementation of Behavioral Plans

Assisted Living Facility Training for Limited Mental Health Licensure

Chapter 4

Lawrence Schonfeld, Ph.D.
Professor and Interim Executive Director

Amber M. Gum, Ph.D.
Associate Professor

Louis de la Parte Florida Mental Health Institute
University of South Florida
Chapter 4

Chapter Directions

Be sure to read the Introduction at the beginning of the manual before proceeding with the chapter presentations. A PowerPoint presentation for this chapter is available at www.BackerActTraining.org and is also printed at the end of this chapter.

A PDF and a Word version of the Behavioral Analysis Form discussed later in this chapter is available at bakeracttraining.org and in Appendix B.

Chapter Description

This chapter provides information about how ALF staff can help mental health professionals to develop behavioral plans. This chapter also provides information about how ALF staff can implement behavioral plans, especially by implementing behavioral techniques to reduce problem behaviors and increase desired behaviors.

It is very important to recognize that the behavioral techniques in this chapter work for many different kinds of behaviors - regardless of the person’s diagnosis.

Learning Objectives

This section combines two sections of the mental health training course required by the Administrative Code: Behavior Management and Development and Implementation of Behavioral Health Plans. Participants should be able to:

1. Understand how ALF staff can implement a behavioral plan;

2. Understand the short and long term goals of a behavioral plan, especially those goals emphasizing desired behaviors to replace the problem behaviors;

3. Identify each resident’s rewards; and

4. Encourage residents’ use of self-management techniques, including self-monitoring, self-reinforcement, and behavioral contracts.

Time Frame:

About 2 1/2 hours

Materials

LCD Projector/PowerPoint Slides
Handouts
Outline

I. Introduction ........................................................................................................... 151

II. The Role of ALF Staff in the Behavioral Plan ........................................... 151

III. Recognizing Problem Behaviors ................................................................. 151
    A. High Frequency Problem Behaviors ......................................................... 152
    B. A Behavioral Approach: The A-B-C’s ..................................................... 153
    C. The Behavior Analysis Form .................................................................... 153
    D. Exercise: Case Example using the BAF ................................................... 155

IV. Problem Definitions .......................................................................................... 157

V. Developing the Behavioral Plan ........................................................................ 158
    A. Preserving Individual Freedom ................................................................. 160
    B. Short Term Goals and Long Term Goals ................................................. 160

VI. Behavior Management ..................................................................................... 161
    A. Rewarding People: Techniques for Increasing Desired Behaviors .......... 162
       1. Identify Each Resident’s Rewards ......................................................... 162
       2. Shaping ............................................................................................... 162
       3. Premack Principle .............................................................................. 163
       4. Prompting ............................................................................................ 163
       5. Modeling ............................................................................................ 164
       6. Chaining ............................................................................................. 164
       7. Backward Chaining .......................................................................... 165
    B. Techniques for Decreasing Problem Behaviors ........................................ 165
       1. Extinction ............................................................................................ 166
       2. Social Restitution .............................................................................. 166
       3. Response Cost .................................................................................... 166
       4. Exclusion Time-Out .......................................................................... 166

VII. Problems Encountered .................................................................................. 167
    A. Consistency ............................................................................................. 167
    B. Staff Biases and Stereotypes ................................................................... 168
    C. Satiation .................................................................................................. 168
    D. Generalization ......................................................................................... 168
    E. Individuals with Memory Problems ......................................................... 168
VIII. Overview of Reality Orientation ............................................. 169

IX. Types Of Orientation .............................................................. 169
   A. Time ................................................................................. 170
   B. Place ............................................................................. 170
   C. Person ........................................................................... 170
   D. Circumstance .................................................................. 170
   E. Memory and Concentration ............................................. 170

X. Causes of Disorientation ........................................................... 171

XI. Reality Orientation ................................................................. 171
   A. Creating an Environment ............................................... 171
   B. Communicating Effectively ............................................. 172

XII. Self-Management Approaches ............................................... 172
   A. Self-monitoring ............................................................... 173
   B. Tasks or “Homework” Assignments .............................. 173
   C. Behavioral Contracts ..................................................... 174
   D. An Example of a Behavioral Contract ............................ 174

XIII. Conclusions ........................................................................ 175
I. INTRODUCTION

In an assisted living facility (ALF), it is required that all residents have a service plan based on the assessed needs in self-care/activities of daily living, medication and medical concerns, activities, etc. to ensure that the individual maintains or improves upon the highest quality of living possible.

For some individuals, a behavioral health plan is required. The plan describes targeted problem behaviors which may adversely affect one’s placement or interfere with the quality of life, and the plan clearly identifies what actions staff, the resident, family members, etc. must follow, as well as methods for evaluating and altering the plan on a regular basis. In this section we will discuss behavior management. Behavior management refers to the methods we use to reduce problem behaviors and increase desired behaviors.

II. THE ROLE OF ALF STAFF IN THE BEHAVIORAL PLAN

Behavioral health plans for ALF residents are developed by external mental health professionals. Mental health professionals are usually not employed by the ALF; they are often under contract from a mental health center or other agency. As a result, ALF staff members are more often involved with the implementation of the plan than with the development of a plan. The role of ALF staff is more likely to include: Recognizing the occurrence of problem behaviors, administering techniques to reward desired behaviors and reduce problem behaviors, communicating with other staff and the mental health professionals about progress, and maintaining the plan as strictly as possible. The ALF staff is therefore more than just the “eyes” and “ears” of the plan.

III. RECOGNIZING PROBLEM BEHAVIORS

Residents requiring a behavioral plan may exhibit “maladaptive behaviors” or “problem behaviors.” The typical behavioral plan will focus on high frequency problem behaviors which affect the quality of life of the individual, their families or friends, staff or others. Examples include:

- Shouting and/or cursing loudly with no apparent provocation;
- Staying in bed all day;
- Hitting (but not necessarily seriously assaulting) other people (staff, residents, visitors);
- Hoarding food or other items;
- Stealing from others;
- Using the bathroom improperly;
- Memory problems and disorientation;
- Lack of self-care skills (activities of daily living);
• Smoking in areas where smoking is prohibited;
• Refusing to take medications; and
• “Talking” to individuals who are not there.

The ALF staff member should report such behaviors to the facility administrator and the mental health professional to determine which behaviors should be managed within the ALF. The mental health professional will be responsible for incorporating such observations into the plan.

A. High Frequency Problem Behaviors

Problem Behaviors
• High frequency problem behaviors reported by resident, staff, family members, or other residents.
• Interfere with participation in program, threaten placement, reduce quality of life.
• Please note that suicidal behaviors, combative/assaultive, or other behaviors which place the resident or other residents in imminent danger may not be manageable in an ALF and must be addressed according to ALF policies and procedures. In most cases, such dangerous behaviors are not high frequency, i.e., are rare occurrences.

Questions regarding problem behaviors include the following:

• Is it a frequently observed problem?
• How often does the behavior occur?
• When does the behavior occur?
• What usually happens before the behavior occurs?
• What usually happens after the behavior occurs?

Behaviors Addressed in a Behavioral Health Plan
• Behaviors that interfere with
  ■ participation in the program
  ■ Placement in the least restrictive environment
• Behaviors identified by the client as problematic
• Behaviors that if changed (modified, acquired or eliminated) would increase the resident’s opportunities for enjoyment of life.
• Behaviors which meet one of these conditions are problematic.
• Behaviors which are inconsistent with all the conditions are not problematic.
Each ALF should have policies and procedures for addressing what to do in response to behaviors that place the resident or others in imminent danger. These include suicidal ideation or behavior, combative behavior, physical assault, fire-setting, etc. Such behaviors may not be manageable in an ALF and are not addressed by the “typical” behavioral plan of ALF residents. However, all such behaviors must be reported to the ALF administrator.

**B. A Behavioral Approach: The A-B-C’s**

- **Antecedents** → **Behavior** → **Consequences**

In a behavioral approach, the behavior is viewed as the problem, not the resident. This approach relies on staff observations and attempts to find out which events precede or “trigger” the behaviors (antecedents) and which consequences occur immediately after and may serve as a “reward” or encouragement for the person to continue that behavior. Without the ALF staff’s observations, the mental health professional and others who develop the behavioral plan will have great difficulty understanding the day to day problems and progress a resident will experience.

The behavioral approach is often called the “A-B-C’s” referring to Antecedents, Behavior, and Consequences. Problem behaviors just don’t happen out of the blue. When the unusual behavior occurs, we observe what the resident was doing or saying immediately before the behavior and who the resident was with. These are Antecedents, and being aware of them helps ALF staff to predict when they may occur again. We then look for immediate Consequences, such as attention from staff, which may reward a person and encourage the behavior.

**Problem behaviors don’t happen out of the blue!**

They are usually triggered by an event called the antecedent. Examples: being left alone, too much noise, a request by a staff member, or seeking attention.

They are immediately followed by a positive consequence. Examples: attention from others, being left alone, or not being bothered by others.

**C. The Behavior Analysis Form**

ALF staff members’ observations are crucial to a plan. To help staff make simple, objective observations, Jackson and Patterson (1982) developed the Behavior Analysis Form or “BAF” to record the A-B-C’s. When an unusual behavior occurs, a staff member writes a brief description of what
was said or done (Behaviors) in the center column. In the first column, staff record what happened immediately **before** the behavior (Antecedents). In the third column, staff record what happened immediately after the behavior stopped (Consequences).

### Behavior Analysis Form (BAF)

Resident’s Name: ___________________________________

# __________________   Unit: _______________________

<table>
<thead>
<tr>
<th>ANTECEDENT(S)</th>
<th>BEHAVIOR(S)</th>
<th>CONSEQUENCE(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>Observed Behavior:</td>
<td>Interpersonal Interaction:</td>
</tr>
<tr>
<td>Time:</td>
<td></td>
<td>Other Environmental Interactions:</td>
</tr>
<tr>
<td>Location:</td>
<td></td>
<td>Recorder:</td>
</tr>
<tr>
<td>Persons in Vicinity:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specifics of Interaction:</td>
<td>Duration of Behavior:</td>
<td></td>
</tr>
<tr>
<td>Other Events:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Date:         | Observed Behavior: | Interpersonal Interaction: |
| Time:         |              | Other Environmental Interactions: |
| Location:     |              | Recorder:       |
| Persons in Vicinity: |          |                |
| Specifics of Interaction: | Duration of Behavior: |                |
| Other Events: |              |                |
If you have just observed an unusual or disruptive behavior, take a minute afterward (when things calm down) to record the event on the BAF as follows:

1. Begin in the middle column (Behavior) and write down exactly what you saw or heard and how long it happened. Do not include what you believe led to its cause.

2. Go back to the first column - Antecedents. Record what happened immediately before the behavior occurred.

3. Now go to the third column - Consequences. Record what happened immediately after the behavior occurred.

D. Exercise

Instructor reads the following example and discusses how to record behavior

**Instructor to Students:** “How would you enter this information using the BAF?” A completed BAF is shown on the next page. A discussion follows.

It’s 7 p.m. on January 23, 2012. The evening staff consists of Ms. Green (the ALF administrator) and Bob Jones (the evening supervisor). The residents in an ALF are about to begin their daily meeting.

One of the residents, Mr. Smith, who always seems to spend too much time in his room, begins to head toward his room. When one of the residents, Mr. Johnson, yells to him “Would you like to join the group?” Mr. Smith turns and begins to yell: “I can’t stand this place!” and he begins to throw magazines, newspapers, and some books on the floor. He continues to yell and throw things for another two minutes.

Ms. Green, the administrator, speaks to him for a while and tells him he doesn’t have to participate. Soon he begins to calm down and goes to his room. Another resident yells, “Where are you going?” but he doesn’t answer and goes to his room.
### Behavior Analysis Form (BAF)

Resident's Name: Mr. Smith  
# 00000000     Unit: East Wing of Johnson Boarding Home

<table>
<thead>
<tr>
<th>ANTECEDENT(S)</th>
<th>BEHAVIOR(S)</th>
<th>CONSEQUENCE(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date:</strong> Jan. 23, 2012</td>
<td><strong>Observed Behavior:</strong> Yelled “I can’t stand it here” Began throwing papers &amp; magazines.</td>
<td><strong>Interpersonal Interaction:</strong> Ms. Green spoke with him a few minutes, told him he didn’t need to go to the meeting. He stopped yelling and went to his room.</td>
</tr>
<tr>
<td><strong>Time:</strong> 7 PM</td>
<td><strong>Duration of Behavior:</strong> 2 minutes</td>
<td><strong>Other Environmental Interactions:</strong> Other residents asked him where he was going.</td>
</tr>
<tr>
<td><strong>Location:</strong> Meeting Room</td>
<td></td>
<td><strong>Recorder:</strong> Bob Jones</td>
</tr>
<tr>
<td><strong>Persons in Vicinity:</strong> Mr. Johnson, six other residents; Ms. Green (admin.), B. Jones</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specifics of Interaction:</strong> While Mr. Smith was heading toward his room, Mr. Johnson asked him to join the others</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other Events:</strong> Evening meeting</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Discussion of Case Example

The problem behavior is Mr. Smith yelling “I can’t stand this place” and throwing magazines, newspapers, and books. We write the underlined statements in the behavior column.

In the “antecedents column” we write that it occurred at 7 PM, about when the meeting was to start, and after Mr. Johnson and others invited him to attend. In the third column, the consequences were the ALF administrator coming over to calm him down, telling him he didn’t have to attend, and Mr. Smith going to his room. Note that we are not saying that he has no right to spend time in his room. It is his reaction - the yelling and throwing magazines and papers - that we find problematic,
and at the same time, this example illustrates that access to the room and escape from the request can be viewed as probable rewards for the problem behavior.

IV. PROBLEM DEFINITIONS

Introduction

For some individuals, a behavioral plan may be required. The purpose of such a plan would be to address targeted problem behaviors which may adversely affect one’s placement or interfere with the quality of life. The plan clearly identifies what actions staff, the resident, family members, etc. must follow, as well as methods for evaluating and altering the plan on a regular basis. In this section we will discuss behavior management. Behavior management refers to the methods we use to reduce problem behaviors and increase desired behaviors. If a behavioral strategy goes beyond simply modeling and rewarding positive behavior, it should not be implemented without professional direction, supervision, and coaching.

The Role of ALF Staff in the Behavioral Plan

Typically, behavioral plans for ALF residents are developed by external mental health professionals. Mental health professionals are usually not employed by the ALF; they are often under contract from a mental health center or other agency. As a result, ALF staff members are more often involved with the implementation of the plan than with the development of a plan. The role of ALF staff is more likely to include: Recognizing the occurrence of problem behaviors, administering techniques to reward desired behaviors and reduce problem behaviors, communicating with other staff and the mental health professionals about progress, and maintaining the plan as strictly as possible. The ALF staff is therefore more than just the “eyes” and “ears” of the plan.

The behavioral plan defines behavior problems to be addressed. Staff must be aware of the resident’s problem behaviors and report their occurrence to the administrator and mental health professional. Other unusual behaviors not targeted in the plan may also be observed and should be reported. ALF staff is encouraged to use the “BAF” to record all such observations of problem behaviors and report them.

It is tempting for staff members to rely on a diagnosis. A diagnosis is useful for categorizing symptoms or prescribing medications, but doesn’t specify problem behaviors. Describing behavior as “depression” or “anxiety” or “aggression” makes it difficult to determine what the person is exactly doing or saying that is problematic.

Conversely, recording problems on a BAF using terms that others can observe makes it easy for everyone to determine if and when the problem
behavior occurs. Examples of simple definitions of problem behaviors are as follows.

**Examples of Problem Definitions**

- Does not participate in group activities;
- Refuses to take a bath;
- Smokes cigarettes in the ALF (which is prohibited);
- Refuses to take medications;
- Begins to yell and curse after a family visit; or
- Makes frequent negative self-statements.

**Defining Problem Behaviors**

By using simple, objective definitions, the person’s success with respect to the targeted behavior can be easily evaluated. Three characteristics of a “good” behavioral definition of a problem behavior include the following:

- It is *objective*, i.e., it is based on what you see or hear;
- It is *specific*, in that it describes your observation in very simple terms that others can understand; and
- It is “parsimonious” - it avoids assumptions about “underlying causes.” If given a choice between a simple explanation based on observable events and a more complex explanation based on non-observable events, the staff member is encouraged to choose the simple explanation.

When in doubt about how to define the behavior, a useful exercise for ALF staff is to answer the question: “How will I know if or when the problem is improving?” When they answer these questions, they will steer away from diagnoses and move toward objective behavior definitions.

When given a choice between a simple explanation and complex one, choose a simple explanation.

**V. DEVELOPING THE BEHAVIORAL PLAN**

The Florida Administrative Code (Chapter 58A-5 Assisted Living Facilities, Section 58A-5.029 Limited Mental Health, Part 3.A) provides the framework for developing, implementing, and evaluating behavioral plans. The Community Living Support Plan describes how the input from the mental health resident, the mental health case manager, and the ALF administrator lead to a plan within 30 days of admission to ALF or within 30 days after receiving the appropriate placement assessment. Key components of plans address:
• Specific needs of the resident

• Clinical mental health services to be provided by the mental health care provider

• Frequency and duration of such services

• Other services and activities to be provided by or arranged for by the mental health care provider or mental health case manager

• Obligations of the facility to facilitate and assist the resident in attending appointments and arranging transportation to appointments for the services and activities

• A description of other services to be provided or arranged by the facility

• A list of factors pertinent to the care, safety, and welfare of the mental health resident and a description of the signs and symptoms particular to the resident that indicate the immediate need for professional mental health services

• Is in writing and signed by the mental health resident, the resident’s mental health case manager, and the ALF administrator or manager and a copy placed in the resident’s file. If the resident refuses to sign the plan, the resident’s mental health case manager shall add a statement that the resident was asked but refused to sign the plan

• Is updated at least annually

Behavioral Plans

When behavioral plans are formulated at admission, the goals are often very basic - orientation to the ALF, identifying personal care needs, etc. Later, the comprehensive plan is developed and is reviewed and updated over time. Residents must participate in and consent to the development of the plan. In some cases, a guardian’s consent must be obtained in lieu of the resident’s. The ALF should document how the plan was explained to the resident or the guardian. As the Mental Health coordinator, Resident and Case Manager develop a written plan, it is recommended that it include:

• Specific needs and goals;
  ■ Short term goals reflect small changes;
  ■ Long term goals reflect how person will behave/interact after intervention complete;

• Services by mental health provider; and
Goals At Admission to help adjustment may include many of the following:

- Orientation to room location, roommate
- Management strategies for resident
- Need for behavioral contracting;
- Need for special security features;
- Additional resources to access; and
- Personal care needs based on health assessment (ADL’s, diet, etc.).

A. Preserving Individual Freedom

A behavioral plan for an ALF resident must balance the resident’s independence, freedom, and individuality with the staff’s actions. Ethics and policy dictate that we keep the ALF resident informed about his/her progress and not merely impose behavioral techniques without their participation in developing the plan.

B. Short Term Goals and Long Term Goals

There are often short term goals and long term goals in a behavioral plan. Short term goals involve small changes in behavior and can be modified over time. An example is “the resident will reduce episodes of yelling in group meetings by 50%.” Short term goals are assessed at staffings and modified as progress toward the goal is continually assessed.

A long term goal remains relatively constant and involves the final outcome after completing the plan. For example, it might state, “the resident will participate in group meetings by speaking in a reasonable tone” (goal for desired behavior), and “resident will not yell or curse during group meetings” (goal for problem behavior). The plan can be terminated when the long term goal is accomplished.

There are often two types of goals. The first is for the resident to learn a desired behavior that improves his/her quality of life. The second goal is suppressing the problem behavior. ALF staff often focus too much on suppressing the problem behavior and not enough on teaching the desired behavior.

In the earlier example, the resident was observed “yelling and cursing” when asked if he would like to attend a group activity. If we only focused on decreasing the yelling and cursing, it would be tempting to look for “punitive” methods such as denying certain privileges to stop that behavior.
However, staff should focus on questions such as: “What positive, adaptive behavior is expected to replace the maladaptive behavior?” and “What skill must the person learn to improve functioning?” In the example, we might list the adaptive goal as “increase group participation” or “develop conversational skills” and at the same time ignore the person until he stops yelling.

**Behavioral Goals:**

**Short-term Goals:**

- Reasonable increases in desired behaviors (For example - encourage participation in group activity)
- Simultaneous decreases in problem behavior (For example - ignore yelling, cursing)

**Long-term Goal:**

- Final, expected outcome of the behavior modification procedure

**Behavior Management**

- Procedures that rely on principles of learning to change behavior
- Increase desired behaviors
- Decrease problem behaviors
- Behaviors attained must be of a socially relevant nature
- Relies on objective and measurable outcomes
- Focus on the behavior as the problem, not the person

**VI. BEHAVIOR MANAGEMENT**

“Behavior management” is a set of procedures that rely on principles of learning to change behaviors. The goals are to increase *socially relevant*, adaptive behaviors and at the same time reduce or eliminate problem behaviors. Behavior management emphasizes teaching skills, rewarding people for their accomplishments, and remaining sensitive to their rights and freedoms. ALF staff members participate in the plan by rewarding desired behaviors and encouraging the resident’s progress toward the short and long term goals.

Although behavior modification usually involves baseline observations, evaluation techniques, etc., we recognize that most ALF staff members are not involved in mental health “treatment.” However, they are involved in the day-to-day activities of the behavioral plan.
A. Rewarding People: Techniques for Increasing Desired Behaviors

If the ALF staff members know the residents in their facility well, then they will know which rewards these residents enjoy. When administered by ALF staff, these rewards will lead to increases in desired behaviors. The next section describes what rewards we should use and how to use them to encourage adaptive behaviors.

1. Identify Each Resident’s Rewards

We identify each resident’s rewards in the initial assessment when he or she first arrives at the ALF, through conversations with the resident, and by simple observations. A staff member should not assume that everyone finds money or food to be a motivator, or that what the staff member enjoys or works for is the same for a resident. However, a staff member who praises or compliments the resident, pats him or her on the back, or says “Nice work!” is providing the easiest and best reward of positive attention.

Reward Immediately After the Behavior

When a reward is given immediately after the desired behavior occurs, it increases the likelihood that the behavior will be repeated. Techniques for rewarding people after they have accomplished a desired behavior or at least made an attempt to reach that goal include: shaping, the Premack Principle, prompting, modeling, and chaining.

2. Shaping

Shaping involves rewarding a person’s attempts at reaching the goal. We don’t always expect a person to learn a new skill or behavior on the first try. If the person makes an effort “in the right direction” or exhibits a new behavior that resembles the final goal, we might reward him/her for making the attempt. The next time, he/she makes an attempt, we might make the criteria slightly more difficult before rewarding the person. We would hold off on giving the reward until we see a second response which is closer to the final goal.

Positive Reinforcement Example

- **Shaping** - you reward the resident’s attempt at the desired behavior. The next time, you wait until the attempt is a little closer to the desired behavior, and then reward. Each time, you reward for closer and closer attempts.

- **Problem** - Mr. Jones leaves his room a mess and fails to make the bed

- **Goal** - teach him how to keep his room organized and clean.
• **Plan** - Reward Mr. Jones if he attempts to straighten the bed sheets. The next time, require that he straighten the pillow and sheets before rewarding him. The next time, reward him after he adds the bedspread.

### 3. Premack Principle

This technique involves using a behavior or activity the person is most likely to do frequently (a high probability behavior) to reward a behavior we want to increase (low probability behavior). For example, we might encourage a resident who becomes withdrawn and stays in his room all day by asking him/her to join the other residents in a social activity for just a few minutes before returning back to the room. If he/she succeeds, then the staff would praise this participation and then take him back to the room. The next day, the staff might ask for a few more minutes before he/she goes to the room.

Another example is the individual who would rather spend time talking to one staff member in particular (high probability behavior), but refuses to bathe (low probability behavior). To increase bathing, that staff member might say “If you take your bath now, I will be happy to spend the next half hour talking with you about politics.” Note that each of these statements requires that we learn which activity the resident does often and which activity should be learned or increased.

#### Example of Using the Premack Principle (using a high probability behavior to reinforce a low probability behavior)

- **Problem:** Mr. Smith stays cooped up in his room (high probability behavior), rarely socializes, and is becoming withdrawn.

- **Goal:** to encourage and increase Mr. Smith’s participation/activities with other residents.

- **Plan:** Staff prompt Mr. Smith by saying: “Mr. Smith, if you join the recreation hour with the others for just 5 minutes, you may return to your room.”

  Staff reward Mr. Smith by praising his efforts in group, and returning him to his room.

### 4. Prompting

When we prompt someone, we provide cues to direct the person toward the target behavior. Prompts can be visual, verbal, gestures, modeling, physical assistance (occasional or complete). If the individual exhibits the desired behavior, it must be followed by a reward/positive reinforcer. Using a written prompt or a picture, such as a sign, people with memory
problems can be reminded of where to find the bathroom. A calendar in a resident’s room may help them to remember activities or appointments. Staff members can go over “ground rules” before starting a group activity. These are all reminders or cues.

5. Modeling

Modeling involves having the staff member demonstrate a skill or behavior for the individual and then asking the individual to attempt the same skill.

Prompting and Modeling

- **Prompting** - Provide a verbal cue, written cue, a gesture, or some other reminder, and then reinforce the attempt.

- **Modeling** - Model a certain behavior, asks the resident to try it, and reward an attempt.

- **Example** - Pretend to shave by moving an electric razor up and down on your own face, then ask the resident to try it on himself. Praise the resident for the attempt and provide a few pointers for improvement.

- **Chaining** - Divide task into a series of steps. Prompt the person to try the first step. After completion, prompt the next step and then reward. After success at the two steps, prompt for a third step and then reward.

- **Backward Chaining** - Start with the end step and progress until the first step is achieved.

- **Example** - Mr. Green has memory problems and can’t remember where the dining room is.

- **Plan** - Begin at the dining room on the first day and reward. On the next day, begin a little further away and then go to dining room and reward. Increase the number of steps on successive days before rewarding.

6. Chaining

The last technique involving reward may sound complicated, but it is not necessarily so. Chaining involves rewarding the person after he or she completes a series of behaviors toward a final goal. First, a complex behavior is divided into a series of steps or sequences. The individual is prompted to begin the process by attempting the first component in the sequence. After the person completes the first step successfully, the staff member prompts the second step and then rewards. After the resident is successful at the end of both the first and the second step, the staff member prompts the third step and rewards at the completion of that third step.
7. Backward Chaining

Backward chaining begins with the final step and works backward. It is a useful technique when working with individuals who experience memory problems such as the early stages of dementia. A staff member might teach such a person how to find the cafeteria by starting at the cafeteria and eventually, over several days, teach him/her to find the cafeteria from another room or floor.

B. Techniques for Decreasing Problem Behaviors

As before, this section assumes that the behavioral plan dictates which procedures should be used and that whenever possible, positive techniques for increasing adaptive behaviors are emphasized. Goals in a behavioral plan also involve reducing problem behaviors. One way staff can do this is to encourage desired behaviors that are incompatible with the problem behavior. For example, participating in a group activity (desired behavior) is incompatible with sitting in the corner and cursing loudly (problem behavior). This section describes several techniques that can be used comfortably and appropriately in an ALF that will lead to decreases in the problem behaviors. They include: extinction, response cost (fines or loss of certain privileges), and exclusion time-out. These are defined in the next section.

Techniques for Decreasing Behaviors

- **Extinction** - Ignore person immediately after a maladaptive behavior occurs.
  
  - **For Example** - When Mr. Jackson begins to curse loudly in a group meeting, all staff are instructed to ignore him and begin talking to other residents. As soon as he stops and begins to participate normally, the staff pay a lot of attention to him.

- **Social Restitution** - a resident creates a mess and is required to clean it up.

Other Techniques for Decreasing Behaviors

- **Response Cost** - an individual is fined or loses a privilege.
  
  - **For Example** - If a resident throws food on the floor in the dining room, he is “fined” by losing the privilege to join the other residents on a planned outing to the mall.

- **Exclusion Time Out** - a disruptive person may be requested to sit away from others until he/she becomes calm.
1. Extinction

Extinction involves no longer rewarding the problem behavior. Often extinction means ignoring the person’s problem behavior immediately upon noticing that they are doing the targeted, undesirable behavior. Ignoring the problem behavior is useful when the attention a person receives following the problem behavior helps to keep the behavior going. If the plan requires staff to completely ignore a behavior when it occurs, all staff must ignore the behavior immediately. They can then turn their attention back to that person once the problem behavior stops and the desired behavior begins.

Although there are other variations on extinction, we recommend the simplest form: ignoring the problematic behavior. This simple form of extinction involves the least restriction on freedom and rights of ALF residents.

One drawback to the use of extinction is the possibility of an “extinction burst.” When extinction is first applied in response to the problem behavior, the person may exhibit a sudden and temporary increase in the frequency of that behavior before it eventually declines and is extinguished completely. This may occur due to a person’s anticipation that the loss of reinforcement is only temporary.

For example, a person who is being ignored whenever a person raises his or her voice inappropriately may become even louder until someone intervenes. It is necessary for staff members to realize that patience and consistency are key to the successful use of extinction, and to not resort to the old behaviors of reinforcing the unacceptable behavior.

2. Social Restitution

This requires the individual to make a corrective action after the maladaptive behavior. For example, an individual who throws food on the dining room floor is asked to clean up the mess.

3. Response Cost

When the problem behavior occurs, the person is “fined” or loses a privilege. For example, the person who becomes very disruptive in a group activity may lose the privilege of joining the others on a trip to the mall.

4. Exclusion Time-Out

In some cases, a person may need to leave a room entirely if she or he is engaging in seriously disruptive problem behavior and does not stop. This
procedure only works if removing the person from the room causes him or her to “miss out” on an activity he or she enjoys. In this case, the person is motivated to stop the problem behavior to avoid exclusion in the future. A potential drawback to the use of exclusion is that, when staff ask the client to leave the room, the client may engage in more problem behaviors or refuse to leave.

VII. PROBLEMS ENCOUNTERED

A number of problems are likely to occur in the use of behavioral management. These include failure to implement an intervention plan consistently, staff biases or stereotypes, satiation, generalization of new skills, and working with individuals with memory problems.

Problems Encountered & Solutions

- **Staff often do not implement a plan in a consistent manner:** Everyone must follow the behavioral plan in the same way.

- **Staff stereotypes or biases affect their participation in the plan**
  - Behavior management can be effective for all residents if applied consistently and if we avoid predictions of failure before we try!

- **Satiation**
  - A reward loses its value if a resident receives too much of it
  - Develop a list of alternative rewards to use.

- **Generalization**
  - Will the new behavior generalize to other settings or staff?

- **Memory Impairment & Dementias**
  - Develop simple goals, and increase use of cues, prompts, etc.

A. Consistency

Behavioral plans must be followed in a consistent manner by all staff. Some staff will reward certain behaviors as described by the plan, while others will not. Some staff members ignore certain problem behaviors, while others react or pay attention to the behavior. When staff members perform inconsistently, the plan “falls apart.”

To overcome this inconsistency, encourage staff to communicate. Discussing behaviors recorded on the BAF during staff meetings allows everyone to hear and discuss the observations and what to do about them. Providing staff with a written prompt such as an instruction, written in quotation marks, and placed in the chart, will allow everyone to respond exactly the same. For example, an instruction might state that whenever Mr. Smith...
refuses to bathe, staff members are to encourage him by saying “Mr. Smith, as soon as you are done with your bath, I will play cards with you.” Informing everyone involved in the plan (resident, staff, family, etc.) about the benefits of adhering to the plan increases the chances for its success.

B. Staff Biases and Stereotypes

Unfortunately, some staff members have biased attitudes or hold stereotypes about residents. Some believe that older adults’ behaviors can’t be changed, that a resident has no potential rewards, or that all behaviors are biologically caused and can’t be managed by behavioral techniques. We encourage you to implement the plan in a consistent manner and avoid predictions of the resident’s failure before we even try implementing it.

C. Satiation

Sometimes the value of certain rewards is diminished as the individual adapts to it. If food is always used as a reward, the person may become full. If the person has earned several privileges that day, earning more might not be as great a motivator. For such occurrences, it is wise to consider a list of reinforcers, such that if the first one no longer motivates the person, a second or third choice on the list might.

D. Generalization

Another concern is the generalization of newly learned behaviors. A behavior may change only in certain locations or in response only to certain staff members. You can make sure that residents’ behaviors are encouraged in other settings - again by maintaining consistency in how they reward and how they ignore behaviors. Family members and significant others who visit the resident should also be encouraged to follow the plan the same way.

E. Individuals with Memory Problems

Some residents may experience memory problems that will create greater challenges in the application of behavioral modification. Often staff members believe that it is normal to expect memory loss with older age. However, there is a reason for significant memory loss and staff should be aware that some types of memory loss may be temporary and reversible, while others may be permanent and perhaps progressive.

“Confusion” is a temporary and reversible condition. Confusion may result from reactions to medications, illness, or head injury. Individuals experiencing depression may also exhibit problems or pseudodementia. ALF staff should report any sudden changes in behavior that reflect memory
problems. These can be checked against any changes in medication or changes in emotional state.

The greatest problems occur with memory impairment, an irreversible condition caused by Alzheimer’s Disease, stroke, brain injuries, etc. Dementias often represent a slow, degenerative process of memory, language skills, and executive functions. ALF staff should be encouraged to implement the behavioral plan by recognizing that many behavioral techniques have worked well for people with memory impairment.

VIII. OVERVIEW OF REALITY ORIENTATION

Those of you who work with residents who have mental illnesses need to be aware of the definitions of “reality orientation.” Sometimes a person with a mental illness may not be adequately oriented to time, place, person, or circumstance. In addition, they may have “negative” and “positive” symptoms of those illnesses. Their symptoms can interfere with their ability to function in any environment. In some instances, their symptoms may make completion of even basic tasks more difficult. How a mental illness affects a person will vary considerably. Consequently, it is important that needs be assessed individually.

A person who is not oriented well to time, place, person and circumstances will benefit from reality orientation.

Reality orientation is designed to repeatedly provide a person with information about their environment in order to increase their ability to function.

It is important to note that many people with a serious mental illness are well oriented to time and place. People can function independently even with the symptoms of hallucinations or delusions. Other people have a great deal of difficulty coping with their symptoms.

Low motivation can be one of the most difficult and frustrating symptoms of mental illness to treat. By involving the person you can begin to discover what is reinforcing to the them and what is not.

IX. TYPES OF ORIENTATION

There are several mental health terms that are used to describe the symptoms in which people are unable to identify time, place, person, or circumstance. One of the most common terms is “confusion;” another is “disorientation.” Generally, the mental health professional will indicate in their assessment the areas in which the person is disoriented; time, place, person, or circumstance.
Chapter 4

We are going to discuss these four areas of disorientation and their potential implications and effects on the person’s ability to function.

A. Time

Disorientation to time may involve the inability to accurately know the year, month, day, time of day, or season. You can generally determine if a person is oriented to time by asking them about it.

Disorientation to time has practical implications for a resident. A person who is disoriented to time may get up and dress in the middle of the night. They may get ready for appointments that have already occurred. They may need prompting to come to meals or attend to personal grooming.

B. Place

Disorientation to place may involve the inability of a person to state the name or location of where they live. Does the person know where they are? Can they find their way around the facility and the immediate neighborhood? A person who is disoriented to place may not be able to return home if they should leave.

C. Person

Sometimes a person may be sufficiently confused that they are unable to report important information about themselves, such as their name or address. Disorientation to person extends to others and can be seen when the person is unable to identify staff, family or friends who visit. If they are experiencing delusions, they may believe that they are someone else and not respond to their own name being called.

D. Circumstance

A person who is disoriented to their circumstances may not have the ability to explain their current situation. They may have little insight into the nature of their mental illness and how it affects their circumstances.

E. Memory and Concentration

A person who is disoriented may have problems with memory and concentration. Memory impairments generally affect recent memory first, i.e., they may be able to recall events vividly from their childhood but are unable to remember what they had for dinner yesterday. The ability to concentrate is frequently impaired in individuals with severe mental illnesses.
A person may have difficulty focusing or concentrating for a variety of reasons. For example, they may be anxious, hear voices, or be distracted by other activity in the environment. You may develop the mistaken impression that a person with impaired concentration is disoriented, when in fact, the person is not focusing on your questions.

X. CAUSES OF DISORIENTATION

Disorientation may occur very rapidly or slowly over time. Rapid onset of disorientation may indicate an acute physical condition, such as a stroke, and should be brought to the immediate attention of a physician.

Disorientation may be caused by physical/organic, biological, or mental illnesses. Examples of physical/organic causes include Alzheimer’s disease, stroke, high fever, alcohol or other drug abuse, side effects of medications, or trauma. Side effects of prescribed medications may be especially problematic with older adults. Examples of mental illnesses are schizophrenia and severe mood disorders.

It is very important therefore, that disorientation be carefully assessed by professionals.

XI. REALITY ORIENTATION

Someone who is not well oriented or is confused is best helped in an orderly, calm environment. They may require a lengthy period of time to adjust to their new home. The needs of a person for and their receptivity to “reality orientation” may vary according to the cause of the disorientation. A person who is disoriented due to delusional thinking may respond differently to a staff member attempting to “orient” them to “person” then they might if they had mild symptoms of Alzheimer’s disease.

There are things you can do that will help a person who is disoriented. First, create an environment that meets their needs. You can also communicate clearly.

A. Creating an Environment

- A calm, ordered setting will be more reassuring.
- Place a calendar with the current day highlighted either in the person’s room or in a prominent place in the ALF.
- Place a large clock in all the main areas of the facility.
- Place a calendar of events in a prominent place. Place a large sign with their address and phone # in a prominent location.
Chapter 4

Behavior Management Techniques

• Provide a quiet area to use if they want to get away from people and noise.

• Minimize changes to the person’s living area and prepare them for any changes that may occur.

• Wear name tags.

• Place a person’s name on the door of their room.

• Assist the person in clearly marking their personal possessions.

• Have all rooms labeled clearly, e.g., kitchen, office, and bathroom.

B. Communicating Effectively

Remember that people’s needs vary. You will want to modify your interactions to meet their needs.

• Address a person by their name every time you interact.

• Give your name every time you approach them.

• Do not assume that the person is aware of who you are.

• Use clear and understandable language, but do not talk down to the person.

• State the main ideas you want to talk about first.

• If you are assisting the person in a task, state what you are doing as you perform the task. For example, tell the person that you are taking their bed linens to be washed.

• If you are giving instructions to perform a task, give instructions for each step of the task in sequence.

• Repeat information as often as necessary.

• Ask the person to repeat instructions unless it becomes too frustrating for them.

XII. SELF-MANAGEMENT APPROACHES

Many residents are capable of not only understanding their service plan, but also being “in charge of” managing their own behaviors, called “self-management.” A self-management approach is useful for increasing generalization, self-control, and independence.
Rather than the staff member “doing something” to the resident, it is the resident who learns to define the problem, identify his/her personal antecedents and consequences, and apply self-reward techniques to increase adaptive behaviors. The resident works on the plan with the staff member who serves as a motivator and teacher. Techniques include self-monitoring or logging one’s behavior, practice using homework or assignments, and behavior establishing contracts.

Self-Management Methods

- **Self-Monitoring** - A resident uses logs or diaries to record target behavior.

- **Task, Assignments** - A staff member suggests a task for a resident to attempt; motivates resident, discusses progress.

- **Behavioral Contract** - Resident and significant other identify contingencies and reinforcers in verbal or written contract.

With a staff member or another person, the resident learns how to apply behavior techniques to increase or maintain self-management.

**A. Self-Monitoring**

Self-monitoring involves the resident logging or writing down when a problem behavior occurs, in addition to a little information about what he/she was doing before (antecedents) and after (consequences). A resident can easily learn to record his/her own behavior using a diary, notebook, or log. The staff member can encourage this by discussing the results each day with the resident.

For example, a resident will be asked to start noticing when he/she has makes a negative “self-statement” such as “I’m no good” or “I’ll always be a failure.” Each day, the staff member and resident can spend a few minutes discussing the antecedents to the behavior, practicing relaxation, and developing a few positive statements to dwell on such as “I’m glad I’m doing better these days” or “I have a good relationship with my family.”

**B. Tasks or “Homework” Assignments**

Tasks or “homework” assignments by the staff allow the resident to practice new skills away from the staff. For example, a shy individual may be asked to visit a community recreation center and bring back a brochure for discussion with a staff member as a way to “break the ice” of finding what activities he or she might like to undertake.
C. Behavioral Contracts

A behavior contract is an agreement between the resident and the staff or significant other (e.g., a spouse). It spells out the expected behavior and the consequences if the behavior occurs (e.g., reward) or does not.

D. An Example of a Behavioral Contract

The following section provides an illustration of a behavioral contract between the ALF and the resident. Let’s assume that, as part of a plan, Mr. Smith (the resident) and the ALF staff member Mr. Jones establish a contract. Mr. Smith will focus on trying to visit the dining room on time and not to smoke inside the ALF. In return for visiting the dining room on time, Mr. Jones agrees to play his favorite game - chess - with him. If Mr. Smith does not smoke, Jones will let Mr. Smith select the videotapes for the residents to view.

Also identified are any penalties. In this case, Mr. Smith agrees to sacrifice one cigarette if he smokes in the ALF. The contract must be signed by both parties so that it shows it is a mutual agreement. It should be viewed as desired behaviors to be accomplished rather than punishment.

Behavioral Contracts

An agreement (usually written) between the resident and one or more other people (staff, family, etc.)

- Problem behaviors and desired behaviors are defined in simple, but detailed terms;
- Rewards for accomplishing the desired behavior are clearly stated; and
- Consequences for not accomplishing the behavior are also stated.

Behavioral Contract

Alfred Smith agrees to:

- Arrive on time to the dining room for dinner.
- Not smoke in ALF

Bob Jones agree to:

- Play chess with Mr. Smith after dinner
- Allow Mr. Smith to select that evening's videotapes

Bonus - For each day Mr. Smith accomplishes both goals, he receives a novel from the ALF library.

Penalty - Each time Mr. Smith smokes in the ALF, he must give up one cigarette.

By signing below, I agree to follow each of the terms in this contract.

_________________  ________________
Alfred Smith      Bob Jones
XIII. CONCLUSIONS

Residents requiring a behavioral plan may exhibit problem behaviors. This chapter focused on the ALF staff member’s role in developing and implementing the plan as it pertains to high frequency problem behaviors to be managed in an ALF.

The resident must be an active participant in the plan. If he/she cannot comprehend the plan, a guardian or family member may be involved in its development. How residents or guardians participate in the plan must be documented.

Problem behaviors affect one’s quality of life. The role of ALF staff is to identify these behaviors, report their occurrence, and reward, ignore, or modify the behavior according to the plan. Staff must learn not just to eliminate the problem behavior, but to reward desired behaviors to take its place.

Each resident’s problem behaviors must be described in simple and observable terms. Diagnoses or other global labels do not describe what the resident is doing or saying. Similarly, each resident’s rewards should be identified so that we reward a person immediately after the adaptive behavior is accomplished or at least attempted.

The greatest challenge to the success of a behavioral plan is the consistency of having staff follow the plan. All staff must prompt in the same way, reward accomplishments in the same way, ignore behaviors in the same way, etc. If even one staff member takes different actions, the problem behavior will persist. Consistency is encouraged by good communication through staffings or service plan meetings on a regular basis. Staff training will help them to overcome biases and stereotypes that they may hold, which will in turn improve the implementation of the plan.
Chapter 4

Behavior Management Techniques

Assisted Living Facility
Limited Mental Health Training

Role of ALF Staff

For some individuals, a mental health plan is required. The plan describes targeted problem behaviors which may adversely affect one’s placement or interfere with the quality of life, and the plan clearly identifies what actions staff, the resident, family members, etc. must follow, as well as methods for evaluating and altering the plan on a regular basis.

The role of ALF staff is more likely to include: Recognizing the occurrence of the targeted behaviors, recognizing other problem behaviors, administering rewards and other consequences contingent on certain behaviors, communicating with other staff and the mental health professionals about progress, and maintaining the plan as strictly as possible. The ALF staff is therefore more than just the “eyes” and “ears” of the plan.

Frequent Problem Behaviors

- Interfere with participation in program, threaten placement, reduce quality of life.
- Is it a frequently observed problem?
- How often does the behavior occur?
- When does the behavior occur?
- What usually happens before the behavior occurs
- What usually happens after the behavior occurs?
Behavior Analysis Form

Problem Behaviors Don’t Happen out of the Blue!

They are usually triggered by an event called the antecedent. Examples: being left alone, too much noise, a request by a staff member, or seeking attention.

They are immediately followed by a positive consequence. Examples: attention from others, being left alone, or not being bothered by others.

To help understand this we look for the A-B-C’s OF BEHAVIOR

Antecedents ▶ Behavior ▶ Consequences

Behaviors Addressed in a Behavioral Plan

- Behaviors which interfere with participation in the program
- Behaviors which place the person at risk of losing placement in ALF
- Behaviors identified by the resident
- Changes in behaviors which would increase enjoyment of life

Suicidal, combative/assaultive, fire setting or other behaviors which place the resident or other residents in imminent danger - may not be manageable in an ALF and must be addressed according to ALF policies & procedures.
Chapter 4

Definitions

Examples of Problem Definitions
- They Do not participate in group activities
- Refuses to take a bath
- Smokes cigarettes in the ALF (which is prohibited)
- Refuses to take medications
- Begins to yell and curse after a family visit
- Makes frequent negative self-statements

Examples of Good Definitions
- Objective - observations of what you saw/heard
- Specific - describes in very simple terms
- Parsimonious - Avoids assumptions about “underlying causes.”

Community Support Living Plan

MH coordinator, Resident & Case Manager develop written plan which specifies the:
- Specific needs and goals
  Short term goals reflect small changes
  Long term goals reflect how a person will behave after intervention is complete
- Services by mental health provider
- Non-clinical services provided by ALF
  Consult the Personal Safety Plan established for each resident

Behavioral Goals

Short-term Goals:
- Reasonable increases in adaptive behaviors (For example - encourage participation in group activity)
- Simultaneous decreases in maladaptive behavior (For example - ignore yelling, cursing)

Long-term Goal:
- Final, expected outcome of behavior modification procedure
Behavior Modification

- Procedures which rely on principles of learning to change behavior
- Increase adaptive behaviors
- Decrease maladaptive behaviors
- Behaviors attained must be of a socially relevant nature
- Relies on objective and measurable outcomes
- Focus on the behavior as the problem, not the person

Rewarding Adaptive Behaviors

- Identify each resident's rewards through the initial assessment, interviews, and observations
- What does the person enjoy doing? Will he or she “work” for the reward?
- Apply the reward immediately after the desired behavior

The goal is to continually increase positive behaviors

Positive Reinforcement Techniques

Shaping - you reward the resident's attempt at the desired behavior. The next time, you wait until the attempt is a little closer to the desired behavior, then reward. Each time, you reward for closer and closer attempts.

Problem - Ms. Jones leaves her room a mess, fails to make the bed

Goal - teach her to make the bed.

Plan - Reward Ms. Jones if she attempts to straighten the bed sheets. The next time, require that she straighten the pillow and sheets before rewarding her. The next time, reward her after she adds the bedspread.
Chapter 4

Premack Principle Example

This technique involves using a behavior or activity the person is most likely to do frequently (a high probability behavior) to reward a behavior we want to increase (low probability behavior).

**Problem:** Mr. Smith stays cooped up in his room (high probability behavior), rarely socializes, and is becoming withdrawn.

**Goal** - to encourage and increase Mr. Smith’s participation/activities with other residents.

**Plan** - Staff prompt Mr. Smith by saying: “Mr. Smith, if you join the recreation hour with the others for just 5 minutes, you may return to your room.” Staff reward Mr. Smith by praising his efforts in group, and returning him to room.

Examples

**Prompting** - Providing a verbal cue, written cue, a gesture, or some other reminder, then reinforce the attempt.

**Modeling** - Staff member models a certain behavior, asks resident to try it, and rewards attempt.

**Example** - Staff member pretends he is shaving by moving an electric razor up and down on his own face, then asks resident to try it on himself. Praises the resident for the attempt and provides a few pointers for improvement.

Chaining Examples

- **Chaining** - Divide task into a series of steps. Prompt person to try first step. After completion, prompt next step, then reward. After successful at the two steps, prompt third step & reward.

- **Backward Chaining** - start with end step and progress until first step is achieved.

- **Example** - Mr. Green has memory problems and can’t remember where dining room is.

- **Plan** - Begin at dining room on first day and reward. Next day begin a little further away, then go to dining room and reward. Increase the number of steps on successive days before rewarding.
Techniques for Decreasing Behaviors

- Extinction - Ignore person immediately after maladaptive behavior occurs.

- Example - When Mr. Jackson begins to curse loudly in a group meeting, all staff are instructed to ignore him and begin talking to other residents. As soon as he stops and begins to participate normally, staff pay lots of attention to him.

- Social Restitution - Resident creates a mess. Is required to correct, clean it up.

- Overcorrection - restitution which goes beyond the immediate damage the person caused.

Techniques for Decreasing Behaviors (cont’d.)

- Response Cost - Individual is fined, or loses a privilege.

- Example - If a resident throws food on the floor in the dining room. He is “fined” by losing the privilege to join the other residents on a planned outing to the mall.

- Exclusion Time Out - a disruptive person may be requested to sit away from others until he/she becomes calm.

Problems Encountered & Solutions

- Staff often do not implement a plan in a consistent manner: Everyone must reward or extinguish in the same way.

- Staff stereotypes or biases affect their participation in the plan - Behavior management can be effective for all residents if applied consistently & if we avoid predictions of failure before we try.

- Satiation - A reward loses its value if a resident receives too much of it - Develop a list of alternative rewards to use.

- Generalization - Will the new behavior generalize to other settings or staff?

- Memory Impairment & Dementias - Develop simple goals, increase use of cues, prompts, etc.
Chapter 4

**Slide 19**

**Basically, Human Behavior:**

- Is complex
- Is not random
- Has meaning
- Has a cause and effect
- Does not occur in a vacuum

**Slide 20**

**Factors That Can Affect Behavior**

- Transitions
- Loss of independence and privacy
- Loss of control
- Sensory changes
- Pain
- Medications
- Confusion
- Emotional conditions

**Slide 21**

**Methods of Support**

- Get to know each resident
- Talk with the Person
- Observe the person
- Review information
Effective Listening Techniques

- Adopt a physical position that shows you are interested
- Give the person your full attention
- Watch for nonverbal messages
- Be aware of your own biases
- Look at the situation from their point of view
- Don’t interrupt

Behavioral Support Steps

1. Identify the problem. Whose problem is it?
2. Assess the problem. What is actually happening?
3. Create a plan of action. Involve the person in problem-solving.
4. Implement the plan. One step at a time.
5. Evaluate the plan. Were the outcomes satisfactory?
6. Ongoing assessment. If the plan stops working, try a new plan.

Common Behaviors

- Distrust
- Depression
- Withdrawal
- Denial
- Excessive Physical Complaints
- Manipulation
- Aggressiveness
Chapter 4

Staff Reminders

- Attitude is important – Be a positive influence and a good role model.
- Social courtesies are important – Treat people respectfully.
- Reassure people, give positive feedback.
- Keep people informed of changes in schedules.
- Monitor the environment for conditions that are distracting and disturbing.
- Continue to increase your knowledge and skills.

Reality Orientation

Reality Orientation is designed to repeatedly provide a person with information about their environment in order to increase their ability to function.

Information such as:

- Time
- Place
- Person
- Circumstance

Assess Each Person

- Many people with a serious mental disorder are well oriented.
- Some people function independently even with the symptoms of hallucinations or delusions.
- Other people have a great deal of difficulty coping with their symptoms which interfere with their ability to function.
Disorientation or Dementia

- A person who is disoriented may have problems with memory and concentration.
- Disorientation may be caused by physical/organic/biological or mental health conditions.
- Examples of physical conditions would include Alzheimer's disease, senility, stroke, substance abuse, or side effects of medications.
- Examples of mental health conditions would include schizophrenia and severe mood disorders.

Create an Environment

- A calendar in a prominent place with the current month, date, and day
- Large clock in all main areas
- Calendar of events in a main area
- Large sign with address and phone #
- Provide a quiet, calm, ordered setting
- Minimize changes to living area and prepare a person when changes are going to be made
- Wear name tags
- Place their name on the door of their room
- Assist them in marking personal possessions
- Label common areas such as the kitchen, etc.

Clear Communication

- Address a person by their name each time you interact with them.
- Give your name each time you approach.
- Do not assume the person is aware of who you are.
- Use clear, understandable language.
- Do not talk down to a person.
- State main ideas you want to talk about first.
**Clear Communication (cont’d.)**

- When assisting a person in a task, state what you are doing as you perform the task.
- When giving instructions to perform a task, give instructions for each small step of the task.
- Repeat information as often as necessary.
- Ask the person to repeat the instruction unless it becomes too frustrating for them.
- Do not assume they will remember instructions from previous situations, therefore, repeat as often as necessary.

**Self-Management Methods**

- Self-Monitoring - Resident uses logs or diaries to record target behavior
- Task, Assignments - Staff member suggests a task for resident to attempt; motivates resident, discusses progress
- Behavioral Contract - Resident and significant other identify contingencies & reinforcers in verbal or written contract
- With staff member or other person, resident learns how to apply reinforcement principles to increase or maintain self-management approaches

**Behavioral Contracts**

An agreement (usually written) between the resident and one or more other people (staff, family, etc.)

- Target behavior is defined in simple, but detailed terms
- Consequences (rewards) for accomplishing the desired (target) behavior are clearly stated
- Consequences for not accomplishing the behavior are also stated
Crisis Intervention Techniques

Assisted Living Facility Training for Limited Mental Health Licensure

Chapter 5

Annette Christy, Ph.D.
Associate Professor

Peter E. Gamache, Ph.D.
System of Care Educator

Department of Mental Health Law and Policy
Louis de la Parte Florida Mental Health Institute
University of South Florida
Chapter Directions

Be sure to read the Introduction at the beginning of the manual before proceeding with the chapter presentations. A PowerPoint presentation for this chapter is available at www.BakerActTraining.org and is also printed at the end of this chapter.

Chapter Description

Staff who work in Assisted Living Facilities need to be ready to help a person experiencing a mental health crisis. Staff respond most effectively when they are aware of the needs of the person in crisis. This chapter will provide information and techniques on how to help the person through the crisis.

Learning Objectives

Participants should be able to identify and discuss the following:

1. Appropriate responses to mental health crisis situations experienced by Assisted Living Facility residents;

2. Suggestions and guidelines for a “crisis plan” for responding to persons with mental health crises;

3. Information necessary for evaluating a crisis and determining the most appropriate response;

4. Factors that contribute to a crisis;

5. Procedures to respond to persons who may react in self-injurious or violent ways toward others; and

6. Resources that are needed to respond to a crisis in the ALF.

Time Frame:

30 minutes

Materials

LCD Projector/PowerPoint Slides
Handouts
Outline

I. Introduction ................................................................. 190

II. Potential Crisis Situations ............................................. 190
   A. Identifying a Potential Crisis ........................................ 190
   B. Developing a Crisis Plan ............................................. 193
   C. Considerations in Evaluating a Crisis ......................... 195
   D. De-Escalation Approaches ........................................ 196

III. Crisis Intervention ...................................................... 196
   A. Questions to Ask ...................................................... 196
   B. Responding to a Crisis ............................................. 198

IV. Suicidal and Violent Behavior ........................................ 201
   A. Suicidal Behavior ...................................................... 201
   B. Violent Behavior ...................................................... 203
   C. Dos and Don’ts ....................................................... 203

V. Baker Act ....................................................................... 205
   A. Commitment Criteria ............................................... 208

VI. Crisis Prevention .......................................................... 209
   A. Get to Know the Residents as Individuals .................... 209
I. INTRODUCTION

You need to be ready to help an ALF resident experiencing a mental health crisis. You can respond most effectively when you are aware of the needs of the person in crisis. As with any crisis situation, appropriate preparation and training will provide a better response.

Crises are situations in which a person believes they are overwhelmed. They usually believe they are “helpless” and that their situations are “hopeless” and cannot easily be solved. The person may have limited “coping” skills which have been ineffective in stressful situations. As a result, a person in crisis often experiences physical and emotional distress that might include muscular tension, headaches, fear, anger, and confusion. They may either believe that they are unable to take action on their own, or they may decide on courses of action that endanger themselves or others.

Some mental illnesses have “signs” that help identify a potential crisis early; others do not. Signs may include refusal of prescribed medications, fluctuations in behavior from one extreme to another, or the anniversary date of a loss (such as death of a loved one).

It’s wise to have a plan of response prior to a crisis. Just as we might have a fire drill, having a plan of response to a mental health crisis will help provide a consistent, rational and appropriate response that protects residents and staff.

It is equally important that after the crisis situation is over that you (1) evaluate how the person in crisis is feeling (2) meet with other staff members to evaluate the actions taken and the results of those actions and (3) determine how other residents are feeling and thinking. Offer support and reassurance without violating the person’s right to confidentiality.

Because some mental health crises may involve suicidal or violent thoughts or actions, these important issues will be presented in detail.

II. POTENTIAL CRISIS SITUATIONS

A. Identifying a Potential Crisis

There are a number of reasons why a person may experience a crisis. For example, we are all more vulnerable to crisis after missing a lot of sleep, experiencing the loss of a loved one or a job, or during or after a physical illness. However, for the person with a serious mental or emotional disorder, the experience or return of symptoms of the illness can trigger the emotional and psychological distress that leads to crisis situations. The symptoms of some illnesses often become worse as a result of normal life
stresses, changes in medications, or changes in a therapist. Even when a person is taking medications, they may still be vulnerable to situations that threaten self-esteem or safety. This vulnerability is increased if the person stops taking medications that reduce symptoms such as hallucinations, anxiety, or depression.

The very nature of some symptoms such as hallucinations or anxiety can lead to a crisis. For example, a person who is diagnosed as having schizophrenia or even an anxiety disorder may experience ideas or emotions that lead them to believe they are in danger or being punished when they are not.

People with serious mental or emotional illnesses have often experienced many “losses” or “personal crises” in their lives. Families may have rejected them or been unable to deal with the symptoms of their illnesses. They or their families may have had expectations of achievement that were delayed or stopped by the condition of the mental disorder. Their losses often reduce their “self-esteem” and increase their vulnerability to negative thoughts and depression. A person can sometimes believe that suicide or making suicidal statements is the only way to stop further losses, relieve their pain, or reduce the losses experienced by others.

Many people with a mental illness have little confidence and have not developed effective ways to cope with stressful situations. Identify potential crises situations in advance will help prevent harm to the individual in crisis, other residents, and ALF staff.

Prevention

Make a plan with the resident for what to do in each of these situations. Building a partnership with your local Community Mental Health Center (CMHC) can help you to learn more about how to prevent crises and address them when the occur.

Be aware of situations that can lead to a crisis

This includes when the person:

- Stops taking medications;
- Begins using illegal drugs or alcohol;
- Reports hearing more voices or seeing things that others do not see or hear;
- Starts saying things that do not make sense or seems confused about who they are, where they are, time markers, or the steps that lead to an event (i.e., disorientation to person, place, time, situation);
Chapter 5

Crisis Intervention Techniques

- Stops talking, becomes isolated, or appears to lack the energy and motivation to do things he/she usually enjoyed in the past;

- Has a change in mood or attitude that is sudden or that happens a lot;

- Experiences health problems that are chronic (go on for a long time) or acute (come on suddenly, emergencies)

- Experiences stressful situations;
  1. A relationship break-up;
  2. The death of family member, significant other or friend;
  3. The loss of a job or housing; and
  4. Other losses that mean a lot to the person.

Act early in a situation that could lead to a more severe crisis

Simply giving some of your time, a good listening ear, and expressing genuine interest to someone with a troubling situation can help. In fact, attending to changes in a person before these changes become a crisis situation may prevent a crisis.

Not paying attention and failing to respond early may lead a person to believe that attention only comes when they are in a crisis. The following actions can help to prevent a more severe crisis:

- Ask what the person is thinking or feeling.

- Encourage them to talk with you about the situation.

- Ask the person what you can do to help, or if help from another person or other people is wanted.

- Do not ignore the situation and hope it will go away.

- Know what mental health services and transportation are available in your community.

- Know what resources are available to each person (Medicaid, insurance, eligibility for public supported services, etc.).

- Know what arrangements have been made by your ALF for emergencies or other telephone or on-site consultation from a qualified mental health professional.
• Be familiar with responsibilities and limitations related to assistance from law enforcement responding to mental health crises.

• Make sure the person knows to reach out when he or she needs help.

• Have a Advanced Directive in place that will help with decision making (see Appendix A).

Communicate with residents and other staff about the situation

• Tell other staff and your supervisor at your ALF what changes you have observed in the person’s behavior. If staff don’t tell each other their observations and concerns, they may be caught unaware when a situation builds to a crisis.

• Contact the person’s case manager, counselor or therapist to express your concerns.

• Communicate regularly with other people involved in the person’s treatment. Learn when their case managers or other mental health professionals are available, and try to keep them informed of changes you observe.

• Encourage the people living in your facility to let you know when things are going well for them and when they are not. In other words, don’t just attend to “negatives.” However, do not ignore the “negatives.”

• Listen to the people living at your facility. Your facility is their home where they want to feel safe and know someone cares about what happens to them.

B. Developing a Crisis Plan

Make certain that important information about each person is available at the assisted living facility

This information should include the following:

• Copy of Advanced Directive;

• Personal Safety Plan;

• Birth date;

• Social security number;
• Medical conditions and physical limitations;
• Allergies;
• Weight, height, general body build, and the presence of distinguishing characteristics (scars, facial hair, tattoos, etc.);
• Name, address, and phone number of:
  ▪ The person has identified someone for this responsibility;
  ▪ Family members;
  ▪ Legal guardians (if any);
• Names, dosages, and frequency of prescribed medications;
• Insurance coverage (including Medicaid);
• Name, agency, and phone number of:
  ▪ Case manager;
  ▪ Therapist;
• Psychiatrist, psychologist or physician (if under the care of one of these professionals); and
• Any other mental health professionals under contract to the ALF to respond to mental health or medical emergencies.

Have agreement and written procedures for responding to a crisis - see Section VII Personal Safety Plan

• Decide ahead of time which staff will be designated or available to help and what outside assistance is available.

• Decide ahead of time which written policy and procedure to follow (e.g., a “checklist” for crisis management).

• The policy should include when to call outside sources for help, copies of contracts, if applicable, and names and telephone numbers.

• Maintain a phone list of community resources, including:
  ▪ Remember 911
  ▪ Crisis hotline
  ▪ Suicide hotline
Keep this list in a prominent location near a phone, keep it updated, and make sure all staff know where to find it!

Know how to follow this plan.

There is nothing better than planning and preparation. It increases the consistency of how situations are handled and reduces the stress for both the person in crisis and the staff that deal with the situation.

Review with the person what they can do when they are in a crisis.

Be sure a person knows how to reach their case manager, therapist, or other support personnel.

C. Considerations in Evaluating a Crisis

(To the trainer: Encourage audience participation by asking for examples of how making decisions is affected when stressed and in crisis. List these on a blackboard or flip chart. Read the following after the list is written down)

Someone who is in crisis may show significant increases or decreases in their emotions or may appear confused. A person’s ability to think clearly may be impaired because they have difficulty concentrating, or their thoughts may be disorganized or distorted. They may either withdraw or demand immediate solutions to their situations. They may perceive their normal environment as threatening or hostile. Their actions may seem impulsive, and their goals may be unclear. They could be very focused and intense and act in ways that are dangerous to themselves or others. A situation may not seem like a crisis to you, but to the person who is experiencing distress, it is a real crisis to them.

(Ask the audience to compare the preceding statement with examples provided by participants. If the audience is undecided whether a particular example could be a crisis, ask what information may be needed to make that decision.)

In order to provide important information to a case manager about a crisis or potential crisis situation with a person, you will need to gather more
specific information about what they are thinking and how they are feeling. Talk to them and ask questions that will help you understand their distress. Do they have plans that are harmful to themselves or others? How immediate is the situation? Have there been any significant behavior changes? Does the person have a known history of other crisis situations? Be prepared to answer questions the case manager will ask.

D. De-Escalation Approaches

The following four steps can be taken to approach a situation in need of de-escalation:

1. Sort out the facts to determine who was involved, what occurred, when it occurred, where it occurred, and why the person is upset;
2. Focus on opportunities for resolution rather than the challenges;
3. Prioritize options for shared decision-making; and
4. Follow-up to prevent re-escalation.

Work toward achieving dialogue as much as possible. Engaging in a dialogue (communicating so that others want to actively listen, and actively listening so that others want to communicate) is very different than monologue, which is when someone does not want to connect and wants to be heard or seen. The person who is in crisis may need to use monologue or “vent” in one direction before he or she is open to engaging in dialogue. Meet this person where they are with their understanding of the situation and their readiness to engage in dialogue. Keeping a person talking in an escalated situation is progress.

To prevent re-escalation, following up with this person will show that you care about what they went through. Checking in with this person can also identify potential frustrations or concerns early before they become critical.

III. CRISIS INTERVENTION

A. Questions to ask

Is the person disoriented?

- Does the person know their name, the names of family members, or staff they frequently interact with?
- Does the person know where they are (e.g., the state, city, facility name, or their own room)?
• Does the person know major time markers (e.g., the date of their birth, current date, or how long they have been a resident)?

• Does the person know the steps that led to an event (e.g., what just happened or what brought them here)?

What are the person’s plans?

• What is the person’s intention in this situation? Does the person intend self-harm or harm to other people or property?

• If the person expresses an intention to self-harm or harm others, does the person state how this would be carried out?

• Does the person have the means or access to carry out a threat of self-harm or harm to someone else?

• If a person states an intention of suicide by taking an overdose of pills, try to determine if the person has either prescription over-the-counter pills, or other drugs.

• If a person states an intention of self-mutilation, ask if the person has any knives, razors, or other sharp objects.

• Does a person reporting a plan to jump off a building say where this plan might be carried out?

• If the person speaks of self-harm, try to determine if the person has begun to carry out the plan. Examples include the following:
  ■ Purchased pills at the store;
  ■ Tried to purchase a gun;
  ■ Tried to obtain sharp objects; and
  ■ If a person intends to hurt someone else, is there a plan to carry this out?

How immediate are the person’s plans?

• How immediate is the threat? Does the person intend to carry out the plan today, next week, or sometime in the indefinite future?

• Does the person mention a time frame for carrying out any act of harm to self or others? How immediate is the crisis situation?

• Is the threat only to be carried out if something happens or does
not happen? For example, a person may state an intention to hurt another person if they catch them stealing their belongings.

- In some situations, a person’s emotional level rises rapidly and the person tries to find immediate relief, becoming more and more demanding. In other situations, a person may calm down rapidly after being very angry. This is important information to provide to the mental health professional.

**What behavior changes have you observed?**

- Have you noticed changes in the person’s behavior? For example, changes in their normal sleeping habits such as staying up all night or not sleeping either during the day or the night.

- Refusing to take medication for medical or emotional problems.

- Seeing or hearing things that others do not see or hear.

- Appetite changes.

- Increased or decreased interactions with others.

- Change in interest in what is going on in the ALF.

- Pacing, rocking, or repetitive behaviors.

- Does the person appear more depressed or show mood swings?

**What is the person’s history?**

One of the best predictors of future behavior is past behavior. Therefore, the person’s prior experiences with crisis situations are important, especially the outcomes of those previous crises. This information may be helpful for any mental health professional who becomes involved in the current crisis.

It you can’t find out anything but still suspect the person is experiencing a crisis, contact the person’s case manager or the clinician who has a contract with your ALF.

**B. Responding to a Crisis**

**Remain calm**

Your goal is to have the person remain in control or regain control.

- It is unlikely that a person will try to control him or herself if you appear to be losing control.
• Use a calm, even voice tone.

• Do not overreact to a situation.

• Do not make sudden movements.

• Do not touch the person unless invited to do so.

• Do not give the crisis energy. If the person is the only one displaying increased emotions, less energy will go into the situation.

• Keep your goals in mind. This is not the time to address past issues.

This is not the time to criticize the person. Once you have determined that this is a crisis, your goal should be to stay calm. Criticizing will aggravate the situation.

Be aware of your surroundings
Try to move the interaction away from other individuals.

An audience seldom helps a situation become calm

• A lot of activity may interfere with getting the attention of the person.

• Asking the person to join you in another area demonstrates your concern and desire to give them your full attention.

Do not corner a person or let yourself be cornered

• A person who is agitated may be frightened and react strongly to the belief that they are being cornered.

• The ideal place is one where either you or the person can leave the situation without coming close to others.

Do not meet where a person could grab something to hurt themselves or you

• A kitchen is usually not a good place to meet because knives or other utensils may be easily available.
Try to choose a place to meet where you can be observed by other staff

- Other staff should be alerted to be available to assist if you need them.
- You may feel less vulnerable if others can see what is happening.

Have a phone nearby

- The person may want to speak with someone.
- You may need to call and get information.
- You may need to summon assistance.
- If you need to leave the person to talk privately on the phone, be certain that the person continues to be observed.

Give the person plenty of space

- Getting too close could frighten the person.
- Getting too close could place you in danger.
- Stay at least five feet away from the person.
- Do not make sudden movements. The person may be fearful and misinterpret your moves.

Tell the person what you are going to do before you do it

The person needs to understand that you are trying to help. Let them know what you are doing and why.

- A person may have irrational thoughts, and explaining your actions may reassure them.
- Take a hopeful stance that the situation can be dealt with successfully. Try to establish trust and rapport with the person. Communicate that something can be done, that help is available, and that the situation will eventually get better. Focus on what can be done and how feelings can change.
Communicate clearly

- Get the attention of the person.
- Call the person by name.
- Try to establish eye contact. This shows that you have the person’s attention.
- Give clear directions.
- Make one request at a time.
- Ask if the person understands what is being said or requested.
- Make simple statements.
- Complicated explanations may not be useful for someone in crisis. The person may have difficulty concentrating on long or involved explanations.

IV. SUICIDAL AND VIOLENT BEHAVIOR

A. Suicidal Behavior

Suicide is a major risk for people with serious mental illnesses. This danger exists both for people with mood disorders as well as for people with schizophrenia.

15% of people with a major depressive disorder commit suicide.

10% of people with schizophrenia commit suicide.

10 -15% of people with bipolar disorders commit suicide.

Common Myths About Suicidal Behavior

Myth: Talking about suicide will give someone the idea to try it.

Facts:

- Asking if someone is thinking about suicide will not cause that person to attempt suicide.
- Asking questions about suicide often shows the person your concern.
Chapter 5

Myth: People who talk about suicide don’t kill themselves.

Facts:

• Most people who commit suicide have talked about it in the past.

• Threats of suicide should not be ignored.

• Only by asking questions about suicide will you be able to obtain information about the threat of suicide.

Myth: If someone really wants to commit suicide, no one can prevent it.

Facts:

• Most people have mixed feelings about ending their lives.

• Most people want to live even if they find it very painful.

• Frequently, suicide is a temporary urge or response to feelings of being overwhelmed or hopeless.

• Usually people are “lethal” in suicide terms for a limited period of time, sometimes only seconds or minutes.

• By getting people the attention they need, painful feelings can often be relieved.

Myth: Someone who has made a number of suicide attempts is not really serious.

Fact:

• Most people who commit suicide have made previous attempts.

Suicide Prevention

Be alert to early warning signs of suicide intent

• The person begins talking about death and dying.

• The person appears to be more depressed and hopeless.

• The person stays alone and rejects efforts to interact.

• The person expresses feelings of worthlessness and guilt.

• The person reports hearing voices commanding self-harm.
• The person’s mood suddenly changes.

Behave in a supportive manner
• Express your concern.
• State that you are aware of the person’s feelings.
• Do not declare that the person’s thoughts are wrong.
• Keep communicating with the person.

Protect the person in the immediate situation
• If a person speaks of suicide, ask if the person has a plan.
• If they have the means available for self-harm, ask the person to give you the pills, weapon, etc.
• It is up to mental health professionals to evaluate the person and determine their need for treatment.

B. Violent Behavior

Evaluate the potential for violence
• Do not ignore threats of violence.

Take action to reduce the risk of someone being hurt
• Do not hesitate to ask for help from other staff, case managers, therapists, mental health professionals, or the police is necessary.

If the potential for violence exists, contact the case manager, therapist, psychiatrist, mental health professional, contracted staff, or ALF manager.

C. Dos & Don’ts

DO take seriously every suicidal threat, comment, or action. Suicide is no joke. Don’t be afraid to ask a person if they are really thinking about committing suicide. The mention of suicide won’t plant the idea in their heads. Rather, a person will know that they are being taken seriously and are better understood than they suspected.

DO be willing to listen. You may have heard the story before, but hear it again. Be interested, strong, stable, and firm. Tell the person that every-
thing possible will be done to help them get through this most difficult or painful time.

**DO** be firm but supportive. Provide the person with some strength by showing that you are present and available.

**DO** something tangible. Give the person something definite to hang onto, such as arranging for them to see someone else such as a therapist, counselor or maybe even a significant other.

**DO** look for signs of depression, such as poor appetite, poor sleeping patterns, and high anxiety or fear.

**DO** explore recent separations. Has there been a recent breakup in a relationship? Has the person experienced recent “losses?”

**DO** ask if they have a history of suicide attempts, mental disorder, or depression. For example, ask if they have ever felt that way before and what they did then.

**DO** look for evidence of psychosis. Are they hearing voices (hallucinations) telling them to harm themselves or others?

**DO** ask the person to tell you if their situation seems hopeless to them.

**DO** ask about the present use of alcohol and drugs.

**DO** ask the person if they have a suicide plan.

**DON’T** dismiss a suicidal threat and underestimate its importance. Never say, “Oh, forget it. You won’t kill yourself.” That kind of remark discounts what the person is saying and feeling which could challenge them to prove they are serious.

**DON’T** try to shock or challenge the person by saying “Oh, go ahead and do it.” Such a remark might be hard to hold back if the person has been repeating threats or seemed bothersome to have around, but it is a careless invitation to suicide.

**DON’T** try to analyze the person’s behavior and confront them with your interpretations of their actions during a crisis. Simply gather relevant information that will aid a mental health professional to establish a diagnosis.

**DON’T** argue with a person about whether they should live or die. The only position to take is that you will do whatever it takes to get immediate help for them.
DON’T assume time heals all wounds and things will get better by themselves. That might happen, but it can’t be counted on.

DON’T try to handle everything by yourself. Seek a mental health professional for backup as soon as possible.

DON’T try to impose solutions or options. A solution may seem like a good one to you, but not for the person, especially when they feel that their situation is hopeless. Exploring options and ideas for alternative ways to approach the situation is much more beneficial.

DON’T discount a person’s feeling of hopelessness. Instead, clarify what you are hearing them say, obtain further information to help you see their situation from their point of view, and offer your understanding and support.

DON’T alienate the person by threatening police involvement or any other punitive measures.

DON’T patronize or elicit guilt by saying things such as, “You shouldn’t be drinking. That just makes you more depressed.”

DON’T confront delusional statements. A person will think that they are not being understood and may become frustrated or fearful.

DON’T hesitate to call the police if you think that the safety of the person (or others) is in danger.

V. BAKER ACT

CIVIL COMMITMENT (FLORIDA STATUTES 394)

There may be times when a resident of an ALF who is suffering from a mental illness may be in such a crisis that psychiatric hospitalization is indicated. The Florida law (the “Baker Act”) that governs the “commitment” or admission of individuals to inpatient psychiatric care provides criteria and procedures for two types of admissions: voluntary and involuntary. As an ALF staff member, you may be called upon to assist in carrying out the procedures outlined by the Baker Act, but you will not be allowed to initiate commitment proceedings (unless you are a mental health professional [physician, clinical psychologist, licensed social worker, psychiatric nurse, licensed marriage family therapist or licensed rehabilitation counselor]) — see involuntary examination. Some relevant provisions of the Baker Act for caregivers in ALFs include the following:
Voluntary Admissions

1. **Criteria.** A Baker Act receiving facility or CSU may receive...any person 18 years of age or older making application by express and informed consent for admission or any person age 17 or under for whom such application is made by his or her guardian. If found to show evidence of mental illness, to be competent to provide express and informed consent, and to be suitable for treatment, such person 18 years of age or older may be admitted to the facility. A person age 17 or under may be admitted only after a hearing to verify the voluntariness of the consent.

2. **Selected Voluntary Procedures Most Relevant for ALFs:**

   a. All persons, who are 60 years and older and who have been diagnosed as suffering from dementia, for whom voluntary transfer to a psychiatric facility is being sought from an Assisted Living Facility must be assessed by designated professionals for their ability to give expressed and informed consent.

   b. The facility may not admit as a voluntary patient a person who has been adjudicated incapacitated, unless the condition of incapacity has been judicially removed (this means anyone with a guardian appointed by a court as per Florida Statutes 744).

   c. The health care surrogate or proxy of a voluntary patient may not consent to the provision of mental health treatment for the patient (a voluntary patient is one presumed to be competent to consent to treatment). A voluntary patient who is unwilling or unable to provide express and informed consent to mental health treatment must either be discharged or transferred to involuntary status.

394.463 **Involuntary Examination**

   (1) **CRITERIA.**—A person may be taken to a receiving facility for involuntary examination if there is reason to believe that the person has a mental illness and because of his or her mental illness:

   a. 1. The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; or 2. The person is unable to determine for himself or herself whether examination is necessary; and (b)1. Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent...
that such harm may be avoided through the help of willing family members or friends or the provision of other services; or 2. There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.

(2) INVOLUNTARY EXAMINATION.—

(a) An involuntary examination may be initiated by any one of the following means:

1. A court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination, giving the findings on which that conclusion is based. The ex parte order for involuntary examination must be based on sworn testimony, written or oral. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, a law enforcement officer, or other designated agent of the court, shall take the person into custody and deliver him or her to the nearest receiving facility for involuntary examination. The order of the court shall be made a part of the patient's clinical record. No fee shall be charged for the filing of an order under this subsection. Any receiving facility accepting the patient based on this order must send a copy of the order to the Agency for Health Care Administration on the next working day. The order shall be valid only until executed or, if not executed, for the period specified in the order itself. If no time limit is specified in the order, the order shall be valid for 7 days after the date that the order was signed.

2. A law enforcement officer shall take a person who appears to meet the criteria for involuntary examination into custody and deliver the person or have him or her delivered to the nearest receiving facility for examination. The officer shall execute a written report detailing the circumstances under which the person was taken into custody, and the report shall be made a part of the patient's clinical record. Any receiving facility accepting the patient based on this report must send a copy of the report to the Agency for Health Care Administration on the next working day.

3. A physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for
involuntary examination and stating the observations upon which that conclusion is based. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, a law enforcement officer shall take the person named in the certificate into custody and deliver him or her to the nearest receiving facility for involuntary examination. The law enforcement officer shall execute a written report detailing the circumstances under which the person was taken into custody. The report and certificate shall be made a part of the patient’s clinical record. Any receiving facility accepting the patient based on this certificate must send a copy of the certificate to the Agency for Health Care Administration on the next working day.

(b) A person shall not be removed from any program or residential placement licensed under chapter 400 or chapter 429 [includes Assisted Living Facilities] and transported to a receiving facility for involuntary examination unless an ex parte order, a professional certificate, or a law enforcement officer’s report is first prepared. If the condition of the person is such that preparation of a law enforcement officer’s report is not practicable before removal, the report shall be completed as soon as possible after removal, but in any case before the person is transported to a receiving facility. A receiving facility admitting a person for involuntary examination who is not accompanied by the required ex parte order, professional certificate, or law enforcement officer’s report shall notify the Agency for Health Care Administration of such admission by certified mail no later than the next working day. The provisions of this paragraph do not apply when transportation is provided by the patient’s family or guardian.

A. Commitment Criteria

A person may be taken to a receiving facility for involuntary examination if there is reason to believe that due to the symptoms of their mental disorder:

The person has refused a voluntary examination after receiving a clear explanation of the procedures and purpose of the examination or is unable to determine for himself or herself whether an examination is necessary.

Without care or treatment the person is incapable of taking care of him/herself even with help from a significant other or is likely to harm him/herself or others in the immediate future.

(To the Trainer: Ask the participants this question: “If you see someone is
actively talking and responding to unseen or unheard voices, do they meet the criteria for commitment?)

Answer: No, they do not. Actively responding to hallucinations does not meet the criteria for commitment. Unless the person is engaged in behavior which is an immediate harm to themselves or others, many symptoms of mental illness would not meet the criteria.

Having a mental illness is not reason enough to use the Baker Act law to commit someone. A person whose behavior meets the criteria for voluntary or involuntary examination and/or admission are in the most extreme condition of their mental disorder. There are often many interventions which can occur before a person reaches a crisis.

VI. CRISIS PREVENTION

One significant intervention is preventative crisis management, which is intervening before a person reaches a crisis condition. Intervening early could eliminate the possibility of circumstances becoming a crisis and reduce the trauma a person often experiences during crisis situations. It can reduce the stressful impact on other residents and staff and reinforce a positive, supportive way for a person to cope with a situation that could otherwise lead to a crisis.

A. Get to Know the Residents as Individuals

We’ve already talked about getting to know each resident as an individual. Become familiar with their likes, dislikes, sleep habits, daily routines, people they spend time with, what is stressful to them, how they usually cope in difficult situations, and any other information that helps you to know them when they are not in crisis. This gives you good information that will help you to “tune” into changes when they occur.

Each person is unique in their needs, their ability to communicate those needs, and their perception of those needs. An important aspect of treating each resident as a person is to learn to see situations from their point of view. Approaching any situation with the belief that you know what is best for someone invalidates that person’s experience and is disempowering. Preparing a plan on how to handle a crisis situation should begin with the person at a time when they are not in crisis. Discuss with them what they want and need should the condition of their mental illness warrant the need for crisis intervention. One type of planning is the use of advanced directives. Another is developing a Personal Safety Plan (see Appendix C).
Assisted Living Facility
Limited Mental Health Training

Crisis Intervention

Crisis Risks for Persons
with Severe Mental Disorders

- For most people with serious mental health disorders, symptoms change over time; that is, they get better or worse as a result of normal life stresses.
- The nature of symptoms can lead to a crisis.
- Many people with a serious mental health disorder experience depression. Sometimes, suicide is believed the only way to get help with their pain.
- Some people with serious mental health disorders may have difficulty coping with stressful situations.

Be Aware of Situations
that can Lead to a Crisis

- Stops taking medications
- Begins using illegal drugs or alcohol
- Increases in hallucinations
- Saying things that don’t make sense
- Stops talking, avoids people, and appears to lack energy
- Mood or attitude changes suddenly or frequently
- A stressful situation occurs such as an acute health problem or the loss of a significant other
Act Early

- Ask about thoughts and feelings
- Encourage them to talk
- Ask the person what you can do to help
- Do not ignore the situation and hope it will go away
- Simply giving some of your time, a good listening ear may prevent a crisis
- Not paying attention and failing to respond early may lead residents to believe that attention only comes when they are in a crisis

Act Early (cont’d.)

- Know what mental health services and transportation is available in your community
- Know what resources are available to each person
- Know what arrangements have been made by your ALF for emergencies
- Be familiar with responsibilities and limitations related to assistance from law enforcement

Communicate with Others

- Tell other staff at your ALF what changes you have observed.
- Contact the person’s case manager, counselor or therapist to express your concerns.
- Establish a means to communicate regularly with other people involved in the person’s treatment.
- Keep case managers informed of changes you observe.
- Encourage the person to let you know when things are going well for them and when they are not.
- Listening to the person is always helpful
Chapter 5

Developing a Crisis Plan

- Make certain that important information regarding each resident is available at the assisted living facility.
- Have an agreement and written procedures for responding to a crisis.
- Train your staff on how to follow the plan.
- Review with the residents what they can do if they are in a crisis.

Evaluating a Crisis

- Plans
- When or how immediate
- Behavior changes
- History

De-escalation Approaches

1. Sort out the facts to determine who was involved, what occurred, when it occurred, where it occurred, and why the person is upset;

2. Focus on opportunities for resolution rather than the challenges;

3. Prioritize options for shared decision-making; and

4. Follow-up to prevent re-escalation.
Questions to Ask

1. Is the person disoriented?
2. What are the person’s plans?
3. How immediate are the person’s plans?
4. What behavior changes have you observed?
5. What is the person’s history?

Responding to a Crisis

- Remain calm.
- Be aware of the immediate surroundings.
- Give the person plenty of space.
- Tell the person what you are going to do before you do it.
- Take a hopeful stance that the situation can be dealt with successfully. Try to establish trust and rapport with the individual.
- Communicate clearly.

Myths About Suicide

1. Talking about suicide will give someone the idea to try it.
2. People who talk about suicide do not act on it.
3. If someone really wants to commit suicide, no one can prevent it.
4. Someone who has made a number of suicide attempts is not really serious.
Suicide Prevention

1. Be alert to warning signs of suicidal intent.
2. Be supportive.
3. Protect the person in the immediate situation.

Violence

1) Evaluate the potential for violence.
   *Do not ignore threats of violence.*
2) Take action to reduce the risk of someone being hurt.
   *Do not hesitate to ask for help from other staff, mental health professionals, case managers, police, etc.*
3) If you believe that the potential for violence exists, contact mental health professionals, case managers, and facility staff for an examination.

The Baker Act

- Provides the criteria and procedures necessary to intervene in a crisis situation where an individual may be a danger to him/herself or others due to symptoms or conditions of their mental disorder.
- Protects people from unnecessary or inappropriate commitment; therefore, the criteria and procedures are specific with a strict definition of what constitutes a mental health crisis requiring use of the baker act.
Voluntary Examinations
Criteria

- Person has requested or agreed on their own to a psychiatric examination.
- 18 years old or older.
- Legally competent.
- If 17 years old or younger, then the guardian would provide the request for an examination.

Voluntary Admissions
Criteria

- An examination has determined the person meets criteria for inpatient emergency treatment.
- Person has requested or agreed on their own to psychiatric treatment.
- 18 years old or older.
- Legally competent to give informed consent.
- If 17 years old or younger, then the admission would occur only after a court hearing to verify that the consent is voluntary.

Exceptions for Voluntary Admissions

- Person is 60 years or older with diagnosed dementia and has not been assessed for their ability to give an informed consent.
- Person has been found incapacitated by a court and a guardian has been appointed.
- There is a healthcare surrogate or proxy currently consenting for the person’s medical or mental health treatment.
Chapter 5

Who can Initiate an Involuntary Examination?

- Court order stating the person appears to meet the criteria for involuntary examination.
- A law enforcement officer can transport a person to a receiving facility who meets the criteria for involuntary examination.
- A physician, clinical psychologist, psychiatric nurse, clinical social worker, or licensed mental health counselor can complete a certificate stating they have examined the person within the last 48 hours and found the person met the criteria for involuntary examination.

Crisis Intervention Trained Officers

Some police departments/sheriff’s offices have implemented Crisis Intervention Training (CIT). This involves training some officers on issues specific to persons with mental health disorders. While any law enforcement officers may initiate a Baker Act exam, in any situation where you need to call law enforcement (including to consider a Baker Act exam) you should ask if a CIT trained officer/deputy can come to the ALF.

Involuntary Admission Criteria

- Person has refused a voluntary examination even after receiving a clear explanation of the procedures and purpose of the examination.
- The person is unable to determine for himself or herself whether an examination is necessary.
- Without care or treatment the person is incapable of caring for himself/herself even with help from a significant other.
- The person is likely to harm himself/herself or others in the immediate future.
Get to Know the Residents as Individuals

- Likes and dislikes
- Sleep habits
- Daily routines
- People they spend time with
- What is stressful to them
- How they cope in difficult situations
- Any information that helps you know them when they are not in crisis so that you can tune in to changes when they occur
Notes:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Chapter 6

Annette Christy, Ph.D.
Associate Professor

Department of Mental Health Law and Policy
Louis de la Parte Florida Mental Health Institute
University of South Florida
Chapter Directions

Be sure to read the Introduction at the beginning of the manual before proceeding with the chapter presentations. A PowerPoint presentation for this chapter is available at www.BakerActTraining.org and is also printed at the end of this chapter.

Chapter Description

This chapter provides a brief overview of trauma and trauma informed care.

Learning Objectives

- Knowing the definition of trauma and types of trauma
- Understanding the multiple ways people are exposed to trauma and the nature of trauma
- The types of problems people have as a result of trauma
- The meaning of trauma informed care and new ways of thinking that must be a part of trauma informed care
- The triggers for trauma and the impact of trauma for individuals
- What universal precautions for trauma mean
- The importance of trauma screening and assessment of safety by staff qualified to do these screenings and assessments at ALFs

Time Frame:

20 minutes

Materials

LCD Projector/PowerPoint Slides
Handouts
Outline

I. Introduction...............................................................................................................222

II. Substance Abuse and
    Mental Health Services Administration (SAMHSA) ...........222
I. Introduction

It is likely that many of the people residing in Assisted Living Facilities have experience trauma in their lives. The impact of this trauma is something that ALF staff should consider when making decisions about how to interact with ALF residents.

II. SAMHSA’s National Center for Trauma Informed Care

The Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Center for Trauma Informed Care[^1] describes what it does and the importance of considering trauma as follows:

- “SAMHSA’s National Center for Trauma-Informed Care (NCTIC) is a technical assistance center dedicated to building awareness of trauma-informed care and promoting the implementation of trauma-informed practices in programs and services.

- Traumatic experiences can be dehumanizing, shocking or terrifying, singular or multiple compounding events over time, and often include betrayal of a trusted person or institution and a loss of safety. Trauma can result from experiences of violence. Trauma includes physical, sexual and institutional abuse, neglect, intergenerational trauma, and disasters that induce powerlessness, fear, recurrent hopelessness, and a constant state of alert. Trauma impacts one’s spirituality and relationships with self, others, communities and environment, often resulting in recurring feelings of shame, guilt, rage, isolation, and disconnection. Healing is possible.

- Although exact prevalence estimates vary, there is a consensus in the field that most consumers of mental health services are trauma survivors and that their trauma experiences help shape their responses to outreach and services.

- Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. NCTIC facilitates the adoption of trauma-informed environments in the delivery of a broad range of services including mental health, substance use, housing, vocational or employment support, domestic violence and victim assistance, and peer support. In all of these environments, NCTIC seeks to change the paradigm from one that asks, “What’s wrong with you?” to one that asks, “What has happened to you?”

[^1]: SAMHSA’s National Center for Trauma Informed Care: [http://www.samhsa.gov/nctic/](http://www.samhsa.gov/nctic/)
The Power Point presentation that follows can be used as a resource to present ALF front line staff with the key information they need about trauma and trauma informed care. The time demands/scope of this training are such that broader issues of whether and how ALFs with limited mental health licenses are addressing trauma cannot be addressed. In short, front line staff would ideally have the support of case management staff and administrators who have built a trauma informed system within their ALF. Conducting the screens and assessments for trauma are likely beyond what should be expected of many front line staff. However, they need to be made aware of trauma as an issue, the need to consider trauma experience in decisions they make about how to work with ALF residents, and that they need to raise trauma as a concern to ALF administration and senior staff as needed. The purpose of this Power Point is to use it as a guide to accomplish this goal.
Traumatic triggers come in many forms. A trigger is a reminder of past traumatizing events. Many things can be a possible trigger for someone. For example, what seems like an "ordinary" request such as, "Make sure the children are ready for school on time," can be a trigger for a survivor whose abusive partner terrorized and punished her if the children were late for school. Part of our work is in changing our frame so that we always keep in mind that survivors’ responses to seemingly neutral events and interactions with people may reflect a trauma response. Survivors may have adopted long-term patterns that reflect their efforts to adapt to a traumatizing life. We also work to hold in mind that this behavior and these patterns reflect strategies that survivors have developed to keep themselves safe—that is, they reflect strength and resiliency.

**What Happens When Someone Is Triggered**

We can understand how it might be for a survivor of a flood, like a survivor of Hurricane Katrina, who was swept away as water rushed into her house. We can understand how she might feel frightened when someone turns on a shower without warning—just the sound of sudden water may reawaken the old experience. In a similar way, a person who has experienced terroristic abuse and control by a partner or family member may be triggered by encountering a person in authority. A survivor whose abuser made and enforced “rules” in the house may feel anxious or frightened even by the words “shelter rules.”

**Can We Eliminate Triggers?**

Once we become aware of triggers, we might feel an impulse to “get rid of all the triggers.” Of course, we will avoid violent images or angry tones in our speech, keep video and film with aggressive content out of the common shelter areas, and try to make the environment calm. But there will always be trauma triggers that we cannot anticipate and cannot avoid. Part of trauma-informed work is supporting survivors as they develop the skills to manage trauma responses both in our shelter and elsewhere in the world.

**Examples of Possible Triggers**

Traumatic triggers come in many forms. A person might be triggered by a particular color of clothing (“My batterer always wore a plaid jacket home from work, and that’s when he would come after me”), by the smell of a certain food (“I was cooking when the batterer attacked me”), or even the time of year (“When it snows I remember the night I got pushed out into the snow in my nightgown”). Encountering such triggers may cause us to feel uneasy or afraid. Sometimes we know why we are feeling a certain way and other times we aren’t sure why. Recognizing when we are being triggered is an important part of building the skills to manage our trauma responses.

Online free training related to trauma is also available at the de la Parte Florida Mental Health Institute at the University of South Florida. This training was created with funding from the Florida Department of Children and Families. Those conducting training may want to consider showing one of the Webinars about trauma as part of the training day, or as a supplement to the training.

This training can be found at: http://bakeracttraining.org. Gaining access to the training requires a log in. Questions about this online training can be addressed to bakertrain@fmhi.usf.edu.

Following are screen shots from the most current versions of our online training. This should give the reader of these materials a sense of what is available online.
Chapter 6

Trauma Informed Care

Welcome to Baker Act Training

Through a contract with the Florida Department of Children and Families, the Department of Mental Health Law and Policy at the University of South Florida has developed statewide on-line training on Baker Act (civil commitment) procedures in Florida. This on-line training supplement the instructor led one-day workshop offered every other year.

Continuing Education

As of July 1, 2010 Miami-Dade AHEC will provide Continuing Education (CE) Credits for Guardians, Nurses, and Social Workers. Please see each module for more information on how to apply.

Technical Assistance

For Technical Assistance
Please Email: baketrain@fmh.usf.edu

Available Courses

Introduction to the Baker Act
To begin this course, click the "Introduction to Baker Act" link. Complete each lesson.

Emergency Medical Conditions and the Baker Act
Developed for Emergency Room staff but available to anyone interested in taking this course.

Individual Rights and the Baker Act
Open to anyone interested in taking this course.

Law Enforcement and the Baker Act
Developed for Law Enforcement but available to anyone interested in taking this course.

Long Term Care and the Baker Act
Developed for individuals working in a long term care facility but available to anyone interested in taking this course.

Minors and the Baker Act
Open to anyone interested in taking this course.

Suicide Prevention
Open to anyone interested in taking this course.

Trauma Series
Understanding Trauma and Effects, and Trauma-Informed Care

Why People Die by Suicide
In his new theory of suicidal behavior, Thomas Joiner proposes three factors that mark those most at risk of death: the feeling of being a burden on loved ones, the sense of isolation, and, perhaps chillingly, the learned ability to hurt oneself. He tests the theory against diverse facts taken from clinical anecdotes, history, literature, popular culture, anthropology, epidemiology, genetics, and neurobiology—facts about suicide rates among men and women, white and African-American men, war veterans, athletes, prostitutes, and physicians; members of cults, sports fans, and citizens of nations in crisis.
## Trauma Series

Webinar for Baker Act Training
Understanding Trauma and Effects & Trauma-Informed Care

Victoria Hanson, MDW & Mark Dillard, Ph.D.
Department of Child & Family Studies
College of Behavioral & Community Sciences
University of South Florida

Please watch the webinar videos, review material, and pass the quiz with a score of 80% or better.

## Course Material

- Understanding Trauma & Effects Slides (PDF)
- Trauma-Informed Care Slides (PDF)
- Webinar Video: Understanding Trauma and Effects
- Webinar Video: Trauma-Informed Care

## Quiz

- Trauma Quiz

## Certificate of Completion and Continuing Education - CE

Please Note: CE Verification is handled separately by USF Continuing Education and not by Miami-Dade AHEC

- Certificate of Completion Trauma Series
- CE Professionals Information
- CE Verification and Application Form

## Course Evaluation

Your opinion matters. Click here to take the evaluation.
Chapter 6

Assisted Living Facility
Limited Mental Health Training

**Trauma Informed Care**

**Slide 1**

**Trauma**

It is likely that many of the people residing in Assisted Living Facilities have experienced trauma in their lives.

The impact of this trauma is something that staff need to consider when making decisions about how to interact with ALF residents.

**Definition of Trauma**

- The experience of violence and victimization including sexual abuse, physical abuse, severe neglect, loss, domestic violence and/or the witnessing of violence, terrorism or disasters.
Chapter 6

**Types of Trauma**

- Acute Trauma: A single traumatic event that is limited in time.
- Chronic Trauma: The experience of multiple traumatic events.
- Complex Trauma: Both exposure to chronic trauma, and the impact such exposure has on a person.
- System Induced Trauma: Traumatic removal from home, admission to a detention or residential facility, or multiple placements within a short time.

**Exposure to Trauma**

- Trauma can occur from:
  - Being in a car accident or other serious incident
  - Having a significant health concern or hospitalization
  - Sudden job loss
  - Losing a loved one
  - Being in a fire, hurricane, flood, earthquake, or other natural disaster
  - Witnessing violence (what some call "vicarious violence")
  - Experiencing emotional, physical, or sexual abuse

**Exposure to Trauma**

- Trauma Can Be…
  - A single event
  - A connected series of events
  - Chronic lasting stress
Exposure to Trauma

- Exposure to traumatic events make it more likely that people have:
  - chronic health conditions
  - substance abuse
  - high risk situations
  - mental health symptoms
  - further traumatization

Trauma Experience

It is a person’s experience of the event, not necessarily the event itself that is traumatizing.

It is important to get to know something about the trauma experience of the ALF residents in your facility so that you can make decisions about how to work with these residents for the best outcomes.

Trauma Informed Care

- There has been a recent move toward developing systems that are “trauma informed.” This includes
  - Providing the foundation for a basic understanding of the psychological, neurological, biological, and social impact that trauma and violence have on people.
  - Incorporating proven practices into current operations to deliver services that acknowledge the role that violence and victimization play in the lives of most people, including ALF residents
**Trauma Specific Interventions...**

- Are designed specifically to address the consequences of trauma in the individual and to facilitate healing.
- Treatment programs generally recognize the following:
  - The survivor’s need to be respected, informed, connected, and hopeful regarding their own recovery
  - The interrelation between trauma and symptoms of trauma (e.g., substance abuse, eating disorders, depression, and anxiety)
  - The need to work in a collaborative way with survivors, family and friends of the survivor, and other human services agencies in a manner that will empower survivors and consumers

---

**New Way of Thinking**

Rather than thinking about a person in terms of “what is wrong with you?” the trauma informed approach should focus on a different question – “what has happened to you?”

---

**Impact of Traumatic Events**

- Traumatic events that people have had in their lives can be “triggers” for harmful and difficult to manage behaviors
- Behaviors that helped a person survive a crisis in the short term, can become habitual or have a long term impact
- This is why screening ALF residents for trauma is so important
Triggers

- We all have triggers!
- People who have experienced trauma also have triggers, but they may be different from what we are used to from our own experience.
- This is why understanding each person’s unique triggers is so important.
- Knowing about them can help you to make decisions about how to work with each ALF resident.

---

Triggers

- Seeing, feeling, hearing, smelling something that reminds us of past trauma.
- The response is as if there is current danger.
- Thinking brain automatically shuts off in the face of triggers.
- Past and present danger become confused.

---

Triggers

[Diagram showing the relationship between triggers and outcomes]
Universal Precautions

- Presume that every person in a treatment setting has been exposed to abuse, violence, neglect, or other traumatic event(s).

Part of the universal precautions is asking:

What happened to you?

Trauma Screening

- As front line staff if you learn that someone has had trauma experience you can speak with your ALF administrator or other senior staff about having a trauma screen/assessment done for that person.

Trauma Informed Screening

- Trauma-informed screening involves training that is beyond the scope of this training for front line staff for ALFs with Limited Mental Health Licenses.

- It is helpful for front line ALF staff to know that such screening is possible. Ideally, ALF administrators will seek out this training and implement screening and assessment.

- An online training recorded “webinar” is available on this topic at www.BakerActTraining.org.
Trauma Informed Care

Chapter 6

Trauma Screening

- Knowing about a person's history of trauma can help to create a plan about how to address their behavior.
- The primary goal of trauma screening is to avoid traumatizing persons further.
- Screening also informs the personal safety plan and can inform decisions about appropriate services and treatment, detect potential for suicidality, and encourages a "partnership of safety" with the individual.

Assessment of Safety

- Before screening for trauma, it is essential to determine a person's:
  - safety from any current life-threatening circumstances
  - their medical and psychological stability
  - any substance impairment, and
  - current and available supports.
Advance Directives for Mental Health Treatment

Assisted Living Facility Training for Limited Mental Health Licensure

Appendix A

Annette Christy, Ph.D.
Associate Professor

Department of Mental Health Law and Policy
Louis de la Parte Florida Mental Health Institute
University of South Florida
Advance Directives for Mental Health Treatment

(Please refer to the Psychiatric Advance Directives Toolkit for instructions to complete this worksheet.)

1. Symptom(s) I might experience during a period of crisis:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

2. Medication instructions.
A. I agree to administration of the following medication(s):

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

B. I do not agree to administration of the following medication(s):

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

3. Facility Preferences.
A. I agree to admission to the following hospital(s):

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

B. I do not agree to admission to the following hospital(s):

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
C. Other information about hospitalization:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

4. Emergency Contacts in case of mental health crisis:

Name: ________________________________
Address: ________________________________
Home Phone # ___________________________  Work Phone # ___________________________
Relationship to Me: ______________________

Name: ________________________________
Address: ________________________________
Home Phone # ___________________________  Work Phone # ___________________________
Relationship to Me: ______________________

Psychiatrist: ____________________________  Work Phone # ___________________________

Case Manager/Therapist: ___________________  Work Phone # ___________________________
5. **Crisis Precipitants.** The following may cause me to experience a mental health crisis:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

6. **Protective Factors.** The following may help me avoid a mental health crisis:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

7. **Response to Hospital.** I usually respond to the hospital as follows:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

8. **Preferences for Staff Interactions.**

A. Staff of the hospital or crisis unit can help me by doing the following:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
B. Staff can minimize use of restraint and seclusion by doing the following:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

9. I give permission for the following people to visit me in the hospital:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

10. The following are my preferences about ECT:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

11. Other Instructions.

A. If I am hospitalized, I want the following to be taken care of at my home:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
B. I understand that the information in this document may be shared by my mental health treatment provider with any other mental health treatment provider who may serve me when necessary to provide treatment in accordance with this advance instruction. Other instructions about sharing of information are as follows:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

12. Legal documentation for Advance Directives:

A. Signature of Principal

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full impact of having made this advance instruction for mental health treatment.

Signature of Principal: ___________________________ Date: ________

Nature of Witnesses

I hereby state that the principal is personally known to me, that the principal signed or acknowledged the principal’s signature on this advance instruction for mental health treatment in my presence, that the principal appears to be of sound mind and not under duress, fraud, or undue influence, and that I am not:

• The attending physician or mental health service provider or an employee of the physician or mental health treatment provider;

• An owner, operator, or employee of an owner or operator of a health care facility in which the principal is a patient or resident; or

• Related within the third degree to the principal or to the principal’s spouse.

B. Affirmation of Witnesses

We affirm that the principal is personally known to us, that the principal signed or acknowledged the principal’s signature on this advance instruction for mental health treatment in our presence, that the principal appears to be of sound mind and not under duress, fraud, or undue influence, and that neither of us is: A person appointed as an attorney-in-fact by this document; The principal’s attending physi-
cian or mental health service provider or a relative of the physician or provider; The owner, operator, or relative of an owner or operator of a facility in which the principal is a patient or resident; or A person related to the principal by blood, marriage, or adoption.

Witnessed by:

Witness: ________________________________ Date: ______

Witness: ________________________________ Date: ______

STATE OF FLORIDA, COUNTY OF ____________________________

C. Certification of Notary Public

STATE OF FLORIDA, COUNTY OF ____________________________

I, __________________________ , a Notary Public for the County cited above in the State of Florida, hereby certify that ______________________________ appeared before me and swore or affirmed to me and to the witnesses in my presence that this instrument is an advance instruction for mental health treatment, and that he/she willingly and voluntarily made and executed it as his/her free act and deed for the purposes expressed in it.

I further certify that ___________________________ and ________________________, witnesses, appeared before me and swore or affirmed that they witnessed _____________________ sign the attached advance instruction for mental health treatment, believing him/her to be of sound mind; and also swore that at the time they witnessed the signing they were not (i) the attending physician or mental health treatment provider or an employee of the physician or mental health treatment provider and (ii) they were not an owner, operator, or employee of an owner or operator of a health care facility in which the principal is a patient or resident, and (iii) they were not related within the third degree to the principal or to the principal’s spouse. I further certify that I am satisfied as to the genuineness and due execution of the instrument.

This is the ________ day of ______________, 20_____.

Notary Public

My Commission expires: ________________

D. Statutory Notices

Notice to Person Making an Instruction For Mental Health Treatment. This is an important legal document. It creates an instruction for mental health treatment. Before signing this document you
should know these important facts: This document allows you to make decisions in advance about certain types of mental health treatment. The instructions you include in this declaration will be followed if a physician or eligible psychologist determines that you are incapable of making and communicating treatment decisions. Otherwise you will be considered capable to give or withhold consent for the treatments. Your instructions may be overridden if you are being held in accordance with civil commitment law. Under the Health Care Power of Attorney you may also appoint a person as your health care agent to make treatment decisions for you if you become incapable. You have the right to revoke this document at any time you have not been determined to be incapable. YOU MAY NOT REVOKE THIS ADVANCE INSTRUCTION WHEN YOU ARE FOUND INCAPABLE BY A PHYSICIAN OR OTHER AUTHORIZED MENTAL HEALTH TREATMENT PROVIDER. A revocation is effective when it is communicated to your attending physician or other provider. The physician or other provider shall note the revocation in your medical record. To be valid, this advance instruction must be signed by two qualified witnesses, personally known to you, who are present when you sign or acknowledge your signature. It must also be acknowledged before a notary public.

Notice to Physician or Other Mental Health Treatment Provider. Under Florida law, a person may use this advance instruction to provide consent for future mental health treatment if the person later becomes incapable of making those decisions. Under the Health Care Power of Attorney the person may also appoint a health care agent to make mental health treatment decisions for the person when incapable. A person is “incapable” when in the opinion of a physician or eligible psychologist the person currently lacks sufficient understanding or capacity to make and communicate mental health treatment decisions. This document becomes effective upon its proper execution and remains valid unless revoked. Upon being presented with this advance instruction, the physician or other provider must make it a part of the person’s medical record.
Behavior Analysis Form

Assisted Living Facility Training for Limited Mental Health Licensure

Appendix B

Annette Christy, Ph.D.
Associate Professor

Department of Mental Health Law and Policy
Louis de la Parte Florida Mental Health Institute
University of South Florida
# Behavior Analysis Form (BAF)

Resident’s Name: _____________________________________    #_________________   Unit: __________

<table>
<thead>
<tr>
<th>ANTECEDENT(S)</th>
<th>BEHAVIOR(S)</th>
<th>CONSEQUENCE(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>Observed Behavior:</td>
<td>Interpersonal Interaction:</td>
</tr>
<tr>
<td>Time:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persons in Vicinity:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specifics of Interaction:</td>
<td>Duration of Behavior:</td>
<td>Other Environmental Interactions:</td>
</tr>
<tr>
<td>Other Events:</td>
<td></td>
<td>Recorder:</td>
</tr>
</tbody>
</table>

| Date:         | Observed Behavior: | Interpersonal Interaction: |
| Time:         |              |                |
| Location:     |              |                |
| Persons in Vicinity: |              |                |
| Specifics of Interaction: | Duration of Behavior: | Other Environmental Interactions: |
| Other Events: |              | Recorder:      |
Personal Safety Plan

Assisted Living Facility Training for Limited Mental Health Licensure

Appendix C

Annette Christy, Ph.D.
Associate Professor

Department of Mental Health Law and Policy
Louis de la Parte Florida Mental Health Institute
University of South Florida
**Personal Safety Plan**

Name: __________________________   Date:   ____________   Facility: ______________________________

(Modified for use in Limited Mental Health Assisted Living Facilities)

You can document on this form suggested calming strategies IN ADVANCE of a crisis. You can list things that are helpful when you are under stress or are upset. You can also identify things that make you angry. Staff and individuals receiving services can enter into a “partnership of safety” using this form as a guide to assist in your treatment plan. The information is intended only to be helpful; it will not be used for any purpose other than to help staff understand how to best work with you to maintain your safety or to collect data to establish trends. This is a tool that you can add to at any time. Information should always be available from staff members for updates or discussion. Please feel free to ask questions.

1. **Calming Strategies:**

   It is helpful for us to be aware of things that help you feel better when you’re having a hard time. Please indicate (5) activities that have worked for you, or that you believe would be the most helpful. If there are other things that work well for you that we didn’t list, please add them in the box marked “Other”. We may not be able to offer all of these alternatives, but we would like to work together with you to determine how we can best help you while you’re here.

   | ☐ Listen to music | ☐ Exercise | ☐ Read a book |
   | ☐ Pace in the halls | ☐ Wrapping in a blanket | ☐ Have a hug with my consent |
   | ☐ Write a journal | ☐ Drink a beverage | ☐ Watch TV |
   | ☐ Dark room (dimmed lights) | ☐ Talk to staff | ☐ Medication |
   | ☐ Talk with peers on the unit | ☐ Call a friend or family member | ☐ Write a letter |
   | ☐ Voluntary time in the quiet room/comfort room | ☐ Read religious or spiritual material | ☐ Hug a stuffed animal |
   | ☐ Take a shower | ☐ Go for a walk with staff | ☐ Do artwork (painting, drawing) |
   | ☐ Other? (Please list) | | |

2. **What are some of the things that make you angry, very upset or cause you to go into crisis?**

   What are your “triggers”?

   | ☐ Being touched | ☐ Called names or made fun of | ☐ Security in uniform |
   | ☐ Being forced to do something | ☐ Yelling | ☐ Physical force |
   | ☐ Loud Noise | ☐ Being isolated | |
   | ☐ Contact with person who is upsetting | ☐ Some else lying about my behavior | |
   | ☐ Being restrained | ☐ Being threatened | |

3. **Signals of Distress:**

   Please describe your warning signals, for example, what you know about yourself, and what other people may notice when you begin to lose control. Check those things that most describe you when you’re getting upset. This information will be helpful so that together we can create new ways of coping with anger and stress:

   | ☐ Sweating | ☐ Clenching teeth | ☐ Crying |
   | ☐ Not taking care of self | ☐ Breathing hard | ☐ Running |
   | ☐ Yelling | ☐ Clenching fists | ☐ Hurting others |
   | ☐ Swearing | ☐ Throwing Objects | ☐ Not eating |
   | ☐ Pacing | ☐ Being rude | |
   | ☐ Injuring self: (Please be specific) | ☐ Other? (Please list below) | |
4. Preferences Regarding Gender and Others:
Do you have any preferences or concerns regarding who serves you when you are upset or angry?

☐ Women staff  ☐ Men staff  ☐ No preference

Language____________________________________  Ethnicity____________________________________

Culture ______________________________________________

Of a particular Religion___________________________________

5. Preferences Regarding Physical Contact:
We would like to know about your preferences regarding physical contact. For example, you may not like to be touched at all or you may find it helpful to have a hug or be touched appropriately when you are upset.

Do you find it helpful to be hugged or touched appropriately when you are upset?

☐ Yes  ☐ No  Comments:___________________________________________________

6. Medical Conditions:
Do you have any physical conditions, disabilities, or medical problems such as asthma, high blood pressure, back problems, etc., that we should be aware of when caring for you during an emergency situation?

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

7. Room Checks:
Room checks are done at night to make sure you are okay. In order to make room checks as non-intrusive as possible is there anything that would make room checks more comfortable for you?

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

8. Anything Else?
Is there anything else that would make your stay easier and more comfortable? For example do you have any special issues like cultural, diet, sexual preference, appearance, etc. that you think could contribute to misunderstandings or cause problems for you? Please describe:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
Notes:
Residents’ Rights

Assisted Living Facility Training for Limited Mental Health Licensure

Appendix D

Annette Christy, Ph.D.
Associate Professor

Department of Mental Health Law and Policy
Louis de la Parte Florida Mental Health Institute
University of South Florida
When an Assisted Living Facility Discharges a Resident
S. 429.28(1)(k), F.S.

*Every resident shall have the right to:*
At least 45 days’ notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally incapacitated, the guardian shall be given at least 45 days’ notice of a non-emergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.

When an Adult Family Care Home Discharges a Resident
S. 429.85(1)(l), F.S.

*Each resident shall have the right to:*
Have at least 30 days’ notice of relocation or termination of residency from the home unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. If a resident has been adjudicated mentally incompetent, the resident’s guardian must be given at least 30 days’ notice, except in an emergency, of the relocation of a resident or the termination of a residency. The reasons for relocating a resident must be set forth in writing.

Distributed courtesy of Florida’s Long-Term Care Ombudsman Program, administered by the Florida Department of Elder Affairs.
Assisted Living Facility and Adult Family Care Home
Residents’ Bill of Rights

Section 429.28 and 429.85, Florida Statutes (respectively)

No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident shall have the right to:

Live in a safe and decent living environment, free from abuse and neglect.

Be treated with consideration, respect and with due recognition of personal dignity, individuality, and the need for privacy.

Retain and use his/her own clothes and other personal property.

Unrestricted private communication including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum.

Participate in and benefit from community services and activities to achieve the highest possible level of independence, autonomy, and interaction with the community.

Manage his/her own financial affairs unless the resident (or the resident’s legal representative) authorizes the administrator of the facility to provide safekeeping for funds.

Share a room with spouse if both are residents of the facility.

Reasonable opportunity to exercise and to go outdoors at regular and frequent intervals.

Adequate and appropriate health care consistent with established and recognized standards.

Exercise civil and religious liberties including personal decisions. No religious beliefs, practices, nor attendance at religious services, shall be imposed on any resident.

Thirty (30) days notice to AFCH residents and forty-five (45) day notice to ALF residents of relocation or termination of residency except in cases of emergency.

Present grievances and recommend changes in policies, procedures, and services to the staff of the facility without restraint, interference, coercion, discrimination, or reprisal. This right includes access to ombudsmen volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.

(ALF) Be free from physical and chemical restraints other than those prescribed by the resident’s physician. The use of physical restraints shall be limited to half-bedrails and only upon the written order of the resident’s physician and the consent of the resident or the resident’s legal representative. [S. 429.41(1)(k)].

(AFCH) Be free from chemical and physical restraints. [S. 429.85(1)(k)].
Cooperative Agreement

Assisted Living Facility Training for Limited Mental Health Licensure

Appendix E

Department of Mental Health Law and Policy
Louis de la Parte Florida Mental Health Institute
University of South Florida
Cooperative Agreement Between
Assisted Living Facility With A Limited Mental Health License
And Mental Health Provider

Assisted Living Facility (“Facility”)
Name: ____________________________________________________________
Address: _______________________________________________________

Mental Health Provider (“Provider”)
Name: ____________________________________________________________
Address: _______________________________________________________

Emergency Numbers:
Mobile Crisis, if available: ___________________________ 24/7 Crisis Line: ___________________________

For Residents Served By Fact: __________________________________________
For Residents Served By Intensive Case Management: __________________________

Purpose:
To identify the responsibilities of the Mental Health Provider (“Provider”) and the Limited Mental Health Assisted Living Facility (“Facility”) to ensure delivery of appropriate community-based services to mental health residents. The agreement specifies directions for accessing emergency and after-hours care for the mental health resident and a method by which the staff of the facility can recognize and respond to the signs and symptoms particular to any resident and indicate the need for professional services. See Florida Statutes sections 394.4574; 429.02; 429.075.

The Mental Health Provider Shall:

1. Initiate referrals of individuals whose needs can best be met in an assisted living facility.

2. Offer case management services to individuals served by the provider residing in the Facility and provide the Facility with the case manager’s phone number & location. Contact information will be documented in the Individualized Community Living Support Plans.

3. Furnish the Facility staff with the Provider’s 24-hour emergency crisis telephone number. This shall be documented in the Individualized Community Living Support Plans. The provider agrees that the provider’s staff will attempt to intervene to avert law enforcement involvement or the initiation of the Baker Act whenever possible.

4. Develop an Individualized (meets the specific needs of the resident) Community Living Support Plan with each mental health resident served by the Provider with input from the Facility Administrator. The plan will be completed within thirty days after the mental health assessment is finished. The Plan will include signs of crises and symptoms particular to the resident and will identify strategies to avert crises.

5. Link individuals served by the Provider with appropriate community mental health services in accordance with the individual’s community living support plan and mental health services plan.

6. Provide services to residents without regard to race, age, sex, religion, economic status, sexual orientation, or physical handicap.
7. Discuss with the Facility Administrator, or designee, issues pertinent to the care, safety and welfare of the residents. This does not preclude the mandatory reporting requirements abuse, neglect or exploitation of aged or physically or mentally disabled adults as provided for by Florida Status Chapter 415.

8. Within available resources, provide technical and clinical training to assist the facility in program and staff development issues.

**The ALF Facility Shall:**

1. Notify the Provider if a Facility resident may qualify as a mental health resident.

2. Working with the Provider, assist in the development of the mental health resident’s Community Living Support Plan.

3. Keep a copy of the Community Living Support Plan for each mental health client on site (but preserve confidentiality) and assure staff is familiar with the plan and individual resident needs.

4. Facilitate mental health resident’s participation in the development of their Community Living Support Plans.

5. Facilitate mental health resident’s participation in mental health and other appropriate activities.

6. Facilitate provision of privacy and confidentiality during Case Management visits for Facility mental health residents.

7. Provide support services indicated in the resident’s community living support plan.

8. Recognize and report behavioral changes/actions which could indicate the need for professional services to any resident such as: change in food intake, compliance with medication, side effects of medication, change in sleep habits, increased or decreased activity, suicidal thoughts and/or behaviors, delusions and hallucinations, physical or verbal aggression.

9. If the resident declines services, the Facility shall document such refusal and obtain the resident's signature indicating the declination. The document shall be maintained in the resident’s file at the Facility.

**Acceptance/Refusal of Services:**

All services provided pursuant to this agreement shall be in accordance with resident rights, including the right of the resident, or resident’s guardian, or healthcare surrogate to accept or refuse clinical mental health services.

**Financial Consideration:**

There shall be no financial obligation placed on one party by the other as a result of this agreement.

**This agreement is executed when signed and dated below.**

For Facility:  

---

Signature  

Print Name  

Owner/Administrator  

Title  

Date  

For Provider:  

---

Signature  

Print Name  

C.E.O./ President  

Title  

Date
Appendix E

Notes:

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________
Community Living Support Plan

Assisted Living Facility Training for Limited Mental Health Licensure

Appendix F

Department of Mental Health Law and Policy
Louis de la Parte Florida Mental Health Institute
University of South Florida
Community Living Support Plan

Resident’s Name: ____________________________________________

Assisted Living Facility: _______________________________ Administrator __________________________

Address: _______________________________________________ Phone#: __________________________

Mental Health Provider: ________________________________ Case Manager: __________________________

Address: _______________________________________________ Phone # __________________________

Emergency Mental Health Numbers: __________________________

Medicaid Eligible: ☐ Yes ☐ No Waiver/Type: ☐ Yes ☐ No

The specific needs of the resident to enable the resident to live in the assisted living facility:

1. The clinical mental health services to be provided by the mental health provider in order to meet the resident’s needs and the frequency and duration of such service:

<table>
<thead>
<tr>
<th>Service</th>
<th>Frequency</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Other non-clinical services and activities to be provided by or arranged for by the mental health care provider or mental health case manager and the frequency and duration of such services and activities:

<table>
<thead>
<tr>
<th>Service</th>
<th>Frequency</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. The responsibilities of the facility to assist the resident in attending appointments, (e.g. arranging transportation to appointments and activities) and additional supports:

<table>
<thead>
<tr>
<th>Service</th>
<th>Frequency</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4. The special needs of the resident (i.e., substance abuse, head injury, medical, forensic issues) and any precipitating factor which may indicate the need for professional services.  
______________________________________________________________________________________  
______________________________________________________________________________________  
______________________________________________________________________________________  
______________________________________________________________________________________  

5. Identify strategies to diffuse a potential crisis (as report by resident/family and case manager/service provider): Recommend using Personal Safety Plan, Form# 3124, at [http://www.dcf.state.fl.us/programs/samh/mentalhealth/laws](http://www.dcf.state.fl.us/programs/samh/mentalhealth/laws) available in English and Spanish and attach to this Plan.  
______________________________________________________________________________________  
______________________________________________________________________________________  
______________________________________________________________________________________  
______________________________________________________________________________________  

6. Identify barriers which may prevent resident from receiving services deemed necessary and plan to eliminate the barriers (i.e., transportation, insurance coverage, location):  
______________________________________________________________________________________  
______________________________________________________________________________________  
______________________________________________________________________________________  
______________________________________________________________________________________  

7. Additional needs or services requested by the resident:  

Resident’s Signature ____________________________ Date ________________  
Case Manager ___________________________________ Date ________________  
Administrator’s Signature ________________________ Date ________________