UAI RESOURCE MANUAL

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Resource Manual
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I. Foreword

The Uniform Assessment Instrument (UAI) manual is designed to align and implement the values and direction of the Department's Vision and the Division of Medicaid Mission.

This Uniform Assessment Instrument (UAI) Resource Manual is also designed to help regional reviewers, providers and other personnel understand the complex and procedural requirements for an objective client assessment. The purpose of the manual is threefold:

1. A resource for the regional staff,
2. A standard working model which will be easy to update, and
3. A "train the trainer" component for new staff.

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Purpose of Uniform Assessment Instrument

The purpose of the Uniform Assessment Instrument (UAI) is to gather information for determining a client's care needs, service eligibility and for planning client services. The UAI is a multidimensional questionnaire which assesses a client's functioning level, social skills, and physical and mental health. It provides a comprehensive look at a client but includes only those elements that are necessary for developing a negotiated service agreement, that are cost-efficient to gather, and that assess a client's actual functioning level. The UAI was carefully designed to provide a standardized way of conducting a client interview to ensure that all clients have an objective assessment of their needs.

Advantages of the UAI

For the Client:

- Focus on all client needs and resources in one assessment,
- Reduces duplication of assessments, and
- Ensures objective assessment of the client's needs.

For the Provider:

- Provides a comprehensive picture of the client prior to initiation of a service on an ongoing basis,
- Fosters transfer and sharing of information among providers,
- Serves as a management tool,
- Serves as a tool for advocacy and funding, and
- Reduces paperwork.

For the Idaho Taxpayer:

- Provides characteristics of elderly clients and those with physical, developmental, and mental disabilities along the full spectrum of services,
- Tracks outcomes of these clients, and
- Targets services to the client's unmet needs.

II. UAI General Form Instructions

The UAI is comprised of a limited assessment and a full assessment:

> Limited Assessment (UAI Sections 1 and 2). The limited assessment covers general information and functional abilities and supports.
>
> Full Assessment (UAI Sections 1 through 4). The full assessment is a multidimensional evaluation of a client's functionality and is to be completed during a face-to-face interview with the client. Any other information from medical records, family members, etc., should be used when available. The preferred source of information is the client.

In some situations (i.e. a cognitively-impaired client), other sources of information may be necessary. Be sure to note on the form when other sources are used to gather information. Also, if necessary, obtain a translator for clients who have communication problems and/or other limitations.

Completing the Assessment

Each page of the UAI contains an essential set of data to be recorded in the spaces provided. Some specific points about completing the assessment are:

1) Occasionally, an accurate answer may not fit one of the answer options. In this case, please write in the answer.
2) If the answer to a question is unknown, write Unknown. Do not leave the question blank and do not mark No. There is an important difference between No and Unknown.
3) Please use the spaces next to the Comment section to specify/describe an answer which does not fit one of the categories listed.
4) Some questions are open-ended. Although these are not intended to be included in a database, they are important for gathering information about the client. In addition, there are numerous comment boxes for additional information which might be helpful in assessing the client's care needs. If necessary, add additional pages for comments.
5) In assessing the client, consider his/her current difficulties/behavior over the last two weeks.

Some final points about completing the assessment are:

1) Use a check mark (√) or an (X) to mark the appropriate response, and
2) Make sure every question has the appropriate number of responses recorded.
3) The individual(s) completing each section of the UAI must sign in the appropriate space on p. 12. and include requested information.

Crediting Primary and Secondary Sources of Information

As mentioned previously, the client is the preferred source of information for the Uniform Assessment Instrument. However, secondary sources, including the medical record, the primary care physician, family, and others, can be consulted to verify the reliability of the information if the assessor notes differences between the client's reported situations and his/her observed needs. Further, the assessor should document carefully all primary and secondary sources of information, both on UAI Page 1 in Questions 15 and 16, and also in the numerous comment spaces provided throughout the instrument. Questions 15 and 16 include spaces to identify the names of the sources with their telephone numbers. In addition, the assessor can attach additional pages for comments.

UAI Focus on Client's Current Functioning Level and Actual Need

The purpose of the Uniform Assessment Instrument, as mentioned earlier, is to assess the current abilities/behaviors of the client and determine his/her care needs in the foreseeable future. Current is defined as within the last two (2) weeks and foreseeable means in the next thirty (30) days. It is very important that the assessor consider the actual needs of the individual, not potential needs which may or may not occur.

Assess the client according to his/her independent living skills and consider actual needs which will impact the client within the next thirty (30) days, not potential needs. Just because a client is in a facility, does not mean that he/she can not prepare meals.

Changing Assessment Information

Information on the assessment may be revised in order to change incorrect information. All information collected during the intake process will need to be verified and possibly changed at the time of the face-to-face assessment with the UAI.

The Interview Process

Interviews take place in a variety of settings, at different levels of interactions, and for different purposes. The UAI interview is a goal-directed interview designed to elicit pertinent data, impart specific information, and assess needs. It provides a data base, which is examined and analyzed to identify functional abilities and limitations from which appropriate referrals will be made. It attempts to give the service agency an understanding of client problems or needs and is the basis for determining necessary services or treatment.

Steps in the Interview Process:

1. Establish Initial Rapport with the Client & Structure the Interview Setting

- Meet the client face to face, preferably in his/her own environment.
- Introduce yourself, your function or role, and make a connection.
- Assure privacy as much as possible.
- Reduce interruptions, control noise, and control traffic flow.

2. Explain the Interview Process

- Explain what you'll be doing, the types of questions you'll be asking and the general information you're trying to elicit.
- Explain how the information will be used and with whom it will be shared.
- Let the client know that he/she may mention information they may have forgotten at any time in the interview.
- Tell them that they can correct the information given at any time in the interview, if they feel they may have told you something incorrect.

3. After Obtaining Basic UAI Information, Clarify the Presenting Problem

- After gathering the basic information, clarify the presenting problem or reason for seeking services.
- State this in the client's own words and give enough detail to assure clarity.

4. During the Interview Be Attentive and Observant

- During the assessment, be attentive to what the client says.
- Keep at eye level with the client.
- Use your senses to gather information.
- Watch and observe the environment and the client.
- Listen carefully to the quality and tone of the client-s voice --- you may pick up coughs, wheezes, the click of dentures, for instance, which will be helpful to note.

5. Question Appropriately

- Ask questions one at a time.

- There will be a tendency to rely mostly on closed questions, since we may see our mission as only completing the form.
- Remember we are gathering data and assessing the situation, not just filling out a form.
- Closed questions are most helpful when brief, direct answers are needed.
- Open-ended questions are the better choice when you want to elicit more in-depth information.
- Avoid leading questions.
- You may want to repeat to the client to assure that you have heard and recorded it correctly.

6. Barriers to Effective Interviewing

- Language is one of those barriers. If the client is not fluent in English, you will have to arrange for an interpreter.
- When using an interpreter, remember that you are interviewing the client.
- Other barriers to effective interviewing are the use of jargon, specialized language, and acronyms.
- Be sure the client understands what you are saying. Tailor your language to the client's understanding.

7. The Client's Attention Span

- The attention span of the client may impact the interview.
- To keep the client's attention, you can attempt to uncover your information by more open-ended questions.
- Allowing the client to pace and even walking with him/her can be helpful.
- Verifying information with secondary sources is very important in this situation, as well.

8. Asking Sensitive Questions

- When asking the client about what could be sensitive information, be direct and straightforward.
- Explain the purpose of the questions and show acceptance of the replies.
- Assure privacy as much as possible.

9. Dealing with a Client's Reluctance to Answer

- At any time, a client may be reluctant to answer questions.
- Explanations at the beginning of the interview covering the types of questions and how they will be used are helpful in gaining the client's cooperation.
- The interviewer might want to examine the objectionable questions to see if there is another way to gather information or if stating the question in another way elicits an answer.
- Examine the client's objection itself, which could give some clues for a solution.
- Ultimately, a client may refuse to answer some questions
- It is important to document the circumstances of the client's refusal.

10. The Interviewer as a Block to Communication

- Interjecting one's own opinions may have a judgmental tone.
- Keep the focus on the client.
- Jumping to conclusions, finishing the client's sentences, and offering solutions before having all the information cuts off communication.
- Every interviewer needs to examine personal interviewing strategies to find these types of communication blockers.

11. Analyzing the Completed Instrument

- Areas of strength and of limitation or need are identified. The assessor should consider such things as:

  *What deficits exist in the client's ability to fulfill self-care requirements?
  *What potential risks to self-care ability exist?
  *What health problems exist?
  *How capable is the client to meet the demands of these health problems?
  *What measures could enhance the health, independence, and satisfaction of the client/caregiver?
  *What services can contribute to these?

- The UAI assessment data is the basis for referrals and care plan considerations. Prioritize the issues.
- Be sure to ask the client/caregiver what he/she thinks would be helpful and most important to address his/her specific needs.

12. Interviewing an Elderly Client-Special Considerations

- It is important to give the client enough time to respond to your questions.
- Be sure to speak clearly, facing the client. Lower the pitch of your voice, speak distinctly.
- Be alert to confabulating (misrepresenting or falsifying information) when dementia is present. Verify information with a caregiver, physician, nurse, or a medical record whenever possible.
- The elderly are subject to multiple diagnoses with the physical, mental and social well being closely interrelated.
- When determining measures of functional status, examine the ability to function independently despite disease, physical and mental disability and social deprivation.
- Few persons of any age wish to permit detailed and intrusive measures of performance without perceiving a clear relationship to their well being. Explain the process prior to the interview.
- Memory may be a problem. Persons of all ages are prone to underestimate or overestimate events of the past especially if the events are remote or routine. Ask questions that require numerical answers.
- When assessing the assistance available from family or friends consider both, what the elderly client expects and what others are prepared to offer.

III. Assessing Mentally Ill Persons Using the Uniform Assessment Instrument

by
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Introduction

This training module was presented to Regional Medicaid Services, Region I, June 2002 by Dr. Marie Parkman, Chief Psychologist for Region I Mental Health in Coeur d'Alene. Dr. Parkman notes that her training module is by no means exhaustive and encourages you to learn as much about the major mental illnesses as possible. Additionally, having access to current client psychiatric and psychological assessments, and interviewing case managers and psychosocial rehabilitation workers, is a critical part of accurately assessing persons with severe and persistent mental illness for services.

In the following materials, Dr. Parkman has focused on the following illnesses: Schizophrenia, Bi-Polar Affective Disorder, Major Depression, and Borderline Personality Disorder.

She recommends that you have the current Diagnostic Criteria of Mental Disorders available as a desk reference, (DSM-IV), research valid internet resource sites with regards to the major mental illnesses, and expand your professional library.

Three Things to Remember about Mental Illness

1. Mental illnesses are **brain disorders.**

2. Individuals with these disorders *cannot* or will not communicate their functional deficits accurately.

3. Medications are only **partially effective** in controlling the symptoms of these disorders.

Functional Assessment Factors

Major Mental Illness

In psychiatry, individuals with major mental illness are most often evaluated in terms of whether the symptoms of the illness are in an *acute, chronic or residual* status.

However, other researchers (Resnick, 1998), have proposed that evaluation of *dynamic and static* factors provide more useful information concerning client risk and function.

Static Factors: Static factors are those aspects of the client's condition or life which are not subject to change by intervention. These include such things as: age, sex, childhood abuse, no family, past behavior, history.

Dynamic Factors: Dynamic factors are those aspects of the client's condition or life which can be changed by intervention or control of the situation. Some examples of dynamic factors include: living situation, management of psychiatric symptoms, management of health conditions, increased access to available medical and social supports.

Individuals with persistent and severe mental illness, will display *fluctuating functional levels* to the extent that these dynamic factors are addressed by ongoing intervention.

Keep in mind that the following information for the Functional Criteria for Mentally Ill Persons, although quite extensive, may not be all inclusive.

Functional Considerations for Mentally Ill Persons
UNIFORM ASSESSMENT INSTRUMENT

SECTION TWO-Functional Abilities, Supports and Related Information

1. PREPARING MEALS:

All Disorders:

- Individuals with mental illness are high risk for anemia and malnutrition. Their food intake usually consists of junk food, comfort foods, prepared foods or snacks.
- Burners can often be left on.
- Personal hygiene after toileting and before food preparation is often neglected, making these clients high risk for hepatitis infection.
- Individuals with mental illness often do not make the link between their eating behaviors and other medical conditions, such as diabetes, high blood pressure, acid reflux, hyperlipidemia or in taking medications properly.
- Rotten food or no food at all in the refrigerator is common.

Schizophrenia:

- Individuals with schizophrenia have extreme difficulty in maintaining adequate nutrition. Often they eat only one meal per day or do not eat at all. Due to their poor body cathexis, they often do not recognize signs of hunger or poor eating.
- Extreme caffeine consumption is common.
- Refrigerator can be left open, often containing rotten food.
- Food can often be prepared in dirty pans and left out for extended periods without refrigeration.
- Perishable food can be left out on the counter for extended periods when returning from the grocery store before it is refrigerated.
- Individuals with this illness have been known to eat tainted or rotted food without any awareness that it is bad.
- Individuals with this illness can become so disoriented, delusional, or confused that dangerous non-nutritive substances can be ingested, such as solvent, cleaning fluids, glass, or feces.

- Delusions can also result in bizarre eating rituals or beliefs about combinations of foods or that food is poisoned.
- Individuals with this disorder often cannot remember the steps needed to prepare a meal.

Major Depression:

- Individuals with major depression often lose their appetite and completely stop eating, resulting in significant weight loss.

- Other individuals experience extreme hypersomnia, often sleeping up to 20 hours per day and experiencing extreme mental confusion on rising. This usually leads to eating whatever is available and returning to bed.

- Most individuals with Major Depression experience chronic, debilitating fatigue, whether it is the vegetative or agitated type of depression, which saps their ability to deal with even the most minor tasks. Adequate food preparation is a low priority for energy expenditure. Also, cleanup after food preparation usually requires more energy than the person has and piles of dirty dishes and pans are common.

- Individuals with Major Depression are distractible, forgetful and have poor short-term memory. Burners can be left on, unattended for hours.

- Personal hygiene is poor.

- Consequences of poor eating in regard to other health conditions such as diabetes is usually neglected either because of feelings of hopelessness, lack of energy or poor concentration and memory.

Bipolar Disorder/Mania:

- During manic phases, individuals often stop eating completely with huge weight loss, often up to 100 pounds. The individual sees this as desirable.

- During manic phases, eating becomes hedonistic and pleasure oriented without regard to consequences possible due to other medical conditions such as diabetes, hyperlipidemia, high blood pressure or in taking medications correctly.

- Significant behavioral disorganization is common in manic phases, leading to complete disruption of any regular routine or ability to engage in systematic behaviors, such as cooking, cleaning up dishes, shopping, etc.

- Grandiose or persecutory delusions may be present in which the person believes that the food is poisoned or that bizarre combinations of food give special powers or abilities.

Borderline Personality Disorder:

- Individuals with this disorder are characterized by rapid shifts in affective states, leading to behavioral and emotional dyscontrol. Their ability to manage their environment effectively is completely determined by the intensity and duration of negative internal states. "Run-away freight train" anxiety states can completely dominate the individual's behavior for days, during which time the individual's behaviors are aimed exclusively at eliminating or managing this negative internal state. Meal preparation and clean up are a low priority during these times.

- Don't be fooled by the "pseudo-competence" of individuals with BPD. Cognition is intact, but behavior is disorganized and poorly regulated in all aspects of ongoing functioning.

- Individuals with this disorder often have co-occurring eating disorders such as bulimia and anorexia nervosa.

2. EATING MEALS:

Schizophrenia:

- Individuals with this disorder can often complain of nonspecific stomach pain or a choking sensation which results in their limiting their eating.

- Somatic delusions can often be present which inhibit eating.

- Paranoid delusions can result in refusal to eat unless certain conditions are met.

Major Depression:

- Individuals with this disorder often complain that food smells foul or has a foul taste, which results in their not eating.

- Individuals with this disorder often complain of nausea upon eating and discontinue eating.

Bipolar Disorder:

- During episodes of mood disturbance, co-occurring eating disorders become very pronounced, primarily bulimia.

- Individuals report that often food is prepared, but because of distractibility, it is never eaten.

- During manic episodes or manic delirium, pica can occur, including eating dirt, rocks and sticks.

Borderline Personality Disorder:

- During periods of mood disturbance or conflicts in significant interpersonal relationships, eating disorders can get (out) of control to a very serious degree, resulting in emergency room visits.

3. TOILETING:

Schizophrenia:

- During periods of psychosis, incontinence of urine and feces is common, usually with minimal or no awareness on the part of the client.
- During periods of psychosis, these individuals can use the bathtub as a toilet or urinate and defecate indiscriminately in their apartment.
- Individuals with this disorder have extreme difficulty in remembering and executing the steps required for maintenance of a colostomy or catheter.
- Personal hygiene after toileting can be poor, especially for clients with dumping syndrome.
- Regular handwashing and understanding of the importance of handwashing is generally poor.
- In women, proper use and disposal of sanitary devices for menses can be very poor.

Major Depression:

- During severe depressive episodes, incontinence of urine can occur. Incontinence of feces is less common.
- Overall personal hygiene is poor, with infrequent bathing or changing of clothes or underwear. Handwashing is also poor.
- Cleansing after eliminating can be poor.
- In women, proper use and care of sanitary devices during menses is poor.
- Care of colostomy or catheter devices is poor, due to impaired concentration.

Bipolar Disorder:

- During manic phases, public urination and defecation is common, without any awareness on the part of the client as to the inappropriateness of the behavior.
- Maintenance of a colostomy or catheter would be impaired by distractibility, poor judgment or poor memory.

- Manic women can be completely unaware of the onset of menses.

- Handwashing after toileting during manic episodes is probably absent.

Borderline Personality Disorder:

- Individuals with this disorder are not usually characterized with problems with toileting, unless it becomes a dynamic of an ongoing relationship struggle.

- Maintenance of a colostomy or catheter device would likely be spotty and inconsistent, depending on the individual's ongoing affective disturbances.

- Self-care for individuals with this disorder with dumping syndrome would also be inconsistent depending on the current affective states.

4. MOBILITY:

Schizophrenia:

- Individuals with this disorder can experience side effects to medications which make walking, balance and coordination difficult in ongoing locomotion.

- Individuals with this disorder often complain of tightness, soreness or muscle pain which limit their physical activity levels.

- Individuals with this disorder can experience postural hypotension as a side effect to medications.

- Some individuals with this disorder develop tardive dyskinesia, an involuntary movement disorder which affects their ongoing coordination and locomotion.

Major Depression:

- Some individuals who suffer from depression experience pronounced psychomotor retardation in which any type of movement is a major expenditure of energy.

- Individuals who have experienced protracted depressive episodes experience a loss of muscle strength, lose physical stamina and become quite limited in their ability to get around. This is often erroneously attributed to "laziness", when, in fact, the individual has effectively been bedridden for an extended period of time.

- Individuals with ongoing depression complain of lack of energy, fatigue, dizziness and feelings of muscle weakness. Poor coordination is a common complaint.

- Individuals with this disorder complain of difficulty standing for long periods, especially in lines at the grocery store, etc.

- Individuals with this disorder will often complain that a short trip to the store completely wore them out.

Bipolar Disorder:

- During manic episodes, these individuals display ongoing psychomotor agitation, often walking for miles. During these periods, they can develop severe blistering on their feet and not feel them.

- During manic episodes, these individuals will often be unable to remain in their residence, often crisscrossing town on foot several times during the day, because of a pressure to keep moving. If at home, continual pacing, which the individual cannot stop, is very common.

Borderline Personality Disorder:

- Individuals with BPD are not often characterized as having problems with mobility, unless it is due to medications, medication side effects, or intoxication on substances, which is a frequent self-harm behavior for individuals with this disorder. Episodic, intense alcohol abuse is often used to stop the "run-away freight train".

5. TRANSFERRING

Schizophrenia:

- In individuals with this disorder, any behavior which requires the execution of a sequential set of steps needs to be evaluated carefully to determine if the client actually can understand, remember and execute the steps required to complete the task.

Major Depression:

- In individuals with this disorder, the role of psychomotor retardation, fatigue, poor concentration, muscle weakness, irritability and apathy would need to be evaluated in terms of whether it is likely that the client can execute the given task.

Bipolar Disorder:

- During manic episodes, these individuals are characterized by impulsivity, irritability, uncooperativeness and a general carelessness about their personal safety and physical integrity. These factors would need to be taken into consideration when evaluating the client's capacity for transferring when required.

Borderline Personality Disorder:

- Individuals with this disorder can have pronounced dependence or hostile dependence upon others. This dependence is intense and non-volitional. Obvious difficulties can arise in a situation where a person with this disorder requires assistance with transferring.

6. PERSONAL HYGEINE

Schizophrenia:

- Individuals with this disorder very frequently have a very poor connection with the body and its condition. Shaving, hair grooming and oral care are characteristically neglected and often require continual prompting.

- When hygiene is attempted, often the result is inadequate because the client has failed to master all the steps of the process. It is common to see a man with large patches of unshaved area on his face, for example.

- Consistent oral hygiene is an ongoing problem for many clients with this disorder.

- Sometimes, clients with this disorder will engage in bizarre grooming or hairstyles, such as shaving all the hair on their bodies or shaving their heads.

Major Depression:

- Consistent personal hygiene is an ongoing difficulty for individuals with depression, because of limited energy levels,hypersomnia, rumination, depressed mood and self loathing.

- Individuals with this disorder may go many days without attending to hygiene and then clean-up for some specific event that requires their attention. They usually describe this as requiring a monumental effort.

- Oral hygiene is usually poor.

Bipolar Disorder:

- During manic episodes, individuals with this disorder can either completely neglect personal hygiene or become totally obsessed with it, spending most of the day grooming.

- During manic episodes, grooming can become somewhat bizarre in terms of outlandish hairstyles, hair tints, loud make-up or repeated showering and toothbrushing.

- During manic episodes, extreme distractibility is present, often leading to incomplete hygiene.

Borderline Personality Disorder:

- Individuals with this disorder have extreme difficulty in maintaining consistency in behavior over time and this includes personal hygiene. During negative affective states, personal hygiene of all types is likely to be extremely poor. Many of these individuals come from background of extreme abuse and neglect where personal hygiene was never learned or stressed.

- Since individuals with this disorder often come from backgrounds of abuse and neglect, often basic hygiene skills have never been learned.

7. DRESSING

Schizophrenia:

- One of the hallmarks of this disorder is inappropriate dress, either in mismatched clothes or odd appearance, wearing dirty clothes or wearing clothes which are seasonally inappropriate.

- Individuals with this disorder have special difficulty in choosing the right clothing for the right situation.

- Seasonally inappropriate clothing is particularly marked, such as wearing a down parka in 100' heat or a nightgown and no shoes in 20' winter weather. Frostbite or heat exhaustion can be of particular concern for these clients.

- Wearing appropriate footwear is also of special concern.

- Appearance can be disheveled, unkempt, or in disarray.

- Sometimes, mode of dress is influenced by delusions, such as wearing a bedsheet as a toga because of the belief that one is a Roman God.

- In other instances, refusal to change or modify clothing can be influenced by delusions, such as thinking that one's clothing is alive.

Major Depression:

- Just getting dressed in the first place is often the major obstacle for individuals with this disorder. There is a marked tendency to stay in bathrobe or bedclothes the entire day, because of the energy needed to get dressed.

- Cleanliness of clothing is often an issue because laundry has not been done in some period of time.

- Clothing can be wrinkled, unkempt, disheveled or in disarray.

- Often the clothing which is chosen is that which is easiest, not necessarily that which is most appropriate or the most flattering. Many individuals with depression do not feel that anything they do matters, and this includes how they look.

Bipolar Disorder:

- During manic periods, individuals with this disorder can dress flamboyantly, in loud colors, and inappropriately in many ways, either to the situation, seductively, or seasonally.

- Public disrobing during manic phases can occur.

- Generally, the individual is unwilling and unable to see how the clothing is inappropriate to the situation, because of distorted judgment.

- Excessive makeup and loud hair colors are common in women.

- During manic phases, buying sprees of lots of inappropriate clothing, which will not be used later, is common.

Borderline Personality Disorder:

- Individuals with this disorder sometimes can be inordinately influenced by fad fashions, wearing inappropriate clothing in certain situations or by the opinions of others. The mode of dress is also influenced by affective states, much in the same manner as major depression and mania. Sometimes, inappropriate clothing is worn in rebellion against perceived overcontrol.

- Since many of these individuals come from backgrounds of abuse and neglect, often appropriate dressing and clothing has not been learned or valued in the environment.

8. BATHING

Schizophrenia:

- Individuals with this disorder have marked impairment in the area of regular bathing and hair care which can be quite persistent and require ongoing prompting to complete. Sometimes, there can be angry opposition to requests for showering and washing hair which do not appear rational to others.

- Some individuals with this disorder do not appear to be aware of their own body odor.

- Sometimes, showers are taken, but soap and shampoo are not used, rendering the activity ineffective, or all steps are not completed: for example, hair is washed, but not combed out.

- Some individuals with this disorder will resist all attempts to get them to bathe, even if it means being ejected from housing or eating establishments.

- Because of these difficulties, sometimes other inducements must be used to obtain the individual's cooperation with regular bathing.

Major Depression:

- Regular bathing is also a difficulty for individuals with major depression, either through lack of energy, hypersomnolence, apathy or feelings of hopelessness.

- Sometimes, the activity is incomplete or inadequate: for example, hair is washed, but not combed out, styled or set. Or, in another example, a woman may bathe, but leave inch long hair on her legs, because it was "too much effort".

- When depression is severe, the individual may not be aware of body odor or the condition of the body.

- During depression, a person may lie in the bathtub for hours, but never actually wash.

Bipolar Disorder:

- During manic phases, individuals can become obsessed with personal cleanliness, showering several times a day, or completely neglect it, as in schizophrenia.

- If pre-occupied with cleanliness during a manic phase, the individual might buy copious and extravagant amounts of soap, facial products, make-up, shampoo, and conditioners that he would not normally buy or use.

- During a manic phase, the individual might color, style or arrange hair in an outlandish fashion. Blue, pink and purple hair is not uncommon results.

- Bathing in public places, such as the lake, can occur.

Borderline Personality Disorder:

- Individuals with this disorder experience extreme shifts in affective states from depression to elation or paranoia. During disruptions of mood or during conflicts in their interpersonal relationships, deficits in bathing and hair care can be present. Some individuals with this disorder can become quite obsessive about personal care, showering many times a day. Others can be quite neglectful of bathing and showering on a regular basis, being too pre-occupied with managing negative internal states.

- Since many of these individuals come from background of abuse and neglect, often basic personal hygiene skills have not been learned.

8. ACCESS TO TRANSPORTATION

Schizophrenia:

- Often individuals with this disorder have access to public transportation, but do not use it because of their discomfort in being around others in that close proximity.

- Often there is marked impairment in the ability to get to stores and appointments without assistance from others. Clients report getting sidetracked, overwhelmed or confused on their way to the store or appointments and returning home without completing the errand.

- Individuals with this disorder often cannot operate a motor vehicle, either because of slowed reaction time due to medications or inability to handle all the stimulus discrimination required to safely operate a motor vehicle.

- Paranoid ideation can interfere with use of public transportation, especially when the individual perceives that others are looking at him critically or thinking bad things about him.

- Sometimes, the individual's delusions will prevent him from entering certain buildings, cars, or buses or only allow him to leave the home at certain times of the day or under certain specified conditions, which he is very likely unwilling to communicate to others.

- Sequential information processing is disrupted in this disorder. Therefore, any task requiring multiple steps is very difficult, such as setting up transportation with the NICE bus or multiple transfers.

Major Depression:

- Individuals with this disorder often find it a major effort just to get ready to leave the house, and subsequently never leave.

- Driving is often difficult due to poor concentration, memory and distractibility.

- Due to slowed thinking, confusion, distractibility and anxiety, use of public transportation is often difficult, with the individual taking the wrong bus or getting overwhelmed and returning home.

- Individuals with this disorder are often very self conscious in public, find it difficult to be around other people, and often become exhausted in the middle of a task, such as shopping and simply return home without completing the errand.

Bipolar Disorder:

- During manic phases, individuals with this disorder experience extreme disorganization of behavior and extreme distractibility. They are vulnerable to getting sidetracked when in public by some extraneous stimulus.

- During manic phases, driving is not safe for these individuals because of impaired judgment, grandiosity, distractibility and irritability.

- During manic phases, individuals with this disorder may be hyperverbal, irritable, flamboyant or disorganized in their behavior to the extent that public transportation providers may not be comfortable in transporting them.

- During manic phases, these individuals have a great deal of difficulty in consistent, organized goal-directed behaviors. Completing errands or attending appointment is very difficult for them to accomplish.

Borderline Personality Disorder:

- Individuals with this disorder can experience transient paranoid states in which they find it very difficult to be around other people, especially on public transportation.

- During periods of intensely negative internal states, these individuals find it very difficult to leave the home.

- Individuals with this disorder often suffer from severe states of depression and experience similar difficulties to individuals with major depression.

10. FINANCES

Schizophrenia:

- In the first few years of the onset of this disorder, most clients with this disorder require a payee to assist them in managing their finances.

- An inordinate amount of client's funds can be spent on tobacco products. Recent NARSAD research indicates that the vulnerability to addiction to tobacco products stems from nicotine's stimulating the pre-frontal cortex, which helps the client overcome some of the symptoms of the schizophrenia.

- Budgeting efforts with individuals with this disorder can start with managing as little as $5 per week and then building up from there. Continual repetition of budgeting skills and paying bills is needed for clients to learn budgeting skills.

- Some individuals with this disorder will always need assistance with paying bills on a regular basis and adhering to a budget. In some instances, this stems from the meager amounts of funds available to the client.

- Individuals with this disorder are easily exploited by others. Quite often they are easily intimidated into giving money to others.

Major Depression:

- Individuals with this disorder may have the money to pay their bills and just not pay them. Sometimes this is due to disruptions in time sense. In others, it is due to poor concentration, disorganization and fears of making a mistake.

- Some individuals with this disorder will simply pay the bills, but then not balance the checkbook to see if the funds are actually available because they lack the concentration and attention required to accomplish this task.

- Yet again, other individuals with this disorder will pay all the bills and not leave enough money for food or other necessities.

Bipolar Disorder:

- During manic phases, individuals with this disorder are characterized by inappropriate spending, not paying bills and often squandering money on nonsensical items.

- During manic phases, individuals with this disorder can become very grandiose, thinking that they have large sums of money that they do not have.

- During manic phases, grandiose tipping, or giving away of money, sometimes to complete strangers, is common.

- Buying sprees, usually of nonessential items, is common.

- After the manic phase is over, these individuals usually experience extreme regret or remorse about spending behaviors which have had negative consequences.

Borderline Personality Disorder:

- Individuals with this disorder are often characterized by inappropriate spending, not paying bills or spending money on others in an attempt to keep them around.

- Individuals with this disorder will often spend excessive amounts of money on items to impress others or to fit in.

- Individuals with this disorder are easily exploited by others, especially in the area of money.

11. SHOPPING

Schizophrenia

- Individuals with this disorder find it very difficult to make an accurate shopping list, get to the store, shop for value for the items on the list, get the items home and properly put away. Completing such a task is dependent on sequential information processing, which is especially impaired in persons with this disorder.

- Often, paranoid feelings or thoughts interfere with the individual's ability to shop.

- There can be extreme interpersonal aversiveness present, making being in a store around people extremely difficult for these clients. This can result in late night shopping or just going into a convenience store for a couple of items.

- Individuals with this disorder can have a great deal of difficulty in prioritizing items to be bought on their budgets.

- Necessary personal items are often not obtained, leading to the deficits noted in hygiene and grooming areas.

- Problem solving can be quite impaired, with the individual not being able to exercise alternatives.

Major Depression:

- Concentration, attention and memory are adversely affected in this disorder, making it difficult to construct a shopping list and execute it effectively, much as in schizophrenia.

- Often, individuals with this disorder report becoming so overwhelmed by the idea of the effort required to shop appropriately, that they never go at all or just buy a few items.

- Individuals with severe depression sometimes will stop eating because of the effort involved in obtaining groceries.

- Individuals with this disorder often need someone else to help them "get going" on a task in order to complete it.

Bipolar Disorder:

- Some individuals with this disorder continue to have problems with inappropriate spending, even when stable. There is a tendency to buy pleasure items, rather than necessities.

- During manic phases, individuals with this disorder do not take care of basic necessities, which can be viewed as too mundane to bother with.

- Since behavior, judgment and perception become impaired during manic phases, activities such as a shopping list, shopping for value, or budgeting usually are abandoned during these periods. Problem solving becomes quite impaired.

- Sometimes during manic phases, individuals with this disorder can become fixated on buying a particular kind of product with which they are preoccupied.

Borderline Personality Disorder:

- Individuals with this disorder can be very disorganized in their ongoing behavior, which is vulnerable to disruption by their interpersonal relationships and negative internal states. Usually, there is spotty skill development, with one area being fine and a related area not learned. So, a shopping list may be prepared, but then there is no knowledge on how to shop for value.

- Since many individuals with this disorder have histories of abuse and neglect, often there is inadequate knowledge about basic nutrition, menu planning or basic needs.

- Sometimes individuals with this disorder find it very difficult to do anything alone and feel the need to be accompanied when shopping or doing other activities in the community.

12. LAUNDRY

Schizophrenia

- Since sequential information processing is impaired in individuals with this disorder, laundry can be very difficult. Individuals with this disorder have trouble remembering all the steps required to complete laundry adequately. For example, one step may be remembered to the exclusion of others such as: laundry is sorted, but soap is forgotten.

- Since memory can be impaired, laundry can be left in the washer and not put in the dryer.

- Going to a public Laundromat can be difficult for these individuals either because of paranoid ideation, interpersonal aversiveness, or delusions.

- Ironing is particularly difficult for individuals with this disorder because of the steps required, the attention to detail, and the likelihood of becoming distracted during the task. Also, individuals with this disorder are vulnerable to burning themselves and not being aware of it.

- If there is some disruption of the regular routine for completing laundry, the whole task becomes disrupted. For example, if the soap machine is out of soap, the client is likely to return home rather than going next door to the supermarket and buying some soap. Problem solving can be quite impaired.

Major Depression:

- Individuals with this disorder tend to put off doing laundry until everything they own is dirty. They then become so overwhelmed with the enormity of the task that they simply wear dirty clothes.

- Sometimes individuals with this disorder will do as much laundry as energy permits, sometimes only getting one load done or partially done.

- Attention, concentration and memory are impaired sometimes leading to soap not being put in the washer, the lid being left up or wet clothes left in the washer.

- Ironing usually involves more energy than these individuals have.

- Individuals with depression often find it difficult to be in public places and sometimes will not go to a Laundromat unless someone else accompanies them.

- Individuals with this disorder often need someone else to help them "get going" on a task in order to complete it.

Bipolar Disorder:

- During manic phases, any routine behavior has a tendency to be neglected, due to behavioral disorganization.

- During stable periods, individuals with this disorder can continue to be bothered with extreme distractibility which interferes with task execution and completion. They are extremely vulnerable to task disruption due to impaired concentration.

- Even when stable, individuals with this disorder can find it difficult to develop and maintain a routine of regular activities.

Borderline Personality Disorder:

- Individuals with this disorder can show great variability in their ability to complete this task depending on their learning history, the intensity of their affective state disruptions and their general ability to organize behavior. Some individuals will show no difficulty at all, while others will have extreme impairments.

13. HOUSEWORK

Schizophrenia:

- Many individuals with this disorder show marked impairments in this area due to deficits in sequential information processing and impaired problem solving.

- Washing dishes and disposing of garbage is especially difficult for these clients.

- Cleaning out refrigerator is also very difficult for these clients.

- Sometimes, the individual's dwelling can be very dirty without any apparent awareness on the client's part, such as dust, carpet, and bathroom.
- Some individuals with this disorder horde things such as newspaper, garbage or other items in the residence.

- Because of the distorted sense of time in this disorder, these clients can often think that they recently cleaned the residence when in fact several months have elapsed.

- Individuals with this disorder have difficulty establishing and maintaining a regular routine of household maintenance.

- Sometimes there can be a dangerous use of cleaning fluids or cleaning materials inappropriately mixed together.

- A small number of clients with this disorder can be obsessively clean about their residence.

Major Depression:

- Individuals with this disorder find household maintenance extremely difficult on a consistent basis because of limited energy levels, bouts of depression and anxiety as well as feelings of hopelessness.

- Sometimes, individuals with this disorder need someone else to help them "get going" on tasks in order to get them completed.

- Individuals with chronic depression usually set housekeeping as a very low priority.

- Piles of dishes and dirty laundry are common as well as problems taking out the garbage.

- Sometimes, household tasks are completed in spurts, depending on mood and energy available.

Bipolar Disorder:

- During manic phases, behavior, judgment and problem solving become impaired and household task are usually not completed.

- During stable period, individuals with this disorder have problems with distractibility, poor concentration and task disruption.

- If the manic phase resolves into an episode of Major Depression, often the uncompleted household tasks are still not completed.

- Some individuals with this disorder compulsively clean during manic episodes, leading to problems with their neighbors for running vacuums late at night and so forth.

- Judgment can become impaired as to the proper use of cleaning materials. Cleaning fluids can sometimes be dangerously mixed together.

Borderline Personality Disorder:

- Individuals with this disorder have spotty skill development. Do not assume that because laundry tasks are known that housekeeping tasks are known as well.

- Because of the common occurrence of abuse and neglect in these individuals, often basic skills in this area have not been learned.

14. WOOD/COAL SUPPLY

Schizophrenia:

- Heating in this fashion is dependent on the ability to carry out a sequence of tasks. Individuals with this disorder would probably find heating with wood or stoking a coal furnace difficult to maintain on a consistent basis.

- During an increase of paranoid symptoms, individuals with this disorder would find it difficult to go outside to get wood.

- Due to distractibility, individuals with this disorder would be vulnerable to task disruption or poor judgment, such as leaving the door open on the wood stove or furnace.

- Since individuals with this disorder have difficulty in ascertaining proper body temperatures, there is the likelihood that a consistent temperature would not be maintained, with the home either being too hot or too cold.

- It is likely that smoke detectors would not be properly maintained.

Major Depression:

- Heating with wood or coal would likely require more physical stamina or energy to maintain than a person with this disorder would have. There would be a real risk of no heat at all or inconsistent heat.

- It is likely that smoke detectors would not be maintained.

- Due to distractibility, poor memory and concentration, the stove door could be left open. Even if the person realized the mistake, it might be more energy than they have to get up and close the door. Passive suicidality is a consideration here.

Bipolar Disorder:

- During manic phases, behavior becomes disorganized and judgment impaired, making heating in this fashion very dangerous.

- During stable periods, these individuals are very vulnerable to distractibility and task disruption, such as leaving the store door open and forgetting about it.

- Smoke detectors are unlikely to be maintained.

Borderline Personality Disorder:

- Individuals with this disorder can show great variability in their ability to complete this task depending on their learning history, the intensity of their affective state disruptions and their general ability to organize behavior. Some individuals will show no difficulty at all, while others will have extreme impairments.

15. NIGHT NEEDS

Schizophrenia:

- Individuals with this disorder often have persistent auditory hallucinations, which gain intensity over the course of the day and are the worst at night. Whereas the client may have the ability to cope with these hallucinations during the day when other activities are available, they may become unmanageable at night, leading to disruption of sleep, increased use of emergency services, or need for additional supports.

- Individuals with this disorder can also experience increased feelings of paranoia at night with a feeling of being watched or spied on.

- Intensity of delusions and acting out on delusions can become more pronounced at night.

- Rumination and preoccupation with worries can become more intense at night.

- Initial insomnia is common. Often these clients complain that they can sleep during the day but not at night.

Major Depression:

- Most individuals with this disorder report that depression is usually worse at night as is rumination, worry and feelings of hopelessness.

- Major depression is characterized by insomnia of various types including initial insomnia, middle insomnia and early wakening without return to sleep

- Some individuals with major depression complain that they feel exhausted all day, but then cannot sleep at night. Sleeping during the day, but not at night is common.

- Some individuals with this disorder complain of feelings of being watched at night, hearing mumbling, or music playing which do not occur during the day.

- Some individuals with this disorder complain of extreme fearfulness at night or difficulty going out at night in the community.

Bipolar Disorder:

- During manic periods, individuals with this disorder typically do not sleep. Often, they are out in the community. Otherwise, they usually engage in behaviors that can be disruptive to neighbors such as playing loud music, running the vacuum, etc without any awareness of the inappropriateness of the behavior. If delusions and hallucinations are present, these become more intense at night.

- During stable periods, individuals with this disorder may experience increased anxiety and rumination at night, as well as lingering insomnias of the various types.

Borderline Personality Disorder:

- Individuals with this disorder find night time extremely difficult, especially if they are living alone or experiencing the "runaway freight train" anxiety states. During these states, they often will not sleep for days, with increasing feelings of distress.

- Individuals with this disorder can experience transient psychotic and paranoid states. These become much more marked at night and the individual's ability to tolerate these states at night is decreased.

- Individuals with this disorder can sometimes have a marked fear of falling asleep.

- When alone, sometimes individuals with this disorder sleep with all the lights on.

- Post Traumatic Stress Disorder is a frequent co-occurring disorder in individuals with Borderline Personality, which results in nightmares and difficulty in coping at night, especially when alone.

16. EMERGENCY RESPONSE

Schizophrenia:

- Individuals with this disorder tend to under or over respond to emergency situations. Impaired problem solving and ability to carry out sequential tasks would be a consideration in evaluating this area.

- Due to paranoia, hallucinations or delusions, individuals with this disorder will often not seek emergency assistance, even when homeless and indigent.

- Due to interpersonal aversiveness, individuals with this disorder who are stable will often not seek even emergency medical attention.

- Individuals with this disorder are often frightened by attention from others, even when in need.

- Individuals with this disorder often require the assistance of someone they know well in order to access needed emergency services, even something as benign as emergency energy assistance to prevent power from being shut off.

- Any novel situation would be high risk for an inadequate response, without the intervention of someone else.

- Emergency situations would increase disorganized thinking, and perhaps behavior.

- Some individuals with this disorder experience extreme ambivalence in their thinking process, making decision making extremely difficult.

- Due to a poor connection with bodily sensations, individuals with this disorder can sometimes sustain serious injury without feeling pain or can interpret bodily sensations within the context of ongoing delusions.

- If paralyzed by psychotic symptoms, an individual with this disorder may not respond to an emergency at all or in a bizarre manner.

Major Depression:

- Individuals who experience hypersomnolence as a symptom of depression may not be roused by an emergency situation.

- Individuals with hypersomnolence report a protracted period of mental confusion and disorganized thinking upon rising which would significantly impair their capacity to respond to an emergency situation if roused from sleep.

- Since attention, concentration and memory are impaired in this disorder, the ability to rapidly engage in adequate problem solving in a novel, fast paced situation would be impaired. Circular thinking is very pronounced.

- Psychomotor retardation can be quite marked in this disorder, making a timely response to an emergency less likely.

- Individuals with depression of the more anxious, agitated type would experience an increase of these symptoms and would likely be unable to arrive at a decision as to what to do in a timely manner.

- Ambivalence and fear of making mistakes is also present in this disorder, which is likely to impede the individual's thinking in responding to emergency situations.

- In severe depression, the experience of hopelessness is so intense, that appropriate medical attention may not be sought out.

- If experiencing psychotic symptoms, an individual with severe depression may not respond at all.

Bipolar Disorder:

- During manic phases, judgment, and problem solving are impaired. Sometimes, grandiosity is also present, leading to a diminished perception of the dangerousness of situations. Behavior is poorly integrated and impulsive. Therefore, capacity to respond to emergency situations of all kinds is impaired.

- Individuals experiencing mania routinely do not feel pain and sometimes sustain serious injuries without any awareness of the injury.

- During stable phases, response to emergency situations is improved, but distractibility, disorganized thinking and impulsivity may still be present.

- If behavior is being directed by delusions or hallucinations, the individual may not respond to the emergency at all or in a bizarre manner.

Borderline Personality Disorder:

- Individuals with this disorder are characterized by a biologically based over-sensitivity and over-reactivity to environmental stimuli. There is a tendency to over-react to relatively minor stressors as though they were major emergencies.

- Individuals with this disorder respond to emergencies with decreased coping and may become clinging, helpless, demanding or anger in response to emergencies or other stressors.

- Individuals with this disorder routinely have more perceived emergencies, especially at night.

17. MEDICATIONS

Schizophrenia:

- Individuals with this disorder vary widely in their capacity to make the link between their symptoms and their behaviors as well as the link between taking medication and an amelioration of symptoms. Medication compliance is most often attached to this link.

- Some individuals with this disorder report that the side effects to the medications are not worth the slight amelioration of symptoms they experience taking the medications.

- Some individuals with this disorder experience a decrease in paranoid feelings as an *adverse* effect of the medications, because of ongoing delusions not impacted by the medications.

- Some individuals with this disorder experience a *decrease* in daily functioning capacity because of medication compliance, e.g. hypersomnolence and weight gain, as examples.

- Many individuals with this disorder need ongoing medisets, med prompts or daily medication drops in order to comply with medications, because they simply forget to take them or have no insight into how the medications improve their functioning.

- Some individuals with this disorder have hallucinations warning them not to take the medications for various reasons.

- 25 % of women with a mental illness will be talked into going off their medications by their significant other on a routine basis.

- Sometimes, the families of individuals with this disorder either do not enforce medication compliance once first rank symptoms go into remission or actively encourage the client to discontinue medications once first rank symptoms are gone.

- It is fairly common that individuals with this disorder express a willingness to take medications as prescribed, but then simply lack the skills to follow through on a consistent basis with taking the medications.

- Some individuals with this disorder actively deny that they have a mental illness and will not comply with medications, even under a court order. Sometimes, repeated involuntary hospitalizations and numerous adverse consequences have to occur before the individual will accept medication. It is sometimes the case that it is to avoid these consequences, not because the individual has accepted the existence of the mental illness.

- Some individuals with this disorder find psychosis preferable to reality.

Major Depression:

- Because of profound feelings of hopelessness, some individuals with this disorder will not believe that the medications can help them and sometimes only take the medications because family or others wish it.

- Individuals with severe depression symptoms sometimes only resolve into severe dysthymia, without a complete remission of symptoms, making motivation to continue with medications difficult at times.

- Some individuals treated for severe depression experience adverse medication side effects such as large weight gain, impotence, rashes and hair loss.

- Since individuals with this disorder always evaluate how things are going through the mood state they are currently experiencing, lethality of medications is always a consideration depending on current mood. Ability to manage medications safely fluctuates with the present mood.

- In severe depression, stabilization is a long and difficult process, sometimes taking several years, with many ongoing residual symptoms. Assisting the client in maintaining motivation and compliance is a major effort during this process.

- Some individuals with this disorder, once some level of functioning is restored, can become secretive about increasing symptoms of depression, sleep disturbance or other symptoms for fear of making things worse, i.e., like they were before the medications.

- In the case of serotonin slump, individuals with this disorder can be taking medications as prescribed and experience a gradual increase in depressive symptoms until a state of major depression once again exists, even though they are taking the medications as prescribed.

- Most individuals with severe depression experience ongoing residual symptoms which fluctuate in intensity on a daily basis, despite taking medications as prescribed, which can often be incorrectly attributed to a personality disorder.

Bipolar Disorder:

- During a manic phase, complete noncompliance with medications is common. Sometimes, there is partial compliance with medications which "put the brakes" on the episode, such as Klonipin.

- During a manic phase, alcohol or drug abuse can be occurring.

- Some individuals who take medications primarily for mania complain of feeling dead or flat when "stable" which tempts them to adjust their medication dosage in order to experience feelings.

- When in a stable period, most individuals with this disorder remain symptomatic to some degree. They experience sleep disturbance, distractibility, racing thoughts, disorganized thinking, poor concentration and attention and forgetfulness, even though they are taking their medications as prescribed.

- In stable periods, daily fluctuation of mood is likely, even when taking medications as prescribed.

- In recent years, there has been a marked increase in individuals with this disorder who display rapid cycling mood between hypomania and depression every few days which is often incorrectly attributed to a personality disorder.

- Medication compliance is often directed by the current mood being experienced.

- Distractibility and forgetfulness are major components in ongoing medication compliance.

Borderline Personality Disorder:

- Individuals with this disorder are characterized by rapid shifts of mood between depression and elation, persistent anger, and "runaway freight train" anxiety episodes. There is an understandable tendency on the part of the individual and medical providers to try to stabilize these affective shifts or states, often resulting in quite complicated medication regimens. There is a tendency on the part of the individual to take a medication for whichever state he is currently experiencing, leading to the reputation of this group of clients as "medication noncompliant".

- Oftentimes, individuals with this disorder are also diagnosed as having Bipolar Disorder and have medications for that disorder as well.

- Individuals with this disorder use suicide attempts as a primary coping mechanism to handle ongoing problems. Therefore, the individual's current stressors and the lethality of the medications needs to be evaluated with that fact in mind.

- Individuals with this disorder get sidetracked on a daily basis from any kind of regular routine and have difficult in maintaining consistent performance in all activities. This includes taking medications regularly.

- During "runaway freight train" anxiety episodes, individuals with this disorder will take any medication or use alcohol or drugs to attempt to stop the episode.

- Individuals with this disorder are particularly vulnerable to being talked into going off their medications by a significant other or friend to gain acceptance or approval.

- Individuals with this disorder engage in "therapy interfering behaviors", in some cases as a defense. Medication non-compliance is a major therapy interfering behavior to be addressed in ongoing treatment.

18. SUPERVISION

Schizophrenia:

- As individuals with this disorder age or develop health problems, the need for ongoing supervision and daily assistance increases. Schizophrenia has a progressive dementia as one of its features with increasing age, especially in disorganized type.

- The presence of persistent and severe symptoms of psychosis, as well as residual symptoms which result in self neglect, increase the need for ongoing supervision and assistance with activities of daily living.

Major Depression:

- During active episodes of depression, individuals with this disorder require assistance in all activities of daily living, as well as monitoring of suicidal risk.

- Even though receiving medications, some individuals with this disorder continue to have severe impairments in ongoing energy level, attention and concentration and problem solving. They just don't have enough energy to get everything done to maintain themselves adequately.

- Many individuals with this disorder respond to someone to assist them in getting an activity going, a "jump start" that assists them in completing the activity on their own. This "jump start" can be faded over time.

Bipolar Disorder:

- It is extremely difficult to provide supervision for individuals with this disorder who are in a manic phase, outside of a hospital setting. Individuals who are experiencing hypomania can often be redirected, but require one on one supervision until medications start taking effect, which is generally determined by whether the client is sleeping a normal time or not.

- When stable, individuals with this disorder often require considerable assistance in organizing their daily activities in a productive manner. Supervision and structure in daily activities are very helpful in increasing the client's ability to organize and complete tasks, especially individuals with multiple demands on them, such as children.

Borderline Personality Disorder:

- Individuals with this disorder are sometimes characterized as having "hostile dependence", meaning that they feel dependent on others, may even demand that others take care of them, but then hate the person upon whom they feel dependent. This should be borne in mind when considering the supervision needs of individuals with this disorder.

- Individuals with this disorder have also been characterized as engaging in "splitting" behaviors, namely, pitting professional staff against one another, usually centering around treatment or resource needs. Careful coordination with the individual's ongoing therapist and psychiatrist is necessary to determine the individual's actual needs.

- Because of the abuse and neglect histories of many of these individuals, real dependency issues do exist.

- A major therapy interfering behavior for individuals with this disorder often manifests itself in either demands for intensive supervision through hospitalization or rejection of supervision of daily activities which would be helpful in organizing the individual's life and environment more effectively.

- Demands for more supervision by these individuals usually manifests itself as an increase in the individual's ongoing self-harm behaviors.

- Whether increased supervision is appropriate should be determined in conjunction with the individual's ongoing therapist and psychiatrist.

ETIOLOGY OF BORDERLINE PERSONALITY DISORDER

MARSHA LINNAHAN, Ph.D

"THREE LEGGED STOOL"

Marsha Linnahan, PhD, University of Washington, is considered the foremost expert in the area of exploration of the etiology and treatment of individuals with Borderline Personality Disorder. Dr. Linnahan's formulation of the etiology of this disorder is as follows:

BIOLOGICALLY BASED OVER-REACTIVITY TO STIMULI

TRAUMA

PERSISTENT PATTERN OF INVALIDATION

Obviously, the effect of these factors can vary enormously between individuals, leading to the variety noted in this disorder's behavioral correlates.

IV. UAI SECTION ONE-General Information

IMPORTANT: The assessor who completes Section 1 should sign his/her name and add agency name, telephone, and date in the appropriate space on p. 12 of the UAI form.

Do not leave blank spaces on the form unless directed to skip certain sections or questions.

Item Number	Item Directions
1) Confidentiality	Be sure to obtain an Individual Service Plan and Informed Consent form (HW0623) and discuss it with the consumer. Please have him/her read and sign it prior to the completion of the interview. It does not necessarily need to be signed at the beginning of the interview. Discuss the importance of the release of information form with the client. The original is kept by the Regional Medicaid Service office and the yellow copy is left with the client. This is done at the time of the assessment. **Prompts:** • This is an excellent time to explain to the client the UAI purpose and process. • When possible, quote the client's exact words with his/her answers. This is especially helpful in the event of a hearing for denial of services.
2) Social Security Number	Record the number in the box provided.
3) Client Name	Print the client's legal name in the following order: Last name, first name, middle name or initial. *(Note: if the client goes by middle name, print the full middle name.)*
4-5)Medicaid/Medicare Numbers	Record the numbers in the boxes provided. Check the numbers to make sure the digits are recorded correctly. If there is no number, leave blank.

6) DOB	Enter the birth date with two digits for the month and day, and four digits for the year. (mm/dd/yyyy)
7) Sex	Indicate the sex of the client.
8) Lives Alone	Indicate if client currently lives alone.
9) Annual Income	*(To be completed by the Area Agency for Aging only.)* Review current poverty guidelines to indicate if client's annual income is above or below poverty level. Note number of people currently living in the household.
10) Client Address	List the client address and telephone number and give travel directions if necessary. If the client lives in a facility, note the facility name and use the facility's address.
11) Marital Status	Check the box for the appropriate marital status.
12) Race / Ethnic Origin	Check the box for the appropriate racial group or ethnic origin.
13) Emergency Contact	List emergency or family contact name(s), including relationship and telephone number.
14) Referred By	List the name of the individual and agency that has referred the client for an assessment. Include the telephone number and date of referral.
15 - 16) Sources of Information	Primary information is obtained from the client or an informant when the client clearly is not capable of responding to assessment items. Collateral information is obtained by using supporting and secondary information sources to supplement information obtained from the client. Secondary sources include the medical record, physician, other providers and any other person knowledgeable about the client. Collateral information can either be verbal or written and must be

	documented in the comments section. More space is provided on the last page of the UAI form.
17) Assessment Date	Assessment Date: Date when the assessment is completed. Assessment Type & Sections Completed: Check the appropriate box for type of assessment. *Initial* is the first UAI completed for the client and includes UAI Sections 1-4. *Update* or limited assessment is completed if there has been a recent significant change in the client's functioning. A significant change is a major change in the client's status that affects more than one area of the client's functional or health status, and requires a review or revision of the care plan or negotiated service agreement. A limited assessment includes general information, functional abilities and supports, Sections 1 & 2. *Annual* refers to the yearly administration of the UAI.
18) Place of Assessment	Check only one box to designate the place of assessment. Usual Housing Arrangement: Check only one box to designate the usual place of residence. If the client resides in a custodial facility, please list the date of admission.
19) Substitute Decision-Maker	Check any number of boxes as appropriate and add clarifying information in the comments section. Informal decision-maker means there is not a legal arrangement for decision-making through a court or administrative agency.
20) Primary Language	List the primary language of the client. Check the appropriate box, either YES or NO, if the client requires an interpreter.
21) Legal Status	Indicate if client is on probation/parole, committed, and/or involved in any criminal proceedings. Use COMMENT space to include additional information.
22) Preparing for discharge from hospital, nursing facility, or institution	If the client is preparing for such a discharge, check YES and indicate planned discharge date. Add any necessary comments to explain.

23) Major Problem(s)… Anticipated Changes	Briefly describe the major problem(s) the client is experiencing at the time of the UAI and any anticipated changes. Be sure to include what assistance the client is seeking and who can provide that assistance.
24-29) Primary Caregiver Information	If a caregiver exists, check whether the caregiver is paid and the source of payment if applicable. Note if the caregiver is present during the assessment and whether he/she is readily available. Write the name, address, and telephone number of the caregiver (if available). If the caregiver is not a spouse or relative, briefly describe this relationship. Check the appropriate age category of the caregiver and indicate the days and times when he or she is available to the client. Also include the years and months the caregiver has been serving the client and any special training the caregiver has received. **NOTE: If the client resides in a custodial living arrangement, skip to page 3, #31. Similarly, if the client does not have a primary caregiver, skip to page 3, #31. If the client resides in a custodial living arrangement, but intends to move out of the facility, items 25 - 30 should be completed based upon potential (or future) caregivers.**
30) What kind of help or additional supports, etc.	Include comments about what kind of assistance the caregiver needs to continue to provide care. Obtain the caregiver's opinion about what he/she thinks is required for additional help or support. Attach additional sheet if necessary.
31 - 32) Additional Caregivers/Supports	List the names of any additional caregivers who provide support to the client. Check the appropriate box to indicate whether the caregivers are paid or unpaid. Include comments related to availability, or concerns about specific caregivers/supports listed. List any information you deem relevant. Also, indicate whether you believe the client can direct his/her care, i.e. supervise caregivers. **Prompts:** • Inquire about other areas of support, which the client may not readily identify, such as support from family, community volunteers, church, etc.

33) Abuse, Neglect, or Exploitation	` Evaluate whether or not the client is currently experiencing or at risk for these situations and check only one box. **IMPORTANT: Any indication of abuse, neglect, or exploitation REQUIRES referral for assessment/investigation.**

V. UAI SECTION TWO-Functional Abilities, Supports and Related Information

General Information for Assessing Functional Abilities, Supports and Related Information

Measurements of functional abilities and supports are commonly used across the country as a basis for differentiating among levels of long-term care giving. Functional abilities and supports are the degrees of independence with which a client performs Activities of Daily Living (ADL), Continence, Mobility, and Instrumental Activities of Daily Living (IADL).

There are three important points to remember when assessing functional abilities and supports:

1. Functional abilities and supports are measures of the client's impairment level and need for personal assistance. In many cases, impairment level and need for personal assistance are described by the help received, but this could lead to an inaccurate assessment. For example, a disabled client needs help to perform an activity in a safe manner, but he/she lives alone, has no formal supports, and receives no help. Coding the client's performance as independent because no help is received is very misleading in terms of the actual impairment level. In order to avoid this type of distortion, interpret the Activities of Daily Living (ADLs) in terms of what is usually needed to safely perform the entire activity.

2. Second, an assessment of functional abilities and supports are based on what the client is able to do, not what he/she prefers to do. In other words, assess the client's ability to do particular activities, even if he/she doesn't usually do the activity. Lack of capacity should be distinguished from lack of motivation, opportunity, or choice. This is particularly relevant for the IADLs mentioned above. For example, when asking someone if he/she can prepare light meals, the response may be "No", he/she does not prepare meals, even though the client may be able to do so. The client should be coded as not needing help. If a client refuses to perform an activity, thus putting himself/herself at risk, it is important to probe for the reason why the client refuses, in order to code the activity correctly. The emphasis in this section is on assessing whether ability is impaired. Physical health, mental health, cognitive, or functional disability problems may manifest themselves as the inability to perform ADL, Continence, Mobility, and IADL activities. If a client is mentally and physically free of impairment, there is not a safety risk to the client, and the client chooses not to complete an activity due to personal preference or choice, indicate that the client does not need help.

3. The emphasis of the measurement of each of the functional activities should be how the client usually performed the activity over the past two weeks. For example, if a client usually bathes with no help or reminding/cuing, but on the date of the interview requires some assistance with bathing, code the client as not requiring help unless the client's ability to function on the date of the assessment accurately reflects ongoing need.

There are several components to each functional activity, and the coded response is based on the client's ability to perform all the components. For example, when assessing the

client's ability to bathe, it is necessary to ask about his/her ability to do all of the bathing activities such as getting in and out of the tub, preparing the bath, washing, and towel drying. Therefore, interviewers will need to probe in detail in order to establish actual functional level.

Some questions in the section are personal and the client may feel somewhat embarrassed to answer (e.g., toileting, bladder and bowel control). Ask these questions in a straightforward manner and without hesitation. If you ask the questions without embarrassment or hesitation, the client will be more likely to feel comfortable. If the client is embarrassed, it is your responsibility to reassure the client that it is O.K. and that you understand how he/she could feel that way. Let the client know that answers to these questions are important because they will help you better understand his/her needs and provide a care plan that is right.

There is a space at the end of each Functional Abilities and Supports section to record comments. Use this space to comment on functioning in the areas of ADLs, Continence, Mobility, and IADLs. Comments should include the type of equipment used/needed to perform the activity and/or information about caregivers.

Use the space provided to record any problems with continued care giving. These may include, but are not limited to, poor health of the caregiver, employment of caregiver, caregiver's lack of knowledge about ways to appropriately care for the client, or a poor relationship between the client and the caregiver. The space can also be used to record whether the caregiver has a "backup" or someone who can provide for the client when the caregiver is not available.

Informal care refers to services the client's spouse, relative, or other individual(s) are both physically and mentally able and willing to provide, at all the times, the services generally are needed.

The Rating Scale:

Use your judgment to pick the most appropriate rating for Assistance Required, Available Supports and Unmet Needs. Consider both paid and unpaid supports.

Assistance Required: Base the selection of the appropriate code on the client's ability to perform each activity on the day of review. If the client is in a custodial facility, base the selection according to how the client would perform each item if the client lived on his/her own. If the client has a temporary problem on the day of the review which interferes with how the activity is usually performed, base selection on the client's most typical performance. If the client often has a wide variations in performance of the activity, base selection on the most dependent performance.

Available Supports: Indicate the degree of existing supports; paid or unpaid, that are not paid by the Department of Health and Welfare or the Idaho Commission of Aging. This support can be from families, friends, neighbors, volunteers, church, and caregivers, etc. "Available" refers to help that an agency or client has agreed to provide.

Unmet Needs: Requires the assessor's decision on the level of unmet need: None, Minimal, Extensive, and Total.

Comments Column: Include any explanatory information related to the rating, as well as the names of any available supports.

The Comment Space:

Use the comment space to include additional information, other concerns related functioning, considerations for care planning and notes about specific ADLs and IADLs.

Evaluating Reported vs. Observed Information:

Information reported by a client regarding functioning abilities should be verified with secondary sources if the trustworthiness of the information is in question. For example, a client may state that they are able to complete a task but in reality may have problems doing so.

Rating Able But Unwilling Clients:

In rating an able but unwilling client, specify any difficulties with cuing versus capabilities and willingness to perform any of the ADLs or IADLs in the comment space.

Functional Abilities Descriptions

(N=None, MI=Minimum, MO=Moderate, E=Extensive, and T=Total)

Important: The assessor who completes Section 2 should sign his/her name and add agency name, telephone number and date in the appropriate space on page 12 of the UAI form.

1. Preparing Meals:	None: Possess cognitive and physical abilities to safely prepare all meals. Minimal: Capable of preparing meals with cueing or supervision. Moderate: Requires physical assistance with at least one meal per day and can fix other simple meals. Assistance provided may be in the form of a home delivered meal. Extensive: Requires complete physical assistance with all meals but can assist with certain tasks. Total: Requires complete physical or cognitive assistance with all meals and is unable to assist with any tasks. Is unable to access a refrigerator or microwave. **Prompts:** • Does the client need a specially equipped stove or specially arranged kitchen?

	• Consider the client's ability to carry meals from counter to table. If they have a walker, ask how they manage to prepare meals. • Inquire what the client fixed for breakfast, lunch or dinner the day preceding the interview or what they will be preparing for their next meal. Have them give you details on how they prepare the meals. • Request to observe the kitchen, meal prep area and refrigerator. Check for dust on cans. • How are you getting your meals? Home delivered meals? How many? Facility provided? • Are you on a special diet? • What is a normal breakfast for you? Lunch? Supper? • What is the most difficult for you to fix? Easiest? • How do you get the foods you need to fix a meal? • How do you open jars? Cans? Can you peel potatoes? • Do you ever forget and leave a burner on? When was the last time? What happened? • Observe for mental concentration during the interview. • Does anyone ever help you with meals? Who? • What types of foods do you keep on hand? **Examples:** None: Should be able to use a can opener, open jars (with or without an adapter), remove protective cover from freezer packs, heat leftovers in microwave or conventional oven, peel carrots, potatoes, prepare their own meals and feel they can do so and maintain nutritional needs, and furthermore, doesn't want anyone preparing their meals. If they are just having coffee and doughnuts, need to find out why. Minimal: Should be able to do most tasks with perhaps a desire for a meal prepared by someone else just for variety. Moderate: Needs assistance with main meal, doesn't want home delivered meals, can heat soup, prepare toast, make lunchmeat or peanut butter sandwiches, and snacks, and eats some raw fruits and vegetables. May need to have meals prepared ahead for easy retrieval and heated in microwave or on stove (assuming is safe). May have a home delivered meal once or twice a week. Extensive: Needs assistance with completion of all meals, receives home delivered main meals, no community or family support system, has special dietary needs. May be able to assist with some meal prep but unable to sequence the complete task. Total: This would be an individual who is unable to access and prepare any food. The person would be unable to intake nutrition

	without the physical assistance of another person. A person with the ability to go to a kitchen or cupboard and fix themselves a sandwich or open a can does not meet these criteria. All meals at all times need to be prepared by someone else due to inability physically (non-ambulatory) or mentally (dementia, mental retardation, or mentally ill to point of not being able to meet nutritional needs). No community or family support system. May or may not be sufficient to just receive home-delivered meals. All meals may need special preparation, i.e. pureed for tube feeding.
2. Eating Meals:	None: Can feed self, chew, and swallow solid foods without difficulty or can feed self by gastrostomy tube or catheter. Minimum: Can feed self, chew, and swallow foods but needs reminding/cuing to maintain adequate intake, or may need food cut up. Moderate: Can feed self only if food is brought to them. Extensive: Can feed self but needs standby assistance or cuing. May have occasional gagging, choking, or swallowing difficulty, or require assistance with feeding appliances. Total: Must be fed by another person by mouth, or gastrostomy tube. **Prompts:** • Does the client need special utensils such as built-up spoon, fork, non-spill cup, or plate guard? • Does the client need to be monitored while eating because of choking, chewing or swallowing difficulties? • Ask the client if they have dentures? Do they cause any difficulties with eating? • Are there some types of foods you can no longer eat? • What are they? Why? (dentures, missing teeth, swallowing) • How do you get meals from the stove or counter to the table? • Can you serve up your own plate? (Observe for tremors, strength of grasp by holding out your index and middle finger and have them squeeze) • Have you ever gagged or choked while eating? When was the last time? • Note: Fit of clothes.

	Examples: None: Is able to dish up own food, transfer to table, no choking or swallowing problems, no special utensils required. Should be consuming at least 2 meals/day with consistency. Minimal: Requires encouragement to follow dietary needs, i.e. diabetic, low salt, low fat, etc. May be in training program to learn ADL's. Moderate: No problems with eating, but has difficulty transferring food to comfortable place to eat due to having to use walker to keep balance. If they usually eat in the kitchen on a breadboard and they're okay with this, then should be a minimal. This category also includes someone who tires very easily while eating with, for example, lung problems and oxygen therapy. For a client who is bed bound, may be able to feed self with set up, or may need assistance with fluids. Extensive: Client may have problems with swallowing due to stroke and is at risk for choking. May have Parkinson's and feeds self but requires constant cleanup, or someone to steady their hand. Total: This is a score for those individuals who do not have the ability to feed themselves any food. This individual must be fed by another person by mouth or feeding appliance. Must be fed or tube fed. Client may be unable to tube feed self due to stroke with dominant side paralysis, quadroplegia, mental retardation, comatose.
3. Toileting:	None: Can toilet self without physical assistance or supervision. May need grab bars / raised toilet seat or can manage own closed drainage system if has a catheter or sheath or uses protective aids. Minimal: Needs standby assistance or cuing for safety or task completion. May need some physical assistance with parts of the task such as clothing adjustment, washing hands, etc. Moderate: Needs physical assistance with parts of the task such as wiping, cleansing, clothing adjustment. May need a protective garment. Extensive: Cannot get to the toilet unassisted. May or may not be aware of need. Total: Physically unable to be toileted. Requires continual observation and total cleansing. Needs someone else to manage care of closed drainage system if they have catheter or sheath.

	Prompts: • Does the client have the awareness of the need to toilet? • Does the client recognize the need to toilet but can not do so without the assistance of another person? • Inquire if the client has any bowel or bladder “accidents”. • Do you take a "water" pill? • Do you wear protective garments? Pads or Pull-ups? How do you dispose of these? Note for odors, cleanliness, and proper disposal of toileting items. • Are you able to clean yourself after toileting? Does anyone ever help you with this activity? Who? • Catheter Care: Who assists you with this activity? Last UTI? • Ostomy Care: Who assists you with this activity? Who does set up? Clean up? Disposal? **Examples:** None: Has no bladder or bowel problems, is slow but able to get to bathroom on time. Or, has occasional bladder incontinence but able to take care of own needs with cleaning self and proper disposal of incontinence supplies. Minimal: Has stress incontinence, and can care for self, except needs assist with disposal of soiled items, i.e. in assisted living situation or daily removal from living quarters. Moderate: Needs assistance with toileting; clothing adjustment, pericare, protective garments. Extensive: Needs to be assisted to the bathroom. May need to have a toileting schedule; unaware of need. Total: This individual does not have the awareness to toilet themselves. Or may have the awareness but are physically unable to do so without the assistance of another person. Unable to go to the bathroom. Requires protective garments to be checked, changed and pericare done on a regular basis. Needs caregiver to care for catheter or colostomy.
4. Mobility:	None: Can get around inside and outside without assistance. Minimal: Can get around inside without assistance but needs assistance outside. Moderate: Needs occasional assistance inside and usually needs

	assistance outside. Extensive: Can only get around with regular assistance both inside and outside. Total: Cannot move around even with regular assistance. **Prompts:** • Identify if the client needs equipment to assist nurses/other with care. • Would you mind standing up and walking about 10 steps, turn around and return to your chair? (It is easier to observe transfers, balance, pace, gait, posture, and orientation in this manner). • What other type of equipment do you use to get where you need to go inside? Outside? • How far can you walk without having to stop and rest? • What do you do when you get too tired or short of breath? • When was the last time you fell? What happened? • Do you ever have periods of extreme weakness or fatigue? How often. Can you describe the circumstances? **Examples:** None: May be in a wheelchair but can get around independently in or out of home. Have handicap access doorways. May have assistive devices to assist in reaching items, transferring out of chair, etc. May use other devices for ambulating, walker, cane, prosthetics, but if they can manage independently and have no history of falls in the past 3 months or so. Minimal: May need assist getting to the outside, but able to manage once outside. May need occasional assist into Dr's office (once/month), or standby assist outside. Does not go outside except to Dr. appointments. Moderate: Due to variable status requires assist with mobility on some days inside. Always requires help when outside on outings and/or on uneven surfaces. Extensive: Requires direct assist with mobility at all times. Total: Immobile.
5. Transferring:	None: Can transfer independently and can manage own position changes. Minimal: Transfers and changes position most of the time but

	needs assistance on occasion. Moderate: Can assist with own transfers and position changes but needs assistance most of the time. Extensive: Can assist with own transfers and position changes but needs assistance all of the time. Total: Transfers / position changes must be done by one person all of the time. **Prompt:** • Identify if the client needs an overhead frame, slide board, etc. • Who helps you in/out of vehicles? • Does anyone ever help you with this activity? Who? • How much assistance do you need to get from the chair to the bed, etc? **Examples:** None: Consistently transfers safely and independently from sitting to standing position and back again. Good balance. Minimal: Occasionally unable to transfer safely and requires assist. Moderate: Able to participate with transfers, but requires direct assist most of the time to do so safety. Able to push self up from chair, but requires hands on assist to maintain balance during the position change. Extensive: More often than not is unsteady, tremulous, dizzy and requires direct assist with position changes. Total: Must have another change transfer them directly. Unable to participate at all.
6. Personal Hygiene:	None: Can manage personal hygiene without reminders, assistance, or supervision. Minimal: Can manage personal hygiene but must be reminded/cued at least some of the time. Moderate: Performs personal hygiene but requires physical assistance to complete. Extensive: Caregiver performs most personal hygiene but client

	assists. Total: Dependent on others to provide all personal hygiene. **Prompts:** • Who does your hair? (if they say they do it, you could ask them to raise their arms as high as they can to determine ROM. • How do you clean your glasses? • How do you care for your fingernails/toenails? • How do you take care of your dentures? • How do you set up and prepare items for shaving? **Examples:** None: Maintains good hygiene by self. Minimal: Requires cuing to complete general hygiene tasks. Moderate: Requires some assistance with some tasks. Extensive: Total:
7. Dressing:	None: Can dress / undress and select clothing without assistance or supervision. Minimal: Can dress / undress and select clothing but may need to be reminded / supervised. Moderate: Can dress / undress and select clothing with assistance. Extensive: Caregiver dresses / undresses and selects clothing but client assists. Total: Dependent upon others to do all dressing / undressing. **Prompts:** • Identify if the clients needs special consideration with manipulation of closures, i.e. zipper, Velcro, etc. • How do you decide what to wear for the day? Note: appropriate attire for situation and cleanliness. • What is most difficult part for you about getting dressing? • Where do you put soiled clothing?

	• Do you wear special garments? TED hose, orthotics? • How do you put your TED hose on? • Can you snap, button, and zip your clothing? • Does anyone ever help you with this activity? Who? • Has anyone complained about your grooming or dress? • Observe for clothing that is appropriate for the season. **Examples:** None: Minimal: Moderate: Some assistance is needed which is more than just prompting. Extensive: Total:
8. Bathing:	None: Can bathe without reminders and without assistance or supervision. Minimal: Can bathe without physical assistance but may need reminding or standby assistance. Moderate: Requires assistance or cuing with parts of bathing, (i.e., washing back, feet, rinsing hair, etc.). Includes people who cannot get into / out of tub and may require some other assistance. Extensive: Caregiver bathes the client with client' assistance. Total: Dependent on others to provide complete bath, including shampoo. **Prompts:** • Do you shower or bathe? How often? • Can you set up all the articles you need to complete? • Can you shampoo your hair? Reach your feet and backside? If no special equipment, who would you ask? • What do you do to keep from falling in the tub/shower? • Do you feel safe getting in/out of tub/shower? • Does anyone ever help you with this activity? Who? How often? **Examples:** None:

	Minimal: Moderate: Needs assistance getting in or out of tub/shower or needs help with any other bathing tasks. Extensive: Total:
9. Transportation	None: Can drive safely or is capable of using alternate transportation without assistance. Minimal: Can use available transportation but needs instruction or physical assistance to get to or from transportation vehicle. Moderate: Can use available transportation if physical assistance or cuing is provided to both get into and out of vehicle, but assistance is not needed during trip. Extensive: Is dependent upon being accompanied to access the community. Total: Medical condition is such that an ambulance is required. **Prompt:** • Identify if the client needs a specially equipped van or car. • How do you get to where you need to go? • Are there family members or support from the community who help you with transportation? • Are they able to continue to help you? • If family or friends are not available, how would you get there? • Have you experienced problems trying to arrange for a ride? **Examples:** None: Minimal: Moderate: Extensive: Total:
10. Finances:	None: Handles financial business matters. Minimal: Needs occasional assistance with financial business

	matters. Moderate: Needs help with some financial business. Extensive: Needs extensive helping managing financial business matters. Total: Unable to handle financial business matters. **Prompts:** • How do you get your bills paid? • How do you know how much money is in your account? • Do you run out of money at times? • Did you go without food or medicine because of this? • Does anyone ever help you with this activity? Who? **Examples:** None: Minimal: Moderate: Extensive: Total:
11. Shopping:	None: Can shop without assistance. Minimal: Shops without physical assistance but may need to be reminded / supervised. Moderate: Can shop with physical assistance or cuing from caregiver. Extensive: Caregiver shops but client assists. Total: Totally dependent upon others for shopping. **Prompts:** • How do you get to the store to buy groceries or personal items? • How do you get the items into your house/apartment and put away? • Do you enjoy shopping? • Does anyone ever help you with this activity? Who? **Examples:**

	None: Minimal: Moderate: Extensive: Total:
12. Laundry:	None: Is capable of doing laundry. Minimal: Does laundry without assistance but may need to be reminded / supervised. Moderate: Can do laundry but needs physical assistance or reminding/cuing from caregiver. Extensive: Caregiver does the laundry but client assists. Total: Totally dependent upon others to do laundry within/outside the home. **Prompts:** • Where are the washer and dryer? • How many times a week/month do you do laundry? • How often are your bed linens and towels laundered? • How does laundry get folded and put away? • Does anyone ever help you with this activity? Who? **Examples:** None: Minimal: Moderate: Extensive: Total:
13. Housework:	None: Performs housecleaning with no assistance. Minimal: Physically capable of performing all housecleaning but needs to be reminded / supervised. Moderate: Performs light housecleaning without supervision or cuing and caregiver handles physically difficult housecleaning. Extensive: Performs light housecleaning with supervision or cuing and caregiver handles physically difficult housecleaning. Total: Totally dependent upon others for all housecleaning.

	Prompts: • Do you do your dishes yourself after each meal? • Do you have a vacuum cleaner? Can you use it? • How do you get your tub/shower, toilet, sinks cleaned? • How do the floors get swept/mopped? • Who changes the linen on your bed? Turns the mattress? • How do you clean out your refrigerator? Does it automatically defrost? • How does the garbage get taken care of? Who takes it out? • Does anyone ever help you with housekeeping? Who? **Examples:** None: Minimal: Moderate: Extensive: Total:
14. Wood/Coal Supply:	None: Maintains wood/coal supply with no assistance. Minimal: Can maintain wood/coal supply with occasional assistance. Moderate: Can maintain wood/coal but needs to be reminded / supervised. Extensive: Can maintain heat if wood/coal is brought into living area, but is physically unable to carry wood/coal and needs assistance with chopping and stacking. Total: Totally dependent upon others for assistance. **Examples:** None: Minimal: Moderate: Extensive: Total: Needs someone to cut wood, bring it to their home and stack it.
15. Night Needs:	None: Needs no assistance from another person during the night. Minimal: Requires hands on or standby assistance 1-2 times per night.

	Moderate: Requires hands on or standby assistance 3-4 times per night. Extensive: Requires hands on or standby assistance 5 or more times per night. Total: Requires staff to be up and awake all night. **Prompts:** • When was the last time you got up at night and felt confused about where you were? What did you do? **Examples:** None: Minimal: Moderate: Extensive: Total:
16. Emergency Response:	None: Needs no assistance to get outside of present dwelling or get emergency help. Is able to use the phone in emergency situations. Minimal: Needs supervision and / or verbal cuing to get outside of present dwelling or get emergency help. Moderate: Caregiver must assist to get outside of present dwelling, but client can assist. Extensive: Requires some physical assistance to get outside of present dwelling. Total: Requires total physical assistance to get outside of present dwelling. **Prompts:** • Have you ever called 9-1-1 in an emergency? Anyone else? • How would you leave your home/apartment in event of an emergency? Who would you call? • Have you had an emergency situation in the past? Recently? • Tell me how you would handle an emergency such as falling in the bathtub or their bedroom. **Examples:**

	None: Minimal: Moderate: Extensive: Total:
17. Medication:	None: Can self-administer medication without assistance. Minimal: Requires minimal assistance (i.e. open containers or use a mediset); understands medication routine. Moderate: Requires occasional assistance or cueing to follow medication routine or timely medication refills. Extensive: Requires daily assistance or cueing; must be reminded to take medications; does not know medication routine; may not remember if took medications. Total: Requires licensed nurse to administer and/or assess the amount, frequency, or response to medication or treatment. A treatment is defined as an in home skilled nursing treatment. **Prompts:** • Can you tell me what medications you are taking? Or What are you taking medications for? (many people know this, but not technical names) • How often do you take them? • Have you taken your medications today? • Do any medications need to be broken/crushed? • When did you take your last PRN medication? • Do you keep your medicines in the bottles, or in a Medi-set? Who fills it for you? • Do you have trouble opening medicine bottles? • When was the last time you forgot to take a medication? What happened? • Does anyone ever help you with your medications? Who? **Examples:** None: Minimal: Moderate: If client needs assistance filling mediset and needs reminders, score moderate. Extensive: If the client can not remember the what, the when, or

	the why of their medications, score extensive. Total:
18. Supervision:	Complete SECTION FOUR – Psychological/Social/Cognitive prior to completing # 18 Supervision. The UAI computer software will then take the Section Four scores and determine the scoring for supervision. The reviewer will need to then identify the client's unmet needs for supervision. The scoring determination is based on weighted factor points for each cognitive behavior. The score for each of the cognitive behaviors will be multiplied by these factor points. For example, if a client is frequently assaultive and requires professional consultation for a behavioral program, the reviewer will give the client a score of three on the UAI form. This amount is then multiplied by the factor points for assaultive behaviors (4) to total 12 points toward the need for supervision. • Disorientation 3 points • Memory 2 points • Judgment 3 points • Hallucinations 1 point • Delusions 1 point • Anxiety 1 point • Depression 1 point • Wandering 4 points • Disruptive 4 points • Assaultive 4 points • Danger to Self 4 points • Alcohol/Drug 1 point • Vulnerability 4 points Once Section Four is completed, the client's total scores will determine the need for supervision. The scoring determinations are as follows: None 0-15 points Minimal 16-30 points Moderate 31-45 points Extensive 46-60 points Total 61-100 points
Environmental	**IMPORTANT:** This environmental section should only be

Assessment	completed if the client is seeking services in the home or from the Area Agency on Aging (AAA). Otherwise SKIP THIS SECTION. Note whether the information recorded is based upon the client's (or client representative's) report or assessor's direct observation. Identify in the blank provided whether the source of the information is reported or observed. Try to verify as much of the reported information as possible in assessing the internal and external environment.
19-20. Environment Exterior – Interior:	This assessment evaluates the conditions, circumstances, and influences surrounding and affecting the actions and behavior of the client, family, and caregiver(s). The environment includes the client's own personal space to the broader concept of the community. The assessment of the environment is vital to planning. Look at the residence *(i.e. - review the exterior environment: sidewalks, handrails, windows, roof, general maintenance, lighting, and neighborhood safety, etc.)*. Inside the residence, observe the adequacy of floors, bathing facilities, toilet, lighting, cleanliness, any stairs, the various systems for heating, cooling, and lighting, kitchen appliances, and any other safety factors. Give your general observations, not a professional evaluation, about the suitability of the home. Any problem areas should be identified in the Plan of Care Considerations Summary on the last page of the UAI.
21. Are There Other Needs?	Use this comment box to address anything around the home, inside or out, which needs care or repair. Also comment on any need for specialized environmental controls for disabled clients. This environmental assessment is to assist persons to live at home in the least restrictive environment, if possible, and the information from the comments should be considered in developing a plan of care. Include comments about neighborhood, transportation access, etc.
22. Assistive Devices and Medical Equipment:	Check the assistive devices or medical equipment that the client has or needs. Also, indicate if an assistive device / technology assessment is needed. Record any additional needs not covered by the list in the comment box. **Prompt:** • An "assistive device / technology assessment needed" should be checked "Yes" if:

	1. The assessor has identified that a device may help the client function at a higher level, but the client does not have one at this time, or, 2. If the client has a devise which is not working properly.
23. Additional Nutritional Risk Information	Make sure a YES or NO response has been given for every question in this section.
24. Diet Information	If the client is NOT on a special diet ordered by a physician, SKIP to page 8. If the client is on a diet ordered by a physician, specify which diet(s) from the choices listed. If none of the choices matches the physician order, please specify in the OTHER blank. *(For definitions of the types of diets, please see the DEFINITIONS section later in the manual.)*

VI. UAI SECTION THREE-Health Information

This section is not intended to be used to diagnose a problem. It is to record current conditions or diseases for which the client is being treated or may need a health care referral. A list of diagnosis categories with examples can be found at the end of the chapter. The medical record should be used to identify diagnosis and interventions.

The assessor who completes Section 4 should sign his/her name and add agency name, telephone, and date in the appropriate space on page 12.

1. Primary Physician's Name:	Print the name of the primary physician. If the name is unknown, write UNKNOWN. If the client has no primary physician, write NONE.
2. Telephone:	List the telephone of the primary physician. If not known, write UNKNOWN.
3. Current Diagnosis:	Document current confirmed diagnoses by health/mental health professionals and medical problems identified by the client or family. Note any sexually transmitted diseases under the urinary/reproductive Section. Note any tuberculosis treatment un the Respiratory Section.
4. Pertinent History:	Document physical and mental health history which is relevant to current functioning. Include the dates of hospitalizations and mental health treatments.
5. Last Hospitalization:	List the reason for and the date of the last hospitalization.
6. Medications:	List all currently prescribed medications and their dosage. If the client is preparing for discharge from a hospital, nursing home, or institution, list only the medications that will be taken after discharge. Use the route and frequency codes listed. **Prompts:** • Be sure to inquire whether the client requires special medication considerations such liquids, pill form, or crushed pills.

	• It is helpful to ask the client/caregiver to show the assessor the actual prescription bottles to verify accuracy of the information. • Note if the client uses any type of schedule reminders, multiple day pill packs, etc. • Medications can be a clue to identify a diagnosis not mentioned or inadvertently omitted in Questions # 3 & 4-Current Diagnosis and Pertinent History.
7. Comments:	List medications prescribed but not purchased, prescribed and purchased but not taken, prescribed for someone else but used by the client, etc. Add an additional page if necessary to document medication usage. **Prompts:** • Be sure to note whether client requires liquids versus pill form, crushed pills, etc. • Are there medications which have been prescribed but not purchased? • Are there medications prescribed and purchased but not taken?
8.Over the Counter Medications/Home Remedies:	List whether the client uses over-the-counter medications. Include what, why, how often and effectiveness of the medication. Also note if client's use of over-the counter medications is physician directed. **Prompts:** • Include herbal remedies and dietary or food supplements.
9. Bladder Control: **10. Bowel Control:**	Continence is the ability to control urination (bladder) and elimination (bowel). Incontinence may have one of several different causes, including specific disease processes and side-effects of medications. **Prompts:** • Do you get to the bathroom on time? • How often do you have accidents?

	• Do you use pads or Depends?
11. Skin Problems:	Include dry areas, rashes, stasis, ulcers, red areas, pressure sores/decubitus ulcers, open sores, open wounds, and/or any open sore that has not healed in the last thirty (30) days.
12. Treatments/ Therapies:	List all treatments/therapies currently provided, unless preparing for discharge from a hospital, nursing facility, or institution. In this case, check treatments that must be provided after discharge. List all treatments/therapies which are physician ordered / referred, or otherwise authorized which are provided by or under the direct supervision of a licensed or certified professional therapist, by other providers, or family. For each treatment or therapy, write in the appropriate frequency code from the list. A complete list of therapies and definitions for therapies can be found at the end of this chapter.
13. Identify Assistance Required:	Identify any assistance required to follow through with the treatments/therapies required.
14. Recommendation Need to be Made:	Indicate if a client needs to be referred to a physician for a medical condition not currently being address. Use the Other spaces to address any possible interventions/care not listed. Add any additional information on the comment page at the end of the UAI or attach a separate sheet.
15. Vision	
16. Hearing:	
17. Receptive Speech:	The ability to comprehend the verbal or spoken language.
18. Expressive Speech	The ability to communicate with spoken language.

19. Nutrition:	If not known by the client or caregiver, estimate height and weight.
20. Allergies:	Includes allergies to medications (e.g. codeine, penicillin); environmental (e.g. dust, pollen); and food (e.g. seafood, milk).

Explanation of Diagnosis Categories

Alcoholism/Substance Abuse: Includes alcohol, prescription, illegal and over-the-counter drug abuse.

Blood-Related Problems: Includes Erythenia, Leukemia, Lymphoma, Splenic Disorders, Anemias, and Hepatitis.

Cancer: Cancer is not a single disease, but a group of disorders where normal body cells are transformed into malignant ones. If a client reports cancer as a diagnosis, it is important to ask what type and ascertain the location of the tumor. Treatments include radiation and chemotherapy, and there may be side effects such as weight loss, poor appetite, skin irritation, diarrhea, weakness, fatigue, and pain. The assessor may want to ask a significant other about the client's prognosis.

Cardiovascular Problems:

Circulation Problems include disturbance in the circulatory system, such as Peripheral Vascular Disease. These problems may be evident by edema (swelling) of the extremities, ulcers, gangrene, discoloration, absence of pulse in the extremity, and severe pain. This is also the code to give someone who is taking medication for high cholesterol.

Congestive Heart Failure is a condition caused by loss of pumping power of the heart, resulting in fluids collecting in the body.

Heart Trouble includes atherosclerosis (fatty deposits in the arteries), arteriosclerosis, cardiovascular disease, coronary artery disease, and heart attack.

High Blood Pressure, **or Hypertension**, is persistent elevation of the arterial blood pressure.

Dementia:

Alzheimer's disease is a progressive neurological problem of unknown etiology, characterized by loss of memory, confusion, agitation, loss of motor coordination, and decline in the ability to perform routine tasks, personality changes, loss of language skills, and eventual death. Clients often exhibit emotional instability, and problems such as wandering, depression, belligerence, and incontinence may develop.

Non-Alzheimer's includes organic brain syndrome, chronic brain syndrome, and senility.

Developmental Disabilities:

Mental Retardation is characterized by below average general intellectual functioning existing concurrently with deficits in adaptive behavior, manifested during the developmental period. Significantly below average is considered to be an IQ of 70 or below.

Autism: Autism is a developmental disability which appears in childhood, resulting from a lack of organization in brain functioning. Symptoms include self-absorption, inaccessibility, aloneness, inability to relate, highly repetitive play, rage reactions when interrupted, predilection for rhythmical movements, and language disturbances.

Cerebral Palsy: A developmental disability caused by damage to the brain in utero or during birth, resulting in various types of paralysis and lack of motor coordination, particularly for muscles used in speech.

Epilepsy/Seizure Disorder: Disorder which results from a sudden loss of consciousness accompanied sometimes by muscular contractions or spasms.

Related Conditions include Friedreich's Ataxia, Multiple Sclerosis, Muscular Dystrophy, and Spina Bifida.

Digestive, Liver, Gall Bladder: Intestinal problems may include a wide range of digestive tract disorders. Common problems are peptic and duodenal ulcers, colitis, diverticulitis, hiatal hernia, or gall bladder disease. Symptoms include indigestion, heartburn, nausea, belching, bloating, vomiting, diarrhea, weight loss, constipation, and pain. Other problems in this category include cirrhosis and chronic liver disease.

Endocrine/Gland Problems:

Diabetes results from an insufficiency of insulin production by the pancreas and is characterized by the body=s inability to utilize glucose (sugar). Diabetes causes infections or poor healing of legs and other complications. Depending on the type of diabetes, duration, and severity, a special diet, oral medication, and/or insulin injections may be required.

Thyroid Problems include disorders which affect functioning of the thyroid gland, such as hypothyroidism (under active thyroid) and hyperthyroidism (overactive thyroid).

Other Endocrine Problems include thyroid nodules and thyroiditis (inflammation of the thyroid).

Eye disorders: Include cataracts (age-related change in the transparency of the lens), glaucoma (elevation of pressure of fluid within the eye causing damage to the optic nerve), blindness, conjunctivitis, and corneal ulcers.

Immune System Disorders: Includes Lupus, Acquired Immune Deficiency Syndrome, and HIV Positive clients.

Muscular/Skeletal:

Arthritis is an inflammatory condition involving the joints which ranges in severity from occasional mild pain to constant pain that can cause crippling. Types of arthritis include rheumatoid and osteoarthritis; location may include hands, neck, back, hips, legs, or joints.

Cerebral Palsy: A developmental disability caused by damage to the brain in utero or during birth, resulting in various types of paralysis and lack of motor coordination, particularly for muscles used in speech.

Epilepsy/Seizure Disorder: Disorder which results from a sudden loss of consciousness accompanied sometimes by muscular contractions or spasms.

Related Conditions include Friedreich's Ataxia, Multiple Sclerosis, Muscular Dystrophy, and Spina Bifida.

Osteoporosis is a bone-thinning process with loss of normal bone density, mass, and strength. Osteoporosis is a major cause of fractures of the spine, hip, wrists, and other bones. Symptoms include loss of height, dowager=s hump, and fractures.

Other includes degenerative joint disease, bursitis, and tendinitis.

Neurological:

Brain Trauma/Injury includes brain tumors which are lesions in the brain that cause varied symptoms including headaches, lack of motor coordination, seizures, or tremors. Also includes brain damage due to an accident or incident which significantly affects intellectual or adaptive functioning.

Epilepsy (non-DD related): Disorder which results from a sudden loss of consciousness accompanied sometimes by muscular contractions or spasms.

Spinal Cord Injury is permanent damage to the spinal cord resulting in paralysis (loss of sensation and movement) to all or some limbs and the trunk of the body.

Stroke (Cerebral Vascular Accident - CVA) is an acute episode that exhibits loss of consciousness, confusion, slurred garbled speech or inability to speak, loss of mobility, and either left or right side paralysis due to loss of oxygen to the brain. A stroke may leave permanent effects such as inability to speak or comprehend speech (aphasia), memory loss, confusion, paralysis, and contracture (shortening and tightening of muscles).

Other Neurological Problems includes Parkinson's Disease (a progressive neuromuscular disorder characterized by tremors, shuffling gait, and muscle weakness), polio, and tardive dyskinesia.

Psychiatric Problems:

Anxiety Disorders are characterized by patterns of anxiety and avoidance behavior. While anxiety is a normal part of existence, these disorders cause impairment in social occupational functioning.

Bipolar Disorder includes mixed, manic, depressed, and seasonal. Manic Disorder is characterized by a distinct period of abnormally and persistently elevated, expansive, or irritable mood.

Major Depression see the definition for DEPRESSION located in SECTION FOUR, Psychological/Cognitive/Social.

Personality Disorder includes paranoid, schizoid, schizotypal, histrionic, narcissistic, antisocial, borderline, avoidant, dependent, obsessive compulsive and passive aggressive. Characteristics include enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are inflexible and maladaptive and cause either significant functional impairment or subjective distress.

Schizophrenia includes disorganized, catatonic, and paranoid types and is characterized by patterns of delusions which are false beliefs, hallucinations, incoherence or marked loosening of associations, flat or grossly inappropriate affect, and disturbances in psychomotor behavior.

Respiratory Problems:

Black lung (Pneumoconiosis) is a chronic, disabling lung disease which results from accumulation of coal dust in the lung tissue.

COPD is chronic obstructive pulmonary disease.

Pneumonia is characterized by fluid in the lungs.

Other includes TB, bronchitis, emphysema, asthma, and allergies.

Urinary/Reproductive Problems:

Renal Failure may be acute or chronic.

Other Urinary/Reproductive Problems includes inflammation of the bladder, infection in the kidneys or other parts of the urinary tract, urinary tract infections, urinary retention, urinary incontinence, and disorders of the male genital organs and female genital tract (i.e., irregular menstrual cycles).

All Other Problems: Includes anything not coded above.

Definition of Treatments and Therapies

Bladder Control Program: An individualized program designed to restore, improve, or maintain voluntary or automatic bladder function that is appropriate for the client=s need.

Bowel Control Program: An individualized program designed to establish voluntary or automatic emptying of the bowel.

Case Management/Care Coordination Assistance: A method of managing the provision of health care to clients to improve the continuity and quality of care, such as coordinated services through the Idaho Commission on Aging, targeted case management for MI/DD clients, etc.

Catheter Care: The management and care of a client who requires an artificial means for emptying the bladder. Catheterization may include indwelling, Foley, straight, retention, French, Condom, External, Texas, or suprapubic catheters.

Chemo/Radiation Therapy: Administration of chemical reagents (medication or radiation) in treatment of disease that have specific and toxic effects on the microorganism causing the disease.

Decubitus Care: Measures used to treat open skin conditions that occurred as a result of excessive prolonged pressure over a bony prominence.

Developmental Therapy: Therapy directed toward the rehabilitation/habilitation of physical or mental disabilities in the areas of self-care, receptive and expressive language, learning, mobility, self-direction, and capacity for independent living or economic self-sufficiency.

Diabetic Management: Assistance and guidance with developing a comprehensive, multidisciplinary program to control and manage a diabetic client.

Dialysis Treatment: Mechanical elimination of impurities from the blood during kidney failure.

Licensed Nursing Care: Provision of care by a licensed RN or under the supervision of an RN.

Medication Management: Monitoring the needs for and the reactions to medications.

Occupational Therapy: Defined therapy program designed to gain/regain skills that will assist a client to reach a higher level of skills regarding direct personal care and household activities (bathing, dressing, cooking, eating, etc.).

Ostomy/Colostomy Care: Training in the methods of cleaning and maintaining ostomy/colostomy. Cleansing of an opening in the abdomen through which body waste passes to the outside of the body. This includes the skin area around the opening. Reapplication of ostomy bag, if needed.

Physical Therapy: The treatment of disorders with physical agents and methods to assist in rehabilitating clients and restoring normal function following an illness or injury.

Psychotherapy: A therapy program for which the goal is to attain a relatively healthy state of mind (i.e., the client is able to cope with and adjust to the current stresses of every day living in an acceptable way).

Psych / Social Rehabilitation Services: Services designed to meet the psychological and social rehabilitation needs of clients, including such things as behavioral management programs, social skills training, aggression management, and anger control.

Range of Motion/Strengthening (ROM): Passive, active-assertive, active, and resistive exercises involving the extension, flexion, and rotation of a joint. Includes exercises to increase endurance, bed mobility, and self-exercises under supervision.

Recreation Therapy: The prescribed use of recreational and other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional, and/or social disadvantages.

Respiratory Therapy: A treatment which introduces drug or moist air or vapor into the lungs for therapeutic purposes. Treatment may include oxygen administration, intermittent Positive Pressure Breathing (PPS), steam and/or medication conduction.

Restorative Therapy: A defined therapy program designed to gain/regain skills in motor activity (transfer, ambulation, bowel and bladder training, etc.).

Speech Therapy: An individualized program to increase receptive or expressive exchange of information

Tracheostomy/Suctioning: The management of surgically created opening in the trachea, the adjacent skin, and associated appliances (e.g., dressing, cannula, topically applied medications). The process by which fluid or gas is withdrawn from the body such as tracheostomy, nasonarygeai, or gastric.

Tube Feeding: The administration of nourishment and fluids via a tube, such as a gastrostomy (stomach tube), nasogastric tube (naso-oral tube), or intravenous feeding such as hyperalimentation.

Wound or Skin Care: Measures used to treat open skin areas or post-operative incisions to promote healing. Excludes decubitus and tracheostomy.

Other(s): Write in type. Enter comments on potential treatment/therapy referrals in the space provided.

VII. UAI SECTION FOUR-Psychological / Social / Cognitive Information

In this section it is important to assess the client need. This section is <u>not meant to diagnose</u> the client but to record specific abilities and limitations which will assist in identifying appropriate resources.

It is very important when assessing a person with a mental illness diagnosis to assess and access other supporting and verifying information. This particularly includes the person's psychosocial assessment.

Other information worth noting in the comment spaces includes:

- **A situation where the assessor has concerns about his/her rating,**
- **Family problems, recent death, stresses, etc,**
- **Any description of legal issues related to Questions 9. Disruptive/Socially Inappropriate Behavior, 10. Assaultive/Destructive Behavior or 12. Alcohol/Drug Abuse,**
- **Quality of life issues,**
- **Provider/physician input,**
- **Positive/negative triggers which initiate certain behaviors (families may accept unusual behavior as normal for the client), and**
- **Any other emotional problems or needs.**

IMPORTANT: The assessor who completes Section Four should sign his/her name and add agency name, telephone, and date in the appropriate space on p. 12 of the UAI form.

1. <u>Orientation:</u> The ability to relate to person, place, time and/or situation.

In assessing orientation, it is important to determine if the client has an understanding of his/her surroundings and relationships to people around (orientation to person), knows where he/she is (orientation to place), the month and year (orientation to time), and knows why he/she is being interviewed (orientation to situation). Adequate assessment of these areas is an important indicator of a client's ability to function and care for himself/herself with minimal supervision.

0. Oriented to person, place, time and/or situation.
1. Occasionally disoriented to person, place, time, or situation, but is sufficiently oriented to function independently if in familiar surroundings.
2. Frequently disoriented to person, place time or situation, even if in familiar surroundings, and requires supervision and oversight for safety.
3. Always disoriented and requires CONSTANT supervision and oversight for safety. Extensive intervention needed to manage behavior.

Prompts:

- Ask the client: May I ask you some standard questions we ask everybody? How old are you? What is the date? What is this place called? What year were you born? Who is the President? Governor?

2. <u>Memory:</u> The ability to recall and use information.

There are several different types of memory that can be assessed. Short-term verbal memory is probably the most important type of memory to assess because it influences a client's ability to communicate with others and to remember and subsequently follow instructions in a work, home, or care setting. Long-term memory is not as important for daily functioning but does affect the client's quality of life. Written or visual memory, also, is not as important as short-term verbal memory, in terms of daily functioning, but is important for the client in terms of being able to function well in a work situation. Also, visual memory, such as of written instructions, can be used to offset impairments in verbal memory.

0. Does not have difficulty remembering and using information. Does not require directions or reminding from others.
1. Occasionally has difficulty remembering and using information. Requires some direction and reminding form others. May be able to follow written instructions.
2. Frequently has difficulty remembering and using information, and requires direction and reminding from others. Cannot follow written instructions.
3. Cannot remember or use information. Requires continual verbal prompts.

Prompts:

- During the interview, determine if the client can remember your name and why you are talking with him/her.
- You can also ask if the client remembers details of a recent situation, such as, what did you have for breakfast this morning?
- To formally assess memory, explain to the client that you will identify for him three common items which you will ask him to recall later in the interview.

3. <u>Judgment:</u> The ability to make appropriate decisions, solve problems, or responds to major life changes.

Judgment refers to the client's ability to make choices or decisions that are in his/her best interest. Examples include: the types of people the client chooses to be around, the way the client spends resources, and risky situations the client chooses for fun or thrill, but which endanger his/her safety. Often a client's judgment is impaired because he/she cannot see the consequences of certain actions.

0. Judgment is good. Makes appropriate decisions.
1. Occasionally, judgment is poor. May make inappropriate decisions in complex or unfamiliar situations. Needs monitoring and guidance in decision-making.

2. Frequently, judgment is poor. Needs protection and supervision because client makes unsafe or inappropriate decisions.
3. Judgment is always poor. Cannot make appropriate decisions for self or makes unsafe decisions and needs intense supervision.

Prompts:

- Where do you plan on living? Where the client has few options and cannot live alone.
- What are you going to do when your savings account is empty?

4. <u>Hallucinations:</u> The visual, auditory, tactile, olfactory or gustatory perceptions that have no basis in reality.

Hallucinations are perceptual distortions that people sometimes experience. Loss of sleep, too much caffeine, abuse of drugs, and even alcohol, head injury, and other causes can lead to hallucinations. People with mental retardation or schizophrenia sometimes report hallucinations. This item assesses if the client has hallucinations which impair his/her ability to function. Auditory and visual hallucinations are most distracting to people compared to other types of distorted perceptions. If the client experiences hallucinations, does this cause him/her significant problems in communicating with others, trusting others, making rational day-to-day decisions, concentrating, etc?

0. No hallucinations currently.
1. Occasionally has a hallucination which interferes with functioning, but currently well controlled, may be taking medication.
2. Frequently has a hallucination which interferes with functioning and may require medication and routine monitoring by behavioral health professional.
3. Presently has a hallucination which significantly impairs ability for self-care, may or may not be taking medication.

Prompts:

- Have you heard any sounds or people talking to you or about you when there is nobody around?
- Most often the best approach during an assessment is to be direct and ask, do you hear voices that others do not hear, or experience things others do not experience?
- Have you seen any visions or smelled any smells that others don't seem to notice?
- Have these experiences interfered with your ability to perform your usual activities or work?

5. <u>Delusions:</u> Beliefs not based on fact, such as having special powers, being persecuted or being spied upon.

Delusions are false beliefs not based on reality. Sometimes people experience delusions of jealousy, persecution, or grandiosity, where they think they have special abilities others do not have. Sometimes there is a fine line between what is a delusion and an exaggerated opinion. Therefore, delusional thinking is not an all-or-nothing phenomenon, but can be

viewed as a continuum. This item assesses if delusional thinking is obvious and if these delusional beliefs impair functioning so that more care and/or supervision is needed. Often by just talking with a client, the assessor can recognize delusional beliefs without direct questioning. It is often difficult to assess delusional thinking in people with impaired language skills, and caution should be used.

0. Is not delusional currently.
1. Occasionally has delusions which interfere with functioning, but currently well controlled, may be taking medication.
2. Frequently has delusions which interfere with functioning and may require medication and routine monitoring by a behavioral health professional.
3. Presently has delusions which significantly impairs the ability for self care, may or may not be taking medication.

Prompts:

- Have things or events had special meanings for you?
- Did you see any references to yourself on TV or in the newspapers?
- Do you have a special relationship with God?
- Do you feel someone is inserting thoughts into your head that are not your own?
- Have you felt that you were under the control of another person or force?
- Do you get along with other people pretty well?
- Do you have special abilities or powers that others do not have?

6. <u>Anxiety:</u> Indicated by excessive worry, apprehension, fear, nervousness, or agitation.

Anxiety can be very discomforting and debilitating. We all have different levels of anxiety at different times, but here the focus is on anxiety that impairs a client's functioning. Intense anxiety is experienced as worry, apprehension, fear, nervousness or agitation. If a client experiences panic attacks, he/she may have shortness of breath, palpitations, chest pain, choking or smothering sensations, fear of going crazy, impending doom, etc. Sometimes people experience agoraphobia, where they have intense anxiety and avoid places and situations. They may have a specific anxiety about a specific object or situation, like spiders, or riding in a bus, or anxiety about social situations, and, consequently, avoid these situations to their own detriment.

0. No anxiety currently.
1. Occasionally has anxiety which interferes with functioning but currently well controlled, may be taking medication.
2. Frequently has anxiety which interferes with functioning and may require medication and routine monitoring by behavioral health professional.
3. Presently displays anxiety which significantly impairs the ability for self care, may or may not be taking medication.

Prompts:

- Have you felt worried or anxious?
- Is there anything that bothers you so much that you try to avoid it?

- Do you have chest pains? or Are there times when your heart races? (may be the physical manifestation of anxiety)
- Do you worry enough that you find it difficult to make a meal or eat?
- Do unpleasant thoughts constantly go round and round in your mind?

7. <u>Depression:</u> Indicated by feelings of hopelessness/despair, sleep disturbance, appetite disturbance, change in energy level, lack of motivation, or thoughts of death.

Depression can significantly impair a client's quality of life and ability to function. Most people feel blue or depressed at times. The focus here is the severity and persistence of the depression and how it impairs a client's ability to function. The American Psychiatric Association has published criteria that are helpful in assessing the presence of depression (From the <u>Diagnostic and Statistical Manual of Mental Disorders</u>, 4th Edition):

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful),
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others),
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day,
4. Insomnia or hypersomnia nearly every day,
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down),
6. Fatigue or loss of energy nearly every day,
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick),
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others), and
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

The assessor should not arrive at a formal diagnosis of the client, but assess if some of these symptoms are present and if they impair the client's ability to function.

0. Does not display symptoms of depression currently.
1. Occasionally has depression which interferes with functioning but currently well controlled, may be taking medication.
2. Frequently has depression which interferes with functioning and may require medication and routine monitoring by behavioral health professional.
3. Presently displays depression which significantly impairs the ability for self care, may or may not be taking medication.

Prompts:

- Have you felt unhappy, sad, down or depressed? How often? How much of the time?
- Are you able to switch your attention to more pleasant topics when you want to?
- Have your interests in work, hobbies, social or recreational activities changed?
- Has it interfered with your ability to perform your usual activities or work?
- Are there some days you don't get out of bed? If so, what are the circumstances?
- Do you enjoy being alone?
- Did any special events happen this week for you?
- Do you have friends or loved ones who visit you often? How often? Who?
- What do you do for fun? Entertainment? Crafts?
- Do you belong to or attend any special gatherings? Church, bridge club, bingo, or meal sites?

8. <u>Wandering:</u> Moving about aimlessly, wandering without purpose or regard to safety.

Wandering refers to a client's not using good judgment and moving about without purpose or concern for his/her safety. In extreme cases, the client may be disoriented, experiencing delirium and mental confusion. The client may forget where he/she was going, or have an unreasonable idea of where he/she wants to go. The client may get in harm's way by exposing himself/herself to severe weather, to people who would take advantage, or to dangerous situations. A client who wanders, and potentially places himself/herself in danger, most likely would need a more intense level of supervision.

0. Does not wander.
1. Wanders within the residence or facility and may wander outside but does <u>not</u> jeopardize health or safety.
2. Wanders within the residence or facility. May wander outside; health or safety may be jeopardized, but client is not combative about returning and does not require professional consultation or intervention.
3. Wanders outside and leaves immediate area. Has consistent history of leaving immediate area, getting lost, or being combative about returning. Requires constant supervision, a professionally-authorized behavioral management program, and/or professional consultation and intervention.

Prompts:

- Do you go outside alone?
- Have you ever gotten lost? If so, what did you do?

9. <u>Disruptive/Socially Inappropriate Behavior:</u> Inappropriate behavior such as making excessive demands for attention, taking another's possessions, being verbally abusive, disrobing in front of others, and displaying inappropriate sexual behavior.

Again, because of poor judgment, mental illness, or a character disorder, a client may interact socially with others in an inappropriate fashion and stimulate fear, apprehension, hostility, and even retaliation. Examples include stealing, fighting, threatening gestures, and sexual misbehavior, such as masturbating or exhibiting oneself in public. A client with these behaviors would need a fairly high level of supervision to caution, redirect, or manage his/her behavior. These maladaptive behaviors are displayed by clients in community settings as well as in nursing home and other residential care facilities and, in either case, would need supervision. Records and observations from others are usually quite important in assessing the degree to which socially disruptive behavior is present.

0. Is not disruptive, aggressive, or socially inappropriate, is not dangerous to self or others.
1. Is sometimes disruptive/aggressive or socially inappropriate, either verbally or physically threatening. Is sometimes agitated or anxious. Requires special tolerance or management.
2. Is frequently disruptive/aggressive or socially inappropriate, or is extremely agitated or anxious. May require professional consultation or behavioral management program.
3. Is dangerous or physically threatening and requires constant supervision, a professionally authorized behavioral management program, and/or professional consultation and intervention.

Prompts:

- Have you done anything that has attracted the attention of others?
- Have you done anything that could have gotten you into trouble with the police?
- Have you done anything that seemed unusual or disturbing to others?

10. <u>Assaultive/Destructive Behavior:</u> Assaultive or combative behavior to others.

Clients sometimes display assaultive/destructive behaviors towards others for various reasons. Sometimes they may become assaultive toward others or destructive of property because of organic disorders related to head trauma, epilepsy, mental illness, etc., and, therefore, may require intense supervision. Obviously, these clients would pose a threat in the community or in a residential care facility and would require a high level of supervision. Sometimes, these clients require a behavior management program that is designed and supervised by a mental health professional. If residential treatment is required, it can be very difficult finding appropriate settings with the required structure to serve the needs of these clients and maintain safety. Again, records and observations of others are quite important in assessing the degree to which assaultive/destructive behaviors are present.

0. Is not assaultive or dangerous.
1. Is sometimes assaultive. Requires special tolerance or management, but does not require professional consultation and/or intervention.
2. Is frequently assaultive, and may require professional consultation for behavioral management program.

3. Is assaultive, and requires constant supervision, a professionally authorized behavioral management program, and/or professional consultation and intervention.

11. <u>Danger to Self:</u> Indicated by self-neglect, head banging, suicidal thoughts or attempts, self-mutilation, etc.

Sometimes clients have specific disorders that contribute to self-destructive behaviors. These behaviors can include self-neglect, suicidal thoughts and actions, and mutilation. For example, a client may be depressed or have a borderline personality disorder that contributes to impulsive and self-destructive behaviors, or be mentally confused. It is important that the client be assessed by a mental health professional and that a professionally supervised intervention is implemented. Again, records, observations of others, and information about successful interventions are all important in assessing the degree to which these behaviors are present and the degree to which the client=s level of functioning is impaired. The purpose of the UAI assessment is to determine the level of help and supervision necessary for this client and to determine if the client has been referred to the proper mental health professionals. The level of supervision for these individuals can be quite intense depending upon the severity and persistence of self-destructive behaviors.

Note: Identifying that the client displays self-injurious behavior and requires constant supervision <u>requires a referral for a specialized assessment and/or assistance.</u>

0. Does not display self-injurious behavior.
1. Displays self-injurious behavior (i.e. self mutilation, suicidal ideation/plans, and suicide gestures), but can be redirected away from these behaviors.
2. Displays self injurious behavior, and behavioral control intervention and/or medication may be required to manage behavior.
3. Displays self injurious behavior and requires constant supervision, with behavioral control intervention and/or medication. (Requires an assessment and/or referral for help.)

12. <u>Alcohol/Drug Abuse:</u> Psychoactive substance use to the extent that it interferes with functioning.

It is apparent that alcohol and or drug abuse can significantly interfere with a client's ability to function in families, at work, and in the community. The purpose of this item is not so that the UAI administrator can arrive at a specific diagnosis of alcohol or drug abuse, but to again assess the degree to which alcohol and/or drug abuse impairs the client's ability to function. This item also requires the UAI interviewer to inquire not only about alcohol-related problems, but also other drugs, such as marijuana, cocaine, amphetamines, and over-the-counter products that may be contributing to the client's inability to function well. Besides asking questions about usage of drugs, review of records can be helpful to understand the degree of abuse/dependence and subsequent problems in living.

0. Never abuses.

1. Infrequently abuses which may cause some interpersonal and/or health problems but does not significantly impair overall independent functioning.
2. Sometimes abuses which cause moderate problems with peer, family members, law officials, etc. and may require some professional intervention.
3. Frequently abuses which causes significant problems with others and severely impairs ability to function independently.

13. <u>Self-Preservation/Victimization/Exploitation:</u> The ability to avoid situation in which persons may easily be taken advantage of, and to protect him/herself and property.

The purpose of this section is not to identify any neglect, abuse, or victimization that may be occurring, although the UAI assessor needs to report any identified abuse/victimization to authorities, but to identify if a client has the capacity and judgment to make decisions on his/her own behalf to protect himself/herself from abuse, neglect, and exploitation. For example, perhaps the client does not have the proper judgment and displays inappropriate gullibility toward others so that people may take advantage of him/her financially or sexually. This vulnerability to victimization/exploitation may lead to the client's safety being jeopardized. A client with this vulnerability would need supervision, whether in the community or in a residential setting. Again, records or observations of friends or family members are very helpful in evaluating this potential. Direct questions such as, Have you been abused by anyone in your life? may be helpful. However, frequently people will not share this information because of embarrassment, and collateral information is always helpful.

The definitions for the terms are:

Abuse - The non-accidental infliction of physical pain, injury, or mental injury.

Neglect - Failure of a caretaker to provide food, clothing, shelter, or medical care reasonably necessary to sustain the life and health of a vulnerable adult, or the failure of a vulnerable adult to provide these services for him/herself.

Exploitation - An action which may include, but is not limited to, the misuse of a vulnerable adult's funds, property, or resources by another person for profit or advantage.

Vulnerable Adult - A person, 18 years of age or older, who is unable to protect him/herself from abuse, neglect, or exploitation due to physical or mental impairment which affects the person's judgment or behavior to the extent that he/she lacks sufficient understanding or capacity to make or communicate or implement decisions regarding his/her person.

Note: If abuse is suspected, report it.

0. Is clearly aware of surroundings and is able to discern and avoid situations in which he/she may be abused, neglected or exploited.
1. Is sometimes able to discern and avoid situations in which he/she may be abused, neglected or exploited.
2. Is frequently unable to discern and avoid situations in which he/she may be abused, neglected or exploited.

3. Requires constant supervision due to inability to discern and avoid situations in which he/she may be abused, neglected, or exploited.

VIII. Legal Citations-IDAPA Rules and CFR

IDAPA Rules

CFR You will need to enter Title **42** Section **441.302**