interRAI™

interRAI Assessment System

CMH

interRAI Community Mental Health (CMH) Assessment Form and User's Manual

Version 9.2

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For information or comments on the interRAI Community Mental Health (CMH) Assessment System, visit www.interRAI.org.

Disclaimer

Neither interRAI, the publisher, nor the authors intend that this book should be used in lieu of comprehensive appropriate care. Every reasonable effort has been made to ensure that the information provided is accurate and up to date. However, the person's physician or other authorized practitioner should validate information about drugs and therapies for appropriateness before prescribing.

Licensing interRAI Assessment Systems

About the Country-Specific Examples

This book contains country-specific examples from Canada.

The interRAI instrument suite is intended for global use and is adaptable. The English language used in this publication, as well as the country-specific examples within each instrument, are native to the country that developed the instrument and produced this publication. Items that may vary between countries are flagged in the manual as: [Country Specific]. In the form, the same items are also flagged with square brackets [ ], indicating they are an example from a particular country: [Example—Canada].

If you seek to use this instrument, interRAI can work with you to develop country-specific text as part of licensing use, and you can contact publications@interRAI.org to inquire about translating or localizing the complete publication for your area.

Development of the interRAI Community Mental Health (CMH) Assessment System and Related Materials

The interRAI Community Mental Health (interRAI CMH) Assessment System is a complementary instrument to the interRAI Mental Health (interRAI MH) assessment instrument for in-patient psychiatry and the interRAI Emergency Screener for Psychiatry (interRAI ESP).

The interRAI CMH is intended to be used with all adult populations in community mental health settings to support comprehensive care planning, outcome measurement, quality indicators, and case mix classification to estimate relative resource intensity. It employs a 3-day observation period in order to provide reliable and valid measures of clinical characteristics that reflect the person's strengths, preferences, and needs. In keeping with other interRAI instruments, the basic time frame for assessment was set at 3 days (where appropriate). Triggers for numerous Clinical Assessment Protocols to support care planning decisions are also embedded in the instrument.

In 2001 interRAI began a restructuring initiative to ensure that all its instruments contained common items and definitions for overlapping clinical content. Specialized items that were unique to instruments like the interRAI CMH Assessment System were also updated to be consistent with the measurement approach, terminology, and response sets used in core items. In addition, as part of a large-scale study to refine the clinical and quality applications of the interRAI CMH Assessment System, a new set of mental health CAPs was developed beginning in 2005.

Although not included in this user's manual, a variety of support material is available. This includes (1) standardized scoring schema for creating summary indicators for outcome measurement related to depression, psychosis, anxiety, trauma, behaviour disturbance, negative symptoms, cognition, disability, and pain; (2) decision support algorithms that can inform care approaches and pathways (for example, risk appraisal methods for harm to self, harm to others, inability to care for self); (3) a forensic supplement that can be used to augment the interRAI MH and interRAI CMH assessments by focusing on information specific to the forensic population in mental health in-patient and community programs; (4) a crosswalk to the SCIPP case-mix system; (5) mental health quality indicators that can be used to benchmark the outcomes and processes of mental health services; (6) translations of the interRAI CMH Assessment System into several languages other than English; and (7) a variety of software systems to facilitate data entry, triggering of mental health CAPs, and report preparation at the individual and agency levels.

The interRAI series of assessment instruments comprises an integrated health and social service information system that can be used to assess, respond to, and monitor the status and needs of vulnerable populations. The interRAI CMH Assessment System is specifically designed for persons with mental health concerns receiving services from community mental health programs. Other assessments and problem

identification tools in the interRAI family include the interRAI Mental Health (MH) Assessment System for in-patient mental health care; the interRAI Emergency Screener for Psychiatry (ESP) for acute mental health emergency screening; the interRAI Intellectual Disability (ID) Assessment System for the care of persons with intellectual disabilities; the interRAI Community Health (CHA) Assessment System with specialized modules (mental health, assisted living, functional assessment, and deaf-blind persons) to assess persons living in the community; the interRAI Post-Acute Care (PAC) Assessment System for post-acute care; the interRAI Home Care (HC) Assessment System for care of persons in community settings; the interRAI Contact Assessment (CA) to support home care intake and emergency department processes; the interRAI Long-Term Care Facilities (LTCF) Assessment System for nursing home and long-term care institutional settings; the interRAI Palliative Care (PC) Assessment System for palliative care; and the interRAI Acute Care (AC) Assessment System for acute hospital care.

Contents

Part I

Introduction to the interRAI Community Mental Health (CMH) Assessment System

The interRAI Community Mental Health (CMH) Assessment System is a comprehensive standardized instrument for evaluating the needs, strengths, and preferences of adults with mental illness in community settings. It is designed to be compatible with other internationally used interRAI instruments for long-term care facilities, home care, in-patient mental health settings, acute care, palliative care, and post-acute care. The compatibility of assessment elements improves the continuity of care through a seamless health assessment system across multiple settings and promotes a person-centred approach to care.

The interRAI CMH Assessment System consists of an assessment form, item-by-item instructions, and a series of care-planning protocols. The assessment form enables a service provider to assess key domains of function, mental and physical health, social support, and service use. Particular items also identify those who could benefit from further evaluation of specific problems and risks for decline in health, well-being, or function.

Your goal is to use this information to identify individual needs and appropriate interventions. Where possible and required, you should either provide the needed service or make the appropriate referral. You may not be able to offer services immediately in all problem areas. Nevertheless, a comprehensive assessment and recognition of the person's strengths and problems can be useful as you schedule treatments and assess program outcomes.

Use of the interRAI CMH Assessment Form

The interRAI CMH Assessment Form is a standardized minimum assessment tool designed for clinical use. It is not simply a questionnaire for analyzing the characteristics of the population, nor does it necessarily include all the information required to construct the plan of care. This is particularly true for specialized programs aimed at specific subpopulations of persons with mental illness. Mental health professionals should add supplemental information to the overall assessment process as judged necessary. The items in this instrument describe the performance and capacity of the person in a variety of domains, with the majority of items serving as specific triggers for care planning.

Key points regarding completion of the interRAI CMH assessment follow:

- The assessment form is designed for use by mental health professionals such as nurses, social workers, case managers, psychiatrists, psychologists, family physicians, and recreational and occupational therapists. With appropriate training, however, individuals without a clinical background can generally

perform an accurate assessment. While there are no requirements regarding who performs the assessment, the provider agency is responsible for implementing a quality assurance system to ensure the accuracy of assessments.

- The assessment form consists of items and definitions. It should be used as a guide to structure the clinical assessment.
- The assessment process requires communication with the person and the primary support individual (if available), observation of the person, communication with other members of the clinical team, and review of medical records and other available documents. Where possible, the person is the primary source of information.
- Items on the interRAI CMH Assessment Form flow in a reasonable sequence that can be followed in the assessment. However, the assessor is not bound by this sequence. Items may be reviewed in the order that works best for the person and the assessor.
- Sometimes the assessor must reconcile multiple sources of information that yield seemingly inconsistent results (for example, the person being assessed may report something very different from the response of the person's spouse). In this case, the assessor must use his or her clinical judgment to determine the most appropriate response for the particular item. Assessors should talk in private with each informant, if possible.

Principles of the interRAI CMH Assessment

- Your purpose is to complete a comprehensive assessment of the person, with the goal of
  - maximizing the person's functional capacity and quality of life;
  - addressing physical and mental health problems; and
  - enhancing the person's level of independence.
- To do this requires
  - identifying the purpose of your assessment;
  - identifying psychiatric, functional, medical, and social issues that are current problems or about to become important problems for the person;
  - identifying the person's strengths and assets; and
  - integrating what you see and hear to code accurately each of the interRAI CMH Assessment Form items.
- Information collected using the interRAI CMH Assessment Form can serve to
  - provide a basis for further evaluation of unrecognized or unmet needs; and
  - develop a care plan tailored to the unique life circumstances of the person, ensuring that each limiting or potentially limiting factor is managed to maximize his or her quality of life.
- When introducing the assessment to a person, you should emphasize that the assessment is an integral part of the overall service program.
- Do not expect that all functional, medical, and social matters you identify will be fully and comprehensively addressed immediately. Rather, it is more important that all major functional, medical, and social circumstances that

limit the person's quality of life be identified. This will allow short- and long-term plans to be developed for further detailed evaluation or management.

- Any acute medical matter should be brought to the attention of the person immediately, and the person should be helped to obtain appropriate medical care. As would be expected in standard practice for psychiatry, **instances of risk of harm to self or others warrant special and immediate intervention.**
- It is generally helpful to assess the person's cognitive status and ability to communicate early on, so that you can gauge the reliability of the information you are gathering from the person. There is also a need to be sensitive to the person's reaction to the assessment process and particular issues. There is no one right order in which the sections of the interRAI CMH Assessment Form should be addressed. Take your follow-up cues from the person. Remember, this is not a questionnaire — the person's needs should set the pace and priorities for the assessment process, although you must gather all the information necessary to complete the assessment.
- In situations where there are conflicting sources of information, use your clinical judgment to determine the response that best reflects the person's status.

How to Use This Manual

This manual provides information to facilitate an accurate and uniform assessment of persons served by community mental health programs.

Use this manual alongside the interRAI CMH Assessment Form, keeping the form in front of you at all times. The form itself contains a wealth of information. Learn to rely on it until you internalize the item definitions and procedural instructions necessary for accurate assessment. The amplifying information in this manual should be reviewed prior to completing your first assessment. Then keep the manual handy so that you can continue to refer to it as questions arise during the completion of subsequent assessments. The information in this manual, in which the items from the form are presented sequentially, should facilitate successful use of the form. The initial time invested in this multistep review process will save you time later.

The guidelines that follow summarize our recommended approach to becoming familiar with the interRAI CMH assessment process.

Becoming Familiar with the interRAI CMH Assessment Process

Review the interRAI CMH Assessment Form itself.

- Note how sections are organized and where information is to be recorded.
- Work through one section at a time. Examine item definitions and response options. Review procedural instructions, time frames, and general coding conventions. Are the item definitions and instructions clear? Do they differ from your agency's current practice? What areas require further clarification?

Complete a sample assessment for a person in your program.

- Draw only on your existing knowledge of this person. Enter the appropriate codes on the form.
- Note where your assessment could benefit from additional information. How might you secure specific information? By asking the person? By talking with the family?

(continued)

(continued)

Complete an initial pass through Part II of this manual, "Item-by-Item Guide to the interRAI Community Mental Health (CMH) Assessment Form."

- Part II includes
  - the intent of assessing items;
  - supplemental definitions and instructions for completing the form items;
  - reminders of which items refer to a time frame for observing the person other than the standard 3-day observation period generally used throughout the assessment instrument; and
  - sources of information to be consulted for specific items.
- As you read the item-by-item definitions, review questions that arose as you used the form for the first time to assess a person. Note sections of this manual that help to clarify any coding and procedural questions you may have had.
- Read the instructions that apply to each section of the form. Make sure you understand the information before going on to another section. Review the test case you completed. Would you still code it the same? It will take time to go through all this material. Do not rush. Work through the manual one section at a time to make sure you thoroughly understand the definitions and instructions.
- Are you surprised by any interRAI CMH definitions, instructions, or case examples? For example, do you understand how to code "activities of daily living" (ADLs) or "mood"?
- Do any definitions or instructions differ from what you thought you learned when you first reviewed the form? Would you now complete your initial case differently?
- Do any item definitions or instructions differ from current practice patterns or terminology used in your agency?
- Make notations next to anything you have questions about. Be prepared to discuss these issues during any formal training program you attend.

Future use of information in this manual:

- Keep this manual at hand during the assessment process.
- Where necessary, review the intent of each item in question.
- This manual will serve as a reference as long as you are using the interRAI CMH Assessment Form. Use it on an ongoing basis to increase the accuracy of your assessments.

Part II

Item-by-Item Guide to the interRAI Community Mental Health (CMH) Assessment Form

To facilitate completion of the interRAI CMH Assessment Form and to ensure consistent interpretation of items, this part presents the following types of information for many (**but not all**) items:

Intent — Reason(s) for including the item (or set of items) in the interRAI CMH Assessment, including discussions of how the information will be used by clinical staff to identify problems and develop a plan of care.

Definition — Explanation of key terms.

Process — Sources of information and methods for determining the correct response for an item. Sources include:

- interview and observation of the person;
- discussion with the person's family, caregivers, and members of the health care team; and
- review of any clinical records or other administrative documentation.

Coding — Proper method of recording the response for each item, with explanations of the individual response options.

This item-by-item guide follows the sequence of items on the interRAI CMH Assessment Form. Note that an interRAI CMH section designation appears at the top of the pages that follow; this will facilitate your use of this section as a reference tool in the future.

Section A

Identification Information

Intent

This section provides personal identification information about the person, his or her background, and the reasons for the admission to this program.

A1. Name

Definition

Person's legal name.

Coding

Use printed letters. Enter in the following order:

A1a. First name

A1b. Middle initial

A1c. Family/last name

A1d. Jr./Sr.

If the person has no middle initial or is not a Jr./Sr., leave Item A1b or A1d blank.

A2. Sex

Coding

1. Male

2. Female

A3. Birthdate

Coding

For the month and day of birth, enter two digits each. Use a leading zero (**"0"**) as a filler if a single digit. Use four digits for the year. For example, January 2, 1969, should be entered as:

1	9	6	9		0	1		0	2
Year					**Month**			**Day**	

A4. Marital Status

Coding

Choose the answer that describes the current marital status of the person. If the person is in a common-law relationship, score the item **"2"** for "Married". If the person is in a same-sex relationship that is legally recognized as a marriage, score the item **"2"** for "Married". If the person is in a long-term same-sex relationship that is not legally recognized as a marriage, score the item **"3"** for "Partner/Significant other".

1. **Never married**
2. **Married**
3. **Partner/Significant other**
4. **Widowed**
5. **Separated**
6. **Divorced**

A5. Numeric Identifiers [Country Specific]

NOTE: If not in Canada, please consult your addendum.

A5a. Health card number

Intent

To record the health card number.

Process

Ask the person or primary support person for the person's health card number, or check existing records.

Coding

Write one number per box, starting with the leftmost box. Check the number to be sure the digits have been recorded correctly. Include version code if available; otherwise leave last two boxes blank.

A5b. Case record number

Coding

Record the person's case record number in the boxes provided.

A6. Province or Territory of Usual Living Arrangement and Agency Identifiers [Country Specific]

NOTE: If not in Canada, please consult your addendum.

Intent

To record the province or territory of the person's usual living arrangement, and to identify the specific agency from which the person is receiving help at the time of the assessment, for the purposes of reporting aggregate data.

Process

Each province/territory has a reporting code. Each agency has a unique numeric identifier.

Coding

From the table below, record the two-digit province or territory code in the first two boxes (Item A6a). For a person who does not reside in Canada but was admitted to your agency, use "NA".

Record the agency provider identifier, as identified by your organization, in the spaces provided (Item A6b). When entering the code, always right-justify.

NL	Newfoundland & Labrador	**SK**	Saskatchewan
PE	Prince Edward Island	**AB**	Alberta
NS	Nova Scotia	**BC**	British Columbia
NB	New Brunswick	**NT**	Northwest Territories
QC	Quebec	**YT**	Yukon
ON	Ontario	**NU**	Nunavut
MB	Manitoba	**NA**	Resides outside Canada

A7. Current Payment Sources [Country Specific]

NOTE: If not in Canada, please consult your addendum.

Intent

To record the organization(s) or governmental program(s) responsible for payment of the services rendered by the agency caring for this person. The person may be receiving services paid for by a mix of publicly or privately funded organizations or programs.

Definitions

A7a. Provincial or territorial government plan (this province or territory) — Person resides in the province or territory covered under the provincial/territorial health care plan.

A7b. Provincial or territorial government plan (other province or territory) — Person does not reside in the province in which health services are delivered but resides in another province or territory, and his or her payment is covered by another provincial plan. Also included are new residents to the province who are still covered by the health plan of the province/territory from which they came.

A7c. Federal government, Veterans Affairs Canada (VAC) — Person is fully covered by VAC of the Federal Government of Canada. This includes veterans hospitalized for recognized service-related conditions.

A7d. Federal government, First Nations and Inuit Health Branch (FNIHB) — Person holds First Nation or Inuit status, so his or her services are specifically covered by the FNIHB (formerly MSB) of Health Canada (Non-insured Health Benefits program). This may also include other health programs for First Nations and Inuit.

A7e. Federal government, Other — Person qualifies as RCMP or Canadian Armed Forces personnel, an inmate of a federal penitentiary, or a refugee whose services are specifically covered under a federal plan.

A7f. Workers' Compensation Board (WCB/WSIB) — Person is covered by the Workers' Compensation Board or the Workplace Safety and Insurance Board (or equivalent) regardless of the province or jurisdiction.

A7g. Canadian resident, insurance pay — Person's insurance carrier is responsible for payment.

A7h. Canadian resident, public trustee pay — Describes a circumstance in which, in accordance with applicable law, a public trustee or guardian, or an individual holding a similar office in any province or territory, makes payment for the medical treatment and/or health/support services on behalf of a person who is deemed to be mentally incapable.

A7i. Canadian resident, self-pay — Person is responsible for payment from personal resources.

A7j. Other country resident, self-pay — Person is from another country and manages his or her own payment.

A7k. Responsibility for payment unknown or unavailable.

Coding

Enter **"1"** for payment sources; enter **"0"** for all others.

0. No

1. Yes

A8. Reason for Assessment

Intent

To document the reason for completing the assessment. Each assessment requires completion of the interRAI CMH Assessment Form and development or revision of a comprehensive care plan.

Coding

Enter the number corresponding to the reason for the current assessment.

1. **First assessment** — An initial assessment that is completed for each separate admission.
2. **Routine reassessment** — A comprehensive reassessment at specified intervals during the course of care (for example, 3 months after the initial assessment).
3. **Return assessment** — An assessment conducted when the person returns to your program following a stay in another location (for example, admitted to hospital).
4. **Significant change in status reassessment** — A comprehensive reassessment conducted at any time during the uninterrupted course of care because the person's status or condition has significantly changed. If the person's change in status is accompanied by a stay in another location (for example, admitted to hospital and then return to the mental health program), code "**3**" for "Return assessment".
5. **Discharge assessment, covers last 3 days of service** — Use this code whenever a permanent program discharge is anticipated and a full interRAI CMH assessment is completed. This is a means of closing the clinical record at the point of discharge. Your program will determine the type of discharge assessment to be completed (discharge assessment or discharge tracking only).
6. **Discharge tracking only** — Use this code when the person is discharged without a full interRAI CMH assessment being completed. Discharge tracking items are completed to indicate within a data system that the person is no longer receiving service from the program. Examples include death, an admission to a facility when return to the program is not anticipated.
7. **Other** — For example, research. Any assessment conducted outside of the established assessment schedule for reasons such as quality assurance, clinical research, confirmation of the appropriateness of the current plan (not a routine follow-up reassessment), development of acuity scale, community needs assessment, and so on.

A9. Assessment Reference Date

Intent

To establish a common temporal reference point for the person's assessment. The Assessment Reference Date ensures that a common assessment period is applied to all items, so that all assessment items refer to the person's objective performance, behaviour, and health during the same period of time.

Definition

Assessment Reference Date — The specific end point of the observation period. Almost all items refer to the person's status over a designated time period, most frequently the 3-day period ending on this date. The Assessment Reference Date sets the designated end point of the common observation period, and all items refer back in time from that point. Some cover the 3 days ending on this date, some cover the 30 days ending on this date, and so forth.

Process

Usually, assessments are completed based on information gathered at a single interview. Item A9 is the date of this visit. When an assessment carries over to a required

second interview, this item still records the time of the initial interview. Although the assessor may see the person on different dates, the coding for all items for this assessment refers to the fixed initial date, thereby ensuring the commonality of the assessment period.

Coding

Use four digits for the year. For the month and day of the assessment, enter two digits each, using a leading zero as a filler, if needed.

For example, March 23, 2010, should be entered as:

2	0	1	0
Year			

0	3
Month	

2	3
Day	

A10. Person's Expressed Goals of Care

Intent

The person being assessed is an important member of the health care team. It is essential to ask the person to identify what his or her goals of care are. In that way, the person is encouraged to be an active member of the team. This can also be a starting point to develop a person-centred plan of care.

Process

Use the box provided to document outcomes that the person hopes to achieve as a result of being involved in the community mental health program. These outcomes could involve a wide variety of issues, including improved functional performance, a return to health, a change in living situation, and improved social relations.

Talk to the person, and phrase your questions about goals of care in the most general way possible. For example, ask, "How can we help you?" "What do you hope to gain (achieve) while you're here?" "What would you like to work on while you're here?" "What are you hoping we can help you with?" Encourage the person to express personal goals in his or her own words. Do not make inferences about what you or other clinicians believe should be the goals of care. *Record only those goals expressed by the person him- or herself.* If the person responds but is unable to articulate any goals (for example, says, "I'm only here because my family said I had to come, and there's really nothing wrong with me so there's nothing that you need to help me with"), enter "None". If the person is noncommunicative, record "None".

Coding

Use the large box to record the person's verbatim response, if any. Use the single line of boxes underneath to record the person's primary goal of care. Enter "None" if the person is unable to articulate a goal of care or to give any response.

Example of How to Code Person's Expressed Goals of Care

When asked what he hopes to gain from being in the program, Orlando stated that he "wanted to stay away from booze" and learn how to fix problems instead of turning to the bottle. He then said that his ultimate goal is to "get back with my wife and be a good father to my children." He also said he wanted "help to get back working; any job will do at this point." He knows this is "a lot to try to accomplish, but I've hit rock bottom and am now ready to fight back."

Record in the large box: "stay away from booze", "fix problems instead of turning to the bottle", and "get back working".

Record the primary goal in the row of smaller boxes: "get back with my wife; be a good father".

A11. Capacity [Country Specific]

NOTE: If not in Canada, please consult your addendum.

Intent

To record the person's capacity/competence to make decisions about treatment, property, and disclosure of information on his or her clinical record and to document if another person is authorized to make decisions for the person.

Definitions

A11a. Capable to consent to treatment — Person understands the implications of potential treatments provided and can make informed choices with this understanding. Treatments are anything done for therapeutic, preventive, palliative, diagnostic, cosmetic, or other health-related purposes.

A11b. Capable to disclose information relating to clinical record — Person understands the implications of making information in his or her clinical record available to others for legal, treatment, insurance, or other purposes.

A11c. Capable to manage property — Person understands the implication of decisions he or she could make about selling, buying, giving away or otherwise disposing of, mortgaging, or endowing property. Property includes real estate; life, accident, disability, and income protection insurance; pension or superannuation; cash on hand or in bank accounts/safety deposit boxes; investments; personal property (for example, motor vehicles).

A11d. Has a substitute decision-maker for personal care or financial decisions — Because the person is unable to do so for him- or herself, someone other than the person is responsible for making decisions regarding personal care (for example, health care, nutrition, shelter, clothing, hygiene, and safety issues) or financial decisions. The substitute decision-maker or guardian may be court-appointed; a Power of Attorney as appointed by the person; a family member (spouse, child over age 16, parent with right to access, brother or sister, any other relative); or The Office of the Public Trustee.

Process

For Items A11a, A11b, and A11c, check the medical record or chart for the presence of the necessary forms declaring the person incapable to consent to treatment, manage property, or disclose information relating to the clinical record. If documentation is not available to support an assessment of incapacity, code **"1"** for "Yes", the person is capable.

For Item A11d, obtain information either directly from the person or from other sources, such as family, other health care workers, or the medical record. Ask directly about the existing status of guardianship or a substitute decision-maker. Code "**1**" for "Yes" only if the substitute decision-maker is acting on behalf of the person for current decisions.

Coding

Code for each item.

0. No

1. Yes

A12. Residential/Living Status at Time of Assessment

NOTE: Comprehensive examples for A12 and A14 are given after discussion of A14.

Intent

To document the type of residence the person was living in at the time of the assessment. This item identifies if the person was in a residence that was temporary/tran-

sitional in nature. This information can assist with discharge planning and tracking of locations of referral sources (for example, from the community, from a facility).

Definitions

1. **Private home/apartment/rented room** — Any house, condominium, or apartment in the community, whether owned or rented by the person or another party. Any rented room, for example, resident hotel, whether rented by the person or another person. Also included in this category are retirement communities and independent housing for older adults or persons with disabilities.
2. **Board and care** — A noninstitutional community residential setting that integrates a shared living environment with varying degrees of supportive services of the following types: supervision, home health, homemaker, personal care, meal service, transportation, etc.

   NOTE: In Canada, Board and Care and Assisted/Semi-Independent Living will be combined for analysis and reporting.
3. **Assisted living or semi-independent living** — A second type of non-institutional community residential setting that integrates a shared living environment with varying degrees of supportive services of the following types: supervision, home health, homemaker, personal care, meal service, transportation, etc.
4. **Mental health residence** — A residence, such as a psychiatric group home, where specialized care is provided to adults with mental health problems who need supervision and limited services (meals, housekeeping).
5. **Group home for persons with physical disability** — A setting that provides services to persons with physical disabilities. Typically, persons live in group settings with 24-hour staff presence but are encouraged to be as independent and active as possible.
6. **Setting for persons with intellectual disability** — A setting that provides services to persons with intellectual disabilities. Typically, persons live in group settings with 24-hour staff presence but are encouraged to be as independent and active as possible.
7. **Psychiatric hospital or unit** — A hospital that focuses on the diagnosis and treatment of psychiatric disorders and that is separate from other in-patient facilities, such as an acute, rehabilitation, or complex continuing care hospital. A psychiatric unit is a single unit, located in a general hospital, that is dedicated to the diagnosis and treatment of psychiatric disorders.
8. **Homeless (with or without shelter)** — A homeless person does not have a fixed residence, that is, a home, apartment, room, or place to stay on a regular basis. The person may live on the streets, or outside in wooded or open areas. The person may sleep in cars, abandoned buildings, under bridges. Persons who are homeless may or may not take advantage of existing homeless shelters.
9. **Long-term care facility (nursing home)** — A health care facility that provides 24-hour skilled or intermediate nursing care.
10. **Rehabilitation hospital/unit** — A licensed hospital that focuses on the physical and occupational rehabilitation of persons who have experienced disease or injury with subsequent decline in physical function. A rehabilitation unit is located within an acute care hospital and focuses on the rehabilitation of persons who have experienced disease or injury with subsequent decline in physical function.
11. **Hospice facility/palliative care unit** — A hospice facility (or unit within a facility providing more general care) that provides care to persons who have a terminal illness with a prognosis of less than 6 months to live, as certified

by a physician. The goal of hospice care is to provide comfort and quality of life while assisting the person and family. Palliative care is the care of persons whose diseases are not responsive to curative treatments. It targets pain and symptom relief, without precluding the use of life-prolonging treatments, and provides support systems for the person and his or her family. Palliative care is often provided from the time a person is diagnosed with a life-threatening illness.

12. **Acute care hospital** — An acute care hospital primarily provides the diagnosis and treatment of acute medical disorders. Do not include psychiatric wards of a general hospital, psychiatric hospitals, or rehabilitation hospitals, coded separately.
13. **Correctional facility** — Any jail, penitentiary, or halfway house, whether operated by the local, provincial, or federal government. Correctional staff is responsible for caring for and housing persons sentenced by a criminal court to incarceration.
14. **Other** — Any other type of setting not listed above.

Process

Obtain information through interviews with the person and family. Clinical record review may also be helpful.

Coding

Code for the person's residential/living status at the time of the assessment. Where necessary, right-justify and use leading zeros to fill all boxes.

A13. Postal Code of Usual Living Arrangement [Country Specific]

NOTE: If not in Canada, please consult your addendum.

Intent

To track utilization of services at provincial/territorial and regional levels.

Definitions

Usual living arrangement — The community address where the person usually resides (referred to in Item A12). The usual living arrangement includes a private home or apartment, board and care home, assisted living, or group home. If the person was admitted to your program and is living in a facility on a long-term basis (for example, nursing home), the facility is now the usual living arrangement.

Postal code — The postal code (assigned by Canada Post) of the permanent dwelling, as identified above, in which the person lives.

Process

Review the person's records as necessary. Ask the person and family.

Coding

Enter the alphanumeric code. If the whole postal code is not available, code the first three digits of the postal code (that is, the forward sortation area). If the first three digits are not available, code one of the following:

Z	1	Z		1	Z	1

(for homeless persons)

1					

(not known; for instance, the person is unable to recall his or her postal code, and there is no other source of information)

2					

(not applicable; the person does not reside in Canada)

A14. Living Arrangement

Intent

To establish with whom the person lives at the time of the assessment. This information can help identify individuals who may potentially be available to assist the person.

Process

Obtain information through interviews with the person or family. A review of the clinical record may also be helpful.

Coding

Record the code that reflects with whom the person is living at the time of assessment.

1. **Alone** — Includes living only with a pet or living on the streets or homeless (whether or not the person uses shelters).
2. **With spouse/partner only** — Includes spouse/partner, girlfriend or boyfriend, common-law marriage, or long-term same-sex relationship.
3. **With spouse/partner and other(s)** — Lives with spouse/partner and any other individual(s), whether family or unrelated.
4. **With child (not spouse/partner)** — Lives with child(ren) only, or with child(ren) and other individuals, but **not** with spouse or partner.
5. **With parents(s) or guardian(s)** — Lives with parent(s) or guardian(s) only, or with parent(s) or guardian(s) and other individuals, but **not** with spouse or partner or child(ren).
6. **With sibling(s)** — Lives with sibling(s) only, or with sibling(s) and other individuals, but **not** with spouse or partner, child(ren), or parent(s) or guardian(s).
7. **With other relative(s)** — Lives with a relative (such as aunt or uncle) other than spouse or partner, child(ren), parent(s), or sibling(s).
8. **With nonrelative(s)** — Lives in a group setting (for example, boarding home, long-term care facility, group home, jail) or in shared accommodation with nonrelative(s) (for example, roommate). Excludes single overnight stays, such as in a homeless shelter.

Examples of How to Code Residential/Living Status at Time of Assessment and Living Arrangement

Cathy was admitted to the program following discharge from an in-patient psychiatric stay. She lives in residence on campus at the university.

Code:

A12 (Residential/Living Status at Time of Assessment) = "14".

A14 (Living Arrangement) = "8".

Rationale: A university residence does not fit any of the specific categories, therefore, it would be documented as "Other". The residence situation would be considered as living "With nonrelative(s)".

(continued)

(continued)

David was referred to and made initial contact with the outpatient program 1 week after he was discharged home from the hospital. He lives with his three children. His wife moved out of the home 3 years ago; the children stay with her in another province for 6 weeks during their summer vacation.

Code:

A12 (Residential/Living Status at Time of Assessment) = "1".

A14 (Living Arrangement) = "4".

Rationale: David was living at home at the time of the assessment. Although the children are not with him for the whole year, he does have them most of the time, therefore, the best response would be lives "With child (not spouse/partner)".

Mrs. C was admitted to the program by her psychiatrist, as a community referral. She lives in a seniors' apartment building with her cat, "Johnny," who has been a source of companionship since her husband died.

Code:

A12 (Residential/Living Status at Time of Assessment) = "1".

A14 (Living Arrangement) = "1".

Rationale: A senior's apartment building would be in the "Private home/apartment/rented room" category and although Mrs. C has a cat, the coding for "Living Arrangement" would be **"1"** ("Alone").

A15. Residential Instability

Intent

To document a history of moving among multiple residential settings or a lack of a permanent residence over the last 2 years, as an indicator of a potential problem with housing on discharge.

Definition

Residential instability — Any living circumstances over the past 2 years that are indicative of any one or more of the following types of housing problems: three or more moves between alternative residences, lack of a permanent address, homelessness, or living in a shelter.

Process

Obtain information from the person or family members. Clinical record review may also be helpful, if available.

Coding

Code for presence of one or more indicators of residential instability.

0. No

1. Yes

Examples of How to Code Residential Instability

For over 10 years Orlando owned a home where he lived with his wife and children. Three years ago, because of alcohol abuse, he lost his job, his wife left him and took the children with her, and he had to sell the house. He lived alone in an apartment for about 8 months but then had to leave because he could not pay the rent. As a result, he has lived on the streets during the past two summers and in a men's shelter in the winter.

Code: A15 = "1".

Rationale: Although Orlando was a home owner and had a permanent residence for a number of years, only the past 2 years are of interest in the assessment of residential instability. Given that he has lived on the streets and in shelters over the past 2 years, the "yes" criterion applies.

Cathy moved from her family home to the residence at university 1.5 years ago.

Code: A15 = "0".

Rationale: One move in 2 years does not meet the criterion for residential instability.

Section B

Intake and Initial History

The intake and initial history provides basic information about the person, the context for admission to the program, and his or her past involvement with mental health services. The information in this section does not change during the person's involvement with the program, so it is documented only at the time of the initial assessment.

B1. Reasons for Admission

Intent

To identify problems that contributed to the person's present admission. Persons admitted to mental health programs/agencies may have many problems contributing to their present situation. This item permits recording of multiple reasons because it may be important for the treatment team to address significant problems beyond just the primary reason for admission when developing a care plan and planning for eventual discharge from the program.

Definitions

B1a. Threat or danger to self — Person may have stated intentions to hurt him- or herself, or actually done so, or others have expressed a concern that the person is a danger to him- or herself.

B1b. Threat or danger to others — Person may have stated intentions to hurt someone else, have actually hurt or made an attempt to hurt someone, or others have expressed a concern that the person is a danger to others.

B1c. Inability to care for self due to mental illness — Person's current behaviour shows a lack of competence to care for him- or herself that is likely to lead to imminent harm to self.

B1d. Problem with addiction or dependency — There is concern about substance use or abuse (for example, alcohol or drugs) or nonsubstance addiction (for example, gambling or shopping).

B1e. Specific psychiatric symptoms — Person exhibits symptoms such as depressed mood, hallucinations, delusions, or medication side effects.

B1f. Involvement with criminal justice system, or forensic admission — Person has recently had contact with the police or has been involved in or charged with criminal activity. All forensic admissions are included in this definition.

Process

Ask the person, family, or the referral source.

Coding

Code for all applicable problems. For example, a person may be admitted following an apparent purposeful drug overdose but may also have a problem with alcohol. Then two reasons for admission would be coded **"1"** for "Yes" for Items B1a ("Threat or danger to self") and B1d ("Problem with addiction or dependency").

0. No

1. Yes

B2. Date Case Opened

Intent

To document the date the person was admitted to the program.

Process

Enter the date of admission. If the person was transferred from another program, the date would be the day of transfer. The medical record is likely to be the most reliable source of this information.

Coding

Fill in the boxes with the appropriate numbers. Do not leave any boxes blank. Enter the four-digit year. If the month or day contains only a single digit, fill the first box with **"0"**.

For example, if a person was admitted on March 20, 2010, the date should be entered as:

2	0	1	0		0	3		2	0
Year					**Month**			**Day**	

B3. Origin Is Inuit, Métis, or First Nations [Country Specific]

NOTE: If not in Canada, please consult your addendum.

Intent

To document Aboriginal status, if applicable.

Definition

Aboriginal status — Refers to self-identification as a member of an Aboriginal community and does not require proof (that is, a status card) in order to be coded **"1"** for "Yes".

Process

Ask the person or family members, or check records, if available.

Coding

Select the appropriate response for Aboriginal status.

0. No

1. Yes

B4. Primary Language [Country Specific]

NOTE: If not in Canada, please consult your addendum.

Intent

To record the person's preferred language for day-to-day communication. Communication with the person in his or her primary language, whether English, French, or another language, is preferred. Information about the person's language may indicate the need for an interpreter.

Definition

Primary language — Preferred language for day-to-day communication.

Process

Observe and interview the person and family to determine the language the person primarily speaks or understands. Review any clinical records.

Coding

Enter the three-letter code for the person's primary language in the boxes provided. Enter **"eng"** if the language is identified as English. Enter **"fre"** if the language is identified as French. For other languages, use the table in the appendix to the manual.

Example of How to Code Primary Language

Mrs. K can speak a few words in English but her preferred language is German.

Code B4 = "deu".

Rationale: Code for the language the person prefers to use for communicating with others. Although there are a number of codes in the appendix for different types of German, "**deu**" is used because the person has not specified a particular version of German.

B5. Interpreter Needed

Intent

To determine if the person requires the assistance of an interpreter to communicate with others.

Coding

Code for the need for an interpreter.

0. No

1. Yes

Example of How to Code Interpreter Needed

When arranging admission to the program, Mrs. K's physician informed the staff that an interpreter would be required.

Code B5 = "1".

Rationale: Although the information was not received directly from Mrs. K, it is coded as "Yes" because sources of information other than the person are acceptable. The knowledge that an interpreter is needed will be helpful for the assessment process.

B6. Mental Health Services

Intent

A mental health service history provides information about the person's prior psychiatric care: its location, timing, and duration. This information about previous mental health service may assist in addressing current care needs.

NOTE: Comprehensive examples for Items B6a–f are given at the end of this section.

B6a. Time since last contact with community mental health agency or professional in LAST YEAR

Intent

To identify the person's involvement with a community-based mental health service in the last year.

Definition

Community mental health service — Includes any mental health service provided through a community mental health agency, outpatient clinic, or private office of a mental health professional. Included are the services of psychiatrists, psychologists,

social workers, and other therapists who practice in mental health. Not included in this item are general practitioners, family doctors, internists, and other physicians.

Process Consult with the person, family, past clinical records, and community workers, if available.

Coding Code for most recent contact with a community mental health agency or professional in last year. Exclude this contact.

0. No contact in last year

1. 31 days or more

2. 30 days or less

B6b. Time since last psychiatric hospital discharge

Intent To determine the time of the most recent discharge from a psychiatric hospital stay within the **last 90 days**.

Definition **Psychiatric hospital discharge** — Person was discharged from a psychiatric hospital or unit where he or she stayed for one or more nights and received mental health services. Outpatient services are not included in this item.

Process Ask the person or family, or other health care workers who know the person's mental health history. The clinical record may also contain this information.

Coding Code for time since discharge from last psychiatric admission.

0. No hospitalization within last 90 days

1. More than 30 days ago

2. 15–30 days ago

3. 8–14 days ago

4. Within last 7 days

5. Now in hospital

B6c. Number of psychiatric admissions in LAST 2 YEARS

Intent To record the number of times the person was admitted to hospital for mental health services in the **last 2 years**.

Definition **Psychiatric admission** — Person was admitted to a hospital for mental health services (voluntarily/informal, involuntarily, or forensic) and stayed for one or more nights. Outpatient services are not included here.

Process Ask the person or family, or health care workers who know the person's mental health history. The clinical record may also contain this information.

Coding Code for the number of psychiatric admissions in the **last 2 years**.

0. None

1. 1–2

2. 3 or more

B6d. Number of lifetime psychiatric admissions

Intent

To record the total number of admissions to a mental health facility or unit during the person's lifetime.

Definition

Psychiatric admission — Person was admitted to a hospital for mental health services (voluntarily/informal, involuntarily, or forensic) and stayed for one or more nights. Outpatient services are not included here. Do not include the current admission.

Process

Ask the person or family, or health care workers who know the person's mental health history. The clinical record may also contain this information.

Coding

Code for number of previous psychiatric admissions.

0. None

1. 1–3

2. 4–5

3. 6 or more

B6e. Age in years at first overnight stay in a psychiatric hospital or unit

Intent

To determine the person's approximate age when he or she was first admitted as an in-patient for mental health services.

Definition

The person's age the first time he or she was admitted as an in-patient for mental health services (voluntarily/informal, involuntarily, or forensic) and stayed for one or more nights.

Process

It may be difficult for the person to remember his or her exact age during past events, so try to frame the question around major life phases. For example, was he or she in public school at the time? In what grade in high school? Was he or she married or single? Note that it is only important to estimate an age category.

Coding

Code the appropriate category for age range.

0. Never

1. 1–14 years old

2. 15–24 years old

3. 25–44 years old

4. 45–64 years old

5. 65+ years old

B10f. History of involuntary psychiatric admission

Intent

To identify prior involuntary psychiatric admissions as a context for considering the person's current situation. The definition of involuntary admission may be country- or region-specific.

Definition

Involuntary psychiatric admission — Person was detained in a psychiatric hospital or unit without the consent of the person or his or her designated decision-maker.

Process Ask the person or family, or health care workers who know the person's mental health history. The clinical record may also contain this information.

Coding Code for a history of involuntary psychiatric admissions.

0. No

1. Yes

Examples of How to Code Mental Health Services

Mrs. C had an admission to a psychiatric hospital 40 years ago (at age 24) for depression following the birth of her second child. She cannot recall if she consented to the admission. She has had no further admissions for mental health–related illnesses and has never had contact with community mental health services, although her family physician has been treating her for depression for the past 18 months, following the death of her husband.

Code:

B6a (Contact with community mental health) = "0".

B6b (Time since last psychiatric hospital discharge) = "0".

B6c (Number of psychiatric admissions in last 2 years) = "0".

B6d (Number of lifetime psychiatric admissions) = "1".

B6e (Age at first overnight stay in psychiatric hospital or unit) = "2".

B6f (History of involuntary psychiatric admissions) = "0".

Rationale: Mrs. C's psychiatric admission history is straightforward. Although her family physician is treating her for depression, the "Contact with community mental health" item is coded as **"0"** because the definition for this item specifies that general practitioners are not to be included. The response for "Time since last psychiatric hospital discharge" is **"0"** because Mrs. C's last stay was well beyond the 90-day time frame for this item. She had only one previous psychiatric admission at age 24, thus the "Number of lifetime psychiatric admissions" and "Age at first overnight stay in psychiatric hospital or unit" items are coded as **"1"** and **"2"** respectively. Since she is unable to recall if this admission was involuntary, the default code for this unknown information is **"0"**.

Orlando has had five admissions to a psychiatric unit in the last 6 years, three of them in the last 2 years. His first admission occurred when he was 45, and two of his admissions were involuntary. The community outreach team from the Canadian Mental Health Association had been maintaining regular contact with Orlando during the last year as part of their "Street Support Program." Through their efforts, he agreed to enter detox and then an in-patient alcohol and drug addiction unit 2 months ago. He was discharged 3 days ago.

Code:

B6a (Contact with community mental health) = "1".

B6b (Time since last psychiatric hospital discharge) = "4".

B6c (Number of psychiatric admissions in last 2 years) = "2".

B6d (Number of lifetime psychiatric admissions) = "2".

B6e (Age at first overnight stay in psychiatric hospital or unit) = "4".

B6f (History of involuntary psychiatric admissions) = "1".

Section C

Mental Status

An assessment of mental status can provide information about a person's quality of life, his or her responsiveness and adherence to treatment regimens, and resource requirements. Assessment and documentation of mental status is key to care planning and evaluation of outcomes for persons admitted to a community mental health program.

NOTE: Comprehensive examples for Items C1 and C2 are given after discussion of C2.

C1. Mental State Indicators

Intent

To record the presence of indicators observed in the last 3 days irrespective of the assumed cause of the indicator/behaviour. When combined with other observations in the assessment, these indicators can provide information about the severity of the person's condition.

Definitions

The mental state indicators may be expressed verbally through direct statements or through nonverbal indicators or behaviours that can be monitored by observing the person during usual daily routines.

Mood Disturbance

C1a. Sad, pained, or worried facial expressions — For example, furrowed brow, constant frowning.

C1b. Crying, tearfulness — Distress may also be expressed through such nonverbal indicators.

C1c. Decreased energy — Subjective report indicating a decline in energy level (for example, "I just don't feel like doing anything; I have no energy").

C1d. Made negative statements — For example, "Nothing matters"; "Would rather be dead"; "What's the use?"; "Regret having lived so long"; "Let me die."

- Note that this indicator is distinct from Item C1g on "hopelessness", because it deals with statements about the person's current situation or his or her life to date, whereas hopelessness deals with the person's outlook for the future.

C1e. Self-deprecation — Subjective report indicating a negative view of self (for example, "I'm nothing"; "I'm of no use to anyone").

C1f. Expressions of guilt or shame — Any statements suggesting a feeling of self-blame, self-reproach, self-accusation, or shame, regardless of the legitimacy or cause of the feelings (for example, "I've done something awful"; "This is all my fault"; "I'm a terrible person").

C1g. Expressions of hopelessness — For example, "There's no hope for the future"; "Nothing's going to change for the better."

- Note that this indicator is distinct from Item C1d ("negative statements") because it deals with the person's subjective outlook for the future, either personally or in a more general sense. The aim is to identify feelings of despair about the future and not simply a pessimistic disposition.

C1h. Inflated self-worth — For example, exaggerated self-opinion, arrogance, inflated belief about one's own ability.

C1i. Hyperarousal — Observations of motor excitation, unusually high activity, increased reactivity, or exaggerated startle response.

C1j. Irritability — Marked increase in being short-tempered or easily upset.

C1k. Increased sociability or hypersexuality — Marked increase in the person's level of social or sexual activity; unusually high activity levels.

C1l. Pressured speech or racing thoughts — Rapid speech or rapid transition from topic to topic.

C1m. Labile affect — Objective observation of rapid, abrupt shifts in affect (for example, person may have periods of tearfulness alternating with laughter, with or without an external explanation).

C1n. Flat or blunted affect — Objective observation of an absence of or severe reduction in the intensity of affective expression (for example, person appears indifferent, nonresponsive, or hard to get to smile).

Anxiety

C1o. Repetitive anxious complaints/concerns (non-health-related) — For example, persistently seeks attention or reassurance regarding schedules, meals, laundry, clothing, and relationships.

C1p. Expressions, including nonverbal, of what appear to be unrealistic fears — For example, fear of being abandoned, being left alone, or being with others; intense fear of specific objects or situations.

C1q. Obsessive thoughts — Unwanted, intrusive ideas or irrational thoughts that cannot be eliminated through conscious attempts to ignore or suppress them (for example, thoughts about being responsible for a tragedy, sinister thoughts about his or her children, or reporting that he/she "just can't get this thought out of my head").

C1r. Compulsive behaviour — An uncontrollable, persistent urge to perform an act repetitively, often according to certain rules, manner, or pattern (for example, hand washing, repetitive checking of room or appliances, counting, avoiding stepping on cracks on the sidewalk or tiled flooring).

C1s. Intrusive thoughts or flashbacks — Disturbing memories or images that intrude into thoughts, or unexpected recall of adverse events.

C1t. Episodes of panic — Cascade of symptoms of fear, anxiety, loss of control.

Psychosis

C1u. Hallucinations — False sensory perceptions, of any type, with or without insight, without corresponding stimuli. These may occur in one or more of the senses: hearing (auditory hallucinations), seeing (visual hallucinations), feeling (tactile hallucinations), tasting (gustatory hallucinations), and smell-

ing (olfactory hallucinations). **Do not include command hallucinations in this item.**

C1v. Command hallucinations — Hallucinations directing the person to do something or to act in a particular manner (for example, a voice telling the person to hide in a contained space to avoid contact with enemies, a voice telling a person that he must kill his father before his father kills him).

- Note that command hallucinations are separated from the others because of their severity and the potential lethality if the person acts on them.

C1w. Delusions — Fixed, false, unchangeable beliefs of any of the following types:

- Delusions of grandeur — A false belief characterized by an exaggerated sense of one's own importance.
- Paranoid or persecutory delusions — A false belief of being attacked, harassed, cheated, persecuted, or conspired against.
- Somatic delusions — A false belief related to the body, such as believing that one has cancer, despite exhaustive negative testing.

Exclude beliefs specific to the person's religion or culture.

C1x. Abnormal thought process — Objective observations that indicate abnormalities in the manner that the person is expressing thoughts. Include indicators such as loosening of associations, thought blocking, flight of ideas, tangentiality, circumstantiality, clang association, incoherence, neologisms, and punning.

Negative Symptoms

C1y. Expressions, including nonverbal, of a lack of pleasure in life (anhedonia) — For example, saying "I don't enjoy anything anymore."

- Note that this indicator measures anhedonia, where the person no longer is able to enjoy activities or situations that he or she would normally find pleasurable.

C1z. Withdrawal from activities of interest — Withdrawal from normal pattern of long-standing activities or interactions with family or friends.

- Note that this indicator deals with a substantial reduction in the person's level of participation in activities or involvement with his or her long-standing relationships with others.

C1aa. Lack of motivation — Subjective reporting or objective observation of an absence of spontaneous goal-directed activity related to any aspect of living, such as ADL, IADL, social, or recreational activities (for example, the person may show limited or no motivation to get dressed in the morning, get ready for meals, attend to grooming, or attend activities).

C1bb. Reduced social interactions — This indicator deals with changes in the person's overall level of sociability with others, regardless of the closeness of the tie.

Other Indicators

C1cc. Repetitive health complaints — For example, persistently seeks medical attention; incessant concern with body functions.

C1dd. Recurrent statements that something terrible is about to happen — For example, believes that he or she is about to die or have a heart attack, or that an accident involving the person or a loved one is imminent.

C1ee. Persistent anger with self or others — For example, easily annoyed, angered by care received.

- Be aware of both verbal statements of anger and nonverbal or behavioural signs of persistent anger.

C1ff. Unusual or abnormal physical movements — Objective observation of unusual facial expressions or mannerisms (for example, looking over to the side with no external stimuli to prompt such a gesture), peculiar motor behaviour or body posturing (for example, stereotypies, waxy flexibility), or maintaining an unusual body position for an extended period of time.

- **Stereotypies** — Repetitive motor movement (such as hand-flapping, swinging of legs) where the person resists changing or stopping the movement.
- **Waxy flexibility** — Person's limbs will remain in the position into which they were placed by another person.

C1gg. Hygiene — Person is observed to have unusually poor hygiene (well beyond what is considered culturally appropriate) or has an unkempt or dishevelled appearance.

C1hh. Difficulty falling asleep or staying asleep; waking up too early; restlessness; nonrestful sleep — For example, the person

- experiences an extended time gap between the point at which he or she attempted to fall asleep and the time at which sleep was actually initiated;
- wakes up well before the desired time because of some factor inherent to him or her (exclude situations in which the person is awakened by some external source);
- experiences sleep that is accompanied by repeated tossing and turning, or dreaming that causes motion or wakefulness, such that the person does not feel relaxed when sleeping or rested when awake; or
- is easily awakened during sleep by sounds or movements and experiences one or more periods of awakening after sleep begins.

C1ii. Too much sleep — An excessive amount of sleep that interferes with the person's normal functioning.

Process

Interview the person directly, as for a mental status examination. Keep in mind previous statements made by the person and observations you or others have made of the person's verbal and nonverbal indicators of mental health concerns.

Some people are more verbal than others, and they will make direct statements about their feelings. Others will only disclose those feelings when asked directly. When the person verbalizes feelings or reports on the occurrence of behavioural indicators of distressed mood (for example, crying), ask how long these conditions have been present.

Others may be unable to articulate their feelings because they cannot find the words to describe how they feel, they lack insight, or they have impaired cognitive capacity. Observe the person carefully for any indicator, both at the time of the planned assessment and in any direct contacts you may have with the person during the 3-day observation period covered by this assessment.

Remember to be aware of cultural differences in how these indicators may be manifested. Some people may be more or less expressive of mental health concerns, emotions, or feelings because of their cultural norms. Be cautious not to minimize your interpretation of an indicator based on your expectations about the person's cultural background. On the other hand, it is important to be especially sensitive to these indicators when assessing a person whose culture may make him or her more stoic in expressing concerns.

Consult with clinicians who work with the person or with family/friends who have direct knowledge of the person's typical and current behaviour. Relevant information may also be found in the clinical record, although the level of detail in the record can vary. In situations where there is a discrepancy between what is reported by the person, what you observe, and/or what is reported by others, use your clinical judgment to determine the best response.

Although this section is divided into five subsections (Mood Disturbance, Anxiety, Psychosis, Negative Symptoms, and Other Indicators), the indicators are not necessarily exclusive to a section. Therefore, caution should be taken to avoid completing this section based on diagnosis. Rather, consider the observable signs of all indicators, and document accordingly.

Coding

Code for the presence of each indicator over the last 3 days, regardless of what you believe to be the underlying cause of the indicator. Remember to code for both the presence of the indicator and the number of days in which it was exhibited, no matter how often it was exhibited per day. Use the following codes:

0. Not present

1. Present but not exhibited in last 3 days — Use this code if you know the condition is **present** and **active**, even though it was not observed in the last 3 days.

2. Exhibited on 1–2 of last 3 days

3. Exhibited daily in last 3 days

C2. Sleep Problems Related to Hypomania or Mania

Intent

To identify those who are not sleeping because of a significant increase in energy level (as when experiencing a manic/hypomanic state).

Definition

Sleep problems related to hypomania or mania — Person had a 24-hour period in which he or she got less than 2 hours of sleep because of an increased energy level. Typically, the person does not feel tired even though he or she has not slept.

Process

Ask the person if he or she has ever felt so energized that sleep did not seem necessary. Family/significant others or the medical record may prove helpful as other sources of information. Do not code "Yes" for a person who has not slept because of circumstances associated with normal day-to-day life (for example, staying awake through the day following a night of shift work or long-distance travel).

Coding

Assess based on most recent instance.

0. Never

1. More than 1 year ago

2. 31 days–1 year ago

3. 8–30 days ago

4. 4–7 days ago

5. In last 3 days

Examples of How to Code Mental State Indicators and Sleep Problems Related to Hypomania or Mania

Mrs. C presents as follows: She appears to be sad and she reports periods of tearfulness over the last 2 months. When asked about the last 3 days, she says that she has been crying a lot, up to 3 or 4 times a day. She has had no energy for over 6 months, and she reports this has not changed in the last 3 days. She believes that she is to blame for her husband's death and that she should have taken him to the hospital sooner than she did. She has had what she describes as overwhelming feelings of guilt every day since his death. When asked, she denies feeling hopeless, saying that she really hopes things do get better for her. She reports experiencing occasional periods of irritability and can recall feeling that way 2 days ago.

She used to be a very active person but she is not interested in going out with her friends anymore. Although she enjoyed daily visits with her daughter until a few months ago, she now finds herself not wanting to be very sociable when her daughter drops over every evening. She says, "In fact, I really wish she wouldn't come because I'm tired of her always telling me how sad I look." She has had trouble falling asleep for more than a month. She is awake frequently throughout the night but manages to obtain an average of 5 hours of sleep a night. When asked if she has ever experienced periods when she had so much energy that she couldn't sleep, she said that only happened once or twice, near the end of her pregnancy, when she was "apparently nesting".

Code:	**Rationale:**
C1a (Sad, pained, worried) = "3".	Based on the assessor's observations that Mrs. C appears sad, and on Mrs. C's own report that her daughter is always commenting on it, this item is coded as occurring daily.
C1b (Crying, tearfulness) = "3".	Periods of tearfulness daily over the last 3 days, based on self-report.
C1c (Decreased energy) = "3".	Based on self-report that she has had a decrease in energy for 6 months with no change in last 3 days.
C1f (Expressed guilt, shame) = "3".	Based on self-report of daily feelings of guilt since her husband's death.
C1j (Irritability) = "2".	Irritability on one of the last 3 days, based on self-report.
C1z (Withdrawal from activities) = "3".	Has withdrawn from contact with friends for some time now and continues to do so.
C1bb (Reduced social interactions) = "3".	Reports not wanting to socialize during daily visits from daughter.
C1hh (Difficulty falling/ staying asleep) = "3".	Reports difficulty falling asleep and staying asleep for any significant length of time.
All other items in C1 = "0".	
C2 (Sleep problems related to hypomania or mania) = "0".	Mrs. C's one or two episodes of "nesting" would not apply to this item.

Fred's appearance is unkempt. He has difficulty sitting still, and when asked about this, he says he needs to keep moving around because it keeps the voices in his head from getting too loud. When asked to elaborate, he says that the voices haven't been "too bad lately," they just seem to be talking about all sorts of things right now. However, a few weeks ago, they were telling him to do "bad things," such as find his girlfriend and show her "who the boss is." He knows that the voices are controlled by the Mafia and that eventually they will tell him "exactly what they want me to do. They told me that I am the only one smart enough to take care of things when the time comes." Right now, all he knows is that it will be a "very important assignment, something that will really make a lot of people upset, especially those stupid politicians."

During the interview, the clinician noted that Fred's speech was rapid and that he bounced from topic to topic. At times, Fred spoke in rhymes, saying things such as, "I have a cat that is getting fat. How do you like that?" When asked about talking fast, using rhymes, and jumping from topic to topic, Fred said that people tell him that he does this all the time, that it is no different today than 3 days ago or even months ago. "It's just how I am," he said. When asked about any problems with sleeping in the last 3 nights, Fred said that he normally "sleeps like a log" but he had trouble sleeping last night because he was worried about being forced to take medication when he came for this visit.

Code:	**Rationale:**
C1h (Inflated self-worth) = "3".	Fred has an inflated belief about his role in the Mafia.
C1l (Pressured speech, racing thoughts) = "3".	While the information given by Fred about his tendency to speak rapidly is vague, best clinical judgment was used to code this as "occurring daily" since Fred did say he is not different now than he was a month ago.
C1u (Hallucinations) = "3".	Fred reports auditory hallucinations.
C1v (Command hallucinations) = "1".	Fred denies having command hallucinations in the last few weeks. However, this is coded **"1"** because he reports recent command hallucinations, which are considered clinically significant at this time.
C1w (Delusions) = "3".	Fred has a delusion system involving the Mafia, and he believes he has an important role with the organization.
C1x (Abnormal thought process) = "3".	Fred is vague when describing his unusual speech patterns (jumping from topic to topic, using rhymes throughout his speech). Clinical judgment was used to code this as "occurring daily" since Fred did say he is no different now than he was months ago.
C1gg (Hygiene) = "3".	There is no reason to believe that Fred presents any differently in terms of hygiene at the time of the interview than at any other time. Clinical judgment was used in the absence of a secondary source of information.
C1hh (Difficulty falling/staying asleep) = "2".	Fred reports that he had trouble getting to sleep on 1 night of the last 3.
All other items in C1 = "0".	
C2 (Sleep problems related to hypomania or mania) = "0".	There is no evidence to suggest that Fred has sleep problems related to an increased energy level.

C3. Degree of Insight into Mental Health Problem

Intent

To determine the person's level of awareness of his or her mental health problems and the contributing factors. Insight in this context is not intended to imply an in-depth understanding of the signs and symptoms that the person is experiencing. Rather, the person is assessed as having insight if there is recognition that there is a problem and that he or she is in need of some help. The level at which the person is aware of his or her problems is an important factor to consider for care planning, treatment, and willingness to participate in a treatment plan.

Definitions

Full insight — Person recognizes that a problem exists and appears to understand the problem or that he or she needs treatment.

Limited insight — Person acknowledges some but not all aspects of the problem (for example, underlying causes, treatment options, impact on others).

None — Person appears to have no awareness of his or her difficulties or mental health problems.

Process

Insight can be assessed by asking the person about his or her view of the present situation or what is happening to him or her. Is there recognition that a problem exists? Does the person recognize the causes and the need for help?

Coding

Code for degree of insight.

0. Full

1. Limited

2. None

Examples of How to Code Degree of Insight into Mental Health Problem

Mrs. C knows that she needs help; it was her idea to ask her family doctor to arrange a referral to someone who specializes in mental health problems. She is able to articulate that she has had difficulty accepting her husband's death and dealing with the guilt she is experiencing around this, and she thinks this has a lot to do with what is happening to her and how she feels right now.

Code: C3 = "0".

Rationale: Mrs. C recognizes that a problem exists, and she is making attempts to understand her situation.

Fred has no idea why he had to come to this appointment; he only came because he had nothing better to do and he promised the "pretty nurse" at the hospital that he would keep the appointment. His biggest concern right now is that he will be forced to go back on medication and this might interfere with his ability to "keep up with the messages from the Mafia."

Code: C3 = "2".

Rationale: Fred has no awareness that he is having any difficulty and would thus be assessed as having no insight into his mental health status at this time.

C4. Self-Reported Mood

Intent

To record the person's self-reported mood over the last 3 days. In some cases, the person may report that an indicator was not felt in the last 3 days but it continues to be **present** and **active** in a way that has a meaningful impact on his or her current care needs.

Definitions

These items involve verbal reports of the person's subjective evaluation of three dimensions of mood state (anhedonia, anxiety, dysphoria) over the last 3 days. Ask: "In the last 3 days, how often have you felt. . . ."

C4a. Little interest or pleasure in things you normally enjoy?

C4b. Anxious, restless, or uneasy?

C4c. Sad, depressed, or hopeless?

Process

Ask the person the previous questions directly once you have completed your own ratings of the person's mood state using the other items in the Mental State Indicators section of the assessment. **Only the person's responses** should be used to rate each item. Do not code the items based on your own inferences about the person's mood state, and do not record ratings given by family, friends, or other informants. These items should be treated strictly as self-report measures. If the person is unable to respond (because of cognitive impairment, for example) or refuses to respond, do not dwell on these items, and do not impute responses for the person. In such situations, use code **"8"** for "Could not (would not) respond".

Coding

Code each item using the person's response as to whether/how often over the last 3 days he or she experienced the feelings referenced in Items C4a, C4b, and C4c, regardless of what the person believes to be the underlying cause of these feelings. Code for both the presence of the indicator and the number of days in which it was felt, no matter how often it was felt per day. Persons unable or unwilling to respond should be coded **"8"** for "Could not (would not) respond". Use the following codes.

0. Not in last 3 days

1. Not in last 3 days, but often feels that way — Use this code only if the person indicates the feeling is frequently **present** and **active** but was not experienced in the last 3 days.

2. In 1–2 of last 3 days

3. Daily in the last 3 days

8. Could not (would not) respond

Examples of How to Code Self-Reported Mood

Mr. T's wife reports that her husband is restless and seems depressed. Mr. T is unable to respond to the self-reported mood items because of his cognitive impairment.

Code: All C4 (Self-reported mood) items = "8".

Rationale: This is a self-report item, so Mrs. T's observations are not considered. Code **"8"** is used because Mr. T is unable to respond. Aspects of Mr. T's mood (for example, crying or worried facial expressions, if present) can be coded in Item C1.

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When asked to respond to the self-report mood items, Mrs. C said that she has no interest in doing things that she used to enjoy and that she has had this feeling for some time now. She says that she feels less anxious today than she did a few days ago but she is still feeling "pretty uptight" today. She also says that she has felt sad and depressed most of the time during the last 3 days. In a separate interview, Mrs. C's daughter said that her mother has appeared to be in better spirits in the last 2 days and that she has seemed more interested in watching the TV "soaps" that she has followed for years.

Code: All C4 (Self-reported mood) items = "3".

Rationale: Since this is a self-report item, the assessor codes according to what Mrs. C says, regardless of reports from her daughter.

Section D

Substance Use or Excessive Behaviour

The information collected in this section will be used for early detection of and intervention for addictions. Substance use can have a substantial impact on the course of the psychiatric illness and the person's responsiveness to treatment.

NOTE: Comprehensive examples for Items D1 and D2 are given after discussion of D2.

D1. Alcohol

Intent

To determine if the person's consumption of alcohol is a potential problem by identifying the highest number of alcoholic drinks the person had in a single sitting during the **last 14 days**.

Definitions

Alcohol — Includes beer, wine, liquor, and liqueurs.

Single sitting — Refers to any given point in time (for example, at dinner, after work, while out at a social event, watching television).

Process

Ask the person directly. Start by asking the person, "Do you drink alcoholic drinks?" If he or she says yes, go on to, "When you look back to the last 14 days, what is the highest number of drinks you had during a single episode?" Consultation with family or friends may be necessary. Sometimes it is prudent to talk to the person and family separately. If there is a discrepancy in reporting of the amount taken at a single sitting, use clinical judgment to code this item.

Coding

Code for the highest number of drinks ingested by the person at one sitting over the **last 14 days**.

0. None

1. 1

2. 2–4

3. 5 or more

D2. Number of Days in Last 30 Days Consumed Alcohol to Point of Intoxication

Intent

To determine the person's pattern of alcohol consumption during the **last 30 days**.

Definitions

Alcohol — Includes beer, wine, liquor, and liqueurs.

Intoxication — A condition following alcohol consumption in which the person experiences any one or more of the following: slurred speech, lack of coordination, unsteady gait, attention or memory difficulties, impaired judgment, stupor, or coma.

Process

Ask the person directly if he or she has become intoxicated or drunk at any time during the last 30 days. If the response is yes, determine the frequency of occurrence in the last 30 days. You may consult family or friends if necessary. Sometimes it is prudent to talk to the person and family separately. If there is a discrepancy in reporting of the number of days the person was intoxicated, use your clinical judgment to code this item. (It is not necessary to know the exact number of days, just the appropriate range.)

Coding

Code for the number of days of intoxication in the **last 30 days**.

0. None

1. 1 day

2. 2–8 days

3. 9 or more days, but not daily

4. Daily

Examples of How to Code Alcohol, Number of Days in Last 30 Days Consumed Alcohol to Point of Intoxication

Cathy reports that the last time she had anything to drink was 2 nights ago, when she had a glass of wine. When asked about anything prior to that, she said that she went to a bar last weekend with friends and that she could not remember how many beers she had but estimated that it was at least six or seven over the course of the night. Cathy went on to say that she had been out drinking with friends every Friday and Saturday night of the last month and that they all "had fun, drank a lot, and got smashed" each time.

Code:

D1 (Alcohol) = "3".

D2 (No. of days consumed alcohol to point of intoxication) = "2".

Rationale: Although Cathy had only one drink 2 nights ago, the highest number of drinks consumed in the last 14 days was when she went to the bar (this would be considered a "single sitting"), and it is this episode that is used for determining the response to Item D1. The report of drinking to the point of intoxication is assessed as "2–8 days" because Cathy admits to weekend binge drinking.

Orlando has not had a drink of alcohol of any kind in the past 8 weeks, since his admission to detox and the alcohol addiction unit.

Code:

D1 (Alcohol) = "0".

D2 (No. of days consumed alcohol to point of intoxication) = "0".

Rationale: Although Orlando has an alcohol dependency problem, the code is **"0"** because he has not had anything to drink within the defined time frames for these items. The concern about alcohol dependency will be picked up in Item D5.

D3. Time since Use of the Following Substances

Intent

To obtain an inventory of substances that the person is taking or has taken in the past. These substances can have particularly harmful effects when combined with certain medications that the person may be taking concurrently.

Definitions

D3a. Inhalants — Hydrocarbons found in inhalants are sniffed by users to achieve a high. The inhalants include glue, gasoline, paint, paint thinner, and solvents.

D3b. Hallucinogens — Substances known for the hallucinations they produce. Examples include phencyclidine or "angel dust," LSD or "acid," "magic mushrooms," and "ecstasy."

D3c. Cocaine or crack — Powerful stimulants derived from the coca plant that can be inhaled or smoked.

D3d. Stimulants — Stimulants are often used to control normal fatigue and to create feelings of euphoria. Examples include amphetamines, such as "uppers," "speed," and methamphetamines.

D3e. Opiates (including synthetics) — Includes heroin and the synthetic preparation of methadone.

D3f. Cannabis — Any of various preparations of different parts of the hemp plant that are smoked, chewed, or drunk for their intoxicating or hallucinogenic properties.

Process

Discussion about substance-related problems can be introduced to the person by conveying the importance of the information for care planning or treatment (for example, possible medication interactions). Observe body language and any reluctance in responding. If unsure of the accuracy of the person's response, you may want to check with others (family, friends, and community workers) to determine if they know whether the person has used these substances.

Coding

Code for the most recent time the substance was used.

0. Never

1. More than 1 year ago

2. 31 days–1 year ago

3. 8–30 days ago

4. 4–7 days ago

5. In last 3 days

Examples of How to Code Time since Use of the Following Substances

Cathy reports the occasional use of "grass, but nothing stronger" over the past year, "every few weeks or so when I get together with friends from high school." The last time she used it was 3 weeks ago, when she went home to see her parents. She says the only drug that she has ever tried was "ecstasy" and that she experimented with it only once, about 6 months ago.

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Code:

D3b (Hallucinogens) = "2".

D3f (Cannabis) = "3".

All other items = "0".

Rationale: Cathy's last cannabis use was more than 7 days ago but still within the last month. Because the use of "ecstasy" occurred more than 31 days ago but within the past year, this category would be coded **"2"**. Her denial of use of other substances is the only source of information available about the use of other substances, so those items are coded **"0"**.

David reports that his only use of drugs was "smoking pot in the '70s, like everyone else in university in those days." He stopped using once he decided to pursue a career in law.

Code:

D3f (Cannabis) = "1".

All other items = "0".

Rationale: Although David did use cannabis, it occurred over 1 year ago. The code would be **"1"** for this category of drug; all other categories are coded **"0"**, based on his self-report.

D4. Injection Drug Use (Exclude Prescription Medications)

Intent

To identify problems or risk of potential problems related to injection drug use, such as infectious diseases or criminal activity to support the drug use.

Definition

Injection drug use — This item refers only to illicit drug use (for example, heroin). Do not include prescribed medications, such as intravenous antibiotics or insulin.

Process

Ask the person (or family, if necessary) directly about injection drug use and sharing of needles. If there is a known history of drug use, checking with other sources (such as the family physician or a community worker) may also be beneficial.

Coding

Code for history of injection drug use and needle sharing.

0. Never used injection drugs

1. Used injection drugs more than 30 days ago

2. Used injection drugs in last 30 days; did not share needles

3. Used injection drugs in last 30 days; did share needles

D5. Patterns of Drinking or Other Substance Use in Last 90 Days

Intent

To identify behaviours indicating that the person may have a problem with an alcohol or drug addiction. These observations may be reported by the person **or** by others.

Definitions

D5a. Person felt the need or was told by others to cut down on drinking or drug use, or others were concerned about person's substance use — Others in his or her life or the person him- or herself expresses concern regarding his or her alcohol consumption or use of substances. The concern may have various motivations. For example, a person may be concerned about the amount he or she is drinking since finding out about a friend who recently died from liver disease, or a spouse may express concern that the person has been drinking too much since losing a job. The person, family, or others may also report that there has been trouble because of substance use. For example, family or friends may have withdrawn because of the behaviour of the person when drunk or high, or the person's driver's licence may have been taken away because of driving while under the influence of alcohol/drugs.

D5b. Person has been bothered by criticism from others about drinking or drug use — Person, family members, or others indicate that the person becomes angry or agitated when others express disapproval of the substance use. The person may express that it is "no one else's business how much I drink" or that others are too critical and there is nothing wrong with having a few drinks or using a few drugs.

D5c. Person has reported feelings of guilt about drinking or drug use — Person, family, or others report that the person has experienced feelings of guilt related to his or her substance use. This guilt could have several origins. For example, the person may feel guilty about the emotional and financial distress it has caused the family, the embarrassment it has caused loved ones, or the way he or she treats others when under the influence of alcohol/drugs.

D5d. Person has to have a drink or use drugs first thing in the morning to steady nerves — Person, family, or significant others report that the person drinks/uses drugs or has been observed to do so early in the day. The person may use the expression "I need an eye-opener."

D5e. Person feels social environment encourages or facilitates abuse of drugs or alcohol — Person acknowledges (or family or significant others report) that he or she maintains regular contact with individuals who drink alcohol or use drugs and that this contact makes it more likely that he or she will drink or use drugs when they interact.

Process

Engage the person in a conversation about his or her patterns of substance use. This information may be a sensitive issue for the person and may cause uneasy feelings for the assessor. Care must be taken to acknowledge these feelings. Begin asking about alcohol/drugs with a simple nonjudgmental statement like "Do you drink?" or "Do you ever get high?" It is important that the person not feel judged as if doing something wrong. Address substance use in a gentle way. For example, say, "Like the other questions I asked, I am just trying to find out about you. It doesn't mean that what you are doing is wrong." Ask how he or she feels about his or her drinking/drug use and if others express disapproval of this behaviour. If others express disapproval, ask how this criticism makes the person feel. Discuss the person's substance use with family members, but not while the person is present.

Coding

Code for presence of each indicator in the **last 90 days**, regardless of the amount or number of days of drug/alcohol use, the number of people who were concerned, or the number of times the concerns were raised. Indicators can be reported by the person or by others who know the person.

0. No

1. Yes

Examples of How to Code Patterns of Drinking or Other Substance Use in Last 90 Days

When discussing his alcohol problem, Orlando told the clinician that the worker from the community outreach team had been concerned about his drinking (especially since he was having a drink first thing in the morning as soon as he could get his hands on a bottle), but it was not until his admission to detox (8 weeks ago) that he decided to do something about it. It did not bother him when the caseworker spoke to him about drinking, because "I was too out of it most of the time to really care." When he was in the addiction program, he said, he started to work through some of his feelings of remorse and guilt about the "mess that I have made of things" and he knows that he has more work to do to get his life back on track. He first wants to get "off the street" because he is afraid he will go back to drinking if he "hangs around with the street crowd again."

Code:	**Rationale:**
D5a (Others concerned about person's substance use) = "1".	The caseworker had been talking to him about his drinking in the last 90 days, and Orlando is expressing concern about his alcohol use.
D5b (Person bothered by others' criticisms) = "0".	Orlando was not bothered by the caseworkers' discussing his alcohol use.
D5c (Reports feelings of guilt) = "1".	Orlando is working on dealing with the guilt associated with drinking.
D5d (Has to have drink first thing in morning) = "1".	He had been drinking first thing in the morning prior to his stay in detox, which is within the 90-day time frame.
D5e (Feels social environment encourages alcohol abuse) = "1".	Orlando feels that the "street crowd" has an influence on his drinking behaviour.

Although she admits to substance use (both alcohol and drugs), Cathy denies that she has a problem or that anyone has suggested that she might have a problem, except her parents. When asked to elaborate on this, she responded, "Like, the last time I was home three weeks ago, they said they were 'concerned about me' because I came home drunk, and we got into a fight. They had the nerve to tell me to 'watch my drinking.' I just told them it was none of their business what I do with my life, packed my bags, and came back to the university early. I can't stand it when they get on my case. After all, there's nothing wrong with having a few drinks once in a while. And I'm not like my mom, who would rather have scotch than coffee in the morning; I only drink when I'm out with my friends." When asked whether her friends influenced her drinking pattern, she responded, "Of course, all of my friends drink; it's what university kids do, and I go along with them."

Code:	Rationale:
D5a (Others concerned about person's substance use) = "1".	Cathy reports that her parents have told her to watch her drinking. This would be sufficient to code this item **"1"**.
D5b (Person bothered by others' criticisms) = "1".	Cathy's reaction to her parents' inquiry about her drinking and her comment "it's none of their business" would suggest that she is upset with their expressions of concern.
D5c (Reports feelings of guilt) = "0".	Cathy does not think she has a problem.
D5d (Has to have drink first thing in morning) = "0".	Cathy provided information about not needing an "eye-opener" when she was comparing herself to her mother. Based on this, the assessor determined that Cathy is not drinking early in the day.
D5e (Feels social environment encourages alcohol abuse) = "1".	Cathy states that her social environment does have an influence on her drinking.

D6. Withdrawal Symptoms

Intent

To identify and document the severity of signs or symptoms indicative of withdrawal from alcohol, drugs, or medication. This information assists with care planning around potential or actual withdrawal.

Definitions

None present — No symptoms of withdrawal from alcohol, drugs, or medication are present.

Mild — Symptoms that are typical of early stages of withdrawal from alcohol, drugs, or medication (for example, agitation, "jitters," cravings, gastrointestinal upset, anxiety, hostility, vivid dreaming).

Moderate — Symptoms that are typical of the midstage of withdrawal from alcohol, drugs, or medication, including a noted increase in the severity of early-stage symptoms as well as weakness, sweating, hot flashes, fainting, and muscle twitching.

Severe — Symptoms that are typical in the advanced stages of withdrawal from alcohol, drugs, or medication, including exhaustion, seizures, tremors, tachycardia, disorientation, and hyperventilation.

Process

The best sources for information about withdrawal symptoms are observations and reports from the person and those who have been with the person over the last 3 days.

Coding

Code for the most severe level observed in the **last 3 days**. For example, if the person has symptoms typical of the midstage of withdrawal but also symptoms related to the advanced stage, code as **"3"** for "Severe".

0. None present

1. Mild

2. Moderate

3. Severe

Example of How to Code Withdrawal Symptoms

Orlando reports that he had "bad" withdrawal symptoms after he was admitted to detox 8 weeks ago. He was shaking and twitching all the time, was really irritable, and had lots of problems with his stomach and bowels. However, since "drying out" at detox, he has not experienced any symptoms and he thinks the worst is over.

Code: D6 = "0".

Rationale: Although Orlando did have symptoms of withdrawal, these occurred prior to the 3-day time frame of this item.

D7. Person Has Ever Had a Diagnosis of Substance-Related Disorder

Intent

To identify if the person had a substance-related problem.

Definition

Substance-related disorder — For example, alcohol dependence, any drug-related dependence.

Process

Ask the person, or others who know the person, if necessary.

Coding

Code for the presence of a history of a substance-related disorder.

0. No

1. Yes

D8. Caffeine Use

Intent

To determine whether the person has consumed unusually high amounts of caffeine in the **last 3 days**.

Definition

Caffeinated beverages — Includes coffee, tea, and any caffeinated soft drinks. Standard units for coffee/tea are 1 cup = 8oz/250 ml and caffeinated beverages 12oz/355 ml.

Process

Ask the person or others, or get information through observation of the person's caffeine consumption.

Coding

Code for the highest number of caffeinated beverages consumed in any single day of the last 3 days. If the person's caffeine consumption varied throughout the 3-day period, code for the day with the highest consumption.

0. No coffee or caffeinated beverages

1. 1–2 cups of coffee or 1–4 caffeinated beverages

2. 3–5 cups of coffee or 5–9 caffeinated beverages

3. 6 or more cups of coffee or 10 or more caffeinated beverages

Examples of How to Code Caffeine Use

Fred reports that he never drinks coffee, but he likes cola drinks. When asked how much he had consumed in the last 3 days, he said "a whole lot." The clinician then asked specifically about the largest quantity that he had had in any one day over the last 3 days. He said, "Probably about 3 or 4 glasses a day, that's all I can afford. Sometimes it's not that much if I don't have the money, but my cheque came this week so I was enjoying it."

Code: D8 = "1".

Rationale: Although Fred may be under- or overestimating the amount, code **"1"** (3–4 caffeinated beverages on at least one day of the last 3 days) is the best response available.

Orlando reports that he is drinking about 6 cups of coffee a day now, but before he stopped drinking alcohol and when he was living on the street, he was drinking 1 or 2 cups a day maximum**.**

Code: D8 = "3".

Rationale: The time frame of interest here is the last 3 days, thus the code for 6 or more cups of coffee a day is used.

D9. Smokes Tobacco Daily

Intent

To determine if the person smokes tobacco.

Definition

Smokes tobacco daily — Refers to cigar, cigarette, or any other tobacco product that is inhaled.

Process

Ask the person directly if he or she smokes and how often or how much. Consult with family members if necessary. Reassure the person that he or she is not being judged on his or her smoking behaviour and that it is simply a further effort to find out more about him or her.

Coding

Code for daily smoking.

0. No

1. Not in last 3 days, but is usually a daily smoker

2. Yes

D10. Gambled Excessively or Uncontrollably in Last 90 Days

Intent

To determine if the person has been gambling excessively or uncontrollably in the **last 90 days**.

Definitions

Excessive or uncontrollable — Person is not able to control the urge to participate in the activity despite the negative consequences that may arise.

Gambling — This includes gambling of any type (for example, casino gambling, horse races, lottery tickets, day trading) whether or not legal. It does not usually include investing in the stock market, but in some cases it may be appropriate to include day trading when it is done in an irrational, reckless manner.

Process

Ask the person if he or she has had difficulty controlling the extent (frequency or duration) of the gambling because he or she liked doing it or felt that it was needed, despite others' concerns or negative consequences. Because the person may not be willing to be entirely honest about this behaviour, it is important to consult with family, friends, and other health care workers who have worked closely with the person.

Coding

Code for excessive gambling in the **last 90 days**.

0. No

1. Yes

Example of How to Code Gambled Excessively or Uncontrollably in Last 90 Days

David, who denied alcohol or drug use, reported that his only vice is going to the "track to play the ponies. Most of the time, I keep it under control, but when I get really stressed, I go four or five times a week after work. Except, last month, I took off after lunch on a few days because I thought I had picked some winners — unfortunately, the horses didn't do it for me, I lost a lot of money, and on top of it, I lost a few clients as well. I have it all under control now and have only been going to the track in the evenings."

Code: D10 = "1".

Rationale: Although David says he has things "under control now," there is enough in what he reports to suggest that he does have a problem with gambling.

Section E

Harm to Self and Others

A review of indicators of self-harm, harm to others, and any forensic involvement will assist clinicians in identifying those at risk. For those who are at risk of engaging in these behaviours, it is critical that care planning focus immediately on interventions that address safety and prevention.

NOTE: Comprehensive examples for Items E1–E3 are given after discussion of E3.

E1. Self-Injurious Ideation or Attempt

Intent

To identify persons who are engaging in or who are at risk of engaging in self-injurious behaviour.

Definitions

E1a. Considered performing a self-injurious act — Person has thought about performing an act of self-injury. This includes a command hallucination that is telling the person to harm him- or herself.

E1b. Most recent self-injurious attempt — Includes both lethally motivated suicidal behaviour (intentional, self-inflicted attempt to kill oneself) and behaviour that inflicts intentional self-injury without suicidal intent (for example, self-mutilation). Nonintentional, accidental, or unconscious self-destructive behaviours that may lead to injury or premature death (for example, chronic substance abuse, hyperobesity, noncompliance with treatments for illness, risk-taking behaviour) are not considered self-injurious behaviours for the purposes of this item.

Process

Interview the person and consult with others. Family, if available, should be interviewed separately from the person so that they may express their feelings openly. Check the clinical record, if available.

Coding

Code for most recent instance for each item.

0. Never

1. More than 1 year ago

2. 31 days–1 year ago

3. 8–30 days ago

4. 4–7 days ago

5. In last 3 days

E2. Intent of Any Self-Injurious Attempt Was to Kill Self

Intent

To determine whether the intent of the self-injurious act was to kill him- or herself.

Definition

Self-injurious action was intentionally undertaken with the aim of ending the person's life (regardless of the potential lethality of the method).

Process

Interview the person and consult with family, if available. Family should be interviewed separately from the person, if possible. Check the clinical record, if available.

Coding

Code for intent to end his or her life.

0. No

1. Yes

8. No attempt

E3. Other Indicators of Self-Injurious Behaviour

Intent

To identify other indicators of risk of possible self-injury.

Definitions

E3a. Family, caregiver, friend, or staff expresses concern that person is at risk for self-injury — Person's behaviour indicates to someone else (including a member of the health care team) that he or she is at risk for self-injury, whether or not the person has verbalized thoughts of harming him- or herself.

E3b. Suicide plan — In **last 30 days**, the person formulated a scheme to end own life.

Process

Interview the person and consult with others. Family, if available, should be interviewed separately from the person so that they may express their feelings and concerns openly. Check the clinical record, if available.

Coding

Code for each item.

0. No

1. Yes

Examples of How to Code Self-Injurious Ideation or Attempt, Intent Was to Kill Self, Other Indicators of Self-Injurious Behaviour

When asked about thoughts of harming herself, Cathy said that she has not really thought about this for a long time. When she was in high school, around grade 10, she cut her wrists with a razor blade to get back at her parents for something they had done. She denied experiencing suicidal ideation at that time and she is denying thoughts of harming herself now. She says she just wants to get some sleep and then get through this year at university.

Code:

E1a (Considered performing self-injurious act) = "1".

E1b (Most recent self-injurious attempt) = "1".

E2 (Intent to kill self) = "0".

E3a (Others concerned about person's risk of self-injury) = "0".

E3b (Suicide plan) = "0".

Rationale: Cathy's action of cutting herself when she was in high school occurred more than 1 year ago, and she denied that it was an attempt to kill herself. She is currently denying thoughts of self-harm, and there is no evidence that others are concerned about this.

David reports almost daily thoughts of suicide for the last 6 months and "fairly often" before that. Thoughts of "ending it" started after his wife left him. In fact, he reports that he took a "handful of pills" 5 days ago, thinking that both he and the children would be better off if he were no longer around. The only effect of the pills was to make him sleep longer than usual the following day. His doctor set up the appointment with the outpatient clinic after hearing that David had taken the pills. When asked about a current plan, David stated: "Pills didn't work and I don't have any other plans right now."

Code:

E1a (Considered performing self-injurious act) = "5".

E1b (Most recent self-injurious attempt) = "4".

E2 (Intent to kill self) = "1".

E3a (Others concerned about person's risk of self-injury) = "1".

E3b (Suicide plan) = "0".

Rationale: David's last attempt was within the last week but not within the last 3 days; therefore, "4–7 days ago" applies. His description of why he took the pills would indicate that the attempt was to kill himself. Since he reports "almost daily" thoughts of suicide, "In last 3 days" applies to "Considered performing a self-injurious act." His doctor made the referral after hearing about the last suicide attempt. This is evidence that "others" are concerned, so "Yes" would apply for Item E3a. David has no formulated plan at this time, so "No" would apply for Item E3b.

E4. Violence

Intent

To identify those who are at risk of becoming violent. These items focus on acts of ill-will, active opposition, hostility, or antagonism that may be directed toward others or inanimate objects. Past violence is often the best predictor of future violence. Awareness of those with violent tendencies can help the health care team with management strategies and protect the person, other clients, staff, and others.

Definitions

E4a. Violent ideation — Person reports (or someone else has credible information) that the person has had premeditated thoughts, made statements, fantasized, or planned to take actions of violence toward others.

E4b. Intimidation of others or threatened violence — Attempts by the person to force or deter someone, by using threatening gestures, a threatening stance with no physical contact, shouting angrily, aggressive or intimidating staring, yelling personal insults or curses, using foul language in anger, kicking the wall, throwing furniture, etc. The person may also make explicit threats of violence against others.

E4c. Violence to others — Violent acts that result in physical harm to another person. These are characterized by **purposeful, malicious, or vicious intent** by the perpetrator and can include violence driven by command hallucinations. Violent actions can include, but are not limited to, any physical act of harm to another, such as stabbing, choking, or hitting/beating (with or without a weapon).

Process

This information can be obtained through family, therapist, or self-report, clinical records, arrest records, and other records of judicial proceedings, if available. Family members should be interviewed away from the person so that they can speak openly.

Coding

For each item, code for the most recent instance.

0. Never

1. More than 1 year ago

2. 31 days–1 year ago

3. 8–30 days ago

4. 4–7 days ago

5. In last 3 days

Examples of How to Code Violence

The referral records indicate that a restraining order was obtained to keep Fred from seeing his girlfriend because he had hit her on the face a number of times and had broken her arm about 4 months ago when they were living together, and he threatened to do it again if she continued to refuse to move back in with him. When asked about this, Fred denied having any more thoughts about her because "she's not worth it." He also reported hearing voices that told him to "show her who's boss" a few weeks ago. When asked to elaborate, he said that he had intended to "rough her up a bit, but that was then and this is now and I don't have time for her right now."

Code:	**Rationale:**
E4a (Violent ideation) = "3".	Fred denies having violent thoughts at this time, but he did experience them a few weeks ago when "the voices" were telling him to seek out his girlfriend.
E4b (Intimidation of others) = "2".	The threats against his girlfriend occurred more than 1 month ago but within the past year.
E4c (Violence to others) = "2".	The violent actions against his girlfriend occurred more than 1 month ago but within the past year, and they had a purposeful and malicious intent.

Mr. T has been hitting his wife almost every day for the past month, mostly when she is trying to help him get dressed or into the bathtub. She reports that for the past year he seems to be "hitting out more often, but for no apparent reason." She reports that he was the type of person who "wouldn't hurt a fly" and that this hitting got worse a few months ago, around the time when he started becoming confused more often. She has never known him to threaten anyone.

Code:	Rationale:
E4a (Violent ideation) = "0".	Mr. T is unable to communicate with the assessor; thus this item would be coded **"0"** because he cannot self-report violent ideation and his wife gives no indication that she has heard this from him.
E4b (Intimidation of others) = "0".	There is no evidence that Mr. T has been threatening others.
E4c (Violence to others) = "0".	Although Mr. T has been hitting his wife, there is no evidence that this is with purposeful, malicious, or vicious intent. The behaviour of hitting without malicious intent is documented elsewhere (F1c).

E5. History of Sexual Violence or Assault as Perpetrator

Intent

To document whether the person has engaged in sexual violence toward others in the past. A prior history of sexual violence or assault is a strong predictor of such future acts. Care planning should consider methods to prevent such acts and to protect other clients, staff, and others.

Definition

Sexual violence or assault — Any attempted or completed instances of sexual violence, such as heterosexual or homosexual pedophilia or incest, rape of adult males or females, exhibitionism to adult males, females, or children, or sexual violence toward family members or others.

Process

The person may or may not disclose this information. The information can also be obtained from family, therapists, arrest records, or other available documentation.

Coding

Code for any known history of sexual violence as a perpetrator.

0. No

1. Yes

E6. Extreme Behaviour Disturbance

Intent

To assess if others have concerns (out of knowledge of prior behaviours) that the person may pose a serious current risk of harm to him- or herself or others.

Definition

Extreme behaviour — Any type of **extreme** behaviour known to have put the person or others at **serious** risk. For example, homicide, rape, torture of humans or animals, assault resulting in serious injury to another person, severe self-mutilation, a suicide attempt that would very likely have been successful, or a history of fire setting that did (or had the potential to) cause serious damage to people or property.

Process Consult records, referral sources, community supports, or others who are familiar with the person's behaviour.

Coding Code for the presence of extreme behaviour.

0. No

1. Yes, but not exhibited in last 7 days

2. Yes, exhibited in last 7 days

E7. Police Intervention

Intent To determine if the person has been involved with the police (other than as a victim) and the nature of the involvement. This information is important for understanding the nature of the person's history as it relates to any involvement with the police. It is important for care planning and provides a marker regarding the intensity of the problem behaviour.

Definitions **Police intervention** — Any history of police contact/intervention (for example, arrests, police escort to hospital for psychiatric examination, police intervention to de-escalate a situation with no resulting charges). This item excludes any contact with the police that involved the person as a victim.

Violent behaviour — Violent circumstances include incidents that result in (or could potentially result in) some form of bodily harm to others. Included are threats, intimidations, and attempts to be violent toward others. Robbery is often categorized as a violent crime because it involves face-to-face contact between perpetrator and victim. In contrast, "break and enter" is more likely to be classified as nonviolent because the intent is to avoid contact with and detection by victims.

Nonviolent behaviour — Many circumstances that lead to police intervention fall under this broad category (for example, fraud, automotive theft, trespassing). Property damage would be included here unless the intent was to intimidate or threaten others (which would be classified as a violent circumstance).

Process People are not always honest about or willing to share information about their police contact. You may approach the subject by asking the person if he or she has ever been in trouble with the law. Validate this information with referral sources and a review of clinical records, if available.

Coding Code for most recent instance of police intervention for violent behaviour (Item E7a) and nonviolent behaviour (Item E7b).

0. Never

1. More than 1 year ago

2. 31 days–1 year ago

3. 8–30 days ago

4. 4–7 days ago

5. In last 3 days

Example of How to Code Police Intervention

Orlando denied having any involvement with the police. However, referral records indicate that he had been involved with the police on two occasions in the last year because of alcohol-related, nonviolent disturbances in the community. The most recent incident was 2 months ago. On both occasions, he was taken to the detox centre by the police, and no charges were laid against him.

Code:

E7a (Police intervention for violent behaviour) = "0".

E7b (Police intervention for nonviolent behaviour) = "2".

Rationale: Although Orlando denies experiencing any police involvement, the records indicate otherwise, and the assessor used clinical judgment to determine that the report from the referring source was accurate.

E8. Currently on Probation or Parole

Intent

To determine if the person is currently on probation or parole.

Definitions

Definitions of probation and parole may be country- or region-specific.

Probation — A form of sentencing that occurs within the provincial court jurisdiction; probation can follow a term of imprisonment of up to 2 years less a day or it can occur following conviction for an offense with no time in custody. The maximum probation time is 3 years.

Parole — After having served one-third of a sentence in either the provincial or federal system, a person is eligible to apply for parole and thereby serve the remainder of the sentence in the community or a halfway house. Parole can be revoked and the offender can be returned to custody.

Process

Ask the person and/or family member; check the clinical record or other available documents.

Coding

Code for present status.

0. No

1. Yes

Example of How to Code Currently on Probation or Parole

Fred's referral documents, which were forwarded to the ACT team, indicate that he is currently on probation for a "break and enter" that occurred 18 months ago.

Code: E8 = "1".

Rationale: Although the clinician will want to ask about this, documentation from another source, if it is available, can be used to complete this item.

E9. Currently in a Court Diversion/Support Program

Intent

To record if the person is presently involved in a court-mandated diversion/support program.

Definitions

Court diversion/support program — At the discretion of the courts, a person who has committed a minor offence and has a mental illness is referred to mental health services for treatment and support as an alternative to prosecution.

Process

Ask the person and/or family member; check the clinical record or other available documentation.

Coding

Code for court diversion/support program.

0. No

1. Yes

E10. Restraining Order(s)

Intent

To record whether or not there is or has been restraining order(s) served against the person.

Definitions

Restraining order — Court order placed on a person restricting him or her from doing certain acts or from being in a particular location (for example, contacting another person, staying away from a certain place).

Process

Ask the person and/or family member; check the clinical record or other available documentation.

Coding

Code for restraining order(s).

0. Never present

1. Previous orders(s), but none present now

2. Order(s) present

Examples of How to Code Restraining Order(s)

Orlando reports that he had a restraining order imposed on him 2 years ago, but it is no longer in effect, as far as he knows. He has not had contact with his wife or children for more than a year, and to the best of his recollection, the order was for a 1-year time frame.

Code: E10 = "1".

Rationale: Although Orlando's recollection is somewhat vague in terms of the time conditions, the best information available at this time is his word that the restraining order is no longer in effect.

Fred reported that he was told by "someone" to stay away from his girlfriend, but he cannot recall the specifics of this. He went on to say, "Since she doesn't want to see me, I haven't bothered to get in touch with her anyway, so I don't know what the big

deal is." Referral documentation indicates that a restraining order was placed on him 2 months ago and that it is still in effect.

Code: E10 = "2".

Rationale: Fred's recollection of details is limited. Since information is available from his records, it would be used.

E11. Community Treatment Order(s)

Intent

To record whether or not there is a community treatment order served against the person.

Definitions

Community treatment order — Court order placed on a person requiring that he or she receive mental health treatment in the community.

Process

Ask the person and/or family member; check the clinical record or other available documentation.

Coding

Code for the presence of a community treatment order.

0. Not present

1. Present

E12. Incarceration Status

Intent

To record the person's current incarceration status, or history of incarceration.

Process

Ask the person and/or family member; check the clinical record or other available documentation.

Coding

Code for most recent instance of incarceration.

0. Never incarcerated

1. Released from incarceration more than 1 year ago

2. Released from incarceration within last year

3. Currently incarcerated

Section F

Behaviour

Behaviours that are distressing to the person or others can have a significant impact on areas such as the person's quality of life, relationships with others, and options for community housing. It is important to identify the presence of these behaviours in order to implement appropriate strategies that will enhance the person's ability to live in the community.

F1. Behaviour Symptoms

Intent

To identify the presence of specific observed behaviours, irrespective of their assumed cause. The focus is on behaviours that cause distress or that are potentially harmful to the person or distressing or disruptive to others with whom the person lives. Behaviours may have been observed in the last 3 days, or, if not, still known to be a current issue.

Acknowledging and documenting behavioural symptoms (regardless of their intent), provides a basis for further evaluation, care planning, and delivery of consistent, appropriate care that can help to reduce the severity and frequency of the behaviours.

Definitions

F1a. Wandering — Moved about with no rational purpose. A wandering person may be oblivious to his or her physical or safety needs. Wandering behaviour should be differentiated from purposeful movement (for example, a hungry person moving about the apartment in search of food). Wandering may be by walking or by wheelchair. Do not include pacing back and forth, which is not considered wandering.

F1b. Verbal abuse — For example, others were threatened, screamed at, cursed at.

F1c. Physical abuse — For example, others were hit, shoved, scratched, sexually abused. This item identifies physically aggressive behaviour without making the distinction between intentional and unintentional behaviours, whereas Item E4c, "Violence to others", identifies purposeful, malicious, or vicious intent. Those who were identified in Item E4c will also be identified in this section; others who are physically abusive but without malicious intent (for example, those with dementia) would be identified only in this section.

F1d. Socially inappropriate or disruptive behaviour — For example, made disruptive sounds or noises, screamed out, smeared or threw food or feces, hoarded, rummaged through others' belongings.

F1e. Inappropriate public sexual behaviour or public disrobing — Sexual behaviour should only be considered inappropriate when it contravenes usual social norms (for example, deliberately exposing self, masturbating in public or in a room while others are present, and unacceptable sexual gestures, touching, pinching). Sexual activity in private (either alone or between consenting adults) is not considered here. Public disrobing refers to behaviour that contravenes local laws. In the case of disrobing, remember to code for the absence or presence of the behaviour but not the intent. For example,

code this item "**1**" or higher if a person reports undressing in public because there were no private places available.

F1f. **Resists care** — For example, resists taking medications/injections, ADL assistance, or eating. This category does **not** include instances where the person has made an informed choice not to follow a course of care (for example, the person has exercised his or her right to refuse treatment and reacts negatively as others try to reinstitute treatment). Signs of resistance may be verbal or physical (for example, saying that he or she refuses care, pushing family member away, scratching others).

Process

Take an objective view of the behaviour symptoms. The coding focuses on the person's actions, not the intent behind those actions. It is often difficult to determine the meaning behind a particular behavioural symptom. It is important to start the assessment by recording the presence and frequency of behavioural symptoms. The fact that others have become accustomed to the behaviour and minimize the person's presumed intent (for example, "He doesn't really mean to hurt anyone. He's just frightened") is **not** pertinent to this coding. The basis for coding these items is a determination of whether or not the person exhibits the behaviour symptom.

Observe the person during your assessment. In particular, observe how he or she reacts to attempts by others to respond to his or her needs. Ask family members, friends, or others who provide direct care or support if they know what occurred throughout the day and night for the last 3 days. If possible, try to do this when the person is not in the room. Recognize that responses given with the person present may need to be validated later.

Also, be alert to the possibility that others might not think to report a behaviour symptom if it is part of the person's routine behaviour (for example, others are used to the person wandering, yelling out, or verbal abusive behaviour). Focus attention on what the person's actual behaviour has been over the last 3 days.

A review of information in the record may also be helpful.

Coding

Code for the presence of each behaviour symptom over the last 3 days, regardless of what you believe to be the underlying cause of the behaviour. Remember to code for both the presence of the behaviour and the number of days in which it was exhibited, no matter how often it was exhibited each day. Use the following codes:

0. Not present

1. Present but not exhibited in last 3 days — This code indicates that while the assessor knows the condition is present and active, it was not manifested over the last 3 days.

2. Exhibited on 1–2 of last 3 days

3. Exhibited daily in last 3 days

Example of How to Code Behaviour Symptoms

Mr. T has been hitting his wife on a daily basis during the last 3 days. This occurs when she tries to help him dress and attend to his personal hygiene. She reports that it doesn't seem that he is aware of what he's doing, and she doesn't think he is doing this with the intent of hurting her; rather, it seems more like "He's frightened of something." During the last 3 days, he also resisted her every time she tried to give him his medication (twice a day). No other behaviour problems have been noted.

Code:

F1c (Physical abuse) = "3".

F1f (Resists care) = "3".

All other items = "0".

Rationale: Since the behaviour occurred daily, regardless of the number of times per day, "Exhibited daily" is used. Mr. T's aggressive behaviour does not appear to have malicious intent, thus it was not noted in Section E4c but it is captured here in F1c.

Section G

Cognition

It is important to determine the person's actual performance in remembering, making decisions, and organizing daily self-care activities. These items are crucial factors in many care planning decisions, in part because of their impact upon the person's capability to follow instructions and treatment regimens, and to make independent decisions in the community.

G1. Cognitive Skills for Daily Decision Making

Intent

To record the person's actual performance in making everyday decisions about the tasks or activities of daily living. These items are especially important for further assessment and care planning in that they can alert the assessor to a mismatch between a person's abilities and his or her current level of performance. This may indicate that caregivers, family members, or others are inadvertently fostering the person's dependence.

Definition

Here are some examples of decision-making tasks:

- Choosing items of clothing
- Knowing when to go eat meals
- Using environmental cues (such as clocks, calendars, or posted listings of upcoming events) to organize and plan the day
- In the absence of environmental cues, seeking information appropriately (not repetitively) from others in order to plan the day
- Using awareness of one's own strengths and limitations in regulating the day's events (for example, asking for help when necessary)
- Making prudent decisions concerning how to get to places such as the kitchen
- Where applicable, acknowledging the need to use a walker, and using it faithfully

Process

Interview and observe the person and, where possible and necessary, the family. The inquiry should focus on whether the person is actively making decisions about how to manage tasks of daily living, not whether others believe that the person might be capable of doing so. The intent of this item is to record what the person is doing (actual performance). When someone takes decision-making responsibility away from the person regarding tasks of everyday living, or when the person does not participate in decision making (whatever his or her level of capability may be), the person should be considered as having impaired performance in decision making.

This item also requires you to differentiate between (1) the lack of ability to participate in decision making or the lack of opportunity to make decisions, and (2) making decisions that others may not agree with (for example, refusing treatments, refusing to have a shower). The latter would not be considered impairment if the person was actively involved in making the decision.

Coding

Enter the code that most accurately characterizes the person's cognitive performance in making decisions regarding the tasks of daily life over the last 3 days.

0. **Independent** — Person's decisions for organizing daily routine were consistent, reasonable, and safe (reflecting lifestyle, culture, values).
1. **Modified independence** — Person organized his or her daily routine and made safe decisions in familiar situations, but experienced some decision-making difficulty when faced with **new** tasks or situations **only**.
2. **Minimally impaired** — In specific recurring situations, the person's decisions were poor or unsafe, with cues/supervision necessary at those times.
3. **Moderately impaired** — Person's decisions were consistently poor or unsafe; the person required reminders, cues, or supervision at all times to plan, organize, and conduct daily routines.
4. **Severely impaired** — Person's decision making was severely impaired; the person never or rarely made decisions.
5. **No discernible consciousness, coma** — Person is nonresponsive.

Examples of How to Code Cognitive Skills for Daily Decision Making

Mr. T's wife reports that he is no longer making any decisions. She reports that it has been this way for some months now. Although she has tried to get him at least to tell her what he wants to wear for the day, he just shrugs at her. This lack of involvement in decision making has been consistent over the last 3 days.

Code: G1 = "4".

Rationale: Although it is possible that Mr. T is capable of making simple decisions, he is not doing so. The code that is entered documents what is happening (that is, he rarely or never makes decisions) rather than what might be possible.

It is apparent from conversation with David that he is actively involved in his own decision making. In order to confirm this, the clinician asks him if he ever finds himself in a position where he cannot think through the steps required to make decisions or gets confused and makes unreasonable decisions about basic issues, such as dressing for the weather or making sure he eats. He replied that he is not "having any problems with that kind of stuff; it's the big decisions that I struggle with."

Code G1 = "0".

Rationale: There is no evidence to suggest that David has difficulty with making decisions in order to attend to his activities of daily living.

G2. Memory/Recall Ability

Intent

To determine the person's ability to remember recent events (short-term memory) and to perform sequential activities (procedural memory).

Definitions

G2a. Short-term memory OK — Seems, appears to recall information after 5 minutes.

G2b. Procedural memory OK — Can perform all or almost all steps in a multitask sequence without cues.

Process

Conduct a structured test of short-term memory (for the preferred approach, see the following example). If this is not possible, ask the person to describe a recent event that you should both have knowledge of (for example, the election of a new political leader, a major holiday) or that you can validate (for example, what the person had for breakfast). For persons with verbal communication deficits, nonverbal responses are acceptable (for example, when asked to point to items that are to be recalled, he or she can correctly do so). If there is no positive indication of memory ability, code this item **"1"** for "Memory problem".

Example of a Structured Approach for Assessing Short-Term Memory

Ask the person to remember three unrelated items (such as book, watch, and table) for a few minutes. After you have stated all three items, ask the person to repeat them to you (to verify that you were heard and understood by the person). Then proceed to talk about something else, perhaps by going on to another part of the assessment. Do not be silent; do not leave the room. In 5 minutes, ask the person to repeat the name of each item. For persons with verbal communication deficits, nonverbal responses are acceptable (for example, when asked to point to items that are to be recalled, he or she can do so). If the person is unable to recall all three items, code short-term memory **"1"** ("Memory problem").

Procedural memory refers to the cognitive ability to perform sequential activities. Dressing is an example of such an activity because it requires multiple steps to complete the entire task. The person must be able to perform or remember to perform all or almost all of the steps in order to be coded "**0**" for "Yes, memory OK". If the person demonstrates difficulty in two or more steps, code "**1**" for "Memory problem". Do not confuse physical limitations with the cognitive ability (or inability) to perform sequential activities.

Coding

Code for both short-term and procedural memory.

0. Yes, memory OK

1. Memory problem

Examples of How to Code Memory/Recall Ability

Mr. T was unable to point to the three objects in the room that he had been asked to remember. His wife says that he doesn't seem to remember how to do anything. "He doesn't even seem to know how to put his clothes on anymore; when he did dress himself, he put things on all backwards. It was really strange."

Code:

G2a (Short-term memory OK) = "1".

G2b (Procedural memory OK) = "1".

(continued)

(continued)

Rationale: "Memory problem" is used in this case because Mr. T is not showing evidence of being able to remember the three items. It is not a conclusive observation, but this is a screener item and the absence of a positive response requires that the clinician use the "Memory problem" code. Mrs. T's observation that her husband "can't remember how to do anything" and that he did have trouble with the order of dressing would suggest that he has procedural memory problems.

Mrs. C was able to recall two of three specified words. When asked if she had any problems with doing everyday activities (like laundry) in the proper order, she said she had no problems with activities like that.

Code:

G2a (Short-term memory OK) = "1".

G2b (Procedural memory OK) = "0".

Rationale: Mrs. C was unable to recall all three items; therefore, she does not meet the criterion for "Yes, memory OK". There is no evidence that Mrs. C has procedural memory problems.

G3. Periodic Disordered Thinking or Awareness

NOTE: A comprehensive example for Items G3–G5 is given at the end of this section.

Intent

To record behavioural signs that may indicate that delirium is present. Frequently, delirium (an acute confusional state) is caused by a treatable illness such as an infection or a reaction to medications.

The characteristics of delirium are often manifested behaviourally and therefore can be observed. For example, disordered thinking may be manifested by rambling, irrelevant, or incoherent speech. Other behaviours are described in the definitions that follow.

A recent and perhaps rapid deterioration in cognitive function is likely indicative of delirium, which may be reversible if detected and treated in a timely fashion. Signs of delirium can be easier to detect in a person with intact cognitive function at baseline. When a person has a preexisting cognitive impairment or preexisting behaviours such as restlessness or calling out, detecting signs of delirium is more difficult. Despite this difficulty, it is possible to detect signs of delirium by being attuned to recent changes in the person's usual functioning. For example, a person who is usually noisy or belligerent may suddenly become quiet, lethargic, and inattentive. Conversely, one who is normally quiet and content may suddenly become restless and noisy.

Definitions

G3a. Easily distracted — For example, episodes of difficulty paying attention; person gets sidetracked.

G3b. Episodes of disorganized speech — For example, speech is nonsensical, irrelevant, or rambling from subject to subject; person loses train of thought.

G3c. Mental function varies over the course of the day — Sometimes better, sometimes worse. For example, the person may fluctuate between periods of

being confused and disoriented and periods of being lucid and oriented to time, place, and person.

Process

Ask the person or others who know the person if any of the behaviours have been noticed over the last 3 days. If the response is yes, determine if the behaviour is different from the person's normal functioning.

Coding

Code for the person's behaviour in the last 3 days regardless of what you believe the cause to be, focusing on when the manifested behaviour first occurred and whether it is different from the person's usual pattern.

0. Behaviour not present

1. Behaviour present, consistent with usual functioning

2. Behaviour present, appears different from usual functioning — For example, new onset or worsening; different from a few weeks ago.

G4. Acute Change in Mental Status from Person's Usual Functioning

Intent

To determine if the person has experienced a rapid, unexpected deterioration of his or her mental status, because this can be an indicator of possible delirium.

Definition

Acute change in mental status from person's usual functioning — A rapid, unexpected change in behaviour (for example, increased restlessness, lethargy, is difficult to arouse, altered environmental perception).

Process

Ask the person or others who know the person if there has been a sudden, unexpected change in the person's behaviour. This might include, but is not restricted to, a noticeable increase in restlessness; periods of lethargy or being difficult to arouse; or hallucinations, delusions, or illusions.

Coding

Code for the presence of an acute, sudden change in the person's functioning. Code "**0**" if symptoms are present but the onset was not sudden or unexpected.

0. No

1. Yes

G5. Change in Decision Making as Compared to 90 Days Ago (or since Last Assessment)

Intent

To compare the person's current decision-making ability to that of **90 days ago** (or since the last assessment, if that was less than 90 days ago). The changes may be permanent or temporary, and the cause may be known (for example, psychotropic medication or new pain). If the person is newly admitted to the program, include changes since admission **and** changes during the period prior to admission.

Definition

Change in decision making — Person has demonstrated a change in his or her decision-making ability as compared to **90 days ago**.

Process

Talk to the person, and ask if he or she has noticed a difference in being able to make decisions, or check with others who are familiar with the person to determine if there is a difference now when compared to 90 days ago. To help identify the 90-day

time period, ask the person or others to pinpoint an event that occurred 3 months ago and then relate the person's functioning to that event. For example, if the person visited a family member 3 months ago, ask how able he or she was in making decisions during that trip.

Coding

Code for the person's current decision-making ability as compared to 90 days ago.

0. Improved

1. No change

2. Declined

8. Uncertain

Example of How to Code Periodic Disordered Thinking, Acute Change in Mental Status, Change in Decision Making

Mrs. T reports that her husband has been more restless and more distracted than usual in the last few days. She reports that he seems to have difficulty at meal times; he has been picking at his food as if he doesn't know what to do with a fork. According to Mrs. T, she has been making all the decisions around the house for over a year, and he is "neither better nor worse than he was three months ago."

Code:

G3a (Easily distracted) = "2".

G3b (Disorganized speech) = "0".

G3c (Mental function varies) = "0".

G4 (Acute change in mental status) = "1".

G5 (Change in decision making) = "1".

Rationale: Based on reports from Mrs. T, Mr. T's restlessness, distraction, and apparent uncertainty about how to manage a fork are new behaviours, so G3a and G4 would be coded to reflect these observations. There is no evidence that Mr. T has demonstrated disorganized speech or variation in mental function over the course of the day. Mrs. T confirmed that his decision-making abilities are no different than they were a year ago.

Section H

Functional Status

Mental illness, on its own or with a physical or neurological condition, can compromise the person's ability to perform Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). For example, some mental illnesses or cognitive deficits can limit the person's ability or willingness to initiate or participate in self-care, or constrict his or her understanding of the tasks required to complete Activities of Daily Living (ADLs). As well, a wide range of physical and neurological illnesses can adversely affect physical factors that are important to self-care, such as stamina, muscle tone, balance, and bone strength. Side effects of medications and other treatments can also contribute to a loss of self-sufficiency. In order to maximize the person's strengths and his or her functioning potential, it is important to determine if the person is experiencing any difficulties in performing everyday activities. When assessing ADLs and IADLs, base the assessment on the person's actual performance or capacity to perform the activity, regardless of any cognitive, mental, or physical limitations.

H1. Instrumental Activities of Daily Living (IADL) Self-Performance and Capacity

Intent

To examine the areas of function that are most commonly associated with independent living. Note that ADL function (Item H2) is measured by actual performance (regardless of capacity), but IADL function is measured by **both performance and capacity**.

Definitions

H1a. Meal preparation — How meals are prepared (for example, planning meals, assembling ingredients, cooking, setting out food and utensils). This item should be assessed in terms of the person's ability to put meals together, regardless of the quality or nutritional value of the meal. For example, if the person is able to make cold cereal for breakfast, or put together a cold sandwich and make coffee at lunch, or make toast for dinner without assistance, the person would be scored as independent in meal preparation capacity.

H1b. Ordinary housework — How ordinary work around the house is performed (for example, doing dishes, dusting, making bed, tidying up, laundry).

H1c. Managing finances — How bills are paid, chequebook is balanced, household expenses are budgeted, and credit card account is monitored.

H1d. Managing medications — How medications are managed (for example, remembering to take medicines, opening bottles, taking correct drug dosage, giving injections, applying ointments).

H1e. Phone use — How telephone calls are made or received (with assistive devices such as large numbers on telephone or amplification as needed).

H1f. Shopping — How shopping is performed for food and household items (selecting items, paying money). **This item does not include transportation.**

H1g. Transportation — How the person travels by public transportation (navigating system, paying fare), or drives self (including getting out of house, into/out of vehicles). If the person is capable of arranging for someone to drive him or her from A to B, code **"0"** for "Independent".

Process

Question the person directly about his or her level of involvement in IADLs around the home or in the community in the last 3 days and his or her capacity to perform these activities. You may also talk to family members, if necessary and available. When assessing capacity, you may need to use clinical judgment, which may require speculation (for example, a situation in which a person has never cooked a meal).

Coding

NOTE: Each item has two areas of assessment, one for performance and one for capacity.

Performance — Code for the person's performance over the last 3 days.

Capacity — Code based on the person's presumed ability to carry out the activity. In some cases, this may require speculation on the part of the assessor.

0. Independent — No help, set-up, or supervision needed.

1. Set-up help only — Help is limited to providing or placing an article or device within reach of the person; all other tasks are performed by the person on his or her own.

2. Supervision — Oversight/cueing required.

3. Limited assistance — Help required on some occasions.

4. Extensive assistance — Help required throughout the task, but performs 50% or more of task on own.

5. Maximal assistance — Help required throughout the task, but performs less than 50% of task on own.

6. Total dependence — Full performance of activity during entire period by others.

8. Activity did not occur — During entire period. **NOTE:** You may use this code to score the performance category, but do not use it to score capacity category.

Example of How to Code IADL Self-Performance and Capacity

Mrs. T was asked if her husband participates in anything related to the management of the household, such as making meals, housework, shopping, or taking care of the bills. She said that she had been doing all of this for "a long time now; and he just couldn't do it, even if he had to." She arranges all of their travel and she worries because she doesn't think he could manage to use the phone if he needed to. "I'm doing it all right now." She was then asked about how he manages his medication, and she again reported that she is the one who takes care of it all.

Code:

H1a–f (Performance) = "6".

H1a–f (Capacity) = "6".

Rationale: Mr. T is totally dependent on his wife for IADL (Performance), and if he had to do any one of them, it is unlikely that he could manage on his own (Capacity).

Fred has not prepared a meal in the last 3 days. He said that he could do it on his own if he had to, but why bother, since they get meals ready for him at the group home. He does housework but only when they "get on my case at the group home. I do a good job when I do it. The last time I cleaned my room was a few weeks ago." When asked about managing his money and shopping, he replied, "I take care of all of my own money and no one better touch it. I don't need to buy groceries or anything — they do it for us, but I could if I had to. I did it on my own before I went there. I know how to get bread and milk and stuff — been doing it for years." He reported that he travels around the city by bus or walks and doesn't have any problems with this. When asked about phone use, he responded, "Of course I can use a phone, who doesn't?" Fred is not taking medication at the present time. He admitted that he doesn't like taking meds, and said, "Even when I was taking pills, I didn't always remember to take them like the doc told me."

Performance:	**Rationale:**	**Capacity:**	**Rationale:**
H1a = "6"	Meals are prepared at the home, thus the code would be "full performance of the activity by others".	**H1a = "0"**	If Fred were required to do so, he could likely make meals on his own.
H1b = "8"	Fred has not done housework in the last 2 weeks.	**H1b = "0"**	Fred has the capacity to do housework without help, if necessary.
H1c = "0"	Fred has been managing his finances on his own.	**H1c = "0"**	Fred has the capacity to manage his finances.
H1d = "8"	Fred is not taking medication at this time.	**H1d = "2"**	Fred has a history of noncompliance with medication and it is likely that he would require at least some supervision.
H1e = "0"	Fred requires no help with using the phone.	**H1e = "0"**	Fred is independent with phone use.
H1f = "6"	It has not been necessary for Fred to shop for food or household items as others are doing it for him at this time.	**H1f = "0"**	Fred likely has the capacity to shop on his own.
H1g = "0"	Fred manages to get around with no assistance.	**H1g = "0"**	Fred is fully capable of getting around on his own.

H2. Activities of Daily Living (ADL) Self-Performance

Intent

To record what the person did for him- or herself and how others assisted in the performance of the self-care activities of daily living (ADLs) during the last 3 days.

Definitions

ADL self-performance — Measures based on all episodes of the activity over the last 3 days. The following are the performance-based items.

H2a. Personal hygiene — How the person manages personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, and washing and drying face and hands. **Exclude baths and showers.**

H2b. Locomotion — How the person moves between locations on the same floor (walking or wheeling). If the person uses a wheelchair, this measures self-sufficiency once he or she is in chair.

H2c. Transfer toilet — How the person moves on and off the toilet or commode.

H2d. Toilet use — How the person uses the toilet room (or commode, bedpan, urinal), cleanses him- or herself after toilet use or incontinent episode(s), changes bed pad, manages ostomy or catheter, adjusts clothes. **This item does not include transfer on and off toilet.**

H2e. Eating — How the person eats and drinks (regardless of skill). Includes intake of nourishment by other means (such as tube feeding or total parenteral nutrition).

Set-up help — Assistance characterized by the provision of articles, devices, or preparation necessary for the person's self-performance of an activity. This includes giving or holding out an item the person takes from the helper, if the helper then leaves the person alone to complete the activity. If someone remains nearby to watch over the person, the person is receiving oversight; thus the code would be **"2"** for "Supervision".

The following are a few examples of set-up help. For the personal hygiene item, set-up help might mean providing a washbasin or grooming articles. For locomotion, it might take the form of handing the person a walker or cane. For toilet use, set-up help might be handing the person a bedpan or placing within reach the articles necessary for changing an ostomy appliance. For eating, it might include cutting meat or opening containers at meals, carrying a tray to the table, or giving one food category at a time.

Weight bearing — Persons require varying degrees of physical assistance to complete ADL tasks. A key concept in scoring the degree of assistance is the degree of weight-bearing support provided. When relating to non-upright positions, such support might take the form of a helper holding the full weight of an arm while assisting with putting on a shirt. When relating to standing or walking, such support might mean taking the person's weight by holding him or her under the armpit or allowing the person to lean on the helper's arm. Guiding movements with minimal physical contact and contact guarding with intermittent physical assistance are **not** considered weight bearing.

Process

To describe functioning, the assessor should first get a sense of the episodes in each ADL area over the last 3 days. Determine what the person does for him- or herself and the nature of assistance provided (if any).

When ADL self-performance in an area varies over the last 3 days, identify the three most dependent episodes, that is, the episodes when the person received the greatest care or assistance from others. The summarization that is done to develop the ADL scores (as described below) focuses on the most dependent episodes, providing a picture of the person's need for help from others in managing the ADLs.

- Gather information from multiple sources. For example, from the person, family, staff, and others.
- Ask questions pertaining to all aspects of the ADL activity definitions. For example, when discussing Item H2a, "Personal hygiene", inquire how the person manages washing in the morning, combing hair, brushing teeth, and

shaving. A person can be independent in one aspect of personal hygiene yet require extensive assistance in another aspect.

- Observe how the person is performing the physical tasks.
- Talk with the person to ascertain what he or she does for him- or herself in each ADL as well as the type and level of assistance provided by others.
- If possible, talk with other team members or family members.
- Finally, weigh all responses to come up with a consistent picture of the person's ADL performance for each episode assessed in each area.

Coding

The following are the ADL self-performance coding rules.

If **all** episodes in the last 3 days were performed at the same support level, code the ADL at that level.

Note that regarding the scores **"0"** ("Independent"), **"6"** ("Total dependence"), and **"8"** ("Activity did not occur"), this is the **only** situation in which such a score would apply. In other words, to receive one of these scores, all performance episodes must be at the same level.

Also note that this rule applies when there was only one performance episode during the 3-day period. For example, if over the course of the 3 days the person moved once between locations on the same floor but was bed-bound for the remainder of the time, then the score for Item H2b, "Locomotion", should be based on the single episode when the person moved.

If **any** episodes were at level **"6"** ("Total dependence") **and** other episodes were less dependent, the item should be scored **"5"** ("Maximal assistance").

Otherwise, focus on the three most dependent episodes (or the two most dependent episodes if the ADL was only performed twice). If the most dependent of these episodes would be scored **"1"** ("Independent, set-up help only"), score the item **"1"**. If the most dependent of these episodes would receive a higher score, however, the item should receive the score to match the least dependent of those episodes in the range between **"2"** and **"5"**.

In accordance with these rules and the guidelines that follow, enter the number corresponding to the most correct response.

0. Independent — No physical assistance, set-up, or supervision in any episode.

1. Independent, set-up help only — Article or device provided or placed within reach, no physical assistance or supervision in any episode.

2. Supervision — Oversight/cueing.

3. Limited assistance — Guided manoeuvring of limbs, physical guidance without taking weight.

4. Extensive assistance — Weight-bearing support (including lifting limbs) by one helper where person still performs 50% or more of subtasks.

5. Maximal assistance — Weight-bearing support (including lifting limbs) by two or more helpers, or, weight-bearing support for more than 50% of subtasks.

6. Total dependence — Full performance by others during all episodes.

8. Activity did not occur during entire period — Do not confuse a person's total dependence in an ADL activity (**"6"**) with nonoccurrence of the activity itself (**"8"**). For example, even a person who receives tube feedings and no food or fluids by mouth is engaged in eating (receiving nourishment) and must be evaluated under the eating category for his or her level of assistance in the process. A person who is highly involved in giving him- or herself a tube feeding is not totally dependent and should not be scored **"6"**. In this case, use a lower code, depending on the nature of the help received from others.

Here are general guidelines for recording accurate ADL self-performance.

- The coding scale for ADLs records the person's actual level of involvement in self-care and the type and amount of support actually received during the last 3 days.
- Do not base your assessment on the person's capacity for involvement in self-care, that is, what you believe the person **could** do for him- or herself.
- Do not record the type and level of assistance you think the person **should** be receiving (for example, based on a written plan of care or expectations the family may have). The type and level of assistance actually provided might be quite different from what is indicated in a care plan. Record what is actually happening.
- Engage others who have cared for the person over the last 3 days in discussions regarding the person's ADL functions. Remind these persons that the focus is on the last 3 days only. To clarify your own understanding and observations about each ADL activity (personal hygiene, eating, etc.), ask probing questions, beginning with the general and proceeding to the more specific.

Examples of How to Code ADL Self-Performance

Mrs. T reports that during the last 3 days, she has been doing everything for Mr. T's personal hygiene and toileting, although he does not need help getting off or on the toilet. He walks on his own, and although there is a concern that he will fall again, he walks around without any assistance. He can manage finger foods on his own but when he is using a fork or spoon, she must guide his hand to his mouth; otherwise he does not seem to know what to do. She reports that this has occurred at every meal in the last 3 days.

Code:

H2a (Personal hygiene) = "6".

H2b (Locomotion) = "0".

H2c (Transfer toilet) = "0".

H2d (Toilet use) = "6".

H2e (Eating) = "3".

Rationale: Mr. T is totally dependent on others for his personal hygiene and toilet use, although he can get on and off the toilet himself. He walks on his own. He has required physical guidance from his wife to eat at every meal in the last 3 days.

When asked if she had any problems with managing her personal care, such as grooming, going to the toilet, and eating, Mrs. C reported that she had no problems. The clinician mentioned that Mrs. C did not seem to have any difficulty getting around, and Mrs. C confirmed this.

Code: H2a–e = "0".

H3. Total Hours of Exercise or Physical Activity in Last 3 Days

Intent

To record the person's level of exercise or physical activity over the last 3 days. Moderate exercise or physical activity in connection with activities of everyday life or chosen activities can help keep people fit in many ways. Below a certain threshold of activity, physical functional decline may be accelerated.

It is necessary to understand whether the person is motivated to undertake physical activity, what the person's needs may be, what barriers need to be overcome, and whether health education is needed. Many persons are interested in maintaining health. They usually know that lifestyle practices may be important, but they often need concrete information about how important their own lifestyle is for health maintenance. For example, the person may understand the general importance of exercise and good nutrition but may not be willing or readily able to make changes in his or her lifestyle without some type of support or assistance.

Definition

Exercise or physical activity — Any exercise that involves at least moderate physical activity, such as walking outdoors, swimming, yoga, exercise with machines.

Process

Ask the person (or check with family members) to determine the person's involvement in physical activity in the last 3 days (for example, walking).

Coding

If the accumulated time is between 2 hours and 3 hours, use code **"2"**. Hours of exercise do not have to occur all at once on a given day; they can be accumulated over the course of several instances.

0. None

1. Less than 1 hour

2. 1–2 hours

3. 3–4 hours

4. More than 4 hours

H4. Physical Function Improvement Potential

Intent

To assess the likelihood that the person has the capacity for greater independence and involvement in his or her care. It is important to assess the beliefs of the person, the beliefs of the care professional, and the congruence between the two perspectives with respect to the person's potential for physical improvement.

Definitions

H4a. Person believes he or she is capable of improved performance in physical function — The focus is the person's perception regarding his or her ability to improve in the area of physical functioning.

H4b. Care professional believes person is capable of improved performance in physical function — The focus is the clinician's assessment of the person's capacity to improve his or her physical functioning.

Process

Assess for indications that the person thinks he or she can be more self-sufficient. If appropriate, ask about the person's goals for the next few months. Does the person think that he or she could be more independent or improve in any area of physical functioning?

The care professional is required to make a determination about the person's capacity for improvement in functional performance. Could the person be more

self-sufficient? What is the likelihood that the person will recover or improve physical function with respect to the current disease or condition?

This item can be considered independent of the ADL ratings (Item H2). For example, even if someone is coded as independent in all the listed ADLs, he or she may still have the ability to improve his or her performance in those areas.

Coding

Code for capacity for improvement in physical functioning. Code **"0"** if the person's physical functioning is not compromised and thus improvement is not an issue.

0. No

1. Yes

H5. Change in ADL Status as Compared to 90 Days Ago (or since Last Assessment If Less Than 90 Days Ago)

Intent

To determine whether the person's current ADL status differs from the status of 90 days ago (or since the last assessment, if that was less than 90 days ago).

Process

Ask the person, or others who would be familiar with the person's functioning, if there has been a change in his or her ability to perform ADLs, as compared to **90 days ago**. To help identify the 90-day time period, ask the person or others to pinpoint an event that occurred 3 months ago and then to relate the person's functioning to that event. For example, if the person visited a family member 3 months ago, ask how capable he or she was of activities like eating or walking during that visit.

Coding

Code for the most appropriate category. If there was a change in multiple domains, code for the overall direction of change.

0. Improved

1. No change

2. Declined

8. Uncertain

Examples of How to Code Change in ADL Status as Compared to 90 Days Ago

As Mrs. T was describing the help she provided for her husband, the clinician asked her if she thought her husband had needed more help over the last 3 months in any of the areas discussed. Mrs. T reported that she had noticed a change with his eating, in that she is now doing more than cutting his food, and this has only been happening in the last 2 months.

Code: H5 = "2".

Rationale: Mrs. T is doing more for her husband now than she was 3 months ago, which would indicate that his ADL status has declined.

Mrs. C is not having any difficulty with ADL activities.

Code: H5 = "1".

Rationale: Since there have been no difficulties, and thus no decline, the "No change" option applies.

Section I

Communication and Vision

Difficulties in communicating with others can isolate a person, make it difficult for him or her to provide information about his or her physical or psychological state or conditions, or interfere with his or her understanding of instructions. There are many possible factors that affect communication, such as the aging process; drug-related side effects; and physical, neurological, and psychiatric disorders. In some situations, there can be more than one contributing factor. For example, a person might have aphasia as well as long-standing hearing loss; or dementia with word-finding difficulties and hearing loss. In addition, psychotic symptoms (such as auditory hallucinations) and environmental factors (such as excessive noise), either alone or in combination, can inhibit effective communication. The extent of these problems should be determined, and reduction of the impact should be an early goal of any care plan.

I1. Making Self Understood (Expression)

Intent

To document the person's ability to communicate, whether verbal or nonverbal, during the last 3 days.

Definition

Making self understood — The ability to communicate information content, whether verbal or nonverbal, with communication devices, if needed. This includes expressing or communicating requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these (including the use of a word board or keyboard). Deficits in the ability to make oneself understood (expressive communication deficits) can include reduced voice volume and difficulty in producing sounds, or trouble finding the right words and making sentences.

Process

Interact with the person. Observe and listen to his or her efforts to communicate with you. If he or she has communication devices, encourage their use. Observe the person's interactions with others in different settings (for example, one-on-one, in groups) and different circumstances (for example, when calm, when agitated). Note that this item is not intended to address differences in language understanding, such as only speaking in a language not familiar to the assessor.

Coding

Enter the code that most closely corresponds to the person's ability to make him- or herself understood over the last 3 days.

0. **Understood** — Person expresses ideas clearly without difficulty.
1. **Usually understood** — Person has difficulty finding the right words or finishing thoughts (resulting in delayed responses), **but** if given time requires little or no prompting.
2. **Often understood** — Person has difficulty finding words or finishing thoughts, and prompting is usually required.

3. **Sometimes understood** — Person has limited ability but is able to make concrete requests regarding at least basic needs (such as food, drink, sleep, toilet).
4. **Rarely or never understood** — At best, understanding is limited to interpretation of highly individual, person-specific sounds or body language (for example, others have learned to interpret the person's signalling the presence of pain or need to use the toilet).

Example of How to Code Making Self Understood

Mr. T does not carry on a conversation and can only make simple requests such as asking for a drink or to go to bed.

Code: I1 = "3".

Rationale: Mr. T is only able to make simple, concrete requests.

I2. Ability to Understand Others (Comprehension)

Intent

To describe the person's ability to comprehend verbal information, whether communicated to the person orally, in writing, or through sign language or Braille. This item measures the person's ability not only to hear messages but also to process and understand language.

Definition

Ability to understand others — Person's ability to understand verbal content in whatever manner. It includes the use of a hearing appliance, if needed. This item should not test whether the problem is in understanding a particular language, such as when the person's primary language is different than that normally used by others.

Process

As you interact with the person, you will be able to determine if he or she is able to understand you. If there is some difficulty, pay attention to the amount of clarification or repetition the person requires to process and understand what is being said, and ask the person if he or she sometimes has difficulty understanding or hearing what others are saying. If the information is being provided by someone other than the identified person (for example, a family member), ask the informant if the person in question has any difficulty with understanding information.

Coding

Enter the number corresponding to the most correct response.

0. **Understands** — Clearly comprehends the speaker's message and demonstrates comprehension by words or actions/behaviours.
1. **Usually understands** — With little or no prompting, the person misses some part or intent of the message but comprehends most of it. The person may have periodic difficulties integrating information but generally demonstrates comprehension by responding in words or actions.
2. **Often understands** — Person misses some part or intent of the message. However, with prompting (repetition or more detailed explanation), the person often comprehends the conversation.
3. **Sometimes understands** — Person demonstrates frequent difficulties integrating information, and responds adequately only to simple and direct questions or

directions. When the message is rephrased or simplified or gestures are used, the person's comprehension is enhanced.

4. **Rarely or never understands** — Person demonstrates very limited ability to understand communication, or the assessor cannot determine whether the person comprehends messages, based on his or her verbal and nonverbal responses. Includes situations where the person can hear sounds but does not understand messages.

I3. Hearing

Intent

To evaluate the person's ability to hear (with environmental adjustments, if necessary) during the past 3-day period.

Definition

Hearing — Ability to receive audible sounds, with hearing appliance if normally used.

Process

Evaluate hearing ability after the person has an adaptive hearing device/aid/appliance in place (if the person uses an appliance). Be sure to ask if the battery works and if the hearing aid is on.

Ask the person about hearing function, and observe for hearing function during your verbal interactions. Use a variety of observations to make your assessment (for example, one-on-one vs. in group situations). If possible, observe the person interacting with others (such as family members). Always be mindful of environmental factors (nearby conversations, outside noises) that could influence your assessment. If necessary, consult with the family or with speech or hearing specialists to clarify the person's exact hearing level.

Be alert to what you have to do to communicate with the person. Clues that indicate there is a hearing problem include having to speak more clearly or slowly or using a louder tone or more gestures. Persons with hearing problems may also need to see your face to know what you are saying, or you may have to take the person to a more quiet area to conduct the interview.

Coding

Enter the code that corresponds to the most correct response.

0. **Adequate** — No difficulty in normal conversation, social interaction, listening to TV.
1. **Minimal difficulty** — Difficulty in some environments (for example, when another person speaks softly or is more than 2 metres [6 feet] away).
2. **Moderate difficulty** — Problem hearing normal conversation, requires quiet setting to hear well.
3. **Severe difficulty** — Difficulty in all situations (for example, speaker has to talk loudly or speak very slowly, or person reports that all speech is mumbled).
4. **No hearing**

Example of How to Code Hearing

When trying to get Mr. T's attention, the clinician noted that she had to raise her voice. Mrs. T confirmed this observation and said that he seems to hear better if the room is quiet and the person speaks slowly and louder than normal.

Code: I3 = "3".

Rationale: Mr. T requires a quiet setting (code **"2"**), but it is also necessary for the speaker to speak louder and slower; thus the higher code (code **"3"**) applies.

I4. Vision

Intent

To evaluate the person's ability to see close objects in adequate light, using the person's customary visual appliances for close vision (such as glasses or a magnifying glass).

Definition

Adequate lighting — Sufficient or comfortable lighting for a person with normal vision.

Process

Ask the person or family member if the person has manifested any changes in usual vision patterns over the last 3 days, for example, is the person still able to read newsprint, greeting cards, and the like? Ask the person about his or her visual abilities. Test the accuracy of your findings by asking the person to look at regular-size print in a book or newspaper with whatever visual appliance he or she customarily uses for close vision (such as glasses or a magnifying glass). Then ask the person to read aloud, starting with larger headlines and ending with the finest, smallest print.

Be sensitive to the fact that some persons are either not literate or are unable to read English. In such cases, ask the person to read aloud individual letters or numbers (such as dates or page numbers) or to name items in small pictures.

If the person is unable to communicate or follow your directions for testing vision, observe the person's eye movements to see if his or her eyes seem to follow movements and objects. Although these are gross measurements of visual acuity, they may assist in assessing whether the person has any visual ability.

Coding

Enter the number corresponding to the most correct response.

0. Adequate — Person sees fine detail, including regular print in newspapers/books.

1. Minimal difficulty — Person sees large print but not regular print in newspapers/books.

2. Moderate difficulty — Person has limited vision; is not able to see newspaper headlines but can identify objects in his or her environment.

3. Severe difficulty — Person's ability to identify objects in his or her environment is in question, but the person's eyes appear to be following objects (especially persons walking by). Also include the ability to see only light, colours, or shapes.

Note that many persons with severe cognitive impairment or other psychological problems are unable to participate in vision screening because they are unable to follow directions or are unable to tell you what they see. However, many such persons appear to track or follow moving objects in their environment with their eyes. For persons who appear to do this, code **"3"** for "Severe

difficulty". This is often the best assessment you can do with the technology or resources available at your setting.

4. **No vision** — Person has no vision; eyes do not appear to follow objects (especially persons walking by).

Example of How to Code Vision

When asked about any difficulty with seeing, Mrs. C reported that she wears her glasses all the time because she has problems with reading if she doesn't.

Code: I4 = "0".

Rationale: Although Mrs. C wears her glasses all the time, the assessment would be that she is able to see without problems because of her corrective lenses.

Section J

Health Conditions

While psychological problems are the primary focus of community mental health services, physical health conditions also should be addressed because they can have an effect on the trajectory of the mental illness and the options for care, or they may reflect potential drug-related side effects.

J1. Self-Reported Health

Intent

To evaluate the person's perception of his or her physical health.

Definition

Self-reported health — Person's perception of his or her physical health status over the last 3 days. Do not include perceptions of his or her mental health.

Process

Ask the person, "In general, how would you rate your health?" Do not code based on your own inferences about the person's physical health, and do not record ratings given by family, friends, or other informants. This item should be treated strictly as a self-report measure. If the person is unable to respond (for example, because of cognitive impairment) or refuses to respond, do not dwell on the item, and do not presume responses for the person; instead, code that the person could not/would not respond.

Coding

Record the person's response according to one of the following categories.

0. Excellent

1. Good

2. Fair

3. Poor

8. Could not (would not) respond

Examples of How to Code Self-Reported Health

Mrs. T thinks her husband is in poor health; Mr. T is unable to respond to a question about his health status.

Code: J1 = "8".

Rationale: This is a self-report item. Mr. T is unable to understand or provide a comment on his perception of his health, so "Could not (would not) respond" applies.

Although Mrs. C has some health problems, she responded to the question about her health by saying: "I'd say that I'm in good health, considering everything."

Code: J1 = "1".

Rationale: Since this is the person's own perception, it is coded according to her response.

J2. Problem Frequency

NOTE: A comprehensive example for Items J2–J4 is given after discussion of J4.

Intent

To record the presence and frequency of specific problems or symptoms that affect or could affect the person's health or functional status, and to identify risk factors for illness, accident, and functional decline. Record all problems observed or reported (regardless of cause, whether known or not), even though some of these problems may be related to medication side effects.

Definitions

Balance

J2a. Dizziness — Person experiences a sensation of unsteadiness, that he or she is turning, or that the surroundings are whirling around.

J2b. Unsteady gait — A gait that places the person at risk of falling. Unsteady gaits take many forms. The person may appear unbalanced or walk with a sway. Other gaits may have uncoordinated or jerky movements. Examples of unsteady gaits include fast gaits with large, careless movements; abnormally slow gaits with small, shuffling steps; or wide-based gaits with halting, tentative steps.

Cardiac

J2c. Chest pain — Any type of pain in the chest area, which the person may describe as burning, pressure, stabbing, vague discomfort, and so on.

GI Status

J2d. Acid reflux — Regurgitation of small amounts of acid from the stomach to the throat.

J2e. Constipation — No bowel movement in 3 days, or difficult passage of hard stool.

J2f. Diarrhea — Frequent elimination of watery stools, regardless of cause.

J2g. Dry mouth — A decrease in or lack of saliva (xerostomia).

J2h. Hypersalivation or drooling — Excessive production of or insufficient swallowing/clearing of saliva such that the saliva escapes from the mouth.

J2i. Increase or decrease in normal appetite — Change in normal appetite for any reason.

J2j. Nausea — Unpleasant sensation usually preceding vomiting.

J2k. Vomiting — Regurgitation of stomach contents, regardless of etiology (for example, drug toxicity, influenza, psychogenic).

Other

J2l. Blurred vision — Subjective reporting that vision is blurred, hazy, or unclear.

J2m. Daytime drowsiness or sedation — Person looks drowsy or appears to be sedated.

J2n. Difficulty urinating, urinating 3 or more times a night, or polyuria — Includes inability to void, difficulty starting stream, pain on voiding, or frequent voiding.

J2o. Emergent conditions — Signs and symptoms not otherwise listed that would indicate a developing condition (for example, fever, rash, itching, diaphoresis, frank bleeding, coffee-ground emesis, tarry stools).

J2p. Headache — Any type of headache (for example, migraine, tension).

J2q. Peripheral edema — Person has an abnormal buildup of fluid in foot/ankle/leg tissues.

J2r. Seizures — Disorders of cerebral function that are characterized by sudden episodes of altered consciousness, sensory changes, motor activity, or inappropriate behaviour. May be focal (localized) or generalized.

Process

Ask the person. He or she may not have told others of his or her symptoms. If the person is unable to respond, review available clinical records and consult with the person's family. Remember to code for both the presence of the indicator and the number of days in which it was exhibited, no matter how often it was exhibited per day.

Coding

Code for presence of the problem in last 3 days.

0. Not present

1. Present but not exhibited in last 3 days — Use this code if you know the condition is **present** and **active**, even though it was not observed in the last 3 days.

2. Exhibited on 1 of last 3 days

3. Exhibited on 2 of last 3 days

4. Exhibited daily in last 3 days

J3. Dyspnea (Shortness of Breath)

Intent

To document the presence of shortness of breath and the circumstances leading to dyspnea.

Definition

Dyspnea — Person has reported being, or has been observed to be, breathless or "short of breath."

Process

Ask the person if he or she has experienced shortness of breath. If the answer is affirmative, determine if the symptom occurred with strenuous activity, during normal day-to-day activity, or when resting. If the person is unable to respond, review the clinical record, and consult with clinicians and the person's family.

Coding

Select the appropriate code from the list below. Code for the most severe occurrence during the last 3 days. If the symptom was absent over the last 3 days but would have been present if the person had undertaken activity, code according to the activity level (day-to-day or moderate) that would normally have caused the person to experience shortness of breath.

"Moderate activities" include some type of physical exercise, such as walking a long distance, climbing two flights of stairs, or gardening. "Normal day-to-day activities" include all ADLs (bathing, transferring, dressing, etc.) and IADLs (meal preparation, shopping, etc.).

0. Absence of symptom

1. Absent at rest, but present when performed moderate activities

2. Absent at rest, but present when performed normal day-to-day activities

3. Present at rest

J4. Fatigue

Intent

To describe gradations of fatigue or impaired stamina. Fatigue is associated with some mental health problems, chronic diseases, and end-stage conditions.

Definitions

Fatigue — An overwhelming or sustained sense of exhaustion resulting in decreased capacity for physical or mental work.

Normal day-to-day activities — These include all ADLs (bathing, transferring, dressing, etc.) and IADLs (meal preparation, shopping, etc.).

Process

Ask the person if he or she has felt fatigued or tired lately. If the answer is affirmative, determine the degree to which the fatigue interferes with the person's ability to initiate or complete normal day-to-day activities (ADLs, IADLs). If the person is unable to respond, review the clinical record, and consult with the person's family.

Coding

Select the appropriate code from the list below. If fatigue was absent over the last 3 days but would have been present if the person had undertaken activity, code according to the activity level that would normally have caused the person to experience fatigue.

0. None

1. **Minimal** — Diminished energy but completes normal day-to-day activities.
2. **Moderate** — Due to diminished energy, **unable to finish** normal day-to-day activities.
3. **Severe** — Due to diminished energy, **unable to start some** normal day-to-day activities.
4. **Unable to commence any normal day-to-day activities** — Due to diminished energy.

Example of How to Code Problem Frequency, Dyspnea, Fatigue

Orlando was asked if he had had a problem with any of the listed conditions over the last 3 days, or if not in the last 3 days, if there had been some condition that he had been concerned about. He reported that yesterday he had a headache with some nausea but no vomiting, but these symptoms lasted only for about 4 or 5 hours. He did not have a fever or any other symptom that might suggest the beginning of the flu or other acute illness. He had not had any other problems over the last 3 days, and although he reported that he did have problems with his appetite, diarrhea, and fatigue when he was in detox, he is now feeling better physically than he has in a very long time. He denied any difficulty with shortness of breath or fatigue.

Code:

J2j (Nausea) = "2".

J2p (Headache) = "2".

All other J2 items and J3, J4 = "0".

Rationale: Orlando reported experiencing only two of the symptoms in the last 3 days and only on 1 day, thus "Exhibited on 1 of last 3 days" applies to each. While he reported having had some of the other symptoms in the past, they are no longer of concern and would therefore be coded **"0"**.

J5. Extrapyramidal Symptoms during the Last 3 Days

Intent

Extrapyramidal side effects are commonly seen with the administration of neuroleptic medication. These side effects can be very distressing to the person and his or her family and can be the primary reason for a person to discontinue medication use after discharge from hospital. Recognizing these symptoms early and treating them at onset can improve compliance with treatment.

Definitions

J5a. Akathisia — An extremely unpleasant, if not intolerable, state of motor restlessness, usually felt in the lower extremities. The person may complain of inner restlessness, which should not be confused with restlessness due to anxiety or agitation. The feeling is usually constant, and the person finds it difficult, if not impossible, to stop moving.

J5b. Dyskinesia — Involuntary movements that appear to have no apparent purpose (often observed in the face, lips, tongue, jaw, upper or lower extremities), or rocking or writhing of the trunk.

J5c. Tremor — Involuntary rhythmic movement of the fingers, limbs, head, mouth, or tongue.

J5d. Bradykinesia — A decrease in spontaneous movements, such as reduced body movement or poverty of facial expression, gestures, or speech.

J5e. Rigidity — Resistance to flexion and extension of muscles; increased resting tension of muscles, sometimes called "lead pipe." There is often an overlying "ratcheting" movement (known as cogwheeling) when the joint is passively flexed.

J5f. Dystonia — A long-lasting contraction or spasm in any muscle of the body (muscle hypertonicity), for example, muscle spasms or stiffness, protruding tongue, upward deviation of the eyes. These reactions usually occur 12 to 36 hours after a person is started on a neuroleptic medication. They are sudden and very frightening.

J5g. Slow shuffling gait — Reduction in speed and stride length of gait; person takes slow steps and moves feet in a shuffling manner, usually accompanied by a decrease in pendular arm movement.

Process

Ask and observe the person, and consult other team members, family members, and the clinical record, if available. Code if the symptom is present, whether or not the person is taking psychoactive medication.

Coding

Code for presence of the symptom during the last 3 days.

0. No

1. Yes

Example of How to Code Extrapyramidal Symptoms

Fred reports that he has a "feeling of restlessness where I just can't seem to sit still; no matter how hard I try, my legs just keep moving. A nurse once told me it was likely because of the medication I was on." Fred also has a shuffling walk. When asked about this, he said that he has walked like that for a long time and "It doesn't bother me, except people make fun of me." When the other symptoms were reviewed, Fred said that he did have some stiffness in his joints last year: "The doctor checked it out — you know, she bent my elbow and moved my wrist around — she said I was stiff and called it some fancy name. I don't have it anymore, though." The interviewer checked Fred for cogwheel rigidity; there was no resistance.

Code:

J5a (Akathisia) = "1".

J5g (Slow shuffling gait) = "1".

All other items = "0".

Rationale: Fred is demonstrating akathisia and a shuffling gait. Although he likely had some cogwheeling previously, there is no evidence to suggest this is still a problem; therefore this item would be coded **"0"** for "No" because it did not occur during the 3-day time frame.

J6. Sexual Activity

Intent

To identify (1) any sexual activity that indicates a need for sex education, (2) those who may be at risk for sexually transmitted disease, an unwanted pregnancy, or sexual exploitation, and (3) any sexual dysfunction the person may be experiencing.

Definitions

Performed sexual acts for money, desired objects or favours (includes participation in sex trade) in last 90 days — Includes any act that is normally considered to be sexual in nature and provided in exchange for money, desired objects, or favours.

Reports persistent difficulty with sexual functioning during the last 30 days — Any sexual problem the person may be experiencing, such as loss of interest or drive, impaired erection or impaired ejaculation, or inhibited female orgasm.

Process

This item provides a context in which to investigate the person's sexual activity. Discussing sexual activity is a sensitive matter, so ensure that the discussion is held in private and in a delicate way. It is often a relief to the person who is experiencing sexual functioning difficulty to have the subject approached. Discussing this within the context of health conditions gives the person an opening to report concerns. Ask the person if he or she is sexually active. There are a number of ways to approach the subject. You may want to begin by acknowledging that discussing sexual activity makes some persons uncomfortable, but it is important to know if there is a problem so that effective treatment planning can occur. You can also point out that some medications can cause side effects related to sexual functioning. If the person is not taking medication, you could point out that it is important that all areas of health be reviewed, including sexual functioning. If the person is sexually active, ask if there have been any problems in the **last 30 days**, such as difficulty maintaining an erection, pain during intercourse, or lack of interest.

When appropriate, pursue the topic to determine if there has been any trading of favours. Information about sexual activity may also be obtained from other care providers or family and friends who know the person well. For example, while the person may refuse to discuss or not be forthcoming about his or her sexual activity, it may be known by others that the person has been performing sexual favours as a trade for objects such as cigarettes.

Coding

Code for each item. Note that Item J6a is to be assessed based on a 90-day time frame and Item J6b is to be assessed based on a 30-day time frame.

0. No

1. Yes

J7. Skin Problems

Intent

To document the presence of any skin conditions present during the last 3 days. Those who have a history of homelessness may be particularly vulnerable to skin problems. As well, skin conditions can be a side effect of some psychotropic medications.

Definitions

J7a. Major skin problems — For example, lesions, second- or third-degree burns, and healing surgical wounds.

J7b. Other skin conditions or changes in skin condition — For example, bruises, rashes, itching, mottling, herpes zoster, intertrigo, eczema.

Process

Ask the person if he or she has any bothersome skin problems. If the response is affirmative, ask to see the affected area and code using the appropriate item. If available, the clinical record may also contain information about skin problems. If necessary, check with a family member or care provider who has knowledge of the person's skin condition.

Coding

For each item, code for skin problems present during the last 3 days.

0. No

1. Yes

J8. Foot Problems

Intent

To determine whether foot problems are present and, if so, whether the problems are interfering with the person's ability to walk.

Definition

Foot problems — Includes corns, calluses, infections, fungi, cuts, blisters, ulcers, fissures, swollen feet, cuts that do not heal, rashes, and structural problems (such as hammertoes, absence of nails, and bunions).

Process

Ask the person if he or she has any foot problems. If the response is affirmative, ask if the problem is affecting his or her ability to walk, and about the nature of the difficulty. The clinical record may also contain information about foot problems. If necessary, check with a family member or other care provider.

Coding

Code for the presence of foot problems during the last 3 days.

0. **No foot problems** — No foot problems are present.
1. **Foot problems, no limitation in walking** — Foot problems are present, but the person does not experience problems when walking.
2. **Foot problems limit walking** — Foot problems are present, and they interfere with but do not preclude the person's ability to walk.
3. **Foot problems prevent walking** — Person is unable to walk because of foot problems.
4. **Foot problems, does not walk for other reasons** — Person has foot problems and is not walking; however, the reason the person is not walking is not related to the foot problems.

J9. Falls

Intent

To document whether the person fell in the **last 90 days** and the number of falls the person sustained in the **last 30 days**. Persons who have had at least one fall are at increased risk for future falls. Falls can be a side effect of some medications that are used to treat psychiatric conditions.

Definition

Fall — Any unintentional change in position where the person ends up on the floor, ground, or other lower level; include falls that occur while being assisted by others.

Process

Ask the person if he or she has had any falls in the last 90 days. Also, check with other care providers and family and, if available, review the clinical record for information about the number and timing of falls. (Only the number of falls that occurred in the last 30 days is required.)

Coding

Select the appropriate code.

0. **No fall in last 90 days**
1. **No fall in last 30 days, but fell 31–90 days ago**
2. **One fall in last 30 days**
3. **Two or more falls in last 30 days**

Example of How to Code Falls

Cathy reports that she tripped over a curb and fell when she was going home from a bar with friends about 2 months ago. She only scratched her knee.

Code: J9 = "1".

Rationale: Cathy's fall was not within the last month but was within the last 90 days.

J10. Recent Falls

NOTE: If the person was last assessed more than 30 days ago, or if this is the person's first assessment, skip this item and proceed to Item J11.

Intent

To determine if the person has a recent history of falling.

Definition

Fall — Any unintentional change in position where the person ends up on the floor, ground, or other lower level; includes falls that occur while being assisted by others.

Process

This item is asked at follow-up assessment only, and then only if less than 30 days have passed since the last assessment. Determine if the person has experienced a fall that occurred between the Assessment Reference Date of this assessment and the Assessment Reference Date of the last assessment **if less than 30 days** have passed between the two assessments.

Coding

If this is the first assessment, or if more than 30 days have passed since the last assessment, simply leave this item blank.

If this is a follow-up assessment, with less than 30 days since the last assessment, code for the occurrence of one or more falls since the last assessment.

0. No

1. Yes

[blank] Not applicable (first assessment, or more than 30 days since last assessment)

J11. Pain Symptoms

NOTE: Always ask the person about frequency, intensity, and control of the pain. Observe the person and ask others who are in contact with the person.

Intent

To record the frequency and intensity of any pain the person may be experiencing. This item can be used to identify indicators of pain as well as to monitor the person's response to pain management interventions.

Definition

Pain — An "unpleasant sensory and emotional experience" that is generally associated with actual or potential tissue damage.

Process

Pain is highly subjective. It is what the person says it is. There are no objective markers or tests to indicate when someone is having pain, or to measure its severity. What a person experiences may not be proportional to the type or extent of the underlying tissue damage. Sometimes a specific cause for chronic pain cannot be identified. Regardless, unless the person refuses, pain must always be treated, even if its cause is unknown.

The most accurate and reliable evidence of the existence of pain and its intensity is what the person tells you. Even in cognitively impaired persons, self-reports of pain should be considered reliable.

However, you may not get an accurate answer if you simply ask "Are you in pain?" A person may think of pain as a more intense experience that occurs after an acute event, such as what may be experienced after surgery or spraining an ankle. For example, a woman may have a sore foot that "acts up" when she gets out of bed or in and out of the bathtub but that does not bother her most of the time. So she might deny being in pain. Persons often use different words in describing pain, referring to what they are feeling as "discomfort," "burning," "hurting," "aching," "tightness," "heaviness," "soreness," or a "twinge" or "pang."

If the person states he or she has pain, ask about the degree of control. If the person is unable to tell you if he or she is experiencing some type of painful sensation, observe the person for indicators of pain such as moaning, wincing, or guarding. In some persons, the presence of pain can be hard to discern. For example, persons with dementia may not be able to verbalize that they are feeling pain, although they may manifest pain by particular behaviours such as calling out. Although such

behaviours may not be indicative solely of pain, the assessor needs to make a determination (through assessment) if the behaviours are secondary to pain. If necessary, ask those who have had frequent contact with the person whether he or she complained or showed evidence of pain in the last 3 days. However, the person must **first** be asked directly about frequency and intensity.

J11a. Frequency with which person complains or shows evidence of pain

Measures how often the person experiences pain (reports or shows evidence of pain); includes grimacing, teeth clenching, moaning, withdrawal when touched, and other nonverbal signs suggesting pain. If the person has not demonstrated any pain in the last 3 days because of an effective pain management regimen, the minimum value for pain frequency should be **"1"**.

Coding

0. No pain

1. Present but not exhibited in last 3 days

2. Exhibited on 1–2 of last 3 days

3. Exhibited daily in last 3 days

NOTE: For each of the following items (J11b–J11d), code for the pain the person has experienced in the last 3 days even while receiving treatments.

J11b. Intensity of highest level of pain present

Measures the level of pain as the person perceives it (as described or manifested by the person). Use the following scale to indicate the level of pain experienced. Code for the highest level of pain present.

Coding

0. No pain

1. Mild

2. Moderate

3. Severe

4. Times when pain is horrible or excruciating

J11c. Consistency of pain

Measures the frequency (ebb and flow) of pain from the person's perspective.

Coding

0. No pain

1. Single episode during last 3 days

2. Intermittent

3. Constant

J11d. Pain control

The ability of the current therapeutic regimen to control the person's pain adequately (from the person's point of view). This item describes the adequacy or inadequacy of pain control measures (such as medications, massage, TENS, or

other therapeutic regimen) instituted by the person, caregiver, or clinical staff caring for the person.

Coding

0. No issue of pain

1. Pain intensity acceptable to person; no treatment regimen or change in regimen required

2. Controlled adequately by therapeutic regimen

3. Controlled when therapeutic regimen followed, but not always followed as ordered

4. Therapeutic regimen followed, but pain control not adequate

5. No therapeutic regimen being followed for pain; pain not adequately controlled

Examples of How to Code Pain Symptoms

Fred reports that he has been having horrible cramps in his legs every night during the past week. He reports that he is not getting much sleep, is only resting at night, and feels tired upon arising. He has not been taking any pain medication.

Code:

J11a (Frequency of pain) = "3".

J11b (Intensity of pain) = "4".

J11c (Consistency of pain) = "2".

J11d (Pain control) = "5".

Rationale: Best clinical judgment for coding this screening item for pain would be to record codes that reflect what Fred reports.

Mrs. C reports that she has "arthritic" pain in her hands that "comes and goes." Although she has not noticed any discomfort in the last 3 days, she admits there were times last week when she could barely manage to do anything with her hands. She takes medication for arthritis regularly, and she is not wanting a change in medication at this point.

Code:

J11a (Frequency of pain) = "1".

J11b (Intensity of pain) = "0".

J11c (Consistency of pain) = "0".

J11d (Pain control) = "2".

Rationale: Mrs. C has experienced pain within the last week but not over the last 3 days; thus, code **"1"** applies. Pain intensity, consistency, and control are to be assessed based only on the last 3 days. Mrs. C did not have pain during that time frame; thus the "No pain" and "No issue of pain" responses apply. Her medication is adequately controlling her pain at this time and she is not wanting a change, so J11d is coded as **"2"**.

J12. Bladder Continence

Intent

To determine and record the person's pattern of bladder continence (control) over the last 3 days.

Definition

Bladder continence — Person's bladder continence pattern, taking into account any control plans or devices, such as scheduled toileting plans, continence training programs, or urinary appliances. It does not refer to the person's ability to toilet him- or herself — for example, a person may require extensive assistance in toileting and still be continent. Bladder incontinence includes any dribbling or wetting of urine.

Process

Review the person's urinary elimination pattern with him or her. Make sure that the discussion is held in private. Control of bladder function is a sensitive subject, particularly for persons who are struggling to maintain control. Many persons with poor control will try to hide their problems out of embarrassment or fear of retribution or institutionalization. Others will not report problems because they mistakenly believe that incontinence is a natural part of aging or certain disease processes and that nothing can be done to reverse the problem. Despite these common reactions to incontinence, many persons are relieved when a health care professional shows enough concern to ask about the nature of the problem in a sensitive, straightforward manner.

If necessary, validate continence patterns with others who know the person well (such as family members).

Remember to consider continence patterns over the last 3-day period, 24 hours a day, including weekends.

Coding

A six-level coding scale is used to describe continence patterns. Choose one response to code the person's level of urinary continence over the last 3 days.

Code for the actual bladder continence pattern with urinary device if used. This pattern is the frequency with which the person was wet during the 3-day assessment period. Do not record the level of control that the person **might** have had under optimal circumstances (for example, if a caregiver had been available 24 hours a day to help the person with toileting).

If you are uncertain whether to use code **"4"** for "Frequently incontinent" or code **"5"** for "Incontinent", decide based on the presence (**"4"**) or absence (**"5"**) of any bladder control.

0. Continent — Complete control, including control achieved by cueing or supervision that involves prompted voiding, habit training, and reminders. The person **does not use** any type of catheter or other urinary collection device.

1. Complete control with any catheter or ostomy — Control with use of any type of catheter or urinary collection device.

2. Infrequently incontinent — Not incontinent over last 3 days but does have incontinent episodes (that is, a recent history of incontinence).

3. Occasionally incontinent — Less than daily episodes of bladder incontinence (incontinent on 1–2 of last 3 days).

4. Frequently incontinent — Incontinent daily, but some control is present (the person is not incontinent during each episode of urination). Example: During the day, the person remains dry and is continent of urine. At night, the person wets the bed.

5. Incontinent — No control of bladder; multiple daily episodes all or almost all of the time.

8. Did not occur — No urine output from bladder in last 3 days.

Example of How to Code Bladder Continence

Mrs. C reports that she has noticed an increase in the amount and frequency of "dribbling" over the past few years. She reluctantly admits that though she does have control most of the time, this is a daily problem for her.

Code: J12 = "4".

Rationale: Although Mrs. C complains only of "dribbling," this is still considered incontinence. Because it occurs daily and her "dribbling" means that she is able to control her bladder at least partially, code **"4"** applies.

J13. Bowel Continence

Intent

To determine and record the person's pattern of bowel continence (control) over the last 3 days.

Definition

Bowel continence — Refers to control of the person's bowel movements. This item describes the person's bowel continence pattern with any scheduled toileting plans, continence training programs, or appliances in use. It does not refer to the person's ability to toilet him- or herself — for example, a person can require extensive assistance in toileting and be continent of stool.

Process

The assessment for bowel continence should be completed concurrently with the bladder continence review. Control of bowel function is also a sensitive issue. Be sure to ask about the matter in a sensitive, straightforward manner. If necessary, validate continence patterns with others who know the person (for example, a family member). Remember to consider continence patterns over the **last 3 days, 24 hours a day.**

Coding

Code for bowel continence over the last 3 days. Continence with a bowel device is coded **"1"**. Code **"0"** is reserved for continence without any device. If the person's ostomy leaks, use code **"2"**, **"3"**, **"4"**, or **"5"** to code the frequency of the leaking.

0. Continent — Complete control; **does not use** any type of ostomy device.

1. Complete control with ostomy — Control with ostomy device over last 3 days.

2. Infrequently incontinent — Not incontinent over last 3 days, but does have incontinent episodes.

3. Occasionally incontinent — Incontinent less than daily.

4. Frequently incontinent — Incontinent daily, but person has some control.

5. Incontinent — No control present.

8. Did not occur — No bowel movement in last 3 days.

Example of How to Code Bowel Continence

Mrs. C reports that she has no difficulty with bowel control.

Code: J13 = "0".

Section K

Stress and Trauma

A person's physical and emotional state of well-being can be affected by life events. This section provides a review of major events that may cause a disruption in the person's ability to cope effectively.

K1. Life Events

NOTE: A comprehensive example for Items K1 and K2 is given after discussion of K2.

Intent

To identify specific life events or changes that may affect the person's well-being.

Definitions

Life events — Objective experiences that either disrupt or threaten to disrupt a person's current daily routine and that impose some degree of readjustment.

K1a. Serious accident or physical impairment — Includes any serious accident or physical impairment sustained by the person, regardless of cause. Mental illness is not included in this definition.

K1b. Distressed about health of another person — Person worries about someone within his or her social network who has significant ongoing health problems, who was recently diagnosed with a major illness (including mental health illness), or who has experienced a serious accident.

K1c. Death of close family member or friend — Person has experienced the death of someone he or she considers a close family member or friend.

K1d. Child custody issues; birth or adoption of child — Person has been involved in a child custody dispute, has given birth to or fathered a child, or has adopted a child.

K1e. Conflict-laden or severed relationship, including divorce — Person is experiencing ongoing conflict as part of a significant relationship.

K1f. Failed or dropped out of education program — Person has either been unsuccessful in completing or has failed an education program.

K1g. Major loss of income or serious economic hardship due to poverty — Any loss of income resulting in the need to significantly change his or her standard of living to the point where he or she may have to sell the house, car, or any property. This includes those at all income levels, whether or not they would be considered to be poor **after** the income loss.

K1h. Review hearing — For example, forensic, certification, capacity hearing. Person has gone through a review hearing (an appeal of certification, forensic review, assessment of capacity to give consent), regardless of the outcome.

K1i. Immigration, including refugee status — Person immigrated to this country; this includes those with refugee or landed immigrant (permanent resident) status.

- This category would include a Canadian-born person who left to live in another country for a prolonged period, fully intending not to return (such that she or he gave up Canadian residency) but eventually returned to Canada. This category would not include Canadian citizens who left Canada for temporary visits, such as vacation or a sabbatical, fully intending to return to Canada.

K1j. Lived in war zone or area of violent conflict (combatant or civilian) — Includes members of the military, paramilitary, rebel groups, and other combatants. It also includes those who lived in a war zone or area of conflict who did not actively participate in the fighting but nonetheless directly experienced the conflict/war.

K1k. Witnessed severe accident, disaster, terrorism, violence, or abuse — Person was present at and a first-hand witness to a severe accident, disaster, act of terrorism, violence, or abuse (for example, terrible motor vehicle accident, tornado, bombing, homicide). Do not include watching televised or other media coverage of the event. Also exclude living in a war zone or area of violent conflict (which is coded in Item K1j).

K1l. Victim of crime — Person has been a victim of a crime such as robbery, break and enter, vandalism. Do not include physical assault or abuse in this item.

K1m. Victim of sexual assault or abuse — Any form of sexual abuse/assault experienced by the person, regardless of his or her age when the incident(s) occurred (for example, an adult being subject to nonconsenting fondling, exposure of genitals, sexual intercourse/rape, or having had similar experiences as a child).

- This area should be approached with sensitivity. The recording of the response should not reflect what you believe may have occurred but rather what the person or the record indicates.

K1n. Victim of physical assault or abuse — Any form of physical abuse experienced by the person, regardless of his or her age when the incident(s) occurred (for example, any incident resulting in nonaccidental injury, physical confinement, excessive physical discipline, or withdrawal of necessities of life, such as food and shelter).

K1o. Victim of emotional abuse — Person has been in a pervasive and hostile emotional environment created by an abuser for the purposes of control. The abused person's self-esteem, identity, energy, ability to feel and question, wants, and needs are invalidated by the abuser.

K1p. Parental abuse of alcohol or drugs — One or more of the person's parents (biological, adoptive, step-parent) has/had a drug and/or alcohol problem.

Process

Ask the person about any of the specified events that have had an important impact on his or her life. Also check the available documentation. Although there are other potentially serious life events, only code those that fit into these major categories.

Coding

Code for the time of most recent occurrence of the event.

0. Never

1. More than 1 year ago

2. 31 days–1 year ago

3. 8–30 days ago

4. 4–7 days ago

5. In last 3 days

K2. Describes One or More of These Life Events (Item K1) as Invoking a Sense of Horror or Intense Fear

Intent

For care planning purposes, it will be necessary to assess the intensity of the subjective impact that any one of these life events is having on the person, as a potential indicator of post-traumatic stress.

Process

If the person acknowledges experiencing one or more of the events in Item K1, ask how he or she is dealing with the memory of having experienced such an event. The person may describe (or others may have knowledge of the person reporting) intense fear or horror as a result of experiencing any of the specified situations. For example, the person (or others on the person's behalf) may also describe the presence of disturbing nightmares, episodes of anxiety when he or she thinks of the experience, or periods of intense unexplained anxiety. Do not code what you or someone else believes **should** be the person's response; code for what the person reports or for what someone else has heard from the person and then shared with you. For example, a soldier may or may not have reacted with intense fear or horror to his or her experience in a war zone. Your assessment should be based on the person's subjective reaction.

Coding

Code to reflect whether the person describes one or more of these life events as invoking a sense of horror or intense fear. Code **"0"** if the person did not experience a sense of horror or fear as a result of experiencing one or more of these events, or if the person did not experience any of the events listed in Item K1. If the person refuses to discuss this, code **"8"**. In some situations, the person may not wish to discuss this with the clinical team but has communicated experiencing a sense of horror or intense fear to another source who then reports it to the clinical team. In this case, if the clinical team trusts the information from this secondary source, code **"1"** can be used.

0. No or not applicable

1. Yes

8. Could not (would not) respond

Example of How to Code Life Events, Describes Life Events (Item K1) as Invoking a Sense of Horror or Intense Fear

When asked about experiencing any significant life events, Orlando reported that both of his parents died suddenly in a car accident 10 months ago. The assessor is also aware of Orlando's relationship problems and significant financial difficulties, from information given earlier in the interview. When asked how he has coped with these events, Orlando reported that he misses his parents because he was close to them, and he is struggling with the breakup of his marriage and the loss of his job. When asked specifically about experiencing any difficulty, such as nightmares or episodes of anxiety when he thinks about these events, he responded, "No, I haven't felt that way. I feel mostly sad."

(continued)

(continued)

Code:

K1c (Death of close family member) = "2".

K1e (Conflict-laden or severed relationship) = "1".

K1g (Economic hardship) = "1".

All other K1 items, K2 = "0".

Rationale: The code for "More than 1 year ago" applies to Items K1e and K1g because it was more than 1 year ago that Orlando's wife left him and he lost his job. However, the death of his parents occurred in the past year, thus the code for Item K1c would be **"2"**. Orlando's self-report indicates that he has not experienced the symptoms of intense fear or horror specified in Item K2.

K3. Other Indicators of Abuse of Person

NOTE: A comprehensive example for Items K3 and K4 is given after discussion of K4.

Intent

To document any indicators that the person may have experienced abuse in the last 3 days that is not captured elsewhere and that may be important in planning the person's care.

Definitions

K3a. Fearful of a family member or close acquaintance — Person expresses (either verbally or through behaviour) fear of a family member or other close acquaintance. Such fear can be expressed in many ways. A person may state that he or she is afraid of a family member, or may appear to withdraw whenever that individual is around. This may include fear of physical or emotional abuse or mistreatment. It is not necessary to establish the reason for the fear, only to determine whether it is present.

K3b. Unexplained injuries — Injuries that do not fit the clinical picture or realm of possibility given the circumstances.

K3c. Person has concerns for his or her safety — The person verbalizes that his or her safety is threatened or in jeopardy, based on the actions or words of another person (exclude obvious paranoid ideation).

Process

Information about fear of others or concern about safety can be obtained by asking the person privately if he or she has any concerns about his or her safety when with family members or other close individuals. As well, observations of interactions between the person and others may provide indications that the person feels threatened (for example, signs of pulling away, agitation, or hypervigilance). Observe for injuries (for example, broken bones, cuts, bruises, swelling), and if any are noted, ask the person (or if necessary, others who know the person, being sensitive in approaching the person who may have caused the injuries) about how the injury occurred. If the explanation does not fit your clinical impressions, use your judgment to determine if the injury should be documented as "unexplained". At this point in the assessment process, there is no need to confirm definitively that the fear of another is related to abuse, as the intent of this screening item is only to identify those who are at risk.

Coding Select the appropriate response for each item.

0. No

1. Yes

K4. Family Member(s) Has Been Victim(s) of Physical, Emotional, or Sexual Abuse or Assault

Intent To determine if a member of the person's family was a victim of abuse or assault, because even if abuse is experienced indirectly, it can have an important influence on the person's psychological well-being.

Definition **Family member(s) has been victim of physical, emotional, or sexual abuse or assault —** Person has observed or knows that a member(s) of his or her family has experienced trauma due to physical, emotional, or sexual abuse or assault, at any time in the past.

Process To assess for a history of abuse in the person's family, the information may be obtained from previous documentation or from discussion with the person. This area should be approached with sensitivity, and the recording of the response should not reflect what you believe may have occurred but rather what the person or the record indicates.

Coding Select the appropriate response.

0. No

1. Yes

Example of How to Code for Other Indicators of Abuse, Family Member Has Been Victim of Physical, Emotional, or Sexual Abuse or Assault

Fred denied having any concerns for his own safety, and there is no documentation or evidence to suggest that he has been physically abused during the last 3 days. When asked if any of his family members had experienced sexual or physical abuse, Fred hesitated and then said, "No, and I don't want to answer any more questions about that." A social work report in Fred's previous hospitalization record indicated that his sister was sexually abused by their stepfather over a period of two years when they were teenagers. Apparently, Fred had reported this to his mother but his sister refused to admit that anything was happening.

Code:

K3a (Fearful of family member) = "0".

K3b (Unexplained injuries) = 0

K3c (Person has concern for his or her safety) = 0

K4 (Family member victim of abuse/assault) = "1".

Rationale: Since Fred denies the presence of any of the indicators of abuse, and there is no documentation or evidence to suggest otherwise, code **"0"** would apply to these items. While the information given by Fred at the time of the assessment would suggest a "No" response for Item K4, the report from the social worker indicates otherwise. The assessor must now use clinical judgment to determine the response. The previous documentation of a family history of sexual abuse and Fred's reaction to the question are sufficient to code this screening item as **"1"**.

Section L

Medications

Medications can be used for both psychiatric and nonpsychiatric treatment. Knowledge of the person's actual drug intake can help ensure appropriate treatment, provide information about compliance with medication regimen, and assist with identifying and managing possible adverse drug effects related to side effects of specific medication or drug interactions.

L1. List of All Medications

Intent

To facilitate a medication evaluation by having a single listing of all prescribed and nonprescribed medications taken by the person. This section will help the clinical team identify potential problems related to the consumption of, or failure to take, one or more medications (such as any physical or emotional problems a person may experience as the result of taking one or more medications). For example, identifying how frequently a person uses a PRN (as needed) pain medication, sleeping medication, or laxative may lead the clinical team to do further assessment of the underlying problems that prompted their use. It may also help to identify medication that might cause specific problems such as incontinence or delirium.

Definitions

Medications — These include all prescribed, nonprescribed, and over-the-counter medications that the person consumed in the last 3 days. Medications may be taken by mouth, placed on the skin or in the eyes, injected, given intravenously, and so on. This includes medications taken for mental health problems and medications taken for nonpsychiatric care (including treatment of somatic illness, vitamins, and so on). It also includes prescriptions now discontinued but taken in the last 3 days and medications prescribed PRN (as needed) that were taken during this period. Also included are medications prescribed on a maintenance schedule, such as vitamin injections given once a month, even if they were not given in the last 3 days.

Drug code — These codes may vary depending on what country you are in. For example, some but not all countries use the Drug Identification Numbers (DINs), which is a standardized system for coding medications. An individual DIN code provides information on the drug name, dose, and form of the drug.

For additional definitions of terms under Item L1, see the individual explanations for L1a–L1g.

Process

Ask the person, and family members when appropriate, to list all medications actually taken in the last 3 days. Be certain to specify that this is not just prescription medication, but any medication consumed, regardless of how it was obtained. Ask the person or family member to get out all the medications the person is currently using or has used in the last 3 days. It will help to have the actual drug container, so you can get the proper spelling of the drug name and accurate dosage and frequency. If the person cannot actually get the medications out on his or her own, offer to retrieve them. While you are documenting the medications for the assessment, review the schedule of medications with the person to verify when and how

often he or she takes each medication. However, be sure to tell the person that you need to know about all medications he or she has taken (prescription and others), regardless of how they were obtained. In some cases, it may be possible to get a printout from the person's pharmacy of all current drug prescriptions. If so, confirm that the list is current; that the person is actually taking each prescription, especially those listed as PRN (as needed); and that the person gets his or her drugs only from this pharmacy. In addition, ask the person if he or she (or someone on his or her behalf) visited the drugstore to get any over-the-counter medications. Ask if the person is taking any specific drugs for problem conditions he or she may have mentioned to you (such as constipation, allergies, skin rashes, or fungus infections). The person may also have visited a doctor in the past few days, in which case you can ask whether any medications were changed. If so, determine which ones were added or discontinued. Do not record new medications unless the person has already begun taking them during the assessment period. Record all medications that the person **received** (actually swallowed, inhaled, injected, or applied to skin, eyes, etc.) in the last 3 days. Also record any prescribed medications that may not have been consumed in the last 3 days, but are part of the person's regular medication regimen (such as monthly B-12 injections).

Count only those PRN (as needed) medications that were actually taken by the person in the last 3 days.

In recording the information on the form or in the computer, be sure to check the list of medications twice, so that you do not miss any. Make sure you count medications that may have been discontinued, but were administered in the last 3 days.

NOTE: Herbal preparations in all forms (pills, liquids, powders, teas, etc.) should not be included in Item L1, "List of All Medications". According to the U.S. Food and Drug Administration, herbal preparations are considered nutritional supplements and not medications.

The coding instructions for Item L1 are extensive. Review them carefully, from L1a through L1g; for each drug record, you will need to enter information in all the columns (L1a, L1b, and so forth).

L1a. Name

Coding

Record all prescribed and over-the-counter (OTC) medications that the person took in the last 3 days. This includes any medications (prescribed or OTC) given by staff or taken by the person him- or herself. Identify and record any medications that are part of the person's regular medication regimen (for example, monthly B-12 injections) that may not have been given in the last 3 days. Do **not** record PRN medications that were **not** administered in the last 3 days, or illicit drugs.

L1b. Dose

Coding

Record the dose that was ordered by the physician **exactly** as it appears on the medication containers. Also record the dose of any over-the-counter medications. Occasionally, dosages of medications may change during the 3-day assessment period. In this case, each dosage of medication should be recorded separately.

L1c. Unit

Coding

Use the following list to record the unit:

gtts	(drops)	**mEq**	(milliequivalent)	**puffs**	(puffs)
gm	(gram)	**mg**	(milligram)	**%**	(percent)
L	(liter)	**ml**	(millilitre)	**units**	(units)
mcg	(microgram)	**oz**	(ounce)	**oth**	(other)

L1d. Route of administration

Coding

Use the following list to record the route of administration:

PO	(by mouth/oral)	**REC**	(rectal)	**ET**	(enteral tube)
SL	(sublingual)	**TOP**	(topical)	**TD**	(transdermal)
IM	(intramuscular)	**IH**	(inhalation)	**EYE**	(eye)
IV	(intravenous)	**NAS**	(nasal)	**OTH**	(other)
Sub-Q	(subcutaneous)				

L1e. Frequency

Coding

Use the following list:

Q1H	(every hour)	**Q2D**	(every other day)
Q2H	(every 2 hours)	**Q3D**	(every 3 days)
Q3H	(every 3 hours)	**Weekly**	
Q4H	(every 4 hours)	**2W**	(2 times weekly)
Q6H	(every 6 hours)	**3W**	(3 times weekly)
Q8H	(every 8 hours)	**4W**	(4 times weekly)
BED	(at bedtime)	**5W**	(5 times weekly)
Daily	(once daily)	**6W**	(6 times weekly)
BID	(2 times daily; includes every 12 hours)	**1M**	(monthly)
TID	(3 times daily)	**2M**	(twice every month)
QID	(4 times daily)	**OTH**	(other)
5D	(5 times daily)		

L1f. PRN

Coding

A **"1"** is entered here for medications that were given or taken on an "as needed" basis; a **"0"** should be entered for all other medications. STAT medications are recorded as PRN medications. If a PRN medication was **not** given in the past 3 days, it should **not** be listed.

L1g. Computer-entered drug code: Drug Identification Number (DIN) [Country Specific]

NOTE: If not in Canada, please consult your addendum.

It is important that all the information about the medication (drug name, dose ordered, frequency, and amount administered) be documented accurately in order for the computer software program to generate the appropriate drug code. A specific medication usually has more than one DIN code based on the **strength** (for example, 5 mg, 2 cc) and the **form** (for example, solution, tablets, ampules, syringes, ointment, cream, vial, spray, drops). For example, Haloperidol (Haldol), which comes in oral solution, tablet, and injectable forms, has over 40 distinct DIN numbers. An oral solution of 2 mg/ml of PMS-Haloperidol has a DIN number of 00759503, whereas a long-acting intramuscular dose has a DIN number of 02242631.

When two different strengths of the same medication are used, the DIN number of the highest strength would be used. For example, if a dose of 125 mg of Clozapine (Clozaril) is required, a 100-mg tablet (DIN 00894745) and a 25-mg tablet (DIN 00894737) would be administered in the same dose. In that situation, the DIN number would be that of the 100-mg tablet.

Investigational drugs are coded **"999999999"**. Compounds (topical mixtures prepared by the pharmacist) are coded **"888888888"**.

Example of How to Code List of All Medications

A person received Risperdal 2 mg orally twice a day and Cogentin 2 mg orally once a day during the last 3 days. Yesterday, the person received an injection of Haldol 5 mg IM in the emergency department. The list of all medications would be recorded as follows:

a. Name	b. Dose	c. Unit	d. Route	e. Freq.	f. PRN	g. Computer-entered drug code							
Risperdal	2	mg	PO	BID	0	0	2	0	2	5	2	9	9
Cogentin	2	mg	PO	Daily	0	0	2	2	4	7	2	5	4
Haldol	5	mg	IM	OTH	1	0	0	0	1	7	5	7	4

L2. Adherent with Medications Prescribed by Physician

NOTE: A comprehensive example for Items L2 and L3 is given after discussion of L3.

Intent

To determine if the person has been taking his or her medications as prescribed. This item is important for treatment planning and discharge considerations.

Definition

Adherent — The person is actually taking the medication **as prescribed**.

Process

Ask the person about his or her medications. If the above list (L1) has yet to be filled out, ask general, open-ended questions first, such as "What medications are you taking?" Ask the person if he or she missed taking any prescribed medication over the last 3 days. Ask the questions of the family if the person is unable to answer or if the family member administers the medications. Cross-check the person's responses with the available medication and any known medication orders (if the medication containers are available for inspection). Does the remaining supply seem appropriate relative to when the prescription was filled? Did the person and family member give accurate information about medication administration?

Coding

Code for adherence during the last 3 days. To determine the extent of adherence, consider the entire prescribed medication regimen over the last 3 days and estimate whether it was followed more than or less than 80% of the time.

0. Always adherent

1. Adherent 80% of time or more

2. Adherent less than 80% of time, including failure to purchase prescribed medications

3. No medications prescribed

L3. Stopped Taking Psychotropic Medication in Last 90 Days Because of Side Effects

Intent

To determine if the person stopped taking psychotropic medication in the **last 90 days** because of side effects he or she experienced. This knowledge will be useful for care planning purposes. If the person had side effects in the past, chances are he or she will again, and this information will ensure that preventative steps can be taken.

Definitions

Psychotropic medication — Medication used in the treatment of mental illness.

Side effects — Undesirable, unintended consequences of taking medication. Examples include sedation, extrapyramidal symptoms, sexual dysfunction, and sleeping difficulties.

Process

Ask the person or family if the person has stopped taking medication, either on his or her own or as ordered by a physician, because of medication side effects. The referral source or past records (if available) may also be helpful. Determine if the drug involved was a psychotropic (versus other) medication. It is critical to determine that an **unwanted side effect** was the reason the person stopped taking the medication, rather than general noncompliance (such as forgetfulness) or a desire not to experience a therapeutic effect (such as a reduction in creativity when taking medication to control symptoms of hypomania).

Coding

Code for discontinuation of psychotropic medications in **last 90 days** because of side effects. Use **"0"** if the person did not take psychotropic medication, **or** if the person has not stopped taking psychotropic medication because of side effects in the **last 90 days**.

0. No, or no psychotropic medications

1. Yes

Example of How to Code Adherent with Medication Prescribed by Physician and Stopped Taking Psychotropic Medication in Last 90 Days

Fred has a long history of sporadic compliance with medication. During the interview, he reported that, about a week ago, he stopped taking the medication that the psychiatrist had ordered because it made him drowsy and stiff, and was interfering with his ability to communicate with the voices in his head.

Code:

L2 = "2".

L3 = "1".

Rationale: Fred is not taking the prescribed medication, thus, he is adherent less that 80% of the time. The key for Item L3 is to determine if the decision to discontinue the medication was based on the presence of side effects. In Fred's case, he stopped taking the medication because he did not like both the clinical effect and the side effects; thus the item is coded **"1"**. If Fred had stopped taking the medication only because he did not like the clinical effect (the medication interfered with the voices), and he did not have a problem with side effects, the item would be coded as **"0"**.

L4. Intentional Misuse of Prescription or Over-the-Counter Medication in Last 90 Days

Intent

To document if misuse of medication is occurring or has occurred at any time in the **last 90 days**. This is important for the treatment team to know because it has implications for possible drug interactions as well as physical and mental health.

Definition

Misuse — Overuse or underuse of the recommended or prescribed dosage (for example, taking a greater dose of an analgesic, taking an anxiolytic more often than recommended or prescribed) or using medication for a purpose other than its intended use (for example, taking a diuretic for the purpose of weight control). This item includes the misuse of both prescription and over-the-counter medications.

Process

Ask the person if he or she is taking any medication. If the response is yes, ask about the use (How much? For what purpose? How often?) to determine whether it was being taken as prescribed or as directed on the package. Use clinical judgment to determine if there is evidence of misuse because the person may not readily admit to misusing medication. Consultation with the referral source and family members may assist in discovering medication misuse. Also determine if the person is self-medicating. If so, this may be an indicator of intentional misuse (for example, using a laxative for weight loss).

Coding

Code for intentional misuse of medication over the **last 90 days**. Code **"0"** if the person did not take any medication over the **last 90 days**.

0. No

1. Yes

Example of How to Code Intentional Misuse of Prescription or Over-the-Counter Medication in Last 90 Days

When asked about medication use, Cathy told the assessor that, over the past week, she has been taking "water pills" because she doesn't like the bloated feeling she gets when she has her period. The pills were from a prescription that her mother has. She took two or three pills a day for a couple of days, although the label on the bottle indicated that the pills were to be taken only once daily.

Code: L4 = "1".

Rationale: Cathy was misusing medication in that it was intended for someone else and she was taking it on a self-prescribed basis.

L5. Allergy to Any Drug

Intent

To determine if the person has any known allergies to either prescription or over-the-counter medication.

Definition

The presence of an allergy would be determined by a history of a serious negative reaction to a particular drug or category of drugs.

Process

Ask the person whether he or she is allergic or has ever had a reaction to any drugs. Include reactions to both prescription and over-the-counter drugs administered by any route.

Coding

Code for the presence of any known drug allergy.

0. No known drug allergies

1. Yes

Examples of How to Code Allergy to Any Drug

Orlando reports that he has a sulpha drug allergy.

Code L5 = "1".

Rationale: The person's self-report of drug allergies is acceptable.

Cathy reports that she is allergic to dust, mould, grass, ragweed, cats, dogs, horses, and certain foods (for example, peanuts). She has no drug allergies that she knows of.

Code: L5 = "0".

Rationale: The focus of this item is drug allergies exclusively. Although Cathy has a number of environmental and food allergies, the code would be **"0"** because she reports no known drug allergies.

Section M

Service Utilization and Treatments

This section provides a review of the person's recent service utilization, including mental health care professional involvement, focus, and type of intervention. A review of present service use can be helpful for evaluation and care planning.

M1. Formal Care

Intent

To capture the type and frequency of professional contact that were provided for care or care management to/on behalf of the person in the **last 30 days** or since admission to the program, if less than 30 days ago.

Definitions

Care or care management includes the direct services provided to the person and the management involved in providing the care that was received (for example, care planning conferences, performing assessment). To be included here, the service must have been provided for at least 15 minutes on a given day, although the 15 minutes can be cumulative for the entire day.

M1a. Psychiatrist — A routine, scheduled appointment or a visit with a psychiatrist for assessment or crisis intervention. This includes residents, interns, and staff psychiatrists.

M1b. Nurse practitioner or MD (nonpsychiatrist) — This item includes a very broad spectrum of medical providers or specialists (for example, MD, osteopath) who are either the primary physician or consultants. Also include, for example, an authorized physician assistant; nurse practitioner; nonpsychiatric medical staff, resident, or intern.

M1c. Social worker — A visit with a social worker or social work student for the purposes of assessment or intervention.

M1d. Psychologist or psychometrist — A visit with a psychometrist, licensed psychologist, or psychology student for assessment or intervention.

M1e. Occupational therapist — Assessment or therapy services that are provided or directly supervised by a qualified occupational therapist. A qualified therapy assistant may provide therapy but not supervise others giving therapy.

M1f. Recreation therapist — Participation in hobbies, crafts, and sports activities within a broader supportive context. Recreation therapy (for example, horticultural therapy) permits participation in enjoyable activities while building sociability and self-esteem.

M1g. Nurse — Licensed or registered nurses who traditionally provide assessment and complex or invasive interventions (skilled treatments), education, and referral.

M1h. Home health aide/Personal support worker — Aides who traditionally provide "hands-on" ADL support and simple monitoring (such as taking blood pressure).

M1i. Other mental health staff — For example, addiction counsellor, rehabilitation counsellor, or dietitian. If an addiction counsellor's discipline is listed above, document the formal care services using the disciplines' specific professional designation, rather than "addiction counsellor". For example, if a social worker with training in addiction counselling spent an hour each day with the person on 2 of the last 7 days, **"2"** would be recorded for Item M1c, not Item M1i.

Process

Check the record or contact the relevant professionals to determine the time they spent with the person.

Coding

Code for the extent of contact with each formal care provider.

0. No contact in last 30 days

1. No contact in last 7 days, but contact 8–30 days ago

2. Contact in last 7 days, but not daily

3. Daily contact in last 7 days

Example of How to Code Formal Care

Mrs. C was admitted to the program 3 months ago. During the past 7 days, she was seen once by a psychiatrist and three times by the social worker. She was also seen by her family physician for a routine history and physical 3 weeks ago.

Code:

M1a (Psychiatrist) = "2".

M1b (Nurse practitioner or MD) = "1".

M1c (Social worker) = "2".

All other items = "0".

M2. Treatment Modalities

NOTE: A comprehensive example for Items M2 and M3 is given after discussion of M3.

Intent

To review the type of treatment modalities offered to the person during the **last 30 days** or since admission to the program if less than 30 days ago, or **to be initiated in the next 30 days**.

Definitions

M2a. Individual — Individual therapeutic intervention with a mental health worker (for example, psychiatrist, psychologist, nurse, social worker).

M2b. Group — Any therapeutic group that the person attends, regardless of the focus of the group or who leads it. Do not include self-help groups in this item; rather, include them in Item M2d.

M2c. Family or couple — Any therapeutic intervention program that includes the person and one or more family members or spouse/partner.

M2d. Self-help/consumer group — Any self-help or consumer program not led by a mental health professional, regardless of the type (for example, Alcoholics Anonymous, Gamblers Anonymous, schizophrenia self-help group).

M2e. Complementary therapy or treatment — Any complementary therapy, such as aromatherapy, acupuncture, massage.

M2f. Day hospital/Outpatient program — An out-of-home program for social, recreational, medical, or functional support or treatment.

Coding

Select the appropriate response for each treatment modality.

0. Not offered and not received

1. Offered, but refused

2. Not received, but scheduled to start within next 30 days

3. Received 8–30 days ago

4. Received in last 7 days

M3. Focus of Intervention

Intent

To document the focus of the treatment modalities, listed in Item M2, that the person is receiving or is scheduled to receive.

Definitions

M3a. Life skills training — The focus is to assist the person to better integrate into the community on transition from a stay in an institution to living in the community. Guidance and assistance may include help in finding employment and housing, strengthening social contacts and supports, and obtaining skills for daily living (for example, cooking, cleaning).

M3b. Social or family functioning — The focus is to assist and educate the person and/or the family in any aspect of social or family functioning.

M3c. Detoxification or post-detox stabilization — An outpatient or in-patient service or program that focuses on acute alcohol or drug withdrawal management or post-withdrawal stabilization.

M3d. Alcohol or drug treatment, including methadone management — The focus is to provide support and counselling to assist the person in learning how to control the use of substances, including how to cope with emotional difficulties without turning to these substances. This item also includes methadone programs.

M3e. Vocational rehabilitation — The focus is to assist the person in obtaining suitable employment.

M3f. Anger management — The focus is to assist the person in controlling expressions of anger by encouraging acknowledgement of the anger and the stress that causes the anger, establishing alternative styles of expressing these emotions, and learning how to cope with them.

M3g. Behavioural management — The focus is crisis and maintenance strategies, based on the assessment of behaviour triggers using observation techniques such as Behaviour Observation Records (BORs) and Behaviour Logs. The aim is to reduce the frequency and intensity of the behaviours or to maintain the behaviours at a level that ensures the safety of the person and others around him or her, and to minimize the impact of the behaviours on the person's day-to-day functioning.

M3h. Pain management — The focus is on helping the person deal with acute and/or chronic pain (for example, via medications, relaxation therapy, TENS).

M3i. Crisis intervention — The focus is on responding to a crisis situation.

M3j. Basic needs — The focus is on providing basic needs, or assisting the person in obtaining basic needs such as shelter, food, and clothing.

Process

Review the programs/interventions that the person is receiving and determine the focus of these interventions.

Coding

Code for issues that were a major focus of intervention in the **last 30 days** or since admission if less than 30 days ago.

0. No intervention of this type

1. Offered, but refused

2. Not received, but scheduled to start within next 30 days

3. Received 8–30 days ago

4. Received in last 7 days

Example of How to Code Treatment Modalities and Focus of Intervention

Cathy attended meetings of Alcoholics Anonymous twice in the past week, and she is scheduled to begin group therapy in 3 days' time with the goal of assisting her in recognizing and dealing with her feeling of anger.

Code:

M2b (Group) = "2".

M2d (Self-help/consumer group) = "4".

M3d (Alcohol or drug treatment, including methadone management) = "4".

M3f (Anger management) = "2".

All other items in M2 and M3 = "0".

M4. Electroconvulsive Therapy

Intent

To document any history of receiving electroconvulsive therapy (ECT).

Definition

Unilateral or bilateral ECT received on an in-patient or outpatient basis.

Process

This information can be obtained by asking the person, his or her family, or therapists, or by checking available clinical records.

Coding

Code for the most recent instance of ECT.

0. Never received and not scheduled to begin within next 7 days

1. Received more than 30 days ago

2. Received 8–30 days ago

3. Received in last 7 days

4. Scheduled to begin within 7 days

Example of How to Code Electroconvulsive Therapy

Mrs. C reports that she had ECT when she was hospitalized after the birth of her daughter, many years ago.

Code: M4 = "1".

Rationale: The code for "Received more than 30 days ago" applies to this situation.

M5. Hospital Use, Emergency Room Use, Physician Visit

Intent

To determine the number of times in the **last 90 days** (or since the last assessment if less than 90 days ago) that the person has had (a) an overnight in-patient acute care hospital stay, (b) a visit to the emergency room, or (c) a visit with the family physician.

Definitions

M5a. In-patient acute care hospital with overnight stay (nonpsychiatric) — Any admission to an acute care hospital. Do not include an identified psychiatric/mental health admission.

M5b. Emergency room visit (not counting overnight stay) — Any visit to an emergency room, regardless of reason. Do not include an emergency room visit that resulted in an overnight stay.

M5c. Physician visit (or authorized assistant or practitioner) — Visit with a physician (exclude psychiatrist). This item includes a very broad spectrum of medical providers or specialists (for example, MD or osteopath, who is either the primary physician or consultant). Also include, for example, an authorized physician assistant or nurse practitioner. Do not include visits with a psychiatrist.

Process

Ask the person or check with the primary informal support person, if necessary. Check any available documentation (for example, the referral record).

Coding

For each of the items, enter the actual number of times the event occurred within the last 90 days (or since the last assessment if less than 90 days ago).

Example of How to Code Hospital Use, Emergency Room Use, Physician Visit

When asked, Cathy reported that her last hospitalization was in a psychiatric unit, 2 months ago, following an episode of extreme anxiety. She was admitted after a visit to the emergency room and then she discharged herself against medical advice after 24 hours. She has not seen a doctor since then. Her only other hospitalization occurred when she had her tonsils removed at age 6. However, 2 days ago, Cathy went to the emergency department of the local hospital after being seen by the physician at Student Health Services at the university for complaints of not being able to sleep. She decided to go to the emergency department because the physician had refused to prescribe sleeping medication for her and she felt she could not tolerate another sleepless night. In the emergency room, she was assessed by the casualty officer and then was seen by the mental health crisis team, after which a referral to the outpatient mental health program was arranged.

(continued)

(continued)

Code:

M5a (In-patient acute care hospital with overnight stay) = "0".

M5b (Emergency room visit) = "1".

M5c (Physician visit) = "1".

Rationale: Although Cathy had a psychiatric admission in the last 90 days, it would not be included based on the definition of "In-patient acute care hospital with overnight stay". The admission for the tonsillectomy is well beyond the time frame under consideration; therefore, it would not be included. She was seen in the emergency room twice in the last 90 days, but the visit that resulted in a hospital admission would not be included in "Emergency room visit". The visit resulting in this referral would be counted as an emergency visit. The visit to the physician at Student Health Services would be considered a "Physician visit" in the last 90 days.

Section N

Nutritional Status

A person's nutritional status can be compromised by mental illness as well as somatic issues. Information in this section can be used for early detection of a nutrition problem and can provide baseline information for care planning.

NOTE: Comprehensive examples for Items N1–N4 are given after discussion of N4.

N1. Height and Weight [Country Specific]

NOTE: If not in Canada, please consult your addendum regarding measurements.

Intent

To record the person's current height and weight in order to monitor nutrition, hydration status, and weight stability over time.

Process

Actual direct measures of height and weight should be obtained. In their absence, use estimates from the person, a family member, or your own estimations of the person's height and weight.

Coding

Record the height (Item N1a) in centimetres and the weight (Item N1b) in kilograms, rounded to the closest number. Base the weight on the most recent measure in the **last 30 days**. The following conversions may be useful: 1 inch = 2.54 cm; 1 pound = 0.454 kilograms.

N2. Nutritional Issues

Intent

To identify nutritional issues manifested by weight gain or loss, insufficient fluid intake, or a decrease in food or fluid consumption.

Definitions

N2a. Weight loss — A loss of 5% or more weight in the **last 30 days**, or 10% or more in the **last 180 days**. Marked declines in weight can indicate a failure to thrive; a sign of a potentially serious medical problem; or poor nutritional intake due to physical, psychological, cognitive, or social factors.

N2b. Weight gain — A gain of 5% or more in the **last 30 days**, or 10% or more in the **last 180 days**. Weight gain may be an indication of poor nutritional intake or an eating disorder. A striking degree of excess weight can put a person at risk for many diseases.

N2c. Fluid intake — Less than 1,000 cc per day (or less than four 8-oz cups per day). Person did not consume all/almost all fluids during the last 3 days.

N2d. Decrease in amount of food or fluid usually consumed — A decrease in overall consumption as compared to the amount of food or fluid that the person normally consumes. This item serves as an early marker of future weight loss or dehydration and can therefore identify those who may be in need of individualized attention regarding nutrition.

N2e. Ate one or fewer meals on AT LEAST 2 of LAST 3 DAYS — For the purposes of this item, a meal is composed of a nutritionally balanced plateful or bowlful of food that would normally satisfy the appetite of an average adult in that culture.

Process

Use actual records of weight if available. A subjective estimate of weight change can be used if no written records are available. Identifying a particular time approximately 6 months earlier (such as "compared to last New Year's") may help the person remember his or her approximate weight 180 days ago. You may be able to help the person answer by asking, "How much weight do you think you have lost/gained?" Then compare this with the reported or your estimated current weight of the person. You can also ask, "Have you lost/gained a lot of weight? Do you feel much thinner or heavier?" or "Your clothes seem very loose (or tight) on you. Were you much heavier (or thinner) 6 months ago?"

To assess insufficient fluid intake and amount eaten, ask the person or others who know the person how many glasses of water or other liquid he or she drinks in a day and if his or her food and fluid intake has changed during the last 3 days. When asking about food or fluid intake, consider the full 24-hour period, not just traditional meal times, because a person may decrease intake at meals and opt for more frequent, smaller meals. Any decrease in overall consumption should be considered noticeable.

Coding

Code Items N2a and N2b according to the specified time frames of either 30 days or 180 days. Code Items N2c, N2d, and N2e for the last 3 days.

0. No

1. Yes

Example of How to Calculate Weight Loss or Gain

To calculate the percentage of weight loss, divide the amount of weight the person has lost by his or her **previous** weight reference; then multiply that number by 100.

For example, you have on record that the person weighed 65 kg 3 months ago, and she currently weighs 58 kg. Thus, there was a loss of 7 kg over those 3 months. Since

$7 \div 65 = 0.108$
$0.108 \times 100 = 10.8\%$,

the person has had a weight loss of nearly 11% in 3 months.

The calculation is similar for weight gain. Divide the amount of weight that the person has gained by his or her **previous** weight reference; then multiply that number by 100.

For example, a person tells you that he weighed 84 kg a month ago, and he currently weighs 87 kg. Thus, he has had a weight gain of 3 kg:

$3 \div 84 = 0.35$
$0.35 \times 100 = 3.5\%$

He has had a weight gain of 3.5% in a month.

N3. Presence of Potential Signs of Eating Disorders in Last 30 Days

Intent

To document any signs or symptoms that the person may be experiencing or developing an eating disorder, since this behaviour is not always readily apparent in the early stages solely through weight change.

Definitions

N3a. Binge eating, purging, bulimia — An episode of **binge eating** is characterized by a loss of control over eating, and eating a particularly large amount of food (larger than most individuals would eat given the same or similar time period and circumstances). **Purging** is behaviour such as self-induced vomiting or excessive or inappropriate use of laxatives and diuretics. **Bulimia** is a disorder in which the person has recurrent episodes of binge eating and acts to prevent weight gain by purging or other compensatory behaviours.

N3b. Unrealistic fear of weight gain; statements that suggest a distorted body image — Person has expressed a fear of weight gain or has indicated that his or her body image is incongruent with its actual size.

N3c. Fasting or major restriction of diet — Person restricts food intake or has reported periods of no food intake (fasting). Do not include instances such as fasting for religious practices or not eating meat because the person is a vegetarian.

Process

The person may be hesitant to admit to these symptoms. Consult with others or family members who are familiar with the person's activity, or review the available documentation.

Coding

Code for presence of each item during the last 30 days.

0. No

1. Yes

Example of How to Code Height and Weight, Nutritional Issues, Potential Signs of Eating Disorders

Orlando reports that he is about 6 feet tall and weighs 160 pounds. He says that he is about 5 pounds heavier now than he was 6 months ago and he is feeling better with the weight gain. When asked, he says that he drinks five to six glasses of water or juice during the day and that there has been no change in his eating patterns lately. He notes that he has been eating better in the last few months and makes a point of having a good breakfast and evening meal every day.

Code:	Rationale:
N1a (Height) = "183".	Convert feet to centimetres: 6 feet = 72 inches; 72 x 2.54 cm = 183 cm.
N1b (Weight) = "72.6".	Convert pounds to kilograms: 160 pounds; 160 x 0.454 kg = 72.6 kg.
N2a (Weight loss) = "0".	Orlando has not lost weight.
N2b (Weight gain) = "0".	Orlando has gained weight, but the gain is less than 10% over the past 6 months (5/160 = 8% gain).
N2c (Fluid intake) = "0".	Five or six glasses of water or juice would meet the criterion of more than 1,000 cc per day.
N2d (Decrease in intake) = "0".	No reported decrease in food or fluid.
N3a–c (Potential eating disorder) = "0".	No evidence of a potential eating disorder.

Section 0

Social Relations

This section provides an overview of the person's support network and interpersonal relationships. A strong support network can enhance the person's well-being and his or her ability to live in the community.

01. Two Key Informal Helpers

Intent

To assess the informal support system. This is different from a formal relationship that the person may have with a health care agency.

Definitions

Informal Helper 1 — The primary informal helper may be a family member, friend, or neighbour (but not a paid provider or volunteer). It is not required that the helper actually live with the person, but that he or she visit regularly or would be able to respond to needs that the person may have. This is the individual who is most helpful to the person, whom he or she could rely on, and whom he or she would first call for assistance.

Informal Helper 2 — The second most important informal helper, or the person who, after the identified primary helper, could be most relied on to help or give advice and counsel if needed.

01a. Relationship to person

Definition

The nature of the relationship between the person and the informal helper(s).

Process

Ask the person and the helpers (where available) about the nature of their relationship.

Coding

Code both column 1 (helper 1) and column 2 (helper 2) according to the category that best describes the informal helper's relationship to the person.

1. **Child or child-in-law**
2. **Spouse**
3. **Partner/significant other**
4. **Parent/guardian**
5. **Sibling**
6. **Other relative**
7. **Friend**
8. **Neighbour**
9. **No informal helper**

O1b. Lives with person

Intent

To assess the living relationship between the person and the informal helper(s).

Definition

An informal helper is said to live with the person if they share the same space (house, apartment/flat). This does not include living in an adjacent or neighbouring apartment/flat/house.

Coding

Code both column 1 (helper 1) and column 2 (helper 2) according to whether or not the identified helper lives with the person and for the amount of time they have lived together, if applicable.

0. No

1. Yes, 6 months or less

2. Yes, more than 6 months

8. No informal helper

Areas of Informal Help during Last 3 Days

Intent

To assess the types of support provided by each of the identified helpers during the last 3 days.

Definitions

O1c. Help with child care or other dependants — For example, a family member or friend is available to help the person with babysitting, driving child(ren) to school, or taking a dependant to a medical appointment.

O1d. Supervision for personal safety — Supervision that is required for ensuring the safety of the person. This might include the need for someone to be on hand to prevent wandering, self-harm behaviour, or other behaviours that have the potential of putting the person at risk.

O1e. Crisis support — Support from a family member or friend during a crisis. A crisis refers to a sudden, specific episode of extreme stress for the person (for example, an acute exacerbation of symptoms, the presence of suicidal ideation).

O1f. IADL help — IADL (instrumental activities of daily living) areas include such activities as meal preparation, ordinary housework, managing finances or medications, phone use, shopping, and transportation.

O1g. ADL help — ADL (activities of daily living) areas include such activities as bed mobility, transferring, locomotion in the home, dressing, eating, toilet use, personal hygiene, and bathing.

Process

Ask the person to identify the individual on whom he or she depends for support or help if needed. The person may identify several people who "would help" if asked. Shape the questions with specific statements: "Who helps you shop?" "Who helps with cleaning around the house?" "Who helps you with your meals, bathing, dressing, etc.?" "Who helps you pay your bills?" "Who drives you when you need a ride?" If the person does not receive any support, ask if there is someone who "would help" if needed. If the person is not able to understand or respond to questions, or gives responses that are unclear, evasive, or untrue (for example, refers to husband when you know the husband is deceased), review any agency documentation or ask family/friends, if available.

It is important to understand that some helpers may not be described as informal supports. They may do things in line with normal social relationships — it is what a

daughter or wife is expected to do. Thus, it is useful to concentrate on what help and support is provided, rather than on the label "informal helper".

For **IADLs**, ask the person and informal helper if support is given in meal preparation, ordinary housework, managing finances or medications, phone use, shopping, and transportation. Support can range from the helper doing light housework, to doing all of the shopping and housework.

For **ADLs**, ask the person and informal helper if support is given in any ADL areas such as bed mobility, transferring, locomotion in the home, dressing, eating, toilet use, personal hygiene, and bathing. Support can range from the helper "being there just in case" for safety to the helper providing complete ADL care.

Coding

Code for each area of help provided by the informal helper(s) during the last 3 days.

0. No

1. Yes

8. No informal helper

Examples of How to Code Two Key Informal Helpers

Mrs. T identifies herself as the primary support for Mr. T. She provides supervision for safety and helps with ADL and IADL care for her husband. Their daughter, who lives in the same town, helped with some IADL in the last 3 days by doing some shopping for them and driving them to a few appointments. There has been no need for crisis support in the last 3 days.

Helper 1

Code:	**Rationale:**
O1a (Relationship to person) = "2".	Primary support person is his wife.
O1b (Lives with person) = "2".	Mr. and Mrs. T live together and have been living together for more than 6 months.
O1c (Help with child care or other dependants) = "0".	Mr. T does not require help with child care or other dependants.
O1d (Supervision for personal safety) = "1".	Mrs. T provides supervision for his safety.
O1e (Crisis support) = "0".	Mr. T has not required crisis support.
O1f (IADL help) = "1".	Mr. T depends on his wife for help with IADL.
O1g (ADL help) = "1".	Mr. T depends on his wife for help with ADL.

Helper 2

Code:	**Rationale:**
O1a (Relationship to person) = "1".	The daughter is identified as the secondary support.
O1b (Lives with person) = "0".	The daughter does not live with Mr. and Mrs. T.
O1c (Help with child care or other dependants) = "0".	Mr. T does not require help with child care or other dependants.

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Helper 2 *(continued)*

Code:	**Rationale:**
O1d (Supervision for personal safety) = "0".	The daughter is not involved in providing supervision for his safety.
O1e (Crisis support) ="0".	Mr. T has not required crisis support.
O1f (IADL help) = "1".	The daughter has done some shopping and driven them around in the last 3 days.
O1g (ADL help) = "0".	The daughter has not been involved with ADL care.

Cathy named her parents as the people she would first go to if she needed help with anything, but she has not needed any help from them in the last 3 days.

Code:

O1a = "4" for both columns.

O1b = "0" for both columns.

O1c–g = "0" for both columns.

Rationale: Cathy does not live with her parents. The two people she identified as her supports are her parents. She does not need help with child care or other dependants. She has not had help from her parents in any of the other areas.

O2. Plans for Future Needs

NOTE: Comprehensive examples for Items O2 and O3 are given after discussion of O3.

Intent

To determine if the primary informal support person has made alternative care arrangements should he or she be unable to continue providing care (for example, illness or death of the primary support person).

Definition

Alternative future support or living arrangements — Responsibility for the person's care provision would pass from the primary informal support person to another family member or friend, or a formal health care program/facility or social service (for example, long-term care facility, mental health unit, group home, or assisted-living facility). The arrangement could consist of a verbal agreement with family or friends, or the person's name on a waiting list for placement.

Process

Discuss with the primary informal helper, family, or guardian.

Coding

Code for the status of alternative care arrangements.

0. Alternative plans not considered or not required

1. Alternative plans not made, but under consideration

2. Alternative plans made

O3. Informal Helper Status

Intent

To assess the reserve of the informal support system.

Definitions

O3a. Informal helper(s) is unable to continue in caring activities (for example, decline in health of the helper makes it difficult to continue) — The informal helper, the person, or the assessor believes that a support person(s) is unable to continue providing help. This can be for any reason, including personal health issues, lack of desire to continue, travel difficulties, or other competing requirements (for example, child care, work requirements).

O3b. Primary informal helper expresses feelings of distress, anger, or depression — The primary support person expresses (by any means) that he or she is distressed, angry, depressed, or in conflict because of caring for the person.

O3c. Family or close friends report feeling overwhelmed by person's illness — Family members or close friends of the person indicate to the person or the assessor that they are having trouble coping with the person's illness. They may vocalize feelings of being overwhelmed or stressed.

Process

Interview the person and the informal helper separately regarding the support person's ability to continue providing care. For these items, consider both the current situation and the projected future needs. The informal support person may be willing and able to continue, but the person may worry about being a burden and may state that the support person cannot continue. Take this information into consideration and use your clinical judgment to evaluate the situation. The relationship between the person and the informal helper(s) is a sensitive issue that should be handled carefully. Listen carefully to what is being said and observe closely the interactions between the person and his or her informal helpers.

Coding

Code for all items. If there is no informal helper, code **"0"** for all items.

0. No

1. Yes

Example of How to Code Plans for Future Needs and Informal Helper Status

When asked how she is getting along, Mrs. T admitted that she is feeling "a lot of stress" because of her husband's illness. Over the last few weeks, she has been feeling increasingly overwhelmed with "everything" and is having difficulty doing everything that needs to be done. She does not want him to go to a nursing home but she has been thinking more about this lately, and she talked with her daughter about this last week.

Code:

O2 (Plans for future needs) = "1".

O3a (Informal helper(s) is unable to continue in caring activities) = "1".

O3b (Primary informal helper expresses feelings of distress, anger, or depression) = "1".

O3c (Family or close friends report feeling overwhelmed by person's illness) = "1".

O4. Belief That Relationship(s) with Immediate Family Member(s) Is Disturbed or Dysfunctional

Intent

To describe how the person perceives his or her relationships with family members and how family members, friends, and others perceive these same relationships. Incongruence of these perceptions may be an additional indicator of difficulties in the relationships.

Definitions

Disturbed or dysfunctional relationship — A long-term relationship characterized as being unsatisfactory, unfulfilling, and generally not meeting the emotional needs of each participant.

Others — Individuals who are associated with the person (for example, family members and friends, formal care providers like therapists or family physicians).

Process

The person and family members should be interviewed separately. Ask about their communication with one another. (For example, do they talk about ordinary daily events, household chores, the children?) To what extent do they report that family relationships are based upon mutual respect, affection, and caring? To what extent is the emotional climate between family members filled with hostility and/or resentment? Coding of this item should be based on the views reported by the person, the partner, and others (family, staff, therapist) who have information about or observations of the relationships.

Coding

Code for the response that best describes the reported beliefs about the relationship.

0. **Belief not present** — No problems are reported by either the person or his or her family, friends, or others.
1. **Only person believes** — Person identifies problems with a significant relationship, but the person's family or others do not report or do not believe that problems exist.
2. **Family, friends, or others believe** — Family, friends, or others believe there are disturbed or dysfunctional family relationships, but the person does not believe a problem is present.
3. **Both person and others believe** — Person **and** family member(s) or anyone else who has knowledge of the relationship identifies problems in the relationship.

Example of How to Code Belief That Relationship(s) with Immediate Family Member(s) Is Disturbed or Dysfunctional

Cathy reports difficulty in her relationship with her parents, and the assessor has enough evidence to suggest there are problems in the family relationships.

Code: O4 = "3".

Rationale: Cathy reports problems in the relationship, and, while there is no information about this from the parents, the assessor (other) believes problems exist.

O5. Unsettled Relationships

Intent

To indicate factors that may adversely affect the quality and nature of the person's relationships with others, including family, other care recipients, and staff.

Definitions

O5a. Conflict with or repeated criticism of family or friends — A reasonably consistent pattern of hostility and/or criticism (expressed verbally or with physical gestures) directed toward family or friends.

O5b. Conflict with or repeated criticism of other care recipients — A reasonably consistent pattern of hostility and/or criticism (expressed verbally or with physical gestures) directed toward other care recipients. Unhappiness may be manifested by arguments with others in the program or complaints about the physical, mental, or behavioural status of others in the program.

O5c. Staff report persistent frustration in dealing with person — One or more staff members report an ongoing, repetitive, or continuous sense of frustration in their interactions with the person. Staff may also provide nonverbal cues (for example, facial expressions, physical gestures) that indicate they have difficulty interacting with the person.

Process

If you are not familiar with how the person interacts with family or friends, you may have to consult them directly to determine how they and the person get along, or consult with someone familiar with the person. Check the clinical record, as such information is often recorded in a social work report. To assess staff reports of frustration, talk to as many staff as possible and rely on your own observations. You may also consult with other health care professionals (for example, family physician) who are familiar with the person and his or her interaction with others.

Coding

Code for the presence of each item in the last 3 days. For Item O5a, code **"0"** if the person has no family or friends.

0. No

1. Yes

O6. Strengths

Intent

To identify the person's strengths with specific reference to social support and disposition/personality.

Definitions

O6a. Reports having a confidant — Person identifies one or more individuals with whom he or she is able to talk about personal issues, troubles, or private concerns. The confidant could be a family member. Do not include therapists or formal care providers who might provide similar services in a professional role.

O6b. Consistent positive outlook — Person has a personality that helps him or her to maintain a positive outlook even when experiencing serious problems and symptoms or a severe loss of function. For example, a person with a consistent positive outlook is able to focus on his or her strengths, to work realistically toward achievable medical or personal goals, and to appreciate his or her life and relationships with others.

O6c. Strong and supportive relationship with family — Person indicates he or she has a supportive relationship with family members. The person may be able to "rely on" family members. Family members may be actively involved

in the person's physical care, maintaining the household, managing finances, or helping the person make medical decisions. In a supportive relationship, one or more family members may maintain regular contact with the person, provide comfort and advice, or act as a confidant.

O6d. Reports strong sense of involvement in community — Person conveys a sense of belonging to the community represented by a residential setting or a particular work, family, or social network, and is involved in the life of the community.

Process

To assess the person's outlook, ask the person how he or she views the present situation and the future. To assess for the presence of a confidant in the person's life, ask the person if there is anyone he or she can talk to about personal problems. If the answer is affirmative, ask if he or she regards this individual as a confidant. To assess the person's relationship with his or her family, ask the person how he or she views his or her relationships with family members. Family members, if available, can also provide insight into the nature of the relationship. If there are discrepancies in how different people view the relationship, the assessor should use his or her professional judgment to code this item. To assess for a strong sense of involvement in the community, talk with the person and ask about his or her perception (how he/she feels) about his or her involvement in the community.

Coding

Code for the presence of a consistent positive outlook, a confidant, a strong and supportive relationship with family, and a strong sense of involvement in the community.

0. No

1. Yes

O7. Social Relationships

Intent

To document and describe the person's interaction patterns and adaptation to his or her social environment, and to assess the degree to which the person is involved in social activities, meaningful roles, and daily pursuits. The strength of the relationship may be reflected in the length of time since the most recent interaction occurred (more recent interaction implies stronger relationship).

Definitions

O7a. Participation in social activities of long-standing interest — Person engaged in social activities that have been of long-standing interest to him or her. The activities may be quite varied and should be counted as long as they involve interaction with at least one other person. Examples include attending meetings of informal clubs, religious services, and informal discussion groups.

O7b. Visit with a long-standing social relation or family member — Person was visited by (or made a visit to) any family member, friend, or social acquaintance with a long-standing relationship with the person (for example, a neighbour or fellow member of a community organization or religious group). The focus here is on well-established, informal ties rather than visits by paid staff, volunteers, or new acquaintances.

O7c. Other interaction with long-standing social relation or family member — For example, telephone or e-mail. The person interacted through a means other than a face-to-face visit with a family member, friend, or social acquaintance with a long-standing relationship with the person (such as a neighbour

or fellow member of a community organization or religious group). As with Item O7b, the focus is on well-established, informal ties rather than contacts by paid staff, volunteers, or new acquaintances.

Process

Ask the person for his or her point of view. What activities does he or she enjoy participating in? When was the last time he or she was able to participate? Who tends to visit, and when was the last time that individual visited? Are there other ways the person contacts family or friends (for example, by telephone or e-mail)?

If possible, also talk with family members and friends who visit or have frequent telephone contact with the person. The primary support person may have a good sense of who visits or contacts the person, and can describe the person's most common recent social activities.

Coding

Code for the most recent instance for each item. Use code **"8"** for "Unable to determine" if no information is available from the person or other informants about the person's social relationships.

0. Never

1. More than 30 days ago

2. 8–30 days ago

3. 4–7 days ago

4. In last 3 days

8. Unable to determine

O8. Activity Level

Intent

To obtain a sense of the person's physical stamina and functioning in terms of getting out of the house to take part in community activities.

Definition

Went out of the house or building—This means the person went outdoors, no matter how short the period of time he or she spent outdoors. This could mean going into the yard, standing on an open porch, or walking down the street.

Process

Ask the person or family if the person went outside in the last 3 days.

Coding

If illness or weather did not permit (for example, if it snowed or there was a "tropical" downpour) and the person did not leave the house, but normally would have during a 3-day period, use code **"1"**.

0. No days out

1. Did not go out in last 3 days, but usually goes out over a 3-day period

2. 1–2 days

3. 3 days

09. Length of Time Alone during the Day (Morning and Afternoon)

Intent

To identify the actual amount of time the person is alone.

Definition

The amount of time the person is literally alone, without any other person in the home. If the person is residing in a board and care facility, congregate housing, or other situation where there are other persons in their own rooms, count the amount of time the person spends by him- or herself in the person's own room as time alone.

Process

First ask the person how much time he or she spends alone. Be clear about how "being alone" is defined. If necessary, confirm with family the amount of time the person spends alone.

Coding

Code for the most appropriate category.

0. Less than 1 hour

1. 1–2 hours

2. More than 2 hours but less than 8 hours

3. 8 hours or more

Section P

Employment, Education, and Finances

A person's well-being, self-esteem, and ability to function effectively may be influenced by the person having meaningful employment, being involved in education, having an adequate income, and participating as a volunteer. Information in this section can be helpful in identifying needs related to vocational and financial planning.

NOTE: Comprehensive examples for Items P1–P4 are given after discussion of P4.

P1. Employment Status

Intent

To determine the person's present employment status. This may have an impact on care planning, specifically around vocational issues.

Definition

Employed — Refers to paid work, either part-time or full-time.

Process

Ask the person or family members about the person's employment status.

Coding

Code for present employment status. Use code **"3"** in situations where the person is not seeking employment, regardless of the reasons. This includes a student who is not looking for employment while attending school, a retiree, or a parent who has chosen to stay at home to care for the family.

1. **Employed**
2. **Unemployed, seeking employment**
3. **Unemployed, not seeking employment**

P2. Employment Arrangements (Exclude Volunteering)

Intent

To document the person's employment arrangement.

Definitions

Competitive employment — Person works in a workplace where he or she receives adequate pay for work (minimum wage or better) and does not receive any special support or supervision.

Supported employment — Person receives special support, monitoring, or supervision, such as a job coach, while at work.

Vocational rehabilitation — Person works in a protected work environment that often provides a stipend for work performed (for example, sheltered workshop).

Process

Ask the person, family, or others about the person's present employment arrangement. All three types of arrangements listed include employment either on a full-time or part-time basis.

Coding

Code for the present type of employment arrangement. Use code **"8"** if the person is unemployed.

1. Competitive employment

2. Supported employment

3. Vocational rehabilitation

8. Not applicable

P3. Volunteers

Intent

To document the person's participation in a volunteer program as it relates to the need for vocational care planning.

Definition

Volunteer work — Person currently provides services without compensation, for example, with a community service, program, or group. Note that the person may be employed **and** serve as a volunteer. "Currently provides" implies holding an ongoing volunteer position regardless of whether the person actively fulfilled his or her duties as a volunteer in the last 3 days.

Process

Ask the person, family, or others about the person's involvement in any volunteer program.

Coding

Code to indicate if the person is currently involved in any volunteer activity.

0. No

1. Yes

P4. Enrolled in Formal Education Program

Intent

To document the person's participation in a formal education program.

Definitions

Formal education program — Includes enrollment in any formally recognized education program (for example, elementary or high school, college, university, private vocational/technology/business school, retraining program).

Full-time — Person is taking the usual required course load to complete the program as set by that institution.

Part-time — Person is taking less than the usual required full-time course load.

Process

Ask the person, family, or others about the person's educational activity.

Coding

Code for type of enrollment in a formal educational program.

0. No

1. Part-time

2. Full-time

Examples of How to Code Employment Status, Employment Arrangements, Volunteers, Enrolled in Formal Education Program

Fred reports that he is not going to school and does not have a job. He says that he can't be in school or working or looking for a job right now because he is too busy with the work that he is doing for the Mafia. When asked if he was involved in any volunteer work, he said that because he works for the Mafia for free, "I guess I am a volunteer of sorts."

Code:

P1 (Employment status) = "3".

P2 (Employment arrangements) = "8".

P3 (Volunteers) = "0".

P4 (Formal education program) = "0".

Rationale: Fred is not working and not actively seeking employment. He is not going to school, and although he says he is "a volunteer of sorts," this is part of his delusional system. Clinical judgment would suggest the most reasonable code for the volunteer item is **"0"** for "No".

Mrs. C is employed part-time at a florist shop, and she is not attending an education program. She used to volunteer at a homeless shelter but has not been involved with that work for over 6 months.

Code:

P1 (Employment status) = "1".

P2 (Employment arrangements) = "1".

P3 (Volunteers) = "0".

P4 (Formal educational program) = "0".

Rationale: Although Mrs. C only works part-time, the code for "Employed" applies. Her job is in a competitive work environment. Because she is not currently volunteering at the shelter, code **"0"** applies to Item P3.

P5. Risk of Unemployment or Disrupted Education

Intent

To identify factors that put the person at risk for unemployment or disruption in an education program.

Definitions

P5a. Increase in lateness or absenteeism over LAST 6 MONTHS — Person has been late for or absent from work or school significantly more often than usual during the last 6 months, regardless of the reason.

P5b. Poor productivity or disruptiveness at work or school — Person acknowledges that (or others have advised the person that) he or she is having difficulty meeting his or her obligations at work or school, or his or her behaviour has been disorderly, unsettling, or troublesome in the workplace or at school.

P5c. Expresses intent to quit work or school — Person expresses an intent to quit his or her current job or school program.

P5d. Persistent unemployment or fluctuating work history over LAST 2 YEARS — Person has been unemployed or has not stayed at a job for a substantial portion of the last 2 years (for example, has a consistent pattern of job losses). This does not include retirement; work placements that are part of an education program, such as a co-op program; or seasonal workers who have a long track record of obtaining employment during the work season.

Process

Directly question the person about his or her employment/school situation. Speak with family members (if available) if the person is unable to respond.

Coding

Code for each item. For Items P5a, P5b, and P5c, if the person is not employed and is not attending school, use code **"8"**. For Item P5d, only codes **"0"** or **"1"** apply.

0. No

1. Yes

8. Not applicable

Example of How to Code Risk of Unemployment or Disrupted Education

David reports that there have been "a number of days" in the past few months when he has not been as productive at work as he used to be, and he has been spoken to about arriving late to work on a number of occasions in the past few months.

Code:

P5a (Increase in lateness, absenteeism) = "1".

P5b (Poor productivity) = "1".

P5c (Expresses intent to quit work/school) = "0".

P5d (Persistent unemployment) = "0".

P6. Finances

Intent

To determine if limited funds prevented the person from receiving required medical and environmental support.

Definition

Because of insufficient funds during the **last 30 days**, the person made trade-offs among purchasing any of the following: adequate food; shelter; clothing; prescribed medications; sufficient home heat or cooling; necessary health care, such as dental care.

Process

Ask the person or a family member if prescribed medications, sufficient home heat (electricity, gas), necessary health care including dental care, or adequate food was not obtained because of insufficient funds. Asking financial questions can be a sensitive area. Questioning must be sensitive and respectful to the person.

Coding

Code to indicate whether the person has made trade-offs.

0. No

1. Yes

Section Q

Environmental Assessment

Having a safe and secure home environment is important for those with a mental health problem who live in the community. Assessment of the home environment is especially pertinent for those who live on a limited income. This section can help identify problems that may be easily fixed or areas where the person may require an advocate to assist in addressing problems related to the landlord/tenant relationship.

Q1. Home Environment

Intent

To determine if the home environment is hazardous or uninhabitable.

Definitions

Q1a. Disrepair of the home — For example, hazardous clutter; inadequate or no lighting in living room, sleeping room, kitchen, toilet, or corridors; holes in floor; or leaking pipes.

Q1b. Squalid condition — For example, extremely dirty. There may be dried urine, feces, or dried food on the floor, or infestation by insects or vermin (such as mice or rats). For an environment to be coded as "Squalid condition", the condition must be much more deteriorated than "usual" clutter and household dust and dirt accumulated over a week or so.

Q1c. Inadequate heating or cooling — Heating and cooling systems may be inadequate (for example, too hot in summer or too cold in winter) or inappropriate (for example, too cold in summer or too hot in winter and not controllable by the person or others living there).

Q1d. Lack of personal safety — For example, fear of violence, a safety problem in going to the mailbox or visiting neighbours, or heavy traffic in the street. The person is (or feels) at risk for violence within or immediately outside of his or her home. This can include a real or perceived risk of someone breaking into the home, or of being attacked while getting mail or when leaving or returning home.

Q1e. Limited access to home or rooms in home — For example, the person has difficulty entering or leaving the home, is unable to climb stairs, or has difficulty manoeuvring within rooms. This item includes physical problems with the building that limit access — for example, the person lives on the second floor and must enter or leave on unstable outside stairs, or the person lives in a multi-story building in which the elevator is often broken, or in which stairs do not have the needed railings.

Process

Ask the person's (or family member's) permission to walk through the home. Look for evidence of the problem areas noted in this section. Also ask the person about his or her living environment, during all times of the year, not just the present season. (For example, do the sidewalks get shovelled in the winter?) If the environment cannot be visually inspected, talk to the person or a family member (if necessary) to obtain information about the living environment.

Coding

Code for each item. Use code **"8"** only if a home visit was not possible AND if there is no other individual available to discuss the home environment. For example, the person refuses to discuss his or her home environment and there is no other individual (including family, friends, other formal care workers) available who knows the condition of the person's living environment.

0. No

1. Yes

8. Unknown, home not visited or no information

Section R

Diagnostic Information

This section provides a comprehensive compilation of all of the person's psychiatric and medical diagnoses. It can serve as a summary of the person's overall psychiatric and medical status.

NOTE: Comprehensive examples for Items R1 and R2 are given after discussion of R2.

R1. DSM–IV Provisional Diagnostic Category

Intent

To provide up to four provisional diagnoses (or actual diagnoses, if available at the time of the assessment), according to broad DSM-IV diagnostic categories, as determined by a psychiatrist or attending physician.

Definitions

R1a. Disorders of childhood or adolescence — For example, learning disorders; motor communication disorder; pervasive development disorder; attention deficit and disruptive behaviour disorders; feeding and eating disorders of infancy or early childhood.

R1b. Delirium, dementia, and amnestic and other cognitive disorders — For example, substance intoxication delirium; substance withdrawal delirium; Alzheimer's disease; vascular dementia; dementia due to Parkinson's disease.

R1c. Mental disorders due to a general medical condition not elsewhere classified — For example, catatonic disorder; personality change; or mental disorder due to a specific medical condition.

R1d. Substance-related disorders — For example, alcohol use disorders; amphetamine-related disorders; caffeine-related disorders; cannabis-related disorders; cocaine-related disorders; hallucinogen-related disorders; inhalant-related disorders; nicotine-related disorders; opioid-related disorders; phencyclidine-related disorders; sedative-, hypnotic-, or anxiolytic-related disorders; polysubstance-related disorders.

R1e. Schizophrenia and other psychotic disorders — For example, schizophrenia (paranoid type, disorganized type, catatonic type, undifferentiated type, residual type); schizophreniform disorder; schizoaffective disorder; delusional disorder; brief psychotic disorder; shared psychotic disorder; psychotic disorder due to delusions/hallucinations; substance-induced psychotic disorder.

R1f. Mood disorders — For example, major depressive disorder; bipolar disorder.

R1g. Anxiety disorders — For example, panic disorder; agoraphobia; social phobia; obsessive-compulsive disorder; post-traumatic stress disorder; acute stress disorder; generalized anxiety disorder; substance-induced anxiety disorder.

R1h. Somatoform disorders — For example, somatization disorder; undifferentiated somatoform disorder; conversion disorder; pain disorder; hypochondriasis; body dysmorphic disorder.

R1i. Factitious disorders — For example, factitious disorders with predominately psychological signs and symptoms, or with predominately physical signs and symptoms, or with combined psychological and physical signs and symptoms.

R1j. Dissociative disorders — For example, dissociative amnesia; dissociative fugue; dissociative identity disorder; depersonalization disorder.

R1k. Sexual and gender identity disorders — For example, sexual desire disorder; sexual arousal disorder; orgasmic disorder; sexual pain disorder; sexual dysfunction due to a general medical condition.

R1l. Eating disorders — For example, anorexia nervosa; bulimia nervosa.

R1m. Sleep disorders — For example, primary sleep disorders; dyssomnias; parasomnias.

R1n. Impulse-control disorders not elsewhere classified — For example, intermittent explosive disorder; kleptomania; pyromania; pathological gambling; trichotillomania; impulse-control disorder NOS.

R1o. Adjustment disorders — For example, with depressed mood, anxiety, or mixed depressed mood and anxiety; with disturbance of conduct; with mixed disturbance of emotions and conduct.

R1p. Personality disorders — For example, paranoid personality disorder; schizoid personality disorder; schizotypal personality disorder; antisocial personality disorder; borderline personality disorder; histrionic personality disorder; narcissistic personality disorder; avoidant personality disorder; dependent personality disorder; obsessive-compulsive personality disorder.

Process

Provisional (or actual) diagnoses can be obtained from documentation provided by a psychiatrist/attending physician, or this section can be completed by the psychiatrist/attending physician if the diagnosis is not available.

Coding

Identify all provisional categories of DSM-IV diagnoses determined by the psychiatrist or attending physician and rank their importance as factors contributing to this admission. Record **"1"** for "Most important" beside the category that contains the primary provisional diagnosis. Code as many as three more provisional diagnoses categories (if present) using scores of **"2"** for "Second most important", **"3"** for "Third most important", and **"4"** for "Less important" to reflect the order of importance as factors contributing to this admission. Code **"0"** for "Not present" if the category is not applicable. If an actual diagnosis has been determined, include it in coding this item. If no provisional or actual diagnosis is available, code all categories **"8"**.

R2. Psychiatric Diagnoses

Intent

To document the specific psychiatric diagnoses as determined by the psychiatrist.

Process

Check the clinical record for the psychiatric diagnoses determined by the psychiatrist. This item must be completed on discharge from the program but can be completed sooner if the psychiatric diagnoses have been determined.

Coding Write the specific psychiatric diagnoses for Axis I (Item R2a) and Axis II (Item R2b) and the five-digit DSM code(s) in the space(s) provided. The DSM coding can be completed by the staff or by referring to the medical records department, if available.

Examples of How to Code DSM-IV Provisional Diagnostic Category, Psychiatric Diagnoses

Orlando's provisional diagnoses on admission to the program were "alcohol abuse" and "depression". Although he has had a problem with alcohol for some time, he was referred to the program because of symptoms of depression.

Code:

R1d (Substance-related disorders) = "2".

R1f (Mood disorders) = "1".

All other R1 items = "0".

R2 is left blank.

Rationale: Orlando's symptoms of depression were more of a factor in determining the need for admission than the alcohol abuse, thus "Mood disorders" was coded **"1"** for "Most important" and "Substance-related disorders" was coded **"2"**. There were no other provisional diagnoses; therefore all other items were coded **"0"**. Item S2 was left blank, but it must be completed by the time of discharge.

Fred has had a diagnosis of schizophrenia for a number of years, as documented in the referral notes.

Code:

R1e (Schizophrenia and other psychotic disorders) = "1".

All other R1 items = "0".

R2a = "Schizophrenia".

DSM-IV code = "295.xx".

Rationale: The broad category and the specific diagnosis are known and can be recorded.

R3. Intellectual Disability

Intent To document the presence of an intellectual disability.

Definition **Intellectual disability** — Person exhibits subaverage general intellectual functioning (IQ < 70) and impairment in conceptual, social, and practical skills. Includes diagnoses such as Down syndrome, fetal alcohol syndrome, autism, phenylketonuria, Rett's disorder, Tourette's disorder, and mental retardation.

Process Review the person's record. The diagnosis must be documented in the record.

Coding

Code for the presence of an intellectual disability.

0. No

1. Yes

R4. Medical Diagnoses

Intent

To document the presence of medical diseases or infections relevant to the person's current ADL status, cognitive status, mood or behaviour status, medical treatments, nursing monitoring, or risk of death. Do not include conditions that have been resolved or that no longer affect the person's functioning or care needs. This section **includes** medical co-morbidities and **excludes** psychiatric disorders.

Definitions

R4a. Asthma — Intermittent periods of wheezing and dyspnea as a result of variable and recurring airway obstructions.

R4b. Diabetes mellitus — Any of several metabolic disorders marked by persistent thirst and excessive discharge of urine as a result of abnormal insulin secretion and elevated blood glucose levels. Includes insulin-dependent diabetes mellitus (IDDM) and diet-controlled diabetes mellitus (NIDDM or AODM).

R4c. Hypothyroidism — Subnormal activity of the thyroid gland.

R4d. Migraine — Unilateral head pain, often accompanied by sensitivity to light or visual disturbance.

R4e. Traumatic brain injury — Injury to brain, often caused by traffic or other accidents, that can cause language impediment, seizures, amnesia, functional impairments, and behavioural changes.

Process

Talk to the person and review any available clinical records. Consult with the person's primary physician or nurse practitioner. Talk with family members.

Coding

A limited number of common medical diagnoses is provided. Complete Items R4a–e, coding as indicated. If other medical conditions are present, record for Items R4f–h the diagnoses and the codes in the spaces provided. Refer to the records department or consult a manual for the ICD-10 code.

For each medical condition listed, select the most appropriate response.

0. Not present

1. Primary diagnosis/diagnoses for current stay — One or more diagnoses that are the main reason(s) used to support and justify services being provided.

2. Diagnosis present, receiving active treatment — Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.

3. Diagnosis present, monitored but no active treatment — Person has a diagnosis that is being monitored (for example, with laboratory tests or vital signs), but no active treatment is being provided.

Section S

Discharge

With the exception of Item S1, items in this section are completed only upon the person's discharge from the program, thus completing the record of his or her admission. It is useful for retrospective review if the person is readmitted, for quality-of-care review, and for organizational summary reporting.

S1. How Long Person Is Expected to Receive Services from This Agency

Intent

To determine the length of time the person is expected to stay in the current setting or under the care of this service prior to discharge.

Definition

How long person is expected to receive services — Estimated number of days the person is expected to remain in the program, from the time of the assessment to the time of discharge. You do not need to determine the exact number of days, only a range of dates that apply.

Process

Use clinical judgment to determine the projected time to discharge, given what you know about the person at the time of completing this assessment. This is only a projection, and it is recognized that circumstances may occur that will change the expected time to discharge.

Coding

Count from the Assessment Reference Date (Item A9) and include that day. Select the most appropriate expected time to discharge.

0. 1–7 days

1. 8–14 days

2. 15–30 days

3. 31–90 days

4. 91 or more days

S2. Last Day of Involvement with Program or Agency

Intent

To document the discharge date.

Process

Complete only at discharge.

Coding

Use four digits for the year. For the month and day, enter two digits each, using a leading zero as a filler, if needed.

Example: Person was discharged on April 2, 2010.

2	0	1	0		0	4		0	2
Year					**Month**			**Day**	

S3. Discharged To

Intent

To document the living arrangement to which the person is being discharged.

Process

This item is completed only upon discharge. Code for initial living arrangement at discharge.

Definitions

1. **Private home/apartment/rented room** — Any house, condominium, or apartment in the community, whether owned or rented by the person or another party. Any rented room, for example, resident hotel, whether rented by the person or another person. Also included in this category are retirement communities and independent housing for older adults or persons with disabilities.
2. **Board and care** — A noninstitutional community residential setting that integrates a shared living environment with varying degrees of supportive services of the following types: supervision, home health, homemaker, personal care, meal service, transportation, etc.

   NOTE: In Canada, Board and Care and Assisted/Semi-Independent Living will be combined for analysis and reporting.
3. **Assisted living or semi-independent living** — A second type of noninstitutional community residential setting that integrates a shared living environment with varying degrees of supportive services of the following types: supervision, home health, homemaker, personal care, meal service, transportation, etc.
4. **Mental health residence** — A residence, such as a psychiatric group home, where specialized care is provided to adults with mental health problems who need supervision and limited services (meals, housekeeping).
5. **Group home for persons with physical disability** — A setting that provides services to persons with physical disabilities. Typically, persons live in group settings with 24-hour staff presence but are encouraged to be as independent and active as possible.
6. **Setting for persons with intellectual disability** — A setting that provides services to persons with intellectual disabilities. Typically, persons live in group settings with 24-hour staff presence but are encouraged to be as independent and active as possible.
7. **Psychiatric hospital or unit** — A hospital that focuses on the diagnosis and treatment of psychiatric disorders and that is separate from other in-patient facilities, such as an acute, rehabilitation, or complex continuing care hospital. A psychiatric unit is a single unit, located in a general hospital, that is dedicated to the diagnosis and treatment of psychiatric disorders.
8. **Homeless (with or without shelter)** — A homeless person does not have a fixed residence, that is, a home, apartment, room, or place to stay on a regular basis. The person may live on the streets or outside in wooded or open areas. The person may sleep in cars, abandoned buildings, or under bridges. Persons who are homeless may or may not take advantage of existing homeless shelters.
9. **Long-term care facility (nursing home)** — A health care facility that provides 24-hour skilled or intermediate nursing care.
10. **Rehabilitation hospital/unit** — A rehabilitation hospital that focuses on the physical and occupational rehabilitation of individuals who have experienced disease or injury with subsequent decline in physical function. A rehabilitation unit is located within an acute care hospital and focuses on the rehabilitation

of persons who have experienced disease or injury with subsequent decline in physical function.

11. **Hospice facility/palliative care unit** — A hospice facility (or unit within a facility providing more general care) that provides care to persons who have a terminal illness with a prognosis of less than 6 months to live, as certified by a physician. The goal of hospice care is to provide comfort and quality of life while assisting the person and family. Palliative care is the care of persons whose diseases are not responsive to curative treatments. It targets pain and symptom relief without precluding the use of life-prolonging treatments, and provides support systems for the person and his or her family. Palliative care is often provided from the time a person is diagnosed with a life-threatening illness.
12. **Acute care hospital** — An acute care hospital primarily provides the diagnosis and treatment of acute medical disorders. Do not include psychiatric wards of a general hospital, psychiatric hospitals, or rehabilitation hospitals, coded separately.
13. **Correctional facility** — Any jail, penitentiary, or halfway house, whether operated by the local, provincial, or federal government. Correctional staff is responsible for caring for and housing persons sentenced by a criminal court to incarceration.
14. **Other** — Any type of setting not listed previously.
15. **Deceased**

Process

Complete only at discharge. Review the medical record. If the information is unavailable in the medical record, ask the person or family.

Coding

Choose only one answer and enter the appropriate code.

Section T

Assessment Information

Intent

To document the name of the person who is coordinating the assessment and the date that the person signed the assessment as being complete.

Process

The Assessment Coordinator (who will usually be the sole assessor in the community environment) signs and certifies that the assessment is complete.

Coding

The Assessment Coordinator signs his or her name on line T1 and then puts the date that he or she signed the assessment as complete in T2. Note that the date in box T2 can be different than the Assessment Reference Date (Item A9).

Use four digits for the year. For the month and day of the assessment, enter two digits each, using a leading zero as a filler, if needed.

Example: March 29, 2010.

2	0	1	0		0	3		2	9
Year					**Month**			**Day**	

T

Language Codes

Code	Name of Language
aar	Afar
abk	Abkhazian
ace	Achinese
ach	Acoli
ada	Adangme
ady	Adyghe; Adygei
afa	Afro-Asiatic languages
afh	Afrihili
afr	Afrikaans
ain	Ainu
aka	Akan
akk	Akkadian
alb	Albanian
ale	Aleut
alg	Algonquian languages
alt	Southern Altai
amh	Amharic
ang	English, Old (ca. 450–1100)
anp	Angika
apa	Apache languages
ara	Arabic
arc	Official Aramaic (700–300 BCE); Imperial Aramaic (700–300 BCE)
arg	Aragonese
arm	Armenian
arn	Mapudungun; Mapuche
arp	Arapaho
art	Artificial languages
arw	Arawak
asm	Assamese
ast	Asturian; Bable; Leonese; Asturleonese
ath	Athapascan languages
aus	Australian languages
ava	Avaric
ave	Avestan
awa	Awadhi
aym	Aymara
aze	Azerbaijani
bad	Banda languages
bai	Bamileke languages
bak	Bashkir
bal	Baluchi
bam	Bambara
ban	Balinese
baq	Basque
bas	Basa
bat	Baltic languages
bej	Beja; Bedawiyet
bel	Belarusian
bem	Bemba
ben	Bengali
ber	Berber languages
bho	Bhojpuri
bih	Bihari
bik	Bikol
bin	Bini; Edo
bis	Bislama

*From ISO 639-2 Codes for the Representation of Names of Languages — Part 2: Alpha-3 Code.

Code	Name of Language
bla	Siksika
bnt	Bantu languages
bos	Bosnian
bra	Braj
bre	Breton
btk	Batak languages
bua	Buriat
bug	Buginese
bul	Bulgarian
bur	Burmese
byn	Blin; Bilin
cad	Caddo
cai	Central American Indian languages
car	Galibi Carib
cat	Catalan; Valencian
cau	Caucasian languages
ceb	Cebuano
cel	Celtic languages
cha	Chamorro
chb	Chibcha
che	Chechen
chg	Chagatai
chi	Chinese
chk	Chuukese
chm	Mari
chn	Chinook jargon
cho	Choctaw
chp	Chipewyan; Dene Suline (Dene)
chr	Cherokee
chu	Church Slavic; Old Slavonic; Church Slavonic; Old Bulgarian; Old Church Slavonic
chv	Chuvash
chy	Cheyenne
cmc	Chamic languages
cop	Coptic
cor	Cornish
cos	Corsican
cpe	Creoles and pidgins, English-based
cpf	Creoles and pidgins, French-based
cpp	Creoles and pidgins, Portuguese-based
cre	Cree
crh	Crimean Tatar; Crimean Turkish
crp	Creoles and pidgins
csb	Kashubian
cus	Cushitic languages
cze	Czech
dak	Dakota
dan	Danish
dar	Dargwa
day	Land Dayak languages
del	Delaware
den	Slave (Athapascan)
dgr	Dogrib
din	Dinka
div	Divehi; Dhivehi; Maldivian
doi	Dogri
dra	Dravidian languages
dsb	Lower Sorbian
dua	Duala
dum	Dutch, Middle (ca. 1050–1350)
dut	Dutch; Flemish
dyu	Dyula
dzo	Dzongkha
efi	Efik
egy	Egyptian (Ancient)
eka	Ekajuk
elx	Elamite
eng	English
enm	English, Middle (1100–1500)
epo	Esperanto
est	Estonian
ewe	Ewe

Code	Name of Language
ewo	Ewondo
fan	Fang
fao	Faroese
fat	Fanti
fij	Fijian
fil	Filipino; Pilipino
fin	Finnish
fiu	Finno-Ugrian languages
fon	Fon
fre	French
frm	French, Middle (ca. 1400–1600)
fro	French, Old (842–ca. 1400)
frr	Northern Frisian
frs	Eastern Frisian
fry	Western Frisian
ful	Fulah
fur	Friulian
gaa	Ga
gay	Gayo
gba	Gbaya
gem	Germanic languages
geo	Georgian
ger	German
gez	Geez
gil	Gilbertese
gla	Gaelic; Scottish Gaelic
gle	Irish
glg	Galician
glv	Manx
gmh	German, Middle High (ca. 1050–1500)
goh	German, Old High (ca. 750–1050)
gon	Gondi
gor	Gorontalo
got	Gothic
grb	Grebo
grc	Greek, Ancient (to 1453)
gre	Greek, Modern (1453–)
grn	Guarani
gsw	Swiss German; Alemannic; Alsatian
guj	Gujarati
gwi	Gwich'in
hai	Haida
hat	Haitian; Haitian Creole
hau	Hausa
haw	Hawaiian
heb	Hebrew
her	Herero
hil	Hiligaynon
him	Himachali
hin	Hindi
hit	Hittite
hmn	Hmong
hmo	Hiri Motu
hrv	Croatian
hsb	Upper Sorbian
hun	Hungarian
hup	Hupa
iba	Iban
ibo	Igbo
ice	Icelandic
ido	Ido
iii	Sichuan Yi; Nuosu
ijo	Ijo languages
iku	Inuktitut
ile	Interlingue; Occidental
ilo	Iloko
ina	Interlingua (International Auxiliary Language Association)
inc	Indic languages
ind	Indonesian
ine	Indo-European languages
inh	Ingush
ipk	Inupiaq
ira	Iranian languages

Code	Name of Language
iro	Iroquoian languages
ita	Italian
jav	Javanese
jbo	Lojban
jpn	Japanese
jpr	Judeo-Persian
jrb	Judeo-Arabic
kaa	Kara-Kalpak
kab	Kabyle
kac	Kachin; Jingpho
kal	Kalaallisut; Greenlandic
kam	Kamba
kan	Kannada
kar	Karen languages
kas	Kashmiri
kau	Kanuri
kaw	Kawi
kaz	Kazakh
kbd	Kabardian
kha	Khasi
khi	Khoisan languages
khm	Central Khmer
kho	Khotanese, Sakan
kik	Kikuyu; Gikuyu
kin	Kinyarwanda
kir	Kirghiz; Kyrgyz
kmb	Kimbundu
kok	Konkani
kom	Komi
kon	Kongo
kor	Korean
kos	Kosraean
kpe	Kpelle
krc	Karachay-Balkar
krl	Karelian
kro	Kru languages
kru	Kurukh
kua	Kuanyama; Kwanyama
kum	Kumyk
kur	Kurdish
kut	Kutenai
lad	Ladino
lah	Lahnda
lam	Lamba
lao	Lao
lat	Latin
lav	Latvian
lez	Lezghian
lim	Limburgan; Limburger; Limburgish
lin	Lingala
lit	Lithuanian
lol	Mongo
loz	Lozi
ltz	Luxembourgish; Letzeburgesch
lua	Luba-Lulua
lub	Luba-Katanga
lug	Ganda
lui	Luiseno
lun	Lunda
luo	Luo (Kenya and Tanzania)
lus	Lushai
mac	Macedonian
mad	Madurese
mag	Magahi
mah	Marshallese
mai	Maithili
mak	Makasar
mal	Malayalam
man	Mandingo
mao	Maori
map	Austronesian languages
mar	Marathi
mas	Masai
may	Malay

Code	Name of Language
mdf	Moksha
mdr	Mandar
men	Mende
mga	Irish, Middle (900–1200)
mic	Mi'kmaq; Micmac
min	Minangkabau
mis	Uncoded languages
mkh	Mon-Khmer languages
mlg	Malagasy
mlt	Maltese
mnc	Manchu
mni	Manipuri
mno	Manobo languages
moh	Mohawk
mon	Mongolian
mos	Mossi
mul	Multiple languages
mun	Munda languages
mus	Creek
mwl	Mirandese
mwr	Marwari
myn	Mayan languages
myv	Erzya
nah	Nahuatl languages
nai	North American Indian languages
nap	Neapolitan
nau	Nauru
nav	Navajo; Navaho
nbl	Ndebele, South; South Ndebele
nde	Ndebele, North; North Ndebele
ndo	Ndonga
nds	Low German; Low Saxon; German, Low; Saxon, Low
nep	Nepali
new	Nepal Bhasa; Newari
nia	Nias
nic	Niger-Kordofanian languages
niu	Niuean
nno	Norwegian Nynorsk; Nynorsk, Norwegian
nob	Bokmål, Norwegian; Norwegian Bokmål
nog	Nogai
non	Norse, Old
nor	Norwegian
nqo	N'Ko
nso	Pedi; Sepedi; Northern Sotho
nub	Nubian languages
nwc	Classical Newari; Old Newari; Classical Nepal Bhasa
nya	Chichewa; Chewa; Nyanja
nym	Nyamwezi
nyn	Nyankole
nyo	Nyoro
nzi	Nzima
oci	Occitan (post-1500)
oji	Ojibwa
ori	Oriya
orm	Oromo
osa	Osage
oss	Ossetian; Ossetic
ota	Turkish, Ottoman (1500–1928)
oto	Otomian languages
paa	Papuan languages
pag	Pangasinan
pal	Pahlavi
pam	Pampanga Kapampangan
pan	Panjabi; Punjabi
pap	Papiamento
pau	Palauan
peo	Persian, Old (ca. 600–400 B.C.)
per	Persian
phi	Philippine languages
phn	Phoenician

Code	Name of Language
pli	Pali
pol	Polish
pon	Pohnpeian
por	Portuguese
pra	Prakrit languages
pro	Provençal, Old (to 1500); Occitan, Old (to 1500)
pus	Pushto; Pashto
que	Quechua
raj	Rajasthani
rap	Rapanui
rar	Rarotongan; Cook Islands Maori
roa	Romance languages
roh	Romansh
rom	Romany
rum	Romanian; Moldavian; Moldovan
run	Rundi
rup	Aromanian; Arumanian; Macedo-Romanian
rus	Russian
sad	Sandawe
sag	Sango
sah	Yakut
sai	South American Indian languages
sal	Salishan languages
sam	Samaritan Aramaic
san	Sanskrit
sas	Sasak
sat	Santali
scn	Sicilian
sco	Scots
sel	Selkup
sem	Semitic languages
sga	Irish, Old (to 900)
sgn	Sign languages
shn	Shan
sid	Sidamo
sin	Sinhala; Sinhalese
sio	Siouan languages
sit	Sino-Tibetan languages
sla	Slavic languages
slo	Slovak
slv	Slovenian
sma	Southern Sami
sme	Northern Sami
smi	Sami languages
smj	Lule Sami
smn	Inari Sami
smo	Samoan
sms	Skolt Sami
sna	Shona
snd	Sindhi
snk	Soninke
sog	Sogdian
som	Somali
son	Songhai languages
sot	Sotho, Southern
spa	Spanish; Castilian
srd	Sardinian
srn	Sranan Tongo
srp	Serbian
srr	Serer
ssa	Nilo-Saharan languages
ssw	Swati
suk	Sukuma
sun	Sundanese
sus	Susu
sux	Sumerian
swa	Swahili
swe	Swedish
syc	Classical Syriac
syr	Syriac
tah	Tahitian

Code	Name of Language
tai	Tai languages
tam	Tamil
tat	Tatar
tel	Telugu
tem	Timne
ter	Tereno
tet	Tetum
tgk	Tajik
tgl	Tagalog
tha	Thai
tib	Tibetan
tig	Tigre
tir	Tigrinya
tiv	Tiv
tkl	Tokelau
tlh	Klingon; tlhIngan-Hol
tli	Tlingit
tmh	Tamashek
tog	Tonga (Nyasa)
ton	Tonga (Tonga Islands)
tpi	Tok Pisin
tsi	Tsimshian
tsn	Tswana
tso	Tsonga
tuk	Turkmen
tum	Tumbuka
tup	Tupi languages
tur	Turkish
tut	Altaic languages
tvl	Tuvalu
twi	Twi
tyv	Tuvinian
udm	Udmurt
uga	Ugaritic
uig	Uighur; Uyghur
ukr	Ukrainian
umb	Umbundu
und	Undetermined
urd	Urdu
uzb	Uzbek
vai	Vai
ven	Venda
vie	Vietnamese
vol	Volapük
vot	Votic
wak	Wakashan languages
wal	Wolaitta; Wolaytta
war	Waray
was	Washo
wel	Welsh
wen	Sorbian languages
wln	Walloon
wol	Wolof
xal	Kalmyk; Oirat
xho	Xhosa
yao	Yao
yap	Yapese
yid	Yiddish
yor	Yoruba
ypk	Yupik languages
zap	Zapotec
zbl	Blissymbols; Blissymbolics; Bliss
zen	Zenaga
zha	Zhuang; Chuang
znd	Zande languages
zul	Zulu
zun	Zuni
zxx	No linguistic content; Not applicable
zza	Zaza; Dimili; Dimli; Kirdki; Kirmanjki; Zazaki

List of Abbreviations

AC	Acute Care
ADL	Activities of Daily Living
AL	Assisted Living
ATC	anatomical therapeutic chemical
BUN	blood urea nitrogen
CA	Contact Assessment
CAPs	Clinical Assessment Protocols
CF	Mental Health for Correctional Facilities
CHA	Community Health Assessment
CMH	Community Mental Health
CVA	cerebrovascular accident
ESP	Emergency Screener for Psychiatry
GI	gastrointestinal
GU	genitourinary
HC	Home Care
IADL	Instrumental Activities of Daily Living
ICD-CM	International Classification of Diseases, Clinical Modification
ID	Intellectual Disability
LTCF	Long-Term Care Facilities
MDS	Minimum Data Set
MH	Mental Health
NDC	National Drug Code
PAC	Post-Acute Care
PC	Palliative Care
PRN	pro re nata (“as needed”)
QOL	Self-Report Quality of Life
RAI	Resident Assessment Instrument
RUGs	Resource Utilization Groups
TENS	transcutaneous electrical nerve stimulation
WELL	Wellness

[CODE FOR LAST 3 DAYS, UNLESS OTHERWISE SPECIFIED]

SECTION A. Identification Information

1. NAME

a. (First) b. (Middle Initial) c. (Last) d. (Jr./Sr.)

2. SEX

1 Male **2** Female ☐

3. BIRTHDATE ☐☐☐☐ — ☐☐ — ☐☐
Year Month Day

4. MARITAL STATUS ☐
- **1** Never married
- **2** Married
- **3** Partner / Significant other
- **4** Widowed
- **5** Separated
- **6** Divorced

5. NUMERIC IDENTIFIERS [EXAMPLE — CANADA]

a. **Health Card Number**
☐☐☐☐☐☐☐☐☐☐☐☐☐

b. **Case Record Number**
☐☐☐☐☐☐☐☐☐☐☐☐☐

6. PROVINCE OR TERRITORY OF USUAL LIVING ARRANGEMENT AND AGENCY IDENTIFIERS [EXAMPLE — CANADA]

a. **Province or Territory** ☐☐

b. **Agency Identifier** ☐☐☐☐☐☐☐☐☐☐

7. CURRENT PAYMENT SOURCES [EXAMPLE — CANADA]

0 No **1** Yes

a. **Provincial or territorial government plan (this province or territory)** ☐
b. **Provincial or territorial government plan (other province or territory)** ☐
c. **Federal government**—Veterans Affairs Canada (VAC) ☐
d. **Federal government**—First Nations and Inuit Health Branch (FNIHB) ☐
e. **Federal government**—Other ☐
f. **Workers' Compensation Board (WCB / WSIB)** ☐
g. **Canadian resident, insurance pay** ☐
h. **Canadian resident, public trustee pay** ☐
i. **Canadian resident, self-pay** ☐
j. **Other country resident, self-pay** ☐
k. **Responsibility for payment unknown or unavailable** ☐

8. REASON FOR ASSESSMENT ☐
- **1** First assessment
- **2** Routine reassessment
- **3** Return assessment
- **4** Significant change in status reassessment
- **5** Discharge assessment, covers last 3 days of service
- **6** Discharge tracking only
- **7** Other—e.g., research

9. ASSESSMENT REFERENCE DATE

2 0 ☐☐ — ☐☐ — ☐☐
Year Month Day

10. PERSON'S EXPRESSED GOALS OF CARE

Enter primary goal in boxes at bottom

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

11. CAPACITY [EXAMPLE — CANADA]

0 No **1** Yes

a. **Capable to consent to treatment** ☐
b. **Capable to disclose information relating to clinical record** ☐
c. **Capable to manage property** ☐
d. **Has a substitute decision-maker for personal care or financial decisions** ☐

12. RESIDENTIAL / LIVING STATUS AT TIME OF ASSESSMENT ☐☐
- **1** Private home / apartment / rented room
- **2** Board and care
- **3** Assisted living or semi-independent living
- **4** Mental health residence—e.g., psychiatric group home
- **5** Group home for persons with physical disability
- **6** Setting for persons with intellectual disability
- **7** Psychiatric hospital or unit
- **8** Homeless (with or without shelter)
- **9** Long-term care facility (nursing home)
- **10** Rehabilitation hospital / unit
- **11** Hospice facility / palliative care unit
- **12** Acute care hospital
- **13** Correctional facility
- **14** Other

13. POSTAL CODE OF USUAL LIVING ARRANGEMENT [EXAMPLE — CANADA] ☐☐☐ ☐☐☐

14. LIVING ARRANGEMENT ☐
- **1** Alone
- **2** With spouse / partner only
- **3** With spouse / partner and other(s)
- **4** With child (not spouse / partner)
- **5** With parent(s) or guardian(s)
- **6** With sibling(s)
- **7** With other relative(s)
- **8** With nonrelative(s)

15. RESIDENTIAL INSTABILITY ☐

Residential instability over LAST 2 YEARS—e.g., 3 or more moves, no permanent address, homeless, living in shelter

0 No **1** Yes

SECTION B. Intake and Initial History

[Note: Complete Section B at Admission / First Assessment only]

1. REASONS FOR ADMISSION

0 No **1** Yes

a. **Threat or danger to self** ☐
b. **Threat or danger to others** ☐
c. **Inability to care for self due to mental illness** ☐
d. **Problem with addiction or dependency** ☐
e. **Specific psychiatric symptoms**—e.g., depression, hallucinations, medication side effects ☐
f. **Involvement with criminal justice system, or forensic admission** ☐

2. DATE CASE OPENED

2 0 ☐☐ — ☐☐ — ☐☐
Year Month Day

3. ORIGIN IS INUIT, MÉTIS, OR FIRST NATIONS [EXAMPLE — CANADA] ☐

0 No **1** Yes

4. PRIMARY LANGUAGE [EXAMPLE — CANADA] ☐☐☐

eng English **fre** French

(See appendix in manual for additional codes)

5. INTERPRETER NEEDED ☐

0 No **1** Yes

6. MENTAL HEALTH SERVICES

a. **Time since last contact with community mental health agency or professional in LAST YEAR**—e.g., psychiatrist, social worker ☐
(Exclude this contact)
- **0** No contact in last year
- **1** 31 days or more
- **2** 30 days or less

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b. **Time since last psychiatric hospital discharge**
- **0** No hospitalization within last 90 days
- **1** More than 30 days ago
- **2** 15–30 days ago
- **3** 8–14 days ago
- **4** Within last 7 days
- **5** Now in hospital

c. **Number of psychiatric admissions in LAST 2 YEARS**
- **0** None
- **1** 1–2
- **2** 3 or more

d. **Number of lifetime psychiatric admissions**
- **0** None
- **1** 1–3
- **2** 4–5
- **3** 6 or more

e. **Age in years at first overnight stay in a psychiatric hospital or unit**
- **0** Never
- **1** 1–14
- **2** 15–24
- **3** 25–44
- **4** 45–64
- **5** 65+

f. **History of involuntary psychiatric admissions**
- **0** No
- **1** Yes

SECTION C. Mental Status

1. MENTAL STATE INDICATORS

Code for indicators observed in last 3 days, irrespective of the assumed cause [Note: Whenever possible, ask person]

- **0** Not present
- **1** Present but not exhibited in last 3 days
- **2** Exhibited on 1–2 of last 3 days
- **3** Exhibited daily in last 3 days

Mood Disturbance

a. **Sad, pained, or worried facial expressions**—e.g., furrowed brow, constant frowning
b. **Crying, tearfulness**
c. **Decreased energy**—Statements of decrease in energy level (e.g., "I just don't feel like doing anything; I have no energy")
d. **Made negative statements**—e.g., "Nothing matters; Would rather be dead; What's the use; Regret having lived so long; Let me die"
e. **Self-deprecation**—e.g., "I am nothing; I am of no use to anyone"
f. **Expressions of guilt or shame**—e.g., "I've done something awful; This is all my fault; I am a terrible person"
g. **Expressions of hopelessness**—e.g., "There's no hope for the future; Nothing's going to change for the better"
h. **Inflated self-worth**—e.g., exaggerated self-opinion, arrogance, inflated belief about one's own ability
i **Hyperarousal**—Motor excitation; unusually high activity; increased reactivity
j. **Irritability**—Marked increase in being short-tempered or easily upset
k. **Increased sociability or hypersexuality**—Marked increase in social or sexual activity
l. **Pressured speech or racing thoughts**—Rapid speech, rapid transition from topic to topic
m. **Labile affect**—Affect fluctuates frequently with or without an external explanation
n. **Flat or blunted affect**—Indifference, nonresponsiveness, hard to get to smile, etc.

Anxiety

o. **Repetitive anxious complaints / concerns (non-health-related)**—e.g., persistently seeks attention / reassurance regarding schedules, meals, laundry, clothing, relationships
p. **Expressions, including nonverbal, of what appear to be unrealistic fears**—e.g., fear of being abandoned, being left alone, being with others; intense fear of specific objects or situations
q. **Obsessive thoughts**—Unwanted ideas or thoughts that cannot be eliminated
r. **Compulsive behaviour**—e.g., hand washing, repetitive checking of room, counting
s. **Intrusive thoughts or flashbacks**—Disturbing memories or images that intrude into thoughts, unexpected recall of adverse events
t. **Episodes of panic**—Cascade of symptoms of fear, anxiety, loss of control

Psychosis

u. **Hallucinations**—False sensory perception, of any type, with or without insight, without corresponding stimuli (e.g., auditory, visual, tactile, olfactory, or gustatory hallucinations, excluding command hallucinations)
v. **Command hallucinations**—Hallucination directing the person to do something or to act in a particular manner, e.g., to harm self or others
w. **Delusions**—Fixed false beliefs (e.g., grandiose, paranoid, somatic, excluding beliefs specific to person's culture or religion)
x. **Abnormal thought process**—e.g., loosening of associations, blocking, flight of ideas, tangentiality, circumstantiality

Negative Symptoms

y. **Expressions, including nonverbal, of a lack of pleasure in life (anhedonia)**—e.g., "I don't enjoy anything anymore"
z. **Withdrawal from activities of interest**—e.g., long-standing activities, being with family / friends
aa. **Lack of motivation**—Absence of spontaneous goal-directed activity
bb. **Reduced social interactions**

Other Indicators

cc. **Repetitive health complaints**—e.g., persistently seeks medical attention, incessant concern with body functions
dd. **Recurrent statements that something terrible is about to happen**—e.g., believes he or she is about to die, have a heart attack
ee. **Persistent anger with self or others**—e.g., easily annoyed, anger at care received
ff. **Unusual or abnormal physical movements**—Unusual facial expressions or mannerisms, peculiar motor behaviour or body posturing (e.g., stereotypies, waxy flexibility)
gg. **Hygiene**—Unusually poor hygiene, unkempt, dishevelled
hh. **Difficulty falling asleep or staying asleep; waking up too early; restlessness; nonrestful sleep**
ii. **Too much sleep**—Excessive amount of sleep that interferes with person's normal functioning

2. SLEEP PROBLEMS RELATED TO HYPOMANIA OR MANIA

Person had 24-hour period with less than 2 hours of sleep caused by increased energy level (Code for most recent instance)

- **0** Never
- **1** More than 1 year ago
- **2** 31 days–1 year ago
- **3** 8–30 days ago
- **4** 4–7 days ago
- **5** In last 3 days

3. DEGREE OF INSIGHT INTO MENTAL HEALTH PROBLEM
- **0** Full
- **1** Limited
- **2** None

4. SELF-REPORTED MOOD
- **0** Not in last 3 days
- **1** Not in last 3 days, but often feels that way
- **2** In 1–2 of last 3 days
- **3** Daily in last 3 days
- **8** Could not (would not) respond

Ask: "In the last 3 days, how often have you felt . . . "

a. **Little interest or pleasure in things you normally enjoy?**
b. **Anxious, restless, or uneasy?**
c. **Sad, depressed, or hopeless?**

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SECTION D. Substance Use or Excessive Behaviour

1. ALCOHOL
Highest number of drinks in any "single sitting" in LAST 14 DAYS

0 None **2** 2–4
1 1 **3** 5 or more

2. NUMBER OF DAYS IN LAST 30 DAYS CONSUMED ALCOHOL TO POINT OF INTOXICATION

0 None **3** 9 or more days, but not daily
1 1 day **4** Daily
2 2–8 days

3. TIME SINCE USE OF THE FOLLOWING SUBSTANCES

0 Never **3** 8–30 days ago
1 More than 1 year ago **4** 4–7 days ago
2 31 days–1 year ago **5** In last 3 days

a. **Inhalants**—e.g., glue, gasoline, paint thinners, solvents
b. **Hallucinogens**—e.g., phencyclidine or "angel dust," LSD or "acid," "magic mushrooms," "ecstasy"
c. **Cocaine or crack**
d. **Stimulants**—e.g., amphetamines, "uppers," "speed," methamphetamines
e. **Opiates (including synthetics)**—e.g., heroin, methadone
f. **Cannabis**

4. INJECTION DRUG USE—EXCLUDE PRESCRIPTION MEDICATIONS

0 Never used injection drugs
1 Used injection drugs more than 30 days ago
2 Used injection drugs in last 30 days; did not share needles
3 Used injection drugs in last 30 days; did share needles

5. PATTERNS OF DRINKING OR OTHER SUBSTANCE USE IN LAST 90 DAYS
Presence of behavioural indicators of potential substance-related addiction in LAST 90 DAYS

0 No **1** Yes

a. **Person felt the need or was told by others to cut down on drinking or drug use, or others were concerned about person's substance use**
b. **Person has been bothered by criticism from others about drinking or drug use**
c. **Person has reported feelings of guilt about drinking or drug use**
d. **Person has to have a drink or use drugs first thing in the morning to steady nerves**—e.g., an "eye-opener"
e. **Person feels social environment encourages or facilitates abuse of drugs or alcohol**

6. WITHDRAWAL SYMPTOMS
Severity of signs and symptoms possibly indicative of withdrawal from alcohol, drugs, or medication. Code for most severe level in LAST 3 DAYS.

0 None present
1 Mild—Symptoms typical of early stages of withdrawal (e.g., agitation, "jitters," cravings, gastrointestinal upset, anxiety, hostility, vivid dreaming)
2 Moderate—Increased severity of early indicators, weakness, sweating, hot flashes, fainting, muscle twitching
3 Severe—Symptoms typical of advanced stages of withdrawal (e.g., exhaustion, seizures, tremors, tachycardia, disorientation, hyperventilation)

7. PERSON HAS EVER HAD A DIAGNOSIS OF SUBSTANCE-RELATED DISORDER—e.g., alcohol dependence

0 No **1** Yes

8. CAFFEINE USE
Highest number of caffeinated beverages consumed in any single day of the LAST 3 DAYS.

0 No coffee or caffeinated beverages
1 1–2 cups of coffee or 1–4 caffeinated beverages
2 3–5 cups of coffee or 5–9 caffeinated beverages
3 6 or more cups of coffee or 10 or more caffeinated beverages

9. SMOKES TOBACCO DAILY

0 No
1 Not in last 3 days, but is usually a daily smoker
2 Yes

10. GAMBLED EXCESSIVELY OR UNCONTROLLABLY IN LAST 90 DAYS

0 No **1** Yes

SECTION E. Harm to Self and Others

1. SELF-INJURIOUS IDEATION OR ATTEMPT
Code for most recent instance

0 Never **3** 8–30 days ago
1 More than 1 year ago **4** 4–7 days ago
2 31 days–1 year ago **5** In last 3 days

a. **Considered performing a self-injurious act**
b. **Most recent self-injurious attempt**

2. INTENT OF ANY SELF-INJURIOUS ATTEMPT WAS TO KILL SELF

0 No **1** Yes **8** No attempt

3. OTHER INDICATORS OF SELF-INJURIOUS BEHAVIOUR

0 No **1** Yes

a. **Family, caregiver, friend, or staff expresses concern that person is at risk for self-injury**
b. **Suicide plan**—In LAST 30 DAYS, formulated a scheme to end own life

4. VIOLENCE
Code for most recent instance

0 Never **3** 8–30 days ago
1 More than 1 year ago **4** 4–7 days ago
2 31 days–1 year ago **5** In last 3 days

a. **Violent ideation**—e.g., reports of premeditated thoughts, statements, plans to commit violence
b. **Intimidation of others or threatened violence**—e.g., threatening gestures or stance with no physical contact, shouting angrily, throwing furniture, explicit threats of violence
c. **Violence to others**—Acts with purposeful, malicious, or vicious intent, resulting in physical harm to another (e.g., stabbing, choking, beating)

5. HISTORY OF SEXUAL VIOLENCE OR ASSAULT AS PERPETRATOR

0 No **1** Yes

6. EXTREME BEHAVIOUR DISTURBANCE
History of extreme behaviour(s) that suggests serious risk of harm to self (e.g., severe self-mutilation) or others (e.g., fire setting, homicide)

0 No
1 Yes, but not exhibited in last 7 days
2 Yes, exhibited in last 7 days

7. POLICE INTERVENTION
Code for most recent instance (Exclude contact as victim)

0 Never **3** 8–30 days ago
1 More than 1 year ago **4** 4–7 days ago
2 31 days–1 year ago **5** In last 3 days

a. **Police intervention for violent behaviour**
b. **Police intervention for nonviolent behaviour**

8. CURRENTLY ON PROBATION OR PAROLE

0 No **1** Yes

9. CURRENTLY IN A COURT DIVERSION / SUPPORT PROGRAM

0 No **1** Yes

10. RESTRAINING ORDER(S)

0 Never present
1 Previous order(s), but none present now
2 Order(s) present

11. COMMUNITY TREATMENT ORDER(S)

0 Not present **1** Present

12. INCARCERATION STATUS
Code for most recent status

0 Never incarcerated
1 Released from incarceration more than 1 year ago
2 Released from incarceration within last year
3 Currently incarcerated

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SECTION F. Behaviour

1. BEHAVIOUR SYMPTOMS
Code for indicators observed, irrespective of the assumed cause

0 Not present
1 Present but not exhibited in last 3 days
2 Exhibited on 1–2 of last 3 days
3 Exhibited daily in last 3 days

a. **Wandering**—Moved with no rational purpose, seemingly oblivious to needs or safety ☐
b. **Verbal abuse**—e.g., others were threatened, screamed at, cursed at ☐
c. **Physical abuse**—e.g., others were hit, shoved, scratched, sexually abused ☐
d. **Socially inappropriate or disruptive behaviour**—e.g., made disruptive sounds or noises, screamed out, smeared or threw food or feces, hoarded, rummaged through other's belongings ☐
e. **Inappropriate public sexual behaviour or public disrobing** ☐
f. **Resists care**—e.g., taking medications / injections, ADL assistance, eating ☐

SECTION G. Cognition

1. COGNITIVE SKILLS FOR DAILY DECISION MAKING ☐
Making decisions regarding tasks of daily life—e.g., when to get up or have meals, which clothes to wear or activities to do

0 Independent—Decisions consistent, reasonable, and safe
1 Modified independence—Some difficulty in new situations only
2 Minimally impaired—In specific recurring situations, decisions become poor or unsafe; cues / supervision necessary at those times
3 Moderately impaired—Decisions consistently poor or unsafe; cues / supervision required at all times
4 Severely impaired—Never or rarely makes decisions
5 No discernible consciousness, coma

2. MEMORY / RECALL ABILITY
Code for recall of what was learned or known

0 Yes, memory OK **1** Memory problem

a. **Short-term memory OK**—Seems / appears to recall after 5 minutes ☐
b. **Procedural memory OK**—Can perform all or almost all steps in a multitask sequence without cues ☐

3. PERIODIC DISORDERED THINKING OR AWARENESS
[Note: Accurate assessment requires conversations with staff, family, or others who have direct knowledge of the person's behaviour over this time]

0 Behaviour not present
1 Behaviour present, consistent with usual functioning
2 Behaviour present, appears different from usual functioning (e.g., new onset or worsening; different from a few weeks ago)

a. **Easily distracted**—e.g., episodes of difficulty paying attention; gets sidetracked ☐
b. **Episodes of disorganized speech**—e.g., speech is nonsensical, irrelevant, or rambling from subject to subject; loses train of thought ☐
c. **Mental function varies over the course of the day**—e.g., sometimes better, sometimes worse ☐

4. ACUTE CHANGE IN MENTAL STATUS FROM PERSON'S USUAL FUNCTIONING—e.g., restlessness, lethargy, difficult to arouse, altered environmental perception ☐

0 No **1** Yes

5. CHANGE IN DECISION MAKING AS COMPARED TO 90 DAYS AGO (OR SINCE LAST ASSESSMENT) ☐

0 Improved **2** Declined
1 No change **8** Uncertain

SECTION H. Functional Status

1. IADL SELF-PERFORMANCE AND CAPACITY
Code for PERFORMANCE in routine activities around the home or in the community during the LAST 3 DAYS

Code for CAPACITY based on presumed ability to carry out activity as independently as possible. This will require "speculation" by the assessor.

0 Independent—No help, set-up, or supervision
1 Set-up help only
2 Supervision—Oversight / cueing
3 Limited assistance—Help on some occasions
4 Extensive assistance—Help throughout task, but performs 50% or more of task on own
5 Maximal assistance—Help throughout task, but performs less than 50% of task on own
6 Total dependence—Full performance by others during entire period
8 Activity did no occur—During entire period [DO NOT USE THIS CODE IN SCORING CAPACITY]

	Performance	Capacity
a. **Meal preparation**—How meals are prepared (e.g., planning meals, assembling ingredients, cooking, setting out food and utensils)	☐	☐
b. **Ordinary housework**—How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)	☐	☐
c. **Managing finances**—How bills are paid, chequebook is balanced, household expenses are budgeted, credit card account is monitored	☐	☐
d. **Managing medications**—How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)	☐	☐
e. **Phone use**—How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)	☐	☐
f. **Shopping**—How shopping is performed for food and household items (e.g., selecting items, paying money)—EXCLUDE TRANSPORTATION	☐	☐
g. **Transportation**—How travels by public transportation (navigating system, paying fare) or drives self (including getting out of house, into and out of vehicles)	☐	☐

2. ADL SELF-PERFORMANCE
Consider all episodes over 3-day period.

*If **all** episodes are performed at the same level, score ADL at that level.*

*If **any** episodes at level 6, and others less dependent, score ADL as a 5.*

Otherwise, focus on the three most dependent episodes [or all episodes if performed fewer than 3 times].

If most dependent episode is 1, score ADL as 1. If not, score ADL as least dependent of those episodes in range 2–5.

0 Independent—No physical assistance, set-up, or supervision in any episode
1 Independent, set-up help only—Article or device provided or placed within reach, no physical assistance or supervision in any episode
2 Supervision—Oversight / cueing
3 Limited assistance—Guided manoeuvring of limbs, physical guidance without taking weight
4 Extensive assistance—Weight-bearing support (including lifting limbs) by one helper where person still performs 50% or more of subtasks
5 Maximal assistance—Weight-bearing support (including lifting limbs) by 2+ helpers—OR—Weight-bearing support for more than 50% of subtasks
6 Total dependence—Full performance by others during all episodes
8 Activity did not occur during entire period

a. **Personal hygiene**—How manages personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing and drying face and hands—EXCLUDE BATHS AND SHOWERS ☐
b. **Locomotion**—How moves between locations on same floor (walking or wheeling). If in wheelchair, self-sufficiency once in chair ☐
c. **Transfer toilet**—How moves on and off toilet or commode ☐

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d. **Toilet use**—How uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes bed pad, manages ostomy or catheter, adjusts clothes—EXCLUDE TRANSFER ON AND OFF TOILET

e. **Eating**—How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)

3. TOTAL HOURS OF EXERCISE OR PHYSICAL ACTIVITY IN LAST 3 DAYS—e.g., walking

0 None
1 Less than 1 hour
2 1–2 hours
3 3–4 hours
4 More than 4 hours

4. PHYSICAL FUNCTION IMPROVEMENT POTENTIAL

0 No **1** Yes

a. **Person believes he / she is capable of improved performance in physical function**

b. **Care professional believes person is capable of improved performance in physical function**

5. CHANGE IN ADL STATUS AS COMPARED TO 90 DAYS AGO, OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS AGO

0 Improved
1 No change
2 Declined
8 Uncertain

SECTION I. Communication and Vision

1. MAKING SELF UNDERSTOOD (Expression)
Expressing information content—both verbal and nonverbal

0 Understood—Expresses ideas without difficulty
1 Usually understood—Difficulty finding words or finishing thoughts BUT if given time, little or no prompting required
2 Often understood—Difficulty finding words or finishing thoughts AND prompting usually required
3 Sometimes understood—Ability is limited to making concrete requests
4 Rarely or never understood

2. ABILITY TO UNDERSTAND OTHERS (Comprehension)
Understanding verbal information content (however able; with hearing appliance normally used)

0 Understands—Clear comprehension
1 Usually understands—Misses some part / intent of message BUT comprehends most conversation
2 Often understands—Misses some part / intent of message BUT with repetition or explanation can often comprehend conversation
3 Sometimes understands—Responds adequately to simple, direct communication only
4 Rarely or never understands

3. HEARING
Ability to hear (with hearing appliance normally used)

0 Adequate—No difficulty in normal conversation, social interaction, listening to TV
1 Minimal difficulty—Difficulty in some environments (e.g., when person speaks softly or is more than 2 metres [6 feet] away)
2 Moderate difficulty—Problem hearing normal conversation, requires quiet setting to hear well
3 Severe difficulty—Difficulty in all situations (e.g., speaker has to talk loudly or speak very slowly; or person reports that all speech is mumbled)
4 No hearing

4. VISION
Ability to see in adequate light (with glasses or with other visual appliance normally used)

0 Adequate—Sees fine detail, including regular print in newspapers / books
1 Minimal difficulty—Sees large print, but not regular print in newspapers / books
2 Moderate difficulty—Limited vision; not able to see newspaper headlines, but can identify objects
3 Severe difficulty—Object identification in question, but eyes appear to follow objects; sees only light, colours, shapes
4 No vision

SECTION J. Health Conditions

1. SELF-REPORTED HEALTH
Ask: "In general, how would you rate your health?"

0 Excellent
1 Good
2 Fair
3 Poor
8 Could not (would not) respond

2. PROBLEM FREQUENCY
Code for presence in last 3 days

0 Not present
1 Present but not exhibited in last 3 days
2 Exhibited on 1 of last 3 days
3 Exhibited on 2 of last 3 days
4 Exhibited daily in last 3 days

Balance

a. **Dizziness**
b. **Unsteady gait**

Cardiac

c. **Chest pain**

GI Status

d. **Acid reflux**—Regurgitation of acid from stomach to throat
e. **Constipation**—No bowel movement in 3 days or difficult passage of hard stool
f. **Diarrhea**
g. **Dry mouth**
h. **Hypersalivation or drooling**
i. **Increase or decrease in normal appetite**
j. **Nausea**
k. **Vomiting**

Other

l. **Blurred vision**
m. **Daytime drowsiness or sedation**
n. **Difficulty urinating, urinating 3 or more times a night or polyuria**
o. **Emergent conditions**—e.g., itching, fever, rash, bleeding
p. **Headache**
q. **Peripheral edema**
r. **Seizures**

3. DYSPNEA (Shortness of breath)

0 Absence of symptom
1 Absent at rest, but present when performed moderate activities
2 Absent at rest, but present when performed normal day-to-day activities
3 Present at rest

4. FATIGUE
Inability to complete normal daily activities—e.g., ADLs, IADLs

0 None
1 Minimal—Diminished energy but completes normal day-to-day activities
2 Moderate—Due to diminished energy, UNABLE TO FINISH normal day-to-day activities
3 Severe—Due to diminished energy, UNABLE TO START SOME normal day-to-day activities
4 Unable to commence any normal day-to-day activities—Due to diminished energy

5. EXTRAPYRAMIDAL SYMPTOMS DURING LAST 3 DAYS

0 No **1** Yes

a. **Akathisia**—Subjective feeling of restlessness or need for movement
b. **Dyskinesia**—e.g., chewing, puckering movements of mouth; abnormal irregular movements of lips; rocking or writhing of trunk
c. **Tremor**—Involuntary rhythmic movements of the fingers, limbs, head, mouth, tongue
d. **Bradykinesia**—Decrease in spontaneous movements (e.g., reduced body movement, or poverty of facial expression, gestures, speech)
e. **Rigidity**—Resistance to flexion and extension of muscles (e.g., continuous or cogwheeling rigidity)
f. **Dystonia**—Muscle hypertonicity (e.g., muscle spasms or stiffness, protruding tongue, upward deviation of the eyes)
g. **Slow shuffling gait**—Reduction in speed and stride length, usually with a decrease in pendular arm movement

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6. SEXUAL ACTIVITY
0 No **1** Yes
a. **Performed sexual acts for money, desired objects, or favours (includes participation in sex trade) in LAST 90 DAYS**
b. **Reports persistent difficulty with sexual functioning during the last 30 days**—e.g., loss of interest or drive, impaired erection or impaired ejaculation, inhibited female orgasm

7. SKIN PROBLEMS
0 No **1** Yes
a. **Major skin problems**—e.g., lesions, 2nd- or 3rd-degree burns, healing surgical wounds
b. **Other skin conditions or changes in skin condition**—e.g., bruises, rashes, itching, mottling, herpes zoster, intertrigo, eczema

8. FOOT PROBLEMS—e.g., bunions, hammertoes, overlapping toes, structural problems, infections, ulcers
0 No foot problems
1 Foot problems, no limitation in walking
2 Foot problems limit walking
3 Foot problems prevent walking
4 Foot problems, does not walk for other reasons

9. FALLS
0 No fall in last 90 days
1 No fall in last 30 days, but fell 31–90 days ago
2 One fall in last 30 days
3 Two or more falls in last 30 days

10. RECENT FALLS
[Skip if last assessment more than 30 days ago or if this is first assessment]
0 No **1** Yes **[blank]** Not applicable (first assessment, or more than 30 days since last assessment)

11. PAIN SYMPTOMS
[Note: Always ask the person about pain frequency, intensity, and control. Observe person and ask others who are in contact with the person.]
a. **Frequency with which person complains or shows evidence of pain** (including grimacing, teeth clenching, moaning, withdrawal when touched, or other nonverbal signs suggesting pain)
0 No pain **1** Present but not exhibited in last 3 days **2** Exhibited on 1–2 of last 3 days **3** Exhibited daily in last 3 days
b. **Intensity of highest level of pain present**
0 No pain **1** Mild **2** Moderate **3** Severe **4** Times when pain is horrible or excruciating
c. **Consistency of pain**
0 No pain **1** Single episode during last 3 days **2** Intermittent **3** Constant
d. **Pain control**—Adequacy of current therapeutic regimen to control pain (from person's point of view)
0 No issue of pain
1 Pain intensity acceptable to person; no treatment regimen or change in regimen required
2 Controlled adequately by therapeutic regimen
3 Controlled when therapeutic regimen followed, but not always followed as ordered
4 Therapeutic regimen followed, but pain control not adequate
5 No therapeutic regimen being followed for pain; pain not adequately controlled

12. BLADDER CONTINENCE
0 Continent—Complete control; DOES NOT USE any type of catheter or other urinary collection device
1 Control with any catheter or ostomy over last 3 days
2 Infrequently incontinent—Not incontinent over last 3 days, but does have incontinent episodes
3 Occasionally incontinent—Less than daily
4 Frequently incontinent—Daily, but some control present
5 Incontinent—No control present
8 Did not occur—No urine output from bladder in last 3 days

13. BOWEL CONTINENCE
0 Continent—Complete control; DOES NOT USE any type of ostomy device
1 Control with ostomy—Control with ostomy device over last 3 days
2 Infrequently incontinent—Not incontinent over last 3 days, but does have incontinent episodes
3 Occasionally incontinent—Less than daily
4 Frequently incontinent—Daily, but some control present
5 Incontinent—No control present
8 Did not occur—No bowel movement in last 3 days

SECTION K. Stress and Trauma

1. LIFE EVENTS
Code for most recent time of event
0 Never **1** More than 1 year ago **2** 31 days–1 year ago **3** 8–30 days ago **4** 4–7 days ago **5** In last 3 days
a. **Serious accident or physical impairment**
b. **Distressed about health of another person**
c. **Death of close family member or friend**
d. **Child custody issues; birth or adoption of child**
e. **Conflict-laden or severed relationship, including divorce**
f. **Failed or dropped out of education program**
g. **Major loss of income or serious economic hardship due to poverty**
h. **Review hearing**—e.g., forensic, certification, capacity hearing
i. **Immigration, including refugee status**
j. **Lived in war zone or area of violent conflict (combatant or civilian)**
k. **Witnessed severe accident, disaster, terrorism, violence, or abuse**
l. **Victim of crime**—e.g., robbery (EXCLUDE ASSAULT)
m. **Victim of sexual assault or abuse**
n. **Victim of physical assault or abuse**
o. **Victim of emotional abuse**
p. **Parental abuse of alcohol or drugs**

2. DESCRIBES ONE OR MORE OF THESE LIFE EVENTS (K1) AS INVOKING A SENSE OF HORROR OR INTENSE FEAR
0 No or not applicable **1** Yes **8** Could not (would not) respond

3. OTHER INDICATORS OF ABUSE OF PERSON
0 No **1** Yes
a. **Fearful of a family member or close acquaintance**
b. **Unexplained injuries**
c. **Person has concerns for his / her safety**

4. FAMILY MEMBER(S) HAS BEEN VICTIM(S) OF PHYSICAL, EMOTIONAL, OR SEXUAL ABUSE OR ASSAULT
0 No **1** Yes

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SECTION L. Medications

1. LIST OF ALL MEDICATIONS
Document medications on last page in space provided

2. ADHERENT WITH MEDICATIONS PRESCRIBED BY PHYSICIAN ☐
- **0** Always adherent
- **1** Adherent 80% of time or more
- **2** Adherent less than 80% of time, including failure to purchase prescribed medications
- **8** No medications prescribed

3. STOPPED TAKING PSYCHOTROPIC MEDICATION IN LAST 90 DAYS BECAUSE OF SIDE EFFECTS ☐
- **0** No, or no psychotropic medications
- **1** Yes

4. INTENTIONAL MISUSE OF PRESCRIPTION OR OVER-THE-COUNTER MEDICATION IN LAST 90 DAYS—e.g., used medication such as benzodiazepines or analgesics for purpose other than intended ☐
0 No **1** Yes

6. ALLERGY TO ANY DRUG ☐
- **0** No known drug allergies
- **1** Yes

SECTION M. Service Utilization and Treatments

1. FORMAL CARE
Contact with formal care provider in LAST 30 DAYS (or since admission if less than 30 days)
- **0** No contact in last 30 days
- **1** No contact in last 7 days, but contact 8–30 days ago
- **2** Contact in last 7 days but not daily
- **3** Daily contact in last 7 days

a. **Psychiatrist** ☐
b. **Nurse-practitioner or MD (nonpsychiatrist)** ☐
c. **Social worker** ☐
d. **Psychologist or psychometrist** ☐
e. **Occupational therapist** ☐
f. **Recreation therapist** ☐
g. **Nurse** ☐
h. **Home health aide / Personal support worker** ☐
i. **Other mental health staff** ☐

2. TREATMENT MODALITIES
Code for treatment modalities used in LAST 30 DAYS or since admission if less than 30 days ago
- **0** Not offered and not received
- **1** Offered, but refused
- **2** Not received, but scheduled to start within next 30 days
- **3** Received 8–30 days ago
- **4** Received in last 7 days

a. **Individual** ☐
b. **Group** ☐
c. **Family or couple** ☐
d. **Self-help / consumer group**—e.g., Alcoholics Anonymous ☐
e. **Complementary therapy or treatment** ☐
f. **Day hospital / Outpatient program** ☐

3. FOCUS OF INTERVENTION
Code for types of issues that were a major focus of interventions in LAST 30 DAYS or since admission if less than 30 days ago
- **0** No intervention of this type
- **1** Offered, but refused
- **2** Not received, but scheduled to start within next 30 days
- **3** Received 8–30 days ago
- **4** Received in last 7 days

a. **Life skills training** ☐
b. **Social or family functioning** ☐
c. **Detoxification or post-detox stabilization** ☐
d. **Alcohol or drug treatment, including methadone management** ☐
e. **Vocational rehabilitation** ☐
f. **Anger management** ☐
g. **Behavioural management** ☐
h. **Pain management** ☐
i. **Crisis intervention** ☐
j. **Basic needs**—e.g., shelter, food ☐

4. ELECTROCONVULSIVE THERAPY ☐
- **0** Never received and not scheduled to begin within next 7 days
- **1** Received more than 30 days ago
- **2** Received 8–30 days ago
- **3** Received in last 7 days
- **4** Scheduled to begin within 7 days

5. HOSPITAL USE, EMERGENCY ROOM USE, PHYSICIAN VISIT
Code for number of times during the LAST 90 DAYS (or since last assessment if LESS THAN 90 DAYS)

a. **In-patient acute hospital with overnight stay (nonpsychiatric)** ☐☐
b. **Emergency room visit (not counting overnight stay)** ☐☐
c. **Physician visit (or authorized assistant or practitioner)** —EXCLUDE PSYCHIATRIST ☐☐

SECTION N. Nutritional Status

1. HEIGHT AND WEIGHT [EXAMPLE — CANADA]
Record (a.) height in centimetres and (b.) weight in kilograms. Base weight on most recent measure in LAST 30 DAYS.

a. **HT** (cm) ☐☐☐ b. **WT** (kg) ☐☐☐

2. NUTRITIONAL ISSUES
0 No **1** Yes

a. **Weight loss of 5% or more in LAST 30 DAYS, or 10% or more in LAST 180 DAYS** ☐
b. **Weight gain of 5% or more IN LAST 30 DAYS, or 10% or more in LAST 180 DAYS** ☐
c. **Fluid intake less than 1,000 cc per day (less than four 8-oz cups / day)** ☐
d. **Decrease in amount of food or fluid usually consumed** ☐
e. **Ate one or fewer meals on AT LEAST 2 of LAST 3 DAYS** ☐

3. PRESENCE OF POTENTIAL SIGNS OF EATING DISORDERS IN LAST 30 DAYS
0 No **1** Yes

a. **Any instances of binge eating, purging, or bulimia** ☐
b. **Unrealistic fear of weight gain; statements that suggest a distorted body image** ☐
c. **Fasting or major restriction of diet**—EXCLUDE RELIGIOUS PRACTICES ☐

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SECTION O. Social Relations

1. TWO KEY INFORMAL HELPERS (Helper 1 2)

a. **Relationship to person**
- **1** Child or child-in-law
- **2** Spouse
- **3** Partner / significant other
- **4** Parent / guardian
- **5** Sibling
- **6** Other relative
- **7** Friend
- **8** Neighbour
- **9** No informal helper

b. **Lives with person**
- **0** No
- **1** Yes, 6 months or less
- **2** Yes, more than 6 months
- **8** No informal helper

Areas of Informal Help during Last 3 Days
- **0** No
- **1** Yes
- **8** No informal helper

c. **Help with child care or other dependants**
d. **Supervision for personal safety**
e. **Crisis support**
f. **IADL help**
g. **ADL help**

2. PLANS FOR FUTURE NEEDS
Person or informal helper(s) has plans for alternative future support or living arrangements, if required (e.g., if current informal helper is no longer able to provide support)
- **0** Alternative plans not considered or not required
- **1** Alternative plans not made, but under consideration
- **2** Alternative plans made

3. INFORMAL HELPER STATUS
0 No **1** Yes

a. **Informal helper(s) is unable to continue in caring activities**—e.g., decline in health of helper makes it difficult to continue
b. **Primary informal helper expresses feelings of distress, anger, or depression**
c. **Family or close friends report feeling overwhelmed by person's illness**

4. BELIEF THAT RELATIONSHIP(S) WITH IMMEDIATE FAMILY MEMBER(S) IS DISTURBED OR DYSFUNCTIONAL
- **0** Belief not present
- **1** Only person believes
- **2** Family, friends, or others believe
- **3** Both person AND others believe

5. UNSETTLED RELATIONSHIPS
0 No **1** Yes

a. **Conflict with or repeated criticism of family or friends**
b. **Conflict with or repeated criticism of other care recipients**
c. **Staff report persistent frustration in dealing with person**

6. STRENGTHS
0 No **1** Yes

a. **Reports having a confidant**
b. **Consistent positive outlook**
c. **Strong and supportive relationship with family**
d. **Reports strong sense of involvement in community**

7. SOCIAL RELATIONSHIPS
[Note: Whenever possible, ask person]
- **0** Never
- **1** More than 30 days ago
- **2** 8–30 days ago
- **3** 4–7 days ago
- **4** In last 3 days
- **8** Unable to determine

a. **Participation in social activities of long-standing interest**
b. **Visit with a long-standing social relation or family member**
c. **Other interaction with long-standing social relation or family member**—e.g., telephone, e-mail

8. ACTIVITY LEVEL
In the LAST 3 DAYS, number of days went out of the house or building in which he/she resides (no matter how short the period)
- **0** No days out
- **1** Did not go out in last 3 days, but usually goes out over a 3-day period
- **2** 1–2 days
- **3** 3 days

9. LENGTH OF TIME ALONE DURING THE DAY (MORNING AND AFTERNOON)
- **0** Less than 1 hour
- **1** 1–2 hours
- **2** More than 2 hours but less than 8 hours
- **3** 8 hours or more

SECTION P. Employment, Education, and Finances

1. EMPLOYMENT STATUS
- **1** Employed
- **2** Unemployed, seeking employment
- **3** Unemployed, not seeking employment

2. EMPLOYMENT ARRANGEMENTS (EXCLUDE VOLUNTEERING)
- **1** Competitive employment
- **2** Supported employment
- **3** Vocational rehabilitation
- **8** Not applicable

3. VOLUNTEERS—e.g., for community services
0 No **1** Yes

4. ENROLLED IN FORMAL EDUCATION PROGRAM
- **0** No
- **1** Part-time
- **2** Full-time

5. RISK OF UNEMPLOYMENT OR DISRUPTED EDUCATION
- **0** No
- **1** Yes
- **8** Not applicable

a. **Increase in lateness or absenteeism over LAST 6 MONTHS**
b. **Poor productivity or disruptiveness at work or school**
c. **Expresses intent to quit work or school**
d. **Persistent unemployment or fluctuating work history over LAST 2 YEARS**

6. FINANCES
Because of limited funds, during the LAST 30 DAYS made trade-offs among purchasing any of the following: adequate food, shelter, clothing; prescribed medications; sufficient home heat or cooling; necessary health care
0 No **1** Yes

SECTION Q. Environmental Assessment

1. HOME ENVIRONMENT
Code for any of following that make home environment hazardous or uninhabitable (if temporarily in institution, base assessment on home visit)
- **0** No
- **1** Yes
- **8** Unknown, home not visited or no information

a. **Disrepair of the home**—e.g., hazardous clutter; inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors; holes in floor; leaking pipes
b. **Squalid condition**—e.g., extremely dirty, infestation by rats or bugs
c. **Inadequate heating or cooling**—e.g., too hot in summer, too cold in winter
d. **Lack of personal safety**—e.g., fear of violence, safety problem in going to mailbox or visiting neighbours, heavy traffic in street
e. **Limited access to home or rooms in home**—e.g., difficulty entering or leaving home, unable to climb stairs, difficulty manoeuvring within rooms, no railings although needed

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SECTION R. Diagnostic Information

1. DSM-IV PROVISIONAL DIAGNOSTIC CATEGORY
Identify all provisional categories of DSM-IV diagnoses determined by the psychiatrist or attending physician and rank their importance as factors contributing to this admission (if no provisional diagnosis available, code all boxes "8")

0 Not present
1 Most important
2 Second most important
3 Third most important
4 Less important
8 No provisional diagnosis

a. **Disorders of childhood or adolescence** ☐
b. **Delirium, dementia, and amnestic and other cognitive disorders** ☐
c. **Mental disorders due to general medical conditions** ☐
d. **Substance-related disorders** ☐
e. **Schizophrenia and other psychotic disorders** ☐
f. **Mood disorders** ☐
g. **Anxiety disorders** ☐
h. **Somatoform disorders** ☐
i. **Factitious disorders** ☐
j. **Dissociative disorders** ☐
k. **Sexual and gender identity disorders** ☐
l. **Eating disorders** ☐
m. **Sleep disorders** ☐
n. **Impulse-control disorders not elsewhere classified** ☐
o. **Adjustment disorders** ☐
p. **Personality disorders** ☐

2. PSYCHIATRIC DIAGNOSES
Enter Axis I and Axis II DSM-IV diagnoses, if known. Must be completed on discharge, but also complete with earlier assessments if specific psychiatric diagnosis already determined.

a. **AXIS I:**

1. _____
DSM-IV CODE: ☐☐☐.☐☐

2. _____
DSM-IV CODE: ☐☐☐.☐☐

b. **AXIS II:**

_____
DSM-IV CODE: ☐☐☐.☐☐

3. INTELLECTUAL DISABILITY—e.g., Down syndrome ☐
0 No **1** Yes

4. MEDICAL DIAGNOSES
Disease Code
0 Not present
1 Primary diagnosis / diagnoses for current stay
2 Diagnosis present, receiving active treatment
3 Diagnosis present, monitored but no active treatment

a. **Asthma** ☐
b. **Diabetes mellitus** ☐
c. **Hypothyroidism** ☐
d. **Migraine** ☐
e. **Traumatic brain injury** ☐

Other Medical Diagnoses	Disease Code	ICD-10 code [Example — Canada]
f. _____	☐	☐☐☐☐.☐☐☐
g. _____	☐	☐☐☐☐.☐☐☐
h. _____	☐	☐☐☐☐.☐☐☐

[Note: Add additional lines as necessary for other disease diagnoses]

SECTION S. Discharge

1. HOW LONG PERSON IS EXPECTED TO RECEIVE SERVICES FROM THIS AGENCY ☐
(Count from Assessment Reference Date, including that day)

0 1–7 days
1 8–14 days
2 15–30 days
3 31–90 days
4 91 or more days

2. LAST DAY OF INVOLVEMENT WITH PROGRAM OR AGENCY
[Note: Complete at discharge only]

2 0 ☐☐ — ☐☐ — ☐☐
Year Month Day

3. DISCHARGED TO ☐☐
[Note: Complete at discharge only, and code for expected initial arrangement at discharge]

1 Private home / apartment / rented room
2 Board and care
3 Assisted living or semi-independent living
4 Mental health residence—e.g., psychiatric group home
5 Group home for persons with physical disability
6 Setting for persons with intellectual disability
7 Psychiatric hospital or unit
8 Homeless (with or without shelter)
9 Long-term care facility (nursing home)
10 Rehabilitation hospital / unit
11 Hospice facility / palliative care unit
12 Acute care hospital
13 Correctional facility
14 Other
15 Deceased

SECTION T. Assessment Information

SIGNATURE OF PERSON COORDINATING / COMPLETING THE ASSESSMENT

_____
1. Signature (sign on above line)

2. Date assessment signed as complete

2 0 ☐☐ — ☐☐ — ☐☐
Year Month Day

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SECTION L. Medications (continued from page 7)

1. LIST OF ALL MEDICATIONS

List all active prescriptions and any nonprescribed (over-the-counter) medications taken in the LAST 3 DAYS
[NOTE: Use computerized records if possible; hand enter only when absolutely necessary]

For each drug, record:

a. **Name**

b. **Dose**—*A positive number such as 0.5, 5, 150, 300. [Note: Never write a zero by itself after a decimal point (X mg). Always use a zero before a decimal point (0.X mg)]*

c. **Unit**—*Code using the following list:*

gtts	(drops)	**mcg**	(microgram)	**ml**	(millilitre)	**%**	(percent)
gm	(gram)	**mEq**	(milliequivalent)	**oz**	(ounce)	**units**	(units)
L	(litre)	**mg**	(milligram)	**puffs**	(puffs)	**oth**	(other)

d. **Route of administration**—*Code using the following list:*

PO	(by mouth / oral)	**Sub-Q**	(subcutaneous)	**IH**	(inhalation)	**TD**	(transdermal)
SL	(sublingual)	**REC**	(rectal)	**NAS**	(nasal)	**EYE**	(eye)
IM	(intramuscular)	**TOP**	(topical)	**ET**	(enteral tube)	**OTH**	(other)
IV	(intravenous)						

e. **Frequency**—*Code the number of times per day, week, or month the medication is administered using the following list:*

Q1H	(every hour)	**BED**	(at bedtime)	**5D**	(5 times daily)	**4W**	(4 times weekly)
Q2H	(every 2 hours)	**Daily**	(once daily)	**Q2D**	(every other day)	**5W**	(5 times weekly)
Q3H	(every 3 hours)	**BID**	(2 times daily)	**Q3D**	(every 3 days)	**6W**	(6 times weekly)
Q4H	(every 4 hours)		(includes every 12 hrs)	**Weekly**		**1M**	(once every month)
Q6H	(every 6 hours)	**TID**	(3 times daily)	**2W**	(2 times weekly)	**2M**	(twice every month)
Q8H	(every 8 hours)	**QID**	(4 times daily)	**3W**	(3 times weekly)	**OTH**	(other)

f. **PRN**

0 No **1** Yes

g. **Computer-entered drug code [Example Canada—DIN]**

[Note: Add additional lines as necessary, for other drugs taken]
[Abbreviations are Country Specific for Unit, Route, Frequency]

a. Name	b. Dose	c. Unit	d. Route	e. Freq.	f. PRN	g. Computer-entered drug code								
1.														
2.														
3.														
4.														
5.														
6.														
7.														
8.														
9.														
10.														
11.														
12.														

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interRAI is a not-for-profit, international network of practitioners and research professionals committed to improving health care for persons who are elderly, frail, or disabled. Our goal is to promote evidence-based clinical practice and policy decisions through the collection and interpretation of high-quality data about the characteristics and outcomes of persons served across a variety of health and social services settings.

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