interRAI™

interRAI Mental Health Clinical Assessment Protocols (CAPs)

MH CMH ESP

For Use with Community and Hospital-Based Mental Health Assessment Instruments

Version 9.1
Canadian Edition

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For more information or comments on interRAI and its assessment instruments, visit www.interRAI.org.

Disclaimer

interRAI, the publishers, and the authors do not 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 in the CAPs manual 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. Care professionals are ultimately responsible for providing appropriate clinical oversight and care subject to the professional practice regulations where the person receives care. The recommendations in the CAPs should be reviewed against current care standards in their program sites or jurisdictions.

Licensing interRAI Assessment Systems

Preface

The New Generation of interRAI Clinical Assessment Protocols

As part of a multiyear research initiative to update its entire family of assessment instruments, interRAI is pleased to release new Clinical Assessment Protocols (CAPs) for use with its assessment instruments for community and hospital-based mental health settings. The new CAPs can also be used with the prior generation of interRAI assessment instruments that are used in in-patient settings (RAI-MH). As a result, we hope clinicians using either the prior instrument or the new suite of instruments will benefit from this major initiative.

This set of twenty-one CAPs can be used across the continuum of mental health services, and these CAPs replace the previous Mental Health Assessment Protocols (MHAPs) for the RAI-MH. The release of these mental health CAPs follows the 2008 release of the CAPs for home care, community health, and long-term care facilities. Three working groups are in the process of developing the first generation of CAPs for the interRAI Acute Care, interRAI Palliative Care, and interRAI Intellectual Disability instruments. A release by 2012 is expected for those CAPs.

interRAI Mental Health CAP Development

interRAI's mental health CAPs were developed as part of a multiyear, international collaborative research effort involving the interRAI Instrument and System Development (ISD) Committee and the interRAI Network of Excellence in Mental Health (iNEMH).

There were three main research activities undertaken. First, reviews of international best practice guidelines, including both English and non-English (when available) language guidelines, were used as a starting point for CAP development. Where such guidelines were not available, literature reviews were conducted to identify relevant publications.

Second, through the ISD and iNEMH committees, and with the help of partner agencies like the Canadian Institute for Health Information (CIHI), extensive consultations were made with subject-matter experts from around the world. These committees provided important links with international clinical stakeholders, including direct evaluations of the CAPs by clinicians from Canada, United States, Iceland, Finland, Brazil, Peru, and Hong Kong.

Third, all CAPs were developed based on analysis of interRAI mental health data holdings. More than 350,000 RAI-MH assessments for Ontario psychiatric hospital patients were completed between 2005 and 2009, including admission, discharge, and quarterly assessments. In addition, longitudinal pilot studies of approximately 1,000 Canadian community mental health clients were used to model the CAPs with the interRAI Community Mental Health (CMH). The results of these analyses are included in all the CAPs to provide information on expected trigger rates of those requiring a plan of care, factors associated with triggering the CAPs, and evidence on

longitudinal changes in CAP triggers and outcomes of interest. As part of the ongoing scientific effort related to the CAP development, papers regarding the CAPs will be published in the peer-reviewed literature.[1]

The CAP redevelopment effort has been a true international research undertaking that has focused on improving the quality of care and quality of life of persons with mental health needs. In combination with interRAI's release of a suite of twelve new versions of its assessment instruments, this work represents a unique step forward in developing a truly integrated mental health information system.

[1]For example, Mathias K, Hirdes JP, Pittman D. 2010. A care planning strategy for traumatic life events in community mental health and in-patient psychiatry based on the interRAI assessment instruments. *Community Mental Health Journal* 46(6): 621–27.

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Introduction to interRAI's Mental Health CAPs

interRAI Assessment Instruments

The interRAI family of assessment instruments is designed to comprise an integrated information system, linking multiple health and social service settings. These instruments are used to inform collaborative decision making through a person-centred approach that builds on the person's strengths, preferences, and needs.

The mental health Clinical Assessment Protocols (CAPs) are designed to be used with the mental health assessments in the interRAI family of instruments, including

- RAI-Mental Health (RAI-MH), version 2.0
- interRAI Mental Health (interRAI MH)
- interRAI Community Mental Health (interRAI CMH)
- interRAI Emergency Screener for Psychiatry (interRAI ESP)

CAPs provide an evidence-informed approach to using findings from the interRAI mental health assessment instruments to support the development of comprehensive care and service planning in hospital and community-based settings. They focus on a person's functioning and quality of life with an aim to supporting the recovery process. The emphasis is on an outcome-based approach that uses reassessment over time to target support services and interventions to alleviate the effects of mental health symptoms, promote autonomy, improve psychosocial and physical well-being, enhance community engagement, and support participation in activities that are meaningful to the person.

The CAPs draw from systematic reviews from international literature and expertise on best practice guidelines for different issues affecting persons with mental health needs. The CAPs have been written for clinical audiences and are not intended to be simple restatements of scientific findings. That said, the CAPs are also based on extensive analyses of large interRAI mental health data holdings rather than relying on a consensus panel input alone. In addition, the CAPs fill important gaps in areas where best practice guidelines are rarely available, and they seek to identify areas of agreement where international practice guidelines differ. Finally, the CAPs have a strong connection to interRAI's Mental Health Quality Indicators (MHQIs) that benchmark performance on various outcome measures relevant to mental health services. MHQIs reflect the organizational level manifestation of the quality of care provided at the person level, using CAPs as a basis for clinical intervention.

These CAPs are intended to be used with interRAI's instruments for the mental health sector. However, other interRAI instruments and supplements deal with mental health matters, and the CAPs designed for those instruments address person-level health concerns, including mental health considerations.

interRAI's assessment instruments provide a comprehensive, holistic perspective on the person's life, including personal strengths (for example, support networks, psychological well-being), preferences (for example, personal goals of care), symptoms related to mental illness and physical health problems, environmental factors, service use, community involvement, and quality of life. The CAPs provide a multidimensional view of the person's current situation and life experiences and identify those areas in which the person may benefit from additional supports or formal services. They take into account the functional and quality-of-life implications of mental health symptoms, but they do not prescribe how those symptoms should be managed. They consider a broad range of internal and external conditions that may affect the person's life. In addition, the CAPs are not intended to be used as automated generators of care plans. Instead, they are decision-support tools to inform interactions between clinicians and persons with mental health needs.

Supporting Recovery

The approach to using the CAPs is fully consistent with the principles of models of care that support self-determination and empowerment. These models recognize that the person is defined by more than his or her mental illness. Virtually all persons in in-patient and community mental health settings will have CAPs triggered to support improvement in one or more areas. High-quality mental health services use a holistic approach that supports persons affected by mental illness, including those with severe symptoms, in regaining function, independence, dignity, and hope in their lives.

The CAPs are **not** diagnostic tools aimed at identifying a "cure" for the person's mental illness. Rather, they identify a range of issues in daily life that may be addressed to enable recovery of the person in that domain. The interRAI mental health instruments do not treat recovery as an "all or nothing" outcome. There may be differences in the degree of improvement, trajectory of change, and domains of recovery that different persons experience. However, the underlying assumption is that improvements in quality of life are possible for all persons affected by mental illness.

Targeting Modifiable Outcomes

The CAPs are designed to take an outcome-oriented approach to support and care planning. CAPs are triggered for at least two types of persons: (1) those who are likely to experience improvements in a particular domain with appropriate support, and (2) those who are at elevated risk of further setbacks if effective action is not taken. Some CAPs are more likely to be triggered with subgroups of persons receiving mental health services. For example, older persons are more likely to trigger the CAPs related to falls. Persons in forensic settings are more likely to trigger CAPs related to criminal activity or harm to others. Those with more severe cognitive impairment or acute psychosis will be more likely to trigger the CAP for self-care. For persons who are acutely ill, CAPs related to safety (for example, Suicidality and Purposeful Self-Harm, Harm to Others) will often be the priority.

Collaborative Decision Making

Decision making should be collaborative and inclusive of the person's perspective with the aim of enhancing the person's quality of life and independence as fully

as possible. Although the CAPs will identify areas that probably require attention in the care planning process, the nature and timing of the response to the CAPs should take into account the person's priorities whenever possible. These are identified in the interRAI CMH and interRAI MH's section on the person's expressed goals of care. In some cases (for example, acute psychosis, severe cognitive impairment), it may be less feasible to obtain direct input from the person; however, every effort should be made to empower the person to make meaningful choices in the care planning process. It may also be true that CAPs are sometimes not triggered for issues that are nonetheless important concerns for the person. In those cases, the mental health team should collaborate with the person to identify the underlying factors and response options available to address the concern.

Engaging the Support Network

The CAP process should also include, where appropriate and with the agreement of the person, members of the person's support network (for example, family, friends, peer supports). Social relationships can be affected by the person's mental and physical health. However, the successful movement toward recovery is influenced by the support provided by others, a sense of meaningful engagement in the community, and a shared responsibility for the pursuit of improved well-being. It must be recognized that a supportive environment requires the collaboration of all key stakeholders: the person, the informal support network, the mental health team, and the broader community. To that end, the CAPs do not consider only the individual characteristics of the person, but they also address potential concerns related to the informal support network (for example, family or close friends report feeling overwhelmed, conflicts between the person's and family's values), the care setting (for example, staff frustration with the person), and both the physical and social dimensions of the home environment.

Building on Strengths

Whenever possible, the CAP process should identify and build on the person's strengths. The interRAI mental health instruments include a variety of items dealing with personal strengths, including having, for example, an individual who is supportive of the person's return to the community (for persons in in-patient settings); a confidant; a strong and supportive relationship with family; a consistent positive outlook; and a strong sense of involvement in the community. In addition, there are numerous scales embedded in the interRAI mental health instruments that may be used to determine the person's functional status. This information can be used to provide a context for framing interventions that are appropriately matched to the person's abilities.

The CAPs that are not triggered represent the person's potential areas of strength. They may be helpful to identify resources that can be mobilized to address the triggered CAPs.

Calibrating Response to the Person's Health

The severity of symptoms related to mental illness will influence how CAPs are prioritized and what strategies are implemented to support the recovery process at a given point in time. For example, safety will be a priority for persons who are acutely ill with imminent risk of harm to self or others. For those whose symptoms have improved, the focus will shift toward wellness, social reintegration, return to work or school, and enhanced community participation.

Reassessment of Progress in Recovery

It is essential to use the interRAI mental health instruments and the associated CAPs on an ongoing basis to provide a view of the person's strengths, preferences, and needs over time. Recovery is a nonlinear process that can include improvements in some areas and setbacks in others. Reassessment is needed on a regular basis in order to gather information on outcomes, to identify new considerations affecting the person's ability to function, and to evaluate the effectiveness of the existing care plan. This applies to reassessment *within* settings and *between* settings. The interRAI in-patient and community mental health instruments are expressly designed to permit the ongoing use of the assessment information to support clinical decision making irrespective of the mental health setting in which the person happens to be situated.

Best Practices and Evidence-Informed Decision Making

The CAPs also aim to link the assessment findings to interventions, services, and support strategies that have been demonstrated to be effective practices based on current evidence. The development process for all CAPs takes into account research based on large-scale data from the use of the interRAI mental health instruments (for example, through the Ontario Mental Health Reporting System), consultation with international best practice guidelines, and expert feedback through the interRAI Network of Excellence in Mental Health.

Matching Resources to Needs

The interRAI mental health instruments include numerous items on access to appropriate support services, including education by clinical staff, participation in self-help groups, and family supports. The care planning process should take into account what resources are available, and it should identify and respond to any barriers preventing access to needed services. In some cases, those services may not be readily available within the existing care setting, but a referral to an agency able to offer them may be appropriate.

Continuity of Care Planning and Mental Health System Integration

Although many persons with mental health needs may receive services only through a single agency or sector, the CAPs can be used across the full continuum of mental health services, including both community and hospital-based settings. Although the interRAI assessment instruments support **continuity of care** by providing compatible measures between in-patient and community mental health, the CAPs support **continuity of care *planning*** by providing common protocols across settings. For example, although it may be difficult to address issues related to education and employment during a short-stay in-patient episode, the identification of those issues in the hospital should initiate a process to engage community mental health staff (or private practice professionals) to formulate a longer-term response to the issues. Similarly, safety issues identified through the CAPs related to harm to self, harm to others, and self-care should be communicated to professionals in other sectors assuming a role in providing care and support to the person in advance of the transition being made (subject to the requirements of country-specific privacy laws).

To fully realize the benefits of these CAPs over the course of the person's recovery, it will be important for services to function in an integrated, collaborative manner. In some jurisdictions, there is already a seamless connection of mental health services in hospital settings with those offered in the community. The use of CAPs to support care planning represents a natural extension of those existing collaborative relationships. However, in other jurisdictions these mental health sectors may function separately with relatively few linkages in their service delivery model. In that case, the CAPs provide an opportunity to bring hospital and community-based mental health services together under a common care planning framework. The following simple steps may be taken:

- Develop discharge summaries or recovery plan documents that summarize the assessment findings, CAPs triggered, and care plan response to the CAPs.
- Forward assessment results, including scales and CAPs, to partner agencies with the person's consent (subject to jurisdictional privacy laws).
- Use summaries of multiple interRAI assessments (if available within your organization or partner organizations) to obtain a longitudinal clinical view of how the person has changed, if at all, over time.
- Engage the person and clinicians in partner organizations in a dialogue to support collaborative decision making about the approach the mental health system will use to support the person's recovery.

CAP Components

Each CAP contains the following key components:

- Issue statement: a description of why the CAP domain area is important to consider as part of quality mental health services.
- Goals of care: vary from one CAP to the next but include the possibility of problem resolution, reducing the risk of decline or increasing the potential for improvement.
- CAP triggers: clinical decision support algorithms that link the information gathered from the assessment to the basic issue referenced by the CAP. The trigger levels are described in narrative form. For detailed technical information on the statistical code for the CAP triggers, contact CIHI in Canada or access the interRAI Web site (www.interRAI.org) internationally.
- CAP guidelines: for those triggered, each CAP contains care guidelines to help think through the relevant underlying issues and move toward a plan of care. CAPs guide the plan of care to remove barriers, support autonomy, reduce the risk of decline, and increase the potential for improvement.
- Additional resources: reference materials that may be used to gain more detailed information about the issues addressed by the CAP.

The CAPs also frequently mention interRAI mental health scales that can be used to evaluate the person's status or track outcomes. In some cases, these scales were used as the basis for the CAP triggering algorithms. The appendix provides a summary of interRAI scales and algorithms referred to in the CAPs.

interRAI's mental health CAPs cover issues affecting five main aspects of the person's life:

- Safety
- Social life

- Economic issues
- Autonomy
- Health promotion

An important consideration in the mental health CAP research was to improve the targeting of the care planning protocols based on the likelihood of differential outcomes, including improvement, decline, or increased risk of events (for example, rehospitalization). Compared with the earlier MHAPs for the RAI-MH, the new mental health CAPs are triggered with a higher degree of specificity and lower sensitivity. This means that relatively few people who trigger the CAP will be "false positives" for the issue under consideration, and the overall burden of care planning will be substantially reduced.

Compared to the MHAPs, the average triggering rate for the CAPs has been cut in half. In other words, in in-patient mental health settings the median number of CAPs triggered is five, and 60% of persons assessed have between four and seven triggered CAPs. In community mental health settings, the median number of CAPs triggered is six, and 60% of persons assessed have between four and eight triggered CAPs.

The CAPs triggered will vary from person to person. Some CAPs will tend to cluster together, whereas other CAPs may be relatively independent of the other domain areas triggered. The set of CAPs that tend to most often cluster together are Harm to Others, Interpersonal Conflict, Control Interventions, Criminal Activity, Self-Care, and Medication Management and Adherence. The Smoking and Substance Use CAPs tend to comprise a secondary cluster.

International and Cross-Cultural Applicability of CAP Guidelines

The aim of the CAPs is to provide evidence to inform care planning in mental health settings internationally. However, cultural, legal, socioeconomic, or other factors may constrain clinicians' ability to use some CAP recommendations. In addition, although every effort was made to make the CAPs cross-nationally applicable, some of the terminology used in this document may differ from conventional usage in other countries. Therefore, it may be necessary to adapt some of the concepts and recommendations outlined in the CAPs to fit with local contexts.

The interRAI CAPs are intended to be used cross-nationally. The CAPs should also be applicable to the diverse subpopulations found within multicultural societies. However, as with any aspect of good clinical practice, cultural competence is an essential skill for professionals working with cultural minorities. This requires a clear understanding of and ability to manage one's own cultural values and biases. It also requires an awareness of how others' cultural background may affect their receptiveness to specific types of interventions, perceptions about their condition, and available choices to respond to their needs. It is also important to be aware of how family dynamics may influence the response of the person. That said, the paramount concerns for health professionals are to support the person's strengths and to provide the information needed for the person to choose effective options that will enhance his or her personal recovery.

CAPs by Mental Health Setting

The following chart indicates which interRAI mental health instruments support each CAP.

CAP Name	iCode[a] Label	interRAI Assessment Instrument		
		MH[b]	CMH	ESP
SAFETY				
Harm to Others	mhcHARMOTH	X	X	X
Suicidality and Purposeful Self-Harm	mhcSELFHA	X	X	X
Self-Care	mhcSELFCR	X	X	X
SOCIAL LIFE				
Social Relationships	mhcSOCREL	X	X	
Informal Support	mhcINFSUPP		X	
Support Systems for Discharge	mhcSSDIS	X		X
Interpersonal Conflict	mhcIPCON	X	X	
Traumatic Life Events	mhcTRAUMA	X	X	
Criminal Activity	mhcCRIM	X	X	
ECONOMIC ISSUES				
Personal Finances	mhcFINAN	X	X	
Education and Employment	mhcEDEMP	X	X	
AUTONOMY				
Control Interventions	mhcCTRLINT	X	X	
Medication Management and Adherence	mhcMEDMGT	X	X	
Rehospitalization	mhcREHOSP	X	X	
HEALTH PROMOTION				
Smoking	mhcSMOKE	X	X	X
Substance Use	mhcSUBUSE	X	X	
Weight Management	mhcWTMGT	X	X	
Exercise	mhcEXER	X	X	
Sleep Disturbance	mhcSLEEP	X	X	X
Pain	mhcPAIN	X	X	
Falls	mhcFALLS	X	X	

[a]iCODES are labels used in computer programs to describe interRAI items, scales, and algorithms.

[b]Includes the interRAI MH and RAI-MH version 2.0. Some CAPs have restricted trigger levels in the RAI-MH because of limited response options for specific variables (for example, Falls CAP).

Part I

Safety CAPs

1. Harm to Others CAP
2. Suicidality and Purposeful Self-Harm CAP
3. Self-Care CAP

Section 1

Harm to Others CAP

Issue

Persons with mental health or substance use disorders who are in an in-patient or a community mental health setting may pose a risk of harm to others through violent or aggressive behaviour. Included are purposeful actions or words directed at other individuals (for example, pushing, punching, threatening) as well as indirect actions that are not necessarily directed at a specific person (for example, throwing objects, pushing furniture, slamming doors) that could be harmful to a particular individual. Harm to others may be associated with biological, psychological, social, and environmental risk factors, but ultimately the key issue is that the person has difficulty regulating or coping with emotions such as anger, impulsivity, fear, or distress. Factors that increase the risk of violence or aggression include medication side effects, withdrawal from substances, mental health symptoms, features of antisocial personality disorder, cognitive functioning, discomfort, and fear. Harmful behaviour toward others may also arise if the person is unable to appreciate the consequences of his or her behaviour due to a serious mental disorder. The causes of violent or aggressive behaviour are multifaceted and may involve societal root causes such as poverty, lack of education, and marginalization.

In addition to the direct negative outcomes for the person exhibiting such behaviours, violence and aggression contribute to the continued stigmatization of persons living with or recovering from mental illness and addiction. Often persons with a history of such behaviours are rejected in the search for housing and employment. As a consequence, they have greater difficulty integrating into community settings. These persons may experience isolation and loneliness, and they may be at higher risk of incarceration. For these reasons, treating the root causes of violence and preventing persons with mental illness from harming others may reduce negative stigma and improve community integration for the persons exhibiting these behaviours.

Goals of Care

- Ensure the safety of those at risk of harm.
- Prevent escalation or reoccurrence of harm to others.
- Identify factors that do or may contribute to incidents of harm to others.
- Identify and implement the most efficient and least restrictive intervention to manage current harmful incidents.
- Implement therapeutic interventions for treating factors contributing to harm to others.
- Reduce the risk of harm to others in the future.
- Prevent institutionalization or involvement with the criminal justice system.
- Promote safe integration into community living and involvement.

Triggers

The Harm to Others CAP addresses the imminent risk of harm to others by persons who have demonstrated violent or aggressive behaviour. This CAP applies to persons in emergency settings, in-patient mental health settings, and community mental health programs. To attempt to avoid future harm, this CAP outlines factors to consider for managing persons at risk of harm to others, identifying potential causes of the harm, and establishing interventions to prevent future escalation or occurrence of harm to others. This CAP is meant to address risk of harm to others in the shorter term; it is not intended to serve as an appraisal of long-term risk of violence. The interRAI Forensic Supplement provides additional items that may be used to support that function.

The Harm to Others CAP is triggered according to the presence of violent or aggressive behaviours in the last 7 days or the person's score on the Risk of Harm to Others (RHO) Scale (see the appendix) embedded in the interRAI MH, interRAI CMH, and interRAI ESP. This scale is scored based on a combination of items from these instruments, including patterns of violence, aggressive behaviour, mental health symptoms, and insight. The RHO Scale ranges from 0 to 6, with higher scores indicating a greater risk of harm to others.

TRIGGERED DUE TO HIGH RISK OF HARM TO OTHERS

This group includes persons who

- score 5 or 6 on the RHO Scale.

This group includes about 13% of persons in in-patient mental health settings and 2% of persons in community mental health programs. At follow-up (discharge or quarterly reassessment), 27% of those in in-patient settings still had current violence or aggressive behaviour. Of persons in community mental health programs who triggered at this level, 28% still had current violence or aggressive behaviour at the follow-up assessment.

TRIGGERED DUE TO MODERATE RISK OF HARM TO OTHERS

This group includes persons who

- score 3 or 4 on the RHO Scale; OR
- have had violent thoughts, actions, or acts of intimidation in the last 7 days.

This group includes 21% of those in in-patient mental health settings and 23% of those in community mental health programs. About 25% of those in in-patient mental health and 45% of those in community mental health settings will continue to show moderate risk of harm to others at follow-up.

NOT TRIGGERED

This group includes persons who

- have a score of 0 to 2 on the RHO Scale; and
- have had no violent thoughts, actions, or acts of intimidation in the last 7 days.

About 65% of persons in in-patient mental health programs do not trigger this CAP. Of those who do not trigger this CAP, about 4% will show violence or aggression at follow-up. In the community mental health settings, about 75% of persons will not trigger this CAP and 6% of these persons will exhibit violence or aggression at follow-up. It should be noted that approximately 60% of those admitted as forensic patients are among the not-triggered group. The available evidence suggests that the rate of in-hospital violence is low among the not-triggered group; however, longer-term risks should also be informed by forensic violence risk assessments.

Initial Considerations

For persons exhibiting harm to others, the selected care approach will depend on the following: (1) how recently harm to others has occurred (acuity), (2) the nature of harm to others (for example, type, victim of harm), and (3) the factors that contribute to the person exhibiting harm to others (for example, long-standing mental health problem, antisocial personality, cognitive loss, other institutional and individual factors). With these factors in mind, assess the potential for future actions, ensure the safety of others who may be directly or indirectly at risk, and implement treatments to reduce or eliminate the potential for future harm to others.

Two stages of intervention should be considered for this CAP. The first stage involves responding to immediate incidents of aggression or violence. The second stage involves guidelines for preventing the incidence or escalation of harm to others among persons at different risk levels. The following guidelines apply to both trigger levels.

Current Violence or Aggressive Behaviour

Staff should have formal training in the prevention and management of violent or aggressive behaviour. Individual organizations tailor their staffing, training, and policies to suit their individual needs, but they should ensure that staff who are required to manage these kinds of emergencies have adequate training and refresher courses.

Ensure the safety of the victim or potential victim and others involved in the violent or aggressive event. During an aggressive or a violent incident, make sure that any risks to the person or others involved in or around the incident are minimized. This can be achieved through the following:

- Optimally, one staff member who has received formal training in the prevention and management of violent or aggressive behaviour, who has had experience in dealing with these kinds of behavioural emergencies, and who is familiar with the person in question should take the lead in attempting to de-escalate the situation. Initially, other staff should remain in proximity in case the incident escalates.
- Environmental interventions should be put into effect that produce a quiet and calm environment, that ensure a safe space free of objects that could be potentially used as weapons, and that is away from areas of heavy traffic or gatherings of other staff or care recipients. If possible, the person should be moved to a quieter room or an open space and should be kept in this space until the incident de-escalates. If the person cannot be moved, other staff and care recipients should be moved to another area away from the person in question.
- If environmental changes cannot occur, attempt to remove any objects that could cause harm to the person or potential victims (for example, chairs, tables, glass, pens or pencils, syringes).

Implement interventions to prevent or de-escalate immediate threats or actions of violence. Interventions in this step should be the least coercive and least aggressive possible. Consider the following:

- Try verbal approaches; for example, "talk-down" interventions are intended to make the person feel understood in terms of his or her negative emotions and feelings. Expressions of sympathy and understanding will often shift the

person's attention away from the focus of his or her anger and distress. With this shift in attention and resulting relaxation, the motor component of the violent or aggressive behaviour becomes less severe.

- Use noncoercive behavioural approaches emphasizing calm and nonthreatening speech and body language (for example, keeping distance, talking with calm voice, avoiding crossing arms or putting hands on hips).
- Attempt to establish a therapeutic alliance, an understanding with the person that acknowledges his or her distress and that reminds him or her that staff are there to help. This is enhanced with empathy and understanding toward the person. At this point, it is often helpful to bring the clinician who knows the person best into the interaction. A clinician who has already established a therapeutic relationship with the person may be better able to de-escalate the situation.

Initiate interventions to halt actions of violence or aggression. In instances where the person cannot be de-escalated and where violent or aggressive acts are imminent, action must be taken to control the situation.

- Staff who have been involved in attempting to de-escalate the situation must immediately withdraw from the vicinity and an emergency code should be called. An emergency code (for example, "code white") is usually called over the loudspeaker system in the facility, summoning security staff and personnel from adjacent services to attend the unit or location where the violent person is located.
- Until such time as extra personnel have arrived, the person should be contained in the space in which he or she is located with exits blocked.
- When the summoned staff has arrived at the scene, a team leader must be identified. Who is chosen as team leader will vary from facility to facility and may depend on circumstances. Usually, if security staff has ultimate responsibility for events such as these, the team leader selected will come from among the security staff in attendance.
- Once the team leader has been selected, she or he will conduct a review of events leading to the incident, collect pertinent information regarding the person involved, including past history of violence and previous similar behaviour.
- Together with the team, the leader will develop a plan for managing the situation and will assign roles.
- The first option to be considered according to principles of least restraint would be continuing attempts at de-escalation; however, at the team's discretion acute control procedures may be used. Acute control procedures (acute control medication, mechanical restraint, or seclusion) should only be considered if other strategies, such as de-escalation, have been attempted and failed. The procedures outlined in the Control Interventions CAP should be reviewed prior to their implementation.

Preventing the Occurrence and Escalation of Aggression or Violence

The key to preventing violent behaviour is to know which persons are likely to engage in this behaviour and the causes or triggers for such behaviour. Causes and triggers are highly idiosyncratic and must be determined for each person. Use of the interRAI assessment can be extremely helpful for identifying which person is at risk for such behaviour. The key steps in preventing violence are as follows.

Assess the type and nature of harm to others. The type of harm and the nature of how it is exhibited by the person may provide initial insights into the underlying factors contributing to harm to others. Several key questions should be documented and addressed.

- Was the harm an overt act of violence directed at a particular individual(s) or a random action with no clear intent?
- Did the person threaten violence against another individual or have a plan to commit violence against another individual?
- Is the person demonstrating verbally or physically abusive behaviour?
- Is the person showing signs of agitation (for example, pacing, being hypervigilant) to the point where he or she appears to be losing impulse control?
- Does the person exhibit socially inappropriate behaviours, such as spitting or smearing feces?
- Does the violent behaviour play a role in achieving the person's goals and objectives? Was the violent behaviour instrumental or reactive?

Identify the victim of harm. For current acts of harm to others, determine to whom, if anyone, the harm was directed. This information may lead to further insight into the underlying cause or trigger of harmful actions.

- If the violence was directed at staff:
  - Interview the staff victim to establish any triggers (for example, medication administration, compliance with unit regulations) for the event.
- If the violence was directed at other care recipients:
  - Did the victim act first to provoke the aggressor?
  - Are there characteristics of the victim that could have triggered violence in the person (for example, resembles someone who in the past abused the aggressor)?
- If the violence was directed at family, there may be a variety of issues to consider:
  - Interview the family member to attempt to determine the specific trigger of the violent or aggressive event (for example, was the family member hostile toward the person?).
  - If it is determined that the event was related to a long-standing conflict between the family member and the person, develop an intervention strategy for reducing this conflict (see Interpersonal Conflict CAP).
  - Consider education for family members regarding the person's mental health condition and include strategies for preventing and de-escalating violent or aggressive events.

Determine if a mental health problem or substance use contributes to risk of harm to others. Some persons may experience symptoms (for example, paranoia, command hallucinations, mania, anger, impulsivity) that affect his or her ability to assess and react rationally to changes in the environment (for example, hospitalization, interactions with new or unfamiliar people) and, for this reason, the following should be considered.

Insight: A person who lacks insight into his or her mental health problem may react aggressively to the provision of treatment.

- The person will require one-to-one education and counselling to improve understanding of his or her symptoms and utility of treatments, including

accurate, up-to-date information about his or her illness and treatments for it (for example, the important and effective role of medication in treatment).

Trauma: A person who has experienced a psychological trauma, often unrecognized or untreated, may have an induced agitated state due to triggers related to his or her trauma (for example, sounds, smells, physical environment, conversations).

- It is important to assess trauma and develop care plans for helping the person recover from trauma (see Traumatic Life Events CAP).

Bipolar disorder: Persons with bipolar disorder who are in a manic state may have a pervasive fear of loss of control.

- Treatments for aggressive behaviours of persons with mania should be presented in a way that respects this fear (for example, use statements like "This medication will help you regain control of yourself" rather than "This medication will control you").

Psychotic symptoms or disorders: Persons with psychotic symptoms or disorders may be at risk of harming others due to the nature of certain symptoms (for example, command hallucinations, delusions).

- The risk of aggressive behaviour increases among these persons with comorbid alcohol abuse, substance abuse, antisocial personality, or neurological impairment.
- Persons being treated in settings such as emergency units, in-patient units, or acute treatment units may become aggressive due to fear or confusion. To prevent aggression, assessment and the administration of treatment should be done using calm speech and body language, with clear explanations of all procedures.

Substance use: Persons currently intoxicated or experiencing withdrawal symptoms may be at risk of harm to others due to anxiety, irritability, agitation, impaired impulse control, disinhibition, decreased pain sensitivity, and impaired reality testing. For these persons, it is important to do the following:

- Determine the substances involved, particularly if the person has taken alcohol, cocaine, methamphetamine, PCP, anabolic steroids, hallucinogens, cannabis, or combinations such as alcohol and psychostimulants or benzodiazapines.
- Check vitals, toxicology tests, and blood exams (see Substance Use CAP).
- Provide a safe environment where the person can detoxify from any substances while being monitored without imposing risk of harm to others or self.

Antisocial personality disorder: There are several approaches to preventing further harm to others for persons with antisocial personality disorder who trigger this CAP. These approaches centre on creating a structured and stable environment where there are clear expectations about treatment participation, rules, and consequences.

- It is important to follow through with consequences of any rule violations.
- A lack of consistency in the enforcement of rules and procedures can lead to violent or aggressive behaviour among persons with antisocial personality disorder. In in-patient mental health settings, ensure that there is consistency in the training and regulation of rules or procedures among all staff during all shifts. In all settings, make sure rules and procedures are clearly outlined and reinforced throughout treatment.

- Be aware that some persons may engage in "limit testing" and splitting staff against staff. In both of these events, the person may engage in verbal threats or physically violent or aggressive acts. These aggressive behaviours usually have an instrumental purpose, with the person having a goal or an objective served by the behaviour. At these times, it is crucial for staff to remain empathetic, yet take a consistent and constructive approach toward therapy as well as to maintain the structure of rules and procedures in place.
- Work to prevent conflicts between persons, particularly on in-patient mental health units (see Interpersonal Conflict CAP).
- It is important that the staff act together in responding to these persons. If the person is able to split the staff with one staff person against others or if two different "factions" develop among staff, these persons can use these intra-team conflicts to their advantage.

Dementia or recent cognitive loss: Examples include Alzheimer's disease, a stroke, an intellectual disability, and a decline in cognitive function (use the Cognitive Performance Scale to evaluate cognition). A person with such conditions may have difficulty communicating needs or may lack inhibition, which can lead to aggression.

- Unmet needs such as the urge to urinate, inability to know where to go, or pain may cause aggressive agitation. Similarly, a person may exhibit a challenging behaviour because he or she does not recognize another person or finds the environment unfamiliar and frightening.
- In all cases, aggressive agitation may be prevented by using clear and deliberate communication while facing the person (for example, for support with dressing, the care provider should be in a position where the person can see him or her and provide an explanation to the person about the type of help he or she is about to receive both before and during the dressing activity).
- Review physical signs and symptoms for pain or discomfort (see Pain CAP).

General medical condition: Medical conditions such as delirium, brain lesions, and other neurological syndromes may increase the risk of violence or aggression due to agitation, stress, disorientation, or other factors related to the condition. For these persons

- A full medical evaluation should be performed.
- Restraints should be avoided as they may increase agitation and worsen the person's condition, particularly in persons with delirium.

Medication side effects or nonadherence to medications: Some persons may not be taking medications that treat factors that contribute to violence or aggression.

- Of concern are situations where the behaviour arises in response to an adverse medication effect (such as akathisia) or where the aggression itself represents the idiosyncratic effect of a drug or drug combination.
- Consider complications between medications and lifestyle factors that may reduce the efficacy of medications (for example, effectiveness of certain antipsychotic medications can be affected by changes in smoking patterns).
- For some persons, long-acting psychotropic medications may improve adherence.
- See Medication Management and Adherence CAP.

Factors that may contribute to harm to others for persons living in the community with a history of violence: Persons who trigger this CAP at low to moderate risk and who live in the community may be at risk for future harm to others based on factors such as economic status; interpersonal conflict, including a history of domestic abuse; and social isolation. For these persons

- Review the person's economic status to determine if the person is making trade-offs or is unable to manage his or her finances. A lack of sufficient financial resources or proper management of those resources may lead to violent behaviour, such as violent crime (see Criminal Activity CAP).
- Check if the person is able to manage his or her medication properly.
- Determine if the person has opportunities to participate in or make meaningful and positive social connections. Activities such as working, volunteering, or socializing may promote a sense of accomplishment and involvement in the community (see Education and Employment and Social Relationships CAPs).

Interventions to Facilitate a Safe Integration into Group or Community Settings

Traditionally, seclusion rooms, physical restraints, and acute control medications have been the identified interventions for persons who are at risk to harm others in in-patient mental health units. Although such interventions may provide control of a violent or an aggressive incident, it is important to recognize that they can contribute to further isolation and stigmatization of the person. As such, consideration must always be given to long-term interventions that reduce the risk of harm to others while improving the person's ability to safely integrate with others.

- In many instances, particularly with persons who have cognitive impairment, the escalation from social interactions to aggression or violence can be prevented through proper observation and recognition of events or stimuli that trigger violent behaviour. Consider the option of having a designated person observe group settings to identify and diffuse situations that may lead to behaviour escalations.
- Consider education and therapy for emotion regulation or anger and stress management if these issues are identified areas of need.
- If the person identifies that his or her aggressive behaviour is related to feelings of isolation, loneliness, or anxiety about interacting with other people, implement strategies designed to improve social interaction (see Social Relationships CAP).
- Violence risk associated with mental illness is often related to substance use, and both are related to treatment adherence. Interventions pertinent to these risks, such as vigorous treatment of substance use and monitoring of adherence to treatment, can mitigate risk. Intensive interventions such as assertive community treatment (ACT) are desirable when available.

Additional Resources

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Section 2

Suicidality and Purposeful Self-Harm CAP

Issue

Suicide and purposeful self-harming behaviours are major challenges in in-patient and community mental health settings. Suicidal behaviours are aimed at intentionally ending one's life. Self-harm is a broader term that covers types of deliberate self-injurious behaviour. Both suicidal and self-harming behaviours are often treated with equal importance, despite what may be marked differences in the intended outcome.

Suicide is an intentional, self-inflicted act that results in death. Suicidal behaviours are actions by which a person places him- or herself in harm's way in order to self-destruct. Also termed *suicidal gestures*, these behaviours may include cutting one's wrists or taking unsafe doses of medication (for example, painkillers). The difficulty in distinguishing suicidal behaviours from purposeful self-harm is in determining the person's intent. For example, was the intention of the behaviour to end the person's life, a call for help, or a means of temporary escape? Suicidal behaviours that do not result in death are considered "nonfatal" or, more commonly, "suicide attempts."

Reported risk factors related to suicidal and self-harming behaviour include

- Mental illness (for example, depression, anxiety, bipolar disorder, schizophrenia, borderline personality disorder, eating disorder)
- Substance use (for example, alcohol, street drugs, prescription drugs)
- Psychological symptoms (for example, anger, shame, hopelessness, guilt, impulsivity, dissociation, agitation)
- Abuse (for example, physical, sexual, or emotional abuse; past or present traumatic events; abusive relationships)
- Losses (for example, death and grieving, personal failures, loss of employment or income, divorce, parents' separation)
- Family history of suicide or having a friend who also self-harms
- Difficulty with interpersonal relationships (for example, social isolation, poor personal support systems, eroding friendships, breakups)
- Chronic progressive illnesses for which there may not be an effective medical treatment (for example, multiple sclerosis)

Women attempt suicide more often than men, but they typically use methods that are less likely to cause death. Men will more often choose violent and lethal methods (for example, firearms, hanging), while women tend to choose less disfiguring methods (for example, medication overdose, poisoning).

Purposeful self-harm is an intentional and often repetitive behaviour that involves the infliction of harm to one's body without the intention of ending one's life. Socially accepted means of self-harm (for example, culturally accepted aesthetic modifications such as piercing, tattooing) are not included in this definition. Many terms are used to describe this behaviour, including *self-injury*, *deliberate self-harm*, *self-mutilation*, *cutting*, or *nonsuicidal self-injury*. Self-harming behaviour

may be used as a means to communicate with others or obtain relief from a difficult situation or negative emotional state. Purposeful self-harm is most commonly associated with intentional carving, cutting, or scratching of the skin; burning the skin with cigarettes or lighters; ripping or pulling skin or hair; ingestion of toxic substances; or hitting oneself to cause bruising or fractures. It may be very difficult to distinguish between purposeful self-harm and suicidal behaviour because both behaviours are self-directed and dangerous. However, the majority of persons who engage in purposeful self-harm do not wish to die. Rather, causing the injury may be a coping mechanism that provides temporary relief from psychological distress.

Self-harming behaviours usually begin in early to middle adolescence and peak between ages 16 and 25. The behaviour is more common among young women than young men. Self-harming behaviour may last for years, even well into adulthood. Self-harm has a contagion effect and occasionally young people will participate in self-harming behaviour in groups. Therefore, having a friend who self-harms increases a person's risk of this behaviour.

The majority of people who engage in purposeful self-harm do not intend to die as a consequence of their behaviour. Most will stop a session of self-harm when they have achieved a preferred level of injury; however, acts of self-harm can lead to accidental death or serious injury (for example, cutting into a vein or an artery and being unable to stop the bleeding). These cases may be mistakenly labelled as a suicide or a suicide attempt. It is important to distinguish between purposeful self-harm and suicidal behaviours because there are appropriate (but often different) treatment options for both. However, both behaviours may pose serious risks to the person's well-being.

Goals of Care

- Attend to the person's immediate safety needs.
- Treat self-inflicted injuries using a nonjudgmental approach.
- Assess the person's risk for suicide.
- Identify factors that do or may contribute to incidents of purposeful self-harm or nonfatal suicide attempts.
- Identify and implement therapeutic interventions aimed at treating conditions that contribute to incidents of purposeful self-harm or suicide attempts.
- Reduce the risk of repeated self-harm or suicide attempts.
- Support the person's recovery through the use of community support services.
- Support family and other members of the person's network who are distressed by the purposeful self-harm or suicide attempts.

Triggers

The Suicidality and Purposeful Self-Harm CAP applies to persons in in-patient and community mental health programs, as well as to those in emergency settings. This CAP outlines clinical considerations for persons at moderate to high risk of suicide or purposeful self-harm to ensure the immediate safety of the person and to prevent future self-injurious behaviour.

The Suicidality and Purposeful Self-Harm CAP is triggered according to the Severity of Self-harm (SoS) Scale. This scale is scored based on a combination of items, including a history of self-injury ideation, history of suicide attempts, men-

tal health symptoms, cognitive performance, family concern about the person, and suicide plans. The SoS Scale ranges from 0 to 6, with higher scores indicating a greater risk for harm to self (see the appendix).

TRIGGERED DUE TO HIGH RISK OF HARM TO SELF

This group includes persons who

- have a score of 5 or 6 on the SoS Scale.

This group includes about 25% of persons in mental health emergency settings, 18% of persons in in-patient mental health settings, and 3% of those in community mental health programs.

Among those in in-patient mental health settings who triggered at this level, 85% were admitted due to concerns of self-harming behaviour. Of this high-risk group, 15% engaged in one or more self-harm acts during the in-patient stay.

TRIGGERED DUE TO MODERATE RISK OF HARM TO SELF

This group includes persons who

- have a score of 4 on the SoS Scale.

This group includes approximately 12% of persons seen in psychiatric emergency settings, 12% of persons in in-patient settings, and 11% of those in community mental health settings. Among persons in in-patient mental health settings who trigger at this level, 70% were admitted due to concerns about harm to themselves. About 6% of persons in in-patient mental health settings in the moderate-risk group engaged in one or more self-harm acts during the in-patient stay.

NOT TRIGGERED

This group includes persons who

- have a score of 0 to 3 on the SoS Scale.

This group represents approximately 63% of persons seen in psychiatric emergency settings, 70% of persons in in-patient mental health settings, and 86% in community mental health programs. In this group, fewer than 1% engaged in self-harm acts by the time of discharge from an in-patient mental health program. Some persons in this triggered group may have clinical indicators other than those on the SoS Scale that would lead a clinician to conclude that the level of risk is sufficiently high to warrant clinical action. In such situations, use other available information for addressing the person's risk of harming him- or herself. These guidelines may also be used in those situations.

Guidelines

Safety

In addition to the Severity of Self-harm (SoS) Scale, the Emergency Screener for Psychiatry (ESP) also includes a section for clinicians to rate their subjective appraisal of the risk of self-harm. If the Suicidality and Purposeful Self-Harm CAP is not triggered but the level of risk is judged to be severe or imminent, appropriate steps should be taken to respond to the person's urgent safety needs.

For an acutely suicidal person, it is important to attend to his or her safety, including the removal of any objects that could be used for purposeful self-harm (for example, sharp objects, belts, pills). When a person presents in an emergency setting following an episode of self-harm or a suicide attempt, the assessment should be conducted as soon as possible in an environment or atmosphere that is conducive to discussing sensitive and distressing issues. If needed, place the person where observation is possible without access to potentially injurious objects. Some

circumstances may call for a decision to hospitalize or observe a person one-to-one (for example, persons with extreme agitation, intoxicated persons).

In community or primary care settings, the immediate physical risks of the person who has self-harmed or attempted suicide should be established. In cases where urgent referral to an emergency department is not necessary, a risk and needs assessment should be undertaken to determine the case for referral to mental health services.

Factors that strongly suggest a hospital admission include any of the following:

- The need for medical interventions following a suicide attempt
- Indications of acute psychosis
- Absence of suitable informal supports to assist the person in the community

Assessment

The following guidelines may be relevant in the assessment of persons at risk for suicidal behaviour and purposeful self-harm.

History of self-harm or suicide attempts. It is important to inquire into past suicide attempts and self-harming behaviour. It cannot be assumed that a person with repeated purposeful self-harm (for example, cutting) is not suicidal. Assessment for suicidal risk should be performed even if the person denies suicidal ideation. Repeated self-harm is an indication of underlying and unaddressed mental health issues for which effective treatment may be available. A history of suicidal and purposeful self-harming behaviour is important to consider because it suggests the person may be prepared to resort to such behaviour again. Even if the behaviour occurred several years previously, it is necessary to explore the circumstances around that incident in case a similar situation arises or has arisen again.

If the person has a history of suicide attempts or self-harming behaviour, details about timing, method, level of intent, and consequences of the behaviour should be explored. The following should be included in this assessment.

- Provide a description of what happened (for example, details about the circumstances, timing, method chosen, seriousness of intent, consequences).
- How long ago was the previous suicide attempt(s) or self-harming behaviour?
- What was the most serious past suicide attempt or self-harming behaviour? Previous behaviours that were potentially fatal are of greater concern than multiple nonserious attempts.
- Did the behaviour occur in response to problematic relationships (for example, breakups, bullying)?
- Was there consumption of alcohol and drugs before any previous attempt? (Impulsive self-harm behaviours occur more often in the context of acute intoxication.)
- What did the person think would happen or what did he or she hope would happen (for example, injury versus dying, getting a response from others)?
- How did the person feel afterward (for example, relief versus regret at being alive)?
- Are suicide attempts escalating in potential lethality? Escalating seriousness of suicidal behaviour suggests that the person is depleting coping resources and is at greater risk of dying by suicide.
- Does the person's history include an aborted suicide attempt(s)?

- In what ways do the person's current circumstances mirror those surrounding previous suicide attempt(s) or self-harming behaviour?
- Is there anyone in the person's social network who has purposefully self-harmed or attempted suicide?

Suicide plan. Suicide plans are an indication of an elevated level of risk. When eliciting information about the presence or absence of specific plans for suicide, clinicians should note any steps taken forward with a plan or other preparation(s) for death (for example, writing a note; preparing a will; making financial arrangements; purchasing specific items such as a gun, rope, poison; giving away possessions). Having the preferred means of suicide in one's home (for example, firearms) greatly increases the risk of completed suicide. If no plan is reported, consider under which conditions (if any) the person would attempt suicide (for example, anniversary of spouse's death, promotion denied at work).

Mood disorders. Major depression is the diagnosis most commonly associated with suicide. However, less severe forms of mood disorders are also associated with self-harming behaviour (for example, dysthymia, mild depression). Scores higher than 6 on the Depressive Severity Index (see the appendix) are associated with higher scores on the SoS Scale. Clinical presentations of feelings of hopelessness, guilt, remorselessness, helplessness, anhedonia, and agitation or an unnatural calmness of persons with severe depression are also important considerations in suicide risk assessment. Other diagnoses associated with suicide include schizophrenia, alcohol or other substance abuse, and borderline and antisocial personality disorder.

The role of family and other informal supports. Families and other informal supports can have an important role in the care, assessment, and treatment of a person's self-harm and suicidal behaviours and should be involved whenever appropriate. As a source of corroborating information, family members or friends may have suspected or spotted signs of self-harming and suicidal behaviour prior to disclosure or contacting mental health services. If they are to provide support to the person who has purposefully self-harmed, informal helpers should be included in discussions about safety. There should also be an open discussion about what to do in the event of an emergency if thoughts of self-harm or suicidal behaviour recur. In some cases, the person's perceived responsibility toward his or her family and friends may protect against future self-harming behaviour (for example, a parent's responsibility for his or her children).

The appropriateness of involving the person's family and friends is determined by several factors. When a person is acutely suicidal, the first responsibility is to work to protect his or her safety. This may involve breaching confidentiality through contacting and consulting with family or friends. If the person does not wish that others be contacted and it does not compromise his or her safety, then confidentiality must be maintained. On occasion, a person's risk for self-harm or suicide attempt is perpetuated by his or her social relationships (for example, abusive relative, marital disturbances, bullying). In this context, the person's safety should be the main priority.

Recording behaviour/structured case notes. After initial and ongoing assessments, chart notes should clearly identify the person's level of risk and plans for treatment and preventive care. Chart notes should be augmented with structured assessments, including relevant risk assessments, previous psychiatric history, previous treatment received, and concerns expressed by family or friends. Hospitalizing the person affords the opportunity to observe and record behaviour(s), ascertain what is usual or unusual behaviour, and appraise the risk for purposeful self-harm or suicidal behaviour.

Other Considerations

- **Persons with dementia or cognitive impairment:** The risk for suicidal behaviour in this group is generally considered low. That is not to say, however, that it does not occur. Depression, delusions, and one's awareness of the loss of cognition are common occurrences in dementia, yet also potential risk factors for suicidality, even among persons with no previous history of suicidal behaviour. Suicidal ideation among persons with dementia may be addressed with appropriate pharmacological therapy for the underlying psychiatric conditions (for example, depression). Further, the greater level of supervision that accompanies cognitive decline may act as a protective factor. Preventive measures should focus on suicidal ideation after initial diagnosis while keeping in mind that suicide can occur well after a dementia diagnosis has been established.
- **Pain:** There is evidence of a relationship between pain severity and suicidal ideation. If the person is experiencing pain, see Pain CAP.
- **Assisted suicide** is the act of intentionally helping to end a person's life at his or her request. In assisted suicide, another individual may provide the means to complete suicide (for example, prescribing a lethal dose of medication, setting up lethal devices); however, the suicidal act is performed by the person who made the request for assistance. **Euthanasia** is the intentional termination of life to relieve suffering. Unlike assisted suicide, individuals performing euthanasia are directly involved in the act of terminating life (for example, directly administering a lethal injection). There are major international differences in the legality of euthanasia and assisted suicide. In some countries, both acts are prohibited in the criminal code, but in others one or both may be legal, accepted, or tolerated.

  Assisted suicide is usually considered in the context of terminal illness and end-of-life care; however, it should not be assumed that terminal illness necessarily increases suicidality. Mental health professionals may be involved in such requests in order to assess the person's mental status and mood, particularly the presence of an underlying depression that if treated could defer the person's wishes for ending his or her life. Mental health professionals work closely with family members and may also be involved in providing bereavement support following an assisted suicide.

Interventions

Interventions in response to the Suicidality and Purposeful Self-Harm CAP should be based on a collaborative and an informed process between the person and mental health professional and should be focused on safety and attenuation or prevention of suffering. The person's strengths and preferences should be taken into account when developing a recovery plan. If appropriate, the person's family or other support individual(s) should be involved and provided with information about medications, upcoming appointments, and key contacts to call, if needed. Educating family members about the signs and dangers of purposeful self-harming behaviour, in addition to the types and benefits of intervention, will assist in treatment adherence and future prevention. Staff should also work to dispel any myths and stigma that family or other supports may have about suicidality and purposeful self-harm (for example, clarifying that talking about suicide does not make a person suicidal and a person who attempts suicide will not always remain suicidal).

Where possible, follow-up should be done by the same health care provider to maintain a therapeutic relationship and improve attendance at appointments and treatment adherence. The weeks immediately following a hospital discharge are a time when suicide risk is highest. Therefore, follow-up should occur within the first

week of discharge from hospital and in the weeks thereafter to assess ongoing risk and to encourage participation in subsequent interventions.

Interventions for purposeful self-harm and suicidal behaviour fall into three broad categories: psychological, pharmacological, and social. A combination of these treatments is beneficial in some cases.

Psychological interventions. Episodes of purposeful self-harm and/or suicidal behaviour are often precipitated by personal problems, either from past or present circumstances. The following interventions target these problems and reduce self-harming behaviour through improved coping skills and social functioning:

- Problem-solving therapy
- Cognitive Behavioural Therapy
- Interpersonal therapy
- Dialectical behaviour therapy
- Behavioural therapy/modification
- Insight-oriented therapy
- Relaxation therapy
- Family/couple therapy
- Group therapy
- For persons who are considering suicide or self-harm in response to the experience of a traumatic life event (for example, loss of a family member or friend, loss of employment), see interventions described in Traumatic Life Events CAP.
- For persons with a substance use problem, see interventions described in Substance Use CAP.

Pharmacological interventions. The main goal of pharmacological interventions (for example, antipsychotics, antidepressants, anxiolytics) is the relief of acute symptoms (for example, anxiety, depression, agitation, psychosis) that may be influencing suicidal thoughts and self-harm. Pharmacological interventions should accompany broader and long-term treatment goals.

Social and service level programs. The focus of social and service level programs is to improve contact with community-based services following treatment for a purposeful self-harming or suicide attempt. Effective case management can place the person in touch with local services that act in conjunction with the treatment plan to focus on long-term recovery (for example, self-esteem training, supportive housing, employment support skills). Consider the following:

- Case management
- Vocational rehabilitation
- Outreach services (for example, crisis response)
- Peer support networks
- Supportive housing
- Specialized or general community services

Social relationships. Purposeful self-harm and suicidal behaviour may be profoundly distressing for the person's family or friends. The recovery plan should not

only focus on the person but also should aim to address the impact of the behaviour on others who provide support to or depend on the person. It may also be the case that problems in social relationships could be precipitating factors leading to self-injury. Finally, the availability of informal support for crisis intervention may be an important resource for the person in community settings. See the Social Relationships, Informal Support, and Support Systems for Discharge CAPs.

Person contracting. The use of "suicide prevention contracts" or "no-harm contracts" (for example, "I will not harm myself before my next appointment") should not be considered as a sole substitute for a comprehensive clinical response, as there is no evidence that they are effective in reducing suicide. However, the willingness to enter (or refuse to enter) into a no-harm contract may provide a clue as to the person's suicidal intent. A refusal to enter into a no-harm contract may warrant the reassessment of suicide risk.

Nonpunitive responses. Persons who have self-harmed or attempted suicide should be treated with the same care, respect, and privacy as any other person. The distress associated with this behaviour should be taken into full account by the health care providers involved in the person's care. Therefore the use of punishments such as time outs, physical restraints, acute care medications, seclusion, or ignoring the person are not effective interventions for reducing or eliminating self-harming or suicidal behaviours. In cases where restraint use is necessary (aggressive or violent behaviour), it should be clearly and calmly communicated to the person that it is for his or her safety and that of others.

Considerations for purposeful self-harm behaviour. The goals of these structured and facilitated interventions are to assist the person in learning alternative and healthy means of coping with intensely negative emotions. Persons who use self-harm as a *coping mechanism* for problems or emotions may benefit from the following intervention(s):

- **Problem-solving therapy:** This brief approach helps the person learn basic problem-solving skills by moving through a series of steps, such as identifying the problem(s), reviewing possible solutions, or reappraising the problem. Self-harm is often the result of a personal problem or crisis in a close relationship. In these cases, assistance with solving the problem is needed, rather than focusing on the self-harm.
- **Dialectical behaviour therapy (DBT):** This therapy combines sessions of individual therapy, group therapy, and social skills training. During individual therapy, cognitive-behavioural techniques and skills training are used to teach persons how to regulate emotions (for example, identify and label emotions, increase positive emotions), how to increase mindfulness (for example, learn to live "in the moment"), how to accept and tolerate intense emotions without resorting to self-harm, and how to become more assertive and problem solve. Group therapy sessions provide a social context to use and practice these four skills. DBT has been shown to be an effective intervention for those who self-harm, with and without associated borderline personality characteristics.
- **Pharmacological therapy:** Medications may occasionally be prescribed (for example, benzodiazepines, antidepressants); however, their effectiveness as a singular form of treatment has not been established.
- **Contagion effect:** Self-harm behaviours appear to have a contagious effect among peers. Strategies to address this effect include reducing communication about self-harm within the peer group; reducing the public exhibition of

scars and wounds; and using individual counselling rather than open group discussion of self-harm behaviours, which can be triggers for group members.

- **Modification of pain pathways:** The focus is to reduce the physical damage to the body through use of "harmless pain" (for example, taking a cold shower, eating a jalapeño or hot chili pepper, or drawing red lines on the skin with a red marker). If the sight of blood is important in the self-harming act, squeezing ice cubes made out of red juice can mimic the look of blood.

Prevention

- Effective prevention of self-harm and suicidal behaviour lies in early detection and intervention. The sooner warning signs are identified and interventions put in place, the better the outcome to avoid a crisis.
- A health care provider's knowledge and attitude toward self-harm and suicidal behaviour reduces future recurrences. Compassionate and respectful engagement with persons who have self-harmed or attempted suicide is not only a person's right but an effective means of preventing further self-harm and suicidal behaviour and minimizing the stigma associated with self-harm.

Additional Resources

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Section 3

Self-Care CAP

Issue

Self-care refers to the ability to carry out ADL and IADL activities, as well as self-directed treatment-related activities (that is, being given control over the services one receives). It also includes self-determination: the ability to pursue a purposeful and meaningful life. Self-directed treatment is also known as self-management of one's illness. Understood this way, self-care is an important component of personal recovery. The ability and willingness to care for oneself is a prerequisite to autonomy and independence. Problems with self-care (for example, improper nutrition and poor hygiene) may result in the person's basic needs not being met, with the potential for more severe problems. In addition, problems with self-care can lead to unemployment, psychosocial distress, isolation, and diminished self-worth. Re-establishing a sense of mastery of self-care is important for recovery and quality of life.

The inability to care for oneself can be a reason for involuntary admission to hospitals and is associated with an increased risk of permanent placement in a residential setting. Hence, loss of ability to care for oneself can be a major threat to the person's opportunity to function independently in the community.

Treatment of the acute situation (for example, psychosis, depression) may re-establish the person's ability to care for him- or herself. The presence of coexisting physical and mental health conditions can make it a challenge to identify the potential for greater independence in self-care. Further, persons with schizophrenia and other psychotic disorders have a higher rate of co-morbid illnesses, such as substance-related disorders and metabolic syndromes.

Care providers should focus on promoting self-care by noting changes in ability and new indications of potential for independent decision making. Since some persons may not be able to regain complete autonomy in self-care, it is important to find a way to enable even those with limited capacity to make decisions for him- or herself. If the person has never learned to care for him- or herself (for example, because of learning disabilities or sensory deficits) it may involve supporting the person in acquiring new self-care skills.

Inability to care for oneself can also lead to stigmatization and labelling. Although a person who is acutely ill may require supportive care to meet basic needs, it is important to guard against perceiving the person as incapable of making his or her own decisions.

The goal of optimizing a person's self-determination must be balanced with the responsibility of the care provider to ensure that the person is protected from harm that may result from his or her impairment.

Goals of Care

- Ensure that the person is safe from harm.
- Alleviate presenting mental health symptoms.
- Provide support and care for the person's basic functioning.
- Promote independence in self-care.
- Build on strengths and identify emerging opportunities that support self-care.
- Identify and address any underlying barriers to recovery of self-care.

Triggers

The Self-Care CAP identifies two groups: (1) persons who are experiencing substantial difficulty with self-care for whom the treatment of acute mental health symptoms must take priority, and (2) persons whose less severe symptoms permit a focus on strengths that can be built on to support their involvement in more complex decisions about self-care. This CAP applies to persons in in-patient, community, and emergency mental health settings.

The triggers for this CAP are based on the interRAI Self-Care Index (SCI) to identify the person's risk of adverse outcomes related to the inability to care for oneself on a scale of 0 to 6 (see the appendix). The SCI uses a combination of items related to cognitive skills for decision making, positive symptoms, insight into mental health condition, mania, abnormal thought process, communication, hygiene, decreased energy, and anhedonia.

TRIGGERED DUE TO HIGH RISK FOR INABILITY TO CARE FOR SELF

This group includes persons who

- have a score of 6 on the SCI.

This group includes about 7% of persons newly admitted to in-patient mental health settings, 3% in community mental health programs, and 4% in emergency settings.

The rates for this trigger level are highest among elderly persons in crisis settings and lowest among younger persons in community mental health settings. A provisional diagnosis of schizophrenia or other psychotic disorder is present for about 70% of persons at this trigger level in in-patient mental health settings and 85% in community mental health settings. Cognitive disorders (for example, delirium, dementia) and substance use are also most prevalent at this trigger level in all three mental health settings (about 25% in community and emergency settings and about 15% in in-patient mental health programs).

About three-quarters of persons at this trigger level had *inability to care for self* identified as a reason for admission to in-patient and community mental health programs. In in-patient mental health settings, the average length of stay for this group is 10 days longer than for the not-triggered group, and this group is about five times more likely to be discharged to congregate living settings (for example, long-term care facilities, board and care, group homes) than the not-triggered group (21% compared with 4%). About three-quarters of persons in community mental health programs who triggered the Self-Care CAP at this level had a prior history of involuntary hospital admission. In in-patient mental health settings, about 80% of persons at this trigger level improve by discharge compared with about 50% of persons in community mental health programs at 6-month follow-up.

TRIGGERED DUE TO MODERATE RISK FOR INABILITY TO CARE FOR SELF

This group includes persons who

- have a score of 2 to 5 on the SCI.

This group includes about 48% of persons newly admitted to in-patient mental health settings, 51% in community mental health programs, and 40% in emergency settings.

A provisional diagnosis of schizophrenia or other psychotic disorder is present for about 45% of persons at this trigger level in in-patient and 55% in community mental health settings. Cognitive disorders are present for about 10% of persons at this trigger level in both community and in-patient mental health settings and for about 5% of persons in emergency settings.

Inability to care for self was identified as a reason for admission for about half of the persons at this trigger level in in-patient and 40% in community mental health programs. In in-patient mental health settings, the average length of stay for this group is 6 days longer than for the not-triggered group, and this group is almost four times more likely to be discharged to congregate living settings (for example, long-term care facilities, board and care, group homes) than the not-triggered group (15% compared with 4%). In in-patient mental health settings, about 55% of persons at this trigger level improve by discharge compared with about 30% of persons in community mental health programs at 6-month follow-up; however, 5% and 12% have a worse score for the SCI in in-patient and community mental health settings, respectively. About half of those in community mental health settings at this level have a prior history of involuntary hospital admission.

NOT TRIGGERED

This group includes about 45% of those in in-patient mental health settings, 46% of persons in community mental health programs, and 56% in mental health emergency settings.

Guidelines

The following guidelines apply to persons at both trigger levels. Current performance should not be taken as an indication of permanent capacity for self-care. Persons who are motivated and believe they have this capacity (or develop this belief during the recovery process) are more likely to improve their ability to care for themselves.

Initial Considerations

Identify and assist the person with ADL or IADL difficulties. Determine the specific ADL and IADL self-care difficulties that the person is experiencing.

- ADL includes bathing, dressing, mobility, personal hygiene, eating, toileting, and bed mobility.
- IADL includes preparing meals, doing housework, managing finances, managing medications, using the phone, shopping, using stairs, and transportation.
- For each area where the person is experiencing difficulty, identify the nature of the problem. For example, the importance of eating, bathing, dressing, or getting out of bed may be overshadowed by feelings of hopelessness and worthlessness; feelings of anxiety may impede functioning because the person is unable to concentrate on a task; hallucinations and delusions may preoccupy the person to the extent that self-care is neglected; the person is unable

to take his or her medication because he or she has impairment in his or her capacity to make decisions about everyday living.

- As the longer-term plan of care is developed, steps should be taken to address ADL difficulties that are affecting the person's immediate well-being. For example, monitor intake to ensure the person is getting adequate nutrition or provide assistance with needs related to personal hygiene, bathing, or dressing.
- Efforts should be made to maintain the person's independence as much as possible while providing the assistance that he or she needs. For example, simplifying tasks, giving clear instructions, and staying with the person as he or she completes a task provide opportunities for the person to make decisions (for example, choosing what to wear, choosing to have a bath or a shower).

Self-Determination and Independence in Self-Care

Addressing mental health symptoms. Alleviating the acute mental health symptoms while providing support for the person's basic functional needs is a priority. Since mental health symptoms may be interfering with the person's ability to perform everyday activities, addressing these symptoms can result in either substantial functional improvement or resolution of self-care deficits. Consider the following:

- Determine if the person is having difficulty managing his or her medications or if he or she is not adhering to the prescribed regimen. Medication nonadherence and refusal to take medications is common at both trigger levels, and addressing this issue with the person can be crucial to symptom relief (see Medication Management and Adherence CAP).
- Identify whether the person has a pre-existing diagnosis of dementia, organic brain disorder, cognitive disorder, or any other condition that could cause permanent cognitive impairments (for example, brain injury). Consider whether the person's cognitive impairment is of new onset. Persons with acute changes in mental function may be more likely to recover rapidly, whereas those with pre-existing impairments in cognition may require longer-term support. If the person is experiencing an acute change in mental functioning, appropriate physical examination and laboratory tests should be completed to determine if there is a physiological component to the change.
- Determine if medication side effects are posing a problem for the person with attending to self-care (for example, stiffness, sedation). If so, consider an adjustment of the person's medication regimen.
- Perform periodic re-evaluations of the person's mental status to note changes or improvements.
- Avoid making definitive plans related to discharge (for example, about housing) because the person may improve considerably over time. Although the person may have substantial impairments in functional ability during the acute phase of illness, this may often be altered with effective treatment. For example, bladder incontinence and ADL impairment are quite common in the high-risk group in both in-patient and community mental health settings, which necessitates supportive care from staff or informal helpers; however, this functional loss should not be assumed to be permanent.
- If control interventions are used, an appropriate balance between protecting the person's safety and supporting self-care should be maintained (see Control Interventions CAP). If control interventions are used, plans must be in place to ensure that the person's self-care needs (for example, personal hygiene, toileting) are met.

Self-determination. At this stage in the person's recovery process, the approach involves ongoing treatment of symptoms combined with the use of strategies to facilitate greater autonomy and participation in decision making. Alterations in the plan for recovery should be based on the changes in the person's functioning. Consider the following:

- Identify and build on the person's strengths to help improve his or her self-confidence. For example, if the person is able to do some tasks in meal preparation, opportunities for the person to participate in making meals should be arranged and positive feedback should be used to encourage the person.
- Identify barriers to full independence in self-care and work with the person to develop strategies to minimize or overcome them. For example, if a person has difficulties with his or her personal hygiene, access to showers or laundry and help in using them should be provided.
- Watch for a decrease of the symptoms (or of the intensity of the symptoms) or a decrease in confusion, all of which might suggest an opportunity for increased self-direction and self-determination.
- Address any physical symptoms that may be involved, including pre-existing pain (see Pain Cap), balance problems, and musculoskeletal disease.
- If substance use is present, see Substance Use CAP.
- Regardless of the person's legal status with respect to decision making, as mental health symptoms are resolved, staff should be sensitive to changes in the person's status and seek out opportunities for promoting independent decision making and self-care. Even those with limited capacity should be consistently encouraged to participate in decision making and self-care.

Informal network support. Work with the person to mobilize support from family or friends.

- Focus on finding a balance between the person's self-sufficiency and informal assistance with ADLs or IADLs where needed (see Informal Support CAP).
- Provide restorative education related to ADL and IADL for both the person and his or her informal helpers.
- Provide information about caregiver support groups.
- If the person does not have adequate support from informal sources, provide links to formal service agencies that may be able to provide the person with needed assistance.
- Consider the needs of family or friends who are acting as informal helpers. Rates of distress among informal helpers are strongly associated with both trigger levels for this CAP. See Social Relationships, Support Systems for Discharge, and Informal Support CAPs.
- Is a legal guardian or substitute decision maker involved? Has the person been deemed to be not competent to make certain types of decisions? Country-specific legislation will lead to different rates of restrictions on decision making. If a legal guardian or substitute decision maker is involved, assist that individual in making decisions based on what the decision maker believes the person would have decided if capable of making his or her own decision, which may not necessarily be based on what the decision maker believes is best for the person.

Stigma. Be aware of any stigmatization of the person that may have been the result of difficulties the person had or is having with self-care.

- Guard against labelling and stigmatizing of the person by staff, family, and friends. Whether the person's ability to care for him- or herself has been impaired temporarily or on a more permanent basis, a positive supportive approach that maintains the person's dignity and facilitates independence and self-care wherever possible is essential.
- Counteract any attitudes that may inappropriately constrain the person's movement toward greater autonomy.
  - Help others in the person's social environment recognize that the impairments may be the result of a reversible mental or physical health condition and thus may decrease once these conditions are treated.

Community living. The person's recovery plan should involve strategies for self-reliance in the community. Support engagement of the person in the community, when needed, using a comprehensive intervention approach.

- Consider psychosocial rehabilitation strategies such as the following:
  - Training in independent living and social skills
  - Network enhancement
  - Access to meaningful leisure activities
  - Involvement with a community mental health team or an Assertive Community Treatment program
  - Home care services
  - Peer support programs

Living environment. In community mental health settings, problems with the home environment may also be evident in this group. For example, among persons in community mental health programs, about 13% of the high-risk group have homes considered to be in disrepair and 9% are rated as living in squalid conditions compared to about 1% of the not-triggered group for both types of problems. It is important to consider the safety of the person and other occupants in the home environment as well as compliance with local housing bylaws governing upkeep of property; however, any efforts to address housing problems should be undertaken with the participation of the person in the decision-making process.

Legal justice system contact. During the acute phase of illness, the person may have come into contact with the legal system. For example, about 60% of persons in the high-risk group and 20% in the moderate-risk group were brought into emergency settings by police. About one-third of the former group and one-fifth of the latter group have a history of prior incarcerations among persons in community mental health programs. Therefore, as the person recovers from conditions that have affected self-care, it may also be important to address legal problems the person may be facing (see Criminal Activity CAP). In addition, this contact with police or the courts may have negative consequences for the perception of the person by others. It will therefore be important to work with the person and his or her family and friends to support resolution of any difficulties that emerged during the acute phase of the person's illness.

Additional Resources

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Part II

Social Life CAPs

4. Social Relationships CAP
5. Informal Support CAP
6. Support Systems for Discharge CAP
7. Interpersonal Conflict CAP
8. Traumatic Life Events CAP
9. Criminal Activity CAP

Section 4

Social Relationships CAP

Issue

It is important to consider engagement in social relationships both as a dimension of recovery from mental illness and as a predictor of a variety of quality-of-life outcomes for persons with mental illness. The Social Relationships CAP examines how a person relates to others; how others relate to the person; and how the person initiates interaction, engages with others, and participates in the broader community. Difficulties with social relationships can be the result of problems at the individual, informal network, and broader community levels. That is, stress in social relationships may be exacerbated by specific mental health symptoms such as disturbance in thought processes or delusions. It also may have its origins in a history of an abusive relationship or be the result of a social environment that is not supportive and accepting of the person. Social relationships should be considered from a variety of perspectives, including types of social contacts (for example, family members, friends, neighbours, co-workers), frequency and nature of interaction, location of social activities (for example, in home, in public settings), and participation in community activities.

Strained social relationships can result in isolation, loneliness, and unhappiness. However, the person may also experience threats to basic needs such as food and shelter if relationships with family and friends are compromised to the extent that the person is fully isolated from, or in conflict with, these ties. Therefore, it is critical to consider what factors contribute to problems in social relationships and what aspects of the person's life are exacerbated by the difficulty.

This CAP aims to address factors leading to disruption in social relationships that may ultimately result in isolation of the person from friends, family, and the broader community. Efforts to alleviate problems related to social relationships should not involve the person only. Therefore, this CAP points to the shared experiences of the person, the informal network, and the community. In other words, interventions to support improvements in social relationships should consider the broader social context, and not treat the person in isolation.

Goals of Care

- Identify and address symptoms (for example, aggression, depression, negative symptoms) that isolate the person from others.
- Identify and respond to causes of difficulties in social relationships.
- Strengthen social skills to support effective interaction with others and relationship building.
- Provide opportunities for the person to experience safe and supportive social interactions.
- Support establishment of meaningful social connections.
- Reduce impact of adverse personal experiences on social relationships.
- Foster community integration.

Triggers

This CAP applies to persons in both in-patient and community-based mental health services.

TRIGGERED TO REDUCE SOCIAL ISOLATION AND FAMILY DYSFUNCTION

This group includes persons who

- are experiencing any of the three problems with family function listed here:
  - Family or close friends overwhelmed by person's illness
  - Person or others consider family roles to be dysfunctional
  - Severed or conflict-laden relationship within the last year

AND

- have no confidant

AND

- have any of the four indicators of social isolation listed here:
  - No participation in activities of long-standing interest in the last 30 days
  - Withdrawal from activities of interest
  - Reduced social interaction
  - No in-person, telephone, or e-mail contact with family or friends in the last 30 days

This group includes about 31% of persons in in-patient mental health settings and 17% of persons in community-based mental health programs. Over a 90-day period or by the time of discharge (if fewer than 90 days), the majority of these persons will show improvement in the level of social relationships, but the rate of improvement is not consistent for all groups. For example, those with higher levels of cognitive impairment, higher scores on the CAGE addiction screen, higher levels of aggressive behaviour, and a higher number of prior hospitalizations are less likely to improve. In addition, persons admitted from correctional settings and those in forensic programs are less likely to improve in this CAP.

TRIGGERED TO IMPROVE CLOSE FRIENDSHIPS AND FAMILY FUNCTIONING

This group includes persons with problems related to close friendships and family functioning as indicated by the presence of one or more of the following:

- Family or close friends overwhelmed by person's illness
- Person or others consider family roles to be dysfunctional
- Severed or conflict-laden relationship within the last year

This group includes about 30% of persons in both in-patient and community-based mental health settings. In in-patient mental health settings, about 23% of this group improve by discharge, and about 8% also develop problems related to social isolation. In community mental health settings, about 35% improve and 10% decline in this CAP. As with the social isolation and family dysfunction trigger level, persons in this group are less likely to improve and more likely to decline when conditions like cognitive impairment, aggression, and addictive behaviour are present.

NOT TRIGGERED

This group includes persons who are not currently experiencing indications of problems with family or close friendship interactions. It includes about 38% of persons in in-patient mental health settings and 51% of persons in community-

based mental health programs. The development of subsequent problems with social relationships is relatively uncommon for this group in the in-patient setting (about 9%). However, the rate of new problems related to social relationships is almost twice as high (19%) for this group in community mental health settings. Appropriate support for this group is focused on monitoring for any unexpected mental health symptoms or behaviours that may affect the person's ability to relate effectively with others. In addition, efforts should be taken to update the person's recovery plan as needed and support him or her in strengthening and maintaining social relationships and community-based support.

Guidelines

In community mental health settings, persons who have had fewer lifetime mental health admissions are more likely to improve in the Social Relationships CAP and less likely to decline than those with multiple lifetime admissions. In in-patient mental health settings, cognitive impairment (use the Cognitive Performance Scale embedded in the interRAI Mental Health instruments in the appendix) is associated with a reduced likelihood of improvement. In addition, persons admitted from correctional facilities and forensic admissions are more likely to trigger the Social Relationships CAP at a higher level over time. These findings suggest that approaches to improving function should take into account the person's mental health history and his or her current level of functioning. Interventions should be matched to the person's strengths and abilities and should consider the impact of the person's mental health experiences on his or her social relationships. For example, persons whose first admission happened before adulthood are less likely to be married, have children, or have been employed (an important source of potential friendship ties) than those whose first admission occurred later in life.

For persons experiencing a problem related to social relationships, consider both the potential underlying causes of the problem **and** its consequences for the person. The following issues should be explored as a starting point for either reducing social isolation and family dysfunction or improving social involvement and family functioning.

- What are the dimensions of the social relationships (for example, type of social contacts, frequency of contact)?
- Is the social relationship problem new or is it something the person has experienced over a prolonged period of time? Has there been a recent change, either for better or for worse? If so, what were the circumstances that preceded that change?
- Do behaviours or mental health symptoms (for example, anxiety, depression, aggression, cognitive impairment) affect the person's ability to establish or maintain relationships? Is the person's isolation from others a deliberate, reasoned choice or is it a consequence of mental health symptoms that could be alleviated with treatment?
- How effective are the person's social skills (for example, communication, initiation of interaction, responding to verbal and nonverbal cues) when interacting with others?
- Do family, close friends, and other community contacts provide an environment that supports the person in interacting with others?
- Does the person have a supportive relationship with a teacher or grandparent?
- Does the person have a talent or preferred activity that can be used as a vehicle for establishing new relationships (for example, joining a recreational club)?

- Do physical health issues (for example, pain), functional problems (for example, mobility), or IADL problems (for example, capacity to use transportation) affect the person's ability to interact with informal network members or participate in community and family events?
- Is the person aware of community resources that are available (for example, drop-in centres, recreational programs, volunteer opportunities)? Has the person ever had any involvement with community resources? Does the person want to be involved in such community programs?
- Does the person have a history of substance abuse? If so, what is the response of family and close friends to the behaviour? What are the consequences of the person's substance use for family functioning? (See Substance Use CAP.)
- Has the person experienced stressful life events? Are indications of trauma associated with these events present? Has the person experienced abusive relationships within his or her family? (See Traumatic Life Events CAP.)
- What is the person's view of his or her role in the family? Does the person feel he or she is contributing to any difficulties related to family functioning?
- Does the family play a strong and supportive role in the person's life or is it a major source of stress?
- Does the person want to change or improve interpersonal relationships? Does the person feel hopeful that positive changes in social relationships are feasible? Does the person feel isolated irrespective of objective indicators of his or her level of isolation? Is the person happy being isolated from others or does the person wish to re-engage severed relationships?
- What is the person's perception of his or her responsibility for improving role functioning? What is his or her perception of the support and encouragement provided by others?
- Are there cultural considerations that affect the person's engagement with others that should be taken into account as part of the recovery plan?
- Does the person have access to a phone or e-mail? Does the person live in a rural setting with limited opportunities for community activities?
- Is lack of transportation a barrier to the person's participation in community activities?
- If the family feels overwhelmed by the person's illness, what types of support do family members think would be helpful?

Intervention Strategies for Both Trigger Levels

For the Social Relationships CAP, it is critical that the person and his or her informal network members be central in the care planning discussion. The response to concerns related to social relationships must include the person as an active decision maker and it must achieve a collective commitment to positive change. The person should accept responsibility for responding to issues that have affected social relationships wherever possible; however, this is a *shared* responsibility with the family, close friends, and members of the mental health team. Social relationships are, by definition, not an individual concern.

Initial considerations. The person's capacity to participate in a discussion related to social relationships will be affected by the severity and acuity of current mental health symptoms. Those who are acutely ill or experiencing severe impairment in cognitive function will not be in a position to discuss complex issues related to role

function, family dynamics, interpersonal relationships, or community engagement. In such circumstances, the focus may be more on symptom management and support of the family or close friends to ensure their continued engagement in the person's recovery.

However, as soon as the acute phase of illness has subsided (for example, a reduction or an elimination of disturbances of thought content or form, evidence of improvement in mood and concentration), the person should be actively involved in efforts to address issues related to social relationships. The following actions should be considered and tailored to the specific circumstances of each person and his or her social network.

Readiness to change and self-efficacy: Being ready to change is a dynamic process and the approach should focus on providing support that is congruent with the person's current point in the change process and moving him or her to the next level.

- If the person recognizes that there is a problem but is uncertain if he or she wants to change, help the person identify the reasons for change and the impact of change on his or her well-being. However, if the person is at the point where he or she is prepared to make a change but is not aware of what he or she can do to bring it about, support the person as he or she takes specific actions aimed at improving social relationships.
- Self-efficacy is an important factor to consider during any change process and recovery.
- It is important to work with the person to help him or her understand that personal identity and ability to change is not defined by his or her mental illness. Rather, meaningful engagement in the community becomes an achievable primary goal.

Understanding what might be possible: The key is to first determine the dissonance in how the person and the family appraise their mutual involvement with one another and then determine what it might take to either improve the situation or reduce the risk of it becoming more problematic. This assumes that there are others in the extended network with whom to work. Some persons are less likely to have a history of strong interpersonal relationships. Identify the following:

- Someone with whom the person could interact
- How the person's mental health, cognitive, and functional deficits challenge communication
- How the identified family and friends feel about re-engaging with the person

- The following are examples of the types of approaches that build on the above:
  - Mutual interest by the person and his or her family and friends in re-engaging with each other is the most positive of circumstances. However, it should not be assumed that additional supports are not required for this to succeed. For example, couples or family therapy can help identify problem areas and build on strengths in the relationship.
  - The person has unresolved conflicts with others that affect his or her current level of social participation. Resolution of all conflicts may not be a realistic or necessary goal for supporting the person's engagement with others. However, in some cases old sources of conflict may be amenable to resolution, which would benefit everyone. These conflicts can come from many sources (for example, physical or mental abuse, financial strain, conflict over poor lifestyle choices; see Interpersonal Conflict CAP).

History of substance abuse: Substance abuse can have a profound, adverse impact on family functioning, friendship, and community involvement. Persons with a history of substance abuse are more likely to experience conflict with others, which may in turn harm the viability of important social relationships (see Substance Use CAP). In in-patient mental health settings, higher CAGE scores are associated with the development of new problems in social relationships among those who did not trigger the CAP at admission.

- Referral to an appropriate substance abuse program should be considered where there are current indications of use of illicit drugs, misuse of prescription medications, or subjective indications of substance use problems based on the CAGE items included in the interRAI MH and CMH.
- It may also be the case that some members of the person's informal network support or engage in substance abuse with him or her. In such cases, it will be important to discuss the impact of those relationships on the person's broader social functioning and quality of life. Help the person to recognize and avoid social situations that are not supportive of healthy behaviours. The basic goal is to support the person in establishing new, positive social relationships.

Physical health affecting the person's participation level: Problems with physical health may limit the person's ability to participate in family or community events. For example, if the person feels sick on a continuous basis, is fatigued, or experiences substantial pain, he or she may not pursue social interactions outside the immediate living situation because of these symptoms. In addition, problems with mobility may make it difficult to leave the home if appropriate support is not provided.

- If there are unresolved physical health problems, a physician referral is in order.
- If the person is experiencing ongoing problems with fatigue, he or she may benefit from energy-conserving strategies that will support continued involvement in activities of interest (for example, breaking activities into small, manageable steps; stopping to rest as needed; learning relaxation techniques).
- Difficulty with mobility can be addressed through involvement with an occupational therapist or a physical therapist with the goal of improving strength and tolerance for activity or providing appropriate mobility aids.

C**ommunication and problem-solving skills of the person and family are compromised:** Effective communication can reduce stress and conflict, clarify expectations and responsibilities, and support development of mutual goals. Both the person and the family should be provided support that will help improve communication and problem-solving skills, where appropriate.

- A formal social skills training program can help to improve conversation techniques, conflict resolution skills, and confidence in interpersonal interactions and interpreting social cues.
- A life-skills program may be helpful to increase the person's level of comfort in community settings (for example, shopping, ordering meals, asking for assistance).
- Family counselling can help to improve communication between the person and his or her family.
- Caution should be used with respect to the use of social media to form relationships. Such interactions require more sophisticated social skills than normal in-person communication, it does not give the person immediate feedback, and it could be a source of public humiliation and bullying.

The person has experienced an abusive relationship(s): There is a clear relationship between triggering the Social Relationships CAP and a history of sexual, physical, or emotional abuse, particularly where the person describes those events as having caused intense fear or a sense of horror (see Traumatic Life Events CAP). Such traumatic events can have a profound impact on the person's level of anxiety, self-confidence, and willingness to engage with and trust others. In addition, it may have a structural impact on the family and may, at least in some cases, preclude interaction with specific family members, friends, or other acquaintances who perpetrated the abuse.

- If these conditions are present, the recommendations in the Traumatic Life Events CAP take priority.
- It may not always be in the person's best interest to pursue re-engagement with inactive family or friendship ties. For example, prior abusers may continue to pose a threat to the person's physical or psychological well-being.

Problematic former relationships: Contact with former criminal associates may increase the risk of recidivism. Similarly, for persons who have recovered, or who are in the process of recovering, from addictions, the risk of relapse may increase if the person returns to a milieu conducive to substance abuse. Most persons with this type of history will have trouble setting social boundaries and avoiding problematic social situations.

- Provide the person with information about the risks of re-establishing these ties.
- Help the person identify alternative options for developing new supportive relationships.
- Provide the person with support in addressing any barriers that prevent him or her from engaging in new relationships.
- Help the person establish strategies for engaging in positive relationships.

Role of external factors in the social and physical environment: The person's ability to participate in community activities or to visit with family or friends may be affected by environmental factors such as weather, geographic isolation (for example, living in remote rural settings), lack of adequate transportation, or concerns about safety in public settings. In addition, stigma, intolerance, and lack of acceptance by the community can severely constrain the recovery of persons with mental illness.

- Determine whether the person is aware of, and understands how to make use of, transportation options in the community. In some cases, it may be necessary to arrange in-home services (for example, friendly visiting).
- If poverty is a barrier, make the person aware of community resources to which he or she is entitled, including income subsidization, housing, and subsidized leisure activities that may be available through community recreation centres. It may be necessary for the clinical team to help the person navigate the system to access such services.

Awareness of community supports: Many communities have programs such as club houses, consumer-run drop-in centres, supported socialization groups, and work programs that may help the person make new social connections.

- Provide the person with information about organized activities that may be of interest. Also, consider the person's need for support in establishing initial contact with community programs.
- Reach out to the volunteer association members to try and engage the person.

- Work with family members to have the person re-engage with activities he or she is interested in.
- Identify potential barriers to community engagement (for example, transportation, finances, child care) and assist the person in problem solving to overcome these barriers.

Family education: It should not be assumed that family members have the information needed to be an effective source of support to the person or that family members fully understand what their relative is experiencing.

- Family members may benefit from information about the person's mental illness, coping strategies, ability to balance personal and family needs, or treatment options.
- An effective family intervention will include an educational strategy that addresses the information needs of the person and his or her family.
- If applicable, family members should be advised of support groups targeted toward their needs.

Therapy programs: A variety of options are available for individual, family, couples, or group therapy-based interventions with the aim of reducing isolation and promoting positive re-engagement with family or friends. About 45% of persons in both trigger levels of this CAP are involved in group therapy in in-patient mental health settings compared with about 35% of the not-triggered group.

- Based on the nature of the difficulties in social relationships, consider individual, group, family, or couples therapy (see Informal Support and Support Systems for Discharge CAPs).
- Consider self-help and peer support programs as important resources for supporting the person's recovery.
- Prior to discharge from an in-patient setting, the person should be linked with local community agencies that can provide appropriate supports after leaving the hospital.

Other Considerations

It is important to consider social relationships not only as an outcome but also as a predictor of quality of life and recovery in other domains. For example, among persons receiving community mental health services, the rates of making economic trade-offs between purchasing necessities such as food, shelter, and clothing is four times and five times higher among persons triggering the first and second levels of the Social Relationships CAP. Similarly, persons triggering the CAP to reduce social isolation and family dysfunction are almost two and a half times more likely to experience residential instability compared with those not triggering the CAP. The rates of eating one or fewer meals in the last 3 days rise from below 1% of those not triggering the CAP to 6% and 13% of those triggering the first and second levels, respectively.

In in-patient mental health settings, the Social Relationships CAP is related to length of stay and to the rate of improvement in symptoms of conditions like depression. Social relationships can be valuable sources of support that can aid in recovery from mental illness, and they may provide practical help (for example, accommodation) that may have an impact on the timing of discharge.

Additional Resources

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Section 5

Informal Support CAP

Issue

The relationship between informal support and a person's mental health, functional ability, and quality of life is well documented. An informal social support network may provide a buffer against adverse life events and stressful living conditions, and it may contribute to a person's overall sense of well-being. Informal support networks may include immediate and extended family members, friends, and other members of the community. Persons with a mental illness can receive many kinds of informal help from others, including emotional support, instrumental help, and information. The person's support network can help find solutions to problems, optimize the ability to perform activities of daily living, manage symptoms, cope with both physical and psychological stressors, and provide assistance during times of crisis.

Many persons with mental illness report spending a substantial amount of time alone. They are likely to experience feelings of isolation or loneliness and dissatisfaction with the level of support they receive, and they may lack a sense of belonging to a larger community. Increasing the size and capacity (for example, degree of involvement) of the informal support network may reduce loneliness and social isolation, improve psychosocial functioning, and reduce mental health symptoms. Mobilizing additional supports may also reduce the level of caregiver burden on those already providing help to the person.

Goals of Care

- Identify and link with existing (or potential) sources of informal support.
- Where there is no existing or potential support available, mobilize appropriate formal resources to respond to unmet needs.
- Stabilize and increase (where possible) the size and capacity of the person's informal support network to address the person's needs.
- Rebuild or strengthen family and friendship relationships, where appropriate.
- Enhance the person's sense of well-being, belonging, and overall quality of life.

Triggers

The Informal Support CAP addresses the person's need for help from informal sources. This CAP applies to persons involved in community-based mental health services. The Support Systems for Discharge CAP serves a similar function for persons in in-patient settings.

TRIGGERED TO ADDRESS NEED FOR FUNCTIONAL SUPPORT RELATED TO PHYSICAL DISABILITY OR COGNITIVE IMPAIRMENT

This trigger level focuses on persons who

- need functional support but who do not have identified sources of informal support willing or able to help with these needs; AND
- have one or more indication of
  - Cognitive impairment(s)
  - ADL impairment(s)
  - IADL impairment(s)

About 6% of those receiving community mental health services trigger the CAP at this level. At follow-up assessment, 43% of this group demonstrated a worsening of cognition and 23% exhibited a decrease in subjective health. Twelve percent of this group had more than two visits to the emergency department by the time of their follow-up assessment.

TRIGGERED TO ADDRESS NEED FOR SUPPORT RELATED TO MENTAL HEALTH SYMPTOMS

This trigger level focuses on persons who

- need support related to mental health but who do not have identified sources of informal support willing or able to help with these needs; AND
- have one or more of the following:
  - Any problems with insight
  - Any positive symptoms
  - Any depressive symptoms

About 4% of those in community mental health settings trigger the CAP at this level. At follow-up assessment, 52% of this group demonstrated a worsening of cognition and 31% exhibited a decrease in subjective health. Seven percent of this group had more than two visits to the emergency department by the time of their follow-up assessment.

NOT TRIGGERED

Persons in this group

- have an identified source of informal support for functional impairments and mental health needs; OR
- do not need the types of support identified in the interRAI CMH.

This group includes about 90% of those in community mental health settings.

Guidelines

Initial Considerations

Each person's network will reflect a unique constellation of informal support resources. To formulate an intervention for informal support, consider the following:

- Identify the person's strengths, preferences, and needs using the various measures of functional status, mental state indicators, and social relationships available in the interRAI Community Mental Health Assessment. Consider the person's stated goals of care, and ask what types of informal help the person feels would be most beneficial. Interventions are more likely to be successful if they are based on the person's priorities.
- Identify the person's existing sources of informal help as well as previous sources of assistance that are no longer engaged with the person. This may identify potential untapped sources of support for current needs.

- Determine whether the person's existing social network is unable to cope or is affected by pervasive conflict. Do the person's family members or friends reinforce undesirable behaviours? Does the person have others who could be mobilized to provide help when needed?
- Determine what other community resources are available to build or enhance the person's informal network. If family or friends are unable or unwilling to provide assistance, consider facilitating access to community volunteer or social services as an alternative source of support.

Interventions

Consider interventions that may increase the capacity and sustainability of the informal network to provide ongoing support.

- Target education to increase understanding of mental health issues.
- Explore additional support options to reduce the burden on the existing support network.
- Provide professional counselling services (see Social Relationships CAP) for both the person and the potential source of informal support if persistent conflict or dysfunctional relationships hinder the ability to provide support.

Social skills training. Consider whether social skills training would be appropriate to address specific difficulties that the person might have in social situations and to increase the person's ability to mobilize informal support when needed.

- The key elements of social skills training include behaviour-based instruction, modeling, corrective feedback, and contingent social reinforcement. This involves teaching the person specific behaviours that are critical for success in social interactions, social adjustment, and enhancement of the person's social network.
- In addition, these interventions support development of independent living skills that may therefore reduce the dependence on others for informal support.

Identify and address potential barriers to provision of informal support. Consider the following potential barriers that may make it difficult for the person to obtain needed informal support:

- **Cultural or language barriers:** Are there cultural considerations that limit the person's ability to request assistance or that constrain who may act as an informal support (for example, provision of support related to personal hygiene)? Consider the use of formal support services or volunteers if they would be more culturally acceptable as a substitute. If language barriers are present, engage members of the person's cultural community to provide assistance with translation.
- **Competing time demands for informal helpers:** Employment or school obligations may hinder the ability of some informal support network members to provide help when needed. Discuss the situation with the person and the informal helper(s) to establish a schedule where other network members could be mobilized to supplement the assistance provided by the primary source of support.
- **Transportation:** In some cases, some sources of informal support may be willing to help but are unable to do so because of transportation barriers. Discuss alternative sources of transportation with the informal helper, including asking other network members to provide transportation for the primary helper when needed.

- **Lack of awareness of existing resources to support informal helpers:** Family and friends who are feeling overwhelmed by the person's situation may not be aware of supports that they may be able to draw on themselves. In these situations provide the informal helper(s) with information about how to access resources in the community (for example, family support groups related to specific mental health conditions).
- **Health issues:** Health concerns may pose a barrier for some informal support members. Be sensitive to changes in the health of informal helpers that have the potential to disrupt the support available to the person. For informal helpers who are experiencing health problems, encourage them to take care of their own health and consider reallocating responsibilities for tasks that are too difficult for them to others in the informal support network.

Address conflict or dysfunction in the social network. If the provision of informal support is hindered by family dysfunction or conflict among the network members, consider family or couples therapy to address interpersonal problems (see Social Relationships and Interpersonal Conflict CAPs).

Enhance informal network. Adequate support resources may be available from the person's social networks, but the quality and quantity of support may need to be increased to meet the person's needs. In such cases, focus on current relationships and encourage the person, family, and friends to explore ways to function more effectively. This might include interventions that focus on

- Increasing understanding
- Changing attitudes
- Improving interaction skills
- Increasing communication
- Coordinating responsibilities
- Strengthening bonds within positive relationships
- Removing structural barriers to support
- Providing support to network members

Change attitudes or beliefs. Both the person and the social support network may have beliefs that interfere with the provision and receipt of support. Counselling may be helpful to address underlying fears and beliefs that may hinder the capacity of a person from receiving help, or of a social network member from providing support.

Consider the following:

- Does the person believe that requesting assistance from others is a sign of weakness?
- Does the person hide needs from family or friends?
- Do the network members believe that providing support undermines the independence or dignity of the person?
- Do the network members believe that there is nothing they can do to be helpful?
- Does stigma related to mental illness prevent the person from receiving needed informal support?

Incorporate family or friends into treatment. Interventions can be implemented by themselves or can be built into varied treatment modalities.

- Interventions include self-help groups, support groups, and family therapy.

- Where possible, family members and others connected to the person should be involved in the person's treatment, with his or her consent. This may support the recovery of both the person and his or her informal helpers who have been affected adversely by the consequences of the person's mental illness. Consider the following:
  - Are there family members or friends who may be willing to provide support but who have not been approached for help?
  - Are others who are potential sources of support willing to be involved in the treatment programs?
  - Do family and friends understand that their participation in therapy is appropriate and beneficial?

Consider family interventions. It is important to involve family members in network interventions, especially when the family represents the main cluster of support in the person's life. However, the ability to do this depends on the person's consent for such interventions and the family's willingness to engage. Including family members in treatment regimens enhances the efficacy of these treatments, helps reduce relapses and improve functioning, decreases family burden, and improves family functioning. Family psycho-education programs should include features of engagement, support, and skills-building. There are generally three components to family interventions:

- Building an alliance with the family
- Educating the family about the person's mental health and other care needs
- Using individualized interventions specifically designed for each family to address their own set of circumstances

Additional Resources

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Section 6

Support Systems for Discharge CAP

Issue

Planning for a person's discharge should begin at the point of admission to an in-patient mental health program. Resources and supports needed to facilitate and sustain a successful re-entry into the community should be identified. Persons who receive adequate discharge planning are less likely to become socially isolated and less likely to experience rehospitalization in the months following hospital discharge. Without an effective discharge plan, the risk of readmission is high. Within six months of being discharged from in-patient programs, the rate of readmission ranges from 20% to 40%.

Discharge to the community without adequate support arrangements can result in unnecessary emotional hardship for the person and his or her family. The high rates of homelessness and poverty among persons with severe mental illness point to the need for the person, hospital staff, and community partners (for example, community mental health teams, family physicians, care providers at health clinics, private practice mental health professionals) to work collaboratively in building an effective discharge plan. Doing so not only may contribute to a better quality of life for the person but also will reduce the risk of avoidable readmissions. Effective discharge planning considers both the health and social needs of the person. Issues concerning housing, employment, income, and support networks are key considerations.

Goals of Care

- Mobilize supports to facilitate successful community engagement.
- Arrange for housing and social service options for persons who may need additional support (for example, those expected to be homeless).
- Facilitate links to the support required to sustain and strengthen the person's ability to effectively manage the recovery process in the community.

Triggers

The Support Systems for Discharge CAP identifies persons who may experience difficulties post-discharge as a result of lack of resources (for example, no social support, homeless). This CAP applies to persons in in-patient mental health settings. The Informal Support CAP serves a similar function for persons in community mental health programs.

TRIGGERED

This group includes persons

- who do not have a family member or friend who is willing to provide help with ADLs/IADLs, child care, crisis support, or supervision for personal safety after discharge; OR

- whose living arrangement (permanent or initial) upon discharge is "homeless"; OR
- who do not have a support person who is positive toward the person's discharge to the community.

About 37% of persons in in-patient mental health settings trigger this CAP.

NOT TRIGGERED

This group includes persons who

- do not require supports; OR
- have identified supports in the areas listed above and are not expected to be homeless on discharge.

This group includes about 63% of those in in-patient mental health settings.

Guidelines

Community connections while in the hospital. Efforts should be made to help the person maintain his or her housing and community social support connections during the hospital stay.

- In many cases, the last recollection that family members or others have of the person prior to admission will be that of a crisis situation. It is important that they are involved during the in-patient stay and see the process of recovering. This can improve the likelihood that family members or friends will be receptive to supporting the person on his or her discharge home.
- Keeping as much of the community context as possible intact while the person is in the hospital will help to minimize disruptions in the transition from the hospital to the community.

Availability of informal and formal support systems. Supportive relatives, friends, or other members of the person's community can play a pivotal role in helping the person adjust successfully to his or her post-discharge environment. Thus, it is important to consider potential informal support persons and resources.

- Does the person have family or others who will be available to provide support once the person is discharged?
- To what extent are the family members and other informal support network members prepared to be involved?
- What kind of help and support are they able or prepared to provide?
- Are there any relationship issues or conflicts that make it difficult for a family member, friend, or other to help or for the person to accept help? (See Social Relationships and Interpersonal Conflict CAPs.)

Limited or nonexistent informal supports. In situations where there are limited or nonexistent informal supports, formal support resources should be considered.

- Identify the type of support the person is likely to need for successful community living.
- Identify the resources available in the person's community.
- Prior to discharge, depending on the needs and preferences of the person, connect him or her with the following:
  - Home care (for example, for ADL support or rehabilitation)

- Follow-up medical or mental health care (for example, physician, psychiatrist)
- Community support services for assistance with instrumental needs (for example, transportation to or from appointments, hot meals)
- Social services (for example, identifying a place to live, income support, food banks)
- Mental health support services (for example, caseworker, support groups, counselling)
- Recreational programs that may provide the person with an opportunity to enjoy positive social interactions and enhance social skills.

Adequacy of living arrangements. Successful discharge will be profoundly affected by the stability and quality of post-discharge living conditions. The person's living conditions can play a major role in either supporting or hindering mental wellness and fostering and sustaining a successful transition to community living. Thus, it is important to assess the physical and social characteristics of the post-discharge destination. Consider the following:

- Is the discharge destination likely to support and enhance the person's ability to function? For example, if the person will be living in a boarding home or group home setting, is it reasonably clean and maintained? Does the location allow for access to necessities (for example, grocery store, pharmacy)?
- Are there any conditions of the living arrangements that are likely to have a negative impact on the person's ability to function (for example, homelessness, poorly maintained boarding homes, living among conflict-laden relationships, isolated)?
- Are there any conditions of the living arrangements that are likely to have a positive impact on the person's ability to function (for example, close proximity to the person's social support network, an atmosphere that supports the mental health recovery process)?

Adherence. Not taking psychotropic medication as prescribed is a frequent cause of readmission following discharge, as is not following up with discharge plans (for example, not attending social programs or therapies).

- Determine whether there are current or prior problems with adherence to medications and therapies, and how likely it is that these problems will hinder the person's recovery in the community.
- If needed, determine whether someone in the person's community support network is willing to work with the person to take his or her medications as prescribed and to participate in recommended treatments, social programs, and therapies.
- Also, see Medication Management and Adherence CAP**.**

Severity of symptoms. The interplay between successful discharge and the severity of the symptoms experienced by the person should be considered.

- Review any mental health symptom assessment findings in the light of how they may affect successful discharge. Consider the following:
  - Are there cognitive or behavioural problems?
  - Does the person manifest frequent disturbing behaviours, such as screaming or verbal abuse?

- Are there problems with hallucinations, delusions, or incoherence that may be disruptive?
- Are there frequent symptoms of mood disorders (for example, depression or mania)?
- Does the person have a history of suicidal ideation or suicide attempts (see Suicidality and Purposeful Self-Harm CAP)?

- Determine the support network's capacity to cope with the person's mental health symptoms.
  - Are members of the person's social network able to provide support in crisis situations?
  - Do they need support and counselling to improve their own capacity to help with the person's mental health symptoms?
- Provide information that will help the person and his or her social support network members address concerns should the severity of the symptoms increase (for example, when to seek help immediately, provide a list of emergency support systems available in the community).
- Encourage the person and family to access community support (for example, a schizophrenia support group, an Alzheimer's support group, a community peer support group for mood disorders).

Dangerousness. Consider the Risk of Harm to Others (RHO) Scale (see the appendix) to evaluate the person's potential for danger to others.

- Is there evidence of violent ideation?
- Does the person have a history of violence?
- Before attempting to reconnect relationships severed by violence or abusive behaviour, consider the safety of other persons and their willingness to re-engage. Any intervention to re-establish such ties must take into account the risks, strengths, preferences, and needs of both parties (see Harm to Others, Criminal Activity, and Interpersonal Conflict CAPs).
- Provide information about community resources available to the person and his or her informal social support network (for example, anger management programs, emergency contacts).

Economic stability. The adequacy of the person's income should be considered as part of the discharge plan.

- If the person's economic situation is an underlying cause of homelessness, consider alternative housing options prior to discharge.
- If personal finances are identified as an issue, see Personal Finances CAP.

Meaningful engagement. Meaningful engagement in the community setting can help to facilitate successful discharge.

- Determine whether the person has employment, school, volunteer work, or recreational activities that he or she will be able to re-engage in upon discharge.
- Explore the person's plans or interests in employment, school, volunteer work, or recreational activities, and assist him or her, where possible, to begin the process of returning to or initiating such activities prior to discharge (see Education and Employment CAP).

Interpersonal skills. Mental illness can hinder or prevent the development of the social skills needed to build and maintain positive relationships. As a result, loneliness and alienation are common experiences for persons with mental illness. Consider the following for an evaluation of the person's ability to engage with others:

- Assess the person's ease of interacting with others, the quality of interpersonal relationships, and the person's involvement in social activities.
- Does the person have the social skills to mobilize informal supports when needed? Does the person know who to approach for help if needed?
- Build on the person's interpersonal strengths, skills, and interests. Provide opportunities for positive social interaction through recreational and social programs.
- Explore formal mental health programs (for example, social skills groups) that provide a safe environment for the person to develop new social skills.
- Offer counselling, as needed, to assist in resolving relationship issues arising from past traumatic experiences (see Traumatic Life Events CAP).

Physical functioning and life skills. Use the embedded interRAI ADL and IADL scales to determine the person's functional ability and consider the following:

- Does the person have any physical impairment that limits his or her physical functioning, such as the ability to dress, eat, and bathe independently?
- Are there others who may be called on to provide ADL or IADL support if needed?
- Does the person have access to physical rehabilitation services if needed?
- Mental illness and the experience of institutionalization can also greatly affect a person's ability to perform tasks like cooking nutritious meals, cleaning, and shopping. Consider involvement in a life-skills program that is initiated prior to discharge and will continue post-discharge.
- If needed, assist with arranging community support services (for example, Meals on Wheels, home care) prior to the person's discharge (see Self-Care CAP).

Evaluation of previous discharge plan(s). If the person was readmitted following a hospital stay in the last six months, review the previous discharge plan.

- Determine what aspects of the previous discharge plan were effective in facilitating a successful transition to the community.
- Identify factors that contributed to a difficult transition or were not successful parts of the previous plan.
- Incorporate these insights into the current discharge plan.

Additional Resources

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Section 7

Interpersonal Conflict CAP

Issue

The presence of interpersonal conflict can challenge the quality of life for persons receiving mental health services. Such conflict can be disturbing to the person and can negatively affect the person's social life, including employment, community involvement, the availability of informal support, and successful community living. The presence of positive and satisfying relationships with others will help the person through his or her recovery process.

Mental illness may lead a person to feel ashamed, overwhelmed, and resentful of being put in a position of need and may make him or her feel anger at him- or herself or others. A person may feel anxious, fearful, or frustrated with his or her situation and these feelings may present as anger. Hospitalization may also evoke a sense of loss, confusion, frustration, and powerlessness. These emotions often lead to resentment and hostility toward those readily accessible to the person, including staff and other care recipients.

Interpersonal conflict may be characterized by irritable mood, hostility, resentment, negativity, anger, and aggression. Persistent symptoms of increased arousal, such as that of irritability or outbursts of anger, have been included as criteria for the potential diagnosis of a number of mental health disorders. Without intervention, such conflicts may place the person or others at risk of possible harm. When such conflicts become a pervasive aspect of a person's daily life, they can also exacerbate mental health symptoms (for example, depression, anxiety, irritability) and affect the person's recovery and community integration. In in-patient mental health settings, interpersonal conflict is associated with higher rates of restraint use and higher risk of elopement.

The Interpersonal Conflict CAP addresses the issue of conflict that a person may have in his or her relationships and interactions with others. In the in-patient mental health setting, such conflict may involve staff, other care recipients, and family. In the community, such conflict may involve formal caregivers, family, friends, employers, and others in the person's immediate social environment. The focus of this CAP is to address interpersonal relationships that have, or have the potential for, anger issues related to interpersonal conflict.

Goals of Care

- Prevent escalation of the conflict.
- Reduce the intensity and number of individuals involved in the conflict.
- Identify underlying causes of conflict with others.
- Identify patterns of emotional responses that increase interpersonal conflict.
- Alleviate underlying causes of conflict.
- Develop coping strategies and interpersonal social skills.

Triggers

The Interpersonal Conflict CAP considers the characteristics both of the person (for example, his or her anger toward others) and of the relationship between the person and others. In addition, the CAP takes into account close, personal ties (for example, friends, family), weak ties (for example, relationships with other care recipients), and formal ties with staff members. This CAP applies to persons in both in-patient and community-based mental health settings.

TRIGGERED TO REDUCE WIDESPREAD CONFLICT

This group includes persons who have two or more of the following indicators:

- Persistent anger with self or others
- Conflict with or repeated criticism of family or friends
- Conflict with or repeated criticism of other care recipients or staff
- Staff members report persistent frustration in dealing with the person

This group includes about 15% of persons in in-patient and 24% of persons in community-based mental health settings. The CAP is more likely to be triggered at this level by persons with no insight into their mental health condition, a higher score on the positive symptoms scale, and greater cognitive impairment. In in-patient mental health settings, persons who are under 25 or over 85 are most likely to trigger at this level. Almost one-quarter of in-patients with a personality disorder trigger at this level compared with about 13% of those with a mood disorder and 8% of persons with an eating disorder diagnosis. By discharge from an in-patient mental health setting, approximately 55% of those triggered at this level will show improvement in the level of interpersonal conflict, but the rate of improvement will not be consistent for all subgroups. The improvement rate for this group in community mental health settings is 40% over six months.

TRIGGERED TO REDUCE CONFLICT WITHIN SPECIFIC RELATIONSHIPS

This group includes persons who have only one of the following indicators:

- Persistent anger with self or others
- Conflict with or repeated criticism of family or friends
- Conflict with or repeated criticism of other care recipients or staff
- Staff members report persistent frustration in dealing with the person

This group includes about 28% of persons in either community or in-patient mental health settings. As with the first trigger level, about half of this group will improve by discharge from an in-patient mental health setting. About 40% of this group will improve in community mental health settings over a 6-month period. However, about 8% of persons in this trigger group will escalate to the higher level of interpersonal conflict (widespread conflict) in both in-patient and community mental health settings.

NOT TRIGGERED

This group includes persons who are not currently experiencing persistent anger or interpersonal conflict with family, friends, other care recipients, or staff. This group includes about 57% of persons in in-patient and 48% in community mental health settings. The development of interpersonal conflict is relatively uncommon for this group (about 10% in either setting). Care for those in this group is focused on monitoring for any unexpected symptoms or behaviours that may affect the person's ability to relate in a positive way to others.

Assessment

Initial review. For persons experiencing interpersonal conflict, complete a review to (1) determine the nature of the interpersonal conflict, (2) identify factors that may be contributing to the problem and its occurrence or persistence, and (3) assess the potential that the hostility may intensify in order to ensure the future safety of the person and others who directly or indirectly may become involved in the conflict. The review process should involve the person who is experiencing the conflict and, where possible, others who are involved in the conflict.

Nature of the interpersonal conflict.

- Determine the frequency of the conflict as well as the situations and environmental factors related to occurrences of conflict.
- Identify the relationship of the persons in conflict.
- Determine if this is the first instance of this conflict. If not, how long has it been present and are there strategies that have been effective in diffusing previous occurrences? A history of interpersonal conflict is the greatest predictor of future conflict.
- Does the person feel he or she is contributing to the conflict?
- Does the person want to change or improve interpersonal relationships?
- Are there indications that others who support the person are distressed or overwhelmed by the person's condition?
- Does the conflict appear to be threatening the viability of the person's relationship with friends, family members, or confidants?

Evaluation of possible causes.

- Is the person experiencing a sense of powerlessness or fear in relation to being in a restrictive environment (for example, loss of personal space or items while in an in-patient mental health unit or congregate housing in the community)? Such feelings of powerlessness or fear may manifest themselves as anger and hostility.
- Are there specific anxiety-provoking situations that trigger or exacerbate the conflict?
- Is transference/countertransference present in the therapeutic relationship? Are external factors influencing the response of the person and staff member(s) toward each other (for example, a staff member reminds the person of an abusive family member, which in turn triggers a reflexive, hostile response)?
- Are physical symptoms (for example, pain, sleep disturbance) contributing to the conflict?
- Does the person have a history of substance use? Is there active substance use? Is the person experiencing substance abuse withdrawal?
- Has the person experienced stressful life events? Items on the assessment address, among other things, death of a close family member or friend, major loss of income or home, serious accident, victim of crime, abuse by others, and involvement in warfare or hostilities. Are there indications of psychological trauma associated with these events? If so, see Traumatic Life Events CAP.

- Has there been a recent change in the person's medication regimen or treatment program?
- Does the person have insight into his or her mental health problems? Is the person cognitively intact? (Consider the person's Cognitive Performance Scale score as a source of information on cognitive status.)
- Are family members or others contributing to the conflict? How?
- Do those involved in the interpersonal conflict understand the underlying factors associated with the interpersonal conflict?
- How does the person feel about his or her illness and how does he or she perceive the impact of the illness on his or her life?
- Are the person's mental health symptoms (for example, delusions, impulsivity, labile affect) contributing to the conflict? Consider these specific issues:
  - Those with personality disorders are at high risk for interpersonal conflict.
  - Persistent anger with self or others is often associated with depression.
  - Psychotic symptoms such as hallucinations or delusions, or negative symptoms such as withdrawal from family activities may precipitate hostility. The interRAI Positive Symptoms Scale (see the appendix) provides information on the severity of psychotic symptoms (higher scores indicate more severe symptoms).
  - Anxiety may precipitate flashbacks.
  - Interpersonal conflict may arise due to the person's impaired perception or to others' reactions to or misunderstanding of the symptoms.
  - A tendency to react to situations on impulse with a lack of deliberation or planning and difficulty in delaying gratification may lead to conflict with others.
- Do cultural considerations influence the conflict or need to be taken into account as part of the care plan? What might appear to staff as a strained relationship might be acceptable to that culture and that person.

Considerations for Care Approaches

Once the evaluation of the underlying causes and consequences of the conflict have been completed, recovery will be supported by improving the person's insight and empowering him or her to improve relationships.

Addressing the concern with the person.

- If the person is severely cognitively impaired, in a crisis state, or experiencing an acute psychotic episode, he or she will probably not be capable of engaging in a helpful discussion about conflict with others. Specifically, this discussion will need to take place once the person has stabilized and can be engaged in a meaningful discussion.
- Strategies aimed at reducing resistance to care, gaining more insight, and improving relationships are more likely to be effective once the person's feelings have been acknowledged and he or she agrees that interpersonal conflict is affecting his or her quality of life.
- Gaining the person's consent to work with the others involved in the conflict will also assist in resolving the conflict.

- A relationship involving persons with different cultural backgrounds might require couples or family therapy, provided that the persons involved are agreeable and feel that the conflict is an issue that needs to be addressed.
- If appropriate, in community settings where staff contact is less frequent, staff can attend meetings involving the person and his or her informal helpers and those in the person's immediate social environment (for example, employer, landlord) to address ongoing concerns or new developments with regard to interpersonal conflict.

Pharmacological treatment.

- If the person is presently taking medication, a review should be completed to determine its effectiveness. In some cases, a change in medication may be required to improve symptoms related to the hostility.
- Medication should be reviewed with consideration given to potential side effects that exacerbate the interpersonal conflict. For example, antidepressant use may induce behaviour that results in increased hostility or irritability. Persons with bipolar disorder are particularly sensitive to this.

Skills training.

- Persons who are persistently hostile may benefit from
  - Social skills training
  - Anger management
  - Conflict-resolution skills
  - Relaxation training
  - Assertiveness training
- Family or couples therapy may be useful in identifying and altering patterns of interaction and communication in the family or couple unit that contribute to conflict.

Cognitive impairment.

- Use the interRAI Cognitive Performance Scale (CPS) (see the appendix) to determine the person's level of cognitive impairment.
- For persons with a cognitive problem (a CPS score of 2 or higher), consider one or more of the following programs to reduce interpersonal conflict:
  - Cognitive stimulation
  - Memory enhancement
  - Problem solving
  - Dyadic counselling
  - Skills training for informal helpers

Substance use.

- Substance use can contribute to interpersonal conflict in a number of ways.
  - Loss of control, compulsiveness, and disregard for negative consequences related to addictive behaviour can be a direct cause of conflict.
  - Repeated episodes of disturbed behaviour or hostility related to intoxication can have an immediate and long-lasting negative impact on relationships.

- Economic hardship caused by spending on drugs or alcohol or from loss of employment often results in conflict (see Personal Finances CAP).

- Referral to an appropriate substance abuse program should be considered where there are current indications of the use of illicit drugs, misuse of prescription medications, or subjective indications of substance use problems based on the CAGE items included in the interRAI MH and CMH (see Substance Use CAP).

Physical symptoms.

- Pain may lead to irritable or hostile behaviour and thus should be considered as a possible contributing factor when a person reports indicators of pain. The interRAI Pain Scale (see the appendix) offers information about the frequency and severity of pain (higher scores indicating a more severe pain experience; also see Pain CAP).

- Other items to consider are those evaluating fatigue and physical discomfort, including shortness of breath, potentially distressing extrapyramidal symptoms, and headache.

- Persons with mental health problems sometimes lack self-awareness of these physical symptoms, and informal helpers or staff may need to monitor closely and observe for nonverbal indicators of discomfort.

- When present, the effects that health symptoms can have on mood and interactions with others should be discussed.

Role of family members. If family members exhibit hostile behaviour toward the person, assess for underlying factors and, where appropriate, offer family or couples therapy and refer family members to self-help groups. Consider the following in the assessment:

- Is the family overwhelmed by the person's illness? Has the family experienced stressful life events (for example, abuse, major loss of income) that remain unresolved?

- Is there a high level of criticism, hostility, and emotional involvement within the family?

- Is the family compelled to make economic trade-offs between purchasing necessary food, shelter, clothing, or medication that is leading to strained relationships?

- Do family members understand the nature of the illness? With the person's consent, consider counselling and education for the family so that they can better understand the illness and the nature of its effects on both the family unit and the person.

Stress and personal loss.

- Stressors such as loss of income, school failure, involvement with the criminal justice system, or child custody issues may cause interpersonal conflict (see, for example, Education and Employment, Criminal Activity, Traumatic Life Events, and Personal Finances CAPs).

- The involvement of the person in treatment programs (for example, substance abuse, eating disorder) may lead to a loss of self-esteem, self-control, and contact with his or her social network. Such losses may be expressed through interpersonal conflict.

- Stress management techniques should be taught to reduce the impact of these losses.

Dynamics in the therapeutic relationship.

- Staff members must be aware of the potential development of interpersonal problems in the therapeutic relationship.
- Consider if there has been a loss of an objective viewpoint that is interfering with the therapeutic relationship. If so, the clinician should seek out peer support or clinical supervision.
- When present, boundary violations and attempts to divide the clinical team will affect the dynamics of the therapeutic relationship.
  - A person who engages in "boundary violations" seeks personal information concerning staff or other care recipients to use later to his or her advantage. There may also be attempts to establish personal or even intimate relationships with staff outside the boundaries of appropriate professionalism to gain advantage or favors.
  - Creating division in the clinical team occurs when one staff member or group is pitted against another, through the spreading of rumors or other miscommunications, distortions of the truth, or identifying certain staff members as "good" and others as "bad."
  - In such situations, the staff must maintain professionalism and should try to understand the dynamics of the situation in order to minimize the effects on those involved and to prevent a recurrence.
- Appropriate interventions to prevent boundary violations and divisions among the clinical team include the following:
  - Staff education about these issues and measures to ensure continuing awareness of staff, including orientation of novice providers or students in the clinical setting.
  - Monitoring of the dynamics within therapeutic relationships by the clinician(s) involved, managers, and peers.
  - Maintaining open and frequent communication between and among staff to resolve conflicts and disputes, especially when such conflicts have arisen related to the person's behaviour.
  - Where appropriate, the promotion of a culture of explicit "limit setting" on the in-patient unit.
  - Clear rules and policies concerning behaviour with consistent application of the rules, including fair and immediate consequences for breeches of the rules.

Personality traits.

- Certain personality traits may lead to persistent interpersonal conflicts affecting a wide range of relationships.
- Such conflicts might be associated with emotional instability, persistent anger, exaggerated sense of self-worth, devaluation of others, and a predisposition to solve conflicts through self-injurious behaviour.
- Dialectical behaviour therapy (DBT) and its component interventions (for example, mindfulness, distress tolerance, emotional regulations, interpersonal effectiveness) may be effective for a wide range of psychopathology involving personality disorders, though evidence for its effectiveness in conditions other than borderline personality disorder is not as well established.

Additional Resources

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Section 8

Traumatic Life Events CAP

Issue

Post-traumatic stress disorder (PTSD) can occur in persons who experience, witness, or are confronted with a life-threatening event. Potentially traumatic life events can include motor vehicle accidents; combat or military exposure; victimization as a result of a violent crime, abuse, a terrorist attack; or a natural disaster. Not all such events trigger psychological trauma; however, when combined with an intense sense of fear, helplessness, or horror, these experiences can lead to debilitating consequences for the person.

Most people who experience a traumatic event recover without serious problems. However, some people go on to develop acute stress disorder (ASD) or PTSD. ASD occurs within 1 month of the traumatic event and is a short-lived (2 to 4 weeks) anxiety reaction. It is important to note that a diagnosis of ASD is not predictive of PTSD; however, treating someone with ASD can help prevent the onset of PTSD.

According to the National Collaborating Centre for Mental Health, 25% to 30% of people who experience a traumatic life event can go on to develop PTSD. In those who do, symptoms usually begin within 3 months of the trauma, but the course of the illness varies. Acute PTSD occurs in cases where the symptoms last only 3 months. Some people recover after 6 months, while others have symptoms that last much longer (chronic PTSD). Delayed-onset PTSD occurs when the symptoms first appear at least 6 months after the traumatic event. Many people who experience traumatic life events do not seek treatment for months or years after the onset of post-traumatic stress symptoms, and in some cases, they may never seek treatment.

Persons with serious mental illness are exposed to high rates of physical and sexual abuse, as well as other potentially traumatic events. Experiences of abuse and victimization are more common among persons diagnosed with a psychotic disorder, a borderline personality disorder, a substance-related disorder, or an eating disorder.

The psychological impact of traumatic life events can be treated even if symptoms present years after the trauma. In the general population, the lifetime prevalence of PTSD is reported to be approximately 8%. Prevalence rates are highest among people who experience sexual assault or events involving mass casualties (wars or natural disasters). The lifetime prevalence of PTSD is higher in women (10% to 14%) than in men (5% to 6%) and is more prevalent in persons who have underlying vulnerabilities, such as co-morbid psychiatric diagnoses. Responses to treatment may differ depending on the type of trauma experienced and the timing of the treatment relative to the occurrence of the traumatic event.

Goals of Care

- Ensure the person is in a safe and secure environment.
- Reduce crisis-related symptoms (immediate suicide risk, aggression toward others).
- Treat co-morbid disorders prior to the commencement of treatment for trauma-related symptoms.
- Address underlying symptoms linked to trauma (for example, flashbacks, sleep problems).
- Support healthy self-care behaviours related to medication management, eating, grooming, and physical activity.
- Increase the person's ability to understand his or her feelings.
- Prevent or reduce trauma-related conditions (for example, substance abuse).
- Protect against relapse and prevent future abuse.
- Restore family relationships, where appropriate.

Triggers

The Traumatic Life Events CAP identifies two groups of interest who have experienced a potentially traumatic life event: (1) those who are in immediate danger due to current abuse, and (2) those who have experienced one or more traumatic events that evoked an intense sense of horror or fear. Persons who have experienced abuse at any time in their lives may have ongoing concerns for personal safety and these concerns should be addressed as high priorities. This CAP applies to persons in both in-patient and community mental health settings.

TRIGGERED TO ADDRESS IMMEDIATE SAFETY CONCERNS

This trigger level focuses on persons who are in immediate danger due to current abuse. Included are those who

- have experienced one or more of the following traumatic events in the last 7 days: sexual abuse, physical abuse, emotional abuse, or criminal victimization; OR
- are fearful of others or currently have concerns for personal safety.

About 10% of those in in-patient mental health settings trigger the CAP at this level, compared with about 12% of those in community mental health settings.

This group has higher levels of anxiety than the group triggered to reduce the impact of prior traumatic life events and the not-triggered group, and this difference is more pronounced in community mental health settings. In in-patient mental health settings, 23% had six or more lifetime in-patient mental health admissions, compared to 30% among persons receiving community-based mental health services.

TRIGGERED TO REDUCE THE IMPACT OF PRIOR TRAUMATIC LIFE EVENTS

This group includes persons who

- have experienced one or more of the following traumatic life events:
  - Serious accident or physical impairment
  - Death of a close family member or friend

- Lived in a war zone or an area of violent conflict
- Witness to a severe accident, a disaster, an act of terrorism or violence, or abuse
- Victim of crime
- Victim of sexual assault or abuse
- Victim of physical assault or abuse
- Victim of emotional assault or abuse

AND

- describe the event(s) as having evoked an intense sense of horror or fear.

This trigger level considers both the occurrence of the traumatic event and the person's subjective response to the event. About 15% of those in in-patient mental health settings trigger the CAP at this level, compared with about 21% of those in community mental health settings. This group has higher levels of anxiety than the not-triggered group, and the rates are relatively similar for both in-patient and community-based mental health settings. In in-patient mental health settings, 18% have six or more lifetime in-patient mental health admissions, compared to 23% among persons in community-based mental health services. Despite the quality-of-life impact of traumatic life events, only 10% of persons in this trigger level in in-patient and 15% of persons in community-based mental health settings receive interventions for trauma.

NOT TRIGGERED

This group includes persons who

- have not experienced the above-mentioned life events.
- experienced an event but do not report a subjective sense of horror or an intense fear associated with the event. In some cases, this group may include persons who are emotionally numb to the traumatic event but who are nonetheless adversely affected by it.
- experienced a stressful life event not listed above (for example, loss of income, economic hardship, divorce).
- those who may have experienced a stressful life event but, because of factors such as positive coping skills and strong social networks, did not trigger the CAP.

Guidelines

Initial Considerations

The person's history can provide important information for treatment and prognosis.

- Obtain a detailed history of the exposure and the person's early responses to the trauma (also consider the responses of others close to the person) in order to understand the nature, severity, and recency of the events. The information can be obtained from the person and from collateral sources, such as case or medical files.
- Recognize the difficulty that some persons may experience in discussing traumatic life events. It is important to both establish a therapeutic relationship with the person and acknowledge that he or she may require opportunities over time to disclose information.

- Establish the timeline of when the person began to experience traumatic stress-related symptoms and when the traumatic event occurred.
- Determine if there is a family history of post-traumatic stress disorder.
- Determine the person's perspective on the effect of these experiences on him- or herself and others.
- Explore how the person has coped until now and what strategies, if any, the person has used to make him- or herself feel better.
- Determine if the person has associated features or co-morbid disorders. Does the person have another mental health diagnosis? Does the person have a past or current history of substance abuse? Is there a history of substance abuse in the person's family?
- Previous exposure to trauma can cause a person to become more susceptible to subsequent trauma. This can influence the development of PTSD and complicate treatment and recovery. It is important to determine if the person has a history of previous trauma and if treatment was sought. Determine what types of treatments were used in the past and if they were successful.

Interventions

Safety. The first priority for intervention is to ensure the safety and well-being of the person; thus an assessment of the person's current situation is necessary.

- Assess the person's current social environment. Determine if the person is in an environment where he or she is in danger of continued abuse or other trauma. In such instances, the person's safety should take priority.
- For persons demonstrating traumatic stress symptoms as a result of current abuse, consider both the underlying causes of the abuse and its consequences on the person. The immediate concern is to protect the person's safety and to begin the process of building trust with the clinical team. Longer-term goals can then be established to develop a treatment strategy, increase the person's social function, and reduce the impact of the traumatic experience on the person's ability to relate to others.
- Determine if the person is demonstrating any self-initiated behaviours that pose a danger, such as self-injury, suicidal ideation, an eating disorder, or substance use. Persons who feel trapped in an abusive relationship or anticipate continued exposure to traumatic experiences have an increased likelihood of acting on suicidal ideas (see Suicidality and Purposeful Self-Harm CAP).
  - The immediate focus in these cases is to reduce crisis-related symptoms and severe disruptive behaviours. This would focus on increasing the person's ability to tolerate and manage symptoms rather than resorting to self-injurious behaviour. Treatment of trauma-related memories or symptoms should not commence until immediate dangers have been addressed and resolved.
  - Ensure that the person has professional and informal social supports. Involving the person's family members, if appropriate, and other sources of support in the treatment plan may increase awareness of, and assist in decreasing, the potential for deliberate self-harm or suicide.
- Determine if the person is at risk of harm to others. Does the person report violent ideation? Are there indications of persistent anger, hostility toward others, or aggressive behaviours by the person? (See Harm to Others CAP.)

Special Considerations

Emotional numbing. Determine if the person is having difficulty expressing emotions (part of the avoidance symptoms related to PTSD).

- Does the person feel emotionally numb? If so, how long has the person been experiencing this?
- Are there any nonverbal indications of emotional numbing (for example, posture or mannerisms indicating apathy or deadened responses to others)?
- The treatment for emotional numbing focuses on re-connecting with and managing emotions.

Hypervigilance. Determine if the person has been exhibiting abnormally intense watchfulness or wariness.

- Does the person feel on guard or easily startled most of the time? Does the person feel especially alert or hyperaware of the environment? Where does the person sit in a room? Does he or she always need to face the door or windows? What typical safety or security measures does the person demonstrate? Does the person lose time in a conversation? Has he or she lost hours or days?
- Be aware of the person's perceptions of authority. Does the person tend to react negatively to any type of authority figure? Does the person question authority without foundation?
- When with a person who is demonstrating hypervigilance, be mindful to not aggravate the symptoms.
  - Be aware of the person when he or she approaches you, and do not catch the person by surprise.
  - Do not touch the person without permission.
  - Be aware of interpersonal physical spacing, sudden or jerky body movements, and loud noises.
  - Avoid jokes or pranks.
  - Provide options that will increase the person's comfort level, such as offering a chair on entering the room.
  - Be mindful of what you wear and avoid clothing (for example, camouflage) that may be associated with traumatic memories.
  - Discuss the impact of the hypervigilant behaviour on the person, friends, family, and other social relations.
- When hypervigilance is identified, consider the reason(s) for it. If there is current abuse, the treatment focus would ***not*** be to decrease these symptoms. Rather, the immediate priority would be to ensure the person's safety.
- For those who must be hypervigilant for professional reasons (for example, police officers, military, and other trauma-related professionals), treatment allows the person to use hypervigilance in the professional sphere without evoking continued trauma-related symptoms.

Co-morbid disorders. Determine if the person has any co-morbid disorders. Many persons who meet the criteria for post-traumatic stress disorder also meet the criteria for other mental health disorders. Depression, substance abuse, and other anxiety disorders are particularly common in persons with PTSD.

- A major consideration for intervention is to prevent secondary disorders and to appropriately diagnose and treat other concurrent conditions when present.
- If the person has depressive symptoms of mild to moderate intensity, it should not affect the treatment strategy. If the person exhibits severe and incapacitating depression, the treatment of trauma-related symptoms would be inadvisable as a first-approach treatment strategy; rather, the depression should be treated first.
- In cases where the person has a history of substance abuse, the identification and treatment of co-morbid mental health and medical illnesses take priority to avoid triggering a relapse.
- Pharmacotherapy for trauma-related symptoms should be considered in addition to psychotherapy in cases where the person has severe co-morbid depression or severe hyperarousal. These conditions could substantially affect the person's ability to benefit from psychotherapy alone.

Aggressive behaviours. Determine if the person has been demonstrating aggressive behaviours (for example, consider the person's score on the Aggressive Behaviour Scale; see the appendix).

- Treating the symptoms that relate to re-experiencing the event, such as flashbacks, can help to reduce aggressive behaviours.

Military exposure. Determine if the person has any military exposure.

- Those serving in the military may have been excessively exposed to death and other experiences that may induce horror or intense fear. As a result, veterans tend to have high rates of ASD and PTSD.
- As with all trauma, the recovery environment plays a large role in how the experience is recalled and managed.

Specific therapeutic interventions. Therapeutic interventions for trauma typically need to be provided across the continuum of mental health services. A short-stay in-patient admission is likely to address immediate concerns, but involvement in community settings providing ongoing mental health services will likely be required to effectively address the longer-term consequences of traumatic life events.

Targeting trauma-related symptom reduction as the major clinical outcome. Treatment goals include reducing the person's overall level of emotional distress, as well as the specific target symptoms that may impair the person's social or occupational function. These interventions can be used alone or in combination to address emotional distress and reduce trauma-related symptoms.

- **Pharmacotherapy:** Medication management is effective for treatment of trauma-related symptoms, as it successfully reduces core symptoms and associated depression and disability.
  - Current evidence suggests that selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs) are the first-line medication treatment for both men and women with trauma-related symptoms. These medications treat re-experiencing, avoidance/numbing, and hyperarousal, and reduce clinical symptoms such as suicidal, impulsive, and aggressive behaviours, which are known to complicate the treatment of trauma-related symptoms. They are also effective for common co-morbid psychiatric disorders, and have few known side effects.

- In the initial stages of treatment, watch for signs of akathisia, suicidal ideation, and increased anxiety and agitation.
- Once the person has responded to the medication, it should be continued for at least 12 months before gradual withdrawal is initiated.

- **Cognitive Behavioural Therapy (CBT):** The focus of Cognitive Behavioural Therapy is to overcome difficulties by identifying and changing dysfunctional thinking as well as behavioural and emotional responses through a systematic process.
  - CBT is a systematic approach with an emphasis on a combination of both cognitive and behavioural (for example, imaginary exposure therapy) strategies.
  - Treatment includes developing skills, modifying beliefs, identifying distorted thinking, and changing behaviours.
  - Assumptions are tested and identified to challenge distorted and unrealistic thoughts to enhance behavioural change.

Targeting functional improvement with or without the reduction of trauma-related symptoms. For persons with chronic PTSD, functional improvement may be more important than the reduction of trauma-related symptoms.

- **Psychosocial rehabilitation:** The focus of psychosocial rehabilitation is to improve function with a primary emphasis on symptoms of dissociation, impulsivity, affect lability, somatization, interpersonal difficulties, or pathological changes in identity.
  - Components of psychosocial rehabilitation include social skills and job skills training, vocational rehabilitation, case management, and family support.
  - Determine if the person demonstrates high-risk behaviours and difficulties with self-care or independent living skills. Is the person socially inactive? Is the person unemployed? Does the person encounter barriers to various forms of treatment and rehabilitative services? If so, consider a psychosocial rehabilitation program.
  - Psychosocial rehabilitation should occur concurrently with other forms of trauma treatment or shortly after the completion of symptom-reduction trauma treatment.

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Section 9

Criminal Activity CAP

Issue

It is important to recognize that the majority of persons with a history of mental illness are not involved with criminal activity. However, some persons with a mental illness are at increased risk of becoming involved in crime. For example, difficulties that the person is experiencing as a result of his or her mental health problems may result in him or her being vulnerable to exploitation by others already involved in criminal activities, which in turn can lead to the use of illicit drugs, prostitution, or street crimes (for example, shoplifting, muggings, robbery). Alternatively, others may interpret the person's behaviour as aggressive, belligerent, or threatening, resulting in police involvement and possible apprehension, arrest, or criminal charges. Some mental health symptoms (for example, command hallucinations and delusions) can also result in a person's involvement with the criminal justice system. For example, a person who is experiencing paranoid delusions may think that a family member is plotting against him or her. If the person acts on these beliefs by physically harming the family member, he or she may be charged with aggravated assault.

If present, involvement in crime is important to consider when conducting assessments in a mental health setting for three reasons. First, persons involved in criminal activity may pose an increased risk to the safety (for example, by violence, exploitation) and security (for example, through theft, fraud, extortion) of others. Steps must be taken to assess the person's risk for violence or harm to others using, for example, structured risk assessments or a forensic consultation (also see Harm to Others CAP). Second, there may be legal proceedings under way or court-ordered restrictions in place (for example, peace bond, probation, or parole conditions) that can affect how the person is treated, who the person is allowed to associate with, and access to legal representation and appearances in court. Third, if the person continues to engage in criminal activity, this will be disruptive to treatment or rehabilitative efforts, and it will complicate and frustrate attempts for the person's autonomous community living.

Criminal activity often occurs in environments characterized by troubled relationships, verbal and physical abuse, victimization, unemployment or unstable employment, insecure housing, and poverty. In these environments, recovery from mental illness is much more difficult and less likely to occur.

For a person with a mental illness who has a history of criminal involvement, a key focus for his or her recovery plan would involve interventions designed to prevent further involvement with the criminal justice system. Here, social determinants of health, such as employment, housing, and social support, are critically important. A person without a job and a place to live is more likely to return to criminal activity. Further, the person may have associated with others who were involved in criminal activity. In these situations, without positive family or other forms of social support, the person may drift back to these relationships, which in turn could influence future criminal behaviour. These outcomes must be avoided to promote recovery.

Goals of Care

- Ensure the safety and security of the person, treatment staff, and community.
- Address mental health symptoms (for example, depression, anxiety, psychosis).
- Address criminogenic needs (for example, anger/hostility, substance abuse, antisocial orientation) that lead to criminal activity.
- Minimize the risk of involvement in criminal activity.

Triggers

The Criminal Activity CAP applies to persons in either in-patient or community-based mental health programs.

TRIGGERED TO REDUCE RISK OF VIOLENT OR NONVIOLENT CRIMINAL BEHAVIOUR

This group includes persons who

- have experienced police intervention for any history of violent crime or nonviolent crime within the past year; OR
- were admitted from a correctional facility or have been identified as a forensic admission.

Approximately 24% of persons in in-patient and 45% of persons in community mental health settings are triggered in this group. Compared with the not-triggered group, persons in this group are much more likely to be discharged to a correctional setting and not have an individual in the community who is supportive of the person's discharge.

NOT TRIGGERED

This group includes persons who have not experienced police intervention for any violent crime or nonviolent crime in the past year. This group may also include persons who have a criminal history but without police involvement. Although persons in this group may not trigger this CAP, they may trigger other CAPs, such as Harm to Others.

Guidelines

Persons triggering the Criminal Activity CAP will require further evaluation regarding the nature of previous criminal activity, its origins, and the risk posed to others as a consequence of the criminal activity. Information about involvement with the criminal justice system should be obtained from the person as well as from collateral sources (for example, police, correctional facilities, probation and parole officers, youth justice authorities, forensic clinicians, case notes).

This population will require interventions designed to minimize the risk of harm to others and of their continuing criminal behaviour.

Some persons triggering this CAP may have had police involvement that did not result in criminal charges. For example, police officers may have responded to a report that a person who appeared confused and disoriented was wandering the streets. When the situation was assessed by the police, the person may have been taken to the hospital for a mental health assessment and charges were not laid. Many of the following guidelines apply to those with a history of criminal justice involve-

ment. However, the guidelines may also be helpful when assessing and determining interventions for those who have been identified by police for nonviolent behaviour.

Safety and Security of the Person, Treatment Staff, and Community

Evaluation. Consider the following when evaluating safety and security issues:

- One-half of those who trigger this CAP have committed violent acts, of which common assault is the most frequent.
  - If a violent act occurred, identify the details of the act (for example, how and when did it happen, who was involved, what was the extent of the injuries).
  - Also see Harm to Others CAP for further assessment considerations.
- About two-thirds of persons involved in criminal activity have committed acts related to property crime or drugs. Drug-related crimes include dealing or trafficking as well as use and possession. Persons who trigger this CAP are twice as likely to trigger the Substance Use CAP for current use of substances than the not-triggered group. There is also a higher likelihood of triggering this CAP among persons with gambling problems.
  - Determine if drugs or alcohol were involved in the criminal activity or if the person is presently using substances.
  - Determine if gambling is an issue.
  - Assess for immediate problems with withdrawal from substances.
  - See Substance Use CAP for further evaluation considerations.
- This group is twice as likely as the not-triggered group to trigger the Interpersonal Conflict CAP.
  - Determine if interpersonal conflict is present. If so, see Interpersonal Conflict CAP for further evaluation considerations.

Interventions.

- Monitor and control for evidence of ongoing criminal activity (for example, threats, extortion, drug dealing, theft).
- Ensure that the person complies with any legal restrictions that are in place (for example, peace bond, restraining order, bail, probation or parole conditions), including restrictions on making phone calls to others, associating with other criminals, or contacting spouse or partner. Should a violation occur, follow jurisdiction-specific protocols, such as requirements for reporting to a parole officer.
- Ensure that the person is provided access to legal counsel and court appearances as required.
- Monitor visits by family and friends for aggressive or threatening behaviour or for contraband being brought into or out of the institution.
- Quite apart from legal restrictions, it is often helpful to restrict the person's access to criminal associates, as these associations will promote further criminal activity. If it is not possible within the particular jurisdiction to enforce such restrictions, encouraging alternative associations and activities should be undertaken.
- In situations where the person is threatening or violent, ensuring safety of the person and others may require the use of control interventions (for example,

physical restraint, seclusion, chemical restraint). Legislation in local jurisdictions and operating standards, guidelines, and policies of the hospital or mental health agency will govern how these control interventions are to be used. Recently, many jurisdictions and hospitals have undertaken programs to reduce the use of these control procedures through staff training, early identification of impending violence or threats, and alternative methods of de-escalation. Nevertheless, where laws permit, these control interventions should be used to ensure safety when necessary. (See Harm to Others and Control Interventions CAPs.)

- If needed, consider available options for protecting others and staff (for example, when appropriate, isolating the person concerned, using seclusion, ensuring that all staff are notified of potential risk). See Control Interventions CAP.
- See Substance Use and Interpersonal Conflict CAPs for intervention strategies specific to these areas.

Addressing Symptoms of Mental Illness

Evaluation. The following information concerning those persons who trigger this CAP suggests additional information to consider.

- Persons who trigger this CAP are more likely to have a history of involvement with the mental health system, with 26% of persons in the triggered group having six or more lifetime psychiatric admissions compared to 20% of those in the not-triggered group. Personality disorder, substance abuse, and schizophrenia are more common diagnoses among this group.
- See Rehospitalization, Support Systems for Discharge, Informal Support, and Substance Use CAPs for issues to consider for assessment in these areas.
- Assess the nature of the mental health symptoms and the impact they may have on the person's involvement with the criminal justice system. For example, determine if hallucinations or delusional thinking influenced the person's behaviour.

Interventions.

- The person's capacity to participate in a discussion related to involvement in criminal activity will be affected by the severity and acuity of his or her current mental health symptoms. Those who are acutely ill or who are experiencing severe impairment in cognitive function may not be in a position to provide meaningful information about criminal history or engage in a discussion of steps that need to be taken to reduce criminal involvement. In such situations, the immediate focus should be more on symptom management.
- Persons with a history of involvement in crime may be resistant to participating in treatment or taking prescribed medication. When acutely ill persons refuse consent to treatment, laws in the local jurisdiction (mental health law, consent and capacity laws) will govern steps that must be taken to pursue treatment without the person's consent (for example, involving a substitute decision maker, trustee).
- At this stage, clinical interventions will focus on traditional mental health care and pharmacotherapy directed to the amelioration of symptoms of mental illness. Treatment targets mental health symptoms and psychological distress. The emphasis of treatment is a combination of psychopharmacology and psychiatric treatment (for example, psychosocial therapy, behavioural therapy, psychotherapy). Personality disorder, substance abuse, depression, and schizophrenia have been found to be the most common types of disorders

among those who engage in criminal activity. Women triggering the Criminal Activity CAP are more likely than men to show symptoms of schizophrenia. In a majority of cases, mental health symptoms will be combined with substance abuse. Treatment is designed to address these underlying psychiatric symptoms.

- Persons triggering this CAP often have trust issues that can impede success of treatment of psychiatric symptoms. It is important to develop a therapeutic alliance with the person to help build trust between the person and the clinician. This will in turn help with the success of the treatment.
- As the symptoms of acute illness subside, treatment should be directed toward moving the person from control interventions (if they were necessary) or a locked in-patient unit, toward decreased restrictions in an open hospital unit and eventual discharge to outpatient care and autonomous living in the community. For persons with previous criminal involvement, especially those with a history of violence, this process should be thought of as a gradual stepwise process, with close monitoring and demonstrated success at each step before a move to the next step is taken. The duration of this process is highly variable, ranging from hours to days and in some rare cases, months, depending on the success of treatment and the assessed risk for violence and harm.
- For persons with a history of nonviolent criminal behaviour, a focus on engagement in the community, housing support, and reducing stigma associated with criminal history may need to be incorporated into the treatment plan.

Addressing Criminogenic Needs

Evaluation. "Criminogenic needs" are personality and behavioural factors that predispose a person to ongoing involvement in crime. Consider the following in the assessment of criminogenic needs.

- History of abuse, early involvement with the child welfare or youth justice system, limited education, chronic unemployment, residential instability, and dependence on social assistance for income is common among this subpopulation.
- Persons in this group not only have been more involved in the perpetration of crime but also are more likely to have been the victims of crime.
- Persons in this group may be resistant to change or may not believe it is possible to change their involvement in criminal activities. For such persons, it is a lifestyle he or she has developed over a long period of time.
- Addressing criminogenic need is equally important in women as in men. Women are just as likely to return to criminal activity as men if the criminogenic need is not addressed.
- Addressing criminogenic need is equally important in persons with mental illness as with persons without mental illness.

Interventions. As soon as the acute phase of the mental illness has subsided, as indicated by a reduction of mental health symptoms, the person should be actively engaged in discussing his or her involvement in criminal activity.

- Information provided by the person should be combined with other file information or assessments relevant to the person's risk for re-offending. A number of specific assessments focus on identifying criminogenic factors underlying criminal re-offending (for example, the Level of Service Inventory–Ontario Revision [LSI-OR], interRAI Forensic Supplement).

- Information from all sources should inform the development of a targeted treatment and recovery strategy that is appropriate for the person's assessed risk for criminal activity, while taking into account characteristics like sex, age, mental health symptoms, and cognitive ability.
- Treatment plans should incorporate measures to ensure safety and security of the person, treatment staff, family, and others in the person's community.
- There should be a focus on promoting the person's involvement in activities and programs that provide opportunities to be exposed to and engaged in pro-social attitudes, skills, and behaviours. Examples include
  - Vocational programs
  - Cognitive behavioural programs for addressing anger, frustration, and self-defeating behaviours
  - Life-skills programs
  - Education completion programs
  - Volunteer activities

For the purpose of delivering interventions, these factors can be grouped broadly as follows:

Antisocial orientation: Persons who have a history of antisocial behaviour that extends back to adolescence (that is, a history of conduct disorder), who have committed diverse crimes (for example, property offenses, offenses against persons), and who have a criminal record of numerous criminal charges and convictions are more likely to commit further crimes. Those persons often have attitudes and beliefs supportive of involvement in crime and often associate with others who are involved in criminal activity. In a mental health setting, the person will often be diagnosed with antisocial personality disorder. It is important to understand that criminal orientation and mental illness can co-occur and consideration of the impact of the following on the plan of care should take place:

- Those with evidence of antisocial personality or "psychopathy" may be manipulative, attention seeking, or exploitative. These persons can be very disruptive and even damaging in clinical settings, especially on in-patient units. They may engage in boundary violations in which they seek personal information concerning staff or other care recipients to use later to their own advantage. They may attempt to establish personal or even intimate relationships with staff outside the boundaries of appropriate professionalism to gain advantage or favors.
- They may also engage in behaviour such as spreading rumors or other miscommunications or distortions of the truth that result in one staff member or group being pitted against another. This, in turn, creates divisions among the clinical team.
- Appropriate interventions to prevent boundary violations and attempts to create divisions in the clinical team include
  - Staff education about these issues and measures to ensure continuing awareness of staff, including orientation of novice providers or students in the clinical setting
  - Monitoring of the dynamics within therapeutic relationships by the clinician(s) involved, managers, and peers
  - Maintaining open and frequent communication between and among staff to resolve conflicts and disputes, especially when such conflicts have arisen related to the person's behaviour

- Where appropriate, the promotion of a culture of explicit "limit setting" on the in-patient unit
- Clear rules and policies concerning behaviour with consistent application of the rules, including fair and immediate consequences for breeches of the rules

- Some persons with antisocial orientation will also be litigious ("jail house" lawyers), seeking legal remedies for what he or she perceives as unfair application of hospital rules, alleged professional misconduct by providers involved in his or her care, and infringements on his or her "rights" by the hospital or its staff. Interventions to prevent successful legal actions include
  - Meeting with the person as a team or group and not individually
  - Documenting carefully and in detail all clinical contacts with potential legal implications in mind
  - Keeping the hospital's legal counsel fully informed of the person's activities and seeking the counsel's advice early on any threatened legal action by the person

Substance abuse: Substance abuse predisposes persons to criminal activity in various ways. If the person is using illegal substances, he or she is at risk for criminal charges for possession. If the person is abusing alcohol, he or she is at risk for criminal charges for offenses like driving while intoxicated or public intoxication. Alcohol abuse is a known contributor to violent behaviour, and this is especially so among persons with schizophrenia. In a mental health setting, these persons will more likely be diagnosed with one of the substance use disorders (see Substance Use CAP).

Lack of involvement in pro-social relationships and activities: Pro-social relationships with a spouse, family, or co-workers, at home, in the workplace, or at school and in one's spare time are strong sources of positive reinforcement for noncriminal behaviour and attitudes.

- Intervention strategies should be directed first at identifying barriers and obstacles to establishing pro-social relationships.
- Where barriers and obstacles have been identified, whether it be conflict with spouse or family, lack of employment or education, or lack of social skills, treatment strategies should be directed at reducing the identified deficits. Such strategies may include
  - Anger and conflict management
  - Marital and family counselling
  - Educational and/or vocational programs (see Education and Employment CAP)
  - Leisure skills counselling

Minimizing the Risk of Involvement in Criminal Activity

Evaluation. The following information identifies post-discharge risks.

- Persons in the triggered group are less likely than others to have a supportive, noncriminal network of friends or family in the community.
- For persons in the triggered group, continuing involvement in criminal activity and problematic interpersonal interactions are likely to alienate him or her from critical sources of formal and informal support. It is important for

treatment staff, correctional staff, and volunteers to work with the person to build a self-sustaining discharge and recovery plan that includes pro-social activities and relationships. The plan must recognize the person's legal right to community living and recovery.

- A person in the triggered group may have outstanding criminal charges pending adjudication in court. Alternately, he or she may be released from the mental health care program to serve the balance of a criminal sentence in a correctional facility or under a probation or parole order. It is critical to the person's recovery that the correctional system addresses the mental health problems adequately.

Interventions. A comprehensive treatment and discharge plan that addresses the criminogenic needs (for example, substance abuse, pro-criminal attitudes) underlying the person's involvement in criminal activity is critical to ensure that the person can make a successful transition into the community that will allow recovery to take place. The plan should include the following components:

- In some jurisdictions, the hospital or mental health agency may be required by law to notify the authorities of the person's discharge. It will always be helpful for the clinical team to establish contact with institutional or community-based correctional agencies (probation and parole authorities) and the police or the courts to coordinate mental health recovery needs and conditions of release (if present) when the person is discharged to the community.
- The discharge plan from an in-patient mental health unit should specify the location, agency, providers, and responsibilities of an outpatient mental health service or community-based mental health care agency. A first appointment should be made and communicated clearly to the person. There should be an explicit plan for housing, income, vocational pursuits, social support, and recreational activities.
- Where appropriate and possible, the outpatient or community-based agency should attempt to provide the following:
  - Support and counselling to re-establish or repair damaged or dysfunctional marital and family relationships
  - Support for involvement in pro-social activities in the community, including work, education, and leisure
  - Community-based programs to address substance abuse

Other Considerations

Persons who trigger this CAP may be especially resistant to discussing the nature and extent of their activities, and may not adhere to treatment efforts. Some may be "career criminals." The view that the person has of him- or herself, his or her friendships, and strategies for economic survival may be based on criminal activity. It is important to encourage and support interest in and efforts to undertake pro-social activities, however limited, as a central strategy for long-term recovery.

Current evidence suggests that many of those who trigger this CAP will re-offend in one way or another. It would be important for the person, his or her mental health practitioners, and family to have realistic expectations regarding this risk. The fact that the person has not committed a serious re-offense should be taken as an indication of a qualified success.

The person may have family and friends as well as involvement in the community (for example, school, work) that can support recovery and efforts to avoid further involvement in criminal activity. Recovery strategies should build on existing

pro-social attitudes, skills, and activities that will deter the person from involvement in future criminal activity.

Where past social relationships have become challenged, consider options to re-engage estranged family members, if appropriate. This may include substance abuse counselling; engaging social service agencies to identify sources of income, housing, or jobs; or setting up trial social re-engagement efforts.

For some older persons, aging may have mitigated the risk for re-involvement in criminal activity. Older offenders are less likely to re-offend and in some cases, criminal involvement may have occurred in the distant past and the person's more recent history shows strong evidence of pro-social behaviour and attitudes. In such situations, it is important not to exaggerate the risk of future criminal behaviour for these persons. A focus on physical and mental health needs might be more important than concern about future criminal involvement.

Additional Resources

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Part III

Economic Issues CAPs

Section 10

Personal Finances CAP

Issue

The purpose of the Personal Finances CAP is to assist persons with mental illness whose lives are affected by problems related to personal finances. Economic hardship may result from a point-in-time life event that led to a major loss of income (for example, the loss of a job) or may be a persistent problem over the person's lifetime. Examples of important risk factors for economic hardship include unemployment, substance abuse, and excessive or uncontrollable gambling. Further, exploitation by a partner, spouse, or other family member can result in economic hardship.

A person with mental illness may be found to be legally incapable of managing his or her property (including finances). The main risk factor for being incapable of managing property is moderate to severe cognitive impairment. The inability to manage one's finances increases a person's vulnerability to financial abuse and reduces autonomy in making personal economic choices. Such persons may require limited to total assistance from others to manage their finances.

As a result of economic hardship (no matter the cause), persons with mental illness may experience negative consequences like residential instability, living in a home environment that is hazardous or in disrepair (for example, inadequate heating or cooling, infestation), or living in poor-quality housing where personal safety is threatened. Other negative consequences of economic hardship may include inadequate nutrition and weight loss, depression, and reduced level of social participation. The affected persons are likely to lack a consistent positive outlook and to experience interpersonal conflict with family or friends.

Goals of Care

- Identify barriers to income security.
- Establish short-term support, as needed, for shelter, food, clothing, and medication.
- Help the person secure an income (through either employment or social assistance) that is adequate to pay for food, clothing, shelter, and medications.
- Assist the person in securing stable housing.
- Ensure that the person's property and finances are secure from abuse if the person is found to be incapable of managing his or her property.
- Ensure that problems related to substance use or gambling are addressed.

Triggers

The Personal Finances CAP triggers two groups of interest: (1) those who are experiencing economic hardship because of a major loss of income or poverty; and (2) those who are not experiencing hardship but who have been assessed to be incapable of managing property, including finances, or who require limited to total

assistance to manage their finances. This CAP applies to persons in both in-patient and community mental health settings.

TRIGGERED DUE TO ECONOMIC HARDSHIP

This trigger level includes all persons who

- have suffered a major loss of income or serious economic hardship due to poverty; OR
- have made economic trade-offs during the last 30 days because of limited funds.

About 15% of persons in both in-patient and community mental health settings trigger the CAP at this level.

TRIGGERED DUE TO INABILITY TO MANAGE FINANCES

This trigger level includes persons who are not experiencing economic hardship but who

- have been formally declared incapable of managing their property; OR
- need limited or total assistance in managing their finances.

About 21% of persons in in-patient mental health settings and 11% of persons in community mental health programs trigger the CAP at this level.

NOT TRIGGERED

This group includes about 64% of persons in in-patient mental health settings and 74% of persons in community mental health settings.

Guidelines

Initial Considerations

The immediate goal for a person experiencing economic hardship or financial management issues is to secure the person's safety and security through adequate income support, housing, and access to nutritious food.

- When the economic hardship is a result of unemployment, help the person secure employment that matches his or her capabilities (see Education and Employment CAP). For those who require it, supported employment has been shown to be more effective than sheltered workshops. Supported employment, integrated with mental health services, improves the success rate of obtaining competitive employment for persons with mental illness.
- Ensure the person receives timely and adequate services to help with any mental health issue, such as depression, inability to sleep, feelings of hopelessness, and interpersonal relations with family and friends.
- Explore options for building the person's capacity to self-manage finances (for example, money management training).
- When the person is deemed incapable of managing his or her property, including finances, ensure the person's needs are provided for in a reasonable and timely manner, and protect the person from financial abuse.

Interventions Related to Economic Hardship

Identifying causes of and addressing consequences of financial issues. The following guidelines will assist clinicians in identifying and addressing economic hardships for persons who trigger this CAP. The person should be engaged in discussions about his or her personal financial situation as soon as an issue is identi-

fied. Ongoing assessment and revision of intervention strategies should occur as the person becomes more (or less) effective in managing his or her finances.

Income.

- Determine if the person has an income or adequate financial support.
- Determine whether the person has adequate financial resources to pay for food, clothing, shelter, and medications (for both self and family) by finding out if he or she makes or has made trade-offs in purchasing the necessities of life for discretionary purchases or has substance abuse or gambling problems.
- If the person has a source of income, but it is not adequate to support him or her and his or her family, help the person secure a supplementary source of income. If no other sources are available, consider a program of instruction or refer the person to a trustworthy financial counselling service to learn ways to live within the limits of the available income by managing finances and debt. Such education programs can range from learning the basic principles of budgeting to learning how to manage more complex financial issues (for example, managing debt, declaring bankruptcy).
- If there is a need, help the person access community agencies, such as food and clothing banks, that provide aid in subsidizing food, clothing, and shelter.
- Help the person access, navigate, and understand the available social assistance programs to ensure that he or she obtains any financial and other assistance (for example, subsidies for child care, housing, or food) for which the person is eligible.
- In some situations, it may be beneficial to involve the person in a discussion about the need for long-term formal or informal support to manage his or her finances.
- Consider the possibility of financial abuse in situations where there is evidence to suggest that someone else (usually a partner or family member) has exerted control of the person's money or other economic resources against the interests of the person, resulting in a psychologically damaging state of financial dependency. The victims of this abuse, who are usually female, also often experience psychological abuse. Financial abuse can include, but is not limited to, stealing from or defrauding the person, withholding money needed to buy food or medication, and denying access to and about financial resources. If financial abuse is identified, discuss options with the person, such as individual counselling or a referral to a program specific to persons in an abusive relationship.

Employment.

- Determine if the person is experiencing economic hardship as a result of unemployment, problems related to absenteeism, insufficient hours of work for part-time employees, limited benefits, or poor wage rates.
- For guidelines related to employment issues, see Education and Employment CAP.

Housing and living arrangements. Those with economic hardship experience high rates of residential instability (for example, during the past two years have made three or more moves, have no permanent address, are homeless, are living in a shelter). They are also more likely to have serious problems in the home environment (for example, squalor, inadequate heating or cooling, concerns for personal safety). In these cases, explore the following:

- What is the person's housing situation? Where does he or she live? If in a hospital setting now, where does the person plan to live upon discharge? Does

the person's home provide adequate shelter, sanitation, heating/cooling, and security? If the person does not have a place to live, help the person find suitable accommodations.

- What is the person's living arrangement (for example, lives alone, lives with family/siblings, lives in congregate housing)? If with others, are those people willing for the person to move back into their home? To what extent are family members providing the person with financial or other support (for example, purchasing groceries, medications; helping pay rent or other bills; preparing meals; augmenting income)? If the family is providing financial support, explore the person's feelings about this. If appropriate, facilitate discussion between the person and the family regarding the impact of this support on the person and the family.
- Has the person experienced residential instability in the recent past? If yes, what were the reasons for it (for example, unstable income, poor financial management, interpersonal conflict, lack of awareness of housing options)? Ask the person about the reasons and discuss how the situation could be corrected.
- Is the person's living environment unsafe? If yes, help the person develop strategies to address the issue(s) with the landlord. In some cases, it may be necessary for the clinical team to act directly. In such circumstances, obtain the person's permission to advocate for the person or intervene with the landlord for improved conditions.
- Is the person accessing housing subsidies, if available? If needed, provide the person with information on financial and community support programs available for accessing subsidized housing.

Nutritional status. Persons who trigger the economic hardship level of this CAP are more likely than others to have experienced a weight loss of 5% or more in the last 30 days or 10% or more in the last 180 days. In community mental health settings, these persons are about five times more likely than those who did not trigger the CAP to have eaten one or fewer meals within the last 3 days.

To assess the person's nutritional status, determine the following:

- If the person experienced any recent weight loss, was it a consequence of not being able to afford adequate meals?
- Is the person not eating to save money?
- Does the person make reasonable food choices given the available budget? Is the person making use of available programs to subsidize the cost of food? Are there strategies the person could use to increase his or her food purchasing power?
- Has the person made trade-offs involving food (for example, skipped buying food to pay rent)? Does the person feel he or she has a secure source of adequate food to meet personal nutritional requirements?
- If any of the above conditions apply, determine the possible reasons (for example, inadequate income, cognitive impairment, depression, limitations in ADL or IADL) and take the necessary steps to address them. Consider the preceding Income and Employment sections, and other CAPs, such as Self-Care, and Weight Management.

Substance use. To what extent is substance use, including alcohol and illicit drugs, affecting the person's financial situation? Is the person making economic trade-offs between drugs or alcohol and the necessities of life, such as food, shelter, and clothing?

- If the person is dependent on substances, or makes trade-offs, provide the person with information about substance use and its consequences.
- Encourage the person to identify the behaviours that caused problems in his or her life and to explore alternative ways of dealing with stress and difficult situations.
- If substance use is problematic, refer the person to an appropriate treatment program and see the Substance Use CAP for further guidelines.

Health conditions.

- Does the person or someone in the person's family have a health condition leading to substantial financial costs not covered by a public health care system? Is the person's income being used to cover major medical expenses? In such cases, discuss options for available financial subsidies.
- Is the person making economic trade-offs in purchasing medications that make him or her nonadherent to prescribed regimens? Explore the availability of subsidy programs that support the purchase of necessary medications. Alternatively, subsidies (for example, food stamps) may be available for purchase of other necessities, which will free up finances for purchase of medications.

Problem gambling. There are many types of gambling (for example, playing casino games or slot machines, purchasing lottery tickets). Gambling becomes a problem when it interferes with work or school, causes financial problems, or affects family and other relationships. The impact of problem gambling often extends beyond the person to his or her family, friends, and other significant relationships, including those in the workplace. Consider the following:

- Possible signs of problem gambling include
  - An unexplained significant financial loss
  - Work- or school-related difficulties
  - Excessive borrowing
  - Engaging in illegal activities
  - Social or emotional problems with family or friends
  - A preoccupation with gambling
- Possible risk factors include misguided beliefs about the odds of winning and working or living near gambling locations.

Determine if the person has any insight into his or her gambling as a cause of financial problems.

For persons with problem gambling, consider the following types of interventions:

- Link the person to a counsellor who has experience working with persons with mental illness who are also problem gamblers.
- Explore with the person the impact of gambling on him or her, the family, and other social relationships.
- Help the person articulate the reasons for the gambling behaviour and the arguments for change (motivational interviewing).
- Ask the person about personal debt levels and to whom the debt is owed. Debt is a common outcome of problem gambling. If substantial debt has been incurred, encourage the person to seek the assistance of a financial counsellor at a debt management service.

- Ask the person how he or she finances the gambling. If the person is cashing employment cheques or disability income cheques to support gambling habits and as a result is unable to pay the rent, encourage the person to consider options that will protect the income at the source (for example, with the employer or disability income office).
- Identify alternatives to gambling.
  - If social isolation, boredom, or a lack of social network is contributing to the person's gambling problems, help the person to engage in other meaningful social activities.
  - Suggest activities that the person can pursue with friends that do not involve gambling.
  - Identify the person's preferences regarding leisure and recreation activities, including past ones that were given up because of gambling as well as new interests. If appropriate, refer the person to a recreation therapist.

Interventions Related to Incapacity to Manage Property/Finances

Cognitive impairment is the primary mental health problem affecting financial decision making. However, the person's financial decision making may be compromised for other reasons (for example, delusions, hallucinations, disorganized thoughts). The person's cognitive capacity may also be compromised by physical problems (for example, delirium).

- If there is a concern that the person is not able to manage his or her finances, determine if an assessment for competency should be initiated. This should be done according to jurisdictional regulations.
- If the person is deemed incapable of managing his or her finances, refer to the designated decision maker for any matters related to finances.
- What type or degree of assistance does the person require to manage property/finances (for example, shopping, paying bills, balancing chequebook)? Depending on the type and degree of assistance needed, assist the person or arrange for appropriate assistance (see Self-Care CAP).
- Does the person have some potential for making reasonable daily financial decisions? Has the person made such decisions recently? Is the person's current difficulty with financial management related to mental health or general health complications that could be treated? Has there been an attempt to give the person an opportunity to make choices when funds to purchase goods or services are limited?
- Are there subsets of choices the person could make, even if he or she has been declared incapable of making financial decisions? For example, encourage the decision maker to find ways to incorporate the person's preferences when an item is being purchased on his or her behalf.

Financial abuse. A person who is found to be incapable of managing his or her property or who depends on others for assistance with financial management without a formal designation may be at elevated risk of abuse by others. It is imperative to recognize the signs of potential financial abuse or neglect. Determine if any of the following apply.

- Are the person's basic needs (shelter, food, and clothing) being adequately met? Is there evidence of numerous unpaid bills even though someone has been designated to pay the bills? Are there signatures on someone else's cheques and other documents that do not resemble that person's signature? Are cheques or other documents signed by the person even though he or she

is not capable of understanding what he or she is signing? Is there a concern that a designated decision maker is not responding to requests for assistance in a reasonable and timely fashion (for example, the decision maker neglects to purchase medication renewals on time)?

- Is the person generally isolated or lonely with no visitors and/or relatives? Do family members, caregivers, or designated decision makers isolate the person or restrict the person's contact with others? Is the person allowed to speak freely with others and have contact without the caregiver being present? Does the person appear withdrawn, frightened, secretive, helpless, or angry in the presence of the family, caregiver, or decision maker? How does the person characterize his or her relationship with the substitute decision maker? Does the caregiver, family, or decision maker show reasonable commitment to the person's welfare? Does the person have insight into his or her incapacity to manage finances and wish to appoint a substitute decision maker?
- It is wise to review the rights and responsibilities of a decision maker with the person and the decision maker. The existence of any of these indicators does not mean that financial or another type of abuse has occurred, but investigation may be warranted and a remediation program may be needed.
- If there is evidence of neglect or abuse, make an immediate referral to a credible source of help (for example, a counsellor, a social worker, an elder abuse team). Determine if there is a willing and trusted person to step in to manage the financial affairs on behalf of the person. Depending on the laws of the jurisdiction, there may also be a legal requirement to refer the case to a public agency or legal authority for further review.

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Section 11

Education and Employment CAP

Issue

Unemployment rates for persons with serious mental illness are very high and may be related to the disabling effects of mental illness or addiction, the stigma and discrimination associated with mental illness, and the lack of employment opportunities. The risk factors for unemployment and disrupted education include increased lateness or absenteeism from work over the last 6 months, poor productivity or disruptiveness at work or school, an expressed intent to quit work or school, and persistent unemployment or a fluctuating work history over the last 2 years.

This CAP focuses on the process of enabling persons with mental illness to access, return to, or maintain employment, education, or other meaningful activity (for example, volunteering) as critical steps in recovery, successful rehabilitation, and community integration. Meaningful employment or participation in education or a volunteer activity has the potential of increasing self-esteem, alleviating mental health symptoms, and reducing dependency and relapse. In addition to securing income, employment presents persons with mental illness opportunities to develop relationships, friendships, a sense of belonging, and a natural network of resources. Competitive employment, in particular, helps provide a sense of purpose, a sense of pride, and acknowledgement of one's contribution to society.

Goals of Care

- Identify the person's strengths and preferences for work, school, or volunteer involvement.
- Eliminate barriers to meaningful engagement in work, school, or volunteer activity.
- Reduce the risks associated with unemployment or dropping out of school.
- Find meaningful involvement in employment, an education program, or volunteer service.
- Help the person develop an increased sense of self-esteem and self-worth.
- Broaden the person's social network.

Triggers

The Education and Employment CAP identifies two groups of interest: (1) those who are at risk of losing employment or dropping out of school; and (2) those who are in need of support for employment, educational participation, or involvement in volunteer activities. This CAP applies to persons in both in-patient and community-based mental health programs.

TRIGGERED TO REDUCE THE RISK OF UNEMPLOYMENT OR DROPPING OUT OF SCHOOL

This group includes persons who have one or more of the following four indicators of risk:

- An increase in lateness or absenteeism over the last 6 months

- Poor productivity or disruptiveness at work or school
- An expressed intent to quit work or school
- Persistent unemployment or fluctuating work history over the last 2 years

This CAP level is triggered for about 23% of persons in in-patient mental health settings and 22% of those in community mental health settings.

TRIGGERED TO SUPPORT EMPLOYMENT OR EDUCATIONAL PARTICIPATION

This trigger level includes three subgroups:

- Persons of any age who are unemployed but seeking employment
- Persons ages 15 to 65 years who are unemployed and are NOT seeking employment but who have minimal impairments in ADL and cognitive function, few indications of positive symptoms, full insight into their mental health condition, and minimal indications of behaviour problems
- Persons ages 10 to 30 who have recently dropped out of or failed school

This CAP level is triggered for about 13% of those in in-patient mental health settings and 22% of persons in community mental health settings.

NOT TRIGGERED

Persons in this group are

- employed or at school with no apparent risk of losing employment or dropping out of school.
- retired.
- unemployed and not seeking employment but who have major mental health or disability issues.

This group includes about 64% of those in in-patient mental health settings and 61% of persons in community mental health settings.

Guidelines

The following guidelines focus on helping the person achieve his or her education and employment goals, including obtaining or keeping a job, pursuing schooling, or being engaged in meaningful social roles, such as volunteering. These guidelines may be targeted to those who have been unemployed for awhile and who wish to re-enter the workforce, and to those who have been separated from their job because of short- or long-term disability and who wish to return to their job.

Interventions for Reducing the Risk of Unemployment or Loss of Employment

Use a strength-based approach to identify the skills and characteristics in which the person excels.

- This type of approach can help the person choose and organize vocational goals, and can instill a sense of self-esteem and self-efficacy.
- This approach uses a motivational interviewing framework that asks about prior successes in work, volunteer, and school experiences and focuses on the personal characteristics that contributed to those successes.

Help the person identify any barriers to achieving his or her vocational goals (either obtaining a new job or returning to his or her former job).

- If the person lost his or her job because of mental illness, help the person talk about the illness and the events that led to the job loss. Barriers such as low self-esteem and lack of motivation should be included in this discussion.
- Identify or develop strategies that the person could use to address such situations in the future.

Determine the presence of functional or physical limitations in performance of daily tasks (for example, activities of daily living or instrumental activities of daily living).

- Physical limitations such as extrapyramidal signs, fatigue, or drowsiness may be associated with medications or medical conditions. These should be ruled out or addressed as a cause of functional limitation or lack of stamina.
- A review of the person's medications should be conducted, as medications can have a profound effect on a person's reading or working skills (for example, interfering with the ability to concentrate). Does the person have a medication management or adherence problem? If so, see Medication Management and Adherence CAP.
- Performance of routine daily tasks may also be limited by cognitive function and problems with daily decision making. To acquire and keep a job, the person has to have the capacity to know when to wake up or have meals, which clothes to wear, what transportation to use to get to work, and which medications to take. If any limitations in this area are identified, develop appropriate memory aids or cues in collaboration with the person (for example, visual cues, posting a calendar with the work schedule, or reminders regarding essential daily tasks).
- The person may also require strategies to improve personal hygiene if he or she is not already motivated or able to maintain appropriate grooming.
- Assess the person's vision and potential need for a referral for an ophthalmologic examination. If the person reports not being able to read because of poor eyesight, his or her vision may be correctable with eyeglasses or an adjustment of medication.
- Social skills are the key to success in many employment and educational environments. If the person has difficulty functioning in social situations, consider programs to enhance the person's social skills or social functioning (for example, social training, social cognition training).

Interventions to Improve Employment Outcomes, Including Sustained Employment

Personal occupational goals.

- Help the person identify his or her employment, career, or educational goals and interests.
- Review with the person his or her knowledge and insight about his or her illness.
- Work with the person to identify the supports or resources required to pursue his or her goals.
- If the person is interested in starting his or her own business, encourage him or her to investigate support programs for starting a small business (for example, micro-financing, courses on setting up a business).

- If the person is not interested in employment or education, assess whether he or she has other goals, such as having a meaningful role in the community through volunteering.

Readiness for employment.

- Discuss how the person feels about being ready to work. What insight does the person have about the impact of his or her mental illness on functioning and about his or her readiness to enter or return to a work environment? If the person has no or poor insight, help him or her evaluate the situation objectively.
- Refer the person to a vocational program for assessment of interests, aptitudes, and transferable skills.
- Provide the person with information about the job demands inherent in vocational areas of interest vis-à-vis his or her skills, interests, and aptitudes.
- Determine whether the person has the required skill set or knowledge to obtain employment in his or her preferred area. If he or she does not, is he or she interested in attending a vocational program to learn the requisite skills? If he or she does, assist the person, as needed, with an appropriate placement.
- Conflict with family and friends can contribute to social isolation and affect the person's likelihood of unemployment, motivation to seek employment, and ability to stay employed. Almost 25% of persons who are experiencing issues with education or employment believe that a relationship with an immediate family member is disturbed or dysfunctional. Consider the following questions when assessing the person's social relationships.
  - Does the person have an informal support system (for example, family, friends) and a confidant, or is the person isolated from others?
  - How supportive is the person's family? Is interpersonal conflict a problem?
  - How supportive is the family regarding the person's employment goals? How supportive is the family about any change in social benefits status?
  - Does the person participate in community events and social activities, visit family and friends, or receive visitors? If not, are there financial barriers (for example, an inability to pay for transportation) preventing the person from participating?
  - Help the person address issues such as lack of social support; interpersonal conflict with family, friends, or co-workers; or financial difficulties (see Social Relationships, Interpersonal Conflict, and Personal Finances CAPs).

Literacy skills. Functional literacy may be necessary for success in employment and education opportunities.

- Assess the level of literacy required for the job, school, or volunteer position.
- Arrange for a functional literacy test to assess the person's ability to read, write, calculate, speak and understand, and sign (for the deaf) and communicate in other symbolic forms of language, according to need. Literacy is a continuum of these skills, which are necessary for everyday life in the home, at work, in education, and in the community.
- Assist the person with enrollment in a literacy program, if needed, for basic literacy training.

Support for the person's mental health needs. Consider the need for the following:

- Monitor the person's mental health and employment status for early identification, diagnosis, and treatment.

- Maintain regular contact, including on-the-job assessment, by the clinician or care team.
- In collaboration with the person, develop a plan to prevent relapse in mental health symptoms or substance use that considers workplace triggers, early warning signs of relapse, and a plan of action to seek support, assistance, and/or treatment.
- Provide training to develop job-coping skills, such as recognizing emotional responses to situations in the workplace and developing skills to manage them effectively.
- Help the person deal with social assistance programs to ensure that the person's employment does not threaten his or her entitlement (for example, the impact of employment on benefits through a disability support program).
- Encourage skill development that supports a return to work (for example, communication, stress management).
- Help the person develop awareness of his or her work style, cognition, and personality traits that could support work or act as barriers to a return to work.
- Maintain ongoing assessment of the person's needs related to employment and interventions tailored to such needs.
- In the weeks preceding employment or a return to employment, help with maintaining a daily routine that approximates a work schedule.

Workplace considerations. Consider the need for the following:

- Discuss with the person the risks and benefits of disclosure so that the person can make an informed decision about disclosing his or her disability to the employer.
- Assist the person in making arrangements for any needed workplace accommodation (both technical and social context), including being able to keep appointments with the clinical team for therapy and medications.
- Investigate the kind of on-the-job training the employer is prepared to offer.
- Information for the employer and the person regarding the names and telephone numbers to contact in an emergency.
- Subject to the person's readiness to return to work, develop a gradual (or phased) return-to-work plan in collaboration with the employer and, if available, a vocational specialist.
- Provide education for the employer and co-workers about mental illness, stigma, discrimination, harassment, recovery, the role of meaningful employment, and the role of a supportive work environment.

Supportive employment, part time or full time. There is a strong association between being at risk of losing employment and economic hardship. Vocational rehabilitation in the form of Supported Employment (SE) or Individual Placement and Support (IPS) programs is more effective in helping persons with severe mental illness to secure competitive employment than are sheltered workshops or prevocational training. SE refers to paid work that takes place in typical work settings with ongoing on-site support services. It is a person-centred approach to help the person obtain and keep competitive employment that fits his or her goals, preferences, strengths, and abilities; that is, meaningful employment. A key principle of SE is that the person be engaged in competitive employment as quickly as possible (for example, after discharge from the hospital) with support and training on the job.

Evidence suggests that persons with severe mental illness benefit most from supported employment, particularly when it is integrated with appropriate mental health programs. Ideally, vocational rehabilitation services are provided by trained professionals, such as vocational counsellors or occupational therapists. When such resources are not available or supported employment is not accessible, clinicians should engage the person in meaningful activities of his or her choosing.

Considerations for Supported Employment (SE).

- The type and level of support in SE should be based on the person's need**.**
  - The most common problem that persons with mental illness encounter on the job is with interpersonal relationships. Poor self-esteem, actual or perceived stigma, or self-stigma may contribute to the person's poor interpersonal relationships. Poor self-esteem may also lead to poor self-evaluation of performance.
- Develop a plan for ongoing support from mental health services and collaboration with a "vocational specialist" or with work/life personnel within large companies if available. Close linkage with the treatment team should be maintained throughout the person's SE.
- Engage family, friends, and co-workers to support the person through SE.
- Assess the workplace capacity for accommodating the person's needs. Larger companies may have work/life counsellors or departments. Smaller companies may have fewer resources available. Privacy laws would prohibit employers from asking about specific illnesses, but they should receive information on necessary or recommended accommodations (for example, breaks during the day, shorter work hours, fewer days per week). In some cases, the person may consent to share aspects of his or her health-related conditions (for example, nature, symptoms, emergency contacts) with the employer.
- Assess the workplace environment and the type of accommodation (both technical and social context) before placement. Specific questions in assessing the workplace include the following:
  - Is the current or potential employer supportive?
  - Does the potential employer have written information about the person's illness (for example, nature of the illness, who to contact in case of emergency)? How does the person feel about disclosing his or her illness to the employer?
  - What type of accommodation would the person require to enable him or her to perform the job? Would the person need to leave during work hours for an appointment with his or her therapist? If yes, is the employer agreeable to this plan?
  - Are the employees in the workplace accustomed to having persons with disabilities as co-workers? What are the employer's hiring practices for persons with disabilities?
  - What information related to mental illness, stigma, discrimination, and creating healthy workplace environments has been provided to the employees at the workplace?
  - What have the person's relationships with his or her employers and co-workers been like?

Education/Schooling

For many, ongoing education is an essential part of the recovery process. Many of the assessment and intervention measures related to employment are also relevant to one's education or schooling. However, this section outlines specific considerations for reducing the risk of dropping out of school or helping the person enter an education program.

Assessment.

- What is the person's career interest or objective?
- Was the person at school before his or her current hospitalization? What was the person studying?
- Does the person have insight into the connection between his or her mental illness and the disruption of his or her schooling?
- Is the school aware of the person's mental illness or hospitalization?
- What were the risk factors for the disruption of the person's studies?
- What is the school environment like? Is it understanding and supportive of students with mental illness? Was the person subject to bullying or intimidation?
- Are there concerns that the preferred career may not be the most appropriate for the person (for example, stressful environment, high interpersonal skill level required)?
- If the person was previously in school, assess his or her readiness to return. What is the person's insight into his or her readiness to return? Assess whether the school environment, including the teachers and classmates, is equally receptive to the participation of the student.
- If the person was previously not in school, identify the reasons for not being in school and assess the person's career aspirations and any barriers to pursuing them.
- Encourage the person to identify the personal strengths that he or she could bring to the learning experience.
- If the person left school prior to completing a secondary education, explore alternative educational options, including night school and adult classes.

Interventions.

- Arrange for a psycho-educational assessment to help identify the person's cognitive strengths and barriers, and to rule out learning disabilities.
- Help the person develop strategies for using his or her strengths in the school environment.
- Assist the person in arranging for an individualized education plan (which outlines the available assistance and accommodations) with his or her educational institution.
- Encourage the person to contact the school, college, or university counselling service for students with disabilities to receive specialized counselling and support for academic success.
- Discuss with the person the option of seeking assistance from a career counselling service or career resource centre to identify the best school or educational setting for him or her.

- Help the person to identify peer supports for particular subject areas or with student life in general.

Volunteering

Volunteering or participating in social activities may help the person alleviate feelings of loneliness and may help establish a natural social network or a network of peer supports.

- Assess the person's previous and current levels of interest and participation in volunteer activities.
- Help the person identify volunteer activities that are or have been meaningful, and help him or her find and be involved with suitable activities.
- Help the person identify and contact resources in the community that could help to find volunteer work.

Country-Specific Considerations

Substantial cross-national variation in the economic situation of the country is likely to exist, which translates into different opportunities for employment. For this reason, consider the following:

- Even if full employment is not an option, use the CAP guidelines to move the person toward fuller employment opportunities.
- In countries where the economy is poor, encourage the person to think about local opportunities that can be capitalized on (for example, seeking microfinancing for a cottage industry).
- If the economic situation in the country is such that job opportunities are not available, the objective then becomes helping the person engage in his or her community through meaningful activity valued by the person and others.
- International variations in regulatory frameworks govern the rights and entitlements of persons with disabilities, including persons with mental illness. Members of the clinical team should be aware of such laws and understand how they can be used to support the person.
- There may be cultural variations in how persons with a mental illness are responded to in places of employment. Clinicians should be aware of any stereotypes that the person may be confronted with and provide support to help him or her manage such situations (for example, assertiveness training, social skills training). If the person is prepared to do so, he or she can take on an advocacy role through raising awareness of the challenges and benefits of work and school for persons in the recovery process.

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Part IV

Autonomy CAPs

Section 12

Control Interventions CAP

Issue

Many persons admitted to acute care mental health in-patient programs may present a risk of harm to themselves or others. For this reason, immediate interventions may be needed to control erratic, unpredictable, aggressive, or violent behaviour, whether targeted at themselves or others. Control interventions include the use of restraints, seclusion, and acute control medications (ACM). When used, these interventions may induce their own physical or psychosocial trauma. Thus, any control intervention should be considered an intervention of last resort and should, at most, only be used as a temporary intervention in a psychiatric emergency.

The primary reason for use of control interventions in in-patient mental health settings is to control violent behaviour. However, these interventions are frequently used in response to agitated behaviour or anger or to prevent behaviour from escalating to where there may be harm to self or others. With older persons, reasons given for restraint use include protecting the person from falls and accidents, providing postural support or positioning, facilitation of treatment (for example, prevent the person from pulling out IV lines), and management of nonaggressive behaviour such as wandering. There is strong evidence that physical restraints *increase* demands on staff because they create more work to check on the person's status frequently throughout the day. Also, the person often declines in physical and mental health, thereby leading to increased future staffing needs. Thus, restraints are not particularly effective in avoiding problem behaviours and are associated with many new negative outcomes.

Control interventions may be effective in containing aggression and violence in the short term, but they can have serious negative physical, social, and psychological effects. The use of control interventions, particularly when employed on an ongoing basis, can be a major barrier to the person's recovery from mental illness. The loss of control, social isolation, shame, and stigma attached to being restrained, for example, can exacerbate feelings of despair and hopelessness and can lead to more agitation, distress, and reduced coping skills. The behaviour disturbances that are sometimes the justification for restraints may be exacerbated as the person becomes agitated by the discomfort caused by restrictions in his or her movement. Key risks associated with the use of ACM are respiratory depression or arrest, cardiovascular complications, seizures, neuroleptic malignant syndrome, and acute dystonia. It has been suggested that seclusion can increase suicidal ideation, and there is the risk of physical self-harm (for example, fractures caused by hitting the door or wall).

Goals of Care

- Minimize the length of time and number of control interventions used.
- Balance safety of the person, staff, and others with the person's freedom and comfort.
- Identify underlying medical or psychiatric symptoms related to the use of restraints, seclusion, or ACM.
- Treat underlying medical or psychiatric symptoms that could lead to the use of restraints, seclusion, or ACM.
- Identify and implement alternative care approaches.
- Monitor and evaluate alternative methods and their outcomes.

Triggers

The Control Interventions CAP applies to persons in in-patient mental health settings and takes into consideration the circumstances related to the use of control interventions (for example, whether the control intervention occurred in the context of a psychiatric emergency). Although this CAP describes different scenarios in which control interventions may be used, it should not be considered a clinical justification for their use. In general, the CAP provides guidance in how to implement alternatives to control interventions in both emergent and nonemergent situations.

TRIGGERED TO ELIMINATE THE NEED FOR CONTROL INTERVENTIONS — PERSONS IN A PSYCHIATRIC EMERGENCY SITUATION

This group includes persons who

- have experienced a physical restraint (mechanical, chair prevents rising, or physical or manual restraint by staff), seclusion, or ACM in the 3 days prior to the assessment; AND
- were in a psychiatric emergency situation, as indicated by one or more of the following:
  - Suicide attempt in the 3 days prior to the assessment
  - Violence toward others in the 3 days prior to the assessment
  - Score of 13 or higher on the long version of the interRAI Positive Symptoms Scale (PSS Long) (see the appendix)
  - Extreme behaviour disturbance in the 7 days prior to the assessment
  - Command hallucinations in the 3 days prior to the assessment
  - Aggressive Behaviour Scale (ABS) score of 6 or higher (see the appendix)

This trigger group includes about 12% of persons in a mental health in-patient setting. Over a median 19-day period, approximately 63% of persons in this group will become free of control interventions and 18% will still be experiencing control interventions associated with an emergency situation. Of special interest are the almost 20% of persons who triggered into this group initially in the context of an emergency, but who, after almost 3 weeks, are still experiencing control interventions despite no longer being in an emergency situation. This transition should **not** be considered an improvement in status.

TRIGGERED TO ELIMINATE CONTROL INTERVENTIONS — PERSONS **NOT** IN A PSYCHIATRIC EMERGENCY SITUATION

This group includes persons who

- have experienced restraints, seclusion, or ACM use in the 3 days prior to the assessment *but were not in a psychiatric emergency situation as described above*; OR
- have had a long-term history of ongoing restraint use, perhaps in another care setting (for example, long-term care).

This trigger includes about 11% of persons in a mental health in-patient setting. Over a median 19-day period, 66% of persons triggering in this group no longer have control interventions, 31% will continue to experience control interventions not associated with an emergency, and 3% will experience control interventions in the context of a psychiatric emergency.

NOT TRIGGERED—ABSENCE OF RESTRAINTS, SECLUSION ROOM, OR ACM

While not triggered by the use of control interventions, attention should be paid to addressing problems that could lead to their use, including harm to others (see Harm to Others CAP), self-harm (see Suicidality and Purposeful Self-Harm CAP), and falls (see Falls CAP). This group includes about 77% of persons admitted to in-patient mental health settings. Over a median 19-day period, just over 2% of persons in this group will experience control interventions not associated with an emergency, and fewer than 1% will be subject to control interventions in the context of an emergency.

Guidelines

Control interventions are part of a continuum of responses to disturbed behaviour, but they should be used only as a last resort. Efforts to address such behaviour should begin with the least invasive approach (for example, verbal intervention, addressing the person's needs when possible, voluntary medication) before using more intrusive interventions. As well, the person may be offered and agree to take PRN medication in order to avert escalation of aggression or violence. If these less invasive attempts fail or if there is imminent risk of serious harm, a show of force may be required. If this fails, consider an acute control medication, physical restraint, or seclusion.

Although safety is considered the most important short-term goal when managing disturbed behaviour, collaboration between the person and the clinical team is important to develop improved long-term outcomes. Even though the person may understand the need for emergency interventions, he or she may often feel frightened and abandoned in those situations.

- Where possible, the person should be engaged in a discussion regarding the type of control intervention that he or she would prefer should it be necessary. This information should be documented on the person's chart and the preferred intervention should be used.
- Maintain contact with the person during the episode where a control intervention is in effect in an effort to reduce negative feelings about its use.
- Discuss the incident with the person afterward and engage the person in a discussion about strategies that may be used to manage risks to his or her or other persons' safety.

When considering control interventions, evaluate their appropriateness as follows:

Often appropriate:

- Acute danger to self or others

Sometimes appropriate:

- To prevent a person, who has been admitted on an involuntary basis, from leaving prior to assessment or transfer to a locked facility

Rarely appropriate:

- A history of previous self-injury or aggression but no current indicators
- Lack of resources to adequately supervise the person
- To prevent a person who has been admitted on a voluntary basis from leaving prior to assessment
- To reduce risk of falls

Never appropriate:

- As a punishment
- Re-creating how the person was managed in his or her previous setting (for example, restrained during a prior long-term care home stay)
- For convenience or comfort of other care recipients or staff

Actions to Consider in the Context of an Emergency Situation

Can the use of a control intervention be avoided? Examples of preventive strategies include

- Redirecting the person with calm, simple, clear, and reassuring directions, and removing environmental hazards and others from the immediate vicinity.
- Providing the person with an opportunity to safely vent his or her emotions.
- Providing one-on-one intervention/supervision, as tolerated by the person. Persons who are agitated, restless, and pacing may be willing to be accompanied by a staff member while verbally releasing anger and frustration.
- Avoiding speaking in loud, forceful, or urgent tones that may further aggravate the person.
- Promoting a person-centred model of care where the person is actively involved in the decision-making process regarding his or her care and retains or regains his or her sense of self-determination.

Control intervention in the context of a psychiatric emergency. There are a limited number of situations in which control interventions may need to be applied on an emergency basis to prevent harm to self or others. As soon as the immediate need passes, the person must be evaluated for elimination of that intervention. Consider the following:

- Has an in-person evaluation by a physician been performed on a timely basis (for example, within 1 hour of initiation of the control intervention)? Has the record been reviewed and have other team members been consulted to determine the reason for the use of restraint, seclusion, or ACM? It may be possible to identify and resolve the needs, risks, or problems that resulted in control intervention use. In addition, this review may help identify other less restrictive interventions. Consider carefully any continuation of control interventions (for example, beyond 2 to 4 hours).
    - Conduct a clinical review of the person within 24 hours of the initiation of a control procedure.

- Require new orders and an in-person evaluation if the restraints are to continue.

- What is the person's history regarding psychiatric diagnoses? Review the person's medication regimen to ensure that appropriate medications are used to manage mental health problems such as psychotic disorders or mania.
- Does the person have unmet needs? Many behavioural emergencies are manifestations of unmet health, functional, or psychosocial needs that can often be reduced, eliminated, or managed by addressing the conditions that produced them. Determine whether behaviours are the result of unmet needs in other, nonbehavioural areas (for example, pain/discomfort, fatigue, hunger, thirst, fear, bowel/bladder, boredom, need to move around, overstimulation) and implement alternative strategies to meet such needs.
- Is the behaviour a symptom of a new condition and of sudden onset? Acute medical conditions can result in delirium or acute psychotic episodes associated with behavioural change. If delirium is suspected, a review of all possible causes of delirium should be explored and managed as necessary.
- Was abusive behaviour toward another person provoked or unprovoked? Identifying provoking factors will assist in determining care plan interventions focused on preventing future abusive behaviours toward others. The following are examples of treatment strategies:
  - If the person wandered into another's room, a harsh response by the occupant may make the wanderer strike out (behaviour provoked). Some persons may need to be separated to prevent the behaviours.
  - If the abuse was not a result of provocation, determine whether underlying medical or mental health problems are affecting the person's reactions to others.
  - Approach the person in a calm, quiet, soothing manner.
  - If the person is being physically abusive, move away from him or her, allow the person some space, and reduce the person's sense of being trapped. Remove others from the situation. When it seems safe, approach the person in a calm, reassuring manner. Persons often mirror behaviour of those around them.
  - Consider the physical environment and determine if overstimulation or understimulation may be factors that affect abusive outbursts. Appropriate interventions may include, but are not limited to, adjusting awakening and retiring schedules, adapting mealtimes, providing one-on-one activities and variations in current activity schedules, adjusting medication schedules.
  - Take steps to improve the continuity of care (for example, use a primary nursing care approach). Is one staff member assigned to the same person over long periods of time to build up an understanding of his or her individual strengths, preferences, needs, and idiosyncrasies? A sense of familiarity with a consistent caregiver can reduce and may even eliminate periods of abusive behaviour.
- If physical restraints are used in an emergency situation, see notes in the following section for specific considerations.

Actions to Consider in the Context of a Nonpsychiatric Emergency

Physical restraints are the most common control interventions for persons not in a psychiatric emergency situation. Restraint use is more common among older persons

in in-patient mental health programs, but age should never be considered a justification for use of any control intervention, including restraints. When physical restraints are used, the person's plan of care must identify the following:

- The clinical rationale for use of the restraint.
- The specific time(s) for application and a regular schedule for checking the status of the person when the restraint is applied. For persons with new restraints, the person should be checked at least every 15 minutes for the first 2 days and every hour for the following 5 days.
- A plan to monitor the person's response to the restraint.
- The person's consent (or proxy consent if the person has been deemed not capable to provide consent) to the restraint use.
- Specific actions to address the person's ADL needs (for example, toileting, personal hygiene).
- A schedule for regular ambulation to reduce health risks related to restraints (for example, pulmonary embolism, pressure ulcers, pain). An Ontario coroner's inquest related to this issue recommended a minimum schedule for ambulation of 15 minutes every 8 hours, when safe to do so.
- A systematic plan outlining steps to eliminate the use of the restraint as soon as possible, including an explanation to the person of what he or she must do to have the restraint removed. Establish a target date by which the restraint will be removed. If this target date is not achieved, re-evaluate the need for restraint use and document reasons that this target date was not achieved.
- Complete a thorough assessment, including a review of the person's usual daily routine compared with the present one, any mobility aids that are in use, factors related to risk of falls, and patterns of wandering and abusive or physically aggressive behaviour directed toward others. The outcome of this review should focus on identifying care approaches that do not involve the use of a control intervention.
- If a control intervention is temporary and necessary to facilitate the treatment of an acute illness (for example, IV antibiotics to treat pneumonia), consider the least restrictive form of restraint, closely monitor the person, and devise a plan to eliminate use of the restraint as soon as possible.

Actions to Consider in the Context of Any Control Intervention Use

Policy, documentation, and review. The legislation and policies developed in most jurisdictions emphasize that control interventions be used only in emergency situations, and only after other less restrictive measures have failed. Staff should be aware of facility policies and the related provincial, state, or federal legislation regarding restraint use and documentation. As well, staff should receive general training in the management of disturbed behaviour, including crisis prevention, and specific training in the use of control interventions, including medical risks associated with their use. The use of control interventions should be thoroughly and accurately documented to facilitate review of their use. Even when not mandated by legislation, facility policy should dictate the information to be documented about control intervention use. The duration of restraint use and the person's response to it should also be documented. In addition to individual documentation, ongoing review of the use of these interventions must be performed on a regular basis for the purposes of monitoring practice patterns and trends.

When control interventions are used, the following should be documented:

- The circumstances leading to the incident.

- Alternatives to the control intervention that were attempted.
- Assessment and reasons for the intervention.
- If an ACM is used, the medication information (that is, name(s), dosage, route, and time of administration).
- Effectiveness of the intervention.
- The person's mental status before and following the use of the intervention.
- In the case of ACM use, monitoring and documentation of vital signs, level of consciousness, changes in psychomotor activity, medication side effects.
- For all control interventions, monitor for and document any emotional responses, such as an increase or a decrease in levels of agitation, anxiety, and verbalizations of aggression or intent to harm self or others and a sense of hopelessness and loss of self-control. There may be a risk of triggering a flashback to a traumatic event in those persons with a history of experiencing abuse.
- The type and intervals of monitoring. It is considered most appropriate to perform continuous monitoring, whether by audiovisual methods or by constant observation. It is considered reasonably appropriate to perform in-person evaluations at frequent scheduled intervals (for example, every 15 minutes). Longer intervals between observations are considered unsafe. Also observe for the potential of psychological trauma as a result of the control intervention.

Debriefing. A debriefing process may assist in developing or maintaining a therapeutic rapport between the person and those involved with his or her care. The debriefing process should be used for both the person and staff involved to review

- Circumstances leading to the use of a control intervention.
- Effect of the intervention.

Additional Resources

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Section 13

Medication Management and Adherence CAP

Issue

Medication management entails optimizing the desired clinical outcomes associated with prescribed medications. The primary concern should be the clinical benefit derived from the medication and not merely the issue of nonadherence. Effective medication management involves full engagement of the person in the treatment plan through creation of a therapeutic alliance. It considers the person's overall response to the medication, any associated adverse effects, and the current appropriateness or therapeutic effectiveness of the medication. Consideration must be given to the person's values, preferences, choices, barriers related to mental and physical health issues, and specific functioning problems.

Adherence is a sub-domain of medication management. Adherence means taking medications as prescribed by the physician, in the right dosage, at the right times, and for the entire prescribed period. Adherence requires that the person understand the role of medication in symptom control and improvement in his or her quality of life through possibly preventing relapse. Drivers for nonadherence include dosing frequency or complexity, multiple medications, side effects, drug interactions, financial considerations, ineffective communication about the medication, fear of medications, or limited insight regarding mental illness. Nonadherence may be an important source of concern and distress for families and friends. In situations where family members or others are available and involved, these individuals should be engaged with medication management to support the person's ongoing care and recovery. The World Health Organization states that just over 40% of persons receiving antipsychotic medications did not use medications as prescribed. Nonadherence rates tend to vary based on type of medication and mental health diagnosis.

In the community mental health setting, adherence may reduce relapse rates, prevent rehospitalization, and facilitate social engagement and the pursuit of meaningful roles. In the in-patient mental health setting, adherence improves safety and promotes the person's rehabilitation and recovery. In the forensic system, adherence may assist transfer to less restrictive custodial settings and the community.

The capacity to manage medications is a particularly important instrumental activity of daily living (IADL) that affects the ability of persons with mental illness to remain independent in the community. Impaired medication management skills will increase the risk of medication errors and adverse side-effects, which may pose a serious threat to the person's health.

Finally, a strategy to improve medication management should involve respect for the person's right to make autonomous decisions about treatment, consistent with jurisdictional legislation. In this context, issues related to safety (that is, risk of harm to self or others) should also be taken into consideration.

Goals of Care

- Stabilize the person's medical and mental health concerns.
- Eliminate or reduce the person's concerns about the medication regimen.
- Implement a medication regimen that increases the likelihood of successful adherence.
- Support safe use and independent management of medication, with assistance as needed.
- Reduce the risk of relapse and hospital admissions.

Triggers

The Medication Management and Adherence CAP applies to persons in either in-patient or community-based mental health programs. This CAP has two trigger levels based on the underlying causes of difficulties related to medication use, using a variety of items related to cognition, positive symptoms, physical health, and medication use.

TRIGGERED FOR PROBLEMS WITH MEDICATION MANAGEMENT AND ADHERENCE RELATED TO COGNITIVE DEFICITS AND POSITIVE SYMPTOMS

This group includes persons who

- have impaired cognitive function (based on the Cognitive Performance Scale [CPS]; see the appendix) OR positive symptoms related to psychosis or mania; AND
- have any one of the following three conditions:
  - Are adherent to medication regimens less than 80% of the time
  - Have refused medications in the last 3 days
  - Have an impaired capacity to manage medications and therefore require supervision or assistance by others

This CAP level is triggered for about 47% of persons in in-patient settings and about 27% of those in community mental health settings. It is more commonly triggered by older adults in both settings, including about 80% of those in geriatric psychiatry units. The rate is lowest in forensic psychiatric units, at about 28%.

The rate of hospitalization to a mental health program at follow-up for those in the community was about 25% for the two triggered groups, compared with about 15% in the not-triggered group.

TRIGGERED FOR HAVING PREVIOUSLY STOPPED TAKING MEDICATION DUE TO SIDE EFFECTS

This group includes persons who do not meet the criteria for level 1, but who

- have previously stopped taking medication(s) due to side effects; AND
- are currently experiencing one or more of the following potential drug-related side effects (or negative health effects):
  - Extrapyramidal symptoms (for example, dystonia, akathisia, dyskinesia)
  - Sleep disturbance
  - Dizziness, vertigo, lightheadedness

- Anticholinergic effects (for example, dry mouth, constipation, blurred vision)
- Seizures
- Emergent conditions (for example, rash, neuroleptic malignant syndrome)
- Weight gain
- Diabetes
- Hypersalivation, drooling
- Sexual dysfunction

This CAP level is triggered by about 5% of persons in both community and in-patient mental health settings. This trigger is somewhat more common among younger persons, as well as those with a mood disorder diagnosis.

NOT TRIGGERED

This group includes anyone who does not fall into either of the preceding subgroups. It includes those who

- are nonadherent or refusing medications but who are not cognitively impaired or experiencing positive symptoms.
- have previously stopped taking medications due to health-related side effects but who are not currently experiencing health problems.
- have no current issues of nonadherence, refusal to take medications, or problems with medication management. This group forms a majority of the not-triggered group.

This group also may include persons who have health conditions that are not captured in the interRAI mental health assessment instruments (for example, photosensitivity, cardiac effects, hyperglycemia). These issues may be detected with other available clinical documentation, and appropriate care planning initiatives should be undertaken. This group may also include persons who are cognitively intact but who refuse to take the medication as part of a personal choice (with the exception of cases where there is a legal framework that can enforce the use of medications).

In in-patient mental health settings, about 2% of the not-triggered group will refuse medications and about 5% will develop problems with medication management. In community mental health programs, about 15% will have medication management problems at follow-up.

Although medication management and adherence are not immediate issues for the not-triggered group, it is still necessary to have measures in place to support appropriate medication use.

Guidelines

Assessment of Nonadherence

Consideration of the person's perspective should be the first step before measures to address adherence are established.

Nature of nonadherence. The extent of the person's nonadherence with his or her medication regimen should be evaluated. Measures for assessing the extent include

- Direct measures (for example, laboratory testing of blood and urine)
- Indirect measures (for example, pill counts, prescription refills)
- Subjective measures (for example, self-reports, collateral reports from family or clinician)

- Unexpected clinical relapse

To clarify the nature of the observed or reported nonadherence, consider the following:

- Is this the first instance of nonadherence or is it a subsequent occurrence?
- What medications are not being adhered to? Consider both psychotropic and somatic medications.
- Is there a tendency to over- or underdose?
- Is the medication in question the most appropriate treatment available or are there other approaches that may have fewer side effects?
- Is the nonadherence a purposeful action or is it an unintentional consequence of not understanding the medication regimen, difficulties with memory, or confusion?
- If the nonadherence is purposeful, why is the person making that choice? Is the person's rationale for nonadherence reasonable (for example, experiencing health-related side effects)?
- Does the person have misunderstandings about the medication?

Contributing factors for nonadherence. The following questions may help to determine which factors contribute to the person's nonadherence.

- Does the person report any of the following problems or concerns?
  - Adverse health or medication side effects
  - Fear of future episodes of health side effects
  - Medication not helpful
  - Too many medications
  - Forgetfulness
  - Delusional explanations (for example, fear of poisoning)
  - Medication made person feel different from others or stigmatized
  - Medication is an unwanted reminder of illness
  - Feelings of loss of autonomy or of being controlled by medication
  - Medication is interfering with social relations, employment, driving, schooling, or other activities
  - Loss of trust in health care providers or professionals
  - Cost of medication
  - Difficulty getting prescription filled (for example, lacks transportation)
  - Actively testing alternative therapies or nonpharmaceutical strategies for symptom control
- Does the person have the cognitive ability to manage his or her medications? Does the person understand the clinician's instructions? Does the person have problems remembering the instructions? Does the person have a dual diagnosis that may interfere with understanding specific aspect(s) of medication use?
- Is the person reluctant to receive treatment?
- Is there an association of nonadherence with the person's mental health disorder? For example, when a person with a bipolar disorder experiences hypomanic or manic episodes, he or she may discontinue medication because the

medication is viewed by the person as interfering with pleasure or satisfaction associated with these mood states.

- Does the person have a substance use problem (for example, cannabis, alcohol, benzodiazepines, illicit drugs)? Does the person overuse medications?
- Does the person have serious medical conditions that may cause mental health symptoms?
- Does the person understand the role of medication for symptom control?
- Does the person appreciate the risk of relapse associated with nonadherence?
- Does the person sell the medications for money?
- Is the medication regimen too complex?
- Is the dosage or route of administration an issue of concern?
- Is there a problem with access to medications (for example, in receiving regular prescriptions, having them dispensed, affordability)?
- Are there any religious or cultural beliefs that interfere with the person's adherence?
- Does the person have any informal supports in the community who can assist him or her in taking medications appropriately?
- Do the person's informal supports in the community interfere with or act as barriers to the person's adherence?
- Does the person or family have any negative attitudes or beliefs about taking medications?
- Is there an effective partnership between the person and his or her health care provider(s)?

Specific trigger group issues. For persons with cognitive deficits or positive symptoms, determine the following:

- Does the person have any memory deficits that affect his or her ability to adhere?
- Does the person have the ability to understand the regimen and follow the necessary steps for adherence?
- Are there specific subtasks of medication management that the person can perform independently?
- Does the person have delusional thinking about his or her medications?
- Does the person have disorganized thinking?
- Does the person have fluctuating moods (for example, euphoric, expansive, irritable, demanding) that might affect his or her adherence to the prescribed medication regimen?

For persons experiencing side effects, subjective distress may influence the person's attitude toward the prescribed medication and thus the extent of adherence. Assessment of side effects should include determining

- The type, duration, and severity of the adverse effects
- If the person has had similar adverse effects in the past
- What steps the person has taken in response to past side effects
- The impact of these side effects on the person's physical or social functioning

(for example, staying at home because of embarrassment related to side effects) (see Social Relationships CAP)

- The symptoms that the medication is intended to manage
- Whether there is an increase in mental or somatic symptoms
- Whether the dosage of the current medication should be altered or whether an alternative medication should be considered
- Whether the person would prefer an alternative method of medication administration
- Whether medication interactions are affecting adherence
- Whether the medication regimen can be altered to eliminate or minimize any side effects that might be having an impact on the person's adherence
- Whether there is alternative medication that the person would find more acceptable

Intervention Strategies, Applicable to Both Trigger Levels

Interventions to address issues related to adherence and medication management should typically be multidimensional. Forming an effective therapeutic alliance with the person and family is important, as is avoiding the impression of paternalism. Even in cases where the person is unable to provide consent to treatment, it is important to collaborate with the person in selecting pharmacological treatment options. The following intervention options should be considered and tailored to the specific circumstances of each person.

Psychoaffective. Psychoaffective interventions explore the person's view of taking medication in relation to his or her goals and aspirations. For instance, taking medication may be associated with being ill, psychotic symptoms may be seen to play a protective role in preserving self-esteem, or the person may believe that extrapyramidal side effects alienate him or her from others. Perceptions and beliefs such as these may influence medication adherence. Clinicians should explore such feelings and perceptions with the person to help him or her achieve his or her social goals and to minimize the risk of relapse. This requires the development of a positive therapeutic relationship that considers the following:

- An awareness of the person's perception of the clinician's interest.
- Shared decision making and an equal partnership between the person and the clinician in developing the medication regimen. Such a relationship implies that clinicians actively engage the person (to the extent that the person is able) in his or her treatment planning and decision making.

Education and family support. Educational interventions aim to provide meaningful and relevant information to the person and family or others about the person's illness and symptoms, medication regimen, risks and benefits, side effects, relapse prevention, and the importance of adherence. Such education should be appropriate for the person's clinical status and cognitive ability and includes

- One-on-one or group education sessions for the person
- Involvement of the person's family in education, if the person agrees and the person would benefit from such involvement
- Written information, audiovisual presentations, and clinically approved online resources

Be mindful of the person's and family's ability to comprehend the information provided during education sessions (for example, language barrier, the person's cog-

nition, cultural perspectives) and of situations where the family members do not support the person's use of psychotropic medications.

Behaviour and practical barriers. Consider interventions that target, shape, or reinforce specific behavioural patterns related to a person's medication adherence. These strategies include skill building and practice activities regarding

- Taking medications
- Adapting the medication regimen to the person's needs and daily routines (for example, persons may be taught to link taking of medication with certain daily activities, such as mealtime or bedtime)
- Using medication packaging to help the person remember to take medications (for example, pill boxes divided by day of the week and time of day)

Addressing practical barriers related to medication adherence include

- Assisting the person in resolving transportation barriers in getting to appointments or to the pharmacy for new prescriptions or refills
- Assisting the person in accessing financial resources for medication purchases if economic issues are a concern (see Personal Finances CAP)
- Modifying the dosage or route to simplify the medication regimen (for example, using depot injections)

Cognitive therapies. Cognitive interventions address a person's reasons for not following the prescribed medication regimen. These interventions require that the person be actively engaged in making decisions related to the medication treatment. As part of the cognitive therapy process

- Encourage the person to examine the full range of factors affecting adherence, considering his or her own beliefs, values, or goals
- Actively engage the person in making personal choices and accepting responsibility
- Help the person focus on his or her concerns about treatment and the consequences of adherence to a medication regimen versus nonadherence
- Use motivational interviewing, whereby the person is encouraged to articulate the positive consequences of taking medications

Socioenvironmental. Socioenvironmental interventions aim to influence medication adherence by appealing to feelings, emotions, social relationships, and social supports. Activities include

- Establishing strategies that assist the family in developing and maintaining a supportive role (for example, provide the family with information about and facilitate participation in counselling or informal support groups)
- Providing supportive home visits
- Working with the person and members of his or her informal and formal support network to devise a plan to promote adherence (for example, taking turns to remind the person to take the medication)

Legal. Medication management involves respect for the person's right to make autonomous decisions about treatment, consistent with jurisdictional legislation.

- Country-specific mental health legislation may provide a legal framework for clinicians to intervene when persons do not follow a prescribed medication regimen. For example, mental health legislation in some jurisdictions provides for community treatment orders for a person who is discharged into

the community to ensure that he or she follows the prescribed medication regimen.

- For those in in-patient mental health settings, there may be a legal framework that provides for treatment against the person's will when it is determined that the person presents a risk of harm to self or others.
- In some jurisdictions, the person may elect to refuse medications pending the results of a review board to determine if he or she must take medications against his or her wishes.

Evaluating Effectiveness of Interventions

Follow these guidelines to evaluate the effectiveness of the interventions instituted:

- Establish adherence targets and measures.
- Monitor adherence through direct (for example, pill counts) and indirect (for example, laboratory testing) measures.
- Monitor medication side effects, cognitive function and symptoms, and clinical outcomes.
- Evaluate the person's perspective on the effectiveness of interventions.

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Section 14

Rehospitalization CAP

Issue

Evidence suggests that avoiding rehospitalization is an important priority for persons receiving mental health services. Rehospitalization might increase a sense of stigmatization and reduce the person's self-confidence that he or she is able to recover. Rehospitalization may be the result of person-level factors such as mental health symptoms, lack of informal supports, and functional deficits, as well as poor quality of care (for example, continuity of care, availability of services). Avoidable hospitalizations resulting from unaddressed personal factors and poor quality of care may incur unnecessary economic costs to the mental health system.

A subset of persons with mental health problems are discharged and readmitted to the hospital multiple times. In Canada, between 2003 and 2004, 37% of those who had been discharged following in-patient mental health treatment were rehospitalized, compared to 27% of persons discharged following treatment for non-mental health related conditions. It has been estimated that 30% to 40% of persons with severe and persistent mental illness will be rehospitalized within 6 months of discharge, 35% to 50% will be rehospitalized within 1 year, and 65% to 75% within 5 years. The Organization for Economic Co-operation and Development reports the range of rehospitalization to the same mental health hospital to be from 6% to 32% for persons with schizophrenia residing in its twelve member countries. The range is similar for persons with bipolar disorders. The use of assessment and person-centred care planning can play an important role in reducing the risk of rehospitalization by identifying and minimizing a person's risks and designing a person-centred recovery plan.

Goals of Care

- Minimize the effects of specific mental health symptoms contributing to risk of rehospitalization.
- Develop and implement a recovery support plan with the person that includes personal supports, a crisis-management plan, and actions for ensuring integration between in-patient and community services.
- Engage the person in a coordinated and comprehensive mental health program.
- Maintain residence in the community and avoid future hospitalizations.

Triggers

The Rehospitalization CAP identifies persons who have a history of multiple in-patient mental health hospitalizations and characteristics placing them at risk for readmission to a mental health in-patient setting. This CAP applies to persons in emergency settings and in-patient mental health settings, as well as to persons in community mental health programs. This CAP provides information to guide

discharge and recovery planning that will minimize the risk of the person returning to an in-patient mental health setting.

The Rehospitalization CAP is not limited to specific diagnostic groups. It considers five characteristics that are strongly associated with readmissions:

- Hospitalization in the previous 2 years
- Positive Symptom Scale score of 3 or higher
- Cognitive Performance Scale score of 3 or higher
- No insight into mental health condition
- Lives alone

TRIGGERED DUE TO HIGH RISK OF REHOSPITALIZATION

This group includes persons who

- have been hospitalized three or more times in the last 2 years; AND
- have one or more of the characteristics listed above.

This group includes about 14% of persons in in-patient mental health settings. About 9% of persons triggering at high risk are rehospitalized within 90 days, and about 16% are rehospitalized within 180 days. In community mental health programs, about 6% of persons trigger this CAP.

TRIGGERED DUE TO MODERATE RISK OF REHOSPITALIZATION

Persons can trigger at this level in two ways. This group includes persons who have been hospitalized three or more times in the prior 2 years, but who

- do not have any of the characteristics listed above; OR
- have been hospitalized one or two times in the prior 2 years AND have one or more of the above characteristics.

About 29% of persons in in-patient mental health settings will trigger at this level. Of those who trigger due to moderate risk, about 6% were rehospitalized within 90 days and about 11% were rehospitalized within 180 days following discharge. In community mental health programs, about 23% of persons trigger this CAP.

NOT TRIGGERED

This group includes all persons who have not been hospitalized in the prior 2 years. About 56% of persons in in-patient mental health settings will not trigger the rehospitalization CAP. Of those not triggering this CAP, about 3% will be rehospitalized within 90 days and about 6% within 180 days of discharge. In community mental health programs, 70% of persons will not trigger this CAP.

Guidelines

A number of issues must be considered for developing a care plan to prevent future hospitalizations among persons triggering this CAP. These considerations include treatment of mental health conditions that contribute to the person's risk of rehospitalization as well as development of a comprehensive discharge plan for persons in in-patient mental health settings or action plan for community support for those in community-based mental health programs.

Initial Considerations

A comprehensive review of the person's mental health status and present mental health services and interventions, as well as the characteristics of his or her envi-

ronment and community should be conducted to help guide the development of a discharge or recovery support plan. It is also important to explore the barriers and opportunities that arise based on the person's status, his or her environment, and the interaction between them.

Challenges and recovery. Determine what the person believes to be the challenges facing him or her with living in the community and what is important for him or her.

- Is the person experiencing frustration in a particular aspect of his or her life (for example, lack of financial resources, does not like present living arrangement, unable to find employment)?
- Is the person experiencing frustration with the amount or type of mental health support services he or she is receiving (for example, perceives that he or she is not receiving enough help or support)?
- How does the person define quality of life for him- or herself?
- What would bring hope and meaning to the person's life?

Mental health issues. Review specific mental health conditions that may be contributing to the person's risk of rehospitalization.

- Is the person experiencing impaired cognitive functioning? If so, is this impairment related to a mental health problem (for example, severe depression, schizophrenia) or to a cognitive disorder (for example, early dementia)?
- Does the person have severe or persistent symptoms of psychosis? These symptoms could include hallucinations or delusions, as well as "negative symptoms" such as social withdrawal or anhedonia.
- Is the person lacking insight into his or her mental health condition? If so, determine if insight can be influenced by treating specific symptoms (for example, hallucinations) or whether the lack of insight is related to the person's inability to accept his or her mental health condition.
- Do barriers exist that affect the person's ability to manage medication or interventions? Does the person have difficulty with managing medications or treatments? (See Medication Management CAP.) What is the nature of the specific barriers or concerns with medication management and treatment, as identified by the person, the family, and clinical care providers?
- Has the person experienced recent stress that has rendered him or her more vulnerable to coping with his or her mental health problem or less hopeful for the future?

Social and family ties. Review the person's social and family history.

- Does the person have social contacts or confidants who can provide support? (See Social Relationships CAP.)
- Determine if the person participates or has the opportunity to participate in meaningful activities such as volunteering, employment, or education (see Education and Employment CAP).
- Review the person's relationship with his or her family to determine areas of strength in the relationships (for example, one or more family member is supportive of the person, family members are willing to learn more about what they can do to support the person's recovery). Also determine if there are areas in the family relationship that create a strained environment (for example, communication among family members and the person is critical or ineffective, or family members feel overwhelmed with providing support).

This will assist in determining the need for family involvement, counselling, or psycho-education prior to discharge and as part of the person's ongoing recovery plan.

Community support. Review service and community supports available to the person.

- Since living alone is a risk factor for rehospitalization, determine if a person who is living alone could benefit from informal supports or services such as supportive housing.
- Is the person presently involved with community services that have been shown to reduce the risk of rehospitalization, such as Assertive Community Treatment and case management?
- Identify geographic issues that may pose a barrier to the person's involvement in services, supports, or activities.

Past hospitalizations. Consider the impact and the conduct of prior hospitalizations.

- Were previous hospitalizations terminated prematurely?
- Had clinical symptoms substantially remitted before discharge?
- Were interpersonal conflicts adequately addressed?
- Were aftercare services adequately planned?
- Was the in-patient treatment and discharge planning aligned with community treatment planning?

Interventions to Reduce Risk of Rehospitalization

A detailed and comprehensive discharge or recovery support plan should be developed. For persons in in-patient mental health settings, the discharge plan must begin at admission and incorporate information obtained from the full assessment as well as the person's expressed goals of care.

The plan must be a coordinated effort, responsive to the person's circumstances, and respectful of the person's goals and privacy. There must also be an awareness of the need for evaluation and adjustment in the plan in recognition that reducing the risk of rehospitalization is an ongoing process. Specifically, the discharge or recovery support plan should consider the following:

Address challenges, as identified by the person, with living in the community. Help the person explore options to address his or her identified challenges.

- Provide support to the person in articulating the exact nature of the challenge (for example, if housing is an issue, is it the location, the type, or the inability to find affordable housing; if it is a lack of financial resources, is it the lack of accessing available social support, is there a need for financial counselling) and options available to him or her.
- Encourage the person to take an active role in determining how best to overcome these challenges. The clinical team should focus on fostering the person's sense of mastery and independence while at the same time provide guidance and assistance where needed.
- Assist the person in accessing community resources where applicable. The type of assistance may range from providing the person with information only to helping the person negotiate his or her way through the system.

Address unresolved issues. Rehospitalization is not always an adverse outcome. It can be used as an opportunity to introduce clinical interventions that deal with problems not addressed prior to the stay (for example, substance use).

- If medication management is an issue, consider options that will optimize the clinical outcome of the prescribed medications and the person's engagement in the treatment plan (for example, simplifying the medication schedule or changing to long-acting medication). (See Medication Management and Adherence CAP for other intervention strategies.)
- For some substance use disorders, the hospitalization may afford a good opportunity to introduce medications that reduce cravings associated with substance abuse, particularly alcohol, opioid, and tobacco use (see Substance Use and Smoking CAPs).
- Consider and implement interventions best suited to the person's situation. This may include one or a combination of
  - Supportive therapy
  - Problem-solving skills training
  - Social skills training
  - Family therapy
  - If negative symptoms are present, consider Cognitive Behavioural Therapy.
  - For persons with severe and persistent mental illness, Assertive Community Treatment has been shown to reduce hospitalizations.

Ensure the person has a personal safety plan. The plan should include activities the person can use to recognize and avoid crisis. This would involve

- Recognition of the triggers of a mental health crisis (for example, have the person think about "What am I like when I'm feeling less well?")
- Activities to do to avoid crisis (for example, "What can I do when I'm feeling less well?")
- Activities to avoid when coping with crisis (for example, "What behaviours should I avoid when I don't feel well?")
- A list of emergency contacts and supports

Community supports and services. Consider issues around timing and access to community supports and services, including

- Ensure the person experiences a coordinated transition between the in-patient and community settings. For example, following discharge, time to accessing community supports needs to be as soon as possible to reduce the likelihood of rehospitalization.
  - If possible, help the person establish initial meetings or appointments and provide reminders for the person.
  - If necessary and available, provide transportation to initial appointments.
- If the person is receiving formal community mental health support from a number of agencies, a plan should be established to facilitate a collaborative and an integrated system of support where the person and the formal service providers work together in making decisions.
- Attempt to develop community support collaborations (for example, respite care) where formal services are limited for subsets of persons with mental

health conditions (for example, persons with intellectual disability). If supports cannot be established and hospitalization is necessary, ensure the hospital has documentation related to the person's status, goals, and needs based on the most recent assessment done in the community.

Psycho-education. Psycho-education should be included as an integral part of the person's recovery plan.

- Promote family engagement and psycho-education. Family involvement in treatment has been found to significantly reduce risk of rehospitalization and to increase support available to the person.
- If substance use is an issue, provide relapse prevention education and supports. Help the person identify the triggers, behaviours, and environmental factors that contribute to his or her risk of substance abuse. Develop, with the person, a list of actions or behaviours that can be implemented to avoid relapse. (See Substance Use CAP.)

Social environment considerations.

- Designated staff (from both the in-patient mental health setting where the person is being discharged from and the community program that will be working with the person on his or her discharge) should assume responsibility for the transition between treatment settings, ensuring the necessary services are available when needed and that any lapses in follow-up care are corrected.
- If necessary, assist the person in accessing affordable housing.
- If necessary, provide information about and assist the person with applying for a drug benefit program.
- Provide the person with information about community crisis outreach teams (for example, emergency shelter, food, clothing).
- If personal transportation is not available, review potential alternatives such as subsidized public transportation or a ride share program through informal networks.
- Provide support and information regarding options for meaningful involvement in the community, including
  - Vocational rehabilitation, including supportive employment
  - Access to volunteer opportunities
  - Recreation activities
  - Education opportunities
- Explore opportunities for involvement in peer support, such as
  - Self-help groups
  - One-to-one peer support

Additional Resources

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Part V

Health Promotion CAPs

Section 15

Smoking CAP

Issue

Any amount of tobacco use can be harmful to the user and others who are exposed to secondhand and thirdhand smoke. Smoking and other tobacco use is known to cause a wide variety of diseases, including cancer (for example, mouth, larynx, esophagus, lung), respiratory diseases (for example, chronic obstructive pulmonary disease), heart disease and stroke, accidental injuries, and complications during pregnancy. The vast majority of smokers become addicted at a young age, and these individuals continue with the habit until major health effects become evident. Tobacco use remains the leading worldwide cause of preventable illness and premature mortality.

When an addicted tobacco user suddenly stops using tobacco or greatly reduces the amount used, he or she typically experiences withdrawal symptoms usually starting within a few hours of the last cigarette, peaking about 2 or 3 days later, and lasting for up to several weeks. Withdrawal symptoms can include dizziness, irritability, weight gain, depression, anxiety, sleep disturbances, and headaches.

Tobacco use is common among persons with mental illness, sometimes because it functions as a form of "self-medication." Nicotine stimulates the release of many of the chemicals that are imbalanced due to mental health conditions such as mood disorders (for example, dopamine, serotonin, and norepinephrine). This chemical stimulation may temporarily improve mood until the person ceases tobacco use and the chemical imbalances return. Thus, tobacco use among persons with mental illness creates a cycle where tobacco is used to alleviate mental health symptoms while also increasing risks to the person's physical health.

Rates of use among those with mental health problems are two to four times higher than in the general population, with the highest prevalence found among those with addictive disorders, schizophrenia, schizoaffective disorder, and bipolar disorder. The following are possible explanations for these high rates: (1) nicotine may be used to temporarily alleviate symptoms and psychotropic drug side effects by elevating various chemicals in the body; (2) shared genes may predispose people with mental health and addictive disorders to initiate and maintain tobacco use behaviours; and (3) common social and environmental determinants, such as ease of access and availability of tobacco, poverty, and stressful environments, may influence tobacco use within this population. People with severe mental illness have also been reported to be only one-fifth as likely as the general population to stop smoking.

Changes in mood and behaviour can occur when the person stops using tobacco, even in the absence of a previous history of psychiatric illness. A person who has a long history of using tobacco to help manage negative moods or stressful situations will have a strong urge to smoke when feeling upset, lonely, depressed, or overwhelmed. In addition, regular smokers who may not smoke due to smoking restrictions in hospitals may experience acute nicotine withdrawal symptoms (for example, feelings of frustration, anger, impatience, restlessness, difficulty concentrating, and tiredness). Pharmacological and cognitive behavioural treatments can help tobacco users manage these symptoms and improve the likelihood of successful quitting, while smoke-free policies and access restrictions may help to provide a supportive quitting environment.

Persons in in-patient mental health settings who have not been given a prescription for nicotine replacement therapy have been shown to be more than twice as likely to be discharged from the hospital against medical advice. Therefore, in addition to proper treatment for any type of mental illness, it is important to provide appropriate supports to help persons cope with restrictions on tobacco use in the short term and to provide ongoing education and support to encourage cessation of tobacco use over the longer term. The presence of a mental illness in no way should diminish the person's right to access effective smoking cessation programs and treatments. Several smoking cessation treatment and withdrawal management options exist and are effective, including psychological and pharmacological interventions.

The Smoking CAP outlines factors to consider for providing appropriate cessation treatment to daily tobacco users who have been abstinent for the past 3 days and those who have not been abstinent for the past 3 days. For those who have not smoked in the past 3 days, it provides strategies for managing withdrawal symptoms and encouraging sustained quitting. For daily smokers who have not been abstinent in the last 3 days, it provides strategies for promoting willingness and readiness to quit. Although this CAP deals mainly with persons who use tobacco daily, it is important to consider withdrawal and cessation among all persons who use tobacco, regardless of frequency.

Goals of Care

- Manage smoking withdrawal symptoms.
- Educate about the benefits of smoking cessation.
- Promote willingness and readiness for smoking cessation.
- Reduce or stop smoking.

Triggers

This CAP applies to persons in both in-patient and community mental health programs. The CAP also applies to emergency mental health settings where persons may be experiencing withdrawal symptoms because of not smoking during the acute phase of treatment. Two different trigger levels are identified based on current status of tobacco use and frequency of use.

TRIGGERED TO MANAGE WITHDRAWAL SYMPTOMS

This group includes persons who

- are normally daily tobacco users but who *have not used* tobacco in the last 3 days.

This group may be at elevated risk of experiencing tobacco withdrawal symptoms and should be assessed for the severity of withdrawal and managed immediately. Once withdrawal symptoms are managed appropriately, strategies outlined in the guidelines for promoting smoking cessation or reduction should be implemented by the mental health care provider.

This group includes about 33% of persons in in-patient and 1% of those in community mental health settings. These rates may vary substantially across jurisdictions, depending on local restrictions on smoking in hospital settings, as well as country-specific differences in smoking rates in the overall population.

TRIGGERED TO ENCOURAGE SMOKING CESSATION OR REDUCTION

This group includes persons who

- are daily smokers who *have smoked* within the last 3 days.

This group should be advised of the benefits of quitting or reducing their tobacco use and encouraged to do so at all regular visits with the mental health care provider. Once the person is ready to quit or reduce smoking, appropriate treatment strategies outlined in the guidelines should be implemented by the mental health care provider. This group includes about 12% of persons in in-patient and 50% of those in community mental health settings.

NOT TRIGGERED

This group includes about 55% of those in in-patient mental health and 49% of those in community mental health settings.

Guidelines

This CAP can apply to other forms of tobacco use, but it draws mainly from the evidence for cigarette smoking cessation. The guidelines are organized to address withdrawal symptoms from tobacco among persons who typically use tobacco daily, but who have not used it in the prior 3 days. For persons experiencing withdrawal as well as for those who are daily smokers not in withdrawal, the guidelines present approaches for determining willingness and readiness to quit tobacco use, strategies for promoting cessation or reduction in smoking, and considerations for maintaining cessation or reduction of tobacco use within in-patient and community mental health settings. It should be recognized that some persons will not want to participate in a smoking cessation program. In these situations, the person's choice should be respected once he or she has been provided with appropriate information on smoking cessation.

Encouraging sustained abstinence. The following should be determined for those who are daily smokers but who have not used tobacco in the last 3 days in order to encourage sustained abstinence.

- Determine if the person is experiencing tobacco withdrawal symptoms (see withdrawal symptoms item in the interRAI assessment). Consider the person's self-report as well as objective clinical observations.
- Conduct an assessment of the person's level of nicotine dependence to help determine whether symptoms are attributable to tobacco use (rather than to the person's mental health status) and inform appropriate treatment approaches. Persons with a high degree of dependence may experience severe withdrawal symptoms and require nicotine replacement therapies (NRT) to address the physiological dependence. These interventions include nicotine patches, gum, sprays, inhalers, and lozenges.
- Determine if the person is exhibiting behaviours that are distressing to him- or herself or to others as a result of tobacco withdrawal (for example, agitation, frustration, aggression, anger). This may have a negative impact on that person's quality of life, relationship with others, and options for discharge (see Harm to Others and Interpersonal Conflict CAPs).
- Determine why the person has not used tobacco in the last 3 days. If the person has not used tobacco based on personal choice or willingness to quit, consider interventions to support cessation. For persons who have not used tobacco due to a lack of opportunities to access or use tobacco (for example, hospital regulations do not permit the person to use tobacco), it is important

to first assess willingness to quit or reduce tobacco use prior to implementing tobacco cessation and reduction strategies.

Strategies to encourage and support tobacco cessation or reduction. Smoking cessation interventions should be considered for persons who are current smokers, including those who were unable to smoke in the last 3 days.

- Advise the person of the importance of quitting smoking in a nonjudgmental and an unambiguous manner. Provide clear, consistent advice to quit and emphasize immediate and long-term benefits of quitting.
- Assess the person's willingness to change smoking behaviour. Ask about his or her willingness to quit or reduce tobacco use (for example, ask: "Have you ever thought about quitting smoking?" or "Are you interested in quitting or reducing your tobacco use?").
- If the person is willing to consider quitting, determine his or her readiness to change. Persons addicted to tobacco may be at different stages of readiness for change. For example, some may be unaware of the problem or have never considered changing their behaviour and may not be prepared to consider changing it. Others may be thinking about quitting the use of these substances, so they may be more open to receiving information about treatment options and support programs. Start by asking about any previous quit attempts (for example, ask: "Have you ever tried to quit or reduce the amount of tobacco you use?" or "What are some of the challenges you faced when trying to quit or reduce your tobacco use in the past?"), as well as the person's intentions for when he or she would like to begin quitting or reducing tobacco use (for example, ask: "When would you like to try quitting or reducing your tobacco use: within the next 30 days, within the next 6 months, sometime beyond 6 months?"). Persons who are willing and ready to change their tobacco use behaviour are more successful at quitting.
- Address any perceived or actual barriers to quitting. These may include social ties that facilitate smoking or discourage cessation, incorrect beliefs about beneficial effects of smoking (for example, stress reduction), and reinforcing behaviours associated with tobacco use (for example, smoking while drinking coffee).
- Regularly monitor tobacco use, including frequency and amount.

For those not willing or ready to change behaviour. Strategies to promote smoking cessation or reduction should be implemented. Treatment should focus initially on building motivation and readiness to quit smoking, developing the cognitive and behavioural skills needed to manage nicotine withdrawal, urges to smoke, and triggers for relapse, and to secure necessary social support both inside and outside the treatment environment.

- Help the person begin to think seriously about quitting. Ask about his or her feelings toward his or her own tobacco use and the pros and possible cons of using tobacco. Identify reasons for tobacco use. These may include social, psychological, and physiological (for example, self-medication) factors.
- Offer information on quitting and reducing tobacco use and any other assistance that can be provided.
- Help build motivation for change. Encourage gradual reduction as a possible first step toward quitting. Suggesting that the person try reducing or quitting for one day can help build motivation and confidence for future quit attempts.
- For those not able to smoke within in-patient settings, monitor for withdrawal symptoms and treat appropriately (see previous section of the guidelines).

Implement strategies to support tobacco cessation or reduction for those willing or ready to change behaviour.

- Strengthen commitment to change by reinforcing reasons for quitting or reducing tobacco use and by exploring new ones. Start by asking about the reasons for change. Understanding why the person is motivated to change, demonstrating empathy, and reinforcing the person's reasons can help provide a safe and supportive environment for behaviour change to occur.
- Assess the person's level of nicotine dependence to help inform appropriate treatment approaches. Does the person smoke immediately after waking up? How many cigarettes does the person smoke each day? How difficult does the person find it to be in nonsmoking environments (for example, airplanes)? Does the person smoke even if feeling ill?
- Persons with a high degree of dependence may experience severe withdrawal symptoms and require pharmacological therapies to assist with their quit attempt, including nicotine replacement therapy or medications to address the physiological dependence.
- Encourage gradual reduction as a possible first step toward quitting with complete cessation as an ultimate goal.
- Recommend pharmacological treatment. Various forms of pharmacological treatment (either alone or in combination with NRT) are known to be effective at reducing cravings and other withdrawal symptoms while persons work on enhancing the behavioural and cognitive skills they require to sustain their quit attempt.
- Provide Cognitive Behavioural Therapy (CBT) and/or motivational interviewing (MI) approaches to reinforce cessation or reduction and to understand and address possible triggers for relapse. The combination of CBT with pharmacological interventions has been found to be effective and is necessary to optimize treatment outcomes. CBT may need to be tailored to suit the needs of those with specific mental health and addiction disorder(s).
- Secure necessary social supports, including other members of the mental health team, family, and friends both inside and outside the treatment environment. Creating a supportive environment will help to reinforce the person's decision to quit smoking and remain tobacco free.

Considerations for maintaining cessation or reduction of tobacco use.

- Continue to reinforce the decision to quit or reduce tobacco use and acknowledge any successes made thus far.
- Address any barriers to sustained quitting or triggers for smoking.
- Provide relapse-prevention treatment with pharmacological interventions of up to 12 months as required.

Considerations of the environment.

- Consider the effect of any smoking restrictions within the in-patient or community setting (for example, group home environment). Are there policies or restrictions for tobacco use or access? How is the exposure to other persons' smoke managed? Is access to tobacco readily available?
- It is recognized that staff members may also smoke. For this reason, it is important to be sensitive to how this might affect those who want to quit or those who are actively involved in a smoking cessation program. For example, knowing that a staff member had a cigarette during a coffee break may have a bearing on the person's approach to smoking cessation. In countries with

legislation regarding thirdhand smoke, there may be a requirement for staff to change their clothing after smoking. In many jurisdictions, support procedures and smoking cessation interventions are available for health care providers through employee services.

- Consider what other supports exist within the environment. Is continuous education and support available to the person? Are smoking and withdrawal symptoms continuously monitored? Is a treatment summary included in the discharge plan?
- Consider the consequences of secondhand and thirdhand smoke. Find out whether the person lives with a nonsmoker or a child. Advise the person of the harm caused by second- and thirdhand smoke and encourage the person to smoke outside and away from those who do not smoke or who are trying to quit.
- Take into account potentially hazardous situations, such as a smoker who requires oxygen.

Other treatment considerations.

- Professionals with appropriate training and authority to prescribe pharmaceutical agents should provide these services. However, some pharmacological therapies, such as NRT, are available over the counter in retail stores.
- Tobacco use should be characterized and treated as an addiction, using a chronic disease approach. Regular tobacco use is often not merely a habit.
- People with mental health disorders who stop smoking while taking medications for their illness should be monitored to determine if modifications to their medication dosage are necessary.

Additional Resources

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Section 16

Substance Use CAP

Issue

The use of illicit drugs or the inappropriate use of alcohol or medications may have an important effect on well-being. This CAP applies to persons with a diagnosis of a substance use disorder as well as those with concurrent mental health disorders. Although it is evident in the general population, problematic substance use is especially common among persons with mental illness. Substance use disorders are characterized by the DSM-IV and ICD-10 in two general ways: (1) disorders related to the pattern and consequences of substance use itself (for example, dependence, harmful use); and (2) disorders produced by the pharmacologic effects of the substance(s) abused (for example, intoxication, withdrawal, substance-induced mental disorders).

The serious consequences associated with substance abuse are well known and include the loss of contact with family and friends, reduced safety, ill health, employment and financial difficulties, and even death. Substance use often exacerbates mental health symptoms and the distress associated with primary mental health disorders. Many persons who abuse substances may not know how to stop this behaviour or may not see it as a problem.

When combined with mental illness, substance use can interfere with the person's ability to participate in a rehabilitation or recovery program and can reduce the effectiveness of pharmacological and nonpharmacological treatments and interventions. It may also cause nonadherence to treatment and a consequent lack of motivation to change behaviour, thereby reducing the chance of recovery.

The misuse of prescribed and over-the-counter medications is also important to consider. Persons who take medication(s) for other than intended purposes (for example, cold or flu preparations to aid sleep, diuretics for weight loss) or who exceed the recommended dosage (for example, overuse of analgesics, laxatives) may be at an elevated risk of adverse health outcomes.

In addition to examining the actual use, it is important to consider the social and behavioural indicators of problematic use. These are addressed in the interRAI mental health instruments by a measure based on the CAGE addictions screen (see the appendix).

Goals of Care

- Determine the person's readiness to change substance use behaviours.
- Help the person develop a recovery path to decrease or eliminate problematic substance use.
- Prevent the adverse effects of substance use and withdrawal.
- Provide education to the person to understand, recognize, and cope with signs of relapse.
- Strengthen the person's social ties and remove social and economic barriers that may hamper success with his or her chosen intervention option.

Triggers

The Substance Use CAP includes two groups: (1) persons who have current problematic substance use, where the aim is to reduce or eliminate substance use; and (2) those who have a history of problematic substance use, where the aim is to maintain abstinence. This CAP applies to persons in in-patient and community-based mental health services.

TRIGGERED DUE TO CURRENT PROBLEMATIC SUBSTANCE USE

This group includes persons who have any of the following:

- Illicit drug use (for example, inhalants, hallucinogens, cocaine and crack, stimulants, opiates, cannabis) in the last 90 days
- Injection drug use in the last 30 days
- Consumption of five or more alcoholic beverages in a single sitting in the last 14 days
- Intentional misuse of medication(s) in the last 90 days

About 36% of persons in in-patient mental health settings and about 20% of persons in community-based mental health settings will trigger at this level. They are mainly males, persons under the age of 25 years, and those with a diagnosed substance-related disorder.

Unemployment is much higher in this group than among persons who are not triggered (32% versus 10%), as is the proportion of persons who do not have a strong or supportive relationship with their family (42% versus 29%). Further, about 25% of this triggered group make trade-offs among things such as purchasing food, shelter, and clothing because of limited finances, compared to 5% among those who do not trigger in this CAP.

TRIGGERED DUE TO PRIOR HISTORY OF PROBLEMATIC SUBSTANCE USE

This group includes persons with a history of substance use who have not used such substances in the last 90 days but who have the potential to relapse, particularly if the social environment includes factors conducive to relapse. Persons will trigger at this level based on any of the following:

- A history of illicit drug use but no use in the last 90 days
- A history of injection drug use but no use in the last 30 days
- Any one of four behavioural indicators of potential substance-related addiction, based on the CAGE addictions screen
- A social environment that facilitates or encourages drug or alcohol use (which is an additional trigger in the interRAI Community Mental Health Assessment instrument)

This group includes about 7% of persons in in-patient mental health settings. They are more commonly age 25 or older and have a substance-related, psychotic, or mood disorder. About 9% of persons in community-based mental health programs are also included. They are mainly persons under the age of 45 years and those with a substance-related or an anxiety disorder.

Persons in this group have a higher unemployment rate (20% versus 10%) than those who are not triggered. They are more likely to lack a strong and supportive relationship with family than those in the not-triggered group (37% versus 29%, respectively). The need to make trade-offs between purchasing food, shelter, and clothing because of limited finances is also higher in this group compared to those who are not triggered (15% versus 5%).

NOT TRIGGERED This group includes all other persons, including about 57% of persons in in-patient mental health and 71% of persons in community-based mental health settings. In the time between the initial and the follow-up assessments, fewer than 2% will use illicit drugs or consume five or more alcoholic beverages in a single sitting. About 16% of persons in this group who use community mental health services will be assessed as misusing medications at follow-up.

Guidelines

Approaches to address problematic substance use among persons receiving community-based or in-patient mental health services may include interventions that involve treatment to achieve abstinence (complete cessation of substance use) or harm reduction (safer methods of substance use). With each approach type, interventions for psychosocial rehabilitation and education are needed, as are a number of considerations to avoid psychological, social, and medical complications.

For this CAP, the principal approach to care is similar for both trigger groups: persons who recently used substances and persons who have not used them recently but did in the past. However, there may be specific considerations that are only applicable to a particular triggered group. Regardless of the treatment model used (abstinence versus harm reduction), there are numerous issues to consider.

Evaluation of the Substance Use Situation

Before implementing an intervention, a thorough analysis of the issues surrounding a person's substance use is necessary. This includes an analysis of the degree of substance use, the person's motivation for change, and the presence of issues related to substance use, such as physical, social, and emotional issues.

Assess the person for withdrawal symptoms. When substance use is accompanied by a physiological dependence on the substance, there may be withdrawal symptoms after a cessation or reduction of substance use, particularly for addiction to alcohol and opioids. Symptoms may include seizures, dysrhythmias, hallucinations, and delirium.

- Assess the frequency, nature, and severity of the person's withdrawal symptoms. Help and educate the caregivers to recognize the symptoms of withdrawal, including the following:
  - Psychomotor agitation
  - Autonomic hyperactivity (for example, sweating, tachycardia)
  - Hand tremors
  - Insomnia
  - Nausea or vomiting
  - Transient visual, auditory, or tactile hallucinations
  - Illusions
  - Anxiety
  - Seizures
- Interventions can include medication, investigations for structural or metabolic causes (for example, CT scan, EEG), correction of fluids and electrolytes.
- Substitution or maintenance treatment, and post-withdrawal interventions (for example, psychosocial interventions).

Assess the degree of dependency and patterns of substance use. For persons who trigger this CAP at either level, determine if the current or prior pattern of substance use is or was based on psychological or physiological dependency. A CAGE Scale score of 2 or higher is an initial indicator of dependency and should be followed by more in-depth assessment to determine the degree of dependency. In order to delineate the physiological, social, and psychological effects of dependency on the person, it is important to characterize the person's current or prior pattern of substance use. Consider the following:

- How and when did the person begin using substances?
- How often and what amount of substances did or does the person use?
- What types of substances were or are used? Different substances may influence behaviours differently.
- How many times has the person thought about and attempted to quit? What is the longest period of abstinence?
- Were any of the person's prior attempts to quit successful?
- If or when the person succeeded in quitting, what were some of the key factors that helped him or her to quit or stay abstinent?
- There may be biological factors that can affect a person's tolerance of substances such as alcohol (for example, age-related changes in liver function).
- If there is no evidence of dependency, determine how much of the substance(s) the person consumes in order to assess the risk of becoming dependent. The detection of illicit drug use is sometimes difficult due to denial by the person. In many cases, family, friends, or primary helpers may be the best source of information about the person's substance use.
- As with any family involvement, the person should give his or her consent for the clinical team to discuss such issues with family members.
- Problematic substance use may not be detected at the initial assessment but may be reported in the follow-up assessment, including at discharge. When planning for the person's discharge, address recommendations for follow-up treatment and support and include consideration of the environment to which the person will be discharged. Environmental and social factors (for example, being surrounded by other substance users) can lead to further problems with substance use or relapse.
- Determine the degree to which substance use is affecting the person's life in terms of physical health, psychosocial well-being, familial and social relationships, financial status, employment, and legal status.

Evaluate the person's motivation for change. For persons who trigger at either level of this CAP, use the stages of change approach described by Prochaska and DiClemente as a guide to determine the person's motivation to continue, or relapse into, using substances. There are specific interventions to consider at each stage.

- **Precontemplation stage:** The person has an increased interest in information about the problem and its impact on him- or herself and others. At this stage, it is helpful if the person has a constructive relationship with someone who cares about and supports him or her. Interventions to consider centre on *engagement*.
  - Focus on increasing communication about substance use. This effort can be enhanced through empathy and honest communication about the person's substance use.

- **Contemplation stage:** In addition to precontemplation, the person is experiencing and expressing feelings about his or her problems and possible solutions, as well as feelings and thoughts related to her or his behaviour.
- **Preparation stage:** The person is aware of the problem behaviour and its emotional repercussions, chooses to and commits to act, or believes in his or her ability to change with the assistance of social alternatives for the problematic behaviours (for example, societal change, self-help groups, possible participation in family activities). For both the contemplation and preparation stages, interventions should focus on *persuasion.*
  - Use motivational interviewing and functional assessment to focus on the person's perception and degree of motivation.
  - The interviewing and counselling approach should emphasize what the person has achieved so far and acknowledge his or her personal strengths and progress toward recovery.
- **Action and Maintenance Stage:** The person uses alternatives to problematic behaviours and avoids the stimuli that elicit the problem behaviours. In this stage, the person is being rewarded by others for making changes and expanding the nonproblematic social alternatives. Interventions using **active treatment** are needed.
  - Create a behavioural action plan and develop alternative responses to cravings. Have the person use setbacks (that is, substance use) in a positive, productive way to learn from them and prevent future setbacks. The aim is to identify reasons for the use of the substance and to develop alternative coping strategies together with the person.
- **Relapse prevention:** Triggers and chances of relapse need to be considered and prevented when the person is already at the Action and Maintenance Stage. It is important to determine if the person has created new coping skills to face the social environment.
  - Implement strategies for *relapse prevention* by setting goals that reinforce a healthy lifestyle.

Evaluate the social, economic, psychological, and medical issues related to substance use.

- **Support system:** Substance use may affect the person's relationships with family or friends. However, a supportive network of family and friends may help the person move toward recovery or avoid the triggers for relapse.
  - Determine if the person's substance use has strained informal (for example, family or friends) and formal support services.
  - Evaluate whether the person has problems with family conflict, social ties, abuse, or violence and provide interventions accordingly (see Interpersonal Conflict and Harm to Others CAPs).
  - Determine if the person has family members or close confidants who are willing to provide ongoing support throughout the recovery and relapse prevention periods.
- **Economic hardship:** Substance use may affect the person's financial situation in a variety of ways.
  - The cost of purchasing the substance may force the person to make trade-offs with necessities like food, shelter, or clothing (see Personal Finances CAP).

- If the substance use affects the person's work performance, there is an increased risk of job loss and ongoing unemployment (see Education and Employment CAP).
- In some cases, economic hardship may lead the person to engage in criminal activity as a means of obtaining money to purchase substances (see Criminal Activity CAP).

- **Medical complications:** Prolonged substance use can cause multiple neurological deficits, such as memory impairment, aphasia, apraxia, agnosia, and disturbances in executive functioning as well as peripheral neuropathies that persist beyond the usual duration of intoxication or withdrawal.
  - Persons using illicit drugs or consuming large amounts of alcohol are more likely to experience higher rates of injury related to falls (see Falls CAP) and motor vehicle accidents.
  - Hallucinogens are associated with flashbacks, characterized by the recurrence of perceptual symptoms that were experienced during past intoxication. These perceptual symptoms include geometric images, flashes of colour, intensified colour, halos around objects, macropia, and micropia.
  - Current or prior substance use should be considered when older adults present with cognitive deficits, fatigue, and depression, as these may be misattributed to dementia.
- **Transmission of infection (for example, hepatitis, HIV):** Persons who take drugs intravenously with shared needles are at higher risk of developing not only skin infections but also more serious conditions, such as HIV, hepatitis, and bacterial endocarditis.
- **Risk of adverse interactions of medications:** Concurrent use of alcohol or drugs with prescribed medications may be dangerous. Review the medications that the person is taking to identify potential interactions. Inform the person of the dangers of interactions and monitor for evidence of adverse drug effects.
- **Concurrent disorders or conditions:** Determine if a mental health disorder is also present (that is, a concurrent or co-occurring disorder). Examples include psychotic disorders, cognitive impairment resulting from prolonged substance use, anxiety disorders such as post-traumatic stress, and somatic problems. Each disorder has different implications for the person's support needs and trajectory toward recovery.
  - For persons with concurrent disorders, include a treatment plan to address both the issue of substance use and the co-morbid mental and physical health problems.
  - Evaluate the possibility that the person is using substances as a form of self-medication to cope with mental health symptoms.
- **Psychosocial context:** Evaluate the person's tendency to use substances compulsively, irrespective of the negative consequences he or she experiences.
  - Is there a family history of substance use?
  - Does the person's current social environment perpetuate substance use?
  - By acknowledging the pattern of use, the person may be more accepting of treatment.
  - Identify personal and social strengths the person can draw on (for example, supportive family, insight about the substance use).

- **Misuse and overuse of medications:** The assessment should include a detailed review of the type (both prescribed and over-the-counter medications), amount, and frequency of medication use. Attention should be given to
  - Persons who present with physical symptoms, such as pain (see Pain CAP), to assess the risk of analgesic overuse, or gastrointestinal symptoms, to assess the risk of overuse of antacids or laxatives
  - Persons who report difficulty sleeping (see Sleep Disturbance CAP), to assess the risk of overuse of prescribed or over-the-counter medications such as sleep aids and cold or flu preparations
  - Persons with cognitive impairment who may be unable to take medications safely
  - Persons with perceived weight problems, to assess the risk of misuse or overuse of diuretics, laxatives, or weight-loss medications (see Weight Management CAP)

Recommendations for Interventions

In addition to the interventions to help the person move through the stages of change, several strategies can be implemented to help the person recover from problematic substance use and to avoid relapse.

Referral to an addiction specialist or a substance abuse program. Referral to an addiction specialist or a substance abuse program may be necessary. The person should be informed of the available options, such as detoxification programs, inpatient addiction programs, group therapy, family therapy, cognitive behavioural therapies, concurrent disorder programs, and self-help groups. If the person has a concurrent mental health condition, refer the person to a concurrent disorders program, if available.

Harm reduction. Although the ultimate goal for treatment of problematic substance use may be abstinence, some persons may not be ready or motivated for such change. For these persons, a focus on harm reduction should be pursued. The availability and legal status of harm reduction programs vary internationally and should thus be considered when providing advice. Harm reduction approaches include providing assistance to

- Manage safety, personal, and housing needs.
- Obtain education about and referral to programs, such as safe injection sites, safe consumption rooms, needle exchange programs.
- Participate in "safe drive" practices, such as designated driver programs, using public transportation or taxis, and installing an alcohol breath screening ignition-locking device in the person's vehicle.
- Provide education and strategies for moderation of substance use.

Involvement of others. With the consent of the person, involve family members and others in the person's support network throughout the treatment process. It is also important to address any psychological or physical trauma experienced by family members as a result of the person's behaviour. Family members should be educated about their role in facilitating recovery and in the identification of relapse triggers.

Referral to a 12-step program. These programs provide structure and peer support for persons in recovery from problematic substance use (for example, Alcoholics Anonymous).

Consideration of a therapeutic community. A program where the person resides in a community with others at various stages of recovery, typically for at least 18 months. Assistance with decision making is available early in the treatment, which emphasizes independent living free of substances.

Pharmacological interventions. A variety of pharmacological interventions may be considered, particularly for harm reduction approaches. Long-acting doses may be helpful in preventing withdrawal symptoms.

Education about medication use. The person should be informed about the importance of taking medications as prescribed and should receive appropriate interventions (for example, pain-management program, referral to a sleep clinic). With the person's agreement, the family and others in the person's support network should help monitor medication use. This would include notifying the person's physician(s) of any identified medication misuse or overuse. The physician could then simplify the regimen to reduce the number of times each medication is taken.

Additional Resources

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Section 17

Weight Management CAP

Issue

Weight management can be a complex and multifactorial problem among persons with mental illness, both in community and in-patient mental health settings. Schizophrenia and mood disorders, including bipolar and major depressive disorders, are associated with chronic overweight and obesity, while depression is also linked to malnutrition.

Among persons with a mental health problem, the risk of physical disorders such as weight gain, obesity, metabolic abnormalities (for example, diabetes), and cardiovascular disease, is of great concern. Clinically significant weight gain associated with psychotropic therapies is a known risk factor for metabolic syndrome, Type II diabetes, and cardiovascular disease. Sedentary lifestyles and poor nutrition also contribute to adverse weight management outcomes, which are further exacerbated by smoking and substance abuse, and maintained by poverty and the stigma of mental illness. This vulnerable population has disproportionately higher morbidity and mortality rates relative to the general population. Attention to these physical health deficits is important because cardiovascular mortality is high, and it is twice as likely in persons with schizophrenia in comparison to the general population. Obesity can have profound effects on self-esteem, well-being, and quality of life. Identifying physical health risks is an important step in improving the outlook for persons suffering from a mental illness.

Some persons with mental illness are at an increased risk of malnutrition. Malnutrition encompasses both under- and overnutrition. Nutritional status has an important effect on health and recovery from physical and mental illness. Poor nutrition can lead to increased risk of morbidity and mortality, impaired mental and physical function, apathy, depression, self-neglect, increased risk of complications, reduced immune response, longer hospital stays, and reduced quality of life.

The Weight Management CAP identifies factors associated with unhealthy weights and offers interventions to reduce or attenuate altered body composition. Both pharmacological and nonpharmacological strategies are considered, as are personal features that interact with social variables.

Goals of Care

- Identify underlying causes of problems related to weight management.
- Address acute mental health and medical conditions that complicate weight management therapy.
- Review impact and appropriateness of medications related to weight management.
- Provide education and counselling around healthy eating and lifestyle behaviours.
- Achieve and maintain a healthy weight.

Triggers

This CAP identifies two different triggered levels based on the underlying causes of difficulties related to weight management: (1) persons who demonstrate problems related to body composition, and (2) persons with problematic eating behaviours. The Weight Management CAP applies to persons in both in-patient and community mental health settings.

TRIGGERED FOR BODY COMPOSITION

This group includes persons who exhibit any of the following:

- Body Mass Index (BMI) of 30 or higher
- BMI below 18.5
- A low BMI and experiencing rapid weight loss

This CAP level is triggered for 35% of those in in-patient settings.

TRIGGERED FOR PROBLEMATIC EATING BEHAVIOURS

This group includes those who do not meet the criteria for the above trigger level but who engage in any of the following problematic eating behaviours:

- Fasting (not for religious reasons)
- Binge eating
- Unrealistic fear of weight gain

This CAP level is triggered for 7% of those in in-patient settings.

NOT TRIGGERED

The not-triggered group for this CAP includes anyone who does not fall into either of the preceding groups. About 58% of those in in-patient mental health settings do not trigger this CAP.

Guidelines

Initial Considerations

In discussing a treatment plan with the person, it is important to first address acute mental health symptoms and immediate health concerns to ensure the person's safety. The intervention should then focus on identifying potential reasons for body composition issues or problematic eating behaviours to determine a person-centred intervention strategy. For both trigger levels, the assessment and education for the person's readiness for change in lifestyle and diet are important for the implementation of a weight management strategy. Even though weight change may be a primary reason for persons triggering this CAP, the interventions should emphasize the person's health and well-being rather than physical changes in weight.

Triggered Due to Body Composition

Determine whether the person's body composition represents an immediate risk to the health and well-being of the person.

- Review the person's medical status. A thorough medical assessment is needed for persons of high or low body composition or persons who have experienced rapid weight loss. These tests will assist with targeting interventions, such as dietary restrictions or supplements, to improve physical health. If the person has not had a medical review for the current assessment, a number of standard laboratory tests can be completed including

- Complete blood count
- Complete metabolic profile (sodium, chloride, potassium, glucose, blood urea nitrogen, creatinine, protein, albumin, globulin, calcium, carbon dioxide, alkaline phosphates, total bilirubin)
- Serum magnesium
- Thyroid screen
- Blood glucose
- Cholesterol
- Cortisol
- Urinalysis
- Skin tests for immune functioning

- Determine if the person has chronic physical health conditions (for example, diabetes) that are related to his or her body composition and refer the person to specialist care, if available.

Considerations for Overnutrition

Review the person's eating patterns. Problematic eating behaviours may be related to mental health symptoms such as depression or to prior attempts to restrict diet. Referral to a nutritionist or dietitian may be needed to develop a sustainable healthy meal plan.

- Review the types of foods the person prefers to determine if the person is engaging in binge eating in response to mental health symptoms. For example, large intake of simple carbohydrates, such as cookies or breads, may produce an increase in serotonin, which may briefly elevate a person's mood and reinforce the eating behaviour.
- Determine if the person has attempted different forms of diets, particularly those that involve restricting types of foods or calories. Restricting diet is often a short-term solution only and may result in overeating to compensate for excessive hunger.

Review the person's medications. Side effects of many psychotropic and nonpsychotropic medications affect appetite and weight. An assessment of all medications should be conducted to determine which medications may contribute to weight gain. After reviewing the person's medications, determine what impact, if any, the medications are having on weight gain and modify the regimen if possible. Modifications may include discontinuing the medication and substituting with one less likely to affect appetite, reducing dosages, or adding drugs to combat appetite.

- Determine if the person is taking medications that are associated with increased appetite, greater susceptibility to hunger, or diminished satiety.
- Identify new medications and dosage changes. Review the duration of treatment and note the time of the onset of symptoms.
- Ask whether the person has discontinued medications due to undesired side effects.
- Review all medications to identify those that might be associated with altered body composition. Many psychotropic medications routinely and predictably produce weight gain. Some rarely do, but most will affect appetite or weight in some persons.

- Antipsychotic medications are broadly divided into two categories: (1) first-generation, "typical," or "traditional" antipsychotics; and (2) second-generation, "atypical," or "novel" antipsychotics.
  - First-generation antipsychotic medications have modest effects on weight. The more potent antipsychotics, such as haloperidol, have been reported to have the least liability for weight gain.
  - Serious problems with weight gain, metabolic syndrome, and diabetes have been reported among persons treated with certain of the second-generation antipsychotics (for example, clozapine and olanzapine).
- Anticonvulsant mood stabilizers have also been reported to cause weight gain; however, when combined with atypical antipsychotics, it is not clear that the combination is more deleterious than the antipsychotic alone.
- Antidepressants comprise multiple classes of medication that may have diverse effects on body composition. The serotonin-specific reuptake inhibitors (SSRIs) have been used successfully for weight reduction, but later rebound weight gain makes them unreliable in this regard. Tricyclic antidepressants sometimes contribute to weight problems.
- Anxiolytics are not strongly associated with metabolic problems.

- If weight gain or metabolic complications occur on a first line of psychotropic medication therapy, switching to an agent with a favourable metabolic profile can improve body weight. The switching protocol should consider the entire mental health and physical condition of the person and the pharmacological profiles of both agents.
  - Develop a long-term tailored therapy, with consideration given to selecting low weight gain liability medication(s).
  - Provide education and strategies for dealing with the risks and benefits of specific drug therapies (see Exercise CAP).
  - Consider switching to a less problematic medication under conditions of exacerbation of co-morbid illness, persistence of positive symptoms, or residual negative symptoms. Take into account the person's safety, psychiatric stability, and social and environmental support.
  - In some cases, pharmacological intervention may be considered for persons who do not respond to lifestyle interventions alone.

Determine patterns of physical activity. Vigorous activity may not be feasible or available for all persons triggering this CAP due to overnutrition.

- Assess perceived barriers to physical activity, either verbalized or demonstrated by the person.
- Discuss with the person a strategy for gradually increasing his or her physical activity based on compensation for these barriers (see Exercise CAP).

Behavioural/lifestyle interventions. Provide education and counselling around lifestyle changes that will help the person control and manage his or her weight. Behavioural interventions deal with exercise and diet with a focus on three goals: improved nutrition, increasing physical activity, and learning cognitive-behavioural strategies to reinforce positive changes in dietary habits and physical activity.

- Work with the person to determine a preferred weight management strategy based on nutrition and exercise.
- Refer the person to nutritional therapy with a focus on basic nutritional principles, developing healthy eating menus and recipes, weight management techniques, cooking skills, and grocery shopping.

- Implement Cognitive Behavioural Therapy to sustain healthy meal choices, patterns of eating, and physical activity.

Considerations for Undernutrition

Review potential reasons for the person's undernutrition.

- **Functional deficits:** Determine if there are current functional deficits that make it difficult for the person to prepare meals.
  - How functional is the person in regard to daily living skills, especially shopping and cooking? (See Self-Care CAP.)
- **Constrained financial resources:** Weight management issues may be a direct result of the person's inability to afford or to access healthy foods.
  - Poverty may limit access to health care, essential support services, and healthy living environments, which increases the risk of poor health (see Personal Finances CAP).
- **Medication side effects:** Commonly used medications can cause a wide range of serious gastrointestinal side effects that affect appetite, absorption, and transit of nutrients. For example, the nonsteroidal anti-inflammatory drugs cause problems such as gastric and duodenal ulcers, diarrhea, precipitation or relapse of inflammatory bowel disease, and pancreatitis.
  - Determine if the person is experiencing medication side effects that are resulting in undernutrition.
  - Do medication side effects influence the person's appetite?
  - Do medication side effects induce nausea or vomiting?
  - Is the person taking medication that can increase metabolism and appetite? If so, provide education to the person about healthy food options.
- **Mental health and substance use:** Determine if there are current mental health symptoms that are affecting the person's food consumption or eating behaviours, resulting in undernutrition.
  - Does the person present with mental health symptoms that affect his or her appetite and influence undernutrition?
  - Does the person exhibit psychotic symptoms that cause him or her to avoid food because of feelings of paranoia or vivid hallucinations?
  - Does the person's affective disorder promote apathy, self-neglect, or nutrient loss? Persons with depression commonly present with anorexia and weight loss as a direct result of depression (apathy or self-neglect) or because of a medication side effect. Good nutrition should therefore be regarded as a priority.
  - Has the person triggered the Traumatic Life Events CAP?
  - Does the person use substances that affect appetite, uptake of nutrition, or desire to eat? (See Substance Use CAP.)
  - Does the person demonstrate chronically reduced pleasure response to sucrose or fat-based foods?
  - Does the person demonstrate a fear of swallowing?

Interventions.

- Psycho-education may be needed if the person engages in unhealthy eating behaviours (see next section).
- Oral nutritional supplementation should be taken to promote weight gain.
- Protein/calorie supplements should be taken between meals to preserve appetite and maintain food intake.

Eating Behaviours That May Result in Problems Related to Body Composition

Determine the reason for the person's eating behaviours. The first stage of developing an intervention strategy with the person for problematic eating behaviours is to determine if the behaviours are related to a mental health condition, to a specific expression of an eating disorder, or to both.

- For example, conditions such as depression or trauma may be associated with fasting as a form of self-harm or hopelessness. Also consider other mental health conditions listed in the Mental Health and Substance Use section.
- Persons may engage in problematic eating behaviours intentionally due to issues directly related to the person's weight perceptions and distorted views of self. These persons may be expressing early behaviours of an eating disorder. Proper assessment and intervention at this stage may prevent the escalation of these behaviours into a chronic condition.

Review the person's eating patterns. Determine if the person's current dietary patterns include a restrictive pattern of eating and overeating.

- How long does the person go without eating? Drinking?
- Does the person skip meals? If so, how often does this occur?
- Is there evidence that the person is restricting intake of specific foods?
- Is the person demonstrating binge-eating behaviours?
- Has the person been grazing or night eating?
- Has the person been drinking excessively in an attempt to produce a feeling of fullness?

Attitudes toward eating behaviours. Establish the person's attitudes and behaviours associated with problematic eating behaviours.

- Have there been any recent changes in weight and the person's weight history?
- Determine the person's desired weight. How would he or she feel if he or she weighed more or less than that ideal weight?
- Does the person see him- or herself the same way friends and family do?
- Does the person have rules about how many calories he or she consumes in a day, or about certain foods he or she refuses to eat?
- Does the person experience periods in which he or she consumes an unusual amount of food and is unable to control the amount of food consumed?
- Does the person use medications or stimulants (for example, caffeine, laxatives) to control his or her appetite?

Determine the person's readiness for change in his or her eating behaviour. In some jurisdictions, medical interventions may be implemented if the person is in need of urgent medical care; however, if the person requires nonurgent inter-

ventions, that person must consent to the intervention. Use the stages of change approach described by Prochaska and DiClemente as a guide to determine the person's motivation to change his or her eating behaviours (see reference list in the Substance Use CAP). This model has been conventionally applied to substance use disorders; however, it may also be helpful for problematic eating behaviours.

- Persons at the precontemplation stage may not be ready to change eating behaviours. At this stage, use understanding and empathy in educating the person about the health risks associated with problematic eating behaviours.
- It is important for the person to have insight into his or her eating behaviours and have a willingness to engage in activities to change the behaviours. Typically, persons at the contemplation stage or higher are ready to engage in active treatment to change eating behaviours.

Provide psycho-education about the health risks of the eating behaviours. The education process should help the person realize the health risks related to the behaviours and develop personal goals to improve the eating behaviours. The education may be offered in combination with Cognitive Behavioural Therapy to address the following:

- Long-term health consequences of problematic eating behaviours
- Proper nutrition
- Fear of weight gain with a healthy nutritional meal plan
- Distorted body image and self-esteem

Promote peer support. Ensure that the person is surrounded by people who are supportive of his or her recovery.

- Encourage the person to connect with friends or family members who will help reinforce healthy eating behaviours.
- Connect the person with peer groups that are supportive of behaviour and lifestyle changes.
- Determine whether the person is using Internet-based peer groups that promote problematic eating behaviours (for example, pro ana Web sites). If so, provide education about the risks these Web sites will pose for his or her recovery.
- Offer supervised meals. For a person who is restricting his or her diet, consider implementing a peer support program or clinical intervention in which another individual oversees the person's consumption of meals.

Additional Resources

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Section 18

Exercise CAP

Issue

Physical exercise is important for achieving optimal health and functioning. The Exercise CAP identifies persons who are physically inactive and aims to assist them in modifying factors that prevent achieving an appropriate level of exercise.

According to the Public Health Agency of Canada, two-thirds of Canadians ages 25–55 are not meeting the recommended level of physical activity set by Canada's Physical Activity Guide to Healthy Active Living. When persons report having an inadequate level of physical activity, productivity in all areas of that person's life may be reduced, including meeting family needs and workplace demands. Poor physical health and inactivity can be related to physical ailments, disabilities, and mental health problems. Depression, anxiety, and other emotional problems are major causes of inactivity. Health care providers play an important role in helping the person identify the key risk factors for inactivity and in promoting physical fitness.

Goals of Care

- Identify and understand the reasons for low levels of physical activity.
- Increase knowledge and confidence for engaging in exercise.
- Establish an appropriate, person-centred, and goal-driven fitness program.
- Increase hours of physical activity to the recommended level for the person.
- Improve energy level, confidence, self-awareness, and overall sense of well-being.

Triggers

The Exercise CAP has two trigger levels based on persons who have not engaged in an appropriate level of physical activity: (1) those who are capable of being physically active, and (2) those who are less capable due to a medical condition. This CAP applies to persons in both in-patient and community-based mental health programs.

TRIGGERED TO INCREASE PHYSICAL ACTIVITY AMONG PERSONS WHO ARE CAPABLE OF BEING PHYSICALLY ACTIVE

This group includes persons who have

- no or less than one hour of physical activity in the last 3 days; AND
- no to moderate levels of cognitive impairment (based on a Cognitive Performance Scale [CPS] score of 0 to 4) or ADL impairment (based on an ADL Hierarchy Scale score of 0 to 4).

This triggered group includes 19% of persons in in-patient and 35% of those in community mental health programs. Among persons in in-patient mental health programs who trigger at this level, 55% had engaged in physical activity by discharge. In community mental health programs, 76% who triggered at this level had engaged in physical activity by follow-up.

TRIGGERED TO INCREASE PHYSICAL ACTIVITY BUT REQUIRES ADDITIONAL CONSIDERATION DUE TO A HEALTH CONDITION

This group includes persons who are experiencing

- the above-mentioned conditions; AND
- any of the following medical conditions:
  - Dizziness, vomiting, fatigue, ataxia or balance problems, emergent health conditions, edema, extrapyramidal side effects, pain, and moderate or severe substance use withdrawal.

This triggered group includes 10% of persons in in-patient and 29% of those in community mental health programs. Among persons in in-patient mental health programs who trigger at this level, 51% had engaged in physical activity by discharge. In community mental health programs, 60% who triggered at this level had engaged in physical activity by follow-up.

NOT TRIGGERED

Persons in this group

- were involved in an hour or more of physical activity in the last 3 days.
- experience severe cognitive impairment (based on a Cognitive Performance Scale [CPS] score of 5 or 6) and/or severe ADL impairment (based on an ADL Hierarchy Scale score of 5 or 6). For these persons, involvement in a structured exercise program may not be possible. However, other opportunities to incorporate physical activity as part of the person's daily routine should be explored.

This group includes about 71% of those in in-patient mental health and 36% of persons in community mental health settings.

Guidelines

The Exercise CAP facilitates participation in exercise, for the benefit of physical and mental health well-being. Specific benefits include better health, weight management, improved sleep, and increased energy. Prior to initiating any new exercise regimen, an appropriate clinical evaluation should be completed.

Personal Choice

For persons who trigger this CAP at both levels, it is essential to involve the person in choosing the goals and strategies for exercise and physical activity.

- Engage the person in a discussion about his or her personal preferences for activity, such as dancing, walking as a part of daily life or as a planned activity (for example, alone, with others, when doing certain activities, over a fixed course), bicycling, or exercise classes.
- Assist the person in identifying his or her level of interest and readiness to begin exercising, including discussing past activity levels (for example, was the person always inactive or is inactivity of recent onset). Persons who previously enjoyed exercise are more likely to return to exercise and adopt a future lifestyle in which exercise is a part of a weekly routine.

- If the person has little or no interest in exercise, consider how exercise might help the person reach other goals. Tailor the message to issues the person has raised in other areas and how exercise may help. For example, physical activity may increase energy, improve social functioning, and reduce sleep problems.
- Education about the general health benefits of physical activity should be provided, noting that exercise does not need to be strenuous to have mental and physical health benefits.
- Allow for a broad range of activity opportunities in a physical activity program. For instance, use a menu-sampling approach that allows personal choice and may help the person determine preferences and develop new activity interests.
- Engage the person in discussions about any barriers that might prevent him or her from increasing exercise levels or from maintaining these levels. Proposed activities must have a realistic chance of being implemented. For each barrier, consider solutions.
- A low pressure approach is most likely to be effective in increasing the person's receptiveness and readiness to change.
- Enthusiastic, knowledgeable, and supportive leaders are very important to any exercise program.

Approaches to Improve Physical Activity

Identifying causes and consequences of physical inactivity.

Social isolation: Regular physical activity can improve physical health, but it may also have mental health benefits. Exercise can alleviate secondary symptoms of schizophrenia, such as depression, low self-esteem, and social withdrawal. Group physical activities can help reduce stigma and social isolation and can offer opportunities for social interaction.

- Help the person identify others who share an interest in a sport or physical activity the person prefers. An exercise partner can provide an opportunity for socialization and it can be a motivating factor to attract the person to exercise.
- In some situations, it may be beneficial for staff to participate in exercise programs with the person to model the behaviour as well as to provide encouragement. As the person becomes more engaged in the exercise program, staff can then decrease their involvement.
- Provide education on how physical activity is an important way to build social relationships and community engagement.

Nutrition: Persons with poor nutrition and who are undernourished are limited in their capacity to engage in physical activity (see Weight Management CAP).

- Monitor the person's diet to determine if he or she is eating a balanced diet and drinking appropriate amounts of fluids. It is important to manage hydration during exercise, as excessive sweating can cause dehydration and adverse health outcomes, regardless of weather conditions.
- Determine whether the person is obtaining adequate nutrition. If the person is making economic trade-offs between food, shelter, and clothing, see Personal Finances CAP.

Mental health as a cause of physical inactivity: Persons with serious mental illness often report poor levels of physical fitness. Depression can limit exercise because of fatigue, lethargy, pain, memory loss, appetite loss, lack of motivation,

and increased social withdrawal. Negative symptoms of schizophrenia may serve as a barrier to participation in activity programs, sports, or recreational activities.

- Integrate physical activity programs as a core part of mental health services.
- Aerobic and resistance exercise should always be considered as it provides anxiolytic and antidepressant effects that may be used to treat moderate and more severe depression, usually as an adjunct to standard treatment.

Aging and physical co-morbidities: Physical activity can influence the rate and extent of physiological and cognitive changes in the aging process.

- Loss of muscle strength appears "typical" in older adults; however, regular strength training three times per week can minimize, and in some instances reverse, this loss.
- Men and women ages 65 years and older can show loss of bone density. Fracture risk can be reduced through vitamin supplementation and weight-bearing exercises.
- Persons with osteoarthritis may benefit from an exercise regimen where at least 50% of the exercise time involves a nonweight-bearing or low-impact environment, such as aquatic exercise or bicycling.
- For persons with cardiovascular problems, an exercise regimen is an important part of a comprehensive plan to restoring the person's physical health.

Substance use and co-morbid disorders: Substance use may further reduce the level of physical activity among persons with mental health problems. Provide education about the physical and mental benefits of exercise and fitness, such as improved mood, increased self-confidence, and reduced symptoms of both anxiety and depression.

- Incorporate physical activity (for example, walking programs) into alcohol and other substance abuse programs.
- Monitor persons who may be going through withdrawal because they may be at increased risk for falls and injuries (see Falls and Substance Use CAPs).
- Persons who misuse prescription medications (for example, benzodiazepines) may experience more falls as a result of the adverse side effects of the medication. These persons should therefore be advised to perform physical activity with caution. Falls occur at about twice the rate in persons who trigger the CAP in in-patient settings compared with those who do not trigger the CAP (see Falls CAP).
- Encourage participation in sports and group activities (to increase teamwork, communication, and interpersonal skill development) as opposed to largely solitary activities, such as weight training.

Sleep deprivation: Sleep deprivation has been associated with poor physical fitness levels. Lack of sleep can cause decreases in the restorative body functions and immune maintenance functions, resulting in decreased motivation to take part in activities or physical exercise.

- A 30-minute nap and light evening exercise should be promoted to ensure good quality sleep and motivation for exercise the following day, forming a positive cycle; however, vigorous exercise at night may interfere with sleep.
- Determine if the person is experiencing a sleep disturbance. If so, see Sleep Disturbance CAP.

Medication side effects: Exercise increases heart rate and stimulants may contain compounds that can further elevate heart rate. Generalized sedation, postural hypotension, dehydration, and impaired psychomotor abilities are common drug reactions that are experienced with medication use. Some specific types of medications, such as benzodiazepines, result in side effects that diminish a person's balance. In addition, some medications for cardiovascular problems cause hypertension. Metabolic syndrome is a common side effect experienced in persons taking atypical antipsychotic drugs (especially olanzapine and clozapine). Metabolic syndrome refers to a group of symptoms that include weight gain, high blood pressure, high triglycerides, low high-density lipoprotein, and insulin resistance, all of which increase one's chance for developing heart disease, diabetes, and stroke. Polypharmacy may further compromise motor function and lead to increased fall risk.

- Review current prescribed medications, over-the-counter medications, and recreational drugs (including alcohol) that the person may be using.
- If present, consider the impact of extrapyramidal side effects (for example, impairment in balance and coordination, muscle rigidity, trembling). Extrapyramidal side effects occur at substantially higher rates among persons triggering this CAP in both in-patient and community mental health settings. For example, one-third of persons in community-based programs who trigger the CAP have extrapyramidal symptoms compared with one-quarter of those who do not trigger the CAP. The differences in rates are even greater for persons in in-patient settings.
- The following are common drugs affecting mobility and their adverse reactions:
  - Tricyclic antidepressants: may cause postural hypotension, tremor, cardiac arrhythmias, or sedation
  - Benzodiazepines and sedative hypnotics: may cause sedation, weakness, decreased coordination, or confusion
  - Narcotic analgesics: may cause sedation, decreased coordination, or confusion
  - Antipsychotics: may cause postural hypotension, sedation, or extrapyramidal effects
  - Antihypertensives: may cause postural hypotension
  - Beta-adrenergic blockers: may decrease ability to respond to workload

Treatment Options

Interventions should be individually tailored to address the person's preferences, medical conditions, and mental health history.

General interventions for physical fitness program.

- Alert the person to the risks of inappropriate weight gain and the benefits of weight loss that can be achieved by increasing levels of physical activity.
- Take baseline measures of weight, height, BMI, waist circumference, and blood pressure to monitor the person's progress.
- Assess the current levels of physical activity and readiness to make long-term lifestyle changes.
- Reinforce the need for taking medication as prescribed and provide the person with information about the following:

- Medication, food, or beverage use with significant stimulating effects should be carefully monitored before engaging in exercise.
- Medications that may cause drowsiness (for example, antihistamines) and result in worsened reaction times, poor balance, and decreased coordination should be avoided during certain exercises.

- Recognize personal preferences in the treatment plan.
- Incorporate recommended general physical activity guidelines, which suggest
  - 60 minutes of light physical activity every day; or
  - 30 to 60 minutes of moderate activity, 4 times a week; or
  - 20 to 30 minutes of vigorous activity, 4 times a week.
- Begin with light activities and build up to moderate and vigorous ones.
  - **Light:** for example, walking, gardening, yoga, tai chi, softball
  - **Moderate:** for example, brisk walking, hiking, water aerobics, cycling, swimming, skating
  - **Vigorous:** for example, fast dancing, aerobics, jogging, tennis, cross-country skiing, hockey
- Activities should build on endurance, flexibility, and strength.
  - **Endurance activities** help the heart, lungs, and circulatory system stay healthy (for example, walking, jogging, swimming, recreational sports) and should be carried out 4 to 7 days a week in the exercise plan.
  - **Flexibility activities** help increase joint mobility and keep muscles relaxed (for example, reaching, bending, stretching, yoga, tai chi) and should be carried out 4 to 7 days a week in the exercise plan.
  - **Strength activities** help muscles and bones stay strong (for example, lifting weights, push-ups, sit-ups) and should be carried out 2 to 4 days a week in the exercise plan.
- Emerging technologies provide physical fitness activities using home-based interactive computer games. These may offer the person privacy and potentially greater enjoyment than conventional fitness programs, which in turn may increase motivation and sustained exercise regimens.
- Providing feedback is a critical component of self-monitoring and self-regulation because as a person achieves small increases in activity, his or her self-efficacy will build.

Walking. Walking, either in the form of organized group walks or home-based walking, is one of the easiest, safest, and most inexpensive types of exercise. It is also one of the most popular forms of exercise among those with and without chronic illness. Walking can be a group activity, serving as a forum for the practice of newly found social skills and the development of friendships with other persons in recovery. Moreover, walking programs can be continued following discharge from treatment as part of an ongoing recovery program.

Behaviour modification. Behaviour modification programs are effective because they have better long-term adherence rates and encourage physical activity during leisure time or unsupervised home-based activities. A behaviour modification program aims to enhance motivation by setting goals and self-monitoring achievements in increased activity levels.

Approaches for Persons with Health Conditions That May Affect Exercise

Initial considerations. Evaluate the person's physical health to identify the presence of any physical conditions that may affect exercise tolerance.

- Involve the person in discussions with the team about health issues such as cardiovascular and pulmonary conditions or musculoskeletal problems that may affect his or her ability to exercise.
- If the person has any of the following conditions, physical activity should be initiated slowly and progress gradually:
  - Physical signs and symptoms that require medical attention, including chest pain or pressure, shortness of breath, heartbeat irregularities, unplanned weight loss, arthritis, recent hip surgery, dizziness, and difficulty with balance
  - Skin conditions (for example, open sores) or a communicable disease
  - A history of seizures
  - Back, joint, or bone problems that could be worsened by engaging in exercise
  - Motor skill coordination problems

Use a comprehensive approach to identify factors associated with physical inactivity. Ask the following questions:

- Is excessive weight identified as a barrier to exercise? If so, see Weight Management CAP.
- Does the person have a fear of exercising or is there an underlying social phobia that may be interfering with the person's activity level?
- Does the person manage stress effectively? Does he or she do an activity that elicits relaxation for at least 15 minutes per day?
- How does the person feel about his or her health? Does the person feel that health is a barrier to engaging in physical activity? In community mental health settings, 53% of the persons who trigger this CAP report fair or poor self-rated health compared with 32% who do not trigger the CAP. Similarly, persons who trigger this CAP in in-patient programs have double the rate of poor self-rated health compared with those who do not trigger the CAP.
- Is physical pain a barrier? If so, see Pain CAP.
- Is the person taking any medications that may be causing adverse side effects? Is alcohol or other substance use present? If so, see Substance Use CAP.
- What is the physical, social, and emotional impact of physical inactivity on the person? Engage the person in a discussion of goals and expectations for improvement of his or her physical fitness.

Intervention and support. Provide information about health-related activities and programs that are appropriate and attainable. This information should also help increase the person's perceived internal control over exercise levels. Develop concrete implementation plans for the program, considering potential barriers identified by the person.

- Restrict activities that are unsafe for the person. Use professional opinion as required.
- Help the person set achievable, realistic, and measureable short-term goals that provide positive feedback when reached.

- Plan proactive steps to avoid and prevent injury, illness, and disease as appropriate.
- Consider linking behaviour change related to exercise with other health promotion activities (for example, decreasing or quitting smoking). There are health benefits for both and encouragement may come from multiple individuals (for example, a smoking cessation group would encourage exercise).
- Where medically safe, recommend moderate to vigorous physical activity as a way to reduce stress and cultivate positive psychological effects.

Additional Resources

Bouchard C. 2001. Physical activity and health: Introduction to the dose-response symposium. *Medicine and Science in Sports and Exercise* 33(6): 347–50.

Tetlie T, Heimsnes MC, Almvik R. 2009. Using exercise to treat patients with severe mental illness: How and why? *Journal of Psychosocial Nursing and Mental Health Services* 47(2): 32–40.

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Section 19

Sleep Disturbance CAP

Issue

Regular and restful sleep is critical for achieving optimal mental, physical, and emotional well-being. Sleep problems are associated with tiredness, decreased memory and concentration, and impaired psychomotor performance. They are a major contributing factor to fatal road accidents, falls, heart disease, cognitive decline, stroke, loss of productivity, impaired quality of life, and increased mortality. Further, sleep disturbances can affect performance in work and school, hinder a person's ability to participate in social activities, and reduce community involvement. Finally, sleep is essential for normal brain functioning, and a loss of sleep may result in mood swings, hallucinations, and abnormal hormonal rhythms. Sleep disturbance impairs quality of life as well as many areas of physical function. Aside from the interplay between sleep disturbance, depression, and anxiety, there is some evidence of a relationship between sleep disturbance and cardiovascular disorders.

It is common for adults in the general population to experience sleep problems within their lifetime. The most frequent sleep problem is insomnia, which is more pervasive in women, the elderly, and those with medical or psychiatric disorders. Persons experiencing insomnia may describe symptoms that include difficulty falling asleep, frequent wakening during the night, early-morning wakening, daytime sleepiness, and a general reduction in well-being.

Sleep disorders are formally classified in the International Statistical Classification of Diseases, Version 10 (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). They are also fully described by the International Classification of Sleep Disorders (ICSD), which identifies eighty-eight different types. The aim of the Sleep Disturbance CAP is not to provide a specific diagnosis but rather to identify factors to consider in any situation where problems sleeping arise in hospital or community settings.

Sleep problems can result from temporary stressors or life changes, substance use, age-related changes, mental health problems, somatic illnesses, and environmental issues such as noise. The reciprocal relationship between sleep disturbance and health can result in a rapid downward spiral in the person's mental and physical well-being if the sleep disturbance is not identified and responded to appropriately. Therefore, in mental health programs, problems with sleep can impede the person's recovery from mental illness.

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Goals of Care

- Address underlying mental health, physical, or environmental causes of the sleep disturbance.
- Decrease the frequency and severity of interrupted sleep.
- Improve the quality and quantity of sleep to enhance overall well-being.
- Prevent relapse of sleep problems.
- Reverse insomnia-related morbidities (for example, depression, disability, impaired quality of life).
- Reduce the risk of accidental injury due to tiredness while awake.

Triggers

The Sleep Disturbance CAP identifies two groups of persons who are experiencing current sleep problems: (1) those with severe cognitive impairment who may not benefit from direct educational interventions, and (2) those with less severe or no cognitive impairment. The Sleep Disturbance CAP applies to persons in both in-patient and community mental health settings.

TRIGGERED DUE TO CURRENT SLEEP DISTURBANCE AND SEVERE COGNITIVE IMPAIRMENT

This trigger level includes persons

- with severe cognitive impairment (based on a Cognitive Performance Scale [CPS] score of 5 or 6); AND
- who have experienced problems such as awakening earlier than desired or having difficulty falling asleep, restless or nonrestful sleep, interrupted sleep, or too much sleep.

About 2% of persons in in-patient and 1% of persons in community mental health settings trigger at this level. Although improvement in sleep disturbance is commonly possible, about one-third of persons in this trigger level do not improve.

TRIGGERED DUE TO CURRENT SLEEP DISTURBANCE AND NO WORSE THAN MODERATE COGNITIVE IMPAIRMENT

This trigger level includes persons who

- are within the range of no cognitive impairment to moderate cognitive impairment (based on a Cognitive Performance Scale [CPS] score of 0 to 4); AND
- have experienced the above-mentioned sleep problems.

About 38% of persons in in-patient and 42% percent of persons in community mental health settings trigger at this level. About one-quarter of persons in this trigger level do not improve by follow-up.

NOT TRIGGERED

This group includes about 60% of persons in in-patient mental health and 57% of those in community mental health settings.

About 8% of this group will have sleep problems at the follow-up assessment. This group also includes persons who have a sleep disorder diagnosis but who do not have trouble sleeping at the time of the assessment. For those persons, it would be reasonable to assume that his or her current self-management approaches to sleep problems are effective.

Guidelines

Before treating sleep disturbances with interventions, it is important to consider the following.

Nature of the Sleep Disturbance

- Determine the main sleep disturbances affecting the person and describe the symptoms (for example, the nature, duration, pattern, and severity of the sleep problem).
- Identify any circumstances that might have been present at the onset of the sleep problems (for example, stressful life events).
- Sleep disturbance may occur on just one night, causing nothing more than residual tiredness the following day, and not interfere with a normal sleep the

next night. However, sleep disturbances may persist for several days, weeks, months, or even years. Therefore, it is useful to separate sleep disturbance into three duration categories: transient (lasting less than 7 days), short-term (lasting from 7 days to 3 weeks), and long-term (lasting more than 3 weeks).

- An evaluation of the sleep disturbance can be accomplished through an evaluation of the person's sleep and wakefulness patterns over a 24-hour period and a review of a weekly sleep diary.
- Identify any family history of sleep disorders.
- Where appropriate, interview the person's bed partner.

Potential Causes of Sleep Disturbances

Consider the presence of primary sleep disorders. Sleep disorders can be divided by symptoms into three groups: insomnia, hypersomnia, and parasomnia:

1. **Insomnia:** The person has one or more of the following symptoms:
   - Difficulty in falling asleep
   - Frequent waking during the night
   - Early-morning wakening
   - Daytime sleepiness
   - A general loss of well-being through the person's perception of a bad night's sleep
   - Trouble falling or staying asleep, and feeling unrefreshed on awakening

   The two types of insomnia are *primary*, which is a disorder that persists for more than a month, and *secondary*, which is a symptom of another underlying problem.
2. **Hypersomnia:** The person has excessive daytime sleepiness, which may be caused by a number of factors, including insufficient sleep syndrome, depression, a neurological disorder, and drug side effects. Hypersomnia can also be caused by primary sleep disorders, including obstructive sleep apnea syndrome (OSAS), narcolepsy, idiopathic or recurrent hypersomnia, or circadian rhythm disorder.
3. **Parasomnia:** During sleep, the person may demonstrate acute, unusual, or disruptive physical acts. These acts are characterized by partial arousals before, during, or after the occurrence, and they can occur during different stages and times of the night. Most parasomnias are precipitated or perpetuated by stress, and an interaction between biological and psychological factors is presumed in many cases. Following are some common parasomnias:
   - **Narcolepsy:** Sudden bouts of overwhelming and involuntary (spontaneous) sleep. The person often experiences daytime sleepiness and hallucinations.
   - **Rapid eye movement behaviour disorder:** Acting out violent or dramatic dreams during REM sleep.
   - **Restless leg syndrome (RLS):** A neurological disorder that causes leg pain or makes a person feel the need to move the legs.
   - **Obstructive sleep apnea syndrome (OSAS):** Breathing stops for brief periods of time during sleep, typically caused by something (for example, enlarged tonsils, tongue) blocking the airway.

- **Somnambulism:** During sleep, engaging in activities normally associated with consciousness, such as walking or bathing.
- **Desynchronosis:** Commonly known as jet lag, this can cause restless nights, increased stress, and decreased daytime functioning for those who travel.

Female hormones. The reproductive life cycle of a woman has an important influence on sleep. During the menstrual cycle, pregnancy, postpartum period, menopausal transition, and postmenopause, the hormonal changes may result in disrupted sleep.

Stress and anxiety. Physical or emotional stress can cause anxiety, trigger nightmares and night terrors, and cause problems falling asleep and staying asleep. Persons with sleep problems in in-patient settings experience a rate of anxiety indicators that is about double that of those without sleep problems. For example, about 13% of the not-triggered group has daily anxious complaints, compared to more than 23% in the two triggered levels. Anxiety, depression, and elevated stress are common causes of bruxism (grinding of the teeth), which, when it occurs during sleep, may lead to reduced length or quality of sleep, headache, facial pain, and damage to the person's teeth.

Mood disorders. There is a strong link between various mood disorders and sleep disturbance. For example, persons with bipolar disorder may have difficulty falling asleep or staying asleep. Scores on the interRAI Mania Scale (see the appendix) are two to three times higher in the triggered groups than in the not-triggered group in in-patient settings. Similar increases are also evident for the Depression Rating Scale (see the appendix). In community mental health settings, about one-quarter of those who trigger this CAP had hypomania or mania in the previous year, compared with about 12% of those in the not-triggered group.

Sleep problems are among the most common symptoms in persons with depression. The prevalence of symptoms of underlying psychiatric illness, particularly depression and anxiety, increases with the severity and chronicity of insomnia. Insomnia is often the reason that depressed persons seek help, and relief of the sleep disturbance may encourage adherence with antidepressant treatment. The ability of different drugs to improve sleep early in the treatment is often important. Successful treatment for anxiety is likely to also translate into positive outcomes for sleep problems and depression.

Co-morbid disorders. Sleep problems are common in persons with mental health disorders, including depression, anxiety (post-traumatic stress disorder, generalized anxiety disorder), bipolar disorder, schizophrenia, dementia, and substance abuse. In fact, insomnia as a result of another mental disorder is the most common sleep disorder, according to the DSM-IV criteria. Sleep problems are also associated with neurological and medical disorders like restless leg syndrome (RLS), periodic limb movements disorder (PLMD), and chronic fatigue syndrome.

Medical conditions may also cause sleep disturbance. Examples include arthritis, heart failure, pulmonary (including breathing difficulties) and gastrointestinal disorders, stroke, polyuria, and incontinence. Pain is a particularly important consideration (see Pain CAP). Sleep disturbance is one of the most prevalent concerns for persons with chronically painful conditions. In community mental health settings, about one-quarter of persons who trigger this CAP report daily pain, compared with 8% of the not-triggered group. The rates in in-patient mental health settings are 18% and 11%, respectively.

Aging. The treatment of sleep problems in people over age 65 needs to take into account the physiological changes associated with aging. When the sleep disorder occurs secondary to another medical condition, it is imperative that the underlying

disorder be treated first. Sleep tends to be shallower during this time of life, causing older persons to wake more often. Also, changes in sleep and circadian rhythm may occur with aging and thus a different threshold for "normal sleep" may apply.

Substance use and over-the-counter and prescription medication. Consider substance and medication use as potential causes of sleep disturbance. Sleep and waking processes are controlled and influenced by a wide range of neurotransmitters and brain receptors. Therefore, any drug that enters the brain and affects these receptors can change both sleeping and waking. The use of alcohol and illicit drugs may cause various types of sleep disturbance, as can side effects of prescription or over-the-counter medications. In addition, persons may attempt to use such substances as a strategy to reduce sleep problems.

Sleep difficulties caused by substance dependence appear to predispose persons who are in remission to relapse. For example, the acute consumption of alcohol has a brief sleep-induction effect, and withdrawal from alcohol is associated with insomnia. Dependence on alcohol disrupts sleep, which in turn increases the likelihood of alcohol consumption leading to the perpetuation of alcohol use/dependence and relapse (see Substance Use CAP).

Use of over-the-counter sleep medication (for example, those containing diphenhydramine or doxylamine) or other medication with sedating effects (for example, dimenhydrinate) can result in sleep disturbances. Other medications that can cause or aggravate sleep problems include antidepressants, beta-blockers, bronchodilators, clonidine, cortisone, diuretics, levodopa, methyldopa, nicotine, phenytoin, progesterone, quinidine, resperine, sedatives, and sympathomimetics including decongestants.

Environmental factors. Sleep difficulties may be attributed to a variety of social and work-related factors such as shift work, sleep patterns of a live-in partner that are opposite to the person's, noise (inside or outside), or living in a group environment (for example, residence, group home).

Intervention Options

Once an evaluation of the physical, social, and emotional impact of the sleep problem has been completed, engage the person in a discussion of the goals and expectations for improvement in sleep. The discussion around interventions should be guided by the person's preferences and tailored to address the person's diagnosis, medical history, and mental health history. In many cases, behavioural and environmental therapies are sufficient to address sleep disturbances; however, in other cases, medications are also required. The management of sleep disturbances that are secondary to mental, medical, or substance abuse disorders should focus first on the underlying conditions. Medications and somatic treatments may provide the most rapid symptomatic relief from some sleep disturbances, but these may not be usable for some persons (for example, those with substance abuse disorders). In some cases, it may be necessary to refer the person to a sleep specialist for treatment or additional evaluation of causes.

Sleep hygiene. Sleep hygiene interventions should be considered first in most situations. Efforts to improve sleep hygiene should be sustained even when a pharmacological approach is required. Although it may be difficult to engage persons with severe cognitive impairment in some aspects of these interventions, it is nonetheless possible to assist the person in following some basic principles of good sleep hygiene (for example, restricting caffeine consumption). The following are some sleep hygiene interventions:

- Use the bed only for sleep and sexual activities.
- Exit the bed if unable to sleep. Relaxation activities (for example, soft music,

meditation, aromatherapy) and anxiety management may be used before attempting to sleep again. There is some evidence that electronic sleep aids that produce "white noise" or pleasant environmental sounds are helpful.

- Develop a regular routine of rising and retiring at the same time each day.
- Ensure a restful environment, including a comfortable bed in a cool, well-ventilated room and protection from light and noise.
- In in-patient mental health settings, staff should make every effort to control noise, lighting, and other distractions that may not be conducive to sleep. If staff members are aware of someone having difficulty sleeping, they should try to get that person into a single room or an environment that would remove extraneous factors affecting sleep.
- Make going to sleep a familiar routine.
- Prepare for sleep with 20 to 30 minutes of relaxation or a bath.
- Have a light snack (such as warm milk or a banana) to help induce sleep.
- Physical exercise contributes to better sleep practices. People who regularly exercise report fewer episodes of sleeplessness; however, fatigue associated with sleep disturbances may make exercise more difficult. Daytime exercise routines are more effective than late-night exercise routines, which can actually make it difficult to fall asleep.
- Cognitive exercises (for example, counting backward, visualization) may be useful as a means of distraction from day-to-day worries.
- The sleep diary should include specific dates and times to record when medications were taken, stressful situations, food intake, and physical exercise or activity. Persons with adequate cognitive function can be encouraged to maintain his or her diary. For persons with severe cognitive impairment, this type of documentation should be prepared by others who are present during typical sleep hours.
- Using a daily diary, calendar, or notebook as a way of organizing the day's activities and writing down the things to be remembered for the next day before going to sleep may help reduce stress and anxiety through gaining a sense of being organized.
- Actions to be avoided when promoting good sleep hygiene include
  - Late afternoon napping
  - Going to sleep too early in the evening
  - Heavy eating before bedtime
  - Consuming caffeine or high energy drinks after noon
  - Consuming substances that may cause fragmented sleep (for example, tobacco products, alcohol, and medications or high energy drinks that contain caffeine or other stimulants)
  - Thinking about life issues and solving problems when trying to fall asleep

Behavioural therapies.

- **Cognitive Behavioural Therapy (CBT)** aims to identify dysfunctional beliefs and attitudes about sleep, replace them with more adaptive substitutes, and help to control the person's sleep environment. The therapy can be used to identify and change behaviours or beliefs about sleep. CBT may be more effective than medications in improving sleep in the long term. CBT has been

shown to improve sleep quality, reduce the use of medications, and improve the health-related quality of life among persons with chronic sleep difficulties.

- **Sleep restriction therapy** aims to reduce the anxiety of lying awake in bed. Over time, people undergoing sleep restriction become tired earlier in the evening and fall asleep more easily.
- **Total sleep deprivation (TSD)** works to improve depressive symptomatology for persons with a bipolar disorder. TSD usually requires a person to stay awake through the night, three times a week. TSD works best in a group where people stay awake by playing games, taking walks, and having conversations with other group members. The aim of TSD is to avoid naps and to provide a positive social experience.
- **Relaxation therapy** focuses on reducing factors like tension and stress, which may precipitate sleep disturbances. It may include muscle relaxation or guided imagery.
- **Stimulus control therapy** aims to help re-associate the bed, bedtime, and bedtime stimuli with sleep rather than with the frustration or anxiety resulting from lying in bed trying to sleep. Persons undergoing stimulus control are instructed to (1) only go to bed when tired; (2) only use the bed for sleeping and sexual activities; (3) leave the bed if he or she has not gone to sleep within 15 to 20 minutes and to go back only when he or she feels sleepy again (repeated as often as necessary through the night); (4) get up at the same time each morning, regardless of the amount of sleep achieved the previous night; and (5) not sleep during the day.
- **Paradoxical intention** is based on the concept that performance anxiety prevents proper sleep. The person confronts his or her fear of staying awake by staying awake. As the person stops trying to fall asleep, the performance anxiety related to attempting to fall asleep is reduced. This decreases the concern about the consequences of a lack of sleep and decreases performance anxiety about falling asleep.
- **Bright-light therapy** establishes a healthy sleep-wake cycle using the timing of light therapy based on the pattern of the sleep-wake cycle disturbance. This treatment has been found to be beneficial to persons with dementia who experience poor sleep quality. It should be noted that there is little evidence that bright-light therapy is effective for insomnia, but there is some evidence for its effectiveness for delayed sleep-phase syndrome.

Considerations for special populations.

- **Children or persons with intellectual disabilities:** A combination of environmental, behavioural, and educational strategies is recommended.
- **Older persons with cognitive impairment:** Management of behavioural issues associated with syndromes such as "sun-downing" requires an integrated approach (pharmacological and environmental).

Complementary and alternative therapies. Meditation techniques may assist the person in achieving greater relaxation prior to attempting to sleep. Aromatherapy, including jasmine, lavender, and other essential oils, may induce a state of restfulness.

Oral appliances, respiratory equipment, and sleep disorder surgery.

- **Oral appliances:** Many persons with sleep apnea try to use oral appliances to treat the condition. Mandibular-advancement devices help keep the airway

open by placing pressure on the lower jaw so that it moves forward. Tongue-retaining devices prevent the tongue from falling backward and over the airway during sleep. Mouth guards may be used to prevent tooth damage related to teeth grinding.

- **Respiratory equipment:** Some people choose nonsurgical treatments for sleep apnea, such as respiratory equipment and respiratory medical equipment supplies. An effective nonsurgical treatment option is a continuous positive airway pressure (CPAP) device. It uses a face mask to blow air into the mouth, forcing the throat to stay open during sleep. CPAP devices can initially be challenging to use; concerns include discomfort because of the tight straps and a feeling of claustrophobia. For persons with less severe constriction of the airway, low-cost sleep aids that open the nasal passages (for example, nasal strips) may be effective.
- **Sleep disorder surgery:** Typically, surgical interventions focus on the nose and throat and are limited to treating obstructive sleep apnea.

Sleep medications. Although behavioural and environmental approaches should be considered as a first treatment option, in some cases the most appropriate strategy involves a pharmacological treatment. Sleep medications can have a variety of side effects and complications when mixed with other medicines, alcohol, or illicit drugs. Prescribed medications should be used intermittently (alternate nights or less frequently) where possible, in the lowest effective dosage, and for the shortest term (no more than four weeks). Medication should be gradually discontinued to prevent rebound insomnia. Short-acting medications are better for persons who have difficulty falling asleep, but tolerance and dependence may develop more quickly. Long-acting medications are more suitable for those with frequent or early-morning wakening. These drugs may be less likely to cause rebound insomnia; however, next-day sedation and a loss of coordination are more likely to occur. Hypnotic use should be avoided for persons with respiratory disease or severe hepatic impairment and those who are prone to problems with addiction.

The risks of treating older people (over 60 years) with sleep medications may outweigh the benefits. Older persons (especially those at risk of falls and with cognitive impairment) who are prescribed medications should be closely monitored to determine if the prescription continues to be justified. The benefits of these drugs may not justify the increased risk, particularly if the person has additional risk factors for adverse cognitive or psychomotor events.

Prescription medications for sleep disorders can by classified as

1. **Hypnotics:**
   a. Benzodiazepines are the most widely prescribed and used sleep medications on the market. They can be addictive and can cause drowsiness the day after use, especially in the potent, long-lasting forms. They are well known to increase the risk of falls and are not recommended for treating chronic sleep problems.
   b. Non-benzodiazepine drugs (Z-drugs) are becoming more widely used, but they may be just as likely as the benzodiazepines to cause rebound, dependence, and neuropsychiatric reactions.
   c. Barbiturates are rarely used as they may cause problems with addiction, abuse, and overdose.
   d. Melatonin receptors stimulate the body to produce melatonin, a hormone that regulates sleep cycles. This is not as effective as other sleep medications, but they have fewer side effects and a lower potential for addiction.

2. **Antidepressants:** These drugs can be effective in treating sleep disorders when the cause of sleeplessness is depression.
3. **Antipsychotics:** These medications are mostly used to promote sleep for persons with major psychiatric disorders. The sedative and anxiolytic effects of these medications help reduce daytime anxiety and agitation.

Long-term treatment with medications may be beneficial in a very small number of persons. Nevertheless, long-term users may overestimate the benefits of continued use. After a period of rebound symptoms immediately after withdrawal, many chronic users will return to the same sleep pattern (drug free) that they previously associated with the use of medications. As with all prescribing, the potential benefits and risks of medications have to be considered in the context of the clinical circumstances of each case. Sleep medications should not be used for longer than 4 weeks; however, to avoid side effects, sleep medications should not be discontinued abruptly.

Additional Resources

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Section 20

Pain CAP

Issue

The International Association for the Study of Pain defines pain as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage." It may be related to damage to any tissue, organ, or system and may include musculoskeletal injuries (for example, arthritis, fractures, peripheral vascular disease, wounds), neurological conditions (for example, diabetic neuropathy, herpes zoster), and cancer. Pain intensity (severity) is subjective, and it may not be proportional to the type or extent of tissue or system damage. Pain is also strongly associated with psychological symptoms, such as depression, but the causal pathway is not always clear. However, effective treatment approaches may reduce both the subjective severity of the pain and the related psychological symptoms.

It is estimated that 17% to 44% of adults in Canada have chronic pain (estimates increase to 60% for those over 65 years of age), with an approximate associated cost of $6 to $8 billion each year. The 2004 Pain in Europe survey reports that about 19% of adults across sixteen European countries have chronic pain and suggests that pain-related absenteeism costs European economies €34 billion per year. In Australia, it is estimated that about one in five adults has persistent pain, associated with 36.5 million lost work days per year. Approximately 30% of the U.S. population has persistent pain, with an associated estimated cost of $120 billion per year in treatment, lost revenues, and wages.

Persons reporting pain in mental health settings should not be discounted as "malingerers" or "attention-seekers." In addition, it is important to bear in mind that pain per se is not the condition that leads to verbalizations of pain or which affects mental health, it is the physical and emotional response to pain (that is, suffering) and its associated consequences that varies from person to person. For example, many persons may live with chronic, moderate, or severe pain for years without expressions of pain or adverse consequences (that is, they *are not* suffering) while others, who objectively appear to have sustained the same extent of injury or who have comparable physical, imaging, and laboratory presentations, may have substantially more dysfunction related to their pain—they *are* suffering.

When pain is reported, it should be considered an important quality-of-life problem that should always be given high priority in care plan development. Severe and frequent pain can have an adverse impact on the person's recovery from mental illness. It may exacerbate or prolong psychological symptoms; increase feelings of hopelessness, anxiety, and depression; reduce social interaction and community participation; lead to decreased appetite, disrupted sleep, and misuse of prescription medications; and place a strain on the person's support systems. It is essential to work with the person and family members to identify approaches to control the impact of pain so that the person feels empowered to address other challenges.

Goals of Care

- Identify the etiology of the pain and manage the pain with the most effective treatment modalities.
- Assess risk(s) for adverse outcomes (for example, addiction, suicide, exacerbation of existing mental illness) related to the use of medication for pain relief.
- Minimize or prevent potential adverse outcomes such as substance abuse, self-harm, adverse interactions between analgesic and psychotropic medications, withdrawal, and depression.
- Increase the person's understanding of the relationship of pain to somatic and psychological problems (for example, the interconnectedness of a cancer diagnosis, subsequent pain, and possible depression).
- Monitor response to treatment and adverse effects.

Triggers

The Pain CAP applies to persons in in-patient and community mental health settings. It identifies two groups for specialized follow-up. The groups are distinguished by the severity and persistence of the reported pain, not the likelihood of cure.

TRIGGERED AT HIGH PRIORITY LEVEL

This trigger level includes persons with

- pain that is described as severe, horrible, or excruciating (whether the pain occurs daily or less frequently).

This group includes about 3% of persons in mental health in-patient settings and 7% of persons in community mental health programs. Over a 2-week period, almost 60% of in-patients who trigger at this level will have some improvement and 34% will improve to the point of either no pain or less than daily mild or moderate pain. For persons in community mental health programs who trigger at this level, 40% will have some improvement in pain, and about 30% will go on to have no pain or less than daily mild or moderate pain over an average period of 90 days.

TRIGGERED AT MEDIUM PRIORITY LEVEL

This trigger level includes persons with

- daily pain that is described as mild or moderate.

This group includes about 10% of persons in in-patient mental health settings and 9% of persons in community mental health programs. Over a 2-week period, 46% of persons in an in-patient mental health setting who trigger at this level will improve to the point of either no pain or less than daily mild or moderate pain; less than 3% will experience an increase in pain to the point that it is severe or excruciating. For persons in community mental health programs who trigger at this level, 51% will improve over an average period of 90 days, to the point where there is no pain or less than daily mild or moderate pain. Almost 14% will experience an increase in pain to the point where it is described as severe or excruciating.

NOT TRIGGERED

Persons in this group have no pain or less than daily mild to moderate pain. This group includes 86% of persons in in-patient and 84% of those in community mental health settings. Over a 2-week period in in-patient mental health programs,

approximately 3% of these persons will have an increase in pain. Five percent of persons in community mental health programs who did not trigger the Pain CAP will have an increase in pain over an average period of 90 days. Approximately 10% of those in in-patient and 7% of those in community mental health programs have less than daily mild to moderate pain. Although the majority of these persons will resolve to no pain (47% and 58%, respectively), some will have an increase in pain (8% and 19%, respectively). Thus, it is important to be vigilant for new or worsening pain in those who may not initially trigger the Pain CAP.

Guidelines

The process for treatment and management of pain is basically the same for the high-priority triggered group and the medium-priority triggered group. For all groups, one should make sure there is not an acute medical condition causing the pain and also that the pain, regardless of its acuity, could not be best managed by addressing the underlying medical condition. An interdisciplinary approach to pain assessment and management is recommended.

Special Considerations

There are likely to be many different causes of acute or chronic pain in the mental health setting. The Pain CAP assumes a generalist approach to pain, recognizing that, regardless of the type of mental health service (specialized or general, in-patient or outpatient services), the clinical team has an obligation to respond to expressions of pain. The following is an overview of important conditions and issues closely associated with pain in the context of mental illness.

Co-morbid physical health problems. The assessment and management of persistent pain may require active management of any underlying and concomitant conditions, such as fibromyalgia, arthritis, and cancer. Clinicians must be alert for the presence of a somatic illness that could cause pain and could lead to a mental health problem, such as depression or anxiety, which could further exacerbate pain severity. For all age groups, pain levels are higher among those persons with provisional diagnoses of mental disorders due to a general medical condition or somatoform disorders.

Co-morbid psychopathology. The dynamic and reinforcing interplay between pain and psychopathology makes it impossible to treat either condition independent of the other. As well, the presence of one or more co-morbid psychiatric conditions makes it more difficult to treat persistent pain. Assessment for psychiatric conditions is important in the management of persistent pain. If such an assessment suggests the presence of a psychiatric condition, pain treatment and management should occur in a collaborative manner between the health care provider(s) who manage the pain or treat the etiology of the pain and the mental health care team.

- **Depression:** Persons with persistent pain related to a medical condition are at substantial risk of developing depression and should always be assessed for depressive symptoms. It is common for persons with clinical depression to initially present to the family physician with pain symptoms alone; and it has been suggested that 11% to 20% of those who have chronic pain associated with a somatic condition will also have a major depressive disorder as a consequence of the pain. Conversely, it has been suggested that, for those with a diagnosis of depression, up to 65% will have pain in one or more areas. In in-patient mental health settings, 27% of persons had pain during 1 or 2 of the last 3 days, while 15% had daily pain. There is a direct connection between

pain severity, frequency, and level of interference with daily activities, and the number and severity of depressive symptoms. Independent treatment of one or the other should have a carryover effect, but current standards call for the treatment of both depression and pain because of the strong interconnectedness between the two conditions.

- **Substance use:** For persons with persistent pain, substance use disorders are the second most common co-morbid Axis I psychiatric condition (after depressive disorders), with prevalence rates from 3% to 19%. In mental health in-patient settings, the presence of a substance use disorder increases with the frequency and intensity of pain, ranging from 25% in those who report no pain to 33% in those reporting daily mild or moderate or any severe or excruciating pain. In addition, the prevalence of illicit drug use (for example, opiates and cocaine) increases with the frequency and intensity of pain, ranging from 2% in those who report no pain to 13% in those who report daily mild or moderate or any severe or excruciating pain. Among persons in in-patient mental health programs, misuse of prescription medications increases from about 12% in those with no pain to about 30% in those with the highest pain levels on the interRAI Pain Scale (see the appendix).
- **Other psychiatric diagnoses:** Pain is a common occurrence for persons with other psychiatric diagnoses; however, some diagnoses are associated with lower rates of pain while others have higher rates. For example, the rate of daily pain in the last 3 days for persons with a diagnosis of schizophrenia or other psychotic disorder, eating disorder, or dementia or delirium was 7%, 11%, and 14% respectively. Higher rates of daily pain and any pain in the last 3 days were reported by those with a somatoform disorder (approximately one-third and one-half, respectively) and anxiety disorders (approximately one-fifth and one-third, respectively). These observations are in keeping with reports of differences in pain sensitivity, pain perception, and reporting of the pain experience associated with different mental health conditions.
- **Social determinants:** Persons with a history of trauma related to physical, emotional, or sexual abuse are considerably more likely to have pain, compared to others who have not been victims of such abuse. Pain may be one manifestation of depression related to such trauma, but it may also reflect the ongoing impact of injuries sustained as part of the original abuse. Among persons with higher pain levels in in-patient mental health settings, there are higher rates of reported problems in family role functions, absence of confidants, and family feelings of being overwhelmed by the person's illness. In addition, persons with higher levels of pain are less likely to be employed. Among persons in community mental health programs with higher pain levels, higher rates of problems in family role functioning are reported.

Evaluation of Pain within a Mental Health Context

Once it has been determined that the person has pain, a thorough assessment must be performed.

- Complete a detailed history of the pain, including location, intensity, frequency, and characteristics (for example, "sharp," "dull," "lancinating," "burning").
- Determine the location of the pain. This is important for care planning (for example, pain related to peripheral vascular disease will require a different approach compared to arthritic pain).
- Determine if the pain is constant, changes over time, or comes and goes (intermittent). If it is intermittent, ask about its frequency, duration, and the

circumstances under which it occurred. The person's pain experience may vary by site, time of day, and activity.

- Ask the person to describe the pain. Descriptions may be helpful in determining the cause of the pain. Neuropathic pain is often described as "burning," "pins and needles," shooting, or feelings of numbness; whereas musculoskeletal or visceral pain is sometimes described as cramping, crushing, throbbing, stabbing, or tightness.
- Determine if there are modifiable factors that make the pain better or worse. These may include behaviours (for example, moving, staying in the same position), consumption of food or substances (for example, chocolate, alcohol), physical exertion, or pain-management strategies (for example, maintaining an appropriate medication schedule). Where possible, it is better to take a preventative approach to avoid future pain.
- Conduct a physical examination and appropriate laboratory studies to help identify an acute medical condition that may be causing the pain and also to determine if the pain, regardless of its acuity, could not be best managed by addressing the underlying medical condition.
- Review the current interventions for pain, their efficacy, and side effects, if any.
- Determine which cultural factors may affect the manifestation of pain. For some cultural groups, a tendency toward stoicism may hinder the person's willingness to express pain. However, there may be a tendency for staff or informal caregivers to inappropriately discount pain indicators among persons who are more expressive about health concerns than expected based on cultural norms.
- For pain assessment and management in the mental health setting, consider the interplay between a mental health problem and the pain experience. Investigate other factors that might be important in the management of pain.
  - Determine if the pain is leading to or has led to mental health problems, such as anxiety or depression.
  - Determine if the person has a history of prescription or nonprescription medication use or abuse.
  - Determine if there is a history of illicit drug use.
  - Identify the cause of the pain (for example, cancer, arthritis, an injury at work, or a traumatic event).
- Pay attention to differences in pain perception among those with a mental illness.
  - Persons with a diagnosis of schizophrenia tend to feel less pain, have a higher pain threshold, or simply report less pain, all of which might lead to a delay in the diagnosis and treatment of a serious medical condition.
  - Persons with eating disorders and bipolar disorders tend to show a decrease in pain perception, which may lead to delayed reports of symptoms related to an acute illness and adverse consequences.
  - Persons with a diagnosis of a somatoform disorder or an anxiety disorder have heightened pain perception; however, the pain experience should not be ignored. Pain is a personal experience, and while it may be exaggerated based on the mental health clinical picture, the pain is not any less real to the person.

- In persons with a history of drug misuse, abuse, dependency, or addiction, it is important to determine if there is drug-seeking behaviour in order to obtain medication.

- Respond to any expressions of pain with an appropriate evaluation. Increased pain perception and sensitivity, as seen in persons with a diagnosis of depression, may adversely affect daily functioning and quality of life, regardless of its cause and "expected" intensity.
- Approach each person's individual pain experience with sensitivity and do not undervalue it.

Management of Pain

Regardless of etiology, pain should be regarded as an important vital sign and monitored on a regular and scheduled basis. Both pharmacological and nonpharmacological interventions should be considered. Treatment options, including their risks, should be discussed with the person (and family as appropriate). It should also be noted that persons with serious pain associated with a disease that may be terminal may need extensive pain management. Chronic pain is best managed through interdisciplinary team multimodality interventions.

Pharmacological intervention. Pharmacotherapy is most often the first step for managing most pain, regardless of severity; however, there are numerous issues to consider that are specific to the mental health setting.

- For persons receiving an analgesic medication, regular pain reassessment is recommended (for example, route, dose, frequency). This will facilitate optimal pain control.
- Before starting a new medication, identify all medications the person is taking, including prescription, over-the-counter, herbal, and illicit drugs.
- If there is a possibility that the person is drug-seeking, or has a history of drug dependence or addiction, the pharmacological benefit should be weighed against the possibility of reactivating the addiction or dependence. The issue of undertreatment or overtreatment must also be considered. The possibility of a concurrent substance abuse disorder may necessitate the use of nonpharmacological interventions. Conversely, it is important to keep in mind that those with substance use problems may have real pain for which they are not drug-seeking, and may require significantly higher doses or frequency of pain medication as a result of tolerance.
- There are some psychotropic medications that may be used to treat pain (for example, selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants (TCAs) are usually indicated for the treatment of depression but some have been shown to be effective for management of some types of pain. Considering such an approach may help to streamline a potentially complicated medication regimen.
- Care is needed with the use of opioids, which are often indicated for acute severe cancer pain, as well as for chronic nonmalignant pain. When managing the pain of older persons, the dose of some drugs should be lowered and other drugs should not be given.
- As with any pharmacological intervention, attention should be given to reducing, managing, and monitoring for adverse events associated with analgesics (for example, see Falls CAP).

Nonpharmacological intervention. For persons with addictions to prescription medications or illicit drugs, it is important to identify nonpharmacological interventions that are effective for managing pain.

Nonpharmacological approaches are important in pain management for all persons experiencing pain because they

- May potentiate the effect of analgesic medications
- Usually have minimal adverse effects
- Give the person and family a sense of participation and control
- May address functional decline, mood, and social isolation

Nonpharmacological approaches generally take two forms:

- **Physical interventions** generally focus on physical conditions that result in a sensation of pain and may require a specific referral to a member of the multidisciplinary team, such as occupational therapy or physiotherapy for assessment and intervention. Examples include
  - Acupuncture
  - Transcutaneous electrical nerve stimulation (TENS)
  - Heat and cold applications
  - Massage
  - Exercise
  - Immobilization of the affected joint or limb
  - Environmental assessment for safety (for example, to prevent falls or injuries)
- **Psychological interventions** (individual or group) generally focus on altering pain perceptions and improving coping. Examples include
  - Distraction or relaxation (for example, imagery, counting, music, humour)
  - Meditation
  - Coping skills training
  - Cognitive Behavioural Therapy
  - Hypnotherapy
  - When pain control cannot be adequately achieved, it is important to help the person live with the pain so that life becomes bearable. In such cases, psychosocial support would be extremely important.

Education.

- Discuss the cause of the pain, pain assessment findings, goals of treatment, plan of care, prognosis, treatment options, and side effects.
- Provide information to the person and his or her family (where appropriate) regarding the type of pain medication that was started and where it stands in the analgesic ladder, how quickly the medication will take effect, and possible adverse effects.
- Highlight the importance of managing the pain and its consequences (strengthen the internal locus of control).
- Discuss strategies that focus on managing everyday activities when the presence of pain is a distraction (for example, using a calendar, daily planner,

or memo book for keeping appointments; if reading is difficult, use a voice recorder as an audio reminder of things to do).

Referral to a pain specialist. A referral to a pain specialist or clinic is recommended when

- A cause is not readily identified
- The person's expression of pain consistently presents as an underestimation or exaggeration of what would be expected
- The mental health team is unable to manage the pain symptoms

Evaluation.

- The person's pain experience should be evaluated at specified intervals.
- Adjustment to pain-management strategies should occur as required following each evaluation.

Additional Resources

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Section 21

Falls CAP

Issue

A fall is defined as an unintentional change in position where the person ends up on a lower level (for example, floor, ground, seat). Falls are a major cause of unintentional injury to persons of all ages. According to the New York State Department of Health, falls are the leading cause of injury-related hospitalizations for children and for persons over 25 years of age, and they are the leading cause of unintentional injury-related death in persons 45 and over. According to Health Canada, about one-third of those over the age of 65 fall each year. Further, falls are the leading cause of injury and the sixth leading cause of death for this age group. Falls are one of the most common problems threatening the independence of older persons.

Although there is extensive literature on falls in the elderly, including numerous randomized clinical trials on multifactor interventions, falls have received very little attention in the mental health literature. Nonetheless, many of the risk factors and interventions considered for older populations may be applicable to younger persons with mental health problems who fall, and they will certainly be relevant for older persons in in-patient and community mental health settings. As in the general population, older persons and persons with dementia have been shown to have higher rates of falls than others in in-patient mental health settings.

The psychotropic medications used to treat mental health conditions have been shown to be associated with an increased risk of falls in the elderly; however, recent studies in mental health have also demonstrated this effect in younger persons in in-patient mental health settings. In addition, some medications may increase the risk of injury associated with a fall. For example, antipsychotic medications that raise prolactin levels are associated with reduced bone mineral density, which may in turn increase the risk of fractures with a fall. Falls may be associated with disability and other conditions, such as substance use, delirium, adverse drug reactions, dehydration, incontinence, and infections.

Effectively addressing the risk of falls is an important priority in supporting the person's autonomy and community integration. Fear of falling, by either the person or informal helpers, may be a factor that limits the person from leaving his or her house with the consequence of increased isolation and reduced participation in community life. In addition, some strategies to reduce fall risk may actually exacerbate the problem and cause the person distress (for example, physical restraints).

Goals of Care

- Minimize the impact of risk factors for falls.
- Prevent future falls.
- Reduce fear of falling as a barrier to physical activity and community engagement.

Triggers

The Falls CAP applies to persons in both in-patient and community-based mental health settings. It identifies two groups of persons for follow-up to reduce the risk of future falls.

TRIGGERED DUE TO HIGH RISK OF FUTURE FALLS

This group includes persons who have

- multiple prior falls.

This group includes about 6% of persons in in-patient mental health settings, and 2% in community-based mental health programs. In both settings, the rates for persons over 65 are about four times higher than for younger persons. About two-thirds of this group will fall again at follow-up in community mental health settings.

TRIGGERED DUE TO MEDIUM RISK OF FUTURE FALLS

This group includes persons who have

- one previous fall.

This group includes about 9% of persons in community-based mental health programs and about half of this group will fall again at follow-up.

NOT TRIGGERED

This group includes persons with no falls in the previous 90 days. It includes about 94% of persons in in-patient mental health settings and 89% in community-based mental health programs. About 4% of the persons with no history of falls in community mental health programs will have a fall at follow-up compared with about 1% of those in in-patient mental health settings.

Guidelines

General Care Plan Considerations

The initial priority for intervention should be on improving the person's safety. Those who trigger the CAP at either level are highly susceptible to another fall in the near future. It is important to not be complacent for persons who have fallen previously but were not injured. In many cases, the difference between an injurious and a noninjurious fall may have been simply a function of chance. The occurrence of a fall should generally be treated as a serious warning for imminent risk of harm to the person. Restraints should be avoided as a fall-prevention strategy. They are not associated with a decreased risk of falls or injury associated with falls. The person's right to maintain mobility, despite a slightly elevated risk of falling, should be considered of paramount importance. In fact, restraint use can lead to deconditioning, agitation, and confusion, all of which will greatly *increase* the risk of future falls. In some jurisdictions, health care regulations preclude the use of restraints for falls prevention.

To better understand the circumstances of the fall(s), consider the following:

- Does the person need a program to improve gait, strength, or balance? In in-patient mental health settings, persons with problems with balance at the time of admission have five times the rate of falls when compared with those without the problem. In community mental health programs, persons in the highest risk group are six times more likely to have a gait disturbance than those in the not-triggered group.
- Have the person's medications been reviewed for their possible effect on falls, including factors such as balance, gait, strength, sensory perception,

and cognition? A recent study of falls in psychiatric hospitals reported that the following medications were all associated with an increased risk of falls: alpha-blockers, nonbenzodiazepine sleep aids, benzodiazepines, H2-blockers, lithium, atypical antipsychotics, atypical antidepressants, anticonvulsants and mood stabilizers, conventional antipsychotics, laxatives, and stool softeners. For example, extrapyramidal symptoms associated with medication use are more common among persons triggering the Falls CAP. In community mental health settings, the rates of a slow and shuffling gait, bradykinesia, or tremor are about two to five times higher in the high-risk compared with the not-triggered group. Blurred vision, another common medication side effect, is associated with falls in both in-patient and community mental health settings.

- Has consideration been given to postural changes in blood pressure, cardiac arrhythmias, dizziness from any cause, presence of pain, and specific impairment in movement? Dizziness is strongly associated with being in either CAP trigger level in community mental health programs (47% and 26% among the high-risk and moderate-risk groups, respectively, compared with 10% in the not-triggered group).
- Does the person have problems with cognitive functioning or ADL impairment that increases the risk of falls? Consider the Cognitive Performance Scale (CPS) (see the appendix). Persons triggering the Falls CAP tend to have higher CPS scores. This may indicate that the person is unable to judge the safety of the environment appropriately or may not adjust to hazards in the environment to avoid falling.
- Does the person have ADL impairment that might increase his or her risk of falling (for example, difficulty dressing the lower part of his or her body, resulting in risk of losing balance)?

Understanding previous falls. A history of falls is the best predictor for future falls. Persons who fall are at a higher risk of falling again, often under similar circumstances. This is particularly true for persons who have had multiple falls. It is essential that the history of falls be reviewed with the person, family, and staff, as well as checked against information in the medical/clinical record.

- What were the circumstances of the fall?
  - When did the fall(s) occur? (Day? Evening? Night?)
  - Where did the fall happen? (Bedroom? Bathroom? Living room? Corridor? On stairs? Outside?)
  - Was the person intoxicated or in a withdrawal state from substance use?
  - How serious was the injury, if any, associated with the fall?
  - Has the person's fear of falling increased in response to the fall?
- Were any changes to the plan of care made after the fall? Are these changes still applicable to the current situation, or does the care plan need updating?
- If the person was using an assistive device, evaluate the safety of the device (for example, the brakes on a walker, appropriate height of the walker or cane).

Medication use. Review medication that the person is taking and adjust as necessary. Consider the following in the evaluation:

- Is the person taking psychotropic medication known to be associated with an increased risk of falls (for example, an antipsychotic, an anxiolytic, a sedative/hypnotic, or an antidepressant)?

- Does he or she take sleeping pills regularly? If so, for how long has the person been taking these medications?
- Are medications given regularly or PRN? PRN medications may be associated with a higher risk of falls.
- If psychotropic medications are taken, consider screening for extrapyramidal side effects.
- Is the person taking an antihypertensive? Has the dose been changed recently? Was a postural blood pressure reading obtained for a number of days after any change?
- Is there a history of an arrhythmia, which may be intermittent?
- Does the person have difficulty breathing or getting sufficient oxygen when moving (aerobic ability)?
- Does the person have a history of or evidence of a peripheral neuropathy?
- Does the person have diabetes mellitus, which may be under very tight control?
- Is there a history of a seizure disorder?
- Has the person had a medication, especially a steroid, discontinued?

Physical performance. Assess for limitations in physical performance, including balance, gait, muscle strength, and endurance deficits.

- Does the person have difficulty maintaining a sitting balance? Does the person need to rock his or her body or push off on the arms of a chair when standing up from a chair?
- Does the person have difficulty standing up or maintaining a standing position? Does the person have difficulty when beginning to turn around?
- Does the person have a gait problem (for example, unsteady gait even if walking with a mobility aid or personal assistance, slow gait, take small steps)?
- Does the person have musculoskeletal problems, such as kyphosis (curvature of the spine), weak hip flexors from extended bed rest, or shortening of a leg?
- Does the person have vitamin D deficiency that could be affecting his or her gait and muscle strength? If present, appropriate amounts of supplements should be provided.

Where appropriate, consider the following intervention strategies:

- Involve the person in activity programs that provide exercise for balance, muscle strengthening, and flexibility. Special interventions for physical performance should be considered following a period of low activity as a result of illness or other change in status **and** following a fall.
- Ensure that the person is able to use his or her assistive device appropriately and encourage him or her to use grab bars in routine activities like toileting. For persons in the community, check the bathroom for presence of grab bars and discuss strategies for their installation, if needed. For frail elderly persons with gait problems or dizziness, it may be necessary to provide the person with a scheduled toileting program and physical assistance to get to the toilet.

Vision problems. Determine if the person has a problem with vision, as this may be contributing to his or her risk for falls. Consider the following:

- Is the person experiencing blurred vision? If so, is it related to initiation of a psychotropic medication? Adjust as necessary if the medication is contributing to vision problems.

- Does the person have other vision problems? Visual field deficits, cataracts limiting light perception, and use of inappropriate eyeglasses are especially common problems.
- Has the person been assessed for vision problems and are there any ophthalmologic diagnoses? Is the care plan up to date in terms of medical and environmental treatments for these conditions? Does the person have diabetes?
- Does the person wear eyeglasses for reasons other than reading? Have the eyeglasses been assessed recently to ensure satisfactory correction?
- Does the person neglect (appear not to see) objects on one side of the visual field?
- Does poor illumination in the environment affect visual ability?
- Ask the person about his or her ability to differentiate contrasts and surface textures. Persons with visual impairments may have difficulty detecting changes in levels (for example, stair steps) or the type of surface he or she is walking on (for example, dry, wet, or icy pavement).
- Some potential interventions related to vision include the following:
  - Ask the person what he or she can see when looking straight ahead. Be aware of what the person can see in his or her field of vision and place needed objects (for example, mobility aids and dishes) accordingly.
  - If the person has difficulty with differentiating contrast and surface textures, environmental modifications may be useful (for example, use of tape to mark stair steps). In addition, orientation and mobility training may be offered to support navigation and improve awareness of external environmental conditions.
  - Practice orienting the person to his or her living environment, keeping in mind what he or she can see. Use visual cueing as reminders and for orientation.
  - Seek advice of occupational therapists for visual cueing. They have special expertise in treating and providing consultation for neglect of one side of the body or one side of the visual field. These impairments normally result from a stroke.
  - Consider referral to an optometrist or ophthalmologist if the person has not had an eye examination in the past year or if new visual problems or perceived changes are identified.

Neurological and cognitive problems. The presence of a neurological or cognitive problem can affect balance, coordination, and awareness of one's surroundings.

- Does the person have a neurological disease, such as multiple sclerosis, Parkinson's disease with a tremor or rigidity, or a stroke with one-sided weakness?
- Does the person have a metabolic syndrome, such as diabetes, hypertension, or hyperlipidemia?
- Is the person cognitively impaired (one of the more important risk factors for falls)?
- Does the person consider him- or herself (or appear to consider him- or herself) able to function at a higher level than is safe? For persons with serious ADL impairments, standing up alone or getting out of bed alone may be risky behaviours resulting from unmet needs (for example, a need to void).

Some potential interventions related to the above include the following:

- Review the medications the person is taking to determine if they are affecting the person's level of consciousness, daytime drowsiness or sedation, cognitive performance, judgment, and sensory perception.
- Introduce measures that avoid the onset of behaviours that put the person at risk (for example, address pain, thirst, hunger, need to toilet). Attending to these needs on a routine basis (for example, implementing a scheduled toileting plan for those persons who have problems with balance and ambulation) may prevent the person from trying risky behaviours. Scheduling routine contacts with the person throughout the day may also aid in ensuring that his or her needs are being met in a timely manner. If pain is an issue, see Pain CAP.
- Encourage the person to explore his or her perception of the physical limitations and their impact on the person's well-being. Help the person to build on strengths to adapt to the limitations.
- A person with cognitive impairment is less able to learn exercises and learn to use assistive devices for mobility; however, he or she can improve with practice and repetition. While the person may take a longer period of time or require greater intensity of intervention to improve, efforts should be made to facilitate activity, mobility, and improved balance. The person may respond well to activities that were enjoyable in the past.
- A referral to an occupational therapist, physiotherapist, or recreational therapist may be appropriate.

Cardiorespiratory problems. A review for any problems associated with cardiorespiratory function should be considered as possible contributing factors relating to falls.

- Does the person have a problem with blood pressure, an arrhythmia, an especially slow heart rate?
- Monitor pulse and blood pressure for the following:
  - Check for bradycardia, tachycardia, or irregular pulse.
  - Take blood pressures when the person is lying down, sitting up, and standing (after 2 minutes) to detect postural hypotension.
  - Compare blood pressures before breakfast and about 20 minutes after breakfast to evaluate for postprandial (after meal) hypotension.
- Is the person taking cardiopulmonary medications, diuretics, or other medications that might predispose him or her to hypotension?
- Is the person bothered by dyspnea? In community mental health settings, the rate of dyspnea is approximately two times higher among persons who triggered the CAP than it is among those who did not trigger the CAP.
- Does the person have an anxiety disorder that may precipitate physiological responses (for example, tachycardia, shortness of breath)?

Care planning suggestions for cardiorespiratory problems include the following:

- Ensure that the necessary physical examination and laboratory studies (for example, electrocardiogram) have been carried out.
- Routinely help or instruct the person to get up from the bed or chair slowly, allowing for time to balance at the edge of the bed or chair.
- Consider daily use of support hose.
- Encourage the person to avoid large meals (have more frequent small meals) and/or rest after each meal.

- Review all medications that can cause blood pressure changes. Consider changing the medication, or dose, or timing of the dose as indicated. Consider if the timing of taking the medication minimizes its negative effects. For example, taking a diuretic in the evening may increase urinating frequency at night; getting out of bed at night places the person at greater risk of falling. Consider a morning dose, if possible. Medication that may increase sedation should be taken at night.

Environmental factors. Consider the following to identify hazards as well as making sure that proper assistive devices and spatial and structural features are in place:

- Assess the environment and provide for
  - Proper daytime and nighttime lighting
  - Elimination of glare
  - Proper height of bed and chairs
  - Proper bars, handrails, and devices in bathroom
  - No-shine floor/carpet, nonskid strips
  - Clear hallways, bedrooms, and bathrooms to be free of obstacles
- Persons using wheelchairs and walkers need enough space to manoeuvre safely. A 1.5-metre (5-foot) turning radius is considered ideal for most wheelchair users.
- Check for any recent change in the environment (for example, the person just moved into a new home). If the person has made such a move, has he or she been well oriented to the environment?
- Can the person get into the bathroom with an appropriate mobility aid? Doorways less than 90 cm (36 inches) wide may be a problem.
- Is there a need for alternative types of seating (for example, chairs, wheelchairs)? Assessment by a therapist can determine the best seating in accordance with the person's physical condition.
- Is the adaptive equipment being used properly?
- Is the assistive device in good condition? Sometimes people use canes, walkers, and wheelchairs that are not suitable for their size and height. Has the person's status changed, or is there any other reason to believe a new device is needed?
- Is the device new to the person? Does the person need additional training in how to use the device, when to use it, and what safety procedures must be taken?
- Are those helping the person aware of how much help or supervision the person needs?
- Does the person's footwear fit properly?

Additional Resources

American Geriatrics Society, British Geriatrics Society, American Academy of Orthopedic Surgeons Panel on Fall Prevention. 2001. Guideline for the prevention of falls in older persons. *Journal of the American Geriatrics Society* 49(5): 664–72.

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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

Appendix

interRAI Mental Health Scales and Algorithms

Description of scales and algorithms for the interRAI MH, CMH, and ESP (in alphabetical order of acronyms)

Abbreviation or Acronym	Scale	Items in the Scale	Interpretation of Scores
ABS	**Aggressive Behaviour Scale (ABS)** Measure of the frequency and diversity of aggressive behaviours.	Verbal abuse Physical abuse Socially inappropriate/ disruptive Resists care	Scores range from 0 to 12. Higher scores indicate greater frequency and diversity of aggressive behaviour. 0 = no signs of aggression 1–4 = mild to moderate aggression 5+ = more severe aggression
ADL HIERARCHY	**Activities of Daily Living (ADL) Hierarchy Scale** Measure of functional performance, reflecting a person's ability to carry out activities of everyday living.	Personal hygiene Locomotion Toilet use Eating	Scores range from 0 to 6. 0 = independent 1 = supervision required 2 = limited impairment 3 = extensive assistance required; level 1 4 = extensive assistance required; level 2 5 = dependent 6 = total dependence
ANHEDONIA	**ANHEDONIA** Reflects frequency of symptoms related to anhedonia.	Anhedonia Withdrawal from activities of interest Lack of motivation Reduced social interactions	Scores range from 0 to 12. Higher scores indicate higher levels of anhedonia.
CAGE	**CAGE** Screens for substance use.	Felt need to **C**ut down on substance use **A**ngered by criticisms from others **G**uilt about substance use "**E**ye-opener" (drinking/using substances in the morning)	Scores range from 0 to 4. A score of 2 or higher is considered to indicate a potential problem with substance addiction.

Abbreviation or Acronym	Scale	Items in the Scale	Interpretation of Scores
CPS	**Cognitive Performance Scale (CPS)** Describes the person's cognitive status.	Daily decision making Short-term memory Expression (i.e., making self understood) Self-performance in eating *See Figure 1*	Scores range from 0 to 6. 0 = intact 1 = borderline intact 2 = mild impairment 3 = moderate impairment 4 = moderate to severe impairment 5 = severe impairment 6 = very severe impairment
COMMUNICATION	**COMMUNICATION** Summary of two communication measures.	Making self understood Ability to understand others	Scores range from 0 to 8. Higher scores indicate poorer communication.
DRS	**Depression Rating Scale (DRS)** Measure of the frequency of indicators of negative mood.	Negative statements Persistent anger Unrealistic fears Repetitive health complaints Repetitive anxious complaints Sad, worried facial expression Crying or tearfulness	Scores range from 0 to 14. 3+ = indicative of possible depression 6+ = indicative of more severe depression
DSI	**Depressive Severity Index (DSI)** Alternative measure to DRS for depressive symptoms.	Sad, pained facial expressions Negative statements Self-deprecation Guilt/shame Hopelessness	Scores range from 0 to15. Higher scores indicate more depressive symptoms.
IADL CAPACITY	**Instrumental Activities of Daily Living (IADL) Capacity Scale** Estimate of higher-level function, reflecting others' perceptions of a person's ability to carry out IADLs.	Meal preparation Ordinary housework Managing finances Managing medications Phone use Shopping Transportation *Note: In other interRAI instruments the IADL capacity scale includes an item on stairs.*	Scores range from 0 to 42. Higher scores indicate less capacity.

Abbreviation or Acronym	Scale	Items in the Scale	Interpretation of Scores
MANIA	**MANIA** Measure of frequency of symptoms of mania.	Inflated self-worth Hyperarousal Irritability Increased sociability/ hypersexuality Pressured speech Labile affect Sleep problems due to hypomania	Scores range from 0 to 20. Higher scores indicate more manic symptoms.
PAIN	**PAIN** Measure of frequency and intensity of pain.	Pain frequency Pain intensity	Scores range from 0 to 4.* 0 = No pain 1 = Less than daily pain 2 = Daily pain but not severe 3 = Daily severe pain 4 = Daily excruciating pain
PSS	**Positive Symptoms Scale (PSS)** Two measures of the frequency of positive symptoms.	**PSS short** Hallucinations Command hallucinations Delusions Abnormal thought process **PSS long** PSS short + Inflated self-worth Hyperarousal Pressured speech Abnormal/unusual movements	PSS short scores range from 0 to 12. PSS long scores range from 0 to 24. Higher scores indicate higher levels of positive symptoms.
RHO	**Risk of Harm to Others (RHO)** Reflects risk of harm to others.	*See Figure 3*	Scores range from 0 to 6. Higher scores indicate increased risk of harm to others.
SCI	**Self-Care Index (SCI)** Reflects risk of inability to care for self due to psychiatric symptoms.	*See Figure 4*	Scores range from 0 to 6. Higher scores indicate decreased ability to care for self due to psychiatric symptoms.
SoS	**Severity of Self-harm (SoS)** Reflects risk of harm to self.	*See Figure 2*	Scores range from 0 to 6. Higher scores indicate increased risk of self-harm.

*Earlier versions of the pain scale had values ranging from 0 to 3.

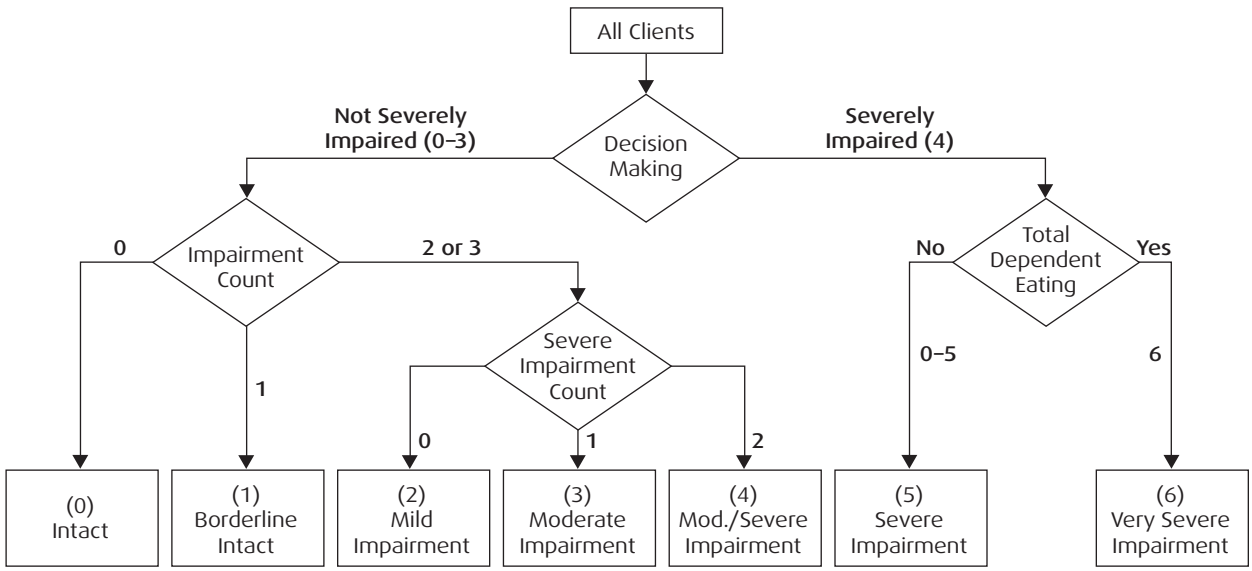

Figure 1. interRAI Cognitive Performance Scale (CPS)

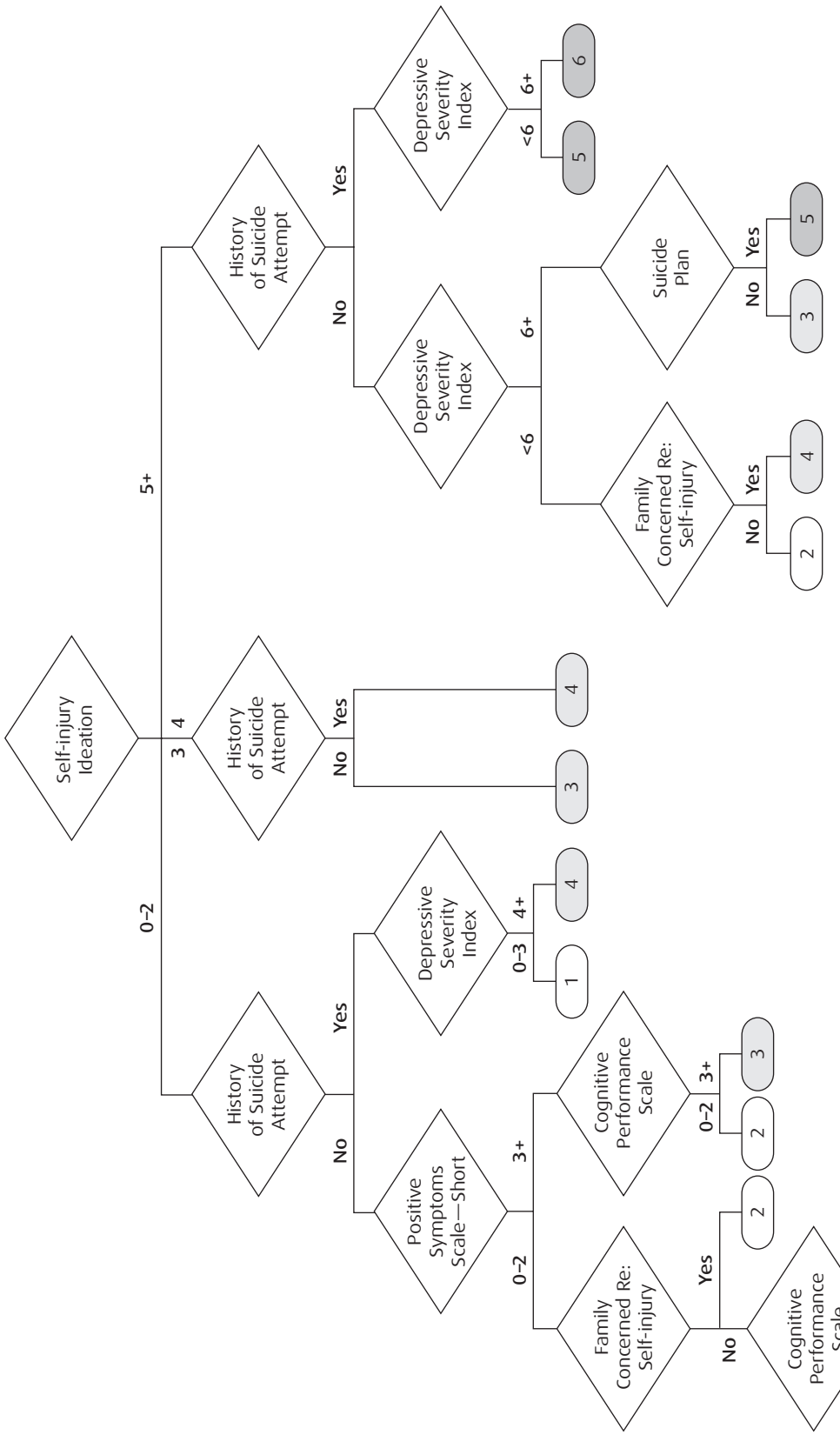

Figure 2. interRAI Severity of Self-harm (SoS) Scale

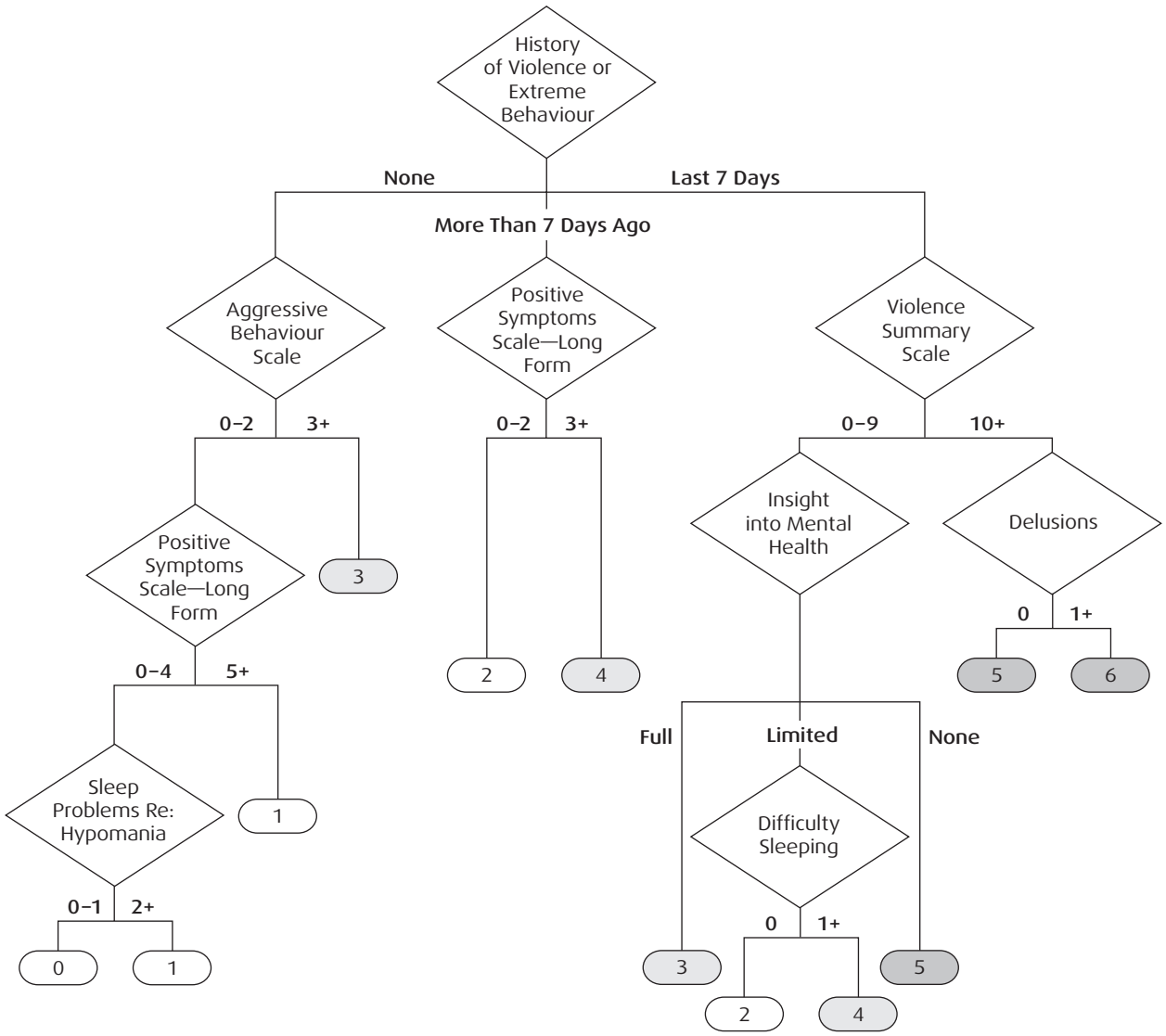

Figure 3. interRAI Risk of Harm to Others (RHO) Scale

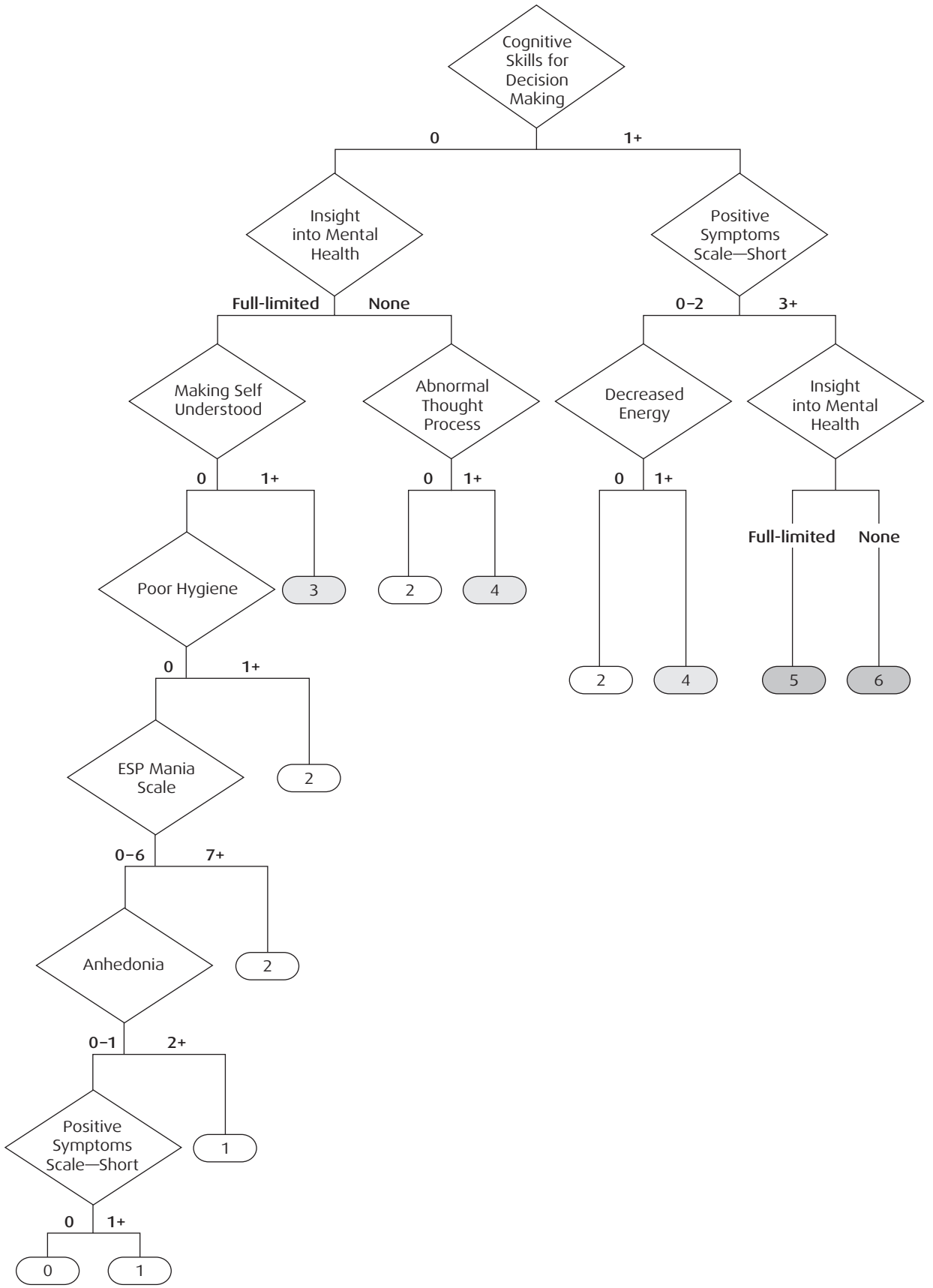

Figure 4. interRAI Self-Care Index (SCI)

Integrated Health Information System

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.

Every instrument in the interRAI family of tools and applications has been developed for a particular population, yet the instruments are designed to work together to form an integrated health information system—a global standard. As an organization, interRAI maintains the highest level of quality for the measures used in our instruments. Each instrument is the product of rigorous research and testing to establish the reliability and validity of items, outcome measures, assessment protocols, case-mix algorithms, and quality indicators.

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interRAI Post-Acute Care (PAC)
interRAI Acute Care (AC)
interRAI Palliative Care (PC)
interRAI Mental Health (MH)
interRAI Community Mental Health (CMH)
interRAI Intellectual Disability (ID)
interRAI Mental Health for Correctional Facilities (CF)
interRAI Contact Assessment (CA)
interRAI Emergency Screener for Psychiatry (ESP)
interRAI Self-Report Quality of Life (QOL)

The interRAI suite of instruments is offered in multiple languages, in print and electronic formats.

For more details, visit:

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