



A Systematic Overview of Mental Health for Therapy Practitioners

Overview of Mental Illness



Dementia or Depression

Depression in the elderly is often misdiagnosed as dementia.



Depression

- Complains about cognitive loss in detail
- Makes little effort to perform even simple tasks
- Demonstrates marked variability in performance of tasks of similar difficulty
- Changes in affect are pervasive

Dementia

- Few complaints of cognitive loss; if any, these are vague
- Performance of tasks of similar difficulty is consistently poor
- Affect is shallow
- Labile



Mental vs. Physical

- Don't take mental health symptoms personally
- Mental health symptoms = physical health symptoms
- Complications from physical illness = complications from mental illness
 - Wound from diabetes
 - Manipulative behavior from borderline personality disorder
- Setting your own boundaries to keep yourself safe is required
- Ensuring you take care of your own mental health is required, as this type of work can be emotionally challenging and at times exhausting

Medications



Medications

- Factors that can impact how medications work
 - Type of mental disorder (depression vs. schizophrenia)
 - Age, gender, and body size
 - Physical illnesses/co-morbidities
 - Habits such as smoking and drinking
 - Liver and kidney function
 - Genetics
 - Other medications and herbal/vitamin supplements
 - Diet
 - Whether medications are taken as prescribed

Medications

Medications - It is important to know the medications your patients receive and any known side effects.

- Type
- Dose
- PRN vs. scheduled
- How long patient has been on the medication
- Want to be informed prior to starting medications, any change in medications, awareness of contraindications of all medications, etc.
- A strong relationship with pharmacist, GNP, nursing, and physician is key.



2012 CMS Initiative

- CMS developed a national action plan to improve behavioral health management and to safeguard nursing home residents from unnecessary antipsychotic drug use.
- The goals were to improve non-pharmacologic interventions for behavioral health management in nursing homes and, therefore, to reduce inappropriate antipsychotic medication use in nursing homes and other care settings.

(CMS, October 2012)



Reasons for the CMS Initiative

- **Nationwide there is a high prevalence of antipsychotic drug use in nursing homes.**
- **Antipsychotic medication:**
 - Can be dangerous to residents
 - Is poorly regulated in regard to utilization in some states
 - Can be expensive
 - Is sometimes given without first trying other methods to address issues
 - Is believed to lead to many residents' death when used inappropriately
 - Is often considered a chemical restraint



Antipsychotic Medication Reduction
Role of Therapy

- Review with nursing residents currently on psychoactive medications.
- Determine if therapeutic interventions may reduce the need for psychoactive medications.
- Assess resident if indicated:
 - Develop program to address behavioral issues
 - Utilize cognitive testing to help impact of different medications
 - Educate the facility staff on behavioral techniques
- Develop system to facilitate referrals to therapy before a patient is put on antipsychotic medications.
- Assist with determining the optimal dose with cognitive testing.



Antipsychotic Medication Reduction
Therapy Screens

- Questions to ask during the screen for looking at medication reduction:
 - How long has this behavior been occurring that resulted in the use of the medication?
 - What interventions/approaches have been successfully or unsuccessfully attempted?
 - Ask "why" the resident is displaying that behavior five times. What need is the resident trying to communicate?
 - What time of day does the resident exhibit concerning behaviors?
 - Is there a functional maintenance program (FMP) in place to address the concerning behaviors?



Antipsychotic Medication Reduction
Determining the Need for Skilled Intervention

- Proceed with skilled intervention if an FMP has never been established to address:
 - Impairments in ADLs
 - Behavior issues
 - Ability to be involved in purposeful activity
 - Communication, pragmatics
 - Risk for falls
 - Poor positioning
 - Reduced mobility
- Proceed with skilled intervention if the FMP which was developed is no longer effective



Schizophrenia

<u>Common Medications</u>	<u>Common Side Effects</u>
•Thorazine	•Drowsiness
•Clozaril	•Dizziness when changing positions
•Haldol	•Blurred vision
•Geodon	•Rapid heartbeat
•Risperdal	•Rigidity
•Invega	•Persistent muscle spasms
•Zyprexa	•Tremors
•Seroquel	•Restlessness
•Abilify	•Tardive dyskinesia (muscle movements a person cannot control)

Depression

<u>Common Medications</u>	<u>Common Side Effects</u>
•Prozac	•Headache
•Celexa	•Nausea
•Zoloft	•Blurred vision
•Paxil	•Sleeplessness
•Lexapro	•Drowsiness
•Effexor	•Agitation or jitteriness
•Cymbalta	•Dry mouth
•Wellbutrin	•Constipation
	•Bladder problems
	(Most resolve quickly)

Bipolar Disorder

<u>Common Medications</u>	<u>Common Side Effects</u>
•Zyprexa	•Loss of coordination
•Depakote	•Frequent urination
•Abilify	•Slurred speech
•Tegretol	•Irregular heartbeat
•Risperdal	•Changes in vision
•Geodon	•Excessive thirst
•Clozaril	•Nausea, vomiting, stomach pain
•Lithium	•Anorexia, loss of appetite, weight changes

Anxiety Disorders

Common Medications

- Klonopin
- Ativan
- Xanax
- Buspar



Common Side Effects

- Weakness
- Fatigue, trouble sleeping, grogginess
- Blurred vision
- Lightheadedness
- Excitement
- Confusion
- Nervousness

Nutrition



Nutrition

- Food and the patient's relationship with food is one primary basic need. Abuse or misguided decisions may be the patient's attempt at struggling with control.
- Consult with your dietitian and/or nursing team for collaboration surrounding possible nutritional contributions to mental illness.
- Although research related to nutrition and mental illness effects is controversial, there are two widely accepted tests that are highlighted on the next slide which could have a dramatic effect on your patient's functioning.

Nutrition

- **Vitamin B12 Deficiency**
 - Slow cerebation, confusion, memory changes
 - Delirium, with or without hallucinations and/or delusions
 - Depression
 - Acute psychotic states and (more rarely) reversible manic and schizophreniform states
- **Vitamin D Deficiency**
 - Meta-analysis found low Vitamin D concentration is associated with depression and highlighted the need for randomized controlled trials of Vitamin D for the prevention and treatment of depression to determine whether this association is causal.

Assessments



Assessment - Overview

- **Read or talk to the patient to get the history.**
 - Clues to behavior triggers
 - Indicators of meaningful activities
- **Engage family/friends when possible.**
- **Observe the patient.**
 - Take multiple days
 - Various times of day
 - Function may fluctuate
 - Observe the behaviors that nursing and/or family have expressed concern over
- **Assure that analysis drives application to treatment daily.**
- **Analyze the time of day that seems to present a pattern in the undesirable behavior.**

Highly Recommended

- **Nursing Home Behavior Problem Scale (NHBPS)**
- **Independent Living Skills Survey (ILSS and ILSS-SR)**
- **Allen Cognitive Level Tests (all)**
- **Geriatric Depression Scale (GDS)***
- **Interest Checklist/Modified Interest Checklist***
- **Hamilton Anxiety Scale (HAM-A)***
- **Ross Information Processing Assessment – Geriatric (RIPA-G)**
- **Sensory Diet Exploration: Activity Checklist**

General Assessments

- **Nursing Home Behavior Problem Scale (NHBPS)**
- **Independent Living Skills Survey (ILSS-SR and ILSS-I)**
 - Self Report (SR) or Knowledgeable Informant (I) - available on YouTube
 - 103 items in 12 skill areas
 - \$25 www.psychrehab.com/assessment_assessment_ilss
- **Kohlman Evaluation of Living Skills (KELS)**
 - Score sheet is in SMART under Clinical Forms
 - Adolescents and adults with brain injury, cognitive impairment, and short-term psychiatric needs
 - 17 basic living skills in the areas of self-care, safety and health, money management, transportation and telephone, and work and leisure
 - \$35 for AOTA members, \$45 for non-members

General Assessments

- **Interest Checklist/Modified Interest Checklist***
 - MOHO and Cognitive Disabilities frame of reference combined
- **Caregiver Supplemental Questionnaire***
- **Katz Index of Independence in Activities of Daily Living**
- **Assessment of Motor and Process Skills (AMPS)**
 - <http://www.innovativeotsolutions.com/content/amps/>
 - Must attend a specialized training course in the standardized AMPS administration procedures and be calibrated as a valid and reliable AMPS rater
- **Canadian Occupational Performance Measure (COPM)**
 - www.caot.ca \$52.45
 - Self assessment of change of performance over time
 - Not to be used for patients with cognitive impairments

Assessments

- **Psychogeriatric and Risk Behavior Assessment Scale (PARBAS)**
 - \$35 www.sciencedirect.com
 - For older adults living in the community
 - Assesses self neglect, non-compliance, substance abuse, risk toward self or others, aggressive behavior, emotional distress, suicidal behavior, personal security, risk of victimization, and financial security
- **Community Integration Questionnaire (CIQ)**
 - Original use was for patients with a TBI; expanded to CVA, SCI, but has face validity for mental health
 - Brief, reliable measure of an individual's level of integration into the home and community
- **WHO Quality of Life-BREF (WHOQOL-BREF)**
 - Assesses the individual's perceptions in the context of his/her culture and value systems and personal goals, standards, and concerns



Depression Assessments

- **Geriatric Depression Scale (GDS)***
 - Long form and short form
 - Multiple languages available
 - Apps for iPhone and Android available
- **Beck Depression Inventory (BDI-II)**
 - Copyright applies, \$121/kit www.pearsonassessments.com
 - Self report, self scored 21 questions
 - Short form, 7 questions, primary care provider administers
- **Patient Health Questionnaire (PHQ-9)***
 - Optional replacement for BDI
 - Multiple choice, self inventory for depression, anxiety, alcohol and eating disorders, and somatoform



Anxiety Assessments

- **Beck Anxiety Inventory**
 - 21 questions, multiple choice, self-report
 - \$121/kit available at www.pearsonassessments.com
- **Hamilton Anxiety Scale (HAM-A)***
 - 14 symptom-oriented questions
 - Administered by the clinician in about 10-20 minutes. The clinician must choose the possible responses to each question by interviewing the patient and by observing the patient's symptoms.



Cognitive Assessments

- **Allen Cognitive Level**
 - Routine Task Inventory - Expanded (RTI-E)*
 - Allen Diagnostic Module (ADM) - placemat, key fob, etc.
 - Large Allen Cognitive Level Screen - 5 (LACLS-5)
 - Cognitive Checklist (screen)*
- **Cognitive Performance Test (CPT)**
 - Previously associated with Allen, but separate now
 - Uses functional tasks that require problem solving
- **St. Louis University Mental Status (SLUMS)***
 - Research shows relevance to mental health as well as dementia (form states dementia)
- **Montreal Cognitive Assessment (MoCA)***
 - www.mocatest.org Various versions are available online

Cognitive Assessments

- **The Brief Cognitive Assessment Tool (BCAT)**
 - Research supports use with schizophrenia and links to function
 - <https://www.thebcat.com>
 - Also available in Spanish
 - Must be a member to get full access (approximately \$175-\$195)
 - Takes 10-15 minutes to administer the full BCAT
 - Differentiates mild cognitive impairment (MCI) from dementia
 - Created for professionals in SNF, ALF, and ILF
 - Online scoring gives factor scores, clinical considerations, and a test report
 - Three free self-assessments are available for patient use (do not require a license to access):
 - Memory
 - Driving
 - Power Mobility

Cognitive Assessments

- **Clock Drawing Test***
 - Taps into a wide range of cognitive abilities including executive functions
 - Quick and easy to administer and score with excellent acceptability by subjects
 - Can be used for monitoring cognitive changes
- **Delirium Screening and Management Card***

Communication Assessments

- **Functional Assessment of Communication Skills for Adults (ASHA FACS)**
 - Research on adults with aphasia due to left hemisphere CVA and adults with cognitive-communicative disorders resulting from TBI
 - Has face validity for cognitive disorders related to psychiatric diagnoses
 - \$124 for members, \$165.00 for nonmembers www.asha.org
- **Arizona Battery for Communication Disorders (ABCD)**
 - Target population is persons with dementia, but face validity exists for communication disorders related to psychiatric diagnoses
 - \$270 for kit available at www.proedinc.com

Communication Assessments

- **Ross Information Processing Assessment - Geriatric (RIPA-G)**
 - Norm-referenced assessment battery designed to identify, describe, and quantify cognitive-linguistic deficits
 - Research completed for TBI
 - Geriatric, Second Edition (RIPA-G:2) for 55 and older
 - \$142/kit available at www.proassessments.com
- **Functional Linguistic Communication Inventory (FLCI)**
 - Target population is persons with dementia, but face validity exists for communication disorders related to psychiatric diagnoses

Speech

- **Voice Assessment**
 - Consensual Auditory-Perceptual Evaluation of Voice (CAPE-V) *
 - GRBAS Scale
 - Aegis Voice Disorders Tool *
 - Voice problems may be present
 - Functional problem manifested due to poor coping strategies (screaming or yelling causing vocal fry, etc.)
 - Dry mouth, a side effect of medications, can result in voice or swallowing issues



Sensory Assessments

- **Adolescent/Adult Sensory Profile**
 - A trait measure of sensory processing patterns and effects on functional performance
 - \$135/kit at www.pearsonassessments.com
- **ACL Sensory Stimulation Rating Sheets*** - 1 and 2
- **Sensory Diet Exploration: Activity Checklist**
- **Hearing screening - often correlates with depression**
 - Apps available for minimal to no cost and give pass/fail for recommendation for full exam

Visual Perceptual Assessments

- **Developmental Test of Visual Perception - Adult (DTVP-A)**
 - Six subtests are: copying, figure ground, visual-motor search, visual closure, visual-motor speed, and form constancy; a composite score is obtained
 - \$239 at www.proedinc.com
- **Motor-Free Visual Perceptual Test (MVPT-3)**
 - Perceptual tasks include spatial relationships, visual discrimination, figure-ground, visual closure, and visual memory
 - \$140 for the kit at www.therapro.com
- **Assess visual perceptual impairment vs. hallucination**
 - Visual attention
 - Oculomotor control

Falls Assessments

- **Which test for which patient and why?**
 - Combine test with the patient's likes/dislikes.
 - Choice of test depends on the patient's ability to follow commands.
 - Some people with schizophrenia are able to follow the instructions without difficulty while others are not able to complete the tasks appropriately due to disorganized thought processes.
- **DOCUMENT THE CHOICE OF TESTS AND WHY YOU CHOSE THAT TEST. THIS IS EVIDENCE OF SKILLED SERVICE!**
- **Caregiver/care partner input for behavior patterns.**
 - 24 hour nursing report or stand-up meeting

Falls Assessments

- **Start with an easier test with good success rate. This allows you time to build rapport.**
 - Modified Sensory Integration Test (MSIT)
 - Tinetti – requires ability to follow directions
 - Timed Up and Go (TUG)
 - Functional Reach – watch for substitutions
- **Advance to more complex tests, especially for community ambulators.**
 - Berg
 - Dynamic Gait Index
 - 6 Minute Walk Test
 - Single Leg Stance – simple to follow, difficult test



Falls Assessments

- For patients who are unable to follow instructions for formal balance tests, describe how much assistance they require with static/dynamic standing balance with/without UE support.
- Describe gait with respect to balance deficits such as wide base of support (WBOS), path deviation, lateral trunk sway, loss of balance with changing directions or head turns, etc.
- Balance scores can be less predictive of falls for people with mental illness due to disorganized thoughts and poor safety awareness.
- People with severe mental illness are more likely to put themselves in situations that place them at risk for falls.



Physiological Status

- **Pain**
 - McGill Pain Scale - 0 (least) to 10 (worst)
 - Visual Analog Scale (VAS)* - can be horizontal or vertical
 - Wong-Baker FACES Scale - available in our Pain Program
 - Pain Assessment In Advanced Dementia (PAINAD)
 - Discomfort Scale for Dementia of the Alzheimer's Type (DS-DAT)
- **Borg Scale of Perceived Exertion, or Modified Borg**
- **Heart rate and quality**
 - Thready, pounding, irregular, etc.
- **Respiration rate and quality**
 - Deep, shallow, irregular, etc.



Motor Assessments

- **Fugl-Meyer Assessment for LE and UE**
 - Based on CVA, has face validity for other motor impairments
 - Ceiling effect possible
- **9-Hole Peg Test** - for fine motor
- **Box and Block Test**
 - Wide variety of populations tested
 - Free, but supplies are required or can be purchased for ~\$200
- **Action Research Arm Test ***
 - Tested on CVA, MS, TBI, has face validity for any motor issue
 - Free, but need supplies - including a cricket ball!

Intervention



Overview to Interventions

- We know that mental health issues often result in lack of participation in life activities, including therapy, as well as a multitude of behaviors that are maladaptive or disruptive to the environment.
- Intervention strategies vary as widely as the manifestations of mental health disorders.
- We start with general principles of motivation and building rapport.
- Next we move into Behavior Modification programs.
- We continue with Behavior Strategies and then Intervention Techniques.
- We finish by looking at common areas for therapy intervention.

Approach and Rapport

- **Approach and rapport take time!**
 - Long-term: May address more physical needs such as pain reduction with hot packs or diathermy. Talk to the patient and build a relationship. Move to mental health goals later.
 - Short-term: Processing speeds due to mental illness are often delayed. Speak slowly, and wait for a response.
- **As a stand-alone service, this is not a covered service. It must be integrated into your other skilled services.**
- **Be genuine. This population can read through a "fake" relationship development.**



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Approach and Rapport

- **Demonstrate interest in the individuals; compliment them and ask about the areas they have interest/values in.**
 - Listen sincerely
 - Talk to them daily – every time you see them
- **Eye contact** – modify based on patient's response
- **Body language** – closed arms mean anger or resistance
- **Direction of physical approach** – do not approach from behind
- **Flexible agenda** – have your co-created goals in mind, but know that secondary goals may be more pressing to the patient and working on those may allow you to work on your longer term goals later



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Approach and Rapport

- **Reliability**
 - Do what you say you are going to do and when you say you are going to do it
 - Be early vs. late, but on time is best
- **Acknowledgement of mistakes and apologies**
- **Use of humor** - really depends on the patient!
- **Communication**
 - Tone of voice
 - Use of positive communication
 - Suggest vs. order
- **Personal space/physical contact – be aware**



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Approach and Rapport

- **Explanation of intervention strategies**
 - Don't talk down – collaborate
- **Respond to “inappropriate” comments** – be gentle but firm
- **Celebrate differences!**
- **Be aware of dress**
 - No lab coat
 - Fun and bright colors are good
 - Be aware of skin exposure
- **Do not take things personally**
- **Respect privacy needs**

Intervention Strategies



Motivating the Unmotivated

- Use Interest Checklist, My Way, or other means to determine what is personally motivating, valuable, and meaningful to the patient. (See resource section in program manual.)
- Treat in the room.
- Work with patient to educate on what therapy is and why.
- Bargain.
- Just “go on a walk” and end up in the therapy room.
- “Let’s go get a cup of coffee.” Walk to nursing cart to get pain pill.
- Offer pain relief—hot packs, e-stim, massage—empathize to motivate.
- Get personal.
- Talk about the patient’s day to work on cognition, role performance, etc.
- Explain how therapy can help the patient achieve his/her goals.

Intervention Strategies

- **Encourage patients to take an active role in and ownership of the process.**
 - Sometimes they don't appear to care about the outcome. Allow them the time to process and understand the desired outcome.
 - They may surprise you; they may understand more than you think they understand about their situation.
- **Contractual agreements – formal or informal commitment which gives the patient control.**
- **Establish times/routines – be consistent, stick to it!**
- **Use the Behavior Strategies**
- **Use the Intervention Techniques**

Intervention Strategies

- **Design a program for behavioral change that includes both:**
 - Positive reinforcements
 - Praise
 - Reward system within the facility
 - Manicure/hand massage
 - Play their chosen music
 - Special seat at the table
 - Natural negative consequences
 - No extra smoke break, etc.
- **Involve the entire team of caregivers**
 - The more consistency, the more effective
 - Decreases staff splitting (patient goes to caregiver who doesn't know about the plan)
 - Improved opportunity for patient to receive positive reinforcement

General Long-Term Intervention Strategies

- Celebrate and appreciate people's differences!
- Allen Cognitive Level assessment
- Purposeful activities or meaningful occupations
- Coping skills training
- Optimal communication
- Behavior modification
- Exercise prescription
- Medication management
- Community (re)integration
- Values clarification activities
- Health care literacy
- Caregiver education

Behavior Modification



Changing behaviors to more healthy choices



Behavior Modification Overview

- **Recognize the behavior for what it truly is:**
 - A form of communication, attempting to get needs met
 - A clue to uncover the person's need; a message to us
- The point of behavior modification techniques is to change undesirable or harmful behaviors and replace them with healthier, more desirable ones.
- When applied properly, the technique can be effective in working with anyone with mental illness.
- Help clients take responsibility for behaviors, thus to elicit change and create good habits that can impact the patient's outcomes for long-term placement.

Behavior Modification Process: Overall Steps

- **Determine target behavior with nursing/caregiver.**
 - Nursing Home Behavior Problem Scale
 - Stand-up/start-up meeting or QA&A
 - Observation, screens, CNA report
- **Assess and analyze the person and the behavior.**
 - Antecedent Behavior Monitoring Log – See resources in program manual
 - Behavior Management Tracking Form to track interventions used and determine the most effective technique – See resources in program manual
- **Attempt one intervention technique at a time, monitor for effectiveness, and modify as needed.**
- **Teach caregivers/care partners techniques.**
- **Document every step of the way.**

Behavior Modification: A Team Approach

- **Educate the staff regarding the intent of behaviors.**
 - Many times staff will take the behavior personally, that the resident is purposefully acting out to affect them or to make their job harder.
 - Staff may think that the resident is just choosing to be difficult when actually the resident cannot control the behavior.
 - When this attitude is present, then staff members are not even considering the possibility that there is a legitimate cause for the behavior.
- **The more staff is involved in the solution, the better the adherence to the plan.**



Selecting a Behavior to Address

- ASK: Does the behavior significantly violate the rights of others, including other persons with dementia, family, and staff?
- ASK: Does the behavior pose a significant threat to anyone's health/safety?
- ASK: Does the behavior make it significantly more difficult to meet the basic needs of the resident or to comply with regulations?



Behavior Analysis Considerations

- Physical Conditions
- Illness, pain, infections, medication side effects
- Psychological Conditions
- Fear, loneliness, grief, depression
- External Factors
- Telephone, PA system, weather, interactions with others
- Environmental Factors
- Sensory processing / modulation, excess stimulation, conflicting cues
- Task Related Issues
- Too complicated, excess steps



Assessing the Behavior and Possible Cause

- What **specifically** occurs?
 - Behaviors should be described accurately in specific, objective, and observable terms.
 - "Hits caregiver with a closed fist" vs. "Is aggressive."
 - "Removes dentures during mealtime and cleans with tongue" vs. "Socially unacceptable."
- **When** does it occur?
- **How often?** What is the **SCOPE?** (see next slide)
- **Who** is it a problem for? What is the **SEVERITY?** (see next slide)
- Events surrounding? A-B-C (see 2 slides later)
- What is the need?
- Past interventions?



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Assessing the Behavior

The American Medical Association recommends the following:

Scope: The behavior occurs...

- **Rarely:** irregularly, no more than a few times a month
- **Occasionally:** irregularly, as much as a few times a week
- **Often:** regularly, almost daily
- **Continuously:** regularly, many times daily

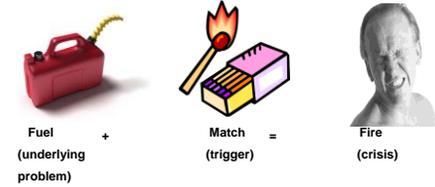
Severity: Behaviors posing...

- **Minimal risk** to the individual or others, or are rarely disruptive socially (e.g., anxious or wanders safely)
- **Slight risk** to the individual or others or are sometimes disruptive socially (e.g., throws food or mildly verbally abusive)
- **Moderate risk** to the individual or others or are often disruptive socially (e.g., goes into others' rooms or wanders unsafely)
- **Major risk** to the individual or others, or are always disruptive socially (e.g., defecates in public or becomes violent)



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Behavior Analysis: Cause



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Behavior Strategies

•At times it may be more applicable to create an intervention plan with short- and long-term strategies based on a specific impairment or a specific behavior.
 •The Behavior Strategies are resources to use for your reference as well as handouts for educating and practicing with other therapists, nurses, and caregivers.

Attention Span	Catastrophic Reactions	Disrobing	Hallucination	
Manipulative Behavior	Paranoid Behavior	Physical Aggression	Resistance to Care	Unjustified Complaining
Unsafe Movements	Verbal Aggression	Wandering	Yelling and Screaming	Hoarding

Intervention Techniques

- Validation
 - Rescuing
 - Distraction
 - Bridging
 - Chaining
 - Task Break Down
 - Reminiscing
 - Memory book/wallet
 - Reality Checking
 - Redirecting
 - Environmental modification
 - Humor - self directed
 - Ask for the person's help
- Reassurance
 - Rechanneling
 - Sensory intervention
 - Stimulation
 - Modulation
 - Diet
 - Stress Reduction
 - Relaxation
 - Meditation
 - Music
 - Idea planting
 - (Re)Orientation
 - Empowerment

Sensory Processing



Sensory Processing and Integration

- Sensory processing is the gateway to motor activity.
- Sensory is built on three basic systems: tactile, vestibular, and proprioceptive.
- Goal is to determine person-specific preferences and create an environment or "tool kit" the patient can be independent with to modify his/her sensory input.
- Difficult to research as there are so many variables, and it is all about individual preferences. Consider:

Music	Light	Colors	Textures
Seating	Ace Wrap	Squeezies	Aromas
Tastes	Brushing	Weights	Noises

Sensory

- **Over-stimulation**
 - Decrease noise: TV, radio, paging system
 - Decrease light: dimmer lights
 - Weighted blanket*
 - Rocking chair
 - Slow rhythmic music and motion
- **Under-stimulation**
 - Increase access to radio, musical instruments, TV
 - Increase light: open blinds, ensure patient has activity within his/her visual field
 - Exercise, dance, or other movement based activities
 - Hand rub or back rub

Sensory Processing and Integration

Specialty techniques—additional training required

- **Wilbarger Protocol for Sensory Defensiveness/Deep Pressure and Proprioceptive Techniques (DPPT)**
 - Known commonly as the brushing technique
 - Increases coordination of movement, functional communication, sensory modulation, and self regulation
- **Hugs and Tugs**
 - Proprioceptive input and deep pressure
- **Masgutova Techniques**
 - Sensory or proprioceptive stimulation for a reflex, followed by motor response
 - Create or enhance a neurological pathway

Visual Perception

- **Visual inattention**
 - Daily tasks that require visual motor skills, i.e., tying shoes, putting on socks, putting on makeup
 - Activities that require visual motor skills, i.e., peg board, beading
 - Train client to recognize need for non-distracting environment
 - Client requires a quieter room for functional tasks including dining

Self Care and IADL Programming



Self Care and IADL Programming

- **Consistency is key. Routine, routine, routine! Use cueing, checklists, etc.**
- **Include many purposeful tasks**
 - Basic self cares: DAILY work toward self-initiated independence
 - Make the bed: DAILY
 - Clean room: DAILY
 - Sweeping, dusting, vacuuming, setting and clearing tables
 - Folding own clothes

General Exercise for Mental Health

How does exercise help depression and anxiety?

Exercise probably helps ease depression in a number of ways, which may include:

- Releasing feel-good brain chemicals that may ease depression (neurotransmitters and endorphins)
- Reducing immune system chemicals that can worsen depression
- Increasing body temperature, which may have calming effects



General Exercise for Mental Health

Exercise has many psychological and emotional benefits.

It can help:

- **Gain confidence** - Meeting exercise goals or challenges, even small ones, can boost self-confidence. Getting in shape can also make you feel better about your appearance.
- **Take your mind off worries** - Exercise is a distraction that can get you away from the cycle of negative thoughts that feed anxiety and depression.
- **Get more social interaction** - Exercise may give the chance to meet or socialize with others. Exchanging a friendly smile or greeting when walking around your neighborhood can help elevate mood.
- **Cope in a healthy way** - Doing something positive to manage anxiety or depression is a healthy coping strategy.



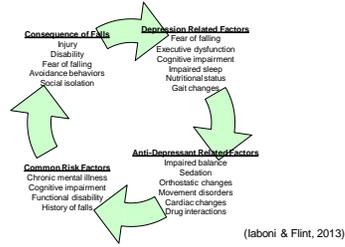
Falls Reduction



Falls Reduction

- Those with mental health and substance abuse issues are 1.5-5. times more likely to fall than the general elderly population (Finkelstein et al., 2007)
 - Changes with disease process
 - Cognition
 - Impulsivity
 - Sensory perceptual processing
 - Hallucinations and/or delusions
 - Motor control and motor planning
 - Refer to medication section, especially PRN medication usage
 - **Select assessments based on interests and ability**
 - **Analyze behaviors**
 - Understand fears
 - Observe for attention, hallucinations, delusions

Interplay of Falls and Depression and Treatment



Falls Intervention

- **Medications**
 - 2 week lag time before full impact of medication changes
- **Wii, Virtual Reality, etc.**
 - Many times a younger client is more engaged with this "normalized" activity
- **Balance in kitchen, bathroom, etc.**
- **Use what is already in the room.** "Show me how to do it right." "Do you need to use the bathroom?" "Let's walk down and see what they're having for lunch today."

Falls (continued)

- **Aegis Therapies Programs**
 - Balance Management for Patients with Cognitive Impairments
 - Look Up - Reach Up
 - Reach High - Reach Low
 - Standing - Stepping
 - Strengthening During Activity
 - Falls and Balance Management
 - Crosswalks from Berg and Tinetti from Balance Management Program Manual
 - Focused intervention based on deficits noted on standardized tests



Antecedent Behavior Monitoring Log

Directions: All staff should observe resident behaviors for the period indicated. Identify each noted behavior as inhibiting patient's safety or independence.

Start Date _____ Time _____ End Date _____ Time _____

Check If Ongoing _____

Where was the resident?

What happened before the behavior? (could be immediately before or earlier in the day)

Describe behavior: What did resident say/do?

What did staff do to intervene?

What was the resident's response to interventions?



Behavior Tracking Tools

BEHAVIOR MANAGEMENT TRACKING					
	Baseline	Week 1	Week 2	Week 3	Week 4
Behavior 1					
Behavior Modification Techniques					
Behavior 2					
Behavior Modification Techniques					
Medications or Changes					
Impact of side effects?					
Nursing Consult?					
Pharmacy Consult?					
Doctor Consult?					
Notes:					



Transition from Skilled Therapy



Transition Considerations

- **Communication**
 - Guardian
 - Mental health practitioner
 - Family or support system
 - Social worker
 - Interdisciplinary team
- **Cognitive scores**
- **Commitment through courts**
- **Community resources**
- **Housing availability**



Skilled Nursing Facility/Long-Term Care

•Partner with the Activities Department or Recreation Therapy for ongoing involvement in any of the following as appropriate.

•You can work with them in setting up programs like these on the right, as two people working together on a project often have better outcomes.

•Involve other residents, peers, and friends as appropriate.

- Brain Gym
- Nintendo DS XL – Brain Age
- Birthday Club
- Holiday Club
- Gardening Club
- Trivia Night
- Strive to Thrive
- Exercise Groups
- Hugs and Tugs

Supportive Housing or Home

Community Integration Activities – Use the Community Integration Questionnaire

- Grocery store/drug store – make lists and purchases
- Calls to get prescriptions refilled – medication management
- Go to the bank – money management
- How to structure the day
- Meal planning and practice in the environment
- Take the bus, call to set up transportation
- Navigating using maps, bus schedule, GPS/phone
- Go out for coffee or to a restaurant
- Social appropriateness, how to ask for help, dealing with verbal confrontations



Supportive Housing or Home

- Use the social worker – either the SNF social worker or a community or county social worker, as they are the experts
- Friends, family, and public support
 - Home health – psychiatric nursing is available
 - Case workers
 - Guardianship
 - Caregiver education
 - Find actual commitment
- Supportive work options
- Leisure activity analysis and options for implementation



Billing and Medicare Regulations



Billing Codes (As of July 11, 2014)

- Know your MAC and the LCDs
 - WPS
 - Development of Cognitive Skills: ...persons with acquired cognitive impairments resulting from head trauma or acute neurologic events including CVA...not indicated for patients with chronic progressive brain conditions without reasonable potential for restoration.
 - SI: ...techniques used in treatment for adults should be coded with CPT code 97112.
 - Cahaba
 - Development of Cognitive Skills: ...Restore ONLY. Must be billed with other OT procedures. Must show ability to retain learned info. Just memory improvement is not covered, must be functional.
 - SI: ...no more than 4-6 visits, no more than 30 minutes/session.



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Billing Codes (As of July 11, 2014)

- NGS and CGS
 - SI: ...should be used infrequently with Medicare population
 - Cognitive Skills Development is usually billed inclusive in other codes. Coverage for 97532 is limited to the following conditions:
 - 310.1 Personality change due to conditions classified elsewhere
 - 310.81 Pseudobulbar affect
 - 310.89 Other specified nonpsychotic mental disorders following organic brain damage
 - 310.9 Unspecified nonpsychotic mental disorder following organic brain damage
- First Coast: 97532 is for neurological disorders.
- Novitas
 - Some states—a chronic progressive condition must have potential for restoration.
 - Other states—soft language that some reviewers could restrict coverage if the only diagnosis is dementia. It may be medically necessary for patients with acquired cognitive impairments from head trauma, acute neurological events (including cerebrovascular accidents), or other neurological disease.
 - Other states—no restrictions.
- Palmetto and Noridian: No specific restrictions



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Billing

This is from the SNF Medicare Manual:

- Skilled observation and assessment may also be required for patients whose primary condition and needs are psychiatric in nature or for patients who, in addition to their physical problems, have a secondary psychiatric diagnosis.
- These patients may exhibit acute psychological symptoms, such as depression, anxiety, or agitation, which require skilled observation and assessment such as observing for indications of suicidal or hostile behavior.
- However, these conditions often require considerably more specialized, sophisticated nursing techniques and physician attention than is available in most participating SNFs.
- Therefore, these cases must be carefully documented.



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Billing

This is from the Outpatient (Part B) Medicare Manual:

- Occupational therapy is ... treatment concerned with improving or restoring functions which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning.
- Such therapy may involve: The planning, implementing, and supervising of individualized therapeutic activity programs as part of an overall "active treatment" program for a patient with a diagnosed psychiatric illness, e.g., the use of sewing activities which require following a pattern to reduce confusion and restore reality orientation for a schizophrenic patient.

Billing

Application of Medicare Guidelines to OT Services

- ...However, where an individual's motivational needs are not related to a specific diagnosed psychiatric illness, the meeting of such needs does not usually require an individualized therapeutic program. Such needs can be met through general activity programs or the efforts of other professional personnel involved in the care of the patient. Patient motivation is an appropriate and inherent function of all health disciplines, which is interwoven with other functions performed by such personnel for the patient.
- Accordingly, since the special skills of an occupational therapist are not required, an occupational therapy program for individuals who do not have a specific diagnosed psychiatric illness is not to be considered reasonable and necessary for the treatment of an illness or injury. Services furnished under such a program are not covered.

Documentation

How to enhance documentation specific for the mental health components of care



Documentation Responsibility

- Documentation throughout the course of the therapy episode is a professional responsibility and a legal requirement.
- Documentation is necessary for reimbursement. Insufficient or absent documentation is not going to justify to any payer source that the services were reasonable, necessary, and appropriately billed to allow approval of your claim for payment.
- Documentation should be clear and convincing.
 - Sell to the reviewer through telling the patient's "story."
 - That this patient's **condition is so complex** that it will improve only through the skilled intervention of a therapist.
 - That the treatments we are providing are indeed **skilled** and could not be provided by anyone but a therapist.

Mandatory for MDS

- **MDS Section E - Behaviors, includes frequency**
 - Hallucinations and delusions
 - Physical and verbal behavior directed toward self or others, including impact on self (rejection of care) or others
- **MDS Section D - Mood, symptoms within the last 2 weeks**
 - Little interest in doing things
 - Feeling down or depressed, bad about oneself, life not worth it
 - Sleep or appetite disturbance
 - Low energy, moving so slowly that others notice
 - Poor concentration
 - Short tempered

Addendum

Wandering and Attention Span

Wandering



Understanding Wandering for Better Intervention

Even though wandering may pose a safety risk to the patient, there are beneficial side effects of wandering. Interventions should focus on understanding the "why" of the behavior and, if it appears to be therapeutic, allowing it to continue in a controlled and safe level.

Types of Wandering:

- **Continuous Wanderer**
 - They wander more than 50% of the time.
- **Sporadic Wanderer**
 - They roam intermittently and in bursts of time.



Types of Wandering (continued)

- **Exit Seeker**
 - They repeatedly attempt to leave their environment.
 - They will generally tell you they are looking for someone or something and need to go somewhere.
 - They are obsessed with returning home because they cannot recall why they are there or don't want to be where they are.
 - There can also be a remnant of previous work role or an attempt for the person to put meaning and purpose into his/her life.
- **Akathesiac**
 - Restlessness and pacing behavior.
 - This can be as a result of prolonged use of psychotropic medications.
 - Other drugs can also cause the restlessness.

Types of Wandering (continued)

- **Modeler**
 - Because of their cognitive impairment, they get caught up in following someone else.
 - This is also a type of *echopraxia*, the involuntary mimicking of another's behavior. If the person they are mimicking leaves an area, they too want to leave.
- **Self-Stimulator**
 - They may focus on the desire to turn the knob of a door.
 - They may not necessarily care about leaving but rather getting stimulation from the physical action of opening the door.
 - Others may wander for something to do.
 - May wander down the hallway touching everything repeatedly.
 - This type of wandering is often a sign of under-stimulation or lack of structure.

Wandering

To analyze the wandering behavior, assess the following:

- Does the patient have enough social interaction, or has it decreased?
- Does the patient have a history of relieving stress through physical exercise?
- Does the patient have a long history of wandering?
- Can the patient find his/her bathroom/bed/kitchen independently?
- What time of day does the wandering seem to be most prevalent?
- What type of wandering is exhibited?
- Does wandering increase after family visits?
- Is the day structured with meaningful activities?
- Are there any underlying unmet physical needs (hunger, pain, etc.)

Attention Span



Attention Span

- **Attention can be subdivided into four components:**
 - **Sustained attention:** Ability to maintain task vigilance over the course of the task, maintaining accuracy until completion without the need for re-direction or re-instruction.
 - **Selective attention:** Ability to attend to specific and necessary stimuli required to complete a task or succeed in a situation. Requires the selection of salient information and disregard for non-pertinent information.
 - **Alternating attention:** Allows the capability to focus on a task, tolerate an interruption, and return to the original task while maintaining the set and the accuracy.
 - **Divided attention:** Ability to respond to the demands of more than one stimulus at a given time.



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Attention Span Assessment

- **Assess for early signs of loss of attention such as:**
 - Stopping a task midstream
 - Avoidance of certain environments such as refusal to go to therapy gym when others are there or refusal to go to the dining room for meals
 - Insistence on doing same tasks in therapy every day
 - Agitation and resistance when more challenging activities are introduced
- **Determine maximum attention times and modify tasks to fit that time frame**



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Attention Span Interventions

- Adjust the presentation so that the patient does not have to differentiate between the stimulus that requires action and the extraneous information.
- Gradually increase distraction in a systematic way to evaluate effectiveness of compensatory strategies or adaptations you have made.
- Train caregivers on approach to eliminate distraction, remove distraction if performance deteriorates, and provide appropriate cueing to regain attention to select task if distraction interrupts.
- Teach the patient to self identify warning signs of loss of attention or triggers and what to do about them.



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Attention Span Interventions

- Teach the patient to identify the conflicting stimulus and request that it be removed or remove it themselves (e.g., too many food choices or clothing choices presented).
- Teach the patient to create and use "place markers" when alternating attention. If unable, teach task breakdown and hierarchy so that he/she can handle one aspect of the task at a time. Good example: Cook with and without a recipe.
- Teach the patient to recognize when he/she is being asked to "multi-task." Teach/develop methods to selectively respond to the PRIORITY task and then handle the secondary task next.
- Help the patient identify when there are other unpredictable, multiple, simultaneous demands for attention. Teach modification of the situation to allow for one demand at a time.



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iPad/iPhone/Android Apps

- **Breath Pacer**- Breathing techniques for stress management- \$2.99
- **2Do**- Task management app to assist with scheduling- \$14.99
- **Pomodoro Timer**- Time management/productivity- \$0.99
- **Optimism**- Mood charting- Free
- **My Mood Tracker**- Self awareness, Lite is Free, full is \$9.99
- **ACT therapy apps**- 6 modules based on Acceptance and Commitment Therapy- \$2.99/ea
- **Occubuzz**- Activity and mood tracking- Free
- **SuperBetter**- Personal resilience- Free
- **PTSD Coach**- Designed for vets- Free
- **Fluidity**- Sensory tool- Free



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Thank you!

Enjoy the rest of the Conference!