

# **Crisis Issues for the Aging Consumer (A Public Forum)**

*Sponsored by the NE Regional Crisis Grant*

This report highlights the dialogue from two public forums held in the northeast region of Wisconsin, related to crisis issues/response for aging consumers. The Northeast Regional Crisis Grant sponsored these forums to identify the needs and system response to aging consumers during times of crisis within the region.

The mission of the grant is to build capacity for county crisis systems to respond to those in crisis through bringing technical assistance and training related to best practices in crisis prevention/intervention to those who provide services to various populations at risk for crisis. One of the identified populations is aging consumers with dementias and mental health issues. There have been numerous efforts by various workgroups and committees to document the issues specific to crisis prevention/intervention among the aging population.

This forum was intended to elaborate upon earlier efforts to identify issues and make recommendations regarding best practices for this population. The forum was also meant to bring resources together to share expertise and perspective, and give participants some new ideas about dealing with classic problems related to crisis response for the aging population.

The forum was structured around a scenario (see appendix, pg 1) that often creates problems for care providers from various parts of the system. A panel of persons representing the different parts of the system was asked to comment on the scenario from their perspective, then the participants were given an opportunity to comment on their concerns or to ask follow-up questions. The panel consisted of perspectives from Nursing Homes, Assisted Living Facilities, Law Enforcement, County Aging Disability Resource Centers and Crisis teams, the Community Integration Initiative, the Alzheimer's Association, Board on Aging and Long Term Care Ombudsman, Division of Quality Assurance and the Northeast Regional Office/Area Administration.

There were 51 participants at the forum in De Pere and 76 participants at the forum in Wautoma. Participants came from a variety of backgrounds, including direct service staff (case managers, social workers, therapists, crisis workers, care staff) and administrators from both public and private facilities, law enforcement, hospital chaplains, representatives from the Department of Health and Family Services, advocates for those with dementias and some identified family members of persons with dementias.

A summary of the discussion at the forums follows, along with a summary of written responses that were provided by various persons prior to or following the forums (appendix, pgs 2-29).

## DePere Forum, May 21, 2007

**Moderators:** Sharon Locklin, Grant Coordinator, Northeast Regional Crisis Grant  
Bill Kelsey, Manager, Wisconsin Community Integration Initiative, Northeast Region

**Panel:** Yvonne Rochon, Social Worker at Brewster Village (Outagamie Co Nursing Home facility), Ann Coyle, Manager of Gardenview Assisted Living Facility in Menasha, Diane Mandler, Outagamie County Crisis Services Manager, Mike Maus, Outagamie County Aging Disability Resource Center, Becky Reichelt, Director of the Alzheimer's Association of Greater Northern Wisconsin, Diane Dietz, Behavioral Consultant for the Community Integration Initiative/Northeast Region, Amy Panosh and Julie Button, Ombudsman from Board on Aging and Long Term Care, Paul Peshek, Division of Quality Assurance/Nursing Homes, Chris Craggs, Area Administration/Northeast Regional Office. Special guest, Chris Hendrickson from Area Administration/Central Office.

**Chris Hendrickson** was invited to share some background on the earlier work of SCOPE Workgroup, which was a State/County workgroup, established by the DHFS Secretary to provide recommendations regarding High risk/High need individuals. The work began by identifying high risk/need youth and adults, using data from DHFS provided by the counties. Their work consisted of three focus areas—developing definitions of “high risk/need” youth and adults, analysis of cost issues, and identification of barriers to serving this group of individuals and related recommendations. Based upon the definition of high risk/high need individuals and the cost analysis, they looked at individuals whose treatment costs were over \$50,000/year. The group then made recommendations to address these barriers and best practices, including some policy changes and initiatives (i.e., changes in the 55 Laws, a DQA workgroup, web casts for surveyors and providers). Chris indicated that the full report is available and he would be glad to share it with interested persons.

**Yvonne Rochon** (Brewster Village) began the responses to the scenario. She indicated that there was a need for a careful assessment, along with data showing the progression of symptoms (the scenario indicated the woman had been at the nursing home for two years, so there were probably warning signs before the actual incident listed in the scenario). Were there changes in the environment? Were there medical issues?

At Brewster Village, they are fortunate to have two physicians who specialize in gerontology. They also have well-trained and educated staff, good managers and work closely as a team. Some of the interventions utilized are one-to-ones,

environmental modifications, keeping everyone safe. They tend to avoid doing 51's and using psychiatric units because those tend to be inadequate for persons with dementia, who often get sent back over-medicated. They use their consulting doctors to prescribe meds when needed, but sometimes meds can make things worse, and even when they work, there are always side effects.

Even with all of these things in place, things can unravel and challenging behaviors are a growing issue. There is a concern about being cited by DQA due to aggression toward other residents/staff or falls. These situations are also very difficult for the individual, their family and the staff. They work hard on engaging the family and supporting staff.

A couple of recommendations in addition to above would be to look at whether some of these individuals with challenging behaviors actually need palliative care—is there “terminal delirium?” Often times behavior symptoms that are ongoing (rather than an isolated incident such as the one in the case scenario) are caused by an underlying delirium--what some doctors are terming "terminal delirium". Whether or not this is caused by environmental issues vs. pain (either psychological and/or physical pain from some medical condition that we may never diagnose); the question has to be asked if we aren't better treating this ongoing delirium with pain medications rather than psychotropics. Often, these people are comfort care focus, or minimally invasive workups/treatments are authorized only. Palliative care discussions should begin at this point if simple diagnostic assessments and oral antibiotics are not working to clear the delirium. Of course, all symptoms need careful assessment/approaches/adjustments to environment, etc. prior to any medication interventions at all because of the high rate of side effects with medications in this vulnerable population. I sometimes believe pain medications to manage the behaviors are so much more humane than all the psych meds that we already know do not work well with frail elderly. The goal should always be comfort at this point in someone's life if all else fails, especially with those who suffer from a long and debilitating disease such as dementia.

Also, it would be great to have regional access to a geropsych unit, made up of a multi-disciplinary team who has expertise in geriatrics and dementia.

*\*See Appendix, pgs 21,22 For written commentary.*

**Ann Coyle**, Gardenview Assisted Living, said she would like to be called in to see the person in the scenario. She felt she could gain a good deal of insight about the resident if she were to go to the hospital “incognito” to observe the person and try to determine why she was combative. She felt that having all private rooms like she has at her facility would help. While her facility is not an Alzheimer’s facility, all staff are certified to do dementia care. She would insist on having this woman’s family involved in the planning process, would speak to the hospital staff to get their perspectives. She would approach the planning

process through good communication, good behavioral charting and collaboration (hopefully a team meeting with all involved prior to discharge from the hospital).

**Sharon Locklin** discussed the written response (Appendix, pg.23) provided by **Todd Freeman**, Appleton Police Dept/Crisis Intervention Team (CIT). Officers do get some dementia training during their 40-hour CIT training. In general, law enforcement do not feel doing a Chapter 51 on an elderly person and transporting them to a psychiatric unit in handcuffs is appropriate, though they will if safety cannot be maintained any other way. CIT officers are trained to work closely with their crisis workers to produce more positive outcomes for the consumer.

**Mike Maus/Diane Mandler**, Outagamie County—Unfortunately, this is not an unusual scenario for them. It's important to rule out medical issues that may be underlying the behavior. A general hospital that can deal with both medical and behavioral issues would be preferable to transporting the person to facilities outside of the community, which is tough on the family. The question would be to seek a 51 or a 55 in this case.

The scenario is disturbing in that after two years without problems, why are there problems now? There were likely some symptoms where intervention could have occurred prior to the incident. The other disturbing thing is that the issue of not wanting someone back after an incident is a common problem. They feel like they are constantly looking for placements, and these placements end up being farther and farther away.

Having an Adult Disability and Resource Center (ADRC) is helping to do intervention earlier to prevent crisis. Usually they are contacted when the family panics due to lack of resources. They can direct the family to the resources early on in the process.

**Diane Dietz**, Community Integration Initiative/Northeast Region, reported that symptoms among those with developmental disabilities are similar to the general aging population. It is difficult to diagnose dementias due to the lack of a good history, and often persons are non-verbal. Behaviors often precede cognitive decline. When behaviors occur, it is important to rule out delirium and other medical causes. It is also important for caregivers to provide good documentation (describe the specific behavior of concern, when and where it is occurring, etc). Quality data can help target causes/approaches to problem behavior and thus target interventions.

**Becky Reichelt**, Alzheimer's Association of Greater Northern Wisconsin stated that her organization is not called by providers early enough in the process. They offer themselves as a resource for providers but are often not utilized until after the crisis occurs.

Becky also indicated that not all dementias are due to Alzheimer's nor are they the same. There needs to be a thorough assessment and accurate diagnosis. While Alzheimer's is the most common, it is not the only dementia, and the care specifics vary by type of dementia.

It's important to look at why the behavior is occurring, which involves getting a good social history. She referenced Dr. Desai's thinking that behaviors always occur for a reason. She also referenced the STAR Model, developed by Dr. Howell as a pretty comprehensive assessment. Becky stated that the person needs a good memory assessment to help determine the type of dementia and the appropriate approach to the individual. There are Memory Clinics throughout the state, and she would be happy to connect caregivers to a local memory clinic if they contact her.

Becky also shared that her organization provides "Dementia Care Specialist" training. The individual will reflect the attitude of the caretakers, and it is important for caregivers to have a positive and willing attitude.

**Amy Panosh/Julie Button** from the Board on Aging and Long Term Care/Ombudsmen provided handouts (Appendix, pgs 24-29) and provided highlights of the handouts. They emphasized the importance of prevention and said they are a good resource for helping to prevent crisis if they are contacted early on in the process. They also discussed the importance of a good social and behavioral history, including "likes" and "dislikes" and precursors to behavioral symptoms. It is also important to look for other underlying medical conditions.

They discussed the importance of having trained staff who are knowledgeable in behaviors, meds, Alzheimer's, etc) and having support for families available. They emphasized person directed care and culture change, and that there is a national campaign to assist with culture change.

The ways in which Ombudsman could be helpful in the scenario are: 1) Make sure that those in need receive treatment and not just meds and restraint; 2) Facilitate the communication between the psychiatric unit and the nursing home and help them to identify realistic expectations based upon each facilities capabilities; 3) Help both sides to prepare for the return of the client, have a discharge planning meeting with the psych unit and the nursing home; and 4) Provide education on how to minimize the effects of "transfer trauma," which often happens when this population is moved from one facility to another.

Amy and Julie finished by encouraging people to utilize them as a resource.

**Paul Peshek**, Division of Quality Assurance/Nursing Homes addressed the scenario, saying that unfortunately everyday someone in this state is caught in

this type of scenario. The problem seems to occur when everyone throws up their hands in frustration and are not willing to work with challenging situations and a “stand-off” occurs. Everyone needs to be aware of their responsibility for this person and need to do their best for this person.

In this case, the responsibility of the nursing home is to bring the person back or to work with the team to find an alternative placement (this is true even with immediate discharge). It appears in the scenario that there is an inability to provide services across all environments. To prevent this situation, pre-established relationships are important (psychiatric, agencies like the Alzheimer’s Association, Ombudsman and other team members). We are all responsible and accountable for this person and need to provide the best and least restrictive way to meet her needs. This may involve finding a new and creative approach. While DQA staff cannot consult, they will direct facilities to the resources that exist for consultation.

**Chris Craggs**, DHFS/Northeast Regional Office/Area Administration, reinforced that the responsibility for this consumer is shared by everyone. He pointed out that while the regulations are extensive, they do describe what the expectations are for all in ensuring that the care of the person is safe and orderly. (See appendix, pg. 2- ).

He recommended an approach that begins with the end in mind—what is likely to happen and what supports you may need to have in place should problems occur—as the initial assessment and planning is done. Getting caught by surprise as happened in this scenario is due to not paying close enough attention. Chris also encouraged people to contact him when they have concerns and questions, the earlier the better, and emphasized the importance of collaboration and communication.

### **Summary of Discussion with participants**

- Chris Hendrickson thanked the panelists and indicated his concern that mental health commitments are a set-up for trauma or re-traumatization in this scenario..
- Amy Panosh responded that it can be very traumatic for a person to go to 2, 3 or 4 facilities during this time of crisis. All facility staff (Pysch, CBRF, NH) need to be educated on transfer trauma (definitions, symptoms, and ways to avoid the trauma from occurring). In the scenario that was provided, the resident may have PTSD due to history in WWII. By transferring her to a psych unit, this certainly would have exacerbated her PTSD. If the CBRF/NH had the resident seen by a psychiatrist and a good diagnosis was made and also a good social history was conducted, the transfer might have never had to happen.

- Additionally, a teamwork approach should be used when a facility has a resident that has challenging behaviors. The team should consist of aides, nurses, psychiatrist, primary physician, family, resident, social worker and if needed, the ombudsman.
- Sometimes individuals are “dumped” on units while it takes a long time to set up the new placement.
- There is a shortage of geropsych units—Mendota has a unit, but there is a long waiting list
- The 51 system is not appropriate and is traumatic for people with dementia, but there doesn't seem to be many other options
- Before doing an ED, it's important to look at the whole picture—could staff and/or peers be setting her off?
- Perhaps we need to look at palliative and hospice care
- Nursing homes fear citation if they have situations like this on their units
- Funding issues are a problem—for example, a CBRF reported that when a resident ran out of funds they had to move her to a nursing home to reallocate funds in order to return her to the CBRF—this took 30 days and was traumatic when it would be simpler just to reallocate the funds to the CBRF without making the resident move
- Family care may help this, although there have still been placement issues in Family Care Counties—it's not just the funding mechanism it's also not having adequate resources for placement
- In Fond du Lac County, a Family Care County, the Care Management Organization is willing to pay an established amount, so you need to find providers willing to provide care for that established amount
- Perhaps there should be an enhanced rate for people with more intensive needs
- In Outagamie County, they use crisis beds in an apartment for diversion from the hospital for adults, and they are looking to expand this for other target groups such as aging, those with developmental disabilities and youth
- Sharon Locklin indicated that in working with the seventeen counties in the region, it appears that a regional response to these situations would work best—she envisions having a regional crisis team who could

respond to situations like this and set up wrap-around services in the home community, working with the county resources and other existing resources

- Need to look at the root cause of the behavior—what signs were missed?
- Facilities need to develop in-house crisis teams and the county needs to look into this too--When you see the first signs, pull together a crisis team of key staff from that setting, county crisis staff, family, etc
- Need to educate providers—many refuse placements due to unfounded fears or lack of knowledge or skills to do crisis prevention planning
- Brown County has 2 beds designated in a nursing home for crisis beds—available only to residents in that county
- Paul Peshek indicated that DQA continues to work on follow-up to the SCOPE recommendations—they are discussing a team for nursing home situations so that there would be someone to go in and help with behaviors
- DQA is also providing \$5,000 for a web cast training on difficult behaviors by Dr. Desai (a geropsychiatrist) this fall
- County crisis models have traditionally been based on mental health—need appropriate responses for other target groups—aging, AODA, youth, DD
- Now is an ideal time to look into regional teams
- There are too many silos—medical, psychiatric, etc—yet due to funding cuts there are fewer resources available in each area—we need to integrate better, which would involve state/county collaboration
- Need help recruiting more geropsychiatrists, nurses—perhaps we could improve current provider knowledge through web casts (for CME's) and telehealth consultation—except folks are nervous about the technology
- Need to broaden the view of treatment to more than just medications (include environment, quality of life, etc)
- Need a culture change, which involves staff training, person-directed planning to better meet needs, with a focus on prevention of behaviors—we need consultants who show staff how to approach people—there are consultants and excellent training curriculums out there

- Becky Reichelt encouraged people to contact them—the Alzheimer’s Association is available 24/7 to do consultation but they don’t get many calls from providers
- It was suggested that the Alzheimer’s Association provide a summer “Dementia Care Specialist” training (they hadn’t been doing this because of scheduling issues at facilities due to increased vacations)—college students who are often hired on as additional staff in the summer would have an opportunity to take the course then
- In response to potential citations, Paul Peshek indicated that there are four basic questions that surveyors ask: When did the provider know something? When did they do something about it? What did the providers do about it? What should they have done about it? In other words, if the provider is documenting and reporting problems, making reasonable attempts to intervene, using resources available, they are less likely to receive a citation.

### **Where do we go from here?**

1) Need to mobilize an effort to address issues raised. The Northeast Regional Crisis Grant holds Aging Crisis Connections meetings quarterly, which is a logical place to work on identified issues. The next meetings are June 6<sup>th</sup> and September 5<sup>th</sup> in Appleton. Sharon will send notice out to forum participants.

2) Need more training. Include dementia issues in Law Enforcement training, get more direct care staff trained, including physicians. The Alzheimer’s Association is hosting a 2-day conference in Appleton on August 8<sup>th</sup> and 9<sup>th</sup>—behaviors will be part of that and physicians often attend along with other care providers. Check out the website ([www.alz.org/qwwi](http://www.alz.org/qwwi)) for details. The Alzheimer’s Association also offers Dementia Care Specialist training several times a year.

3) We all need to work together. We need a shared vision of shared responsibility for aging persons that involves culture change. Crisis intervention is not about “a place” and we need to bring the services to the individual in their home community, and we need a focus on quality improvement.

4) Send the report on the forum out to participants, county directors, state staff and other interested persons and post it on the NE Regional Grant website ([www.nercrisisgrant.com](http://www.nercrisisgrant.com)).

## **Wautoma Forum, May 31, 2007**

Opening comments were made by Glenn Johnson, Director for Waushara County DHHS. Sharon Locklin and Bill Kelsey were moderators.

Scenario viewpoints were shared from several people including a police officer, an aging and disability resource spokesperson, Yvonne Rochon from Brewster Village, Andrea Grothe, RN from Heartland-Preston assisted living, Don Olander - Police Officer in Wild Rose, Mike Maus – Outagamie County Aging and Disability Resource Center, Diane Dietz- Community Integration Initiative/Northeast Region, Amy Panosh – Ombudsman, Carol Kriemelmeyer – Ombudsman, Paul Peshek – Division of Quality Assurance/Nursing Homes, Dan Zimmerman – Bureau of Mental Health Substance Abuse Services. Moderators were Bill Kelsey – Community Integration Initiative/Northeast Region and Sharon Locklin – Northeast Regional Crisis Grant.

**Yvonne Rochon** stated that often in situations like the scenario when a client's behaviors escalate, a Chapter 51 is sought and police come to manage the situation, the client is placed in a psychiatric unit under heavy sedation. The client is usually returned to the LTC facility in 3 days and still under the effects of the heavy sedation, which causes the client to be more susceptible to falls and wound problems. This could lead to citations. At Brewster Village, they take a preventative approach using careful, comprehensive assessment and planning. They also have an environment that is more conducive to preventing crisis— instead of the large long institutional halls, they have small pods, which are more homelike, and try to keep the same staff working in the pods. They do everything they can to manage the behavior in-house before contacting the police. (See response from DePere forum and appendix, pg for more elaboration).

**Andrea Grothe, RN**, the spokesperson from Heartland-Preston assisted living would seek staff input as to the circumstances surrounding the outburst. She felt a less aggressive approach could solve the situation before it escalates. Try using music to soothe the client or removal from a shared room, if the roommate is part of the problem. Check the medication and consider another type of drug. Andrea also stated that use of a stabilization unit for clients who return from psych units would be very beneficial. (Also see written response, Appendix, pgs. 30, 31).

The viewpoint shared by **Don Olander**, Wild Rose Police officer, is that their primary concern is to make the situation safe. The approach should be a non-threatening one, much like the approach to a mental health client. Often that will de-escalate the situation and prevent the person from having to be transferred to a psych unit. Crisis Team Intervention (CIT) training is a great way to learn new approaches. He shared his experience taking the CIT course, a 40-hour

program at Fox Valley Technical College. Sharon Locklin cited an example of how this approach worked when Don was involved in a challenging case in Wild Rose, and how having law enforcement involved in planning process helped produce a positive outcome for the consumer and family involved.

**Mike Maus** from the Outagamie County Aging and Disability Resource Center believes that a daytime response will differ from a night/weekend response due to lack of resources. He called upon his experience working on geropsychiatric units. The need is for patience and a creative approach when there's a lack of resources available. Dementia can cause a client to remember unpleasant events from the past. Sometimes the history of a client does not get documented as it should and background information from family members regarding the client's distress is critical. Try simple interventions first. Many times a walk outdoors or just letting the client vent their feelings can alleviate their aggressiveness. Mike also supported officers getting CIT training and shared his experience with officers who have had the training as positive.

**Diane Dietz** – CII, stated that many elderly, developmentally disabled clients are non-verbal and this can make diagnosis difficult. There is a lack of resources, including doctors and psychiatrists who specialize in this target group. Data collection from this target group is lacking. Down syndrome clients are also more susceptible to Alzheimer's disease. The focus should be on prevention and to avoid crises from occurring.

**Sharon Locklin** talked briefly about the great resource we have with the Alzheimer's Association. This association offers a class at the area technical colleges titled "Dementia Care Specialist". This is a wonderful class for any caregivers or persons who deal with Alzheimer or dementia clients and focuses on why the behaviors are occurring and how commitment, positive attitude and working together are the keys to success in dealing with this target group. Caregivers need support and burnout is a common occurrence. There are also resources like the Memory Clinics that the Alzheimer's Association supports, which help with assessment and diagnosis of dementias. Contact information for the Alzheimer's Association is in the handout.

**Amy Panosh** – Board on Aging and Long Term Care Ombudsman, is an advocate for the over sixty population who reside in nursing homes or assisted living facilities. She responded that it can be very traumatic for a person to go to 2, 3 or 4 facilities during this time of crisis. All facility staff (Psych, CBRF, NH) need to be educated on transfer trauma (definitions, symptoms, and ways to avoid the trauma from occurring). In the scenario that was provided, the resident suffered from PTSD from her history with WWII. By transferring her to a psych unit, this certainly would have exacerbated her PTSD. If the CBRF/NH had the resident seen by a psychiatrist and a good diagnosis was made and also a good social history was conducted, the transfer might have never had to happen.

Additionally, a teamwork approach should be used when a facility has a resident that has challenging behaviors. The team should consist of aides, nurses, psychiatrist, primary physician, family, resident, social worker and if needed, the ombudsman.

When incidents occur, ask the questions of who, what, when, where and why. The answers to these questions can indicate what factors may lead up to an incident and clues to becoming proactive. Dementia clients respond very well to structure and hands-on activities. Trying to find out what type of dementia a client suffers from is a tool in assisting that person. Providing the same caregiver to a dementia client is also helpful. Well-trained staff and communication are critical in providing care. Knowledge of side effects of medication is very useful as well. Being familiar with different cultures is another key to being effective in proper care. Clients have protected rights, which include follow through on treatment, clear and realistic expectations, preparation and education for transfer and return to a facility setting, and quality of life. (Also see written response, appendix pgs 24-29).

**Carol Kriemelmeyer**- BOALTC Ombudsman, said the history of individual is of utmost importance. Staff can generally pinpoint what incidents led up to a break in a client's tolerance. Working as a team with staff and available resources is critical. When questions or concerns arise, contact other agencies for direction.

**Bill Kelsey** – CII, followed up on remarks by Amy and Carol, saying the generation gap may be contributing to client agitation. The current generation often lacks perspective as to culture of the previous generation and inadvertently violates an older person's value system. An individualized program and crisis plan needs to be in place for each client, which reflects that client's value system. This can also alleviate roommate mismatches and work as preventative against stress for the client, staff and peers.

**Paul Peshek** – DQA. The providers may be concerned about receiving citations from the state if they take the client, but the DQA's primary concern with this scenario is that the nursing home facility and the psychiatric hospital do not want the client. Involuntary discharges can occur but the facility is still responsible for a suitable placement for each client. Pre-established relationships are a plus when a crisis occurs. All entities involved have an active role. The focus needs to be on the person and how to best meet their individual needs as a collaborative effort of the different entities. Paul did state that a facility that monitors and documents different interventions will be at less risk of receiving citations from the DQA. Contacting the DQA for information regarding a difficult situation/behavior is also appreciated. While they cannot act as consultants, they can steer facilities toward valuable resources.

**Dan Zimmerman** – Bureau of Mental Health Substance Abuse Services. Education and providing training to entities are the keys to success in dealing

with clients who have mental health issues. Targeting underlying causes of trauma is critical in dealing with many clients. Trauma can be both in witnessing or experiencing distasteful experiences. While a client may be medically ready for discharge, it is not the same as client readiness for transfer or placement. Communication and cooperation between providers must be in place. Some counties already have programs in place, like the Mobile Intervention Unit, for meeting client needs. Dan can and does act as consultant regarding regulations and resources that might be available to help facilities. (See appendix, pg. 2 for written response).

**Kate Surprise** from Waushara County stated her concern is regarding facilities that will not take a client in, or as a return client, because of feeling they are not able to meet their needs. Some of the facility representatives present stated that keeping the client safe and the ability to meet their needs can be challenging because of the problems at facilities with staffing levels. The safety of frail individuals is a concern. Also, psychiatric clients do not have mental health doctors on-hand for immediate response to questions.

**Sharon Locklin** asked facility representatives what they needed from the counties or other referring entities to be able to serve a client with a history of challenging behaviors. They indicated that they needed more staff training and support during times of crisis. They also needed to be sure they wouldn't get cited or that the families of the other residents wouldn't be upset if there were risks for their family members.

#### **Summary of Discussion with participants:**

- Chapter 51 law is not appropriate for dementia clients
- Nobody seems to want responsibility for the Alzheimer/dementia target group of clients
- There is a need to make better use of outside resources when dealing with challenging situations/behaviors
- Trained/knowledgeable staff is a key element to crisis prevention
- Create a person-centered care plan for each client and not just a risk assessment
- Have a risk management team for each client
- A clients competency needs to be considered/assessed and when necessary the power of attorney for health care or guardianship must be in place
- Determine what supports need to be in place for facilities who take in difficult clients prior to placement
- Utilize all available resources as much as possible
- Contact the Area Administration Human Services Coordinators and other state agencies when questions arise.

Participants were encouraged to continue to mobilize around these issues and to participate in regional groups, such as Aging Crisis Connections, to work on identified issues.