# ACTIVITIES OF DAILY LIVING (ADL)

## BEHAVIORAL DEFINITIONS

1. Demonstrates substandard hygiene and grooming, as evidenced by strong body odor, disheveled hair, or dirty clothing.
2. Fails to use basic hygiene techniques, such as bathing, brushing teeth, or washing clothes.
3. Evidences medical problems due to poor hygiene.
4. Consumes a poor diet due to deficiencies in cooking, meal preparation, or food selection.
5. Impaired reality testing results in bizarre behaviors that compromise ability to perform activities of daily living (ADLs).
6. Demonstrates poor interaction skills as evidenced by limited eye contact, insufficient attending, and awkward social responses.
7. Has a history of others excusing poor performance on ADLs due to factors that are not related to mental illness.
8. Demonstrates inadequate knowledge or functioning in basic skills around the home (e.g., cleaning floors, washing dishes, disposing of garbage, keeping fresh food available).
9. Has a history of loss of relationships, employment, or other social opportunities due to poor hygiene and inadequate attention to grooming.

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## LONG-TERM GOALS

1. Increase functioning in ADLs in a consistent and responsible manner.
2. Understand the need for good hygiene and implement healthy personal hygiene practices.
3. Learn basic skills for maintaining a clean, sanitary living space.
4. Regularly shower or bathe, shave, brush teeth, care for hair, and use deodorant.
5. Experience increased social acceptance because of improved appearance or functioning in ADLs.
6. Family, friends, and caregivers provide constructive feedback to the client regarding ADLs.

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| SHORT-TERM OBJECTIVES | THERAPEUTIC INTERVENTIONS |
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| 1. Describe current functioning in ADLs. (1, 2, 3) | 1. Assist the client in preparing an inventory of his/her positive and negative functioning regarding ADLs.<br>2. Ask the client to identify a trusted individual from whom he/she can obtain helpful feedback regarding daily hygiene and cleanliness. Coordinate feedback from this individual to the client.<br>3. Review the client's diet or refer him/her to a dietician for an assessment regarding basic nutritional knowledge and skills, usual diet, and nutritional deficiencies. |
| 2. List the negative effects of not giving enough effort to | 4. Ask the client to identify two painful experiences in which |

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| responsible performance of ADLs. (4, 5, 6) | rejection was experienced (e.g., broken relationships, loss of employment) due to the lack of performance of basic ADLs.<br>5. Review with the client the medical risks (e.g., dental problems, risk of infection, lice) that are associated with poor hygiene or lack of attention to other ADLs.<br>6. Assist the client in expressing emotions related to impaired performance in ADLs (e.g., embarrassment, depression, low self-esteem). |
| 3. Verbalize insight into the secondary gain that is associated with decreased ADL functioning. (7) | 7. Reflect the possible secondary gain (e.g., less involvement in potentially difficult social situations) that is associated with decreased ADL functioning. |
| 4. Identify any cognitive barriers to ADL success. (8) | 8. Refer the client for an assessment of cognitive abilities and deficits. |
| 5. Participate in a remediation program to teach ADL skills. (9) | 9. Recommend remediating programs to the client, such as skill-building groups, token economies, or behavior-shaping programs that are focused on removing deficits to ADL performance. |
| 6. Acknowledge ADL deficits as a symptom of mental illness being inadequately controlled or treated. (10) | 10. Educate the client about the expected or common symptoms of his/her mental illness (e.g., manic excitement or negative symptoms of schizophrenia), which may negatively impact basic ADL functioning; reflect or interpret poor performance in ADLs as an indicator of psychiatric decompensation. |
| 7. Stabilize, through the use of psychotropic medications, psychotic and other severe and persistent mental illness | 11. Arrange for an evaluation of the client by a physician for a prescription for psychotropic medication. |

symptoms that interfere with ADLs. (11, 12, 13, 14, 15)

12. Educate the client about the proper use and the expected benefits of psychotropic medication.
13. Monitor the client for compliance with the psychotropic medication that is prescribed and for its effectiveness and possible side effects.
14. Provide the client with a pillbox for organizing and coordinating each dose of medication; teach and quiz the client about the proper use of the medication compliance package/reminder system (see the Medication Management chapter in this *Planner*).
15. Coordinate the family members or caregivers who will regularly dispense and/or monitor the client's medication compliance.

8. Remediate the medical effects that have resulted from a history of a lack of ADL performance. (16, 17)

16. Arrange for a full physical examination of the client, and encourage the physician to prescribe any necessary ADL remediation behaviors.
17. Refer the client to a dentist to determine dental treatment needs; coordinate ongoing dental treatment.

9. Implement skills that are related to basic personal hygiene on a consistent daily basis. (18, 19, 20, 21)

18. Provide the client with written or video educational material for basic personal hygiene skills (e.g., *The Complete Guide to Better Dental Care* by Taintor and Taintor, or *The New Wellness Encyclopedia* by the editors of the University of California, Berkeley wellness letter).
19. Refer the client to an agency medical staff for one-to-one training in basic hygiene needs and techniques.

20. Conduct or refer the client to a psychoeducational group for teaching personal hygiene skills. Use the group setting to help teach the client to give and receive feedback about hygiene skill implementation.
21. Encourage and reinforce the client for performing basic hygiene skills on a regular schedule (e.g., at the same time and in the same order each day).

10. Utilize a self-monitoring system to increase the frequency of implementing basic hygiene skills. (22, 23)

22. Refer the client to a behavioral treatment specialist to develop and implement a program to monitor and reward the regular use of ADL techniques or develop a self-monitoring program (e.g., a check-off chart for ADL needs) with the client.
23. Provide the client with regular feedback about progress in his/her use of self-monitoring to improve personal hygiene.

11. Utilize community resources to improve personal hygiene and grooming. (24, 25)

24. Review the use of community resources with the client (e.g., laundromat/dry cleaner, hair salon/barber) that can be used to improve personal appearance.
25. Coordinate for the client to tour community facilities for cleaning and pressing clothes, cutting and styling hair, or purchasing soap and deodorant, with an emphasis on increasing the client's understanding of this service and how it can be used.

12. Terminate substance abuse that interferes with the ability to care for self. (26, 27)

26. Assess the client for substance abuse that exacerbates poor ADL performance.
27. Refer the client to Alcoholics Anonymous (AA), Narcotics

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| | Anonymous (NA), or to a more intensive co-occurring enabled treatment program (see the Chemical Dependence chapter in this *Planner*). |
| 13. Implement basic skills for running and maintaining a home or apartment. (28) | 28. Teach the client basic housekeeping skills, utilizing references such as *Mary Ellen's Complete Home Reference Book* (Pinkham and Burg), or *The Cleaning Encyclopedia* (Aslett); facilitate this teaching from the client's natural supports. |
| 14. Report as to the schedule that is adhered to regarding the regular use of housekeeping skills. (22, 29, 30) | 22. Refer the client to a behavioral treatment specialist to develop and implement a program to monitor and reward the regular use of ADL techniques or develop a self-monitoring program (e.g., a check-off chart for ADL needs) with the client. |
| | 29. Provide the client with feedback about the care of his/her personal area, apartment, or home. |
| | 30. Encourage family members and caregivers to provide regular assignment of basic chores around the home. |
| 15. Implement basic cooking skills and eat nutritionally balanced meals daily. (3, 31, 32, 33) | 3. Review the client's diet or refer him/her to a dietician for an assessment regarding basic nutritional knowledge and skills, usual diet, and nutritional deficiencies. |
| | 31. Educate the client on basic cooking techniques (see portions of *The Good Housekeeping Illustrated Cookbook* by the editors of *Good Housekeeping*, or *How to Cook Everything* by Bittman). |

32. Refer the client to or conduct a psychoeducational group regarding cooking skills and dietary needs; monitor changes.
33. Facilitate the client's enrollment in a community education cooking class or seminar.

16. Take steps to increase safety and health in the home setting. (34, 35, 36)

34. Join the client in an inspection of his/her living situation for potential safety hazards; prioritize and ameliorate safety concerns.
35. Assist the client in advocating with the landlord, home provider, or family members to remediate safety hazards, insect infestations, or other problems.
36. Facilitate the client's involvement with programs that assist low-income or special-needs individuals with safety equipment (e.g., free smoke or carbon monoxide detectors).

17. Terminate engagement in high-risk sex or substance abuse behaviors. (37, 38)

37. Teach the client about high-risk sexual behaviors and refer to a free condom program (see the Sexuality Concerns chapter in this *Planner*).
38. Teach the client about the serious risk that is involved with sharing needles for drug abuse; refer the client to needle exchange and substance abuse treatment programs.

18. Sign an intervention action plan that will be implemented when cognitive decompensation begins. (39)

39. Develop a written, signed intervention plan (e.g., call a treatment hotline, contact a therapist or a physician, go to a hospital emergency department) to decrease the potential for injury, poisoning, or other self-care problems during periods of mania, psychosis, or other decompensation.

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## DIAGNOSTIC SUGGESTIONS

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
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| 297.1 | F22 | Delusional Disorder |
| 295.90 | F20.9 | Schizophrenia |
| 295.70 | F25.0 | Schizoaffective Disorder, Bipolar Type |
| 295.70 | F25.1 | Schizoaffective Disorder, Depressive Type |
| 295.40 | F20.81 | Schizophreniform Disorder |
| 296.xx | F31.xx | Bipolar I Disorder |
| 296.89 | F31.81 | Bipolar II Disorder |
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