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Using Tailored Activities to Reduce Behavioral Symptoms in a Memory Care Unit

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Abstract

Residents with dementia that demonstrate behavioral symptoms are highly prevalent in skilled nursing facilities (SNFs), particularly in memory care units. With the use of individualized activities, the Tailoring Activities for Persons with Dementia (TAP) program provides a non-pharmacological approach to reducing behaviors and decreasing caregiver burden for persons with dementia. TAP is primarily used in homes, but it was adapted for use in the memory care at Hamilton Trace Family-First Senior Living with five residents. TAP demonstrated great success in reducing and preventing behavioral symptoms in the residents. TAP principles were used to create resources to benefit all current and future residents by individualizing their care and improving their quality of life. The staff indicated high usefulness and likelihood to utilize the resources in the future. The positive results of this project indicate a promising non-pharmacological intervention to improve the quality of life of residents and staff in memory care units.

Using Tailored Activities to Reduce Behavioral Symptoms in a Memory Care Unit

Introduction

One of the most prevalent diseases in older adults is dementia, affecting nearly 50 million people worldwide (World Health Organization [WHO], 2020). Behavioral symptoms are common symptoms of the disease, affecting 50-80% of persons with dementia (PWD) (Gaugler et al., 2014), with the most common symptoms being anxiety, depression, agitation, delusions, and hallucinations (Bennett et al., 2019; Yang et al., 2020). Nearly two-thirds of residents in nursing homes have a diagnosis of dementia (Gaudler et al., 2014), with a high prevalence of behavioral symptoms among these individuals (Brown et al., 2015). DiBartolo et al. (2013) noted that these symptoms take away from the residents' quality of life and can be harmful or disruptive to other residents or staff. To address these behaviors, non-pharmacological treatment should be the initial treatment option for these residents (Gaugler et al., 2014).

The program developer completed the Doctoral Capstone Experience (DCE) in the memory care at Hamilton Trace Family-first Senior Living, which is a CarDon and Associates Inc. building located in Fishers, Indiana. This facility includes long-term care, rehabilitation, assisted living facility, and memory care. The therapy offered at this site includes occupational therapy (OT), physical therapy (PT), and speech therapy (SLP), all of which treat residents in memory care on a rotating schedule. At a given time, there is one registered nurse (RN) and two certified nursing aides (CNAs) working in the memory care. Residents in the memory care displayed behavioral symptoms consistently throughout the day with an increase in the afternoon, leading to increased staff burden. Additionally, staff members lacked the resources and knowledge on ways to engage residents meaningfully given their cognitive abilities.

CarDon and Associates Inc. aims to assist residents in the memory care with personalized activities by getting to know their experiences, interests, and needs (CarDon & Associates Inc., n.d.), however, this was initially not reflected in the activity options for the residents. Halfway through the DCE, the facility hired a memory care director who began engaging the residents in activities, but they were generic and unindividualized group activities.

To provide the residents with individualized and meaningful engagement to reduce their behavioral symptoms, the program developer modified the Tailoring Activities for Persons with Dementia (TAP) program for use at this site. Gitlin et al. (2008) reported that the overall goal of TAP is to reduce behavioral symptoms of persons with dementia and reduce caregiver burden by utilizing individualized activities that match the person's capabilities and interests. The program developer engaged five residents that displayed the most significant behaviors in the TAP protocol. Following the success of the implementation, the program developer created resources that determined preferred activities for each resident, activity suggestions based on their Global Deterioration Scale (GDS) score, and suggestions to reduce resistance to care. This paper will address the benefits of utilizing individualized activities to reduce behavioral symptoms of individuals with dementia and staff burden in a memory care unit.

Background

Residents in nursing homes often experience occupational deprivation due to a lack of opportunities for continued growth and engagement (Mjorud et al., 2017; Sanetta et al., 2019). As a result, residents often demonstrate an increase in behavioral symptoms (Sanetta et al., 2019). A needs assessment was completed to better understand the effects that behavioral symptoms have on the residents and staff at Hamilton Trace and what is already in place to combat these symptoms. The memory care has 20 resident beds. The residents are evaluated by

an SLP and staged on the GDS, with most residents functioning at levels five to six, indicating moderately severe to severe cognitive declines. At CarDon facilities, dementia stages are associated with a CarDon Heart of Caring color, so once the resident is staged, their color is posted on their doorway to assist staff in understanding their needs. Nearly all 20 residents experienced behavioral symptoms to some degree. The staff lacked the knowledge to engage residents in meaningful and appropriate activities to target these symptoms. From the needs assessment, it was determined that there was a great need for management of behavioral symptoms for the residents to improve engagement, quality of life, and decrease staff burden.

Following the needs assessment and a search of the literature, the program developer determined that the residents and the staff would benefit from a modified version of TAP. TAP has been primarily used in homes and involves three phases. The first phase is evaluation, which involves evaluating the PWD's preserved capabilities, physical environment, interests, and the caregiver's communication and management techniques (Gitlin et al., 2008). Phase two of TAP is implementation when the program developer brainstorms three activity prescriptions based on the information from the evaluation and instructs the caregiver in using these activities with the PWD (Gitlin et al., 2008). The activity prescriptions consist of an activity, a goal, and a specific implementation technique, and they are reviewed and modified as needed during the sessions (Gitlin et al., 2008). The third phase of TAP is the generalization phase, when the program developer provides techniques to reduce behavioral symptoms during ADLs (O'Connor et al., 2014).

Developers designed TAP for use in the home setting, and results have been overwhelmingly positive (Gitlin et al., 2008; Gitlin et al., 2009; Marx et al., 2019; O'Connor et al., 2014; O'Connor et al., 2017). Gitlin et al. (2008) found that compared to a control group, the

PWD that went through all TAP sessions in their home demonstrated less shadowing, repetitive questioning, argumentation, agitation, and they had greater activity engagement and ability to keep busy (Gitlin et al., 2008; O'Connor et al., 2017). Additionally, TAP has led to caregivers experiencing increased self-efficacy, reduced burden, being less upset with behavioral symptoms, and enhanced skills (Gitlin et al., 2008; Gitlin et al., 2009; Marx et al., 2019).

Given the benefits that TAP has shown in homes, OTs have modified TAP for use in other settings, such as hospitals (Gitlin et al., 2016) and outpatient centers (Oliveira et al., 2019). Similar to home settings, TAP yielded benefits for the PWD, caregivers, and staff in these adaptations (Gitlin et al., 2016; Oliveria et al., 2019). Given the success of modifying TAP to work in settings other than the home, its high replication potential (Gitlin et al., 2009), and literature to support the use of individualized activities in long-term care facilities (Travers et al., 2016), the program developer modified TAP to work in a residential care facility.

Gaugler et al. (2014) identified individualized activities as an effective non-pharmacological method for managing behavioral symptoms in long-term care. In a review of seven randomized controlled studies and one non-randomized controlled study, Mohler et al. (2018) identified limitations in studies that utilized tailored activities to reduce challenging behavior and improve the quality of life for PWD in long-term care. Mohler et al. (2018) indicated that in seven of the studies, the nursing staff was not trained on the use of activities which led to a lack of day-to-day carryover in the other studies. The program developer addressed this shortcoming with TAP by training the RNs and CNAs on the use of activities, frequency, grading suggestions, and appropriate timing.

Mohler et al., 2018 recommended that future research focus on the methods used to select appropriate activities for residents. The program developer did so by completing an

extensive protocol for evaluating and brainstorming activities that specifically matched the residents' abilities. Lastly, while the activities in the studies reviewed by Mohler et al. (2018) were tailored to the PWD's interests, they did not vary substantially from one another based on the residents' abilities. The program developer addressed this weakness by creating resources that made suggestions for how to modify commonly preferred activities based on each dementia stage.

Theory and Frame of Reference

Allen's Cognitive Levels frame of reference (FOR) was used to guide the implementation of TAP in the memory care. This FOR focuses on the role of cognition, habits, and routines while analyzing activities (Cole & Tufano, 2008). A vital component of this FOR is its belief in task equivalence, which proposes that providers use tasks with similar physical and cognitive demands to predict performance on activities (Cole & Tufano, 2008). The program developer followed the TAP protocol and used the Allen's Cognitive Levels Screen (ACLS) to evaluate the residents' current cognitive functioning. As outlined by Gitlin et al. (2009), the program developer used the ACLS score to then create meaningful activities that matched their abilities to maximize each resident's success and engagement. Using this FOR, the program developer highlighted TAP's principles of providing activities that best meet PWD abilities to maximize their occupational performance (Gitlin et al., 2009).

The Person-Environment-Occupation (PEO) model was also used during the implementation of the program. This model aims to maximize the fit between the person, their desired occupations, and their environment (Cole & Tufano, 2008). The interaction of these three components results in their occupational performance, maximized when all three parts are working together and minimized when there is a disruption in one or more components

(Cole & Tufano, 2008). Prior to the implementation of TAP, the residents at Hamilton Trace experienced declining physical and cognitive functions in an unfamiliar environment, and their opportunities for occupations were not meeting their needs for fulfillment and expression. The combination of these components minimized their occupational performance and contributed to behavioral symptoms. The PEO model is often used with the implementation of TAP (Gitlin et al., 2008; Marx et al., 2019) by ensuring the PWD's environment is conducive to the activities. For example, the program developer provided environmental and setup instructions for the activities to the staff to ensure the residents could meaningfully engage.

Project

Project Design

The TAP protocol was completed with five residents that exhibited the most frequent behavioral symptoms. The program developer then utilized TAP principles to create resources for the memory care staff to engage all of the residents in meaningful individual and group activities to reduce behaviors.

The TAP creators adapted the behavioral symptom checklist from the Neuropsychiatric Inventory Questionnaire (NPI-Q), a valid tool for assessing behavioral symptoms for PWD (Jonghe et al., 2003). The program developer kept all items from the original behavioral symptom checklist and added the requirement to indicate the frequency of the behaviors and when the behavior occurs, see Appendix A. Following observation and discussion with the nursing staff to choose residents to involve in the TAP protocol, a member of the nursing staff filled out the behavioral symptom checklist for each of the five residents to determine which behaviors to target and at which time of day.

The program developer created a resident engagement measure to determine how engaged the resident was in each activity and completed it after each time a resident was offered a preferred activity. This measure noted refusals and length of engagement time, and it included four positive and four negative engagement factors based on factors from the Observational Measurement of Engagement (OME) (Cohen-Mansfield et al., 2009), see Appendix B.

The program developer created a mood measure used to track positive emotions and behavioral symptoms immediately before, during, immediately after, 10 minutes after, and 30 minutes after participating in an activity. The positive emotions used to measure mood were determined by definitions created by Green and Reid (1996). The behavioral symptoms included were based on the behavioral symptom checklist, see Appendix C. The mood measure was used to determine the effect that preferred activities had on improving mood and reducing behavioral symptoms.

Following the implementation of the activities, the program developer provided the memory care staff with resources to be used in the future. The memory care director, director of nursing, the regional director of all CarDon memory cares, one RN, and six CNAs completed a survey on how useful they found the resources and the likelihood they are to use them in the future, see Appendix D.

Implementation

Five residents were chosen to participate in the TAP protocol based on observation and suggestions from the staff about the frequency of their behaviors. The program developer completed the TAP protocol with one resident at a time. One staff member completed the behavioral symptom checklist on each resident to determine which behaviors to target and at

what time of the day. Next, each resident was evaluated with the ACLS and Mini-Mental State Examination (MMSE) to determine cognitive abilities and mental status. The program developer administered the Activity Inventory with the resident's family members to assess the resident's past and current interests. Based on the information gathered in the assessments, three to four activity prescriptions were created that matched the resident's capabilities. The program developer continued to do the activities throughout the weeks and completed the mood measure and resident engagement measure each time a resident refused or participated in an activity. Activity prescriptions were presented to the RN and CNAs that described the activity, suggested timing, materials needed, cues, setup, and duration. This process was repeated with each of the five residents in the program.

Halfway through the DCE, a new memory care director was hired to improve programming and group activities in the memory care unit. The program developer collaborated with the new director to determine resources that would be useful based on the TAP principles. Based on this, the following resources were created: A preferred activities binder with activity suggestions for each resident in the memory care based on their interests and abilities; group activity suggestions with how to modify each activity for residents at each GDS level; resistance to care resource to reduce behaviors during ADLs for the nursing staff; and activity ideas for future residents based on their GDS level and interests. The program developer held an in-service to present the materials to the memory care staff, who then completed the satisfaction survey on the resources. The program developer then disseminated to the therapy staff the results of the TAP protocol, the resources created, and the role that the therapy staff can have in maintaining the longevity of the resources.

Project Outcomes

The program developer analyzed the results of the resident engagement measure to determine how engaged the residents were during preferred activities. Table 1 indicates how many times activities were provided to the resident, the number of refusals, the average length of engagement, and the median value across all four positive and all four negative engagement factors for each activity. Due to the low sample size of the ordinal data obtained from the Likert Scale measures, using the median as the measure of central tendency was appropriate (Sullivan & Artino, 2013).

The results indicate a high level of positive engagement and low level of negative engagement in four of the five residents, demonstrating how appropriate the preferred activities were matched to their interests and abilities to achieve greater engagement. The use of individualized activities is therefore supported in these results to increase resident engagement. Resident three demonstrated a low median for positive engagement factors. The engagement measure was likely inappropriate given their cognitive functioning as indicated by the ACLS. The program developer provided the staff with education on sensory-based activities that they could engage resident three in following this finding, given the benefits that sensory-stimulating activities can have on residents functioning at lower levels of dementia (Marx et al., 2017).

Table 1

Results of Resident Engagement Measure

Resident	ACLS score	Number of times activities were introduced	Number of refusals	Average length of time engaged in minutes	Median for positive engagement factors	Median for negative engagement factors
1	3.6	19	2	20.2	4	1

2	3.0	18	1	16	4	1
3	1.6	10	0	2	1	2
4	3.4	12	2	20.2	4	1
5	3.0	8	1	15	3	1

The results of the mood measure were analyzed to determine the overall trend in residents' moods and behaviors before, during, and after participating in a preferred activity. Table 2 illustrates these results. The behavioral symptoms that were targeted for each resident as indicated by the behavioral symptom checklist are included. The overall trend in behavioral symptom change was determined by an increase or decrease in behaviors before the activity to immediately after the activity. If the overall change was a decrease in behaviors, the average duration of how long the reduction of behaviors occurred after the activity is noted. Lastly, the overall change in positive mood was determined by an increase or decrease in positive mood indicators before and after the activity.

The results indicate an overall decrease in behaviors in four of the five residents surrounding the activities, likely due to the activities targeting the time of day when each resident demonstrated the most behaviors. The activities did not appear to decrease the behaviors for longer than 10 minutes, and two residents continued the behaviors immediately after completion of the activities. This demonstrates the need for increased carryover from the staff to ensure the continuation of activities for longer effects on the residents' behaviors. This result does however support the use of activities to prevent well-known behaviors from occurring. Additionally, four of the five residents demonstrated improved mood while completing the activity. Resident three

did not demonstrate any decrease in behaviors, likely due to the lack of engagement as noted in Table 1.

Table 2

Results of Resident Mood Measure

Resident	Behavioral symptoms targeted	Trend in behavioral symptom change	Duration of change in behaviors (mean)	Trend in positive mood change
1	Agitation, apathy, dysphoria, argumentation, wandering	Decrease	10 minutes	Increase
2	Wandering, agitation, irritability, aberrant motor disturbances	Decrease	Immediately after	Increase
3	Agitation, dysphoria, euphoria, restlessness, frequent vocalizations	Neutral	N/A	Neutral
4	Repetitive questioning, anxiety, frequent vocalizations	Decrease	10 minutes	Increase
5	Wandering, agitation, irritability	Decrease	Immediately after	Increase

The memory care director, director of nursing, regional director of CarDon memory cares, six CNAs, and one RN completed a satisfaction survey for each resource provided following the in-service to present the resources. Table 3 describes the median for how useful they found the resource and the median for the likelihood they will use the resource in the future.

The results indicate that overall, the staff found the resources to be very useful and they are very likely to use them in the future. Additional comments were provided on the survey, indicating their great appreciation, how beneficial they find the resources, and their gratitude.

Table 3

Results of Staff Satisfaction Surveys

Resource	Usefulness of the resource	Likelihood for using the resource in the future
Preferred Activities Resource	5	5
Resistance to Care Resource	5	5
Group Activities Ideas	5	5
Future Activity Ideas Resource	5	5

Summary

A goal of CarDon Family-First Senior Living is to provide residents in memory care with personalized activities that are based on their individual needs and interests (CarDon & Associates Inc., n.d.). This was accomplished by implementing a modified TAP protocol and creating individualized resources for the memory care staff at Hamilton Trace Family-First Senior Living. The goals of TAP are to reduce the behaviors of persons with dementia and caregiver burden (Gitlin et al., 2008). Brown et al. (2015) indicated how prevalent a diagnosis of dementia is in long-term care facilities, along with a high prevalence of behavioral symptoms in these residents. Through a needs assessment, a similar experience at Hamilton Trace was discovered, leading to a great need for a nonpharmacological program to reduce residents' behavioral symptoms in the memory care. TAP has shown to be effective with clients in the home, hospital, and outpatient settings (Gitlin et al., 2008; Gitlin et al., 2016; Oliveira et al.,

2019), and given the results following its use at Hamilton Trace, it also demonstrates benefits in memory care units.

Following the implementation of the TAP protocol with five residents in the memory care, the residents demonstrated improved mood, indicated by a reduction of behavioral symptoms following the individualized activities. The results suggest that implementing the activities before known behavioral symptoms occur can reduce their occurrence and improve mood while the symptoms are happening. Resources were then created based on TAP principles that the memory care staff can use to implement preferred activities for all residents to increase meaningful engagement, quality of life, and reduce resistance to care. Following an in-service to describe these resources, the memory care staff reported the resources are highly useful and a great likelihood they will utilize the resources in the future.

Conclusion

The burden on nursing staff in memory care units can be reduced by providing individualized care to residents using the TAP protocol. The TAP protocol accomplishes this by reducing and preventing behavioral symptoms of the residents. Resources and training were provided to the memory care staff for use with current and future residents. Additionally, the resources were provided to the regional memory care director for use at other CarDon facilities. By completing the TAP protocol, the program developer learned how beneficial individualized care is, especially for persons with dementia. Additionally, the program developer discovered the importance of appropriate cueing, set-up, and grading of activities to increase engagement with each resident.

The American Occupational Therapy Association (AOTA) (2015) describes OT's role in a skilled nursing facility to include program development to instruct staff on ways to reduce the behaviors of residents with dementia. Creating the resources and advocating to the therapy and memory care staff illustrated what additional role OTs should have in a skilled nursing facility to further the profession of OT. Additionally, the therapists at Hamilton Trace mostly utilized a maintenance approach with residents with dementia. The program developer had the opportunity to advocate for the therapists to expand their approach to include health promotion and prevention approaches to meet all the needs of the residents. OTs should continue to be utilized in memory care units as consultants for how to reduce behaviors in the residents with a non-pharmacological approach with their unique skillset.

Appendix A

Behavioral Symptoms Checklist (Adapted from NPI-Q)

Resident: _____ Staff member filling out survey: _____

How often does the resident experience the following behavioral symptoms, and do they routinely occur at certain times in the day?

Behaviors	0 times	1-3 times	4-6 times	7+ times	Specific time of day they experience it, if so
Aberrant motor disturbances: Doing things over and over, repeatedly picking at things, pacing without purpose					
Aberrant vocalization: scream, talk excessively or make strange noises, frequent verbal outbursts					
Aggression: Shout angrily, slam doors					
Aggressive to others physically					
Agitation: Hard to handle, uncooperative, rejection to care, restless in general, asks repetitive questions/statements					
Anxiety: Nervous, worried, frightened for no apparent reason, tense or fidgety					
Apathy/indifference: Lost interest in the world around him/her, lost interest in things, difficult to engage					
Appetite and Eating: Change in appetite, weight, or eating habits					
Delusions: Beliefs that are not true (ex. Others are stealing or want to harm person)					
Disinhibition: Act impulsively, do or say things that are embarrassing, say things hurtful to others					
Doing things harmful to him/herself					
Dysphoria: Sad, depressed, crying, low spirits					
Elation/Euphoria: Too cheerful					
Hallucinations: Hearing or seeing false voices or visions					
Irritability/Lability: Easily disturbed, moods very changeable, abnormally impatient, rapid emotional changes, cranky					
Sleep disorders: wander at night, up all night, go into others' rooms at night					
Wandering: Roaming without purpose, wandering into others' rooms					
Resistive to care during ADLs					
Argumentative with others in conversation					

Appendix B

Resident Engagement Measure

Activity: _____

Number of time completing this activity:

Date:

Refusal

Did the resident refuse the activity?

Were you able to redirect them? If so, what worked:

Duration

Amount of time in minutes they were visually focused, physically occupied, had body turned towards the stimulus:

Positive Indications of Engagement

How often did these actions occur during the activity:

Held the stimulus

(1)__ none of the time (2)__a little of the time (less than 16 seconds (3)__ some of the time

(4)___ most or all of the time

Manipulated the stimulus

(1)__ none of the time (2)__a little of the time (less than 16 seconds (3)__ some of the time

(4)___ most or all of the time

Talked about the stimulus

(1)__ none of the time (2)__a little of the time (less than 16 seconds (3)__ some of the time

(4)___ most or all of the time

Did the resident ask questions or demonstrate curiosity?

(1)__ none of the time (2)__a little of the time (less than 16 seconds (3)__ some of the time

(4)___ most or all of the time

Negative Indications of Engagement

Inappropriately manipulated the stimulus

(1)__ none of the time (2)__a little of the time (less than 16 seconds (3)__ some of the time

(4)___ most or all of the time

Did the resident appear bored or disinterested?

(1)__ none of the time (2)__a little of the time (less than 16 seconds (3)__ some of the time

(4)___ most or all of the time

Did the resident resist attempts to participate in the session?

(1)__ none of the time (2)__a little of the time (less than 16 seconds (3)__ some of the time

(4)___ most or all of the time

Was the resident disruptive?

(1)__ none of the time (2)__a little of the time (less than 16 seconds (3)__ some of the time

(4)___ most or all of the time

Appendix C

Mood Measure

Activity: _____ Date: _____ Number of time completing activity: ___

Did the resident demonstrate:

Behavioral symptom:	**Before**	**During**	**Immediately after**	**10 minutes after**	**30 minutes after**
Aberrant motor disturbances: Doing things over and over, repeatedly picking at things, pacing without purpose					
Aberrant vocalization: scream, talk excessively or make strange noises, frequent verbal outbursts					
Aggression: Shout angrily, slam doors					
Aggressive to others physically					
Agitation: Hard to handle, uncooperative, rejection to care, restless in general, asks repetitive questions/statements					
Anxiety: Nervous, worried, frightened for no apparent reason, tense or fidgety, afraid to be apart from caregiver					
Apathy/indifference: Lost interest in the world around him/her, lost interest in things, difficult to engage					
Appetite and Eating: Change in appetite, weight, or eating habits					
Delusions: Beliefs that are not true (ex. Others are stealing or want to harm person)					
Disinhibition: Act impulsively, do or say things that are embarrassing, say things hurtful to others					
Doing things harmful to him/herself					
Dysphoria: Sad, depressed, crying, low spirits					
Elation/Euphoria: Too cheerful or happy					
Hallucinations: Hearing or seeing false voices or visions					
Irritability/Lability: Easily disturbed, moods very changeable, abnormally impatient, rapid emotional changes, cranky					
Sleep disorders: wander at night, up all night, go into others' rooms at night					
Wandering: Roaming without purpose, wandering into others' rooms during day					
Resistive to care during ADLs					
Argumentative with others in conversation					
Other:					

Positive moods	**Before**	**During**	**Immediately after**	**10 minutes after**	**30 minutes after**
Appropriate socialization					
Smiling					
Laughing					
Reported enjoyment					
Positive talk about activity					
Other:					

Appendix D

Employee Resource Satisfaction Survey

Preferred Activities Resource

This resource is useful for me:

(1) Strongly Disagree (2) Disagree (3) Undecided (4) Agree (5) Strongly Agree

Likelihood of utilizing this resource in the future:

(1) Definitely not (2) Probably not (3) Possibly (4) Probably (5) Definitely

Individual Activity Ideas Resource

This resource is useful for me:

(1) Strongly Disagree (2) Disagree (3) Undecided (4) Agree (5) Strongly Agree

Likelihood of utilizing this resource in the future:

(1) Definitely not (2) Probably not (3) Possibly (4) Probably (5) Definitely

Group Activity Resource

This resource is useful for me:

(1) Strongly Disagree (2) Disagree (3) Undecided (4) Agree (5) Strongly Agree

Likelihood of utilizing this resource in the future:

(1) Definitely not (2) Probably not (3) Possibly (4) Probably (5) Definitely

Resistance to Care Resource

This resource is useful for me:

(1) Strongly Disagree (2) Disagree (3) Undecided (4) Agree (5) Strongly Agree

Likelihood of utilizing this resource in the future:

(1) Definitely not (2) Probably not (3) Possibly (4) Probably (5) Definitely

Additional comments:

_____

_____

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