“Investigating the Current Issues with Diagnoses and Treatment Implemented for Residents at a Local Mental Health Facility”

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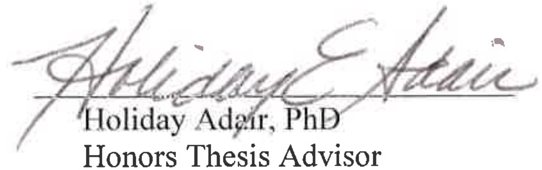
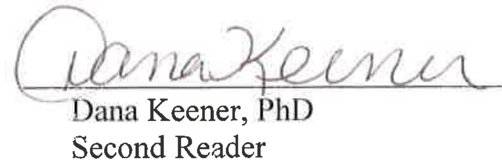
24 April 2017	 Holiday Adair, PhD Honors Thesis Advisor
April 24 2017	 Dana Keener, PhD Second Reader
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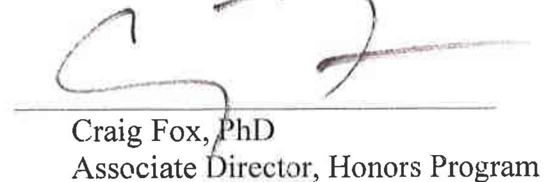
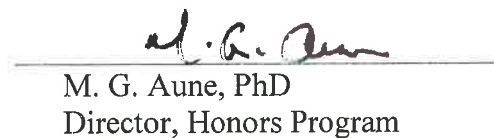
21 April 2017	 Craig Fox, PhD Associate Director, Honors Program
24 April 2017	 M. G. Aune, PhD Director, Honors Program

Investigating the Current Issues with Diagnoses and Treatment Implemented for Residents at a Local Mental Health Facility

Over the past century, much progress has been made in the mental health field regarding how to define and detect disorders, distinguishing one disorder from another, and how to treat them. Leaders in this field are always trying to conceptualize disorders with more objectivity, while also considering the external and internal factors that may affect the presentation and treatment of each disorder. One example of this is the many revisions to a guidebook known as the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), which is currently in its 5th edition (APA, 2013). With every new edition of the DSM that goes into circulation, something has either been added, removed, or remodeled to create a classification system that would have more practical use in clinical settings. It is crucial that clinicians use the most recent edition of the manual to make diagnoses so that people can get the most comprehensive treatment for their disorder.

This paper will review how the changes to the classification system of disorders (i.e. the DSM-5) affect the way professionals in mental health conceptualize and diagnose disorders, and how this changes treatment. The accurate diagnosis of a disorder influences the development of an effective treatment plan. Most recent treatment approaches for mental health clients have shifted from a narrow focus on symptom reduction (mostly with medication) to the broader goal of functional recovery (Horan et al., 2011). The ultimate challenge of any recovery-oriented treatment is to deliver quality services that will allow the person to have the greatest chance of leading a successful life (Fukui, Davidson, Holter, & Rapp, 2016). A successful life may be

defined differently by each individual, but generally means they would be able to get the most out of life and function to the highest ability in social, occupational, and other settings.

While considering the evidence-based changes to the DSM, the current program at a mental health residence (LTSR) that is using an outdated classification system (DSM-IV TR) will be investigated. In a residential setting, such as the LTSR, the quality of treatment is of vital importance as all of the residents have chronic disorders. Any gaps in the treatment process could lead to worse health outcomes for them. Although the purpose of the DSM-5 is to offer the best diagnostic information available to develop a comprehensive treatment plan for clients, suggestions for the most appropriate evidence-based treatment options are not provided. For that reason, this paper will also review evidence from recent studies that support the most recommended psychosocial treatments for the disorders seen at the LTSR to make suggestions for improvement.

The LTSR: Objectives, Program & Issues

The facility that was investigated is a small LTSR located in a rural borough of south-western Pennsylvania. It is a nonprofit organization that facilitates recovery of individuals through advocacy and education. One of the main goals of the organization is to create a society in which all people can live with respect, dignity, and the opportunity to reach their full potential.

This residence opened the early 2000's. It is one of the two housing options offered for those seeking mental health services from the local county. All individuals who want to apply for housing at the LTSR must be 18 years of age or older, must be a resident of the county, and have a debilitating mental disorder. The LTSR is a locked facility. Residents are not allowed outside of the facility without staff permission and supervision. If a resident were to leave for an extended

period, it would have to be approved by a counselor first. Three mental health technicians with at least a bachelor's degree in psychology or a related field work around the clock to ensure the safety of the residents, and either a nurse or counselor is present or on-call at all times. The nurse and counselors are typically separated from the residents for most of the day; an appointment allows residents to have contact with them.

Objectives outlined in the treatment plans of every resident include

- stabilizing the resident's conditions and medical regimes;
- eliminating acute psychiatric symptoms;
- completing individual treatment goals;
- helping residents complete trial leaves;
- developing a plan of continuity of care for all of the residents after they leave the facility.

There is no fixed time frame for the length of stay in the treatment program at this facility so that the individual can move at her own pace through the treatment. The services that are supposed to be provided, as advertised by the LTSR, include medical and psychiatric services, counseling and therapy, transportation, recreational activities, money management, and vocational assistance. However, the LTSR has only been providing a basic of those services at the present time. They offer enough so that the residents will get by, but not so much so that they might make any progress in their treatment and recovery goals. It seems that treatment at the LTSR is still focused more on symptom reduction rather than on recovery.

The services that are currently offered include medication management, transportation, psychiatric services, and money management. The nursing staff handles medication management. One of every resident's first treatment goals, when they enter the LTSR, is to learn

the names of all of their medications, and to practice self-administering them on a set schedule. Once they meet that goal, they are required to self-administer their medication under staff or a nurse's supervision in the morning and evenings. Refusal to do so later than an hour after the designated time for an entire day will result in the resident being put on in-house, where he is not allowed to leave the facility for passes or other activities.

Residents receive transportation for passes and to other rehabilitation centers that they might be required to or choose to go to. All of the residents' money is managed by the supervisors, and it is kept in locked safe that only they can open. The money can go towards passes that the residents earn, or other items that the residents might want to purchase that are safe to keep in the facility. Residents who need assistance with their finances have representative payees who take care of their housing and utility payments, medical expenses, food, and other needs.

In their free time, the residents are encouraged to stay active. All bedroom doors are locked so residents can not isolate in their rooms. The LTSR has a recreation room where they can exercise, as well as a craft room with supplies so they can express their creativity. Psychiatric services are also offered. A psychiatrist visits the facility once every week for an hour and typically sees three residents at a time. The psychiatrist usually sees those that are unstable or residents that are ready to be discharged. Each resident will usually be able to see the psychiatrist at least once every other month to check up on medications.

In-house activities include groups held by the residents or mental health technicians such as resident council, current events, and illness management and recovery. Residents are also encouraged to participate in chores around the facility which, if they complete, allow them to

earn points that go towards a pass. The passes are part of a community incentive program, where the residents can earn snack passes, dinner passes, day passes, overnight passes, or buddy passes. The number of passes they receive is based on the number of house rules they follow and chores they complete. House rules deal with how they manage their hygiene, infectious control, behavior around peers, and involvement in other daily activities.

There are currently sixteen individuals in the LTSR, and the most prevalent disorders among them are schizophrenia, schizoaffective disorder, and bipolar disorder. The disorders interfere with their daily lives and prevent them from living safely on their own. Residents are referred to the facility on an involuntary commitment or a voluntary commitment. Although, most commitments start off at 3 months, all residents have had stays that extended past that. Presently, the average length of stay in the facility is approximately two years (1.83 years or one year and ten months). The longest duration of stay is over five years. For at least a quarter of the current residents, this is also not their first time living there.

Many of the residents are stable, but their baseline is still far too dysfunctional to allow them to leave. A few of the residents are also continually being re-admitted to the hospital. The LTSR had over ten hospitalizations in the last year. All of the residents living at the LTSR were diagnosed based on criteria in the DSM-IV. The use of this older model of classification could be problematic for those suffering with schizophrenia or other psychotic disorders as argued in the next section.

Currently, there is no psychosocial therapy offered at the facility, although it clearly states in the program description that it is to be offered. There is also very little supportive counseling offered, unless a resident is unstable or requests to see a counselor. In the past, the LTSR held

group sessions of Dialectical Behavioral Therapy or Cognitive Behavioral Therapy at least once a week for all of the residents that were willing to attend. However, there were some changes in the staff and administration in the last year at the LTSR, and now there is nobody who is qualified to run the sessions anymore. The only psychosocial treatments the residents receive now are the rehabilitation sessions that they can be transported to at other facilities. However, a majority of the residents do not go to other rehab centers.

For most of the residents, their only form of treatment is whatever the LTSR offers, which is very little to none at the moment. The facility's only formal way of targeting their clients' symptoms is through medication adherence. Although for all of the residents disorders, medication is necessary, the current treatment approach is very limiting and ineffective if the goal is to help residents recover. Drugs are effective in decreasing or eliminating some but not all symptoms.

In contrast to using only one form of treatment, the adoption of a balanced approach that uses medication and psychosocial therapies is highly advantageous. The medications help to eliminate or decrease symptoms and prevent relapses, while the psychosocial treatments would provide the residents with the tools necessary to reach their social and educational, or vocational goals so they may be able to leave the LTSR and live their lives to the fullest.

Overall, the LTSR is intended to be a middle ground between the hospital and home. It is not meant to become an individual's permanent home, but to prepare them for when they will be on their own and to integrate them back into their community. Most of the residents have goals to move out and away from the LTSR once they feel they are capable or once their commitment is up. Nonetheless, with the current amount of residents relapsing and returning to the hospital, or

being re-admitted to the program, it is clear that the quality and quantity of treatment interventions offered at the LTSR are below standard.

High recurrence and hospital re-admittance rates have been associated with the course of treatment individuals receive in any mental health care setting (Sohn, Barret & Talbert, 2012). Certainly, it is also relevant to keep in mind that while one could necessarily attempt to “fix” the current program at the LTSR that is only one piece of a large and very complex puzzle that is the mental health system. To effectively free these individuals from the perpetual cycle of hospital-rehabilitation-home, it is important for all of the pieces to function together with the same goals in mind about what is best for the individual.

Relevant Changes to DSM

Since the publication of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) half a century ago, the classification system for psychological disorders has had many readjustments. All revisions in the DSM have improved on its reliability, validity, and clinical utility. The most recent manual was released in 2013, and transitions from the previous version (DSM-IV-TR) to the DSM-5 were expected to be complete by January 1, 2014. (American Psychiatric Association [APA], 2013). By revising the DSM, American Psychiatric Association (APA) aims to align with the current version of the World Health Organization’s *International Classification of Diseases* (ICD-10). The ICD-10 is the classification system that has been adopted by a majority of countries around the world.

The DSM’s primary goal is to enhance the care of individuals with psychiatric disorders (APA, 2013). It is a way of reducing complex information into a more user-friendly form for mental health professionals to use. The most recent edition includes multiple diagnostic features,

associated features supporting diagnoses, subtypes and specifiers, development and course, risk and prognostic factors, diagnostic measures, functional consequences, and culture-related diagnostic issues for all diagnoses. These features can help professionals connect the diagnosis to the individual's personal experiences. APA emphasizes that the current diagnostic criteria are the best available description of how mental disorders are displayed. It is meant to serve as a guide for organizing information that can improve the accuracy of diagnoses and focus the treatment of mental disorders (APA, 2013).

For the residents at the LTSR, the changes in diagnostic criteria of schizophrenia could facilitate an accurate understanding of the severity of their disorders across the symptom dimensions and influence their individual courses of treatment. It may also shed light on the issues with the residents' responsiveness to certain psychosocial interventions over others. Despite the recommendations from APA, the LTSR still utilizes the older classification system.

The first change to discuss is the removal of the multi-axial system, which involved documenting a diagnosis on five axes. Axis I was the primary diagnosis that needed immediate attention. Axis II contained pervasive issues such as personality disorders or an intellectual disability. Axis III was for reporting medical or neurological problems that were relevant to treatment. Psychosocial or environmental stressors that influenced client's treatment were identified on Axis IV. Lastly, Axis V allowed for professionals to provide a Global Assessment Functioning (GAF) rating that indicates the overall level of impairment. The removal of this system was a major structural change to the DSM, and the first one since the DSM-III (Kress, Barrio Minton, Adamson, Paylo, Pope, 2014). Although the multi-axial system was adopted by

many insurance and governmental agencies, the utility of it in clinical settings was low, and it was not required for diagnosing a mental disorder (APA, 2013).

The DSM-5 has abandoned the multi-axial system in favor of assuming a well-rounded non-axial conceptualization of disorders. Axes I, II, and III have been eliminated so that clinicians can list disorders and other conditions together. What was previous considered Axis IV, psychosocial and environmental factors, was removed to increase accessibility of treatment for those who might only have problems in those areas (Kress et al., 2014).

Practitioners are still advised to make notes on contextual information of their clients. Understanding this information could lead to a more holistic conceptualization of symptoms and a better understanding of stressors and a better predictor of prognosis of a disorder. The DSM-5 has also included a Cultural Formulation Interview (CFI) that can assist clinicians in the understanding a client's contextual information and its impact on symptoms (APA, 2013). The GAF scale, or Axis V, was removed due to it's perceived lack of reliability and poor clinical utility. Now, APA suggests that clinicians use the World Health Organization Disability Assessment Schedule (WHODAS) 2.0 to assess a client's functioning.

Various issues amounted from using the DSM-IV-TR to diagnose psychotic disorders. The boundaries between different disorders were loosely defined, and distinctions between subtypes of schizophrenia were ambiguous. For a diagnosis of schizophrenia, emphasis had been wrongly placed on symptoms such as auditory hallucinations, thought broadcasting, delusions of control, and delusional perception, all otherwise known as first rank symptoms. The schizophrenia subtypes, which included catatonic, paranoid, disorganized, residual, and undifferentiated were rarely utilized in clinical settings.

The DSM-5 adjusted for these issues; specifically, the subtypes have been eliminated, and there is no longer a focus on bizarre delusions and other first-rank symptoms (APA, 2013). With the removal of schizophrenia subtypes, diagnosis of schizophrenia is conceptualized dimensionally. The severity of symptoms, which varies from patient to patient and affects the choice of treatment, can be assessed using the Clinician-Rated Dimensions of Psychosis Symptom Severity (C-RDPSS) scale that has been added in the DSM-5 (APA, 2013).

Tandon, Bruinjazeel and Rankupalli (2013) assessed the impact of revisions to the DSM-5 diagnostic criteria on individuals diagnosed with schizophrenia using older editions of the DSM. Their data suggested that the changes would have little impact on the application of schizophrenia, with less than 2% of their participants not meeting the DSM-5 criteria. Mattila et al. (2015 had similar results in their review of the consequences of changes to the diagnostic criteria. They collected the data of 5233 patients from 22 double-blind trials that studied the efficiency of second-generation antipsychotics as a treatment for psychotic episodes.

Mattila and colleagues found that 99.5% of schizophrenic patients who had been diagnosed using older versions of the DSM still met the criteria in the DSM-5. Although it may not affect the applicability of the diagnostic name to a patient's disorder, the changes to the DSM-5 have empirical support. For instance the elimination of schizophrenia subtypes was appropriate since differences in symptom characteristics between subtypes were not statistically significant. Also, the DSM-5 offers much more than older manuals do in terms of descriptive features and measures to help professionals make the diagnosis and treatment more individualized for the client.

Resident Engagement in Treatment

Most treatment approaches have shifted from a more traditional medical view where the professionals have all the power over patients' care, to a collaborative recovery-oriented treatment approach. Recovery-oriented care involves individuals with a disorder improving their health and wellness, living self-directed lives, and striving to reach their full potential. This type of care that prioritizes autonomy, empowerment, and respect for the individual receiving treatment, and an equal therapeutic relationship between the clinician and the client (Dixon, Holoshitz, & Nossel, 2016).

The LTSR, although having the end-goal of functional recovery for residents, is more aligned with the traditional view of care. Most of the decision-making about the residents' care is made by the psychiatrist and counselors. There is a lack of collaboration between professionals and the residents in the development of treatment plans and treatment goals. The problem that may stem from the professionals' tendency to underestimate their clients' preferred level of involvement in treatment (Ambigapathy, Chia, & Ng, 2015).

It also could be that the providers are concerned that the residents may not have the capacity to make mindful decisions involving their care (Dixon et al., 2016). In a cross-sectional study of 900 outpatients with mental disorders, a majority of the patients had self-reported that although they wanted to be involved, their providers did not want to know their desired level of involvement in decision making (Cuevas & Penate, 2014). These perspectives are dangerous, especially when they come from professionals who are making decisions that can affect clients' lives. The clients' participation in the decision making should matter.

A person-centered approach to treatment planning is more recovery-oriented and can be more beneficial for the client. The approach involves understanding each client in the context of his family, history, culture, specific needs, unique strengths, and hopes and dreams for recovery (Dixon et al., 2016). An aspect of person-centered care where the LTSR is lacking is shared decision making; it involves the collaboration of two equals (Dixon et al., 2016). Increasing client participation in treatment decision making has some advantages. In one review of patient involvement in treatment planning, patients reported a higher quality of life; increased satisfaction and trust; reduced anxiety; empowerment; greater responsibility and independence; and better overall health as just a few of the possible benefits (Vahdat et al., 2014).

In a cross-sectional study of shared decision making, patients who reported high levels of involvement in the treatment planning process also seemed to show more positive attitudes towards medications, openness towards trying therapy and higher self-efficacy (Cuevas & Penate, 2014). Self-efficacy is one of the many client factors associated with improved clinical outcomes (Dixon et al., 2016). Another study mentioned that shared decision making in treatment planning was linked to more acceptance of advice from professionals, adherence to medications, patient satisfaction due to reduced anxiety or increased understanding of treatment options, and increased satisfaction with their treatment plans (Gravel, Legare, & Graham, 2006)

Regarding patient involvement in treatment goals, Turner-Strokes, Rose, Ashford, and Singer (2015) found in their study that patients who were more engaged in their goal development process showed significantly better outcomes for adherence to rehabilitation, goal attainment, motivation, goal-specific performance, and functioning. Another study on patient engagement and goal setting found an association between patients who received structured goal-

setting where their values and priorities were considered, and increases in treatment engagement and adherence to interventions. The results of this study show that patient engagement in treatment may be dependent on how consistent treatment goals are with the patient's personal life goals (Ogawa et al., 2016). These studies show that increasing recovery-oriented perspectives among professionals and emphasizing patient involvement in treatment decision-making can impact patients' satisfaction with themselves and their treatment, influence their willingness to adhere to treatment, and aid in their recovery.

Psychosocial Interventions for Schizophrenia and Other Psychotic Disorders

Antipsychotics, in the treatment of schizophrenia, are used to stabilize and manage the positive symptoms. Positive symptoms include hallucinations, delusions, and racing thoughts. Although positive symptoms are the focus of pharmacotherapeutic treatments, the strongest predictors of a lack of treatment engagement and success are actually negative symptoms (apathy, lack of emotion, poor functioning), as individuals with severe negative symptoms often withdraw due to a lack of motivation or defeatist attitudes.

Negative symptoms of psychotic disorders, in general, are associated with poor long-term prognosis and lower levels of functioning (Staring, Huume, & Gaab, 2013). If recovery is the goal, as it is at the LTSR, then medications alone are not sufficient to treat individuals with psychotic disorders. Providing psychotherapy as an adjunct to medications will reduce the negative symptoms (apathy, lack of emotion, poor functioning) and help the person learn how to adaptively function in her community so she can go on to lead a personally meaningful and productive life. The following therapeutic interventions are those often used for individuals with schizophrenia.

Social Skills Training (SST):

Social skills training (SST) is based on social learning theory. In SST, a client's social functioning is targeted to improve the ability to perform in social situations, manage the daily tasks of life, and reduce distress in social situations (Turner, Gaag, Karyotaki, & Cuijpers, 2014). For schizophrenia, any dysfunctional behavior could potentially be targeted for a skill to be learned or re-acquired. Some of the types of training include interpersonal skills training and coping skills. Skills training has expanded, since its start, to include emotional regulation, work related skills, and money management which are necessary for learning independent living (Kern et al., 2014).

Data from 22 social skills training studies show that this intervention was effective for increasing acquisition of social skills and daily living skills. It was not as effective in reducing symptoms or relapse (Kern et al., 2014). Another meta-analysis by Turner et al. (2014) found that SST was more efficient for reducing negative symptoms when compared to other interventions. Most psychotherapies in this study had only slight differences in effects due to all of them having common factors (including therapeutic relationship, expectations for therapy, and other extratherapeutic factors such as social support). This issue may be resolved if some of the components that were successful in skills training are included in a treatment plan that also includes another psychosocial intervention such as Cognitive Behavioral Therapy (CBT).

Cognitive Behavioral Therapy for Psychosis (CBTp):

CBT for psychosis is based on the idea that one's cognitions can influence feelings and behaviors. For an individual with schizophrenia, it would be used to promote awareness of the links between thought processes, emotions, and behaviors. The individual's dysfunctional

thoughts would be targeted to create changes in symptoms and functioning with CBTp (Turner et al., 2014). This therapy assumes that hallucinations and delusions can be modified as a target for intervention. The primary goal of CBTp is to help individuals become more cognitively flexible and to challenge their maladaptive cognitions by restructuring the way they perceive their symptoms and consider alternative explanations for psychotic experiences (Turner et al., 2014).

There is evidence that CBTp, when delivered in community mental health settings, has improved outcomes. CBTp was quantifiably more effective for improving outcomes, than basic care (i.e. only medicinal interventions). The effects of CBTp have been shown to continue even after treatment, and advantages derived from this treatment have been found at six month and five year follow-ups with individuals (Kerns et al., 2014). CBTp is associated with improvements with delusional beliefs and beliefs about hallucinations (Kukla, Davis, & Lysaker, 2013).

One review of CBT interventions for schizophrenia found that personal recovery focused CBTp interventions significantly impacted emotional functioning, negative symptoms, work functioning, and participation in social relationships (Nowak, Sabariego, Switaj, & Anczewska, 2016). A meta-analysis on CBT in 2006 found that CBT plus medication and case management led to substantial pretreatment and posttreatment improvements in all symptoms, positive and negative, when compared to those only receiving routine care (Butler, Chapman, Forman, & Beck, 2006).

Peer Services (PIS):

Peer Implemented Services (PIS) is a relatively recent recovery-oriented approach for psychotic patients. Peers are individuals who have recovered from a mental disorder and can

function successfully on their own. They may continue to receive mental health services, but the mental health system also employs them and work alongside professionals. The rationale behind this service is that those who have lived through similar experiences can become pillars of support and respect for individuals recovering from the same disorder (Kerns et al., 2014). They may also offer guidance and insight that a professional, who has never had a mental disorder could not.

Peer providers and consumers can form unique bonds that counselors and other professionals may not be able to offer. Peers can create supportive experiences for the consumers, such as validation of personal experience, a sense of belonging, shared activities, a sharing of coping strategies, recognition of personal accomplishments, and trust. Peer provider roles include case manager aides, community aides, outreach workers, vocational counselors, providers of self-help educational services among other functions (Fukui, Davidson, Holter, & Rapp, 2010).

Qualitative research and non-controlled studies on the use of peer support specialists and case management aides have shown benefits for those with severe mental disorders. There is also evidence that working as a peer support specialist can be beneficial to the peer provider. Peer providers have shown improvements in job satisfaction and a decreased need for mental health services (Kerns et al., 2014). A study of the impact of peer-led self-help groups found that they showed statistically positive effect on outcomes of self-esteem, self-efficacy, and social support (Fukui et al., 2010). Individuals who received peer services have shown increases in social engagement and quality of life. Studies have also shown that peer-led education services on self-

management have led to reduced levels of depression and anxiety, increased self-perceived recovery, and increased empowerment (Kerns et al., 2014).

Family Psychoeducation (FPE):

Family-based interventions developed out of the understanding that schizophrenia and other psychotic disorders cause social (e.g., occupational, school, relationships) and cognitive (e.g., memory, attention, executive functions) impairments and relatives of individuals with mental disorders often assume a lot of the responsibility for the patient (Kerns et al. 2014). FPE assumes that most concerned family members need information and support to best help the clients cope with their challenges. It also assumes that they may not have easy access to such information (McFarlane, 2016).

With FPE, family members are incorporated into the client's treatment and rehabilitation. Content typically includes

- illness and medication management;
- service coordination;
- assistance with improving family communication;
- structured problem solving and instruction;
- implementing coping strategies;
- expanding social support networks;
- crisis planning (McFarlane, 2016).

Studies have shown that families can become a risk or protective factor for developing a mental disorder. The family environment also plays a significant role in the outcomes after returning from hospitalization (McFarlane, 2016). Involving the family in interventions and

giving them the knowledge of proper supportive behaviors could help to increase positive outcomes of therapy and decrease re-hospitalization rates. Family-based services for those with serious mental disorders have been associated with greater treatment retention and increased customer satisfaction (Kerns et al., 2014).

Studies reveal that FPE it can be beneficial to clients with psychotic disorders. Compared to no psychosocial intervention, FPE increased caring attitudes among family members and treatment compliance among clients. It also has been associated with improvements in client functioning and reductions in family perceived burden of care. It is particularly beneficial in the early years of the course of a disorder when improvements in functioning can have drastic and long-term effects (McFarlane, 2016).

Psychosocial Interventions for Bipolar Disorders

The DSM-5 (APA, 2013) separates bipolar disorders into bipolar I disorder and bipolar II disorder. Bipolar I disorder, is characterized by at least manic episode lasting one week. A manic episode is a period of abnormally irritable or elevated mood and increased goal-directed activity or energy that is severe enough to cause impairment in social and occupational functioning and can lead to hospitalization (APA, 2013). Bipolar I individuals can also suffer from hypomanic or major depressive episodes in their lifetime, but only a manic episode is needed for diagnosis. At the LTSR, bipolar I disorder is the one most prevalent among the residents along with schizophrenia.

Bipolar II individuals must have had at least one hypomanic and one major depressive episode in their lifetime (APA, 2013). A hypomanic episode is similar to a manic episode however it is shorter in duration and less severe (does not cause social and occupational

impairments). Similar to schizophrenia and other psychotic disorders, medications are at the foundation of treatment for a bipolar disorder. Bipolar individuals tend to have difficulty keeping with the medication, so medication adherence alone leads very few people into actual remission (McHanon, Herr, Zerubavel, Hoertel, & Neasciu, 2016). Psychosocial interventions can be provided in addition to medication in order to increase adherence to medications and the likelihood of going into full remission. Below are some of the best evidence-based psychosocial interventions for bipolar disorders19.

Cognitive Behavioral Therapy (CBT):

Cognitive Behavior Therapy (CBT) has been adapted to address thought and behavioral patterns specific to bipolar disorder. It is based on Beck's theory that describes maladaptive thoughts and behavioral patterns as instrumental to the development of depression. Goals in CBT for bipolar disorder, like with CBT for psychosis, usually address problem thinking and behaviors. Typically treatment involves teaching skills to identify and modify maladaptive thoughts, practice medical adherence, and engage in positive behaviors within regular routines (McHanon et al., 2016).

In a multi-site study that compared various psychotherapies with a control group, CBT significantly improved bipolar patients' relationship functioning and life satisfaction. CBT for bipolar disorder has been linked to improvements in mania, reduction in depressed mood, and higher quality of life (Ye et al., 2016). In a meta-analysis of psychotherapies for bipolar disorder, individuals that received both CBT and psychoeducation exhibited significantly fewer anxiety and depression symptoms, had fewer hospitalizations, and had better social-occupational functioning when compared to those who only took medication (Salcedo et al., 2016). Studies

have shown that CBT has also had significant long-term effects on preventing relapse in bipolar individuals who were in remission (McHanon et al., 2016).

Mindfulness-based Cognitive Therapy (MBCT):

Mindfulness-based cognitive therapy (MBCT) is a group treatment that was established for unipolar depression. It has since been adapted for bipolar depression. MBCT combines meditation practices and CBT exercises to change the relationship that people have with their thoughts and emotions. The goal of MBCT is generally to increase the client's early detection of depression relapse and learn skills to change thinking and behavioral patterns that may lead to depression (McHanon et al. 2016).

MBCT has demonstrated in various research evaluations that it can successfully reduce depressive relapse, residual depression, and anxiety severity. Outcomes of MBCT for bipolar disorder have shown that participants have greater ability to observe their thoughts and feelings in a less judgmental and reactive manner and experienced less depression. Results were also favorable for the reduction of depression severity and relapse in individuals in remission as well as those who are currently having a depressive episode (McHanon et al., 2016).

Family-focused Therapy (FFT):

Interventions that target dysfunctional family interactions have been found to be effective in treating bipolar depression. It was developed to target high expressed emotions and reduce maladaptive interpersonal interactions with relatives of those who were at risk or had bipolar disorder. The goal of FFT is to increase positive interactions within a family and educate family and individuals on possible coping skills, as well as engaging the person's support network in treatment and relapse prevention (McHanon et al., 2016).

Several studies have found that FFT can effectively reduce bipolar depression compared to no treatment and other interventions. It was as effective as CBT in leading to recovery from bipolar depression within one year (McHanon et al., 2016). Bipolar individuals in FFT have exhibited faster recovery from baseline depressive symptoms and spent fewer weeks in depressive episodes (Salcedo et al., 2016). It has also been associated with long-term relapse prevention effects. This could be due to patients in FFT having more supportive family circles and family members having more skills to monitor mood and cope successfully.

Dialectical Behavioral Therapy (DBT):

DBT was created for individuals who had Borderline Personality Disorder (BPD); however the emotional dysregulation associated with BPD can also be extended to other disorders where emotional problems have been known to exist such as bipolar disorder (McHanon et al., 2016). DBT is aimed for individuals who are difficult to treat, suicidal or have difficulty managing emotions. Goals of DBT are to increase understanding and awareness of emotions and problem-solving. The typical skills taught include mindfulness, distress tolerance, interpersonal effectiveness, and emotional regulation (McHanon et al., 2016).

DBT skills training has shown to be significantly more effective than a control group of adults who met the criteria for anxiety or depressive disorders. When compared to medication alone DBT was able to reduce depression severity in treatment-resistant adults successfully. Similar results were seen in an outpatient program that used DBT among multi-diagnostic patients (Salcedo et al., 2016).

A pilot study among adolescents with bipolar disorder showed that it was capable of successfully reducing suicidal behavior, emotional dysregulation, and depression severity. A

study of a DBT treatment for bipolar individuals revealed that it could improve depressed mood and decrease suicidality (Salcedo et al., 2016). Although there is limited research on DBT for bipolar adults, evidence has shown that it may be an effective treatment as it has been associated with reduced symptoms of depression, emotional dysregulation, and suicidality across patients with various disorders. Also, it has been used to treat bipolar adolescents with success.

Suggestions for Improvement to LTSR

The LTSR, while not seemingly doing danger to their residents, is not giving them the best service. The program should make it clearer that its focus is on leading people to recovery and allowing them to reach their full potential. The residents are currently receiving limited treatment and their progress towards recovery is relatively static. Despite many residents being re-admitted to hospitals and re-entering the program, the LTSR has not recognized this as an indicator that the quality of their current program may be lacking. According to the World Health Organization (2003), quality of mental health care involves how services increase the chances of desired mental health outcomes for clients and are consistent with current evidence-based practices.

The LTSR needs to focus on improving the overall quality of their services. One way to do this is to have professionals follow the current most effective and efficient care guidelines. For instance, adopting the DSM-5 as a guide for conceptualizing the residents' disorders. If the counselors at the LTSR have a better understanding of the residents' disorders, then they can influence how the residents conceptualize their disorders and they can lead them to have a healthy understanding of their diagnoses. Based on past research, the residents' diagnoses might not change much. Nonetheless, changing the structure and features of diagnoses to those in the

DSM-5 in the residents' cases facilitates a clear understanding of symptom severity and promotes the use of a common language among all mental health professionals involved with the residents.

Moreover, the DSM-5 offers many assessment measures that can be used for the initial evaluation and treatment monitoring progress. The assessments are all located in Section III of the DSM-5. The LTSR typically does an initial and an annual evaluation of residents' conditions. To increase understanding of each resident's prognosis, they should also consider using the Self-Rated Level 1 Cross-Cutting Symptom Measure (SR-CCSM, APA, 2013) throughout the resident's stay at the facility. This measure may help the counselors to recognize variables that could affect the resident's treatment progress and would warrant a change of intervention as well as track the changes in their symptom presentation over time.

The World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0, APA, 2013), which assesses disability in six domains (i.e. understanding and communicating, getting around, self-care, getting along with people, life activities, and participation in society) can also be used at regular intervals during treatment to track changes in the resident's level of disability over time. The problem areas that are indicated by the individual's scores may call for additional interventions.

Not every person has the same language, religion, spirituality, family structure, rituals, customs, morals, etc, but all these cultural aspects still affect how clients and clinicians and everyone else involved in the health care process understand illness and engage in care. The Cultural Formulation Interview (CFI, APA, 2013), allows clients give their own interpretation of their illness and helps to place it in the context of their lifestyle and environment. The CFI should be used at initial assessment of the new-coming residents so that professionals at the LTSR can

develop an individualized treatment plan for each person. Having a more culturally competent understanding of each resident can promote their engagement and satisfaction with the program. Lastly, the DSM-5 offers the Clinician-Rated Dimensions of Psychosis Symptoms Severity measure (CR-DPSS, APA, 2013). This is used to assess the primary symptoms of psychosis and their severity. At the LTSR this assessment could be utilized throughout the resident's treatment process to track changes in their symptom severity and identify patterns related to life stressors and symptom exacerbation or reduction.

In addition to the DSM, there are other assessments that the LTSR can use to gauge the effectiveness of treatment and outcomes. Patient satisfaction is a well-known risk factor for relapse and non-adherence to treatment (Sohn, Barret & Talbert, 2012). Staff members at the LTSR should prioritize making all areas of treatment a positive experience for the residents. Patient Reported Outcomes Measures (PROMs) are becoming increasingly popular tools to measure patients' perceptions of their impairment, disability, and well-being post-intervention. PROMS such as the could be used at the end of treatment with a resident to evaluate their experience and give information on what they can change in the program for patients with similar disorders (Lambert & Burlingame, 1996).

Patient satisfaction surveys such as the Patient Satisfaction Questionnaire Short Form could also be adapted for use in the LTSR, to measure the resident's attitudes towards treatment received and the professionals they deal with throughout their time in the facility (Marshall & Hays, 1994). Patient reported measures should be used intermittently at the LTSR to gauge the resident's attitudes towards treatment and outcomes. A better understanding of client's

experiences in care will allow LTSR to identify gaps in service and quality and recognize issues affecting patient care and redesign their program to deliver better care.

The LTSR is meant to aid the residents in their process of recovery. If this is so, then the staff at the facility should have a recovery-oriented perspective for their services. This change includes making treatment more person-centered and allowing the residents to have more input on the development of their treatment plans and treatment goals. Increasing the residents' participation in treatment decision making may enhance their self-efficacy to complete treatment goals, and have a more accepting perspective of the treatment offered. The desired level of involvement in the decision making differs from resident to resident. Before any treatment plans are created, the counselors should try to understand the residents' willingness to be involved in their treatment, and when appropriate include them as much as possible in the decision-making.

Measures like the Self-Advocacy Scale (Brashers, Haasm Neidig, 1999) or the Control Preference Scale (Degner, Sloan, Venkatesh, 1997) can be used at the beginning of the residents' treatment at the LTSR to determine their preferences for participating in treatment planning. After the counselors get a sense of a resident's stance on participation, they should try to work with her as much as possible to come up with a plan for her treatment while in the program. This includes involving each resident in the development of her treatment goals, in the decisions of what psychotherapeutic interventions she may want to try, and with what medications she takes. Counselors should also make it a point to monitor resident's goal achievements and get the residents' feedback on aspects of their treatment plans throughout their stay in the program.

Residents may show low willingness to participate in treatment because they feel they are not educated enough to have a say or that they aren't equal to the professionals (Vahdat et al.,

2014). This is why it is important that the professionals at the LTSR have recovery-oriented perspectives because this perspective emphasizes empowering the client and an equal relationship between the client and professional. The counselors and psychiatrist at the LTSR should try to develop mutual communication and increase their sharing of knowledge with the residents. Developing a positive therapeutic relationship and providing the residents with more knowledge on treatment options may encourage them to be feel more confident talking to the professionals, be more engaged in treatment, and make informed decisions. By increasing the residents' participation, they may gain a sense of control over their care and may feel more motivated to follow their treatment plans and work on completing their treatment goals.

The LTSR also has to consider their lack of intervention methods. They need to build treatment plans based on each resident's individual needs that include more than just medicinal interventions and some non-specific counseling. Residents should receive psychosocial group therapy, and individual therapy sessions. Considering that the LTSR is a relatively small residence, it would be difficult to perform all the types of therapies that were mentioned in the sections above. Instead, counselors should work with the residents to see which treatment might suit them best. If such therapy is not able to be offered by a professional at the LTSR, they should be given the opportunity to go to another place that offers it. Transportation is provided at the LTSR. While few of the residents take advantage of it, the LTSR could provide them service going to and from whatever therapy they attend.

Overall, CBT stood out among the rest of the therapeutic approaches as the most recommended form of treatment. A group version of CBT was previously offered at the facility so it is possible that the residents can receive this therapy in this facility. To use any form of

CBT requires an extensive amount of training to reach professional standards. Still, it would be beneficial if the current professionals be trained in CBT for psychosis and bipolar disorder since these are the most common diagnoses seen in the LTSR. Along with CBT, Dialectical Behavioral Therapy (DBT) could be used to help build the residents' mindfulness and reduce their negative symptoms and depression. Social Skills Training will be another useful therapy that can easily be taught in groups at the LTSR or integrated into CBT. It will be especially practical for the residents who want to start living independently as it includes lessons on money management, medication management, coping skills, and vocational skills.

Family Focused Therapy would be of great benefit for residents that have family members who are highly involved. It might not be feasible for all residents, as their relationships with their families are very different. Also considering each resident's cultural context, some residents' families may not choose to get involved or feel comfortable being involved in treatment. Many of the residents are older and have had these disorders for most of their lifetime. Their family might not be involved as much in these cases. FFT might be more useful for younger residents so it should still be considered. However, the LTSR may not be the proper setting to provide this type of therapy. If the counselors believe that it might be rewarding for a particular resident, then they should recommend to the family of the resident another place that offers that service.

Psychoeducation should be provided alongside whatever psychotherapy is chosen. Even though many individuals are older and have lived with their disorders for most of their lives, providing psychoeducation about their disorders may help to validate their experiences and accept their disorders more than just giving them medications to reduce their symptoms. Peer

programs would also be a great addition to treatment, especially in this setting. Many residents only deal with other residents who might exacerbate their symptoms and staff members who might empathize with them but can not clearly understand what they are experiencing. A peer provider could be a significant influence during therapy sessions. Having a peer demonstrate adaptive and coping behaviors and positive attitudes during therapy sessions could help residents enjoy treatment more and want to attend regularly.

Similar with skills training, aspects of mindfulness based cognitive therapy can be integrated into the program in daily activities or included in other therapy sessions. Dialectical Behavioral Therapy, for instance, already incorporates mindfulness as a skill to be learned. The LTSR should consider incorporating meditation into therapy and daily groups. It could help reduce depressed mood and anxiety, according to results across studies. It would help to promote a more therapeutic atmosphere if all staff members were trained in meditation exercises. For the staff members who are around the residents more often, knowing meditation techniques may make good group activities and be useful in situations where the residents are agitated.

To summarize, the LTSR needs to begin using the DSM-5 for their diagnostic titles. The assessments the DSM-5 provides could promote a clear understanding of each resident's personal experience with his disorder. Also, the professionals at the LTSR need to start taking a recovery-oriented view to service, and incorporate person-centered approach to their treatment. They need to begin engaging the residents in the development of treatment plans and goals. The LTSR should begin to incorporate measures for quality assurance into the program. Patient-reported measures of satisfaction and outcomes make good evaluators of quality assurance, and they should be included in the services for every resident. Eliciting feedback from residents and

involving them in their care delivery gives an opportunity to address aspects of care that need improvement and to monitor performance while considering meeting resident goals. Finally, the LTSR needs to start including psychosocial interventions in the services offered. Reforming their current program to include more than just medication as a treatment for residents can help improve outcomes.

Conclusion

This paper investigated the current program at a long-term structured residence (LTSR) for those with mental disorders. It found that the LTSR's diagnostic system is outdated and problematic. There is an issue concerning the quality of care given at the residence. Residents at the LTSR are not receiving the appropriate amount of treatment so that they may make progress on their road to recovery.

The paper reviews the changes made to the outdated diagnostic system that the LTSR is using and the logic behind those changes. The APA (2013) recommends that the most recent diagnostic classification system, the DSM-5, be used in treatment settings to facilitate the most accurate and dimensional understanding of disorders. Also, included in the DSM-5 are a variety of assessment measures that can be utilized by professionals to develop the most comprehensive treatment plans for their clients.

However, the DSM-5 does not include actual evidence-based treatments for each disorder, which the LTSR also lacks. Thus, recommended psychosocial treatment approaches for the most common disorders seen at the LTSR were reviewed. Included were Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Family Focused Therapy, Peer

Implemented Services, Social Skills Training, and Mindfulness-based Cognitive Therapy. A brief description and evidence of positive outcomes were given.

Recommendations for the best psychosocial interventions that should be offered at the LTSR were made, and how the residents could benefit from being included in treatment decision making was discussed. It was proposed that the LTSR update their current diagnostic system to the DSM-5. Also, suggestions of appropriate assessments that can be utilized by the counselors to improve their quality of treatment, outcomes, and understanding of their resident's distresses were included.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Ambigapathy, R., Chia, Y.C., Ng, C.J. (2015). Patient involvement in decision making: a cross sectional study in a Malaysian primary care clinic. *BMJ Open 2016* 6(1).

Brashers, D.E., Haas, S.M., Neidig, J.L. (1999). The patient self-advocacy scale: measuring patient involvement in health care decision-making interactions. *Health Communications 11*(2), 97–121. doi: 10.1207/s15327027hc1102_1

Butler, A.C., Chapman, J.E., Forman, E.M., Beck, A.T. (2006). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review 26*, 17-31. Retrieved from http://www.cloudpsychology.com.au/wp-content/uploads/2013/07/Empirical-Status-of-CBT.pdf.

Cuevas, C., Penate, W. (2014). To what extent psychiatric patients feel involved in decision making about their mental health care? Relationships with socio−demographic, clinical and psychological variables. *Acta Neuropsychiatrica 26*, 372−381.

Degner LF, Sloan JA, Venkatesh P. (1997) The control preferences scale. *Canadian Journal of Nursing Research 29*(3), 21–43.

Dixon, L.B., Holoshitz, Y., & Nossel, I. (2016). Treatment engagement of individuals experiencing mental illness: Review and update. *World Psychiatry 15*(1), 13-20. doi: 10.1002/wps.20306

Gravel K., Legare F., Graham I.D. (2006) Barriers and facilitators to implementing shared decision-making in clinical practice: a systematic review of health professionals' perceptions. *Implementation Science 1*(16). doi:10.1186/1748-5908-1-16

Henning, C. (2016). A guide to patient reported measures: Theory, landscape, and uses. Retrieved from http://www.monmouthpartners.com/assets/pdf/A%20Guide%20to%20Patientm%20Reported%20Measures.pdf

Janicak, P.G., Marder, S.R., Tandon, R., & Goldman, M. (Eds.). (2014). *Schizophrenia: Recent advances in diagnosis and treatment.* New York: Springer

Kern, R.S., Horan, W.P, Glynn, S.M, Reddy, G.L., Holden, J., Granholm, E., . . . Spaulding, W.D. (2014). Psychosocial Rehabilitation and psychotherapy approaches. Janicak, P.G., Marder, S.R., Tandon, R., & Goldman, M. (Eds.), *Schizophrenia: Recent advances in diagnosis and treatment, (*pp. 275-312). New York: Springer.

Kress, V., Barrio Minton, C.A., Adamson, N.A., Paylo, M.J., Pope, V. (2014). The removal of the multiaxial system in the DSM-5: Implications and practice suggestions for counselors. *The Professional Counselor, 4*(3), 191-201. doi:10.15241/vek.4.3.191

Kukla, M., Davis, L.W., Lysaker, P.H. (2013). Cognitive behavioral therapy and work outcomes: Correlates of treatment engagement and full and partial success in schizophrenia. *Behavioral and Cognitive Psychotherapy,* 1-16. doi: 10.1017/S1352465813000428

Lambert, M.J., Burlingame, G.M. (1996). Outcomes questionnaire (OQ 45.2). Salt Lake City, UT: OQ Measures.

Marshall, G.N., & Hays, R.D. (1994). The patient satisfaction questionnaire short-form. Santa Monica, CA: RAND Corporation.

Mattila, T., Koeter, M., Wohlfarth, T., Storosum, J. Brink, W., Haan, L., Derks, E., Leufkens, H., Denys, D. (2015). Impact of DSM-5 changes on the diagnosis and acute treatment of schizophrenia. *Schizophrenia Bulletin 41* (3), 637-643. doi: 10.1093/schbul/sbu172

McMahon, K., Herr, N. R., Zerubavel, N., Hoertel, N., & Neacsiu, A. D. (2016). Psychotherapeutic treatment of bipolar depression. *Psychiatric Clinics of North America*, *39*(1), 35-56. doi:10.1016/j.psc.2015.09.005

Nowak, I., Sabariego, C., Switaj, P., & Anczewska, M. (2016). Disability and recovery in schizophrenia: A systematic review of cognitive behavioral therapy interventions. *BMC Psychiatry 16.*

Ogawa, T., Omon, K., Yuda, T., Ishigaki, T., Imai, R., Ohmatsu, S., Morioka, S. (2016). Short-term effects of goal-setting focusing on the life goal concept on subjective weel-being and treatment engagement in subacute inpatients" A quasi-randomized controlled trial. *Clinical Rehabilitation 30*(9), 909-920. doi: 10.1177/0269215515622671

Sohn, M., Barrett, H., Talbert, J. (2014). Predictors of consumer satisfaction in community mental health center services. *Community Mental Health Journal*, *50*(8), 922-925. doi:10.1007/s10597-014-9702-2

Salcedo, S., Gold., A., Sheikh, S., Marcus, P., Neirenberg, A., Deckersbach, T. Sylvia, L. (2016). Empirically supported psychosocial interventions for bipolar disorder: Current state of research. *Journal of Affective Disorders 201,* 203-214. doi:10.1016/j.jad.2016.05.018

Staring, A.B.P., Huume, M.B., Gaab, M. (2013). Cognitive behavioral therapy for negative symptoms (CBT-n) in psychotic disorders: A pilot study. *Journal of Behavior Therapy and Experimental Psychiatry 44*(3), 300-306. doi:10.1016/j.jbtep.2013.01.004

Tandon, R., Bruinjazeel, D., Rankupalli, B. (2013). Does change in definition of psychotic symptoms in diagnosis of schizophrenia in DSM-5 affect cases. *Asian Journal of Psychiatry 6* (4), 330-332. http://dx.doi.org/10.1016/j.ajp.2013.05.011

Turner-Strokes, L., Rose, H., Ashford, S., Singer, B. (2015). Patient engagement and satisfaction with goal planning: Impact on outcomes from rehabilitation. *International Journal of Therapy and Rehabilitation 22*(5), 210-216. doi: 10.12968/itjr.2015.22.5.210

Vahdat, S., Hamzehgardeshi, L., Hessam, S. & Hamzegardeshi, Z. (2014). Patient involvement in health care decision making: A review. *Iranian Red Crescent Medical Journal 16*(1). doi: 10.5812/ircmj.12454

World Health Organization. (2003). Quality improvement for mental health. Retrieved from http://www.who.int/mental_health/resources/en/Quality.pdf.