Psychology and Psychiatry in Long-Term Care: Objective and Subjective Experiences in the treatment of mental disorders at Terence Cardinal Cooke Health Care Center

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Table of Contents

Introduction

Terence Cardinal Cooke is 559-bed skilled nursing facility – home to residents in units for geriatrics, Huntington's disease, HIV/AIDS, specialty children's hospital, and sub-acute rehabilitation. It was also my home for ten weeks as I studied and learned from the residents and staff at TCC. I worked with both physicians and nurses: there are three infectious disease physicians and three internal medicine/geriatric physicians, for an average of about 90 patients per doctor. There are three psychologists for the 559 beds, for an average of about 190 patients per psychologist – a number that seems unreasonably high.

I do have to be fair – not every patient is in need of psychology services at TCC. But as people live longer with chronic illnesses that are more manageable in the modern medical world, the spotlight turns to mental health care. Brock Chisholm, the first director of the World Health Organization, saw it in 1954: "Without mental health there can be no true physical health."[1] And yet, over 60 years later, we still seem to think of mental health as something separate and auxiliary; if we can take care of it, that's wonderful. If we don't, then it's not worth worrying about.

TCC's spiritual and emotional care is not always lacking. The pastoral care and palliative care teams here are supreme in their handling of end of life issues and comfort care for the dying. I have never seen such a group of people (from the palliative care consultant to the social workers asking about advanced directives) so apt at handling the intense, emotionally charged discussions of end of life care.

[1] Kolappa, Kavitha, David C. Henderson, and Sandeep P. Kishore. "No Physical Health without Mental Health: Lessons Unlearned?"Bull World Health Organ 91 (2013): 3-3A. Bulletin. World Health Organization. Web. 3 Aug. 2015

TCC has a large percentage of residents with issues with their mental health, but this is seen in other nursing facilities as well. The national and New York state prevalence of mental illness among nursing home admissions in 2005 were 27.4% and 23.6%, respectively.

I chose to focus on psychology and psychiatry services at TCC because, in my first week here, I was struck by the number of individuals with behavioral issues, or those described as "psychotic" or "difficult." If someone acts out, as it seemed, it is because they have depression and therefore the only thing we should look at is their therapy and medication. But we overlook that maybe there is something about being here at a nursing facility – about living a life that is not your own – that inherently causes someone to become depressed and have no other outlet for their anger than to act out.

Of course, I understand that these are often very appropriate terms to use for the many patients who do experience psychosis, or who do make the staff's jobs more difficult to do. But it struck me as incongruous with the pattern of compassion seen in many of the other aspects of care in this facility. Through my research and observations recorded here, I look to understand the attitudes surrounding mental health and psychology at TCC and uncover what is missing in this part of the continuum of care.

Data

I amassed a large amount of data about mental health care at TCC. These numbers are astounding, but they should not prevent one from seeing the individual people that are still struggling with mental health issues and mental illness. The numbers indicate trends and flaws

in the ICD-9 diagnosis system; it should not be forgotten, though, that these numbers indicate individuals who are in need of more emotional and psychological care.

Over all programs, 67% of individuals at TCC have a diagnosed mental disorder. This does not include those with organic brain disorders (such as Alzheimer's disease or dementia), but rather those mental illnesses classified under categories of mood disorders, drug and alcohol related mental illnesses, anxiety, depression, eating disorders, personality disorders, and schizophrenic disorders (see appendices).

Many of these mental disorders are in combination with other illnesses, or are caused by a more chronic illness. It's well known fact that mental illnesses are influenced by a variety of factors, including genetics, environment, background, culture, etc. We know these things, but from what I've seen I worry that we forget that when someone has a mental illness, the reality that they experience is as real to them as what those who don't, or do and aren't affected as much, observe every day.

Episodic Mood Disorder

43% of all individuals have been diagnosed with Episodic Mood Disorder (EMD, ICD-9 Diagnosis 296.9), which makes up 65% of all individuals with a mental disorder (including those with EMD and another mental disorder). But what is episodic mood disorder? When going through the lists of ICD-9 diagnoses for mental disorders, I was struck by the specificity of each of them. There are 50 different categories of bipolar disorder relating to the frequency of symptoms, the type of symptoms, and the remission or lack thereof. However, Episodic Mood Disorder seemed to be a "catch-all" category that makes up any unspecified mood disorder that

does not fall into any of the other categories.[2,3] One may argue that mental disorders are not as clearly, clinically defined as physical diseases, but with the specificity of so many of the other diagnoses, it seems odd that this one vague diagnosis is held by so many.

Of additional concern was the prevalence of EMD amongst Discrete (HIV/AIDS) patients and residents. On the surface, it appears as though EMD is diagnosed relatively consistently across all programs, with slightly higher numbers for the Huntington's disease unit and slightly lower numbers for Sub-Acute Rehab and Specialty Hospital. Geriatrics (60%) and Discrete (64%) showed little significant difference in the overall diagnosis of EMD, but when broken down to those only diagnosed with EMD (no other mental disorder diagnoses), some units of Discrete showed 29%[4] isolated diagnoses of EMD (average of all discrete was 17%), and Geriatrics showed 14% diagnosis of EMD.

It's easy to point out this data and leave it in its raw, clinical form, but it is imperative to relate this to the experience of being on the Discrete unit: often the patients are younger, less physically sick, and supposedly brought there by their own choices. As I have experienced in my observations of case conferences, it is less obvious to many of them why they cannot go home. There is a certain stigma to their being there in that they have been brought there by addiction, sex, or any of the other factors that lead someone to contract HIV.

Here comes in another point, however: addiction is often not organic, just like obesity. There are genetic factors that can increase someone's risk for obesity, but more often than not,

[2] Mayo Clinic Staff. "Mood Disorders." Diseases and Conditions. Mayo Clinic, 11 Nov. 2014. Web. 3 Aug. 2015.
[3] "What Is a Mood Disorder Not Otherwise Specified?" WiseGEEK. N.p., n.d. Web. 3 Aug. 2015.
[4] As a percentage of those diagnosed with a mental disorder (total) in the program

the factors that lead to someone becoming morbidly obese are psychological or environmental in nature.

Addiction is similar in this way – I spoke with people who had been abused and exploited. Some had lost their children at the hands of their family members, or had lived lives that were beyond their control. Addiction is a vice, but it's a vice that honestly makes people feel like they can control or choose something for themselves, or it may just make them feel better for a little bit. As we can see in this program, it does not have favorable results, but you can't hear about these stories and not understand that sometimes people don't have control over their lives in a way that allows them to avoid addiction or experiences that lead to getting HIV.

This comes back to this "Episodic Mood Disorder," which is present amongst the diagnoses of 55% of Discrete individuals: when someone has anger or frustration related to their condition or placement in a nursing facility, episodes of mood disturbance are so incredibly understandable. Residents are told what to eat, when to eat, when they get to shower, when they can go outside – anyone who experienced a life outside these walls has reason to act out or to experience distress. If you have a background of difficulty or a chronic, deadly diagnosis, if you have some anger at your life or the people who constrict you to there – choosing how you respond to a situation is something you can control, and an outlet of frustration. But is it to be classified as "Episodic Mood Disorder"?

Depression (Not Elsewhere Classified)

20% of individuals at TCC have ICD-9 Diagnosis 311, Depressive Disorder (Not Elsewhere Classified – NEC). This is highest amongst geriatric residents, with 56.4% of all those diagnosed with depression NEC in the geriatric units. This can be compared with the national nursing home rate of 49% in 2011-2012.[5] Other reports cite 14% of long-term care residents having major depressive symptoms and 17% having minor depressive symptoms.[6]

Neither of these studies cite whether this depression was diagnosed pre-admission or while at the facilities, and the distinction is also not made between nursing homes and skilled nursing facilities, which changes the interpretation of the data. Whereas the 20% of all residents with depression seems reasonable, the fact that this is highly prevalent amongst the more elderly population brings into question how we treat depression in an aging population, which is the subject of books and many much longer reports.

Anxiety, Unspecified

Anxiety also falls under one of those diagnoses with many different specifications, including anxiety elsewhere classified (as in classified by another mental disorder that produces anxiety) and generalized anxiety disorder, which both have low percentages in the TCC population.

[5] "QuickStats: Percentage of Users* of Long-Term Care Services with a Diagnosis of Depression,† by Provider Type — National Study of Long-Term Care Providers, United States, 2011 and 2012." Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, 31 Jan. 2014. Web. 3 Aug. 2015.
[6] Thakur, Mugdha, and Dan Blazer. "Depression in Long-Term Care." JAMDA (2008): 82-87. AMDA. Web. 3 Aug. 2015.

However, 24% of TCC's population have anxiety states not elsewhere classified, or ICD-9 diagnosis 300.0. Once again, there is not much specified here, and the specificity of anxiety is directly related to the treatment. For example, a patient may have anxiety related to their diagnosis, their housing situation, their placement at the facility, their family, their money, their inability to procure drugs or alcohol, or any other number of reasons related to their health or lives. It is impossible to get this information from a single diagnosis, just like EMD serves to only label but not provide any information about the status of the patient.

There is little available data on the prevalence of this specific category of anxiety in the national population, but in a study of mental disorders in nursing homes in the Netherlands (obviously not able to be correlated to the United States, but within reason to frame this data), the prevalence of anxiety disorders ranged from 0-20%.[7]

Demographics

There was no significant difference in prevalence of mental disorders amongst males and females; about half of the women and half of the men at TCC have some diagnosed mental disorder. This is different from the general population, in which 23% of women and 16.8% of men have a mental illness (numbers which appear to be exceptionally low to begin with).[8]

Age seems to play somewhat of a significant part in the prevalence of mental disorders; percentage amongst people in that demographic category increases steadily and peaks at those

[7] "Result Filters." National Center for Biotechnology Information. U.S. National Library of Medicine, n.d. Web. 3 Aug. 2015.
[8] "Substance Abuse & Mental Health Services Administration." SAMHSA Uniform Reporting System (URS) Output Tables. N.p., n.d. Web. 3 Aug. 2015.

aged 41-50 years, with 95% of patients in this age category. The average rate of those 51-110 years is 70%.

Race in the general population seems to be a factor in the diagnosis of mental illness; in 2010, 25.4% of those diagnosed have two or more races, 20.6% are White, 19.7% are Black, and 18.3% are Hispanic.[9] At TCC, the numbers are similarly different, albeit significantly higher. Out of all of the people at TCC of that race, 82% of White individuals, 62% of Black individuals, and 67% of Hispanics have a diagnosed mental disorder. However, Black residents at TCC make up the highest percentage of those diagnosed mental illness (out of total people with a mental health diagnosis), with 42% (compared to 26% Whites and 30% Hispanic).

With knowledge of the high quality pastoral services at TCC, it is reasonable that there is not a significant difference in mental disorders amongst those affiliated with different religions. In religious groups that make up more than 2% of the overall TCC population (there are 21 different religious traditions represented in the TCC population), the percentage of those within a religious group with a mental illness diagnosis ranges from 60-70%. The only exception to this is Judaism; 86% of those who identify as Jewish upon admission have a diagnosed mental disorder.

It is easy to present this data and not remark on its significance because much of it is aligned with the general population (although much higher proportionally). However, what one must discern from a close look at mental disorders by race, age, religion, and gender is that these factors are just a few of those that contribute to the differential development of mental

[9] Stein, Jeannine. "Mental Illness Struck One in Five U.S. Adults in 2010: Report." Los Angeles Times. Los Angeles Times, 19 Jan. 2012. Web. 3 Aug. 2015.

disorder(s) in an individual and in a population. Although there are diseases that affect people differently according to their demographic information, mental disorders are particular in that factors beyond genetics affect their development, and it's because of these factors that someone's experience with mental disorders cannot be put into a numerical, easily understood form.

Combination of Mental Disorders

This type of logic of specific diagnoses and inclusion of all factors has the potential to lead down a very circuitous path of endless numbers of diagnoses in an attempt to quantify mental illness. However, the majority individuals with Mental Disorders at TCC have only 1-2 diagnoses (62%). The most commonly uniquely diagnosed mental disorder is Episodic Mood Disorder.

Personal Patient Testimonies

It is not easy to be depressed, or struggle with your mental health. It's most certainly not easy to talk about it, either – as the patient or the listener. If you asked me at the beginning of this internship if I could identify psychosocial distress in patients, I would have said, of course! I work in mental health awareness year round at Columbia. But ask me if I could've estimated its immense burden on patients, and I wouldn't have been more wrong.

I was fortunate to hear even just a few stories and get to know a few people that offered me a deeper understanding of what it's really like to be confined to a place that you don't want to be in, without many choices of your own. Listening and providing emotional

support is surprisingly taxing, as the supporter inevitably internalizes some of the anger, frustration, hopelessness, despair, and even happiness that the person they are listening to feels. It's easy to internalize so much distress and difficulty patients are experiencing and not realize the impact it has on them until you learn that it has had a profound impact on yourself.

This is not something we've learned in our talks about palliative care, or advanced directives, or anything else. We've been told to get invested in the patient's lives and their stories, not distance ourselves in order to protect our own psyche. But when you work so closely with a patient or a patient population, it's very easy to take off some of their burden by absorbing it yourself.

I am in no way saying that I know exactly how it feels to be as depressed as those I've talked to. All of this exists on a spectrum on which we would not be at the same point. I've taken in only a fraction of what they feel, and yet that's enough to debilitate a person. If I feel only a bit and it takes me over, what does the entire illness do to them?

All patient names have been changed and all identifying information has been removed.

Patient #32: "Sam"

Sam is a resident in the Discrete program who has issues with speech, memory, and walking. Even more striking is his demeanor – he acts often like a small child. He is very happy at times and very angry at others, and this mood can fluctuate greatly. I've spoken with him almost three times a week during my internship, and he often displays the same unyielding depression and desire to go home.

It's impossible to capture truly what it's like to speak with someone of this level of depression and honestly create the entire picture of a person in a few words. Like so many people here, Sam has a story beyond his illness and beyond his outbursts or childlike attitude.

He was born to a large family and was beaten everyday by his alcoholic father. He talks about this and instantly becomes sunken and sad. You can just see on his face that this is not something you get over. Moreover, if this is a model for how people handle anger that they learned at a very young age, it's unreasonable to say that someone is deliberately acting out, or even difficult, if in their mind this is how they see the world.

He ran away from home at 12 to New York City, which, during the 1970s, was a completely different city – very dangerous and full of drugs. He was homeless, using heroin and cocaine and drinking, and was found in Washington Square Park by an older man who took him in. I could never fully discern his relationship with this man, but it seemed like much of the father-son relationship Sam was missing. When Sam talks about him, it isn't in a romantic way – almost as if he was his companion for much of his life. This man died about a year ago, which, in addition to his medical issues, led Sam to TCC. But he also talks about a child named Sam, a wife, and losing both of them – clearly there's something more that we have yet to be able to piece together with him.

I can't say that I can piece together all of these different stories and find a way to make them fully describe Sam's personality and life. I can't even tell what is true. But I can say that something went on in Sam's past, something beyond what most people experience, that has contributed to depression of his magnitude.

Patient #84: "Emily"

Emily is a discrete patient whom I visited with another intern because of the reputation she has received as violent and difficult in our morning meetings. I wasn't necessarily scared that we would face violence from her, but I was apprehensive towards the idea of trying to get someone to talk if they really don't want to.

She told us how she doesn't want to be there, and how she can walk even though they don't want her to because of her medical issues. She did a strut around her room and really is very steady! She had a confidence in her stance, standing tall and proud, probably because her issues in the past had prevented her from walking and she managed to work her way to doing that.

She told us about her daughter, who's pictures are on her wall. They are all pictures of a little girl, but she's definitely not of the age to have an 8 year old! She said her little girl *was* 8. Her brother, in a drug-induced state, dropped her from the 37th floor of her building, killing her. I have family members who have lost children – it is not a burden that goes away. It's like a surgeon cutting you open and deciding that they won't sew you back up – you'll just have to exist in this broken, exposed state indefinitely.

Emily has a life story, significant things that have lead her here, and real reasons to be depressed or to act out. She is a person with an illness, and, like so many others, her illness has a real, definitive cause.

Psychology and Psychiatry

TCC only has one in-house, “on-staff” psychologist – a doctor who mostly serves the clinic for people with developmental disabilities and the specialty hospital (for individuals with severe developmental disabilities who live at TCC).

The rest of the psychologists and psychiatrists are contracted, most through Medical HealthCare Services PC, a private group of psychologists and psychiatrists in New York City. Through Medical HealthCare Services, TCC has two psychologists who each visit twice a week for the entire geriatric program (as well as Huntington’s and Sub-acute rehab). There is an additional contracted psychologist for the Discrete program who is here every day. Roughly, with 392 individuals with diagnosed mental disorders, that amounts to 8.6 minutes per patient per week, which does not factor in breaks, charting, care plan meetings, etc.

It is also perfectly valid that not every individual with a diagnosed mental disorder needs to see a psychologist. Through my survey of a sample of patients, I found that a small number were completely nonverbal and probably would not be able to take part in supportive therapy. More about the findings of this survey can be found in the section below.

There are five psychiatrists through Medical HealthCare Services that are licensed to practice at TCC, three of which visit regularly, approximately every other day (and weekends if there are emergent cases).

Data

New prescription of anti-psychotics is a quality improvement issue with which many nursing facilities struggle. At 12.2%, TCC is below the national benchmark of patients with

active anti-psychotic prescriptions, which was set to 21% in 2012.[10] However, 48.5% of individuals have active prescriptions for anti-anxiety medications or anti-depressants.

Those in the Huntington's Disease units have the highest usage of these medications; this can be attributed to the issues caused by the organic changes is brain chemistry that happen because of the disease. If they are excluded from the data, then anti-psychotic use becomes 9.4% and anti-anxiety medication/anti-depressant use becomes 47.6%, as a percentage of total individuals in included programs (discrete, geriatrics, and sub-acute).

This is compared to a national study of psychiatric medication use in the United States in 2010, which found that 13% of men and 24% of women aged 65+ use anti-depressants, and approximately 7% of women and 5% of men aged 65+ use anti-anxiety medications.[11] 98.1% of individuals at TCC using anti-psychotic medication are also on anti-anxiety medication or anti-depressants.

Psychiatry consults are recorded in 50.7% of all individuals at TCC, or 76.1% of those with diagnosed mental disorders. This is compared with psychology visits, which are only recorded in 20.2% of individuals at TCC, or 30.4% of those diagnosed with mental disorders. 17.1% of individuals at TCC receive psychology visits and psychiatry consults, which makes up 25.6% of all individuals with mental disorders.

91.8% of those currently using anti-psychotic medications have a recorded psychiatry consult within the past year, although only 20.5% of those on anti-psychotics see a

[10] "Antipsychotic Medication Use in Nursing Facility Residents | American Society of Consultant Pharmacists." Antipsychotic Medication Use in Nursing Facility Residents | American Society of Consultant Pharmacists. American Society of Consultant Pharmacists, n.d. Web. 3 Aug. 2015.
[11] "America's State of Mind." Medco (n.d.): n. pag. Web. 3 Aug. 2015.

psychologist. Similarly, 87.6% of those currently using anti-depressants or anti-anxiety medications have a recorded psychiatry consult in the past year, and 31.4% of those on those medications have seen a psychologist in the past year.

Whereas 100% of those on both anti-psychotics and anti-anxiety medication or anti-depressants have had a psychiatry consult within the past year, only 20.9% of those on both medications have had a psychology visit in the past year. This is the subject of the completed survey, as those patients without psychology visits and with both types of medications were surveyed to determine their approximate need for psychology.

The consistency of psychiatry consults is somewhat of a positive note within this sea of numbers: most of those who are on light to heavy doses of psychiatric medication are seen by a psychiatrist, or at least have been in the past year. There are some inconsistencies with these consults, however. While the psychiatry notes describe seeing each patient, it is unclear how much time is truly spent with each person (which is inconsistent in psychology visits). The average psychology session (for the general public) is 45-50 minutes. As seen in the calculations for TCC, this is not feasible for the number of people that the psychologists see. Some notes indicate longer periods of therapy.

Additionally, many of the psychiatry notes say at the bottom “greater than 50% of the visit time was spent providing counseling and/or coordination of care while on this patient’s unit/facility.” Although it is unclear as to the exact meaning of this statement (which accompanies 96% of the psychiatry consult notes of those surveyed in the survey), it is clear that not the entirety of the consult time (of variable length) is spent directly assessing the individual’s need for psychiatric medication with that individual.

Documentation discrepancies also arise in the translation of psychiatry orders to actual medication changes by each individual's primary care physician. In a study of the first two quarters of 2015 at TCC, it was found that 41% of psychiatry consults for patients on psychotropic medications lacked an acknowledging note by the attending physician stating their agreement or disagreement with the psychiatrist's suggestions. Additionally, 20% of those orders from psychiatrists were inconsistent with the eventual medications and dosages these patients were placed on. The biggest discrepancies were in the geriatric population, which saw 63% of all orders (n = 30) missing an acknowledging physician note.

I cannot comment on the appropriateness of psychiatric consults for any of these patients, because, not being a psychiatrist myself, I don't fully understand the mechanisms through which the drugs work, or the chemical imbalances created by mental disorders. However, a 2002 American Association for Geriatric Psychiatry (AAGP) study of the care of psychiatric patients in nursing homes showed that 27% of Medicare payments for psychiatric services in nursing homes are medically unnecessary, 9% have no mental health documentation, and 3% are "questionable."[12]

Survey

Based on the above statistical information, I pulled out 52 patients (excluding specialty hospital residents – those with severe developmental disabilities) who were on both anti-psychotic and anti-anxiety/depressant medications. These individuals have seen a psychiatrist

[12] Mintzer, Jacobo. "Care of the Psychiatric Patient in the Nursing Home: Challenges and Opportunities." Long-term Care Forum 1.3 (n.d.): n. pag. American Association for Geriatric Psychiatry. Web. 3 Aug. 2015.

within the past year but have not seen a psychologist within the past year (many of them had not ever, or for more than 2-3 years).

In order to narrow down this population, I developed a ranking system from 1-3, where 1 was “needs follow up,” 2 was “should follow up,” and 3 was “no follow up at this time.” Upon looking at past psychology notes or requests for psychology consults, past psychiatry notes, and medical progress notes, I found that many in this group had never seen a psychologist before and were completely nonverbal, which put them in category 3. Also included in category 3 were those with multiple diagnoses including (but not always) schizophrenic disorders and were stated as stable on current medication without past psychology consults. The main distinction between category 1 individuals and category 2 individuals is that the category 1’s had previous psychology notes or requests for consults and either expressed continuation of psychology services or never had a follow up. Category 2 individuals either had few psychiatric medications (1-2), a single diagnosis of episodic mood disorder and several (3-5) psychiatric medications, or were listed as receiving supportive therapy in psychiatry but had not seen a psychologist.

This narrowed the group of 52 into the three categories, with 12 in category 1, 18 in category 2, and the remainder in category 3. I conducted surveys (see appendices for questions) on each of these 30 individuals in categories 1 and 2, with a 70% return rate (21/30). Those who were not available to take the survey were assessed through a comprehensive review of their chart, including psychiatry, medical, nursing, and social work notes. Of the 21 surveyed, 8 (38%) of those were directly with patients who sat to complete the survey and the remainder were with care members on the unit or with residents that did not wish to complete the survey.

At the end of the survey, I assessed each individual's emotional need and whether or not this was being met at the current time. 33% (10/30) were deemed not in need of additional emotional care due to lack of verbal ability or significant cognitive deficits. 17% (5/30) received care from pastoral care, volunteers, recreation, or family that was significant enough to take care of emotional needs. The remaining 50% (15/30) were deemed in need of emotional care through psychology due to little family involvement and apparent emotional distress. One of those expressed need of a Spanish-speaking psychologist, and at the current time none of the three main psychologists speak any Spanish. There is, however, a Spanish-speaking psychiatrist.

In this small sample population, it is clear that there is a lacking in psychology for those who receive psychiatric medications who aren't disqualified from psychology due to lack of verbal ability or other avenue for emotional support.

Personal Experiences

Although I've presented a large amount of data here, this would not have been calculated, and not be meaningful, without the subjective and objective experiences I've had while at TCC. Since I started tracking individuals on June 1, 2015, I have tracked over 100 patients closely through morning reports, committee care plan meetings, and the surveys and individual talks I've had. I've also helped put back together a substance abuse support group with one of the psychologists.

Through all of these experiences I've been forming opinions about what I see beyond the numbers. One might say that these have no basis in a research paper, but observation and opinion here leads to interpretation of the raw data in a way that is meaningful.

While at TCC I have worked heavily with the Discrete program, so many of my conversations, interactions, and observations come from that group of people and their staff members. As with the patients, all names and identifying information has been removed.

On Psychology and Psychiatry

Psychologists and psychiatrists often have to break through to a level of consciousness and understanding that is beyond what is presented to the world. It's almost analogous to having a very close friend. Someone must be able to identify that this is a person they can trust and open up to them.

Psychology is even harder than psychiatry, because it rests on the idea that someone can unload an emotional burden upon another person who is unrelated to them and not connected to them. The upside to this idea is that one can feel a bit lightened by the unattached nature of a psychologist, as they are beyond their scope of familiarity and can be impartial.

It's slightly more complicated at TCC. While psychology is, as we've shown, one of the smaller departments, it can have a significant effect on how someone is cared for. Let's talk about "John" (Patient #40). John has emotional issues that vary from day to day and go from being incredibly happy and motivated to being so sad that he won't get out of his bed, even when he had to go to the bathroom. He speaks very quietly and quickly, almost in a manic state. John has always talked to a psychologist, but he talked about being worried that if he says he has been depressed or possibly suicidal, they won't let him go home or do the things he enjoys.

This is the difficult balance: we want someone to tell us that they're feeling depressed or suicidal because we want them to get help. But they don't want it in their chart for fear of it becoming an impediment to going home. Maybe we don't want to send someone home if they are that depressed, but I feel as though it's even worse for them to not share those feelings out of fear of going home.

The need for trust between psychologist and patient raises issues not just at this facility. It's more widespread, as Columbia University has seen at times as well. Having one psychologist for a very diverse group of people means that there will inevitably be those that even a high-caliber, well-versed, experienced psychologist like we have will not be able to meet the needs of everyone. Unlike those on the outside, or Columbia students, or anyone else, though, that is the only person they have. If someone needs a Spanish-speaking psychologist, they're stuck. It's not the fault of the current psychologists that are here; rather, it is up to the facility to take care of their emotional needs as well, and this is not happening at TCC right now.

Morning Report

Morning report (known more formally as "Daily Patient Monitoring Report") is a meeting of all disciplines for an hour in the morning to go over any incidents, acute changes in conditions, admissions, or transfers that have happened in the past 24 hours. Pretty much everyone is in attendance: medical, nursing, social work, dietary, recreation, administration, interns, psychology, and pastoral care.

The actual report has the bare minimum: what is notable, who is in charge of the issue, and whether or not it is resolved. Prepositions and adjectives are absent, but sometimes those

missing words tell a lot more about what the members of the meeting have said. I tracked the 398 patients in morning report and took notes not just on what happened clinically to the patients, but what the members of the table said about them.

Most of the time the discussions are about falls, infections, appointments – all things that don't really pertain to behavior or mental health issues. I'll report here on some of the more striking conversations I had heard:

Patient #36: "Nick"

Nick was reported as saying he hoped the entire facility would burn down with the people in it. He had a previous arson conviction, so they took this very seriously. Several words used to describe him were "scary," "sociopathic," "anxious," and "aggressive."

Some of these words may in fact be accurate. I've meet with Nick several times – he's addicted to pain medication and in fact will do anything to get his medication. This kind of behavior is difficult to redirect, as they've said in meetings, but what it comes down to is that he's an addict and needs help, not labels. After one of us interns spoke out on his behalf, the mood in the room changed. He was called a "tortured soul," not an addict.

Patient #39: "Jake"

James was reported as making several phone calls to the post office and "threatening" them about a check he is waiting on. Everyone knows James – he walks around all of TCC talking about his billion dollar check. He's offered everyone, including me, Bentley's, Jaguars, and diamonds and anything extravagant.

What struck me about the conversation about James was that they said his "life choices" led him here, as a discrete patient, which we've shown already means nothing if someone lives in a family or world of systemic issues.

Patient #71: "Charles"

Charles is a patient on the Huntington's Disease unit that has appeared in report almost every week. He doesn't have the usual choreic symptoms of HD – rather, he experiences a lot of psych disturbances. However, he was never spoken about in a way like he is "dangerous" to anyone. In report, they said that psychological issues like his are the "nature of the beast" that is HD.

These are just a few of the patients I tracked. Truly, most of the time, the issues at morning report are medical and not psychological or behavioral, but when they are psych/behavioral issues, they are often associated with discussions like these. I once heard it said that "if someone wants to kill themselves here, there's nothing we can really do." This is not only scary, but it's just wrong. Maybe the person who said it didn't realize what they were saying, but there's *always* something we can do.

What struck me more than this was the different attitudes with which people talked about different types of residents. Some of that is seen above – there's a sort of stigma that surrounds the discrete residents that doesn't exist in the discussion of HD patients. HD is a genetic disease, whereas AIDS must be contracted. In my mind, however, there is no difference in how we must treat them. It's absolutely horrific that something like HD exists, but also

horrible that if someone is led to drugs by their life experiences or lack of other choices, they can also get something equally as deadly and much more stigmatized.

It's true for Nick, Jake, John, Emily, and Sam, the five discrete patients I've described already. But it's not just them – when someone has a behavioral issue in discrete, it is treated much differently than a behavior issue in the other units. Only in discrete is the disease seen as the product of choices, rather than circumstances.

Additional morning report transcripts can be found in the appendices.

Committee Care Plan Meetings

Care plan meetings (CCP's) are such a different environment from any other meeting or experience on which I've already elaborated. Some of the attitudes seen above are absent because everyone there is from the same unit (different disciplines). Again we have social work, nursing, psychology, dietary, recreation, the intern (me!), and sometimes pastoral care.

I've seen a group of people in these meetings who really care about the needs of the discrete population specifically, which differs from the other units. The same issues are talked about here as at morning report, but with a different attitude. Rather than looking at the issues as issues, the issues are looked at as people. This transcends the usual lens put on mental illness and mental health. Rather than limiting a person's mental health to what they do, in CCP, there is the chance to see a person for everything that goes into them being at TCC.

This happens partially through the presence of people who work for only that unit but also through the occasional presence of family and residents themselves. I'm not saying that bringing people into CCP allows them to tell us their entire life story and have us listen and

apply that to their care. But sometimes we can see how their family reacts, and how often the family doesn't fully understand the nature of the disease. There are many patients who have no mental capacity to make medical decisions (or other decisions, for that matter) whose families insist that they do. I've seen the care team try to explain that to someone.

Through CCP we can see the whole picture – even the sides of patients that I don't see because I have "substitute syndrome" – when I go into a patient's room or see them in the hall, they'll react differently to me because I'm new and different, not because that's how they always react. In CCP I've seen people normally calm and smiling upset because that's how they react to news no one would like – that they can't go home or that they can't get a pass to go outside. This is where I've seen behavior that is so often labeled as "difficult"; it is indeed difficult to talk to someone who is shouting at you about their discharge plan. But unlike in other circles, at CCP it seems like they understand that it's not because someone is difficult or psychotic that they respond like that. They can see that it is so incredibly difficult to have AIDS and be confined to a nursing facility, and to have dealt with the circumstances that led them to get AIDS.

Many of the Discrete patients are homeless, past drug users, people who've had unprotected sex, or other features that many people would see as "undesirable." I've heard people say we should not accept those who are homeless, or smokers, or past drug users. In my very last CCP of the summer, after becoming very close with the group of people in those meetings, I heard one of the social workers say (paraphrased): "We have a mission here. We can't pick and choose who we take care of." This is one of my favorite social workers – particularly because of how much she cares about the people she takes care of and how

passionately she cares for them – and she gets it. Who are we to decide that their circumstances are to be any less respected because they have a disease you can't see as easily (most of the time) – because they have something happening in their mind, in their feelings, in the core of their being?

I have many transcripts from CCP's, which can be found in the appendices.

Conclusion

It's safe to say that my experiences allow me to make the conclusion that psychology services are significantly lacking here – there aren't enough psychologists and they have too many patients. But what is even more lacking is the respect that psychology deserves as a discipline that provides more holistic care than an MD ever will. Being in a good state of mental health, or even just sometimes experiencing that kind of mindset is, in my opinion, more important than being pain free or disease free. Someone could say that being depressed won't kill you unless you do it yourself, which is sad, but on the surface I guess it's true. However, if you get a deeper understanding of what being depressed really does to someone with few outlets for their depression, it's plain to see that depression, or any of the other issues that people have when they're sick, when they have AIDS, or when they're at a long-term care facility, can speed up the process of dying in the least pleasant way. Sometimes we want people to no longer suffer, which is why we have such well-developed palliative care programs and hospice consults. But to have someone suffer the entire way, and with something that affects every inch of their body and soul, is even worse than being in physical pain.

Mental pain creates physical pain. Mental pain makes physical pain worse. There's physical pain that is beyond mental control, of course, but experiencing difficulty with your mental health makes any physical pain much worse.

I've always thought that everyone deserves to feel good. Even if they don't have a diagnosed mental illness, they can see someone so that when they feel down, they can feel better. I haven't even touched upon the number of people at TCC who probably have a mental illness or psychosocial distress that doesn't fall into any specific category and are not diagnosed. These people deserve emotional and psychological care just as much as anyone else. But we can't even get to them when there's so many issues surrounding the diagnosed already.

It's a broken system, not just at TCC, but in the world. Those with mental health issues are stigmatized. Their illnesses aren't respected as chronic – meaning that it's assumed you can "get over it" or "snap out of it" just like you can sometimes be cured of something physical. There are people who feel better for a very long time, and even for their whole lives, after receiving treatment. But so many also struggle with their mental health every day, when they're sad, or even when they're happy. It doesn't just go away, and it shouldn't be treated as something that is a phase, or someone acting out, or someone trying to get attention.

I can't possibly say I know the solution. But after a summer at TCC, I've come to see the world of mental health issues outside of the liberal, intellectual Columbia bubble. We have our own counseling and psychological care issues at Columbia, but they pale in comparison to the issues facing a population with so much less of a voice and so much less of a choice.

If I can say anything about what I've learned here at TCC, I would say that we need to fight harder to de-stigmatize and normalize appropriate mental health care and respect for the issues that so many people in Discrete, so many people at TCC, so many people in NYC, and so many people in this country deal with every day.

It's not auxiliary, or "just okay" if it isn't taken care of. These issues are happening right now to real people with feelings and stories, and they won't go away because we decide to put a Band-Aid on a bullet hole. We've certainly got work to do.

Appendices

In the appendices I've put some of the information I've gathered here this summer. I'd love to include it all, but the sheer numbers of people would make this far longer than is readable. All patients have been randomly assigned a number and identifying personal information has been changed or removed.

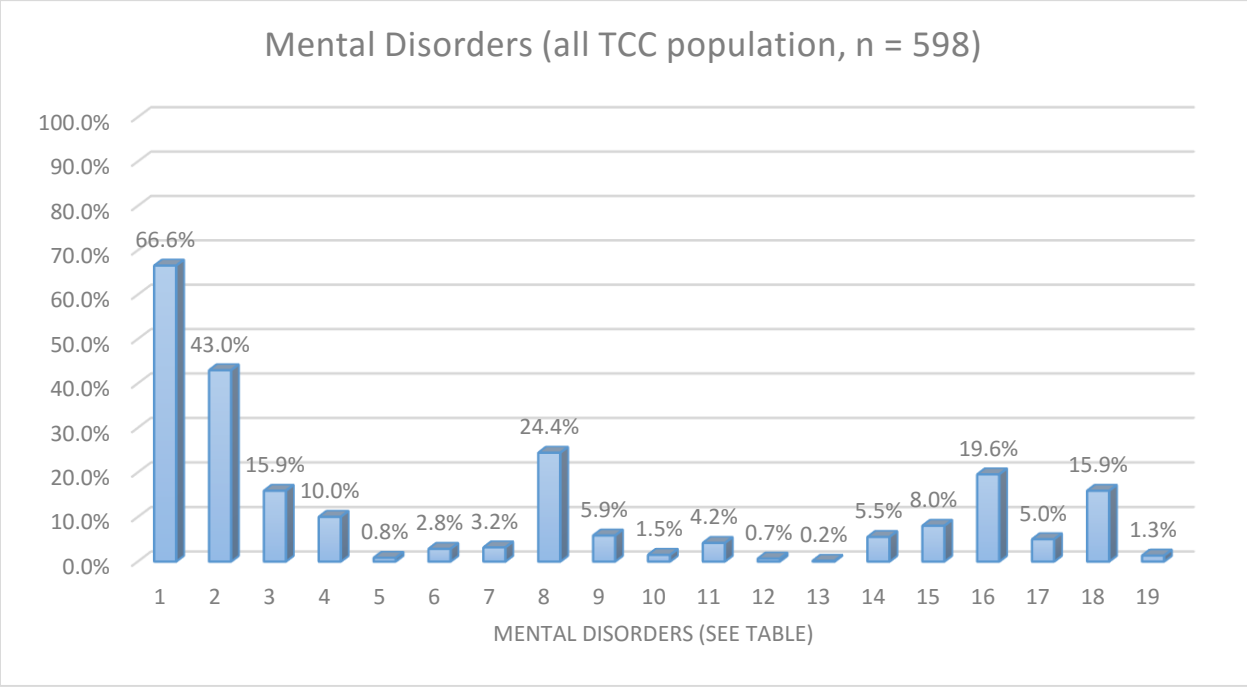
Diagnoses

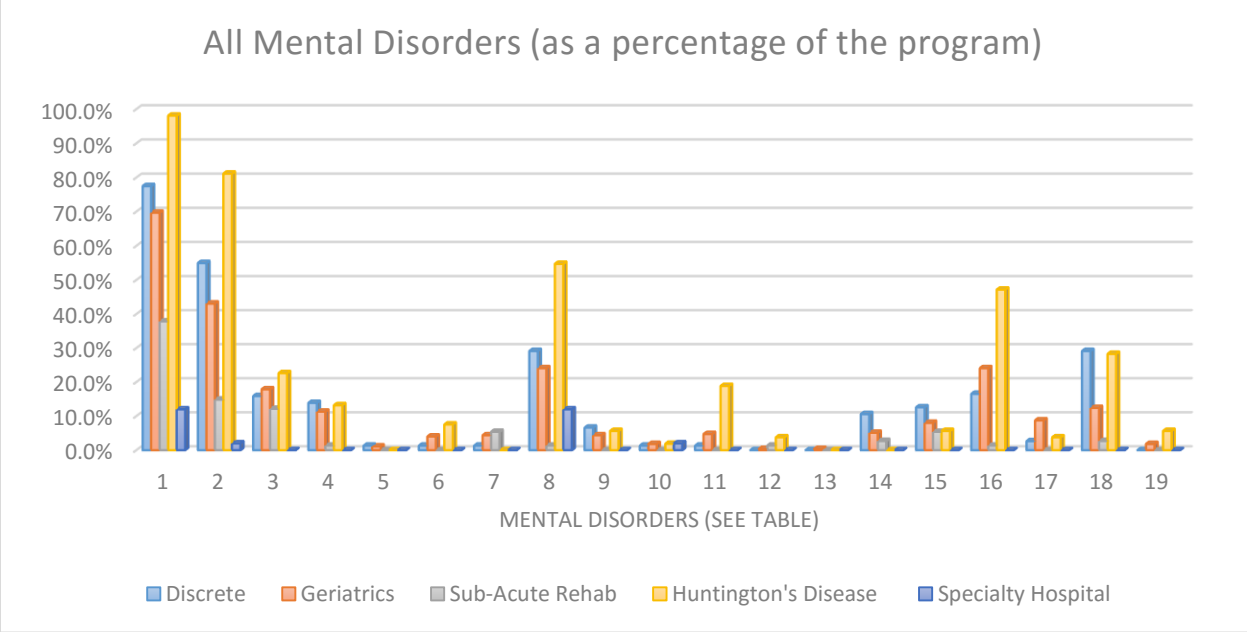
Number	Diagnosis	ICD-9	Description
1	All Mental Disorders		
2	Episodic Mood Disorder	296.9, 296.90, 296.99	Applies to mood swings; symptoms include agonistic behavior, appropriate affect, blunted affect, blunting of mood, complaining of feeling unhappy, crying associated with mood, cyclic mood swings, despiritment, disturbance in mood, diurnal variation of mood, ecstasy, elevated mood, emotionally cold, emotionally distant, euphoria, euthymic mood, faddy behavior, feeling of failure, feeling abandoned, feeling angry, feeling emotionally hurt, feeling mixed emotions, feeling of discouragement, flat affect, hyperirritability, hypomanic mood, incongruity of mood, indifference, mood anorexia, mood disorder, mood disorder in full remission, mood disorder with manic features due to general medical condition, mood sing, mood swings, moody, non-delusional perplexed mood, over-optimism, physiological disturbance associated with mood, pleasurable affect, rebound mood swings, restricted affect, right hemispheric organic affective disorder, seasonal affective disorder, seasonal variation of mood, sensitivity, severe mood disorder with psychotic features, mood-incongruent, sublimation, temperamental, unpleasurable affect, unpredictable in mood, variability of mood, volatile mood
3	All Bipolar Disorder	296.0-296.6	A mental illness that brings severe high and low moods and changes in sleep, energy, thinking, and behavior
4	Bipolar - Unspecified	296.7	Bipolar I Current NOS
5	Mental/Behavioral Problems	V40	Not considered acceptable as a principal diagnosis as it describes a circumstance which influences an individual's health status but not a current illness or injury, or the diagnosis may not be a specific manifestation but may be due to an underlying cause
6	General Mental Disorder	293.9, 294.8, V11, V40.2	Transient Mental Disorder NOS, Mental Disorder NEC, Personal History of Mental Disorder
7	Drug/Alcohol Induced Mental Disorders	291, 292	Physiological and psychological symptoms associated with withdrawal from the use of a drug after prolonged administration or habituation; the concept includes withdrawal from smoking or drinking, as well as withdrawal from an administered drug
8	Anxiety-Unspecified	300.00, 300.09	apprehension of danger and dread accompanied by restlessness, tension, tachycardia, and dyspnea unattached to a clearly identifiable stimulus; apprehension or fear of impending actual or imagined danger, vulnerability, or uncertainty; feeling of distress or apprehension whose source is unknown; unpleasant, but not necessarily pathological, emotional state resulting from an unfounded or irrational perception of danger; compare with fear and clinical anxiety
9	Generalized Anxiety Disorder	300.02	An anxiety disorder characterized by excessive and difficult-to-control worry about a number of life situations. The worry is accompanied by restlessness, fatigue, inability to concentrate, irritability, muscle tension, and/or sleep disturbance that lasts for at least 6 months

s	Anxiety (NEC)	293.84	Anxiety disorder due to a general medical condition, due medical disorder, organic anxiety disorder
11	Adjustment Disorder	309	Feeling of great sorrow, sorrowful response to an immediate cause; self-limiting and gradually subsides within a reasonable time, suffering and distress associated with loss
12	Eating Disorder	307	A broad group of psychological disorders with abnormal eating behaviors leading to physiological effects from overeating or insufficient food intake
13	Personality Disorder	301	A diverse category of psychiatric disorders characterized by behavior that deviates markedly from the expectations of the individual's culture; this pattern of deviation is pervasive and inflexible and is stable over time. The behavioral pattern negatively interferes with relationships and work.
14	Drug Dependence	304	A state, psychic and sometimes also physical, resulting from the interaction between a living organism and a drug, characterized by behavioral and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes avoid the discomfort of its absence. Tolerance may or may not be present. A person may be dependent on more than one drug.
15	Drug Abuse (no dependence)	305	The use of drugs, alcohol, or prescription drugs for a reason other than which it was intended or in a manner or in quantities other than directed
16	Depressive Disorder (NEC)	311	Unpleasant, but not necessarily irrational or pathological, mood state characterized by sadness, despair, or discouragement; may also involve low self-esteem, social withdrawal, and somatic symptoms
17	Disturbance of Conduct (NEC)	312	Includes under-socialized conduct disorders (unaggressive and aggressive), socialized conduct disorder, disorders of impulse control NEC, mixed disturbance of conduct and emotions, other specified disturbances of conduct NEC, unspecified disturbance of conduct. Disorders mainly involving aggressive and destructive behavior and disorders involving delinquency. It should be used for abnormal behavior, in individuals of any age, which gives rise to social disapproval but which is not a part of any other psychiatric condition. To be included, the behavior must be abnormal in its context
18	Schizophrenic Disorders	295	A major psychotic disorder characterized by abnormalities in perception or expression of reality. It affects the cognitive and psychomotor functions. Common clinical signs and symptoms include delusions, hallucinations, disorganized thinking, and retreat from reality
19	Delusional Disorders	297	Includes paranoid state (simple), delusional disorder, paraphrenia (schizophrenia characterized by delusions), shared psychotic disorder (related persons of the same family share the same delusions), other specified paranoid states, and unspecified paranoid state

Mental Disorder Data

All Mental Disorders





	All MD*	All MD (excluding just EMD)*	Combination EMD and MD*	Combination EMD and MD**	Combination EMD and MD***	Only EMD*	Only EMD**
TCC (ALL)	**66.6%**	**56.5%**	**32.9%**	**49.5%**	**76.7%**	**10.0%**	**15.1%**
Discrete	**77.5%**	**64.2%**	**42.4%**	**54.7%**	**77.1%**	**13.2%**	**17.1%**
Unit 1	81.0%	57.1%	47.6%	58.8%	66.7%	23.8%	29.4%
Unit 2	73.1%	53.8%	38.5%	52.6%	71.4%	19.2%	26.3%
Unit 3	73.1%	57.7%	46.2%	63.2%	75.0%	15.4%	21.1%
Unit 4	80.8%	65.4%	46.2%	57.1%	75.0%	15.4%	19.0%
Unit 5	76.9%	73.1%	34.6%	45.0%	90.0%	3.8%	5.0%
Unit 6	80.8%	76.9%	42.3%	52.4%	91.7%	3.8%	4.8%
Geriatrics	**69.7%**	**60.2%**	**33.2%**	**47.6%**	**77.1%**	**9.5%**	**13.6%**
Unit 1	66.7%	41.7%	20.8%	31.3%	45.5%	25.0%	37.5%
Unit 2	70.4%	59.3%	29.6%	42.1%	72.7%	11.1%	15.8%
Unit 3	64.3%	53.6%	26.8%	41.7%	71.4%	10.7%	16.7%
Unit 4	81.6%	73.7%	42.1%	51.6%	88.9%	7.9%	9.7%
Unit 5	70.6%	66.7%	31.4%	44.4%	80.0%	3.9%	5.6%
Unit 6	66.7%	60.8%	45.1%	67.6%	88.5%	5.9%	8.8%
SAR	**37.8%**	**28.4%**	**5.4%**	**14.3%**	**36.4%**	**9.5%**	**25.0%**
Unit 1	60.7%	42.9%	3.6%	5.9%	16.7%	17.9%	29.4%
Unit 2	62.5%	50.0%	12.5%	20.0%	50.0%	12.5%	20.0%
HD	**98.1%**	**86.8%**	**69.8%**	**71.2%**	**86.0%**	**11.3%**	**11.5%**
Unit 1	100.0%	87.5%	79.2%	79.2%	86.4%	12.5%	12.5%
Unit 2	95.8%	87.5%	66.7%	69.6%	88.9%	8.3%	8.7%
Specialty	**12.0%**	**12.0%**	**2.0%**	**16.7%**	**100.0%**	**0.0%**	**0.0%**
Unit 1	10.7%	10.7%	3.6%	33.3%	100.0%	0.0%	0.0%
Unit 2	13.6%	13.6%	0.0%	0.0%	N/A	0.0%	0.0%

*As a percentage of all patients/residents
**As a percentage of all patients/residents with MD
***As a percentage of all patients/residents with EMD

Mental Disorders by demographic group, as a percentage of that demographic group

Religion

Catholic (248)	179
	72.2%
Christian (48)	30
	62.5%
Baptist (109)	67
	61.5%
Non-Denominational (20)	14
	70.0%
Muslim (18)	11
	61.1%
Protestant (20)	14
	70.0%
Pentecostal (10)	8
	80.0%
Methodist (5)	2
	40.0%
Jehovah's Witness (6)	5
	83.3%
Unknown (38)	21
	55.3%
None (17)	9
	52.9%

Buddhist (4)	2
	50.0%
Jewish (22)	19
	86.4%
Episcopalian (8)	5
	62.5%
Presbyterian (2)	1
	50.0%
Seventh Day Adventist (2)	1
	50.0%
Hindu (2)	0
	0.0%
Russian Orthodox (2)	2
	100.0%
Greek Orthodox (3)	2
	66.7%
Mormon (1)	1
	100.0%
Lutheran (3)	2
	66.7%
Other (7)	3
	42.9%

Age and Gender (single)

Males (300)	198
	66.0%
Females (298)	200
	67.1%
0-20 yr (24)	2
	8.3%
21-30 yr (27)	6
	22.2%
31-40 yr (11)	8
	72.7%

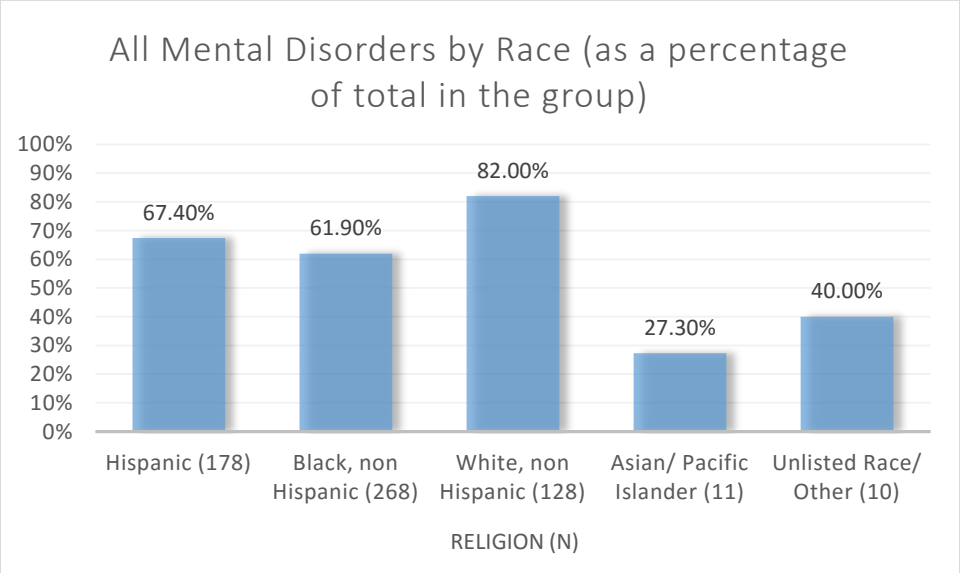
41-50 yr (54)	51
	94.4%
51-60 yr (116)	91
	78.4%
61-70 yr (127)	98
	77.2%
71-80 yr (113)	65
	57.5%
81-90 yr (85)	60
	70.6%
91-100 yr (29)	15
	51.7%

Age and Gender (combinatorial)

Males	0-20 yr (16)	1
		6.3%
Males	21-30 yr (13)	2
		15.4%
Males	31-40 yr (3)	3
		100.0%
Males	41-50 yr (29)	28
		96.6%
Males	51-60 yr (69)	53
		76.8%
Males	61-70 yr (84)	59
		70.2%
Males	71-80 yr (53)	33
		62.3%
Males	81-90 yr (24)	16
		66.7%
Males	91-100 yr (8)	3
		37.5%
Males	101+ yr (0)	0
		0.0%

Females	0-20 yr (9)	1
		11.1%
Females	21-30 yr (14)	4
		28.6%
Females	31-40 yr (7)	5
		71.4%
Females	41-50 yr (23)	23
		100.0%
Females	51-60 yr (46)	38
		82.6%
Females	61-70 yr (51)	39
		76.5%
Females	71-80 yr (58)	32
		55.2%
Females	81-90 yr (62)	44
		71.0%
Females	91-100 yr (21)	12
		57.1%
Females	100+ yr (4)	2
		50.0%

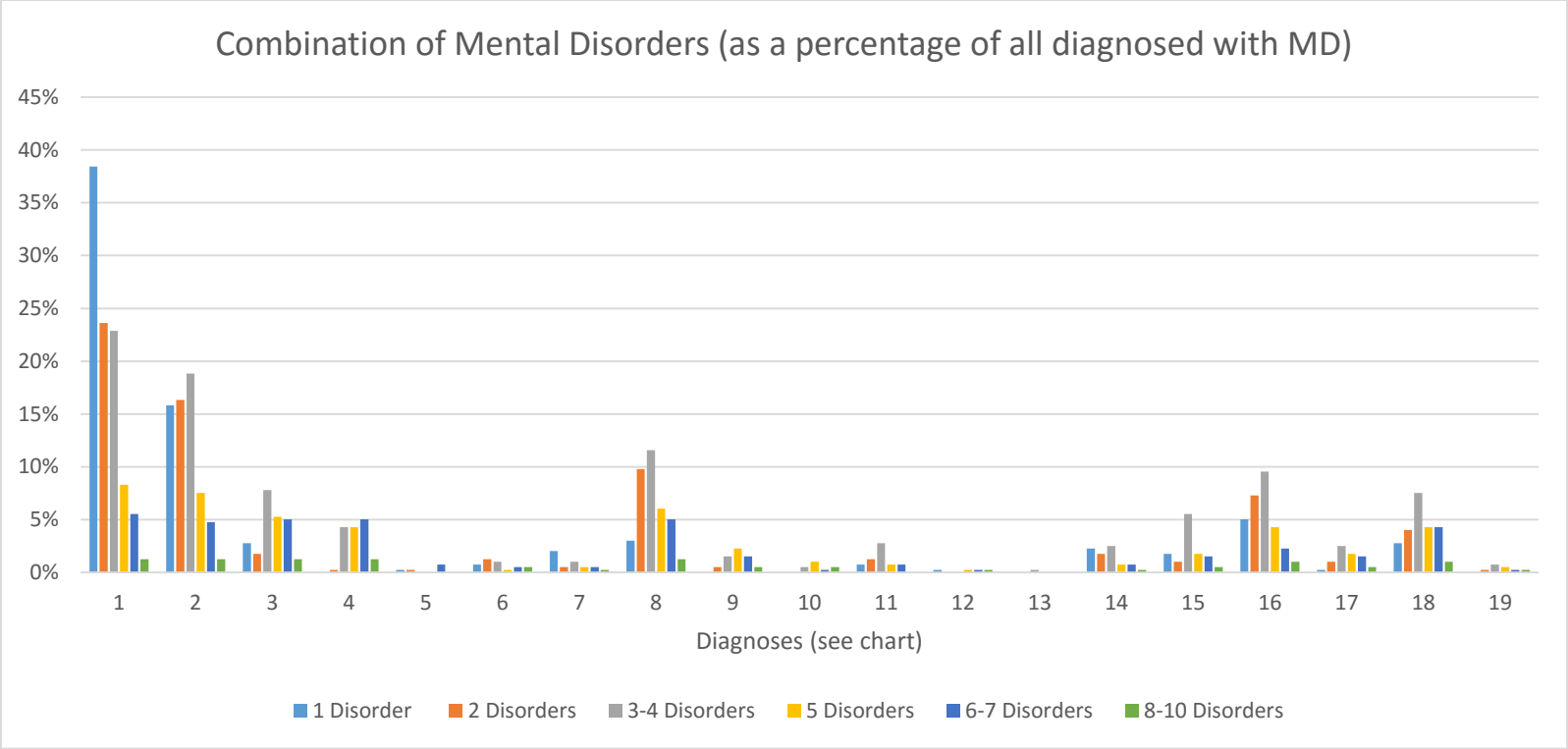
Race



		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
Males (300)	#	198	136	45	33	2	6	15	65	12	5	11	2	1	23	23	60	14	52	3
	% (diagnosis)	49.7%	52.9%	47.4%	55.0%	40.0%	35.3%	78.9%	44.5%	34.3%	55.6%	44.0%	50.0%	100.0%	69.7%	47.9%	51.3%	46.7%	54.7%	37.5%
	% (all demo)	66.0%	45.3%	15.0%	11.0%	0.7%	2.0%	5.0%	21.7%	4.0%	1.7%	3.7%	0.7%	0.3%	7.7%	7.7%	20.0%	4.7%	17.3%	1.0%
	% (total)	33.1%	22.7%	7.5%	5.5%	0.3%	1.0%	2.5%	10.9%	2.0%	0.8%	1.8%	0.3%	0.2%	3.8%	3.8%	10.0%	2.3%	8.7%	0.5%
Females (298)	#	200	121	50	27	3	11	4	81	13	4	14	2	0	10	25	57	16	43	5
	% (diagnosis)	50.3%	47.1%	52.6%	45.0%	60.0%	64.7%	21.1%	55.5%	37.1%	44.4%	56.0%	50.0%	0.0%	30.3%	52.1%	48.7%	53.3%	45.3%	62.5%
	% (all demo)	67.1%	40.6%	16.8%	9.1%	1.0%	3.7%	1.3%	27.2%	4.4%	1.3%	4.7%	0.7%	0.0%	3.4%	8.4%	19.1%	5.4%	14.4%	1.7%
	% (total)	33.4%	20.2%	8.4%	4.5%	0.5%	1.8%	0.7%	13.5%	2.2%	0.7%	2.3%	0.3%	0.0%	1.7%	4.2%	9.5%	2.7%	7.2%	0.8%
0-20 yr (24)	#	2	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
	% (diagnosis)	0.5%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	% (all demo)	8.3%	4.2%	0.0%	0.0%	0.0%	0.0%	0.0%	4.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	% (total)	0.3%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21-30 yr (27)	#	6	3	1	1	0	0	0	5	0	1	0	0	0	0	0	0	0	0	0
	% (diagnosis)	1.5%	1.2%	1.1%	1.7%	0.0%	0.0%	0.0%	3.4%	0.0%	11.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	% (all demo)	22.2%	11.1%	3.7%	3.7%	0.0%	0.0%	0.0%	18.5%	0.0%	3.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	% (total)	1.0%	0.5%	0.2%	0.2%	0.0%	0.0%	0.0%	0.8%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
31-40 yr (11)	#	8	6	2	1	1	1	0	4	1	1	0	0	0	0	1	1	0	2	0
	% (diagnosis)	2.0%	2.3%	2.1%	1.7%	20.0%	5.9%	0.0%	2.7%	2.9%	11.1%	0.0%	0.0%	0.0%	0.0%	2.1%	0.9%	0.0%	2.1%	0.0%
	% (all demo)	72.7%	54.5%	18.2%	9.1%	9.1%	9.1%	0.0%	36.4%	9.1%	9.1%	0.0%	0.0%	0.0%	0.0%	9.1%	9.1%	0.0%	18.2%	0.0%
	% (total)	1.3%	1.0%	0.3%	0.2%	0.2%	0.2%	0.0%	0.7%	0.2%	0.2%	0.0%	0.0%	0.0%	0.0%	0.2%	0.2%	0.0%	0.3%	0.0%
41-50 yr (54)	#	51	42	18	16	1	1	4	27	6	1	2	1	0	8	11	17	2	18	1
	% (diagnosis)	12.8%	16.3%	18.9%	26.7%	20.0%	5.9%	21.1%	18.5%	17.1%	11.1%	8.0%	25.0%	0.0%	24.2%	22.9%	14.5%	6.7%	18.9%	12.5%
	% (all demo)	94.4%	77.8%	33.3%	29.6%	1.9%	1.9%	7.4%	50.0%	11.1%	1.9%	3.7%	1.9%	0.0%	14.8%	20.4%	31.5%	3.7%	33.3%	1.9%
	% (total)	8.5%	7.0%	3.0%	2.7%	0.2%	0.2%	0.7%	4.5%	1.0%	0.2%	0.3%	0.2%	0.0%	1.3%	1.8%	2.8%	0.3%	3.0%	0.2%
51-60 yr (116)	#	91	63	20	13	0	5	5	36	7	1	7	0	0	7	14	27	6	26	2
	% (diagnosis)	22.9%	24.5%	21.1%	21.7%	0.0%	29.4%	26.3%	24.7%	20.0%	11.1%	28.0%	0.0%	0.0%	21.2%	29.2%	23.1%	20.0%	27.4%	25.0%
	% (all demo)	78.4%	54.3%	17.2%	11.2%	0.0%	4.3%	4.3%	31.0%	6.0%	0.9%	6.0%	0.0%	0.0%	6.0%	12.1%	23.3%	5.2%	22.4%	1.7%
	% (total)	15.2%	10.5%	3.3%	2.2%	0.0%	0.8%	0.8%	6.0%	1.2%	0.2%	1.2%	0.0%	0.0%	1.2%	2.3%	4.5%	1.0%	4.3%	0.3%
61-70 yr (127)	#	98	54	23	14	1	2	7	32	2	3	11	2	0	15	13	33	7	25	1
	% (diagnosis)	24.6%	21.0%	24.2%	23.3%	20.0%	11.8%	36.8%	21.9%	5.7%	33.3%	44.0%	50.0%	0.0%	45.5%	27.1%	28.2%	23.3%	26.3%	12.5%
	% (all demo)	77.2%	42.5%	18.1%	11.0%	0.8%	1.6%	5.5%	25.2%	1.6%	2.4%	8.7%	1.6%	0.0%	11.8%	10.2%	26.0%	5.5%	19.7%	0.8%
	% (total)	16.4%	9.0%	3.8%	2.3%	0.2%	0.3%	1.2%	5.4%	0.3%	0.5%	1.8%	0.3%	0.0%	2.5%	2.2%	5.5%	1.2%	4.2%	0.2%
71-80 yr (113)	#	65	40	15	8	0	1	1	18	3	0	3	0	0	2	8	18	5	12	1
	% (diagnosis)	16.3%	15.6%	15.8%	13.3%	0.0%	5.9%	5.3%	12.3%	8.6%	0.0%	12.0%	0.0%	0.0%	6.1%	16.7%	15.4%	16.7%	12.6%	12.5%
	% (all demo)	57.5%	35.4%	13.3%	7.1%	0.0%	0.9%	0.9%	15.9%	2.7%	0.0%	2.7%	0.0%	0.0%	1.8%	7.1%	15.9%	4.4%	10.6%	0.9%
	% (total)	10.9%	6.7%	2.5%	1.3%	0.0%	0.2%	0.2%	3.0%	0.5%	0.0%	0.5%	0.0%	0.0%	0.3%	1.3%	3.0%	0.8%	2.0%	0.2%
81-90 yr (85)	#	60	39	15	7	1	3	2	20	5	2	2	1	1	1	1	15	8	11	3
	% (diagnosis)	15.1%	15.2%	15.8%	11.7%	20.0%	17.6%	10.5%	13.7%	14.3%	22.2%	8.0%	25.0%	100.0%	3.0%	2.1%	12.8%	26.7%	11.6%	37.5%
	% (all demo)	70.6%	45.9%	17.6%	8.2%	1.2%	3.5%	2.4%	23.5%	5.9%	2.4%	2.4%	1.2%	1.2%	1.2%	1.2%	17.6%	9.4%	12.9%	3.5%
	% (total)	10.0%	6.5%	2.5%	1.2%	0.2%	0.5%	0.3%	3.3%	0.8%	0.3%	0.3%	0.2%	0.2%	0.2%	0.2%	2.5%	1.3%	1.8%	0.5%
91-100 yr (29)	#	15	8	1	0	1	3	0	3	1	0	0	0	0	0	0	5	2	1	0
	% (diagnosis)	3.8%	3.1%	1.1%	0.0%	20.0%	17.6%	0.0%	2.1%	2.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4.3%	6.7%	1.1%	0.0%
	% (all demo)	51.7%	27.6%	3.4%	0.0%	3.4%	10.3%	0.0%	10.3%	3.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	17.2%	6.9%	3.4%	0.0%
	% (total)	2.5%	1.3%	0.2%	0.0%	0.2%	0.5%	0.0%	0.5%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.8%	0.3%	0.2%	0.0%

Hispanic (178)	#	120	82	38	24	3	1	5	42	9	1	4	2	0	13	15	27	8	28	1
	% (diagnosis)	30.2%	31.9%	40.0%	40.0%	60.0%	5.9%	26.3%	28.8%	25.7%	11.1%	16.0%	50.0%	0.0%	39.4%	31.3%	23.1%	26.7%	29.5%	12.5%
	% (all demo)	67.4%	46.1%	21.3%	13.5%	1.7%	0.6%	2.8%	23.6%	5.1%	0.6%	2.2%	1.1%	0.0%	7.3%	8.4%	15.2%	4.5%	15.7%	0.6%
	% (total)	20.1%	13.7%	6.4%	4.0%	0.5%	0.2%	0.8%	7.0%	1.5%	0.2%	0.7%	0.3%	0.0%	2.2%	2.5%	4.5%	1.3%	4.7%	0.2%
Black, non Hispanic (268)	#	166	99	30	19	1	11	9	52	8	5	8	0	1	16	22	47	14	43	1
	% (diagnosis)	41.7%	38.5%	31.6%	31.7%	20.0%	64.7%	47.4%	35.6%	22.9%	55.6%	32.0%	0.0%	100.0%	48.5%	45.8%	40.2%	46.7%	45.3%	12.5%
	% (all demo)	61.9%	36.9%	11.2%	7.1%	0.4%	4.1%	3.4%	19.4%	3.0%	1.9%	3.0%	0.0%	0.4%	6.0%	8.2%	17.5%	5.2%	16.0%	0.4%
	% (total)	27.8%	16.6%	5.0%	3.2%	0.2%	1.8%	1.5%	8.7%	1.3%	0.8%	1.3%	0.0%	0.2%	2.7%	3.7%	7.9%	2.3%	7.2%	0.2%
White, non Hispanic (128)	#	105	74	27	17	1	5	5	48	8	3	12	2	0	4	11	39	8	23	6
	% (diagnosis)	26.4%	28.8%	28.4%	28.3%	20.0%	29.4%	26.3%	32.9%	22.9%	33.3%	48.0%	50.0%	0.0%	12.1%	22.9%	33.3%	26.7%	24.2%	75.0%
	% (all demo)	82.0%	57.8%	21.1%	13.3%	0.8%	3.9%	3.9%	37.5%	6.3%	2.3%	9.4%	1.6%	0.0%	3.1%	8.6%	30.5%	6.3%	18.0%	4.7%
	% (total)	17.6%	12.4%	4.5%	2.8%	0.2%	0.8%	0.8%	8.0%	1.3%	0.5%	2.0%	0.3%	0.0%	0.7%	1.8%	6.5%	1.3%	3.8%	1.0%
Asian/ Pacific Islander (11)	#	3	0	0	0	0	0	0	2	0	0	0	0	0	0	0	1	0	0	0
	% (diagnosis)	0.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.9%	0.0%	0.0%	0.0%
	% (all demo)	27.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	18.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	9.1%	0.0%	0.0%	0.0%
	% (total)	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Unlisted Race/ Other (10)	#	4	2	0	0	0	0	0	2	0	0	1	0	0	0	0	3	0	1	0
	% (diagnosis)	1.0%	0.8%	0.0%	0.0%	0.0%	0.0%	0.0%	1.4%	0.0%	0.0%	4.0%	0.0%	0.0%	0.0%	0.0%	2.6%	0.0%	1.1%	0.0%
	% (all demo)	40.0%	20.0%	0.0%	0.0%	0.0%	0.0%	0.0%	20.0%	0.0%	0.0%	10.0%	0.0%	0.0%	0.0%	0.0%	30.0%	0.0%	10.0%	0.0%
	% (total)	0.7%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.5%	0.0%	0.2%	0.0%

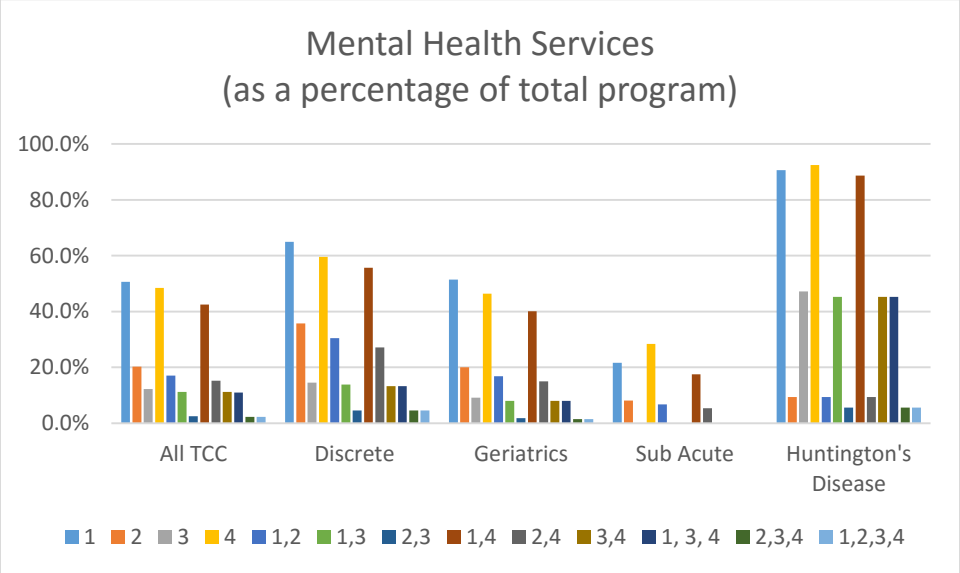
Combinatorial Mental Disorder Diagnoses

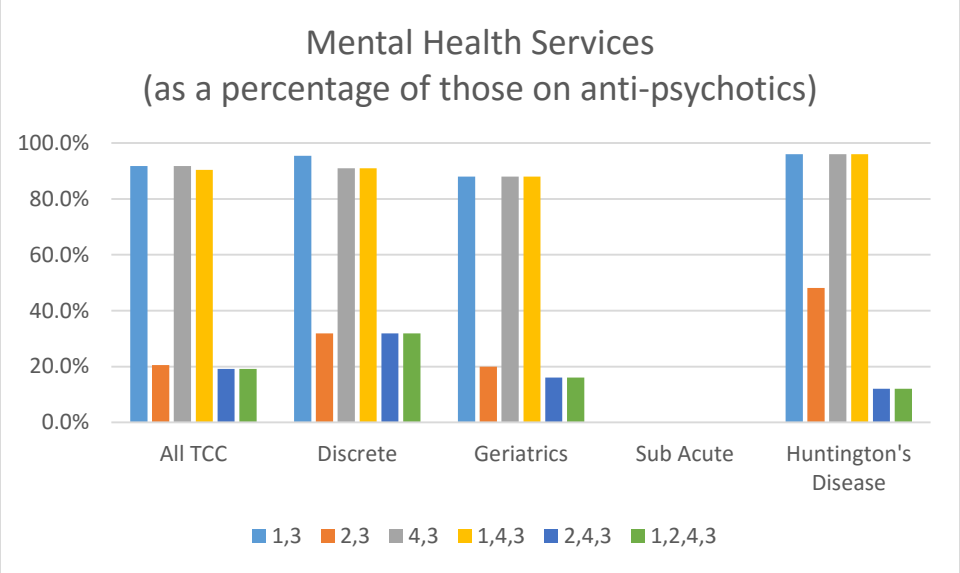


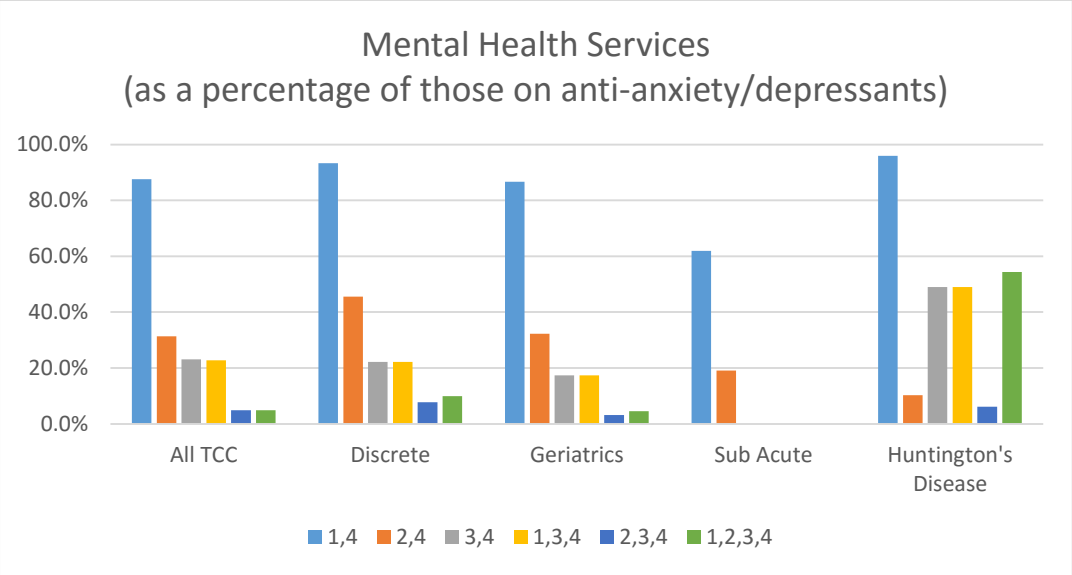
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
1 Disorder	38%	16%	3%	0%	0%	1%	2%	3%	0%	0%	1%	0%	0%	2%	2%	5%	0%	3%	0%
2 Disorders	24%	16%	2%	0%	0%	1%	1%	10%	1%	0%	1%	0%	0%	2%	1%	7%	1%	4%	0%
3-4 Disorders	23%	19%	8%	4%	0%	1%	1%	12%	2%	1%	3%	0%	0%	3%	6%	10%	3%	8%	1%
5 Disorders	8%	8%	5%	4%	0%	0%	1%	6%	2%	1%	1%	0%	0%	1%	2%	4%	2%	4%	1%
6-7 Disorders	6%	5%	5%	5%	1%	1%	1%	5%	2%	0%	1%	0%	0%	1%	2%	2%	2%	4%	0%
8-10 Disorders	1%	1%	1%	1%	0%	1%	0%	1%	1%	1%	0%	0%	0%	0%	1%	1%	1%	1%	0%

Psychology/Psychiatry Data

1 = Psychiatry Consults
2 = Psychology Visits
3 = Anti-Psychotics
4 = Anti-anxiety/Anti-depressants






Mental Health Services
(as a percentage of those on anti-anxiety/depressants)
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
All TCC
Discrete
Geriatrics
Sub Acute
Huntington's Disease
1,4
2,4
3,4
1,3,4
2,3,4
1,2,3,4

Survey

Questions

Question 1:

How do you feel today, on a scale of 1-10 (10 being the best, 1 being the worst):

1 2 3 4 5 6 7 8 9 10

How do you feel emotionally today, on a scale of 1-10?

1 2 3 4 5 6 7 8 9 10

Question 2:

Have you been visited by a psychologist before?

Yes No Don't Know Can't Answer

If so, how many times?

1-2 3-5 6-9 10+

Do you know the name of your psychologist?

Yes No Don't Know Can't Answer

Name: _____

Question 3:

When was the last time you saw the psychiatrist?

1-3 weeks 4-6 weeks 7-12 weeks More than 3 months

When you saw the psychiatrist, did you talk to them about how you are feeling?

Yes No Don't Know Can't Answer

Do you feel better since starting to take the medication they gave you?

Answer: _____

Suggestions: Yes, no, sometimes, some days, at certain times of the day

Question 4:

Do you feel as though you have someone to talk to about your feelings?

Yes No Don't Know Can't Answer

Who would you like to talk to about what you're going through?

Answer: _____

Suggestions: psychologist, chaplain/spiritual leader, family member, volunteer

Question 5:

Do you have family around here that you talk to?

Yes No Don't Know Can't Answer

If so, how often do you talk to them?

More than once a week Once a week Once every 2 weeks

Once a month Once every 2 months Once every 6 months

Once a year Less than once a year

Results

Question 1

- 5 reported 10,10
- 3 reported somewhere between 3 and 8
- 1 nodded to feeling good
- 22 did not respond/were not asked/were not interviewed

Question 2

- 2 reported never seen psychology
- 3 reported yes to psychology
    - 1-2 times for one
    - 10+ times for the next (every week)
- 25 did not respond/were not asked/were not interviewed

Question 3

- 4 reported seeing the psychiatrist, all reported feeling better on meds
- 26 did not respond/were not asked/were not interviewed

Question 4

- 6 reported having someone they could talk to
    - 3 recreation therapist/volunteer
    - 2 family
- 1 reported not having someone they could talk to
- 23 did not respond/were not asked/were not interviewed

Question 5

- 6 reported having family that came in
    - 3 once a month
    - 1 once every 2 weeks
    - 1 once a year
    - 1 when they came
- 2 reported having no family that came in
- 22 did not respond/were not asked/were not interviewed

Emotional Care

- 10 were deemed not in need of additional emotional care, due to lack of verbal ability, cognitive deficits, or lack of attention
- 2 were deemed satisfied by Pastoral Care
- 2 received care from volunteers, recreation therapist, or activities
- 1 received care from family
- 15 are deemed in need of emotional care through psychology (1 in need of Spanish psychology services)

Morning Reports

Discrete

#24: Psych requested for him after he came back lethargic and intoxicated.
#31: Verbally abusive to staff, loud and abusive to nurse, not given meds, verbally assaultive. Suggestion: focus on triggers.
#32: Threatened aide with cane, psych saw him and increased medication. Under observation for suicidal ideation and depression, but seems fine to nurses. Called "disturbed, sociopathic, manipulative" (See above section for "Sam")
#34: Attacked a nurse who tried to take out dirty laundry. Suggestion: redirect behavior and care plan accordingly.
#36: Reported he hoped the entire facility would burn down with the people in it. (See above section for "Nick")
#39: Made phone calls to post office and threatening them. (See above section for "Jake")
#40: Tried to take money out of a nurse's purse. Later refused showers and was verbally abusive to staff. Also, was given supportive therapy after depression and crying.
#56 & #82: Roommate altercation, so psych was requested for both.
#57: Refuses to get cleaned up after incontinence, lack of capacity, described as "mentally deranged" and "childlike."
#60: Feeling depressed, which is discharged related. Periodically wants to be discharged but can't do his medications alone.
#61: Returned from pass intoxicated.
#84: Refused medication, violent. Altercation with another resident. (See above section for "Emily")
#86: Psychotic and demented, so he can't go back to apartment. Must see psych.
#88: Wouldn't let housekeeping clean for him, described as "obnoxious" and given 30 day notice.

Geriatrics

#42: Sleeps on floor and has issues with psych medications.
#65: Altercation with roommate and other residents, so psych was called.
#68: Depressed and not eating, so sent to hospital because of change in mental status

Sub-Acute

#77: Depression lifting but still in shell.

Huntington's Disease

#49: Needs to be seen by psychiatry because nurse thinks she is abusing her roommate.
#50: Medication is in juice, and is prone to psychotic episodes. Regularly calls 911 to get police to come.
#71: Experiences many psych disturbances. (See above section for "Charles")
#74: Wanting to get out of unit, very noncompliant. New behavior issues.

Committee Care Plan Meetings (CCPs) – all Discrete

#32: Sisters work very hard to get him discharged, but his home state has trouble taking people with medical problems. Depressed because he wants to go home.
#39: Psych needs to evaluate him for his threats (see above section about "Jake"). Long discussion about if he went to jail and how that would further debilitate him. Discussion about how his delusions are very real to him and that they post office should understand he is not violent.
#62: Not taking meds and depressed, but should see psychology and not psychiatry because it seems like depression about life and not biochemical.
#101: Hearing voices, seeing things. Opening door and screaming, seems schizophrenic. Suggestions: Psychiatry change in medications.
#102: Supposed to see lawyer and guardian about discharge. Refuses to cooperate and speak to them but wants to be discharged.
#103: Weight problems, which might be indicative of depression and delusions.
#107: Rough, loud tone. Described as "nutty."
#108: Manages other residents' money and might not be handling it well.

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