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Bridging Mental Healthcare

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Bridging Gaps in Mental Healthcare

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Contents

Executive Summary

Hospitals comprise of patients with both physical and mental illnesses. Within these settings, an obvious lack of the necessary mental health training and competencies exist, resulting in negative attitudes and/or feelings toward this patient population. Unfortunately, these negative attitudes and lack of training/competency significantly impact the therapeutic relationship and treatment provided to these patients, adding to the disparities that exist within these patient's physical and mental health care. Compounded with these disparities in care, is the difficulty these patients often experience in even accessing and receiving appropriate, quality care, leaving them commonly underdiagnosed and undertreated. As a result, disparities in health care outcomes become even more apparent, with an urgent need for more attention placed on not only the obvious gaps but also in the reduction of the stigmas/negative attitudes toward this population.

More specifically, the role nurses have in providing the most consistent presence to patients highlights the impact that focusing these training/educational interventions on nurses, as the hands and feet toward improved patient care, will have on the success of all proposed change procedures. While an overall feeling exists amongst healthcare providers surrounding their lack of competency or ability to appropriately provide care to this population, creating a more routine/ongoing educational intervention that addresses and dissipates these feelings could lead to nurse's improved perception of their skills and knowledge enhancing patient care. To adequately identify the existing attitudes and bias, a self-administered survey called the Error Choice Test (ECT) was used, while the Behavioral Health Care Competency (BHCC) tool was used to determine the self-reported competencies. Additionally, training was focused on

enhancing each attendee's knowledge, competency, and overall attitude toward patients with mental health complaints.

Bridging Gaps in Mental Healthcare

Due to the current healthcare climate, one's ability to adapt to the growth and changes that permeate healthcare is vital to their success. More specifically, obvious problems exist surrounding not only the care of mental health (MH) patients in the United States but also in adequately addressing the negative attitudes that saturate each healthcare provider's lack of quality care. Research has identified that healthcare providers (including RNs) lack the necessary behavioral healthcare competencies to provide appropriate care to patients presenting with mental health complaints, highlighting the existing lack of training, education, and changes in negative feelings (Kingston, 2019, p. 1). Through the promotion of a heightened awareness of the gaps that exist within quality mental healthcare, a path toward EBP changes and changes in attitudes/stigma will follow, with subsequent contributions made toward improved mental healthcare and quality outcomes. With the goal of addressing this problem and lending aid to the existing gaps through EBP change procedures, the proposed PICOT question seeks to answer: In Emergency Department personnel (P), how does education regarding fair treatment of persons presenting to the Emergency Department with psychiatric/mental health complaints (I) compared to no education (C) affect the behavior of healthcare personnel when treating psychiatric/mental health problems (O) within three months (T)?

Rationale for the Project

In 1963, John F. Kennedy created the Community Mental Health Act of 1963 with hopes of shifting MH patients from the state hospital system to more local or community resources (Kalter, 2019). Instead, these patients were deinstitutionalized with no healthcare system to rely on, and even though these state hospital programs were well-funded, the money was not used for other resources like community health resources and centers, which would have only created

more avenues for the mentally ill (Kalter, 2019). Additionally, the AAMC projects that there will be a shortage of as many as 3,400 psychiatrists by 2032, amplifying the strain that has been and will be placed on Emergency Departments across the U.S. (Kalter, 2019). According to the U.S. Department of Health and Human Services Centers for Disease Control and Prevention [CDC], it is estimated that over five million visits to the Emergency Department (ED) each year are related to MH conditions, shedding light on the necessary cultural changes needed within the ED to effectively cater to this growing population (Bredimus, 2020, p. 48). NAMI Texas includes a couple MH patients' accounts, describing their time in the ER as "very upsetting" with "very little control over your circumstances" and the "process was so very arbitrary," continuing to state that "they strip your dignity" (2019). One patient even references her time in the ED stating, "I was told several times I was just physically wasting space….. they put me in a room where I stayed for hours on end. I've stayed in the ER for up to three days prior to going to a psychiatric hospital" (NAMI, 2019).

Furthermore, the obvious gaps within the current structure of mental healthcare highlight the significance surrounding necessary changes that adequately address a growing problem. It is estimated that the cost of a MH patient's 18-24 hour stay in the ED is around 2,264 dollars, not including the costs incurred by security personnel and sitters (Winokur et al., 2017, p. 420). Additionally, Winokur et al. also explains that a restraint episode can add about 4 to 6 hours, on average, to an ED stay (2017, p. 420). Through the steadily growing numbers of MH patients presenting to the ED, along with their subsequent organizational/system impacts on the ED, much influence can be made by addressing the specific failures in the ED. If specific MH, trauma-informed education was provided that addressed nurses' negative attitudes, compassion fatigue, and promoted confidence when caring for MH patients, this populations time in the ED

may lend a more pleasant, therapeutic experience providing the healing environment necessary for more quality care and eventual discharge home (Molloy, L., Fields, L., & Trostian, B., 2020, p. 30).

Literature Synthesis

Registered Nurses (RNs) in the ED report that negative attitudes and feelings of inadequacy in their care of MH patients presenting to the ED are primarily related to insufficient education that promotes skills, knowledge, and competency in care (Ngune et al., 2021; Sambach et al., 2019; Bredimus et al., 2020; Russell et al., 2017). Additionally, the discrepancies in the quality care deserved in this population of patients can also be attributed to ED staff perceptions that MH patients are not as ill and are less deserving of their care, when compared to medical patients (Winokur et al., 2017, p. 420). Ngune et al. explains that mental health nurses (MHNs), as opposed to ED RNs, have a higher reported level of confidence and positive empathy related to their feelings of competence in treating MH patients (2021, p. 633). While the presence of knowledge to care for MH patients was never the issue, focused educational interventions showed statistically significant improvements in RNs feelings of confidence and competency in caring for MH patients, assessed with a BHCC pre- and post-test survey for comparison (Winokur et al., 2017; Ngune et al., 2021; Hall et al., 2016; Sambach et al., 2019; Bredimus et al., 2020; Russell et al., 2017). More specifically, using a trauma-informed care (TIC) and Mental Health First Aid educational approach shows RN's improved abilities to interact with MH patients, discuss traumatic experiences, maintain a safe environment, and effectively manage conflicts with MH patients (Hall et al., 2016, p. 50; Bredimus et al., 2020, p. 4). As is the case with other required certifications, consideration should be made regarding the annual mandating of this education for all hospital staff to ensure that MH patients receive the highest

quality of care as a direct result from an obvious improvement in competency and confidence throughout hospital staff (Russell et al., 2017, p. 181).

Project Stakeholders

When managed effectively, stakeholders are an instrumental part in minimizing organizational change resistance, subsequently determining a change initiatives success and its positive influence on an organization (Shirey, 2012, p. 400). While the primary stakeholders affected by this change includes ED staff and administrators, multiple opportunities exist for inter-professional collaboration comprising of EBP change experts/mentors, clinical experts, MH advanced practice RNs (APRN), and MH community resource experts (Melnyk & Fineout-Overholt, 2019, p. 273). Additionally, through the improved competency for ED staff to care for this population, the care and quality outcomes for patients and their family members presenting to the ED with mental health complaints will be immensely affected. Nurses, physicians, and ancillary ED staff will be gatekeepers in this change initiative, largely determining its degree of success. In order to achieve this goal of improving the quality of mental healthcare given to MH patients in the ED, gathering allies and change champions who will not only play an instrumental role in culture changes but will also lend aid to any potential resistance, is vital for successful change initiatives.

Implementation Plan

Bridging the gap between EBP change and clinical practice is essential to enact a sustained, cultural change. Education alone will not change behavior and interventions must be tailored to target groups and settings, including individual, team, and organizational approaches (Melnyk & Fineout-Overholt, 2019, p. 278). Major steps in the implementation phase are described by Melnyk & Fineout-Overholt (2019) as establishing a formal implementation team,

building excitement, disseminating evidence, developing clinical tools, piloting the EBP change, preserving energy sources, developing a timeline for success, and continually celebrating success (pp. 279, 289). To appropriately plan for the application of these major steps to the proposed project, it will be necessary to start by gathering individuals with an interest in the project, its results, and its impact on the care of MH patients that present to the ED. Next, it is imperative to build excitement for this project amongst the ED staff and all stakeholders who will be key in the project's success. Third, presenting the supporting evidence to project stakeholders, administration, and those carrying out the necessary change, along with ensuring the understanding of the subsequent impacts this change will have on MH patients, will be vital for the successful implementation of all proposed changes. Fourth, involves the gathering/development of appropriate clinical tools, including the specific mental health education, pre-/post-tests (ECT and BHCC), and methods for ongoing education, which will inform the important step of piloting the EBP changes. Fifth, is the development of an effective timeline that carries out each step within a reasonable timeframe, which will be vital for the preservation of energy sources that will significantly impact the project's success. Sixth, solidifying how the qualitative and quantitative data will be evaluated is important prior to piloting the intervention. Lastly, ongoing celebration of successful, improved outcomes that impact the targeted patient population will be important to the sustained effects of this project.

Timetable/Flowchart

Developing a timeline that timely and adequately carries out each step of the implementation design is of fundamental importance to the project's success. Melnyk & Fineout-Overholt (2019) emphasize that further steps should be taken to critically appraise, evaluate, and synthesize evidence (4-6 weeks), formulate practice recommendations (1 week),

gain stakeholder support (2-3 weeks), disseminate evidence and educate staff (2 weeks), implement practice changes (2 weeks) (p. 283). These steps will be embraced and closely followed in this EBP change process, some overlapping and even occurring simultaneously. While the anticipated timeline to carry out these steps will be 12 weeks, some areas are unable to be bound by the limits of a timeline, warranting ongoing implementation and evaluation (i.e. eliminating barriers, celebrating success, measuring clinical outcomes, and/or analyzing measurement data to refine practice/processes). (See appendix B for more detailed timetable)

Data Collection Methods

Melnyk & Fineout-Overholt (2019) explain the importance of evaluating clinical practice outcomes before, shortly after, and at a reasonable length of time after the EBP change implementation (p. 290). If this project is approved, education including videos and informational power points will be made available online through a link sent via secure email to program participants. Participants will be instructed to take the ECT and BHCC surveys before partaking in the educational content and immediately after completing the content, with a guarantee that first and last names will remain anonymous. Additionally, participants will be given two weeks to complete the educational content and pre-/post- surveys. Data will then be anonymously obtained from the ECT and BHCC survey through qualtrics links provided within the email to identify existing attitudes, bias, and competency levels pre- and post- education. Additionally, the educational intervention will be assessed by scores obtained from error choice test (ECT) and BHCC scores, which represent nurses' attitudes, competency, and levels of confidence in their ability to respond to, identify, and handle MH patients presenting to the ED. This data gained from the BHCC instrument will be useful data to reflect and gauge the success of educational outcomes, with improved competency/attitudes reflected by higher scores.

After completion of the educational content, including interviews or patient statements exploring any recognizable/therapeutic differences in their experiences while in the ED pre- vs. post-education will be useful in adding to the strength of the intervention. Additionally, including data that magnifies the effect that improved competency had on the average length of a MH patient's stay, patient satisfaction scores, or on the number of recurring MH-related ED visits, compared to the preceding calendar year, could strengthen the evidence of the education's impact on improved quality/therapeutic care for MH patients. To effectively evaluate the process of change, a survey could be conducted with program participants cultivating an open-line of communication, informing subsequent recommendations on ways to strengthen, enhance, and perfect the inclusion of this educational content moving forward.

Cost/Benefit Discussion

The costs of this project were analyzed based on the different factors that will be necessary to adequately carry out this project. These costs include staff nurse and clinical educator estimated hourly wages of 25-45$/hour, primarily used in the planning/piloting phases of this project, with estimated totals based on 80 hours of time, ranging from 2,000-3,600$. Additionally, it will be necessary to account for the hourly wage costs to ensure EBP experts/mentors are readily available during the planning and implementation phases of the project (at least 40-80 hours), which are based on the average hourly wage ranges according to glass door of 83.5$/hour (3,340-6,680$). Additional costs related to the use of Wi-Fi, educational tools, and any additional supplies will be minimal, as these are available for use at the site undergoing change. Ongoing costs will be primarily related to the time required for continued research, along with the time needed for adequate follow-up with program

participants/the population affected, which are subject to change based on the actual time that is required to ensure there are sustained EBP culture changes.

The benefits of this project far outweigh the costs. If improved competency, knowledge, and attitudes result in the presence of a more therapeutic relationship/culture within the ED and improved quality of care outcomes, significant reductions in costs related to unnecessary or excessive ED visits/readmissions for patients with MH complaints could result. Additionally, the average time these patients spend in the ED could be dramatically reduced (also reducing costs). Another resulting benefit could be the overall improvement of staff morale due to the reduction of negative feelings and enhanced knowledge/competency, which will improve workplace satisfaction. Most importantly, contributions toward bridging the numerous gaps that exist within quality mental healthcare could be the most significant benefit from this EBP change project.

Discussion of Results

A benchmark project was conducted for the proposed changes, therefore, results are limited. However, there has been positive feedback for the implementation of this proposed project from the ED director and clinical educator, who are also part of the senior management team/administration. Expected results of this study are based on research findings from other studies that have implemented similar proposed education/educational tools, using pre- and post-tests to evaluate the overall results. These results include improved post-educational knowledge and competency, with subsequent findings supporting changes in negative attitudes (i.e. improved attitudes/thoughts/feelings) post-education, all represented by higher post-educational ECT and BHCC scores. Additionally, the expectation that there will be higher scores post-education will not only objectively reflect the improved attitudes/knowledge/competency but

also explain how the implementation of these aspects inform the subsequent enhancement of the quality/therapeutic care given to mental health patients. Likewise, improved, positive subjective thoughts/feelings from MH patients on the quality of care received are anticipated post-intervention, reflected through patient interviews that describe the therapeutic culture changes.

Conclusions/Recommendations

Recommendations for the next step include working on the piloting of this project. Additionally, strengthening the ongoing education that will be used for future interventions to enhance the quality of care MH patients receive, along with the improvement of this intervention's integration within healthcare facilities, will be key to the continuation and growth of project successes. While this specific intervention is focused on a specific level one trauma ED, future studies that expand this intervention to EDs across the country will be important for not only the continued goal of bridging gaps in research but also in creating consistency of quality, therapeutic care for MH patients throughout every level of care. Additional studies could be focused on other ways to improve the disparities of MH care, along with ways to decrease the shortage of resources/facilities/providers that are available to care for this population.

To conclude, implementing education to ED staff with the intention of improving the quality of care for MH patients will require strategic planning and thoughtful steps to ensure its success. While this study explored an important gap that exists within healthcare and nursing literature, emphasis is placed on the need for not only the continued exploration of these therapeutic relationships but also on the ongoing evaluation of strategies that enhance each healthcare provider's ability to provide quality mental healthcare. Assurance that an EBP practice culture exists within the current workplace where change is desired will provide an ease

to the implementation of any desired EBP changes. Additionally, continual focus on the driving force behind these practice changes, best described by Freeman's theory that recognizes the importance of "who or what really counts," will provide motivation to continue when barriers are faced or resistance arises (Shirey, 2012, p. 399).

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Appendix A

Timetable/Flowchart

Project Component	**Timeframe**
Develop a vision for change	1-3 weeks
Identify and narrow EBP project	1-3 weeks
Evaluate current practice and analyze quality data	4-6 weeks
Engage staff/stakeholders, evaluate the infrastructure, and establish formal teams	2-4 weeks
Develop and refine PICOT question	1-2 weeks
Develop search strategy, conduct the search, and critically appraise, evaluate, and synthesize the evidence	4-6 weeks
Formulate practice recommendations	1 week
Celebrate any current successes of the project thus far	Ongoing
Gain stakeholder support	2-3 weeks
Assess and eliminate any barriers	Ongoing
Develop clinical tools	1 week
Celebrate successes of project to date	Ongoing
Conduct rapid cycle pilot and gain approval for change	Variable
Disseminate evidence and educate staff	2 weeks
Implement practice changes	2 weeks
Celebrate successes of the project to date	Ongoing
Measure clinical outcomes, analyze measurement data, and refine practice/processes	Ongoing
Celebrate success!	Ongoing

(Melnyk & Fineout-Overholt, 2019, p. 283)