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The Need for Change in Mental Health

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The Need for Change in Treating Mental Illness Benchmark Study

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Executive Summary

Mental illness is a field of healthcare that remains misunderstood and continues to hold a negative stigma in the eyes of society. Hollywood has made many movies in which persons with mental illnesses are portrayed as dangerous, insane, impulsive, random and unable to be a functioning member of society due to their behaviors related to the illness. This portrayal, and other represented scenarios, has continued to feed the disillusionment of what mental illness truly is and how it can be experienced. Mental illness can be described as a disease process that cannot be seen with human eyes like a wound, broken bone, or muscles sprains and tears. There have been no genetic markers to identify the specific gene that can cause psychosis, although intense testing has been and continues to be done. Scientists have been able to determine if there is a genetic predisposition for psychosis in those with a first degree relative that suffer from psychosis, although there is a strong tendency for it. Wood et al. describes stigma as a marked disgrace associated with a specific characteristic or quality that person possesses (2016). In patients that are experiencing an acute exacerbation of psychosis, the Emergency Room can be the only place of refuge found from overwhelming symptoms that are no longer manageable. Unfortunately, most patients that are seeking care for exacerbations of symptoms are not provided holistic care accompanied by compassion. Patients are treated with medications and then discharged with no short-term or long-term care planned for, unless it is admission to another facility. No hospitality is offered to mentally ill patients and often they are not treated for medical disease processes in conjunction with psychiatric processes. It is imperative, especially of late, that those experiencing an exacerbation of psychotic symptoms receive holistic care for psychiatric and medical disease processes including, but not limited to talk therapy, medications, and discharge planning that will assist the patient in gaining accountability for their actions such as medication and treatment

compliance, and networking with other vital businesses that can help establish long-term care and will follow-up out-patient.

Rationale for the Project

This project was formed from a need for improvement in healthcare services provided to persons diagnosed with a mental illness. A person is often defined by the mental illness they suffer from instead of the person that they truly are. People can be heard saying “she is schizophrenic” or “he is bipolar”. There is no distinction between the person and their mental disorder. Wood et al. states that patients have reported feelings of being unsafe and described experiences of verbal and physical abuse from healthcare providers while seeking treatment at an inpatient facility (2016). These emotions, feelings, and fears are a common feature among persons that have considered seeking treatment for the disorder they are suffering with.

The security and sanctuary that these people seek is not found in Emergency Rooms because of misconceptions and stigma. It is imperative that healthcare providers be provided with education about mental disorders, the proper way to approach people suffering with mental disorders, proper communication methods, and be reminded that holistic care is to be given to all people without bias or judgement. Florence Nightingale persistently advocated for all persons, regardless of religion or social class, to be provided healthcare and argued that no person held the right to deny provision of care. Ms. Nightingale describes how people are multi-dimensional. She explained that the physical component of a person is cared for by medicine and nursing, but that it is imperative that the psychological, social, and spiritual components be addressed as well. She warns against the lack of stimulation in what is called a sickroom and identified that psychological components that are neglected can cause physical illnesses (Selanders, 1998). With the blatant neglect of care for the mind, the body is unable to recover from illnesses. When a person with Type II Diabetes is provided education about disease management, education about lifestyle changes, including diet and exercise, is the main point. Healthcare providers

describe how difficult it can be to maintain a lifestyle change because of the unwillingness to change the way that one thinks. If caregivers can continuously preach and provide education about the importance of getting the mind to understand the importance of lifestyle changes for a person with diabetes, why is it so different for someone with a mental illness?

Project Goal

The goal of this Benchmark Study is to bring awareness of the need and importance of providing fair and holistic care to patients presenting to the Emergency Room experiencing acute exacerbation of psychosis. There has been a noted gap in healthcare provided to those with mental illnesses and there is an increase in exacerbations due to the decrease in provision of care related to the negative stigma associated with mental illness. Patients seeking care when experiencing a state of acute psychosis are generally treated with medications and quickly discharged as long as there are no suicidal or homicidal ideations or tendencies. Treatment provided is very short-term in nature and there are no follow up appointments or check-ups with the patient to encourage long-term compliance. Patient involvement is imperative in the provision of care to encourage accountability. Medication is used to treat psychosis, but therapeutic communication is not included in the provision of care. It is imperative that this practice be evaluated and updated to utilize best practice that is supported by surmounting evidence. Another goal of this study is to shine the light on the lack of education that medical healthcare providers possess in order to properly care for a person with special needs. Anti-psychotic medications may need to administer during provision of care, depending on the level of aggression possesses, but this should be utilized only when needed and after all less invasive procedures have been attempted. As a psychiatric nurse for 2.5 years, I experienced many situations in which a person experiencing an exacerbation of their symptoms would become agitated and the situation could quickly escalate to be a dangerous one. However, many times after theses escalated behaviors have been managed, the person would explain that no one was listening to them. During debriefing sessions, I

would be able to pin-point when the patient began exhibiting warning signs and what the trigger was for that exacerbation. When I was able to comprehend that there are many times that a dangerous situation can be prevented, I was able to talk to the patients in my care, and eventually throughout the hospital, and prevent these events simply by listening. I would let the patient say what was going on, what they needed, and what helps them. I would get a small group of people together immediately to look into addressing the needs not being met. I would consistently communicate with the patient where we were at in the process of addressing those needs. Medications were often not used when I could intervene early before it reached a certain point. There were times that I was able to use therapeutic communication to decrease agitation after the patient had already become combative. The patients that I cared for received the best care that I could provide, and they were given respect and dignity, just as any other person would expect when receiving care. This type of care should be provided at all times, by all healthcare providers regardless of the diagnosis a person possesses.

Detailed Discussion of the literature

There has been a shift from hospital-based care to community-based care. Some of these shifts are less focused on patient-centered needs resulting in promotion of non-hospital care that overlooks extremely ill patients in need of long-term care to assist in transition to the community. Because of the shift, patients are left with the only option of seeking care in medical emergency departments that have not been designed for the needs of mentally ill patients. Many of the patients spend hours or days waiting treatment which is now termed boarding. Psychiatric visits weigh heavily on the emergency department resulting in more time, increased inpatient admissions, transfer, and occupy a higher percentage of self-pay or charity-care. The number of visits to a psychiatric emergency room are increasing due to deinstitutionalization, an increase in substance abuse, and mental health problems. Boarding is described as emergency room patients whose evaluation is complete and the plan of care has been determined, but there are no open beds to accept the patient for continued care.

Deinstitutionalization is the process of placing long-term inpatient psychiatric treatment with less isolated community-based mental health services (Schmidt, 2017).

Many people experience sub-optimal screening for, and management of, physical health disorders and diminished access to quality care. Stigmatization and discrimination by health professionals is a familiar experience by those suffering with mental illnesses, especially during exacerbation periods due to the instability of the personality and behaviors. Non-helpful relationships with professionals are considered impersonal relationships that contain no space for negotiation for the relationship nor of the support and treatment provided. Non-helpful professionals were described as pessimistic and uncaring professionals who were paternalistic and disrespectful. Contextual factors that were considered non-helpful are discontinuity, insufficient times spent with the patient and coercion (Ljungberg, 2015).

Reasons for delay in care and treatment seeking have been discussed by professionals to determine why there is a gap in care provided to those suffering with exacerbations of mental illness. Some of the reasons discovered are the symptoms were not perceived as psychotic experiences, individuals experienced shame and embarrassment causing them to hide the symptoms, the level of embarrassment became overwhelming as the symptoms continued to grow that the patient isolated themselves, symptoms were simply attributed to typical teenage behaviors, and the respect by others for autonomy and privacy of emerging adults (Yarborough, 2018). Other reports reasons are the misunderstanding of the role of the patient as help-seeker and the role of the healthcare professional as helper, the physical location in which the meeting was to take place was inconvenient, gossip and rumors or perceived stigma became a significant barrier to help-seeking and engagement. Healthcare providers reported experiencing diagnostic uncertainty when attempting to treat a patient, therefore, the provider would continue to monitor the patient which became known as the “wait-and-see”

approach. The provider would "wait-and-see" what symptoms continued to occur which caused a significant delay of treatment (Kvig, 2016).

Stigma associated with mental illness was equated to misunderstanding and discrimination from others and led to negative impacts on self, emotions, behaviors, and recovery. Experiences described by participants in the research study report labels of dangerous and unpredictable. Negative labeling and stereotyping of psychosis occurs within social networks including friends and family. Negative labeling and stereotyping is present in the inpatient setting with the most common forms of discrimination being verbal abuse. Participants explained that medication was offered too quickly and therapeutic communication was not utilized. Participants from ethnic minority groups explained that mental health stigma worsened when faced with racism. There was a reported reduction in opportunities and an increase in discrimination which often led to exacerbations of symptoms, resulting in inpatient treatment by those experiencing stigma associated with mental illness. Avoidance was prevalent by those diagnosed with a mental illness during admission to an inpatient facility. Stigma was a source of emotional distress which had an effect on self-esteem and confidence (Wood, 2016). Patients report that loneliness is another feeling experienced that alters perception of self and others. The persistent subjective feeling of loneliness has shown to be a strong independent indicator of multiple physiological changes and poor health outcomes.

People with serious mental illnesses experience multiple health disparities, higher medical co-morbidities, and lifespans 10-30 years shorter on average than the general population (Cook, 2015). Cabassa et al. also reports that persons with schizophrenia and other SMI have shortened life expectancies compared to the general population largely due to preventable medical conditions (2017). Upon presentation to emergency rooms, there should be a rapid identification of medical and psychiatric needs. Physical Illness has been shown to cause or exacerbate psychiatric symptoms in up to one-fourth of agitated patients in the emergency room (Chennapan, 2018). Experiences of diagnostic

over-shadowing where emerging somatic symptoms are attributed to their psychiatric illness rather that physical co-morbidities. One important initiative that does support people to access supportive physical healthcare, has been the introduction of nursing staff who take on coordinating roles at the intersection of physical and mental healthcare. It is imperative that a safe place be created in which patients can achieve a sober state or work through strong emotions. This can enable discharge to a lower level of care in a shorter amount of time (Nordstrom, 2019). Short-term therapies may be efficacious and practical, although they are often overlooked in the emergency room setting. The American Association for Emergency Psychiatry (AAEP) supports non-coercive de-escalation as a primary intervention, with the goal being to calm the patient, not sedate them. Calm patients are better able to participate in care. Sedated patients are more likely to wake up agitated, which creates an ongoing cycle (Nordstrom, 2019).

Medications that reduce emergency room hospital admissions are second-generation antipsychotics such as Abilify, Geodon, or Risperdal, and maintenance antipsychotics such as Risperdal Consta or Zyprexxa Zydis.

Most stakeholders recognize the importance and flexibility of SDM (Shared Decision Making) in SMI (serious mental illness), although it is not routine in mental health services. Mental health nurses should elicit consumer preferences and establish a collaborative therapeutic relationship, and encourage and engage families in treatment decision-making when it is preferred by the patient (Huang, 2019). In the initial stage, patients and providers engage in exchange of information. In the second stage, options are discussed and evaluated. In the third stage, the patient and provider work collaboratively to resolve disagreement or conflict (Angell, 2015). Shared decision making enhances beneficence and autonomy for each patient (Corrigan and Angell, 2015). Offering people with SMI opportunities for choice and self-determination is considered a critical component of recovery-oriented care (O'Connell, 2015). Mental health crisis plans are not uncommon and person-centered treatment plans are valuable tools used in

many treatment facilities. Some patients are provided assistance in creating what is considered a Mental Health Advanced Directive. This is a form that the competent patient, not experiencing an exacerbation of psychotic symptoms, can put in order with the healthcare provider to determine what treatment is effective and is to be used in the event that a psychotic episode occurs and the patient is unable to make a sound decision at that time. It is a sort of agreement that is held between the provider and the patient. This increase autonomy and accountability for behaviors exhibited during exacerbation (Corrigan and O'
Connell, 2015).

Several peer navigator interventions have been studied as a way to enhance treatment compliance and accountability. In one study peer navigators were described as a provision of emotional support, provided assistance in problem-solving capacities, and created a more receptive relationship with the patient because there was an unspoken understanding of experiences (Sheehan, 2017). Participants with a peer navigator remained out of the hospital nearly twice as long as their counterparts (O'Connell, 2018). Participants were empowered to increase use of routine health services and screenings, develop improved relationships with health providers and to increase their self-management of healthcare (Kelly, 2017). The most promising interventions seem to focus on self-management approaches that aim to improve self-management indicators and peer navigator interventions that aimed to improve healthcare linkages (Cabassa, 2017).

Project Stakeholders

Stakeholders for this project will initially impact the patient and their families. With the appropriate care provided, the patient and family will be able to receive the help that is needed to maintain safety. The hospital as an organization is a major stakeholder in this intervention as well. Not only will the patient receive the proper care, but the compassion and guidance given to one patient will be communicated to others increasing the willingness to seek help and encourage accountability and

compliance by the patient. People suffering with a mental disorder will begin to present to the hospital seeking that compassionate care that others have received and talked about. Social workers will be able to guide patients and their families to the proper networks to receive help. Nursing staff will feel more confident in providing unbiased care to those that others have seen as dangerous and "insane". Healthcare providers will also feel more confident in being able to maintain safety for each person involved in the intervention. There will also be an increase in the safety that other patients in the hospital will experience, knowing that the healthcare providers are able to confidently provide safe and holistic care to others that seem to be more difficult. The city will also be affected with the success of this intervention. People will begin to see those with mental disorders as people and not the disorder itself. Those with mental disorders will find that they are welcomed into places they had not been welcomed in before because there will be a greater understanding and the misconceptions will begin to be dismissed. People with this special need will be more accountable for their own actions and feel a sense of accomplishment with a decrease in exacerbation. They will have the option to seek a higher education without fear of discrimination and hold jobs as well. With this intervention, those suffering with a mental disorder will be able to seek help in the emergency department, without fear of being medicated and then dismissed, and will be able to feel like a successful and functioning member of society.

Plan for Implementation

To implement this project, I will begin by gathering a team of specialists. Two nurses (one medical-surgical and one psychiatric), two unit technicians (one male and one female), two physicians (one medical and psychiatric), a representative for security, the Emergency Room charge nurses, the Emergency Room director, a social worker, a case manager, a pharmacist, and a representative from administration. This team will help to create a detailed list of steps through the intervention that will be followed with possible adverse outcomes considered at independent phases. Education will be provided

to the team regarding mental illness, use of therapeutic communication, and the importance of utilization the least invasive procedures being exhausted. Policies will be reviewed with the team and pre-testing and post-testing about policies and procedures will be administered prior to the intervention being initiated. Any person that is unable to answer all questions correctly will be provided remediation. Concerns about the intervention will be discussed and addressed by the entire team, with all departments being present and accounted for. After each intervention is administered, there will a debriefing time. This debriefing will address concerns of the intervention, areas that need an increased focus, and pieces within the situation that were not thought of and addressed prior to the intervention. At 3 months, 6 months, 9 months, and 1 year, evaluations will be done of the intervention to determine overall effectiveness and the risk vs. benefits of continuing the intervention. At various points during that year, I would expect the number of team members to grow, specifically nursing staff and physicians providing care. I expect networking to become greater and the success of the intervention to become a priority for the hospital and healthcare providers throughout the community.

Timetable/Flowchart

Patient presents to the ER with acute exacerbation of psychosis. The patient is registered, triaged, and placed in a room within 30 minutes of presentation to the emergency room. The room should be in a quiet part of the hospital, preferably close to the nurses' station but in a lower traffic area so that there is not a high level of stimulus. The patient should be introduced to the psychiatric nurse within 5 minutes of being settled in the room. At this time, the psychiatric nurse will establish a report with the patient and perform a basic psychiatric evaluation to determine functionality in the present state. After the psychiatric evaluation has been completed, the medical nurse will present to the room and with the assistance of the psychiatric nurse, a physical assessment will be performed with the authorization of the patient. Establishing a relationship with the psychiatric nurse will allow for a therapeutic environment to be formed. This will also help the patient trust the medical nurse. Trust is a vital

component of the relationship formed with a patient suffering from a mental illness. It is important to note that a unit technician and security will be located nearby in case help is needed due to escalating behaviors in which therapeutic communication is ineffective. Assessments should be completed within an hour of presentation to the room. At this point, the patient and nurses will determine the reason for the visit, triggers, warning signs, what has worked for the patient in the past, past medical history, past drug usage (medical and recreational), and what the patient has utilized for treatment therapies including what has and has not worked. After obtaining all of this information, the nurses and patient will quickly be able to create a care plan in which the patient has provided input and direction for seeking care that will be long-term. The unit tech will be introduced to the patient and will stay with the patient for safety and security while the nurses then meet with the interdisciplinary team. The interdisciplinary team consists of a medical physician, psychiatrist, security, medical nurse, psychiatric nurse, social worker, case manager, and the director of the emergency room. The proposed plan of care will be introduced and then discussed within the team. Negotiations will be suggested for changes to the plan of care. This can take up to one hour, depending on how busy the emergency room is and how much information was provided by the patient. There may also be other people involved in the family contacts that need to be made to determine a better understanding of the situation. The social worker and case manager will provide suggestions for networking after discharge in order for the patient to gain support for long-term care. If the patient requires admission to a facility of any kind, this will also be addressed during the team meeting. After completing the proposed plan of care, the physicians and nurses will present to the patients room and deliver the suggested changes. The team will take the time to answer questions and encourage input from the patient so that compliance is more likely and accountability is encouraged. Evidence suggests that during this time, a peer navigator should be contacted and introduced to the patient. A peer navigator is a person that has personal experience with various mental illnesses. This experience can be from overcoming their own personal battle with mental

illness or direct experience with a person suffering with a mental illness. This part of the intervention is strongly encouraged to be initiated before leaving the hospital. Making this introduction between the peer navigator and the patient allows for another relationship to form that can be therapeutic. This will also provide a support person that can continue to encourage the patient to be accountable after leaving the hospital. While continuing treatment (IV fluids, IV antibiotics, lab work, radiographic tests, etc.) the patient is served a warm meal, offered clean clothes and a shower if it is needed and appropriate. If the patient is considering harming themselves or others, then safety will be the number one priority and treatment will be provided accordingly. Once all contacts have been made and communication has been established, the patient is either transferred to the floor to receive further care that includes holistic care and maintaining accountability during their stay, they are discharged, or they are transferred to another facility for the appropriate care needed.

In the event that talk therapy is ineffective and the patient presents with escalating agitation and aggression towards other that poses an imminent risk of harm to self or others and medication must be used for safety, then the intervention will be halted until safety of the patient and staff is able to be obtained and the patient is in a more cooperative state. At this time, the intervention will be initiated as planned.

Data Collection Methods/Planned Evaluation

The evaluation of my plan will be performed over a period of 1 year with full plan evaluation at 3 months, 6 months, 9 months and 1 year. The following are the different areas of the plan that will be evaluated for efficacy and needed changes at each evaluation period or more often if necessary.

At the time the patient arrives at the Emergency Room: Evaluate the level of psychosis and how it is managed by the nurses and unit techs. Was therapeutic communication used? Was therapeutic touch utilized? Was the patient encouraged to be involved in care? Were appropriate boundaries established and maintained? This will be done using self-assessment surveys as well as peer surveys.

Debriefings will be done after each intervention and the notes from these meetings will be utilized to determine efficacy of the intervention and behaviors exhibited by the patient and staff members.

Intervention properties: This area will be evaluated during the intervention and altered based on the results. The following is a basic list of the questions that will be answered. More questions will be added when the team is assembled and details of the intervention are reviewed.

Where was the room located, and what was the stimulus level? The stimulus level could change based on the time of day so that information will need to be included.

If medications were used, was it voluntarily or involuntarily?

Were restraints used? If so, what behaviors lead up to the need for restraints?

What could have been done differently to improve the outcome of the situation?

If the intervention is initially ineffective and medications and/or restraints are utilized, is there a change in the relationship between the patient and staff members? This includes, but is not limited to, behaviors and verbal communication. What does the interaction between the interdisciplinary team and the patient look like? Is the relationship paternalistic? Authoritative? Passive? Open? Presentation of the team to be open for patient involvement will guide the success or failure of the intervention.

Does the patient possess the competency to be an active member of their own treatment team? If not, who has guardianship and what is the relationship with this person like? There are some people that carry guardianship of a patient with special needs, but the relationship is strained and occasionally tense due to the burden of responsibility that accompanies that obligation of care. If there is a guardian, their involvement is imperative as well and all methods of communication must be exhausted and documented.

What psychiatric and medical history can we obtain from the patient? What kind of treatment has been utilized? What was successful and what was not?

Does the patient appear to want to be involved in the treatment process and are they receptive to the plan of care?

Was informed consent obtained to be involved in the pilot study and is the patient or guardian truly of sound mind to give consent?

Introduction of Peer Navigator: Willingness to participate with a peer navigator should be examined and consent must be provided. The peer navigator will be provided education about the importance of maintaining boundaries with the patient as well as education about the importance of maintaining HIPPA. Forms will be signed by each person providing care stating that they understand the aspects of the study and agree to maintain patient privacy at all times. Once this step has been initiated, it will be evaluated by a member of the team. The parties will be observed to obtain fair judgement that both are comfortable with each other and have an understanding of the process. The following are minimal observations that will be reported. The list will be increased after the team has been established and has discussed this area of the intervention.

How receptive is the patient to the peer navigator?

Monitor the interaction between the navigator and the patient. Make notes about body language and communication utilized.

Once introductions are made and a therapeutic relationship has been established, assist in setting up outpatient services that are needed to manage long-term treatment with guidance and encouragement from the peer navigator. Set up inpatient services if that is necessary instead.

Follow-up:

With the patient at 1 week and then 1 month to determine compliance with the treatment plan agreed upon at discharge. According to Martin et al (2021) there remains a data gap about compliance-related discussions between providers and patients.

Determine if the patient has experienced more exacerbations since discharge. If so, has the patient been readmitted for the same diagnosis at the same facility or other facilities?

Meet with the peer navigator to determine how they feel the patient has done and any concerns they have about the intervention, their own involvement, and concerns about the patient. Are we providing the appropriate knowledge and education for the patient to successfully transition to become an active member of society? Are we networking correctly and can we increase our networking size to include other areas of service that we may not be meeting unintentionally.

Immediate changes will be suggested and made after each encounter during a debriefing with the entire interdisciplinary team. At 3, 6, 9, and 12 month meetings, team members will determine efficacy of the intervention and determine what changes need to be made to improve the intervention. We will discuss what is working well, what could be added, and what could be done away with.

Cost/Benefit

The cost of this intervention will be different at each facility that it is initiated at. I determined cost of care provided to patient without funding at the facility that I am currently employed at. The following information is based on a 5 hour visit to the emergency room by a patient exhibiting psychosis without funding:

- Presentation of the patient to the Emergency Room with registration and triage is $1500.00
- Usage of supplies including, gloves, IV placement, cups, cleaning supplies, and wound care supplies is $600.00
- Various medications used such as antipsychotics, Benadryl, Tylenol, and antibiotic creams for wounds wound be minimal at $600.00
- Nurse pay is $130.00
- Unit technician pay is $62.00
- Physician pay is $983.00

- Pharmacist pay is $250.00
- Security pay is $90.00
- Housekeeping is $10.00

Let us consider the cost providing care to 3 and 6 patients under these circumstances. Treating 3 patients in this situation in one day will accrue a cost of $12.672.00. For 6 patients, the cost will be $25,344.00. For 3 patients per day for 7 days, the cost is $88,704.00. For 6 patients, it is $177,408.00. Providing care for 3 patients per day, for 30 days would accrue a cost of $380,160.00. For 6 patients, it is $760,320.00. At one year, providing care for 3 patients every day, there is a total cost of $4,561,920.00. For 6 patients in the same time frame, there is a cost of $9,123,840.00. These are ranges for patients that are unfunded. What is known about patients that are unfunded, and even some that are funded, that the account is rarely paid. What this means, is that the totals that I have provided is money that is lost by the hospital for providing minimal care to patients that are continuously being seen in the Emergency Room, but not being truly treated.

Now let us determine the benefits of initiating this intervention. Initially the amount of money spent will increase due to the increased number of parties directly involved with providing the appropriate care needed for short-term and long-term management of psychosis. There will be an added cost of 2 nurses instead of 1 and a psychiatrist ($109.00 per hour) as well as a physician. The visit will longer, requiring more pay for each department. These patients will still be unfunded at the time the intervention begins. What I expect to happen is that at 3 months, the team will be able to obtain statistics proving that the intervention has stabilized the number of admissions for exacerbation of psychosis. At 6 months, statistics will show that the number of cases for psychosis exacerbation has decreased and accounts are receiving minimal payments. At 9 months, the statistics will provide evidence of a continuing decline in admissions with an increase in payment received on these accounts. The same information will be obtained at the 1-year mark of the initiation of the intervention. Care

provided will be more compassionate and holistic in nature. Medical disease processes will be more controlled in this group. Patients will report better management of symptoms and an increase in accountability and treatment compliance. The hospital will also report a decrease in lost profits and an increase in payment for services rendered.

Overall Discussion/Results

The results of this benchmark study are expected to be monumental for those involved by the end of one year and after. There will be an increase in patient satisfaction and job satisfaction with the initiation of the intervention. Nursing staff will feel a sense of security when they are properly equipped with the appropriate knowledge and skill to handle unstable situations. They will also feel a sense of self-satisfaction when results of the intervention appear in their favor and improvements are made because of the compassion and holistic care that was provided in a time of sheer crisis for the patients seeking help. There will be a decrease in the need for mechanical and chemical restraints used during interventions for exacerbations of psychosis. There will be a decrease in the number of staff injuries related to psychotic behaviors in the emergency room. There will be an uncomfortable time of adjustment as well as those that may not be on board with the intervention. Some will see it as a waste of time and resources. Others will see it as a hopeless project. My goal is to open the eyes of healthcare providers in my facility and educate them about the disservice that we are providing, based on a diagnosis. Healthcare providers were and are still being taught to provide unbiased and holistic care to all persons that are placed in our care. It is vital that we alter the way that we think and feel about mental illness and improve health care that is provided to those suffering with this illness so that they too can have successful lives without fear of rejection and oppression.

Recommendations

Before the intervention begins, policies and procedures for dealing with patients exhibiting aggression and psychosis should be reviewed. Research should be done on other nearby hospitals to

determine common practices versus best practice. Education should be provided about mental illnesses, symptoms, exacerbation management, therapeutic communication, holistic care, and adverse events that can occur when symptoms are not controlled appropriately. Classes that teach compassion should also be attended by those included in the intervention. Updated information about the use of mechanical and chemical restraints needs to be obtained and taught to each member of the intervention, as well as other hospital staff to prevent unnecessary use of these when other lesser interventions have not been exhausted. There should also be an evaluation period prior to the introduction of the intervention to determine how special needs patients are treated and what kind of care is truly provided. I would suggest that a person that is not involved with the intervention, but has experience working with special needs patients should shadow emergency room healthcare providers and providers on unit floors to get a true feeling of the treatment provided. It is very easy to be nice and kind when one knows they are being watched. Results of these evaluations should be unbiased and not manipulated. Self-defense training would also be beneficial for staff as this would equip them with the ability to protect themselves and also create a sense of safety with the newly acquired skill. I also recommend that each person that provides any kind of service to persons suffering with mental illness perform self-evaluations to determine if they will be able to properly provide treatment to the patient. We can no longer hold the patient accountable for suffering with a mental illness. Mental illness does not discriminate when choosing its' victim. Therefore, we should not discriminate when we provide care. We should each take an in-depth look at ourselves and determine how we truly feel about this topic and why we feel as such.

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