Mental Health: Breakdowns in Health Care Service throughout the Continuum of Patient Care and Recommendations for the Future

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Abstract

This phenomonelogical work integrates the relevant literature along with a lived experience of mental healthcare. The article considers the role of consumers as participants in healthcare services and as contributors to the knowledge base. The article highlights the potential for phenomonelogical studies to be beneficial to the literature, since they can be analyzed to distinguish what, if any, similar areas exist, and as a result, what areas might be improved.

Keywords: *Mental Health Care, Health Care, Nursing, Nursing Training, Medical Ethics, Evidence-Based Practice.*

Introduction

According to the American Psychiatric Association, mental illnesses can be described in the following way: "Mental illnesses are health conditions involving changes in emotion, thinking or behavior (or a combination of these). Mental illnesses are associated with distress and/or problems functioning in social, work or family activities"[1]. In addition to providing a definition of mental illness, qualifying statistics are also shared to characterize and provide further insight regarding the prevalence of mental illness in the US: "Nearly one in five (19 percent) U.S. adults experience some form of mental illness. One in 21 (4.1) percent has a serious mental illness. One in 12 percent (8.5) percent has a diagnosable substance use disorder"[1]. Still, mental illness is described as treatable, and the majority of people impacted by it, as able to function in daily activities; however, a percentage of people experiencing a mental health crisis may need to be hospitalized[1]. This paper will consider a lived experience of mental health care provided in a public hospital setting to hopefully add to the understanding of mental health care treatment and to progress the quality of care. This result can be qualified through the reading of the comparative literature. This article will take a phenomonelogical approach: "Because phenomonelogical studies are concerned with the life world of actual people who have undergone a specific experience, they are able to illuminate our understanding of that experience as it occurs in the real world"[2]. Lastly, mental health care should definitely be analyzed as mental health can impact more than the person experiencing a mental illness, but the community as whole, including public safety, and also have multifold impact on public funding[3,4]. Ultimately, successful and effective treatment of the mentally ill, is an investment that could be considered beneficial to the entire society, and conversely, the failure or breakdown of such interventions can also be considered a vital matter of collective concern as well[3,4].

The Lived Experience: Before discussing the lived experience it could be helpful to provide additional details regarding how and why such articles are written. While reasoning can be diverse, the following information will provide a rather general context assuming that every reader may not be familiar with this variety of article. In another article, the author asserts that: "[s]ome literature

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about illness, or about practice, while concerned with particular times, places, and circumstances, offers a truth that transcends those particulars and can be read on several levels"[2], and that: "[r]eading such works often requires self-evaluation and reflection on the part of practitioner"[2]. While this article is not directed towards practitioners specifically, it is written with the goal that it might contribute something of use. For example, a comparative review could illuminate a thread that could be predictable, and perhaps preventable[5].It should also be noted that an experience may be more or less a fluke. Also, the literature could contain bias due to submissions or entries that were provoked by incredibly favorable or incredibly unsatisfactory experiences. Still, people who receive treatment should arguably have a chance to evaluate the service that was provided and contribute to knowledge regarding the subject matter. Unfortunately, at times, the particularities of mental illnesses and the discrimination against this population has served as an excuse why people with this ailment should not be heard[2]. It is helpful to understand the merits, and perhaps limitations, of such a methodology as described by another author: "[t]he phenomonelogical approach cannot stand alone, but excellent practice cannot do without it"[2].

According to researchers, mental illness could be described as a relatively short experience or it could refer to a chronic illness that requires specialty services[2]. The author was diagnosed with a disabling brain disorder that is characterized by disordered thinking. Due to this ailment, the author was hospitalized a total of five times in an inpatient facility; four hospitalizations were with a private non-for-profit provider of mental health care services, and one hospitalization was in a public psychiatric hospital. The last two hospitalizations were due to what the author would assert were misunderstandings between herself and her family regarding her wellbeing and psychological state. This is necessary to disclose and explore because although,"[s] evere mental illness creates a situation in which it is difficult to trust oneself, one's perceptions and the assessment of one's abilities"[5], persons with ailments, at times,can comprehend if they are well or unwell, and compliant with medication; in addition, "[t]here is a fine line to be drawn here. While participants can and do look forward to the future, they can never completely forget the experiences they have had while ill. Indeed, they must not; their efforts to maintain their health actually rest on the knowledge of their illness"[2]. While having a family and support system is important and potentially very helpful to a person struggling with an illness, there can also be complexities in these relationships; in another article: "[p]eople also described their difficulties with being in a dependent role and often controlled by others"[5] and elsewhere, "[s]everal people spoke to the loss of this sense of independence when they became ill. One respondent described getting ill as an infantilization"[5]. Ultimately, this article will more specifically explore the last admission into inpatient treatment at the public institution, which presented the most problems, during a time when the author considered herself to have been fully aware due to not experiencing any symptoms at the time.

I was involuntarily admitted to a public psychiatric facility after family member's expressed concern, although I eventually agreed to go, even though I asserted that I was not experiencing symptoms. At intake, I was advised that I needed to take a medication under my tongue, which, I stated I did not want to take because I had already taken my prescribed medication and was not sure how it would interact with that medication. After refusing the medication, I was grappled by their staff members and forced into a holding room. I advised them when they grappled me that I would simply take the additional medication; their response was it was "too late" and in the holding room I was held down by several people and administered injections in to the arm. I was then taken from the holding room to a unit and into a sterile room with another patient that resembled a jail. I did not feel safe because the person appeared entirely unstable. I was advised that my medication was being changed to something different, though I advised the staff that I had taken multiple medications since being diagnosed and had had the best success with my currently prescribed medication, which I requested be administered in a higher dosage if deemed necessary. I was ignored and told the court would not allow me to leave unless I agreed to have my medication changed and administered by injection at a medical site. I felt this was unnecessary, but eventually agreed because I felt it was directly related to my ability to be discharged. When I received the initial injection while still there, I had a highly negative reaction to the medication causing uncontrollable movements, which I reported to the nurse. I was told that I was making up the uncontrollable movements, and could in fact keep still if I wanted. Eventually, I was provided with a medication that was supposed to counteract the uncontrollable movements.

After a week passed, having been administered the shot, and in spite of the reaction, I was administered an additional dose that was suppose to last for a month this time instead of a week. I was not prescribed anything to help control the uncontrollable movements after discharge. I was given a court case during which time the doctor that was prescribing my medications was supposed to give a statement; the hospital had a person I had never seen before report on his work with me which was incredible because the doctor that had been working with me was of an entirely different race. I stayed in this hospital for four weeks, compared to having stayed approximately one week when admitted to the private hospital, during which time my greatest complaints were perhaps not benefitting from the "coloring" therapy, but always feeling much better after a week and able to return to daily activities and employment. I had never been administered shots or held down at the private institution, and certainly not multiple times. I frequently wondered if the revenue was not a reason for the continued hospitalization 4x the length whilst I was sane and aware,though admittedly withering away in depression caused by my presence there. I continued to have uncontrollable movements after leaving the hospital that increased in severity and resulted in me being admitted four times into the emergency room at an area hospital. Although the severity of the movements decreased with the temporary medication I was provided at the emergency room, during which time I had the appearance of a full seizure, I continued to have uncontrollable movements that never went away, and which were a cause for concern by the general psychiatric nurse whose patient I was after discharge.She did not understand why I was having the movements even a year plus later after my hospitalization. I discovered the following side effect listed for the medication I was injected with during research for this paper: "Risperidone may rarely cause a condition known as tardive dyskinesia. In some cases, this condition may be permanent. Tell your doctor right away if you develop any unusual/uncontrolled movements (especially of the face, lips, mouth, tongue, arms or legs)"[6]. My uncontrollable movements are currently few and far between, but still visibly happen at times, which I immediately try to cover-up, at home and a work,due to self-consciousness and concern that I appear as normal as I can, to avoid being placed back under hospitalization. However, my case seems rather mild in comparison to cases that were in the media regarding the same institution. I read additional reports including negligence and death in custody at the same public facility I was admitted to: "[A patient died after] his third day at the institution — from a blood clot that moved to his lungs, triggered by a broken neck, according to a medical examiner's report. The patient's roommate told investigators that [the patient] repeatedly asked for help the night before he died and complained of being unable to move his legs. Staff didn't believe him and thought he was feigning paralysis, according to testimony during a John Doe investigation in 2013. [The patient's] death at the mental health complex was one of six deaths in the institution that year examined by an independent doctor retained by Disability Rights Wisconsin. The doctor concluded that significant failures in medical care contributed to the deaths of [the patient] and three other patients"[7].

This excerpt from another article captures the experience: "[f]rom the psychosocial perspective, people with mental illness are recovering from many traumatic experiences, in addition to the illness itself. The way the individual is treated in the mental health system causes multiple traumas, as he or she faces negative professional attitudes; insufficient help, programs and professionals that disempower and devaluate the individual; and side effects from psychopharmaceutical treatment"[8].

III. Discussion

Mental health care is a very complex field driven by research, scholarship, clinical trials and various types of investigations and clinical practice that elucidate areas for growth and improvement – much like many different fields. It should be noted that: "[t]hroughout the history of psychiatry there have always been consumer-survivors who have spoken out against their experiences, who have advocated for their rights and for humane treatment for those diagnosed with mental illness"[8]. I would contend that this population is at risk for maltreatment due to the very nature of their illness. In the provision of services there can be experiences that are laden with purposeful or accidental mistakes. Investigations could elucidate predictable issues that participants face in receiving services. I would argue that this article alone cannot do that, but when considered along with the comparative literature, it may provide an avenue for such conclusions[5]. I summarize the major points discussed in this article here: a.) lack of information provided about the medication to be administered during intake, b. lack of personal safety in the unit, c. illegitimate reporting via a medical professional the consumer never interacted with, and d.) poor medication assessment and punitive

medication. Another author referencing lived experience mental health care concluded that: "[t]he data of their experiences creates a map of critical issues and tasks for consumers and case managers that can be used in training and to improve case management services"[5]. The body of literature could reveal certain themes, such as: a gap in the literature, a problem with translation from evidence-based to clinical practice, a problem with particular facilities (public vs. private, or certain locations), reflect the need for consideration regarding how long mental health care professionals have been working in certain units, and how that impacts biases and the level of care – all areas I have seen discussed in extant articles, though not an exhaustive list in terms of the types of considerations that might be provoked. Ultimately, in the literature there is currently a word being used that qualifies the types of people contributing such articles, "prosumers"[8]: "[p]rosumers model a vision of participatory treatment and recovery that includes people with mental illness as full partners and collaborators in their individual treatment and rehabilitation and in the design, delivery, and evaluation of mental health services"[8].

Conclusion

This article provided information on a particular lived experience of mental health care seeking to provide data that could be compared to additional literature with the goal of facilitating improvement to mental health care services; additionally,"[i]n provoking thoughtfulness in practitioners, a phenomenological approach also has the potential to have a significant impact on the experience of those who come to us for help"[2]. Ultimately, phenomenological studies alone are not enough to drive research and interventions[2]; however: "[c]ollaborative efforts between consumers and providers are needed to improve services for critical issues such as relapse preventions (Davidson, 1997)"[5]. In a field as sensitive and important as mental health care, both for the individual and the greater community, it would very unfortunate not to request or utilize such feedback. It would also represent a missed opportunity not to carefully review and clarify the commonalities present in these different report mechanisms, particularly if, matters are elucidated that can be avoided. This kind of additional review including available data and materials from the literature, questionnaires, and various related materials, would be nothing less than worthwhile for all stakeholders involved.

Ethical Clearance: Hereby, I, Kimberly N. Howard consciously verify that for this manuscript "Mental Health: Breakdowns in Health Care Service throughout the Continuum of Patient Care and Recommendations for the Future" the following is fulfilled: 1) This material is the authors' own original work; it has not been previously published elsewhere. 2) The paper is not currently being considered for publication elsewhere. 3) The paper reflects the authors' own research and analysis in a truthful and complete manner. 4) The paper properly credits the meaningful contributions of co-authors and co-researchers. 5) The results are appropriately placed in the context of prior and existing research. 6) All sources used are properly disclosed (correct citation). Literally copying of text must be indicated as such by using quotation marks and giving proper reference. 7) All authors have been personally and actively involved in substantial work leading to the paper, and will take public responsibility for its content.

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