Border Disputes: Diametrical Differences Amongst Psychiatrists, Nurses, And Crisis Specialists Within An Emergency Room Milieu

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Citation

Abstract

Numerous societal factors have given rise to acute psychiatric conditions in patients referred for mental health evaluation and treatment at a specified emergency room (ER). Some of these risk factors include homelessness, domestic violence, unemployment, and poverty; acute and recurring mental illnesses; comorbid disorders, and the effects of war as evidenced by soldiers returning home from overseas with signs of post-traumatic stress disorder (PTSD) symptoms. The increase in referrals from correctional facilities, jails, juvenile detention centers, group homes, nursing homes, and schools points to institutions overwhelmed and having difficulty managing their specific populations. As a result, these groups and individuals are referred for psychiatric emergency services. Nurses at the selected ER are primarily trained to respond to patients with physical medical emergencies and occasionally do not understand psychiatric clinical descriptors that impact on mental health patients. There is a need to educate ER nurses regarding psychiatric conditions and how best to respond to a patient's illness predicament. In addition, no crisis specialist is assigned to triage duties in the ER to assist nurses in forming a comprehensive assessment that can determine if the referral to psychiatric screening is appropriate. This study's focus centers on psychiatric screening centers in the state of New Jersey (USA).

DIALOGUE

Community outreach programs exist in most communities to address ongoing healthcare needs of individuals affected by behavioral health impairments. A large component of this outreach effort is screening and evaluation designed to facilitate a referral to an appropriate level and type of healthcare intervention. Screening and evaluation are intended to detect potential illnesses in the community; they are typically the gateway for impaired individuals seeking access to diagnostic and treatment services along a continuum of therapeutic care provided by specialists and experts. Behavioral health services include outreach programs in the community for purposes of engaging the target population of those with some impairment. One component of this outreach is the screening and evaluation of mental health disorders for referral to an appropriate level of care. These services are distributed according to need and often co-located with ancillary services.

Screening and evaluation programs may also include crisis intervention. The goal of a screening and crisis intervention program (SCIP) is to provide stabilization to a client with urgent and immediate needs that have been identified within an outreach community service. The SCIP does not provide treatment and intervention, only an interim stabilization so that the client can then progress to the next stages of a confirmatory diagnosis and treatment if needed. Many behavioral health screening services include crisis intervention. The goal of a screening and crisis intervention program (SCIP) is to provide both on-site and off-site stabilization services in its designated county. SCIP is the county's designated psychiatric screening program that identifies community-based mental health services as an alternative, and when clinically appropriate, to inpatient public psychiatric hospitals. All screening centers are located in, or adjacent to, emergency rooms. Screening centers operate 24-hours a day, 7 days a week for the purpose of evaluating patients for a mental illness.

Under the New Jersey psychiatric screening law, the Department of Mental Health Services (DMHS) is responsible for developing, updating, and readopting every 5 years, screening regulations to provide more detailed guidance regarding the state's screening system. DMHS considers public input critical to the development of

accurate, current, and helpful standards. It has looked to the Governor's Task Force on Mental Health, Acute Care Task Force, Screening Regulations Work Group, State Mental Health Planning Council, Systems Review Committee, advocacy and industry groups, and ongoing communications with the public (New Jersey Division of Mental Health Services, 2008).

As recently as 2008, changes to New Jersey's screening law were proposed and consisted of the following recommendations:

1. Changing from a stationary center within a hospital to a more mobile service with greater community accessibility;

2. Expanding mission from crisis response and hospital referral to early intervention and linkage to community resources;

3. Performing psychiatric evaluation through telepsychiatry;

4. Adding greater detail to the provisions role in commitment evaluation, including instances when conditional discharges are violated;

5. Updating staffing qualifications, training and certification requirements;

6. Updating the waiver section;

7. Updating designation section, possibly adding provisions regarding the termination or suspension of a designation; and

8. Updating the confidentiality section (New Jersey Division of Mental Services, 2008, p. 6).

SCIP administrators are presently exploring the option of moving from a hospital setting to a mobile clinic to provide greater accessibility. The move from the ER would give the program its own environmental structure as well as greater latitude in providing psychiatric screening to mental health patients.

At present, there are between 300 and 400 patients who present to the designated county ER monthly and who are then referred to the screening and crisis intervention program (SCIP) for a mental health evaluation. SCIP is under contract with the Department of Mental Health (DMH) to provide psychiatric mental health screening in a designated county in New Jersey and is based at the selected ER. SCIP represents a cross section of the services available to the community (correctional facilities, juvenile detention centers, military bases, schools, nursing homes, group homes, state agencies, and private residencies). SCIP is employed by a larger non-profit agency to provide mental health services in a designated county and are not employees of the selected ER.

All patients must be triaged in the ER and when medically cleared by an ER physician, will be referred to the mental health crisis unit if they require further evaluation. Those patients referred to the crisis unit will be assessed by a crisis specialist and, in some cases, seen by a psychiatrist to determine if hospitalization is justified.

Not all triage staff at the selected ER are mental health nurses or psychiatric screeners; thus questions conveyed to patients by triage staff sometimes do not include the essential preconditions to establish mental status:

- Is depression evident?

- Is there suicidal/homicidal ideation present?

- Are there paranoia, psychosis, catatonic or substance induced behaviors?

Not all ER staff is trained to follow the crisis screening protocols, nor are crisis specialists assigned to the ER to assist with the screening process. Lack of representation of crisis staff in the ER can sometimes complicate referrals to a crisis unit when triage nurses are unclear of reason for referral; they lack understanding of chronic and acute mental health history and cannot assess for mental status criteria.

The mental health triage protocol used in the ER is intended to determine if a patient meets criteria for a crisis screening. Nurses are occasionally unable to articulate the protocol when questioned by crisis staff and often will arbitrarily send patients to crisis screening without consulting first with a certified crisis screener. This has led to questions regarding the appropriateness for the referral and tension between crisis specialists and ER staff. The protocol, as interpreted by the crisis team, is that the ER nurse must alert a crisis specialist in advance when a referral to the crisis unit is initiated. This advance notification by ER nursing staff promotes a collaborative effort in determining cause/reason for referral and helps in providing psychiatric justification for the referral since most ER nurses are trained in physical

medical emergency, not mental health assessment and treatment.

Nurses in the selected ER are not all trained to triage mental health patients or provide mental status examinations on the crisis unit. There is occasionally resistance primarily from administrators at the selected ER to have crisis specialists stationed in triage to assist nurses with establishing a mental status disposition as well as to coach, teach, and advise. The absence of these teaching and coaching tools has given rise to increased frustrations on the part of crisis clinicians as some referrals are deemed inappropriate and counterproductive to the screening referral process. On the other hand, there is benefit in collaboration as some ER nurses have expressed a desire to understand mental health triage and assessment. The problem is nurses are pulled in different directions and assigned where their superiors believe they are most required.

CLINICAL DISCOURSE

Differences in philosophy and approaches to evaluating mental health patients in an emergency room (ER) setting exist and will often give rise to trends, parameters, and limitations that shape the evolution of decision making and clinical outcomes. In many instances, patients will be initially assessed, and a psychiatric review of symptom specific behaviors will take effect at the point of triage.

The ability to understand a patient's illness predicament as she or he evolves through triage is imperative since decisions made during this phase will legitimate their reason for referral to psychiatric emergency services (PES). On the other hand, a triage assessment could justify a patient's discharge from the ER with referrals to community mental health services. Just because a subject is brought into the ER or is self-referred, this does not mean he or she is a candidate for PES. In addition, the critical nature in the treatment of mental health patients requires an examination of cause, effect, and outcome. More importantly, patient care must enjoin a collaboration of emergency medical practices along with psychiatric dynamics. This union of the two camps of medicine is essential in providing a balanced effort that will hopefully improve clinical integrity. While the two groups command their own unique specialties, their collaboration in the treatment of psychiatric disorders is essential.

Likewise, nurses as well as those who classify themselves as mental health nurses, have similar responsibilities, despite the fact that one group believes its efforts serve patients referred for physical medical emergency while the other group of nurses aligns itself with coherent treatment, wellness, and recovery initiatives. A common denominator must be found that unites the two groups in providing patient care. Conversely, the problems that exist at the selected ER stem from lack of communications between ER physicians and psychiatrists, but they also affect ER nurses and nurses assigned to the inpatient psychiatric units. There are apparent social/cultural differences that transcend the two departments and, likewise, contribute to the disparities that are obvious but equally factor into limitations in patient care. The effects of these restrictions can be felt on the psychiatric crisis unit as crisis specialists feud with ER personnel to control their territory.

Given the significance of the decisions made at triage on clinical outcomes, the need for specific training of ER staff and personnel to conduct effective psychiatric evaluations becomes clear. However, nurses working at the point of triage continue to manifest a lack of understanding in how best to evaluate mental health patients and, likewise, are hesitant in providing space in the ER for crisis specialists to offer assistance and collaboration in the initial assessment stages. This lack of collaboration can lead to inappropriate referrals to PES and thus can make it difficult to establish reasonable disposition criteria that would be in the best interest of the patient. Furthermore, nurses assigned to triage duty at the selected ER are trained specifically in physical medical and emergency procedures and often do not possess the clinical expertise that is found in the area of psychiatric emergency services. Mental health nurses that specialize in this area are often excluded from triage duties at the selected ER.

Triage nurses working in this environment, in fact, are hesitant to go to the crisis unit, as many are not comfortable interacting with acute and chronic patients. Some have been overheard as saying they would prefer being assigned to the emergency room and that they did not go to nursing school to work with crazy people. This mentality has a debilitating effect on patients suffering from a mental illness, especially since many patients appear to be keen to the attitudes manifested by nurses assigned to the crisis unit. Those attitudes on the part of nurses are perceived as despondent, indifferent, and confrontational. More importantly, the relationship between nurses and crisis specialists is further strained since the two groups are not proactively aligned in their efforts to evaluate and diagnose the psychiatric

behaviors.

The juxtaposition of the two groups is argued along the lines that "I am right and you are wrong"—without providing an iota of evidence that supports an argument of who is right and who is wrong. Evidence requires an investigation of the facts, and, without it, the argument is moot. Therefore, what can be attributed to the in-fighting? Is there evidence of polarization between the two groups, or are there ideological differences that run counter to patient care? Further, this begs the question: Are we witnessing a territorial dispute amongst crisis specialists and ER personnel?

What does appear obvious is that crisis specialists and ER nursing personnel assigned to PES have conflicting views and are not always in agreement on disposition and treatment outcomes. Conversely, some nurses believe they are experts in the field of psychiatric emergency services—despite the fact that many have no formal training in mental health screening. On the other hand, crisis specialists believe they possess the expertise because they went to school. While these opposing groups argue about who is right and who is wrong while professing behind closed doors that "we agree in principle," the patient, unfortunately, continues to suffer.

In the study of animal behavior, one can often see a pattern of territorial presence that predates human existence. Indeed, empirical evidence directs one to observable features of species "from slime molds to insects, from fish to birds and from animals to humans" who are, as Ardry, Bliss, Halldobler, and Wilson (as cited in Baldwin, 2007) indicated, carving out their own unique space. The preservation of such territory, according to Baldwin, is defended as a restricted domain, not allowing others to participate and regarding them as an invader or menace. Furthermore, possession of territory suggests an apparent indoctrination by the owner to retain at any expense, despite implicit threats or challenges.

Are there lessons to be learned, as Baldwin (2007) intimated, in understanding this phenomenon of territoriality? Further, is there an agenda to exercise control over property by coercion, in light of what appears to be an adversarial relationship between crisis specialists and ER personnel? According to Baldwin, preservation of property appears as simple to massive divisions of animal life. Next, the title holder or landlord of a property habitually exercises authority as far as possession is concerned. In addition,

control of territory means overpowering the occupant or finding another location. Finally, territory must be protected less invaders attempt to remove the owners.

Mental health nurse practices, on the other hand, require integration and collaboration. They presuppose a tendency to try and understand the patient's illness predicament. Mental health nurses' efforts are intended to foster compassion, friendship, responsibility, and the opportunity to treat the psychiatric behavior. Some researchers further argue that nursing, as we know it, has been sequestered from the mainstream in providing patient care, and now it is time for nurses to reclaim their role in the forefront of patient care by enjoining wellness, recovery, and holistic principals that are concurrent and synonymous with universal treatment practices (Buchanan-Barker & Barker, 2005).

What must be recognized in the healthcare system of today is that it is evolving into its own unique specialty of patient service delivery. The concept of the physician as having complete autonomy in the field of medicine is now undergoing a dichotomy of medical care sharing with those who have demonstrated their own special identity, status, autonomy, and, ultimately, consortium (Baldwin, 2007). Simultaneously, and primarily as a result of these new players, as Baldwin has maintained, there has materialized a new set of rules "governing (and constraining) the work of medical care, including practice protocols and treatment guidelines," (p. 98).

Conversely, a level of accountability is required which rates physician performance through a variety of assessment tools that are designed to regulate physician behavior. The message is that others in the field of medicine who have crafted their own unique specialty are also capable of delivering similar services. Mental health nurses have similar challenges as they work to gain access to territory previously possessed by medicine. Their work with mental health patients is critical if they are to reclaim their rights as lead facilitators in assessment, diagnosis, treatment, and disposition for the mentally ill. Baldwin (2007) said that if nurses desire some portion or access to territory held or claimed by medicine, they must successfully challenge in one of the following ways:

1. By co-opting or taking over medical tasks and functions by force or subterfuge;

2. By seeking to gain the support of powerful allies such as the law, the courts and public opinions;

3. By seeking out newly defined or abandoned territories;

4. By substantially shifting the argument to a different level or in a different direction, hoping to develop a consensus which will enable them to work together in a harmonious and integrated way. (p. 100)

An integrated approach to providing services to mental health patients hypothesizes a collaborative effort enjoining psychiatric care with medical urgency. Mental health patients deserve the same attention, time, and energy that are afforded patients presenting for physical medical emergency. Subterfuge, or co-opting these efforts by use of force, hinges on non-professional tactics and can ultimately lead to serious conflicts amongst nurses and administrators (Baldwin, 2007). By working to gain support of the courts as well as public opinion, nurses retain their professional integrity and nurturing relationship with their patients.

In contrast, a question that has emerged pertains to the role of the mental health nurse and his or her relationship to psychiatry. Are we witnessing a paradigm shift in patient care as Keen (2003) suggested? He stated that the hyphenated job title "psychiatric-mental health nursing" (p. 29) implies an identity conflict. "Perhaps the reluctance to jettison either 'psychiatric' or 'mental health' indicates ambivalence about medical allegiance or nursing ideologies" (p. 29). The possibilities referenced point to dissociation from the norm. "Are we primarily a profession allied to medicine (psychiatric nurses) or should we be more professionally autonomous and psycho-socially oriented (mental health nurses) (p. 29)?"

Hally and Hardy (as cited in Keen, 2003) posited that many nurses retain the title of "nurse" while adopting professional individuality with general nursing whereas Holmes (as cited in Keen, 2003) maintained others choose to ally themselves "with other mental health professionals, and accelerate the evolution of a novel generic metal health worker (p. 29)." What remains as a missing link to this equation is how to narrow the territory by uniting all components in treating mental health disorders. Nurses may associate themselves with a particular discipline; however, they are supposed to serve the best interest of the patient and, likewise, promote the holistic principals of wellness and recovery. Should it matter what their title is if the intended purpose is patient care?

From Keen's (2003) perspective, there remains a qualifying argument to address the duties of nurses, when one considers the apparent shift in responsibilities to those focused largely on managing deviant behaviors. Morrall, Howell, and Norman (as cited in Keen) maintained that nurses have been similarly situated in roles as police officers to control "difficult behavior that proves unresponsive to psychiatric treatment or punitive threat" (p. 29). Specific to this apparent paradigm shift is the emphasis placed on public safety and risk management, based on recent United Kingdom (UK) legislative proposals, as referenced in Keen, giving nurses greater latitude in managing patient behavior. In essence, it changes the nurses' role entirely to that of a law enforcement officer. According to Bean, Morrall, Barker, and Watkins (as cited in Keen), it also signifies a difficult road ahead for nurses who would otherwise exercise fair, unprejudiced, and impartial treatment to patients.

Therefore, the mental health-psychiatric nurse's role is ambiguous at best—with no clearly defined treatment parameters. Furthermore, Harrison posited (as cited in Keen, 2003) that the nurses' role ambivalence appears counter-productive to assessment, diagnosis, and treatment of patient symptomatology.

The nurses' role has become one of assessing symptom and risk and maintaining safety and administering medication. The provision of therapeutic and recreational activities is thought of as somebody else's job, either the occupational therapist or unqualified staff. Activities are not viewed as a vital component of treatment or as important as medication…ward staff need supervision and training to change custodial care into therapeutic care… collaborating closely in care provision will facilitate this. In sharing therapeutic roles, {nurses} will then be more able to define their own core skills. (p. 30)

Whatever other political, cultural, and economic circumstances emerge over the historical horizon, psychiatric-mental health nursing will have little meaning without a clearly defined purpose and perspective, according to Keen.

The established parameters of psychiatry have also undergone challenges in modern times in ways that threaten its intended purpose and responsibility—to assess, diagnose, and treat the patient. What are the factors of corrosion? Is there evidence of probable corruption? An exact determination based on social-cultural horizon-scanning is

not definitive, according to Keen (2003). However, there are arguably four classifications that threaten psychiatry's legitimate leadership:

- Increasing popularity and acceptance of non-medical approaches to psychological distress;

- Pressure on psychiatry to respond positively to politicians tougher 'social control' and behavior management agendas;

- Dramatic advances in understanding the biological basis of human behavior;

- Internal professional conflicts about diagnosis, treatment, and the social purpose of psychiatry. (p. 30)

In this era of post-modernism, questions have been raised regarding "alternative interventions for psychological discomfort" (Keen, 2003, p. 30). The emphasis on choice stems from diametrical differences in treating mental illnesses and scrutiny regarding traditional psychiatric practices. More people are diligently pursuing non-medical advances for their suffering: "From self-help groups, through New Age therapies, to political activism, potential patients seem increasingly impatient with standard psychiatric formulations" (pp. 30-31). The surge in opposing conventional medical wisdom is thought to be attributed to advances in technology, electronic media, television, and academic incentives.

Today, people learn about their illnesses from a multitude of sources in and out of their immediate environment. Technology has expanded to include a wide array of learning topics found on the Discovery channel, the History channel, the Biography channel, and the Learning channel (Sachs, 2006). These resources appear limitless. However, if nurses are serious about a patient's wellness potential, the effort to direct and evaluate them using, sometimes, selective methods, must be pursued. Those who profess a new spiritual enlightenment believe that alternative treatment options can mitigate their pain and hardship, according to Keen.

IMPLICATION OF FINDINGS

Are there universal implications in what appears to be tragic circumstances surrounding the treatment of mental health patients? A review of the literature would suggest that mental health practitioners, as well as their counterparts (nurses), differ in advancement, assessment, and outcome processes.

More importantly, clinical observation regarding patient care at the selected ER often denotes an atmosphere of intrigue and intimidation. Crisis specialists who are charged with the responsibility of assessing mental health patients frequently encounter ER nurses who are confrontational, dictatorial, and indifferent. There are instances when the crisis unit is acute and equally unsafe, due to patient volume, sometimes exceeding the number of beds—in multiple digits. The crisis unit has a maximum bed capacity for six patients. Yet, there have been, on occasion, up to 20 or more patients referred to the crisis unit and as many as 15 housed on the crisis unit at one time awaiting assessment and disposition. The apparent overflow in patient volume on the crisis unit points to ineffective triage practices. Furthermore, there are evidentiary signs (based on the number of patients brought to the crisis unit) that these practices can lead to acrimonious implications regarding patient safety.

Is there evidence that the parties have familiarized themselves with clinical best practices in arriving at a consensus—to collaborate, assess, diagnose, and treat the psychiatric illness? In addition, what is the role of the psychiatrist, or, rather, does he or she factor into the equation in directing patient care? When one considers that psychiatric directives have been challenged and, in some instances, circumvented by ER nursing administrators because they differ with the protocol? More importantly, what gives a nurse the authority to override a medical doctor's decision?

On the other hand, where does this place the crisis specialists in demonstrating that they can exercise some degree of leadership and accountability to their patients? After all, they are charged with the responsibility for assessing them while they are in crisis. However, control in managing the mental health patient is frequently stripped from the crisis specialist by ER personnel because they disagree on process and planning.

What must be considered, and is equally connected to decision making by crisis screening personnel, is whether it is worth the effort to remain in their present location. The initial idea behind the implementation of PES in New Jersey addresses the premise that mental health patients will no longer be housed in asylum type facilities, that they will be

treated in community mental health nomenclatures, and that treatment initiatives will be expeditious and outcome driven.

In the 1980s, the state of New Jersey established screening laws to guide mental health practices, and legislature directed the Department of Mental Health Services (DMHS) to regulate those practices in accordance with the law. What this meant is that those suffering from a mental illness would be brought into a designated ER and evaluated, and if they required further evaluation, they would then be referred to PES. This process of evaluation meant that a patient would be referred for the following criteria:

A client shall receive a thorough assessment if he or she is referred to a screening center because he or she has behaved in such a manner as to indicate that the person is unable to satisfy his or her need for nourishment, essential medical care or shelter, so that it is probable that substantial bodily injury, serious physical debilitation or death will result within the reasonably foreseeable future. (University Behavioral Healthcare, 2007, p. 26)

DMHS declared that all screening centers be located in or adjacent to emergency rooms in each county in the state of New Jersey. Furthermore, screening practices required that prospective candidates interested in applying for positions as crisis specialists meet minimal requirements as established by DMHS. In accordance with screener certification requirements (qualifications and duties), the following is applicable:

1. Each screening center shall have one or more screeners available on each shift who shall be certified by the Division.

2. Screener certification shall be granted to individuals who have completed the Division's screener certification course.

3. The following shall be prerequisites to the Division's screener certification course:

    a. Evidence of the following educational/experiential background. Although a master's degree is preferable, any of the following is acceptable:

        a. A master's degree in a related field plus one year of experience in a psychiatric setting; or

        b. A bachelor's degree plus 3 years' mental health experience, 1 of which is in a crisis setting; or

        c. A bachelor's degree plus 2 years' mental health experience, 1 of which is in a crisis setting and currently enrolled in a master's program; or

        d. A registered professional nurse designation with 3 years' mental health experience, 1 of which is in a crisis setting. (University Behavioral Healthcare, 2007, pp. 36-37)

The mental health facility authorized to provide these services in a designated county in the state of New Jersey must abide by the state's requirements and will thoroughly review applications to ensure that anyone considered for positions at the designated screening center meet those requirements.

Based on a review of educational/experiential criteria, screening requirements appear as all encompassing; they include certified mental health screeners and professional nurses with 3 years' mental health experience, "1 of which is in a crisis setting" (University Behavioral Healthcare, 2007, p. 37). Unfortunately, as of now, no experienced mental health nurses function in this capacity on the crisis unit. In addition, there are no uniform screening protocols across PES initiatives in New Jersey that direct and guide this process. In other words, screening centers operate independent of one another, and although the underlying regulatory requirements are evident, nurses' practices are not.

Some screening centers demand that nurses meet all requirements as described in the law; others, however, succumb to systemic and bureaucratic pressures and thus acquiesce to ER administrators by allowing them to dictate the terms. What these administrators understand, based on the regulations, is that nurses must be assigned to a crisis unit 24 hours a day. What does it matter if they are or are not trained in mental health standards?

Nurses at the selected ER are assigned to the crisis unit by

management as a matter of rotation. This rotation is seldom based on mental health experience and rarely factors into ER management's decision. Nurses are assigned because it is a regulatory requirement. They can range from nurses with several years of experience working in an emergency room to nurses just completing their licensure requirements. In most instances, however, they are trained to take care of patients in the ER, and often they waste no time informing crisis staff they are not sitting on the crisis unit for 12 hours to monitor aggressive and agitated patients. A nurse's presence is generally visible when a patient requires vitals and/or medications.

It, therefore, becomes clear that descriptions in triage and screening include fundamental principles that embrace best practices when evaluating mental health patients and that these actions include collaboration of nurses with crisis specialists.

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