

7-2020

Ethical Considerations For Outpatient Behavioral Healthcare In North Texas

Carolyn B. Guillory
University of New England

Follow this and additional works at: <https://dune.une.edu/theses>



Part of the [Educational Leadership Commons](#), and the [Psychiatric and Mental Health Commons](#)

© 2020 Carolyn B. Guillory

Preferred Citation

Guillory, Carolyn B., "Ethical Considerations For Outpatient Behavioral Healthcare In North Texas" (2020).
All Theses And Dissertations. 307.
<https://dune.une.edu/theses/307>

This Dissertation is brought to you for free and open access by the Theses and Dissertations at DUNE: DigitalUNE. It has been accepted for inclusion in All Theses And Dissertations by an authorized administrator of DUNE: DigitalUNE. For more information, please contact bkenyon@une.edu.

ETHICAL CONSIDERATIONS FOR OUTPATIENT BEHAVIORAL HEALTHCARE
IN NORTH TEXAS

By

Carolyn B. Guillory

M. Ed. May 1987 – May 1991

B.S. January 2012 – May 2014

B.S. May 1982 – May 1985

A DISSERTATION

Presented to the Affiliated Faculty of

The College of Graduate and Professional Studies at the University of New England

Submitted in Partial Fulfillment of Requirements

For the Degree of Doctor of Education

Portland & Biddeford, Maine

July 17, 2020

Copyright 2020 by Carolyn B. Guillory

ABSTRACT

ETHICAL CONSIDERATIONS FOR OUTPATIENT BEHAVIORAL HEALTHCARE
IN NORTH TEXAS

The purpose of this Interpretative Phenomenological Analysis (IPA) study was to examine caregivers' perceptions of practices for outpatient behavioral health care. Effort was made to gain insight into the components of ethical service delivery. Significant data on the providers' perceptions of care was identified in literature reviews, though it was not the case for perspectives of consumers or caregivers. This population has been identified as one which is likely to experience unaffordable, fragmented, and confusing behavioral health systems (Baker, 2015). Attempts to inform research by addressing the quality of treatment was a focus. The Research Problem: Since 2016, the suicide and child mortality rate for children has increased by 27% in the north Texas region (Smith, 2019). Adults who need behavioral healthcare are displaced and being taken to county jails (Gately, 2017). Qualitative research methods were structured interviews in conjunction with the IPA research design to learn of lived experiences. The eight participants were caregivers to consumers receiving behavioral healthcare from the Serene Horizons Health Center (SHHC), a pseudonym to maintain confidentiality. The study sought to answer:

- What services have caregivers deemed as integral for outpatient program compliance?
- What services do caregivers attribute as motivational forces which encourage consumers to actively participate in available services?

Findings identified consistent perspectives from all participants. Perceptions of integral factors for program compliance yielded quality service, professional conduct, and accessibility to services. Factors which encouraged motivation were identified as the consumers feeling cared for, supported, and motivated. Value was identified in experiencing a provider who cared for them by being supportive and motivating. Service provision will require rejuvenation, interagency education and collaboration, and advocating with a sense of urgency at the legislative level. Ethical behavioral healthcare should be practiced in all health care disciplines.

Key words: Accessibility, Professional, Conduct, Service

University of New England

Doctor of Education in
Educational Leadership

This dissertation was presented
by

Carolyn B. Guillory

It was presented on
May 31, 2020
and approved by

Michelle Collay, Ph.D.
Lead Advisor
University of New England

Kimberly Roberts-Morandi, Ed.D.
Secondary Advisor
University of New England

Gerald L. Johnson, B.S., LCDC
Affiliate Committee Member
Substance Abuse Consultant

DEDICATION

To my late parents Ada R. Boyd, Freddie G. Boyd, and my late Sister Cassandra Lenston.

You have given me the love, confidence, and support to keep me forever gracious.

To my best friend and long-time supporter, Gerald L. Johnson.

You have always believed in me.

And to my brother and sisters, Eugene Lenston, Rosemary Williams, Glenda Lenston,

Ruth Boyd-Okogun.

Thank you for unconditional love.

ACKNOWLEDGEMENTS

To Dr. Michelle Collay, Dr. Kimberly Roberts-Morandi,
and Gerald L. Johnson, B.S.

With much gratitude for unconditional support, guidance,
and encouragement.

To my Colleagues in our cohort
Thank you for supporting my goals and a great team spirit.

To the participants in this study
Deepest appreciation for sharing your truth, lived experiences and insight
related to outpatient behavioral healthcare.

TABLE OF CONTENTS

| | |
|--|----|
| CHAPTER 1: INTRODUCTION..... | 1 |
| Statement of the Problem | 5 |
| Purpose and Rationale for the Study | 7 |
| Central Research Questions..... | 8 |
| Conceptual Framework | 8 |
| Rationale and Significance | 10 |
| Assumptions, Limitations, and Scope | 11 |
| Definition of Terms | 12 |
| Conclusion..... | 14 |
| CHAPTER 2: LITERATURE REVIEW..... | 16 |
| Personal Interest | 16 |
| Recommended Mental Health Practices..... | 17 |
| Current Demand for Service..... | 18 |
| How Minimal Change Impacts Service Delivery..... | 19 |
| Economic Impact of MHSUD | 19 |
| Provision of Service for Clients with MHSUD | 20 |
| Legislative Action | 21 |
| Medical Insurance Coverage | 21 |
| Legal Requirements for Involuntary Treatment | 24 |
| Ethical Ramifications | 25 |
| Continuity of Care | 25 |
| Local Resources in the North Texas Region | 25 |
| Theoretical Framework | 28 |
| Conclusion | 32 |

| | |
|--|----|
| CHAPTER 3: METHODOLOGY | 35 |
| Purpose of the Study | 35 |
| Research Questions and Design | 36 |
| Site Information and Population..... | 36 |
| Sampling Method | 37 |
| Instrumentation and Data Collection Procedures | 38 |
| Data Analysis..... | 39 |
| Conclusion | 39 |
| CHAPTER 4: RESULTS | 41 |
| Data Collection..... | 42 |
| Vignettes to Establish Participant understanding the Concept Ethical Practices | 45 |
| Data Analysis and Coding Transcripts | 45 |
| Thematic Development | 45 |
| Implications | 48 |
| Theme 1: Accessibility | 49 |
| Sub-theme 1: Resource..... | 50 |
| Theme 2: Professional Conduct..... | 50 |
| Sub-theme 1: Positive or Negative Conduct | 51 |
| Sub-theme 2: Emotional Safety | 52 |
| Theme 3: Service..... | 52 |
| Sub-theme 1: Education | 53 |
| Sub-theme 2: Causal Relationship..... | 53 |
| Conclusion..... | 54 |
| CHAPTER 5: CONCLUSION | 55 |
| Intepretation of the Findings | 58 |

| | |
|---|----|
| Interpretation 1: Accessibility | 58 |
| Interpretation 2: Professional Conduct | 59 |
| Interpretation 3: Service | 59 |
| Implications | 60 |
| Review of Frameworks in Support of the Study | 61 |
| Recommendation for Action 1: Accessibility | 62 |
| Recommendation for Action 2: Professional Conduct | 62 |
| Recommendation for Action 3: Service | 63 |
| Recommendation for Further Study | 63 |
| Recommendation 1 | 64 |
| Recommendation 2 | 64 |
| Conclusion | 64 |
| REFERENCES | 69 |
| APPENDIX A: Request Participation Letter | 76 |
| APPENDIX B: Consent for Participation in Research..... | 77 |
| APPENDIX C: Sample of Vignettes | 81 |
| APPENDIX D: Interview Guide | 83 |

TABLES

| | |
|---|----|
| Table 2.1: Percentage of Noninsured Table | 24 |
| Table 4.1: Demographics of Participants | 44 |
| Table 4.2: Presentation of Main Themes..... | 47 |

FIGURE

| | |
|---|----|
| Figure 2.2: Research Questions and Frameworks | 31 |
|---|----|

CHAPTER ONE

INTRODUCTION

Researchers at the University of Texas at Austin noted mental health disparities have become a very prominent concern in Texas (Hogg, 2018). “More than two-thirds of Texas’ licensed psychologists, over half the licensed psychiatrists, and social workers practice in the five most populated counties, leaving the remaining 249 counties without mental health providers” (Hogg, 2018, p. 32). Given the limited physical access to services, there may be even more, incidences of those with poor health, a lack of care, and a lack of health coverage than in urban areas (Hogg, 2018). As a result, the availability of care for the population of individuals with mental health and substance use disorders (MHSUD) in rural areas is unlikely. Simply put shortages across the mental health workforce decreases access to mental health care. Factors related to accessibility translate into limited access to care with a demand greater than the supply of providers in both urban and rural settings. Rural communities are more likely to have fewer options for local resources (Hogg, 2018). The prevalence of the needs of this vulnerable population speaks to the urgency of this concern. It is of equal importance to note some of these persons not receiving care are parents, spouses, and adults caring for others. With or without changes in the system, these citizens will become responsible to represent their communities as leaders, stakeholders, and authority figures now and for upcoming generations.

Significant data about perceptions and experiences of those providing outpatient behavioral healthcare was obtained from literature reviews in the north Texas region and other localities. It was predicted that there may be relevant findings since this researcher's personal experience in this field has shown Texas faces challenges not common to some other states. For example, the Mental Health Authority (MHA) for this region is a contracting organization and

was noted to be deadlocked over contract disputes with the largest provider of mental health services in this area (Garcia, 2020). It was also predicted care could be interrupted if the two organizations did not come to terms. The authority oversees state funding, awards, and financial support by allotting funds for services to other subcontractors (Garcia, 2020). The other option for management of behavioral healthcare funding is for there to be state operated local mental health authorities. As a result, many challenges make accessing and use of mental health services complexed. Guidelines, partnering organizations, and eligibility requirements are factors that vary from one agency to the next and are only a few of the factors affecting service delivery (National Alliance on Mental Illness, 2019).

In September 2019, the National Alliance on Mental Illness (NAMI) presented a report to address the challenges and struggles of persons living with MHSUD (National Alliance of Mental Illness, 2019). The web page addressed continued disparities in access to mental and physical wellness affecting 60 million children and adults (National Alliance of Mental Illness, 2019). Throughout the United States, the report also acknowledged minimal increases in MHSUD services, given the projected expectations from the installation of the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 (National Alliance of Mental Illness, 2019). The Act is a federal law which was established to prevent health insurers from providing unfavorable benefit limitations on behavioral health care (Weber, 2013). Specifically, the report noted the goal of the 2008 Act was the provision of comparable and equitable insurance laws which might enhance the opportunity for coverage to the MHSUD population (National Alliance of Mental Illness, 2019).

Prior to the MHPAEA insurers were reported to have unfairly imposed sanctions such as: denying coverage to persons with mental illness or substance use disorders citing pre-existing

conditions; imposing limitations with maximum monetary coverage and maximum days of stay in a facility resulting in people reaching lifetime maximum limitations/the end of coverage; and charging larger copayments than was required by medical insurance forcing people to forego treatment (Weber, 2013). The underpinnings of the NAMI report (2019) and Weber's (2013) research reflect the persistence of systemic failures to those needing outpatient behavioral healthcare. Other findings addressed services to persons living with MHSUD as fragmented systems which can be unaffordable and confusing, thereby placing individuals at higher risk for adverse events (Hogg, 2018).

According to Mueser (2003), "Adults living with MHSUD is a population most likely to be vulnerable, poor, stigmatized because of their condition, and least likely to be afforded equitable human rights" (para. 6). The findings revealed a disproportionate number of individuals with MHSUD arrested and taken to jails, though not because of committing a crime. There are insufficient numbers of outpatient facilities to treat manageable conditions and few inpatient facilities with bed availability (Gately, 2017). The children needing services are faced with the same dilemma. Smith (2019) indicated this was a time where child specific funding has decreased 2016 - 2017 and 2017 - 2018. These conditions have resulted in a call for putting an end to long term stigmatism, notable social isolation, victimization, incarceration, and outcomes that reflect failing systems of care (World Health Organization [(WHO)], 2015). Advocates for better care of this population identified that sheer awareness of notable maltreatment to persons needing behavioral healthcare should warrant improved efforts toward ethical and equal care (Jané-llopis, Anderson, & Hosman, 2011).

For this study, behavioral healthcare was defined as the effort to advance mental health, resilience, and wellness (Substance Abuse and Mental Health Services Administration, 2014).

Mueser (2001) identified concerns of poor treatment and reflected on the plight of those living with MHSUD before the Mental Health Parity (MHPA) of 2008. The findings by Jané-Ilopis et al., (2011) reflected continued inequities in both service delivery and a lack of care even after mandates of the Mental Health Parity Act (MHPA) of 2008. Research by Mueser (2001) and Jané-Ilopis et al. (2011), though dated, provided a physical timeline, and added value to the significance and longevity of those inequities. Even after the enactment of the MHPA of 2008, changes appeared to be minimal given the continued failing of systems that were designated to provide behavioral healthcare (Jané-Ilopis et al., 2011).

The lack of care to this population is an ethical concern and has been noted to limit the quality of life for those needing help (Baker, 2015). The regulation in quality of services to American citizens is based on public health ethics which promotes and protects the health of the population (Tasioulas & Vayena, 2015). A very basic description for the role of public health rests with the quality of healthcare for the health of the public; the provision of treatment using moral foundations; an acknowledgment that limited resources may pose ethical challenges; and resolutions for tensions between individual liberty and collective benefits (Tasioulas & Vayena, 2015). One study addressed ethical public healthcare and supported respect for individual autonomy (Bayer et al., 2006).

The focus of this study was to examine practices of providers in outpatient behavioral healthcare in the North Texas Region. An effort to gain insight into the components of ethical service delivery for the continuity of care was one objective. Interviews were used to obtain first-hand perceptions and experiences from the viewpoint of those who support persons with MHSUD. The assessment tool was pre-established and included statements of inquiry intended

to generate information which filled gaps in existing literature. Further, the interview process was geared towards directly addressing the research questions guiding this study.

The definition of ethical public health care by Bayer (2006) has been adopted as a baseline measure of ethical service delivery to the MHSUD population. Also, the definition of ethical services was utilized to determine whether studies in the literature review reflected ethical service delivery to the target population. Little research with a topic of ethical behavioral healthcare was found. Addressing this gap in the existing literature on the forefront of caregivers' concerns provided approaches to improving the quality of care.

Statement of the Problem

The behavioral healthcare services in the north Texas region are far from adequate. Thousands of Texas residents living with MHSUD meet the criteria for placement in treatment centers and outpatient care. Though, services are not being rendered. Since 2016, the suicide and child mortality rate for children has increased by 27% in the north Texas region (Smith, 2019). Adults, who need behavioral healthcare are displaced and being taken to county jails (Gately, 2017). Reportedly there are no appropriate or accepting facilities on an outpatient or inpatient basis delivering care to those with MHSUD (Gately, 2017). "The lack of significant investment in behavioral healthcare has resulted in a ranking of third from last in the nation for mental healthcare spending in Texas" (Peavey, 2019, para. 3). In addition, there is increasing evidence which identified significant detrimental effects that untreated MHSUD has on people's lives (Jané-llopis et al., 2011).

According to data from Health and Human Services (2018), approximately one in five Americans experienced a mental illness condition that interfered with daily activities. At least 60% of people who will have mental health issues will have manifestations as teens. Substance

abuse has continued to increase in the last 20 years to over 20,000,000 individuals nationwide (HHS, 2018). These findings are indicators that the behavioral health needs of people experiencing MHSUD are not being met by local communities (Baker, 2015). There is much speculation regarding solutions to what has been identified as a national crisis (Hogg, 2018). These concerns were valid and consistent with recent research findings in this study.

Baker (2015) noted the most common cause of the lack of care to those needing behavioral health services is the lack of accessibility due to costs. Another study suggested the demand for psychiatric services is greater than the availability of service providers (Hogg, 2018). The Hogg (2018) and Baker (2015) studies are consistent in supporting the theory of limited availability of qualified providers and/or services. As a result, many individuals fell between the cracks and did not have any means to access the same level of care as those who were insured (Hogg, 2018). Other research focused more on the quality of care by espousing treatment provision should go much further than just addressing accessibility problems. Specifically, Liégeois & Van Audenhove (2005) stated, “Empowering individuals and assisting them to become fully participating members of the community should be the goals of community-based care” (para. 2). These same researchers identified value in building the skills of the individual receiving services.

Texas-based mental health providers may soon face increased seriously ill cases should they continue to fail to provide treatment to persons who are plagued with these debilitating conditions (Peavey, 2019). The federal government has acknowledged gaps in services and noted the following findings in 2013 for Texas: 50.1 million age twelve or older are binge drinkers; 24.6 million age twelve or older were current illicit drug users; 19.8 million age twelve or older were current marijuana users; and 20% of adults in Texas had a mental illness (Substance Abuse

and Mental Health Services Administration, 2014). The number of individuals functioning at impaired levels has spilled over into the workforce in Texas. Due to the prevalence of substance abuse, there is a lack of seasoned, educated workers which has been identified by Congress as a workforce crisis (Substance Abuse and Mental Health Services Administration, 2014).

Purpose and Rationale for the Study. The purpose of this study was to examine caregivers' perceptions of practices of outpatient behavioral health care and gain insight into components of ethical service application. Findings led to concerns which addressed the increasing child mortality and suicide rates; and the systemic problem of an introduction to the justice system due to the lack of treatment (National Alliance on Mental Illness, 2019). It was believed by this researcher there were solutions to these dilemmas. Fortunately, acquired data on outpatient behavioral health treatment, from the viewpoint of caregivers provided valuable perspectives and informed research.

Gaining insight into components of ethical service practices that contributed to the continuity of care was useful data for the north Texas region. Again, there appeared to be innumerable studies that reflected the perspective of behavioral healthcare providers (Hogg, 2018). Efforts to attain research containing first-hand accounts of the lived experiences of the consumer through the eyes of caregivers or otherwise were unsuccessful. As a result, furthering research by adding previously unidentified perspectives from caregivers was invaluable to the research community. Documenting findings has yielded enhanced information and should guide the use of ethical standards in service provision for providers practicing in the north Texas region and society at large. The detailed experiences were provided for this purpose. The caregivers

provided many examples to clearly communicate their loved ones and their own experiences. The interaction with the participants was closely examined by the principal researcher. The research questions were established with the intention of guiding research and were used to seek information and serve as groundwork for holistic outpatient behavioral healthcare in Texas. Careful consideration for establishing the research questions was considered for obtaining the information sought related to ethical behavioral healthcare.

Central Research Questions

RQ1: What services have caregivers deemed as integral for outpatient program compliance?

RQ2: What services do caregivers attribute as motivational forces which encourage consumers to actively participate in available services?

As previously mentioned, one of the objectives of this research was to identify useful components of outpatient behavioral health, which has shown to increase wellness. Interviews were conducted with the caregivers of consumers at Serene Horizons Health Center (SHHC), a pseudonym to protect privacy, to gain their perspectives based on personal observations and experiences. Ethical and professional communication were of prime importance to offer respect to the study participants and demonstrate appreciation for their feedback. The insight gained related to ideals and ethical considerations toward the provision of holistic outpatient behavioral care informed members of the profession. Interviews with the caregivers allowed the researcher to document a new perspective.

Conceptual Framework

A comprehensive framework for the provision of care took into consideration the following, “Be prepared to provide an assessment; counseling; ambulatory and residential

detoxification; and residential treatment for consumers experiencing MHSUD who present to primary care facilities” (Baker, 2015, para. 2). For example, services that are commonly offered in behavioral health settings are individual or group counseling depending on the need. The treatment planning should be established and coordinated to best meet the needs of each consumer on an individualized basis regardless of the entity (Hogg, 2018). The same study also noted that consumers with MHSUD must be allowed to participate in the establishment of treatment goals and objectives. Again, working with individuals to establish desired achievements will empower individuals (Liégeois et al., 2005). Also, these practices were consistent with the ideas of living fulfilled lives. One study shared, “Positive psychology is a discipline which celebrates the strengths and virtues of people and aims to assist in lives that are richer and more satisfying” (Bayer et al., 2006, p. 16). It was this researcher’s belief that the studies of Bayer et al. (2006) were foundational, the value the message brought to this body of research added to the richness of historical studies on mental health and wellness. Subsequent research has continued to build upon that work. Communities must embrace the recognition that services should be available in every realm of healthcare the customer may choose to frequent. Individuals may present themselves for MHSUD treatment to public behavioral health care centers, they may present to private health clinics, hospitals, or primary care facilities (Baker, 2015).

Researchers have suggested there is a need for interactive social relationships that exist among residents in a community to include MHSUD care (Hogg, 2018). Building strong communities to include the establishment of neighborhood behavioral healthcare may address the limited accessibility to services noted by Baker (2015). He has contributed both theory and ideas which offer significant value for a better quality of care of consumers.

Rationale and Significance

Reduction in the impact of treatable behavioral healthcare conditions was the overarching goal for services provide to consumers with MHSUD. Finding ways to treat mental health disorders creates an expansive dilemma (Substance Abuse and Mental Health Services Administration, 2019). Jané-Ilopis et al. (2011) suggested at minimum there must be ethical considerations in providing outpatient behavioral health services. Current systems are failing to take ethical responsibility for providing the quality of care which should be afforded to this population (Jané-Ilopis et al., 2011).

When persons with mental health and substance use disorders are arrested and taken to jail the outcome is not therapeutic. Generally, there is not a mental health professional in the county jails of the north Texas region. During the moment, the arrest may be beneficial in another way to uninformed individuals who summon law enforcement. For example, a person who trespassed on private property would no longer be a nuisance. A person who was detained and deemed to be a danger to self would be placed on suicide precautions and watched at a ratio of one to one. One officer is generally assigned to watch for the precaution though no therapeutic treatment is offered. Even more concerning is the fact that persons incarcerated without known history behavioral health concerns are housed in the general inmate population. As previously mentioned, this population is more likely to be victimized, and exposed to even greater dangers. Little research has been found to address the experiences of these incarcerated individuals. To document such actions would be verification of systemic failures to meet the needs of those with MHSUD.

The significance of the experiences by this vulnerable population speak to the urgency a lack of care mandates (Baker, 2015). These findings gave credence to the value of this topic and

body of research. The number of persons still requiring MHSUD care in the Texas region alone continues to grow (Hogg, 2018). The combined statistics of the Substance Abuse and Mental Health Services Administration (2014) for abuse of alcohol, illicit drugs, and marijuana revealed 94 million persons were affected (Substance Abuse and Mental Health Services Administration, 2014). These figures do not take into consideration the effects MHSUD had on families or other interpersonal associations (Substance Abuse and Mental Health Services Administration, 2014). Notable concerns existed for consumers who may function at a level less than someone free of mental health or substance use concerns, though still required to function in familial and economic roles with minimal to no support (Hogg, 2018). Without changes in the healthcare system, these citizens were unable to function with optimal wellness.

Assumptions, Limitations, and Scope

There is an assumption that much of the care provided to consumers with MHSUD has been inadequate or many consumers have been victims of unjust and unethical treatment. Based on this assumption, an effort was made by this researcher to objectively review the available literature. A discussion of findings was provided in the literature review. An effort was made to identify alternatives more consistent with ethical care. Again, the definition of ethical outpatient behavioral health care was detailed in the definitions section of this study.

The researcher documented the experiences of patients from the observation and perspective of caregivers. Through these efforts, it was believed this study identified components of quality outpatient care. Service providers should be armed with resources and referrals to address impending behavioral healthcare needs (Baker, 2015). Although leaders may not perform the care, it would be most beneficial for there to be tools in place to guide the

providers through services, resource assistance, and referrals. This study drew upon the perspectives of caregivers regarding components of ethical care and the continuity of services.

Although federal funding has been designated to address the service deficits there are limitations to what is currently available (Peavey, 2019). There may continue to be limitations in the availability of programs and services as organizations become recipients of funding to provide services. Still, funds for MHSUD support may continue to be insufficient for some time. Determining which approaches have been effective and ineffective for consumers has been informed by this research and would thereby enhance service delivery. The desired result would be increased overall wellness of those needing MHSUD care (Baker, 2015). As previously mentioned, the scope of the failed investment in behavioral healthcare has resulted in a ranking of the state of Texas as third to last in the nation for behavioral healthcare spending (Peavey, 2019).

Definition of Terms

Adverse Events – Circumstances that may contribute to the inability of an individual to function at a level of optimal mental health or a condition that may contribute to that individuals' deterioration (Baker, 2015).

Behavioral Health Care - The promotion of mental health, resilience and wellbeing; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities (Substance Abuse and Mental Health Services Administration, 2014).

Ethical Public Health Care – The recognition, exploration, and resolution of ethical issues that present in the practice of public health. The obligation of the healthcare provider to respect

individual autonomy while acquiring and applying scientific awareness for the improvement and protection of public health (Bayer et al., 2006).

Holistic approach – The provision of care that begins with ensuring the needs of an individual are met to include basic food and shelter; access to continued mental health and medical treatment; community skills support; and a financial means to aid in optimal self-sufficiency (Baker, 2015).

Mental health – A state of wellness in which an individual is aware of his or her potential, can cope with everyday stressors of life, can be gainfully employed, and can contribute to his or her community (World Health Organization, 2015).

Mental health condition (disorder) - A syndrome that presents in an individual which clinically results in a significant disturbance in emotional regulation, behaviorally, or in cognition and functioning (Stein et al., 2010).

Outpatient programming – Structured programs usually held on the campus of a treatment facility, that focuses on education; psychiatric medication management; socially accepted and inappropriate behaviors; and physical and mental wellness (Substance Abuse and Mental Health Services Administration, 2015).

Public health ethics - Justifications for the health of the public; moral foundation; ethical challenges raised due to limited resources for health promotion; and tensions either perceived or real between individual liberty and collective benefits (Tasioulas & Vayena, 2015).

Substance use disorder – Use of alcohol and /or drugs recurrently causing significant functional and clinical impairment such as failure to meet major responsibilities at work, home, or school; health problems; and disability (Substance Abuse Mental Health Services Administration, 2015).

Conclusion

The provision of behavioral healthcare, in general, has become a topic of interest to stakeholders and policymakers (Peavy, 2010). As the number of individuals who have MHSUD increases, so does the probability that these conditions will present in all facets of their lives and communities (Hogg, 2018). Each organization desiring to provide ethical care to those presenting for mental health and substance use care must make every effort to provide services, regardless of whether consumers are insured (Peavey, 2019). Although it may not be known how the care will be paid for, the fact remains that the MHSUD consumers are not going away absent intervention (Hogg, 2018).

The study was conducted at Serene Horizons Healthcare Center (SHHC), located in the north Texas region. The facility has been given a pseudonym to protect the privacy of the consumers for compliance with the Federal Education Rights and Privacy Act (FERPA). The facility provides outpatient services to children. Participants for the study were adults who are caregivers to persons served by the center.

There are many dynamics involved when treating a population of individuals generally at higher risk for adverse events (Ngui et al., 2015). At the recent legislative session on July 28, 2019, legislators discussed mental health care in the Texas region which resulted in an allocation of 745 million to invest in the Texas behavioral health system (Peavey, 2019). Noted recommendations to legislators were to address the frequency of those with MHSUD being arrested as no treatment alternatives existed (Peavey, 2019). Some debate existed regarding building new psychiatric hospitals and was said to conflict with the idea of providing the least restrictive environment (National Alliance on Mental Illness, 2019). However, quality

behavioral care must take place and ethical considerations may serve to empower individuals to be active, productive community members (Bayer, 2006).

CHAPTER TWO

LITERATURE REVIEW

The purpose of this literature review was to provide a summary of service provision and practices to consumers living with mental health and substance use disorders (MHSUD) in the United States. Many contemporary programs are funded through an appointed governmental mental health authority (MHA). The MHA is often an entity that already operates within the state. The responsibility of the MHA is to allocate funding to qualifying community organizations. However, the Texas region which was the focus of this study does not have a state-operated MHA. In the north Texas region, organizations have provided contract services in a managed care-type system for several years. Then a new contracting agency assumed the process. The process of changing the MHA has complicated the continuity of care concept. The variability in service provision of behavioral healthcare has directly impacted the quality and availability of services. Relevant research was reviewed, and apparent gaps in the literature, especially those that influenced the provision of services, were revealed.

Personal Interest

Personal interest in the study of ethical practices for outpatient behavioral healthcare was accompanied by more than 16 years of psychiatric services experience. Several different populations were provided service by this researcher. It seems the greatest amount of progress, given adequate staff support, has been observed in those who have struggled with MHSUD. These mental health concerns are not going to resolve themselves, as indicated by the statistics to follow, which suggested that the lack of services problem has continued to grow (HHSC, 2018). The identified needs for both children and adults in the Texas region have reflected ineffective

systems. This study was focused on identifying the desired quality for ethical services which might assist to sustain businesses interested in addressing those needs.

Recommended Mental Health Practices

The literature review guided refinement of the research questions as well as provide a clearer picture of the status quo of mental health services in the north Texas region. One study identified an ineffective program and exemplified the frequent pattern in which psychiatric crisis programs had been put in place to meet the needs of Texas residents (Hogg, 2018). More effective program models were said to begin with the client's presentation to an outpatient mental clinic; an initial assessment by a licensed clinician with a referral based on the findings; symptoms which warranted more in-depth examination resulted in a psychiatric evaluation; a level of care would be recommended ranging from least restrictive outpatient services and medication monitoring to more restrictive inpatient services if deemed necessary; and psychotropic medications were prescribed from a medical doctor (Baker, 2015).

The research questions guiding this study sought to identify integral components of outpatient behavioral healthcare. Innovative practices that have been observed or experienced that enhanced retention was highlighted. Documented practices of both providers and patients in alignment with ethical care guided further research. The work to be completed on this topic was in the very early phases. It was predicted that as the research continued there would be questions that better served to address the issues faced by this population which contributed to unethical and poor-quality care. Creswell (2014) noted that the significance of a study conveys the importance of a problem to an audience and may also serve to be a voice for those who are under-represented.

The researcher believed that professional knowledge about this topic was a positive factor, though care was taken to maintain objectivity. Reported findings based on observations by caregivers of their firsthand experiences with outpatient MHSUD treatment added a new dimension of research. Prior to this study perspectives from caregivers of persons receiving behavioral health services were unfounded. While the provision of ethical outpatient care is the overarching goal, there was an equal awareness of the need to report the true lived experiences of consumers. The caregiver reports enlightened and informed research from a new viewpoint. The lived experiences were accompanied by examples and details to clarify questions.

Current Demand for Services

According to The Health and Human Services Commission (HHSC, 2017), the need for the availability of mental health services has continuously grown over the past twenty years and is at all-time high. At least 20 % of Americans have suffered from either a substance abuse problem or a debilitating mental illness serious enough to interrupt daily activities (HHSC, 2018). Other resources addressed government funding with the following goals: making mental healthcare more accessible; funding research to aid in reversing these trends; and the emergence of the most current evidence-based findings on the cusp of the fight to end these crippling conditions (HHSC, 2017). Clearly, there is much work to be done to meet the needs of the MHSUD population in this country. “Occupational stress and work-related mental health problems have a number of major socio-economic consequences such as absenteeism, labor turnover, loss of productivity, and disability pension cost” (Jané-llopis et al., 2011, para.17). Clemens (2011) and Jané-llopis et al. (2011) shared a prediction that depression and its effects were currently at the top of the list of problems for contributing to a poorer quality of life and unhealthy individuals. Clemens (2011) also reported MHSUD as the number one cause of

premature deaths in the world by the year 2030. More statistics to support the need for better outpatient behavioral healthcare were presented in a report from the World Health Organization (WHO; 2019). A very dismal statistic noted that, every 40 seconds someone in the world loses their life to suicide. The number of confirmed suicides worldwide as of October 2019 was 800,000 lives. Mental, neurological, and substance use disorders made up 10% of the global burden of disease and 30% of the non-fatal disease burden. As many as 264 million adults and children suffered from major depression. Finally, the number of mental health workers varied from below two per 100,000 in low-income countries to over 70 per 100,000 in high-income countries (WHO, 2019). Findings from medical researchers suggested that poor physical health could result from poor eating habits as well as daily use of alcoholic beverages (Beaglehole, Bonita, Horton, Adams, Alleyene, & Asaria, 2011). Based on many of those findings, researchers suggested support and services can contribute to a better quality of life for those living with MHSUD.

How Minimal Change Impacts Service Delivery

One area of focus in the literature was the impact minimal focus, funding, and energy was given to ethical service delivery for the MHSU population. The current state of the unmet need was described by the Health and Human Services Commission (HHSC, 2017) as a need which is greater than ever previously documented. Further, the deficit in services has continuously grown over the past twenty years (HHSC, 2017).

Economic Impact of MHSUD

The economics of care to the MHSUD populations has impacted those needing services, and the economy as well. As previously mentioned, Baker (2015) reported accessibility as the number one cause of inadequate service delivery. When service is not available through

behavioral health providers, the need spills over into primary health care (Baker, 2015). The result of decreased availability to primary health care is only one example.

Ngui et al. (2010) shared another study that found a lack of treatment negatively impacted services due to a lack of options. Specifically, individuals seeking treatment for mental health often seek care at public service clinics and are prescribed costly medications (Ngui et al., 2010). Similarly, Baker (2015) noted substance use and mental healthcare management has grown significantly in primary care settings. It was also pointed out that untreated psychiatric disorders have a direct relationship to chronic medical health (Ngui et al., 2010).

Failure to consider an individual's inability to pay for services by consumers with MHSUD has contributed to the accessibility of service concern. Providers in the medical arena gave less regard to the poor, such as those with fixed incomes. Service delivery for physical health was found to be more consistent as compared to mental health (Ngui et al., 2010). Further, many patients with physical health problems were provided services free of charge. The free services were provided as preventative care for physical conditions, which was never the case for mental health and substance abuse care. The impact of the economic situation of consumers is a huge factor regarding access to and quality of care. A lack of funding and poor quality of practices disproportionately affect the poor, already at greater risk for having mental disorders (Ngui et al., 2010).

Provision of Services for Clients with MHSUD

Other findings addressed services to persons living with MHSUD as fragmented systems that were unaffordable and confusing Jané-Ilopis et al. (2011). These researchers also noted that behavioral healthcare must take place and ethical considerations should drive decisions to empower individuals to be active, productive community members. Efforts to address the

mental health and substance use needs have been disjointed and inaccessible resulting in numbers which have continued to increase since 2009 to over 20 million nationwide (HHS, 2018).

Another example of impending repercussions from this problem is that Texas-based mental health providers are beginning to face high-risk patients nearing dangerously debilitating conditions (Peavey, 2019). Examples of the negative economic impact of poor mental health were found in related literature which noted staggering numbers of individuals functioning at impaired levels currently in the workforce in Texas (Substance Abuse and Mental Health Services Administration, 2014). Due to the prevalence of substance abuse, congress has called the need for seasoned, educated workers a workforce crisis in Texas (Substance Abuse and Mental Health Services Administration, 2014). Kotter (2008) shared that when a true sense of urgency is absent, the opportunity for change is doomed. To address the opportunity for change, he noted leaders should create and maintain that sense of urgency. Increasing statistics opposite the need for care is evidence contributing to the detrimental effects untreated MHSUD has on people's lives (Jané-llopis et al., 2011). This crisis has directly impacted chronic conditions and reduced wellness for the MHSUD population (Baker, 2015). The disadvantageous effects of poor community mental healthcare are a worldwide problem for more than just the mental health care sector (Nguí et al., 2010).

Legislative Action

Legislation has become a very significant factor in the quality of medical and behavioral healthcare (Baker, 2015). The United States (US) introduced legislation that both offered and mandated health care in 2010 when former President Obama introduced the Affordable Care ACT (ACA; Amadeo, 2018). The goal of the ACA was to improve the quality of health care and

lower cost for those who did not have the benefit of obtaining health insurance from an employer (Amadeo, 2018). The results of the actions did have some benefits for consumers with MHSUD related to equity in behavioral health being more like medical coverage.

Medical Insurance Coverage

Medical insurance generally includes behavioral health insurance which pays for mental health and substance abuse-related conditions (Jané-llopis et al., 2011). It is believed that for many, knowledge of services for mental health and substance abuse are not as well-known, as a result, many continue to suffer in silence (Jané-llopis et al., 2011). Noted recommendations to legislators were said to address the unwarranted frequency of those with MHSUD being arrested as no treatment alternatives are available (Peavey, 2019).

Ethical care of consumers requiring care for MHSUD carried many legal considerations for ethical provision of behavioral health treatment. A much different area of focus identified a need for legislation to encourage dialogue between legal professionals and mental health professionals. When mental health workers are educated on important ethical and legal constraints through joint workshops and conferences, issues that may impact daily practices can be better anticipated (Shapiro, 1997). More dialogue by professionals was a consideration which would better protect the licensed provider and the consumers being served.

Several studies cited in this literature review stressed healthcare ethics as being very valuable to the quality of care (Tasioulas & Vayena, 2015). These professionals advocated for regulation in quality services to American citizens as the core of public health ethics (Tasioulas & Vayena, 2015). A manager of a small local inpatient psychiatric facility revealed the two major concerns for servicing persons with behavioral health needs, ethics and a high quality of care, which encourage a good reputation in the community (R. Taylor, personal communication,

2/15/19). A similar report espoused the necessity to ensure service delivery is humane, fair, and the least restrictive alternative (Texas Health and Human Services Commission Behavioral Health Ombudsman Texas Health and Human Services, n.d.).

A recent study on insurance rates in the north Texas region reflected this district was slightly better than both the national and state averages for uninsured residents in every ethnic and racial sector (Maddox, 2019). These statistics have conveyed this region may not be an ideal area to practice medical and behavioral health care. The table below provides a summary of the percentages of individuals who would be self-pay customers due to a lack of insurance (Maddox, 2019).

Table 2.1

Percentage of Noninsured October 2019

| Race and Ethnicity | United States | Texas | North Texas Region |
|---|---------------|-------|--------------------|
| White (all ethnicity) | 90.6 | 82.1 | 76.8 |
| Black or African American alone | 87.7 | 84.1 | 82.9 |
| American Indian and Alaska Native alone | 78.4 | 77.6 | 72.8 |
| Asian alone | 90.8 | 86.7 | 85.2 |
| Hispanic or Latino (of any race) | 78.8 | 71.4 | 64.6 |

Legal Requirements for Involuntary Treatment

Legal status for voluntary versus involuntary consumers was addressed by Schneider (2016) who studied mandatory community mental health and substance abuse treatment. The researcher addressed the need for a high ethic of care in outpatient mental health services for involuntary, court-ordered treatment (Schneider, 2016). Specifically, the care of these patients is mandated and a requirement to avoid an inpatient commitment. “Ethically-driven challenges are many of the medications used to treat mental illness were labeled for other uses, posing risks for legal and ethical implications; the ability of a mentally ill person to give consent was questionable; challenges existed in the use of newer medications or treatments when clinicians may not have the benefit of evidence-based practice; providers struggled with situations when all treatments had been unsuccessful; and involuntary patients often had negative attitudes towards

being mandated to receive treatment, which may affect the outcome” (Schneider, 2016, para. 3). To address many of those issues the same researcher recommended incorporating women’s health, primary care, and emergency care to meet patient needs during an evident shortage of mental health practitioners. He further suggested successful treatment programs need these dynamics in place to become well established. Zibler (2016) also looked at ethical considerations for individuals who were required to participate in community mental health services. He noted a myriad of ways a person may be mandated to access services. He further noted treatment difficulty most often occurred when patient attitudes were counterproductive to their treatment.

A brief look at historical American psychiatric care noted, beginning in the 1950s, psychiatric hospitalization for long-term treatment was no longer practiced (Schneider, 2016). Chronically mentally ill persons began to receive mental health treatment on an outpatient basis. Again, some of the patients released for community care were required to go to treatments that were court mandated. Specifically, a person is court-ordered for mental health behaviors must comply with the recommended treatment to prevent deterioration, relapse, and inpatient court-commitment. This process was noted to set the stage for ethical concerns of patient autonomy and beneficence. The autonomy or freedoms of a patient were controlled by the conditions stated in the order for their outpatient treatment. Discussion related to ethics maintained the following: treatment was considered ethical when the benefits of treatment and the potential for adverse side effects were established (Zibler, 2016).

Ethical Ramifications

Still another group of researchers Munetz, Galon, & Frese (2003) addressed ethical concerns of mandatory community treatment and noted the three most prevalent groups affected.

Those groups were mentally ill offenders, forensic psychiatric patients, and civil patients with no involvement in the legal system with a diagnosis of serious mental health conditions.

Particularly, individuals with schizophrenia, bipolar depression, and major depression, tended to have more frequent episodes of inpatient hospitalization requiring involuntary treatment with medication (Munetz et al., 2003). In this study there was careful review of treatment and supporting documentation of how mandated care must be provided. For consideration as ethical care noted findings were as follows: there must be quality, comprehensive mental health care which is adequately structured and funded; the treatment and care must be provided in the least restrictive alternative manner; the mandatory approach should only be used when other less restrictive options have been ineffective; programs should be structured around the capacity to serve rather than the dangerousness of the patient; and consumers must be allowed to participate in the development of their care and treatment plan (Munetz et al., 2003). Individualized treatment plans and patient involvement allows the individual to make decisions in their care (Hogg, 2018).

Continuity of Care

Some research stressed a full-service continuity of care model. Ideally, full-service care was identified as a network of providers armed with verified resources and referrals to address the impending behavioral healthcare needs. In addition, quality behavioral care must take place and ethical considerations may serve to empower individuals to be active, productive community members (Jané-Ilopis et al., 2011).

Local Resources in the North Texas Region

Persons who suffer from mental health disorders, intellectual disabilities, and substance use disorders are among the most underserved members of our society (Hervey, 2019). The

problem of Texas citizens being arrested and exposed to incarceration has been approached from a new angle. The effects of the problem are not specific to any sociological group. All racial, economic, and religious groups are affected, and the wide range of clients has necessitated a commitment to the promotion of better care. As a result, the Texas criminal justice system established a task force charged with the mission of providing resources to persons needing behavioral health care (Hervey, 2019). The resource is called the Texas Mental Health Resource Guide and was printed in its first edition. Services in the manual are available to consumers with or without criminal offenses.

The Substance Abuse and Mental Health Services Administration (SAMHSA, 2015) listed 73 facilities in the north Texas region that provide both inpatient and outpatient treatment. There was a total of seven inpatient facilities. The total combined number of hospital beds for inpatient behavioral healthcare was approximately 580. However, Houston had almost three times the number of beds at 1,549. Even San Antonio had significantly more inpatient beds for licensed facilities at 847 beds (Maddox, 2019). The current number of inpatient behavioral health beds in the north Texas Region is consistent with Baker (2015) who noted a lack of accessibility to services as the primary barrier to MHSUD consumers. A better picture may be viewed when comparing the number of inpatient behavioral health beds in most major public hospitals. The closest large county or state-run hospitals have approximately 150 behavioral health beds, like Jan Johnson White, a pseudonym for a facility in a region adjacent to the north Texas region (Maddox, 2019).

Some outpatient services are available from public clinics such as the county mental health and mental retardation (MHMR) centers. Private, for-profit organizations that take private insurance are available to the insured. Faith-based organizations exist with limited resources

through local churches. Forensic services are provided specifically to those who are a part of the criminal justice system after an illegal offense. Again, the forensic task force operated with the goal of bringing an end to the unnecessary exposure of persons with MHSUD to the Texas criminal justice system when it is unwarranted and to guide individuals toward optimal wellness (Hervey, 2019).

Theoretical Framework

Collaborative care was the theoretical concept which has been most consistent throughout the available research. Lake & Turner (2017) approached the issues related to outpatient MHSUD treatment and proposed the use of a more interdisciplinary collaborative model. In a primary care setting, they suggested a focus on preventative services. A different study was conducted by psychiatrists who sought to unveil programs that would treat individuals holistically (Lake & Turner, 2017). Another study focused on collaboration of services and noted the following suggestions: supporting the patient to modify their lifestyle by increasing physical exercise and consuming a better diet; educating clients on the idea of mind and body through meditation; introducing products that may be natural, safe, affordable and useful for common illnesses that will not have contra-indications to psychiatric medications; and making therapy more accessible (Edmunds, Frank, Hogan, McCarty, Robinson-Beale, & Weisner, 2017).

Jané-llopis et al. (2011) studied mental health concerns and suggested mental health has not been treated as a societal problem, but more of an individual problem. As a result, many persons with mental illness lack support at home and in communities which may lead to isolation and suffering in silence (Jané-llopis et al., 2011). Suggestions for effectively treating mental illness from the standpoint of mental health promotion included: educating parents to foster well-being in the parent-child relationship at home; assistance in providing support in schools at all

levels of education; assisting working individuals or those desiring to work to realize and train for occupational goals; making employers and managers aware of effective strategies to assist in the promotion of a healthy work environment; and providing systematic support to older adults to encourage more civic trust and participation in a more social environment (Jané-llopis et al., 2011). Finally, to ensure that service delivery is humane, fair, and the least restrictive alternative, Texas mandates are in place (Texas Health and Human Services Commission Behavioral Health Ombudsman Texas Health and Human Services, n.d.). The positive result of cared for individuals equates to them feeling supported and becoming contributors to the society where their autonomy is valued and they are successful (Bayer et al., 2006).

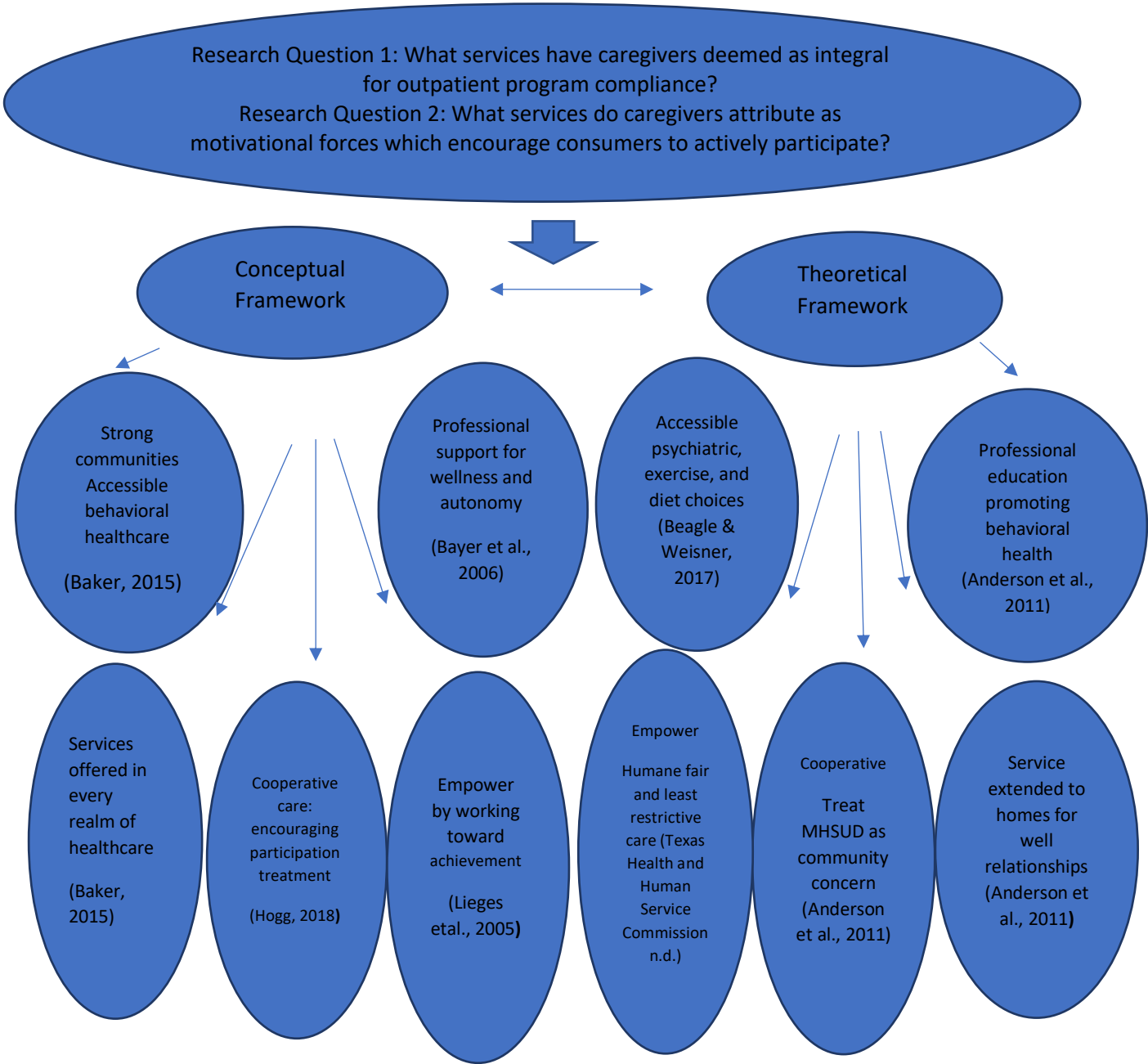
Recent research has noted an effort to bring resolution to these profound concerns in the north Texas region which resulted in the allocation of 745 million to invest in the Texas behavioral health system. Noted recommendations driving the outcome was advisement to the legislators addressing the frequency of those with MHSUD being arrested when no treatment alternatives were available (Peavey, 2019). The quality of care was noted to be important in opportunities for holistic wellness. Ngui et al., (2010) identified critical inequalities in mental health care, have been a great burden throughout the world, and an important health issue that presented immense ethical challenges.

Finally, one relevant study addressed the need for the wellness of caregivers in crises. Morality concerns were found by Michelle (2017) who addressed the necessity of emergency preparedness plans to include behavioral health care. The focus of the study on emergency care primarily spoke to the needs of first responders to have a resource for debriefing post-disaster relief. Importance was placed on the relationship that emergency facilities' staff should have with behavioral health care providers and noted that it should be a great relationship (Michelle,

2017). The study also recommended establishing healthcare coalitions that regularly support each other. Systems noted to be fragmented were described as difficult to navigate, and services were stated to be difficult for the consumer to access. The complex dynamics of many of the available services resulted in persons falling through the cracks (Ngui et al., 2010). See the figure detailing the interaction of the research questions, frameworks, and ideal scenarios in Figure 2.2.

Figure 2. 2

Research Questions Conceptual and Theoretical Framework in Support of the Study



The graphic in figure 2.2 depicts the interrelatedness of the research questions, the conceptual framework, and the theoretical framework. Both frameworks offer ideas on how the research questions can be actualized in concept and theory. The conceptual framework established a guide for basic characteristics of an effective behavioral health system for the north Texas region. The theoretical framework provided simplified techniques by which the desired characteristics of the conceptual features might be attained. For example, Baker (2015) proposed the concept of the need for strong communities with accessible health care. Again, Edmunds et al. (2017), suggested a theory for meeting the consumer with MHSUD needs through strong communities offering psychiatric care and medication management; exercise programs and dietary education; access to medications that most household have on hand such as cough medicine that would not have contraindications to psychiatric medications; and other general wellness recommendations. In another example, Bayer (2006) conceptualized providing professional support for wellness and autonomy as a guide to care. Jané-Ilopis et al. (2011) recommended providing professional education to employers for workers needing support, and well parent-child in home relationship building to reach the guide for wellness. The wealth of existing literature found in this study was like pieces of a puzzle that only required time and effort to establish a road map to quality, ethical behavioral healthcare. These frameworks coupled with this study's recent findings on caregiver perspectives offered exceptional opportunity to meet the need of the consumer, the community, and to some degree the previously mentioned well worker shortage.

Conclusion

Ngui et al (2010) proposed the following ideas as solutions to the world's mental health epidemic: local services in the community would minimize negative social stigma; agencies in

the community can exercise effective resource management of mental disorders; and advocacy can assist individuals to contribute to one's quality of life. There are many dynamics involved when treating a population of individuals that are generally at higher risk for adverse events and advocacy might fill the gap (Ngui et al., 2010).

Providers must assume more accountability for ensuring that those served experience the best possible care (Dale, & Lee, 2016). Every organization must make effort to provide for the care of all patients that present, regardless of whether they are insured or not substance abuse and mental illness is not going away (HHS, 2017). It would be a proactive stance for the patient, community, and society at large for these facilities to initiate finding funding sources for the disadvantaged (Schneider, 2016).

This research was found to be invaluable in providing guidance to the service and care of persons in need of outpatient mental health services. The research presented here has shown that outpatient mental health services are much needed by many. In this study, it was believed that the gap in services was the result of inadequate education and funding. This information was a noted guide for service providers to be advocates and liaisons for many people not able to advocate for themselves.

Many of the studies reviewed are supported by empirical evidence-based findings (Hogg, 2018). While there are many different ideas regarding the most effective therapeutic components to successfully meeting the needs of individuals requiring extra community support, there is no question that the services are not enough (Peavey, 2019). As incidences related to mentally ill citizens or those with substance abuse disorders continue to consistently occur in the United States, the inefficient service model has created a dilemma which will become more apparent to those who are unaware of this situation (Ngui et al., 2010) Without systemic changes for the

benefit of those living with MHSUD, unmet needs will continue to grow (Hogg, 2018). Finally, this researcher believes the nature of this research was a beginning to a better, more sophisticated model of services that has captured important facts. The best interest of today's population of persons with MHSUD concerns requires that they be engaged to foster their active participation (Ngui et al., 2015).

An overview of the existing literature suggested deficits in education, isolation of mentally deteriorated consumers, and legal failures in providing services while avoiding a violation of their patients' rights. These findings are a small fraction of problems and solutions. More research will be conducted to provide an even clearer picture of the existing problems and services that have not been effective.

CHAPTER 3

METHODOLOGY

This qualitative interpretative analysis study was conducted at Serene Horizons Healthcare Center (SHHC), located in the north Texas region. A pseudonym was assigned to the participating research site. The researcher was required to comply with the Texas Board of Nursing and the Texas Board of Licensed Professional Counselors rules for conducting research. As a result, it was necessary to protect the identity of the agency and study participants. Compliance within ethical guidelines requires adherence to the FERPA guidelines. SHHC provides outpatient services to children. Participants for the study were from the adult demographic. Participation was voluntary and each person was informed of the purpose and their rights in the study when deciding to participate. Extra care was used to protect confidentiality for participants and the research throughout the study, as participants had family members in service with SHHC.

Purpose of the Study

The purpose of this study was to examine caregivers' perceptions on practices of outpatient behavioral health care to gain insight into components of ethical service application. The reduction of the increased mortality and suicide rate of children in the north Texas region (Smith, 2019) and the systemic problem of detention or incarceration due to a lack of treatment was a second objective (National Alliance on Mental Illness, 2019). Finally, attempts to inform research by addressing the limited treatment options to this population was a focus.

Findings helped inform research on available services, appropriate diagnosis of MHSUD, the prevention of needless suicides in children, and an increased awareness for the elimination in

unwarranted incarceration by practice law enforcement. In addition, acquired data on outpatient treatment from the viewpoint of caregivers offered a valuable perspective. The objectives to gain insight into components of ethical service practices, inform researchers and practitioners of an enhanced quality of care, and address the needed continuity of care were achieved.

Research Questions and Design

The following research questions guided documentation of practices deemed as both ethical and necessary in behavioral healthcare.

RQ1: What services have caregivers deemed as integral for outpatient program compliance?

RQ2: What services do caregivers attribute as motivational forces which encourage consumers to actively participate in available services?

An interpretative phenomenological analysis served as the research design which sought to address the research questions for this study. Further, the data yielded findings which aligned with and built upon previously existing research.

Site Information and Population

The study was conducted at an established health facility in the north Texas region. The facility was Serene Horizons Health Center (SHHC), which is a pseudonym for the actual facility. These provisions were established to protect the privacy of patients and to avoid violation of FERPA and UNE program guidelines. Study participants were caregivers to persons with MHSUD who have received outpatient care. The phenomena that emerged from data were interpreted by the researcher and yielded findings. Specifically, findings provided the perspectives of the patient through the caregivers' understanding and experiences.

The facility served children on an outpatient basis and provided outpatient health and behavioral health services. Programs were provided to individuals who attended voluntary. The

center at capacity served up to 500 individuals per week on an outpatient basis. The provision of outpatient services is based on patient need. There was an average of 100 patients served weekly on an outpatient basis in the clinic. The center is located within the city limits in the north Texas community, and is accessible by public transportation.

Sampling Method

To address the research questions for this study, the research design was an interpretative phenomenological analysis which encompassed structured interviews of participating caregivers of the consumers being served. Structured interviews with participants allowed the researcher to gain insight on information that might not otherwise be obtainable. At each stage of the study, a continuous review of research and relevant historical data were incorporated. The idea was to document aspects of the most relevant, effective, and innovative service systems that encouraged treatment compliance. Favorable components for quality and ethical services were noted.

Site permission to conduct research at this facility was granted by administrative leadership staff. This researcher served in an employment capacity for the SHHC where caregiver demographic and contact information was authorized for use by administration to access potential participants in this study. The research sample consisted of adult caregivers who were invited by email to participate in the study. The number of participants sought was 8 to 12. Eight caregivers volunteered to participate and were formally enrolled in the study. The active participants were asked to sign a voluntary consent form which included a notice of participants' rights. Confirmation that the participants were not actively enrolled in any behavioral or healthcare services at SHHC was secured. Before scheduling the interviews, a designated meeting area was determined which was safe, comfortable, where privacy and confidential information could be discussed, and was conducive to performing interviews. Using their

preferred method of contact, participants were reached by this researcher to schedule the interview. Again, the sample consisted of caregivers for consumers receiving outpatient behavioral healthcare. The interviews were recorded using an audio voice recorder.

Instrumentation and Data Collection Procedures

This researcher conducted interviews and analyzed the perceptions of participants. Structured interview questions were used to guide the data collection. The inquiry encompassed a qualitative interpretative phenomenological analysis (IPA) which allowed the researcher to make sense of the participants' lived experiences through caregiver responses. Roberts (2010) described IPA as the method to attain the experiential perspective of a study participant. Creswell (2007) noted that the IPA assists the researcher to describe commonalities between study participants' lived experiences of a phenomenon or concept.

Data collection tools entailed documentation using paper, pens, an audio voice recorder, and pre-established interview questions. An individual file was compiled for each interviewee to capture and store other relevant data related to participants' lived experiences. Structured interviews and vignettes were employed to collect information on components of ethical behavioral health care. The interpretive phenomenological analysis captures lived experiences on the participant's terms (Smith, Flowers, & Larkin, 2009).

Interviews lasted 30-40 minutes. The interview questions were designed to gain insight that informed research and filled gaps in the literature. There was value in establishing a rapport with each participant before beginning the interview as each shared openly. Alase (2017) noted that building a rapport with the interviewee will enhance information sharing. Smith et al. (2009) noted that, when a bond is developed with the participant through interacting, the relationship allows for the smooth gathering of information. The first few minutes of each

interview allowed the participant to share observed experiences related to the persons with MHSUD in which they cared for. Pre-established interview questions were the same for all participants and were presented in the same order during each session.

Data Analysis

Analysis of the collected data began with transcribing the interviews from the audio recorder to paper. After all data were transcribed, the transcripts were read two additional times for clarity. Graneheim & Lundman (2004) suggested reading the transcripts at least three times to comprehend what is said. The familiarity with common themes and concepts results in a better understanding of the perception of caregivers for those served in outpatient health settings (Graneheim & Lundman, 2004). Creswell (2007) detailed the IPA process as follows:

- 1) Each interview will be read to gain an understanding of the experiences.
- 2) Each interview will be reread two additional times to begin noting the assigned meaning to concepts.
- 3) Concepts are coded by breaking down interviews into manageable segments.
- 4) Themes common to participants will be assigned.
- 5) Accuracy checks ideally with the participant and a peer will be completed.

Conclusion

The literature has offered a wealth of information regarding innovative practices which were found to be beneficial to the MHSUD providers and community. The problem of practice for this study emphasized caregivers' experiences with outpatient behavioral healthcare services. The increased mortality and suicide rates of children compounded by unwarranted introduction to the justice of adults provided a backdrop for this research. Recognition exists that failed social service systems early in one's life may eventually be actualized in the adult criminal justice systems. This researcher was pleased to see the compiled research filled gaps in literature

and guided reduction of the ineffective practice of incarceration as a substitute to inadequate services in the north Texas region. In addition, the valuable strategies learned from the various literature resources were very informative.

Ngui et al. (2010) proposed the following ideas as solutions to the world's mental health epidemic: "Local services in the community would minimize negative social stigma; agencies in the community can exercise effective resource management of mental disorders, and advocacy can assist individuals to contribute to one's quality of life" (p. 7). There are many dynamics involved when treating a population of individuals who are generally at higher risk for adverse events and advocacy might assist to fill the gap (Ngui et al., 2010). A realistic look at services in the north Texas region suggested in a state with 254 counties, behavioral health services are far from adequate and in some rural counties, often non-existent (Hearvey, 2019). A long-time topic of debate has been the best direction to take in dealing with persons in the criminal justice system who would be better served with alternatives to incarceration.

Documentation reflected the lack of services for persons with MHSUD is crippling their abilities to function at their full potential (HHS, 2017). It was determined that new and valuable knowledge has been gained. Particularly, viewing services through the eyes and experiences of participant caregivers has offered information not previously documented. As previously mentioned, one of the objectives of this research was to identify useful components of outpatient behavioral health, which has been shown to increase consumer participation. Secondly, establishing protocols and services consistent with practices of ethics and continuity of care was key. Finally, providing information and facts transferable to other health care entities was useful information to address what was identified as a crisis for Texas. Service quality can also be enhanced.

CHAPTER 4

RESULTS

Roberts (2010) has asserted that qualitative research is based on the philosophical principle of phenomenology, which is attained from an individual's experiential perspective. As a result, an interpretative phenomenological analysis was employed to examine caregivers' perspectives of outpatient behavioral healthcare in the north Texas region. Services provided by organizations in this and other regions has been detailed in the review of literature. Both the site and participants in this study are reflective of other regions. The setting was the Serene Horizons Health Center (SHHC), a pseudonym for the actual clinic, located in the north Texas region. The center provided outpatient health and behavioral healthcare to children. The assessment of existing practices was performed in effort to identify factors that to enhance service delivery to consumers needing care for mental health and substance use disorders (MHSUD).

The purpose of this study was to examine the practices of providers in outpatient behavioral healthcare for the north Texas region. Efforts to gain insight into the components of ethical service delivery for the continuity of care was one objective. Structured interviews were used to obtain first-hand perceptions and experiences from the viewpoint of those who supported persons with a MHSUD. The assessment tool was a pre-established set of interview questions, which were prompts of inquiry intended to generate information to fill a gap in existing literature. Further, the interview process was geared towards directly addressing the research questions guiding this study. To gain an understanding of the lived experiences of the participants and their loved ones, the following research questions were posed:

RQ1: What services have caregivers deemed as integral for outpatient program compliance?

RQ2: What services do caregivers attribute as motivational forces which encourage consumers to actively participate in available services?

Data Collection

Site permission to conduct research at this facility was granted by administrative leadership staff. Data was gathered over a period of six weeks at SHHC. This researcher was employed as a registered nurse for SHHC. One aspect of job responsibilities entailed establishing a file for family contact of consumers receiving services. The file contained caregiver demographic and contact information which was readily accessible to the individual in the nurse role. The administrator authorized use of this information for the purpose of obtaining research participants. Serving in this role at SHHC and administrative authorization to invite caregivers to participate provided a resource pool. The research sample consisted of adult caregivers who were invited by email to participate in the study. The goal was to obtain 8 to 12 respondents. Invitations to inform on the purpose and nature of the study were sent out to fifty-two caregivers who had emails on file. Invitees were asked to respond by email if interested in learning more about the study. For each respondent who expressed further interest, the potential participant was asked to provide more information. Specifically, their cell phone number, two days of availability, and a time frame of one hour on each day was requested. Each respondent was texted one of the two times for the confirmation of an initial phone contact. During the call, the respondent was educated on the purpose and goal of the research study and given details on the format for data collection. Voluntary respondents who expressed an interest in proceeding were provided a statement informing there would be no consequences for non-participation.

Further, there would be no actions taken to prevent access to services they would normally obtain regardless of participation. Each participant who volunteered to proceed in the study was formally enrolled and asked to a sign consent form that included subjects' rights. Confirmation that no respondent was actively enrolled in any behavioral or healthcare services at SHHC was secured. Before scheduling the interviews, a designated meeting area was determined which was safe, comfortable, private, confidential, and conducive to conversation. An appointment was set for a face to face interview with each participant. There were two successful in-person interviews and the remaining six were conducted via Facetime. The University of New England's Institutional Review Board mandated precautionary measures to avoid personal contact, in response to the COVID19 virus precautions. The interviews were recorded using an audio recorder, then transcribed, and saved in a Microsoft Word document.

The Creswell (2007) model for managing data offered thoroughness and was adapted for this IPA study. The data was only handled by the principal interviewer. Each participant file included the voluntary consent, the patient rights statement, the set of vignettes, the interview questions, and the manually transcribed responses. Files were numerically coded, kept in a locked box, and placed in a locked cabinet. Throughout the coding process each recording was listened to and reviewed against the transcripts several times for accuracy and to remove any details which might divulge personally identifiable information or violate confidentiality. After several reviews, the final transcripts from interviews were provided to the participants by email for member checking and to allow for clarification/corrections. In addition, a copy of each transcript was provided to the research affiliate for a peer review check. There were no noted requests for revisions to the transcripts by the participants nor the research affiliate.

The participants' demographic information was collected and listed in a chart to identify the characteristics of the cohort for this study. The participants ranged in age from 22 to 49. No data regarding the exact relationship between the caregiver and person in treatment was collected for reporting. All the participants in the study were female. Based on this researcher's daily interaction with caregivers, it was determined that the participants in the study were representative of the parental/immediate caregiver participation for most other clinical events. There were six participants who were Black or African American, the race was listed as it was reported, and no inquiry was made to clarify distinctions. One of the participants was Hispanic, and one was White. See the demographic characteristics of the participants in Table 4.1.

Table 4.1

Demographic Characteristics of Study Participants

| Demographic Characteristics of Study Participants | | | |
|--|------------|---------------|------------------|
| Participant # | Age | Gender | Race |
| Participant # 1 | 30 | Female | Black |
| Participant # 2 | 22 | Female | Hispanic |
| Participant # 3 | 35 | Female | Black |
| Participant # 4 | 46 | Female | Black |
| Participant # 5 | 30 | Female | White |
| Participant # 6 | 56 | Female | African American |
| Participant # 7 | 39 | Female | Black |
| Participant # 8 | 49 | Female | Black |

Vignettes to Establish Participant Understanding of the Concept of Ethical Practices

Each participant's interview was preceded by the presentation of three vignettes followed by three possible responses. Each presented a scenario that may occur in a clinic. Vignettes were formulated by the principal interviewer as a standard method for assessing the participants' understanding of the concept of ethical services. Vignettes were used to ascertain the depth of understanding each participant had regarding what constituted ethical services. Education through a pre-established script would be provided if the participant failed to respond to scenarios in a manner demonstrating a clear understanding of the concept. Responses to the vignettes were then evaluated to determine the participant's level of understanding of ethical practices. Of the eight participants, each person communicated a clear understanding of the three examples. Consequently, there was no need to elaborate on defining the concept for the participant to have a baseline understanding of the focus in the study. One participant did not agree with any of the options for one of the scenarios. Her ideas were noted on the form and a sample is detailed (Appendix C). The research questions served as a basis to establish the focus of inquiry for study participants. The interview questions were pre-established, though participants were given an opportunity to share additional thoughts and ideas. The lived experiences of the participants and their loved ones were captured using an audio recorder.

Thematic Development

Repetitive words or phrases were highlighted and when the data was reviewed those with multiple mentions were designated as themes. For example, words or phrases such as caring staff, flexible to consumer needs, exactly what we need, or always available led to the establishment of a service theme. There was a total of three predominantly emerging themes which consistently emerged during the study. There were five sub-themes which presented less

often, though they were still significant. There were eleven codes which were the basis of the themes. The added value of rereading the transcripts was evident. When rereading them, themes emerged which had not been noticed previously. The transcripts were forwarded to the participants for member checking. In addition, they were sent to the research affiliate for a peer review. There were no concerns, requests, or suggestions for a revision to the transcripts, so the unaltered documents were then added to member files. After the member check and peer review, each audio recording was destroyed. The transcribed data was the resource to complete analysis.

Each code was analyzed in a manner consistent with the layout of the emerging themes. The three emerging themes, five sub-themes, and eleven codes are detailed in Table 4.2.

Table 4.2

Presentation of Main Themes

| Emerging Themes | Sub-themes | Linguistic Responses | Codes |
|--|--|---|--|
| <p><i>Accessibility</i></p> <p>Access to the center without barriers</p> <p>Referral to other organization or service commonly used</p> | <p><i>Resource</i></p> | <p>Participant # 4 “If therapy was any further, we would not be able to go there.”</p> <p>Participant # 2 “I lived in a different town, no provider that I knew about lived in my town, you had to have a car.”</p> | <p><i>Transportation/ Geographic</i></p> <p><i>Financial concern</i></p> |
| <p><i>Professional Conduct</i></p> <p>The manner served to reflect a code of conduct</p> <p>An unacceptable action in providing service</p> <p>Sense of security assist to reduce feeling of ill at ease</p> | <p><i>Positive and Negative Conduct</i></p> <p><i>Emotional Safety</i></p> | <p>Participant # 3 “The doctor said I can’t keep changing medicine every time, we switched to another doctor.”</p> <p>Participant # 5 “My child is better because of the right medication and therapy”</p> | <p><i>Supportive</i></p> <p><i>Strong values</i></p> <p><i>Motivating</i></p> |
| <p><i>Service</i></p> <p>A factor which assist in learning for one party</p> <p>An act performed as best practice</p> <p>Factor has a direct relationship on a result</p> | <p><i>Education</i></p> <p><i>Causal Relationship</i></p> | <p>Participant # 6 “But if my child gets all that he needs, distance doesn’t matter.”</p> <p>Participant # 8 “The counseling has helped him become more active in sports and peers.”</p> | <p><i>Caring staff</i></p> <p><i>Flexible to consumer need</i></p> <p><i>Exactly what we need</i></p> <p><i>Puts consumer needs first</i></p> <p><i>Always available</i></p> <p><i>Offers flexible hours</i></p> |

Implications

The themes that emerged from the data are identified in the table above. There were three primary themes which possessed commonality. Each of the themes directly impacted the resolution or outcome of the presenting condition. For example, a consumer who has been referred to a behavioral health center may be advised by a school counselor to obtain a mandatory assessment. If there is no clinic which is accessible by location or cost is prohibitive, it is unlikely the concern will be addressed. Similarly, if a facility is accessed and there is a concern that staff are insensitive or unprofessional the opportunity for progress is limited. When no other barriers to service exist, a center that is not accepting new patients leaves little hope for a positive outcome. The participants shared experiences which developed as themes of ideal conditions in behavioral health settings. These concepts of accessibility, professional conduct, and quality service were the three main themes described through the lived experiences of the caregivers in their own personal way. Creswell (2014) provided categories for themes as described them as ordinary, unexpected, hard classification, and major or minor. The major themes resulted in major ideas and minor themes were secondary ideas. For this study there were five minor themes/sub-themes.

The lack of services was identified as being the result of a limited availability of qualified providers or services (Baker, 2015). Accessibility resonated throughout this study as an issue due to financial circumstance or geographical location. In addition, one participant mentioned the concern there are not enough doctors. Her perspective coincided with reports in existing literature.

Professional conduct was shared equally to accessibility and all participants reflected on their experiences. References were made to the loved ones receiving the best possible care or

exactly what they needed. One caregiver shared, “If my child gets all that he needs distance does not matter”. Another caregiver shared, “The neurological referral was what I needed to feel confident that speech therapy would be useful”. The value of providing services in an ethical manner was not new to the behavioral healthcare field. “For the protection and welfare of persons and groups with which the professional work, psychologists are urged to abide by the aspirational goal of encouraging ethical behavior by students, supervisees, colleagues, and employees” (Fisher, 2009, p. 459).

Service, too, was identified as equally important as accessibility and professional conduct. Fisher (2009) noted, “Staff can be helped to understand their job responsibilities and the limits of their responsibilities; and they can be encouraged to take initiative, but not step beyond their job description” (p. 459). The participants in the study provided many examples of the desired qualities of service in their current treatment settings.

Theme 1: Accessibility

Access to the center without barriers was related to physical barriers such as transportation; financial barriers such as not having insurance or an inability to pay for services; and the lack of availability of services within a reasonable geographic area. All eight of the participants noted accessibility as very significant. This barrier served to support existing research and confirmed accessibility continued to be a gap in services.

Baker (2015) shared accessibility as being the most common cause of a lack of behavioral healthcare. Hogg (2018) noted there are many persons who do not access services because they do not have means to access the same level of care as those who are insured. Each participant gave a perspective regarding the effects of barriers for the services needed by their family. Participant # 2 shared, “I lived in a different town and then we moved, but it still was a

different town, so I drove there.” Another mentioned, “You had to have a car to get to the clinic, there was no provider that I knew about in the town I lived.” Participant # 7 noted, “These mental health services can be very expensive no matter how much money you make, some people’s only way around could be public transportation.”

Sub-theme 1: Resource. Resource was identified here as an entity which may provide a referral to another organization or service commonly used by the population served. Three of the eight participants referenced topics related to this theme. Much of the expressed dissatisfaction with former services was the result of an inadequate resource referral. Respondents noted either a clinic was closed or the interaction with staff was less than desirable. Participant # 3 identified having limited resources personally. To meet some financial needs, she braided hair on occasion. In addition, she noted that many people who received assistance through SHHC were poor. Resources were an important dynamic for caregivers not knowing when loved ones would experience challenges. Participant # 4 expressed an appreciation for assistance with crisis situations and even posed the question, “Where else would you go for help?”

Theme 2: Professional Conduct

Professional conduct was identified here as the manner a person was served and treated to reflect a code of conduct. The affiliation was important as the nature of the professional relationship placed the loved one, and likely the caregiver, in a vulnerable position. There must be a trusting relationship. Ngui, et al. (2011) shared, “Ethical implications of inequalities for people with mental health are profound should address respect, justice, beneficence, and non-maleficance” (para. 1). The benefit of receiving support may result in contributors to society taking advantage of services, participation in programs, and exercising their autonomy through wellness activities which are valuable to success (Bayer et al., 2006). Similarly, the caregivers in

this study reported their loved ones actively participating in services and associated the participation as exhibitions of autonomous actions. One caregiver noted, “The teacher expressed difficulty my son was having sharing and interacting with other children, the service was so great my son has play dates with two children from therapy.” Still another respondent shared, “My son quit taking his medication and realized he was getting into more trouble, so he asked to be put back on his medication.” These are just two incidences of findings in this study which both supported theory from previously existing research, as well as contributed new information on perspectives and lived experiences of the participants. The value of the findings reflected useful facts which filled gaps in existing literature. The accounts shared enlightened previously unreported accounts of the benefits to receiving ethical behavioral healthcare.

The professional conduct theme showed to be as valued by the study participants as the theme of accessibility. One participant expressed many positive experiences related to the professional services that have enhanced the quality of her child’s life. Participant # 4 shared sincere feelings in stating, “Psychotherapy allows my daughter to be open, she is vulnerable and making progress.” Participant # 5 attributed the empowerment in her child to the right medication management and the comfort level the child has with the therapist.

Sub-theme 1: Positive or Negative Conduct. This sub-theme was identified here as an action which is or is not acceptable practice when providing service to a population. Three of eight reflected on experiences related to the conduct of behavioral health staff. Tasioulas and Vayena (2015) noted that public health ethics are based on moral foundations and ethical challenges which are raised due to limited resources for health promotion. Participant # 3 shared this experience, “My son was misbehaving at school and the doctor raised his medicine, but then the medicine was too strong, and he was sleeping all day at school. I went back to the doctor and

had to wait a long time, then the doctor said we need to make up our mind because she can't keep changing his medication on every visit. We switched to another doctor.”

Professional conduct is generally guided by professional standards as alluded to previously. This study, however, has indicated appropriate ethical conduct is not always a given. Participant # 5 noted, “When you try to find other providers and you explain your experiences people get rude, we have worked with incompetent people in the past and it was very frustrating.”

Sub-theme 2: Emotional Safety. Emotional safety was described here as a factor or service which provide a sense of security and may prevent those served from experiencing the feeling of ill at ease. Three of the eight caregivers expressed their thoughts and their perceptions on emotional safety and described experiences which closely aligned with professional conduct. It was shared by one participant that it is expected for loved ones to feel and be safe in a facility providing medical and behavioral healthcare. Participant # 3 perceived the clinic's play area as safe for her child to play because it was always clean. Participant # 4 noted, “The setting is safe to open up and share” in describing experiences about the therapy sessions.

Theme 3: Service

Service was described here as an act performed which is best practice for the population served. This theme resonated in each of the eight participants' interview responses. Participant # 2 shared mental and medication services, comfort with the doctor, and the ability to come in on short notice as important. She was not happy to learn that her past doctor had retired and noted, “My sister saw the doctor I had, now he's retired and the new doctor is not good, there needs to be a push toward better training.” Participant # 3 was pleased that she can see the doctor, get the prescription, and get it filled at the center instead of going to the pharmacy. In this way, the provision of services that affords the end-user with the convenience of a single location also

provided emotional and physical support. In addition, she noted, “Service should be the same in quality in any health or behavioral health setting.” These accounts of experiences shared by the caregivers have provided examples of the benefits to a continuity of services. The consistency in care offered a sense of reliability, which is support.

Sub-theme 1: Education. Education was described here as a factor which assist in learning for one party. Two of eight participants provided feedback that led to the identification of this sub-theme. Participant # 2 reflected on her son not wanting to take his medication. She shared he learned the value of it the hard way and noted, “He realized he was getting into more trouble and asked to be put back on his medication.” Participant # 8 was adamant that the failure in services to the MHSUD population was an issue and noted, “There must be an awareness of services through preventative care and outreach, because if people don’t have knowledge, they don’t access services.” The provision of learning opportunities to the consumer provided new ways to approach challenges for the consumer and most likely the caregiver. When it was assumed that knowledge existed related to a subject, it resulted in uncertainty or misinformation to the person receiving service.

Sub-theme 2: Causal Relationship. A causal relationship was described here as a factor which has a direct relationship to a result. The premise of the correlation was much like an “if then” result where a consequence was the result of a previous action. For example, if a person reports feeling depressed, the provider is better able to alleviate symptoms through cognitive behavioral therapy and medication therapy if warranted. For this theme four of the eight participants focused on experiences which resulted in another occurrence. Participant # 7 provided related input and shared what she did not understand prior to therapy, “I found out from the therapist he was having separation anxiety from his dad moving out and he was depressed.”

Participant # 8 related to this theme and shared, “The counseling has helped him become more active in sports and peers.” Participant # 7 also discussed concerns regarding a therapy center in her zip code and began to reflect on the stay home directives to minimize the spread of the virus. She noted, “I should be thankful for anything we still have; we have to give thanks and pray about all that we do have.”

Conclusion

The goal of this study was to examine current ethical practices of providers in outpatient MHSUD clinics for the north Texas region. Findings based on the experiences of the eight participants suggested ethical service delivery was a necessary component of quality. The participant who was displeased with services opted to take their business to another clinic. Of the expressed displeasure no negative connotations nor complaints were about SHHC. Each shared negative experience referenced a former clinic or another existing clinic, all of which were accessed after a referral. If random referrals were made to other services without knowledge of quality the risk for falling through the cracks existed. Hogg (2018) found that, when people fall through the cracks, they are already at a disadvantage by not having access to the same level of care as those who are insured. Although a clinic leader may not perform the care, it would be most beneficial for there to be tools in place to guide the consumers through services, resource assistance, and referrals. The participants expressed a common sentiment their child was getting the best service or the service they needed. Factors such as service, professional conduct, accessibility, resources, educational enrichment, positive relationships, and some degree of safety were identified as important.

CHAPTER 5

CONCLUSION

The purpose of this interpretative phenomenological analysis (IPA) was to examine practices of outpatient behavioral health care to gain insight into components of ethical service application. Effort was made to address systemic unwarranted detention of the mental health substance use disorders (MHSUD) population due to the lack of treatment. The prospect of discovering alternative or even amenable service solutions for consumers with mental health and substance use disorders was the underlying motivation for this study. Sutton (2019) noted that an IPA is focused on understanding how the participants subjectively experience their world. The nature of this study sought to gain in-depth accounts of lived experiences from front line stakeholders, the caregivers. The interview process unveiled lived experiences of the caregivers which were observed and reported as the actual experience of the loved one. The selection of the IPA has proven to be an effective research design for this qualitative study. The results of the research questions which established the guidelines for the interview prompts were as follows:

RQ1: What services have caregivers deemed as integral for outpatient program compliance?

The interviews revealed all eight caregivers shared similar perceptions regarding defined integral requirements to support consumer compliance with needed services. Further, the caregivers identified positive professional conduct and consistency in working with the same service provider as beneficial in supporting consumer engagement and confidence. Each participant also established that the quality of the assistance/intervention and proximity of the clinic to private or public transportation options as a key to the success of their loved one's engagement with needed/required services. Responses from all participants identified service

quality, high levels of positive professional conduct, and accessibility to consumers as necessary for the success of the clinic as well. Liegeois & Van Audenhove (2005) noted the quality of services should empower individuals by assisting them in being active members of the community. Key ideas posed by study participants with respect to their definition of successful intervention were described as clinics that employed caring staff who were flexible to consumer needs, available for crisis, and offered flexible hours.

RQ2: What services do caregivers attribute as motivational forces which encourage consumers to actively participate in available services?

Each of the respondents contributed to the research through sharing their lived experiences that pertained to clinical assistance and service provision. Overwhelmingly, the response to this question was the impact of the positive, supportive relationships established while engaged in services. Particularly, two caregivers expressed the relationship with the provider as the reason for their loved ones' social and emotional growth, interest in extracurricular activities, and increased interactions with peers. Additionally, two participants expressed excitement to see their loved one had established healthy relationships as they made friends with peers from their group sessions. The skills reported to have been demonstrated to the caregivers by the loved ones in services added value to this study. Several participants reported opportunities to learn and grow in a safe environment. Other key ideas which were expressed were the caregiver's impression that the provider cared for consumers through being supportive and motivating. This was illustrated during interview responses such as, "When I can access the therapist to get support it is a real deal breaker." Another caregiver shared, "I think the success of a clinic depends on caring customer service and the availability of staff when you need them."

The themes that emerged from this study identified experiences of a cohort of eight caregivers who experienced behavioral healthcare through their loved one's services. The initial goal of obtaining ten to twelve participants did not manifest most likely due to a limited pool of respondents. All respondents were from the Serene Horizons Health Center (SHHC), a pseudonym to protect the privacy of consumers served, the caregivers, and the facility. The response rate to the participation request was 15% of the caregivers invited. The ethnicities served at SHHC were predominantly African American or Black, Hispanic, and White. The participants were representative of the racial make-up of consumers served at the clinic. There was no formal inquiry to determine the percentages of the actual diversity for the population being served. It is believed by this researcher that the sample group is closely representative of other schools in the north Texas region based on report from the organization's registrar. Her department compiles and reports statistics annually. Therefore, findings were generalizable to some degree when not considering the gender makeup of the participants. All the volunteer participants were female. The dominance of the female participation was consistent with existing interaction from the clinic nurse role for obtaining authorization for treatment, medication, and other daily concerns.

Effort to gain insight into the components of ethical service delivery for the continuity of care was a primary objective. The reduction of the increased mortality and suicide rate of children in the north Texas region (Smith, 2019) and the systemic problem of incarceration due to a lack of treatment (National Alliance on Mental Illness, 2019) was the second objective. Finally, attempts to inform research for resource provision, by addressing the limited treatment options to this population, were focal points.

Structured interviews were conducted to obtain firsthand perceptions regarding experiences of caregivers who supported consumers with MHSUD. Prior to now, this researcher's efforts to find studies detailing first-hand accounts of the lived experiences from the caregiver standpoint were unsuccessful. Instead, findings in the literature review yielded innumerable studies which reflected the perspective of behavioral healthcare providers and organizations. Introducing a new perspective to existing research and the behavioral health community has provided opportunities to better address consumer needs. Furthering research by adding previously unidentified perspectives from caregivers was also useful to benefit the research and support community. The findings contributed to enhanced service delivery through participant feedback. In addition, personal perspectives of effective practices have informed research for the north Texas region and society at large.

Interpretation of the Findings

Each participant interviewed was presented with pre-established prompts. Any dialogue more than the prompts was recorded and documented in the actual interviews (Appendix C). Several themes emerged from the interviews with three main theme and five sub-themes. The main themes were shared more often and with more detail than the sub-themes. The participants were very open and shared both positive and negative experiences regarding their perception of the treatment and services received.

Interpretation 1: Accessibility

Accessibility resonated throughout this study as an issue due to financial circumstance or limitations with geographical location. In addition, Participant # 3 mentioned the idea there are not enough doctors available to the consumer. Her perspective aligned with findings in the existing literature. The lack of services in the north Texas region was identified as being the

result of the limited availability of qualified providers or services (Baker, 2015). Statistics for Texas in 2018 did not show promise for increased service delivery or availability (Hogg, 2018). It was noted that half of the licensed psychiatrists and social workers and more than two-thirds of the psychologists practiced in the five most populated counties (associated with large urban centers), leaving 249 counties without local behavioral health services Hogg (2018).

Interpretation 2: Professional Conduct

Positive professional conduct was equally aligned to the reporting of the need for accessibility and all participants detailed experiences that supported their claims. References were made to the loved ones receiving the best possible care or “exactly what they needed”. Again, psychologists are urged to adhere to the aspirational goal of encouraging ethical behavior by students, supervisees, colleagues, and employees and to enforce the protection and welfare of persons or groups with which they work (Fisher, 2009). Positive professional conduct was established as a necessary component for quality care with respect to the consumer’s treatment. This is supported through prior research which emphasized that operating under professional codes of conduct would be most beneficial to the patient and the provider (Schneider, 2016). Participant # 2 described professional conduct as: “The provider treating a person whether they have insurance or not, just helping no matter what.”

Interpretation 3: Service

The importance of the quality of service, was aligned with the importance of accessibility and professional conduct. Fisher (2009) noted staff can be guided to understand their job responsibilities as well as its limits; and they can be trained to take initiative without overstepping boundaries. As identified earlier professional conduct was related to the manner in a person is served to reflect a code of conduct. Staff persons working in behavioral healthcare

must take certain liberties to ensure the needs of vulnerable consumers are met. Care must be used to refrain from violating the rights of the individual. For example, a consumer may be court-ordered to take medications in an inpatient hospital. If the person refuses the medication, they can be given the medicine by injection which may require a brief hold by staff, just long enough to administer the medication. However, the same consumer may refuse to eat and has the right to do so. Staff may only perform within specified guidelines which are ethical and legal. The administration of high quality, ethical care was deemed as necessary and was communicated through descriptions of experiences. Participant # 6 shared that her son takes medication, speech, and occupational therapy through their clinic and noted none of those are as important as the referrals and support benefits, he receives from SHHC services.

Implications

The interpretative phenomenological analysis (IPA) design was chosen to evaluate data obtained for outpatient behavioral healthcare in the north Texas region. The implications from the findings are that there are several factors necessary for successfully treating consumers. The newly obtained data supported existing research and indicated accessibility to services remains a relevant concern as well as a barrier. The barrier has a two-fold effect: it limits which services are accessible to the MHSUD community as well as choices in the quality and scope of services. Fortunately, there were no reports to reflect any dissatisfaction of behavioral healthcare services at SHHC by the study participants. Even if a caregiver was not pleased with any aspect of the services identified at SHHC, there are no other providers for behavioral healthcare in the same geographical area.

Previous research noted providers of mental health and substance abuse services believed existing systems had done well in managing conditions (Edmunds et al., 1997). Although the

research sharing this perspective was dated, it added some consistency to the perceptual claims made by participants in this study. Clearly, there was significant experiential information that filled some of the gaps in literature. Particularly, outpatient behavioral healthcare was presented from the experiences and perspective of caregivers. Given that persons receiving treatment for MHSUD were a protected class in research, there does not seem to be a better resource to obtain the information gathered via these interviews. This study has yielded data and provided a collective resource for those seeking services, researchers seeking to enhance these findings by furthering this study, and for improved service planning.

Review of Frameworks in Support of the Study

The conceptual framework for this study that guided the research was the importance of ethically treating consumers with mental health and substance use disorders. Each person's dignity and respect should always be maintained (Ngui et al., 2010). In addition, the conceptual framework for this study was based on the idea of service to one consumer at a time; the provision of service should be tailored to the consumer's needs; the consumer should be included in the establishment of a treatment plan; and all medical and behavioral health organizations should be trained and equipped to handle any situation (Hogg, 2018). Communities must recognize services should be accessible across each segment where health care will be sought, as consumers may present at outpatient mental health clinics, hospitals, primary care facilities, and even jails (Ngui et al., 2010).

The theoretical framework guided the research through an understanding of general principles which should be included to enhance the current services to the MHSUD population. The framework offered a model of what could be considered necessary supports for effective behavioral health systems. A group of psychiatrists focused on collaboration of services made

the following recommendations: supporting the patient to modify their lifestyle by increasing physical exercise and consuming a better diet; educating on the idea of mind and body through meditation; introducing products that may be natural, safe, affordable, and useful medications for common illnesses that will not have contraindications to psychiatric medications; and making therapy more accessible (Edmunds, et al., 2017). This model offered a holistic perspective which is often referred to as “wrap-around care” in behavioral health settings. The premise was based on the idea of meeting all possible needs which have shown to be deficient. In addition, it addressed services which increased the likelihood a consumer would have ideal continuity in services. Ideal services should yield voluntary program compliance, success to clinics, and better outcomes for behavioral healthcare.

Recommendation for Action 1: Accessibility

The concern regarding accessible service was a multifaceted dilemma. The participants in this study identified accessibility as a priority though none are currently experiencing this problem. If there is going to be a decrease in failure to access services, high level intervention is required. In 2019, \$745 million dollars was allotted for behavioral health services in Texas (Peavey, 2019). A portion of that funding should be dedicated to funding the establishment of one organization as the permanent mental health authority of Texas. Within that organization, the establishment of zones should be mapped out to include even the most remote geographical locations. Current zones exist though travel for many is more than one hour each direction. Dedicated funding to zones which have no access to behavioral health services should go toward recruiting and procurement of services and providers until those organizations can become self-sufficient.

Recommendation for Action 2: Professional Conduct

Again, the provision of training to staff interfacing with health or mental health concerns is imperative. Persons who present for behavioral healthcare may appear to be disoriented or difficult to manage. It is the responsibility of each staff person to interact appropriately or if necessary, ask a colleague for assistance with a consumer. The consumer should be professionally handed off to a staff person who has been informed and equipped to address the dynamics of the case. This practice should exist in all facets of care as it will support the opportunity for the consumer to receive the deserved treatment.

Recommendation for Action 3: Service Delivery

Again, given the nature of behavioral healthcare it is safe to assume that many who present for care may demonstrate an altered mental status. Therefore, staff who serve in healthcare and behavioral health care should be provided training specific to the needs of consumers. All staff should be prepared to address consumers presenting alone or accompanied by others, with the level of care required for their condition. In the behavioral health arena, there are state mandates that a person presenting must be assessed and stabilized before they can leave or transfer to another facility. With the stabilization comes the potential that the consumer may not have insurance. Again, funding allotted for behavioral health care will be required to maintain quality services and access to ethical care.

Recommendation for Further Study

In consideration of the findings for this study two areas of concern warranted recommendations for further study. The value of continued research could offer much needed care to those who might not otherwise receive it. The first recommendation is related to the limited number of respondents, single clinic participation, dichotomous gender representation,

and more racial diversity. The second recommendation is for providers to take the initiative to become informed on care for consumers with MHSUD.

Recommendation 1

The participation of caregivers was eight, which resulted in a limited respondent rate. The eight participants were sufficient to be within the recommended sample sizes for IPA research. A future study, however, should seek to recruit from a larger prospect base to include more than one clinic site offering diversity by gender and race and a larger population to seek respondents from. In addition, a better determination of generalizability would be the result.

Recommendation 2

Prior actions to overhaul the existing system have not shown enough change to counter the excessive numbers of untreated consumers noted in the literature review (Hogg, 2018). Each provider of medical or behavioral health services should take it upon themselves to be informed and educated on effective practices to ethically provide quality care. There are smaller systems in place that have provided care to consumers and families for many years. The National Alliance for Mental Illness (NAMI) is a very good resource to learn more about services targeted at putting the consumer first (Gately, 2017). In addition, free continuing education courses are available at <https://www.Texashealthsteps.com>. On this site, classes are offered as modules and generally offer a certificate for course completion.

Conclusion

Addressing the gap in literature regarding treatment of persons needing behavioral health contributes to the solution of consumers going without services. The population of consumers who are not currently in services for behavioral health care did not have a voice in this study. This study identified various reasons people access services as well as reasons they choose to

discontinue services. Many constructs, indicative of quality service, are both spelled out and actualized through an organization's mission and values. Where quality and ethical programming exists, there will be ample evidence of successful service provision seen in the care for consumers and their loved ones. Again, it was best stated in one study that a reduction in the impact of treatable behavioral healthcare conditions is their overarching goal at the Substance Abuse and Mental Health Services Administration (SAMHSA, 2019). Placing this goal as one which is universal would certainly be a positive step. Subsequently, the call for putting an end to stigmatism, social isolation, victimization, and incarceration is a key element at the forefront of failed systems of care (World Health Organization, WHO, 2015). These reports suggested the needs of the untreated MHSUD community are expansive.

Service provision will require reorganization of approaches at the most basic community levels. Interagency education and collaboration to form behavioral alliances will be needed at the mid-level. Lobbyists and stakeholders must create a sense of urgency within legislative bodies to support legislative changes that address behavioral intervention and supports. Again, as described by Kotter (2008), when a true sense of urgency does not exist, the potential for change is doomed.

Intermediate models such as collaborative care seem feasible. It was suggested that more work with behavioral healthcare in primary care settings might be an early solution (Hogg, 2018). Jané-llopis et al. (2011) studied mental health concerns and operated from the idea that mental health has not been treated as a societal problem, but more of an individual problem. An individual needing behavioral healthcare may or may not operate with use of logically or socially appropriate mental and physical ability. The individual who requires assistance from an outside source may or may not have a caregiver. In the instances where there is no caregiver, the

wellbeing of the individual may fall to community members, schools, hospitals, or even grocery stores to name a few. The need for help will likely present away from the consumer's home. It will require a different approach than identifying the service need as an individual problem.

The health promotion perspective for effectively treating mental illness included: educating parents to foster well-being in parent-child relationship at home, assistance in providing support in schools at all levels of education; assisting working individuals or those desiring to work to realize and train for occupational goals; and making a full-service continuity of care model (Ngu et al., 2010). Ideal full-service care was identified as a network of providers armed with verified resources and referrals to address the impending behavioral healthcare needs. (Baker, 2015). These practices are evidence-based and should receive serious consideration in efforts to better serve consumers in this region.

This study is merely a beginning in the researcher's personal efforts to work toward the establishment of better behavioral healthcare resulting in well consumers and better qualities of life. The United States and the world are currently in crisis due to the spread of the COVID19 virus. The mandates politically as well as educationally advised social distancing as precautionary measures to avoid the spread and contagion. For this study, the requirements resulted in a transition from face to face interviewing to meeting electronically. Therefore, the possibility existed that more respondents may have been interested in participation in the study. The desired increased level of participation translates into more informed findings and recommendations. As a result, more studies on these areas of focus would certainly be beneficial.

The findings from this group of participants included both recollections of positive and negative experiences. Most of the reports for current services were positive. The research itself

provided useful dynamics related to the conceptual framework of this study. The most relevant concepts to guide efforts toward repairing the broken behavioral health system were:

- To build stronger communities with accessible behavioral healthcare (Baker, 2015)
- To provide services for behavioral health needs in every realm of healthcare (Baker, 2015)
- There is a need for professional support for wellness and autonomy (Bayer et al., 2006)
- Empower consumers by working toward their desired goals (Liegeois et al., 2005)
- Cooperative care should encourage participation in treatment planning, goals, and objectives (Hogg, 2018)

In addition, the theoretical framework and research findings offered techniques or possible solutions. These theories offer promise when employed, to achieve some of the needed services such as:

- Accessible psychiatric medications, common ailment medications, exercise, and dietary education/choices (Edmunds et al., 1997)
- Services extended to in home to build well relationships there (Jané-llopis et al., 2011)
- Professionally educate communities by promoting behavioral health (Jané-llopis et al., 2011)
- Empowerment by treating consumers humane, fair and with the least restrictive alternative care (Texas Health and Human Service Commission, n.d.)

- Cooperatively treat MHSUD as a community concern not an individual concern (Jané-llopis et al., 2011)

Texas legislators allocated \$745 million dollars to invest in the Texas behavioral health system on July 28, 2019 (Peavey, 2019). Clearly, the problem of inadequate behavioral healthcare was no secret. The appeals to government officials to make the suicide and the mortality rate of children top priority are not resolved (Smith, 2019). Noted recommendations to legislators from stakeholders and local officials were to address the frequency of those with MHSUD being arrested as no treatment alternatives are available (Peavey, 2019). This funding should go toward treating MHSUD in infancy, or when children are diagnosed, as has been the case for some whose caregivers participated in this study. This researcher believes the study provided a clearer picture of the problems faced by caregivers as well as consumers needing services. Findings denoted recommendations to inform caregivers, the research community, and providers in behavioral healthcare regarding solutions for the north Texas region.

Hogg (2018) stated, “Consumers continue to face parity-related barriers to mental health and substance use care including denials based on medical necessity, lack of access to an adequate provider base, and prescription cost challenges” (p. 40). These conditions have suggested providers had some choice in decisions to treat or not to treat. “Making good ethical decisions requires a trained sensitivity to ethical issues and a method for exploring and weighing the considerations that should impact our course of action” (Velasquez, Moberg, Meyer, Shanks, McLean, DeCosse, André, & Hanson, 2009, para. 12). This study has provided scenarios and examples of the lived experiences of caregivers. Evidence from these findings continues to reflect the benefit of quality ethical care. The benefit is the wellness of consumers living a better quality of life and improved long-term outcomes to the consumers being served.

REFERENCES

- Alase, A. (2017). The Interpretative Phenomenological Analysis (IPA): A guide to a good qualitative research approach. *International Journal of Education and Literacy Studies*, 5(2). <https://doi.org/0.7575/aiac.ijels.v.5n.2p.9>
- Amadeo, K. (2018). *Obama's health care reform plan: How insurance companies changed Obama's healthcare reform plan*. The Balance. <https://www.thebalance.com/obama-s-health-care-reform-plan-3305753%0D>
- Amadeo, K. (2019). *How Trump's health care policies will raise premium prices for you*. The Balance. <https://www.thebalance.com/how-could-trump-change-health-care-in-america-4111422>
- Anfara, V. & Mertz, N. T. (2015). *Theoretical frameworks in qualitative research* (2nd ed.). Los Angeles, CA: Sage.
- Baker, J. G. (2015). Accessing the public mental health system. *Texas Medicine*, 111(2), 44–46. <https://www.texmed.org/Template.aspx?id=32765%0D>
- Bayer, R., Gostin, L. O., Jennings, B., & Steinbock, B. (Eds.) (2006). *Public health ethics: Theory, policy, and practice*. <https://www.globaloup.com>
- Beaglehole, R., Bonita, R., Horton, R. Dams, C., Alleyene, G., & Asaria, P. (2011). Priority actions for the non-communicable disease crises. *The Lancet*, 377, 1438–1437.
- Bloomberg, L.D., & Volpe, M. (2016). *Completing your qualitative dissertation: A road map from beginning to end* (3rd ed.). Thousand Oaks, CA: Sage.
- Bryan, B. (2017). *Obama defends Obamacare: "America is stronger because of the Affordable Care Act"*. Business Insider. <https://www.businessinsider.com/barack-obama-statement-on-obamacare-affordable-care-act-2017-3%0D>

- Cahn, S. (2014). *Exploring ethics: An introductory anthology*. New York: Oxford University Press.
- Cherry, K. (2018). *The five levels of Maslow's Hierarchy of Needs - How Maslow's famous hierarchy explains human motivation*. <https://www.verywellmind.com/what-is-maslows-hierarchy-of-needs-4136760%0D>
- Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed approaches* (4th ed.). Thousand Oaks, CA: Sage Publications.
- Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). Los Angeles, CA: Sage.
- Dale, H., & Lee, A. (2016). Behavioral health consultants in integrated primary care teams: A model for future care. *BioMed Central Fam Practice*, 17(97). <https://doi.org/10.1186/s12875-016-0485-0>
- Department of Health and Human Services. (2015). *Centers for Medicare & Medicaid services: Official information healthcare professionals can trust*. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Mental-Health-Services-Booklet-ICN903195.pdf%0D>
- Department of Veterans Affairs. (2018). *Mental health outpatient services design guide*. <https://www.cfm.va.gov/til/dGuide/dgMHOP.pdf%0D>
- Edmunds, M., Frank, R. Hogan, M. McCarty, D., Robinson-Beale, & R. Weisner, C. (Eds.). (1997). *Managing managed care: Quality improvement in behavioral health*. Washing, DC: National Academies Press.
- Fisher, M. A. (2009). Ethics based training for non-clinical staff in mental health settings. *Professional Psychology: Research and Practice*, 40(5), 459–496.

www.centerforethicalpractice.org/ethics-based-training-for-non-clinical-staff%0D

Gately, P. J. (2017). *Texas mental health system fails to address real problems.*

<https://namitexas.org/texas-mental-health-system-fails-address-real-problems/>

Garcia, N. (2020, February). *Contract disputes over mental health care services could leave thousands without aid in Dallas County.* Dallas Morning News.

<https://dallasnews.com/news/public-health/2020/2/11contract-dispute-over-mental-health-care-services-could-leave-thousands-without-aid-in-dallas-county/>

Graneheim, U.H., & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures, and measures to achieve trustworthiness. *Nursing Education Today*, 24(2), 105–112.

Health and Human Services. (2017, April). *HRSA awards \$200 million to health centers nationwide to tackle mental health and fight the opioid overdose crisis.*

<https://www.hhs.gov/about/news/2017/09/14/hrsa-awards-200-million-to-health-centers-na>

Health and Human Services. (2017, September). *Release of HHS mental health and substance use disorder parity action plan.*

<https://www.gov./blog/2018/04/23/release-hhs-mental-health-substance-use-disorder-p>

Hervey, B. (2019). *Texas mental health resource guide: A book for mental health & substance use disorder resources across the state of Texas* (1st ed.).

<https://www.txcourts.gov/media/1444700/texas-mental-health-resource-guide-email-corrected-09092019.pdf>

- Hogg Foundation for Mental Health. (2018). *A guide to understanding mental health systems and services in Texas* (4th ed.). http://hogg.utexas.edu/wp-content/uploads/2018/11/Mental-Health-Guide_4th-Edition.pdf
- Jané-Ilopis, E., Anderson, P., Stewart-Brown, S., Weare, K., Wahlbeck, K., Cooper, C., & Litchfield, P. (2011). Reducing the silent burden of impaired mental health. *Health Promotion International*, 26(1), 59-74. <https://doi.org/10.1093/heapro/dar051>
- Kotter, J. [Harvard Business School Review]. (2008, March 13). *The Importance of Urgency* [Video]. Youtube. https://youtu.be/zD8xKv2ur_s
- Lake, J., & Turner, M. S. (2017). Urgent need for improved mental health care and a more collaborative model of care. *The Permanente Journal*, 21, 17-24. <https://doi.org/10.7812/TPP/17-024> pub: 08/11/2017
- Maddox, W. (2019). *Behavioral health: Dallas County's growing physician shortage*. D Magazine. <https://healthcare.dmagazine.com/category/behavioral-health/>
- Mueser, K.T., Torrey, W.C., Lynde, D., Singer, P., & Drake, R. (2001). Implementing evidence-based practice for people with severe mental illness. *Journal of Nervous and Mental Disorders*, 200(3), 230–235. <https://doi:10.1097/NMD.0b013e318247cb5b>
- Munetz, M. R., Galon, P.A., & Frese, F. J. (2003). The ethics of mandatory community treatment. *Journal of Academic Psychiatry Law*, 31(2), 171–183. <https://pdfs.semanticscholar.org/1acc/d5141fc7010bb595726cfddeb8fe8ed0730a.pdf>
- Ngui, E. M., Khasakhala, L., Ndeti, D., & Roberts, L. W. (2010). Mental disorders, health inequalities, and ethics: A global perspective. *International Review of Psychiatry*, 22(3), 235-244. <https://doi.org/10.3109/09540261.2010.485273>

- Peavey, E. (2019). *Expert: The impact of Texas' \$745 million investment in mental health*. D Magazine. <https://healthcare.dmagazine.com/2019/07/28/expert-the-impact-of-texas-745-million>
- Ravitch, S.M., & Riggan, M. (2012). *Reason and rigor: How conceptual concepts guide research* (2nd ed.). Thousand Oaks, CA: Sage.
- Roberts, C. M. (2010). *The dissertation journey: A practical and comprehensive guide to planning, writing, and defending your dissertation*. (2nd ed.). Thousand Oaks, CA: Corwin-Sage.
- Saldana, J. (2009). *The coding manual for qualitative researchers*. Thousand Oaks, CA: Sage
<https://www.file:///F:/coding%20parsons%20Saldana%202009.pdf>
- Schneider, M. (2016). Clinical and social contexts of ethical issues in mental health care. *AMA Journal of Ethics*, 18(6), 567–571.
<https://doi.org/10.1001/journalofethics.2016.18.6.fred1-1606>
- Shapiro, D. L. (1997). Ethical dilemmas for the mental health professional: Issues raised by recent supreme court decisions. *Hein Online*, 34(177), 177-202.
<https://heinonline.org/HOL/LandingPage?handle=hein.journals/cwlr34&div=12&id=&page=%0D>
- Shapiro, M. (2018). *Why including a behavioral health component to an emergency preparedness plan is critical*. <http://www.nacchopreparedness.org/why-including-a-behavioral-health-component-to-an-emergency-preparedness-plan-is-critical/%0D>

Smith, C. (2019, November 19). With suicide rates and child mortality on rise in Dallas, experts urge for more help for kids' mental health. *Dallas Morning News*.

<https://www.dallasnews.com>

Smith, J., & Osborn, M. (2007). *Interpretative phenomenology analysis in qualitative psychology: A practical guide to research methods* (pp. 53-80). London: Sage.

<http://med-fom-familymed>

research.sites.olt.ubc.ca/files/2012/03/IPA_Smith_Osborne21631.pdf

Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method, and research*. Thousand Oaks, CA: Sage.

Stein, D. J., Phillips, K. A., Bolton, D., Fulford, K.W.M, Sadler, J. Z, & Kendler, K. S. (2010).

What is a Mental/Psychiatric Disorder? From DSM – IV to DSM – V. *Psychological Medicine*, 40(11), 1759-65. <https://doi.org/10.1017/S0033291709992261>

Substance Abuse and Mental Health Services Administration. (2015). *Behavioral Health Barometer: HHS Publication No. SMA-16-Baro-2015-TX 2015*.

<https://store.samhsa.gov/system/files/sma16-baro-2015-tx.pdf%0D>

Substance Abuse and Mental Health Services Administration. (2015). *Substance use disorders*.

<https://www.samha.usegov/disorders/substance-use>

Sutton, J. (2015). Qualitative research: Data collection, analysis, and management. *Canadian Journal of Hospital Pharmacy*, 63(3), 226–231. <https://www.ncbi.nlm.nih.gov>.

Tasioulas, J. & Vayena, E. (2015). *Public health ethics*.

<https://plato.stanford.edu/entries/publichealth-ethics/>

Texas Health and Human Services. (n.d.). HHS Ombudsman Behavioral Health Help.

<https://hhs.texas.gov/about-hhs/your-rights/office-ombudsman/hhs-ombudsman-behavioral-health-help>

U. S. Department of Health and Human Services (n.d.). *Behavioral health treatment and services*. SAMHSA: Substance Abuse and Mental Health Services Administration

<https://www.samhsa.gov/find-help/treatment>

Velasquez, M., Moberg, D., Meyer, M.J., Shanks, T., McLean, M.R., DeCosse, D., André, C., &

Hanson, K. O. (2009). *A framework for thinking ethically*. Markkula Center for Applied

Ethics at Santa Clara University. [https://www.scu.edu/ethics/ethics-resources/ethical-](https://www.scu.edu/ethics/ethics-resources/ethical-decision-making/a-framework-for-ethical-decision-making/%0D)

[decision-making/a-framework-for-ethical-decision-making/%0D](https://www.scu.edu/ethics/ethics-resources/ethical-decision-making/a-framework-for-ethical-decision-making/%0D)

Wheatley, M. J. (2013). *Leadership and the new science: Discovering order in a chaotic world*.

White, G. [Guy E White]. (2014, August 5). How do I choose a dissertation methodology?

[Video]. Youtube. <https://www.youtube.com/watch?v=IZKVxtDShvE>

World Health Organization. (2008). *Global Burden of Disease: 2008 Update*.

World Health Organization. (2019). *World Mental Health Day 2019: Focus on suicide*

prevention. [https://www.who.int/news-room/events/detail/2019/10/10/default-](https://www.who.int/news-room/events/detail/2019/10/10/default-calendar/world-mental-health-day-2019-focus-on-suicide-prevention)

[calendar/world-mental-health-day-2019-focus-on-suicide-prevention](https://www.who.int/news-room/events/detail/2019/10/10/default-calendar/world-mental-health-day-2019-focus-on-suicide-prevention)

Zilber, C. (2016). *Ethics considerations of involuntary outpatient treatment*. Psychiatric News.

<https://doi.org/10.1176/appi.pn.2016.12a16>

APPENDIX A
REQUEST PARTICIPATION LETTER

Invitation to Research Participation

March 19, 2020

Greetings,

my name is Carolyn Guillory and you may also know me as the clinic nurse. I am sending this correspondence as I am excited to share exciting news related to patient care. I am studying to become a Doctor of Education, through the University of New England and I have reached the research phase of this journey. I am hopeful that you would be interested in participation.

The research topic is Ethical Considerations for Outpatient Behavioral Healthcare. The method for this research is to interview caregivers of persons receiving behavioral healthcare services. The objective is to improve the quality and ethical practices provided to persons needing care. The research is not related to this center or the organization. It is strictly being conducted as an independent study which is completely voluntary. You will be asked to sign a consent for participation which can be cancelled at any time.

All information will be kept using a coded numerical system. No names will be associated with the records. We will only compile general information such as: age, gender, race, you are your relationship to the person in services. All files will be kept in a locked file and inaccessible to other personnel. The interviews will be reviewed and analyzed to document information shared with the researcher. As a result, interviews will require recording using a digital voice recorder. If you would like to contribute to this study for better mental health, please respond to my email. The address is Cguillory@une.edu. You may also contact me at: (469) 724 – 6249. Thank you for your time and I look forward to working with you for a brighter tomorrow.

Best Regards,

Carolyn B. Guillory, M. Ed., RN, LPC

APPENDIX B
CONSENT FOR PARTICIPATION IN RESEARCH FORM

| |
|-----------------|
| Version 8.22.18 |
|-----------------|

UNIVERSITY OF NEW ENGLAND
CONSENT FOR PARTICIPATION IN RESEARCH

Project Title: Ethical Considerations for Outpatient Behavioral Healthcare

Principal Investigator(s): Carolyn Guillory

Introduction:

- Please read this form. You may also request that the form is read to you. The purpose of this form is to give you information about this research study, and if you choose to participate, document that choice.
- You are encouraged to ask any questions that you may have about this study, now, during or after the project is complete. You can take as much time as you need to decide whether you want to participate. Your participation is voluntary.

Why is this research study being done?

The research is being conducted to address the need for improved outpatient behavioral healthcare. Current research reflects the experiences of providers. There is no research which addresses the experiences of persons or family members of persons who receive services.

Who will be in this study?

Caregivers to persons receiving services at the Serene Horizons Behavioral Healthcare Center.

What will I be asked to do?

Each participant will be asked to respond to questions. Questions will be presented in a one on one interview format. Upon receiving participant written consent, the interview will be recorded by a digital voice recorder.

What are the possible risks of taking part in this study?

There are no projected risks, participation is voluntary. The interview may be stopped at the request of the participant at any time.

What are the possible benefits of taking part in this study?

The responses to the interview will assist to further available research and information related to ethical outpatient behavioral healthcare.

What will it cost me?

There are no costs for participation.

How will my privacy be protected?

No names will be recorded. Each participant will have a file number which will be attached to each document collected. The research will seek to gather general information such as: age, gender, race, and relationship to person care for.

How will my data be kept confidential?

Responses will be kept in an individual file with a numerical identifier. No personal information will be included other than general information that cannot be linked to participants or those cared for.

What are my rights as a research participant?

- Your participation is voluntary. Your decision to participate will have no impact on your current or future relations with the University.
- Your decision to participate will not affect your relationship with Serene Horizons.
- You may skip or refuse to answer any question for any reason.
- If you choose not to participate there is no penalty to you and you will not lose any benefits that you are otherwise entitled to receive.
- You are free to withdraw from this research study at any time, for any reason.
 - If you choose to withdraw from the research, there will be no penalty to you, and you will not lose any benefits that you are otherwise entitled to receive.
- You will be informed of any significant findings developed during the research that may affect your willingness to participate in the research.
- If you sustain an injury while participating in this study, your participation may be ended.

What other options do I have?

- You may choose not to participate.

Whom may I contact with questions?

- The researchers conducting this study is: Carolyn Guillory
 - For more information regarding this study, please contact the University of New England's Department of Education: Michelle Collay, Ph. D. at (207) 602 - 2010
- If you choose to participate in this research study and believe you may have suffered a research related injury, please contact
- If you have any questions or concerns about your rights as a research subject, you may call Mary Bachman DeSilva, Sc.D., Chair of the UNE Institutional Review Board at (207) 221-4567 or irb@une.edu.

Will I receive a copy of this consent form?

- You will be given a copy of this consent form.
-

Participant's Statement

I understand the above description of this research and the risks and benefits associated with my participation as a research subject. I agree to take part in the research and do so voluntarily.

Participant's signature or
Legally authorized representative

Date

Printed name

Researcher's Statement

The participant named above had sufficient time to consider the information, had an opportunity to ask questions, and voluntarily agreed to be in this study.

Researcher's signature

Date

Printed name

APPENDIX C

SAMPLE OF VIGNETTES

Table 2 Sample of Vignettes: Ethical Considerations for Outpatient Behavioral Care by Participant #00600

Instructions: The following vignettes are provided as a tool to guide you with understanding the basis for this research study. Please select the response which you feel best answers the question at the end of the scenario. There are no correct or incorrect answers and your responses will not be scored. The results will be reviewed and may assist the interviewer to explain ideas or concepts.

1. Priscilla is a young woman presented to a clinic to have her son; Juan tested for ADD/ADHD (attention deficit/hyperactivity disorder) because he cannot focus in class. Priscilla had delayed the appointment because she speaks little English and is unable to read or write. Juan is 7 years old, and though he can read his understanding is not advanced enough to explain some concepts on the initial paperwork. The day Priscilla and Juan came for their appointment there was no one available to speak their native language. The interpreter line was an option, but it is very expensive to use. The receptionist told Juan to be a good boy and help his mother fill out the paperwork. What should the clinic do for Priscilla and Juan which would suggest they are providing ethical services for language barriers?

- a. Let Juan help his mother complete the paperwork
- b. Ask if there are other people in the lobby who speak Priscilla's native language
- c. Request a clinic staff person call the language line and guide Priscilla with forms
- d. Ask the housekeeping staff who also speak the same language to assist Priscilla

2. Richard came to the clinic because he wanted to get counseling for his son David, who has gotten in three fights at school in one month. David is 10 years old and is especially aggressive to girls at his school. Richard completed the paperwork and told the receptionist they need to speak to a male counselor because women cannot help David. The receptionist does not like the way Richard speaks negatively about women, but she is polite and asks them to be seated. The receptionist enters the information into the computer and assigns David to be interviewed by Sheila. There is a male counselor available, but the receptionist feels Richard and David need to learn a lesson. What should the receptionist do in response to Richard's request for a male counselor?

- a. Assign the case to the male counselor and note in the computer Richard's concerns
- b. Give the case to Sheila because she has five years more experience than the male counselor
- c. Tell Richard that the male counselor does not have much experience and she recommends a female counselor
- d. Schedule Richard for next week but tell him a female counselor is available immediately

Participant 00600 noted:

"I really don't agree with any of the options." "I would suggest talking to the parent and explaining that the level of experience of the female counselor far outweighs the male counselor." "I would let him know the outcome may be different with the female counselor and let him choose."

3. Mary brings her daughter, 18-year-old Stacy to the clinic because she was caught smoking marijuana behind the school yesterday. Mary does not have insurance but was referred by the school counselor because the clinic has a sliding scale payment option, based on income verification. While Mary is completing the paperwork, another family comes in to be seen. The second family is covered with Blue Cross/Blue Shield insurance and the clinic is on the insurance plan. The receptionist knows that is only one counselor has an appointment left today. She thinks she should give it to the family with insurance, because the center will be paid more. What should the receptionist do regarding which family should receive the only appointment for that day?

- a. Give the appointment to the insured family because the clinic needs the better payment amount
- b. Tell Mary she will have to come back tomorrow because there are no more appointments

- c. Assign Mary and Stacy to the last appointment of the day
 - d. Tell Mary that she must see a student because she does not have insurance
-

Although Participant # 00600 did not agree with the available options in the second scenario, she did respond sharing her ideas which are highlighted in yellow. It was determined by the researcher the goal of the activity was fulfilled. The participant clearly demonstrated an understanding of the concept of ethical practices. As a result, no remediation attempts were necessary prior to beginning the interview process for this or any other participant.

APPENDIX D

INTERVIEW GUIDE

File Number: 4

Age of Participant: 46

Age of Loved One: 10

Gender of Participant: Female

Race of Participant: Black

Relationship of Caregiver to Loved One: Mother

Are you interested in seeing the results of the completed study? No

Interview Questions and Instructions

The following questions have been established for a structured interview with caregivers to persons with mental health or substance use disorders. You will be provided with prompts or open-ended questions. Please respond freely as there are no incorrect answers. Do you have any questions before we begin?

1. Interviewer: **Which services have you personally observed/experienced, and consider important to the success of your loved one's outpatient mental health and/or substance use treatment?**

Participant 4: **Psychotherapy** (service theme), any kind is good for mental health. The therapist **allows my daughter to be open, she is vulnerable** (service theme) (professional conduct theme) and it helps her to make progress. **The therapist is a strong one** (professional conduct theme).

2. Interviewer: **Which services have you personally observed/experienced, and consider important to the success of an outpatient mental health and/or substance use clinic?**

Participant 4: **The setting where we go is safe to open up and share** (Causal relationship theme)(Safety theme)(.professional conduct theme) It helps to not keep things all bottled up because my daughter can't make progress if she)don't get the problems out there.

3. Interviewer: **How significant would you say distance your loved one must travel to access services is for continuity of care?**

Participant 4: **Distance is very significant** (accessibility theme). **If the therapy were any further, we would not be able to go there** (accessibility theme).

4. Interviewer: **How significant is the availability of public transportation for likelihood of continued services at an outpatient clinic?**

Participant 4: **I think in public transportation access is major for the center's success and the patients** (accessibility theme) (service theme). **People like to be independent and not rely others** (empowerment on theme). Plus, it allows people to be in your private business. There are other options like UBER, but I would not use it, nor would I ride the bus. But It is about more than just our needs.

5. Interviewer: **What is your belief regarding the necessary components of ethical mental health services and/or substance use services?**

Participant 4: **I think the opportunity to use the transit system is important** (accessibility theme). Everybody needs help sometime (service theme) (cooperative theme). **We all need an outlet that is positive, instead of alcohol, drugs, or sex which kids are getting into earlier than ever now** (service theme) (professional conduct theme).

6. Interviewer: **What services have you personally observed/experienced and consider a source of motivation for patients?**

Participant 4: **The availability of the therapist at times other than the scheduled appointment is a big deal** (service theme). **When I can access the therapist to get support or answers it is a deal breaker** (professional conduct theme).

7. Interviewer: **Can you give me an example of the concept *ethically sound practices*?**

Participant 4: **A place practicing ethically is a place where there is comfort, clean and it needs to be a place where you have privacy to share feelings** (professional conduct theme). Knowing what you share is only shared with those who need to know adds a sense of comfort as well (safety theme). **My daughter allows the therapist to share with me what they process in the last part of their session. So, I do not get surprises 6 weeks later** (professional conduct theme).

8. Interviewer: **Based on your personal experiences and observations, what if anything has contributed to a breakdown in outpatient care to your loved one with mental health and/or substance use concerns?**

Participant 4: **When providers try to sway the patient to see things their way** (undesirable/unethical conduct theme.). Also, when the cost of services is astronomical (undesirable/unethical conduct theme). I am a self-employed contractor, so my insurance is not the best. I must be aware of costs even if they are necessary to help me manage (accessibility theme).

9. Interviewer: **What are your thoughts regarding additional services you would encourage for your loved one?**

Participant 4: **I would like to see her interaction in a small group setting** (empowerment theme). She interacts with family but not too much with other people. I think **it could build communication and social skills (empowerment theme)**. In a therapy setting she would not have any fears and probably no episodes (professional conduct theme). Sometimes she may hit if someone makes her uncomfortable, but mostly other kids.

10. Interviewer: What suggestions do you have for a better quality of services in the North Texas Region?

Participant 4: If a center is going to have high quality services, they need to have providers that have strong beliefs (professional conduct theme). The therapist should not change her opinion to agree with a patient professional conduct theme. The patients need strong persons professional conduct theme.

Interviewer: Thank you for your time. I will send you a copy of our interview for your input on whether I captured your information and ideas. Thanks again.