Patients' experience of psychiatric care in emergency departments: A secondary analysis

Barbara Harris
Ross Beurmann
Samantha Fagien
Mona Shattell, PhD, RN, FAAN
Patients’ experiences of psychiatric care in emergency departments: A secondary analysis

Barbara Harris PhD, RN (Assistant Professor) *, Ross Beurmann RN, MSN (Associate Dean for Research and Faculty Development), Samantha Fagien RN, MSN (Graduate Student), Mona M. Shattell PhD, RN, FAAN (Graduate Student)

School of Nursing, DePaul University, 990 W. Fullerton Ave., Chicago, IL 60614, USA

A R T I C L E   I N F O

Article history:
Received 27 December 2014
Received in revised form 5 September 2015
Accepted 10 September 2015

Keywords:
Emergency psychiatric service
Nurse patient relationship
Mentally ill persons
Qualitative research
Patient centered care
Health communication

A B S T R A C T

The number of psychiatric emergencies presenting to EDs in the United States continues to rise. Evidence suggests that psychiatric ED care encounters can have less than optimal outcomes, and result in stress for providers.

The primary aim of this study is to describe the perceptions of ED visits by persons experiencing emotional distress, identifying themes among these that may guide nursing interventions that minimize stress and optimize outcomes in the treatment of psychiatric emergency. This secondary analysis used a qualitative, phenomenological method to analyze a de-identified data set originally collected in a study of experiences of psychiatric emergency in a community based crisis management setting.

Findings consist of three major themes: “Emergency rooms are cold and clinical”, “They talk to you like you’re a crazy person”, and “You get put away against your will”. An overarching theme through all three is the influence of RN communication, both positive and negative, on patient perceptions of their ED encounters.

While nurse–patient communication is basic to all areas of practice, it may be a low priority in the urgent and chaotic context of the ED. However, our findings suggest that increased attention to timely, empathic and validating communication and openness to the patient’s reality may decrease severity of symptoms, optimize outcomes, and decrease provider stress.

© 2016 Published by Elsevier Ltd.

1. Introduction

Out of 95 million Emergency Department (ED) visits in the United States (US), 12.5% are related to mental health and substance abuse issues (Owens et al., 2010) and the number is expected to continue to rise, straining the emergency care system in the US (Hospital Safety Center, 2014). Psychiatric emergencies include suicidal ideation, extreme panic, overwhelmed with life situation and/or symptoms of illness as well as injury and illness that result from mental illness. While staff to patient ratios in the ED vary across the US, as does the presence of psychiatric specialist providers in the ED, the key factor that problematizes psychiatric care in the ED is lack of support for this care, in the form of infrastructure, provider skills and personnel and material resources (Innes et al., 2013; Vandyk et al., 2013). Some ED encounters with persons experiencing psychiatric emergencies are not effective and may contribute to recidivism, leading to further strain on the system (Adams and Nielson, 2012; McKenna, 2011). In addition, care encounters can be stressful for both persons seeking treatment and those who are providing it (Clarke et al., 2007; Slade et al., 2010), leading to less than optimal care outcomes for persons with mental illness and negative experiences for providers (Plant and White, 2013; Zun, 2012). Importantly, negative provider attitudes resulting from these encounters can exacerbate distress for patients, furthering the cycle of patient distress, provider stress and system strain (Wellstood et al., 2005). Registered nurses (RNs) may experience these phenomena most acutely as they take primary responsibility for managing the care of patients in the ED (Elias et al., 2013; Emergency Nurses Association, n.d.).

A number of models for psychiatric care in the ED have been implemented to address these problems and while some have been effective, these are far from universal in implementation (Substance Abuse and Mental Health Services Administration, 2014) and even when they are, the quality of the encounter between person and provider is central to effective intervention. The RN and other providers must be equipped to form effective alliances with psychiatric patients (Marynowski-Traczyk et al., 2013; Wilson and Zeller, 2012). Although other providers, such as care technicians, social workers, psychiatrists and psychologists and sometimes psychiatric nurse practitioners, may assist in care provision, staffing varies greatly in US EDs, depending on region and model of care, so that the RN is often the one responsible for managing care from admission to
discharge (Emergency Nurses Association, n.d.). RNs want to provide effective care but can experience a number of barriers to achieving this, including institutional policy and procedure, physical environment of the ED, and lack of specific knowledge and skills around the care of these patients (Marynowski-Traczyk and Broadbent, 2011; Zun, 2012). Beyond additional education on how to approach and meet the needs of psychiatric patients, ED RNs will also need to find ways to better understand the individual needs and unique presentations of psychiatric patients in order to form effective alliances with those who seek their care.

The primary aim of this study is to describe the perceptions of ED visits by persons experiencing emotional distress. This paper offers an analysis of qualitative findings from interviews with nine psychiatric patients around care sought for psychiatric crises. The analysis of these reports of ED visits can provide insight into how persons in emotional distress perceive and attribute meaning to their care encounters in the ED, which is essential to RNs’ abilities to relate to patients. In addition, there are definite differences between a psychiatric emergency and a medical emergency; understanding how these shape persons’ behaviors and perceptions during ED encounters can suggest interventions to decrease stress and optimize the outcomes of psychiatric emergencies. This information may also assist RNs to deal with stress inducing feelings of powerlessness and uncertainty that have been identified as resulting from care encounters with persons experiencing psychiatric crises. (Plant and White, 2013; Zun, 2012).

2. Background

There are few studies of the experiences of ED visits by persons with mental illness. Those studies that do exist suggest that individuals in emotional distress perceive a number of ED characteristics to have a negative impact on their wellbeing. Some characteristics are part of the ED experience for everyone; however, persons with mental illness, especially while in an acute phase of illness, can perceive these differently or have a difficulty coping with them. EDs are stimulating environments, which can be frightening and agitating, while lack of privacy can inhibit efforts to cope with these factors (Cerel et al., 2006; Gillig et al., 1990; Innes et al., 2013). Persons with mental illness also perceive a lack of compassion from ED providers (Clarke et al., 2007). This may stem from the nature of their needs, which can be very different from those of persons with physical complaints. It may also be related to ED staff feeling unprepared to identify or meet the needs of mental health patients (Kerrison and Chapman, 2007). Such perceptions may also arise from experiencing a provider’s negative attitudes toward mental illness (Cerel et al., 2006; Ross and Goldner, 2009) or from providers’ beliefs that the care of these patients takes time away from acute medical patients (Camilli and Martin, 2005). These negative attitudes can exacerbate the symptoms of mental illness or actually precipitate aggression (Kerrison and Chapman, 2007; Wilson and Zeller, 2012).

A lack of knowledge and practice guidelines increases the burden of providing care to persons with mental health needs, as does the reality that these patients can also require more nursing time and resources than non-psychiatric cases and may spend an extended period of time in the ED simply waiting for psychiatric service to be available (McKenna, 2011). As Zun (2012) notes, extended wait time with minimal care provided can lead to increased agitation and distress for persons with acute mental illness.

Models of care have been developed and implemented in EDs over the past decade to better serve persons with mental illness, including a psychiatric ED within the general ED (McKenna, 2011), peer support programs in EDs and situating advanced practice RNs who specialize in mental health in the ED (Migdole et al., 2011). These models are far from universal and are usually only found in large, urban areas in the US, as are the following crisis-oriented services identified by the Substance Abuse and Mental Health Services Administration (SAMHSA). These include 24-hour crisis stabilization beds, short term crisis residential beds and peer crisis services, which while relatively new, are showing early signs of effectiveness both in crisis management and decreased health care costs (Shattell et al., 2014; Substance Abuse and Mental Health Services Administration, 2014).

Regardless of the setting, RNs must find ways to effectively meet the needs of patients with mental illness and at the same time develop strategies that decrease the stressful aspects of the caregiving experience that can also reinforce negative attitudes toward this group of patients. In the majority of EDs in the US, RNs with generalist level education are responsible for care coordination of persons with mental health crisis. Other personnel, such as emergency medical technicians and nursing assistants, may assist, but ultimate responsibility for care decisions and communication with the person and provider lies with the RN. Education on mental health topics, aggression management and substance abuse can increase an RN’s sense of control and confidence (Emergency Nurses Association, n.d.; Gordon, 2012; Kerrison and Chapman, 2007) but persons experiencing psychiatric emergency, just like anyone else, will express their feelings, needs and concerns in individualized ways so that applying skills and techniques alone will not be adequate. A foundational principle of psychiatric nursing care is the need to understand and respect the unique personhood of the patient as the basis of effective intervention (Halter, 2013). Studies suggest that this is what psychiatric patients want and need in care encounters (Lilja and Hellzen, 2008; Shattell et al., 2007).

3. Method

This is a secondary analysis of data collected in a 2012 qualitative, phenomenological study of patients’ perceptions of a community-based crisis facility, which serves as an alternative to EDs for persons in emotional distress (Shattell et al., 2014). A benefit of secondary analysis is the ability to decrease participant burden by using existing data to answer new questions or illuminate related phenomena (Heaton, 2008). The data from the original study revealed a great deal of information regarding persons’ experiences in EDs and how these shaped their treatment. The DePaul University Institutional Review Board approved the original study and determined that the current study was exempt from review because the data had been de-identified.

3.1. Sample

The sample in this secondary analysis included 9 participants who had visited the crisis treatment setting for a variety of reasons. In their interviews about experience in the crisis treatment setting, they volunteered information about previous experiences using the ED. A majority of participants were female and reported some college education; the majority also reported being unemployed. Data were not collected on the degree to which illness impacted function but given the data on employment, it may be fairly high for this sample. The original study did not collect information regarding the participants’ ED visits, such as whether or not it was their first visit, or whether they were alone or accompanied. All participants were within the ages of 21 and 65; specific ages were not collected as this was felt by professionals at the data collection site to be an area of sensitivity for some clients.

3.2. Data collection and analysis

Data collection occurred in the community-based crisis facility. Flyers were posted to recruit clients of the facility. Those who
expressed interest in participating in the study informed a staff person at the facility who relayed the contact information to the researchers. The researchers then contacted the client to conduct a screening via telephone to ensure they were oriented, in contact with reality and otherwise able to participate. After that, an interview time was set. All interviews occurred at the study site following completion of the consent process and were audiorecorded and transcribed verbatim.

Data for both the original and current studies were analyzed through an interpretive process associated with existential phenomenology (Thomas and Pollio, 2002). With the existential phenomenological approach, figural themes arise from the data and are interpreted within the context of the participants’ psychological ground, which for this study is the experience of psychological crisis. Meaning units were extracted from the data and grouped to generate themes. Researchers performed initial analysis and identification of meaning units individually. Then regular meetings were held to compare, discuss and develop themes. The themes were then applied to the original data to confirm and refine themes.

3.3. Limitations

This study is a secondary analysis. The interview questions were originally designed to investigate the feelings of persons in emotional crisis toward an alternative treatment setting. Participants in the original study often discussed ED experiences as a contrast to the alternative setting. Therefore, the data may not include positive ED experiences they may have had. The data also do not provide information on the nature of the ED experiences discussed, such as whether participants went to the ED voluntarily or not, or were accompanied or not.

4. Findings

Our analysis of the interviews of individuals in emotional distress about their experiences of EDs uncovered three figural themes: “Emergency rooms are cold and clinical”, “They talk to you like you’re a crazy person”, “You get put away against your will”.

4.1. “Emergency rooms are cold and clinical”

Smells of bleach, human bodily functions, harsh lighting, noises and the fears and memories of frightening or painful previous ED encounters that were triggered by these sensory experiences were identified by participants as aspects of the ED that were difficult to handle. Participants in this study described ED lights as being so bright they “knock you back” and the smell of bleach to be “heavy and static”, increasing the negative feelings related to their illnesses. As one participant noted, “just being in there... the smells made it hard to breathe, smelly- like and I thought I was going to pass out and die right in there”. Another noted that the chaotic sounds of “big machines and the hurry of footsteps” were frightening and precipitated feelings of panic.

The cold, clinical nature of the ED was noted to increase anxiety for some. One individual stated, “You don’t know what a nurse is going to do when she’s in a uniform.” For this person, a uniform meant “they are not like just people now [that they have a uniform on]”. Others connected these negative associations with uniforms to previous distressing ED or health care encounters. In addition, the use of medical terminology they did not understand was reported to exacerbate stress and loss of control for participants.

Stress over lack of privacy was also a salient theme. Doors and curtains being left open for the protection and observation of psychiatric patients was a source of discomfort, as were frequent checks by staff, particularly if these were done without attempts to interact with the patient.

Long wait times and non-availability of psychiatric providers also increased distress. Being alone while waiting for a qualified psychiatric examiner to arrive greatly increased anxiety and symptoms for some: “Being alone in a room for hours...When I am alone, my thoughts just spiral down, I think the worst things.” Another said that if someone had at least come in to let her know how much longer the wait would be, or to ask how she was, she would have felt cared for.

4.2. “They talk to you like you’re a crazy person”

Participants identified the judgmental demeanor of doctors, carelessness of staff, and constant supervision as behaviors that communicated negative assessments of them because of their mental health issues. There is the perception that they are being talked to like a “crazy person”. One individual concludes, “They’re not talking to you like you’re a person, a person who’s just got a regular problem.” Another said, in regard to care following a suicide attempt, “it’s like you know they know... about what you did and you know they are thinking you are crazy. They don’t even want to look at you”.

Routine communications in the ED can also cause added stress for persons in emotional distress. One participant stated, “In the ED... so much pressure, like you have to know your therapist’s name and medication dosages... I could talk if he just wasn’t pushing...” The behavior of ED staff who are under time pressure to efficiently triage and care for patients was interpreted by some participants as indicative of a lack of caring: “When I see them constantly watching the clock I’m thinking that maybe what I’m really saying to them is not that important, or maybe this is not the job for them.”

Routine care-related requests can be perceived differently by persons in emotional distress. One participant became greatly distressed with the request to remove her clothes and put on a hospital gown. She suffered from post-traumatic stress disorder (PTSD) and stated, “For them to be like, ‘Hey, just take your clothes off. Change into this gown.’ It’s kind of – that triggers me. It’s hard for me to go through that.” She did not feel able to articulate her distress related to the request. Another felt that abrupt requests showed a lack of understanding of her emotional vulnerability.

Lack of eye contact during routine requests was identified by over half of the participants as a factor that increased their discomfort and signified a lack of caring: “If they care, they look at you, they make eye contact, that’s how I know they care. In the hospital, they are not giving eye contact to you... then you’re not getting help because they are not seeing you.” Abrupt requests delivered with minimal eye contact or without even brief inquiries as to how the patient was feeling were felt by several participants to communicate a negative judgment of them for having mental health issues, or for related actions, such as a suicide attempt. For others, such interactions were interpreted as practitioners to be judging the concerns of other ED patients with medical problems as being more important than their emotional distress. This can be intensified when, as one participant related, negative comments are overheard: “...hearing the nurses speak of the psych patients and talk about them is not that important, or maybe this is not the job for them.”

Lack of privacy was also an important factor. For some, the request to remove clothes and put on a hospital gown was perceived as indicative of a lack of caring: “When I see them constantly watching the clock I’m thinking that maybe what I’m really saying to them is not that important, or maybe this is not the job for them.”

4.3. “You get put away against your will”

Loss of freedom is a common feeling among individuals in emotional distress in the ED. Several factors, including the experiences discussed above, contribute to this. One individual mentions the fear of being held against her will and likens this to being treated like a criminal: “They will hold you for 72 hours against your will while they evaluate you... even a criminal they can’t do that to...” Some participants worry that saying the wrong thing will cause them to be labeled as a “flight risk”. Two participants reported how stressed
they felt trying to monitor what they said to prevent having further restrictions placed on them. The procedures referenced by participants here are standard processes to ensure patient safety. However, there is the fear that these will be applied without good cause: “If you come in saying, ‘I hate the world,’ one of those comments could wind you up being held against your will if they wanted to.” For one participant, this fear was “just as scary as the symptoms” for which she was trying to get help. The worry over this possibility results in individuals needing to calculate carefully what they say and do not say, which is difficult because, “when you are in a crisis it is already hard to control yourself”.

A sense of loss of control can also occur related to non-availability of resources. One participant found herself in the ED of a hospital that did not have an inpatient psychiatric unit. The way in which decisions about disposition of her care were handled left her feeling out of control and without viable options:

I was really over the edge, and I told them I was ready to off myself and everything. What’d they say? Well, then we don’t have a site for it here…8:00pm at night, and they said, ‘Well, we could transport you to wherever you wanna go, but where I wanna go they say, ‘Well, we could get you there, but your Medicare won’t cover that. It’s like a $1,000.00 transfer fee’. I’m like, ‘I don’t have a thousand dollars so now what?’

5. Discussion

The perceptions of ED experiences chronicled here make visible the ways in which aspects of the ED environment and care encountered considered routine by providers are experienced as anything but routine by patients in emotional distress. These perceptions also make clear how powerful perceptions of provider actions were in shaping ED experiences. These findings are congruent with and expand on the findings of the few existing studies in this area.

The first theme demonstrates how the ED environment can exacerbate symptoms and emotional distress, in part as a stimulus to recall previous negative health care encounters. Awareness of this possibility on the part of the nurse may enable him or her to moderate some of the stimuli as an intervention that decreases intensity of symptoms. Lack of privacy in ED settings also contributed to concerns about confidentiality among these participants, which has increased gravity for them, given the persistence of stigma around mental illness (Schrader et al., 2013).

This last concern may take on added importance for clients who perceive the existence of the stigma of mental illness in the ED setting. The second theme addresses the potential of stigmatizing attitudes on the part of the provider to be a source of distress and possible complicating factor in the care encounter. This concern was embodied in participants’ reports of feeling that they were treated differently than persons receiving care for non-psychiatric issues. This parallels findings in Cerel et al.’s (2006) study of patients treated for suicide attempts and their family members. These individuals felt that they were not spoken to or treated in the same way that for suicide attempts and their family members. These individuals felt that they were not spoken to or treated in the same way that psychiatric patients would be. Some felt that they were not spoken to or treated in the same way that psychiatric patients would be. One participant found herself in the ED of a hospital that did not have an inpatient psychiatric unit. The way in which decisions about disposition of her care were handled left her feeling out of control and without viable options:

Other studies confirm the presence of stigmatizing attitudes and related behaviors among RNs in the ED (Innes et al., 2013). Eliás et al. (2013), for example, observed the admit-to-discharge care of 11 psychiatric patients in a Rio de Janeiro hospital ED in 2011. They found that a clear pattern of both delayed and decreased nursing care for psychiatric vs. non-psychiatric patients persisted across psychiatric diagnoses and over the spectrums of nonaggressive to aggressive and reality-oriented, communicative to non-reality oriented, non-communicative patients. It is worth asking if the stigmatizing attitudes held by the RNs are fueled by their feelings of frustration and perceived lack of efficacy with psychiatric patients, as Ross and Goldner (2009) suggest in their review of the literature on mental health stigma among nurses. They noted that in several studies, fear and lack of skills for effective communication with persons with mental health issues were issues underlying stigmatizing attitudes. It may also be that the more frequently a psychiatric patient visits an ED, the more staff develops a negative attitude, especially if previous care recommendations were not adhered to (Zun, 2012). Without data on frequency of ED visits in our study’s participants, it is difficult to make interpretations of their reports regarding staff interaction. Regardless of the underlying dynamics, stigma occurs among nurses toward persons with mental illness, and while some nurses may be aware of these attitudes in their practices (Innes et al., 2013), Delaney (2012) suggests that these may be more subtle and less noticeable than we think.

The third theme identified in this study sheds a bit of a different light on the issue of stigma. On one hand, some of the participants in this study reported provider behaviors that they interpreted as stigmatizing. This was seen most clearly in provider actions that seemed to communicate that providers did not value the time they spent with them. It was also seen in participants’ fears that what they say and do will be judged in such a way as to validate providers’ views that they are “crazy” and need more restriction and less interpersonal intervention. While providers may feel they are simply applying policies to ensure safety, such as frequent checks and limiting the person’s movement in the ED, participants in this study perceived these to be constraining, stigmatizing and reflective of a lack of trust in them. On the other hand, a person who is experiencing a loss of control over emotions and actions related to psychiatric illness may have perceptual distortions or have memories of events that are shaped by their psychiatric condition at the time of the event so it is difficult to evaluate their veracity. Nevertheless, their perceptions, and most importantly, the associated emotions, are genuine to them. In addition, the ED policies that serve to maintain safety of patients and others are essential, particularly given that concern over aggressive psychiatric patients is a major concern among ED RNs (Baby et al., 2014). Neither is likely to change in the immediate future. Thus, it is important for providers to remember that patients need to be given sufficient reason for the implementation of such policies, even if they don’t seem able to take in this information. It is also important to note that frequent eye contact, inquiries into how the person is feeling, what they might need, and clear statements of what is being done and why, can go a long way to keeping a patient calm and in control, as can interventions to address agitating stimuli early in the process (LaRue et al., 2013). When done in a genuine manner, these behaviors communicate caring and increase the person’s sense of safety, as well as the safety of providers and others around them. These interpersonal behaviors can also provide the RN with information needed to formulate more targeted interventions to prevent escalation of aggression. A person who feels safe and understood is much less likely to lose control or resort to physical aggression to get needs met.

The interventions discussed here may seem simple and they are: the challenge lies in building in time and attention to their consistent implementation while practicing in a rapidly changing
environment with a diverse patient assignment. A barrier to implementation may also be that, as Plant and White (2013) found, ED nurses often felt that their work with psychiatric patients was not effective, and that patients who returned frequently to the ED reinforced this perception. Such feelings can decrease motivation to consistently attend to the interpersonal needs of persons with psychiatric emergency and may also foster avoidance of these patients (Ross and Goldner, 2009). RNs in Plant and White’s study also felt that psychiatric patients were often manipulative, which can decrease motivation to attend to their interpersonal needs. However, the findings here suggest that at least some of what RNs find to be manipulative behaviors may simply be the only way psychiatric patients in the ED feel they can get their needs met because of fears that providers do not care or would respond in ways that threaten sense of personal safety. In this way, the cycle of misunderstanding, misinterpretation, avoidance and fear can continue.

Responsibility for breaking the cycle rests with providers. Increased education (Ross and Goldner, 2009), and more years of practice experience can facilitate provider behaviors that break the cycle. Plant and White (2013) note that RNs with more years of experience were less likely to avoid or feel dissatisfied with care encounters with psychiatric patients, possibly because they are more able to see that while results of psychiatric intervention may not be as dramatic or long lasting as with medical intervention, these can still be steps toward healing when looked at over the longer term. Without this perspective, RNs can feel ineffective or powerless, which can lead to the behaviors identified by participants in this study to be evidence of lack of caring (Elias et al., 2013). The chronicity of some psychiatric illnesses, as well as the impact of illness on economic and social dimensions of life, can put the person at risk for frequent episodes of emotional distress (Shattell et al., 2014) which may lead to repeated ED visits. Emphasis needs to be placed on the small steps forward that are made, such as decreased number of ED visits, or decreased acuity during ED visits over time. If providers can accept that movement toward greater levels of wellness and increased satisfaction with life is a long-term process and that there is always room for hope and growth, they can adjust expectations to decrease frustration. In addition, to meet the patient with respect and a sense of shared humanity, communicated through eye contact and genuine and caring inquiries and interactions, is good in and of itself, and for many persons with psychiatric illness, is a component of their recovery process.

6. Conclusion

At the current time, ED visits by persons with psychiatric emergencies continue to increase in the United States, straining the system, stressing providers and leading to ineffective care outcomes. While new models of care continue to emerge, the interaction between the person seeking care and the provider is a constant in all models. The thread running through all three themes reported here is the need for providers’ increased attention to the interpersonal dimensions of the care encounter. Perceptions of RN actions were central shapers of participants’ experiences. According to the participants in this study, it is the “how” more than the “what” that has the potential to either increase trust and comfort or to decrease these. Simple interactional behaviors, while not the whole of effective intervention, have great potential to calm, prevent or minimize aggression and intensity of symptoms, and even contribute to healing, when enacted in a consistent, caring and genuine manner. The challenge for ED RNs and other providers lies in finding the motivation, time and attention to devote to consistent employment of these actions. It is hoped that providers will make an attempt to try to include these behaviors on a more consistent basis and assess outcomes for themselves. It would be beneficial to both if the human connection fostered by the interactional behaviors identified here decreased the stress for patient and provider and paved the way for a more satisfying and effective care encounter.

Conflicts of interest

None declared.

References


