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Treatment of Persons with Mental Illness and Substance Use Disorders in Medical Emergency Departments in the United States

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Medical emergency departments (EDs) in the United States have often been difficult places for persons with mental illnesses and substance use disorders. Emergency department health care professionals are challenged with limited space, time, and resources, they often have minimal training about psychiatric and mental illnesses (including substance-related disorders), and they experience multiple and competing priorities. After initially assessing patients with mental illnesses or substance-related disorders, these patients often are left alone, monitored by untrained, low-level staff persons (e.g., nurse technician or certified nursing assistant) or hospital security personnel. Patients may have minimal interaction with professional ED health care professionals who may be engaged in care with medical emergencies elsewhere in the ED. Emergency health care professionals may feel overwhelmed and ill-equipped to handle psychiatric emergencies within the context of these environments.

More attention needs to be paid to psychiatric patients in medical EDs. ED health care professionals address patients’ basic needs, but often do not address their emotional needs. Further, in EDs, psychiatric patients generally must tell their story at least three times prior to being seen by a mental health professional. This telling and re-telling to persons who may not be empathetic could be harmful. ED health care professionals subject patients to invasive (urine and blood) tests almost immediately and take patients’ clothing and other belongings, leaving them many times in only a thin hospital gown. ED staff often treat all mental illnesses the same—whether someone is there because they are seeking counseling or are acutely suicidal. Most mental health complaints get lumped into “psych eval” (psychiatric evaluation) as a chief complaint, which generally means patients are stripped, searched, have blood drawn, asked for a urine sample, and then made to wait.

In ED settings, mental health issues are not often seen as “real” emergencies. This may especially be true if a psychiatric patient has no outward presentation of mental illness. ED staff sometimes cannot see the impending catastrophe that these patients can feel, be it depression, mania, psychosis, suicide, or homicide. Often, there is a lack of insight on the part of ED staff regarding the sometimes terrifying nature of mental illness. If pain (a completely subjective experience that sometimes requires hospitalization for control) can be an emergency, then so can mental illness (another completely subjective experience). ED staff persons often do not see this, or understand that patients need help, and need help now.

The issue of psychiatric patients in medical EDs is complex and affected by multiple factors. There are fewer community resources for mental health and substance abuse treatment, leading to greater illness exacerbations. There are fewer inpatient acute care beds for persons with psychiatric and substance use disorders, which has led to problems in EDs such as overcrowding and “boarding” (American College of Emergency Physicians [ACEP], 2009; Bender, Pande, & Ludwig, 2008).

Medical EDs are inappropriate for the extended stays of persons needing admission to inpatient psychiatric units because there is no mental health treatment given during this time (ACEP, 2009). In addition, since extended stay persons are considered outpatients, they do not qualify for inpatient meals (however, different hospital EDs compensate for this in various ways). The food available in EDs is often crackers and juices meant for
nauseated children (to see if they can tolerate eating). There is no physical exercise—there is not enough staff for a 1:1 walk around the block, or even through the halls—no mental stimulation, other than magazines from the lobby (if available), and there are no bathing facilities.

Emergency health care and mental health care professionals are acutely aware of these issues and have started to work together to improve clinical services to persons with mental illness and substance use disorders in medical EDs. Manton (2010), an ED nurse who later became a psychiatric and mental health nurse practitioner, advocates for kinder, compassionate care of psychiatric patients in EDs. The American Nurses Association (ANA), American Psychiatric Nurses Association (APNA), International Society of Psychiatric-Mental Health Nurses (ISPN), Emergency Nurses Association (ENA), and American Academy of Emergency Medicine developed a position statement titled, “An Emergency Care Psychiatric Clinical Framework” (APNA, 2010) that provides guidelines for appropriate mental health evaluation in medical EDs. One of the ENA’s (2010) strategic priorities is to improve services to psychiatric patients in EDs. The ENA and APNA have partnered on this issue and now share resources on their respective websites.

We support the collaboration of emergency nurses and psychiatric mental health nurses to improve the care of psychiatric patients in EDs. We hope for dissemination and adoption of clinical guidelines such as the Emergency Care Psychiatric Clinical Framework (APNA, 2010) developed by a consortium of professional organizations. We hope for even more interest by ED health care professionals for better treatment of persons with mental illness and substance-related disorders who present for evaluation in their EDs.

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REFERENCES