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

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ABSTRACT

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.

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, overwhelm 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

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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 23-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