IMPROVING QUALITY OF CARE FOR PSYCHIATRIC PATIENTS
IN THE EMERGENCY DEPARTMENT

By

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The U.S. emergency health care system has become the primary access point for many people with mental illness, but is poorly equipped to meet the needs of patients experiencing psychiatric crises, and may actually cause them additional harm. The purpose of this paper is to review literature on psychiatric care in emergency departments and suggest strategies to improve quality and outcomes, using Betty Neuman’s systems model of nursing and the Institute of Medicine Quality Chasm Report’s six aims for high quality health care as guidelines. Changes in practice and environment are necessary to improve the experiences and outcomes of patients in psychiatric crises, and psychiatric nurses are a critical component in the process, for providing patient advocacy, detecting and preventing iatrogenic crises, and assisting in development of quality measures. Even in a less-than-optimal environment, a focus on safety and patient-centered care of psychiatric patients in crisis can improve outcomes as well as patient and staff experiences.
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INTRODUCTION

Early one June morning in 2008, Esmin Green presented to the King’s County Hospital Center emergency department (ED) in New York with agitation and psychosis. After waiting 36 hours for a psychiatric bed, she fell from her chair in the waiting room, in full view of staff and other patients. Lying face down on the floor, her head under a chair, she writhed and struggled to rise for 35 minutes, while staff members, patients, and a security guard walked in and out of the room without coming to her aid. Finally, she lay still. Her body remained there for another hour before anyone approached (Sherer, 2008).

Although an extreme example, Esmin Green’s story highlights a significant problem in U.S. health care. In recent decades, EDs have become a primary access point for crisis mental health care in the U.S. (Brown, 2007; Zeller, 2010), despite the fact that our emergency medical system, designed to provide rapid, high-intensity responses to medical emergencies, is poorly equipped to handle problems of a psychiatric nature. Diminishing numbers of EDs, a growing aged population, and increasing numbers of Americans lacking medical insurance have combined to form a burden of overcrowding which the Institute of Medicine (IOM) characterizes as having brought hospital-based emergency care in America to its breaking point (IOM Board on Health Care Services, 2007).

Meanwhile, faced with insufficient availability of outpatient mental health programs, people experiencing acute mental health crises have nowhere to turn but the ED, where they are likely to become an additional burden on an already strained system. Due to the lack of inpatient beds, psychiatric patients awaiting admission face long wait times in the ED without adequate psychiatric treatment, in an environment unsuited to deescalating mental health crises, while being cared for by staff who often feel they lack adequate training and experience in dealing with
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psychiatric issues. This situation results in a negative experience for everyone involved (Slade et al., 2007). Several models of psychiatric emergency care have been developed in an effort to improve the experience and outcomes of patients with psychiatric complaints, ranging from additional training for ED staff to the construction of entirely separate psychiatric emergency departments. Regardless of which model may be organizationally, environmentally, or fiscally feasible, there are small, inexpensive changes that can improve the care and experience of psychiatric patients in the ED setting. The author reviews current literature on quality of care for psychiatric patients in the ED, explores existing interventions, and makes recommendations for strategies to improve the experience and care of this population.

THEORETICAL FRAMEWORK

Betty Neuman's (2005) systems model of nursing addresses the impact of the environment on a patient's ability to maintain stability. Neuman postulates that each individual consists of a central core of basic survival mechanisms, surrounded by lines of defense that act as a buffer, reacting to environmental stressors and attempting to prevent damage to the core, and lines of resistance that attempt to return the system to a stable state when the lines of defense are threatened or breached. Environmental stressors include interpersonal, intrapersonal, and extrapersonal factors. The nurse's responsibility centers on prevention at the primary, secondary, and tertiary levels by manipulating the environment to reduce or remove stressors that threaten the stability of the system and introduce factors which help to reinforce it. Patients in psychiatric crisis are particularly vulnerable, having already experienced a breakdown of their lines of defense and possibly also their lines of resistance, and this makes the nurse's protective role all the more critical.
The IOM Quality Chasm report (2001, p. 57) lists the following six aims for high quality health care, which offer potential areas of focus for nursing interventions based on the Neuman model:

- **Safe**—avoiding injuries to patients from the care that is intended to help them.
- **Effective**—providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).
- **Patient-centered**—providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- **Timely**—reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Efficient**—avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable**—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Although originally developed in the context of improving the quality of medical care, these aims are also appropriate for improving the quality of mental health care. While concepts such as timeliness, efficiency, effectiveness, and equity are straightforward in their application to most patient populations, safety and patient-centeredness take on new complexities when considering patients with psychiatric complaints.

In a medical setting, the term *safety* generally brings to mind prevention of physical injuries. Psychological injuries, however, despite being potentially as debilitating and possibly
even harder to remedy, are routinely overlooked in the quest to eliminate iatrogenic incidents in hospitals. Psychiatric patients often have histories of psychological trauma, making them more vulnerable to additional injury, and policies and practices meant to improve physical safety or workflow efficiency can further traumatize such patients. Requiring someone who has been sexually abused, for instance, to undress in front of a stranger can cause significant distress. Seclusion and restraint are also traumatic experiences, particularly for those who have experienced physical abuse or are tormented by paranoid or persecutory delusions, threatening both their physical and psychological wellbeing. The loss of personal choice and control over one’s environment would be frightening to anyone, even more so to someone who has been abused or is suffering from the waking nightmares of psychoses. The noisy, chaotic, and visually stimulating environment of the ED, inflicted upon a psychotic individual already overwhelmed with auditory and visual hallucinations, serves only to exacerbate his or her agitation and distress. A manic patient who has not slept in days is not likely to improve in a setting with such constant stimulation, especially in a room where the lights must remain on for observation purposes.

As with safety, the aim of providing patient-centered care also takes on additional complexity with this population. Mentally ill patients in crisis may have preferences that cannot realistically be met, especially in situations where their safety or that of others is at risk due to their illness. On the other hand, clinicians have a tendency to underestimate the capacity of mentally ill individuals to make their own decisions, thus impeding their ability to manage their illnesses or achieve recovery (Pincus et al., 2007). The fact that individuals may be receiving treatment against their wills does not negate their rights to privacy, dignity, and respectful treatment, nor does it override the existence of any other needs they may have.
HISTORY OF THE PROBLEM

The deinstitutionalization of psychiatric patients in the 1960s resulted in a mass exodus of patients from public psychiatric hospitals, with a subsequent loss of more than 95% of available inpatient beds across the country. By 2005 there were only 17 public psychiatric beds per 100,000 people in the U.S., compared to 340 per 100,000 in 1955 (Torrey, Entsminger, Geller, Stanley, & Jaffe, 2008). Unfortunately, the community mental health supports upon which deinstitutionalization had been predicated largely failed to materialize (Allen, Forster, Zealberg, & Currier, 2002).

Since that time inpatient resources have continued to dwindle, leaving many mentally ill patients in crisis with nowhere to go but the ED. In 2004 alone, the U.S. lost 42% of its inpatient psychiatric beds, while the number of psychiatric emergencies increased by 61% (Slade et al., 2007). ED utilization, meanwhile, has steadily increased over recent decades, rising from 34.2 annual visits per 100 U.S. residents in 1996 to 40.5 in 2006, an average of 227 visits per minute (Pitts, Niska, Xu, & Burt, 2008). The proportion of visits involving mental health emergencies is also increasing, with approximately 1 in 20 patients now presenting with a psychiatric complaint (Hazlett, McCarthy, Londner, & Onyike, 2004).

To compound the problem, the number of EDs has dwindled, in large part due to financial unsustainability, with more than 20% of EDs across the U.S. having closed their doors between 1991 and 2006. EDs have become increasingly overcrowded, resulting in long wait times and delays in treatment even for serious health problems (Pitts et al., 2008). According to the Pulse Report (2010), the average ED wait time nationwide in 2009 was 4 hr 7 min. For psychiatric patients, the lack of both inpatient beds and adequate outpatient services means that
time spent boarding in the ED can stretch into days and even weeks (Bender, Pande, & Ludwig, 2009).

Because EDs are designed to deal primarily with medical emergencies, they are poorly equipped to deal with mental health crises. The American Psychiatric Association Task Force on Psychiatric Emergency Services states that psychiatric emergency services are “...haphazard in their planning and organization” (Allen et al., 2002, p. 5), and Brown (2007) found that methods of handling psychiatric complaints in the ED were unpredictable between as well as within hospitals. Psychiatric patients tend to require extra supervision, placing additional strain on ED staffing levels and interfering with the care of other patients (Allen et al., 2002; American College of Emergency Physicians [ACEP], 2008; Torrey et al., 2008). ED nurses report feeling frustration, apathy, and fear due to inadequate experience and training in dealing with mentally ill patients, and their time-consuming nature and challenging behaviors can foster staff attitudes of disrespect or even hostility (Eppling, 2008; Hart & Ream, 2008; Stefan, 2006; Walker-Cillo, Jones, & McCoy, 2008). Kunen and Mandry (2006) found that many ED physicians mistakenly view mental illness as a minor threat to health, and that countertransference reactions to the mentally ill population can interfere with accurate diagnosis and appropriate care. Since emergency medicine residents often receive no formal psychiatric training (IOM Board on Health Care Services, 2007), ED providers often lack the experience necessary to meet existing standards for psychiatric evaluations, and may instead base decisions on financial consideration or fear of liability (Allen et al., 2002; Bender et al., 2009; Stefan, 2006). In a survey of 328 ED directors, 62% reported that there are no psychiatric services involved in the care of psychiatric patients while they are being boarded in the ED (ACEP, 2008). Important underlying medical
problems may also be missed or ignored when a patient's psychiatric disorder is the diagnostic focus (Kunen & Mandry, 2006; Sherer, 2008).

Not surprisingly, the ED experience is often negative for patients with psychiatric complaints. In their report on admission delays in North Carolina, Akland and Akland (2010) admonish, "EDs and crisis units are not a therapeutic environment for paranoia, out of control thoughts, emotions, and personal nightmares. As a society, we would not condone this treatment for our pets" (p. 2). Indeed, patients have reported perceptions of being punished, stigmatized, and not being taken seriously by staff (Cerel, Currier, & Conwell, 2006). The management of psychiatric patients in the ED usually takes place in an area visible to other patients, and where their conversations can be easily overheard, depriving them of privacy and dignity while potentially upsetting medical patients who witness their behaviors (Bender et al., 2009; Phillips, 2005). The noisy, hectic environment of the ED is not an ideal situation for an acutely ill psychiatric patient (Alakeson, Pande, & Ludwig, 2010), and may actually contribute to escalation of symptoms, resulting in iatrogenic crises (Stefan, 2006). Lengthy wait times cause anxiety, and also increase the risk of escalating behavior (Summers & Happell, 2003). Patients already in psychiatric distress can experience increased levels of agitation as the result of being forced to remove their clothing, being detained for long periods in small bare rooms on uncomfortable hospital gurneys under constant observation, being denied access to a telephone, and having to request permission to go to the bathroom. This is further exacerbated by the threat or use of force and restraints if a patient is uncooperative. Anecdotal evidence suggests that such iatrogenic causes may often result in inpatient psychiatric admission for patients who otherwise might have deescalated sufficiently to be discharged (Stefan, 2006). This could contribute to the
fact that patients with psychiatric complaints have a 22% admission rate, compared to 15% for patients presenting to the ED with physical problems (Hazlett et al., 2004).

The President's New Freedom Commission on Mental Health (2003) states:

"Understanding that mental health is essential to overall health is fundamental for establishing a health system that treats mental illnesses with the same urgency as it treats physical illnesses" (p. 11). Lack of appropriate crisis mental health care for psychiatric patients is a serious problem; “Poor care has serious consequences for the people seeking treatment, especially the most severely ill.” (IOM Committee on Quality of Health in America, 2006, p. 6). This is underscored by the fact that mental illness is now the leading cause of disability in the U.S. (The President's New Freedom Commission on Mental Health, 2003).

LITERATURE REVIEW

A review of the current literature revealed a paucity of information regarding the quality of care received by mentally ill patients in the ED. Most studies have focused on the impact on the ED and recommended procedural and system-level changes which, while offering potential overall improvement to the care received by psychiatric patients in terms of efficiency and timeliness, do not provide specific patient-centered solutions for improving the individual patient's experience or outcomes.

The President's New Freedom Commission on Mental Health report (2003) contains a single mention of emergency care, in a sentence regarding mental health training for several disciplines, among them ED staff. The Quality Chasm report on mental health care (IOM Committee on Quality of Health in America, 2006) also does not address emergency care, instead directing the reader to another report concerning the future of emergency health care in America. Although this third report does point out that ED care of psychiatric patients is
"sometimes less than optimal" (IOM Board on Health Care Services, 2007, p. 61), its recommendations for improvement focus primarily on improving efficiency and flow within EDs. With regard to specific improvements in the care of psychiatric patients, there is mention of a need for change in only two areas: reducing use of seclusion and restraint, and improving coordination of care.

The Illinois Hospital Association has produced a best practices report that, in addition to recommending improvements in triage, medical assessment, medication management, psychiatric evaluation, throughput, and the use of dedicated psychiatric staff or ED staff education, also addresses patient-focused improvements including physical space, patient safety, and comfort (Slade et al., 2007). A literature review on psychiatric boarding produced for the Department of Health and Human Services mentions deficiencies in quality of care and the "crisis in treatment of psychiatric patients" (Bender, Pande, & Ludwig, 2008, p. 11), naming environmental problems, inadequate assessments, inadequate services, and the iatrogenic effects of ED boarding. Their proposed solutions include the creation of separate treatment areas for psychiatric patients, guidelines for seclusion and restraint, and system-level changes such as improving coordination of care, increasing inpatient capacity, and providing mental health training to ED staff and law enforcement. A follow-up report by the same authors summarizes findings from nine hospitals across the U.S., exploring responses to questions regarding the causes and extent of psychiatric boarding; problems with delivery of care for psychiatric boarders; the impact on patients, staff, hospitals, and the overall system; community coordination and collaboration; and practice improvements and solutions suggested by survey respondents (Bender et al., 2009).
Alakeson et al. (2010) propose a seven-point action plan incorporating not only system and procedural process improvements, but also outlining ways to improve individual care of patients. Walker-Cillo et al. (2008) note that the most promising initiatives have been those based on delivery of care rather than managed care gate-keeping. Zeller (2010) proposes a set of treatment goals for emergency psychiatry which include patient-focused strategies such as avoiding coercion, treating in the least restrictive setting, and forming a therapeutic alliance. Stefan (2006) explores ways to reduce inpatient psychiatric admissions from the ED, among them reduction of iatrogenic crises by creating a more appropriate environment of care for patients in mental health crises.

The U.S. is not the only country experiencing problems in this area. Wand and White (2007) examine several models of emergency mental health care delivery in Australia and North America, and Alberti and Appleby (2004) have created an extensive checklist for the U.K.’s National Health System, aimed at improving the management of mentally ill patients in emergency care settings. It includes suggestions ranging from system-level procedural changes down to patient-centered interventions.

**IMPROVING THE QUALITY OF EMERGENCY PSYCHIATRIC CARE**

A number of models have been developed for improving patient flow and care of psychiatric patients in EDs. The mainstay since the 1980s has been the consultation model (Woo, Chan, Ghobrial, & Sevilla, 2007). Problems with this approach include availability of qualified consultants, timeliness, consistency of quality, and continuity of care (Allen et al., 2002). Evaluations of this model in the literature provide little information about improvements in quality of care or patient outcomes (Wand & White, 2007). Another approach mentioned frequently in the literature is the psychiatric emergency service (PES), a separate area either
within the ED or in a standalone facility with its own dedicated psychiatric staff. This model provides a more therapeutic environment, improves timeliness and appropriateness of care, and increases patient safety (Woo et al., 2007). Since the focus is on treatment rather than triage and containment, patients are often able to stabilize and discharge without inpatient hospitalization (Zeller, 2010). Unfortunately, although this model improves safety and offers the potential for more patient-centered care, it is expensive to implement and therefore unrealistic for many organizations to consider.

The addition of dedicated psychiatric staff to EDs is an approach that has shown positive results, and is less expensive to implement and maintain than a PES. Most of the literature on this model comes from Canada, Australia, and the U.K. (Wand & White, 2007), but U.S. hospitals have also begun to adopt it. A pilot program in Louisiana produced positive outcomes in its first year, including a reduction in inappropriate psychiatric admissions, fewer involuntary holds, shorter boarding times, less use of security personnel, and increased staff satisfaction (Eppling, 2008). The delivery of specialized care by psychiatric nurses, despite occurring within the busy ED environment, provides an improved experience and better quality of care for psychiatric patients (Clarke, Hughes, Brown, & Motluk, 2005; Walker-Cillo et al., 2008).

King’s County Hospital Center (2009), in response to the death of Esmin Green in their ED, has undertaken a comprehensive redesign of their behavioral health program. Their eight-point plan to improve quality of care for psychiatric patients includes steps to “…radically change the psychiatric emergency room experience” (¶ 1), and includes a novel approach, the use of peer counselors, full-time employees who have themselves been psychiatric patients, to serve as mentors and help engage patients in the ED. Peer counselors are widely employed in recovery-based mental health care programs, but their role in EDs is relatively new and has yet
to be documented in outcomes-based literature. However, according to Maddy Cohen, manager of an ED crisis program using peer counselors, their presence has provided a good experience for patients and helped to improve staff attitudes toward mental illness (Vine, 2010).

Even in the absence of a separate facility or dedicated psychiatric staff, Alakeson et al. (2010) state that, “Small, inexpensive changes in practice can lead to improvements in ER care for psychiatric patients” (p. 1639). They found, for instance, that training staff in deescalation techniques and changing policies to allow psychiatric patients to remain in their own clothing led to reductions in seclusion, restraint, and length of stay.

Staff attitudes toward psychiatric patients have a great deal of influence on patients’ perceptions of the quality of their care (Cerel et al., 2006; Summers & Happell, 2003). The ED is often the site of a patient’s first experience of mental health care, and a bad experience can foster fear and distrust of psychiatric treatment, resulting in a long-term negative impact on the patient’s prospects for recovery (Zeller, 2010). Clarke, Dusome, and Hughes (2007) note that, “A caring, respectful non-judgemental approach provides reassurance and invites more cooperative behaviour from the person seeking help” (p. 129). In a Swedish phenomenographic study on psychiatric patients’ perceptions of quality of care, the descriptive category most frequently encountered was respect for the patient’s dignity (Schröder, Ahlström, & Larsson, 2006). Like anyone else, patients suffering from mental illness need to feel safe. They want to know they are being listened to and that their needs are taken seriously, and they want to be kept informed about their treatment (Cerel et al., 2006). It is also important to remember that psychiatric illness does not rule out the existence of serious medical problems, and physical complaints should not be minimized or ignored (Sherer, 2008). A calm, caring demeanor on the part of staff, frequent check-ins, responsiveness to physical complaints, and attention to comfort
and basic needs will help to reassure patients that they are in a safe place with people who are working to help them. This allows them to turn their energies toward coping with their illness instead of being frightened of their situation. Non-psychiatric ED staff should receive regular ongoing training regarding mental illness and interacting with psychiatric patients. Such training offers a better understanding of mental health presentations and increases staff’s confidence in dealing with psychiatric patients (Slade et al., 2007). This, in turn, enhances the quality of care received by the patients.

The National Institute of Building Sciences psychiatric facility design guidelines state, “The character of the immediate surroundings can have a profound affect [sic] on the psyche of a psychiatric patient” (Carr, 2010, Building Attributes section, ¶ 2). Unpleasant environmental factors may be modified to some extent, even in an existing ED. To avoid exacerbating mental health crises, patients with psychiatric complaints should be placed in quieter areas, away from the chaos and noise of the waiting room, nursing station, busy hallways, and slamming doors (Bender et al., 2009). Karlin and Zeiss (2006) recommend the use of soft, indirect, full-spectrum lighting, and soothing artwork such as images of nature, which can help to reduce anxiety. Soft murals, subdued colors, and decorative borders can help to provide a less austere environment, and the addition of a table and chair, fixed to the floor for safety, can offer the patient an alternative to sitting or lying on a gurney for long periods of time (Slade et al., 2007). Overhead speakers in patient rooms should be disabled, and earplugs or cordless radio headsets can be offered to help patients cope with noise levels. The ability to watch television, listen to music, read a book, or color in a coloring book offers patients a distraction from their fears and another means of coping with their environment and the boredom and frustration of long wait times. Infrared cameras installed in patient rooms allow observers to monitor patient safety while
offering the opportunity for the patient to close the door for quiet and privacy, and lower the lights to sleep.

Neuman's model provides a framework that may be used to guide nurses in fulfilling their protective role for psychiatric patients in the emergency department and providing care that meets the quality standards listed by the IOM Quality Chasm report. The problems and interventions discussed above are summarized in Table 1, where they have been arranged according to Neuman's three categories of environmental stressors, intrapersonal, interpersonal, and extrapersonal.

Intrapersonal stressors occur within the individual, so include physical, emotional, and cognitive experiences such as feeling unsafe, experiencing physical discomfort, and the emotional overload inherent in a mental health crisis. As shown in Table 1, nurses can intervene to alleviate intrapersonal stressors by presenting a calm and caring manner, making use of therapeutic communication skills, checking in frequently, and being attentive to patients' basic needs and comfort.

Interpersonal stressors occur between individuals, and for psychiatric patients in the ED would include their need to be listened to, have their complaints taken seriously, their loss of privacy and autonomy, loneliness and isolation, and the traumatization that can occur when they perceive their needs are not met, they are frightened, or they are subjected to treatment against their wills (see Table 1). Interventions appropriate for these stressors include use of therapeutic communication, measures to give them some perceived sense of control, as much privacy as can be provided safely, information about their treatment, access to a telephone, and offering visits from peer counselors if available.
Extrapersonal stressors are factors outside the individual, such as sensory overstimulation resulting from the noise, activity, harsh lighting, and uncomfortable accommodations common in EDs. Interventions in this area will vary according to the specific circumstances of each ED, but could range from simple things such as offering ear plugs, providing distractions such as music, books, puzzles, and television, to more extensive changes such as indirect, dimmable lighting and decorating schemes offering soothing colors and artwork (see Table 1).

Improving the quality of care for this population requires a significant change in focus from the traditional emergency medical model, with awareness of and attention to the environmental factors that threaten a patient's ability to maintain, or return to, stability.

PRACTICE IMPLICATIONS

The creation of a more patient-centered approach to the care of mentally ill patients in the ED that preserves their psychological as well as physical safety has the potential to improve their experiences and outcomes despite a less-than-optimal care environment. Psychiatric nurses with an understanding of acute psychiatric conditions should be a critical component of this process, by advocating for better care for these patients, and assisting in identification and remedy of negative environmental stimuli. Advanced practice psychiatric nurses with acute psychiatric experience and an advanced understanding of integrating research into practice should be involved in the development of training and inservices for ED staff in therapeutic approaches and deescalation techniques.

CONCLUSION

The lack of adequate and appropriate crisis mental health care is a problem that has taken decades to reach its current level of magnitude, and it is not something that will be fixed easily or soon. In the meantime, however, it is possible to make changes in practices and mindsets that,
despite not being an ultimate solution, still have the potential to bring about vast improvements in the quality of care received by patients with mental health crises. Although studies do exist on improving the impact of psychiatric patients on the ED, little attention has been paid to the impact of the ED on psychiatric patients. Particular attention should be placed on development and implementation of quality measures for patient experience and outcomes, especially the detection and prevention of iatrogenic crises in this vulnerable population. In the meantime, Table 1 may be used as a tool for beginning the process of assessing existing stressors and guiding interventions aimed at providing better quality of care for psychiatric patients in crisis.
REFERENCES


### Table 1

*Environmental Stressors and Interventions*

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<tr>
<th>Neuman's Category</th>
<th>Stressor</th>
<th>Interventions</th>
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<tr>
<td></td>
<td>Feeling unsafe</td>
<td>• Frequent check-ins&lt;br&gt;• Calm, caring demeanor&lt;br&gt;• Therapeutic communication&lt;br&gt;• Attention to comfort and basic needs</td>
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<tr>
<td>Intrapersonal</td>
<td>Emotional overload</td>
<td>• Calm, caring demeanor&lt;br&gt;• Therapeutic communication&lt;br&gt;• Use of deescalation techniques</td>
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<td></td>
<td>Physical discomfort</td>
<td>• Responsiveness to physical complaints&lt;br&gt;• Attention to comfort and basic needs&lt;br&gt;• Provide beds vs. gurneys&lt;br&gt;• Provide chair / table for alternate seating</td>
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<td></td>
<td>Loss of privacy</td>
<td>• Allow to remain in own clothing&lt;br&gt;• Separate interview/treatment areas away from main ED area&lt;br&gt;• Less intrusive means of monitoring for safety</td>
</tr>
<tr>
<td>Interpersonal</td>
<td>Loss of autonomy</td>
<td>• Provide information about treatment&lt;br&gt;• Offer choice of alternatives when possible&lt;br&gt;• Avoid use of restraints / seclusion</td>
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<td></td>
<td>Need to be listened to</td>
<td>• Therapeutic communication&lt;br&gt;• Peer counselors</td>
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<tr>
<td></td>
<td>Needs taken seriously</td>
<td>• Frequent check-ins&lt;br&gt;• Responsiveness to physical complaints</td>
</tr>
<tr>
<td></td>
<td>Loneliness/Isolation</td>
<td>• Frequent check-ins&lt;br&gt;• Access to telephone&lt;br&gt;• Peer counselors&lt;br&gt;• Distraction (music, radio, TV, puzzles, books...)</td>
</tr>
<tr>
<td></td>
<td>Traumatization</td>
<td>• Calm, caring demeanor&lt;br&gt;• Therapeutic communication&lt;br&gt;• Attention to comfort and basic needs</td>
</tr>
<tr>
<td>Extrapersonal</td>
<td>Sensory overstimulation</td>
<td>• Attention to comfort and basic needs&lt;br&gt;• Use of deescalation techniques&lt;br&gt;• Quiet environment / ear plugs / headphones&lt;br&gt;• Soothing colors / artwork / decorations&lt;br&gt;• Soft, indirect, full-spectrum, dimmable lighting&lt;br&gt;• Distraction (music, radio, TV, puzzles, books...)</td>
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