Why you should read this article:

- To understand the challenges that people may experience when presenting to the emergency department (ED) with mental health issues
- To familiarise yourself with the principles of trauma-informed care and the high prevalence of exposure to childhood trauma among people with mental health issues
- To develop an awareness of the risk of re-traumatising patients during their care in the ED, and how this may be avoided

Trauma-informed care for people presenting to the emergency department with mental health issues

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Abstract

There is a high prevalence of exposure to traumatic events in childhood among people who have mental health issues. Presentation to the emergency department (ED) can be challenging for these patients because the environment and their experience of care can trigger traumatic memories. Trauma-informed care is an approach to practice that is guided by knowledge of how trauma affects people's lives and their healthcare needs.

Despite the increasing prevalence of mental health care delivery in EDs, the level of translation of trauma-informed care into nursing practice in this setting is largely unknown. Therefore, the authors undertook a narrative literature review, the aim of which was to gather evidence relevant to trauma-informed care in the ED and provide guidance on this practice for emergency nurses. Several databases were searched, and the relevant articles found were thematically analysed. Three emergent themes were identified from the literature: an access point for mental health care; staff attitudes; and the ED experience. Emergency nurses need to be aware of the effects of childhood trauma on people presenting with mental health issues and plan their approach to care to avoid potentially re-traumatising patients.

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Keywords

emergency care, emergency services, mental health, mental health service users, patients, patient experience, patient perceptions, patient psychology, professional, psychological care, stigma, trauma

Background

In many countries, emergency departments (EDs) have become people's first point of contact with the mental health care system (Barratt et al 2016, Wand et al 2016, Gill et al 2017). Strategies to ensure appropriate care in the ED for people experiencing mental health issues include the development of specialist mental health nursing staff roles and improved education in mental health care for nursing staff (Bost et al 2018).

A growing body of evidence shows that experiencing trauma in childhood is the single most significant predictor of the need for support from mental health services (Adults Surviving Child Abuse 2012).

A history of exposure to trauma is also associated with higher rates of relapse of mental health issues, reduced engagement with healthcare services and increased substance misuse (Shack et al 2004, Cusack et al 2006, Lommen and Restivo 2009). It has been identified that between 46% and 89% of people who use mental health services have been exposed to past traumatic events (Alvarez et al 2011, Anderson et al 2016, Phipps et al 2019).

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) (American Psychiatric Association 2013) defines trauma as the exposure to actual or threatened death, serious injury or sexual violence in one or more of the following ways:

- Directly experiencing a traumatic event.
- Witnessing, in person, a traumatic event occurring to others.
- Learning that a traumatic event has happened to a close family member or friend.
- Experiencing repeated or extreme exposure to aversive details of a traumatic event.

Trauma-informed care is an approach to practice that is guided by knowledge of how trauma affects people's lives and their healthcare needs (Harris and Fallot 2001). There is no universally accepted definition of trauma-informed care, but one of the most widely cited definitions is from the US Substance Abuse and Mental Health Services Administration (2014), detailed in Box 1.

Trauma-informed care has become increasingly prevalent in specialist mental health services (Hall et al 2016, Beckett et al 2017), while mental health care delivery has become increasingly prevalent in EDs. However, the level of translation of trauma-informed care into nursing practice in the ED is largely unknown (Hall et al 2016). Therefore, the authors undertook a narrative literature review on trauma-informed care in the ED.

Aim

To gather evidence relevant to trauma-informed care in the ED and provide guidance on this practice for emergency nurses.

Method

A literature search of the following databases was undertaken: Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE, PsychINFO, Scopus and Web of Science. The Google Scholar search engine was also used. Keywords used were 'trauma-informed care', 'mental health', 'psychiatric', 'emergency department', 'emergency service', 'staff' and 'nurs*'. The inclusion criteria were peer-reviewed journal articles published between 2003-2019 and available in English that were relevant to the area of trauma-informed care for people presenting to EDs with mental health issues.

Thematic analysis was used to identify the main concepts related to trauma-informed care within the literature.

Findings

The literature search generated 165 articles, only one of which focused specifically on emergency nursing practice and trauma-informed care (Hall et al 2016). However, 36 articles in total were regarded as relevant to the literature review.

Three emergent themes were identified from the literature:

- An access point for mental health care.
- Staff attitudes.
- The emergency department experience.

Discussion

An access point for mental health care

The reviewed literature showed that:

- The percentage of people presenting to EDs with mental health issues was between 2% and 10% of total ED presentations (Fry and Brunero 2004, Roggenkamp et al 2018).
- Most presentations to EDs for mental health issues occurred outside of normal opening hours (Fry and Brunero 2004, Bell et al 2011, Cutler et al 2013, Bost et al 2014, Pavarin et al 2014, Fahimi et al 2015).
- Presentations to EDs by ambulance were more common among people with mental health diagnoses (45%) than among people with non-mental health diagnoses (29%) (Bost et al 2014).

One mental health issue often experienced by adults presenting to EDs was psychosis (Fry and Brunero 2004, Roggenkamp et al 2018), while adolescents most frequently presented with self-harm and substance

Box 1. Definition of trauma-informed care

Trauma-informed programmes, organisations or systems:

- Realise the widespread effect of trauma and understand potential paths for recovery
- Recognise the signs and symptoms of trauma in patients, families, staff and others involved with the system
- Respond by fully integrating knowledge about trauma into policies, procedures and practices
- Seek to actively resist re-traumatisation

(Substance Abuse and Mental Health Services Administration 2014)

Key points

- It has been identified that between 46% and 89% of people who use mental health services have been exposed to past traumatic events
- Trauma-informed care is guided by knowledge of how trauma affects people's lives and their healthcare needs
- Emergency nurses need to develop an awareness of how childhood trauma may affect patients who present to the emergency department (ED) with mental health issues
- The ED environment may trigger fears or traumatic memories for people experiencing mental health issues; therefore, emergency nurses need to plan their approach to care to avoid potentially re-traumatising patients

misuse (Bell et al 2011). In one study of 36 EDs in Australia, Tankel et al (2011) reported that schizophrenia accounted for 18% of all presentations for psychosis and that the number of mental health presentations to EDs had increased. Tankel et al (2011) found no significant difference between urban and rural EDs in terms of the number of presentations for psychosis, despite the well-established association between urban life and risk of schizophrenia (Vassos et al 2012).

The literature showed that most patients who presented to the ED after an episode of self-harm made repeated visits to the ED (Pavarin et al 2014, Ani et al 2017) and were often under the influence of illicit substances or alcohol at the time of arrival (Bell et al 2011, Pavarin et al 2014, Chihara et al 2018). In one study of adolescents presenting to EDs in the US, Fahimi et al (2015) found that 2% of presentations were linked with substance misuse and 4% were linked with mental health issues. Bell et al (2011) found that, among children and adolescents presenting to one Australian ED with mental health issues and/or substance misuse, mental health issues accounted for 49% of presentations, substance misuse for 17% of presentations and dual diagnosis for 34% of presentations.

Staff attitudes

ED staff can have negative attitudes towards people presenting with mental health issues (Clarke et al 2014, Rayner et al 2019). For example, throughout the reviewed literature, ED staff frequently used the word 'challenging' to describe this patient group and patients' presentations were often labelled as 'complex' and 'disruptive' (Plant and White 2013, Clarke et al 2014). This was particularly notable in relation to patients presenting with substance misuse, who were described by emergency nurses as 'resource intensive' and as displaying unpredictable behaviour that made the nurses feel fearful and unsafe (Gerace and Muir-Cochrane 2019). In their literature review, Clarke et al (2014) found that ED staff perpetuated a fear of patients with mental health issues through the language they used in their reports, for example writing that patients often exhibited 'aggressive and bizarre behaviour'.

A further complication is that people presenting to the ED with mental health issues may be brought there against their will by police and may require physical restraint if they pose a risk to themselves and/or to others, which can increase the fear felt by ED staff (Gerace and Muir-Cochrane 2019).

Police who hand over patients to front-line ED staff – for example triage nurses – may unintentionally influence staff's attitudes because of their focus on forensic issues. Police officers have different priorities than ED staff: their focus is on public protection, so the person's health and well-being is not their main concern. The close professional relationship that often exists between law enforcement staff and front-line ED staff could introduce bias or prejudice that may filter through to other staff involved in patient care (Tahouni et al 2015). Similarly, societal misconceptions, such as the assumption that people with mental health issues should be feared, may influence emergency nurses' attitudes and negatively affect patient care (Clarke et al 2014, de Jacq et al 2016).

There was evidence that ED staff sometimes stereotyped mental health service users as manipulative and insincere (Clarke et al 2014, Rayner et al 2019), which could result in staff altering the care they provided (de Jacq et al 2016) and may lead to under-diagnosis, under-treatment and patients' concerns not being taken seriously (Plant and White 2013, Clarke et al 2014). Furthermore, some people with mental health issues present to EDs repeatedly (Clarke et al 2014), which could result in staff considering that the care they provide is 'pointless' (Plant and White 2013).

While most of the literature reviewed identified negative attitudes from ED staff, positive staff attitudes were also found; for example, some ED staff showed compassion and empathy towards people who had self-harmed or attempted suicide (Clarke et al 2014, Rayner et al 2019).

The emergency department experience

The literature demonstrated that people experiencing mental health issues commonly consider ED presentation as a negative event; however necessary, it is often their last resort (Wand et al 2016, Wise-Harris et al 2017). In one Canadian study, Skosireva et al (2014) found that homeless adults with mental illness more frequently reported perceived discrimination because of mental health issues than discrimination because of other factors such as homelessness, poverty, race, ethnicity or skin colour.

The ED environment, with limited private and quiet therapeutic spaces, was found to hinder communication between patients and healthcare professionals; patients were less willing to disclose mental health issues because of the lack of confidentiality, fear of being overheard and associated stigma (Guzmán et al

2018). Harsh lighting, strong smells, high noise levels and a hectic environment can increase patients' stress, trigger feelings of panic and have a negative effect on their well-being and ability to cope (Harris et al 2016). People experiencing mental health issues have described how the ED environment can trigger fears or traumatic memories (re-traumatisation), which may stop them from seeking support (Sondhi et al 2018, Digel Vandyk et al 2018).

In several studies that explored the experiences of people with mental health issues, patients described ED staff's communication with them as 'pushy', disrespectful, insensitive and judgmental (Harris et al 2016, Digel Vandyk et al 2018, Guzmán et al 2018). They have also described how a lack of eye contact from staff during routine interactions increased their discomfort and came across as a lack of caring (Bradbury et al 2017, Wise-Harris et al 2017). Patients felt dismissed and stigmatised, and were unsure whether ED staff understood their needs (Bradbury et al 2017, Wise-Harris et al 2017). Staff making requests that could trigger traumatic memories, such as to remove clothing to put on a hospital gown, could be perceived as a sign that they did not understand patients' vulnerability (Harris et al 2016, Guzmán et al 2018).

Physical examinations could also cause unintentional harm to patients (Elisseou et al 2019). These perceptions could be exacerbated by staff threats of using force or the actual use of force, with patients describing being yelled at, held down and restrained (Digel Vandyk et al 2018). These staff behaviours and methods can increase the severity of patients' signs and symptoms, heighten their risk of suicide and reduce their willingness to seek support in the future (Guzmán et al 2018).

Being known to ED staff could have positive and negative effects for people with mental health issues. In Digel Vandyk et al's (2018) study, people who had frequently presented to the ED over the past year with mental health issues reported feeling judged and labelled, particularly by paramedics and triage staff. In contrast, in Wand et al's (2016) study, people cared for by familiar staff such as mental health liaison nurses reported high levels of satisfaction, because they felt staff took time to listen and talk to them. Not being known to ED staff could result in patients having to go through repeated assessments, which they reported as frustrating and reducing their willingness to engage (Wand et al 2016).

Long waiting times in EDs were frequently cited by people with mental health issues as contributing to their perception that they were a low priority compared with people presenting with physical health issues (Harris et al 2016, Wise-Harris et al 2017). Long waiting times also contributed to people's concerns of compromised care, exacerbating their hopelessness, disempowerment, anxiety and fear of being held against their will (Harris et al 2016, Guzmán et al 2018).

Wand et al (2016) found that early therapeutic engagement (the communication the nurse uses to engage with a patient to form a therapeutic relationship) was associated with improved alleviation of anxiety and agitation, reduced incidence of 'do not wait' presentations (people who do not wait until they are discharged from the ED, but leave of their own accord), and prompt de-escalation of volatile situations.

Limitations

The main limitation of this literature review was that only one article was found with a specific focus on emergency nursing practice and trauma-informed care.

Relevance to practice

Healthcare services that use trauma-informed care can reduce the effects of traumatic experiences and enhance the quality of patient care (Machtinger et al 2015, Marsac et al 2016). Trauma-informed healthcare services use trauma-sensitive practices and embed the principles of trauma-informed care into policies and procedures (Phipps et al 2019).

The concept of trauma-informed care can be used in EDs to promote an understanding of how trauma affects patients and to ensure that every aspect of service delivery is trauma-informed (Fallot and Harris 2009). By viewing care through a trauma-informed lens, the person's risk of re-traumatisation in EDs can be minimised (Mental Health Coordinating Council 2013).

Trauma-informed care acknowledges a person's traumatic experiences, validates them and attempts to understand and respond to them, and it also promotes collaborative and empowering relationships between nurses and people presenting to EDs with mental issues (Isobel 2015).

Nurses who have an awareness of the link between trauma and health outcomes can provide clinical encounters that are less likely to trigger traumatic experiences (Machtinger et al 2015) and develop increasingly collaborative and empowering

relationships with people experiencing mental health issues (Beckett et al 2017). Muskett (2014) identified three main principles of trauma-informed care in practice, outlined in Box 2.

The literature demonstrates that implementing trauma-informed care has positive effects in clinical practice, including a reduction in coercive practices such as physical restraint, chemical restraint and seclusion (Martin et al 2008, Barton et al 2009, Goetz and Taylor-Trujillo 2012, Beckett et al 2017), as well as an improvement in staff's satisfaction with their professional roles (Beckett et al 2017, Hales et al 2017). However, providing trauma-informed care in EDs can be challenging given the clinical environment, the complexity of patients' presentations and the rapid turnover of patients (Hall et al 2016).

Box 2. Main principles of trauma-informed care in practice

- Having knowledge and understanding of the link between the experience of childhood trauma and a patient's current psychopathology
- Working with the patient, their families, friends and other supports in ways that promote and protect the person's autonomy
- Being aware that patients need to feel connected, valued, informed and hopeful of recovery

(Muskett 2014)

Conclusion

EDs can be challenging environments for people experiencing mental health issues and may trigger memories of traumatic events. These patients may encounter ED staff who stigmatise them because of the nature of their presentation, and, in some cases, they may experience coercive practices.

Given the prevalence of exposure to trauma among people with mental health issues, it is important for EDs to become trauma-informed in their approach to the treatment and care of this patient group. Emergency nurses need to be aware of the effects of childhood trauma on people presenting with mental health issues and plan their approach to care to avoid potentially re-traumatising patients.

Within the time constraints of emergency care, emergency nurses also need to develop relationships that promote empowerment and make patients feel valued, informed and hopeful of their recovery.

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