CARING FOR PEOPLE WITH MENTAL HEALTH PROBLEMS WHO PRESENT AT THE EMERGENCY DEPARTMENT: A NURSE EDUCATOR'S JOURNEY

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ABSTRACT

The New Zealand Emergency Department (ED) nurse is faced daily with the challenge of caring for patients of all ages with a wide variety of presenting complaints. Courses are available for ED specialty work such as trauma and paediatric assessment. However, as this thesis argues, it is difficult to access updated and ongoing education in relation to caring for people with mental health problems who present to the Emergency Department. In addition to this education deficit are the challenges of providing care in an overcrowded ED environment. Such factors contribute to a perceived lack of confidence and sometimes ambivalence or frustration on the part of nursing staff in caring for this group. This may result in an inconsistent standard of care for the the person with a mental health problem unless such issues are addressed.

The aim of this research paper was to explore the education needs of ED nurses when caring for people with mental health problems. A literature review was undertaken to investigate the broad education strategies available to overcome these challenges. Diverse approaches were identified such as workshops, clinical guidelines, and mental health consultation-liaison roles. Research was also identified that examined ED nursing attitudes and their learning needs in relation to mental health.

This paper concludes with a discussion of recommendations for the New Zealand setting with the intention of developing a more confident and competent nursing workforce, who are better prepared to care for the person with a mental health problem.

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I would like to thank the many people that have helped me during the course of my studies and contributed to the completion of my thesis.

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SECTION ONE

Introduction to the research inquiry

Introduction

This thesis argues that the person with a mental health[1] problem presenting at the Emergency Department (ED) will receive an inconsistent standard of care until nurses and other ED staff are given effective training and resources. The theme of consistency is emphasised as I see many examples of confident and excellent care being delivered to this group of people. However, as a nurse educator in the ED setting, I am aware of the lack of education opportunities about mental health in comparison to other topics. This education deficit can lead to a lack of confidence on the part of the ED nurse assessing and managing people with mental health problems.

Compounding this lack of education are resource constraints that ED nurses face, such as overcrowding, which is recognised internationally as the most significant problem facing EDs over the past decade. All patients are directly affected as they wait longer for triage, and nursing assessment and management is reduced in frequency or delayed (Ardagh & Richardson, 2004). This problem has been renamed from emergency to hospital overcrowding as it reflects system problems throughout the organisation (Howard, 2005).

In addition to the influences of hospital overcrowding and education deficits, there are the unique features that characterise working in the ED that may impact on the care a person with a mental health problem receives. Wears, Croskerry, Shapiro, Beach, and Perry (2002) describe these features which include the lack of control over the influx of patients and the complete variation of presentations. This 'ED culture' with its frequent interruptions, rapid interventions, and focus on physical

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[1] The World Health Organisation defines mental health as "a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (Mental Health Foundation of New Zealand, 2005, p.1).

illness and injury appears incompatible with what is required for the person with a mental health problem. In contrast, this group often has "complex mental, medical, and social needs" that require time for discussion (McArthur & Montgomery, 2004, p. 488). Waiting in such a crowded and noisy environment for assessment may add to the distress of the person with a mental health problem. For ED staff, while attempting to build rapport with this person, may find it disrupted by the sudden request to " escort your patient in Cubicle 3 to radiology *now*".

It is this challenging emergency setting that I have worked in as a staff nurse and as a nurse educator for the past eight years. As a registered general and obstetric nurse who graduated twenty one years ago , I have minimal pre registration and no postgraduate mental health experience. During this time I have developed my mental health knowledge and skills in a somewhat haphazard manner. As a result I have lacked the confidence to speak with any authority or teach about this group. This creates an over reliance on busy mental health emergency teams and senior ED medical staff to provide education. Every year I start with the fresh objective to create effective ongoing mental health education for staff, however, every year there seems to be other unexpected priorities. This thesis gives me the opportunity to explore this objective rather than let it slip down my list of "things to do".

The first aim of this paper is to identify and discuss the challenges of providing effective mental health education to ED nurses within the constraints of the current ED environment. The second aim is to explore education options used as a way of finding possible solutions. Critiquing the interface between mental health policy and practice in the ED is the third aim, with fictionalised scenarios included to illustrate this interface. Whelan (2003) argues that the failure in ED to adequately assess people with a mental health problem "is a missed opportunity to positively affect the quality of life for both them and their families" (p. 91). Therefore the final aim is to present recommendations designed to improve the quality of care the person with a mental health problem receives in the emergency setting.

The inclusion of practice stories

From my literature review it was apparent that the British and Australian perspective on mental health education for ED nurses was well researched and published. Because the New Zealand perspective was missing in the literature, I have included vignettes based on my personal practice. These are used to illustrate the influences on my role as a clinician and a nurse educator in relation to mental health. The vignettes have been fictionalised to ensure patient confidentiality. Their use relates to the role of narrative as outlined by Benner, Tanner and Chesla (1996). As opposed to objective accounts of case studies or conditions in textbooks, narrative stories allow the writer to include the emotions and contexual factors that influenced their decision making. Stories potentially help to bridge the gap between what is described as ideal in education models such as clinical guidelines with the realities of the individual workplace.

My professional experience and background to this thesis

This section commences with one fictionalised vignette from my professional practice.

Late one night I assessed a man who was a "frequent attender"[2] who had taken an anti-depressant drug overdose. I can remember the response I received when I attempted to bring this patient from the waiting room in to the treatment area. An experienced ED nurse stopped me and declared that the patient could wait because "he was always here attention seeking". Following this statement she turned away from me. There was no room for negotiation. I felt very uncomfortable because the man was sleepy, and so I monitored his level of consciousness and heart rate frequently. I was also stunned that a colleague could feel so frustrated towards this person. Then I felt annoyed with myself that I didn't feel strong enough to challenge the situation, or how to articulate to my colleague about why I was concerned.

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[2] A frequent attender has a pattern of multiple attendances at the ED. Their presenting problems are inclined to be complex "including physical and psychiatric illness, cognitive impairment, psychosocial difficulties, and alcohol and substance abuse" (Royal College of Psychiatrists., & British Association for Accident and Emergency Medicine, 2004, p. 48).

Finally, the situation was resolved unexpectedly by the appearance of the medical registrar who had been expecting this man. He reprimanded me for leaving such a patient in the waiting room and gave me a concise and curt lecture on the risks to the patient of this specific drug overdose. The patient was rapidly transferred to a room for assessment. I recall the sense of relief that the man was being taken seriously, yet frustrated at the injustice that I had been perceived by this registrar as having inadequate knowledge.

As an experienced ED nurse, when I recall this story I can now reflect on the environmental factors that contributed to such a response. At that stage there was no training about how to deal with people with mental health problems. Consequently I didn't ask the patient about suicide because no one had taught me how to do this as part of the assessment. No poisons database was available to access drug overdose information via the computer as occurs today. Case management plans for frequent attenders were not in existence, but are now routine. The nursing structure consisted of one charge nurse, thus he/she was not available after hours to discuss the above dilemma when it occurred. There were no ED consultants available for support. Thus the knowledge and resources were not there to manage the patient effectively, and I felt at a loss to confidently challenge the experienced ED nurse.

Coupled with this poor knowledge and lack of resources, the ED physical environment was very old and cramped at that time. I recall that the interview room used by the mental health emergency team was situated in a windowless cupboard that had holes in the wall.

While the environment and resources were problematic, the focus of the NZ Ministry of Health (MOH) policy at this time was primarily related to trauma, medical and surgical emergency management within the ED setting. Although mental health was mentioned, it was noted that it was not a primary focus of this policy. It was the expectation that "psychiatric triage can be achieved through the use of psychiatric liaison services and the development of common standards and protocols" (MOH, 1999, p. 11).

As a result of this MOH focus, a postgraduate certificate in clinical nursing (trauma and emergency[3]) was developed. I became the ED clinical nurse educator and embarked on a new journey. New technologies were being introduced such as non-invasive ventilation[4]. These technologies are mentioned because they signalled a change in direction for EDs to high acuity patient care that was traditionally the domain of intensive care units. What has this to do with mental health? The organization and maintenance of such technology has been delegated to nursing staff, along with provision of training in its use. As a result significant time is spent on such activities, creating "a challenge when nurses feel that the technical demands of their job seem to override the simple care that their patients may need" (Knaggs, 2003, p.1). This serves as a consistent distraction from building a mental health education strategy for staff.

As part of the postgraduate certificate curriculum I invited guest speakers such as the mental health emergency team and ED medical consultants. All were valuable, but had time constraints. Apart from lectures at university the participants on this postgraduate certificate had local tutorials where mental health speakers could be accessed at times, but once again this was subject to availability. These tutorials also revealed the participants experiences in working with people with mental health problems. These reactions centred around areas of concern such as communication skills, medicolegal issues and the management of complex presentations. It became evident to me as the programme facilitator that the occasional speaker was not enough to meet their needs.

Mental health education had already commenced for the ED nursing staff including triage and general principles of management, a session running approximately two hours with the very supportive mental health emergency team. Triage is a senior

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[3] This certificate contributes towards a masters level qualification. It is funded by the Clinical Training Agency, and is available for nurses who work in publicly funded EDs.

[4] Noninvasive ventilation is the delivery of ventilatory support to a patient who is spontaneously breathing without endotracheal intubation (Hotchkiss & Marini, 1998).

nursing role in the ED, and is defined as the purpose of ensuring "patients are treated in the order of their clinical urgency …It also allows for allocation of the patient to the most appropriate assessment and treatment area" (ACEM, 2000, p. 1). National triage standards for mental health were revised by the Australasian College of Emergency Medicine[5] (ACEM) document (ACEM, 2000). With the move to a new purpose built ED, separate interview rooms were allocated for people with mental health problems away from the hustle and bustle of the main treatment area. All these steps felt such a major improvement for both staff and patients.

As part of my educator role, I also became involved in the revision and redesign of the national triage course over a two year timeframe. This course is facilitated by the College of Emergency Nurses New Zealand[6], and is available to ED nurses nationally. This review coincided with the release of a NZ Ministry of Health guideline focusing on the assessment and management of people at risk of suicide in the emergency department setting (NZ Guidelines Group[NZGG] & Ministry of Health, 2003). The guideline included a mental health triage code framework. The implementation of this framework created some debate among ED nurses which will be discussed in section three.

Attempting to research an emergency nursing perspective in relation to mental health was difficult in the redesign of this course as emergency nursing textbooks and journals had limited information regarding mental health emergencies. There was

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[5] ACEM is an educational institution with a primary aim of the education and examination of emergency physicians within Australasia. Its other aims include ED accreditation, policies and standards, research, publishing and "those aspects of the medico political framework that have a direct impact on health outcomes for emergency patients" (ACEM, 1999, p.1)

[6] The College of Emergency Nurses NZ has aims that include professional development activities, the development of nursing standards, and "expert nursing knowledge and advice at Government and Ministry level" (New Zealand Nurses Organisation, 2005, p.1).

also no published literature related to the use of section 111[7] of the NZ 1992 Mental Health (Compulsory Assessment and Treatment) Act (MHCAT) from an ED nursing perspective. Liaison with mental health colleagues was very valuable during this time, leading to a better understanding of how to use the MHCAT in the emergency department setting. I can remember wishing that I could have more of their time.

During my role with the national triage course redesign, I commenced a new position as an ED nurse educator in a different location. New technologies are being introduced that continue the trend towards more complex patient management in the emergency setting. The international trend of overcrowding exists with a ten percent increase in presentations over the past twelve months (D. Jones, personal communication, 1 September, 2005). I have a very supportive mental health emergency team to network with, but I can find it challenging to find time to catch up with them.

In partnership with the senior nursing and medical team, I am responsible for ensuring the 41 registered nurses have appropriate learning support[8] and training opportunities. Currently their mental health education consists of triage principles, and they have access to reading the document entitled *Assessment and Management of People at risk of Suicide* (NZGG & MOH, 2003). Approximately three nurses attend the postgraduate certificate in clinical nursing (trauma and emergency) each year which will have some mental health component in the curriculum. Apart from these resources, there is no other formalised mental health education.

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[7] Section 111 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 enables a nurse "to detain, for the purpose of an assessment examination, a person who has been admitted to hospital (or who has been brought to a hospital) who is believed to be mentally disordered. This detention cannot be for more than six hours from the time the nurse first calls for a medical practitioner to examine the person (section 111(3))" (Ministry of Health, 2000, p.49).

[8] Learning support includes the concepts of preceptorship, mentorship and clinical supervision (Morton-Cooper & Palmer, 2000).

Gaps such as the care of people with mental health problems in current postgraduate education are recognised by the College of Emergency Nurses NZ (CENNZ) (CENNZ, 2004). It has acknowledged that currently there are education deficits for ED nurses between entering the emergency nursing speciality, and accessing postgraduate tertiary education. A working party of ED nurses has been established by the CENNZ with the aim of developing a national education framework, and this continues to be work in progress.

Looking back at this journey, it is evident how much progress has been made since my experiences as a novice emergency nurse. There are now better working environments and more education. However, there are continuing challenges which face the ED nurse responding to the needs of the person with a mental health problem. Eight years later I still have experiences that expose my own knowledge deficits, as the following fictionalised vignette outlines.

I attended a meeting to discuss the role of restraint in the ED setting. During the course of discussion I asked innocently about where I would find information about chemical restraint in the local restraint guideline being discussed. The look of horror on peoples faces matched the sinking feeling in my stomach as it was explained to me that this was not an appropriate term to use any more. Feeling suitably embarrassed I returned to the ED to ask my colleagues whether they knew about this change in terminology. Some did know and some didn't. I looked up the literature on this theme to discover that this term has been redundant for several years.

When I recollect this experience, I feel a sense of frustration that once again the acquisition of relevant mental health knowledge was gained in a haphazard route. Emergency Department nurses and doctors can attend national courses on topics such as trauma management and paediatric emergencies, and thus recent changes or innovations filter back to the workplace. However, there is no such formal education available for mental health.

This concept of demonstrating ongoing competency is of critical importance for registered nurses as a legislated requirement under the Health Practitioners Competence Assurance Act 2003. This year the Nursing Council of New Zealand (NCNZ) released the revised document entitled *Competencies for the registered nurse scope of practice* which includes specific competencies that nurses engaged in education must demonstrate[9] (NCNZ, 2005). If I am to achieve and maintain these education related competencies in the area of mental health, the following literature review will assist this goal.

Themes from worldwide literature

The literature review for this paper was sourced from New Zealand, Australia, United States of America (USA), Canada, and the United Kingdom. It revealed six broad themes related to emergency nursing and mental health. The first theme focuses on identified knowledge and skills deficits for ED nurses about mental health. The second theme relates to education strategies used internationally to improve ED nurses competence. Potential solutions are diverse, including workshops, training manuals, and internet resources. The publication of guidelines for ED health professionals caring for people with mental health problems is the third theme. Mental health triage frameworks as a type of guideline are the fourth theme. The fifth theme identifies mental health consultation/ liaison nursing as a potential solution to ED challenges. Finally, the sixth theme of ED health professional attitudes was recurrent throughout the areas of writing mentioned above.

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[9] "Promotes an environment that contributes to ongoing demonstration and evaluation of competencies

Integrates evidence – based theory and best practice into education activities

Participates in professional activities to keep abreast of current trends and issues in nursing" (NCNZ, 2005,p.8).

Overview of sections

There are five sections in this thesis. Section one has outlined the source of my interest regarding the challenges of providing effective care to the patient with a mental health problem in the ED. This has been achieved by recollections of my personal journey as both a staff nurse and a nurse educator in this setting. The aims of the thesis and the literature themes have also been presented.

Section two has examined the concept of competence in relation to mental health in the ED setting. A literature review highlighted two main themes. The first theme is negative attitudes towards the person with a mental health problem, how these manifest, what their potential causes are, and an examination of strategies that are available to address these. The second theme explores identified training deficits in ED, and also looks at strategies for possible solutions.

The third section has presented an overview of the guidelines available for EDs in relation to assessment and management of the person with a mental health problem. The main themes discussed are the mental health triage code frameworks used in NZ, followed by a brief discussion about other common themes that arise such as clinical supervision. It also presents a summary of various strategies used to provide clinical supervision for non mental health trained staff in the emergency setting.

Section four focuses on the role of mental health consultation liaison services within the ED setting. Finally an argument for supporting education costs in the healthcare system have been discussed.

Section five draws the thesis to a close by outlining conclusions. Recommendations have been presented as a plan to providing ED nurses with the appropriate training and resources for care of the person with a mental health problem in the emergency setting. A short reflection on my experiences of writing this thesis is also included.

SECTION TWO

Development of mental health competencies for the ED health professional

This section explores the literature related to the theme of mental health competency in the ED setting. Competence is defined as "the combination of skills, knowledge, attitudes, values and abilities that underpin effective performance" (NCNZ, 2005, p.13). As health professionals Mackway-Jones and Walker (1999) observe that we tend to think that skills and knowledge are the only components of developing competency, forgetting that attitudes is also an essential component. The first part of this section looks at the potential causes of negative attitudes, how these manifest amongst staff, and their potential impact on the person with a mental health problem. Education strategies are also explored as to how to address or prevent such attitudes.

Attitudes: their significance and management strategies

Negative attitudes towards people with mental health problems in the ED are portrayed as being 'alive and well' in the literature (Happell, 2005). These can range from pity to anger and can potentially lead to divisions within a staff group if not monitored (Royal College of Psychiatrists & British Association for Accident and Emergency Medicine, 2004). The World Health Organisation (2005) notes that health professionals in general services are often the initial carers for this group in a crisis, and can create barriers to the provision of appropriate treatment. Attitudes are still seen as significant judging by a National Institute of Clinical Excellence (NICE) guideline on self harm that states "analgesia should be offered to people who have self-injured throughout the process of suturing or other painful treatments" (NICE, 2004, p.6). It appears a sad reflection on health professional behaviour that in this document that was only published last year it is necessary to state this.

In addition to health professionals observing negative attitudes amongst ED staff, the consumer perspective is also described in the literature. Hughes and Clarke (2002) report on feedback from ED consumers, which comment on staff lacking compassion and understanding. One narrative by a mother describes how health care

professionals when dealing with her son's mental illness "generally shut down compassion or pity. Not because they are particularly inhumane, but because they face a need to protect themselves from the impossible 'thing' that is beyond their reference points" (Deveson (as cited in Bailey, 1998, p. 10). What is obvious to this mother is the lack of mental health knowledge that generalist health professionals have that contributes to their attitudes. The Royal College of Psychiatrists & British Association for Accident and Emergency Medicine (2004) note that ED staff may express resentment about patients with mental health problems due to their lack of certainty about their management. This uncertainty is also discussed as contributing to attitude problems by McAllister, Creedy, Moyle and Farrugia (2002) in their study about self harm patients, stating staff frustration occurs from not knowing "the person or their world and they usually do not know what happens to the client afterwards" (p. 580).

Apart from not understanding the person's world, another reason for negative attitudes includes the persistence of myths about mental health. One such myth is the belief that questioning a person about suicide will lead to this thought being established in people who are troubled but not suicidal. This is not supported by evidence (NZGG & MOH, 2003). Another study notes that some ED staff believe that people who self harm are attention seeking. As a result they may be deliberately ignored by ED staff who may "react in a manner of deterrence" (Jeffery & Warm, 2002, p. 296). Yet evidence suggests that if an effective psychosocial assessment is received with an initial contact at an ED for self-harm, this may reduce the number of ED reattendances by that patient (Crawford & Wessely, 1998; Cook, Clancy, & Sanderson, 2004).

This issue of discrimination is described by the Mental Health Commission[10] (2004) as being a potential cause of mental health service users having more physical illnesses and dying significantly earlier than the general population. It also refers to

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[10] The Mental Health Commission is a Crown Agency established by the NZ government. Its aims include the monitoring of the MOH and the District Health Boards in the implementation of the mental health strategy. Other aims include mental health workforce development and improving public understanding of mental health (MOH, 2003).

research suggesting that some general practitioners may offer less investigation of physical signs and symptoms. Another report noted that within the ED setting there have been referrals directly to mental health before taking care of physical needs (Mental Health Commission, 2001). Beach, Croskerry and Shapiro (2003) found in their ED case study that a mans symptoms of panic attacks and hyperventilation were put down initially to his mental health history, thus delaying definitive treatment for his heart failure condition. They included in their education recommendations that ED staff need to recognise their potential prejudices towards people with a mental health problem.

Anecdotally many ED nurses are able to relate to such incidents as the above, either recognising it in their own practice or challenging it when they see such assumptions being made by other staff. Having the background knowledge and confidence to confront it is essential. Fraser and Greenhalgh (2001) argue that there is some evidence to suggest that nursing and medical knowledge is "stored in memory as stories ("illness scripts") rather than as discrete facts" (p. 4). Case study presentations such as the above may assist with this storage of knowledge. The use of narrative in the emergency setting is also being explored in order to analyse adverse events that have contributing factors of attitudes (Wears, Croskerry, Shapiro, Beach & Perry, 2002).

In order to change attitudes, Mackway-Jones and Walker (1999) describe four theoretical phases that are involved in this change, which are "perceiving, complying, accepting and internalising[11]" (p. 63). They observe that these four phases will require frequent reinforcement by exposure to education rather than a one off teaching event. This is supported by a study (MOH, 2003) which evaluated the effects of general practitioner education in relation to depression management. The results indicated that local suicide rates decreased initially post education, but were not sustained long term.

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[11] Perceiving is the initial acknowledgment of a topic to which an attitude may have formed, for example, cultural safety. Compliance is when a student agrees with a teacher about the topic even if he/she is not in agreement. Acceptance occurs when the student sees the potential value of the topic in some real – life situations. Internalisation occurs when the student integrates it fully in to his/her practice.

Another strategy for addressing attitudes is described by Morton-Cooper and Palmer (2000) who state that reflection on our values as health professionals is an important activity. Values within the health system are centred around patients and "the ways in which we are expected to respond to their needs as well as their personal dignity and human rights" (p. 15). They further comment on how values are not learned merely by formal education but are heavily influenced by our peers within the work environment. Thus they emphasise the need to bring together the relevant multidisciplinary groups in the work setting to ensure that values can be clarified. This is particularly relevant to the ED setting where nurses work closely with administrative, ambulance and medical staff. The ability to express our values can be as simple as the comment "what are you making him a cup of tea for? You will only encourage him to stay".

King, Kalucy, De Crespigny, Stuhlmiller and Thomas (2004) completed a multi-disciplinary evaluation of a three day mental health training programme for ED staff, including nurses, doctors and ambulance staff. One of the study's aims was to raise awareness of attitudes and myths surrounding mental health. Strategies used to support this aim included consumers being invited to speak about their experiences in ED. The authors comment that this was also intended to show staff that consumers lead normal lives and are not always unwell. Participants commented that they felt they had more empathy and tolerance towards people with mental health problems after this training programme. Another study (Crawford, Turnbull & Wessely, 1998) on a much smaller scale evaluates a combined one hour training session for ED nursing and junior medical staff. This short session had a significant effect on clarifying misconceptions previously held by staff about patients who self harmed. This study notes however its limitations as not being able to evaluate whether such training improved ongoing management of people with mental health problems long term.

Another strategy for addressing attitudes is suggested by McAllister (2003) with the use of written reflective exercises for ED staff to complete and discuss. These exercises present true/ false statements related to the person with a mental health problem. This may enable myths to be exposed that "have subtly seeped into consciousness from old texts and old ways" (p. 135). This is potentially a useful tool for the ED setting, where ongoing maintenance of current knowledge is vital.

There is no doubt in the literature that deficits in health professionals knowledge and lack of confidence contribute to the development of negative attitudes. Potential implications for the person with a mental health problem include delay in assessment or inappropriate treatment. Because of the close team work in ED, it can also lead to tensions if opinion is divided towards care of the person with a mental health problem. Although the studies presenting evaluations of multidisciplinary education were positive, there is little evidence in the literature to demonstrate that it has an effect on professional practice and patient health outcomes compared to health professionals having separate training programmes (Zwarenstein et al, 2005). The challenges of rostering is also an issue for such multidisciplinary training, along with the short time frame that junior medical staff work in the ED. Nevertheless, the close working relationship that ED nurses have with medical and administrative staff make such training options worthwhile to consider.

While attitudes are one of the concepts involved in competency development, skills and knowledge about how to work with people with mental health problems is an important area to explore. It is not the intention to examine every type of mental health presentation but to examine some broader issues including the skills related to communication, assessment, complex presentations and medicolegal issues. Once again, education strategies will be explored as how to address these deficits.

Identification of knowledge and skills deficits in ED
Emergency nurses recognise that their lack of postgraduate mental health experience combined with a limited undergraduate training contributes to their uncertainty in

dealing with people with mental health problems (Crowley, 2000., Broadbent, Jarman & Berk, 2002). In one study, Baston and Simms (2002) observed that

> Chloe the triage nurse thought the man in front of her was obviously crazy. He was looking about him wildly and talking about messages beamed by the radio. She had no idea what to say to him, should she agree with him or tell him it wasn't true, neither idea seemed easy..what should she write on his triage notes? (p. 15).

Such fears about what to say are also acknowledged by other authors. Littlejohn (2004) notes that ED nurses caring for patients post overdose can feel helpless and worry about what to say to help.

What these fears raise for me as a clinician and educator in my own practice is the lack of opportunity to observe an expert assessment of the person with a mental health problem. The interview with the mental health emergency team is naturally conducted in private and with minimal interruptions. Yet for other specialities such as paediatrics I regularly observe role modelling informally, and collect pearls of wisdom such as communication tips. Hudson (as cited in University of Technology Sydney ,2003) argues that ED nursing staff need to have exposure to such mental health nursing skills, which are "sometimes invisible, involve communication, forming therapeutic relationships, utilising empathy and developing rapport. These abilities can be difficult to articulate and therefore need to be demonstrated" (p. 1). It is common to see ED guidelines for mental health presenting broad terms such as 'therapeutic alliance', but how to translate such terms in to practice may be difficult for the ED nurse to achieve without learning support.

Crowley (2000) observes that ED nurses may already have the communication skills but lack personal confidence that these are appropriate to use for the person with a mental health problem. The same author used action research to develop a list of practical phrases for the ED nurse to use in areas such as triage. This area is characterised by "multitasking driven by moment-to-moment changes in demand" (Shriver, Talmadge, Chuong, & Hedges, 2003,p. 3). Establishing rapport with the

person presenting with a mental health problem can be interrupted , thus a mental library of phrases can help. Another ED training programme incorporated such communication tips, including how to "close conversations in ways that did not leave patients feeling unheard or ignored, or leave the nurses anxious that they were leaving patients in volatile states" (Hart, Colley & Harrison, 2005, p. 8). Such skills are essential for the ED nurses repertoire. Perego (1999) suggests counselling skills be added to ED nurses training, but acknowledges that it would be difficult to achieve given the huge range of competencies ED nurses already need to maintain.

Apart from communication skills with patients, another issue raised in the literature was that of communication with the mental health team. For the ED nurse, a lack of confidence in how to refer a person with a mental health problem can lead to misinterpretations when contacting mental health services. In their ED resource manual the Royal College of Psychiatrists and the British Association for Accident and Emergency Medicine (2004) provide very practical tips on communication skills for telephone referrals from both an ED and mental health perspective. It also includes standards for what should be expected by both services in their discussion. Mackway-Jones and Walker (1999) observe that many clinical decisions and activities involve teams, and the skill to communicate effectively enables both the prevention and resolution of "tension and disagreements" (p. 64).

Further to this concept of multidisciplinary communication is the issue of being able to confidently articulate an accurate assessment of the person with a mental health problem, thus avoiding "pitfalls of vague, lay descriptions of people's problems" (Hart, Colley, & Harrison, 2005, p. 26). This is particularly applicable to telephone referrals, where the ability to present a clear story is vital. Arbuthnot and Gillespie (2005) observe that ED nurses lack confidence with describing the behaviours that the person with a mental health problem may present with. They argue that ED staff would benefit from having training to complete psychosocial assessment forms in order to increase their confidence. In addition to psychosocial assessment, suicide risk assessment is also an area where ED health professionals may lack confidence. The following fictionalised vignette illustrates this.

A woman with lacerated wrists is sitting in a cubicle at the start of my shift. The triage nurse has documented in the nursing sheet that the patient feels suicidal. Her attending doctor asks me to be his chaperone whilst talking to her. During his examination he looks at the physical aspects of her wrists, checks on tetanus status, and states her lacerations do not need suturing. He then leaves the room. I was somewhat surprised. What about suicide risk assessment? I sit on the edge of the bed and ask the woman about suicidal ideation, any previous involvement with mental health services. She explains her anxieties, that a family member recently committed suicide, that no one knew she was in ED. After negotiating with her to call a parent for support, I went back and informed the doctor what I had spoken to her about. He explained that he would contact the mental health team who came and reviewed the patient.

While not suggesting that the above is a frequent occurrence, it demonstrates that junior medical staff potentially suffer the same challenges that are identified for nursing, that of lack of knowledge about suicide risk assessment. It demonstrates the importance of ensuring permanent nursing staff have a clear understanding of treatment aims and referral processes to the mental health emergency team. Pembroke (as cited in Arbuthnot & Gillespie, 2005) argues that the ED can be "a lottery for those who self harm, with good practice existing among individuals but rarely across departments" (p. 21).

Other strategies to deal with this knowledge deficit include advanced training for ED nurses. This enables them to complete a risk assessment chart, and can refer directly to mental health services if no medical assessment is required in ED (National Health Service, 2004; Osborne, 2003). However, the implications for training ED nurses needs to be considered along with the ongoing maintenance of these skills if used infrequently.

Complex presentations

The increasing complexity of presentations that have a drug and alcohol component combined with mental health has been recognised as challenging for EDs. Spain (2004) found

> Intoxicated patients, with or without mental disorder, are increasingly being presented to emergency departments for assessment due to concerns about patient or community safety. ED resources are increasingly being tested as we attempt to care for these patients who frequently display impulsive, suicidal or violent behaviour (p.584).

To illustrate the complexity of these presentations a fictionalised scenario has been designed to demonstrate the challenges faced when dealing with people with behavioural disturbances. It also illustrates the range of questions generated by ED nurses in response to this incident.

> **Fictionalised scenario:**
>
> *A man is brought to ED by ambulance with police in attendance. This was due to self harm and aggressive behaviour. He required restraint with pepper spray by police and urgent sedation[12] by ambulance personnel. There is no medical history available from friends or family, no insight whether substance abuse is involved. He smells of alcohol. On arrival he is restrained in police handcuffs. He is stating active suicidal intent and being very aggressive. Physical assessment was difficult due to his behaviour. At a distance he appeared to have no respiratory distress. He was alert, with a pink dry skin, and had arm lacerations that were bleeding slightly. The patient was medically cleared by the ED medical staff. Three security staff were in attendance.*
>
> **Questions related to the police role:**
>
> If a patient arrives in handcuffs with police in attendance, what are the medicolegal issues?
>
> What are the guidelines for transferring a patient to the cells? Who can assess the patient there?
>
> If you think that the police officer is perhaps unsure of procedures, who can an ED nurse ring?
>
> **Questions related to the ED medical/ nursing staff role:**
>
> What does medical clearance consist of in such circumstances? What are the principles?
>
> How do the medical staff arrive at the decision to use urgent sedation?
>
> Does ED have a guideline re what is used for urgent sedation in this ED?
>
> Can you lock someone in a room in ED? Which room should be used?
>
> **Questions related to the role of mental health:**
>
> What can the Mental Health team do realistically during this phase of aggression? When should they be contacted?

Figure 1. A fictionalised scenario and accompanying questions.

Such scenarios cannot be underestimated in terms of the stress and anxiety they cause to all staff involved. There are opportunities to practise other emergencies such as cardiac arrest and major trauma in the ED, but response to this type of scenario tends to be taught informally.

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[12] Urgent sedation is defined as "the use of drug treatments to achieve rapid, short-term behavioural control of extreme agitation, aggression and potentially violent behaviour that places the patient or those around them at risk of physical harm" (Broadstock, 2001, p.iii)

Such complexity in health care education is discussed by Fraser and Greenhalgh (2001) who stress the importance of developing capability in addition to competence. Capability is defined as the "extent to which individuals can adapt to change, generate new knowledge, and continue to improve their performance" (p. 1). This relates to the knowledge explosion within healthcare, and it is no longer possible to retain all the information required to practise within ones head. The emphasis is on knowing how to access information efficiently, and such situations as described in figure one demonstrate the importance of this capability. There are multiple medicolegal issues which need addressing, and these need to written up in a user friendly manner for reference when required in such a crisis. For example, instead of looking for an urgent sedation guideline in one area of the department, a medicolegal guideline in another area, such information should be available at a centralised point. Fraser and Greenhalgh also observe that capability can be enhanced by using such fictionalised scenarios for staff to problem solve in groups, thus challenging them to find the solutions.

Complex presentations also raise the issue of relationship building with other services such as the police. It is interesting to note in England that emergency departments must formalise with the local police, mental health and emergency services a "place of safety" for this type of presentation described in figure one (Royal College of Psychiatrists & the British Association for Accident & Emergency Medicine, 2004). This aims to ensure that everyone is clear about their responsibilities prior to such situations rather than misunderstandings occurring when there is lack of clarity in the heat of the moment. A concept of "place of safety" would be useful to explore in the NZ setting as there are no formalised processes currently.

Medicolegal issues
Progressing from the medicolegal issues raised with complex presentations is the use of section 111 of the MHCAT by ED nurses. An explanation of how to use this section is lacking in the NZ literature on health care and the law (Johnson, 2004). Burgess (2002) quotes the mental health act giving a brief statement about who can

use section 111, the rationale for its use, and that it has a six hour time limit to medical assessment. However, this does not assist the ED nurse in how to use it or how to communicate it in the context of the ED environment. Through our mental health colleagues ED nurses have learned that it is a verbal order, and that ideally the mental health emergency team should be contacted prior to its use. Anecdotally ED nurses can also be unsure about its limitations. This lack of ED focused medicolegal information for nurses is also acknowledged from an Australian perspective by Wand (2004).

Only this year have I heard accidentally through my personal postgraduate studies that a guideline with a detailed section 111 explanation has been developed at one emergency department (Blackmore, 2004). Being able to access such a document and adapt it accordingly is an enormous time saver. This also highlights the difficulty of finding out what policy developments are occurring within emergency nursing nationally. Interestingly, systems have been developed internationally to deal with this challenge using internet technology. An example is a website entitled *"Checklist Improving the management of patients with mental ill health in emergency care settings"* developed by the National Health Service (2004). Its aims include to provide more timely care for this patient group by providing practical examples and suggestions for assistance with this aim. This user friendly website has training examples with link email addresses to facilitators who can provide more information.

Apart from internet technology, another strategy for dissemination of best practice are the use of guidelines which will be discussed in the next section.

SECTION THREE

ED Guidelines for mental health presentations

Clinical guidelines[13] impact on the management of people who present to ED with mental health problems. The goals of such guidelines include the presentation of evidence based practice to clinicians in a user-friendly format, with the intention to "inform, not dictate practice" (Gagan & Hewitt-Taylor, 2004, p.1217). Within the NZ emergency setting, there are two national guidelines that affect nursing practice related to the topic of mental health. These relate to triage and the assessment and management of people at risk of suicide (ACEM, 2000; NZGG & MOH, 2003). These will be discussed and critiqued as there has been some debate raised amongst ED nurses about the challenges of applying these two guidelines in practice.

Guidelines for mental health: triage code frameworks

As previously explained, triage can be defined as ensuring that patients presenting to the ED are assessed and treated according to their clinical urgency. The triage guidelines developed by ACEM are mandatory to use within the NZ emergency department (MOH, 2002b). In order to prioritise patients on arrival, there are five triage categories which each have a maximum waiting time for assessment by medical staff. Triage category one is immediate assessment by medical staff. Triage category two is assessment within ten minutes. Triage category three is a maximum wait of thirty minutes and triage category four is one hour. Finally, triage category five is a maximum wait of two hours.

Triage is specifically a nursing role. A national problem for all EDs is the difficulty meeting triage category times particularly for triage categories three – five. As the ED reaches full capacity because of issues such as access delay to hospital beds, more patients wait outside their assigned triage category number. This international

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[13] A clinical guideline is defined as providing
An evidence based summary of the benefits, risks and contraindications for investigation, treatment and ongoing management of a particular condition or disease. At a service delivery level a guideline is used as a tool to close the gap between how we currently practise (and the outcomes associated with current practice) and other alternative practices (and the outcomes associated with those practices). (MOH, 2002a, p.x).

problem of hospital overcrowding has already been discussed in section two. This leads to frustration for both the triage nurse as well as patients and significant others in the waiting room.

Patients are not triaged according to a specific diagnosis but their presenting signs and symptoms. For example, a patient can present with severe abdominal pain, and is given a triage category two because he/ she requires pain relief within ten minutes of arrival for humane reasons. It is not the role of the triage nurse to decide the cause of the pain. Similarly, for patients with potential mental health or behavioural problems, there should be no focus by the triage nurse on diagnosis, and triage is based on presenting behaviours. For example, a triage category two includes the following descriptors: "violent or aggressive, immediate threat to self or others" (ACEM, 2000, p.6).

Since the above triage framework was developed, the guideline entitled *Assessment and management of people at risk of suicide* has been published (NZGG & MOH, 2003). Incorporated in this guideline is an ED mental health triage scale adapted from an Australian model which focuses on suicide only. This was specifically designed for non mental health trained nurses in the ED, as it was recognised they would not have the specialist knowledge for in depth assessment (Tobin, Chen, & Scott, 1999). This triage framework also has accompanying management criteria about 1:1 observation of the patient according to perceived suicide risk. Having access to specialling criteria has been useful for ED nurses as it aids patient safety. However, this is obviously subject to availability of a person to carry out such observation.

The Ministry of Health and ACEM have endorsed both mental health triage frameworks. As an educator this has created some dilemmas. In 2003 – 2004 I was involved in reviewing the national triage course on behalf of the College of Emergency Nurses. The dilemma facing the review group was the mismatch between the above mentioned triage frameworks. Placed side by side it is clear that there are

some differences that can cause confusion, and nurses attending the triage course have commented on these.

One of the problems is the variation in triage categories. The ACEM (2000) guideline states that deliberate self-harm is a triage category three, whereas the NZGG and MOH (2003) guideline states "attempt/ threat of self-harm" is a triage category two (p.12). In my experience this confuses the novice triage nurse who wants to know which guideline to follow. Currently there is no resolution to this, and participants on this course are advised to consult their own area.

The next problem noted by participants is the reality around assessment of all patients who fall in to the category two of "attempt/ threat of self-harm". For smaller departments with less medical staff available, such as on night shift, this is perceived as unrealistic. Course participants argue that a triage category three is acceptable if the patient fulfils certain criteria. Such criteria include the presence of stable vital signs, no altered level of consciousness, is unlikely to abscond, and no immediate interventions within ten minutes of arrival are required such as an antidote, cardiac monitoring, or charcoal administration. Emotional distress is acknowledged as vital to consider, but will be equally attended to by an empathetic nurse as the medical staff within the thirty minute wait time. Course participants also comment that some medical staff do not agree with the ten minute time frame and are cynical about its use.

Finally, one of the problems highlighted is the different terms used in both guidelines. The NZGG and MOH (2003) uses the term "self harm" in its triage framework. It clearly distinguishes this from the term "*deliberate* self harm", which it defines as injury without the objective to die. However, if I then look at the ACEM (2000) triage guideline, it uses the term "deliberate self harm". This is not defined in the ACEM guideline. Once again, the novice triage nurse is left somewhat bewildered as to the subtle variations in definitions, when standardisation between these two triage code frameworks could have avoided this. A fictionalised scenario has been included to demonstrate this dilemma.

Figure 2. Fictionalised scenario for triage.

There are two sets of guidelines that could be used to guide this situation. The NZGG and MOH (2003) document is designed for patients at risk of suicide only. The ACEM (2000) guideline caters for general mental health. While an experienced ED triage nurse would be able to adapt guidelines and feel reasonably comfortable in doing this, a novice triage nurse would struggle with which guideline to use.

Adapting guidelines can create tension due to an awareness that a review of critical incidents at triage may involve judging the nurses actions against what is considered to be best practice. This currently involves both triage guidelines. As Gagan and Hewitt-Taylor (2004, p.1219) argue "the implementation of national guidelines cannot be dictated and must be weighed up by individual practitioners; however, where available evidence is not used, the reason for this must be justified". This reinforces the need for the two guidelines to be reviewed to reflect what is practised at triage in reality. These problems highlight the importance of having nursing input in to the development of such guidelines. The NZGG and MOH (2003) document had one urban ED nurse as part of the development team, which left rural EDs unrepresented. Jankowski (2001) emphasises the importance of involving all relevant health professionals in regards to operational processes and subsequent evaluation.

Looking outside the NZ setting, one of the most commonly used triage frameworks in England is called the Manchester triage scale (Arbuthnot & Gillespie, 2005). It has received criticism for its self-harm section, which focuses on physical symptoms

rather than behaviours as occurs with the NZ mental health triage guidelines. The Manchester triage scale has been revised and is due for release in November 2005 (Windle, 2005). It is interesting to note in England it is not compulsory to use triage scales in the ED, thus allowing adaptation to local circumstances. This is in contrast to New Zealand where the ACEM triage scale is mandatory to use.

Guidelines for mental health: beyond triage

Apart from the theme of triage, the guideline entitled *Assessment and management of people at risk of suicide* (NZGG & MOH, 2003) has other evidence based information such as urgent sedation and the principles of medical clearance in ED. Interestingly, there have been developments since the original release of the guideline in EDs in 2003. Since commencement of this thesis, the NZGG has launched a project entitled *Self harm and suicide prevention collaborative: A project for emergency departments, Maori health and mental health services* (NZGG, 2005). This project has been commissioned by the Ministry of Health to implement the recommendations of the above mentioned guideline. This project will be undertaken in collaboration with the National Institute of Clinical Studies (NICS) in Australia. The intent of this project is to replicate a NICS initiative currently in progress in Australia entitled "The Emergency Care Mental Health Interface". This is facilitated by the NICS and involves 41 hospitals (NICS, 2005).

The aims of this project include the reduction of wait times for patients with mental health problems in EDs. In order to achieve this aim emergency and mental health professionals are reviewing the processes used in their local settings in order to address identified barriers to quicker assessment. Teleconferences are then held at regular intervals to allow each service to share their progress as potential solutions are found. This is complimented by a website that has access to progress reports as well as international links to useful websites. It is intended that protocols and standards of care are also developed as a result of such collaboration. Staff from NICLS provide change management and facilitation expertise. An ED medical and

nursing adviser are also employed to support the change process at the workplace (NZGG, 2005).

This Emergency Care Mental Health Interface project relates to education and the exchange of ideas as described by the Health Workforce Advisory Committee (HWAC). This committee published a report for the Minister of Health with the aim of providing strategies to develop the NZ health and disability workforce. One of its stated priorities is the ongoing development and evolution of health professionals education. It further advises that "forums to discuss local research and evaluation projects should be used to publicise and share information, and to promote safety, quality, service and workforce improvement" (HWAC, 2003,p. 18). This interface project appears to meet these aims, of providing clinical staff with easy access to appropriate resources and networking opportunities. This also saves valuable time in searching for these independently.

Leaving the NZ setting, there are numerous guidelines about mental health practice in the ED setting available in England. Some examples come from the National Institute for Health and Clinical Excellence (NICE)[14] (NICE, 2004., NICE, 2005). These include the topics of self-harm, and management of disturbed behaviour and/ or violence in ED. A recurrent theme that appeared throughout these guidelines was the concept of clinical supervision. NICE (2004) states for staff working with people who self harm, that "all staff undertaking this work should have regular clinical supervision in which the emotional impact upon staff members can be discussed and understood" (p. 8).

Mental health nurses have been leaders in developing and utilising clinical supervision in their practice, thus this support system is well established in the mental health setting. It is also recognised that models of clinical supervision vary to

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[14] NICE is an independent organization that gives guidance to the National Health Service in England and Wales. Its roles include guidance on clinical practice and health technologies through the publication of guidelines (NICE, 2005).

adapt to different contexts (Mullarkey, Keeley, & Playle, 2001). In some EDs there is no formal clinical supervision, and mentorship is provided by peers. These two concepts come under the term learning support (Morton-Cooper and Palmer , 2000).

Learning support

Morton-Cooper and Palmer (2000, p. 12) observe that learning support is required for ongoing learning in the healthcare system for the following reasons

As a defence against feelings of disorientation, disillusionment and burn-out

As a framework for clarifying our human values

As a way to recover meaning in our social relationships

As a means of providing skill rehearsal and of providing access to appropriate role models in the workplace (both personally and collegially)

As a device for evaluating and disseminating best practice in health care

As a way of acquiring "emotional literacy" (i.e. the ability to deal constructively with our emotions in a mutually beneficial way).

When reflecting on the discussions in this thesis thus far that have related to attitudes and skills and knowledge deficits, it is clear that the principles of learning support as outlined above are very relevant. The strategies discussed such as multidisciplinary training and narrative all relate to achieving the above goals. Learning support to ED by mental health professionals has been provided in a variety of approaches. The employment of mental health nurses has been achieved in urban EDs with high attendances by people with mental health problems or limited mental health hospital support (McEvoy, 1998., Hughes & Clarke, 2002). In North America there has been a move towards psychiatrists based in the emergency department (Roberts, 1997). Other strategies include dedicated mental health emergency rooms that are staffed by mental health multidisciplinary teams and mental health emergency teams that are on-call (Webster & Harrison, 2004). Finally, the role of the mental health consultation-liaison nurse is also mentioned in the literature, and is the focus of the next section .

SECTION FOUR

Mental health consultation- liaison

Introduction

In New Zealand the model of a mental health crisis or emergency team (MHET) is well established to facilitate assessment and management of the person with a mental health problem in the Emergency Department. These vary as to whether they are based within the ED or located elsewhere. In addition to this service, consultation-liaison roles are available in some NZ emergency departments which compliment the work of the MHET. It is not the intention in this thesis to enter the debate about the meaning of such titles as consultation-liaison, as it is acknowledged that it varies with each setting and the intended purpose of the role. A broad definition of consultation-liaison[16] has been included for the purposes of this thesis, which is to establish its impact in the emergency setting, and how it compliments the role of the emergency mental health team.

Historically, the role of the mental health or psychiatric consultation/ liaison nurse in the emergency department developed originally in North America during the 1970s. Its role included direct care of people with mental health problems in ED, education of the ED nursing and medical team, and liaison between the various health professional groups (Roberts, 1997). In the United Kingdom this role also developed with more focus on crisis intervention and the assessment and management of deliberate self harm presentations. This was in recognition that mental health nurses were equally competent as medical staff to complete such assessments, and the role assisted with reducing junior doctor workloads (Beech, Parry & Valiani, 2000; McEvoy, 1998).

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[16] The mental health consultation-liaison nursing role applies mental health knowledge and skills within generalist hospital and community settings. It may have a combination of learning support, consultation, direct clinical work and research activities (Roberts, 1997).

One example of consultation-liaison (Ryan, Clemmett & Snelson, 1997) describes the benefits of a mental health liaison nurse service in an English National Health Service Trust. This was established due to the recognised lack of skills amongst nursing and junior medical staff in the generalist hospital setting, including the Emergency Department. The consultation- liaison nurses were based in the ED and were available for advice in other areas of the trust. Apart from direct assessment and referral of the person with a mental health problem, the consultation- liaison nurses had a teaching role on themes such as medicolegal issues and deescalation techniques. They also chaired a regular multidisciplinary meeting involving the mental health team and ED staff in order to discuss complex mental health presentations.

Moving from the English experience, Gillette and Bucknell (1996) investigated the consultation-liaison role in two Australian emergency departments. This role involved networking and mediating between ED medical and nursing staff and the various psychiatric services such as crisis and community mental health teams. They described this activity as culture brokerage, whereby the consultation-liaison nurse was able to "act as 'translators' of one system, with it's own set of rules and language, to another and were able to bridge gaps in understanding" (p. 400). An example of this culture brokerage included the ED nurses expressing that there was a breakdown in ongoing information about the management being offered to people with mental health problems. The consultation-liaison nurse was able to create solutions to improve communication.

Administrative consultation activities included the development of treatment policies and resource folders. Clinical activities included triage assessment and carrying out debriefing activities. Feedback from the ED nurses commented on the improved relationship between mental health and ED services, and decreased wait times for people with mental health problems. Interestingly, other comments from project participants indicated that they related its success to the fact that the consultation-liaison role was distinct because this position was not employed within the emergency department. This was seen as enabling attitudes to be challenged more

effectively.   A similar finding was observed in another study which evaluated the role of a mental health consultation-liaison nurse in a general hospital (Happell & Sharrock, 2002). Feedback from nurses interviewed indicated that they felt because he/she was not part of the team, but had "outsider status", that he/she came with a fresh perspective (p. 57).

McDonough et al (2004) outline additional benefits of the consultation/ liaison role such as the role modelling that occurred informally. As a result ED staff were more interested in working with mental health patients as they grew in confidence with the support of the consultation-liaison nurse.

Ford (1998) describes her own consultation-liaison role in a general hospital which included an emergency department. She presents case studies to demonstrate the collaboration she provided across different specialties, and the support that can be provided to nursing and medical staff as well as patients. One case study describes challenging behaviours displayed by a patient diagnosed with borderline personality disorder. Her actions are outlined to enable this patient to engage with the staff in the ward. This is very relevant to the ED, in which negotiation skills are sometimes also needed whilst waiting for the MHET to arrive.

While the studies presented describe very positive experiences related to consultation-liaison, there are examples that outline less favourable outcomes. McArthur and Montgomery (2004) describe a pilot project in a rural ED which placed mental health nurses within the ED to collaborate with the already existing crisis team and ED psychiatrist. The aims were to reduce wait times by providing clinical assessment of the person with a mental health problem. However, the mental health nurses found that in reality the underlying pressure from ED staff was to keep this group out of the ED. Because of the incompatibility of the consultation-liaison nurses intentions with those expressed by the ED staff, the pilot project was stopped. It is important to remember that such roles need to be clear in their purpose to avoid disillusionment between the two services.

This potential incompatibility between ED and mental health staff philosophies is further reinforced by Sands (2004). She describes the experiences of mental health nurses working in various triage roles, including those based in emergency departments. Interviews with mental health nurses who worked in ED indicated their perceptions that undue pressure was placed on them by ED staff "to assist in relieving the burden of psychiatric clients on the emergency department" (p.153). This was identified as a significant stress. Morton-Cooper and Palmer (2000) point out that misunderstandings occur between health professional groups and that frequently "another person's agenda is assumed rather than made explicit, so that barriers between professionals build without any attempt to explore the issues behind them" (p.18). It is vital then that in the formation of such roles that objectives are clearly defined for both specialities.

There are at least two initiatives within the New Zealand setting which show consultation liaison being available for emergency settings in conjunction with mental health emergency teams. As one emergency nurse educator describes, having this support has enabled her to develop education for ED nurses about issues such as frequent attenders (K. Blair, personal communication, 1 June 2005).

Despite the growth in this role in the generalist hospital setting, including emergency departments, it is observed that further evaluation is needed in Australasia. The need for more publication on the subject is recommended (Sharrock & Happell, 2000; Sharrock & Happell, 2001).

The value of education
Having discussed what is available in an ideal world for ED nurses, it is inevitable that a financial commitment may well be needed to enhance education and resources. So how can this be justified when the health dollar is scarce? The NZGG and MOH (2003) note that it is not possible to place a cost on the direct and indirect effects of suicide and attempted suicide. This includes costs such as the potential ongoing effects on the family and significant others, as well as hospitalisation and treatment for serious or frequent attempts. Other groups note that "there is a cost to doing

nothing" (HWAC, 2003, p.6). For example, there is the potential for improved staff retention if there is increased career satisfaction due to appropriate training opportunities and clinical supervision. Tobin, Chen and Scott (1999) note that is difficult to put a price on increased staff confidence and improvement of attitudes towards the person with a mental health problem .

When looking at the international scene where mental health services have become innovative within the ED, it is important to note the political policies that steered these changes. For example, improvement in England was prompted in 2001 by a national health strategy entitled Reforming Emergency Care. This was written in response to the identified ED overcrowding and prolonged wait times of the 1990s. One of the targets was to ensure all presentations were admitted, transferred or discharged within four hours of arrival, which has been achieved in over 90 % of cases (Department of Health, 2004). Against this background the mental health trusts are given incentive funding (two hundred thousand pounds) if this target is achieved. It is evident that there has been much financial incentive to fix the problem in the UK, and this has resulted in improved outcomes by reducing wait times in the emergency department.

Finally, it is vital for ED nurses to have resources to keep pace with evidence based practice. As the World Health Organisation (2005) states, reducing training opportunities can be likened to cancelling "all routine maintenance on a passenger aircraft: it will fly on for some time, but the need for consequent major repair, if not the risk of serious adverse outcome, increases with time" (p.94). Inevitably, it will be the person with a mental health problem that will receive a reduced quality of care if mental health training is not regarded as an essential part of the emergency nurses development.

SECTION FIVE

Conclusion and Recommendations

Conclusion

Emergency Departments in New Zealand have been used for the assessment of people with mental health problems since the move towards deinstitutionalised care (Ministry of Health, 2003). The challenges regarding their assessment and management in the ED setting have been explored in this thesis. The theme of how to provide effective ongoing mental health education for ED nurses was chosen because I had identified my own erratic education pathway for mental health. The literature review reflected many of my own uncertainties and experiences in caring for the person with a mental health problem.

The influences of policy on the practice setting have also been explored. There are often unexpected gains from investigating policy documents. In the process of exploring a range of documents about emergency triage I returned to some original documentation. This was to solve something that had been puzzling me and other colleagues about how to triage people with mental health problems presenting at ED. The problem with the NZGG & MOH (2003) document was that there seemed to be a leap from triage code 3 to 4 in relation to suicidal ideation. It appeared illogical that a person with suicidal ideation could wait for an hour to be assessed when the aim was to decrease wait times. This led me to resourcing the original Australian document, from where the NZGG & MOH (2003) triage code framework was adapted. What I discovered was that a crucial word had been omitted. Instead of it reading "*without* suicidal ideation", it read "with suicidal ideation". The puzzle was solved as it was simply a typing error. This significant error was confirmed by email with the NZGG (E.Sutich, personal communication, 6 September 2005).

In addition to examining policies, this thesis has enabled me to explore what strategies are available for ED nurses to provide a consistent standard of care for the person with a mental health problem. Upon reflection, there are no quick fixes. As the DOH (2004) state " Improvement in emergency care must start with the

challenge and not the solution. Each health and social care community faces its own set of issues , and each needs to tailor solutions to meet its own set of needs" (p. 17). It is with these challenges in sight, I will next present recommendations that may offer some solutions.

Recommendations

Recommendation 1: That a revision of the ACEM mental health triage code framework be requested via the CENNZ. This is to align its content with the mental health triage code framework produced by the NZGG, thus reducing the confusion for novice triage nurses caused by having two frameworks.

Recommendation 2: That a letter is written to the CENNZ working party currently working on the development of a national education framework for ED nurses. This letter would ask the working party to consider the development of a national workshop focusing on medicolegal issues related to mental health in the emergency department.

Recommendation 3: That a specific mental health training programme is developed for all ED nursing staff which commences during the orientation period. This will be designed in partnership with a designated group of ED nurses and representatives from the mental health team. The programme will include discussion about negative attitudes and discrimination, communication skills, the MHCAT, complex presentations and suicide risk assessment. These can be incorporated in case study review as part of this training programme.

Recommendation 4: That discussion is initiated with the ED senior nursing and medical teams in regards to the feasibility of multidisciplinary training about people presenting with mental health problems. This refers to involving the ED receptionists and junior medical staff in a training programme with nursing staff when appropriate.

Recommendation 5: That a proposal is developed for a mental health consultation-liaison nurse role within the District Health Board. This proposal can be discussed with key personnel including the ED nursing staff, the senior ED medical team and the mental health service. Its content would also be discussed at senior nursing meetings within the organization in order to receive feedback and gain support about the proposal from other stakeholders.

Recommendation 6: That strategies such as clinical supervision are developed to give appropriate support to ED staff who encounter complex presentations involving the person with a mental health problem.

Reflections on the journey of the educator

Writing this paper has not been an easy task. Having assumed that there would be very little literature on this theme, I was overwhelmed by the amount of material available. This has opened a wealth of resources for me as an educator, and has reignited my own level of motivation to develop a pathway for mental health education in my work setting. It has also been an interesting time watching the developments over the year in relation to the suicide prevention project with the New Zealand Guidelines Group, and I look forward to its implementation in my area.

Although negative attitudes were a strong feature in the literature, I believe the majority of ED nurses wish to provide effective and compassionate care for the person with a mental health problem. However, it is extremely challenging to do so at times when working in an overcrowded environment with high acuity workloads. I also look forward to having more informed discussions and debates with my mental health colleagues now that I can understand a little more of their world through my eyes as an emergency nurse.

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