Emergency nurse’s attitudes toward mental disorders

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Abstract:

The aim of this paper was to present a review of the existing literature concerning attitudes of nurses at the emergency department towards mental illness under the angle of the nursing profession and the healthcare providers. The research questions are:

What are the emergency nurse's attitudes toward mental patients?

What affects the ED nurses' attitudes to MH patients?

A literature review implemented in this study is to give adequate answers to the research questions. The search for articles is found in EBSCO, CINAHL, PubMed, SCIENCE Direct databases and in google scholar. The research key words applied are "Emergency nurse" AND "attitudes" AND "mental illness". This thesis works on the combination of attitudes theories with the modified labeling theoretical framework which is beneficial to the scenery of nursing attitudes toward mental patients and its effect on treatment process of mental patients in the emergency department. This thesis bases on the qualitative content analysis in nursing research approach by Graneheim & Lundman (2004). The findings of the content analysis showed that experiences with nurses were varied, with participants describing both positive and negative interactions. Positive attitudes obtain from the components of nurses. The negative attitudes derive fear, blame, hostility, fragmentation of client care and devaluation of mental health process lack of skill and education, lack of resources/infrastructure to support the provision of safe, competent mental health care. The conclusion includes the recommendations and solutions.

Keywords:	Emergency nurse, mental disorder, mental illness, psychiatric patients, mental patients
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Acronyms

ED _ Emergency department

MH _ Mental health

ENA _ Emergency Nurses Association

ESI _ Emergency Severity Index

CTAS _ The Canadian Triage and Acuity Scale

1. INTRODUCTION

During my study and pratical training, I found that the topic of metal health emergencies either was not popular or was not everyone' s favorite topic. However, this topic is extremely important and has been noticed throughout the history of forming a nurse role. It is reported that mental patients are frequently taken to a hospital emergency department for seeking help from healthcare team. They are often patients who have a serious mental illness which possibly leads to the risk of suicide. Therefore, the provided treatment and caring from emergency department are of immense importance to their lives.

Symptoms of mental illness remain universal among millions of people. (Manton. A, 2014; Shrivastava. A, Johnston. M & Bureau. Y, *2012*). Over the past century emergency departments have experienced a dramatic increase in mental patients and suicidal cases each year and there is no sign of slowing down according to Emergency Nurses Association (ENA), 2013. In the context of this marked increase, emergency nurses are playing the leading role in caring of mental illness. Nurses' attitudes assessment is crucial if the hospital is to deliver effective health care (McArthur, Montgomery. P, 2004). Nevertheless, their attitudes to mental health problems is not fully assessed. The topic of this study is important because improving services is only possible if we take the lived experiences of these vulnerable patients and their family members into account. The aim of this thesis is to analyze the attitudes of emergency nurse toward mental patients and further assess the roots of that attitudes. The mental health patient journey in emergency department in need of improvement is also identified.

1. BACKGROUND

Luhrmann 2000 indicated that:

> The mentally ill are people who deliberately hide razors and then, in private, when their mothers have gone to bed, slice into their flesh until blood seeps into the bedsheets. They hoard sleeping pills for months, collecting new prescriptions even though the old ones are untouched, then wash them all down with vodka and leave a voice-mail message on their doctor's line. They refuse to take out the trash for months, until the stench offends their neighbours and the janitor comes in to find a crawling pile. They skip lunch and eat only one tomato and one can of tuna fish each night, chopping the food carefully into a thousand pieces and eating forkful after tiny forkful for an hour. They act on the basis of voices we cannot hear and beliefs we cannot share. They intend; they decide; they choose. Their illnesses are a part of who they are in a way that seems very different from the alien invasion of cancer.(Luhrmann. T, 2000, pp. 270–271).

MH patients depicted their emergency department manipulation as necessary and unavoidable (Manton. A, 2014). Unmanaged symptoms lead to these feelings of necessity, either of their mental illness or their comorbid substance use (Manton. A, 2014). The chronicity of some psychiatric illnesses, as well as the jolt of illness on economic and social dimensions of life, can bring the person at risk for frequent episodes of emotional divagate which may draw to parroted ED visits (Shattell M et al., 2014). Both patients and their families are impacted by a mental illness crisis which has a great and enduring emotional impact

Emergency psychiatry department is the clinical application of psychiatry in the emergency setting (Lofchy J, Boyles P & Delwo J, 2015). Individuals may show up in psychiatric emergency service settings through their own freely offer, a referral from another psychiatrist, or through involuntary commitment (Lofchy J, Boyles P & Delwo J, 2015). Hillard and Zitek (2014) stated that responsibility of patients requesting psychiatric intervention commonly encompasses crisis stabilization of many severe and potentially life-menace conditions which

could include acute or chronic psychiatric disorders or foretokens similar to those circumstances (Hillard R & Zitek B, 2004).

Clinical practice guideline for the management of major depressive disorder (2009) show that symptoms and conditions behind mental acute can encompass attempted suicide, substance addiction, alcohol dependence, acute depression, presence of illusion, violence, anxiety attacks, and seriously, rapid changes in behavior. The emergency psychiatric department is presented to identify and treat these symptoms, mental conditions (The Department of Veterans Affairs (VA) and The Department of Defense, 2009). Moreover, several medicine side effects present themselves with common psychiatric symptoms (The Department of Veterans Affairs (VA) and The Department of Defense, 2009). A doctor's or a nurse's capability to identify and intervene with these and other medical situation is critical (Lofchy J, Boyles P & Delwo J, 2015). According to Hillard R & Zitek B (2004), patients will be triaged by nurses whose responsibility in deciding which patient can be admitted to the hospital and which one can be discharged from the health facility after the brief treatment. Initial acute psychiatric assessment frequently involves patients with self-harming, self-destructive or suicidal behaviors. The therapeutic effect is mainly based on the arrangement of initial assessment and intervention (Hillard R & Zitek B, 2004)

Based on the government's law applied for involuntary commitment for each country, the distribution of MH patients via police officers, social worker and healthcare provider must commit to the appropriate conditions (Hillard R & Zitek B, 2004). After an MH patient is conveyed to a psychiatric emergency department, a preliminary professional assessment is concluded which may or may not result in involuntary treatment (Hillard R & Zitek B, 2004). Some psychiatric patients may be discharged shortly after being brought to mental health emergency services while others will need further monitoring and the requirements for carrying on with involuntary commitment will endure (Lofchy J, Boyles P & Delwo J, 2015).

Emergency department nurse, many of whom prefer to commit in a highly technological, quick process environment with more readily apparent outcomes (Crowley. J, 2000). Psychiatric patients also carry with them to the emergency department societal stigma, particularly fears that they pose a risk to safety, that they may performance strange and unstable behavior, and that MH patients are to be either concerned or being derisive (Sartorius N 2007, Schulze B 2007).

Primarily because emergency departments are open and available round the clock, the emergency departments will ongoing to be the default meanwhile there is nowhere else to go or while individuals do not know where else to go (Clarke et al. 2007). In light of this, it is meaningful to have an appropriate understanding of how the attitudes of emergency department nurse effect on their clinical decision-making to inform education, interventions, and improve clinical practice in the psychiatric department.

More recently, the emergency departments have received a considerable increase of mentally ill patients with severe cases (Morris D W, Ghose S, Williams. E, Kevin Brown. K & Khan. F, 2018). A substantial number of people with psychiatric illness have contacted emergency departments for psychiatric treatment despite of the fact that the number of graduate psychiatrists has steadily increased (Morris D W, Ghose S, Williams. E, Kevin Brown. K & Khan. F, 2018). Morphen. J (2012) reported the most common reasons why MH care consumers attended emergency department were: • MH problems (54%) • Physical health problems (13%) • Alcohol and/or drug problems (13%) • Overdoses (7%) • Accidents (5%) • Other (7%). Therefore, triage nurses play a prominent role in the caring of mental health patients treated at the emergency department. Approximately one in eight visits to emergency departments in the United States involves mental and substance use disorders (Owen, Mutter, & Stocks, 2010). According to the report by the Agency for Healthcare Research and Quality (2016), the number of acute department visitations related to psychiatric illness and substance-use problem raised over than 44% with suicidal thinking visits developing by nearly 415%.

Over the past few decades, the policy of health care system, in general, has witnessed a remarkable change (Frank R G & Glied. S, 2006). In more detail, there has been a reduction in the number of mentally ill institutions in order to reallocate psychiatric patients back to their community whereas emergency departments have been responsible for dealing with services for patients with most acutely mental health problems (Schmidt. M, 2018). Moreover, this policy has been conducted in the condition that physical and technical infrastructure has not been enhanced enough to support psychiatric patients (Schmidt. M, 2018). For this reason, emergency departments have received a noticeable increase of metal patient presenting to.

According to the American College of Emergency Physicians(2014), bygone the past 40 years, services for mental illness patients have turn into progressively deinstitutionalized, moving away

from inpatient treatment facility (Fitzpatrick. J, Alfes C M & Hickman. R, 2018). As a result, inpatient beds have abated to less than 50,000 countrywide, requiring patients to find another channel for treatment, as well as outpatient facilities, outpatient medical caring department, and public resources (ACEP Emergency Medicine Practice Committee, 2014). Regrettably, those resources have also turn into more and more limited by large-scale budget cuts, leaving MH patients with the medical caring system's last remaining safety place—the emergency department." (ACEP Emergency Medicine Practice Committee, 2014). For instance, the United States has overwhelming influenced by the increase of psychiatric patients in 2010 (Owens, P., Mutter, R., Stocks, C., 2010). Over 6.4 million patients with mental illness which is equivalent to 5% of total cases presented to emergency departments. (Creswell, 2013). This number increased 28% compared to the figures in just 4 previous years reported by the Agency for Healthcare Research and Quality 2016 in Rockville, MD. (National Healthcare Quality and Disparities Report, 2016)

3. Theoretical framework

3.1 Attitudes theories

Attitudes are individual mental processes that determine a person actual and potential response (Ajzen & Fishbein, 2011). According to definitions derived from existing dictionaries, attitudes consists of three particular characteristics including a mental state, a value, belief, or feeling; and a predisposition to behavior or action (American Heritage Dictionary of the English Language, 2019; Oxford Dictionary of English 2019; American Heritage Stedman's Medical Dictionary, 2007; Merriam-Webster's Medical Dictionary, 2019). Assistive statement toward things, circumstances or people which show feelings or mood of a person is defined as attitudes

Theory and research in the social sciences indicate that attitudes are multi-dimensional constructs (Edwards. J. E, 2001). Although we might use the term in a different way in our everyday life, a definition of attitudes by social psychologists is referring to our relatively enduring evaluation of specified phenomenon, person or thing, which is called the attitudes object. This definition provides two aspects of an attitudes. Firstly, attitudes is bipolar, which can be positive or negative, favorable or unfavorable (Eagly, A. H & Chaiken 1993; Robert S. Wyer, Jr., Thomas K. Srull, 2014) Secondly, an attitudes is a response to a person, object, or situation (Eagly. A. H & Chaiken 1993; Hogg. A M. & Vaughan. G 2005). Attitudes of each person varies depending on their distinct conditions. There is no doubt that the concept of attitudes has become a practical term for everyone. Despite of all trenchant criticism of critics, the term of attitudes is now ubiquitous on streets of cities and even play a pivotal role in a significant number of recent methodical studies by psychologist and sociologists in social psychology. From this reason, attitudes are the concept which needs a special attention from students when researching.

Arcording to Eagly. A. H & Chaiken (1993) There are three constitutive attributes of attitudes:

- Affective Component:

Affective component of attitudes involves feelings of an individual toward another person, which may be positive, neutral or negative.

- Behavioral Component:

The behavioral component of attitudes involves possible impacts of distinct situations or objects that generate individual's behavior characterized by cognitive and affective components.

- Cognitive Component:

The cognitive component of attitudes typically involves a value statement. An individual may rely on the belief, ideas, values and other information included in the cognitive component of attitudes

Attitudes is bipolar and can be considered as a reaction to stimulation. all aspects of intellect and behavior are specifically and extensively related to these attributes. This causes great difficulties to create true related and/or contrary cases (Eagly, A. H., & Chaiken, 1993; S. Hogg, M., & Vaughan, G. ,2005). Eagly. A. H & Chaiken (1993) reported that the effective component is connected to the feeling of an individual toward the attitudes object. It shows reflections toward a general favor or disfavor or more particular affective reactivities toward the object. With a connection to attitudes to emotion, the affective component links to the expansion to which one favor or disfavor the objective concern (Eagly. A. H & Chaiken ,1993). The behavioral component is connected to the actions of an individual toward the attitudes object (Eagly. A. H & Chaiken ,1993). Approaching the object is mostly correlated with added positive attitudes toward it, whereas keeping away from the object is mostly correlated with more negative attitudes (Eagly. A. H & Chaiken ,1993). With a connection to attitudes toward emotion, the behavioral component is.: Personality and Individual Differences similarly avoiding concern to whether people approach or evade the objective emotion (Eagly.

A. H & Chaiken ,1993). The cognitive component is connected to how individual judge about the attitudes object (Eagly. A. H & Chaiken ,1993).

This component reflects beliefs that people hold about the object and the attributes they associate with it. The more people associate an object with positive attributes, the more positive their attitudes toward it. With respect to attitudes toward emotion, the cognitive component is likely related to the extent to which one thinks positive or negative thoughts about the emotion or associates it with positive or negative attributes.

These components are explained in figure below.

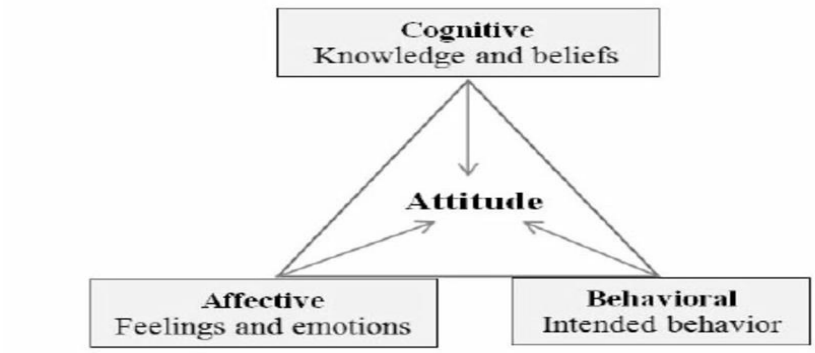

Figure 1: Triadic Model: Components of attitudes (Lee Y-S, Shin S-H, Greiner. P, 2015)

Attitudes can benefit people via valuable functions. Functional areas can be classified into four categories according to Carpenter et al 2012: Knowledge, value-expressive, social adjusted attitudes, ego-defensive (Carpenter et al ,2012)

- Kn**owledge**

  Knowledge attitudes convey the meaning of life. The function of given knowledge by attitudes helps us to clearly perceive today's world. This enables us to confidently predict things that are likely to happen. Attitudes facilitates us to organize and form our experience. In addition, the behaviors of a person can be foreseen via their attitudes.

- **Value-expressive**

Value expressive attitudes enable the expression of the person's centrally values. Self-expression of attitudes can be verbal or non-verbal too. (Carpenter et al 2012). Moreover, Carpenter indicated that concentrating on value-expressive communication of an attitudes rather than value-relevance allows communication behavior to take center stage in considering the relationship between values, attitudess, and behaviors (Carpenter et al 2012)

- **Social adjusted attitudes**

  Social adjustive modulating people's relations (Olson. J ,2019). Olson J (2019) argued that attitudes may often serve contrasting functions for people who differ in self-monitoring. A social-adjustive function promotes the capability to connect with appropriate relations or to impress attractive others (Olson. J ,2019). The social - adjustive function helps them to be more attractive or popular in the eyes of a valued group. A social-adjustive attitudes links with a person concerning about their status, popularity, and how they are viewed by others and will seek objects that assist in developing their desired social image (Carpenter et al 2012).

- **Ego-defensive**

  Ego-defensive functions serve to protect the individual from both internal and external unpleasantness, which mean protecting self-esteem or that justify actions that make us feel guilty (Shavitt & Nelson, 2002). An ego-defensive attitudes function held to protect an individual from threatening or undesirable truths (Shavitt & Nelson, 2002). Threats to self-esteem can be personal failings or poor behavior. Ego-defensive attitudes aid in self-esteem maintenance through multiple processes (Shavitt & Nelson, 2002).

3.2 Modified labeling theory

Thomas J. S published the book Being Mentally III: A Sociological Theory in 1966 which is the former of The Modified labeling theory. Scheff reported that most people are aware of mental illness and its stereotyped imagery in daily life which appears in the shape of terms like "crazy", "loony", "nuts". By linking these mental patients to violent crimes, bias against psychiatric patients are also created by the media as well. Scheff has a strong belief that those

who do not follow the social norms of the society will receive a negative response from society and will be treated as a psychiatric patient.

The above-mentioned responses toward mental patients make them more introverted. Moreover, their mental illness will be stable due to being under the name of a mentally ill person. Consequently, chronic mental illness can be acknowledged as a social role and the societal reaction is the decisive factor in placing a person in the group of mental patients. Scheff stated that hospitalization of a mentally ill person further reinforces this social role and forces them to take this role as their self-perception. Once the person is institutionalized for a mental disorder, they have been publicly labeled as "crazy" and forced to become a member of a deviant social group. Then, the situation becomes more difficult for a deviant person to return to their former level of functioning as the status of 'patient' causes unfavorable evaluations by self and by others

Link et al (1989) reported that the modified labeling theory is a modification of Scheff 's labeling model (Link. B, Cullen. F, Struening. E., Shrout. P, & Dohrenwend. B, 1989). The concentrates on the consequences of labeling patients that seek mental health support, which is contrary to Scheff's model. According to Link et al, a labeled person is forced to follow the norms of society. They conform with expectations of society toward mental illness and are constrained by society. Link furthers identified that chronic mental illness occurs when this role is adopted and become a part of one’s personal identity.

According to Link et al (1989 & 1999), the theory of the modified label framework is perfect to explain stigmatization and its concentration is to well label patients that seek mental health support. The modified label theory is a theoretical framework which nicely illustrates the process of stigmatization. The process reveals how an individual introspects in the meaning of mental disorders among society as well as how he becomes discriminated and its consequences of discrimination. Link et al (1989) reported that the theory was tested by using a sample (n=503) of New York City residents and psychiatric patients in which a Likert scale was used to measure these patients’ perceptions of different variables, comprising the experience of stigmatization and devaluation. From their results, the negative attitudes related to psychiatric illness were clarified.

The modified label theory consists of five steps. The first step of the model concentrates on the internalization by all individuals of their society's perceptions of psychiatric problems. This perception will comprise a different level of negative attitudes regarding mentally ill individuals. These negative perceptions will be composed of society's reduction or devaluation, as well as social distancing or discrimination toward psychiatric patients. Because individuals with psychiatric disorders have internalized society's norms, they understand how other people will view them as mentally ill. These preconceptions impact the remaining steps in the modified label theory. The remaining four steps describe the impact of labeling. During the second step, labeling can occur. Labeling occurs when the patient that seeks mental health support perceives that society's norms and the resulting devaluation and discrimination will now be applied to patients. After labeling occurs, the patient chooses their response to stigmatization. The individual may respond by concealing the illness, limiting social contact, or acknowledging the illness and attempting to teach others about the disorder. In the fourth step, the labeling process and the chosen response to labeling will cause consequences for the stigmatized individual. These consequences can include shame, distancing from others, self-limitation, and other adaptations to labeling. Finally, these adaptations can leave the patient vulnerable to future disorders. The continued mental illness and the patient's response to labeling may leave the individual more likely to have reoccurring exacerbations of a disorder.

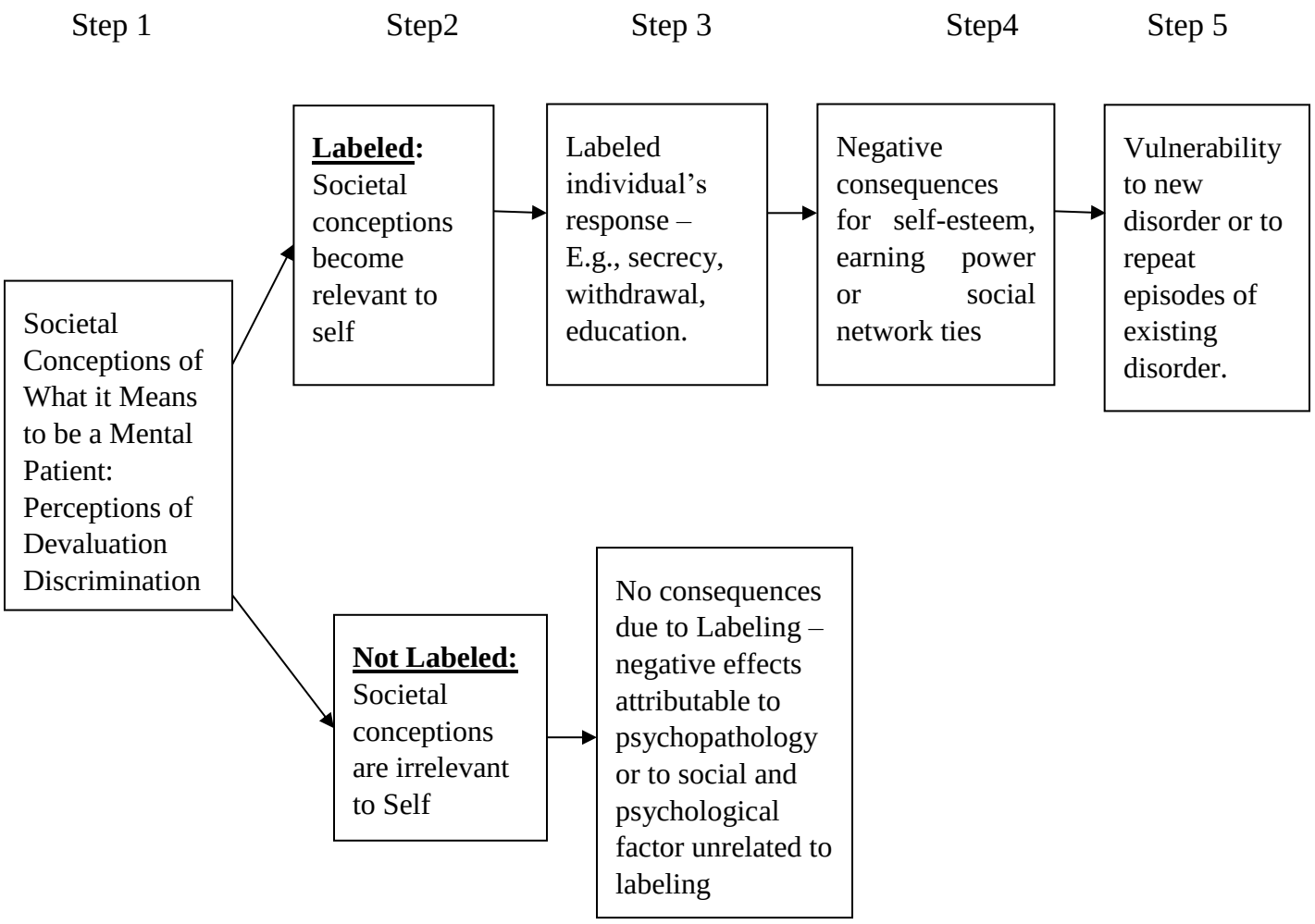

Figure 2: Modified labeled theory framework (Link et al (1989))

3.3 Justification

This thesis works on the combination of attitudes theories with the modified labeling theoretical framework which is beneficial to the scenery of nursing attitudes toward mental patients and its effect on treatment process of mental patients in the emergency department. Modified labeling theory describes the generalized process by which stigmatization of mental illness occurs. Throughout being the labeled phenomenon, in a forecast of stigmatizing

responses from society, may adopt harmful coping mechanisms leading to worse psychological symptoms, diminished social networks, and reduced life opportunities.

4. Aims

The aim of this thesis is to analyze the attitudes of emergency nurse toward mental patients and further assess the roots of that attitudes. The mental health patient journey in emergency department in need of improvement is also identified.

- What are the emergency nurse's attitudes toward mental disorders?
- What affects the ED nurses' attitudes to MH patients?

5. Methodology

The thesis based on a literature review about the articles which have addressed the matter were reviewed to give an understanding to the subject and thereby answering the research questions. Studies have examined the attitudes of emergency nurses for psychiatric patients

5.1 Data collection

In order to retrieve data, numerous search engines with a great number of key words has been used. Google scholar and Arcada's academic databases are mainly used to retrieve data, which consist of Academic Search Elite (EBSCO), Cinahl, Pubmed and ScienceDirect.

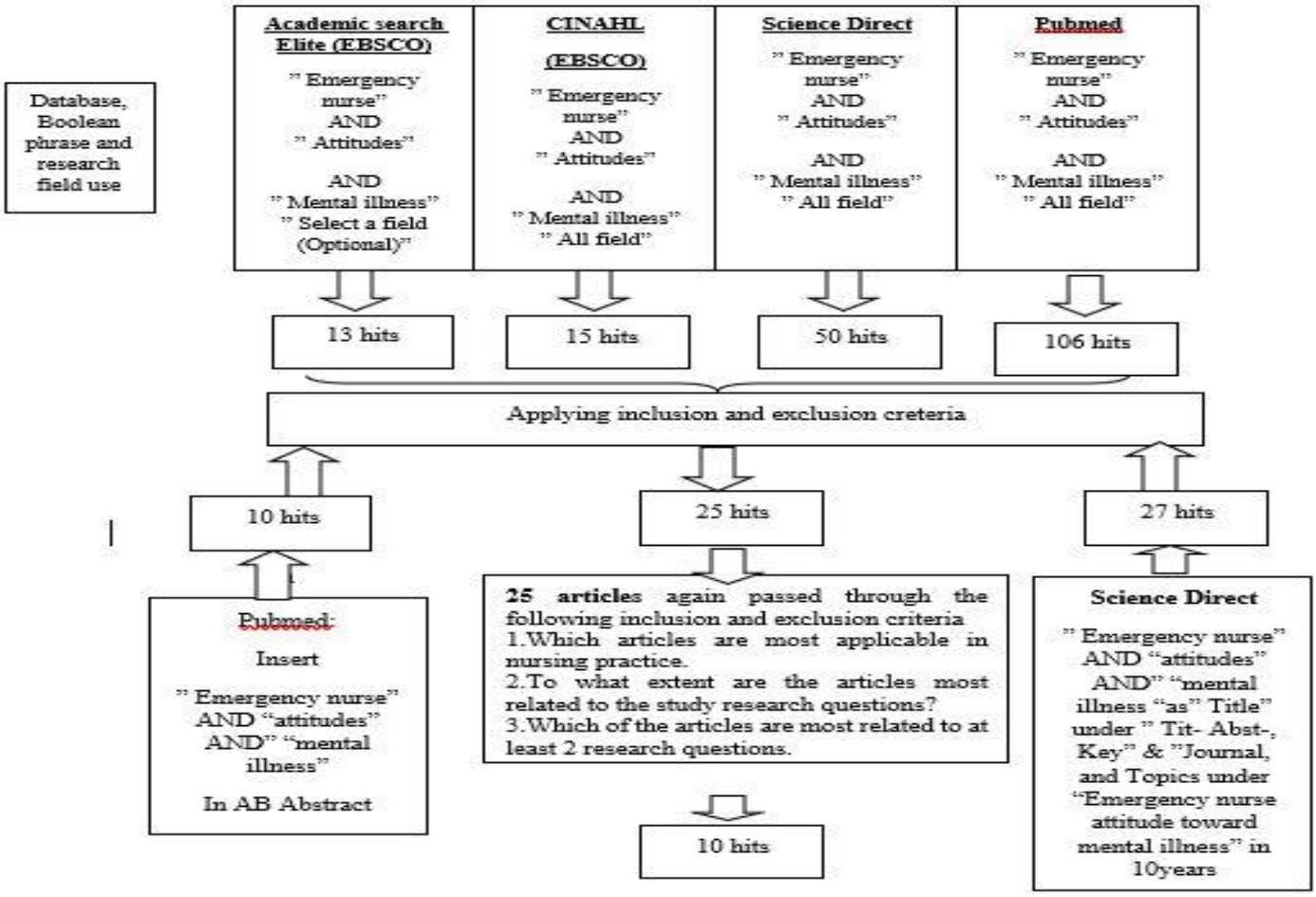

Figure 3: Flowchart detailing data collection and selection of the ten articles

There are three main search phrases which are **Emergency nurse**, **Attitudes**, and **Mental illness.** Ten articles were chosen from the articles which had at least one keyword and involved the research questions in this study. The below table specify the inclusion and exclusion principles used for choosing the eleven articles.

Table 1. Exclusion and inclusion criteria

Inclusion criteria	**Exclusion criteria**
Articles in the English language	Articles in other languages
Articles had the key words "Emergency nurse AND Mental illness" or had the keywords in text	Articles deal with others matters concerning Emergency nurse's attitudes toward mental illness
Articles from 2009-to date	Articles older than 2009
Free full text articles	Articles were not freely available
The articles are original research articles and peer review	The patients are child

Table 1: Exclusion and inclusion criteria

List of chosen articles

The following 10 articles were chosen based on the inclusion and exclusion criteria given in the table above.

1. Buriola. A, Kantorski. L, Sales. C, Matsuda. L, 2016, "Nursing practice at a psychiatric emergency service: evaluation using fourth generation assessment", Texto Contexto Enferm, vol.25,1, available at: http://dx.doi.org/10.1590/0104-070720160004540014
2. Clarke. D. E, Boyce-Gaudreau. K, Sanderson. A. B, Baker. A. J, 2015, "ED Triage Decision-Making with Mental Health Presentations: A "Think Aloud" Study", Journal of Emergency Nursing, vol. 41, 6, p. 496-502.

3. Daggenvoorde, Gijsman & Goossens, 2018, “Emergency care in case of acute psychotic and/or manic symptoms: Lived experiences of patients and their families with the first interventions of a mobile crisis team. A phenomenological study.”, Perspect Psychiatr Care, vol 54, 4, p462-468. Available at: doi: 10.1111/ppc.12247. E.pub 2017 Sep 27.
4. Harris. B, Beurmann. R, Fagien. S, Mona M, Shattell, 2016, “Patients' experiences of psychiatric care in emergency departments: A secondary analysis”, International Emergency Nursing, 26, p 14-19.
5. Manton. A, 2013, Care of the Psychiatric Patient in the Emergency Department, White paper, Emergency Nurses Association.
6. Manton. A, 2014, “Behavioral Health Patients in the Emergency Department”, Journal of Emergency Nursing, vol. 40, 2, Pages p. 112-113
7. Morphet. J, Innes. K, Munro. I, O’Brien. A, Cadeyrn J. Gaskin. C. J, Reed. F, Kudinoff. T, 2012, “Managing people with mental health presentations in emergency departments——A service exploration of the issues surrounding responsiveness from a mental health care consumer and care perspective”, Australasian Emergency Nursing Journal, Elsevier, 15, 148—155
8. Roberge. P, Hudon. C, Pavilanis. A, Beaulieu. M. C, Benoit. A, Brouillet. H, Boulianne. I, De Pauw. A, Frigon. S, Gaboury. I, Gaudreault. M, Girard. A, Giroux. M, Grégoire. E, Langlois. L, Lemieux M, Loignon. C, Vanasse. A, 2016, “A qualitative study of perceived needs and factors associated with the quality of care for common mental disorders in patients with chronic diseases: the perspective of primary care clinicians and patients.”, BMC Fam Pract, 17, 1, p134, Available: doi: 10.1186/s12875-016-0531-y.
9. Sukhera. J, Miller. K, Milne. A, Scerbo. C, Lim. R, Cooper. A & Watling. C, 2017, “Labelling of mental illness in a pediatric emergency department and its implications for stigma reduction education”, Perspect Med Educ, 6, 3, p165-172. Available at: doi: 10.1007/s40037-017-0333-5.
10. Vandyk. A, Young. L, MacPhee. C & Gillis. K, 2018, Exploring the Experiences of Persons Who Frequently Visit the Emergency Department for Mental Health-Related

Reasons, Qualitative Health Research, University of Ottawa, 28, 4, 587–599, available at: DOI:10.1177/1049732317746382

5.2 Content analysis

Content analysis has nearly 60 years of history and is applied through variety study fields. As the beginning, contend analysis defined as a research technique for the objective systematic and quantitative description of manifest content of communication (Berelson, 1952, p. 18) but, over time, it has expanded to also include interpretations of latent content. Content analysis is adequately defined as a set of techniques of which researchers use one or more to make replicable and valid inferences. Analysis of what the text says deals with the content aspect and illustrate the obvious, clearly parts, alluded to as the manifest content (Kondracki. K 2002). Recently, Kimberly A. N (2016) assumed that content analysis is a summarizing, quantitative analysis of messages that follows the standards of the scientific method (including attention to objectivity _ intersubjectivity, a priori design, reliability, validity, generalizability and hypothesis testing based on theory and is not limited as to the types of variables that may be measured or the context in which the messages are created or presented.

This thesis based on the qualitative content analysis in nursing research approach by Graneheim & Lundman (2004). In order to gain and broaden understanding, the method of inductive content analysis is designated in which the researcher read and review selective articles to gain the apparent and dormant meanings through the texts in those articles. The researcher chose this path in the reason that it is brought to a focus about caring patient. Additionally, the inductive approach as quoted by Graneheim & Lundman (2004), which adapt to this research. In this research's content analysis, individual concept or new opinion is explained in its own circumstances within an extensive perspective. The apparent meaning is the manifest content and the latent meaning is acknowledged as the basic or bottom line of the texts. The unit of analysis is the full text which is read and reviewed. In this case, the ten selective articles are the unit of analysis. All the words, texts, phrases or paragraphs relating to each other with regard to either their content or context are acknowledged as meaning units. Markers that are placed on meaning units to classify them together are codes. Codes with similar content are then included in the categories. A series of categories included in themes

identify a key element in the content analysis. By using the inclusion and exclusion criteria when repeatedly reading ten articles, the researcher is able to highlight and code the meaning units in terms of the manifest content of the text. This coding process is performed based on the relationship between codes and the applied keywords in the research. In order to efficiently identify these keywords, they are vibrantly marked with color. This also makes coding easier.

5.3 Listing and categorizing the codes

In the process of reviewing the information again, classifying the pieces of information and its relevant codes into appropriate categories is taken placed. Subsequently, emerging sub themes which are analyzed along with its latent meaning of data, are categorized. In order to prevent the impact of other articles toward the researcher´s understanding and interpretation of the data, each of the articles are read separately. The selected articles which are read carefully, are known as the so-called unit of analysis. The important information which are written down on the margins of the papers are valuable notes. These notes contain the leading keywords of the meaning units that the writer uses as labelling codes in order to easily locate when he is in need of reading or reviewing. Furthermore, these codes are marked with different colors and keywords are either underlined or circled, or even marked with other special symbols. In other cases, they are asterisked as well. To the greatest extent possible, markers and asterisks indicate the level of significance of the codes.

5.4 Research ethics

In contrast to ethical standards, general principles are a set of values standards and principles used to determine appropriate and acceptable conduct at all steps of the research process. Based on the writing instructions and its critical standards in the ethics rules given by Arcada University of Applied Sciences and the book “Understanding nursing research: building an Evidence-based practice” of Grove S & Gray J (2019), the academic thesis is not a direct copy version of any other sources. Accordingly, valuable information from articles are used via a system of referencing with Harvard referencing style. The steps of reading and evaluating articles are performed one by one in the data analyzing process in order to ensure that the

duplicated information generalization process is necessarily diminished. This is of supreme importance as the purpose of each article is not to repeat the information word for word but to give more detailed explanation on existed information of the previous article. During the process of thesis writing, it is imperative not to be subjective and biased when presenting methodology. Instead of that, the writer is rational and self-conscious during the processes of the data collection, analysis and interpretation.

6. Finding

The finding of the primary literature searches is shown in Table 2. From this reviewing of study and combination of all the outlined literature (primary and secondary sources and selected critical research).

Table 2

Identified emergent themes and sub-themes

Theme I: Positive attitudes
Primary sub-theme A: Roles of emergency nurse
1. What makes MH patients feel comforts 2. Competences of emergency department nurses
Them II: Negative attitudes
Secondary sub-themes: Stigma toward mental illness 1. Negative attitudes/ Fear/ Blame/ Hostility 2. Fragmentation of client care and devaluation of mental health process (modified label theories) 3. Shortage of skills and educational base to meet the needs psychiatric clients 4. Shortage resource/infrastructure in assisting the provision of safe and qualified psychiatric health care.

Table 2: Theme, sub themes and categories formed from the content analysis

6.1 Positive attitudes

According to Buriola et al (2016), nurses played a crucial role in giving care directly and were able to organize the multi-disciplinary care toward patients. Because of their management competency, nurses could easily contact and communicate with experts in order to give the best care for their patients. It was identified that the functional service has remained effectively via activities of the nurse with an energized attitude in giving care in the extent of

the multi-disciplinary team organization (1,4,5,7,8). Activities of nurses were acknowledged as a central part of the multi-disciplinary team management, which contributed to constituting the emergency care in psychiatric health (1,4,8). Because the nurses' works was mainly related to the administrative sphere or management sphere, activities of them were also indispensable to the psychiatric emergency service. Moreover, nurses played an important role in the communication between multi-disciplinary team members as well as health care' s safety (1,4,5,7,8). At the emergency service, the nurses' role was further acknowledged as a facilitator of health actions (1,5).

The mental health nurse in the emergency department was highly appreciated by patients. They were responsible for enhancing and advancing the client experience via providing education on mental health and ensuring timely care toward patients by an experienced expert (1,4,5,8). At the emergency service, the families of the service users were given permission to approach the obstacles of the mental illness and family conflicts via welcoming and humanized care. One of the well-known difficulties was the acceptance of the mental disturbance inside the family (1). Nurses were characterized as rescuers in families. Their activities of care which were delivered to the families are the care of "rescue board" were of immense importance to help with the families' suffering when they had a member who needs emergency mental care (1). One of the most important actions of the nurses during the caring process was welcoming. An ideal and welcoming approach to mental patients was comprised of their existential, relational, historical, cultural and situational dimensions (1). In addition, the established bonding between the nurses and family of mental patients also contributes to the expected care with the purpose of maintaining mental health in the context of family (1,8)

There was a multiplicity of applied low-intensity interventions reported by emergency department nurses which were comprised mainly of supportive psychotherapy, lifestyle education, self-help support, motivational interviewing and basic cognitive-behavioral therapy interventions (4). It appeared that nurses are professional in providing low intensity as they were more invested in accordance with their scope of practice (8). In an era of development nowadays, Emergency Severity Index (ESI) scale had proven its outstanding efficiency in classifying patients seeking emergency care to increase the effectiveness and productivity of

treatment (5). Accordingly, emergency department nurses were responsible for processing those patients' demands by instantaneously assessing their mental health problems and distributing them to the appropriate department in order of priority (2,4,5,7,8). The Canadian Triage and Acuity Scale (CTAS) had been continuously updated and specifically designed to classify patients in a specific way.

+ Uncontrolled behavior (Level 1 – immediate attention)

+ Uncertain risk for flight or safety (Level 2 – emergent)

+ Controlled/redirectable (level 3 – urgent)

+ Harmless behavior (Level 4 – less urgent)

+ Chronic harmless behavior (Level 5 – not urgent)

Previous researches have indicated that the initial evaluation and components of triage such as basic history, physical exams, vital signs, laboratory tests and toxicology screens did not make a useful contribution to the consecutive treatment of mental patients. On the contrary, recent studies have proven that the usual components of a medical assessment are of importance's in the care of patients with symptoms of psychiatric disorders at emergency department. Many of those patients have been diagnosed with simultaneous medical disturbance. Suicide assessment was one of significant challenges in psychiatric triage which had many aspects of risk to be considered. There was a vast majority literature concerning triage assessment of psychiatric emergencies has been published in papers which is comprised of widely known risk factors. However, useful tools for predicting risks have not yet been found with the necessary efforts (5).

The coordination between emergency departments and public mental health departments could faster assist the progress of providing placement of boarded patients. Some measures such as mobile crisis intervention teams, urgent walk-in clinics that provide refills and crisis counselors, and 24-hour phone lines have been invested and installed at some communities and public premises in the context of promoting the crisis prevention and management

resources (3). A vast majority of patients seeking emergency care was identified with symptoms relevant to acute psychotic and/or manic expressions (3). It was necessary for patients as well as their families to receive expressions of calmness, empathy, and understanding from the experienced nurses (3).

6.2 Negative attitudes

Many recent studies have identified that these negative attitudes linked with stigma has happened among RNs (1,2,3,4,5,6,7,8,9,10). In general, caregivers in the emergency department have not felt comfortable enough when providing care for mental patients (1,2, 3,5,6,9,10). It was found in most circumstances that psychiatric patients have not received sufficient care (1,2,5,6,9,10). Sometimes, it has even turned out threatening and traumatizing rather than necessary reassuring and hospitality (3). Studies have shown that there is personal animosity between nurses and psychiatric patients who have been considered as challenges, fears during the treatment process (2,5,9,10). In addition, the nurses were not keen to develop their own expertise in giving care to mental patients (1,3,5,6,9,10). The way of caring for these patients have not been consequently perceived as a part of real emergency services but problems or nuisances (5,6,8,9).

It is reported that mental patients are not a high priority when being interviewed. In fact, they did not receive respect from emergency nurses in the treatment process (2,3,4,5,7,8,9,10). They were not treated in a way that a nurse should treat a patient in medical caring (4,5,6). Many of those noted that nurses made a judgment on their concerns to be less important compared to those of others with acute medical cases or medical problems (4,5,6,10). It was noticed that there was not enough essential communication between emergency physician, primary care provider and psychiatric care provider of patients (3,6).

Patients claim that emergency departments nurses were careless in the medical profession and their continuous supervision toward patients was expressed as a negative evaluation of patients' mental illness (1,2,3,4,5,6,7,8,9,10). Employees have had an increasingly negative attitudes when mental patients frequently seek medical treatment at the emergency department especially when patients do not comply with their recommendations (2,4,9,10). Likewise,

many patients have been suffered by hasty requirements from a considerable number of nurses which illustrates a lack of awareness of their emotional injuries or lack of visual communication during the treatment process (4). This could be worse when hearing adverse comments about psychiatric patients that are made by those nurses. Subsequently, they also labelled patients with nicknames (4).

The ubiquitous feeling of loss of freedom existed on almost individuals who are in extreme anxiety in the emergency department. Safety standard processes were applied without reasonable cause for caring for psychiatric patients who were reported in the stress-related condition in ED (4,5). MH patients have declared that their fears derive from that their sayings are judged in the subjective perspective of the caring providers who consider them to be mental people asked for more restriction and less interpersonal intervention (4,9). This matter of fact reflected stigma and a lack of trust of emergency department nurses on MH patients.

There were certain problems with the use of restrictions and limitations. MH patients seem to be forced discharged instantaneously despite not getting enough the care or recommendations they need for follow-up care (5,8,10). The final disposition of patients was only adjusted by a 76% agreement between emergency medicine and psychiatry (5). In connection with discharged MH patients, the ambiguous guidance caused conflicting discharge experiences that many of them were discharged with unstable and insecure conditions (5,10). They did not receive not only adequate intervention but also a treatment plan for aftercare. In addition, some mental health patients claimed that they were even dismissed at midnight without adequate provision of healthcare as well as safe transportation home. Many of those in these cases subsequently out were strolling along in the area of the hospital, carrying out self-destructive behaviors leading to the use of emergency department (5,10).

It has been reported that MH patients in the emergency department had to usually wait for treatment in an inpatient facility (1,2,4,5,6,7,8,9,10). Non-availability of psychiatric clinician or nurse together with waiting for hours are possible reasons for distress intensification (4,5,7). Inadequate safeguarding privacy in emergency department settings is also a mounting concern for MH patients, causing them to be more attended by others. This concern is particularly

severe for patients who are able to perceive the presence of stigma from care providers in their surrounding environment (4).

If Clark et al (2015) findings were accurate, the scores in the CTAS form are adjusted by emergency department nurses. They supposed that their clinical experience could tell them' what score a person's presentation should generate and they adjusted their triage accordingly until this matched. This could be attributed to nurses' perception that there are not essential modifiers provided by CTAS in order to adequately expound on how a person is presenting. The combination of clinical knowledge and experienced-based judgments showed more objectivity and accuracy in assessment process rather than one of them applied alone.

Emergency department nurses bear negative attitudes due to various reasons, which results from following contributors: attitudes of the society, prejudice and/ or preconception of individual, a lack of preparation, organizational environment, safety issues, crowding, insufficient skill base, and knowledge, and inadequate instructions (2,4,5,8,9). Emergency department nurses were expected to give care to mental patients who deliberately do harm to themselves. To a large number of nurses, they experience an inadequacy of knowledge and expertise to fulfill those tasks (5). Furthermore, some challenges that might be taken into consideration when giving care to these patients are risk assessment, annoyance with patients of repetitive suiciding effort records, inadequate resources and time, concerns of safety, inadequate hospital beds, sense of being helpless due to the acknowledged mental system failure (5,9).

7. Discussion

The findings of the content analysis showed that experiences with nurses were varied, with participants describing both positive and negative interactions. Circumstances that MH patients are cared and respected are perceived as positive interaction between the MH patients and nurses whereas negatives interactions with nurses consist of situations when behaviors of MH patients are unfairly and harshly judged by emergency department nurses. Based on the attitude's theories and the labeling model framework, the findings indicated that stigma and labelling toward MH patients, which are time-consuming, unpredictable and/or unfixable, are highlighted problems among emergency department environment. This labelling accidently causes avoidance behavior of emergency department nurses, which can be considered as prejudices and discrimination against patients from emergency department nurses.

The positivity in attitudes of a nurse can be observed and evaluated through four dimensions: confidence in assessment and referral, empathic approach to patients, ability to persuasively deal with patients, and compliance in legal and hospital regulations. Apparently, patients have the right to comment on their received care from nurses as well highlighted their complementarity and availability. MH patients are also in need of common eye contact, care about their feelings, demands and clear statements of what to do or to be done in a reasonable way (4,5,9). Furthermore, nurses, in many circumstances, need to take time with patients to keep them calm and in control. Agitating stimuli in the process can be also early intervened by nurses. To some extent, behaviors of nurses contribute to increasing the feeling of safety of MH patients as well as supplying the nurses with valuable information which benefits forming influent interventions toward the patients in order to release aggression from them (4,5,9). As a matter of fact, a person who behaves with calm assurance is less aggressive (4,5,9).

Our findings clarify the stigma related attitudes. Discussed in this part was the stigma associated with nurses. These negative attitudes could make problems worse, causing patients to avoid aid from nurses due to the fear of being labelled with a psychiatric disturbance. Comprehension the link between labels and context relevant to analytical models that emphasize how stigma may performant a part in defending threat to cognitive self by

rationalizing negative group-based attitudes and discrimination. This research on attitudes toward mental health patients in the emergency department highlights this issue, describing a caring environment which still existing stigma that is not conducive to good mental health care. Education which targeting labeling and stigma reduction for nurses in the unique community context of an acute department, where dissatisfaction is linked with an imbalance between an emergency environment that required rapid symptom mitigation and crowded patients that requires inherently different solutions.

The roots of negative attitudes of emergency department nurses toward MH patients are numerous, have shown several contributing factors: societal attitudes and personal biases, inadequate educational preparation, organizational climate, safety concerns, crowding, caregiver lack of confidence in skills and expertise, and lack of guidelines (2,4,5,8,9). MH patients who have self-harming behaviors, are in need of care and assessment of emergency department nurses. In fact, there are shreds of evidence showing that this necessary care has not been performed in the best way due to the lack of knowledge as well as dedicated professionals. The process of providing care has been facing considerable challenges including inadequate resources, insufficient caring time, triage risk evaluation, uncertainty about patients' safety, sense of frustration toward repeated suicide attempt and sense of apprehension toward the alleged failure of the mental health system. A shortage of system resources leads to the display of what are often complicated, a chronic dilemma to an emergency caring, an acute organization that is perceived as not helpful. The shown stigma against mental patients may be a major obstacle for patients to report symptoms to clinicians (2,3,4,5,6,7,8,9,10). The detection of mental disturbance has been facing hardship in the diagnosing because of the depress of those who got chronic diseases or were diagnosed uncertainly have been normalized. According to recent reports, there are only 62% of patients at ED being in the episode of self-harm have contacted emergency department (2,3,4,5,6,7,8,9,10). More than half of these communications were between patients and psychiatric consult staff instead of emergency physicians (5,8). It was presented that emergency department health staff were received only 3 of 93 recorded cases of patients from psychiatric consult staffs. This failure of monitoring patients' decease due to communication factor seems to make an unexpected

contribution to repeat calls to the emergency department made by mental patients as a result of recurrent symptoms.

Differences in the views of patients and caregivers lead to the stigma which can be attributed to the consequence of the resonation between patient-provider relationship and labelling theory model. For example, the prejudice of a provider toward mental patients may be a reason for their defensive act against him, perpetuating the process of stigma (3,9). Recent research demonstrates that difficulties of labelling patients may intensify the process of social control for nurses whose effort dedicated to the prevention and resolution of deviance. Stigma involves particular social context instead of an individual (9). The negative attitudes have driven to significant delays in the evolution of standards of care for treating mental acute (5,6,7,8).

7.1 Shortage of education

Studies show that a lack of education through health professions training contributed to stigma and shared that educating providers could reduce stigma by emphasizing humanism and teaching core empathy and communication skills. Most educational programs that prepare us to be nurses or other professional caregivers do not have a major focus on psychiatric illness, and even those that do have such a focus rarely include classroom and clinical time devoted to emergency psychiatry. The stigmatizing attitudes held by the RNs are fueled by their feelings of frustration and perceived lack of efficacy with psychiatric patients, which was suggest in their reviews of the literature on mental health stigma among nurses. They noted that in several studies, fear and lack of skills for effective communication with persons with mental health issues were issues underlying emergency department nurses' stigmatizing attitudes (4,5,6). Increased education and more years of practice experience can facilitate provider behaviors that break the negative attitudes. The study shows that emergency department nurse with fulfill education in psychiatric field will be more positive attitudes compares with others (5,6,7). Additionally, emergency department nurses with more years of experience were less likely to avoid or feel dissatisfied with care encounters with psychiatric patients, possibly because they are more able to see that while results of psychiatric intervention may not be as

dramatic or long lasting as with medical intervention, these can still be steps toward healing when looked at over the longer term. Without this perspective, emergency department nurses can feel ineffective or powerless, which can lead to the behaviors identified by participants in this study to be evidence of lack of caring. (1,4,5,8). In order to enhance the quality of health care, better professional qualification is required among nurses in dealing with challenging working conditions at the emergency psychiatric services. Based on the complexity of each emergency health service, appropriate nurses are chosen and assigned to raise the quality of caring (1,4,5,7). Furthermore, the commitment and education of all stakeholders such as family whose inclusion plays also a crucial role in caring are required. The weaknesses of psychiatric health services can be partly attributed to these participants.

Studies focus on education as the most effective interference to decrease stigma, showing that educational interferences should emphasize on mental illness patient- emergency department nurse relationships to encourage humanizing labels for patients with psychiatric illness and by developed nurse's sympathy and commitment. Develop education and practice with reference to the evaluation, diagnosis, treatment and disposition of mental acute patients may also be combined in mental illness residency system and in enduring medical education. Any approach to decreasing stigma in emergency department environment must be multi aspects and multi-level. Our findings focused that educational interference targeted at the individual nurse without in view of the culture in which environment are implemented are in prospect to break down. Our results accentuate the concern of reorganizing encouragement, rewards and external motivators to increase the accomplishment of interferences that are created to facilitate changing attitudes (1,2,4,5,8,9). Finally, our finding grabs attention to the maintain gap in training caring staffs to be capable of managing and developing caring organization. Despite emergency department nurse’s awareness of the community and existing of stigma, they show a depressing sense of impotence to impact organize-level improvement.

Previous research focused that educational interference that standardizes power dynamics and focuses on mental illness patients’ encounter of discrimination and prejudice may reduce stigma. Our findings based on attitudes theories build up with nurse's self-efficacy should be a target of educational interference. Educational interference that focuses on individual

awareness and community aspect might also reduce unexpected evasion behaviors. A dependable recommendation comes from this research is developing education and professional improvement. Research caution, however, that education of individual emergency department nurse is not enough to reduce stigma; system, organization and cultural also require consideration. Any educational interferences in a caring environment should also look at the external agents affecting emergency department nurse-MH patients' interactions and bolster stigmatizing labels.

7.2 Shortage resource/infrastructure in assisting the provision of safe and qualified psychiatric health care.

The emergency department is a rapidly changing environment and external influences such as acuity and capacity problems in the department can exert their effects on a clinician's decision-making or behavior. The challenge for the triage nurse is to rapidly elicit and synthesize information in a systematic and standardized way, to ensure accurate and consistent decision making occurs for all patients. The conditions under which emergency nurses work, however, boosting a special set of thinking and problem-solving strategies which may also derive to error or stereotypically thinking that not bring any interests to the patient. A better understanding of emergency department triage decision-making, particularly when dealing with mental illness patients, has the potential to lead to evidence-informed training and interferences that can improve the accuracy of these often very complicated indication.

The emergency department environment is characterized by fast change. External factors, for example, the issues of acuity and limited resource can give impacts on decision-making process or behavior of a clinician (1,2). The triage nurse is challenged to quickly and systematically process data and information, ensuring that exact decision making applies to all patients (1,2). Nevertheless, triage nurses work in a condition which stimulates and encourages a particular way of thinking and problem-solving. This can cause mistakes which is disadvantageous to the patient. Comprehension of emergency department triage, especially concerning mental health issue, can potentially bring forth evidence-based training and involvement which helps enhance accuracy in dealing with complex situations (2).

Additionally, most of the time, these patients are in a confused and disorganized state, often experiencing delusions and/or hallucinations. These symptoms can severely hamper attempts to communicate and interact with the patient, which can be further complicated by stress caused by the patients' distrust of mental health workers and others involved and the unpredictability of what is happening at that moment (3). The family and relevant others can also be under severe stress and exhaustion, which further complicates the activities in emergency care for these patients (3). Moreover, mental patients usually experience great confusion, suffering from delusions and hallucinations. Consequently, these manifestations can seriously hinder efforts of a clinician in connecting with them, which can be increasingly intricate due to the lack of trust and unpredictability of the situation (3). The patient's family and other related people might cause further complication in the emergency department caregiving activities, as they suffer from a stressful and exhausting situation (3).

The work overload of nurses can put the nursing work into jeopardy. In order to construct efficient psychiatric health care, it will be necessary to achieve appropriate structural dynamics of the health care service based on the users' demand (1,5,9). The excerpts from the professionals' reports support this aspect when they refer that the nursing professionals quite frequently work at more than one sector (1,9). The difficulties the nurses face correspond to what the literature appoints, in that the complex and crowded structural conjuncture of the health services mostly derive from the factors internal and external to the hospital structure they work in, revealing the urgent need for (re)constructions of nursing care practice (1). In order to take control of this situation, appropriate measures should be applied to each medical personnel in which the Patient Classification System, work burdens distribution and resources for ongoing training related to safety and quality care are of tremendous importance. Thus, it is considered that the weakness of the mental health services' organizational structure enhances the need for discussions on the psychiatric nurse care model, as a social commitment in favor of a professional class, which has greatly suffered because of the need for human and material resources, with a view to the consolidation of qualified practice (1,9). The work burden of the health care team has been designated and assessed as an aspect which causes the limitation of problem-solving ability in caring patients with psychiatric disorders. The burden was considered as a factor leading to nurses' dissatisfaction at work (1,5,9). This observable fact is the reason for

the sense of frustration among health care professionals in consideration of enormous care demand

There is evidence which shows that nurses can do their job compromisingly when they are under much pressure (1,5,9). It is noted that activities of the caregiver are not aligned with the service dynamics, which is unsuitable to the demand of mental patients (1,5,9). Report from experts also supports this view, as they consider nursing career requires the caregiver to work in various sectors (1,9). The challenge they encounter goes in line with what is mentioned in the literature, in which both external and internal elements mainly cause the complicated structural conjunction of healthcare service. This shows a vital need to restructure the practice of caregiving (1). In order to reduce the situation, the measure can be applied to suitable health staffing, via System that categorizes patient and identifies the nurse's work burden, as well as the necessary resource for safety and quality training (1,9). The weak structure of mental healthcare encourages further discussion about special nursing care for mental patients. This view, however, encourages much argument, as the society aims at more combined and integrated practice, with reference to the scarce resource of human and materials (1,9). The burden put on healthcare givers is also a hindering factor to problem-solving (1,9). The burden also contributes to the discontent of nurses (1,5,9). This gives them a sense of frustration considering the significant requirement of caregiving (1,5,9).

Among the reasons link with finding and diagnosis of psychiatric disorders, both healthcare staffs and MH patients point out the limited examination time with caring staffs that had an effect on the consideration given to the detection of psychiatric problems. (6,8). Overcrowding in emergency departments is a burning issue of the health care system (4,6,8). One of the convincing reasons for this issue is the frequently long lengths of stay for an increasing number of patients with mental disorders (4,6,8).The study has documented the long length of stay of mental illness patients' complaints compared with those patients who present with medical problems (6).

Among the contributing factors, clinicians and patients say that restricted time of counseling with family physicians results in being less attentive to mental issue diagnosis (6,8). An important reason for this restricted time is the crowding (4,6,8). Long stay of metal patients in

emergency department significantly contribute to the escalation of the situation (4,6,8). A number of researches point out that the length of stay for emergency mental patients keeps increasing compared to that of other patients (6).

As a matter of fact, care for MH patients has no common standard. Accordingly, interpretation of documentation from one care provider to another one can be hopelessly flawed, leading to inadequately subsequent care. It is also noted that used terms in the documentation delivered actively difficulties to the next caring procedure. For example, the importance of adequate discharge planning is well-known; however, in cases of patients frequently cared for in the emergency department for psychiatric needs, discharge plans are often limited, and continuity of care between hospital and community is problematic (5,10). When rapid follow-up does occur, community tenure is prolonged, and engagement with community services increases (5,10). Unfortunately, the participants of this study reported many instances of little to no discharge planning (5,7,8,10).

8. Conclusion

Mental health patients seem to occupy a majority of the emergency patient population in a not-too-distant future. The increasing number of psychiatric patients is bringing pressure to bear on the care providers and the healthcare system, leading to inadequate care outcomes and other adverse consequences such as overcrowding, inordinate length of stay, extensive use of resources and unexpected expenses. Otherwise, many emergency departments are reported to have the insufficient provision of these psychiatric services to patients. As a matter of fact, no measures have been found to resolve the arising problems due to the increasing number of psychiatric patients in the nation's emergency departments.

The results of this research have revealed the perception of all stakeholders on nurses' activities in the working environment at the psychiatric emergency departments. It is proven that nursing care is of the first importance in the conjunction of the multidisciplinary team and humanized care as well as the care dynamics in the psychiatric health department. The respect in caring that MH patients received in some apparent circumstances has demonstrated that the competence and attitudes of nurses are the main principles making psychiatric patients feel their professionalism, sympathy and understanding. On the other hand, the research appointed that the negative attitudes of nurses in acute mental department derived from incoherence in its organizational and human resource structure, causing burdens for nurses and weaknesses of the care offered. Accordingly, the dissatisfaction about nurse expertise is attributed to these weaknesses. The main findings indicate that nurses are challenged by the disturbed work process which they engage in. Furthermore, their fear and negative attitudes are the underlying reasons for the lack of training and education. Nevertheless, their presence in the emergency department is the foundation for dynamism in the work of the medical team.

8.1 Recommendation

Based on the findings in the article “Care of the Psychiatric Patient in the Emergency Department” in the White Paper of Manton Anne (2013), there are some recommendations suggested. One recommendation is for the education system to increase the relevant content of caring for mental patients in nursing and medical education, postgraduate courses, and continuing education/professional development programs. The programs in the field of caring psychiatric patients should be designed for not only emergency department staffs but also non-psychiatric emergency department care providers, which is comprised of assessment criteria applied for psychiatric patients. Another proposal outlined for medical organizations is setting strict guidelines for the initial assessment of suicide risk at triage.

From an overall perspective, the psychiatric acute department can be improved by conducting various approaches to significantly reduce these issues such as conscientious emergency department nurses, special spaces within the acute department for psychiatric patients, mental health treatment services, and separate mental illness acute emergency units. An important part of the solution is to onwards educate emergency department nurses at all levels and duty about psychiatric illness and how to care for MH patients. Additionally, mental health acute nurse and psychiatric emergency department need more research to improve the system and experience of patients. In the nutshell, interferences rooted in sympathy may against stigma. Through that, psychiatric emergency department nurses recognize that the related aspects of care fall within their influence suggest that meaningful change in patients’ healthcare system is possible

8.2 Strength & limitation

The selection of the scientific literature based on the extremely stringent principle of inclusion and exclusion has summoned up the strength of this study. On the other hand, there is no age restriction placed on this study, which means that the findings in this study can be broadly applicable to all people of all ages. As we know, nothing interesting is ever completely one-sided, this study also includes limitations. Only articles published between 2012 and 2019 were referred to this study. Accordingly, older articles have not been used despite their relevant content to this study. Free-access articles in English were rigorously selected for this study. In order to complete this study at the bachelor's level, the amount of cited information from these ten selected articles can be considered to be relatively adequate to reflect the objectives of this paper. Nevertheless, it may be inadequate to explore all aspects of the nurse's attitudes toward mental patients as well as mental illness. There are also limitations in figuring out strong search keywords. Notwithstanding the limitations of this study, the expected purpose and aim of it were achieved without any contradiction or conflict among the content of cited literature.

References

Ajzen & Fishbein, 2011, “Predicting and changing behavior: The reasoned action approach”, Psychology & health, vol.26, 9, p. 1113-1127

American Heritage Dictionary of the English Language. (2019), Houghton Mifflin Harcourt Publish company.

Retrieved March 19, 2019, from https://ahdictionary.com/word/search.html?q=attitudes

American Heritage Stedman’s Medical Dictionary, 2007

Retrieved March 19, 2019 http://dictionary.reference.com/search?q=attitudes&r=66

ACEP Emergency Medicine Practice Committee, 2014, Care of the Psychiatric Patient in the Emergency Department –A Review of the Literature, American college of Emergency Physical (ACEP).

Berelson, B. ,1952, Content Analysis in Communication Research, Glencoe III: Free Press. p. 18.

Buriola. A, Kantorski. L, Sales. C, Matsuda. L, 2016, “Nursing practice at a psychiatric emergency service: evaluation using fourth generation assessment”, Texto Contexto Enferm, vol.25,1, available at: http://dx.doi.org/10.1590/0104-070720160004540014

Carpenter. C, Boster. F. J, and Kyle R. Andrews. K. R ,2012, "Functional Attitudes Theory", Sage Publications, Inc, 7, p. 104–119, Available at doi:10.4135/9781452218410.n

Clarke, D.E., Dusome, D., & Hughes, L, 2007, Emergency department from the mental health client's perspective. International Journal of Mental Health Nursing, 16, 2, 126-131. doi:10.1111/j.1447-0349.2007.00455.x

Clarke. D. E, Boyce-Gaudreau. K, Sanderson. A. B, Baker. A. J, 2015, “ED Triage Decision-Making with Mental Health Presentations: A “Think Aloud” Study”, Journal of Emergency Nursing, vol. 41, 6, p. 496-502.

Creswell. J,2013, ER costs for mentally ill soar and hospitals seek better way, New York Times, available at: https://www.nytimes.com/2013/12/26/health/er-costs-for-mentally-ill-soar-and-hospitals-seek-better-way.html (access 25/03/2019)

Crowley J, 2000, A clash of cultures: A&E and mental health, Accident and Emergency Nursing, Harcourt Publishers Ltd, 8, 1, 2-8.

The Department of Veterans Affairs (VA) and The Department of Defense, Clinical practice guideline for management of major depressive disorder, 2009.

Daggenvoorde, Gijsman & Goossens, 2018, “Emergency care in case of acute psychotic and/or manic symptoms: Lived experiences of patients and their families with the first interventions of a mobile crisis team. A phenomenological study.”, Perspect Psychiatr Care, vol 54, 4, p462-468. Available at: doi: 10.1111/ppc.12247. E.pub 2017 Sep 27.

Eagly, A. H., & Chaiken, S. ,1993, *The psychology of attitudes*. Harcourt Brace Jovanovich College Publishers, 794p.

Edwards. J. E, 2001, “Multidimensional Constructs in Organizational Behavior Research: An Integrative Analytical Framework”, SAGE journal, Vol 4, 2.

Frank R G & Glied. S, 2006, Changes In Mental Health Financing Since 1971: Implications For Policymakers And Patients, Health affairs, Mental Health: Progress & Pitfalls, 25,3, available at: https://doi.org/10.1377/hlthaff.25.3.601

Fitzpatrick. J, Alfes C M & Hickman. R, 2018, “Guide to Mastery in Clinical Nursing: The Comprehensive Reference”, 1st, New York, Springer publishing company.

Graneheim & Lundman , 2004, Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness, Nurse Educ Today, 24, 2, 105-12.

Grove S & Gray J, 2019, “Understanding nursing research: building an Evidence-based practice”, College of Nursing and Health innovation, Texas, volume 4, p98-106.

Harris. B, Beurmann. R, Fagien. S, Mona M, Shattell, 2016, “Patients' experiences of psychiatric care in emergency departments: A secondary analysis”, International Emergency Nursing, 26, p 14-19.

Hillard R & Zitek B, 2004, Emergency medicine approach to psychiatric illness, Emergency psychiatry, New York, McGraw-Hill, 3-14.

Hogg. S M. & Vaughan. G, 2005, Social Psychology, 4th, Prentice Hall, 770p.

Kondracki N, Wellman N, Amundson D, 2002, Content analysis: review of methods and their applications in nutrition education, J Nutr Educ Behav, 34, 4, 224-30.

Kimberly A. N, 2016, Content analysis guide book, Sage publication INC, Cleveland State University, 438p.

Link. B, Cullen. F, Struening. E., Shrout. P, & Dohrenwend. B, 1989, A modified labeling theory approach to mental disorders: An empirical assessment, American Sociological Review, 54, 3, 400-423.

Lee Y-S, Shin S-H, Greiner. P, 2015, “Can education change attitudes toward aging? A quasi-experimental design with a comparison group”, Journal of Nursing Education and Practice, San Diego State University, 5, 9, available at: DOI: 10.5430/jnep.v5n9p90

Link, Bruce G.; Phelan, Jo C. (1999). "The Labelling Theory of Mental Disorder (II): The Consequences of Labeling". A Handbook for the Study of Mental Health: Social Contexts, Theories, and Systems. Cambridge: Cambridge University Press.

Lofchy J, Boyles P & Delwo J, 2015, Emergency Psychiatry: Clinical and Training Approaches, Can J Psychiatry, 60, 7, 1–7.

Luhrmann. T, 2000, “God as the Ground of Empathy”, Journal of the Royal, Anthropological Institute, Royal Anthropological Institute, 16, 1, available at https://doi.org/10.1111/1467-8322.00005

Manton. A, 2013, Care of the Psychiatric Patient in the Emergency Department, White paper, Emergency Nurses Association.

Manton. A, 2014, “Behavioral Health Patients in the Emergency Department”, Journal of Emergency Nursing, vol. 40, 2, Pages p. 112-113

Merriam-Webster’s Medical Dictionary, 2019

Retrieved March 19, 2019
https://www.merriam-webster.com/dictionary/attitudes#medicalDictionary

McArthur, Montgomery. P, 2004, “The experience of gatekeeping: a psychiatric nurse in an emergency department.”, Issues Mental Health Nurse, 25, 5, 487-501.

Morris D W, Ghose S, Williams. E, Kevin Brown. K & Khan. F, 2018, Evaluating psychiatric readmissions in the emergency department of a large public hospital, Neuropsychiatr Dis Treat, 14, 671–679, available at: doi: 10.2147/NDT.S143004

Morphet. J, Innes. K, Munro. I, O’Brien. A, Cadeyrn J. Gaskin. C. J, Reed. F, Kudinoff. T, 2012, “Managing people with mental health presentations in emergency departments——A service exploration of the issues surrounding responsiveness from a mental health care consumer and care perspective”, Australasian Emergency Nursing Journal, Elsevier, 15, 148—155

National Healthcare Quality and Disparities Report, 2016, Rockville, MD: Agency for Healthcare Research and Quality, AHRQ Pub. No. 17-0001.

Oxford dictionary of English, 2019

Retrieved March 19, 2019: https://en.oxforddictionaries.com/definition/attitudes

Owens, P., Mutter, R., Stocks, C., 2010. Mental Health and Substance Abuse Related

Emergency Department Visits among Adults in 2007. HCUP Statistical Brief # 92. Agency for Healthcare Research and Quality, Rockville, MD.

Olson. J ,2019, Advances in Experimental Social Psychology, 1st, Elservier Inc, 59, 5, 84-94.

Roberge. P, Hudon. C, Pavilanis. A, Beaulieu. M. C, Benoit. A, Brouillet. H, Boulianne. I, De Pauw. A, Frigon. S, Gaboury. I, Gaudreault. M, Girard. A, Giroux. M, Grégoire. E, Langlois. L, Lemieux M, Loignon. C, Vanasse. A, 2016, "A qualitative study of perceived needs and factors associated with the quality of care for common mental disorders in patients with chronic diseases: the perspective of primary care clinicians and patients.", BMC Fam Pract, 17, 1, p134, Available: doi: 10.1186/s12875-016-0531-y.

Robert S, Wyer, Jr., Thomas K, 2014, "Cognitive Processes in Attitudes Change", Handbook of Social Cognition, Taylor & Francis group, 2, 1, 74.

Schmidt. M, 2018, Frequent visitors at the psychiatric emergency room – A literature review, Psychiatr Q, 89, 1, 11–32, available at: doi: 10.1007/s11126-017-9509-8.

Schulze B, 2007, Stigma and mental health professionals: A review of the evidence on an intricate relationship, International Review of Psychiatry, 19, 2, 137-155, available at: DOI: 10.1080/09540260701278929.

Shrivastava. A, Johnston. M & Bureau. Y, 2012, "Stigma of Mental Illness-1: Clinical reflections", Mens Sana Monogr, 10, 1, 70–84, available at: doi: 10.4103/0973-1229.90181

Shattell. M., Harris. B., Beavers. J., Tomlinson. K., Prasek. L., Geevarghese. S, 2014, A recovery-oriented alternative to hospital emergency departments for persons in emotional distress: "The Living Room". Issues in Mental Health Nursing, 35, 1, 4–12.

Sartorius N, 2007, Stigma and mental health, The Lancet, 370, 9590, 810-811, available at: https://doi.org/10.1016/S0140-6736(07)61245-8

Sukhera. J, Miller. K, Milne. A, Scerbo. C, Lim. R, Cooper. A & Watling. C, 2017, “Labelling of mental illness in a pediatric emergency department and its implications for stigma reduction education”, Perspect Med Educ, 6, 3, p165-172. Available at: doi: 10.1007/s40037-017-0333-5.

Scheff. T, 1966, Being Mentally III: A Sociological Theory, 3rd, A division of transaction publisher, University of New Jersey.

Vandyk. A, Young. L, MacPhee. C & Gillis. K, 2018, Exploring the Experiences of Persons Who Frequently Visit the Emergency Department for Mental Health-Related Reasons, Qualitative Health Research, University of Ottawa, 28, 4, 587–599, available at: DOI:10.1177/1049732317746382