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ABSTRACT

Visits to the Emergency Department (ED) for mental health reasons account for 10 to 15% of all visits. Consumers of mental health ED services, however, report that they often feel sent to the back of the queue and that their mental health concerns are not taken seriously, suggesting that societal stigma has impacted their care in the ED. In this paper, we systematically explore the research concerning the attitudes of ED professional staff towards those that present with issues related to mental health. Four themes emerge from the literature: consumer perspectives whose tenor is generally one of negativity; staff-reported attitudes and influencing factors such as age, experience, and confidence in working with mental health presentations; the environmental climate of the ED which may not be conducive to good mental health care; and interventions which have been used to evaluate changes in attitudes.

Key words: attitudes; emergency department; mental health; professional; stigma; thematic synthesis

ACCESSIBLE SUMMARY:

- Visits to the Emergency Department (ED) for mental health reasons account for 10 to 15% of all visits. Consumers of mental health ED services, however, report that they often feel sent to the back of the queue and that their mental health concerns are not taken seriously, suggesting that societal stigma has followed them to the ED.
- In this paper, we systematically explore the research concerning the attitudes of ED professional staff towards those that present with issues related to mental health.
- Four themes emerge from the literature: consumer perspectives, staff-reported attitudes and influencing factors, the environmental climate of the ED which may not be conducive to good mental health care, and interventions which have been used to evaluate changes in attitudes.

BACKGROUND

Visits to the Emergency Department (ED) for mental health or psychiatric entrance complaints are estimated to account for, conservatively, 10 to 15% of all visits (Clarke *et al.* 2005, Owens *et al.* 2010). Individuals will present for all manner of reasons ranging from insomnia or difficulty coping with a life crisis, to suicidal thoughts and self-harming acts, to full-blown psychotic episodes (Bullard *et al.* 2008). They may present alone, be accompanied by concerned family members or friends, or be brought in police custody. They may present voluntarily or involuntarily under a court order. Since mental health assessments can often be complex, vague or ambiguous, taking time and patience, they can be seen as challenging to ED staff, many of whom prefer to work in a highly technological, fast paced environment with more readily apparent outcomes (Crowley 2000, Karshmer & Hales 1997).

Mental health patients also bring with them to the ED societal stigma, particularly concerns that they pose a risk to safety, that they may exhibit strange and unpredictable behaviour, and that they are to be either feared or ridiculed (e.g., Sartorius 2007, Schulze 2007, Thornicroft 2007). Although ED staff are professionals and are educated to understand mental health or illness as exactly that, they are, none-the-less, social beings and are subject to the sometimes strong thoughts and feelings towards mental illness and individuals suffering from mental illness that have been engrained in them by society (Croskerry 2000, Ross & Goldner 2009).

Individuals and their families who use ED mental health services frequently complain of feeling that they've been sent to the back of the queue when they present at triage (Clarke *et al.* 2007, Wand & Happell 2001). They report feeling that their concerns are not taken as seriously as if they had presented with a physical complaint (Clarke *et al.* 2007). Furthermore, those with ongoing mental health issues report that their physical complaints are not taken as seriously as are those of individuals with no history of mental illness (Clarke

et al. 2007). While there is evidence to suggest that those with mental health presentations tend to staying longer in the ED (Clarke *et al*. 2006 Slade *et al.* 2001), it is not clear if this is related to lengthier assessments or to some form of systemic discrimination or some combination of both.

Although an often proposed solution to the issues surrounding mental health consumers in general hospital EDs is to establish a separate ED or mental health crisis centre (Clarke *et al.* 2010, Wand 2004), individuals with mental illness and mental health problems will continue to attend at general hospital EDs for a variety of reasons. Primarily because they are open and available 24/7, the ED will continue to be the default when there is nowhere else to go or when individuals do not know where else to go (Clarke *et al.* 2010). In light of this, it is important to have a good understanding of how the attitudes of ED health professionals may impact on their clinical decision-making in order to inform education, interventions, and improve clinical practice in the ED.

This paper reports a literature review which has used systematic methods to synthesize research concerning attitudes of ED professional staff towards those that present with issues related to mental health.

METHODS

Search strategy

Searches of CINAHL, PubMed, PsycInfo, Scopus and the British Nursing Index databases were conducted by a professional librarian. The search terms focused around four concepts (Table 1). Searches were limited to 1995 onwards and English language only articles. Hand searching of the reference lists of previous reviews was also conducted (NICE 2005, Richter *et al.* 2007). The total for all databases after duplicates and irrelevant papers were removed was 796 references. Title and abstract screening then excluded an additional 720 papers. The criteria for exclusion for more detailed analysis were: 1) opinion or discussion articles, 2)

articles that did not contain data that could contribute to a description of the process of staff attitudes towards consumers presenting in ED with mental health disorders 3) exclusively related to management of drugs or alcohol. The remaining 76 articles were retrieved for more detailed examination. Of these, 17 were excluded because they were not relevant to the aims of the paper. Further papers were removed as a result of group consensus resulting in a final count of 42 papers (Table 2).

Table 1
Concepts and controlled language and key word searches

Concepts	Controlled Language and Key words
Hospitals	“accident and emergency" OR "a & e" OR "emergency department*" OR "emergency room*" OR "emergency ward*" OR "general hospital*" OR "general district hospital*" OR "casualty department*" OR "trauma centre*" OR "trauma center*" OR su.EXACT.EXPLODE "Emergency Services" OR su.EXACT "Hospitals"
Mental health consumers	(patient OR patients OR client* OR presentation* OR consumer* OR user* OR client* OR su.EXACT.EXPLODE "Patients") AND ("mental illness*" OR "mentally ill" OR psychiatric* OR "mental health problem*" OR "mental health issue*" OR "substance abuse*" OR alcoholic* OR "substance misuse" OR su.EXACT.EXPLODE "Drug Abuse" OR su.EXACT.EXPLODE "Mental Disorders")) OR (su.EXACT.EXPLODE "Psychiatric Patients") OR (MH “suicide+” OR suicid* OR MH “self-injurious behavior” OR MH “injuries, self-inflicted” OR self-harm OR self-mutilat* OR self-injur*).
Health professionals	nurse* OR physician* OR doctor* OR "health personnel" OR "healthcare personnel" OR "health care personnel" OR "health professional*" OR "healthcare professional*" OR "health care professional*" OR su.EXACT.EXPLODE "Health Personnel".
Attitudes	stigma OR discrimin* OR bias* OR prejudice* OR opinion* OR belief* OR "negative behaviour*" OR "negative behavior*" OR transference OR feelings OR "affective skill*" OR attitude* OR stereotyp* OR empathy OR su.EXACT.EXPLODE "Prejudice" OR su.EXACT.EXPLODE "Respect" OR su.EXACT.EXPLODE "Professional Competence" OR su.EXACT.EXPLODE "Empathy" OR su.EXACT.EXPLODE "Stereotyped

	Attitudes" OR su.EXACT.EXPLODE "Stigma" OR su.EXACT "Social Discrimination" OR "Discrimination" OR su.EXACT.EXPLODE "Attitudes".

Thematic synthesis

A thematic synthesis (Thomas & Harden 2008) approach was used to extract data relating to professional staff attitudes (Barnett-Page & Thomas 2009, Price & Baker 2012). This approach enables the combination of data from range of methodologies whilst maintaining the rigor associated with systematic reviews methods (Liberati *et al.* 2009). Data from included papers were extracted and uploaded into Microsoft Excel 2007. These data were then read and re-read and emerging themes noted, using a constant comparative approach (Thomas & Harden 2008). All themes were discussed and agreed by the author team before being synthesized into the themes presented in this paper.

RESULTS

Forty-two papers published between 1997 and 2011 formed this review. Research was conducted in 10 different countries (Table 2). Views were sought from consumers, their carers and health care professionals, although the majority views were from ED nurses. The majority of the research appeared to focus on those presenting to ED following Deliberate Self-Harm (DSH). The next most prevalent presenting issue was for suicidal behaviour, whilst other forms of mental distress featured less prominently. Most of the research conducted used a survey design (n=24) with questionnaires (most of which were validated) to measure attitudes, although a number of different scales were used. There appeared to be no consensus in which tool provided the most appropriate measure of attitude/experience. Sample sizes ranged from six to 719 participants. A total of 16 papers reviewed focussed on samples of non-mental health trained nursing staff within the ED and two used samples of general hospital nurses (including ED nurses). Six further papers used combined samples of ED nurses and doctors, whilst five papers compared samples of ED staff, general hospital

staff and mental health trained nurses. Three studies presented findings based on samples of primary care professionals, ED clinicians and mental health trained nurses. Seven papers considered the consumer and carer perspective of mental health care provision within the ED and general hospital. Only two papers focussed on children and young people.

Thematic analysis

Four themes emerged from the synthesis: consumer perspectives of attending ED services; ED staff-reported attitudes and associated influences; the environmental climate of the ED; and interventions which have been used to evaluate change in attitudes.

Consumer perspectives

The majority of the literature addressing attitudes encountered in the ED from the consumer's points of view employed a qualitative methodology. In these studies consumers were not specifically asked about "attitudes" but instead described their experiences in the ED, which was then interpreted to be illustrative of healthcare providers' positive or negative attitudes. Although all studies reviewed included a variety of both positive and negative healthcare provider behaviours, the general tenor of the findings was one of negativity. Some research participants described what they perceived as ritual humiliation in EDs (Harris, 2000). Consumers described a range of negative feelings as a result of this process, which included feeling disrespected or embarrassed due to lack of privacy and confidentiality and felt they were punished for self-harming or suicidal behaviours. This perceived punishment was typically illustrated by such verbal behaviour from the ED care provider *as you're wasting my time*, *suicidal behaviour is a sin*, *you're just wanting attention* and other comments perceived by the individual as inappropriate and unwelcomed (Cerel *et al.* 2006, Harris 2000, Summers & Happell 2003, van Loon *et al.* 2004). Being made to wait for what seemed to be longer than individuals who presented with physical ailments (Cerel *et al.* 2006, Clarke *et al.*

2007, Summers & Happell 2003) was further seen as a sign of disrespect, trivialisation of their distress, and lack of empathy (Olsson & Hansagi 2001, van Loon *et al.* 2004).

Not being listened to was another common complaint (Allen *et al.* 2003), further described by Clarke and colleagues (2007) as diagnostic overshadowing where the history of a mental illness diagnosis overshadowed other reasons the consumer may have for attending the ED. Summers and Happell (2003) further reported consumers' need to be seen holistically. Appreciation for technical competence related to providers' ability to tend to physical concerns (van Loon *et al.* 2004), but perceptions of lack of expertise related to mental health issues (Clarke *et al.* 2007) were struggles that consumers experienced when attending an ED.

Although negative reports were the most frequently reported, there was, none-the-less, evidence of positive or accepting attitudes towards consumers with mental health problems. Quotes from consumers described contact with some empathetic individuals who provided information and support (Allen *et al.* 2003, Clarke *et al.* 2007, Summers & Happell 2003). This will be discussed further from the perspective of the healthcare provider.

Staff perspectives

The literature describing ED care providers' perspectives on caring for individuals with mental health problems was a combination of qualitative (n=8), quantitative (n=13), and mixed methods (n=4) studies. In the quantitative studies, eight used a psychometrically validated tool to measure attitudes.

Caring for individuals with mental health problems was perceived as a challenge for ED staff. In addition to the fear and anger engendered by aggressive or bizarre behaviour (Kerrison & Chapman 2006, Pich *et al.* 2009), staff tension was further increased due to the revolving door nature of many presentations and lack of feedback or apparent follow-up resulted in a sense of hopelessness and a *why bother* attitude (Anderson *et al.* 2003, Hadfield

et al. 2009, McElroy & Sheppard 1999). One qualitative study reported that staff perceived individuals with mental health presentations to be manipulative (Bergmans *et al.* 2009) whilst another one stated that complaints were often not seen as genuine on initial presentation (Doyle *et al.* 2007). MacKay and Barrowclough (2003) found that the greater the negative affect of staff towards the individual, the less the propensity to help. Although the general tenor of the literature was one of negative attitudes, as with the consumer perspective, there were reports of compassion and empathy. Suominen and colleagues (2007) reported somewhat of a skew towards "more empathetic" regarding suicidal presentations to two Finnish hospitals. Two articles also reported positive or sympathetic attitudes towards individuals presenting with DSH, one in an Irish sample (McCarthy *et al.* 2009) and one in an Australian sample (McCann *et al.* 2007). A more mixed picture was provided in a qualitative data from Doyle and colleagues (2007), who found that although staff responded to suicidal patients with sympathy and compassion, a judgement of the perceived genuineness of the presentation was often a first response.

Five papers acknowledged the potential significance of the age of ED nurses on attitudes. The majority of these focussed mainly on ED nursing staff and their attitudes towards DSH or attempted suicide. Using the Suicide Opinion Questionnaire (SOQ) McCann *et al.* (2006) found that within a sample of 43 ED nurses from an Australian ED, over 50% were under 35 years old and were less likely to have supportive attitudes towards patients who attempt suicide. In comparison, older nurses, i.e. >35 years old, demonstrated statistically significant supportive attitudes towards this patient group. This was hypothesized as being due in part to professional and life experience informing attitudes over time; although it did not clearly differentiate whether there was a link between age and length of experience. In an earlier study by Anderson (1997), attitudes of ED and community mental health nurses were compared and older nurses (>30 years) in the ED were found to have more

positive attitudes in comparison to their mental health trained colleagues within the same age ranges; although this study did not identify any statistically significant association between ages of ED nurses and attitudes towards suicidal behaviour. More recently, McCarthy & Gibels (2010) focussed on specific age ranges and found that based on overall scores using the Attitudes Towards Deliberate Self Harm Questionnaire, ED nurses aged 41-50 years had more positive attitudes towards patients who self harm than those in younger age groups. The authors also noted that ED nurses between the ages of 31-40 years had more positive attitudes due to the belief that they could in fact work effectively with this patient group. Conlon *et al.* (2010), using the Self Harm Antipathy Scale to study 87 randomly selected ED nurses' attitudes from four hospital sites towards patients who self harm, found that those aged 41-60 years demonstrated overall scores indicating more positive attitudes than those aged <40 years old.

A variable that may be related to age could be level and years of experience. Here the findings were inconsistent. Whilst two papers found that more experienced staff had more positive attitudes towards mental health presentations (Commons-Treloar *et al.* 2008, McAllister *et al.* 2002), two other papers (Friedman *et al.* 2006, Herron *et al.* 2001) reported that years of experience was weakly correlated with more negative attitudes.

Another variable that may have an influence on attitudes and that may or may not be related to age is skill level and perceived self-efficacy in working with individuals with mental health complaints. A number of both qualitative and quantitative studies reported that ED staff generally felt ill-prepared to assess and care for individuals with mental health problems (Doyle *et al.* 2007, Friedman *et al.* 2006, Pich *et al.* 2009, Summers & Happell 2003). The three papers, which measured perceived skill level and attitude, all found that those with greater perceived self-efficacy in assessment and treatment had more positive attitudes (Kishi *et al.* 2011, McAllister *et al.* 2001, Wright *et al.* 2003).

Interventions to improve attitudes

Educational interventions typically take the form of day-long workshops where participants receive education about the psychiatric disorder, for example, Borderline Personality Disorder (Commons-Treolar & Lewis 2008) or suicidal presentations (Appleby *et al.* 2000) with guidelines for assessment. Immediate improvement in confidence in assessment is typically seen. Appleby and colleagues (2000) found that staff with the most negative attitudes showed the most significant improvement on all measures while Commons-Treolar & Lewis (2008) found that those participants who were older (defined as more than 15 years in practice) and hospital-trained were less likely to change their attitude after education. Crawford, Turnbull & Wessley (1998) demonstrated the largest change on an item related to "misuse of services" by individuals with mental health problems. McAllister and colleagues (2009) took a different approach to promoting "attitudinal shifts" by focusing on health promotion strategies with clients with self-harming behaviours. Through teaching solution-focused nursing, they reported that participants expressed an intention to practise in more "person-centred" ways when interviewed after the intervention. Other education interventions relied on psychometric measure of attitudes to evaluate change (Appleby *et al.* 2000, Commons-Treolar & Lewis 2008), some used tools designed for the study which were not validated (Crawford *et al.* 1998), while others did not directly measure attitudes but implied changes in attitudes based on other observations such as self-reported levels of anxiety and irritability (Holdsworth *et al.* 2001) or improved accuracy of triage of mental health presentations (Broadbent *et al.* 2002).

The environmental climate of the ED

ED staff in many of the studies repeatedly made the observation that EDs, as currently configured, may not be appropriate places for people with MH issues to attend in general. This, in turn, was thought to influence attitudes towards consumers with mental health

problems. Concerns, such as the high pressured, high stimulation, noisy and fast paced environments and lack of privacy, were felt to be not conducive to providing optimal care (Marynowski-Traczyk & Broadbent 2011). Insufficient resources in the ED, including long waiting times (Pich *et al.* 2011), lack of specific mental health protocols/triage tools (Kerrison & Chapman 2007), the apparent lack of effective interventions (Anderson *et al.* 2003) and role ambiguity amongst healthcare providers (Wright *et al.* 2003) compound the problems of inadequate space and time for good mental health care (Anderson *et al.* 2003). The continuous need for hyper vigilance on the part of the staff in order to prevent violence or risk to self was perceived as draining (Doyle *et al.* 2007, Kerrison & Chapman 2007, Pich *et al.* 2011).

The organizational climate of the ED appears to shape staff's attitudes towards consumers (Wright *et al.* 2003). Wright and colleagues (2003) found a positive relationship between fairness and equity in the organizational climate and attitudes. They further found the more ambiguous the staff's roles in caring for consumers, the more negative the attitude. Employing a participatory action framework, Heslop and colleagues (2000) sought to determine components of a more productive clinical environment for consumers. After a thorough scoping review profiling their mental health consumer population and the work involved in their care and service, they were able to develop tools to better inform care, such as clinical guidelines and triage risk assessment.

DISCUSSION

Consumer perspective

Consumers report both positive and negative perceptions about ED staff attitudes, with more evidence supporting the latter. The predominance of negative reports may highlight a methodological concern related to reporting bias. Consumers may find negative experiences more salient and emotive, resulting in over-reporting when compared with more positive or

neutral encounters. Sampling bias, with individuals with negative experiences being more likely to come forward for qualitative interviews, is also a possibility. A possible limitation to the available literature is that the majority of studies reviewed did not focus solely on attitudes, but more on perceived behaviours that consumers associate with negative attitudes of staff, e.g. rejection, criticism, frustration, different care in comparison to other non-mental health consumers (Cerel *et al.* 2006, Harris 2000, Summers & Happell 2003; van Loon *et al.* 2004), in comparison with empathetic and information sharing being associated with positive attitudes (Allen *et al.* 2003, Clarke *et al.* 2007, Summers & Happell 2003). This subjective approach could be a significant limitation of the available literature and possibly highlights the need for more rigorous research in this area.

From a consumer's perspective it is understandable that they perceive a sense of rejection from clinicians with whom they come into contact, whether this is intentional or not. For example, ED staff may adopt a 'do no harm' standpoint as a means to avoid exacerbating a person's distress derived from a lack of understanding about the needs of patients at points of acute need or distress and not necessarily based on negative attitudes per se. Doyle *et al.* (2007), Friedman *et al.* (2006) and Hadfield (2009) acknowledge that uncertainty about how to intervene, communicate with and support patients due to perceived lack of skills is a barrier to engagement. Hadfield *et al.* (2009) suggest that another reason could be explained as a defensive position and a means of protecting themselves, and possibly also the consumer, from developing negative attitudes triggered by having no perceived meaningful role in caring for patients who require more specialist care than they believe they can offer; as well as the consequential frustration and loss of empathy evoked by repeat presentations.

Staff perceptions

Staff perceptions in relation to consumers presenting with mental health problems clearly vary within existing research with the overarching theme being of predominantly negative

attitudes towards this client group. The literature reviewed has however attempted to consider what specific factors may influence the nature and development of attitudes.

Age of clinician and length of experience: From the literature reviewed there does not appear to be any consistently found correlation between age of clinician or length of clinical experience and the presence of positive or negative attitudes. Whilst some authors found older ED nurses demonstrated more positive attitudes compared to their younger colleagues (McCann *et al.* 2006), possibly due to increased length and scope of post registration and life experience (Friedman *et al.* 2006). Other authors (Anderson 1997, McCarthy *et al.* 2010) noted that attitudes become less positive after a certain age or length of experience (over 50 years old or 16 years of experience), although they did not clearly hypothesize a reason why this may be the case. It could be suggested that, to a certain point, repeated experience of working with consumers presenting with mental health problems can enable clinicians to enhance their knowledge and skills. As a result, they may feel more confident that their skills enable them to work with this client group and thus demonstrate more positive attitudes (McCallister *et al.* 2002). However, McCallister *et al.* (2002) found that there is no statistically significant link between length of experience and improved confidence when working with this patient group. Conversely, repeated exposure to presentations considered by clinicians as 'revolving door patients' and the perception that little they do changes a patient's situation could result in increasing pessimism, loss of empathy and consequently development of negative attitudes (Doyle *et al.* 2007, Commons-Treloar & Lewis 2008, Hadfield *et al.* 2009, Conlon *et al.* 2010). This may therefore explain why attitudes become less positive after a certain amount of time.

Perceived efficacy of care/skills

Much of the literature reviewed under this theme focussed more on DSH presentations to the ED and general hospital as opposed to mental health consumers as a group, although this may

be due to the heterogeneous nature of individuals presenting to the ED and the different demands this places on ED staff to respond to different types of presentations. It is likely that DSH is a key area of focus in research due to the emotive and often repetitive nature of such presentations. How clinician's perceive DSH presentations, the influence of this on their attitudes or beliefs about the behaviour and subsequent actions has been well documented. Many authors noted that clinicians' perceptions of the efficacy of their interventions and confidence in their skills are key factors influencing attitude development and, subsequently, motivation to engage with consumers (Anderson *et al.* 2003, Conlon *et al.* 2009, Hadfield et al. 2009). Whilst some non-mental health clinicians do possess an understanding that presentations, such as DSH, should be taken seriously (Friedman *et al.* 2006) there is some conflict between this reported positive attitudes and consumers' reports around clinicians' willingness to engage with such consumers or appreciate their role in care giving for this consumer group (Doyle *et al.* 2007, Cerel *et al.* 2006, Harris 2000, Summers & Happell 2003, van Loon *et al.* 2004). This is possibly due to whether or not clinicians perceive that DSH is within the control of the patient. In other words, DSH could be seen as a choice being made by a patient. If the presenting complaint is perceived as outside the patient's control, for example within the parameters of a defined mental disorder, this may be considered more acceptable and 'treatable' by clinicians as they are more likely to feel able to intervene meaningfully and, consequently, more motivated to do so (McKay & Barrrowclough 2005, Hadfield *et al.* 2009). Repetitive presentations, where nothing is seen to have changed or improved, also appear to have a detrimental impact on clinicians' self-perceived efficacy and consequential limited engagement with this sub-group (Doyle *et al.* 2007, Anderson *et al.* 2003, Hadfield *et al.* 2009, Conlon *et al.* 2010, Marynowski-Traczyk *et al.* 2011).

Interventions to address attitudes

Further and more intensive education is often touted as a way to improve attitudes towards mental health presentations. The premise is that if the practitioner better understands the consumer's condition they will have more empathy for the individual and feel more confident in their ability to work with the population. It is perhaps time to reconsider the approaches used in educational interventions and Marynowski-Traczyk *et al.* (2011) suggest that without supporting non-mental health staff to appreciate their role within the overall process of recovery of patients with mental health problems, they are likely to maintain negative attitudes. This can consequently have a detrimental effect on their willingness to engage with and care for such patients. This is a new and helpful perspective to consider when trying to improve attitudes through interventions. Particularly given the impact of repeat attendances in relation to deliberate self-harm or suicidal behaviour on clinicians' attitudes, behaviours and ultimately consumers, as already noted.

The majority of the limited literature available suggests that educational interventions have tended to focus solely on knowledge acquisition around specific conditions, albeit around emotive presentations such as borderline personality disorder and deliberate self-harm. This focus does not seem to necessarily correlate to changes in attitudes and practice being evidenced in results. This said, it has been noted that studies have suggested the age of participants and the nature of pre-registration training, have been associated with a lack of change being effected post-intervention. It may therefore be useful for further research to consider why these factors are potential barriers to promoting attitudinal shifts in order to overcome them.

Educational interventions, to date, have been shown to produce, at least, short-term improvement in attitudes towards individuals with mental health presentations for some

emergency healthcare providers. Whether this change in attitudes translates into a change in behaviour and practice and whether this change is long-lasting has not yet been demonstrated.

CONCLUSIONS

This paper has synthesised contemporary literature which has explored consumers' experiences of attending Emergency Departments. Four themes emerged from the synthesis and included consumer perspectives, staff reported attitudes and associated influencing, the environmental climate of the ED and fourthly, interventions which have been used to evaluate change in attitudes. Substantially more research is needed in this area to understand how consumer experiences can be improved.

Limitations

A potential limitation to some of the research available is that authors have not consistently used validated tools to assess changes in attitudes, or have not focussed on attitudes and instead hypothesized how other observable behaviours correlate to changes in attitudes.

Table 2

Forty-two research papers that formed the literature review; organized by author, date of publication, country of origin, study design, sample and purpose/aim of study

No.	Author	Date	Country	Study Design	Sample	Purpose/Aim of the Study
1	Allen *et al.*	2003	USA	Survey (Questionnaire) Focus groups (n=4)	59 consumers	To develop recommendations for ED mental health services
2	Anderson	1997	UK	Survey (Questionnaire)	40 CMHNs 40 A&E nurses	To compare differences in attitudes towards suicidal behaviour between ED nurses and CMHNs
3	Anderson *et al.*	2003	UK	Grounded theory using semi-structured interview	45 transcripts from nurses and doctors (A&E = 29; Paediatrics =8; Psychiatry =8)	Perceptions of nurses and doctors towards suicidal young people (13-18)
4	Anderson & Standen	2007	UK	Survey (Suicidal Opinion Questionnaire)	179 nurses and doctors (from A&E, Paediatrics, Adolescent inpatient unit)	Attitudes of nurses and doctors towards suicidal young people (13-18)
5	Appleby *et al.*	2000	UK	Evaluation of training	167 health professionals including 21 A&E staff	Assess feasibility and impact of training on clinical skills and attitudes.
6	Bergmans *et al.*	2009	Canada	Semi-structured interview with qualitative analysis	27 A&E staff 25 male consumers	To understand experiences of suicidal substance abusing males in ED settings
7	Broadbent *et al.*	2002	Australia	Evaluation of triage scale	23 pre-post questionnaires Comparison of 225 pre and 189 post admissions	To develop a triage scale; train staff in its use; measure outcomes

8	Cerel *et al.*	2006	USA	Survey web-based	465 consumers 254 family members	To understand the experiences of consumers and family members in the ED following a suicide attempt
9	Clarke *et al.*	2007	Canada	Focus groups	27 consumers 7 family members 5 stakeholders	To determine consumers satisfaction with care received in regional EDs
10	Commons-Treloar, & Lewis	2008a	Australia	Survey (Questionnaire)	140 mental health and ED practitioners	To asses attitudes of mental health and ED practitioners towards consumers with BPD who engage in DSH
11	Commons-Treloar, & Lewis	2008b	Australia	Evaluation of training (Attitudes towards deliberate self harm questionnaire)	99 mental health and ED practitioners	To asses the change in attitudes of ED practitioners towards consumers who engage in DSH following training.
12	Conlon & O'Tuathai	2010	Ireland	Survey (Self-harm apathy scale)	87 ED nurses	To asses attitudes of ED practitioners towards consumers who engage in DSH
13	Crawford *et al.*	1998	UK	Evaluation of training	45 ED nurses, 15 junior medical staff	Compared the psychosocial assessment of DSH before and after a one hour teaching session
14	Doyle *et al.*	2007	Ireland	Survey (Questionnaire)	42 ED nurses	To describe the experience and challenges that ED nurses encounter when caring for consumers with suicidal behaviour
15	Eales *et al.*	2006	UK	Semi-structured interviews with thematic analysis	17 consumers, 30 stakeholders (mainly ED staff)	To determine what is important to stakeholders in a liaison MH service
16	Friedman *et al.*	2006	UK	Survey (Questionnaire)	53 ED nurses, 10 ED doctors	To investigate attitudes of ED staff towards consumers who DSH (lacerate)
17	Hadfield *et al.*	2009	uk	Semi-structured interviews with IP analysis	5 ED doctors	Exploring how ED doctors respond to consumers who DSH
18	Harris	2000	UK	Stories sent via national organisation	6 female consumers	Experiences of consumers who DSH

19	Herron *et al.*	2001	UK	Survey (Attitudes to suicide prevention)	42 ED nurses, 56 CPNs, 35 GPs	To comparison of attitudes of clinicians
20	Heslop *et al.*	2000	Australia	Retrospective record review & focus groups (PAR)	8000 case notes, 8 ED nurses	Establish a comparison of service change over time & explore the difficulties of MH presentations in EDs
21	Holdsworth *et al.*	2001	UK	Evaluation of training	13 nurses from ED and MAU completed 81 diary sheets	Reflective evaluation of training
22	Ito *et al.*	2008	Japan	Questionnaire	75 ED medics, 69 internal medicine, 154 from psychiatry	To explore preferable treatment options for suicidal consumers
23	Kerrison & Chapman	2007	Australia	Semi-structured interviews /focus groups with thematic analysis	Focus group of 5 ED nurses & interviews of 12 stakeholders	Establish training needs of staff
24	Kishi *et al.*	2011	Japan	Web-based survey (Understanding suicidal patients)	323 Nurses	Establish attitudes towards suicidal patients
25	Mackay & Barrowclough	2005	UK	2x2 btn-subject factorial experiment using hypothetical scenarios (IVs: controllability of precipitant for DSH & stability of occurrence)	89 ED medical and nurses	To test Weiner's model of helping behaviour to attributions for DSH in consumers ED staff have contact with
26	Marynowski-Traczyk & Broadbent	2011	Australia	Interpretive phenomenological	6 ED nurses	To describe the experiences of ED nurses caring for clients with a mental illness in the ED
27	McAllister *et al.*	2002	Australia	Questionnaire (Attitudes towards deliberate self-harm)	352 ED nurses	To develop and test a scale to identify important aspects of nurses' attitudes towards consumers who present with self-injury and the perceived effectiveness of the nurses' role
28	McAllister *et al.*	2009	Australia	Evaluation of training (interviews, think aloud, scale; Perceptions of	36 ED nurses	Implement and measurement of effectiveness of an education intervention enhancing nurses responses to consumers who

				Nursing)		present with DSH
29	McCann *et al.*	2006	Australia	Questionnaire (Suicide Opinion)	43 ED nurses	To assess ED nurses' attitudes towards consumers with DSH
30	McCann *et al.*	2007	Australia	Questionnaire; exploratory		To examine ED nurses' attitudes towards, and triage and care decisions with patients who self-harm
321	McCarthy & Gijbels	2010	Ireland	Questionnaire (Attitudes towards deliberate self harm)	68 ED nurses	To examine ED nurses' attitudes towards individuals presenting with DSH
32	McElroy& Sheppard	1999	UK	Action research	22 medical & nursing ED staff	To determine the current status of knowledge & attitudes of A&E staff proving care for DSH
33	McKinlay *et al.*	2001	UK	Questionnaire with vignettes	74 ED/acute medical nurses	To explore nursing staff attitudes towards self-poisoning (?DSH) using the theory of reasoned action model of attitude & behaviour
34	Olsson & Hansagi	2001	Sweden	Interviews	10 consumers	To explore the reason behind repeated ED use from a consumer perspective
35	Pich *et al.*	2011	Australia	Semi-structured interviews	6 nurses	To describe the experience of triage nurses with pt-related work place violence
36	Rhodes *et al.*	2007	USA	Secondary analysis of audiotaped ED visits (871)	20/871 analysed about depression	To qualitatively characterize ED provider-pt discussions re depression
37	Richardson *et al.*	2006	New Zealand	Survey with an open-ended question	27 GPs, 35 ED nurses, 12 ED medics (physicians) & 12 managers	To examine attitudes and perceptions of inappropriate ED attendance
38	Suominen *et al.*	2007	Finland	Questionnaire (Understanding suicidal patients)	115 nurses & physicians	To compare ER staff attitudes towards consumers who have attempted suicide in two general hospitals, one with psychiatric consultation avail and the other without.
39	Summers & Happell	2003	Australia	Telephone interviews; structured questionnaire	136 consumers	To ascertain the level of psychiatric consumer satisfaction with their experience in the ED
40	Sun *et al.*	2007	China	Questionnaire (Domino's suicide opinion questionnaire)	155 ED nurses	To determine casualty nurses' attitudes towards pts who have attempted suicide and identify factors that contribute to those attitudes

41	van Loon *et al.*	2004	Australia	Participatory action research	11 female consumers, to develop a shared narrative presented to 25 stakeholders	To understanding ED helping role with survivors of CSA
42	Wright *et al.*	2003	USA	Questionnaire survey (measure of organisational climate)	109 ED nurses and others	To determine the relationship exists between the ED organizational climate and attitudes toward consumers with mental health issues

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