Mental Health as a Societal Concept Impacting on Emergency Care

Tricia Scott

1 Introduction

Mental health as a societal concept which needs to be addressed has been gathering momentum in the past decade. This is due to a number of policy drivers. The World Health Organisation (WHO) included mental health as one of the Sustainable Development Goals stating how "…depression is one of the leading causes of disability. Suicide is the second leading cause of death among 15-29-year-olds. People with severe mental health conditions die prematurely—as much as two decades early—due to preventable physical conditions" [1]. In 2019 the WHO launched the WHO Special Initiative for Mental Health (2019–2023): Universal Health Coverage for Mental Health to ensure access to appropriate mental health care in 12 priority countries. This was because, despite progress, mental health conditions are associated with severe human rights violations, discrimination and stigma.

Recently, COVID-19 further impacted on population health as the "…COVID-19 pandemic triggers 25% increase in prevalence of anxiety and depression worldwide" [2] and, as Dr. Tedros Adhanom Ghebreyesus, WHO Director General stated, such an increase suggests, "The information we have now about the impact of COVID-19 on the world's mental health is just the tip of the iceberg". Such an increase means, "This is a wake-up call to all countries to pay more attention to mental health and do a better job of supporting their populations' mental health". COVID-19 response plans need to accommodate the should provide support measures; however, major gaps remain in many countries. In all, the most recent Health Atlas declared on average only just over 2% of their health budget was devoted to mental health in 2020, which contributed to the global shortage in mental health services. Such historical underinvestment has largely contributed to the current state

T. Scott (✉)
Independent Education and Research Consultant, North Yorkshire, UK

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of affairs, and countries must act urgently to prioritise mental health services and access to the same.

In the European context, Stewart [3] reported that the most commonly diagnosed mental health diseases include depression, generalised anxiety and eating disorders, whereby the affected person feels sad and/or down, withdraws from social life and experiences anger, substance abuse and suicidal thoughts. Adding to the complexity of the experience, about 25% of the population in many European countries reported that they suffered from at least one mental health condition, anxiety disorders being slightly higher than depression. Compounding factors such as substance use may add to the complexity of treatment and support with the need for additional structures to be arranged to help that person manage their situation.

In the UK context the Office for National Statistics [4] January figures report that "1.49 million people were in contact with mental health services, at the end of December. The majority of these (1,007,387) were in contact with adult services" and "355,807 people were in contact with children and young people's mental health services, at the end of December". Further, "175,083 people were in contact with learning disabilities and autism services, at the end of December" and "20,894 people were subject to the Mental Health Act, including 15,647 people detained in hospital, at the end of December" [5]. These seem disturbing statistics; however, statistics alone, whilst important indicators of the scale of the problem and patterns of access do not reflect or explain the complexity and nuances of the mental health, mental ill-health and mental health crisis experience. That is very much brought to life through the reflections and narratives of the people affected so it is important that we hear their stories and listen to their plight, help people to manage their condition and work responsively with them and their families towards a solution to calm their situation. Locally, mental health is gaining increasing public attention through the work of mental health charities which capitalise on social media to get their message across, e.g. the HRH Heads Together Campaign. Such efforts encourage people from all walks of life to become more receptive to the notion that every family is affected by mental health issues, so there may indeed be a greater awareness of the effects on family members who support someone who is experiencing, e.g. depression, anxiety or a psychotic episode.

Causative factors vary such as relationship breakdown, work pressures, geographical detachment from families as well as chemical and hormonal imbalance and various theories exist to explain the aetiology of mental ill-health. Theoretical concepts and explanations of the potential aetiology of mental illness derive from psychodynamic, behavioural, cognitive, social, humanistic and biological theories [6]. Whilst theoretical understanding provides an important framework, any attempt to address the societal problem means that action is needed, so it is interesting to note how UK local authority election candidates are currently focusing their manifesto on the following key strategies: reducing poverty, improving the environment, supporting the best start in life and ensuring access to quality services. Whilst the UK government White Paper aims to level up specific sectors such as economic disparities, devolution, digital connectivity and housing, there is little reference to what impact these will have on the mental health of the

population [7]. The final report of the Commission for Equality in Mental Health [8] finds that mental health inequalities mirror wider economic and social inequalities and creates sharp social divisions so that many people experience three times the risk of mental ill-health. The emergency services support many of these people through crisis, and action is needed to address the recurrent problem of stigmatised attitudes, fragmented services and a lack of support. There is a clear need to drive change by improving policy and practice, to work at building communities and, most importantly, to do so through the voices of those who live with mental health issues.

The International Classification of Diseases DSM 5 was updated in 2022 to the DSM 5-TR edition. Recent editions of the DSM have received praise for trying to standardise psychiatric diagnosis based on empirical evidence yet concurrently generated controversy and criticism and a crisis in confidence in the reliability and validity of many diagnoses. Common assumptions and dated interpretations of autism provide a good example of societal misinterpretation particularly when considering the difference between dated assumptions about a linear "autism spectrum" which comprises two polarities and which can result in damaging misattribution, invalidation, exclusion and othering. Instead, autism may comprise multiple elements which may or may not be experienced by different individuals, e.g. sensory sensitivities or repetitive behaviours. Most important then is to consider the person as a human being by acknowledging their difficulties when trying to get by in a society which can at best be judgemental and reactionary and to help them return to a state of calm, recover and regain balance so they may make important decisions for themselves about their own care especially when experiencing the fast-paced emergency milieu.

2 The Emergency Care Field

Specific to this book is the urgent and emergency care field which is known to be a highly emotionally charged environment characterised by time-sensitive algorithms and immediate decision-making to direct people to the most appropriate pathway to prevent deterioration. However, whilst a number of major improvements have been made, e.g. mental health liaison or paramedic/mental health nurse teams and policing reform, there is indeed scope for further investment and enhancement in the area of mental health. The doctrine of emergency medicine has traditionally prioritised the physical aspects of patient assessment and treatment, so it is unsurprising that nursing staff sense a lack of relevant training on mental health care which leaves them feeling unprepared to care for their patients effectively including how to support young people, patients who self-harm, autism and/or learning disability. It may therefore be helpful to practitioners to refer to the various guidelines published by the Royal College of Emergency Medicine and to incorporate the recommendations into practice, e.g., the Mental Health Toolkit [9] the Mental Capacity Act Guideline [10] and position statements such as *ED doctors performing MHA assessments in England and Wales* [11].

Emergency practitioners have necessarily been self-critical of previous intolerance of patients presenting with mental health needs and embrace the notion that (a) we should be much more tolerant of people who display signs and symptoms of mental ill-health and (b) mental ill-health is increasingly recognised among the emergency practitioner community itself, as a high-stress occupational group. To do so we must look inward at our own shortcomings and consider more effective ways to respond to someone experiencing mental crisis and to authentically support both patients and colleagues. Whatever the aetiology, mental ill-health is very much a personal experience as the person affected juggles the anguish of their condition and their fear of, e.g. depression, paranoia, hallucinations, delusions, hypomania or suicidal ideation. It is also a family experience as they try to understand what their loved one is going through and, beyond first presentations, often feel they may be unable to cope with a further episode of instability. Staff tend to rely heavily on the information and support of families and Chap. 2 "Learning Disability and Sensory Processing Conditions" suggests some helpful indicators in this regard. Of course, not all people experiencing mental health instability have a devoted and caring family to cushion them in crisis. Many live in isolation, fear, despair and hopelessness compounded by quite difficult personal circumstances such as being homeless, sofa surfing, being out of work or, indeed, following bereavement. It is known that the critical combination of severe depression and hopelessness creates the ingredients for a suicide attempt, yet the emergency system continues to use simplistic and inadequate measures to assess suicidal ideation and risk. Shortfalls within the Manchester Triage System need urgent attention to save lives.

It is vital that we treat people within the emergency pathway with dignity and respect, so it is interesting to consider the words we select when describing people who attend with mental health conditions. A negative narrative seems to have emerged through the use of words such as "challenging", "disruptive", "unpredictable" "aggressive" or "demanding" and such words appear in nursing reports contributing to a negative discourse, perpetuating fears associated with mental health presentations and stigmatising and marginalising this patient cohort [12]. So, in light of the above lack of awareness which can result in misinterpretation and misattribution, how equipped do emergency practitioners feel about approaching and assessing people who display symptoms of mental ill-health? Whilst some people present with fairly innocuous symptoms, others may seem reasonably alert and lucid on first contact then during conversation may reveal some quite distorted thought processes, e.g. paranoia, hallucinations (visual, auditory, tactile) and/or delusions. The ability of a practitioner to recognise these symptoms and respond effectively with authenticity and in compliance with mental health and human rights legislation begs questions about the quality of their training and preparation for role. Indeed, physical health outcomes are poorer, and suicidal risk is increased, where depression, anxiety and other mental health conditions are unmanaged. Additionally, trauma-informed services acknowledge the strong link between trauma and subsequent mental illness. So, what does that mean to the emergency practitioner and allied emergency services? It means that public services need to be trauma-informed and to tread carefully and sensitively when supporting someone who has suffered

violating experiences, e.g. domestic and sexual exploitation or assault, and to remember that it is essential that they feel welcomed within the emergency pathway as a genuine "place of safety".

The Care Quality Commission Report [13] highlighted how ED staff feel unsupported and unprepared to care for their patients' mental health needs, so, for staff to provide high-quality care for their patients, appropriate training is necessary to enhance competence and confidence. Indeed, some staff viewed their mental health support role as outside of their remit relying heavily on psychiatry teams to handle this aspect. The CQC found that mental health training for staff varied, which was often limited to mandatory e-learning that focused on legislation including the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, but not the Mental Health Act 1983. Discharge summaries routinely requested depression screening to be carried out by general practitioners, yet medical teams should be able to have a holistic conversation with patients who are worried or showing signs of depression (p. 21).

How attentive and empathic a practitioner remains is of huge benefit to the person who is living through crisis because this helps to build trust. As an emergency practitioner, being aware of one's own posturing, spatiality, pitch and tone of voice, monitoring expressions of bias and judgemental projections are so important in the formation of a therapeutic interaction with someone who is feeling at their lowest or is experiencing thought disturbance. Indeed, the need to remain mute and unresponsive should also be respected as this may be symptomatic of a deep and painful depression. In social interaction terms, the patient's reaction may provide the "mirror within", the reflection of the emergency practitioner's own projections. So, it is helpful for the emergency practitioner to remain calm, non-judgemental, compassionate and sincere about the situation that person is living through and the anguish they may be expressing. These responses provide lasting impressions. De-escalation involves using calming measures to avoid overstimulation so reducing noise, lights, and presence of too many people, talking the person down to a manageably calm state and empowering the person to exercise agency through choice are essential steps in creating a therapeutic milieu. The core values of a person-centred health service which treats its emergency patients with dignity and compassion should be upheld.

3 New Approaches

The legislative framework for mental health support undergoes regular refinement to ensure that people experiencing mental instability are fully supported and their liberty protected. Throughout the book reference will be made to various pieces of legislation in particular the Mental Health Act and the Mental Capacity Act, and attention is drawn to proposals for legislative change. Chapter 4 "Police Custody Officer" summarises some key legislative changes to support people in custody who may be experiencing mental disturbance and to direct them to the most appropriate location for their needs. It is encouraging then to note that nowadays people in

mental health crisis are less likely to be taken to a police cell as a place of safety and more likely be directed to a health facility. One recent major development consists of the Mental Health Liaison Team which facilitates assessment and support by the most appropriate specialists early in the emergency pathway (Chap. 6 "Mental Health Liaison Team").

The Crisis Care Concordat (CCC, 2014) was launched which involves multi-agency collaboration to action the best solution for the patient, and this approach moves away from the traditional boundaries of practice to embrace a multi-agency, multi-professional collaborative approach. This is a particularly helpful transition considering mind/body relevance central to mental health: mind having causal relevance on behaviour through highly interconnected systems. Parity of esteem between physical and psychological health is highlighted later in the book. Chapter 2 "Learning Disability and Sensory Processing Conditions" draws on the experiences of people who live with a learning disability some of whom may also have an autistic condition. The fact that people who have a learning disability are likely to die 20 years earlier than the rest of the population and due to avoidable causes brings sharp focus to the need to closely examine our systems and processes to ensure that people with a LD/autism are comprehensively assessed within the emergency pathway. It is therefore critical that every patient contact matters so that a person who experiences mental health crisis is treated with the same urgency as those with physical health needs.

4 Where to Find Help

An argument exists that lengthy waiting times for psychological services and an underdeveloped range of alternative care pathways mean patients default to an emergency pathway due to a build up to crisis point. Social value of mental health patients in the emergency pathway is apparent, e.g. paramedics are frequently the first point of contact for people experiencing mental health crisis in the community (Chap. 3 "Paramedic"). In the past, the social value of the patient may have impacted negatively on patient care and treatment due to them being considered a distraction from "real" emergency care problems, usually life- or limb-threatening physical presentations. For people who live with autism, differences in sensory processing can be quite painful for the autistic person and in some situations may induce autistic meltdown as a reaction to extremely stressful situations such as emergency department attendance (Chap. 2 "Learning Disability and Sensory Processing Conditions"). Challenging behaviours add to the complexity of care and can also risk the personal safety of the emergency professionals involved which is of particular concern for practitioners who must establish a differential diagnosis, for example, in the case of a person sustaining a head injury influenced by alcohol consumption.

Mental health crisis may affect anyone regardless of social demographic, so it is helpful to consider the impact on different patient groups, e.g. children and young people (Chap. 8 "Children and Young Peoples' Services") as well as older adults (Chap. 9 "Older People Mental Health") and, indeed, older old. Of relevance is the

need to retain person-centredness, dignity and choice whilst the person is living through a difficult situation such as the older adult who has dementia and who has sustained an injury after a fall which brings them in contact with emergency services. Indeed, poly-morbidity and polypharmacy associated with older people provide additional complexity when assessing and planning care for someone in contact with the emergency services who may be older and mentally ill. The physical aspects of their care need to be thoroughly assessed as they may live with additional physical health problems, e.g. poor diet and nutrition, altered bowel habits, poor dental hygiene, limited health screening and the effects of longer-term medication, particularly psychotropic medication.

One particularly important aspect of emergency care for people experiencing mental ill-health concerns the attempt to take one's own life through an overdose. The public generally do not understand that the narrow therapeutic range of some drugs means that in overdose they may be sufficient to unintentionally kill you whilst other drugs may have a much lower toxicity threshold which may render them safer in overdose. Chapter 10 "Toxicology in Parasuicide" acknowledges that the interval between ingestion/exposure and treatment is critical to establish because accurate timelines determine treatment regimes. Further, there is limited awareness of the fact that few antidotes exist for specific substances, and, therefore, symptomatic treatment may be necessary. Intentionality is key to an accurate mental health assessment and diagnosis which paves the way for accurate treatment and support. However, continued risk assessment and safety of the patient are imperative whilst the patient remains in hospital. Knowledge of various clusters of symptoms associated with a specific toxicity state, otherwise known as toxidrome, is helpful to the practitioner especially when the patient is unable or unwilling to state what they have deliberately ingested. However, this knowledge is recorded as an adjunct to TOXBASE® confirmation and advice. Practitioners should become aware of the role and contact details for the National Poisons Information Service.

This chapter concludes by encouraging emergency services practitioners to become more familiar with the nuances of the vast array of mental health presentations that they could encounter on a daily basis and to adapt one's approach to facilitate a therapeutic and meaningful communication which is calming and helpful. Each chapter takes on a specific emergency discipline and discusses situations of relevance, and occasional scenarios highlight some quite tricky dilemmas and suggest strategies for how staff might respond offering concluding learning points to enable understanding and reflection on personal practice.

References

1. World Health Organization. Mental Health. 2022. https://www.who.int/health-topics/mental-health#tab=tab_1
2. Brunier A. COVID-19 pandemic triggers 25% increase in prevalence of anxiety and depression worldwide. News release. 2nd March 2022. 2022. https://www.who.int/news/item/02-03-2022-covid-19-pandemic-triggers-25-increase-in-prevalence-of-anxiety-and-depression-worldwide

3. Stewart C. Statista. Mental health in Europe - statistics & facts 31st May 2021. 2021. https://www.statista.com/topics/7916/mental-health-in-europe/#dossierKeyfigures
4. Office for National Statistics. Mental health services monthly statistics, performance December 2021, provisional January 2022. 2022. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics/performance-december-2021-provisional-january-2022
5. NHS Digital. Mental health services monthly statistics, Performance December 2021, Provisional January 2022. 2022. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics/performance-december-2021-provisional-january-2022
6. O'Regan PH. Theories of mental health and illness: psychodynamic, social, cognitive, behavioral, humanistic, and biological influences (chapter 10). In: Nurse Key. 2017. https://nursekey.com/theories-of-mental-health-and-illness-psychodynamic-social-cognitive-behavioral-humanistic-and-biological-influences/
7. Bell A. Levelling Up the UK: what does it mean for mental health? Centre for Mental Health. 2022. https://www.centreformentalhealth.org.uk/blogs/levelling-uk-what-does-it-mean-mental-health
8. Centre for Mental Health Commission for Equality in Mental Health. Mental health for all? The final report of the Commission for Equality in Mental Health. 2020. https://www.centreformentalhealth.org.uk/sites/default/files/publication/download/Commission_FinalReport_updated.pdf
9. Royal College of Emergency Medicine. Mental Health in Emergency Departments: a toolkit for improving care. 2022. https://rcem.ac.uk/wp-content/uploads/2022/02/Mental_Health_Toolkit_Feb_2022_Update.pdf
10. Royal College of Emergency Medicine. The Mental Capacity Act in Emergency Medicine Practice. 2017. https://rcem.ac.uk/wp-content/uploads/2021/10/RCEM_Mental_Capacity_Act_in_EM_Practice_Feb2017.pdf
11. Royal College of Emergency Medicine. Position Statement: ED Doctors performing Mental Health Act assessments in England and Wales. 2020. https://res.cloudinary.com/studio-republic/images/v1635416629/ED_Doctors_Performing_MHA_Assessments_in_England_and_Wales_Position_Statement/ED_Doctors_Performing_MHA_Assessments_in_England_and_Wales_Position_Statement.pdf?_i=AA
12. Scott T. It's vital we treat people presenting at ED with mental health issues with care. Emerg Nurse. 2020;28(2):5. https://doi.org/10.7748/en.28.2.5.s1.
13. Care Quality Commission. Assessment of mental health services in acute trusts programme Report: How are people's mental health needs met in acute hospitals, and how can this be improved? 2020. https://www.cqc.org.uk/sites/default/files/20201016b_AMSAT_report.pdf