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The Lived Experiences of Emergency Nurses Caring for Involuntarily Admitted Psychiatric Patients

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Abstract

Abstract: Background: The experiences of emergency department nurses in caring for involuntarily admitted psychiatric patients have been under-documented in Taiwan. The aim of this study was to understand the lived experience of emergency nurses in Taiwan who care for patients who require involuntary admission in the acute phase.

Methods: This study employed a phenomenological methodology. Ten emergency nurses were interviewed. Semi-structured questionnaires were used to collect data. Interviews were audio-recorded and transcribed verbatim.

Results: Four major themes emerged in relation to the implementation of care for involuntarily admitted psychiatric patients: Unclear laws and regulations, nurses' stereotyped perceptions, patient-related risks, and nurses' defense mechanisms. Conclusion: The results showed that emergency nurses experienced a range of challenges when caring for psychiatric patients who had been involuntarily admitted. It is recommended that relevant policies be revised to clarify the responsibilities of the various stakeholders in relation to involuntary admission to improve the safety of emergency nurses in the workplace and the quality of emergency psychiatric care.

Keywords: ***Phenomenology; Emergency nurses; Involuntary admission***

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1. Introduction

Involuntary admission means when the patients are admitted to hospital against their will. Involuntary admission can be used to ensure that psychiatric patients in the acute phase are able to access healthcare services in the emergency department (ED). Patients with a psychiatric disorder constitute about 0.5% of the population under the supervision of the health authority in Taiwan. Of these, 4.8% are expected to become severely ill with only 12.2% of them receiving involuntary treatment [1]. While psychiatric care adheres to the criteria documented in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5), there are significant differences in the rules and regulations governing involuntary treatment and placement of patients with psychiatric disorders. Such differences are often a reflection of social and cultural disparities [2].

In Taiwan, starting in 1990 Mental Health Act (MHA) is the basis for compulsory psychiatric evaluation and treatment. The principles of governing involuntary admission however are not widely understood by the public. Patients with a psychiatric disorder are usually sent to the ED when they present abnormal behaviors or if the family members identify a need for hospitalization [3]. Neither the patients nor their family members know that patients could be hospitalized against a patient's will. Furthermore, involuntary admission could lead to anxiety, distress, anger, aggression, and even violence. As a result, ED nurses often spend time to deal with the distress and conflicts associated with involuntary admission.

Primary health care services provide long-term follow-up for individuals with severe mental illness and act as gatekeepers to involuntary admissions. Unfortunately, there are no provisions for community-based psychiatric treatment and management in Taiwan. The police and emergency medical technicians (EMTs) are the frontline workers in the involuntary admission of psychiatric patients and are the primary source of referrals to the ED [3]. EMTs often cooperate with community health practitioners dealing with psychiatric crisis incidents before patients are sent to the ED. At the ED, these patients often require complex disease management regimens and support from psychiatric emergency services [3]. After triage or the initial assessment process, as high as 51% of patients are discharged. More than half of psychiatric patients who are involuntarily admitted to ED are discharged without further treatment and care, and 37.4% of patients not discharged are transferred to psychiatric ward. 12% of them after treatment one-night can go home. Based on clinical observations, ED nurses believe that these patients should receive additional treatment during the crisis. Unfortunately, there is a lack of under-standing of the involuntary admission mechanism and procedures.

Several studies related to involuntary admission using a quantitative research methodology addressed its legal perspective within a context of human rights considerations [4-6]. Some studies explored the experiences of family members, public health nurses, and psychiatric nurses as they related to involuntary admission [7-9]. To our knowledge, no previous study has sought to address the experience of involuntary admission from the perspective of ED nurses, especially those in Taiwan. The lived experiences of ED nurses mean to understand their first-hand involvement and direct experiences from their own stories. Therefore, the primary aim of this study was to understand the lived experience of ED nurses who care for psychiatric patients who have been involuntarily admitted to hospitals in Taiwan.

2. Materials and Methods

2.1 Phenomenological methodology

Phenomenology explores people's consciousness level and objectively presents their life experiences of the research object. The phenomenological methodology proposed by Husserl involves the intuitive exploration of the essential nature of a phenomenon as it is consciously experienced. The phenomena mentioned by Husserl are generally the phenomena of things experienced through sensory intuition, but the essential phenomena of things that appear in the transcendental intuition (eidetic intuition). Phenomenological research methods can be used for all phenomena in clinical nursing, education and administration [10]. As a research method, phenomenology is concerned with bringing objects of experience and their meaning to conscious awareness [11]. This qualitative methodology was used in this study to explore the essential structure of ED nurses' life experiences in relation to psychiatric patients' involuntary admission. Phenomenology seeks to describe the ways in which phenomena are perceived and understood by individuals' life stories [12]. In this study, the phenomenon under investigation was ED nurses' lived experience of caring for involuntarily admitted psychiatric patients, that is, to capture their descriptions of involuntary admission as consciously experienced.

2.2 Data collection

This study aimed to understand the subjective and lived experience of ED nurses. Data were collected via in-depth face-to-face interviews using an ideographic approach, in which detailed, individual cases are used to develop more general claims. ED nurses who had experience caring for involuntarily admitted patients were eligible to participate. The participants were recruited from two hospitals in Taiwan using the snowballing technique. Saturation was achieved after nine participants had been interviewed. The interviews were conducted by a master-prepared nursing researcher, who The participants decided the location and date/time for the interview. The length of the interviews ranged from 45 to 60 minutes. During the period of interviewing, COVID-19 was well-controlled and not widely spread in Taiwan, therefore, a face-to-face interview method was pursued. The interviews utilized semi-structured and open-end questions. The questions were a set of broad topic areas related to participants' experience of caring for patients who had been involuntarily admitted to the ED. The questions included:1. How was your lived experience of caring for involuntarily admitted psychiatric patients? 2. What was the process of caring for involuntarily admitted psychiatric patients? 3.How to deal with the reaction of different perspectives from families? 4.What was your education training program going? 5. When you had struggles, how did you deal with? 6.Please provide any pictures which could express your experiences? Informed consent was obtained at the beginning of each interview. All interviews were audio-recorded. Data were collected between August 2022 until May 2023.

2.3 Data analysis

After each interview, the recording was transcribed verbatim into a script that included details of sentences, pauses, and special terms. Giorgi's five-step phenomenological method was used to analyze the data. These steps are: (1) read all the data to obtain an overall impression; (2) divide the data into primary meaning units; (3) through reflection and imagination, identify secondary meaning units; (4) transform the meaning units into psychologically sensitive descriptive expressions of lived experiences; (5) synthesize a general psychological structure of the experience and combine subsequent descriptions to form a theme [13].

2.4 Trustworthiness

Lincoln and Guba's criteria of credibility, reliability, transferability, and confirmability were used to confirm the rigor of the study. The researcher had three years of graduate professional training in qualitative study and followed the rigor of qualitative research mechanisms [14]. The researcher conducted all the interviews, confirmed that the results of the analysis were consistent with the participant's reported experience, ensured the authenticity of the research, and retained the original data for retrospective auditing and confirmation of the results. The participants reviewed the results and confirmed the data were consistent with their experiences.

3. Results

The demographic profile of the participants is shown in TABLE 1. The average age of the participants is 35.9-year-old. The length of nursing experiences with acute psychiatric involuntary admissions is about 9 years. The participants consisted of two males and eight females. Among them, only two participants had received training related to acute psychiatric involuntary admission. Four themes representing the lived experiences of caring for involuntarily admitted patients emerged from the analysis: unclear laws and regulations; nurses' stereotyped perceptions; patient-related risks; and nurses' defense mechanisms (TABLE 2).

TABLE 1. **Demographic characteristics of study participants.**

Code	Age	Gender	Hospital Level	Relevant Professional Experience	Education on involuntary admission
A	42	F	district hospitals	9y3m	N
B	30	F	district hospitals	8y3m	N
C	38	F	regional hospitals	14y6m	Y
D	38	F	regional hospitals	14y	N
E	25	F	regional hospitals	2y1m	N
F	34	M	regional hospitals	1y6m	N
G	25	F	regional hospitals	3y1m	N
H	31	F	regional hospitals	9y3m	N
I	52	F	district hospitals	9y1m	Y
J	44	M	regional hospitals	18y10m	N

TABLE 2. **Themes and Sub-themes.**

Theme	Sub-themes
Unclear laws and regulations,	Nurses are uncertain and confused Family members' doubts about involuntary admission Police, EMTs and community health nurses cannot manage involuntary admission
Nurses' stereotyped perceptions	Patients' emotional state creates stress for nurses Worry and fear".
Patient-related risks;	Concern about hurting others Concern about suicide Concern for other patients' wellbeing
Nurses' defense mechanisms.	Vigilance Forced composure

3.1 Theme 1: Unclear laws and regulations

All participants reported a lack of clarity about the laws and regulations governing involuntary admission. This was particularly problematic when no police or other relevant authorities were present to support nurses when performing acute psychiatric in-voluntary admission. ED nurses had to solely take the initiative to decide whether to in-voluntarily admit a psychiatric patient who exhibited abnormal behaviors. Family members were confused about the differences between involuntary admission and compulsory hospitalization. The lack of clarity related to the policy of involuntary admission increased the clinical burden and created poor communication between the ED nurses and the patients and their family members.

This theme was further divided into three sub-themes: nurses were uncertain and confused; family members questioning of involuntary admission; and police, EMTs and community health nurses' inaptitude at managing involuntary admissions.

3.1.1 Nurses were uncertain and confused

Participants reported that they were often unclear about whether patients met the criteria for involuntary admission.

- • • Participant E: "It is not clear whether this patient is eligible for compulsory medical treatment."

The participants gave specific examples of behaviors, such as stealing, roaming in the park, or being obsessed with a certain policeman that led to people being sent to the hospital. Such behaviors however did not appear to meet the criteria for involuntary admission.

- • • Participant G: "There is a kind of stealing for which people were brought to the ER. I have never understood why someone stealing should be sent to the ED. There was one who was forced to seek involuntary admission by the police. The girl was only 19 years old. She was retained in the ED for two consecutive days because she stole things. She had no psychiatric symptoms!"

3.1.2 Family members questioning about involuntary admission

Family members lacked knowledge about the process of involuntary admission for patients who are exhibiting acute psychiatric behaviors or diagnosed with mental illness under the Mental Health Act. For instance, involuntary admission is automatically initiated by the ED nurses or a physician when the patient presents self-harm or harm to others' behaviors. The process of involuntary admission however is the same as that for Compulsory Psychiatric Admission.

This can lead to conflicts between family members and healthcare providers and creates an additional care burden for ED nurses who spend additional time explaining to family members why, for example, the patient does not need to be hospitalized and to convince them to take the patient home.

- • • Participant I: "Family members think that I should call 119 (Taiwan's emergency response line). They insist the patient should be hospitalized. The family members think the patient met the hospitalization criteria. However, when the initial evaluation results came against their wishes, there was verbal abuse and uncivil response, which cause trouble for the ED nurses."

3.1.3 Police, EMTs, and community health nurses' inaptitude at managing involuntary admission

Most of those who bring patients to the ED for involuntary admissions, such as the police, EMTs, or community health nurses, expect the hospital to deal with the issues and resolve the problems associated with such admissions. Currently, these responsibilities fall on ED nurses who may have to act as the patient's advocators. Family members who called the police or the EMT for incidents involving family disputes were confused when they received different information about involuntary admission from the ED nurses.

- • • Participant H: "We asked the police why the patient had to be sent to the hospital. It was actually helpless by calling 119. The police responded that they could not handle it, so they sent the patient to the hospital."
- • • Participant F: "I think there are a lot of things … but the police seemed to be unwilling to deal with it. The patient was probably outside of the house when the family members reported it to the police. It is inexplicable why patients were sent to the ED just because they were drunk or fighting with their families."

Under the Mental Health Act, police, EMTs, or community health nurses can send patients who are in the acute phase to the ED against their will. In emergent situations where there is imminent or actual self-harm or harm to others, the Mental Health Act can be invoked to involuntarily admit a person to a psychiatric care unit.

However, not all EMTs, community health nurses, and ED nurses comprehend the Act. By the Act, EMTs, community health nurses, and Ed nurses are responsible for making the decision about involuntary admission. Due to a lack of comprehension of the Act, ED nurses are con-fused and overburdened.

3.2 Theme 2: Nurses' stereotyped perceptions

The participants described some of the involuntarily admitted patients as ticking bombs that could explode at any time in the ED. This created a fearful and potentially dangerous work environment for ED nurses who had to deliver care while averting potential harm or injury. Such experiences contributed to a stereotyped image of involuntarily admitted psychiatric patients where participants described how their encounters with patients were associated with negative feelings and prejudiced attitudes. This theme was further divided into two sub-themes: "Patients' emotional state causing stress to nurses ", and "Worry and fear."

3.2.1 Patients' emotional states causing stress on nurses

ED nurses reported that involuntarily admitted psychiatric patients often arrived at the ED in an agitated and aggressive state. The nurses felt threatened and worried that something bad could happen at any time.

- • • Participant D: “I think a psychiatric patient is like a ticking time bomb. He is un-predictable. He may have auditory or visual hallucinations. We don’t know! We are afraid and feel distressed. If anything makes the patient angry, he may explode.”
- • • Participant A: “I was under huge stress all the time since the involuntarily admitted psychiatric patient was brought to the ED.”

When providing emergency care to such patients, the nurses reported that they felt unprepared and stressed. They described it as being on the battlefield where they could become the victims at any time. They also described how they perceived such patients as ‘bad luck’, and often felt unwilling to treat them.

- • • Participant J: “He (the patient) was an explosion! I felt resistant!” “I also felt like fighting and shouting out the three words of CPR.... It seemed a “bad luck” if you had it when you are on duty.”

The ED nurses expressed negative opinions about those patients who made frequent visits to the ED:

- • • Participant A: "The psychiatrist is also very aware of these patients and knows their names by heart. They are frequent flyers.”

The participants expressed negative feelings when caring for involuntarily admitted psychiatric patients. The ED nurses were not only caring for the patients but were also acting as safeguards. These multiple roles caused emotional distress, a dreadful work environment, and a constant fear of potential injury and harm while caring for those angry and agitated psychiatric patients. As a result, these negative experiences and emotions interfered with the nurses’ ability to provide an adequate care for the patients.

3.2.2 Worry and fear

While encountering psychiatric patients who exhibited agitated or violent behaviors, frontline healthcare workers were subject to fear and other negative emotions.

• • • Participant I: “Everyone is scared. Although there is security on site, the psychiatric patients were wandering around in the ED. This makes the ED a very dangerous place. Other family members of non-psychiatric patients are also scared by this situation. No one knows when the psychiatric patient is going to outburst because the patient is like an un-timely bomb, and no one can predict what the patient would do next.”

3.3 Theme 3: Patient-related risks

Involuntarily admitted patients are often agitated. ED nurses are at risk of being at-tacked while performing nursing care. The patients are also at risk of self-harm or absconding from physical restraints. Their violent behavior is also likely to affect other types of patients in the ED. All of these factors put ED nurses under immense pressure.

This theme was further divided into three sub-themes: "Concern about hurting others," "Concern about suicide," and "Concern for other patients' well-being."

3.3.1 Concern about hurting others

It is difficult for ED nurses to predict the behavior of psychiatric patients and whether they are likely to be the target of a sudden physical attack. For this reason, patients are often restrained to protect both the patients and the nurses, which often causes distress to patients’ families. Participants reported three main areas of concern: fears of the patients harming others, fears of potential self-harm, and worry about the impact of psychiatric patients on other patients in the ED.

Participant C described one incident in which a patient had harmed another person.

• • • Participant C: “The psychiatric patient was forced to be sent to the doctor. It happened so quickly and it was chaotic! The patient was struggling and fighting with the nurses. At one point, the patient turned his head to others and accidentally touched a nursing student’s forearm which was subsequently bitten by the patient.”

Ed nurses faced dilemmas about using physical restraints with the psychiatric patients. They understood the reluctance of the families to see the patients being restrained, but were also concerned with the potential consequences of not restraining the patients.

• • • Participant E: “Family members feel very distressed when they see that the patient is being physically restrained. There was a chance the patient might run away or hurt him-self. For example, one patient was brought in by an ambulance. The patient eloped before entering the ED. The EMTs had to find the patient and bring the patient back to the ED again. This caused a lot of trouble to us!”

The ED admits patients who require emergent care and treatment. When mentally ill patients are in the acute stage, cognitively incoherent and agitated behaviors cause disturbances to other patients and interfere with their well-being.

• • • Participant B: “There were small spaces between beds in the ED. There were all kinds of patients with emergent conditions admitted there. Those patients who are admitted with other emergent medical conditions need a fairly quiet

environment. However, with the interference and disturbances from the psychiatric patients, the other patients are in an uncomfortable status and unsafe environment."

Under these circumstances, the safety and well-being of family members might also be impacted, which forces the ED nurses to take additional steps and efforts to address these concerns.

- • • Participant B:" The psychiatric patients' family members did not want to accept compulsory medical treatment by the law. When the patients became more irritable in the ED, the other non-psychiatric family members requested the ED nurses to talk to the psychiatric patients. The irritability from the psychiatric patient disturbed and interfered with the other non-psychiatric patients. Therefore, I had to explain the situation to them out of my busy routine."

3.4 Theme 4: Nurses' defense mechanisms

In the process of providing care to involuntarily admitted psychiatric patients, ED nurses are confronted with two conflicting demands: being alert to potential risks and therefore adopting a defensive stance and presenting a professional image of being in control of their emotions. This theme had two sub-themes: " Vigilance" and "Forced composure."

3.4.1 Vigilance

Although ED nurses have previously dealt with patients admitted involuntarily, they always remain guarded and vigilant for any potential risk of injury.

- • • Participant I: "We were informed in advance about involuntary admission. When we receive the notice, we start to be alert. The vigilance towards the incoming patients was at its highest."

3.4.2 Forced composure

As professional nurses, participants believed that they should not express fears and negative emotions at work. This created an internal conflict as they were ought to project a calm and composed professional image.

- • • Participant E: "We can't let patients know about our fears. We need to be calm in front of them even though we were so scared to take care of the violent psychiatric patients. We are professional. It is important not to show our fears."

4. Discussion

Due to the nature of Taiwan's psychiatric healthcare system, the ED has become the first destination for treatment when patients experience a psychiatric crisis. The clinical assessment guidelines for this situation lack clarity for treating non-psychiatric patients [15]. The in-service training for ED staff usually focuses on non-psychiatric care [16]. As a result, ED nurses lack sufficient understanding of the standards and regulations for acute psychiatric care. This has led to an increase in their level of anxiety and stress, especially when caring for mentally ill patients [17]. More than 80% of the participants in this study reported

that they had never received any prior training in relation to psychiatric involuntary admission. Instead, they relied on verbal communication and teaching from experienced ED nurses.

When faced with incidents involving eccentric and violent behaviors, or injuries as-sociated with mental illness, ED nurses would initiate the process of involuntary admission under the incorrect assumption that compulsory hospitalization is required [18]. Under involuntary admission, family members of psychiatric patients are totally de-pendent on the police, EMTs, and community health nurses [19] to evaluate the patient and to decide where the patient should be transferred.

Often time, the police would send the patients to the hospital because they are unable to handle acute situations [20]. Unfortunately, according to Quirke et al. (2019), more than one-third of ED nurses do not know the correct procedure for handling patients with mental illness, an observation that was consistent with the findings of this study. While research has shown that new ED nurses who lack confidence show more respect and sympathy to psychiatric patients compared with those in the general wards [21], their lack of confidence, due to insufficient context-specific education and training, was associated with feelings of isolation [22]. Such feelings and lack of training often morph into negative attitudes and fear when caring for involuntarily admitted psychiatric patients.

Acute symptoms among psychiatric patients include emotional agitation, self-harm, and/or suicidal behavior. Emotional agitation accounts for 50% of all acute symptoms of psychosis [23,24]. Cases involving violent behaviors are usually involuntarily admitted to the ED. One study indicates that nurses in general medical settings often held negative attitudes of fear towards patients with psychiatric illness [25]. This was extremely stressful for ED nurses. Another study found that nurses held more stereotyped perceptions of mental illness than the general public [26]. When dealing with psychiatric patients in an acute phase, they displayed negative attitudes towards the patients, which was also consistent with the findings in this study.

It seems that nurses' negative experiences of caring for involuntarily admitted psychiatric patients have led to stereotypes of psychiatric patients. Unfortunately, these attitudes and stereotypes could negatively impact ED nurses' behavior and ability to per-form adequate care for psychiatric patients [26]. Some participants internalized prejudice towards these patients. For example, a participant stated, "I feel that I am unlucky and I feel worried if they were to be admitted again". This finding highlights the need for in-service training to include interventions designed to address stereotyped attitudes and beliefs about psychiatric patients among nurses.

Studies have shown that most psychiatric patients who were involuntarily admitted to the ED were severely mentally ill. Of these, 10% were emotionally agitated or violent [27]. Ensuring patients' and family members' safety was a major challenge for ED nurses. As other research has shown, nurses who have been physically injured by psychiatric patients became more cautious in their subsequent care of similar cases [17]. The participants in our study described how they experienced a feeling of fear and became vigilant and defensive when encountering involuntarily admitted psychiatric patients. They de-veloped an internal dilemma of whether to continue to care for psychiatric patients despite the potential violence and injury from caring for them [28].

Limitation. The main limitation of this study was recruited only two medical hospitals in south cities of Taiwan. Also, the participants were only two male nurses. As such, the results of this study cannot be generalizable to all ED nurses.

5. Conclusion and Recommendations

The enforcement of psychiatric involuntary admission by the police, EMTs, and community health nurses is complex in Taiwan. The EDs and the coordination processes differ among cities and rural counties. Although standards and procedures are based on the professional division of labor under the Mental Health Act, ED nurses do not have a good grasp nor understanding of what is mandated under the Law.

A number of recommendations emerge from our findings and discussion. First, future amendments to the law should clearly identify the responsibilities of the relevant authorities and personnel and to address the professional boundaries that impact the experiences of ED nurses. Second, hospital administration should strengthen the nurses' role in caring for involuntarily admitted psychiatric patients, and to enable them to con-duct a comprehensive assessment of the patients. Third, establish procedures and standards for a safe workplace for ED nurses to reduce the occurrence of injuries, improve the provisions of mental health care to patients, and decrease the stereotyping of psychiatric patients by ED nurses. Fourth, ED nurses should receive in-service training on the management of involuntarily admitted psychiatric patients. Fifth, communication forums should be available for first-line healthcare providers to discuss difficult situations and to find solutions and reduce feelings of powerlessness and negative attitudes.

Finally, nurse educators should establish a bias-free environment in order to reduce the stereotyping of psychiatric patients. Future research should focus on the relationship between nurses' attitudes and their work performance, and on the experiences of family members of patients with mental illness.

6. Author Contributions

Conceptualization, Rei-Mei Hong and Yu-Ting Wang; Methodology, Rei-Mei Hong; validation, Chin-Nu Lin; investigation, Yu-Ting Wang; formal analysis, Rei-Mei Hong; original draft preparation; interpretation of data for the work, Chin-Yen Han; Yu-Ting Wang & Rei-Mei Hong; writing-review and editing, Chin-Nu Lin. All authors have read and agreed to the published version of the manuscript.

7. Institutional Review Board Statement

This study was conducted in accordance with the Declaration of Helsinki and approved by the Hospital Institutional Review Committee of CHIAYI BRANCH, TAICHUNG VETERANS GENERAL HOSPITAL (approval number: SE18340A). The researcher explained the purpose of the study to the participants and obtained written consent. The principles of anonymity, voluntariness, confidentiality, and privacy were strictly adhered to. No identifying information was recorded.

8. Informed Consent Statement

Informed consent was obtained from all subjects involved in the study. Written informed consent has been obtained from the patient(s) to publish this paper.

9. Data Availability Statement

Not applicable.

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REFERENCES

1. Ministry of Health and Welfare. Mental health administrative work execution results. Published 2021 March 15.
2. Fiorillo A, De Rosa C, Del Vecchio V, et al. How to improve clinical practice on involuntary hospital admissions of psychiatric patients: suggestions from the EUNOMIA study. Eur Psychiatry. 2011;26(4):201-07.
3. Wang JP, Wu CY, Chiu CC, et al. Police referrals at the psychiatric emergency service in Taiwan. Asia Pac Psychiatry. 2015;7(4):436-44.
4. Elisa DF, Claudio B, Vincenzo V, et al. Compulsory admission: are there differences between migrants and natives? Data from a psychiatric emergency service of an Italian metropolitan area. Heliyon. 2023;9(3):e14406.
5. Cochrane RE, Laxton KL, Mulay AL, et al. Guidelines for determining restorability of competency to stand trial and recommendations for involuntary treatment. J Forensic Sci. 2021;66(4):1201-09.
6. Stylianidis S, Georgaca E, Peppou LE, et al. Involuntary psychiatric hospitalizations in Greece: Contemporary research and policy implications. Psychiatriki. 2023;34(3):204-11.
7. Ferracuti S, Parmigiani G, Catanesi R, et al. Involuntary psychiatric hospitalization in Italy: critical issues in the application of the provisions of law. Int Rev Psychiatry. 2021;33(1-2):119-25.
8. Wickremsinhe M, Ramlall S, Wassenaar D, et al. The role of 'micro-decisions' in involuntary admissions decision-making for inpatient psychiatric care in general hospitals in South Africa. Int J Law Psychiatry. 2023;87:101869.
9. Huang BL. Experience of coercive measures for the psychiatric patients as narrated by the psychiatric nurses [Unpublished doctoral dissertation]. 2007. China Medical University, Taiwan.
10. Zahavi D, Martiny KMM. Phenomenology in nursing studies: New perspectives. Int J Nurs Stud. 2019;93:155-62.
11. Valle R, King M, Halling S. An introduction to existential phenomenological thought in psychology. In: Valle R, Halling S, editors. Existential-phenomenological perspectives in psychology: Exploring the breadth of human experience. New York: Plenum Press, USA;1989. 3-16 pp.
12. Gutland C. Husserlian Phenomenology as a Kind of Introspection. Front Psychol. 2018;9:896.
13. Giorgi A. The descriptive phenomenological method in psychology: A modified Husserlian approach. Pennsylvania: Duquesne University Press, USA; 2009.

14. Lincoln YS, Guba EG. Naturalistic inquiry. London: Sage Publications, Inc., UK; 1985.
15. Clarke DE, Brown AM, Hughes L, et al. Education to improve the triage of mental health patients in general hospital emergency departments. Accid Emerg Nurs. 2006;14(4):210-8.
16. Zun L. Care of Psychiatric Patients: The Challenge to Emergency Physicians. West J Emerg Med. 2016;17(2):173-6.
17. Dzubak JL. Managing mental health emergencies in the ED: Safety and continuity are key to successful care. Am Nurse Today. 2017;12(11):6-9.
18. Sugiura K, Pertega E, Holmberg C. Experiences of involuntary psychiatric admission decision-making: a systematic review and meta-synthesis of the perspectives of service users, informal carers, and professionals. Int J Law Psychiatry. 2020;73:101645.
19. Hallam L. How involuntary commitment impacts on the burden of care of the family. Int J Ment Health Nurs. 2007;16(4):247-56.
20. Hazell CM, Koc Y, O'Brien S, et al. Enhancing mental health awareness in emergency services (the ENHANcE I project): cross-sectional survey on mental health stigma among emergency services staff. BJPsych Open. 2021;7(3):e77.
21. Quirke MB, Donohue G, Prizeman G, et al. Experiences and perceptions of emergency department nurses regarding people who present with mental health issues: a systematic review protocol. JBI Evidence Synthesis. 2019;17(9):1877-82.
22. Allison MK, Henderson HM, Curran GM, et al. Emergency Department Nurses' Perceptions of Patient Substance Use, Impact on Sexual Assault Care, and Access to Follow-up Behavioral Health Resources. J Emerg Nurs. 2022;48(6):698-708.
23. Mavrogiorgou P, Brüne M, Juckel G. The Management of Psychiatric Emergencies. Dtsch Arztebl Int. 2011;108(13):222-30.
24. Rodriguez Calzada R, Siesto Marcos M, Roset arisso P, et al. Psychiatric Emergency Prehospital: Incidence and Management of Agitation in Valladolid (Spain). Eur Psychiatry. 2016;33(S1):S444-S444.
25. Ross CA, Goldner EM. Stigma, negative attitudes and discrimination towards mental illness within the nursing profession: a review of the literature. J Psychiatr Ment Health Nurs. 2009;16(6):558-67.
26. Perlman D, Brighton R, Patterson C, et al. Stigmatization and self-determination of preregistration nurses: A path analysis. Int J Ment Health Nurs. 2018;27(1):422-8.
27. Huf G, Alexander J, Gandhi P, et al. Haloperidol plus promethazine for psychosis-induced aggression. Cochrane Database Syst Rev. 2016;11(11):CD005146.
28. Carlsson G, Dahlberg K, Lützen K, et al. Violent encounters in psychiatric care: a phenomenological study of embodied caring knowledge. Issues Ment Health Nurs. 2004;25(2):191-217.