RESEARCH PAPER

Reasons for High Emergency Department Use Among Patients With Common Mental Disorders or Substance-Related Disorders

Les raisons expliquant le recours fréquent aux services d'urgence par les patients souffrant de troubles mentaux courants ou de troubles liés aux substances psychoactives

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Abstract

Aims: This study examined the reasons for high emergency department (ED) use among patients with common mental disorders (MDs), substance-related disorders (SRDs) or co-occurring MDs-SRDs.
Method: Following content analysis, 42 high ED users (three-plus visits/year) recruited in two Quebec EDs were interviewed.
Results: The reasons included barriers to outpatient care, patient disabilities and professional practices. Patients with SRDs trust outpatient services less, those with MDs had important unmet needs and those with MDs-SRDs faced care coordination issues.
Conclusion: Improvements such as ED use monitoring, consolidating MD-SRD practices and continuous training are needed in EDs and outpatient services to enhance access and continuity of care.

Résumé

Objectifs : Cette étude examine les raisons de recours fréquent aux services d'urgences (SU) chez les patients ayant des troubles mentaux courants (TMC), des troubles liés aux substances psychoactives (TLS) ou des TMC-TLS concomitants.
Méthode : Fondée sur l'analyse de contenu, les données de 42 grands utilisateurs des SU (plus de trois visites/an), recrutés dans deux SU du Québec, ont été collectées.
Résultats : Les raisons d'utilisation fréquente sont liées, notamment, aux obstacles d'accès aux soins ambulatoires, aux limitations des patients et aux pratiques professionnelles. Les patients avec des TLS font moins confiance aux services ambulatoires, ceux avec des TMC ont des besoins importants non satisfaits et ceux avec des TMC-TLS sont confrontés à des problèmes de coordination des soins.
Conclusion : Des améliorations telles que la surveillance de l'utilisation des SU, la consolidation des pratiques pour les TMC-TLS et la formation continue sont nécessaires dans les SU et les services ambulatoires pour améliorer l'accès et la continuité des soins.

Introduction

Emergency departments (EDs) are used as a first or last service resort when seeking help for acute conditions or when outpatient resources have been exhausted (Fleury et al. 2019; Navas et al. 2022). A significant number of patients account for a disproportionate amount of ED use; they are referred to as high ED users, defined by three-plus ED visits/year – the lowest standard for high ED use (Pines et al. 2011). High ED use is costly and contributes to ED overcrowding (Morley et al. 2018). Patients with mental disorders (MDs), including substance-related disorders (SRDs), are often reported as high ED users (Moe et al. 2021; Roennfeldt et al. 2021). Most studies on high ED users with MDs are based on hospital health records and investigate socio-demographic and clinical patient characteristics predicting high ED use (Kromka and Simpson 2019). High ED users with MDs are more likely to

have a low income, limited social networks, multi-morbidity, recurring health issues and serious MDs (e.g., schizophrenia) or co-occurring MDs-SRDs (Casey et al. 2021).

Few qualitative studies have explored the reasons why patients with MDs repeatedly use EDs. For these patients, the decision to use the ED instead of outpatient care is rarely taken lightly, nor perceived as desirable (Schmidt et al. 2018). Reasons for disproportionate ED use include difficulty in accessing effective treatment (Wise-Harris et al. 2017), limited alternatives to ED use when in crisis (Aagaard et al. 2014), previous negative outpatient experiences and lack of continuous care (Vandyk et al. 2018). Patients included in these studies usually experienced acute mental distress or complex health conditions (Wise-Harris et al. 2017) or displayed disruptive behaviours that led relatives, the police or other clinicians to refer them to EDs (Poremski et al. 2020).

To our knowledge, no previous qualitative study has investigated reasons for high ED use among patients who exclusively have common MDs (e.g., anxio-depressive disorders). Only two have studied patients with SRDs (McCormack et al. 2015; Parkman et al. 2017) and they found that few were inclined to receive SRD treatments, mostly because of motivational barriers or engagement issues. Common MDs are the most prevalent type of MDs (McGrath et al. 2023), though MDs are known to often co-occur with SRDs (Huỳnh et al. 2020). MD treatments, usually provided in primary care, have been consolidated in current reforms (NCCMH 2011). Historically, services have, however, focused on patients with serious MDs (Fleury et al. 2016). Patients with co-occurring conditions are found to be more difficult to treat, turning alternately to mental health or addiction services without much integration between these (Gaulin et al. 2019). Ascertaining reasons for high ED use, especially for patients with common MDs, SRDs or MDs-SRDs, could offer insights to improve services, especially as these patients may display different needs and different patterns of service use and experience different barriers to care.

This study is based on a conceptual framework adapted from an existing implementation model (Fleury et al. 2019) integrating mental healthcare system features (adequacy, accessibility and continuity of care), patient profiles (urgent and recurrent biopsychosocial problems, support systems and individual disabilities) and professional practices (knowledge of and comfort in treating MDs or SRDs, quality of exchanges with patients and collaboration between clinicians) influencing ED use. It examined reasons for high ED use by comparing the perspectives of patients with common MDs, SRDs or co-occurring MDs-SRDs and aspects that patients identified as helpful in decreasing ED use.

Methodology

Study context

In Quebec, health and social services are mostly public, covering medical and some psychosocial services (Martin et al. 2018). Primary mental healthcare relies on general practitioner clinics and community healthcare centres (mainly providing psychosocial services). The mental healthcare system is complemented by helplines, crisis centres, suicide prevention

centres and detox centres mostly operated by community-based organizations, and counselling services dispensed by psychologists mostly working in private practice. Specialized care is provided in psychiatric departments of general or psychiatric hospitals or, in the case of SRDs, in addiction treatment centres (MSSS 2022). Patients access public MD-specialized services mostly through one-stop services in community healthcare centres.

Study setting, data collection and analytical dimensions

Data from this qualitative study came from a larger mixed-methods research study on high ED users with MDs, conducted in Quebec health territories serving roughly one-fourth of the province's population (Fleury et al. 2020). Two health territories were selected for the present study, including a psychiatric ED in a university region with specialized care, teaching and research mandates and a general ED from a peripherical region with MD staff but less specialized care. Participants had to be 18 years or older, be high ED users (three-plus ED visits/year for MD or SRD issues), speak French or English, be functional enough to be interviewed – if intoxicated or in psychosis, their interview was postponed – and grant the research team access to their medical records. Randomized recruitment was done between March 1, 2021, and May 13, 2022, through a list of 1,008 ED users (identified by ED staff) meeting the aforementioned criteria. Of the first 308 patients reached, 247 agreed to be referred to the research team and be contacted for an interview. To be selected for the qualitative study, patients had to have common MDs or SRDs only or co-occurring common MDs-SRDs. All patients with such diagnoses were included in this study, with an equal number of patients coming from each of the two ED sites. Patients provided prior consent and received a $20 compensation. The multisite protocol was approved by the human research ethics board of the Douglas Mental Health University Institute.

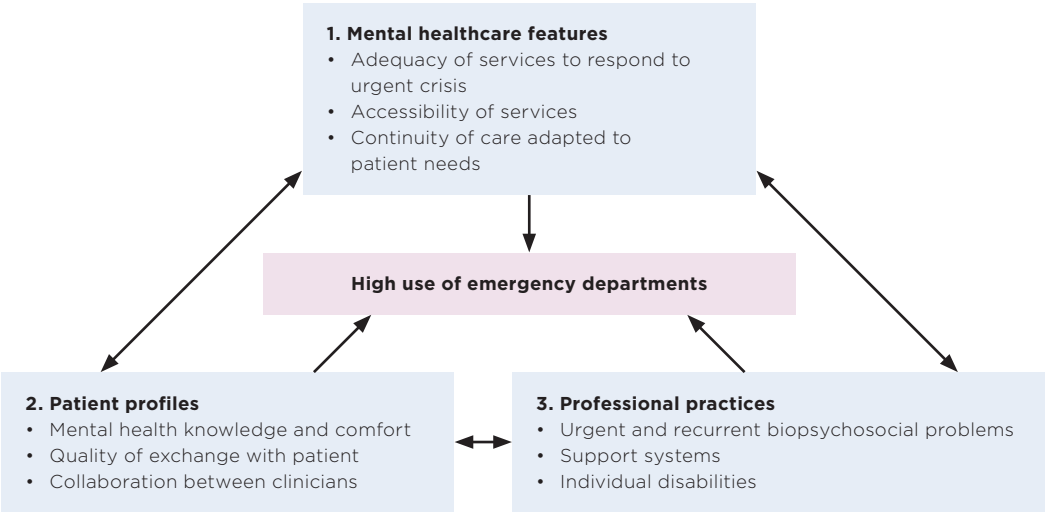
Phone interviews for the larger project lasted about one hour. They included closed and open-ended questions and were conducted by trained staff using an online platform. Medical records for 12 months preceding the interviews were used to confirm high ED use and MD or SRD diagnoses. ED use was measured using data from an ED use database (BDCU [*banque de données communes des urgences*]) (Institut national de santé publique du Québec n.d.), while MD or SRD diagnoses came from a hospitalization database (MED-ECHO [*maintenance et exploitation des données pour l'étude de la clientèle hospitalière*]) (Institut de la statistique du Québec n.d.). Common MD and SRD diagnosis codes were based on the *International Classification of Diseases, Tenth Revision* (ICD-10) (CIHI 2022). Common MDs included anxiety, depressive, adjustment and attention deficit/hyperactivity disorders; and SRDs included alcohol and drug use – induced, abuse, addiction, intoxication or withdrawal (Appendix 1, available online at www.longwoods.com/content/27333). As SRDs tend to be underdiagnosed in medical records (Huỳnh et al. 2021), two standardized scales were included in the interviews and merged with results from medical records: the Alcohol Use Disorders Test (AUDT) (Bohn et al. 1995) and the Drug Abuse Screening Test-20 (Skinner 1982) (see Appendix 2, available online at www.longwoods.com/content/27333).

Self-reported quantitative patient socio-demographic variables included sex, age group, education, civil and employment status, personal income and housing situation. The open-ended questions (Appendix 2) took about 20 minutes to complete out of the one-hour interview time. The interview guide was validated by a steering committee of ED experts, including clinicians and managers, created to support the study design. The open-ended questions, which were recorded and then transcribed, focused on reasons explaining high ED use, the other services patients had used before the ED, recommendations to avoid high ED use, services that would better respond to their needs and what most helped with recovery.

Analyses

Descriptive analyses were produced from the quantitative data, while content analysis was used for the qualitative data, allowing themes to emerge (Vaismoradi et al. 2013). The process involved six steps: (1) familiarization with the data; (2) generating initial codes and the analysis grid; (3) combining codes into themes; (4) reviewing verbatim transcripts for consistency and completeness; (5) presenting and describing themes clearly, with relevant quotes; and (6) interpreting the data. The aforementioned conceptual framework guided the analysis, categorizing the reasons contributing to high ED use into mental healthcare features, patient profiles or professional practices (Figure 1). Themes were examined according to their frequency and percentage of patients reporting them. Data saturation was reached when themes were found to represent enough of the data (Saunders et al. 2018). Study rigour was ensured by combining different strategies: training and close monitoring of the research team, research tools validation by the steering committee and keeping a reflective journal (Patton 2015). Three team members produced the analysis involving an inter-judge agreement on 10% of the verbatim transcripts to minimize the impact of personal biases.

FIGURE 1. Conceptual framework of reasons reported by patients for high emergency department use



Results

Of the 247 ED users referred to the research team, 31 were unreachable, 61 declined to participate and 155 had completed the larger study's interview – a 72% response rate. Of these, 42 had common MDs and/or SRDs (n = 21 per site) and were classified in one of three groups: 43% (n = 18) common MDs only; 40% (n = 17) SRDs only; and 17% (n = 7) co-occurring MDs-SRDs. Of these patients, 43% were women, median age was 42 years, 48% had a post-secondary diploma, 74% were single, 74% were on welfare and 10% were living in supervised housing (Table 1). About half the patients with MDs reported trying to reach a general practitioner before using the ED. In contrast, very few patients with SRDs or co-occurring MDs-SRDs reported seeking help in outpatient services. Reasons leading to high ED use and aspects identified as helpful in decreasing such use are summarized in Table 2. Quotations from patients are presented in Table 3. Both tables are available online at longwoods.com/content/27333.

Mental healthcare system

For all patients, the main reasons for high ED use were associated with accessibility to the mental healthcare system and its adequacy to respond to urgent MD or SRD crises. The ED was considered the most accessible (free, open 24/7), responsive, safe and appropriate service for patients facing a crisis. Many talked about the lack of alternative services; other services were usually closed between 5:00 p.m. and 9:00 a.m. and on weekends and lacked resources. Patients were often referred to the ED by relatives or outpatient care providers. Most participants had trouble accessing regular outpatient care, such as family doctors, social workers, psychiatrists and free public psychologists. For patients with MDs and MDs-SRDs especially, procedures to access MD services via one-stop services were found to be complex and lengthy, with wait times of over six months not being uncommon.

Most patients mentioned lack of continuity of care as another reason for high ED use, with many lacking a regular care provider offering close follow-up care. Patients with a regular care provider often felt follow-up care was not adapted to their needs and that their provider's responses to urgent requests were not swift enough. Patients did not consider this optimal for recovery, as it left them alone and could worsen their health conditions. The few patients who received public psychosocial counselling criticized the limited number of sessions available to them.

Contrasts emerged in patients with SRDs and MDs-SRDs who were more anxious to receive adapted follow-up care from a trusted provider. They found having to deal with different clinicians (general practitioners, MD and SRD specialists) and to constantly repeat their personal history disruptive, which negatively impacted their hopes of progress and recovery. Outpatient services that, when available, were identified as helpful included psychosocial services for patients with MDs and SRDs and specialized addiction treatments for those with SRDs or MDs-SRDs, along with case management for the latter.

TABLE 1. Socio-demographic characteristics of patients with common MDs, SRDs or co-occurring common MDs-SRDs

	Common MDs		SRDs		Co-occurring MDs-SRDs		Total	
	n = 18	42.86	*n* = 17	40.48	*n* = 7	16.67	*n* = 42	100
	N	%	*N*	%	*N*	%	*N*	%
Sex								
Women	8	44.44	6	35.29	4	57.14	18	42.86
Men	10	55.56	11	64.71	3	42.86	24	57.14
Age (years)								
19–35	11	61.11	3	17.65	1	14.29	15	35.71
36–73	7	38.89	14	82.35	6	85.71	27	64.29
Education								
Secondary	11	61.11	8	47.06	3	42.86	22	52.38
Post-secondary	7	38.89	9	52.94	4	57.14	20	47.62
Civil status								
Single, separated, divorced	10	55.56	14	82.35	7	100	31	73.81
Common-law, married	8	44.44	3	17.65	0	0	11	26.19
Employment status								
Work or study	2	11.11	3	17.65	1	14.29	6	14.29
On welfare	16	88.89	11	64.71	4	57.14	31	73.81
Retired	0	0	3	17.65	2	28.57	5	11.9
Personal income ($/year) (*n* = 39)								
0–19K	1	6.25	7	46.67	3	42.86	11	28.95
20–39K	6	37.5	5	33.33	3	42.86	14	36.84
40+K	9	56.25	3	20	1	14.29	13	34.21
Housing situation								
Owned housing	7	38.89	2	11.76	1	14.29	10	23.81
Rented housing	11	61.11	12	70.59	5	71.43	28	66.67
Supervised housing	0	0	3	17.65	1	14.29	4	9.52

K = thousands of Canadian dollars; *N* = number of patients within a group.
MD = mental disorder; SRD = substance-related disorder.

Patient profiles

Patient profiles explaining high ED use were mostly associated with urgent and recurrent biopsychosocial problems. Patients viewed their high ED use as inevitable considering their multiple, complex health issues. Most reported ED visits were due to psychological and physical distress – panic attacks and acute gastro-intestinal issues, among others. More than half reported intoxication problems or issues with medication, while a few had social problems – grievances and interpersonal conflicts, among others. EDs were used as a last resort when patients could no longer self-regulate and had no one else to turn to. Most participants talked about lacking emotional and psychological support from their relatives, clinicians or peers.

Compliance aside, patients with MDs complained more about medication being prescribed too hastily, with no adequate information nor consideration for their overall conditions, which could lead to adverse events.

Disabilities or limitations related to the patients' conditions and lack of health literacy were also driving high ED use. Most struggled with impairment symptoms linked to their conditions (loss of stamina/autonomy) and had trouble recognizing and communicating their symptoms, triggers and needs. That was especially true of patients experiencing new acute symptoms and patients with ongoing SRDs or MDs-SRDs. Many of those participants explained how feeling misunderstood and stigmatized isolated them, leading to periods of withdrawal, low self-esteem and risky behaviours and how they would wait for their conditions to become acute and overwhelming before seeking help, all of which could heighten ED use. More contrast emerged from patients with SRDs who were especially preoccupied about feeling autonomous, to the best of their ability, and anxious about returning to their previous living environment after addiction treatment. This tension was a key reason for relapsing and led to repeated ED use.

For all patients, having a non-judgemental social network was viewed as helpful for maintaining good mental health and reducing ED use. Proper medication, providing patients with more information on their conditions and available resources (especially for those with MDs) and helping them develop symptom management capabilities were identified as key components for decreasing ED use.

Professional practices

High ED use reasons linked to professional practices were mostly associated with the patients' perception of the clinicians' lack of knowledge or comfort toward treating MDs and SRDs. This was especially true of general practitioners, nurses and emergency doctors and in complex crises, which favoured revolving-door services and discouraged patients. About half the patients felt their biopsychosocial conditions were not fully evaluated and care not appropriately planned for their multiple needs. They felt they were being evaluated for acute symptoms only, which did not support recovery and led to high ED use. It often took several outpatient or ED visits to be referred to appropriate outpatient services.

Patients were also critical of the quality of communication with some clinicians, mentioning that they felt judged, not taken seriously, were hastily sent home, thus contributing to the stagnation of their conditions and high ED use. Patients with SRDs or MDs-SRDs particularly felt they were being treated differently. Clinicians were perceived as working in silos, leading to patient confusion on prognosis and treatments and subsequent high ED use. Destigmatization and better-informed assessments were identified as key drivers to improving professional practice. Finding trustworthy, stable healthcare providers who did not judge patients and receiving patient-centred treatments that catered to their needs contributed to lower ED use.

Discussion

This qualitative study explored reasons for high ED use in patients with MDs, SRDs or co-occurring MDs-SRDs. Factors leading to high ED use were mostly linked to mental healthcare features, followed by patient profiles and professional practices. The main reasons found in this study were close to those uncovered in previous ones, which included all types of MDs and SRDs (Poremski et al. 2020; Wise-Harris et al. 2017). ED use was mainly driven by a complex interplay of factors whose cycles led to high ED use. A few notable differences were identified in this study's results, distinguishing needs and barriers to recovery for patients with MDs, SRDs or co-occurring MDs-SRDs. Patients with MDs felt that they should receive more comprehensive MD care from general practitioners and psychosocial resources, integrating patient-centred care and self-management strategies (Menear et al. 2020). Echoing a previous study (McCormack et al. 2015), patients with SRDs showed less interest and trust in outpatient services, preferring to self-manage until needing acute care. Patients with SRDs, including those with MDs-SRDs, were lacking integrated care and experiencing more stigmatization and lower self-esteem (Huỳnh et al. 2020).

Overall, high ED use was mostly found to be justified by insufficient access to outpatient care, lack of ED alternatives in outpatient care when in crisis and insufficient care continuity. Underlying reasons explaining insufficient access to appropriate care by patients echoed challenges reported in other studies on mental healthcare systems, such as insufficient resources, restrictive opening hours and poor care integration (CMHA 2023). Several past reforms have aimed to improve access, continuity and quality of mental health services; mental health services were integrated with primary care in 2005 (Fleury et al. 2016). However, requests for help exceed available resources, and long waiting lists prioritizing the least functional patients persist (Vérificateur général du Québec and MSSS 2023), which explains why patients are frequently being referred to the ED. In Quebec, it may be appropriate to increase the mental healthcare budget, which represents 5–7% of the province's global healthcare budget, to a figure closer to 13% as in the UK (Bartram 2019). Outpatient care, community-based services and early interventions (Colizzi et al. 2020) could also be consolidated.

Even patients who received outpatient services often felt that these lacked patient-centred (Walsh et al. 2022) and recovery-oriented treatments (Mousavizadeh and Bidgoli 2023), thus contributing to negative care experiences, distress and high ED use. While studies have shown that patients with common MDs often favoured psychosocial services over medication (Casey et al. 2021) and that public coverage for psychotherapy has proven effective in countries such as the UK and Australia (Clark 2018; Cromarty et al. 2016), most of these services are not covered in Quebec (Vasiliadis et al. 2015). Psychosocial services, including psychotherapy, should be more accessible to the province's population, as an approach combining psychotherapy and medication is often recommended (van Weeghel et al. 2019).

Study results also outlined the overall vulnerability of high ED users who were mostly poor, had limited networks, a low sense of self-efficacy and a strong feeling of hopelessness.

These patients' difficulty to prevent, recognize or communicate distress were commonly mentioned as barriers to recovery, leading to high ED use – as shown in other studies (Slankamenac et al. 2020). As previously noted (Schmidt et al. 2018), patients turned to the ED when they were no longer able to self-regulate and sought emotional relief (feeling safe and heard), short-term solutions (diagnosis and medication) and recovery planning. To prevent ED use, primary care organized according to the chronic care model (Wagner et al. 2001), including better MD and SRD detection, should be implemented, with integration of the stepped-care model along with patient symptoms management training. EDs should better monitor high ED users and embrace known strategies to reduce high ED use – e.g., individual care plans, case management, peer-support initiatives (Gabet et al. 2023) and short-stay crisis units (Gabet et al. 2020; Wheeler et al. 2015). Several new ED strategies are being deployed in Quebec's current mental healthcare plan (MSSS 2022) to reduce acute care use (e.g., short-stay crisis units [Anderson et al. 2022]), but no initiatives are promoted or prioritized to reduce high ED use. Addiction liaison teams (Blanchette-Martin et al. 2016; Musgrave et al. 2018) that use motivational approaches (Schwenker et al. 2023) could be more consolidated in EDs and better integrated with other key community partners to reinforce treatment adherence among patients with SRDs.

Providing adequate outpatient care was also found to be a key factor protecting against high ED use. In this study as in previous ones (Gentil et al. 2021; Vandyk et al. 2018), many patients felt misunderstood and not properly evaluated by primary care clinicians, which contributed to treatment delays. Studies exploring clinician perspectives on high ED users also reported challenges regarding complex case assessments, mentioning insufficient time spent with patients, lack of best practices guidelines and the inclination to transfer patients to more specialized care (Bodenmann et al. 2021; Li et al. 2022). These findings support the need to develop evidence-based clinical practices in line with Quebec's From Self-Care to Psychotherapy program (MSSS 2021) for MD management and continuous training on MDs and SRDs (Karazivan et al. 2017) for primary care clinicians and other psychosocial care providers. Teamwork (Rosen et al. 2018) and collaborative care between psychiatrists and primary care clinicians (Fleury et al. 2021) may also be better implemented to address complex biopsychosocial issues. Ultimately, EDs should not replace outpatient care.

Limitations

This study has limitations. First, given the stigma patients with MDs or SRDs encounter, participants may not have disclosed all pertinent information and memory bias may have hindered such information. Second, the studied EDs had specialized psychiatric staff and were in large urban territories, limiting generalization to other EDs or areas. Third, the perspectives of high ED users' relatives and clinicians were not accounted for; seeking those perceptions could provide additional insights. Finally, the study results may not be generalizable to other mental healthcare systems, notably those without universal healthcare coverage.

Conclusion

This study found that patients identified multiple barriers to outpatient care, disabilities related to their conditions and professional practices that explained their high ED use. Patients with MDs were faced with important unmet needs, while patients with SRDs mostly differentiated themselves by their lack of trust in outpatient services, and those with MDs-SRDs especially struggled with care coordination issues. This led to potentially disruptive cycles in patient recovery, with the ED being used to alleviate distress and inadequate care. Study findings support the need to improve outpatient services for high ED users. Greater investments are needed in Quebec's mental healthcare system to enhance access to and continuity of diversified care, especially as it pertains to psychosocial services. Extending teamwork and collaborative care with continuous training may help consolidate mental health evidence-based practices in primary care, contributing to the reduction of ED use. High ED users might be monitored more extensively and strategies such as integrated MD-SRD treatments deployed to help these patients. Breaking the cycles leading to high ED use will require efforts from all parties involved in the mental health system.

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Ethics Approval

The Douglas Mental Health University Institute Ethics Committee approved the study protocol. The analyses reported in this paper were also approved by the Comité d'éthique de la recherche en science de la santé of the University of Montreal. Research procedures were in accordance with the ethical standards of the responsible committee on human experimentation (institutional and national) and with the Helsinki Declaration of 1975, as revised in 2008.

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