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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TABLE 2. Reasons reported for high ED use among patients with common MDs, SRDs or co-occurring common MDs-SRDs

Groups	MDs *n* = 18	SRDs *n* = 17	MDs-SRDs *n* = 7	Total *n* = 42
Themes studied	***N* (%)**	***N* (%)**	***N* (%)**	***N* (%)**
1. Mental healthcare system features				
Adequacy of services responding to urgent MD-SRD crises	**17 (94)**	**17 (100)**	**7 (100)**	**41 (98)**
The ED is considered the most appropriate place to receive a rapid response	16 (89)	16 (94)	7 (100)	39 (93)
Some outpatient healthcare services are considered inadequate	10 (56)	9 (53)	5 (71)	24 (57)
Outpatient healthcare services referred patient to the ED during MD-SRD crisis	9 (50)	8 (47)	5 (71)	22 (52)
*Some outpatient healthcare services identified as helpful	10 (56)	11 (65)	6 (86)	27 (64)
Accessibility of services	**18 (100)**	**15 (88)**	**6 (86)**	**39 (93)**
Outpatient care unavailable during an urgent crisis	16 (89)	15 (88)	6 (86)	39 (93)
Long waiting list to access long-term care	16 (89)	8 (47)	6 (86)	30 (71)
Some outpatient healthcare services not available for free	7 (39)	3 (17)	3 (43)	13 (31)
*Short delay for obtaining an appointment in outpatient services	12 (67)	4 (24)	1 (14)	17 (40)
Continuity of care adapted to patient needs	**18 (100)**	**14 (82)**	**7 (100)**	**39 (93)**
Frequency of follow-up care not adapted to patient needs	17 (94)	14 (82)	7 (100)	38 (90)
No designated clinician to provide follow-up care	15 (83)	9 (53)	5 (71)	29 (69)
Lack of follow-up care after ED use	14 (78)	8 (47)	3 (43)	25 (59)
*Frequent and regular follow-up care, adapted to patient needs	10 (56)	8 (47)	3 (43)	21 (50)

Groups	MDs *n* = 18	SRDs *n* = 17	MDs-SRDs *n* = 7	Total *n* = 42
Themes studied	***N* (%)**	***N* (%)**	***N* (%)**	***N* (%)**
2. Patient profiles				
Urgent and recurrent biopsychosocial problems	**18 (100)**	**17 (100)**	**7 (100)**	**42 (100)**
Psychological or physical distress	18 (100)	9 (53)	6 (86)	33 (78)
Substance-related problems	2 (11)	15 (88)	7 (100)	24 (57)
Social problems	4 (22)	1 (5)	0	5 (12)
Problems associated with medication	2 (11)	1 (5)	1 (14)	4 (9)
Support systems	**17 (94)**	**14 (82)**	**7 (100)**	**38 (90)**
Emotional and psychological support	17 (94)	13 (76)	7 (100)	37 (88)
Medication support	12 (67)	6 (35)	3 (43)	21 (50)
Need for more information regarding MD-SRD management and available services	11 (61)	6 (35)	1 (14)	18 (43)
*Receiving adequate emotional and psychological support, adapted to patient needs	10 (56)	9 (53)	6 (86)	25 (59)
*Having a social network that helps maintain health	11 (61)	8 (47)	2 (29)	21 (50)
*Receiving proper medication, adapted to patient needs	5 (28)	3 (17)	2 (29)	10 (24)
Individual disabilities	**15 (83)**	**17 (100)**	**5 (71)**	**37 (88)**
Symptoms of short- or long-term impairments	14 (78)	15 (88)	5 (71)	34 (81)
Lack of knowledge about MDs-SRDs and of guidance to acquire such knowledge	13 (72)	13 (76)	4 (57)	30 (71)
Negative self-image and inadequate living environment	7 (39)	15 (88)	4 (57)	26 (62)
*Feeling autonomous (to the best of the patient's ability), having help to decrease ED use	5 (28)	12 (71)	4 (57)	21 (50)
*Daring to ask for help	4 (22)	8 (47)	0	12 (29)

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Themes studied	***N* (%)**	***N* (%)**	***N* (%)**	***N* (%)**
3. Professional practices				
MD-SRD knowledge and comfort	**17 (94)**	**14 (82)**	**7 (100)**	**38 (90)**
Lack of knowledge, interest or comfort in dealing with MD-SRD problems	17 (94)	13 (76)	7 (100)	37 (88)
Lack of biopsychosocial evaluation, failure to establish a short- or long-term action plan	12 (67)	10 (59)	2 (29)	24 (57)
*Receiving appropriate care (medical or emotional), adapted to patient needs	11 (61)	10 (59)	6 (86)	27 (64)
*Receiving personalized MD-SRD information that reassures the patient	11 (61)	4 (24)	3 (43)	18 (43)
Quality of exchanges with patients	**16 (89)**	**15 (88)**	**6 (86)**	**37 (88)**
Quality of patient/health professional relationship	16 (89)	15 (88)	6 (86)	37 (88)
MDs-SRDs are not taken seriously enough	14 (78)	11 (65)	3 (43)	28 (67)
*Having a stable and trusting relationship with the appropriate care provider	11 (61)	11 (65)	4 (57)	26 (62)
Collaboration between clinicians	**12 (67)**	**9 (53)**	**3 (43)**	**24 (57)**
Clinicians work in silos; diagnosis and treatment can differ from one to the other	9 (50)	8 (47)	3 (43)	20 (48)
*A combination of treatment approaches can help to decrease ED use	5 (28)	5 (29)	3 (43)	13 (31)

N = number of patients mentioning the theme within that group;
% = proportion of patients mentioning the theme within that group.
*Reasons identified as helpful for decreasing ED use.
ED = emergency department; MD = mental disorder; SRD = substance-related disorder.

TABLE 3. Quotations illustrating different themes linked to high ED use, taken from interviews done with patients with common MDs, SRDs or co-occurring common MDs-SRDs

1. Mental healthcare system features
Adequacy of services responding to urgent MD and SRD crises
"It [non-emergency department services] didn't meet my needs. I was at the end, at the limit, you know, at the end of the rope … and just receiving little comments [like] 'take charge, take care of yourself,' or things like that, I wasn't able to [take] it anymore." (Co-occurring MD-SRD group) "I am currently satisfied with my service [in psychology], but it took me a long time to find it." (Common MD group)
Accessibility of services
"For the first six months [on the waiting lists] when I was going through these crises, I had no help, I couldn't recharge, I didn't know of any other place to go." (Common MD group) "When we call them [CRDQ], it's not that things haven't been going well since the day before yesterday, it's that things have not been going well for six months, a year, two years, and sometimes it takes several weeks or even several months before we can enter the system." (SRD group) "Once you get into the system, things can go quickly, but being taken care of by the healthcare system can take a while. But afterwards, once in, things go very well I've found." (SRD group)
Continuity of care, adapted to patient needs
"I have a good relationship with my psychologist [free service from the CLSC], and it's rare that it happens, but it will end, sadly." (Common MD group) "My family doctor knows me. [A]t the walk-in clinics, the doctor doesn't know anything, he doesn't do anything. He doesn't know me. I've done a lot of walk-in clinics, medication changes often between them." (SRD group) "When I came home [post-hospitalization for withdrawal], I was no longer able to walk, but it wasn't just about the use, it was the anxiety that was off the roof [caused by the feeling of being left alone]." (Co-occurring MD-SRD group)
2. Patient profiles
Urgent and recurrent biopsychosocial problems
"I was at my wit's end. [I had u]nbearable anxiety. I had stopped my medication. Nothing was working with my doctor. I was in burnout. I was desperate. I couldn't find help, medications that worked, or even a private psychologist." (Common MD group) "It was a drinking problem, a loss of self-esteem, a need for attention, a need for reassurance. That sums most of it." (SRD group) "When I go to the emergency department it's because I'm lying on the floor, I'm really not okay [psychologically], I'm not able to just get through it, so I need to go to the emergency department because it's beyond me, it's not like a liver attack, it's really beyond my ability." (SRD group)
Support systems
"You know, it's really feeling some support at that point, it's not just getting treatment [receiving medication]." (Common MD group) "She [the social worker] cheered me up a lot by giving me resources that I didn't even know existed. … I would have liked to see her even as an outpatient, but unfortunately, she only does hospital visits." (Co-occurring MD-SRD group)

Individual disabilities
"Sometimes, psychologically, you're not doing so well … . [E]ven if they say you just have to do two more steps to see a psychologist or a psychiatrist, […] it's so discouraging that you don't even want to do it." (Common MD group) "It is important to take the time to calm people in a crisis, to try to make them understand what they are going through because it is always in a state of incomprehension that someone has a panic attack or an anxiety attack because they do not understand what is happening with their body." (Common MD group) "I wait all the time for it to be dramatic. … I always wait [till] the last minute [because of] the embarrassment and the pride and the shame, so I always end up being brought to the emergency department, either by a friend or a family member." (Co-occurring MD-SRD group)
3. Professional practices
MD-SRD knowledge and comfort
"They [the ED staff] remember that you came in and they're kind of tired of seeing you … . [T]hey don't really understand your situation, they don't understand your need, they don't understand why you're all messed up; you know, they're like last week [you were] here and then we gave you meds and then it took a week, [you were] sober, why do you come back to us a week later and now you're drunk again?" (SRD group) "The family doctor … is a good doctor, I love him but the time allocated now I think they are timed, it's very short you know, you have no time to communicate." (Co-occurring MD-SRD group) "My clinic, personally I am very satisfied, because it is a clinic that has a pilot project, the Archimedes clinic, [regular follow-up with a nurse practitioner] […] the doctor, he is there in reference only when needed. Communication is done internally, I'm happy with my clinic. It's working now, so that's all it took." (Co-occurring MD-SRD group)
Quality of exchanges with patient
"I felt judged for being there for a mental health problem at the emergency department, as if I didn't belong. They weren't able to help me. They just send you home or lock you in a cushioned room. No, it's really not great […] there's no procedure in place to help us when we get to the ED." (Common MD group) "There should be more awareness among nurses so that they realize that it is a disease [substance abuse], that it's progressive and degenerative and causes death. Sometimes they tend to think that I'm a good-for-nothing, he doesn't want to help himself, he's been here 14 times." (SRD group) "I have quick appointments with her [general practitioner]. She takes care of my health, I don't feel rushed in her schedule when I go to see her, I feel that she has time to invest in my case." (SRD group)
Collaboration between clinicians
"I've already pushed to see a psychologist, I've already pushed to see a psychiatrist, […] every time […] I've been told things like 'Why? Prove to me that I have to send you.'" (Common MD group) "I was prescribed a drug at the emergency department that my family doctor doesn't know about, and right now I'm on that drug and I don't have anyone to follow me. I don't have any reference. […] Where am I going with this problem? I don't have anyone, I can go on the web, but there is no psychologist specializing in addiction in Quebec City, except [places] like the CRDQ, but they have terrible waitlists." (SRD group) "There is a problem in the current system where we can have psychologists, doctors, therapists but it would take teams that talk to each other, that communicate on the case of the person, because the ED does not respond to the need as such, and [because of] the system, in general, we often end up in a void." (SRD group)

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