

Satisfaction with Emergency Departments and Other Mental Health Services among Patients with Mental Disorders

Satisfaction envers les urgences et autres services de santé mentale chez les patients atteints de troubles mentaux



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Abstract

Background: Few studies have investigated satisfaction with emergency departments (EDs) among patients with mental health (MH) issues. This study evaluated the use of and satisfaction with EDs and other MH services among 328 patients with MH disorders, as well as specific characteristics of patient satisfaction and dissatisfaction.

Methods: A mixed-methods study was conducted in four EDs located in different administrative healthcare regions of Quebec (Canada).

Results: Patients were highly satisfied with staff attitudes in EDs and other MH services (i.e., hospital in-patient services, outpatient services, community organizations). Major sources of dissatisfaction were the information received in EDs concerning community services and the physical environment or climate in EDs and other MH services.

Conclusion: Dissatisfaction with services may be reduced by extending hours of operation in MH services; promoting collaboration between psychiatrists, family physicians and other primary care providers; further integrating EDs with other healthcare services; and improving the characteristically austere and restrictive atmosphere in EDs.

Résumé

Contexte : Peu d'études se sont penchées sur la satisfaction envers les urgences chez les patients qui s'y présentent en raison de maladie mentale. Cette étude évalue l'utilisation des urgences et autres services de santé mentale, ainsi que la satisfaction, auprès de 328 patients atteints de troubles mentaux. L'étude s'intéresse aussi aux caractéristiques particulières liées à la satisfaction ou à l'insatisfaction des patients.

Méthode : Une étude à méthode mixte a été menée dans quatre services des urgences situés dans différentes régions administratives sanitaires du Québec (Canada).

Résultats : Les patients se sont montrés hautement satisfaits de l'attitude du personnel dans les urgences et autres services de santé mentale (c'est-à-dire, les services aux hospitalisés, les services externes, les organismes communautaires). Les principales sources d'insatisfaction concernent l'information remise par les urgences au sujet des services communautaires ainsi que l'environnement physique ou les conditions ambiantes dans les urgences et autres services de santé mentale.

Conclusion : Le taux d'insatisfaction envers les services pourrait être réduit en prolongeant les heures d'ouverture des services de santé mentale; en favorisant la collaboration entre les psychiatres, les médecins de famille et les autres prestataires de soins primaires; en intégrant davantage les services des urgences aux autres services de santé; et en améliorant l'ambiance typiquement austère et restrictive des services des urgences.

WHILE MENTAL HEALTH (MH) SERVICES HAVE BECOME MORE PATIENT-CENTRED, ongoing assessment of patient satisfaction remains important for treatment and service planning (Ruggeri et al. 2006). Studies suggest that patient satisfaction is a major outcome of interest (O'Regan and Ryan 2009), if not the best predictor of service quality (Shiple et al. 2000). Patient satisfaction is, in fact, more reliable than evaluations by MH professionals (Shiple et al. 2000; Woodward et al. 2017) and is strongly related to service use and continuity of care, both viewed as influential in treatment outcomes

(Ruggeri et al. 2006; Woodward et al. 2017). Satisfied patients are more likely to maintain contact with services and comply with medication and treatment regimens, whereas dissatisfied patients drop out from services more frequently (Ruggeri et al. 2006). Because mental disorders often run hand-in-hand with chronic health problems, the long-term and continuous care of affected patients, and their satisfaction with services, is crucial (O'Regan and Ryan 2009). Better understanding of the determinants of patient satisfaction may help improve services.

Research has identified associations between patient satisfaction and service-related factors (Woodward et al. 2017), such as attitudes of MH professionals (Berghofer et al. 2001), and good professional/patient communication (Zahid et al. 2010). Environmental quality (e.g., calm, cleanliness, presence of rules and regulation, which may appear as restrictive measures) also emerged as an important determinant of satisfaction (Berghofer et al. 2001). Reduced wait times and rapid access to services have contributed to higher levels of satisfaction (Eytan et al. 2004; Roper and Manela 2000), as have professional competence (Ruggeri et al. 2007), staff availability (Summers and Happell 2003), continuity of care (Rosenheck et al. 1997) and the quality of information provided by services (Cleary et al. 2009; Zahid et al. 2010).

While studies have assessed satisfaction among patients with MH disorders regarding both hospital (Eytan et al. 2004; Zahid et al. 2010) and community-based (Urban et al. 2015) services, very few have investigated factors associated with satisfaction among patients presenting at EDs for MH reasons (O'Regan and Ryan 2009; Roper and Manela 2000; Summers and Happell 2003). ED services for MH patients involve different operating models. As with other patients, patients with MH disorders may be evaluated in a general ED by an emergency physician, possibly followed by a psychiatric evaluation. Alternatively, patients with MH disorders may be evaluated in a psychiatric ED separate from the general ED. Between these two extremes is the possibility that MH professionals may assess patients in a designated psychiatric location of a general ED or refer them to a psychiatric ED division within the same hospital (Halmer et al. 2015; Zeller 2010).

EDs provide round-the-clock crisis intervention for patients with MH disorders, serving all too often as the main point of entry to specialized MH services (Arfken et al. 2004). Yet, wait times for an MH evaluation in the ED greatly exceed the wait times for a physical examination. In Quebec, 31% of individuals who visit EDs for MH reasons wait eight hours on average before receiving a consultation with a psychiatrist (CSBE 2017). American studies found that wait times for hospital admission were three times longer for patients with MH disorders than for those with other medical conditions (Pearlmutter et al. 2017; Zeller et al. 2014). Considering that the overuse of EDs may reflect gaps in other areas of healthcare delivery (Ruggeri et al. 2006), it is important to identify key factors in patient satisfaction/dissatisfaction with the ED, while taking into account their perspectives on other MH services.

Studies using standardized questionnaires found that most patients with MH disorders were generally satisfied or very satisfied with MH services (Perreault et al. 2006; Williams et al. 1998), with mean satisfaction scores of 80% or higher often reported (O'Regan and Ryan 2009; Summers and Happell 2003; Svensson and Hansson 1994). Williams et al. (1998) contend that such high satisfaction is embedded in the design of evaluations, that is, while the questions guide patients to rate themselves as “satisfied” when services fulfill their overall objectives, any negative aspects remain unreported (Williams et al. 1998). Moreover, while patients with MH disorders expect services to address their problems effectively, they also value other aspects of services, such as positive professional/patient relationships. The use of qualitative methods addresses the limitations inherent in standardized measures by exploring various meanings attached to patient satisfaction. In particular, open questions facilitate expressions of dissatisfaction (O'Regan and Ryan 2009) and highlight areas needing improvement (Perreault et al. 2006). Using mixed methods, this study aimed to: (1) evaluate the satisfaction of 328 patients with MH disorders concerning their use of EDs and other MH services (hospital in-patient services, outpatient services and community organizations) and (2) identify specific aspects of EDs and other MH services with which patients were most, or least, satisfied.

Methods

Study setting

The study was conducted in four EDs that reflected different operating models identified in the literature; they were located in different administrative healthcare regions of Quebec (Canada). The selected EDs were as follows: a psychiatric ED completely separate from the general ED in an MH university institute, which offered no medical services (ED-P); a psychiatric ED that was a division of a general ED located at a separate site (ED-PG-1); a psychiatric ED merged with a general ED (ED-PG-2); and, finally, a general ED where staff included a number of additional MH specialists (ED-G). All sites had in-patient units offering specialized mental healthcare.

Data collection

Participant recruitment occurred between January and June 2017. Site visits were scattered throughout the days and hours that the EDs were operating at peak capacity, according to information provided by ED managers. Clinical team members in the EDs assisted recruitment by evaluating the ability of potential participants to provide informed consent. In cases where patients were too confused to participate in an interview, or were slated for transfer to another hospital unit, the interview was postponed until their MH conditions had stabilized, whether during or after hospitalization. Interviews were conducted in designated offices at the EDs by research assistants trained for this work and supervised by researchers. Patients completed a descriptive questionnaire that was developed based on previous research

(Fortin et al. 2018) and pretested by six ED users. The questionnaire included two standardized scales: (1) the Alcohol Use Disorders Identification Test (AUDIT) (Bohn et al. 1995), measuring alcohol use and sequelae on a five-point Likert scale (10 items); and (2) the Drug Abuse Screening Test-20 (DAST-20) (Carey et al. 2003), measuring consequences of drug use with yes/no responses (20 items). The descriptive questionnaire also included quantitative and qualitative components. The quantitative items concerned socio-demographic and socio-economic characteristics, patient health-related beliefs, self-assessed physical and MH conditions and satisfaction with/utilization of EDs and other MH services. The qualitative items on the questionnaire concerned reasons for ED use and appraisal of EDs and other MH services, including in-patient services, outpatient clinics, day hospitals, local community service centres, walk-in clinics, rehabilitation centres, crisis centres and other services within community organizations, as well as the services of family physicians and private psychologists. All participants provided written consent, and the Douglas Mental Health University Institute research ethics committee approved the multi-site study protocol.

Analysis

The study used a convergent mixed-method design (Pluye and Hong 2014) that integrated quantitative and qualitative data simultaneously. The quantitative data were first screened for missing values, univariate outliers and normality assumptions (skewness and kurtosis). Univariate analyses, including frequency distributions, percentages for categorical variables and central tendency measures for continuous variables (mean values and standard deviations), were performed. Qualitative data collection, and the mixed-method analysis, followed a five-step process: (1) audio-recording of interviews and verbatim transcriptions, (2) preliminary readings by two research team members who read through 10% of the interviews and further separated the data. The team coordinator validated inter-rater reliability at roughly 90%, (3) coding of the remaining 90% of interviews under supervision of the team coordinator, (4) data extraction and integration within units of meaning developed from items in the questionnaire and (5) data analysis (Titscher et al. 2000). Numbers and percentages were calculated for each qualitative variable, separating positive and negative responses, in an effort to assess whether positive or negative responses were more common. All data related to EDs and other MH services were organized into four broad categories, and related sub-categories, as follows: staff attitudes and behaviours, wait times and delays in access to services, physical environment/climate and quality of services received.

Results

Sample characteristics

The participant response rate was 88%, with 328 patients agreeing to participate of 372 invited to the study. Most participants ($n = 172$; 52%) were recruited at ED-P, versus 89

(27%) at ED-PG-2, 38 (12%) at ED-PG-1 and 29 (9%) at ED-G. A majority of interviews were conducted at the EDs ($n = 188$; 57%) and the remainder ($n = 140$; 43%) in in-patient units.

Table 1 – available online at www.longwoods.com/content/25793 – presents participant characteristics. Mean age in this sample was 38.9 years (SD: 15.2). Participants were 51% female; 80% lived in private houses, condos or rental apartments; 80% were single, separated, divorced or widowed; and 62% did not have children. A majority had post-secondary education (56%), were unemployed (67%) and earned less than \$40,000/year (70%). Most participants (62%) rated their MH as fair or poor, although 59% considered themselves to be in excellent physical health. Nearly all participants (91%) viewed their presenting problem at the ED as important or very important. The main reasons for ED use included suicidal ideation or attempt (28%), depression (12%) and anxiety (11%). Moreover, 30% engaged in harmful, or hazardous, alcohol use (AUDIT score = 8 or over), and 28% were affected by drug abuse or dependence (DAST-20 score = 6 or more). Some participants (13%) experienced both alcohol and drug disorders. Another 12 participants (4%) admitted to problems with gambling in the previous 12 months (Table 1).

ED and other MH service use

Participants visited EDs for mental disorders or substance use disorders (SUDs) an average of 2.4 times (SD: 3.8) over the 12-month study period. Forty-five (14%) were frequent ED users, defined as four or more ED visits in the previous 12 months. Concerning general service use, 41% of participants reported having poor knowledge of MH or addiction services. A majority (63%) had used services other than EDs for MH or SUD-related reasons over the study period. Most had a family physician (65%), a psychiatrist (55%) or other healthcare provider (e.g., nurse, social worker) (41%) (Table 1).

Satisfaction with ER and other MH services

The quantitative results on satisfaction with services are shown in Table 2 (available online at www.longwoods.com/content/25793). Concerning EDs, most participants agreed somewhat or totally with the suggestion that staff were respectful (95%) and that staff had a good opinion of them/treated them fairly (91%). Most agreed somewhat or totally that EDs provided adequate treatment for their problems (78%) and gave sufficient information on treatment options (77%). Yet, 40% of participants did not consider the information received on community services adequate to their needs.

Concerning other MH services, 90% of participants felt that service providers had a good opinion of them/treated them fairly. A great majority of participants felt that services outside of EDs responded to their needs (238/297; 80%); they were somewhat or totally satisfied with the care received from family physicians ($n = 182/213$; 85%), psychiatrists ($n = 130/147$; 88%) or their other providers ($n = 130/133$; 98%).

Table 3 (available online at www.longwoods.com/content/25793) presents both positive and negative comments from participants concerning services received at the

ED or from other MH services, based on qualitative data. Illustrative quotations are provided in Table 4 (available online at www.longwoods.com/content/25793). Regarding EDs, 286 (87%) of participants made at least one positive comment, and 173 (53%) made at least one negative comment. Most of the positive comments referred to the respect, calm and courtesy shown by ED staff (191/286; 67%) (staff attitudes/behaviours), followed by quality of services (119/286; 42%); empathy and listening ability among ED staff ($n = 113/286$; 40%) (staff attitudes/behaviours); wait times and access to services ($n = 79/286$; 28%); and the calm, comfort, cleanliness and security provided by EDs ($n = 26/286$; 9%) (physical environment/climate). The 173 participants who made at least one negative comment most often criticized EDs for the lack of calm, comfort, cleanliness and security (69/173; 40%); followed by lack of empathy or listening skills on the part of ED staff ($n = 57/173$; 33%); wait times and delays in accessing services ($n = 57/173$; 33%); quality of services offered ($n = 52/173$; 30%); lack of respect from ED staff ($n = 45/173$; 26%); and rules and regulations (e.g., smoking ban, inspection of personal effects, surveillance), which may appear as restrictive measures ($n = 30/173$; 17%).

Comments made by 119 participants on the quality of services offered at the ED tended to be positive with respect to follow-up ($n = 35/119$; 29%), knowledge of MH among ED staff ($n = 34/119$; 29%) and staff availability ($n = 29/119$; 24%). Of 52 participants who made at least one negative comment on the quality of ED services, most were critical of information received regarding follow-up ($n = 27/52$; 52%); staff availability ($n = 20/52$; 38%); and the availability of activities, meals and socialization ($n = 11$; 21%).

On the question of other MH services, 226 (69%) participants made at least one positive comment and 183 (56%) at least one negative comment. Concerning the former, a majority appreciated the quality of services ($n = 120/226$; 53%); followed by appreciation of staff for their respect, calm and courtesy ($n = 88/226$; 39%); empathy and listening ability of staff ($n = 77/226$; 34%); service environments characterized as calm, comfortable, clean and safe ($n = 10/226$; 4%); rules and regulations ($n = 9/226$; 4%); and reasonable wait times or accessibility of services ($n = 8/226$; 4%). Among the negative comments provided by 183 participants in relation to other MH services, most involved issues with the quality of services ($n = 124/183$; 68%); followed by wait times and access to services ($n = 61/183$; 33%); empathy and listening ability of staff ($n = 20/183$; 11%); rules and regulations ($n = 20/183$; 11%); respect, calm and courtesy of staff towards patients ($n = 16/183$; 9%); and environments that were not calm, comfortable, clean and/or safe ($n = 15/183$; 8%).

Of 120 participants who made at least one positive comment about the quality of other MH services, most concerned follow-up ($n = 53/120$; 44%); staff availability ($n = 46/120$; 38%); and activities, meals and socialization ($n = 36/120$; 30%). Of 124 who made one or more negative comments about the quality of other MH services, most were critical of follow-up ($n = 41/124$; 33%); staff MH knowledge ($n = 41/124$; 33%); staff availability ($n = 28/124$; 23%); and the capacity of services to meet needs ($n = 24/124$; 19%).

Discussion

The characteristics of participants in this study were similar to those in previous studies that assessed ED use for MH reasons in Canada, Australia, New Zealand, the UK and elsewhere in Western Europe (Barratt et al. 2016). Most participants had experienced suicidal ideation or attempts, depression, anxiety and SUDs, which are frequent causes of ED use. Many were affected by negative socio-economic conditions related to low income and unemployment, which are thought to exacerbate MH problems. Patients with MH problems frequently visit EDs because they also need help in other areas (i.e., problems with housing, work or social relationships) (Parkman et al. 2017). As well, a large proportion of participants had not used services outside of the ED in the previous 12 months, which is similar to results of American epidemiological studies (Mojtabai et al. 2002).

Levels of satisfaction with both EDs and other MH services were very high, based on the quantitative results, except for the variable on information received in the ED about community services. ED use seemed to result from ignorance of other MH services, especially among the many patients in this study who were not receiving community follow-up from other sources. Previous research conducted in Australia and Kuwait identified substantial dissatisfaction around information provided by MH services (Cleary et al. 2009; Zahid et al. 2010), similar to our results. Other research from the US reported an association between satisfaction with care and provision of information relevant to patient needs (Roper and Manela 2000).

The qualitative data also revealed more positive than negative comments, although the negative comments were particularly important. The use of open questions allowed participants to make more nuanced observations that revealed key factors of dissatisfaction.

Both quantitative and qualitative findings revealed higher levels of satisfaction with respect to professional attitudes and behaviours, which coincides with the literature (Berghofer et al. 2001). Good therapeutic relationships are needed to ensure continuity of care and positive outcomes among patients with MH disorders. By contrast, negative professional attitudes risk increasing emotional distress in patients and undermining treatment (Harris et al. 2016). A lack of communication skills among patients may also provoke stigmatizing attitudes towards them on the part of MH professionals. Negative professional attitudes are particularly directed at frequent ED users or those less compliant with medications or treatment protocols (Harris et al. 2016).

Results also showed that participants preferred the ED to other MH services for MH issues, particularly because of relatively shorter wait times and rapid access to follow-up services in the ED. According to the literature, satisfaction with ED services is inversely related to wait times: the shorter the wait, the greater the patient satisfaction (Roper and Manela 2000). Concerning other MH services, difficulties and dissatisfaction emerged around problems of access, usually related to the lack of evening and weekend hours or problems in booking appointments. This may explain the high use of EDs for non-urgent situations. In addition, the number of negative comments regarding quality of ED services was less than

half the number reported for other MH services, especially in relation to staff knowledge around MH issues, follow-up and the capacity of MH services to meet patient needs. Some patients deplored the lack of MH expertise among family physicians as previously reported (Su et al. 2011). Furthermore, good follow-up and continuity of care improved levels of satisfaction with services (Fortin et al. 2018). This same study also identified an association between patient satisfaction and fewer unmet needs. In fact, ED services were viewed as less satisfactory in comparison with other MH services but only in terms of the activities, meals and socialization provided at the ED. This finding was not entirely surprising, as EDs are not designed to provide the same type of environment as that offered by community organizations (e.g., day centres, self-help groups) serving people with MH problems. One American study reported higher patient satisfaction with EDs that provided opportunities to engage in activities (Roper and Manela 2000). Finally, participant comments around the physical environment and climate in EDs were overwhelmingly negative, both for EDs and MH services. In this study, as in others from the US, patients with MH disorders associated EDs with noise, lack of privacy and loss of freedom (Harris et al. 2016). Patients admitted voluntarily were less affected by rules and regulations, which may appear as restrictive measures, and were generally more satisfied than those admitted under treatment order (Woodward et al. 2017).

Limitations

Certain study limitations should be acknowledged. First, because the results are limited to particular EDs, they may not be generalized to other ED settings (e.g., in rural areas) whether in Quebec or elsewhere. Second, the mixed methodology was not sensitive to possible differences among patients with MH disorders in terms of the various ED operating models. Third, ED-P participants were over-represented in the sample, whereas the number of ED-G participants was low. It is possible that the over-representation of ED-P patients positively influenced results on some dimensions (e.g., quality of services offered) but may have had a negative influence on others (e.g., rules and regulations). Fourth, the mixed-methods design did not allow us to distinguish possible differences in satisfaction among participants in terms of diagnoses. According to the literature, MH disorders, such as SUD or personality disorders, are often associated with both greater utilization of ED services and greater dissatisfaction with the help received (Lawn and McMahon 2015; Parkman et al. 2017). Fifth, the study design did not allow for the measurement of statistical differences in participant satisfaction with EDs and other MH services. Sixth, it was impossible to measure statistical differences between satisfied and unsatisfied participants, as these two groups were not mutually exclusive. Seventh, considerable disparity emerged in the numbers of comments made by participants, as some were less forthcoming than others in their responses. Finally, patient perspectives were sought exclusively, as ED professionals were not invited to complete questionnaires. Yet, patient perspectives concerning satisfaction with services may differ from those of ED professionals, including physicians or managers, who were not included in the study.

Conclusion

This study was innovative in using mixed methods to evaluate satisfaction with EDs and MH services among patients with MH disorders and to further identify specific areas of satisfaction and dissatisfaction with those services. Results show that participants were most satisfied with staff attitudes and behaviours in both EDs and other MH services. Results also revealed greater satisfaction with EDs, particularly in terms of shorter wait times, relative to other MH services, which may explain the high use of EDs by study participants. By contrast, participants tended to view the quality of services outside the ED more critically. Issues also emerged around the physical environment and climate of both EDs and other MH services, which were important sources of dissatisfaction for patients. Moreover, both quantitative and qualitative data revealed a high level of dissatisfaction with information provided about community services available to patients. Recommendations for reducing dissatisfaction with EDs and other MH services might include extending evening and weekend hours in MH services as a way of improving access; and better continuity of care. The expansion of case management programs may also improve client follow-up to ED visits. Further integration of EDs and other MH services through service agreements, use of liaison officers in EDs and shared staff training may also increase awareness among ED professionals of available services for this patient population. Greater collaboration should also be promoted between psychiatrists and family physicians or other primary care providers in the interests of knowledge translation. Finally, it would be important to transform EDs from austere and restrictive environments to more user-friendly sites conducive to individual recovery.

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A fuller suite of indicators at regional and facility levels covering acute care, long-term care and population health

Your Health System: Insight



Secure access to facility-level comparisons and open-year data, and the ability to compile custom reports

Better data. Better decisions. Healthier Canadians.

