THE PSYCHIATRIC EMERGENCY ROOM AND FOLLOW-UP SERVICES IN THE COMMUNITY

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BACKGROUND

From its inception, proponents of community-based mental health services have believed that effective emergency services were needed to prevent unnecessary hospitalizations that might, in turn, foster chronicity and dependence on institutional care. The initial inpetus for the development of emergency services came from the Community Mental Health Act of 1963 which required emergency care as an "essential" psychiatric service. Many community mental health centers (CMHC's) contracted with general hospitals to operate the emergency component and many general hospitals even obtained funds to establish full scale CMHC's. For general hospitals with inpatient psychiatric units and with emergency rooms such steps were a logical extension. Additionally, there were community pressures that promoted the development of psychiatric emergency services, namely the increase in the number of chronically mentally ill in the community and the dearth of general practitioners in areas served by urban general hospitals.[1] More recently, reductions in public allocations to community mental health have diverted even larger numbers of the indigent, of which chronic mental patients are a sizeable subgroup, to general hospital emergency rooms.[2]

The increasing reliance on emergency room services by chronic mental patients has created pressure for these units "to assume a central role in the management and crisis intervention needs of this population, often functioning as the 'revolving door' between patients and mental health services network."[3] However, it is particularly difficult to deliver quality care to chronic patients in the highly-charged and fast-paced emergency room setting. These patients often need someone to either mobilize or create a social support system for them.[4] In response, these units are now more oriented toward providing crisis stabilization services, often as a major adjunct service.

The nature of psychiatric emergency rooms in general hospitals has been further complicated by the fact that many patients who come to emergency rooms

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either refuse or fail to follow through with referrals to follow-up care. This lack of compliance with referrals is not surprising, since patients often do not come to the emergency room on their own initiative and, thus, may have no interest in further treatment. Others come to an emergency room of their own accord, but expecting immediate relief from their problems. Such patients typically have little motivation for further treatment. Since many emergency room patients are "present oriented" rather than "future oriented," a future appointment may have little, if any, meaning to them.[5]

The pattern to compliance with emergency room referrals by psychiatric patients varies widely, but generally with a substantial proportion of non-compliance. Estimates of compliance with referrals have ranged from 7.1% to 74.1%.[6-10] It appears to make a considerable difference whether the referrals are for inpatient versus outpatient care. Miller and his colleagues[10] found a much higher proportion of compliance with inpatient (91.1%) than outpatient (49.6%) referrals and a similar trend was found by Ungerleider.[11] Chameides and Yamamoto[9] found that almost two-thirds of the patients who visited an emergency room did not make or keep their appointment.

Various crisis stabilization programs have been developed in order to improve the effectiveness of the psychiatric emergency room to prevent hospitalizations and to promote follow-up with community-based services. By providing greater attention to the resolution of the immediate crisis and more adequate clinical assessment, the capacity for patients to benefit from alternatives to hospitalization can be more accurately identified and their willingness to utilize these alternative services may be encouraged.

The present study was an effort to explore the role of the psychiatric emergency room of a general hospital in the deinstitutionalization movement by tracking persons who sought the services of the emergency room, were adjudged not to need hospitalization at the time, and were referred, therefore, to community treatment alternatives. The study was designed to determine who made contact after a psychiatric emergency room visit and for those who did connect with community mental health and substance abuse agencies, what was the nature and amounts of services received.

LOCUS OF THE STUDY

The psychiatric emergency room involved in this study is part of a large urban general hospital on the edge of the main downtown business district of Cleveland, Ohio. The business district is ringed with low-income, heavily unemployed minority population, and hence, a major portion of the clientele of the hospital and emergency room reflect these characteristics. In response to the issue of whether the hospital location has yielded an unrepresentative sample for this study, it should be noted that the characteristics of this study cohort were not inconsistent with the descriptions in the literature for persons using other general hospital emergency rooms.

This general hospital psychiatric emergency room, a contractual development of the local County Mental Health Board, was put in place as the central

emergency component of the county network of publicly-funded mental health services and agencies. The psychiatric emergency room, in turn, developed formal working relationships with the community mental health agencies and the state hospital, altering the pattern in which most hospitalizations occurred and yielding an expanded collaborative system of mental health services.

METHOD

A cohort of 114 individuals from the psychiatric emergency room were tracked through all the publicly-contracted community mental health, drug abuse and alcoholism agencies in the County, as well as the major auxiliary human service agencies, i.e., County Department of Human Services, Bureau of Vocational Rehabilitation, Visiting Nurse Association, and Social Security Administration. The cohort members were tracked for three months from the date of their index visit, i.e., the psychiatric emergency room visit for which they entered the study, or until they were hospitalized in a state psychiatric facility or made a return visit to the psychiatric emergency room. A return visit or a hospitalization were the major outcome indicators, since the receipt of services was expected to reduce the likelihood of these occurring. The dates, nature, and amounts of all services received by the clients were obtained from each agency for a three month follow-up period.

Persons who came to the psychiatric emergency room between January 15 and April 1, 1984 were asked to participate in the study and sign a consent form if they were 1. between 18 and 65 years old, 2. not being referred for psychiatric hospitalization or inpatient detoxification, and 3. a current resident of the County. Once it was determined that a client met the above criteria, research staff approached the client to explain the study, gain consent and conduct a short interview. A 5 dollar incentive payment was offered. Research staff covered all days during this time period, as well as a number of evenings and weekends. There was a 30% refusal rate.

Characteristics of the Cohort

The cohort was almost two-thirds male (62%) and more than two-thirds black (70%). It was a young adult population, with 68% falling between 18 and 35. The average age was 32. Most of the cohort were unmarried; 84% were single, separated, widowed or divorced. Over half the cohort had less than a high school education, with a median of 11 years of education. Public assistance was the major source of income. Forty-one percent reported welfare benefits as their major source of income and 27% reported SSI. At the time of the psychiatric emergency room visit 89% reported being unemployed. Two-thirds lived with family, friends or relatives. One-fourth (26%) lived alone, and five percent in group homes. The remaining small percent were mainly homeless.

In terms of psychiatric status at the index visit, a third were diagnosed as schizophrenic, while another third were not given a diagnosis. Fifteen percent received a diagnosis of some type of substance abuse. The remaining fifth had a variety of diagnoses, such as acute psychosis, and major affective and personality disorders. Almost two-fifths (39%) of the cohort had a substance abuse problem, either alone or in combination with other problems. Three-fourths (74%) of the cohort had at least one prior psychiatric hospitalization sometime in the

past. Half of these psychiatric hospitalizations were within the last two years. Most of these (82%) were in state psychiatric facilities. Half the cohort were currently active with community mental health agencies. Almost all (96%) were currently receiving or had in the past received either inpatient or outpatient mental health services. The most frequently noted presenting problems were hallucinations (20%), alcohol abuse (20%), somatic complaints (19%), bizarre behavior (18%) and severe depression (15%). The major problem types as presented at the psychiatric emergency room were: psychiatric (53%); psychiatric/substance abuse (22%); psychiatric/homeless (3%); substance abuse (14%); substance abuse/homeless (3%); homeless (2%) and other (3%).

RESULTS

Making Contact

Almost three-fifths (58%) of the cohort of 66 cohort members connected with community mental health or substance abuse agencies within three months of their index visit and prior to either a psychiatric hospitalization or a return visit to the psychiatric emergency room. Only 4% connected with substance abuse agencies and half of these also made contact with community mental health agencies. These agencies to which the clients connected included: community mental health centers and core agencies that are designated to serve all the catchment areas in the County; the Bureau of Vocational Rehabilitation, which has a mental health program, and other agencies that have mental health programs or have more specialized mental health agencies, such as a psychosocial rehabilitation agency. When we included those who made contact with mental health and substance abuse agencies after a hospitalization or a return visit within the three month follow-up period, fully 65% of the study cohort were found to have made connection. Initial contact occurred extremely quickly, with 53% of those who made contact connecting the same day and 82% connecting within a week of their index visit. When County Department of Human Service and Social Security Administration were included in the analysis, over three-quarters (77%) of the cohort made contact with a community resource within the three month follow-up period.

Of those who received services (58%) almost all (95%) received them in their first month after the index visit. However, the percentage of those who received services declined in the subsequent two months. Approximately three-fifths (59%) of the service receivers obtained services in their second month and only half were continuing to receive services by the third month.

Nature of Services Received

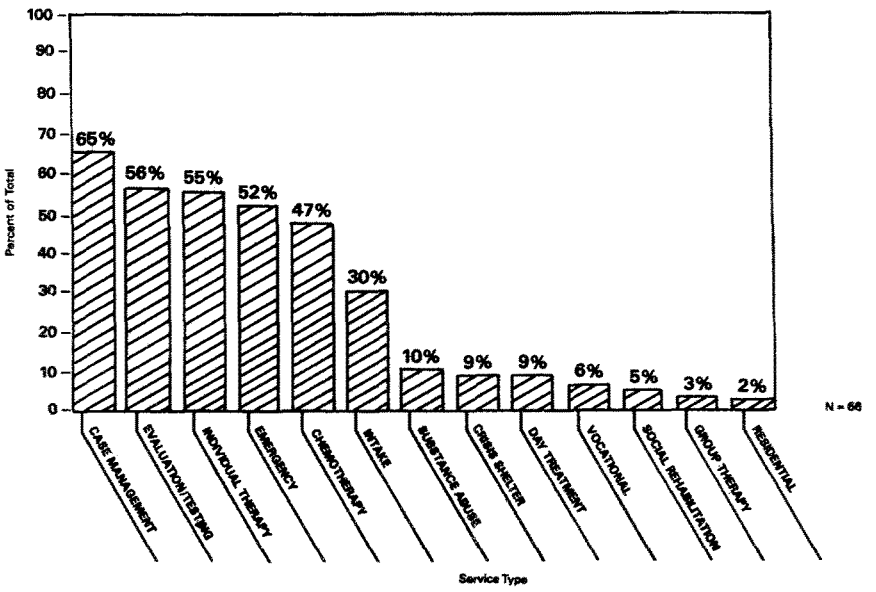
An examination of the proportion of those clients receiving each of the various types of service showed that about half or more of those who got services received what amounted to a basic core of five services: case management (65%), individual therapy (55%), evaluation/testing (56%), emergency service (52%),

and chemotherapy (47%) (see Figure 1). Since this is a population in crisis, it is to be expected that a high proportion might still need emergency services from community agencies even after their PER visit, and that many would require evaluation/testing to assess the nature of their problem. On the other hand, only nine percent were found to have received the services of a crisis shelter. This comparatively low proportion likely reflects the availability of crisis shelter space and not simply need for this service.

Almost everyone (99%) who received services received hourly type services, i.e., service normally received in an hour or less, such as individual therapy and chemotherapy. Since many clients had previously been involved with community services, it is not surprising that only about a third received intake services. However, it was striking how few (21%) received extended type services, i.e., services typically delivered in blocks of hours, such as day treatment or vocational rehabilitation. These extended treatments can be regarded as more oriented toward the rehabilitation of the client. Even the rehabilitation-oriented services that are delivered on an hourly basis e.g., social rehabilitation or group therapy, were received by low proportions of the cohort. Particularly low proportions received day treatment (9%), vocational rehabilitation (6%), residential srvices (2%), social rehabilitation (5%) and group therapy (3%).

FIGURE 1

Percentage Receiving Each Service Type Prior to Either Hospitalization or Return PER Visit



It should be noted that, although over a third of the cohort was identified as having a substance abuse problem, only ten percent actually received substance abuse services. These substance abuse services were delivered by both alcoholism and mental health agencies and included case management, counseling, and emergency services for both drugs and alcohol problems.

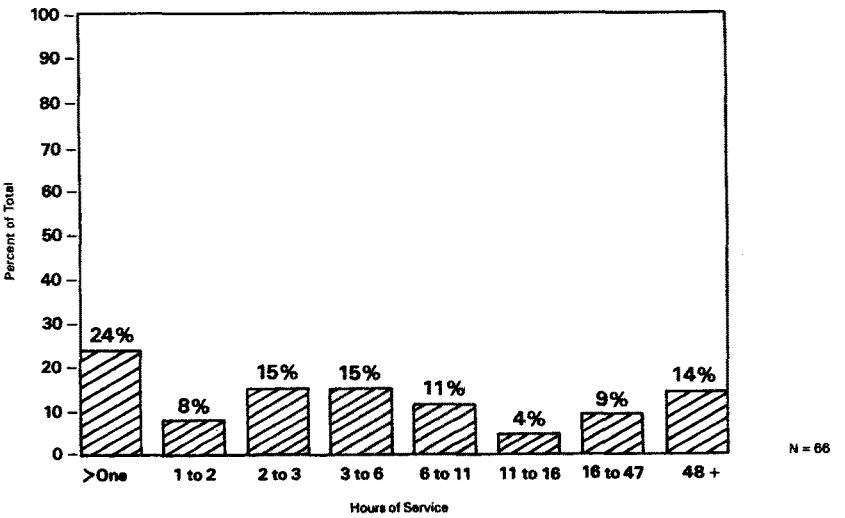
Intensity of Care

The average amount of service hours per month received by the client was used as a measure of the intensity of service received after the index visit to the psychiatric emergency room. Approximately a third of those who received services after the index visit received an average of less than two hours of service per month. Almost one half of the clients received from two to 16* hours of service a month. The median for the receipt of all services was 3.0 hours of service per month. Approximately a fifth received a large average number of hours of service per month, 16 or more. In general it can be said that the cohort received a moderate amount of service per month with relatively few receiving very high or very low amounts of service (see Figure 2).

The service hours were examined more closely on a month-by-month basis for the three-month follow-up period to determine if the clients received care on a more intensive basis during the month immediately following their visit to the psychiatric emergency room. Somewhat surprisingly, the median hours of all service differed only slightly by month and not in the expected pattern. For the first

*All hours of services are rounded to the nearest quarter hour.

FIGURE 2
Average Hours of Service per Month Within Three Months Following Index PER Visit or Prior Hospitalization or Return Visit to PER



month following the index visit, the median was 3.25 service hours, and for the second month it was 3.0 hours and for the third it was 3.50.

An examination of the amounts of the specific services received again highlight that most clients received a modest level of assistance at best. For example, while approximately two-thirds of those who received service received case management, they received a median of a half hour of service per month in the three-month follow-up period. A median of less than an hour and a half of case management was received for the three-month follow-up period. A median of a half hour per month of intake and evaluation/testing and a median of a quarter hour per month of chemotherapy was received. This is consistent with the brief duration typical of these particular services. Individual therapy had a median of an hour and a half per month and, thus, was likely to have been provided on the basis of a session every other week. Group therapy had a median of 2.5 hours, which was most likely one or two sessions per month.

Outpatient substance abuse services were found to be delivered at quite a low intensity level, i.e., relatively brief sessions spread over time, with those who did receive this type of service receiving only a median of a quarter hour per month during the three-month follow-up. For emergency services, which would be expected to be of brief duration, a median of an hour per month was provided. Crisis shelter services would typically be delivered on a more intense basis, i.e., longer duration. This service had a median of 101 hours or about four days of care per month. It is not possible to identify a pattern for residential services, which would normally be of longer duration, since only one person in the cohort received this service. The one individual received an average of 186 hours per month.

For the few clients who received rehabilitative services, i.e., day treatment, social and vocational rehabilitation, more hours of these services were received. However, this has to do with the manner in which these services are delivered. Day treatment and vocational rehabilitation are generally offered in four to five hour blocks of time. Those receiving day treatment received a median of 8.5 hours per month, or about two days of service. Vocational rehabilitation had a median of 26.5 hours per month which is equivalent to about five days of service. Social rehabilitation, which is generally an hourly rehabilitation service, had a median of an hour and a half per month and a median of four and a quarter hours for the three-month period. Of these three services, only vocational rehabilitation can be considered to have been delivered beyond a very moderate level of intensity.

CONCLUSION AND DISCUSSION

The population which uses the psychiatric emergency room is consistent with what has been described in recent literature as the new young chronic population. These are individuals who are already veterans of the mental health system, both inpatient and outpatient, despite their relatively young age. They are also largely unemployed and many are substance abusers. This is a population which has generally been regarded as difficult to serve, because they often refuse follow-up referrals and use community services, including the emergency room, on a demand or crisis basis, rather than with any plan for follow through.

The results found in the present study do reveal a crisis orientation to the use of community services, but one that is more predictable or less erratic than might have been expected. It is also an orientation that may well be reinforced by the pattern of service delivery to this population.

Initial contact for those who did seek services occurred rapidly, mostly within the same week, often the same day. However, while immediate, short-term follow-up happens at a high rate, there is a sizeable decline in the percentage of clients continuing to receive care in the second and third months. Both the initial rapid seeking of help and the subsequent drop-off in use of services bespeak a crisis orientation—when clients are still feeling the crisis acutely they follow-up with community agencies, and when the crisis has subsided, they no longer seek services.

It is not possible to tell from this study how much the agencies themselves play into the drop-off in use of services. However, we can see that the pattern of services offered to clients was not one that would help them to alter their pattern of crisis-to-crisis living. Clients tended to receive a basic core of services: case management, evaluation/testing, emergency services, individual therapy and chemotherapy. A low percentage received any of the extended rehabilitation treatment services. Moreover, the hourly treatment services were offered at a low level of intensity which could only be supportive in nature. A majority of those with substance abuse problems, a sub-group expected to have repeated crises, appeared to be going untreated for these problems at least by the professional mental health and substance abuse systems.

In sum, the community mental health system can be seen to be responsive to psychiatric emergency room referrals and the clients themselves seek services promptly. However, both the service system and the clients alike appear mainly reactive and are seemingly not engaged in a therapeutic process that would impact upon a chronic crisis pattern. Thus, the psychiatric emergency room may well represent another facet of the 'revolving door' problem characteristic of chronic patients, rather than part of the solution to that problem.

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