REPEATED USERS OF A PSYCHIATRIC EMERGENCY SERVICE IN A CANADIAN GENERAL HOSPITAL

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The authors of this study examine the demographic and clinical characteristics of repeated users of psychiatric emergency room services in a general hospital. 37.8% of all the patients (913) seen during one year had one or more visits to the emergency room in the six months preceding the index emergency room consultation. Repeaters were more likely than non-repeaters to be unmarried, self referred and with a history of previous psychiatric treatment for a chronic psychiatric disorder. Factors affecting frequency of use of psychiatric emergency room services among different diagnostic groups were also studied. These results demonstrated the heterogeneity of the needs of the diverse diagnostic groups who over-utilize costly emergency room services. Our findings showed that in a country with universal health insurance, psychiatric emergency services also tend to reflect the gaps in the delivery of health services in the hospital and the community.

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INTRODUCTION

The phenomenon of high utilization of Emergency Room (ER) services by psychiatric patients has been well documented in both the U.S.[1-3] and in Canada.[4-6] Psychiatric ER facilities prior to the deinstitutionalization movement were primarily intended to provide an evaluation and referral resource for acute psychiatric problems. However, utilization patterns reveal that these costly services are extensively used by young, unmarried adults from the lower social class with a chronic psychiatric disorder.[1-4] Chronic repeaters are more likely to be suffering from psychosocial stressors of poverty and isolation.[1,3,7,8]

At least two distinct sub-groups of repeaters have been defined.[9,10] Schwartz et al. found that socioclinical characteristics of repeaters differ depending on the pattern and frequency of their visits to the ER; i.e.: chronic patients with personality disorders repeated more often.[9] Similarly Munves et al. distinguished those who repeated within 30 days from those who repeated after 30 days. The former group differed from nonrepeaters solely by their previous psychiatric contact. This group seems to have turned to the ER in an attempt to obtain further help with an acute crisis. However, the latter group was more likely to be chronically ill with marked psychological, social and economic problems.[10]

While it is widely recognized that more cost effective alternatives for care for these young chronic patients could be established,[11,12] the development of such services (e.g. hospitals and community integrated programs) has been limited.[13] In order to plan feasible and appropriate services for this target population, it is necessary to study carefully their pattern of utilization of psychiatric services. Of particular importance is the ER that serves as an entry point to the health care system and as a drop-in center for some of these patients and is considered to sensitively mirror the gaps in the health care delivery system.[2]

While the profile of Canadian ER users is quite similar to those in the U.S.,[4-6] no recent (after 20 years of the deinstitutionalization movement) Canadian studies have examined in depth the characteristics of repeated users of psychiatric ER services. Thus, it is unknown to what extent the universality and thus increased accessibility of Canada's health care system (inpatient and ambulatory psychiatric service) might influence the overutilization of psychiatric ER facilities. One purpose of our study was to examine this phenomenon. Previous studies[4-6] have failed to address the relative

heterogeneity in diagnostic grouping among ER repeaters. This heterogeneity may reflect diverse motivations for the use of ER services among repeaters which are obscured by analysis which regard these patients as a single entity.

A consistent finding in previous research on repeaters has been the association of specific diagnostic characteristics such as personality disorders,[9] alcohol and drug dependence, and schizophrenia[1,3] with repeated psychiatric ER use. However, none of these studies has examined differences among nonrepeaters and repeaters within separate diagnostic groups. This information could be very useful in refining our understanding of repeaters' needs in order to plan effective hospital and community programs targeted to specific groups of psychiatric patients. To further this aim the present study will examine clinical differences between patients with one repeated visit to the ER (one-time repeaters) and those with two or more repeated visits (several-time repeaters) within these separate diagnostic groups.

METHODS

The Ottawa Civic Hospital (O.C.H.) is an 850 bed (40 of which are psychiatric beds) general hospital serving a catchment area of approximately seven hundred thousand people. Patients treated at O.C.H. are 17 years old and older. The overall pattern of utilizations of our psychiatric emergency service is similar to other North American urban general hospitals.[4]

The study sample consisted of nine hundred thirteen consecutive patients referred for psychiatric emergency consultation (index consultation) during a 12-month period. These patients were assessed by junior and senior psychiatric residents under the supervision of a staff psychiatrist. The residents completed a standardized questionnaire with details of the patient's demographic and clinical characteristics; past and current treatment (including the number of psychiatric ER visits to any hospital in the six months preceding the index consultation); and emergency room management and disposition. Compliance with ambulatory care (mainly psychiatric care) was defined as attendance at the first appointment. Compliance was determined by contacting the physicians or agencies to which patients were referred. The psychiatric residents' attitudes toward the patient and relatives were also recorded. After the emergency assessment, patients completed a brief questionnaire. This consisted of questions related to their level of satisfaction with the psychiatric care received in the emergency ward, perception of the residents' understanding of their problem and their willingness to follow the residents' recommendations for treatment. It was

returned in a sealed envelope to ensure confidentiality and prevent interviewer bias.

The two questionnaires used were multiple choice in format with the exception of the attitudinal scales which were presented in the form of a Likert scale. Each resident received training on the administration of the questionnaires. This consisted of two one-hour sessions during which operational criteria were defined in order to maximize reliability.

The statistical analysis of variables (patients' and residents' characteristics) related to repeated use of psychiatric emergency services were conducted using the CROSSTAB sub-program of SPSS (Chi square).[14] For the analysis, three groups of patients were defined. Group 0 reported no visits to any psychiatric emergency service in the six months preceding the index consultation; Group 1 reported one visit; and Group 2 reported two or more visits. (The percentage calculations for some variables reported in the results were based on less than total numbers for each of the three groups due to missing information in the questionnaire.) The analysis of factors influencing repeated use of emergency services among DMS III diagnostic groups (schizophrenia; affective disorders–dysthymic and major affective; anxiety disorders; personality disorders; substances abuse–alcohol and drug abuse; and other diagnoses) was also conducted using the CROSSTAB subprogram of SPSS. For this part of the analysis, the diagnosis was available for 879 patients.

RESULTS

Of the 913 patients seen in the ER: 1) 69% were 39 years old or younger (82% of this group were between the age of 20 to 39); 2) 1% after the index consultation did not receive a psychiatric diagnosis; and 3) 62.2% (568) did not report visiting any ER in the six months preceding the index consultation, 22.2% (203) reported one ER visit while 15.6% (142) had two or more. Of all repeaters, 61.4% had previously been to the OCH ER, 25.5% were seen in another ER in Ottawa, and 13.1% were seen in ERs in other cities. Of all patients with affective disorders, 22% had major affective disorders and 78% had a dysthymic disorder.

Repeaters (Group 1 and 2) and nonrepeaters (Group 0) were not significantly different ($p \leq .05$) with regard to: sex, race, social class, level of education, employment status, date of ER visit, chief complaint and its duration, degree of urgency to see a psychiatrist, disposition after the index consultation, satisfaction with ER psychiatric care, willingness to follow the residents' recommendations for treatment, perception of the residents' understanding of their problem; the residents' attitude toward patients and their rapport with the patients.

Differences between Repeaters and Nonrepeaters

Tables 1 and 2 outline the significant factors associated with repeated use of psychiatric ER services. *Repeaters (Group 1 and 2)* were more likely than nonrepeaters to: be self referred; be single; have had previous and current psychiatric treatment; be schizophrenic or to have a personality disorder. Of all repeaters: 1) 70.4% were 17 to 39 years of age and the others were 40 and older; 2) 33.7% had an affective disorder and they were the diagnostic group most frequently hospitalized after the index ER consultation. *Group 2 repeaters* were more likely than nonrepeaters to: be between the age of 17 to 39; be unaccompanied on arrival at ER; be separated; have a nonidentifiable precipitating event for the index ER consultation; comply more often with ambulatory follow-up; have a poor rapport with psychiatric residents in ER; and the residents indicated more frequently that there was a lack of mutual understanding between them and the patients concerning the patients' problem and follow-up plans after the index consultation visit.

Diagnostic Categories and Repeaters

Factors associated with repeated use of psychiatric ER service among the different diagnostic categories are shown in Table 3. A common characteristic among repeaters across all diagnostic categories was a history of previous psychiatric treatment and current psychiatric treatment (with the exception of the substance abuse group). In most cases, the differences between repeaters and nonrepeaters were also found between Group 2 repeaters and Group 1 repeaters.

The schizophrenic repeaters (Group 1 = 37 and Group 2 = 30) were younger, less likely to be employed and less likely to be liked or establish good rapport with the therapist than nonrepeaters. The personality disorder repeaters (Group 1 = 38 and Group 2 = 51) were also more likely to be younger (Group 2 versus Groups 0 and 1). In addition, the personality disorder repeaters were more likely to arrive unaccompanied at the ER than nonrepeaters and to be dissatisfied with ER care (Group 2 versus Group 1). The affective disorder repeaters (Group 1 = 78 and Group 2 = 34) were more likely than nonrepeaters to be hospitalized after the ER assessment and to comply with ambulatory follow-up after ER assessment.

TABLE 1
Differences Between Psychiatric Emergency Room Repeaters and Non-Repeaters

	Non-Repeaters	Repeaters[1]		Group		
Patient's Characteristics	Group 0 N^2=568 %	Group 1 N^2=203 %	Group 2 N^2=142 %	0 vs. 1 p	0 vs. 2 value[3]	1 vs. 2
Self-referred to ER	36.2	44.2	51.8	.05	.001	n.s.
Unaccompanied on Arrival at ER	33	38.7	47.9	n.s.	.01	n.s.
Single	33.2	45.6	47.9	.01	.01	n.s.
Age: 17-39[4]	66.9	68.9	76.1	n.s.	n.s.	.05
Separated	12.4	13.5	20.7	n.s.	.05	n.s.
Not born in Canada	16.2	17.4	7.9	n.s.	.05	.05
Previous psychiatric treatment	58.6	85.8	94.2	.001	.001	.05
Current psychiatric treatment	24.5	53.4	67.1	.001	.001	.05
Diagnosis:						
Schizophrenia	12.4	19.4	21.6	.05	.01	n.s.
Personality Disorders	12.8	19.9	36.7	.05	.001	.001
Affective Disorders	47.9	40.8	24.3	.05	.001	.005
Anxiety Disorders	11.8	5.8	5.8	.025	.05	n.s.
Substance Abuse	5.8	9.9	9.4	n.s.	n.s.	n.s.
Other Diagnoses	9.3	4.2	2.2	.05	.02	n.s.
Nonidentified precipitating event for index ER consultation	16.5	21.6	25.4	n.s.	.05	n.s.
Compliance with ambulatory followup[5]	54.5	62.8	70.8	n.s.	.05	n.s.

1. Group 1 = one ER visit in previous six months; Group 2 = two or more ER visits in previous six months.
2. In some cases, percentage calculation based on less than total N due to missing values in the questionnaire.
3. Chi square analysis: n.s. = not significant.
4. 82% were between 20-39.
5. Percentage based on N in each group referred to ambulatory followup: Group 0 N = 292; Group 1 N = 94; Group 2 N = 65.

TABLE 2
Differences Between Psychiatric Emergency Room Repeaters and Non-Repeaters

Psychiatric Resident's Characteristics	Non-Repeaters Group 0 N^2=568 %	Repeaters[1] Group 1 N^2=203 %	Group 2 N^2=142 %	Group 0 vs. 1 p	0 vs. 2 value[3]	1 vs. 2
Disliked this type of patient in their practice	14.6	16.7	28.0	n.s.	.001	.05
Poor rapport with patient	9.1	12.2	17.8	n.s.	.01	n.s.
Lack of mutual understanding (re: patient's problem and followup plans)	9.6	14.3	19.8	n.s.	.01	n.s.

1. Group 1 = one ER visit in previous six months; Group 2 = two or more ER visits in previous six months.
2. In some cases, percentage calculation based on less than total N due to missing values in the questionnaire.
3. Chi square analysis

DISCUSSION

Our findings showed that approximately one third of all the patients assessed by psychiatrists in the emergency room (ER) gave a history of one or more previous psychiatric ER consultations. This is higher than what has been reported in the United States, ranging from 14 to 18%,[10] and in Canada, 23%.[15]

Our results coincide with previous reports distinguishing repeaters from nonrepeaters on the basis of being: unmarried,[1,3,15,16] unemployed,[1,15] self-referred to the ER,[3,8,15] with a history of previous psychiatric treatment,[8,15] requiring hospitalization after the ER assessment (for those with affective disorders), being diagnosed as schizophrenic,[1,3] or as having a personality disorder;[9] and being the subject of poor rapport with the ER therapist.[8] These characteristics are even more prevalent in several-time repeaters than among one-time repeaters. The comparison of our findings with previous research is illustrated in Table 4. Repeaters generally appear to be chronic patients with limited social networks. These patients have been reported to tolerate minimal levels of stress leading to exacerbation of psychiatric symptomatology.[18] Raphling and Lion noted that some of these patients consistently are unable to establish more

TABLE 3
Factors Affecting Frequency of Use of Psychiatric E.R. Services According to Diagnosis

Diagnoses	Characteristics	Comparisons Among Repeaters
Schizophrenia	Age ($\leq$39 years old)	[a]($p<.05$), [c]($p<.05$)
	Unemployment	[a]($p<.01$), [b]($p<.01$), [c]($p<.01$)
	Previous Psychiatric Treatment	[a]($p<.01$), [b]($p<.01$), [c]($p<.01$)
	Current Psychiatric Treatment	[a]($p<.01$), [b]($p<.01$), [c]($p<.01$)
	Resident Disliked Patient	[a]($p<.05$), [b]($p<.05$), [c]($p<.05$)
	Resident Poor Rapport	[a]($p<.05$), [b]($p<.05$), [c]($p<.05$)
Affective Disorders	Previous Psychiatric Treatment	[a]($p<.001$), [b]($p<.001$), [c]($p<.001$)
	Current Psychiatric Treatment	[a]($p<.001$), [b]($p<.001$), [c]($p<.001$)
	Hospitalization	[a]($p<.001$), [b]($p<.001$), [c]($p<.001$)
	Followup Compliance	[a]($p<.05$), [b]($p<.05$), [c]($p<.05$)
Anxiety Disorders	Previous Psychiatric Treatment	[a]($p<.01$), [b]($p<.01$), [c]($p<.01$)
	Current Psychiatric Treatment	[a]($p<.001$), [b]($p<.001$), [c]($p<.001$)
	Resident Disliked Patient	[a]($p<.05$), [b]($p<.05$), [c]($p<.05$)
	Patient Feeling Understood	[a]($p<.05$), [c]($p<.05$)
Personality Disorders	Age ($\leq$39 years old)	[a]($p<.05$), [b]($p<.05$)
	Self-Referrals	[a]($p<.05$), [b]($p<.05$), [c]($p<.05$)
	Previous Psychiatric Treatment	[a]($p<.001$), [b]($p<.001$), [c]($p<.001$)
	Current Psychiatric Treatment	[a]($p<.001$), [b]($p<.001$), [c]($p<.001$)
	Unhappy E.R. Psychiatric Care	[b]($p<.05$)
Substance Abuse	Previous Psychiatric Treatment	[a]($p<.05$), [b]($p<.05$), [c]($p<.05$)
	Current Psychiatric Treatment	[a]($p<.05$), [b]($p<.05$), [c]($p<.05$)
	Followup Compliance	[a]($p<.01$), [b]($p<.01$), [c]($p<.01$)
Other Diagnoses	Previous Psychiatric Treatment	[a]($p<.05$), [b]($p<.05$), [c]($p<.05$)
	Current Psychiatric Treatment	[a]($p<.05$), [b]($p<.05$), [c]($p<.05$)

a. Multiple Repeaters (Group 2) > Nonrepeaters (Group 0).
b. Multiple Repeaters > Single Repeaters (Group 1).
c. Single Repeaters > Nonrepeaters.

stable treatment relations.[7] Some of these patients may feel safer in visiting the ER when unable to cope with their problems due to their difficulty in establishing and/or maintaining long-term therapeutic relationships. Another important characteristic of some repeaters in our study which could interfere with their ER manage-

TABLE 4
Factors Correlated with Repeated use of Psychiatric Emergency Services

Factors	OCH Study	Literature*		
Patient's Characteristics	Statistically Significant ($p \leq .05$) + correlation	Statistically Significant ($p \leq .05$) + correlation	Trend +	No Corre-lation
1. Younger than 40		1, 8, 15	9, 16	3, 17
2. Unmarried	X	1, 3, 15, 16	9	8, 17
3. Unemployed	X	1, 15		8, 17
4. Self-referred to ER	X	3, 8, 15		
5. History of psychiatric treatment	X	8, 15		17
6. Rate of hospitalization after ER assessment	X (for those with affective disorders)	8, 9	1	17
7. Compliance with ambulatory followup after ER assessment	x			
8. Suicidal behavior		1, 17	8	
9. Hostile behavior at ER		8		1, 17
10. Diagnosis				
a) Schizophrenia	X	1, 3	8	9, 17
b) Personality disorder	X	9	1, 8	3, 17
c) Alcohol and drug abuse		3, 9		1, 8, 17
Psychiatrists' Characteristics				
1. Negative counter-transference	X	8		

*Numbers indicate references

ment is their difficulty in relating to the ER psychiatrist. Bassuk and Garson also found that repeaters have difficulty establishing rapport with ER therapists, often provoking intense feelings of dislike.[8] Postgraduate programs need to address these important issues when providing emergency room and chronic care training for psychiatric residents.

The unscheduled drop-in nature of ER treatment may be compensating for the insufficiency of currently existing hospital and community mental health resources in our region to meet the special needs of this patient population. Bassuk et al. support this interpretation in discussing the overutilization of ER services as a sensitive mirror of the gaps in the health care delivery system.[2]

Such a gap indicates the need to define more specifically characteristics of repeaters so that special programs to meet their needs might be developed. Our results demonstrate that several factors that distinguished repeaters from nonrepeaters in ours and previous studies[1,3,8,9] were valid discriminators only for specific diagnostic groups. These findings underline the importance of distinguishing among subgroups of repeaters not only on the basis of frequency of repeated visits, as previous research has done, but also on the basis of diagnosis.

The 81 schizophrenic and personality disorder repeaters (with two or more visits in previous six months) appear to be a group of young adult, unemployed chronic patients who have particular difficulty in establishing rapport with the ER therapist. These patients seem to have some of the characteristics of the young adult chronic patients as described by several authors.[11,12,13] Voineskos proposed new roles for psychiatric emergency services in order to cope effectively with new chronic patients.[15] Community rehabilitation and support programs (with an active case management approach) could help repeaters with schizophrenia and severe personality disorders acquire a better quality of life and may lead to more appropriate use of ER services.[11,12,13,19]

Since a high percentage of all the repeaters had an affective disorder, we conducted a descriptive analysis of possible factors leading to repeated use of the ER among three subgroups of patients with affective disorders. The first consisted of those patients not receiving treatment at the time of the index ER consultation (42% of repeaters with affective disorder). This group had a high proportion of younger patients with a past history of psychiatric treatment and with a tendency not to comply with previous referrals for psychiatric ambulatory treatment. On their repeat visit to the ER their

conditions had deteriorated and a higher number of them required psychiatric hospitalization. These findings point to the need to establish appropriate methods to increase compliance with referrals to ambulatory treatment.[20] Some of the effective ones are: 1) earlier follow-up appointments; 2) providing ER patients with the date and time of the ambulatory appointment and the name of the staff member to whom they have been referred; 3) and when possible follow-up care by the psychiatrist seen in the ER.

Our data and clinical experience seems to indicate a second subgroup, those in therapy with private or other hospitals OPD psychiatrists (37% of repeaters with affective disorder). These patients tend to use the emergency room as an entry point to the psychiatric inpatient service. Due to the difficulties in obtaining an elective admission to psychiatric inpatient units in the city, patients are usually told to come to the ER when they are in need of hospitalization. When a bed is not available in any hospital in the city, patients tend to remain in the ER until one becomes available.

It appears that some of the visits to the ER of patients in a third subgroup, those receiving treatment at the Civic Hospital OPD (21% of repeaters with affective disorder), could have been reduced if they had been able to see their therapist in the hospital OPD. Outpatient therapists dealing with chronic patients who tend to develop frequent crises need to schedule some time for emergency assessments of these patients. This approach in combination with triage systems in the OPD, with nurses who know the patient well could be quite beneficial for the patients, therapists and the ER staff.

Compliance with referrals to ambulatory psychiatric care among repeaters with affective disorders was high. This could be partly explained by the tendency of ER psychiatrists to refer their patients back to their previous therapist. This has been shown to increase compliance.[21]

In general, this study supports previous research which found that a fairly large proportion of repeated users of emergency psychiatric services (especially those repeating more than once in a six month period) to be socially isolated, chronic psychiatric patients who evoke negative reactions from ER therapists. A high proportion were diagnosed as having schizophrenia and personality disorders. An important subgroup of these repeaters are the new chronic patients who have been reported to overutilize psychiatric emergency services. The impact of deinstitutionalization in the last 20 years has led to emergence of new chronic patients who reside in the community[22] and are in need of crisis stabilization services and

specialized hospital and community aftercare programs.[19,23]

Our study clearly demonstrated the heterogeneity of the needs of the diverse diagnostic groups who overutilize costly ER services. This finding lends support to the importance of carefully evaluating the variety of community and hospital programs necessary to meet the needs of these patients in a more clinically effective and cost effective manner.

CONCLUSION

Our results provide some support to the reported observation that psychiatric emergency services tend to reflect the gaps in the delivery of health services in the hospital and the community. Our findings would be useful in planning psychiatric services to meet the needs of our patient population. It appears that some patients would benefit from the development of aftercare programs and the reorganization of hospital-based programs. The extent to which this goal could be achieved, in a country with universal health insurance depends on: better presentation of data to justify needs; the initiative of health care providers and administrators; and on government allocation of resources for these programs.

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