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ORIGINAL PAPER

Mental Health and Addiction Related Emergency Department Visits: A Systematic Review of Qualitative Studies

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Abstract

Mental health and addiction (MHA) related Emergency Department (ED) visits have increased significantly in recent years. Studies identified that a small subgroup of patients constitutes a disproportionally large number of visits. However, there is limited qualitative research exploring the phenomenon from the perspectives of patients who visited ED frequently for MHA reasons, and healthcare providers who provide care to the patients since the overwhelming majority of studies were quantitative based on clinical records. Without input from patients and healthcare providers, policymakers have inadequate information for designing and implementing programs. The purpose of this study was to systematically review the literature of qualitative research on frequent MHA related ED visits. The findings of the review revealed that a lack of community resources and existing community resources not meeting the needs of patients were critical contributing factors for frequent MHA related ED visits.

Keywords Mental health and addiction · Emergency department · Frequent visits · Review

Introduction

Mental health and addiction (MHA) related emergency department (ED) visits have increased in recent decades (Brennan et al., 2014). In response to the continued rise in the number of patients who use ED services for MHA issues, studies have examined the phenomenon, and found a relatively small number of patients with MHA disorders account for a disproportionately large number of ED visits (Lincoln et al., 2016; Meng et al., 2017; Quail et al., 2017). Studies of frequent MHA related ED visits have identified some predictive factors, including schizophrenia disorder (Chaput, Y. J. & Lebel, 2007); personality disorder (Pasic et al., 2005); substance use (Fleury et al., 2015); social and personal stressors (Pasic et al., 2005); and homelessness (Lindamer et al., 2012). The number of MHA related ED visits has also increased among those who do not represent "true" psychiatric emergencies (e.g., acute excitement

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with psychomotor agitation and self-destructive or suicidal behavior) (Mavrogiorgou et al., 2011) but who use ED as a source of support (Catalano et al., 2003; Chaput et al., 2008). In addition, high rates of readmission and ED visits after discharge reflect difficulties in accessing outpatient care and a lack of community services (Aagaard et al., 2014) However, little is known about this issue and the reasons why patients frequently use ED services, particularly from the perspective of patients who visit the ED frequently, and the healthcare providers who work with these patients. An overwhelming majority of studies on MHA related ED visits utilize quantitative analyses based on data from patient's health records (Meng et al., 2017; Quail et al., 2017). A lack of input from the patients who frequently visit the ED, and healthcare providers who work with these patients leaves policymakers with inadequate information on program design and implementation of community service programs.

The aim of this study was to systematically review the literature on MHA related ED visits from the perspective of patients who visit ED frequently, and healthcare providers who provide care to these patients.

Methods

Search Strategy

This review followed PRISMA guidelines for reporting systematic reviews (Moher et al., 2009). Search strategies and terms were developed in consultation with a health science librarian and a researcher in the MHA field. Two authors searched six databases: Cochrane, Embase, PubMed, MEDLINE, PsychINFO, and Scopus. Initial searches were done for each concept, and their common synonyms: mental health; addiction; MHA; and ED. Free-text terms and controlled vocabulary terms were subsequently searched.

The inclusion criteria for the current systematic review included (1) participants (patients with MHA disorders who visited ED frequently and healthcare providers) $\geq$ 18 years old; (2) qualitative or mixed methods study designs; (3) literature published between January 2000 and October 2020. We excluded studies with (1) participants $<$ 18 years old; (2) quantitative methods; (3) non-English language; and (4) non-peer-reviewed publications.

Screening and Selection

Two authors independently screened both titles and abstracts to determine relevance. Full text reviews based on the results of title and abstract screening were conducted by two authors independently. Any disagreements in screening and selection process were resolved through discussion. Articles that met the inclusion criteria proceeded to data extraction and quality appraisal.

Data Extraction and Quality Appraisal

The researchers developed a standardized data extraction protocol to ensure uniformity. For each study, the following data were extracted: authors, country, year of publication, type of study, eligibility criteria, number of participants, types of participants, data collection methods, and findings.

The quality of each study was appraised using the Critical Appraisal Skills Programme for qualitative studies (CASP) (CASP, 2018), one of the most widely used tools in the health and social sciences to assess study qualitative rigour (Dalton et al., 2017; Hannes & Macaitis, 2012). CASP assessment is divided into three categories with a possible total score of 16: Section A includes 6 questions that focus on validity and methodology; Section B is comprised of three questions related to ethical issues, data analysis, and findings; Section C investigates the value of the study in regards to the generalization of the findings (CASP, 2018). The studies selected for this review were assigned a quality score out of 16 as follows: low ($\leq$9), medium (10–13), and high ($\geq$14) quality respectively (Nadelson & Nadelson, 2014). The quality appraisal of each study was assessed by two independent researchers. Any disagreements were resolved through discussion.

Results

Study Selection

A total of 3175 studies were identified. After duplicates were removed, the title and abstract of the remaining 2426 studies were reviewed. Of the 2426, 34 were determined as meeting initial eligibility. The full text of each article was reviewed, and 17 were chosen for further data extraction and quality appraisal. A PRISMA flow diagram presents all phases of the review process (Fig. 1) (Moher et al., 2009).

Summary of Study Characteristics

A majority (14) of selected studies were published between 2010 and 2020, and 3 were from 2000 to 2010. Of the 17 studies, 7 were published by Canadian researchers, 4 were Swedish publications, both the UK and the USA researchers published two studies, and one publication came from Singapore and Denmark respectively (Table 1). Of the total 17 studies, 12 were qualitative and 5 employed mixed methods. There were a total of 12 studies focused exclusively on patient perspectives (Aagaard et al., 2014; Fleury et al., 2019b; Lincoln et al., 2016;

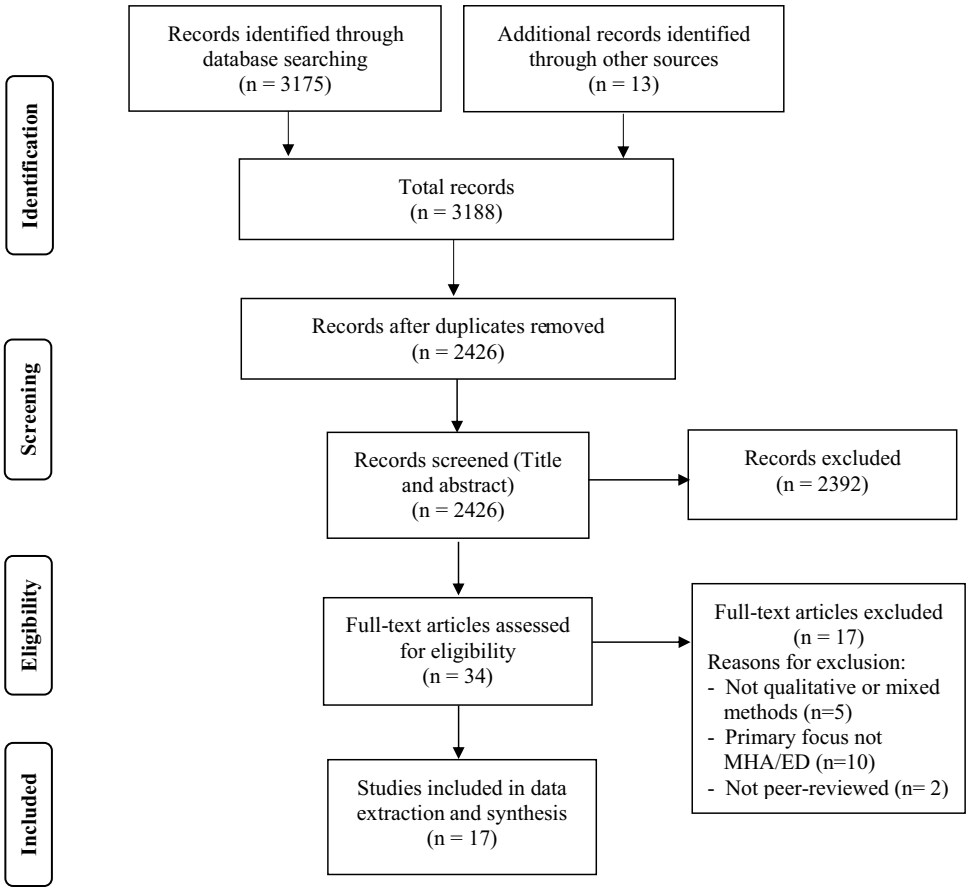

Fig. 1 PRISMA flow diagram showing study selection process

McCormack et al., 2015; Olsson & Hansagi, 2001; Parkman et al., 2017a, b; Poremski et al., 2020; Schmidt et al., 2018; Vandyk et al., 2018, 2019; Wise-Harris et al., 2017). Three studies were exclusive to healthcare providers' perspectives (Fleury et al., 2019a; Schmidt et al., 2020a, b, while two studies incorporated both patient and healthcare provider perspectives (Bergmans et al., 2009; Spence et al., 2008).

Overall, of the 17 selected studies, there were a total of 660 patient participants, and 122 healthcare provider participants. Data were collected by conducting one-on-one semi-structured interviews for all patient participants while studies that were healthcare provider focused, utilized supplemented individual interviews with focus groups.

Are ED Visits Inevitable?

Patients came to ED under different circumstances including perceived inevitable situations, seeking mental health services, and/or involuntary visits, or being redirected by others.

Perceived Inevitable Situations

Patients discussed their ED visits as a last resort when seeking help for intolerable conditions, feeling as though their ED visit was unavoidable and the only way to address their urgent needs (Aagaard et al., 2014; Bergmans et al., 2009; Fleury et al., 2019b; Vandyk et al., 2019). For example, some viewed their chronic health conditions, and MHA issues as a threat to their life (e.g., severe mood symptoms, suicidal behaviors), and needed immediate medical attention (Lincoln et al., 2016; Parkman et al., 2017b; Vandyk et al., 2019; Wise-Harris et al., 2017).

Seeking Mental Health Services

Some patients used ED services exclusively to manage their MHA related symptoms, while others cited using ED services as supplemental care to their usual primary care services (Aagaard et al., 2014; Fleury et al., 2019a). Visiting ED due to psychotropic medications related matters has been documented in the literature, such as the inability to pay, refill, mediation adjustment, and to receive long-acting injectable medications (Fleury et al., 2019a; Poremski

Table 1 Summary of selected studies

Authors (year), country	Study aim	Sample	Methods	Qualitative data collection	Major qualitative findings	Quality appraisal (score)
Aagaard et al. (2014), Denmark	Identify predictors for frequent ED visits	15 patients	Mixed methods	Semi-structured interviews	From patients' perspectives, visiting ED is a last resort in the hope of receiving help for an unbearable situation Three central themes emerged: –Visiting ED was viewed as a personal failure in managing symptoms –ED assessment of the patients' needs was seen as acting as 'gatekeepers', causing concern among patients about whether they were 'sick enough' to receive care as a result of past experiences of rejection –For some, ED utilization was a result of an inability to use usual social networks in crisis, while others viewed their ED visits as a supplement/alternative to their usual professional services	Low (9/16)

Table 1 (continued)

Authors (year), country	Study aim	Sample	Methods	Qualitative data collection	Major qualitative findings	Quality appraisal (score)
Bergmans et al. (2009), Canada	Explore ED experiences of male patients with a history of suicidal behavior and substance abuse, and experiences of healthcare providers serving this population	25 patients and 27 healthcare Providers	Qualitative	Semi-structured 45–120 min individual interviews with patients; Semi-structured 30–90 min individual interviews with healthcare providers	Perspectives of both patients and healthcare providers were shared over five themes: –Reasons for seeking care: Patients: felt there were no other options/it would be fatal to not go Healthcare providers: felt that patients who visit ED frequently were difficult to treat, and often questioned how appropriate the patient's frequent visits were –While in ED: Patients: felt that their frequent visits disturbed ED staff and expected negative interactions Healthcare providers: often felt they were 'being used or manipulated.' –Problematic behaviour: Patients: bad behaviour is more likely to garner attention; aggressive behaviour may present when waiting longer than they perceived to be reasonable Healthcare providers: problematic behaviour increased staff' frustration with the patients; consequences of this behaviour affected both the staff service provision and the care that the patient received –Discharge: Healthcare Providers: felt that patients frequent ED visits was tied to the lack of community resources. As a result, discharge was expected to bring patients back Expectations and roles: Patients: expected to get help, or to ease their pain/issues Healthcare providers: provision of care in ED is often problematic, as interventions in ED rarely provides solutions, but rather acts as a Band-Aid until the patients' next visit	Medium (10/16)

Table 1 (continued)

Authors (year), country	Study aim	Sample	Methods	Qualitative data collection	Major qualitative findings	Quality appraisal (score)
Fleury et al. (2019a), Canada	Identify predisposing, enabling, and needs factors of frequent ED use, and explore barriers and facilitators in symptom management	328 patients from four different EDs	Mixed methods	10-min semi-structured interviews focused on patients' reasons for visiting ED; 40-min structured questionnaire focused on self-reported health and utilization of health care services	Findings are presented through the Anderson Behaviour Model of Health Service Use: –Predisposing factors: socio-demographic conditions, such as unemployment or low income, may aggravate mental health problems, which in turn contributes to increased ED use. Poor knowledge of MHA services was also identified as a key barrier to patients' healthcare utilization –Enabling factors: many participants relied exclusively on ED to manage their problems due to issues with primary care or community services, or a lack of continuation/coordination among mental health services –Needs factors: the biggest motivator for frequent ED utilization was patients' perception of their ED visits as unavoidable, and as the only way to address their perceived urgent and life-threatening conditions. Many possessed comorbidities, increasing their need for resources to address their complex diagnosis	Low (8/16)

Table 1 (continued)

Authors (year), country	Study aim	Sample	Methods	Qualitative data collection	Major qualitative findings	Quality appraisal (score)
Fleury, et al. (2019b), Canada	Explore barriers and facilitators in patients' symptom management in ED using a variety of operational models	12 managers and 9 ED clinicians; ED teams (20); addiction liaison team (8) from four different EDs	Qualitative	25–60 min individual semi-structured interviews with 10 managers and 9 ED clinicians; 4 groups (ED team), 2 groups (addiction liaison), and 1 group (managers) interviews lasting 90–120 min	Four themes were identified: –Health system: resource scarcity (both in and out of ED) was identified as the greatest barrier affecting patient care. Policy-related factors (e.g., insufficient budgets; ED overcrowding) were seen as barriers to effective ED functioning. Facilitators included the quality of relationships with other health systems, such as crisis centres –Patients: often comorbid with complex needs beyond what ED can provide; treatment of patients who frequently visit ED is often suboptimal without a wider and integrated community care response –Organizational: organizational strengths were often characterized by a collaboration between mental health services, leading to more appropriate referrals outside of ED settings, thus reducing mental health crises admissions. Barriers identified were difficulties retaining skilled staff, as well as the distance between ED and psychiatric centres – Professional: a lack of MHA training among staff led to stigma and a lack of understanding regarding patients with comorbid conditions. This, combined with poor knowledge of community services (potentially as a result of frequent staff turnover) present the greatest professional barriers to quality of ED provision. Multidisciplinary interventions, as well as positive inter-professional relations, were considered facilitators for better patient care in a professional context	Medium (13/16)

Table 1 (continued)

Authors (year), country	Study aim	Sample	Methods	Qualitative data collection	Major qualitative findings	Quality appraisal (score)
Lincoln et al. (2016), USA	Examine repeat use of ED using a Community-Based Participatory Research (CBPR) approach	16 patients	Mixed methods	Semi-structured interviews	There were two overarching themes: –Why and how often people would like to use ED: Two-thirds of patients visited ED due to medication-related issues, including inability to pay Half of the patients reported depressed mood or suicidal thoughts prior to visiting ED ED visits related to violent incidences (either as victims or as perpetrators) were common Substance misuse was a contributing factor for many visits Many patients presented to ED in the hopes of receiving a referral for community services –Substance use and mental health issues – experiences of treatment: Patients had complex relationships with formal and informal supports Patients felt that healthcare providers were more focused on their substance use rather than the mental health issues they were attending for and did not treat them concurrently Some attended in the hopes of receiving help for symptoms of their mental illness; instead, they were referred to community detox services	Medium (11/16)

Table 1 (continued)

Authors (year), country	Study aim	Sample	Methods	Qualitative data collection	Major qualitative findings	Quality appraisal (score)
McCormack et al. (2015), USA	Explore relationship between frequent ED visits and evolution, environment, and psychosocial contexts of alcoholism from the perspectives of homeless, and alcohol-dependent patients	20 patients	Qualitative	50-min semi-structured interviews	Four major themes were identified: –Alcoholism: destroyed relationships with family, led to unemployment and homelessness, and derailed future plans and dreams –Homelessness: obtaining secure shelter was often of secondary importance to patients with obtaining alcohol being a priority. Alcohol misuse was the most cited reason for homelessness –Health care: most patients reported being brought to ED for public intoxication, rather than a personal choice to seek care. The majority left before the completion of care, with most citing how they were treated (medically and personally) as the reason –Envisioning the future: many patients had fatalistic views of the future, with doubts regarding long-term survival. Overall, they expressed a desire for the suffering to end	High (16/16)
Olsson & Hansaggi (2001), Sweden	Explore the reasons for repeated ED visits from the perspectives of patients	10 patients	Qualitative	60–90 min semi-structured interviews	Two major themes were identified: –Threat to life and autonomy: patients viewed pain and their symptoms as a threat to their life and autonomy. Immense feelings of anxiety drove them to seek urgent care. They often experienced adverse life situations and struggled with physical and mental health issues, including substance misuse –Encounters in ED: many were unsatisfied with ED services. Patients felt that ED staff viewed their visits as inappropriate and their needs would not be met. When they were referred to community psychiatric services, patients did not continue to follow-up nor did they positively change their help-seeking behaviour	Low (9/16)

Table 1 (continued)

Authors (year), country	Study aim	Sample	Methods	Qualitative data collection	Major qualitative findings	Quality appraisal (score)
Parkman et al (2017a), United Kingdom	Investigate the reasons patients repeatedly attend ED for alcohol-related reasons	30 patients from six different EDs	Qualitative	60–120 min semi-structured interviews	Findings are presented through the Anderson Behaviour Model of Health Service Use: –Pre-disposing factors: many patients had chronic or acute health problems, often co-occurring with a mental health issue, unstable housing, poor social relationships, and/or being unemployed. Patients viewed ED as a safe and immediately accessible place with caring and helpful staff –Enabling factors: the lack of availability of community resources was the main reason for ED visits. Personal resources were often scant, with a lack of positive social support –Needs factors: alcohol use often resulted in injury or issues requiring an immediate attention, causing patients to seek care in ED. Long-standing health issues or self-harm behaviours were also a factor in ED use. Participants perceived their needs to be somewhat higher than service providers did	High (14/16)
Parkman et al. (2017b), United Kingdom	Explore patients' experiences of frequent ED visits due to alcohol-related reasons, and their views on using specialist addiction services	30 patients from six different EDs	Qualitative	60–120 min semi-structured interviews	Findings include: –Low usage of specialist addiction services: was not due to structural barriers impeding patients from seeking help –Views of patients who used the services: they were appreciative of the social aspect of the activities that the services provided, including making friends and interacting with staff –Reasons for not attending: patients believed that they did not need specialist addiction services for their alcohol use; patients often lacked knowledge of what these services could provide –Types of treatments/supports wanted for alcohol misuse related issues: only about one-third of patients wanted alcohol-specific services. A majority of patients wanted help for mental health issues, social support, securing work, and housing issues	High (16/16)

Table 1 (continued)

Authors (year), country	Study aim	Sample	Methods	Qualitative data collection	Major qualitative findings	Quality appraisal (score)
Poremski et al. (2020), Singapore	Investigate the reasons for frequent ED visits, and explore changes in help-seeking behaviours as a result of frequent ED use	44 patients	Qualitative	40–75 min semi-structured interviews	Three themes emerged: –Reasons for voluntary visits: Pharmacological reasons: seeking psychiatric services after office hours included medication refills, dose adjustment or to receive an injection Seeking or avoiding admission: for some, their purpose for visiting ED was to be admitted to inpatient care where they felt safe, comfortable, and received respite from stressors. Others avoided being admitted due to past negative experiences, such as healthcare providers downplaying the severity of their symptoms Seeking external support: patients believed that the ED could address their unmet needs, including talking to someone who listened. This was seen as not possible in outpatient services –Reasons for involuntary use: police would bring patients to ED in cases of self-endangerment (e.g., suicide attempts) and/or public nuisance behaviours related to patients' acute psychiatric symptoms –Substance use: Contributed to both voluntary and involuntary ED visits. However, visiting ED did not address patient's addiction and/or housing issues, often resulting in a return to ED	Medium (12/16)

Table 1 (continued)

Authors (year), country	Study aim	Sample	Methods	Qualitative data collection	Major qualitative findings	Quality appraisal (score)
Schmidt et al. (2018), Sweden	Investigate self-reported needs for care, support, and treatment from the perspectives of patients who frequently visit ED	81 patients	Mixed methods	30–45 min structured interviews	Three themes emerged: –Need to reduce acute suffering: patients sought to obtain help in managing acute psychiatric symptoms through talking to someone to relieve stress, receiving medication in a timely manner, and being admitted to the hospital for personal safety –Need to feel secure: patients viewed ED as a safe and secure place where they could voice their needs for a professional approach which included assurance of privacy and confidentiality –Need for caring encounters with staff: patients desired to feel cared for and understood; to feel welcomed, and to be treated with respect and fairness	Medium (12/16)
Schmidt et al. (2020a), Sweden	Explore healthcare providers' perspectives of patients who frequently use ED	19 healthcare providers	Qualitative	25–85 min individual semi-structured interviews with 19 healthcare providers; 90-min focus group with 6 participants	Two major themes were identified: –Nurturing the encounter with oneself and colleagues for continuous, professional improvement through allowing for constant learning from experience; balancing of one's emotions (between empathetic and professional); being self-insightful (i.e., acceptance of own limitations and strengths); using critical thinking, and finding support in colleagues and managers –Striving for a meaningful connection with the patient through 'becoming a chameleon' (i.e., adjusting presentation based on patient need); working with hope and laughter; seeing each patient as an individual; mastering the art of interaction as a way to build connection; and being content with 'just' an encounter (i.e., sometimes circumstances did not allow for meaningful connections with patients)	Medium (10/16)

Table 1 (continued)

Authors (year), country	Study aim	Sample	Methods	Qualitative data collection	Major qualitative findings	Quality appraisal (score)
Schmidt et al. (2020b), Sweden	Explore healthcare providers' perspectives on the needs of patients who frequently visit ED	19 healthcare providers	Qualitative	25–85 min individual semi-structured interviews with 19 healthcare providers; 100-min focus group with 5 participants	Four themes based on unmet needs emerged: –Need to relieve loneliness: due to limited social support and stigma regarding mental health, patients felt isolated in the community. ED staff provided patients with an opportunity to talk and interact, and patients felt seen and confirmed by ED staff –Need to relieve hopelessness: patients faced challenges every day, including financial difficulties, housing issues, and lack of social activities. Hopelessness was prevalent among patients. ED provided a refuge for patients to temporarily escape from seemingly unmanageable stressors –Need to relieve psychiatric symptoms: patients visited ED in the hope of relieving their symptoms by staying in a place where they felt safe, stable, and calm, while also receiving treatment –Need for cohesive care and support: patients and ED staff agreed that community services are inadequate and provide poor quality care. Patients need comprehensive service plans which include access to community health care and steps for fostering social connections	High (15/16)

Table 1 (continued)

Authors (year), country	Study aim	Sample	Methods	Qualitative data collection	Major qualitative findings	Quality appraisal (score)
Spence et al. (2008), Canada	Investigate experiences of frequent ED visits in men with a history of substance abuse and suicide-related behaviour	25 patients and 27 healthcare providers	Qualitative	45–120 min semi-structured interviews with 25 patients; 30–90 min semi-structured interviews with 17 healthcare providers	Three themes were identified: –Reasons for visiting ED: Patients: ED utilization was necessary and unavoidable. Sometimes they were redirected to ED by their regular care providers, or their family, despite community resources are available Healthcare providers: while life circumstances were difficult for patients, their presentation in ED was indicative of a larger social issue; some felt that they were inappropriately using the system –Patient behaviour: Patients: long waits for assessment, multiple interviews, and confinement in ED were seen as the main cause of patients' disruptive behaviour Healthcare providers: a majority of patients had deficits in expressing their emotion, which hindered communication. Patients' disruptive behaviour was seen as adding to the stressful environment in ED –Identification of repeat visitors/ED experiences: Patients: frequent ED visits negatively impacted their ability to seek and find ongoing care, especially after being identified as a "frequent flyer" Healthcare providers: frequent visits were often unhelpful for both healthcare providers and patients, largely due to the perceived lack of progress resulting from chronic illness	Medium (13/16)

Table 1 (continued)

Authors (year), country	Study aim	Sample	Methods	Qualitative data collection	Major qualitative findings	Quality appraisal (score)
Vandyk et al. (2018), Canada	Explore the experiences of patients who visited ED frequently	10 patients	Qualitative	Semi-structured individual interviews	Three themes were identified: –The overall experience of ED visits: Needing to go to ED: unavoidable with physical complaints legitimizing visits Feeling disrespected: feeling rushed; receiving sub-optimal care Discharged to abyss: before being fully stabilized; reported as often exacerbating symptoms Being known: as a frequent user, positive experiences were premised on ED staff knowing how to provide care, while negative experiences were related to ED staff assuming the reason for the visits or spoke to them unprofessionally –Interactions with healthcare providers: Interactions with ED physicians were often positive; relationships with nurses were variable, with both positive and negative experiences reported; interactions with security staff in the ED were often negative, as they often lacked sensitivity or training on mental health issues Paramedics, police, and the crisis line: when brought to ED by paramedics, patients perceived a lack of sensitivity and respect. However, police officers often treated them with care, despite prioritizing rules and regulations. The crisis line was viewed as minimally helpful with limited usefulness –Protective factors: Work and other coping skills: work gave patients purpose by providing them with a sense of normalcy. Coping skills were developed as time went on, both through formal supports (e.g. strategies learned in therapy) and self-management (e.g. distraction techniques) Social connections: timing and availability were of utmost importance, with social relationships helping to stabilize patients' conditions prior to ED utilization	High (16/16)

Table 1 (continued)

Authors (year), country	Study aim	Sample	Methods	Qualitative data collection	Major qualitative findings	Quality appraisal (score)
Vandyk et al. (2019), Canada	Explore frequent ED use by patients with bipolar disorders	6 patients with bipolar disorders	Qualitative	Semi-structured interviews	Three themes were identified: –Pathways to ED: found to be a result of one of three behaviours: (1) aggressive or disorganized behaviour (often leading to involuntary ED visits) (2) medication seeking, and (3) intense emotions that patients were unable to self manage –Cyclical nature of ED use: ED visits were often preceded by a pattern of emotional and situational factors, such as deterioration of symptoms caused by feeling of loneliness and loss. Many patients felt that existing community services did not meet their complex and persistent needs –Coping skills and strategies: both negative (e.g. drug use) and positive (e.g. connecting with friends) self-management strategies were employed by patients in an attempt to minimize ED visits. Only when self-management failed did they self-refer to ED	Medium (13/16)

Table 1 (continued)

Authors (year), country	Study aim	Sample	Methods	Qualitative data collection	Major qualitative findings	Quality appraisal (score)
Wise-Harris et al. (2017), Canada	Explore experiences of patients with mental health and/or addictions issues who frequently visit ED	20 patients from six different EDs	Mixed methods	30–90 min semi-structured interviews	Three themes were identified: –Diversity of precipitants: there were a variety of acute and chronic health conditions, and mental health and/or addiction issues –Are ED visits avoidable? ED as an unavoidable and appropriate destination: most patients believed that their health concerns needed immediate attention. Their ED visits were seen as resulting from a lack of alternatives, a failure to receive timely access to, or an interruption of community resources. Some felt dissatisfied with current accessible services. Other patients indicated they viewed ED as a gateway to other services that were otherwise difficult to access Reinforcers of ED use: patients reported that their frequent ED visits were supported and directed by their community healthcare providers. Sometimes, their healthcare providers made the executive decision and called police or ambulance to accompany the patient to ED Conflicting messages in ED: Hospital staff often provided conflicting information on whether patients ED visits were appropriate –Negative experiences of care in ED: Stigma and discrimination: because of their frequent ED use due to their mental health and/or addiction issues, patients felt stigmatized by hospital staff. Some viewed long waits in ED as evidence of stigmatization Perfunctory and unsympathetic care: negative ED experiences were often reported as providing superficial treatment, in which patients were discharged without having their concerns addressed. There were also reports of unsympathetic ED staff that made patients feel unwelcome	Medium (10/16)

et al., 2020), while for others the purpose of ED visits was to receive a referral for community services that were otherwise difficult to access (Lincoln et al., 2016; Wise-Harris et al., 2017).

Involuntary ED Visits or Redirected by Others

Some patients were brought to ED by police due to public intoxication, self-endangerment (e.g., suicidal behavior), violent incidents (either as victims or as perpetrators), or public nuisance caused by acute psychotic symptoms (McCormack et al., 2015; Poremski et al., 2020; Vandyk et al., 2019). Other patients reported that their ED visits were redirected or endorsed by their regular care providers or family members despite the availability of community resources (Spence et al., 2008; Wise-Harris et al., 2017).

Perspectives from Healthcare Provider

Healthcare providers viewed that the provision of care in ED is often problematic, as interventions rarely provide solutions, rather they act as a Band-Aid until the patient's next visit (Bergmans et al., 2009). Patients often have comorbidities, with complex needs beyond what ED can provide, and treatment of patients who frequently visit ED is often inadequate without a wider, integrated community care response (Fleury et al., 2019a).

Lack of Social Support and Housing

Patients with MHA disorders face challenges every day, including housing issues, and lack of social support and social connection. Studies have found that a lack of reliable social networks during crisis, seeking external support, and having a safe and secure place to stay were identified to be contributing factors for ED visits among some patients (Aagaard et al., 2014; Schmidt, et al., 2020a, b).

Seeking Social Support

Schmidt et al., (2020a, b) found that due to limited social support and stigma towards patients with mental health disorders, patients felt isolated in the community. To relieve loneliness, patients visited ED where they could talk and interact with ED staff, where they felt seen and confirmed by ED staff. EDs also provided a refuge for patients to temporarily escape seemingly unmanageable situations (Parkman et al., 2017a; Poremski et al., 2020; Schmidt, et al., 2020a, b). Parkman et al. (2017a) found that patients in a specialized addiction program were more appreciative of the social aspect of activities that the services provided, including making friends and interacting with staff. Vandyk et al. (2018) suggested that social connections were critical to patient success in symptom management including timing and availability, and these social relationships helped stabilize patients' symptoms prior to accessing the ED.

Feeling Safe and Secure

For patients who did not have a stable home, a secure place to stay, or were homeless, ED was viewed as a safe and secure place where they could voice their needs for a professional approach, such as assurance of privacy and confidentiality (McCormack et al., 2015; Schmidt, et al., 2020a, b). There was an inherent feeling of safety associated with ED visits due to the immediate access to care and helpful staff (Parkman et al., 2017b).

Inadequate Community Resources

Both patients and healthcare providers viewed frequent ED visits as directly tied to the lack of community resources (Spence et al., 2008; Wise-Harris et al., 2017).

Self-management of Symptoms in the Community

Many patients presented with pre-existing conditions, suffering from MHA issues, or sometimes co-occurring with other chronic or acute health problems (Parkman et al., 2017b). Prior to visiting ED, they often experienced a pattern of deteriorating symptoms (Bergmans et al., 2009). In an effort to reduce ED visits, some patients implemented self-management strategies and coping skills, which included negative coping (e.g., substance use or self-harm) and positive coping (e.g., connecting with friends and family) (Vandyk et al., 2019). In an earlier study by Vandyk et al (2018), patients cited work or other volunteer activities as a key coping mechanism as it provided them with a sense of purpose and feelings of normalcy. Utilizing coping skills including participating new therapies and implementing new strategies has been reported to be associated with reduced ED visits among patients (Vandyk et al., 2018). For some, visiting ED only occurred when self-management failed (Vandyk et al., 2018).

Existing Community Resources

Many patients struggled with an array of challenges. However, patients felt existing community supports did not meet their complex needs (Parkman et al., 2017b). Additionally, patients often dealt with other issues simultaneously including unstable housing, poor social relationships, and/or being unemployed (Aagaard et al., 2014; Parkman et al., 2017a, b; Spence et al., 2008; Vandyk et al., 2018). Poremski et al. (2020) found that patients believed ED would allow them to

address their needs because someone would listen to their concerns, unlike in outpatient programs.

For existing services, some patients reported the Crisis Line having limited capabilities and usefulness (Vandyk et al., 2018). Another study examined the utilization of a specialized addiction service, and low usage of the services was evidenced (Parkman et al., 2017a). In this study, structural barriers were not found to be the reason for the low utilization, rather patients believed they did not require specialized addiction services for their addiction, and a lack of knowledge on what these services could provide was identified as a factor for the low usage (Parkman et al., 2017a).

Additionally, knowledge deficits of existing community resources were identified among ED staff to be a barrier for patients to access community services, therefore, patients were either not referred or referred to inappropriate community services before discharge from ED (Fleury et al., 2019b). However, Olsson and Hansagi (2001) found that referrals to community mental health services did not prove helpful as patients did not follow-up with these services, nor did they make changes to their help-seeking behavior.

Comprehensive MHA Services Care Required

Parkman et al. (2017b) found that community-based resources were often inadequate, and the lack of positive social support made these resources unappealing. As well, inconsistencies in coordination and continuation with mental health services exasperated the need for patients to visit the ED for mental health related issues (Fleury et al., 2019a). Healthcare providers suggested that in order to provide cohesive care and adequate support, comprehensive care including stable social connections and community services (e.g., learning coping skills via therapies, helping with employment or volunteer activities) needed to be included (Schmidt et al., 2020a, b). In the study by Fleury et al. (2019b), healthcare providers identified several barriers in patients' symptom management in EDs and communities including ineffective ED management, lack of resources causing long delays in accessing community services, inadequate services during non-business hours, and lack of training among ED staff regarding comorbid conditions among patients. In order to reduce MHA related ED visits, healthcare providers suggested utilizing existing resources more efficiently such as enhancing the quality of relationships with other health systems (e.g., Crisis Centers), and collaborating between MHA services leading to more appropriate referrals outside of ED settings (Fleury et al., 2019b).

Experiences of ED Visits

The experiences of frequent ED visits according to patients and healthcare providers were mostly negative.

Assessment, Discharge, and Consultation

Patients viewed assessments in ED as acting as 'gatekeepers', causing concern about whether they were 'sick enough' to receive care as a result of past experiences of rejection (Aagaard et al., 2014). Patients also felt that they were discharged without their concerns addressed or before being fully stabilized (Vandyk et al., 2018; Wise-Harris et al., 2017). Patients with addiction issues reported that healthcare providers focused more on their addiction, but their mental health related symptoms were ignored, and they believed that their MHA symptoms should be treated concurrently (Lincoln et al., 2016).

Being Known

As frequent ED visitors, positive experiences were premised on ED staff providing care that met patients' needs, while negative experiences were related to ED staff assuming the reasons for patients' ED visit or speaking to patients unprofessionally (Vandyk et al., 2018). Patients felt care suffered once they had been identified as a "frequent flyer" which negatively impacted their ability to seek and find ongoing care (Spence et al., 2008; Wise-Harris et al., 2017).

Stigma, Discrimination, and Unsympathetic Treatment

Patients felt stigmatized, discriminated against, and received unsympathetic treatment because they had MHA issues and repeated ED visits (Wise-Harris et al., 2017). The long waiting time for having an assessment in ED was viewed as evidence of stigmatization, and unsympathetic ED staff made patients feel unwelcome (Wise-Harris et al., 2017). Patients also felt disrespected and receiving sub-optimal care such as short consultation time, being rushed, and judged poorly by healthcare providers (Vandyk et al., 2018).

Problematic Behavior

Disruptive behaviors among patients in ED were documented including aggression and agitation (Bergmans et al., 2009; Spence et al., 2008). Long wait times for assessment, multiple interviews, and confinement in ED were seen as the main causes of patients' disruptive behaviors (Bergmans et al., 2009; Spence et al., 2008). Healthcare providers expressed that disruptive behavior was associated with the stressful nature of the ED, which increased their frustration with patients, and affected the service and care patients received (Bergmans et al., 2009; Spence et al., 2008).

Interaction with Healthcare Providers

Patients reported that interactions with ED doctors often were positive, however interactions with nurses varied with reported positive (e.g., caring and understanding) and negative (e.g., disrespectful and judgmental) experiences (Bergmans et al., 2009; Olsson & Hansagi, 2001; Vandyk et al., 2018; Wise-Harris et al., 2017). Patients reported that security staff lacked understanding and/or the training to work with patients with MHA issues (Vandyk et al., 2018). Interestingly, before arriving at ED, patients perceived police encounters to be positive and felt as though they were cared for. Conversely, experiences with paramedics who transport patients to the ED were discussed as lacking sensitivity and compassion (Vandyk et al., 2018).

Quality Appraisal

Based on CASP assessment, five out of 17 selected studies were rated as high quality (score received 14–16) (McCormack et al., 2015; Parkman et al., 2017a, b; Schmidt, et al., 2020a, b; Vandyk et al., 2018), in which three studies obtained a full score of 16 (McCormack et al., 2015; Parkman et al., 2017a; Vandyk et al., 2018), nine studies scored in the medium range of quality (score received 10–13) (Bergmans et al., 2009; Fleury et al., 2019b; Lincoln et al., 2016; Poremski et al., 2020; Schmidt et al., 2018, 2020a, b; Spence et al., 2008; Vandyk et al., 2019; Wise-Harris et al., 2017), and three studies earned a score of low quality (score received 8–9) (Aagaard et al., 2014; Fleury et al., 2019a; Olsson & Hansagi, 2001) (Table 1).

Section A in CASP evaluates the validity and methodology. Studies that did not receive full points in this section, showed inadequate discussion of the relationship between researchers and participants, question development/inclusion criteria, failure to consider saturation, and issues with research design (Aagaard et al., 2014; Fleury et al., 2019a; Lincoln et al., 2016; Olsson & Hansagi, 2001; Schmidt et al., 2018, 2020a, b; Spence et al., 2008; Vandyk et al., 2019). Section B in CASP reviews study procedures, methods, and results. Studies lost points for this section due to inadequate discussion of ethics and confidentiality, lack of recruitment information, researcher roles not fully examined, results not explicitly reflecting or supporting themes, rigour in data analysis, and a lack of discussion on data discrepancy (Aagaard et al., 2014; Bergmans et al., 2009; Fleury et al., 2019a, b; Lincoln et al., 2016; Olsson & Hansagi, 2001; Poremski et al., 2020; Schmidt et al., 2018, 2020a, b; Vandyk et al., 2019; Wise-Harris et al., 2017). Section C in CASP assesses the generalizability of research findings. Studies with an insufficient discussion of the implications and transferability of findings received a less perfect score (Aagaard et al., 2014; Lincoln et al., 2016; Olsson & Hansagi, 2001; Poremski et al., 2020; Schmidt et al., 2018, 2020a, b; Vandyk et al., 2019; Wise-Harris et al., 2017).

Discussion

Four major themes were identified in the current review, however, one encompassing theme was evidenced: inadequate community resources and/or existing community resources not meeting the needs of patients. Whether ED visits were inevitable, lack of social support and housing, and their ED experiences were directly or indirectly linked with community resources.

Are ED Visits Inevitable?

In the current reviews, some patients' ED visits were inevitable due to experiencing acute psychiatric symptoms or combined acute physical and psychiatric conditions (e.g., acute psychosis, suicidal behavior, medical emergency), and thus needed immediate medical attention. However, for patients who presented with non-acute symptoms, or visited EDs due to lack of social support or housing, or lack of mental health services during non-business hours, their needs or issues could be managed in the community. For example, psychotropic medication related issues were identified in several of the studies as a factor for ED visits. These visits often took place during non-business hours, which could easily be addressed by community mental health nurses or mental health workers following up with patients in the community, such as reminding patients about the date of medication refill and injectable medication, and help patients make an appointment with their physician for medication adjustments based on patient's response to the medication trial. For patients with alcohol intoxication, rather than go to ED, most (except medical emergency) should go to detox centers where they can receive proper care with experienced staff as most intoxication and withdrawal symptoms can be managed with supportive care (Black & Andreasen, 2014). However, lack of community resources including staff and detox centers or being unsatisfied with existing community services may result in individuals visiting ED with non-acute conditions.

Lack of Social Support

Inadequate social support was reported as a major contributing factor for ED visits in the current review. Lack of social support and social connections result in loneliness and social isolation that are common in individuals with mental illness (Beutel et al., 2017), as social support/connection has been identified as essential in recovering from mental health problems since it decreases isolation, increases access

to resources, and supports individuals in their journey to recovery (Leamy et al., 2011). There are social intervention programs developed to address social support and connection among individuals with mental health problems. For example, peer-support programs are a popular form of social support and social connection, and have played a positive role in patients' outcomes including improved functioning, quality of life, and satisfaction with care, and housing stability, and increased patients sense of belonging and hopefulness while decreased psychiatric symptoms, substance use, hospitalization, and crisis services utilization (Davidson & Guy, 2012; van Vugt et al., 2012; Vayshenker et al., 2016). However, peer-support programs may face some challenges. To be effective, peer-support programs with peer and non-peer mental health workers should be well integrated into the mental health services, and require organizational support including guidance and training (e.g., how to utilize peers, negotiate professional boundaries and accommodating their mental health needs) (Mancini, 2018).

Another intervention has been prompted by the National Health Service (NHS) in England: Social Prescribing (SP) (NHS, 2019). SP enables healthcare providers to make a referral for patients to link workers who help them identify and access activities provided by voluntary, community, and social enterprise organizations at a community level (NHS, 2019). Dayson et al. (2020) found that SP has been associated with improved emotional, psychological, and social wellbeing for patients with mental illness by providing opportunities for sustained engagement in community activities, including participation in peer-to-peer support networks and volunteering.

Lack of Stable Housing

Studies found that safe and stable housing is associated with enhanced social and community integration, in turn, the integration can provide individuals opportunity to access resources including social, emotional, and instrumental supports, make them feel a sense of acceptance and belonging, which can lead to improved physical and mental health in individuals with MHA disorders and homelessness (Cherner et al., 2017; Durbin et al., 2019). Different supportive housing projects in different countries have been developed to help individuals have a stable and safe place to stay although outcome evaluations on these projects have produced mixed findings (Henwood et al., 2013; Kirst et al., 2020). For example, The Housing First project in Canada is an example of addressing housing needs among individuals who experience MHA disorders and homelessness without prerequisites (e.g., some housing projects require individuals to be sober or who are engaging in treatment) (Kirst et al., 2020). A majority of evaluation studies on Housing First showed positive outcomes in physical and mental health, and quality of life (Kirst et al., 2020). Providing safe and stable housing to individuals with MHA disorders has faced ongoing challenges, and more innovative interventions and research are needed.

Discharge Planning

An estimated 20% of patients who visited ED for MHA reasons return for a second ED visit within 6 months (Newton et al., 2010). While patients in nine of the studies reviewed, a clear definition of frequent ED visitor emerged (visited ED ≥ 5 times in the past 12 months) whether they were admitted to inpatient care or discharged from ED. Issues with discharge from ED were identified as a factor for frequent ED visits in the current review, while psychiatric inpatient discharge was also associated with repeated ED visits. Researchers have suggested the period immediately following discharge from inpatient care presents increased risks of serious and even life-threatening adverse outcomes, possible risk factors include premature treatment disengagement, which in turn increases the risk of relapse, ED re-visit, and re-hospitalization (Kalseth et al., 2016; Mann, 2014), unstable housing or homelessness (Nesper et al., 2016), and suicidal behavior (Kalseth et al., 2016). Smith et al.(2020) examined over 15,000 patients who were discharged from psychiatric inpatient care, and found that making an appointment with an outpatient mental health provider following discharge was associated with successful care transition. Making follow-up appointments with outpatient mental health providers has been approved as a cost-effective way to enhance discharge planning, improve continuity of care, and increase rates of successful transitions, thus reducing hospital re-admission (Smith et al., 2020). Although there is limited research on ED post-discharge, scheduling follow-up appointments with mental health providers in the community before patients are discharged from ED may result in a similar successful transition from inpatient care to the community.

ED Experience and Alternative Programs

As vulnerable individuals, patients with MHA issues should be treated with respect and sensitivity via interpersonal interactions in ED and other healthcare services, and their concerns should be addressed before discharge. Instead, the current review revealed that patients were seen as "hard to treat" or "difficult patients", and patients felt rushed and their needs were not met, which may be the result of a lack of MHA training among healthcare providers, an overcrowded and intensive environment in ED, lack of resources in ED, and staff burnout (Gaeta, 2020; Salway et al., 2017).

Innovative alternative destination programs have been developed to address issues with MHA related ED visits.

For example, a novel, pilot emergency medical services integrated program to treat patients experiencing MHA crises in a large urban county in the United States of America. This program allows some patients experiencing a MHA crisis, without acute medical care needs, to be transported to a dedicated community mental health center (CMHC), which maintains a 24/7 Crisis and Assessment Services as an alternative destination to ED (Creed et al., 2018). CMHC has successfully connected patients experiencing crises with mental health and substance use (Henderson et al., 2019). In a qualitative study by Thomas et al. (2018), many patients who used the CMHC services, reported they liked the program because of privacy, their basic needs being met, open communication, active involvement in their health-related decisions, and follow-up care (e.g., discussion of options of referral, referral matching, and referral made before discharge). Another study investigated the re-visit rate of the CMHC program, and found the repeated visit rate of CMHC was significantly lower in comparison with ED repeated visits (34% vs 68% respectively) (Henderson et al., 2019).

Utilizing Technologies

There is growing interest in enhancing mental health services via technology with programs being delivered via web or mobile apps that may help to expand the reach of community MHA services and reduce the demand for MHA services. For example, internet-based cognitive behavioral therapy has been successfully utilized in treating patients with mental health disorders in different countries (Titov et al., 2018). However, technology-delivered MHA services are not routinely integrated into community MHA services, and most have been primarily established by researchers (Lattie et al., 2020). To date, studies examining the use of technological tools for MHA services found that a majority of the tools have been unsuccessful (Bertagnolli, 2018; Gilbody et al., 2015). This in part was due to the process of tool development which did not involve target users, and thus did not meet their needs (Lattie et al., 2020). More studies on developing and implementing technology-based MHA tools including target users (e.g., healthcare providers, patients) are required.

Digital technology has also been used in aiding intervention engagement (Pithara et al., 2020). For example, Care Pathway Tool (CPT) in England, a shared care planning in community-based mental health services, aimed to use technology tools (i.e., mobile app) to improve care delivery and facilitate collaborative work in care planning for patients. This recovery-focused care plan involving patients in their care planning provides healthcare providers and patients direct access to the electronic care plan, thus enhancing effective collaborations resulting in a new form of interaction (Pithara et al., 2020).

Community Resources

Underfunded MHA services have been reported in different countries (Cohen & Peachey, 2014; Kohn et al., 2018; O'Neill & Rooney, 2018), and the current review is in agreement as lack of community resources were identified by patients and healthcare providers as a major contributing factor to frequent ED visits. To address community resources, adequate staff and services including MHA healthcare providers, detox centers, and other resources are vital for accessing timely and satisfactory services that meet patients' needs. Training is essential for staff working with patients living with MHA disorders such as knowledge of MHA disorders, and education on MHA stigma. Social support programs require MHA workers or social workers or link workers to implement while housing, ED alternative programs, and utilizing technologies need financial support. Finally, evaluations of existing community programs regularly are the key to improving the quality of the programs, thus meeting the dynamic nature of patient's needs.

The main limitation of this review is that not one study explored patients' perspectives of how to improve existing community services, and nor were they asked what kind of services would meet their needs in the community as they have first-hand experience in utilizing community resources. Second, few studies addressed patients' engagement with other treatments or programs in the community, and their relation to their ED visits. Third, only one study discussed organizational structure and processes in relation to ED visits. Fourth, all selected studies were conducted in developed countries and were published in English, which may limit views on the context of frequent ED visits.

In conclusion, it became apparent that lack of community resources was directly associated with frequent MHA related ED visits in this review. To address the issue is a complex undertaking that requires services that meet patients' needs via both traditional community programs and innovative intervenetions, and most importantly needs commitment from communities and governments of all levels.

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