

9-8-2008

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**Why Do Patients Seek Emergency Psychiatric Care?
Their Reasons and Characteristics**

A Thesis Submitted to the
Yale University School of Medicine
In Partial Fulfillment of the Requirements for the
Degree of Doctor of Medicine

By
Peter Chih-chi Yang

2007

Abstract

WHY DO PATIENTS SEEK EMERGENCY PSYCHIATRIC CARE? THEIR REASONS AND CHARACTERISTICS. Peter C. Yang, Seth Powsner. Department of Psychiatry, Yale University, School of Medicine, New Haven, CT.

Many believe that psychiatric emergency services (PES) are misused, but there is little empiric data available addressing this issue. We investigated reasons patients actually sought emergent care, and whether alternative facilities could have addressed their needs.

We reviewed 200 consecutive evaluations in a teaching hospital emergency department via chart review. Data collected included psychiatric history, substance use, and contributing etiologies. PES clinicians involved were asked directly about underlying reasons for emergent care and whether suitable care could have been provided in a less acute setting.

Acute behavioral disturbances proved to be the most frequent reason for emergency visits. Half of all visits were because of uncontrollable, potentially uncontrollable, or unacceptable behavior. Direct provider referrals accounted for 31% of visits. Inability to cope with life events accounted for another 6%. Traditional psychiatric illness was a contributing factor in most visits (67.5%); other significant factors were relationship problems (20%) and substance abuse (16.5%). Alternative facilities could have taken care of 26% of visits.

We found that the vast majority of emergent psychiatric visits warranted immediate attention; only a minority (13%) of visits were not urgent. Patients who did

not require emergency care could have been served by walk-in clinics, drug detoxification facilities, or faster access to outpatient treatment.

Acknowledgements

Thank you to Dr. Powsner for your guidance, patience, and support. Special thanks to all of the staff in the Crisis Intervention Unit for helping me get up to speed, always making me feel welcome, and for the laughs.

A heartfelt thanks to mom, dad, Grace, John, and my friends for their continued love and support, without which any of this would be possible.

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Introduction

In the mid-1990's, Hillard defined psychiatric emergencies as “any behavior that cannot be dealt with as rapidly as needed by the ordinary mental health, social service, or criminal justice system in a community” (1). Psychiatric emergency services (PES), he explained, functioned as a “final safety net for people whose needs are not met elsewhere in the human service system.”

The Community Mental Health Centers Construction Act of 1963 (PL 88-164) listed psychiatric emergency services as necessary parts of community mental health centers (2-4). The Act also contained provisions that obligated mental health facilities to serve patients who were unable to pay for services. Instead of being kept for many years in inpatient psychiatric facilities, patients in the 60s and 70s received routine care in the community and were admitted as inpatients for briefer periods during acute crises as psychiatric care was deinstitutionalized. PES served not only individuals in the community who required immediate evaluation, but also the underprivileged and chronically ill who lacked adequate access to the regular health system. Throughout the latter part of the 20th century, there was a further shift from inpatient psychiatric care toward outpatient, community-based care (5).

In 2003, Appelbaum decried a “quiet crisis in mental health services” precipitated by declining reimbursements for mental health services (6). He argued that insufficient reimbursement decreased available outpatient care, reduced available inpatient beds, and generally restricted access for the uninsured. Hospitals facing financial pressures considered closing psychiatric and addiction treatment services (7). Unable to arrange regular care, many patients' mental health deteriorated to a point requiring PES. Whether

they were only supplements or outright alternatives to existing outpatient and inpatient services, PES became a vital resource that helped meet the needs of local psychiatric patients (2, 8-12).

Previous studies supported Appelbaum, showing that availability of community-based services affected both the quantitative and qualitative range of cases seen at local hospitals (13). Alternatives to inpatient hospitalization facilities, such as *crisis-respite* homes, can reduce the time patients spend in PES (14, 15). But, letting patients deteriorate until they require emergency department care, rather than arranging alternatives like walk-in clinics, is not an efficient approach for mental health systems (5, 16-18).

Psychiatric visits constitute a significantly increasing proportion of all ED visits (19). Nationwide PES visits increased 15% from 1992 to 2000—out of proportion to overall emergency visits (19, 20). ED staff point out there has always been some abuse of emergency services for medication, food, and shelter (5, 21-23). However, it is unclear what factors accounted for this increased demand for PES. There have been conscientious efforts to raise public awareness about mental illness so that individuals who may be ill are more quickly brought to medical attention (24). However, some staff theorized that PES workload increased in part because these efforts to de-stigmatize mental illness unintentionally reduced the stigma associated with feigning mental illness.

There are inherent disadvantages to providing care in an emergency setting. Emergency care is more expensive than routine care: in an ED, physicians often take additional precautions to cover worst case scenarios when evaluating unfamiliar patients. Psychiatric emergency services expend resources that might go to provide faster

treatment of traditional emergencies. The additional effort hospital staff expends to evaluate patients in an ED for non-emergent psychiatric treatment also reduces their ability to provide timely care to more urgent psychiatric cases. Moreover, less intense settings such as walk-in clinics, could provide comparable treatment at lower cost (5, 16-18).

Considerable effort and expense goes into the 4,600 psychiatric evaluations performed annually in the Emergency Department (ED) at Yale-New Haven Hospital (YNHH). Nevertheless, patients suffering from recurrent episodes of mental illness might do even better being treated by physicians with whom they have an existing clinical relationship (25, 26). Clinicians who have established relationships with their patients are more familiar with their symptoms and treatments, have access to more reliable information, and can be comforting, familiar faces in times of crisis and distress.

There is little published data available about the frequency with which PES visits are associated with specific types of problems. Some PES visits are triggered by dangerous behavior, symptoms of traditional psychiatric illness, and substance abuse (27). Repeat visits have been attributed to individuals who suffer from more severe illness, have difficulties arranging treatment, and are of certain demographic groups (5, 23, 28-31). There are also instances where emergency department care may not be needed at all. For example, family or friends caring for someone with a mental illness may become overwhelmed by a small crisis and bring that person to the ED because they do not know where else to turn. Likewise, some patients with poor access to the healthcare system come to an ED because they do not know of other treatment options.

Occasionally, people feign symptoms to obtain food and shelter, or to access services (e.g., substance abuse treatment). During hotter weather or precipitation, some patients repeatedly present for emergency services (23). Absence of a cold weather effect is notable, but poorly understood. The *check effect* is a phenomenon that has been observed in patients who receive benefit checks early each month and indulge in illicit substances (23, 32-37). Soon thereafter, they present for emergent care, seeking relief from the consequences substance abuse.

Understanding *why* patients sought PES could reveal information about how adequately the rest of a local healthcare system handles patients with psychiatric needs, as well as offer suggestions about how they could be better served. Perhaps an ED is the only facility open during some hours that patients need treatment. Maybe local patients are unable to find a medical provider that they can turn to for psychiatric issues: people may not be aware of their other medical treatment options. In one small sampling, half of patients surveyed said that they did not have an established plan for crisis situations, and 21% of them said that they had difficulty obtaining access to healthcare elsewhere (27). In such circumstances, it is predictable that people would default to known emergency services.

There is little data describing the advantages that patients and their families may feel are offered by PES. What matters to them in times of crisis? PES do offer prompt attention to patients in distress; PES patients in one survey often felt out of control, were afraid, and/or needed support (e.g., after relationship difficulties) (27). On the other hand, it is important for patients to be involved in planning their treatment, to stay informed about plans and referrals, to be heard and have more time spent on them by care

providers, and to have good relationships with supportive care providers (27, 38, 39). All of these are less likely in an ED setting. Patients might be expected to have established relationships with some outpatient provider. However, for people who lack regular care and regularly utilize emergency services, PES clinicians may offer a level of comfort and familiarity. Patients may also appreciate help that emergency services provide in obtaining referrals, self-help literature, and assistance with medication expenses (27). It is notable that patient *families* have expressed greater interest than patients themselves in seeking medication and admission for a first psychotic episode (39). All in all, there may be many reasons patients seek emergency psychiatric care and the problems affecting their health care remain poorly understood.

A limited amount of information is available from PES visits themselves. ED records of psychiatric evaluations contain details about patients' psychiatric medical histories, but often omit specific information about why patients present to an ED instead of a clinic or office. It can be hard to tell from ED records if visits were truly emergencies, or if patients could have been adequately treated elsewhere.

PES clinicians do make many clinical observations that go beyond what is routinely recorded in written records. By drawing upon their professional experience, patients' histories, and information gathered from collaterals and nursing staff, PES physicians often have a more complete understanding of the multiple factors contributing to patient visits that goes beyond the final diagnosis. For example, although a patient carried a diagnosis of major depression and presented with suicidal ideation, a clinician realized that the precipitating event for this individual was discovering that her spouse was having an affair. In another case, even though a patient initially told emergency staff

that he was having suicidal thoughts, it became apparent that he never planned to harm himself. The patient actually was seeking help for his cocaine addiction and had been told by friends that he would be most likely to receive help by saying that he was suicidal.

In this study, we sought to determine the primary reasons patients presented to our PES for care, and what chronic problems contributed to their troubles. Speaking to PES clinicians soon after patients were evaluated allowed us to gain insight about the complex circumstances surrounding their decision to seek PES. In addition, we examined how often PES clinicians felt alternative services could have provided adequate care to patients, thereby revealing opportunities to improve the local mental health system.

Specific aims and research questions

Specific aims:

1. To determine the main reasons patients obtain emergency psychiatric evaluations at Yale-New Haven Hospital: uncontrollable behavior, convenience, professional referrals, food/shelter, lack of alternatives, need for medication, etc.
2. To determine how frequently certain patient conduct leads to psychiatric evaluation: suicide attempts, violence toward others, bizarre behavior, etc.
3. To determine what acute and chronic psychiatric and social issues contribute to patients' emergency visits: traditional psychiatric illnesses, substance abuse, relationship problems, side effects from medication, medication non-compliance, etc.
4. To assess the demographics of the patients presenting to the ED for psychiatric help.
5. To evaluate what alternatives there may be to emergency psychiatric care.

Research questions:

1. Do a majority of psychiatric patients treated in the ED require immediate care?
2. How much of a care burden could be alleviated by greater availability of alternative treatment options?

Methods

Setting

This study was conducted in the Crisis Intervention Unit of Yale-New Haven Hospital, a 944-bed tertiary care facility that serves a moderately-sized urban center and its surrounding area. The Crisis Intervention Unit is an eight-bed locked psychiatric emergency facility within the Emergency Department. It is staffed by a psychiatrist or psychiatric resident at all times and is the only such unit staffed 24/7 in Connecticut. The hospital handles 462,000 outpatient visits, 96,500 emergency visits, and 4,600 emergency psychiatric evaluations a year of patients 16 years or older (40). There are several walk-in, state-funded psychiatric clinics nearby. A local Veterans Affairs hospital attends to veterans' needs. Long established psychiatric training programs foster a larger than average number of mental health professionals in our area. In Connecticut, there is approximately one licensed psychiatrist for every 2,500 citizens (one per 4 square miles), compared to a nationwide average of one per 9,200 citizens (one per 121 square miles) (41).

New Haven County has a population of 847,000 and is composed of 71.9% Caucasians, 12.6% African-Americans, 10.5% Hispanics, 3.2% Asians, and 1.8% multi-racial or other (42). The median household income is \$50,700, and per capita income is \$24,400. 9.4% of the population is below the poverty line.

Data collection

We examined a block sample of 200 consecutive visits to our PES during the summer (15 days). All patients who presented to our service during the sample period

were included. We collected data via chart review to avoid affecting patient care by necessitating consent. Every evaluation was treated as an individual event, regardless of a patient's prior visits; each visit requires a fresh evaluation. (There were only two return visits by two different people during this 15-day period.) Social class was estimated from education and employment according to Hollingshead's Two Factor Index of Social Position (43). Our institution's Human Investigation Committee approved this study.

The author used an abstraction form (Form 1) to collect data from patient charts for all visits included in this study. Demographics, psychiatric and substance abuse histories, recorded reasons for seeking emergent care, and contributing factors to visits were recorded. He interviewed PES clinicians within 24 hours using the same abstraction form to verify data about each visit. Quick, direct access to clinicians resolved the usual problems of charting omissions and ambiguities. The author met with the PES Medical Director (thesis advisor) every few days to verify and review data about patient visits.

Form 1: Data Abstraction Form. (Page 1 of 2)**Demographics & Social**

Day: S M T W R F A Arrival time _____ AM/PM Depart time _____ AM/PM
 Transportation to ED: walking (walk)/ car/bus (car)/ ambulance (amb)
 Age: _____ (>88 code 90) Race: Afro-Am (aa)/ Asian (as)/ Cauc. (c)/ Hispanic (h)/ Native Am. (na)/ other (o) Sex: M F
 Zip Code _____ (first 3 digits) Known primary care physician Y N
 Insurance: none (-)/ Medicare/Medicaid (med)/ third party (thir) Marital: sing mar wid sep div
 _____ Voluntary (vol)(patient initiated); _____ forced, pushed: by family (fam)/ friend (fre)/ facility (fac)/medical professional (med)/ police or other public servant (pol)/ court/probation officer (off)/ religious official (rel)/ other (oth)(stranger)

Chief complaint _____

From another facility: _____ Lockup (lock)/ _____ Prison (pri)/ _____ Court (cour)
 Clinical facility: State / Private (s/p)
 _____ Clinic (cli)
 _____ Intensive OutPatient (iop)/ _____ Partial Hospital Program (php)
 _____ Group home (MR (ghm)/ Psychiatric (ghp)/ Substance abuse (ghs))
 _____ Supervised living (MR (slm)/ Psychiatric (slp)/ Geriatric (slg))
 _____ Nursing home: placed for frailty (nha)(age)/ medical condition (nhm)/ psychiatric, other disability (nhp) shelter other
 Existing medication: sedative (sed)/ anxiolytic (anx)/ antipsychotic (psy)/ antidepressant (dep)/ mood stabilizing (mood)/ none (-)

History

Past treatment inpatient (inp)/ outpatient (out)/ none (-)
 Known/previous diagnosis: dep bip schiz saff none (-)
 Previous visits: How long ago _____
 Comorbidities, substance abuse: in treatment (itre)/ previously treated (ptre)/ previously diagnosed (diag)/ admitted (adm)/ suspected (sus)/ none (none)
 Which substances: alc mari coc narc sed/benz stim pcp ohal unc
 When, how much last used _____
 Education: 1) Grad-Professional (grad) 2) College degree (col) 3) Some college (scol) 4) High School Grad (hs) 5) Partial HS (shs) 6) 7th-9th grade (jhs) 7) <7th grade completed (ele)
 Employment status of main wage earner(s) in family: 1) executive / professional (exec) 2) upper management (um)
 3) middle management / small businessman (mm) 4) shop keepers / clerical staff / technicians (shop) 5) skilled workers (skw) 6) semiskilled workers (ssw) 7) unskilled workers (usw) 8) unemployed (unem) (receiving unemployment checks? Y / N) / homeless (home)/ incarcerated (inc)(arrested / committed?) / other source (oth)(illicit? Y / N) SSI?
 Breath / Serum Alcohol; Urine Toxicology results _____
 Injuries _____

Conduct and life problems

_____ Suicidal (act min tho)	_____ Shelter
_____ Violent (act min tho)	_____ Traditional psychiatric illness
_____ Other dangerous behavior	_____ Missed diagnosis _____
_____ Bizarre behavior	_____ Substance abuse intx fam mood psy unk
_____ Disorganized, unable to look after self	_____ Side effects from meds _____
_____ Relationship problems	Notes: _____

Form 1: Data Abstraction Form (cont'd). (Page 2 of 2)**Reason for visit to ED** (instead of another treatment facility)

- | | |
|--|--|
| <input type="checkbox"/> Uncontrollable, potentially uncontrollable, unacceptable behavior (beha) | <input type="checkbox"/> No pre-existing relationship with clinician, or only tenuous one (past care long time ago /only one visit) (nrel) |
| <input type="checkbox"/> Overwhelmed (over) | <input type="checkbox"/> Had been to ED before, liked ED (ed) |
| <input type="checkbox"/> No alternative available in timely fashion (time) | <input type="checkbox"/> Most convenient location, time (conv) |
| <input type="checkbox"/> No known alternative at another facility, "didn't know where else to go" (nkno) | <input type="checkbox"/> Need medication (med) |
| <input type="checkbox"/> Provider referral (ref) | <input type="checkbox"/> Missed regular psychiatric treatment appointment (miss) |
| <input type="checkbox"/> Financial factors (insurance doesn't cover at another facility) (fin) | <input type="checkbox"/> Need shelter (shel) |
| | <input type="checkbox"/> Here by mistake (mstk) |

Alternative to ED for treatment:

- | | |
|--|--|
| <input type="checkbox"/> Walk-in clinic (clin) | <input type="checkbox"/> Crisis respite (resp) (counseling, social worker) |
| <input type="checkbox"/> Mobile crisis unit (mob) | <input type="checkbox"/> More flexible insurance benefits (ins) |
| <input type="checkbox"/> Quicker office appointment (quik) | <input type="checkbox"/> None (-) |
| <input type="checkbox"/> Walk-in detox/rehab (dtx) | |
| <input type="checkbox"/> Alternative shelter (shel) | |

Etiology

- Major Depression or other Depressive Disorder
- Bipolar Disorder (type I or II)
- Schizophrenia
- Schizoaffective Disorder
- Psychosis
- Intoxication (alcohol / drugs--marijuana / cocaine/crack / narcotics / sedative/benzo / stimulants / PCP / other hallucinogens / uncertain)
- Relationship problems
- Personality disorder "decomposition"
- Stopped taking medication/ran out
- Bereavement
- Malingering
- Other

Restraints: on entry (ent)/ later (late)/ intermittent (int)/ continual (cont)

Medication received in ED: anxiolytic (anx)/ antipsychotic (psy)/ antidepressant (dep)/ benzodiazepine (benz)/ other sedative (sed)/ mood stabilizing (mood)/ other (oth)

Emergency Treatment Outcome

Medical condition: unchanged (unch)/ improved (imp)/ worsened (wors)

Clinical Global Improvement Scale: I II III IV

Patient went: home (hom)/ back to facility (fac)/ clinic (clin)/ admitted to hospital (hos)/ shelter (shel)/ jail/lockup (jail)/ streets (stre) / crisis respite (resp)

Returned: Y N

Comments

Criteria used to categorize patient visits were established by an *a priori* review with our clinical staff. We sought to determine the actual reasons patients sought emergency care (Tables 1 & 2). These are distinct from diagnoses and social circumstances (both of which are often chronic, not explaining any specific visit). For example, a manic patient running through traffic proclaiming a formula for increased gas mileage comes to PES because of his *uncontrollable behavior*. This patient has a traditional psychiatric diagnosis of bipolar disorder, which actively contributed to his visit. If he were coincidentally homeless, it would not be deemed directly relevant to his visit. Another illustrative example would be a young man sent by his internist for initiation of antidepressant therapy: he comes to our PES because of a *provider referral*. He does meet diagnostic criteria for major depression, but is not suicidal, and presents only on his internist's recommendation. We developed our criteria by reviewing 62 consecutive recent PES visits and polling clinicians for broad types of reasons patients could be triaged to our PES from our ED.

We lumped together uncontrollable, potentially uncontrollable, or unacceptable behavior from our experience that family, friends, and police were often imprecise reporters. Sometimes only an ambulance run-sheet was available to give a sketchy description of events. Still, there was usually some information making it clear when there was behavior far out of the norm. Where details were available, we tallied them separately, e.g., suicide attempt, violent comments (no act), etc.

Data was recorded onto a spreadsheet file (Excel). Descriptive statistics and tabulation were generated by spreadsheet functions, sorting, and counting.

Table 1: Reasons For Emergency Care (in order of precedence). Only the primary reason for seeking emergency care as determined by PES clinicians was recorded.

provider referral	referral by any professional, including outpatient internists, emergency department, etc.
uncontrollable, potentially uncontrollable, unacceptable behavior	patient is feared to be a risk to themselves or others
Unable to cope with current life event	event in patient's life is responsible for severe emotional distress; overwhelmed; no concern for immediate danger
seeking shelter	patient primarily seeks food and/or housing
here by mistake	patient actually seeking another type of facility, such as detox
most convenient location	patient is aware of other locations to obtain care, but hospital is easiest to reach
no alternative available in a timely fashion	patient is aware of other locations, but hospital offers prompter care, such as on a weekend or after hours
no known alternative	patient is unaware of any other locations to obtain care
needed medication	patient is stable and presents only seeking additional medication
had been to ED before, liked ED	patient is clinically stable and presents for social reasons

Table 2: Specific Patient Behaviors (tallied separately). (Patients could have exhibited multiple or none of the following behaviors.)

suicidal	concern that patient intentionally or may intentionally put their life in danger
violent	patient injures or may injure another individual or property
bizarre behavior	patient behaves markedly out of accordance with societal norms
disorganized, unable to look after self	patient is not fully oriented or unable to perform activities of daily living
other dangerous behavior	patient's actions may cause harm to self or others, but without suspicion of active intent

Results

Men and women were seen in equal numbers for psychiatric evaluation (Table 3). The mean age of patients seen was 38.5 years old. Compared to published demographics for this county (42), African-Americans were overrepresented, accounting for 22.5% of patients treated. Caucasians and Asian patients were slightly underrepresented. A minor gender difference was observed in Hispanic patients, where women outnumbered men 5:3.

Table 3: Demographics

	M (%)	F (%)	Total (%)
Caucasian	65 (32.5%)	64 (32%)	129 (64.5%)
African-American	23 (11.5%)	22 (11%)	45 (22.5%)
Hispanic	9 (4.5%)	15 (7.5%)	24 (12%)
Asian	2 (1%)	0 (0%)	2 (1%)
16-17	6 (3%)	4 (2%)	10 (5%)
18-24	16 (8%)	17 (8.5%)	33 (16.5%)
25-34	20 (10%)	22 (11%)	42 (21%)
35-44	25 (12.5%)	26 (13%)	51 (25.5%)
45-54	23 (11.5%)	19 (9.5%)	42 (21%)
55-64	2 (1%)	6 (3%)	8 (4%)
65+	7 (3.5%)	7 (3.5%)	14 (7%)
Mean age \pm SD	37.8 \pm 15.3	39.2 \pm 16.0	38.5 \pm 15.6
Total	99 (49.5%)	101 (50.5%)	200 (100%)

Race: $X^2=20.0995$, $p<0.001$

Table 4: Social Class & Insurance Status

	None (%)	Medicaid/ Medicare (%)	Third Party (%)	Uncertain (%)	Total (%)
1	1	0	4	0	5 (2.5%)
2	2	2	5	0	9 (4.5%)
3	1	10	16	0	27 (13.5%)
4	11	41	35	1	88 (44%)
5	6	27	13	0	46 (23%)
Uncertain	5	14	6	0	25 (12.5%)
Total	26 (13%)	*94 (47%)	*79 (39.5%)	1 (0.5%)	200 (100%)

(* two visits covered by both Medicare and a third party were counted as third party)

Most visits were covered by Medicare/Medicaid (47%) or a third party managed care plan or traditional insurance program (39.5%) (Table 4). Nevertheless, 13% of patients had no known insurance coverage. The Hollingshead Two Factor Index of Social Position estimates social class based upon people's completed education and occupation (43). Individuals of social class 1 have the most education and more lucrative jobs, whereas individuals of social class 5 have less education and more entry-level type jobs. The majority of our patients were of lower social classes; 67% of patients seen belonged to social class 4 or 5. About 1 in 8 individuals in classes 4 and 5 did not have insurance coverage. There was a trend toward a greater proportion of individuals being covered by Medicaid/Medicare in lower social classes. The person in social class 1 who did not have insurance was a middle-aged private business owner who had relapsed on cocaine.

Table 5: Race and Insurance Status. Percentages are of total type of insurance within each race.

	None (%)	Medicaid/ Medicare (%)	Third Party (%)	Uncertain (%)	Total
Caucasian	14 (11%)	62 (48%)	53 (41%)	0	129
African-American	6 (13%)	25 (56%)	13 (29%)	1 (2%)	45
Hispanic	6 (25%)	7 (29%)	11 (46%)	0	24
Asian	0	0	2 (100%)	0	2

The greatest percentages of uninsured patients were observed to be, in descending order: Hispanics (25%), African-Americans (13%), Caucasians (11%), and Asians (0%) (Table 5). However, a higher percentage of Hispanic patients had third party insurance (46%) compared to Caucasians (41%) and African-Americans (29%); Hispanics utilized Medicaid/Medicare least often (29%) among the three races. African-American patients

were the least often insured by a third party (29%) and most often insured by Medicaid/Medicare (56%).

Table 6: Arrival Times and Days of Visits

	Sun.	Mon.	Tues.	Wed.	Thur.	Fri.	Sat.	Total (%)
6-10AM	5	1	0	6	3	3	1	19 (9.5%)
10AM-2PM	5	17	9	7	8	4	9	59 (29.5%)
2-6PM	6	9	9	5	9	8	4	50 (25%)
6-10PM	3	6	9	8	6	5	1	38 (19%)
10PM-6AM	1	5	11	4	4	4	5	34 (17%)
Total (%)	20 (10%)	38 (19%)	38 (19%)	30 (15%)	30 (15%)	24 (12%)	20 (10%)	200 (100%)

Over half of our patients presented between 10AM and 6PM (Table 6). 36% of visits were in the 12-hour period from 6PM through the next morning at 6AM. The busiest days were Monday and Tuesday, and the frequency of visits steadily decreased during the week and through the weekend. It is worth noting that in this block sample of 200 patients over 15 days, Sunday was the 15th day on which the final few patients presented, and it was the only day included three times. The time and day when the greatest number of patients presented was Monday from 10AM-2PM. Overall, patients presented most often in the 10AM-2PM time slot, and visits generally decreased throughout the day into night.

Table 7: Acute problems: Primary Reason for Presenting to Psychiatric Emergency Services

N (%)	Reason (one per visit)
100 (50%)	uncontrollable, potentially uncontrollable, unacceptable behavior
62 (31%)	provider referral
12 (6%)	unable to cope with current life event
11 (5.5%)	most convenient location
6 (3%)	no known alternative at another facility, didn't know where else to go
4 (2%)	no alternative available in a timely fashion
2 (1%)	seeking shelter
1 (0.5%)	here by mistake, intended to go elsewhere
1 (0.5%)	needed medication
1 (0.5%)	had been to ED before, liked ED
200 (100%)	Total

The primary reason that 50% of our patients needed a PES evaluation was because of their uncontrollable, potentially uncontrollable, or unacceptable behavior (Table 7). Examples included:

1) A teenager with bipolar disorder was brought in after getting into an argument with his mother, holding a knife to his throat, and threatening to commit suicide.

2) A middle-aged woman was found by police to be screaming and cursing at cars at the side of the street. When officers approached her, she spat at them and threatened to kick them.

3) A patient with a history of psychotic episodes and multiple inpatient admissions was found in the park sitting in her own feces. She followed basic orders, but only would say her name and “I want to go home.”

Provider referrals accounted for 31% of visits. Referrals came from various professionals: therapists, outpatient psychiatrists, nearby mental health facilities, primary

care physicians, visiting nurses, community clinics, student health services, and our own emergency department staff. Examples:

1) A man with a history of suicide attempts was initially seen for a fall in our ED. However, after physicians noticed worrisome vertical cuts on his arms, they referred him for PES evaluation.

2) A young lady with a history of depression and bulimia reported ingesting 24 Tylenol PM to try to sleep because she ran out of trazodone. Upon hearing about this, her concerned therapist sent her to the hospital despite the patient denying intent to harm herself.

3) A gentleman was referred to the ED from a local mental health center after clinicians there saw him tell a fellow patient “goodbye” and that he was going to jump off of a bridge.

4) A visiting nurse found a patient with a history of bipolar disorder and alcoholism living in a trailer that was in state of complete disarray. She seemed intoxicated, admitted to two days of heavy alcohol consumption, and was not aware of anything worrisome about her living conditions. The visiting nurse referred her for further medical attention because of concern about the patient’s mental state and ability to care for herself.

6% of visits were directly related to stressful life events that overwhelmed patients. Examples included:

1) A woman with a history of bipolar disorder stable on medication presented for help after suffering a panic attack in the setting of a pending divorce from her husband and an engagement to a new gentleman.

2) A lady with a history of depression, anxiety, and a past suicide attempt self-presented after a heated confrontation with coworkers about alleged gossip about her. More than anything else, she remarked that she needed to take some time off from work and wanted to go somewhere where she would not run into anybody she knew.

Table 8: Patient Conduct Actively Contributing to Presentation

N (%)	Problem / Reason (more than one could be tallied per visit)
99 (49.5%)	suicidal (6 actual attempts, 23 minimal attempts, 70 only suicidal thoughts [*])
37 (18.5%)	violent (16 actual instances, 5 minimal instances, 16 thoughts/obscure)
27 (13.5%)	bizarre behavior
17 (8.5%)	disorganized, unable to look after self
4 (2%)	other dangerous behavior

^{*} (or took obscure action, but potentially harmful to themselves)

Real or potential injury was a factor in many visits (Table 8). There was concern about suicide in 49.5% of visits. Among those visits, suicidal comments or gestures were most common (70.7%), whereas 23.2% were parasuicidal attempts, and 6.1% were actual suicide attempts. 18.5% of visits involved actual or possible violence towards others. Patients exhibited bizarre behavior prior to 13.5% of visits. 8.5% of patients were found in a disorganized state.

Table 9: Medical and Social Issues Actively Contributing to Presentation

N (%)	Problem / Reason (more than one could be tallied per visit)
135 (67.5%)	traditional psychiatric illness
40 (20%)	relationship problems
33 (16.5%)	substance abuse (related to use)
6 (3%)	side effects from medication
2 (1%)	missed diagnosis
2 (1%)	seeking shelter

Traditional psychiatric illnesses actively contributed to 67.5% of our patient visits (Table 9). Relationship difficulties between patients and their significant others, family, friends, or co-workers were judged by clinicians to be direct factors in 20% of visits. Direct effects of substance abuse, such as intoxication, substance-induced psychosis and mood disorder, contributed to 16.5% of visits.

Table 10: Possible Alternatives to Emergency Services

N (%)	Alternative
148 (74%)	none
22 (11%)	walk-in clinic
11 (5.5%)	detox center
10 (5%)	quicker office appointment
7 (3.5%)	mobile crisis unit
2 (1%)	alternative shelter

Our clinicians determined that 74% of patients utilizing PES were not suitable to be evaluated in alternate settings based on their presentation (Table 10). The most commonly cited alternative to emergency care was a walk-in clinic (11%). Other possible alternatives to emergency services were detox centers (5.5%), quicker outpatient provider availability (5%), and mobile crisis units (3.5%).

Table 11: Alternatives to Emergency Services by Time Slot

	None (% of total in time slot)	Walk-in clinic	Detox	Mobile crisis	Quicker appoint.	Shelter	Total
6-10AM	15 (78.9%)	2	0	0	1	1	19
10-2PM	46 (78.0%)	5	5	2	1	0	59
2-6PM	36 (72.0%)	5	4	2	3	0	50
6-10PM	29 (76.3%)	4	1	0	3	1	38
10-6AM	22 (64.7%)	6	1	3	2	0	34
Total	148 (74%)	22	11	7	10	3	200

More visits during the 10PM-6AM time slot had alternatives (Table 11). Clinicians felt that a greater percentage of those patients could have been treated elsewhere. Few weekend visits could have been handled by a walk-in clinic. For the 22 patients for whom walk-in clinics were the most appropriate alternative, 10 arrived on weekdays (6AM-6PM), 10 arrived on weeknights (6PM-6AM) and only 2 arrived in our ED on a weekend (partial data shown in Table 11). Among our 40 patients who presented on Sunday or Saturday, other alternative settings were as follows: detox centers for 1 patient, quicker outpatient provider availability for 2 patients, and mobile crisis units for 2 patients. Faster access to established outpatient treatment could have averted some PES visits, mostly after hours or on a weekend: seven of the 10 patients in this group arrived outside of business hours (partial data shown in Table 11).

Table 12: Diagnoses & Long-Term Problems. These are existing conditions that patients had, regardless of involvement in their visit. *Patients may have more than one, including more than one per category.* No other conditions assessed afflicted more than 2% of patients.

	M	F	Total (%)
Major psychiatric illnesses (total)	63	76	139 (69.5%)
Major depression	14	26	40 (20%)
Psychosis NOS	12	14	26 (13%)
Bipolar disorder	10	16	26 (13%)
Schizoaffective disorder	13	9	22 (11%)
Schizophrenia	15	2	17 (8.5%)
Adjustment disorder	6	5	11 (5.5%)
Anxiety disorder	5	5	10 (5%)
Bereavement	0	8	8 (4%)
Mood disorder	4	2	6 (3%)
Post-traumatic stress disorder	1	3	4 (2%)
Substance abuse (total)	36	34	70 (35%)
Alcohol	21	15	36 (18%)
Cocaine/crack	17	15	32 (16%)
Narcotic	10	8	18 (9%)
Marijuana	4	4	8 (4%)
Sedative/benzodiazepine	1	5	6 (3%)
Other/uncertain substance	1	1	2 (1%)
Stimulants	0	1	1 (0.5%)
Other hallucinogen	0	1	1 (0.5%)
Relationship problems	23	27	50 (25%)
Not taking/ran out of medication	20	17	37 (18.5%)
Dementia	4	4	8 (4%)

Table 12 lists previous diagnoses and other long-term problems that patients had, whether or not that problem was responsible for the current visit. Overall, 69.5% of patients carried existing psychiatric diagnoses: major depression, psychosis *nos*, bipolar disorder, schizoaffective disorder, schizophrenia, adjustment disorder, anxiety disorder, bereavement, mood disorder, post-traumatic stress disorder. 15% of patients did not have

any history of psychiatric evaluation or treatment; the others had been previously evaluated/treated, but did not carry formal diagnoses (data not shown). Among patients diagnosed with major depression, women outnumbered men approximately 2:1. Patients who were diagnosed with either schizophrenia or schizoaffective disorder were more commonly men.

Substance abuse was a common issue: 35% of patients had substance abuse problems based on their own admission, collateral information, toxicity results, and/or treatment records. Alcohol and cocaine/crack were the most commonly abused substances. There were no glaring differences in substance abuse between the sexes, although a few more men had alcohol problems, and a few more women abused sedatives/benzodiazepines.

A quarter of patients were impaired by longstanding difficulties with personal relationships among spouses, family, or friends. The scope of these difficulties was broad, ranging from infidelity and domestic violence to disputes about inheritance and problems with coworkers. There was no notable difference in the prevalence of relationship problems between men and women.

18.5% of our patients were non-compliant/non-adherent with psychiatric medication. Aside from purposely choosing not to take medication, other reasons patients failed to follow their prescribed regimens included: impairment from illness or substance abuse, financial/insurance difficulties, and failing to obtain a refill expeditiously.

Table 13: Visit Outcome by Social Class

Social class	Home	Admitted to Hospital	Detox	Back to Facility	Jail / lockup	Crisis respite	Street	Uncer-tain	Total
1	0	4	0	1	0	0	0	0	5
2	2	6	0	1	0	0	0	0	9
3	11	12	1	0	1	2	0	0	27
4	42	34	3	5	2	2	0	0	88
5	22	20	0	2	0	0	1	1	46
Unkno.	10	15	0	0	0	0	0	0	25
Total	87	91	4	9	3	4	1	1	200

Table 14: Visit Outcome by Insurance

Insurance	Home	Admitted to Hospital	Detox	Back to Facility	Jail / lockup	Crisis respite	Street	Uncer-tain	Total
None	13	7	2	0	1	2	1	0	26
Medicaid / Medicare	41	43	1	6	0	2	0	1	94
Third Party	32	41	1	3	2	0	0	0	79
Unknown	1	0	0	0	0	0	0	0	1
Total	87	91	4	9	3	4	1	1	200

Table 15: Visit Outcome by Age

Age	Home	Admitted to Hospital	Detox	Back to Facility	Jail / lockup	Crisis respite	Street	Uncer-tain	Total
16-17	6	4	0	0	0	0	0	0	10
18-24	13	17	0	2	1	0	0	0	33
25-34	16	20	2	1	0	1	1	1	42
35-44	28	19	0	2	1	1	0	0	51
45-54	20	16	2	1	1	2	0	0	42
55-64	2	4	0	2	0	0	0	0	8
65+	2	11	0	1	0	0	0	0	14
Total	87	91	4	9	3	4	1	1	200

Patients were sent home nearly as often (43.5%) as they were admitted to a hospital (45.5%) (Tables 13-15). Much less frequently, patients were sent back to their

previous care facility (4.5%), detox center (2%), crisis respite (2%), or back to police custody (1.5%). There was a tendency for patients over 65 years old and patients in social classes 1 and 2 to be admitted to a hospital versus going home. Patients aged 35-44 were most likely to go home versus being admitted. Among patients with “better” insurance—in a progression of no insurance, Medicaid/Medicare, to third party insurance—there was an increasing tendency for patients to be admitted.

Discussion

Demographics, insurance, and social class

In our sample of 200 consecutive visits, there was surprising parity among the sexes throughout races and age groups (Table 3). The mean age of our patient population and the slightly higher mean age of our female patients relative to males was similar to a population observed by Hatfield, et al. 2000 in which their mean age was 37.1 years old; 35.5 for men and 38.9 for women (10). Most of this minor difference between sexes could be accounted for by a few older outliers; for example, four out of our five oldest patients were female, including a 96-year-old woman. The degree of parity in the number of visits between sexes suggests that both adult men and women are at similar overall risk for needing emergency psychiatric evaluation regardless of age.

It is unclear why African-American patients were overrepresented by a rather large proportion relative to other patients (Table 3). One hypothesis would be that patients with poorer routine healthcare access may over utilize PES. African-American patients did have the lowest percentage of third party insurance (29%) (Table 5); however, our Hispanic patients were almost twice as likely compared to African-Americans to be uninsured. A similar number of our patients had third party insurance (39.5%) compared those with Medicaid/Medicare (47%) (Table 4), raising doubt that simply having “better” healthcare coverage necessarily lowers the chances of requiring PES. A combination of many factors, such as socioeconomic status, prevalence of mental illness, and prevalence of substance abuse may all have contributed to the observed overrepresentation.

Considering that residents of New Haven County have a median household income of \$50,700, per capita income of \$24,400 and that 9.4% of the population is below the poverty line, it seemed like patients of a lower social class were overrepresented (Table 4). Certainly, it would be more difficult for people with severe chronic mental illnesses which require periodic hospitalization to obtain higher education and more prestigious, well-paying jobs. However, certain stressors and life circumstances, such as financial difficulties, family discord, lack of a regular care provider, and substance abuse, may be more often found in lower social classes can create situations where people are more likely to decompensate.

Times and days of visits

We observed two trends for when patients presented for PES (Table 6). There were the most visits on Monday and Tuesday, and the frequency of visits decreased steadily throughout the week and into the weekend. Furthermore, patients most often presented in the late morning into early afternoon, with visits becoming less frequent later in the day, overnight, and into the morning. There are a few possible explanations for the first observation. Perhaps the beginning of the week was busiest because the start of a new work week challenged patients with additional stressors that they did not have during the weekend. Given the decrease in volume later in the week, it did not seem like cumulative stress from day-to-day activities drove more patients to seek PES. Another explanation would be that, given the frequency of relationship problems (20%) and substance abuse (16.5%) (Table 9) contributing to visits, patients had more time on weekends with family and friends and had opportunities abuse substances. Perhaps

patients tried to “hold out” and resolve their difficulties over the weekend. On the other hand, maybe they preferred to take time off from work instead of sacrificing their own weekend time. For time of day, a possibility is that patients sought care most often in late morning into the afternoon because of stressors at the start of a day, such as work, school, and the commute. Also, providers generally treated their outpatients during the day, and providers were a large source of referrals (31%) (Table 7). Similarly, problems arising from relationship difficulties and substance abuse may be more likely to come to a peak at nighttime.

Most psychiatric evaluations were sought for emergent reasons

Most visits (87%) to our psychiatric emergency service were for reasons considered to be emergent: uncontrollable, potentially uncontrollable, or unacceptable behavior; direct provider referrals; and inability to cope with life events (Table 7). Visits prompted literally by behavioral disturbances usually involved physical risks to patients or to those around them. Provider referrals did vary in their urgency; nevertheless, a professional’s opinion that their patient needs immediate psychiatric evaluation is not easily discounted.

Few patients (13%) presented to our service for non-emergent reasons. This percentage likely would have been larger without nearby walk-in clinics (13). Some patients came to our PES because of its convenient location or timing (8.5%). However, few patients arrived unaware of other treatment options (3%); increased publicity about other services would hardly be expected to decrease PES visits.

A majority of our patients underwent psychiatric evaluation because they were potentially harmful to themselves or others (Table 8). Suicide attempts, suicidal thoughts, and violent or otherwise inappropriate behavior were frequent problems affecting our patients. Although the majority of our suicidal presentations only involved suicidal ideation, serious consideration was given to all talk of suicide or signs of suicide attempts. It may reflect how medical establishments are reluctant to delay treatment, even for low-risk patients, for fear of being held liable. Dramatic and well-publicized instances of school violence and suicides may linger in people's minds and foster a zero-tolerance attitude toward violent behavior and suicidal thoughts (44). As previously noted, many more patients presented with suicidal thoughts than actual attempts. A small fraction (2% of survey) of these say they are suicidal or "unsafe" in an effort to obtain inpatient drug treatment: psychiatric evaluation rarely yields any reason to believe they are at risk, and the time for their psychiatric evaluation further delays referral to whatever treatment options are available.

Traditional psychiatric illness played an active role in the majority (67.5%) of patient visits (Table 9). This suggests that the majority of PES visits were by patients it was meant to handle—ones affected by acute psychiatric illness. Other patients were directed to our PES for reasons such as behavior requiring urgent evaluation and care, to provide for patient safety, or perhaps because they had existing psychiatric diagnoses, although they were ultimately found to not be suffering an exacerbation of their mental illness.

Relationship problems were often major stressors for our patients. However, despite an impression among our staff that more men had relationship problems

compared to women because of how often they seemed to be kicked out of their homes by their significant others, the prevalence of relationship problems was similar between men and women (Table 12). Taken in the context of psychiatric illness, a chicken-and-egg paradox emerges with people's relationship problems: Are relationship problems exacerbating psychiatric illness and causing people to contemplate suicide/violence, or are psychiatric issues to blame for strained relationships? Do both scenarios feed into one another? Though our staff had suspected that many patients presented merely because they were kicked out by their significant other, our sample yielded only one case where there was no additional concern for significant depression or suicide.

Alternative treatment options

Our clinicians reported that there were no suitable alternatives to a psychiatric emergency visit in 74% of our cases (Table 10). This information reflects the acute nature of most of our PES visits—suicide, violence, behavioral issues. If there were gross deficiencies in the availability or quality of outpatient clinics or providers, one would expect greater misuse of emergency services. The difference between the 26% of visits that PES clinicians felt could have been handled by alternative services and the 13% of visits that were for non-emergent reasons can be reconciled by realizing that PES clinicians felt some of the emergent visits could have been adequately handled in these alternative settings.

When our clinicians felt that alternative psychiatric care would have been appropriate, they usually recommend walk-in clinics, detox centers, or quicker outpatient provider availability. Walk-in clinics in our area are not open on weekends, nor do they

operate 24 hours a day. Interestingly, based upon the time and days of arrival of our patients who were deemed appropriate for walk-in clinics and other alternative services, 24/7 availability of these other services would only potentially benefit a small portion of our patients. Nevertheless, a noticeably greater percentage of patients who presented overnight 10PM-6AM could have obtained adequate treatment with alternative services, if available (Table 11). The possibility of bias by PES clinicians exists, however. For example, clinicians may have more stringent barometers for the necessity of PES visits if patients choose to present overnight rather than waiting for the morning to speak to their clinicians or clinics.

Detox centers were recommended alternatives for 11 of our patients. Availability is an issue in our area. Crack is a major problem, but local detox centers focus on alcohol and heroin dependence; inpatient treatment for crack/cocaine is essentially unavailable. Several patients admitted that they were told by friends to fabricate stories about being suicidal to receive placement assistance for substance abuse.

Mobile crisis units were rarely recommended as an alternative. Perhaps it is more common practice in our area to immediately seek emergency care, or perhaps police are inclined to bring people to a hospital for evaluation. State funded crisis phone lines may also decrease the need for mobile crisis units. Mobile units are costly and serve only one patient at a time, but it may be worth investigating the benefits of having units available outside regular business hours (4 of the 7 were during nighttime or on weekends).

Surprisingly, alternative shelter was only appropriate for two patients. Certainly, people who were clearly seeking only food or shelter could have been screened out at our ED's triage if they did not have compelling reasons to be seen by PES. Our study was

also conducted during the summertime, when there supposedly would be less urgency compared to winter to obtain shelter. However, from mid-November to mid-April, shelters in our area have a “no-freeze” policy when shelter is offered to anybody who needs it, and shelters do not charge a fee for lodging.

Clinicians felt that patients presenting between 10PM-6AM were most likely to have alternatives to PES care (Table 11). This assessment reflected perhaps the decreased severity of some visits during the nighttime that may not have been made had clinics or other outpatient services been available during those times. Nevertheless, it is possible that clinicians assessed visits during those times with a more critical eye specifically because they were overnight.

Psychiatric illness and substance abuse are major chronic problems

Traditional psychiatric illness was an existing problem for the majority (69.5%) of patients seeking PES treatment. Although our PES served a majority of patients who already had psychiatric diagnoses, 15% of our visits involved patients who were having their first acute episode of mental illness or incident requiring psychiatric evaluation. The remaining PES visits involving patients with previous assessments but without formal psychiatric diagnoses were nevertheless important to ensure the safety of people suffering the effects of substance abuse or an acute social stressor, for example.

Patients presented with a variety of psychiatric illnesses. The most common was major depression, which afflicted 20% of the patients in our study. The prevalence of women with depression compared to men was nearly 2:1 in our study, which was similar to 2:1 ratios seen elsewhere (45). These results are simply observations; this study was

not specifically designed to assess the prevalence of certain mental illnesses in our area. Women outnumbered men about 3:2 among patients with bipolar disorder; other studies have generally observed an equal gender prevalence of bipolar, although findings have varied depending on patient age and between diagnoses of bipolar I and bipolar NOS (46, 47). Schizophrenia and schizoaffective disorder combined were more than two times more common in males compared to females among our patients, with males further outnumbering women among patients diagnosed with outright schizophrenia. Various gender distributions have been observed in other studies, ranging from equal distributions to 1.4:1 male:female ratios, to over 2:1 male:female ratios (48-50).

Substance abuse was an existing problem for 35% of patients (Table 12), and 16.5% of visits were directly related to substance abuse (Table 9). This incidence of substance abuse in psychiatric patients was similar to previous reports (51-53). Alcohol, cocaine/crack, and narcotics—usually heroin—were the substances most commonly abused by our patients; we suspect that their popularity reflected preferred substances in our region. Alcohol was more commonly abused by men compared to women in our study, although not as overwhelmingly as other studies that have observed a 2:1 to 3:1 ratio (54-56). There were few gender differences among substances abused. It is unclear why women were more likely than men to abuse benzodiazepines. One might expect an increased prevalence if more of our women had anxiety disorder and therefore greater access to medication than men, but equally as many men had anxiety disorder.

Beyond patients who presented for reasons directly related to substance abuse, substance abuse likely played a role in hastening many patients' need for PES. Mentally ill substance abusers have greater difficulty adhering to medication regimens and

managing personal finances, which can adversely impact their mental health (52). Furthermore, mentally ill substance abusers are more likely to be violent (53), which was a common (18.5%) contributor to our PES visits.

Trends between social class, insurance, and age for outcome

A rough indicator of the severity of patient visits was whether they were discharged home or admitted to a hospital/inpatient psychiatric unit. In our study, slightly more patients were admitted than were sent home (Tables 13-15). Among the few trends observed, patients with Medicaid/Medicare were more likely to be admitted than patients with no insurance, and patients with third party insurance were even more likely to be admitted. One hypothesis is that people with better insurance had better outpatient care, so that when they presented to PES, they were more likely to have a serious problem requiring hospitalization. Patients with limited access to healthcare because of their insurance status would be expected to more often present with less urgent problems not requiring hospitalization. Alternatively, patient outcomes could reflect reimbursement tendencies and/or differences in discharge planning based upon health insurance. Third party insurance could be expected to be more willing to approve inpatient care than Medicaid/Medicare, and more facilities may accept third party insurance compared to Medicaid/Medicare, thereby offering extra options to those patients. Placement could be especially difficult to find for patients without any insurance.

Patients older than 65 years and members of social classes 1 and 2 were more likely to be admitted to the hospital than others. Patients of social classes 1 and 2 may have been more likely to become admitted for similar reasons to patients with good

insurance coverage. One might postulate that patients over 65 years old would have more serious health problems than younger people, and that clinicians would be inclined to be more careful with them, with regards to either their mental or overall health. It is unclear what reason, if any, accounted for patients 35-44 being the age group most likely to be sent home. Do these patients have less severe disease overall compared to younger people, who may be still adjusting their treatment regimens or suffering their first acute episodes, and older people, who may have other comorbidities requiring hospitalization?

Limitations

This study has its limitations. It is a snapshot of emergencies in one locale, with a denser than average network of local clinics and providers (including a state-operated clinic across the street). This study was conducted during the summer, which may have reduced patients' need for housing and otherwise presented an inaccurate sample of the total cases seen in our PES during the year. Despite data being compiled by a single abstractor, our study relies on diagnoses written by clinicians with variable clinical expertise. And, these clinicians may feel practical pressures to render traditional psychiatric diagnoses: in our state, inpatient psychiatric treatment is much more easily arranged than inpatient substance abuse treatment. Furthermore, despite best efforts to obtain accurate information based upon available PES documentation and clinician interviews, the reliability of this data could have been improved if it were verified with additional sources of information, such as outside providers and family members. Finally, in order to draw more definitive conclusions about many of the above observations, this study would need to be repeated with a larger sample size appropriate to obtain adequate

statistical power. Sampling patients throughout the year would decrease the chances of certain temporal trends influencing overall results.

In retrospect, it would have been interesting to survey our clinicians' response to the work/effort of emergency psychiatric evaluation. Previous anecdotal complaints about patients "just here for shelter" seemed out of proportion to actual numbers. Do such evaluations require extra effort to prove the absence of serious psychiatric illness/risk? There has been also considerable irritation when substance abuse is believed to be a patient's primary problem; yet, the patient feigns depression. Is there less sympathy for substance abusers or perceived abuse of the system?

Conclusion

In conclusion, the vast majority of visits to our psychiatric emergency service were for emergent reasons. Most visits were due to clinical conditions related to traditional psychiatric illness, substance abuse, and other liabilities that no other organization would accept, such as dangerous or uncontrollable behavior. There was great concern for keeping suicidal patients safe from themselves. Longstanding problems for patients included traditional psychiatric illness, substance abuse, and relationship problems. A minority of the cases seen by our PES could possibly have been alleviated by greater availability of community-based services, especially walk-in clinics. However, there was not strong evidence for a need for alternative services during weeknights or weekends.

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