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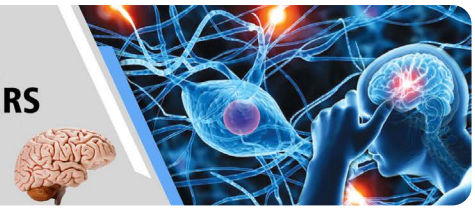

Canadian Hospital Emergency Rooms & Mental Health: Investigating Solutions to Better Support Emergency Room Staff in Providing Walk-in Psychiatric Care

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Abstract

Results/Conclusion: In conclusion it has been reviewed that Canadian general hospital ERs would greatly benefit from staff being given specialized training in psychiatric care and services. As well as that Canadian general hospital ERs lack psychiatric adaptation in providing suitable care and services in order to try and help reduce cyclical re-admissions.

Relevance to Clinical Practice: This literature review holds relevance to clinical practice within its initiative to bring forth a pressing social issue within Canadian society wherein general hospital ERs visits by patients suffering from a psychiatric disorder are concerned. This research seeks to highlight the need for general hospital ER staff support and training wherein psychiatric care and services are concerned.

KEYWORDS: Mental Health; Hospital; Emergency Room; Tool-Kit; Overcapacity; Re-Admission(s).

CONTEXT

The purpose to write this review was inspired by the author's personal experience as a psychosocial worker while visiting an Emergency Room (ER). The author was faced with a situation where an admitted ER patient with suicidal ideations and active self-harm was set to be discharged, where the associated ER nurse to the patient in question, when asked who would find the crisis resources for the client to contact upon discharge, explained that that is not her job that it is the patient's. The patient was observably in distress and crisis (unable to manage emotions, excessive crying, no plans for recovery/rehabilitation, asking for help). The author later sent the ER nurse various resources to hopefully be discussed and used for the client's discharge. The author was stunned by the idea that the client with active suicidal ideations and self-harm would be discharged without any external crisis support organized. Where less than 48 hours later, the author noticed that the same client had been re-admitted to the ER with the same situation. In reflection, the author began to contemplate the necessity of developing a tool-kit for ER nurses to use to help them devise discharge plans that can be used to avoid cyclical re-admission(s) and optimize use of external resources in-patient rehabilitation.

INTRODUCTION

Mental health is a global phenomenon, prevalent in all societies and gender identities. It has been reported that about 1 in 5 Canadians experience a mental health disorder (MHD) in any given year [1]. According to Statistics

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Canada, a 2022 study found that over 5 million Canadians, 15 years of age and older met the diagnostic criteria for a mood disorder (major depressive episode, bi-polar disorder), anxiety (generalized anxiety disorder, social phobia) or substance use disorder (alcohol, cannabis, and other substances) [16]. Within this same study, data showed that about 1 in 3 persons reported that they feel like their mental health needs are either unmet or partially met in terms of health care services provided [16]. This study does not include those who suffer from major psychiatric disorders (such as schizophrenia, personality/ behavioral disorders, etc.,). Both Statistics Canada and CAMH both found that data suggests men are more likely to suffer from a substance use disorder while woman are more likely to suffer from a mood or anxiety disorder [1,16]. CAMH importantly also highlights findings that Canadian individuals earning lower incomes are 3 to 4 times more likely than Canadians earning higher incomes to suffer from a poorer or fairer mental health status.1 Suicide is also another prevalent mental health challenge that affects multiple Canadians per year.1 CAMH reports that about 4,000 Canadians take their life per year on average [1]. Considering the various facts presented by governmental institutions on mental health, it is clear that mental health is a pervasive and growing issue amongst Canadians in modern day society.

OBJECTIVES

This review seeks to consider the use of a tool-kit to help workers in hospital ERs to try and help reduce overcapacity and cyclical re-admission(s) via the use of external mental health resources and support. This review also seeks to emphasize the utility of having a mental health tools kit as a ready-to-use document for hospital ER employees to refer too when devising discharge plans for individuals suffering from a MHD, fostering optimal patient resilience and rehabilitation by using both internal and external resources.

ACCESS TO MENTAL HEALTH SERVICES

As mentioned, data uncovered the statistic that about 1 in 3 persons in 2022 report feeling like their mental health needs are either unmet or partially met in terms of health care services provided [16]. In terms of accessing mental health services, data also shows that only half of the 18.3% of individuals aged 15 years and older in 2022 meeting the criteria for a mood, anxiety or substance use disorder met with a healthcare professional (most likely to be a family doctor or GP - 34.4%) [17]. While fewer individuals reported consulting with a mental health specialist (i.e., psychiatrist, psychologist, social worker for example) [17].

Mental health support in psychiatric facilities (i.e., psychiatric hospitals and/or single psychiatry units in a general hospital) are limited in capacity. Government funding has been dispersed to other services where healthcare is lacking in subsidization in the public sector. Private services are commonly known to be expensive and often are not covered by insurance companies, limiting individuals who suffer from a MHD from accessing private support. Public services have significantly long wait times and are often missing in personal, leaving individuals suffering from a MHD helpless in finding support due to structural and social issues out of their control.

Symptoms of mental health can be provoked and/or exacerbated by situations of inadequate employment [11], inadequate living conditions [13], substance use,1,16 lack of social support [14] or other social elements such as poverty, neighborhood, upbringing15; circumstances under which individuals suffering from a MHD often find themselves in. [4,5,6,10] The inability to access mental health support most often leads individuals to seek help in general hospital (GH) ERs.

ER STATISTICS

Hospital ERs are primarily focused on physical health care. 2022 to 2023 statistics show that Canada-wide, there was approximately 15.1 million Canadians who went to the ER for unscheduled treatments.2 Quebec was reported to be the province with the second highest volume of unscheduled ER visits in 2022-2023 (3,626,684), coming after Ontario who was first (6,213,334) [2]. In third, Alberta (2,227,67) and in fourth British Columbia (1,769,587) [2]. Of these unscheduled ER visits, reasons for visitation include abdominal and pelvic pain proceeded by throat and chest pains were the most common reasons for ER consultation [2] Where individuals seeking help for mental health made-up about 9.4% of the 15.1 million Canadians who frequented the ER in 2022-2023 [2]. Mental health patients visiting GH ERs have been reported to be consulting primarily for anxiety disorders and substance use disorder (as comparable to statistics in the United States of America) [14]. It was also found that on average, recurring visits to the ER by an individual suffering from a MHD is common, finding that about 1 in 5 persons who presented to a general hospital ER for a mental health consultation had revisited said ER within six months [14].

Levin and Aburub cite research studies that report an increases in GH ER visits by mental health patients since 2006 [12]. Mao et al. confirm an uprising trend in visits to GH ERs all around the world by mental health patients as well [14]. As mentioned, GH hospital ERs are mainly focused on physical health care, where mental health care is often triaged as ‘less urgent’ where consequently, wait times for said population tend to be longer, risking to intensify experienced patient distress and frustration levels [7,12].

GH ER staff are not necessarily specialized nor versed in mental health interventions. Levin and Aburub reiterate findings that GH ER nurses possess a lack of knowledge

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on how to best service and care for mental health patients [12]. The authors also present findings suggesting six barriers that GH ER staff face with regards to providing adequate care to mental health patients visiting the ER; which are listed as challenges related to "…reduction in psychiatric beds; lack of resources, especially during busy hours; a long and slow diagnostic process; safety concerns; suboptimal training of emergency department staff; and poor follow-up strategies."[12]. (p27)

MENTAL HEALTH GH ER PATIENT PROPOSED SOLUTIONS

Levin and Aburub in their study suggest certain 'solutions' regarding mental health patients visiting GH ERs which include following the Trieste Model from Italy, which ultimately includes developing "…housing, social clubs, work cooperatives and recreational opportunities" when 1,200 mental health beds close [12] (p28); improving resources for mental health, which essentially alludes to opening more community resource centers as well as offering telemedicine options for psychiatry patients ("telepsychiatry") [12]; having ER departments collaborate with mental health community organizations when having to discharge and/or direct a mental health patient to external services [12]; suggesting that "…all emergency physicians should have a basic understanding of the diagnosis and treatment of psychiatric emergencies"[12] (p29), developing a mini psychiatric unit in the ER, and having more crisis/psychosocial workers in ERs [12]; ER staff should receive basic training in working with mental health patients (ibid. 30); patients should be implicated and involved in the development of their care plan [12]; follow-up with discharged mental health patients [12].

In conjunction with a solution mentioned by Levin and Aburub, referring to establishing a 'mini psychiatric unit' in GH ERs – American GH ER hospitals who pursued pilot projects for 'mini psychiatry units in GH ERs' report positive data, finding that wait times for individuals suffering from a MHD visiting GH ERs with this ER add-on went from 48 hours to about 2 hours [8].

In analyzing articles, interestingly mentioned by Baie Medeiros et al. Canadian research on mental health and ER visitation is not as extensive as compared to American literature and research on the topic of mental health and GH ER visitations [7]. The idea that little research on mental health and ER visits lack investigation in Canada, showcases an importance in researching this evidently prominent situation. Mao et al. in their scoping review found pertinent data corresponding to the use of a multidisciplinary approach [14]. Wherein patients suffering from a MHD go to a GH ER where staff is training and versed in providing mental health care as well as are equipped with resources for external support, GH ER readmission and revisitation rates decrease in percentage [14]. Moreover, Cherner et al. in their study found that GH ER staff require help in location community resources as well as help in navigating the referral process for such, suggesting a tool-kit helping to support staff as a worthy investment [3]. In conjunction with such, Lavergne et al. also cite that GH ER staff require support in helping staff work with mental health patients by supplying them with resources that can be used to target external services upon discharge [9].

Regrettably, a number of the proposed solutions by Levin and Aburub remain unrealistic in the point-of-view of this review. Various community organizations already exist to help individuals suffering from a MHD that are exceedingly helpful in supporting individuals suffering from a MHD that require help; albeit are not commonly known to society, requiring efforts in marking and public promotion. Keeping in mind also, that as various research projects find, individuals suffering from a MHD represent an unfortunately symbolic percentage of individuals categorized in low-income status, where access to internet and electronic devices to acquire knowledge of said community organizations is more often a challenge than a simple search on an iPhone. Moreover, he Canadian healthcare system in current day is undergoing important and significant budget cuts where installing 'mini psychiatry units' in GH ERs is not a feasible proposition given the state of public healthcare funding. In reality, with healthcare workers already being scarce, the need to be supported with a tool-kit guiding their efforts in mental health care would be considered an optimal step forward in ameliorating GH ER practitioner care and services for individuals with a MHD. Perhaps having GH ER staff trained in a mental health course would also prove as useful as well in a like manner. That being said, reviewing the solutions proposed in other research studies it could be deliberated that a tool-kit for GH ER staff might very well be more appropriate in helping GH ER professionals intervene and support mental health patients visiting GH ERs.

GH ER TOOL-KIT PROPOSAL

Given the data reviewed throughout this paper as well as taking into consideration the authors personal experience as written in the context section, a GH ER tool-kit would seemingly be a necessary document to have in GH ERs. When reflecting on the statistics of GH ER visits by mental health patients, a GH ER tool-kit can provide GH ER practitioners and other professionals working in GH ERs who are not accustomed to mental health care and interventions/approaches, can possibly ameliorate patient well-being and favor structured external care upon discharge when a social worker and/or psychosocial worker is not available or inexistent in GH ER.

Annex 1 details an example of a GH ER tool-kit template proposal. Containing within it various community resources ranging from listening/crisis lines, to suicide

materials, to shelters, to affordable external mental health services, to anxiety interventions. The GH ER tool-kit provides information readily available that can help GH ER practitioners potentially avoid pushing mental health patients into the perpetual revolving door of cyclical re-admission(s). By using a tool-kit that places an emphasis on external community support, this can potentially lead to greater access to mental health services for individuals suffering from a MHD. By including community organizations, which can very well also potentially help to reduce overcapacity as well as hopefully lessen GH ER practitioner workload where patient physical health is not the primary concern. The GH ER tool-kit can also potentially get mental health patients help who do not necessarily already have a follow-up.

DISCUSSION

The various studies analyzed throughout this review have collectively stipulated and presented data supporting evidence of this. GH ERs are chiefly for physical health treatments. With the rise in GH ER visits by mental health patients, who are predominantly reported to often be visiting for experienced anxiety/panic attacks or substance abuse, making community resources known to said population type, especially those who do not have access to internet or electronic devices, can very well support the claim stated above respective to mental health patients.

The idea of implementing a tool-kit for GH ERs would ostensibly provide the opportunity to reduce overcapacity and cyclical revisits to GH ERs wherein individuals who suffer from a MHD are concerned. Ready-to-use tool-kits can be used in general hospital emergency rooms by healthcare professionals servicing walk-in patients requesting psychiatric care whom do not need to be admitted and can be discharged. The ready-to-use tool-kit provides healthcare professionals whom are not necessarily trained in psychiatry or general mental health interventions with a useful document that can be devised with a mental health patient equipping them with coping mechanisms and strategies as well as with community resources to contact instead of seeking help in general hospital emergency rooms whom are not dedicated towards psychiatric care.

In conjunction with such, a ready-to-use tool-kit in GH ERs proposes a potential cost-effective solution towards helping healthcare professionals who are versed and trained primarily in physical care and services. Proposed solutions such as a mini-psychiatric unit in GH emergency rooms is theoretically idea and optimal, however the reality of current-day public hospital funding, such is not feasible nor pragmatic unfortunately. Hospitals in Canada, specifically Montréal (Québec) are subject to severe budget cuts where a tool-kit presents as pragmatic in not only considerations of hospital budgets, but also in contemplation of situations of staff shortages.

By helping to support GH ER practitioners who are not acclimated to mental health care and/or interventions/approaches via a GH ER tool-kit, aims at alleviating GH ER practitioners in having to determine a treatment and/or discharge plan with the attending physician, something of which can contribute towards lengthy GH ER wait times for care.[7] It would seem that the Canadian healthcare system in comparison to that of America holds the appearance in lacking determining ways to better cope with the new social reality of increased mental health patients within society in general. Annual trends for individuals suffering from a MHD statistically have been showcasing the need to find solutions in order to better help this identified population.

FUTURE RESEARCH

This review provides the opportunity to test a pilot project by implementing the proposed a tool-kit in this review that contains within it, possible solutions that can potentially alleviate hospital ER overcapacity, avoid cyclical re-admission(s), and enable better patient care for individuals consulting for a MHD. Future research can also use this review to analyze the barriers experienced by Canadians in accessing mental health services within the community; perhaps gaining a better understanding of needs for individual suffering from a MHD might also contribute towards innovating ER initiatives.

DECLARATIONS: None.

ETHICAL APPROVAL & CONSENT STATEMENT

Not applicable – no research subjects.

FUNDING: None.

AVAILABILITY OF DATA AND MATERIALS

Information and referenced articles and statistics used throughout this review can be accessed online.

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Annex 1

MENTAL HEALTH TOOL-KIT (MONTRÉAL (QUÉBEC) EDITION)

CRISIS/MENTAL HEALTH LISTENING LINES

-Tel-Aide (24/7): 514-935-1101

http://www.telaide.org/

-Multi Écoute (24/7): 514-737-3604

https://tel-ecoute.org/

-Écoute Entraide (7 days a week, 8am to 10pm): 514-278-2130 OR 1-855-365-4463

https://www.ecoute-entraide.org/

-SOS Violence Conjugales (24/7): 1-800-363-9010 or by text to 438-601-1211. For chat: https://www.resourceconnect.com/sosvc/chat

-Face-A-Face (Monday to Friday, 9am to 5pm): 514-934-4546

https://faceafacemontreal.org/fr/

-Ligne Parents (help for parents with children aged 0 to 20 years old) (24/7): 514-288-5555 OR 1-800-361-5085

https://www.teljeunes.com/fr/parents

-Tel-Jeunes (6am to 2am): 1-800-263-2266

Text (8am to 10:30pm): 514-600-1002

https://www.teljeunes.com/fr/parents

-Tel-Aines (Monday to Sunday, 9am to 9pm): 514-353-2463

https://tel-ecoute.org/programme-tel-aines/

SUICIDE LISTENING LINES

-National Suicide Line (24/7): 9-8-8

https://988.ca/

-Suicide Action Montreal (24/7): 1-866-277-3553

https://cpsmontreal.ca/

-Centre de Crise de l'Ouest de l'Ile de Montreal (24/7): 514-684-6160

https://www.centredecriseoi.com/

-Le Transit (24/7): 514-282-7753

https://cictransit.com/

-Tracom (24/7): 514-483-3033

https://www.tracom.ca/

-L'Autre Maison (24/7): 514-768-7225

https://centreautremaison.com/

-Association Iris (24/7): 514-388-9233

https://assoiris.ca/index.php/programmes-et-services/centre-d-intervention-de-crise

CRISIS CENTERS (USEFUL IN CASES OF SUICIDE DISCHARGES)

-Centre de Crise de l'Ouest de l'Ile de Montreal (24/7): 514-684-6160

https://www.centredecriseoi.com/

-Le Transit (24/7): 514-282-7753

https://cictransit.com/

-Tracom (24/7): 514-483-3033

https://www.tracom.ca/

-L'Autre Maison (24/7): 514-768-7225

https://centreautremaison.com/

-Association Iris (24/7): 514-388-9233

https://assoiris.ca/index.php/programmes-et-services/centre-d-intervention-de-crise

SELF-HARM INTERVENTIONS

-Try to take a red sharpie and trace a red line on your place of self-harm instead of maiming.

-Try to wear a rubber band and snap the rubber band on yourself instead of maiming.

-Try to talk to family or friends, or try to call a listening line.

-Try to workout or go for a walk.

-Try to make a vision board.

-Try to remember and reflect on your worth.

-Try to remember that you are loved, that people are here to help you. That bad days will happen but that good days will also happen too.

-Try to secure your environment (get rid of self-harming/suicide tools/materials).

-Try to create a safety plan.

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ANXIETY INTERVENTIONS

-Try guided meditation practices (application suggestions: Head Space, Calm, Unplug).

-Try breathing techniques: https://psychcentral.com/anxiety/reduce-your-anxiety-this-minute-3-different-types-of-deep-breathing#abdominal-breathing

-Try grounding exercises (sit up right, both feet on the ground, begin to name things around you): https://www.tothegrowlery.com/blog/2017/4/18/six-different-types-of-grounding-exercises-for-anxiety-intense-emotions

-Try to journal.

-Try to find/engage in a distraction (phone games, television, walks, working out, talk with someone, journal, listen to music, read, go to a museum, clean, organize, etc.,).

-Try to reflect on the positives within the negatives.

-Try to understand what is making you feel anxious (what are you feeling? Where are you feeling this? What has triggered it (event/situation, smell, place, person, photo, etc., for example)? What I am worrying about - will it change my life drastically or will it impact me a year from now? What can I do to ameliorate my experienced feelings?).

-Try to identify what you can control.

-Try to repeat positive mantras to yourself (for example, I am safe, I am okay, this will pass).

-Try to plan (make a vision board).

-Try to make a step-by-step plan on how to solve the issue that is worrying you.

-Try to do art (color, draw, paint, etc.,).

-Try to use phone games (Tetris, Candy Crush, Blockudoku, etc.,)

USEFUL LINKS FOR ANXIETY

https://www.creditcanada.com/blog/how-to-cope-with-financial-anxiety

https://www.verywellmind.com/reframing-defined-2610419

https://www.psychologytoday.com/ca/blog/what-mentally-strong-people-dont-do/201705/how-to-stop-worrying-about-things-you-cant-change

https://www.helpguide.org/mental-health/anxiety/how-to-stop-worrying

https://www.vaniercollege.qc.ca/student-services/files/2023/02/Grounding-Techniques-1.pdf

https://www.anxietycanada.com/sites/default/files/adult_hmsocial.pdf

https://www.anxietycanada.com/articles/thinking-right-tools/?_gl=1*2hro75*_ga*MTY4ODU1NzkyMC4xNjk2MzUwMjY3*_ga_Y4J3VSGKVS*MTY5ODA3NDk4MC4yLjAuMTY5ODA3NDk4MC4wLjAuMA..&_ga=2.46556711.1684164521.1698074981-1688557920.1696350267

https://www.anxietycanada.com/articles/thinking-traps/

https://psychcentral.com/blog/coping-with-what-you-cant-control

https://www.anxietycanada.com/free-downloadable-pdf-resources/

https://www.helpguide.org/articles/anxiety/how-to-stop-worrying.htm

https://www.cci.health.wa.gov.au/Resources/Looking-After-Yourself/Health-Anxiety

AT-HOME, CRISIS INTERVENTION SERVICES

-Le Transit (24/7): 514-282-7753

-UPSJ (24/7): 514-861-8163 OR 514-861-8171

https://ciusss-centresudmtl.gouv.qc.ca/propos/qui-sommes-nous/leadership-et-innovations/urgence-psychosociale-justice-ups-j

AFFORDABLE THERAPY RESOURCES

https://affordabletherapynetwork.com/online-therapists/

https://cbtclinic.ca/

https://www.ordrepsy.qc.ca/

http://www.adeese.org/ressources-aide-en-sante-mentale/

https://amiquebec.org/therapy/

https://www.montrealtherapy.com/

LINKS TO ACCESS VARIED COMMUNITY RESOURCES

https://diogeneqc.org/wp-content/uploads/2019/10/BOTTIN_Diogene.pdf

https://amiquebec.org/resource-list/

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TEMPLATE FOR MENTAL HEALTH PATIENT DISCHARGE FROM AN ER

Example: 37 year-old, single, no children, male. English-speaking, no psychiatric diagnosis, but came into ER with suicidal ideations and active self-harm. No place to stay, poor relations with family (not an option to stay with family). Has a plan to take life but no intention to complete the plan. Would like to get back on track – eventually return back to work, begin to handle thoughts and ruminations (emotional management skills). Patient open to talking but covers his face, says that he is guilty and embarrassed; verbalizes wants and needs help but does not know what to do.

Listening Lines:

1. National Suicide Line (24/7): 9-8-8
2. Suicide Action Montreal (24/7): 1-866-277-3553
3. Tel-Aide (24/7): 514-935-1101

Crisis Centers:

4. Le Transit (24/7): 514-282-7753
5. Tracom (24/7): 514-483-3033
6. L'Autre Maison (24/7): 514-768-7225

Intervention Plan

- Find crisis center to stay until housing is secured.
- Find housing.
- Work on finding affordable follow-up (therapy/ counselling/coaching).
- Develop a routine.

Anxiety Coping Strategies/Mechanisms

-Try to make a vision board.

-Try breathing exercises.

-Try to reflect on the positives within the negatives.

-Make a step-by-step plan on how to solve the issue that is worrying you.