Treatment and follow-up in the psychiatric emergency room can be improved

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ABSTRACT

INTRODUCTION: The first and perhaps only contact many patients have with the psychiatric hospital system is at the psychiatric emergency room (PER). A growing load on the wards has raised the threshold for admission. Thus, it is important to make plans for patients who are seen in the PER, but are not hospitalised. The objective of this study was to investigate what treatment, plans and follow-up patients receive in the PER when they are not admitted.

MATERIAL AND METHODS: This is a review of 100 consecutive PER patient reports from 2012 on patients who were seen by a doctor and not admitted at the Psychiatric Centre Frederiksberg, Denmark. The following issues were investigated: diagnosis, which medical and/or psychotherapeutic treatment was given or recommended, social interventions, objective findings, plans for treatment and referrals, and whether relevant referral was neglected.

RESULTS: A total of 29 patients started psychopharmacological treatment, but only four received a plan for further treatment. Eleven received psychotherapy. Nine received social intervention. A total of 97 were discharged with follow-up. In 14 cases, relevant referral may have been neglected. Eleven reports lacked a description of psychiatrically objective findings, 20 lacked evaluation of suicidality.

CONCLUSION: Doctors in the PER are vigilant to ensure plans for follow-up. However, these plans may sometimes be deficient. Doctors in the PER often use medical approaches to relieve patients' symptoms, but there is a need for a plan for how these treatments should be followed up. Furthermore, there seems to be a need for a stronger focus on psychotherapy and social intervention.

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The first and perhaps only contact many patients have with the psychiatric hospital system is the meeting with health care providers in the psychiatric emergency room (PER). Recent years have seen a growing number of patients seeking the PER and a reduction in the number of psychiatric beds [1]. This has led to an increasingly strict prioritisation of which patients may be offered admission and which should be treated in another setting. The patients often have to await further treatment [2]. It is therefore important to make plans for those patients who are seen in the PER and who are not subsequently hospitalised. Ideally, patients who are not hospitalised should receive the necessary tools to handle their symptoms; and to ensure this, the doctor should evaluate the patient's needs with a focus on all the relevant aspects of the bio-psychosocial model. Previous studies have investigated quantitative data on patients seen in the PER [3-8], but not the qualitative data on the treatment patients receive. The dual objective of this study was, first, to investigate the treatment patients receive and, second, to review the plans for further treatment and follow-up the doctors in the PER make for patients they see in the PER and subsequently choose not to hospitalise.

MATERIAL AND METHODS

We reviewed 100 consecutive patient reports from 30 March to 20 May 2012 on patients who were seen by a doctor in the PER at the Psychiatric Centre (PC) Frederiksberg, Denmark and subsequently sent home. PC Frederiksberg is located in Copenhagen, and it covers the catchment area of Frederiksberg and Vanløse with a population base of 138,117 persons. Its opening hours are from 8 am to 10 pm and there is no option for patients to spend the night in the PER. The PER is staffed by two nurses and a doctor (who is also responsible for the rest of the ward, 86 beds, after the end of normal working hours). On average, there are five contacts (not counting patients who come for planned medication administered by the nurses) and 2.7 admissions per day.

The reports were selected based on the referral log kept in the PER and the electronic patient system. The study was approved by the Danish Data Protection Agency. The 100 PER reports were investigated with regard to:

a) Diagnosis, age and gender of patients.
b) Whether the patient was referred to the PER and the reason for contact with the PER.
c) Which medical and/or psychotherapeutic treatment was given or recommended. This included an evaluation of medical treatment plans. In order to qualify as a treatment plan in this study, the doctors had to include a specific treatment time frame, i.e. a wording such as "a short period" did not qualify, since it is not clear whether this means days, weeks or months.

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d) Psychosocial intervention.
e) Were objective psychiatric findings including an assessment of suicidality included? The assessment of suicidality would not necessarily meet the requirements as defined by the Capital Region's psychiatric hospital service, but were required to include an objective assessment and not just be a reproduction of the patient's own subjective description.
f) Which further referrals were made? Were appropriate referrals possibly omitted? Such cases included patients with alcohol abuse who were discharged from the PER to their general practitioner (GP) without also being encouraged to seek substance abuse counselling, or patients suffering from anxiety who were not encouraged to discuss the possibility of referral for psychotherapeutic treatment with their GP.
g) Were patient reports completed so that they would likely be understood by a GP? Was the language clear or were there for example abbreviations or psychiatric jargon that could distort the meaning?
h) The treating doctor's qualifications and whether the doctor consulted with a senior colleague.

Trial registration: not relevant.

RESULTS

The average age of the patients was 43 years (range 18-87 years). A total of 55 of the patients were women. In all, 26 of the patients were referred to the PER, primarily from other health care providers such as GPs, somatic departments and various psychiatric outpatient settings, but other non-medical operators such as the police and social workers also referred patients. The diagnoses were primarily within the affective and anxiety spectra. These two spectra accounted for nearly two thirds of the diagnoses (**Table 1**).

Patients with diagnoses such as schizophrenia, bipolar disorder or personality disorders had these prior to contacting the PER.

The patients' primary complaints/reasons for seeking the PER were not systematically recorded in the PER reports and were therefore not investigated further in this study.

Eleven reports did not contain a description of objective psychiatric findings, and 20 lacked an objective assessment of suicidality.

Medication

Ten patients had their usual medication changed, in eight cases this was decided by the senior psychiatrist on call. In no case was the maximum recommended dose exceeded. Ten patients were recommended to consult their GP or a private psychiatrist in regard to further medical treatment. A total of 29 patients were started on or given medical treatment, nine of these with two drugs. Thirteen were treated with chlorprotixen, 11 with benzodiazepines, ten with sleeping pills, three with antidepressants and one with antiemetics. Only in four cases were there plans for the (dis-)continuation of the instigated medical treatment (**Figure 1**). One of the 11 patients who received benzodiazepines was given chlordiazepoxide as a treatment for alcohol withdrawal; the remaining ten received it as an anxiolytic.

Psychotherapy and social interventions

In 11 cases, it was documented that psychotherapy had been provided in the PER, primarily psychoeducation. Social interventions were undertaken in nine cases. Such intervention consisted, for example, of establishing visits from homecare assistants or arranging contact with one of the psychiatric centres' social workers. In no case was social services contacted because of the presence of young children in a possibly unstable home; in at least two cases, however, this would – in all likelihood – have been relevant.

Further treatment and follow-up

A total of 97 patients were discharged to follow-up elsewhere (**Table 2**), in several cases at more than one place. Patients were predominantly sent to their GP (46 cases). Other frequent collaborators were: various psychotherapeutic treatment services, private psychiatrists and the Acute Psychiatric Team (this is a team that can contact patients within a few days and support them in their own home during an acute phase). In 22 cases, patients were advised to contact their GP to discuss referral to psychotherapy. Among those, four were for psycho-

TABLE 1

The diagnoses of the patients seen in the psychiatric emergency room.

Diagnoses according to the ICD-10	Patients, n
F00–F09 Organic, including symptomatic, mental disorders	2
F10–F19 Mental disorders due to psychoactive substance use	10
F20–F29 Schizophrenia, schizotypal and delusional disorders	10
F30–F39 Mood (affective) disorders	25
F40–F48 Neurotic, stress-related and somatoform disorders	36
F50–F59 Behavioural syndromes associated with physiological disturbances and physical factors	2
F60–F69 Disorders of adult personality and behaviour	3
F70–F79 Mental retardation	0
F80–F89 Disorders of psychological development	1
F90–F99 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence and unspecified mental disorder	4
Z00-99 Factors influencing health status and contact with health services	7

ICD = International Classification of Diseases.

FIGURE 1

Number of medical treatments initiated in the psychiatric emergency room, with or without a plan for further treatment.

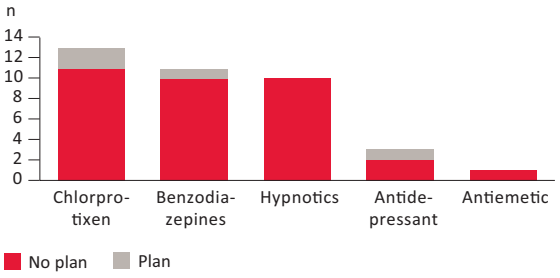

TABLE 2

Follow-up and further treatment for the patients seen in the psychiatric emergency room.

Place of referral	Patients, n
General practitioner	46
Various psychotherapeutic treatment services	19
Private psychiatrist	11
Acute team	9
Medical department	8
Alcohol abuse treatment clinic	8
Other psychiatric centres	7
Community mental health centre	6
Contact the psychiatric emergency rook the following day	6
Centre for the prevention of suicidal behaviour	3
Assertive community treatment	2

logical treatment and 18 for referral to a public outpatient psychotherapeutic treatment programme.

In nine cases, the patients were advised to discuss referral to private psychiatrists with their GP. In 14 cases, an appropriate referral may have been neglected.

Except for the insufficient information on the plans for further medical treatment, the patient reports were evaluated as understandable in 98 of 100 cases.

Doctors in the psychiatric emergency room

A total of 13 doctors treated patients in this study; the median time since graduation was 6.75 years (interquartile range: 5.75-10.75 years). In 44 cases, the doctor was in the first year of psychiatric training (after 6-6.5 years of medical school and 1-1.5 years of rotation, it is possible to apply for an introductory position); in 30 cases, doctors were in GP specialist training; in 13 cases, the doctors were employed in an unclassified position; in eight cases, the doctors were in psychiatric specialist training (a four-year position); and in five cases, the patients were seen by consultants in psychiatry. In 15 cases, the doctors reported that they had conferred with the senior doctor on call.

DISCUSSION

The function of the Danish PERs has changed considerably since they were first established in the 1970s; the PERs have undergone a centralisation and the smaller PERs are no longer open 24 hours a day. Not only have the PERs changed, but also the organization of psychiatric treatment in Denmark as a whole has changed. Among others, community mental health centres have been established, a continued reduction in the number of beds has occurred, and recent years have seen an increase in out-patient psychotherapeutic treatment, and a treatment guarantee has been introduced [9]. Alcohol withdrawal is now often treated in the somatic departments. For this reason, only few patients with alcohol abuse contacted the PER; alcohol abuse was previously one of the most common reasons for contacting the PER [4-6, 8]. Previous studies show a higher prevalence of patients with a diagnosis of schizophrenia contacting the PER [4-6, 8] than was the case in the present study. The less common (only ten cases) presentation of schizophrenia cases in the present study may reflect that previous studies included patients who were subsequently admitted and patients who were only seen by a nurse.

The lack of documentation of mental status (11 patients) and suicidality (20 patients) is something that calls for reflection.

Psychotherapy/psychoeducation was documented in only 11 cases; this low number may be due to lack of time, but it may also be due to the doctors' lack of psychotherapeutic qualifications [10]. Patients were mainly diagnosed with anxiety and secondary affective disorders; and for this group, it is highly relevant and part of current treatment recommendations to offer psychoeducation and psychotherapy, e.g. in the form of flash cards or activity-schedules which can be introduced within the limited timeframe of a consultation in a PER [11, 12].

PERs are often manned by the least experienced doctors who are constantly replaced. As a consequence, the loss of knowledge is great. In part to counter this, there has been a growing focus on the use of consultants in the PER, and the Capital's Regional Psychiatric authority has recently allocated consultants to the larger PERs during the busiest hours.

The increased presence of consultants in the PER will undoubtedly increase the quality of initial evaluation and visitation of the patients who are admitted as well at those who are repatriated.

Recent years have seen a marked proliferation of alternatives to admission. Thus, where previous studies found that around 35% of patients were sent home with no plan for follow-up [4, 5, 8, 9], the present study found that this was only the case for 3%. As far as social

Treatment in the psychiatric emergency room should ideally include all necessary aspects of the bio-psycho-social model, including medication, therapy and attention to the social environment of the patient such as family relations, especially minor children who may also be affected.

interventions are concerned, doctors may neglect their mandatory reporting duty, since it was in no case deemed necessary to issue a report to the social services regarding minor children in a possibly unstable home, despite at least two cases in which it is likely that this would have been relevant.

Another subject of this study that should give rise to further reflection is the use of medication in the PER. One could argue that initiating a treatment with an antidepressant in the PER is questionable, as the contact is often triggered by an acute crisis, and the insight the attending doctor has is more limited than that of the GP who may have known the patient for many years. On the other hand, it may be relevant to supply hypnotics in cases where an acute need to ensure sleep can prevent hospitalisation, or to decrease the dose of a drug if the patient experiences side-effects and cannot contact his or her GP. Naturally, addictive medication should be prescribed with caution, and so should sedative antipsychotics for non-psychotic anxiety. It is unsatisfactory that a clear treatment plan for medication was only found in four cases.

The study was based on data from the PER on PC Frederiksberg, and one must therefore consider whether it is representative of other psychiatric centres. As described above, the doctors working in the PER at PC Frederiksberg were relatively experienced and not medical students as is often seen elsewhere in PERs. The PER at PC Frederiksberg is not among the busiest in the region, so there is no reason to believe that the PER should be less well-functioning than other PERs.

CONCLUSION

Overall, this study shows that doctors in the PER are aware of the importance of making plans regarding who is responsible for patients' follow-up upon dismissal from the PER. Some of these plans, however, appear to be rather deficient. The performed objective psychiatric assessment should be a focus area with regard to documentation in all patient reports. There seems to be a need for an increased focus on psychoeducation (and psychotherapy) in the PER. With regard to social interventions, it seems relevant to focus on information and on developing an increased awareness among doctors in the PER, including an emphasis on the mandatory obligation to report to the social services when children may be at risk.

Doctors in the PER often used medical management of the patients' symptoms, possibly too often. There is a need for better planning and a more structured documentation on how to follow up on this treatment.

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NOTE: Since the data were collected, steps have been taken to heighten the standard of treatment and documentation on PC Frederiksberg. Now the PER reports are no longer just read by a senior doctor, but all reports are subsequently returned to the treating doctor with written comments; thus both improving the doctors training and the treatment of future patients in the PER.

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