PATIENTS USE OF
PSYCHIATRIC SERVICES
IN A UNIVERSITY HOSPITAL
EMERGENCY ROOM

by

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CHAPTER I

Introduction

The care of the psychiatric patient was usually the responsibility of private psychiatrists, large state hospitals, or more recently small psychiatric units in general hospitals. Out patient psychiatric services were provided by private psychiatrists, for clients who could afford them, and publicly supported Mental Health Clinics. When access to traditional psychiatric services became unavailable due to the rising costs of medical care or overcrowding in publicly supported agencies, other alternatives were needed.

One of these alternatives became the emergency room of general hospitals. Originally designed to provide care to accident victims, the injured, and the acutely ill, the emergency room had become the source of health care for the general public who used to obtain services from general practitioners. (O'Boyle, 1972, Stiles, 1976). Emergency room visits increased by 400 percent from 1940 to 1955, largely as a result of the public's demand for quality medical care that was easily accessible. (Shortliffe, et al, 1958). Psychiatric patients comprised between 4 and 28 percent of general emergency room visits. (Nigro, 1970, Amdur and Tuder, 1975).

Most of the recent changes in emergency room care were a response to the increasing volume of patients with both acute and non-acute problems. The innovative use of triage officers re-organized the emergency services substantially. In triage, the most acutely ill patients were seen first, while others with less serious problems were asked to wait or referred to an out-patient clinic. (Stiles, 1976). As the volume of visits increased, house officers were hired, usually for medical, surgical or pediatric patients, (Shortliffe, et al., 1958 and Belaff, 1968). A change designed to alleviate future emergency room problems was the development of emergency room residency programs. (Shriver, 1977).

Since the ratio of psychiatric patients to medical-surgical patients was low, emergency rooms usually expanded psychiatric services with psychiatric nurses or utilized the services of psychiatric residents in training. At Denver General Hospital, a crisis team staffed primarily by psychiatric nurses provided care to all psychiatric patients seen in the emergency room. In Tulare County, a mobile crisis team of psychiatric nurses, working out of the emergency room, provided emergency psychiatric care to patients in their homes. This avoided hospitalization and mobilized support from the patient's family and community resources. (Carter, 1973).

Where psychiatric staff were not available to the

emergency room staff, problems occurred. Making correct diagnoses and assessing patients' dangerous behaviour were the most difficult problems for staff to overcome.

Incorrect diagnoses were often made because time was not always available to spend with the patient to clarify the problems and provide the appropriate referral. Patients' reluctance to identify their needs as psychiatric and no generally accepted format for assessing psychiatric patients' problems also contribute to incomplete assessments and diagnostic errors. (Coleman, 1967, Pattison, 1969).

According to Frederick (1974), in determining how dangerous the patient's behavior was for himself and others, psychiatric personnel tended to overestimate the number of dangerous psychiatric patients. This led to increased numbers of patients being held against their will while waiting for members of the legal system to determine if commitment was necessary. This may have resulted from staff's legal responsibility for patients in addition to an inability to accurately assess the situation due to limited training.

Review of the Literature

The review of the literature demonstrated that psychiatric caseloads ranged from 4 to 28 percent of the general emergency room census. (Nigro, 1970, Amdur and Tuder, 1975). There was a greater percentage of cases noted when the psychiatrist saw all emergency room cases, than when data were recorded from referrals by other emergency room personnel.

Atkin (1967) noted that 7 percent of the 47,576 cases seen in a years time were referred to the psychiatric service. A much higher percentage, 28 (N=133), was found by Nigro (1970), a psychiatrist working as a medical physician in an emergency room. Amdur and Tuder (1975) reported that 4 percent (N=400) of the emergency room patients were diagnosed as psychiatric, although only 2.5 percent were referred for psychiatric consultation.

Diagnosis was also a heterogeneous factor with little resemblance noted between the psychiatric caseload of one emergency room and another. The number of psychotic clients in the psychiatric caseload varied from 2 percent (Nigro, 1970) to 42 percent (Atkin, 1967). Clients with organic

brain syndrome accounted for 13 percent of Atkin's (1967) population but only 4 percent of the cases referred to psychiatry in Amdur and Tuder's (1975) study. Thirty-five percent of the 229 psychiatric cases in Huffine and Craig's (1974) study were diagnozed as character disorder, situational depression of neurotic, while 43.7 percent of Atkin's (1967) cases were similarly diagnosed.

Admission rates for psychiatric patients varied from one emergency room to another and were not generally comparable to rates of admission for all emergency room patients. Shortliffe, et al. (1958) noted that 16 percent of the general emergency room caseload required admission to the hospital. Bridges (1970) cited studies where 15 to 45 percent of the psychiatric population seen in the emergency room required admission to the hospital. Carter (1973) found that the use of a mobile crisis team allowed 75 percent of the clients to be treated at home. Admission rates prior to the development of the crisis team were not listed.

The psychiatric caseloads, by diagnosis, were not consistent from one emergency room to another. However, there were some consistent social and environmental factors in clients that used the emergency room. Huffine and Craig (1973) reported that increased mental illness and suicide rates were related to factors of segregation, high mobility, low income, and increased minority groups. Bartolucci and

Drayer (1973) noted similar factors as well as previous and frequent psychiatric treatment. A majority (73.5 percent) of the clients in Amdur and Tuder's (1975) study had previous psychiatric treatment.

Other demographic variables listed for psychiatric patients using emergency services were: age, sex, race, and marital status. Only age and sex were consistent from one study to another. The majority of the psychiatric clients were female between the ages of 20 and 40. (Atkin, 1967; Rogawski and Edmundson, 1971, Huffine and Craig, 1974). Most psychiatric caseloads had small numbers of elderly clients. Cohen (1976) and Eisdorfer (1977) stated this reflected poor casefinding abilities of medical staff, who incorrectly diagnosed many of the elderly's behavior problems as senility. The number of clients, either white or non-white, was generally a reflection of the predominent race in the community using the hospital for service. Although the majority of clients in Huffine and Craig's (1974) study were black, white clients came more often from segregated black communities or integrated areas than segregated white communities. Atkin (1967) and Huffine and Craig (1974) reported more married clients in their population, but Rogawaski and Edmundson (1971) had more single clients.

In addition to assessing the client for diagnostic purposes, numerous other factors required the attention of

interviewer in the emergency room. Bartolucci and Drayer (1973) suggested that more than one emergency room visit was needed to clarify the problem and begin to help the client resolve his difficulties. In an attempt to more effectively evaluate the client with psychiatric problems in a walk-in clinic, Lazare (1976) developed a hypothesis testing method. He suggested that most problems fell into four categories: biologic, psychologic, social, and behavioral. The interviewer decided early in the assessment process which hypothesis would most likely provide the necessary information. Through additional questions, he validated his assumptions prior to formulating a treatment plan.

Additional strategies were suggested by persons who believed more emphasis should be placed on social information. Coleman and Errera (1963) believed that most psychiatric referrals did not constitute diagnostic dilemma and could be handled by personnel other than physicians. In 1967, Coleman wrote..."regardless of the presenting problem, the underlying problem is often a social or situational impasse." Lazare, et al, (1975) suggested that a customer approach towards patients often produced the most valuable information. By asking the patient what he wanted in the way of help with his problem, health professionals were then able to negotiate or offer him the most appropriate service.

Once the evaluation was completed some sort of referral was made, since policies of emergency rooms rarely permitted clients to return for further treatment. The referral process required physicians to have an awareness of community resources where clients could obtain followup treatment. (Zusman, 1967).

Without intervention from psychiatric personnel, clients often did not follow through with their referrals. Rogawski and Edmundson (1971) found that follow-up rates improved from 30 to 55.6 percent when the therapist made the first appointment for the client. This reduced some of the administrative barriers that often discouraged females and blacks in the lower socioeconimic classes from seeking additional therapy. (Craig, Huffine, and Brooks, 1974). Follow-up rates doubled when the therapist made the first appointment and the length of time until the first appointment was reduced. (Craig, Huffine, and Brooks, 1974; Townsend, 1976).

Diagnosis, age, and the type of therapy also influenced the referral process. Craig, Huffine, and Brooks (1974) found that depressed patients responded three times more often to having the therapist make the first appointment. Clients with a diagnosis of neurosis or character disorder responded better to a shorter waiting period Those clients who remained longest in therapy were usually over 30 years

old and diagnosed as psychotic or personality disordered. Brief therapy candidates were usually under thirty years of age, but diagnosis was not a significant factor.

Even with the success in improving follow-up rates, clients continued to drop out of therapy from the first to their second appointment. Both Townsend (1976) and Craig and Huffine (1976) noted drop out rates from the first to the second appointment of 20 and 12 percent respectively. Neither study contacted clients to discover the reason for the attrition rates.

Clients who were poor at complying with treatment plans were often referred to psychiatric nurses. Coleman and Dumas (1962) saw the role of the psychiatric nurse as that of making home visits to clients who didn't keep appointments, discontinued therapy too early, or hadn't provided the physician with enough information to formulate a treatment plan. More recently nursing's role included patient advocacy, consultation with preventative programs, and dealing with the clients milieu through home visits. (Sloboda, 1976). The flexibility of nursing's role allowed for services to be delivered to clients interested and in need of help, but unable to make use of it in the existing system without added support.

In summary, the literature identified three areas that warrant attention in planning for the delivery of care to psychiatric patients in an emergency room setting, First,

the characteristic of the psychiatric population must be identified in order to plan for service and personnel Second, time and skilled personnel must be available to accurately assess and develop treatment plans for psychiatric patients. Third, coordination between the emergency room and the referral sources is necessary to assist the client with additional appointments without the usual administrative barriers.

Studies in the Setting

The Department of Psychiatry, in the study setting, compiled data on all patients seen by their psychiatric residents in the emergency room during March, 1974. Information was recorded about the client's age, sex, diagnosis, and disposition. Service utilization data included the source of referral, time into the emergency room, and date of the visit. At the time of the study, the Crisis Unit, the emergency room's primary inpatient psychiatric referral, had a capacity of eleven beds.

Data from the study indicated that the emergency room was serving a young population (i.e. 20 to 39 years old), of predominantly males with situational or drug or alcohol problems. The majority of the diagnoses fell into the categories of depression, personality disorder, and drug and alcohol abuse. Police referrals accounted for 30.1 percent of the caseload. Most clients were seen during the

regular work week, with equal numbers on day and evening shifts.

More than half of the clients were hospitalized, with 32.5 percent (N=52) of the patients admitted to the Crisis Unit and 19.7 percent (N=32) transferred to the State Hospital. Twenty-five percent of the patients were referred to out-patient centers. Of this 25 percent, only 5.7 percent were referred to the study hospital's psychiatric clinic. The rest of the patients were offered no follow-up.

Almost 25 percent of the clients' disposition plans indicated they were referred back to the source of their referral to the emergency room. Only one of the referral sources included public or private treatment agencies. Therefore, these treatment agencies could account for only their 15.6 percent of the referrals, which meant the remaining 9.4 percent of the clients probably had no follow-up.

In 1975 the study hospital commissioned A. E. Brim and Associates to study the emergency services department. The study was undertaken for the purpose of providing the hospital with suggestions for increasing the efficiency and revenue of the emergency room.

According to the results of that study, the emergency room had an average yearly census of 32,670 patients, of which 15.2 percent were admitted to the hospital. Another

42.2 percent of the clients were referred to the hospital's out-patient clinic, but less than half followed through with their appointments. In spite of the large caseload and the availability of the out-patient clinic, the emergency room had recorded a decrease in census for the two years prior to the study. Other emergency rooms in the area had not experienced decreases in their emergency room caseloads. Over half of the clients were listed as "no pay" and probably reflected the trend of the medically indigent to use the emergency room, which had been a part of the County Hospital until acquired by the study hospital some two to three years previously.

The Brim (1975) study listed psychiatry as sixth in the list of specialties according to the number of cases seen per month. The psychiatric caseload was approximately 209 cases per month or 7.6 percent of the total emergency room census. These figures are higher than those reported by the Department of Psychiatry the year before.

In 1976 a pilot project, jointly sponsored by the Departments of Psychiatry and Psychiatric Nursing, was carried out between the emergency room and one of the publicly supported Mental Health Clinics. A second year graduate student in psychiatric-mental health nursing and a second year psychiatric resident were located at the clinic for their community practicum. All psychiatric patients

seen in the emergency room who lived in the catchment area of the clinic were included in the project. Patients were referred to the psychiatric nursing graduate student by the psychiatric nurse in the emergency room.

Once the referral was made to the graduate student, she initiated contact with the patient either by telephone or through a home visit. Thirteen patients were referred, but two refused further follow-up after the initial contact. Seven of the 11 remaining patients indicated they would not have followed through with additional appointments without the initial contact being made by the graduate student. By the end of the project, only three patients were in need of continued therapy with the Mental Health Clinic. With the exception of two clients, one had moved from the area and the other died as the result of a previously diagnosed medical problem, the remaining six patients had resolved their problems.

Statement of the Problem

In the study hospital emergency room more psychiatric emergency cases were treated than any other mental health facility in the area. The census in psychiatric emergencies continued to grow even though the total emergency room census decreased. There was also a limited number of staff available to care for the psychiatric patients. (Brim, 1975, Knox, Hersud, and Kiser, 1977).

In order to develop comprehensive programs to provide psychiatric care in the emergency room, ongoing evaluations of the patients and their problems were needed. (Atkins, 1967; Rogawaski and Edmundson, 1971; Huffine and Craig, 1974; and Amdur and Tuder, 1975). Comparisons of the referral process to diagnoses showed that staff were needed to assist and provide the client with the most appropriate follow-up required. As demonstrated in the 1976 pilot project and in the literature (Carter, 1973), active follow-up by psychiatric nurses increased patient response to therapy.

In view of the existing problem, (i.e. shortage of personnel and resources to meet the increasing demand for psychiatric care through the emergency room) data were needed to further identify and confirm future directions for more efficient delivery of care.

Purpose of the Study

In order to provide data to identify current problems which existed in providing care to psychiatric patients in the emergency room, a descriptive study was done. Three areas were evaluated:

1) the service utilization patterns of the emergency room and commonly used referral sources for the psychiatric population, 2) the characteristics of the psychiatric population,

and, 3) the process of delivering care to patients with psychiatric problems in an emergency room setting. To meet the purposes of the study, it was necessary to operationally define each of the major concepts included in the purposes.

The first concept, service utilization patterns, was defined according to the data which indicated how and when the client used the emergency room for psychiatric care. The effect of diagnosis and disposition plans on the client's stay in the emergency room was also studied.

The second concept, selected characteristics of the population, was defined according to the patient's demographic, geographic, and diagnositc characteristics listed on the emergency room records.

The third concept, the process of providing care for psychiatric patients, was defined by information that identified how care was delivered to patients and factors that influenced that process.

CHAPTER II

Methodology

Setting

The study was conducted in the emergency room of a 500 bed university hospital. The hospital was part of a Health Science Center, that included Schools of Nursing, Dentistry, and Medicine, as well as a large out-patient clinic. The emergency room had the largest census in the area with the exception of a large Health Maintenance Organization.

The hospital under study was one of twenty in a tri-county area. The population of the tri-county area was 981,327; 4.2 percent was non-white. The hospital was located in the large metropolitan county where the nonwhite population was 6.35 percent of the 582,773 residents. (Columbia Regional Associates of Government, 1976 and State Employment Division, 1976).

The emergency room saw the greatest number of psychiatric patients in the city. Several factors accounted for the size of the caseload. A contract existed between the County and the hospital to screen all potential police court hold patients and hospitalize a limited number. These clients were brought in by the police for evaluation of their mental status and dangerousness to self or others. The Crisis Unit attached to the Emergency Room had originally

been designed to provide short term care to the indigent. These clients had previously been hospitalized at the State Hospital. Clients who were medically indigent tended to return to the emergency room seeking admission to the Crisis Unit in preference to the State Hospital.

Other factors that may have contributed to the large caseload were the availability of psychiatric residents on a 24 hour basis in the emergency room and the lack of psychiatric emergency services at local Mental Health Clinics. Waiting lists for appointments at the clinics ranged from one to three weeks.

Care of psychiatric patients was usually provided by interns or first and second year psychiatric residents on a 24 hour basis. During the daytime a psychiatric nurse specialist was available to assist in the evaluation and disposition process. Since the Crisis Unit only had a capacity for 11 patients, admissions to other hospitals frequently had to be arranged. This often delayed the process of providing care since no readily available transportation system existed. The waiting time ranged from one to three hours.

Criteria for Selection of the Population

The population studied included all persons seen in the emergency room between January 2, 1976 and May 31, 1976 who requested psychiatric help or whose diagnosis included

traditional psychiatric disorders or psychological terminology. The time of the study was determined to exclude the two major holidays, Christmas and New Years, which were often thought to affect the numbers of clients seeking help.

A subset of this population seen in the emergency room during the last month of the study was randomly selected for additional data collection procedures.

Data Collection Methods

The billing sheets of all patients in the population provided information about the three areas studied. These records included demographic data provided by the patient upon entering the emergency room. Diagnostic and referral data were added to the records by the clerk when the patient left the emergency department.

Service utilization data obtained from the billing sheets included: 1) date of the visit, 2) chief complaint, 3) arrival time, 4) duration of the visit, and 5) disposition plan. Characteristics of the population included: 1) sex 2) age, 3) religious preference, 4) marital status, 5) race, 6) income, 7) address, and 8) diagnosis. Delivery of care data included the person (i.e. resident, intern, or psychiatric nurse) who assumed primary responsibility in caring for the client in the emergency room.

As the data collection progressed, it became apparent that information from the billing sheets was not sufficient

to answer the purposes of the study. For example, information was not available about the source of referral, clients' support systems, previous psychiatric history, and the clients' underlying problem. A policy change by the Department of Psychiatry required that copies of all psychiatric patients' emergency room records be kept in the emergency room. It was then possible to review the hospital record of psychiatric patients seen by the residents during the last month of the study. Forty cases, or 15 percent of these 261 psychiatric patients seen by the residents, were randomly selected for the additional data collection.

Data Analysis

Information from the billing sheets was coded, to maintain anonymity, and recorded on worksheets. The data was then entered into a WANG 2200 computer for analysis. All patients were given a code number so repeat visits could be noted. Frequency tabulations and percentages were obtained for each category. The computer was also used to compare data such as: diagnosis with disposition, time spent in the emergency room with diagnosis and disposition, and the caseloads of the residents, interns, and psychiatric nurse.

Data from the subset of the population were tabulated by hand and percentages were calculated. The worksheet for the raw data of the sample population is included in Appoendix A.

CHAPTER III

Results

Data from the study are presented in order of the operationally defined purposes of the study pp. 15-16. Information from the subset of the population will be noted specifically.

As shown in Table 1, the psychiatric visits to the emergency room totaled 1,478 or 10.7 percent of the total emergency room caseload.

Table 1

Psychiatric Patient Visits Compared With Total Emergency Room Visits on a Monthly and Daily Basis.

	Census	Psychiatric	Percent	Emergency Room
Monthly				
	January	305	11.9	2,558
	February	312	10.4	3,000
	March	305	10.2	2,978
	April	295	11.2	2,627
	May	261	9.8	2,668
Daily				
	Sunday	196	9.9	1,980
	Monday	206	9.8	2,010
	Tuesday	234	12.3	1,904
	Wednesday	203	10.5	1,940
	Thursday	190	10.2	1,862
	Friday	257	13.0	1,989
	Saturday	192	9.3	2,055
Total		1,478*	10.7	13,831

*Due to errors in entering data into the computer these figures were hand tabulated. The most consistent N for computer figures was 1483, indicating a loss or gain of 5 cases.

On a monthly basis, February had the greatest number of both emergency room cases and psychiatric clients. May had the fewest number of psychiatric cases, but ranked third in the number of total emergency room patients.

Weekends were not as busy for the psychiatric service as they were for the emergency room although 7 day a week psychiatric personnel were available. Friday and Tuesday generally had more psychiatric clients while Monday and Saturday had the most general emergency room patients.

Most of the patients (68.9 percent) requested psychiatric help upon entering the emergency room. An additional 8.27 percent had made a suicide attempt. Another 20.3 percent requested medical attention, but were diagnosed with either a primary or secondary psychiatric disorder. Only 2.1 percent listed drug or alcohol abuse as their chief problem. Less than 1 percent of the records were incomplete.

Information about arrival times to the emergency room and the duration of the emergency room visit is presented in Table 2. By shift, more clients were seen during the daytime. However, the busiest hours for psychiatric visits were between 12 noon and 11:00 p.m.

Approximately one-third of the billing sheets had unknown departure times from the emergency room. Completed records indicated 48 percent of the patients remained in

the emergency room less than three hours. However, over 16 percent of the clients stayed in the emergency room more than three hours.

Table 2

Arrival Time and Duration of the Emergency Room Visit for Psychiatric Patients.

Time	Frequency	Percentage
Arrival Time		
8:00 - 12 noon	218	14.7
12 noon - 5:00 p.m.	453	30.5
5:00 p.m. - 11:00 p.m.	487	32.9
11:00 p.m. - 8:00 a.m.	325	21.9
Duration of visit (in hours)		
Less than one	181	12.2
One to two	325	21.9
Two to three	206	13.9
Three to four	127	8.6
More than four	128	8.6
Unknown	516	34.8
Total	1483	100

Information about the source of referral was obtained from the randomly drawn subset of the population. Forty-five percent of the clients were self referred and 40 percent were referred or brought in by the police. The remaining 15 percent were referred by family members or private therapists. The patients designated police referral were over represented in the subset since only 21.2 percent of the

total population was listed as police contact in the data from the billing sheets.

For the total population the most frequently noted disposition plan was no follow-up (See Table 3). This indicated the client was released from the emergency room without a referral. Almost 30 percent of the clients were admitted for treatment on psychiatric units. Admissions to the Crisis Unit accounted for 14.7 percent with

Table 3

Disposition Plans for Psychiatric Patients

Plan	Frequency	Percent
(S) Crisis Unit (P)	218	14.7
(S) Intermediate care (P)	10	.7
Veterans Hospital (P)	27	1.8
State Hospital (P)	187	12.6
Private Hospitals (P)	17	1.2
(S) Other units (M)	44	3.0
(S) Scheduled admission (P)	6	.4
(S) Out patient clinic (P)	40	2.7
(S) Crisis Team (P)	17	1.1
Mental Health Clinics (P)	69	4.6
Out patient-Veterans (P)	13	.9
(S) Out patient clinic (M)	159	10.7
Psychiatric day patient	11	.7
Private physician	49	3.3
Alcohol and Drug	8	.5
No follow-up	571	38.5
Left without being seen	39	2.67
Total	1485*	100

(S) + Study Hospital (M) = Medical service
(P) = Psychiatric service
*Figures are 2 greater than most computer totals indicating a gain by the computer of 2 cases.

15.6 percent transferred to other hospitals. Another 3 percent of the clients were admitted to medical wards at the study hospital. Psychiatric out-patient referrals were infrequent, with 4.6 percent of the patients referred to publicly supported Mental Health Clinics and 2.7 percent referred to the study hospital's out-patient psychiatric clinic. The Crisis Team, which was based in the emergency room and provided outreach services, followed 1.1 percent of the patients.

Emergency room visits of less than one hour and more than four hours were compared with diagnoses and disposition plans. As noted in Table 4, the number of clients with functional psychiatric disorders decreased from the shorter to the longer time period. Almost three times as many clients with organic problems were found in the longer time period than the shorter time category. There was little difference in the duration of the visit for clients with situational and drug or alcohol problems.

There were fewer admissions to the Crisis Unit in the longer time period. Clients transferred to the State Hospital were equally represented in both the short and long time categories. Few patients were admitted to the Veterans Hospital or to private hospitals. However, time until admission to the Veterans Hospital was shorter than time until admission to private hospitals. It should be noted that the Veterans Hospital is in closer proximity to the study hospital, than were private hospitals. Referrals to out-patient

Table 4

Frequency of Diagnoses and Disposition Plans in Shorter and Longer Duration of Visit Categories

Category	Duration of visit (in hours) Less than 1	More than 4
Diagnosis		
Functional	46	19
Organic	12	33
Alcohol and drug	26	27
Situational	103	93
Disposition		
Admission		
Crisis Unit	29	13
State hospital	14	15
Veterans Hospital	4	2
Private hospitals	1	2
Medical wards	4	6
Out-patient		
(S) psychiatric	5	6
(S) medical	15	20
Veterans-psych.	2	-
Mental Health Clinics	6	7
Crisis Team	2	2
Private physician	6	10
Alcohol and drug	1	-
Other		
No follow-up	82	46
Left without being seen	9	-

(S) Study hospital

clinics and private physicians had slightly more numbers in the longer time category than the shorter time category (i.e. 45 versus 36 respectively).

Data describing the demographic and geographic characteristics of the psychiatric population are presented in Table 5. The emergency room has continued to see a younger,

Table 5

Demographic Characteristics of the Psychiatric Population

Characteristic	N (1483)	Per cent	Characteristic	N (1483)	Per cent
Sex			Race		
Male	838	56.5	Caucasian	1305	88.1
Female	645	43.5	Black	128	8.6
			Other	49	3.3
Age (in decades)					
			Address (catchment areas of		
Under 10	6	.4	mental health clinics)*		
10-19	145	9.8			
20-29	605	40.8	NW/SW	546	36.8
30-39	369	24.9	SE	259	17.4
40-49	168	11.4	NE/SE	215	14.5
50-59	105	7.0	NE	234	15.8
60 and over	84	5.7	N	69	4.6
Unknown	1		County 1	45	3.0
			County 2	57	3.8
Religious preference*			Other	60	4.1
			Income		
Protestant	164	11.0	0	219	14.8
Catholic	148	10.0	1-5,000	63	4.2
No prefer.	302	20.3	5-10,000	26	1.8
Unknown	698	47.0	10,000 +	16	1.0
Other	175	11.7	Insurance	156	10.5
			Welfare	307	20.7
Marital status			Project Hlth.	7	.5
			SAIF	7	.5
Single	523	35.3	Cty. contract	315	21.2
Married	264	17.8	SSI and MC	133	9.0
Divorced	203	13.7	Veterans	27	1.8
Separated	76	5.1	Unemploy.	31	2.1
Widowed	46	3.1	Unknown	176	11.9
Unknown	371	25.0			

*N for religious preference was 1487 and for address the N was 1485 indicating gains by the computer.

i.e. 20 to 39 years old, population of predominantly male clients. There were only 84 (5.7 percent) clients over the

Almost half of the billing sheets had no information about religious preference. About 20 percent of the patients stated they had no religious preference. Those clients identifying a religious preference were about equally divided between Roman Catholic and Protestant.

Eighty-eight percent of the patients were caucasian. However, the percentage of non-white clients, 11.9 percent, was greater than the tri-county percentage, 4.35 percent. The race of non-white clients, other than blacks, was Native American, Oriental, and East Indian.

The catchment area of the hospital included the entire tri-county community. Over a third of the patients resided in the catchment area of the NW/SW Mental Health Clinic where the study hospital was located. Relatively equal numbers of clients came from the catchment area of three of the remaining four Mental Health Clinics in the metropolitan county. The fourth clinic in the metropolitan county and the remaining two counties had similar numbers of clients in the emergency room population (i.e. N clinic - 4.6 percent, County 1-3 percent, and County 2-3.8 percent).

Approximately 50 percent of the psychiatric patients had income levels below $5,000 per year or received their income from unemployent or public assistance agencies. Persons with third party insurance or yearly income levels

greater than $5,000 accounted for 15.6 percent of the population. Police hold patients represented 21.2 per cent of the population. However, no financial information was obtained from those clients since the county was obligated to pay for medical expenses. Financial information was incomplete on 11.9 percent of the billing sheets.

In addition to determining numbers and types of patients in the service utilization pattern data, it was necessary to define the psychiatric population in relation to its diagnostic collocation. Manipulation of the date obtained would later identify how care was provided in the emergency room of the study hospital. Traditional psychiatric diagnoses (i.e. schizophrenia, psychosis, endogenous depression, and manic-depressive illness) were listed as functional disorders. Physical problems such as organic brain syndrome, extrapyramidal reactions from neuroloeptics, mental retardation, and medical-surgical illnesses were listed as organic disorders. Alcohol or drug abuse was listed separately. Diagnoses of overdose, personality disorder, reactive depression, suicide attempt, hysteria, anxiety, hyperventilation, paranoia, psychosomatic conditions, and emotionally upset were grouped together as situational problems.

As shown in Table 6, over half of the clients were diagnosed with situational problems. Patients with

Table 6

Diagnoses of Psychiatric Patients Seen in the Emergency Room

Diagnosis	Freguency	Percentage	Diagnosis	Freguency	Percentage
Functional			Situational		
Schizophrenia	186	12.5	Overdose	50	3.4
Psychosis	46	3.1	Personality disorder	180	12.1
Endogenous dep.	9	.6	Reactive depression	245	16.5
Manic-depress.	66	4.4	Suicide attempt	29	2.0
Total	307	20.6	Hysteria	59	4.0
Organic			Anxiety	120	8.1
Medical	91	6.1	Hypervent	13	.9
Organic brain syndrome	30	2.0	Paranoia	11	.7
Extrapyramidal reactions	11	.7	Emotionally upset	33	2.2
Mental retard-ation	18	1.2	Psychosomatic	14	1.0
Total	150	10	Total	754	50.9
Drug and Alcohol	177	11.9	Unknown	98	6.6

*Multiple diagnoses were often noted on clients, but only the first diagnosis entered into the computer was tabulated for this Table. N = 1486, a gain of 3 by the computer.

functional psychiatric disorders accounted for 20.6 percent of the population. Although only 2.1 percent of the clients entered the emergency room with complaints of drug or alcohol abuse, 11.9 percent were diagnosed as drug or alcohol abusers. Ten percent of the clients had organic problems.

Previous psychiatric treatment was not listed on the billing sheets. However, clients' case numbers were used to determine the number of repeated contacts with the emergency room during the study period. There were 1220 patients in the study and 1483 visits to the emergency room. The 263 (17.7 percent) repeat visits were made by 154 (12.6 percent) clients. More than four visits were made by 4.1 percent of the repeat visit clients.

Since both previous psychiatric history and information about the client's support systems were not available from the billing sheets, the records from the subset of the population were utilized. This information is presented in Table 7.

Twenty-five of the 40 patients had previous psychiatric treatment. Eleven of those clients were admitted to a hospital. Five clients had no history of previous psychiatric treatment and only one required admission. Nine of the 10 patients with unknown previous psychiatric histories were admitted.

Table 7

Previous Psychiatric Treatment and Support Systems of Clients in the Subset of the Population

Characteristic	Admitted		Not Admitted		Total
	Male	Female	Male	Female	
Previous psychiatric treatment					
Previous tx.	5	6	6	8	25
No previous	1	0	1	3	5
Unknown	6	3	1	0	10
Support systems					
Supportive	2	1	1	7	11
Non-supportive	1	1	0	1	3
Unknown	9	7	7	3	26

Information about the client's support systems was largely missing from the records. Sixteen of the 26 patients with unknown support system information were admitted to the hospital. Only 3 of the 11 clients with supportive relationships in the community required hospitalization.

The billing sheets indicated who had seen the patient in the emergency room. The psychiatric resident provided care for 56.7 percent of the clients. Interns saw 39.2 percent of the clients. The psychiatric nurse was the primary provider of care for 2.2 percent of patients, although her role involved more initial screening of psychiatric patients and collaboration with both psychiatric

residents and interns. The remaining 1.8 percent of the patients left the emergency room without being seen.

The diagnoses within each of the health professional's caseload are presented in Table 8. The data include multiple diagnoses, and were representative of both the kinds of cases seen by each of the health professionals and the diagnoses they used most often.

The psychiatric residents' caseload included a greater number of functional psychiatric disorders and characterological problems. Medical problems in addition to diagnoses of anxiety and emotionally upset accounted for only a small percentage of the residents caseload. Diagnoses of drug or alcohol abuse represented about 10 percent of the caseload. The largest single diagnosis, reactive depression, accounted for almost 20 percent of the caseload.

The interns' caseload was primarily comprised of medical diagnoses, anxiety, and drug or alcohol abuse. Diagnoses of overdose, psychosomatic conditions, and hyperventilation were not a large percentage of the intern's caseload, but were greater in number than in other health professionals caseloads.

The psychiatric nurse's caseload included a variety of diagnoses. Almost half of the caseload was comprised of diagnoses of reactive depression and emotionally upset.

Table 8

Frequency of Diagnoses in the Caseloads of Residents, Interns, and the Psychiatric Nurse

Diagnosis	Resident	Intern	Nurse	Total P	Total M
Schizophrenia	160	28	2	186	190
Psychosis	55	7	-	46	62
Personality Dis	169	41	2	180	212
Reactive depress.	190	77	11	245	278
Endogenous depress.	3	5	2	9	10
Manic-depress.	65	5	1	66	71
Drug and Alcohol	108	117	3	177	228
Overdose	13	50	2	50	65
Suicide attempt	63	11	1	29	75
Hysteria	53	20	3	59	76
Anxiety	34	133	5	120	172
Hyperventilation	2	20	-	13	23
Medical	25	106	5	91	136
Organic brain syd.	23	15	-	30	38
Extrapyramidal sx.	5	6	1	11	12
Paranoid	12	2	-	11	14
Mentally retarded	11	3	-	18	14
Emotionally upset	22	19	12	33	53
Psychosomatic cnd.	2	17	-	14	19
Unknown	30	43	5	78	98
Total	1045	725	55	1486	1825

P = primary diagnosis.
M = multiple diagnoses.

These diagnoses were more descriptive of the client's presenting problem rather than long standing problems.

Table 9 contains the disposition plans for the following diagnoses: a) schizophrenia, b) psychosis, c) drug and alcohol abuse, d) anxiety, e) medical, and f) emotionally upset.

Table 9

Disposition Plans of Selected Diagnoses

Diagnosis	(CU)	(SH)	VAZ	Pvt.	OPC-(P) (S)	OPC-(P) (C)	CT	(SM) OPC	AD	NFU
Schizophrenia	55	53	5	1	2	11	1	5	0	50
Psychosis	28	14	1	1	3	1	0	2	0	8
Drug and alcohol	20	24	5	1	5	5	0	15	9	118
Anxiety	2	7	0	0	8	5	2	42	0	83
Medical	2	9	1	1	2	1	1	64	0	36
Emotionally upset	3	3	0	0	2	4	5	8	0	20

(CU) Crisis Unit
(SH) State Hospital
(S) study hospital
(C) county
(CT) Crisis Team
(SM) study hospital - medical
(AD) Alcohol and Drug
(P) psychiatric
(NFU)no follow-up

Patients with functional psychiatric disorders were generally admitted to a hospital. More than two-thirds of the patients diagnosed as schizophrenic were admitted or referred to out-patient clinics. Equal numbers of schizophrenic patients were admitted to the Crisis Unit and the

State Hospital. Fewer schizophrenic patients were admitted to private hospitals than to the Veterans Hospital. Over a fourth of the schizophrenic patients were released from the emergency room without a referral. Patients diagnosed as psychotic were usually admitted. Twice as many of these patients were hospitalized at the Crisis Unit as compared with the State Hospital.

Less than one-fourth of the drug or alcohol abuse patients were admitted to psychiatric units. There were almost equal numbers admitted to the Crisis Unit and the State Hospital, although the State Hospital had the only drug and alcohol program. The majority of the remaining clients left the emergency room without additional referrals.

Clients with general medical or surgical problems were usually referred to the study hospital's out-patient medicine clinics, but without additional psychiatric follow-up. Less than one-third of these clients were released without any follow-up. When psychiatric patients with medical problems were admitted, they were more often hospitalized at the State Hospital which had limited medical facilities in comparison with the Crisis Unit.

Clients with situational problems were less often admitted to psychiatric units. However, of those admitted there were more admissions to the State Hospital than the Crisis Unit. Fifty-three percent of the remaining clients were offered no follow-up. Those with referrals

were usually referred to the out-patient psychiatric clinic or medical clinic at the study hospital. Only those clients referred to the crisis team were provided outreach services that maximized their changes of following through with additional therapy.

In order to determine if the psychiatric assessment focused on situational or social problems and included information about the client's support systems the records of clients in the subset of the population were reviewed. Data about support systems were presented in Table 7, p. 32 Those figures indicated that residents had not included information about support systems for 26 of the 40 clients. Three of 5 clients in that sample were sent home without a referral, and their records had no information about support systems. Of the remaining two patients, one had supportive relationships in the community and the other did not.

In reviewing the narrative accounts of the patients visits, 17 of the 40 were primarily distressed over situational or social problems. Fifteen of the clients had situational diagnoses, but two were diagnozed as schizophrenic. The remaining 23 clients had symptoms of psychopathology (i.e. hallucinations, delusions, memory loss, etc.) with the exception of one whose record was incomplete.

Neither the records of the subset of the population

nor the billing sheets had information indicating assistance was provided with follow-up. Only those clients referred to the crisis team, which provided outreach services, were given assistance with follow-up appointments or help in resolving their difficulties. Clients seen during the daytime hours of the week could have received assistance with follow-up appointments, since clinics were open, but none of the records indicated this had been done.

CHAPTER IV

Discussion

The changing role of emergency rooms in health care delivery had created several problems. Many of these problems were amplified in caring for the psychiatric patients who used the emergency room for their psychiatric care. Previous studies, in the literature, identified the problem in obtaining a complete history with the limited time available, inconsistent characteristics of psychiatric patients who used emergency room, and poor follow through with referrals without assistance from psychiatric personnel in obtaining appointments. (Atkins, 1967; Rogawski and Edmundson, 1971; Huffine and Craig, 1974; Amdur and Tuder, 1975; Craig and Huffine, 1976; Lazare, 1976). In order to confirm or refute data from previous studies of the psychiatric population in the study hospital, a descriptive study was undertaken. The study was also designed to provide additional information about the characteristics and delivery of care to psychiatric patients in the emergency room.

The first purpose of the study was to identify and define the service utilization patterns of psychiatric patients using the emergency room. This was done using available information about when and how clients came for psychiatric care in the emergency room.

The number of psychiatric patients in the emergency room caseload increased from 7.6 percent (Brim, 1975) to 10.7 percent. With the addition of the psychiatric nurse to the emergency room staff and the psychiatric team, active casefinding undoubtedly contributed to some of the increase in the number of psychiatric patients included in the study. The availability of the psychiatric nurse in the emergency room also probably increased the number of consultations, but the study was not designed to examine that relationship. In the literature, Nigro (1970) reported the largest percentage of psychiatric cases while working as a physician in the emergency room.

Sixty percent of the clients in the subset of the population were self referred or came at the request of family members or private therapists. In the total psychiatric population 78.8 percent were not listed as police referrals and were a mixture of self and other referred. Almost eighty percent of the patients identified their problems as psychiatric, in contrast to reports in the literature, that patients rarely identify their needs as psychiatric in nature. (Coleman, 1967). This may be related to the finding that patients tended to use the emergency room as a walk-in clinic, with most patients arriving during the weekday daytime hours.

While less than one-third of the psychiatric clients required admission to the hospital, over one-third of the clients left the emergency room without a referral for additional therapy. Usually clients diagnosed as psychotic or schizophrenic require additional follow-up for some combination of psychotherapy and chemotherapy. Patients with longstanding multi-system problems could benefit from even brief supportive therapy. From both the severity and the chronicity of these patients' problems, leaving the emergency room without additional follow-up indicated insufficient services were being provided by emergency room personnel.

The remaining clients were referred to a variety of out-patient resources within the community and a small number were followed by the study hospital (i.e. crisis team - 1.1 percent and the out-patient psychiatric clinic - 2.7 percent). The literature reported minimal patient follow through without assistance from staff in obtaining appointments. (Rogawski and Edmundson, 1971; Craig, Huffine, and Brooks, 1974; Townsend, 1976; Craig and Huffine, 1976). However, only that 1.1 percent of the clients assigned to the crisis team were offered such assistance. The caseload that the crisis team could handle was restricted by the graduate

students' other commitments to course work and inpatient liaison work. By adding staff positions to the team, more patients could be seen through the outreach services.

The most notable influence on the duration of the emergency room visit were diagnoses of functional psychiatric disorders or admissions to the Crisis Unit. More of these patients spent less than one hour in the emergency room. The easy accessability of the Crisis Unit averted delays in waiting for transportation. Patients with functional psychiatric disorders usually had more obvious symptomatology, thus reducing the time of the evaluation process. More patients admitted to the State Hospital were represented in the longer time category (i.e. more than 4 hours) than those admitted to the Crisis Unit. The diagnoses of clients admitted to the State Hospital and the Crisis Unit were relatively similar, except that fewer psychotic patients were in the State Hospital sample. Delays in arranging and waiting for transportation to the State Hospital increased the time spent in the emergency room.

The admission rates to the study hospital Crisis Unit (14.7 percent) were similar to those reported by Brim (1975) for the total emergency room caseload (15.2 percent). However, an additional 15.6 percent of the psychiatric clients were in need of admission but had to be transferred to other hospitals. Data from the Department of Psychiatry in 1974

showed that 32.5 percent of the clients were admitted to the Crisis Unit and 19.7 to the State Hospital. The current figures indicated a more equal distribution of patients admitted to the two hospitals. This might have been a result of increased clients, especially police holds, whom the Crisis Unit could no longer accommodate as they did in the past. Figures for the study hospital's out-patient psychiatry department were half what they were in 1974. These figures represented the same number of clients from 1974 to 1976 indicating the clinic had not been able to accommodate any more patients.

The psychiatric population would seem to have been characterized as including a large number of clients with longstanding multi-system problems who prefered to use the emergency room for their psychiatric care. The emergency room had its own heterogenous group of psychiatric patients whose characteristics were consistent with those reported in previous studies in the setting. (Dept. of Psych., 1974; Brim, 1975).

Client characteristics differed between emergency rooms, but were consistent within the caseload of each emergency room. In the study hospital, most clients were male, single, and over 50 percent had situational problems. Studies in the literature, however, reported a predominance of clients who were married and females in psychiatric populations. (Atkins, 1967; Rogawski and Edmundson, 1971; Huffine and Craig, 1974). Data collection methods for diagnostic

categories were not consistent in the literature so no reliable comparisons could be made of situational problem diagnoses with other studies. The greater number of males in the population may have been the result of the county contract, since more males than females were police referred in the data from the subset of the population. With over one-fourth of the records incomplete for marital status, the total number of single clients may have been inaccurate for the population. No explanation for this difference was possible from the data obtained.

Since a majority of the clients referred to the crisis team had situational or behavioral problems, this may have indicated that most of the referrals to the crisis team were made by the psychiatric nurse who supervised the students providing the outreach services. Data from the 1976 pilot project indicated that outreach had been successful in helping a wide range of clients referred from the emergency room. However, residents' unfamiliarity with the results of the pilot project and the services of the newly organized crisis team may have resulted in few referrals of patients with functional disorders to the crisis team. Outreach services would have been additionally helpful, since the assessments lacked information about support systems or situational problems that might have contributed to the reason for the emergency room visit.

Comparisons of diagnoses with dispositions indicated

that clients were sometimes admitted to facilities that were not appropriate for their particular problem. For example, clients with situational problems such as anxiety or emotionally upset were more often admitted to the State Hospital than the Crisis Unit. This same situation was true for clients with concomitant medical problems, where admission to the Crisis Unit would have provided easy access to the medical facilities of the University Hospital. Admission of equal numbers of clients with drug or alcohol problems to the Crisis Unit and the State Hospital also reflected the problem in admitting clients to facilites with available inpatient beds rather than because of the defined treatment programs.

The emergency room population had remained consistent over time. (Department of Psychiatry, 1974; Brim, 1975). The problems that remained were largely related to service utilization patterns and delivery of care. A shortage of staff and treatment resources contributed to: 1) inappropriate disposition plans, especially admission, 2) a lack of assistance in helping clients resolve their problems or obtain appointments, and 3) lengthy stays in the emergency room obtaining information about symptomatology instead of data about clients social network, coping skills and situational crisis.

CHAPTER V

Summary, Conclusions, and Recommendations

Summary

A descriptive study of patients using emergency room psychiatric services was completed in the emergency room of a 500 bed university hospital. The purpose of the study was to define and evaluate the service utilization patterns, the characteristics, and process of delivering care to psychiatric patients. Clients who requested psychiatric help or were diagnosed with either a primary or secondary psychiatric diagnosis betweeen January 2, 1976 and May 31, 1976 were included in the study.

Billing sheets and emergency room records provided information that suggested the population of psychiatric patients used the emergency room as a walk-in clinic, rather than a place for emergency care. Most of the clients were male, single, between 20 and 39 years old, with limited financial resources, previous psychiatric treatment, and diagnosed with situational or social problems. Less than a third of the clients required admission, and another third of the clients were not given referrals for additional therapy.

With the exception of clients seen by the psychiatric nursing personnel, clients' evaluations included more diagnostic information. Expansion of outreach services for some

portion of the 70 percent of the clients who returned home without follow-up assistance would likely benefit clients and improve the quality of care provided by the emergency room.

Conclusions

Data from the study and comparisons of various categories provided the following conclusions about psychiatric services provided through the emergency room of a University Hospital. 1). Clients' use of the emergency room for psychiatric services was more representative of patterns for a walk-in clinic. 2). The most expedient, efficient care was delivered to clients with functional psychiatric diagnoses or patients admitted to the Crisis Unit. 3). The psychiatric population had continued to increase even though the general emergency room caseload has decreased. The emergency room had become the primary source of emergency psychiatric care in the tri-county area. 4). The characteristics of the psychiatric population consistently include a majority of: singles, males, 20 to 39 year olds, and medically indigent clients with multisystem problems. Programs developed should be for this target population. 5). Clients were usually evaluated, in terms of diagnostic

criteria, then released without additional referral. If a referral was made, help in completing the referral process occurred for a very small percentage of the patients. 6). Disposition plans, especially admissions, were made on the basis of available in-patient resources rather than in conjunction with the client's problems and the specialization of the particular resource. 7). The availability of the psychiatric nurse in the emergency room increased case-finding and provided assistance to clients in need of follow-up through the crisis team. 8). Facilities were inadequate to accommodate the numbers of clients in need of admission and out-patient follow-up. 9). A readily available transportation was needed for clients who required admission to other institutions. This would have alleviated the lengthy stays by clients in need of hospitalization and reduced the amount of staff time caring for the disturbed client. 10). Information gathered by clerks was often incomplete.

Recommendations for Further Study

The psychiatric services in the emergency room require additional study. The recommendations for further study include: 1). In order to more efficiently compare data with previous studies or those of other emergency rooms, a standardized data collection instrument should be developed.

2). Follow-up studies to determine the effect of referral or non-referral on repeat visits to the emergency room. 3). A study of clients referred to the crisis team as compared with the study hospital's out-patient psychiatric clinic to determine differences in the effects of outreach versus traditional out-patient services. 4). A comparative study of psychiatric evaluations as done by residents and psychiatric nurse specialists. 5). A descriptive study of factors that contributed to the decision to admit clients or refer them to out-patient services. 6). A study to determine if the addition of a psychiatric nurse specialist on the evening shift would improve: casefinding, evaluation of support systems, and referral.

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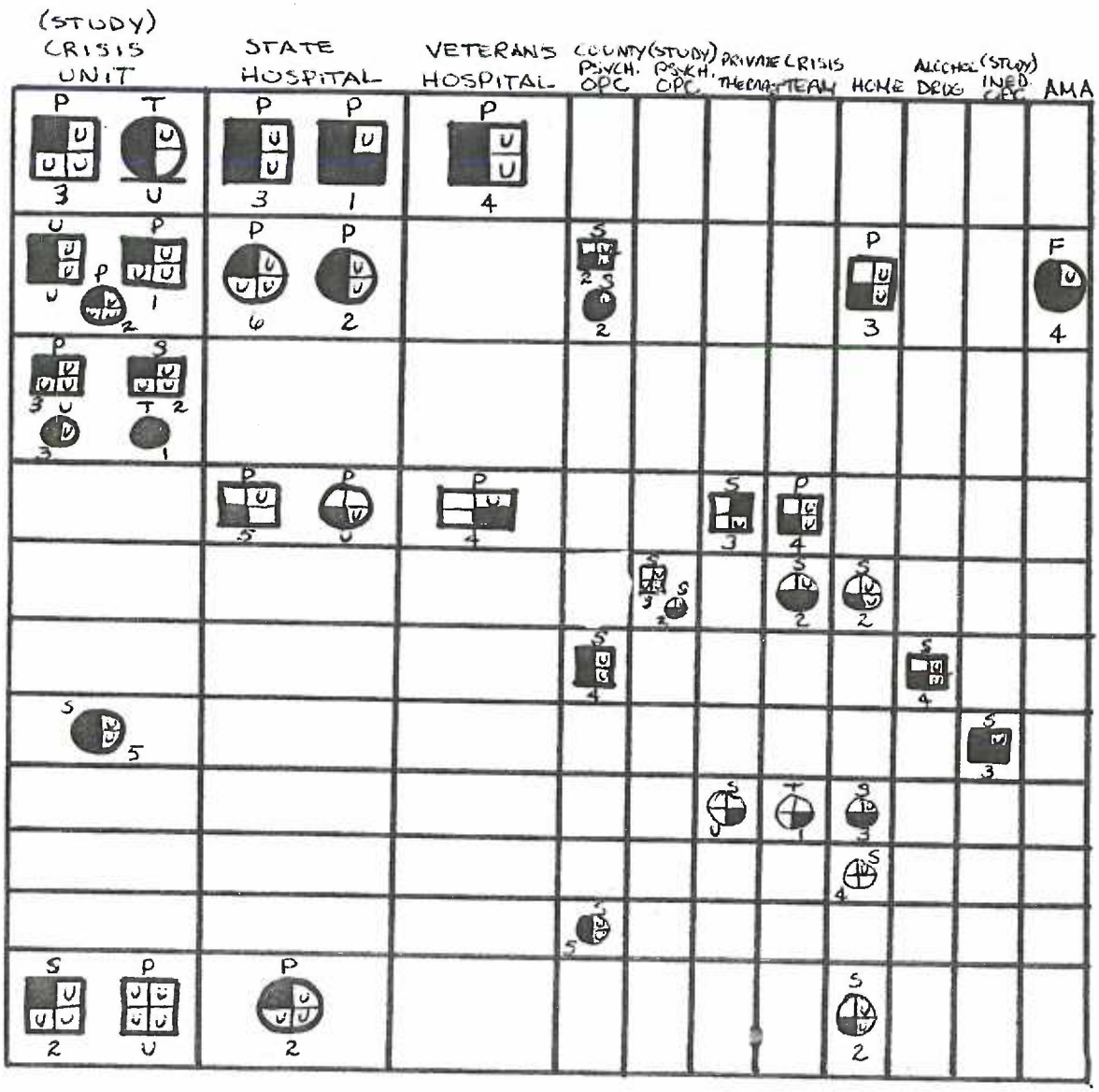
APPENDIX A

Worksheet of Raw Data from Subset of the Population

Worksheet of Raw from Subset of the Population

DISPOSITION



LEGEND:

- MALE
- FEMALE
- U - UNKNOWN

REFERRAL SOURCE

PROBLEM	FAMILY HISTORY
PREVIOUS HISTORY	SUPPORT SYSTEM

AGE

REF. SOURCE
- P - POLICE
- S - SELF
- T - THERAPIST
- F - FAMILY

AGE
- 1 - 10-19
- 2 - 20-29
- 3 - 30-39
- ETC.

FAMILY HISTORY
- ☐ - NO FAMILY HISTORY
- ■ - FAMILY HIST. OF MENTAL ILLNESS

PREVIOUS HIST.
- ☐ - NONE
- ■ - PREVIOUS

PROBLEM
- ☐ - SITUATIONAL
- ■ - PSYCHOPATHOLOGY

SUPPORT SYSTEM
- ☐ - NO SUPPORT
- ■ - POSITIVE SUPPORT

ABSTRACT

An Abstract of the Clinical Investigation of

Sandra Lee Talley

For the degree of Masters in Nursing
Date of Receiving this degree: June 11, 1977
Title: Patients Use of Psychiatric Services in a University Hospital Emergency Room.

APPROVED: _____
Clinical Investigation Advisor

A descriptive study of patients using emergency room psychiatric services was completed in the emergency room of a 500 bed university hospital. The purpose of the study was to define and evaluate the service utilization patterns, the characteristics, and process of delivering care to psychiatric patients. Clients who requested psychiatric help or were diagnosed with either a primary or secondary psychiatric diagnosis between January 2, 1976 and May 31, 1976 were included in the study.

Billing sheets and emergency room records provided information that suggested the population of psychiatric used the emergency room as a walk-in clinic, rather than a place for emergency care. Most of the clients were male, single, between 20 and 39 years old, with limited financial resources, previous psychiatric treatment, and diagnosed with situational or social problems. Less than a third of the clients required admission, and another third of the clients were not

given referrals for additional therapy.

The emergency room psychiatric caseload had increased over time, but the characteristics of the clients were unchanged from those reported in previous studies. Problems noted were related to a shortage of facilities. Admissions were often based on the availability of space rather than the specialization of the resource and the client's problem. Facilities were inadequate to accomodate the number of clients in need of admission or out-patient therapy. A readily available transportation system was needed to decrease the lengthy stays while patients were being transferred to other hospitals for admission.

With the exception of clients seen by the psychiatric nursing personnel, clients' evaluations included more diagnostic information and little assistance in obtaining followup. Expansion of outreach services for some portion of the 70 percent of the clients who returned home without followup assistance would likely benefit clients and improve the quality of care provided by the emergency room.