EM ADVANCES

Experiences of substance-using suicidal males who present frequently to the emergency department

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ABSTRACT

Objective: This qualitative study investigated the repeated use of the emergency department (ED) by men with a history of suicidal behaviour and substance abuse to understand the needs and barriers to care for this high-risk group. Identification of common themes from interviews with patients and health care workers can serve as a basis for improved ED-based interventions.

Methods: Using semistructured interviews, patients, ED staff and family physicians were asked about needs of the aforementioned group. Twenty-five patients were interviewed and completed questionnaires regarding their substance use, aggression, parasuicidal behaviour, alexithymia and childhood trauma. In addition, 27 staff members were interviewed. Interviews were tape-recorded, transcribed and qualitatively analyzed using an iterative coding process.

Results: Of the 25 patients, 23 (96%) had a mood or anxiety disorder and 18 (75%) had borderline personality disorder. One-half of the patients scored high and another quarter scored moderate on alexithymia testing. The ED was viewed as a last resort despite seeking help. Frustration was felt by both patients and staff regarding difficult communication, especially during an acute crisis.

Conclusion: The ED plays an important role in the provision of care for men with recurrent suicidal behaviour and substance abuse. Some of the diagnoses and problems faced by these patients are beyond the purview of the ED; however, staff can identify mutual goals for crisis interventions, allow for frequent communication and seek to de-escalate situations through the validation of the stress patients are experiencing.

Keywords: suicide, emergency, substance use

RÉSUMÉ

Objectif : Notre étude qualitative portait sur les visites répétées à l'urgence par des hommes présentant des antécédents de comportement suicidaire et de chimiodépendance. Nous cherchions à comprendre les besoins de ce groupe à haut risque et les obstacles aux soins. La détermination de

thèmes communs par voie d'entretiens avec les patients et les travailleurs de la santé peut servir de fondement pour améliorer les interventions à l'urgence.

Méthodes : Dans le cadre d'entrevues semi-structurées, nous avons posé des questions au personnel de l'urgence et aux médecins de famille sur les besoins de ce groupe à haut risque. Nous avons également interviewé 25 patients, qui ont aussi rempli des questionnaires concernant leur consommation abusive d'alcool ou de drogues, les agressions, les comportements parasuicidaires, l'alexithymie et des traumatismes dans leur enfance. De plus, 27 membres du personnel ont été interviewés. Les entretiens ont été enregistrés, transcrits et analysés qualitativement à l'aide d'un processus de codage itératif.

Résultats : Des 25 patients de l'étude, 23 (96 %) présentaient un trouble de l'humeur ou un trouble anxieux et 18 (75 %) étaient atteints d'un trouble de la personnalité limite. La moitié des patients ont obtenu un score élevé à l'égard de l'alexithymie et un autre quart a obtenu un score modéré à ce sujet. Même si les patients reconnaissaient avoir besoin d'aide, ils considéraient la salle d'urgence comme leur dernier recours. Tant les patients que le personnel ressentaient de la frustration concernant des communications difficiles, tout particulièrement en situation de crise aiguë.

Conclusion : La salle d'urgence joue un rôle important dans la prestation de soins aux hommes présentant des antécédents de comportement suicidaire et de chimiodépendance. Or, certains diagnostics et problèmes auxquels font face ces patients ne sont pas du ressort de l'urgence. Le personnel peut cependant cerner des objectifs mutuels quant à l'intervention en situation de crise, faciliter la communication fréquente et chercher à désamorcer la situation en reconnaissant le stress que les patients ressentent.

Introduction

Patients presenting with mental health and substance abuse problems account for a significant proportion of all emergency department (ED) visits.[1] These patients are often perceived by ED staff as a burden on resources and difficult to treat.[2–5] Staff responses toward repeat visitors with self-injury can include frustration and anger, which ultimately lead to a reduction of empathy and further stigmatization.[6]

For men aged 10 to 49 years, suicide remains one of the leading causes of death,[7] and the risk increases with concurrent diagnoses of alcohol and substance abuse[8,9] (Rhodes et al., unpublished data, 2001). Such patients frequently seek mental health care through EDs[10] despite the fact that many have a family physician. Men report a cyclic pattern of care marked by unpleasant health care experiences, which can exacerbate symptoms and lead to further avoidance of care until a crisis necessitates intervention. Negative health care experiences in the ED may worsen this already fragmented pattern of care[10] for young men with substance abuse and suicide-related behaviours.

This qualitative study was undertaken to investigate the experiences and substance abuse history of men with a history of recurrent ED visits for suicide-related behaviour and to understand the experiences of the health care workers who provide their care. In addition, through the use of previously described methodological approaches,[11,12] we sought to identify common themes and leading practices in ED-based interventions.

Methods

Study design

Using semistructured interviews, patients and ED staff were asked about the general mental health experiences and health care needs of substance-using and suicidal men. A maximum variation sampling strategy, selecting participants believed to have a variety of opinions, was employed to ensure that broad perspectives were represented.[13]

Setting

The study was conducted between January and October 2004 in the ED at St. Michael's Hospital, a teaching hospital affiliated with the University of Toronto. St. Michael's is a large urban hospital and level 1 trauma centre with 60 000 ED visits per year. About 17% of these visits are from underhoused populations and 8% from mental health patients.

Patient population

English-speaking males aged 18 to 45 years with a presenting complaint of suicidal ideation or any self-reported history of suicidal intent as well as a history of substance abuse problems were eligible. We obtained approval from our institutional Research Ethics Board. All participants provided written consent and received an honorarium of Can$25. The consent process was conducted by a research coordinator with extensive experience in mental health populations. All enrolled participants reported that they were able to read independently. Patients who left without

being seen were not enrolled despite several recruitment strategies.

Staff population

We recruited staff and allied professionals with at least 1-year of ED experience for semistructured interviews. Family physicians (FPs) from both hospital- and nonhospital-affiliated sites, independent office and group practices were recruited. All staff participants provided written consent and received an honorarium of Can$25.

Sampling procedure for patients

ED staff notified the research coordinator about medically stable eligible patients for recruitment after patients had provided verbal permission to release their information. To ensure capture of an appropriate variation of participant characteristics during recruitment, the coordinator maintained a demographic information log to ensure that predefined age ranges and acuity levels were represented. Participants were screened for current substance abuse problems using the CAGE-AID[14] prior to the diagnostic and semistructured interviews.

Sample size

Based on qualitative methodology and prior experience, we estimated that 20 to 25 patient interviews would be required to achieve thematic saturation.[10,15,16] Saturation occurs when no new themes emerge during interviews, indicating that analyses capture the variation and fullness of the participants' experiences.[17]

Semistructured interviews

A master's level research coordinator with prior experience conducting qualitative research interviews with mental health patients conducted all interviews. These interviews were based on previous work by our group and included questions about mental and physical health, suicidality, substance use and service use.[10] The semistructured questionnaire templates are available from the authors upon request.

After obtaining consent, patient interviews were conducted on the psychiatric ward for inpatients and at the Arthur Sommer Rotenberg Chair Suicide Studies, a research facility at St. Michael's Hospital. Patients were asked to discuss their general experiences when receiving mental health care at any hospital. (The study hospital is 1 of about 20 hospitals in the Greater Toronto Area.) To describe their mental health status and diagnoses, patients completed diagnostic interviews including:

- the Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders (DSM) Disorders (SCID) I and II (defines major DSM-IV Axis I and II diagnoses);[18]
- Life History of Aggression, Clinical Version (scores aggression, social consequences, antisocial behaviour and self-directed aggression);[19]
- Lifetime Parasuicide Count (records intentional self-harm or suicide attempts);[20,21]
- Toronto Alexithymia Scale (TAS-20) (measures the alexithymia construct, i.e., difficulty identifying and describing subjective feelings);[22] and
- Childhood Trauma Questionnaire (CTQ) (screens for a history of abuse and neglect).[23]

See Table 1 for demographics and diagnoses.

Patient interviews were driven by the participant and lasted between 45 minutes and 2 hours. Staff interviews consisted of general questions about their attitudes and experiences while providing care to this population of men. They lasted between 30 and 90 minutes and were conducted in private areas associated with the ED or family practice offices. Demographic data for staff were not collected.

Analyses

All interviews were tape recorded, anonymized to ensure privacy and transcribed verbatim by a professional transcription service. Transcripts were verified and entered into N6 (QSR International). All interviews were analyzed and, through qualitative analysis, themes were developed using an iterative coding process, wherein team members developed a codebook and then read and analyzed transcripts prior to coding, rereading and recoding as necessary by other investigators.[15,16] During the iterative process, the codebook was reviewed by the team to avoid inconsistencies. The study team discussed the content of the transcripts, emerging themes and analyses throughout the study. All previously coded text was reviewed and recoded as necessary if coding problems necessitating resolution were identified. This iterative process continued until all text had been coded. Selected quotes from interviews are provided to illustrate our findings.[16]

Results

Fluid themes emerged, including reasons for presenting, patients' behaviour, identification of the repeat visitor and ED experiences, all of which led to the development of a model to understand issues and emergency-based approaches to care.

Patient participants

Twenty-five men were interviewed, either within a week of ED discharge (*n* = 18) or during their admission to the psychiatric

ward (*n* = 7). Any potential subjects perceived to pose a physical threat to the interviewer were excluded (*n* = 2). Patients with psychotic disorders were included. One participant did not complete all of the questions included in the diagnostic interviews. Most participants, 23 out of 24 (96%), had an Axis I mood or anxiety disorder and 18 out of 24 (75%) had borderline personality disorder (BPD). All of the patients reported experiencing at least one form of abuse in childhood (Table 2). Most had an alcohol-related disorder identified by the CAGE- AID.[14] One-half of the men were

Table 1. Sociodemographic and diagnostic information for patient participants

Variable	No. (and %) of patient participants
Demographic information; *n* = 25	
Age, yr	
20–29	8 (32)
30–39	11 (44)
≥ 40	6 (24)
Born in Canada	17 (68)
Marital status	
Never married	16 (64)
Divorced or separated	8 (32)
Living with partner	1 (4)
Parental status	
1 or more children	7 (28)
Lives with children	0 (0)
Work is main activity	6 (25)
Income < Can$19 999/yr*	17 (68)
Completed high school or more	17 (68)
Family physician involved in care	13 (50)
DSM-IV classification	
Axis I; *n* = 24†	
Clinical syndromes	
Mood	23 (96)
Anxiety	19 (79)
Axis II; *n* = 23‡	
Personality disorders	
Borderline	18 (75)
Antisocial	17 (71)
Depressive	11 (48)
Paranoid	9 (39)
Avoidant	7 (30)
Passive–aggressive	6 (26)
Obsessive–compulsive	4 (17)
Narcissistic	4 (17)
Schizoid	3 (13)
Substance disorders	
Alcohol	22 (92)
Substance (other)	16 (67)

*The Canadian Council on Social Development (2004) identified a person living in "straightened circumstances" in 2004; that is, below the poverty line, as having an annual gross income of $20 337.
†One patient did not complete a full diagnostic interview.

triaged to Canadian Emergency Department Triage and Acuity Scale (CTAS) levels I or II (high acuity). Social isolation was common: 24 out of 25 (95%) had never been married or were separated or divorced. None of the men who had children were living with them. Over one-half of the patients had completed high school, yet the majority of them were unemployed and had an annual income below the national poverty level.

Staff participants
Seventeen ED staff members participated, including 6 registered nurses (RNs), 5 physicians (MDs), 2 crisis team workers, 2 security officers and 2 nonmedical staff members.

Themes

Reasons for presenting to the ED

Emergency encounters in the patients studied were driven primarily by a sense of distress and desperation; many were directed or forced to come to the ED against their will. Despite acknowledging a need for help, all the patients stated that they came to the ED when they perceived there were no other options, and they had negative expectations about the visit. One stated, "the hospital is always my last resort … I end up feeling worse … and the waiting … it's more nerve-wracking for me. …" (PT19)

Despite well-documented prior negative experiences and the availability of resources in the community,[24] these patients were often directed or forced to come to the ED by regular care providers, community professionals or family.

One-half of the patients reported having a family physician. One stated, "they don't really like to go in depth into the mind." (PT11) When asked why patients did not seek help from their usual providers, physicians hypothesized, that "it's hard to find a general practitioner (GP) to put up with the behaviours." (ED 9) Several of the FPs felt that the ED was an appropriate care setting: "[a] reassuring and therapeutic environment" (FP6) with "lots of attention; undivided attention … that GPs can't provide." (FP5) In contrast, ED-based staff felt that the setting was stressful. "If someone is severely depressed, I'm bringing him in here where people are puking and bleeding, it just is not conducive to a healing, healthy environment." (ED14)

While many emergency-based health care workers noted that care options for these patients are difficult, e.g., "they are just too disorganized" (ED9), there are "barriers out there" (ED2), others suggested that they are "using the system." (ED4)

Patient behaviour

The behaviour of these patients may be disruptive to an

already chaotic and overburdened ED and may be difficult for health care workers to understand. Suicidal patients may have problems identifying and describing their feelings, as well as articulating their needs. Some were only able to describe what was not working: "I am falling apart … How come? Well, how do I know how come?" (PT18) When tested, nearly 50% of patients scored "high" on the TAS-20. Another 28% scored "moderate," indicating a deficit in their ability to identify, describe or reflect on emotional experiences. Men spoke of their prior ED visits during which they experienced long waits, multiple interviews, confinement, loss of control and untimely discharge. Patients perceived that long waits impacted their ability to stay in control and ultimately contributed to the negative behaviour. "It wasn't until I went into a temper tantrum that the process was speeded up like that" [snaps fingers]. (PT7) Caregivers reported that the setting may worsen behaviour and acknowledged that disruptive patients were likely to be seen sooner: "he's cooperative, he's laying there, he's not fighting … that's the type of patient that gets missed … the squeaky wheel gets the oil." (ED12) Even when cooperative, caregivers are frustrated by the difficulty these patients have while waiting. "They say, 'I want help now; I need it now … don't waste my time.'" (ED4) Staff discussed that the stress associated with these encounters involved "security, verbally talk down, chemically restrain, physically restrain. No one likes to do this; it's high acuity," (ED7) and "it's uncomfortable dealing with the behaviour … the sad thing is the vulnerability, the chance that they will do what they say they're going to do." (ED14) Staff identified the intense emotions these men experienced and the challenges that staff members face when trying to help: "the pain these people are in is horrendous," (ED14) "… see the behaviours as part of the illness. …" (ED14)

Identification of the repeat visitor and experiences in the ED

All patients reported that they had previous negative ED experiences that impacted their ability to seek and find ongoing care, especially after being identified as "frequent flyers." (ED 6, 16, 13) One stated, "well, I notice a big difference if I'm coming in for a medical reason than if I'm coming in for a psychiatric reason … it's almost like they're fed up with me." (PT19)

Of the health care workers interviewed, 77% also stated that these patients had negative experiences. Staff felt that patient visits were stressful because of their repetitive nature and the difficulty conducting assessments, especially when there were competing demands for their time. One stated, "you know they'll do what they say they're going to do … and be back when you know you could be treating a heart attack in the next bed." (ED9) The chronicity of the illness and the perceived lack of progress was a major source of frustration, leaving staff with the sense that "probably there's just nothing that can be done." (ED7) Many were "attracted to the emergency because they can … make an immediate difference. The mental health population doesn't render that result." (ED8) Some FPs understood the frustration: "there's no gratification in the emergency department. You don't get to see the change over time." (FP5) ED staff who reported less frustration viewed their role differently: "rather than placing it on the patient … I tell them, I'm getting the message and it's my job to act on it." (ED14) One caregiver identified a balance: "[the] challenge is interesting … sometimes frustrating." (ED5) Some identified more positive experiences when they acknowledged that these men have "a lot of things going on and it's going to take a lot to straighten them out." (ED15) An understanding beyond the presentation was articulated as, "have you ever met anyone who said 'sign me up for cocaine addiction? I want that!' I haven't met him yet." (ED14)

Discussion

Figure 1 provides a representation of ED-based goals and

Table 2. Summary of the Childhood Trauma Questionnaire*

Rating	Subscale; no. (and %) of patient participants				
	Emotional abuse; n = 23	Physical abuse; n = 23	Sexual abuse; n = 22	Emotional neglect; n = 23	Physical neglect; n = 23
None or minimal	3 (13)	9 (39)	9 (41)	7 (30)	12 (52)
Low to moderate	5 (22)	4 (17)	3 (14)	6 (26)	4 (17)
Moderate to severe	5 (22)	5 (22)	2 (9)	4 (17)	3 (13)
Severe to extreme	10 (43)	5 (22)	8 (36)	6 (26)	4 (17)

*Two participants did not fill out the questionnaire; 1 participant did not fill out the sexual abuse subscale.

interventions for impact when working with suicidal substance-using men who present to the ED in crisis. As noted in Table 1, each of the patient participants had at least 1 Axis I or Axis II diagnosis as well as a history of abuse. Most were identified as having alexithymia. When these patients are in crisis situations, there is a high probability that there will be articulation and problem-solving deficits compromising their ability to recall reassuring episodes of success and social support or quell agitated behaviour.[25–28] Cognitive dysfunction is also associated with alcoholism.[29]

Frequent visitors to the ED with BPD display greater severity of overall psychopathology, depression, suicidal ideation, poorer problem-solving skills and may engender a heightened sense of frustration in staff, especially if there is concurrent substance abuse.[30–32] Although such patients are often felt to be untreatable, both pharmacologic and nonpharmacologic treatment may reduce acute agitation.[33–36] Behaviour therapy has been shown to decrease the number of ED visits in this group.[37–39]

The long-term needs of the patients investigated in this
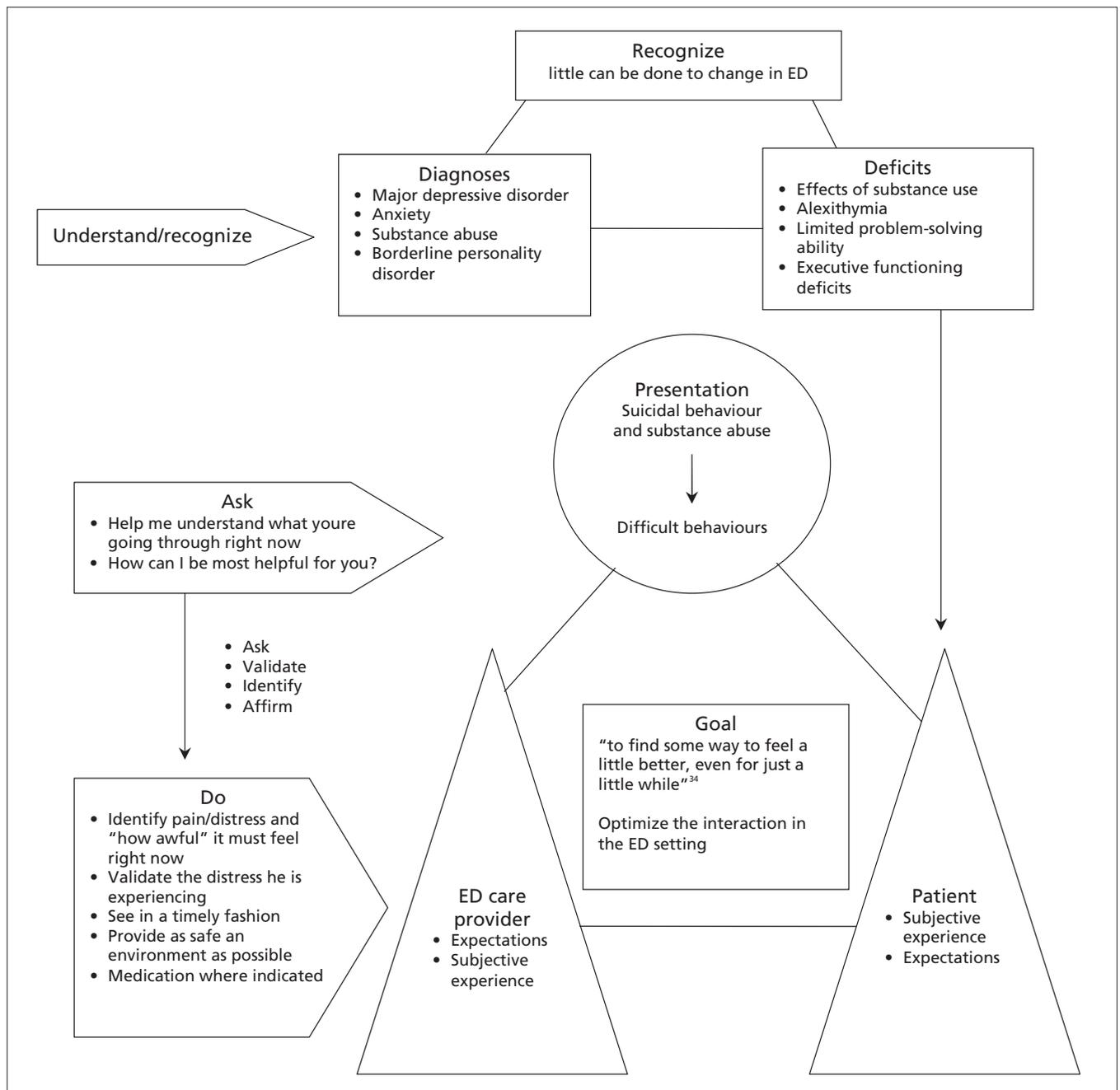

Fig. 1. ED (emergency department)–based interventions with men with recurrent suicidal behaviour and substance abuse.

study will not be met in the ED; thus, realistic goals need to be developed. Health care workers need to be aware that patients with alexithymia have a great degree of difficulty describing and identifying subjective feelings, which may have led to their visit,[40] and they may have an impaired ability to take an empathic perspective.[40,41] In times of crisis ("a psychache"), emotion may drive the person to use maladaptive noncognitive action including self-harm and outbursts to alleviate perceived distress.[42]

Goals in the ED

Recognizing the limitations of the setting, ED staff should attempt to optimize their interactions with these patients. Interventions to help manage suicidal behaviour are needed, since men with this problem will continue to present to the ED in the absence of alternatives (real or perceived). The goal of crisis intervention is to find some way to help patients feel better, even only transiently, through strengthening positive coping strategies while reducing their acute wish for harm.[43]

Framework for intervention

Ask

Core to the philosophy of excellence in care, health care workers need to understand the patient's viewpoint and to become aware of deficiencies in the current system. Men who present to the ED in suicidal crisis require help in the moment. Because maladaptive behaviour is a means to communicate distress, validating the emotional distress is a useful strategy. Retraumatization of this patient population may feed into a pattern of avoidance of care, escalation of self-mutilation, and increased frequency and difficulty of presentations.[10,44] Recognizing that the behaviour is not a personal attack but a sign of distress is an important coping skill for staff.

Do

Preconceived expectations by both health care providers and patients that another ED presentation will not be helpful may contribute to misunderstandings about the goal of the crisis intervention. Addressing the needs of these patients in a timely fashion can be challenging; however, even brief interactions that emphasize positive coping strategies and provide updates regarding waits can assist in the de-escalation of a crisis and prevent disruptive behaviour.[45]

Emotional de-escalation is often necessary before the patient regains the ability to discuss, problem-solve and make safer choices. Validation by the health care worker to acknowledge a patient's efforts to seek help rather than acting in a destructive manner is a useful initial intervention.

Limitations and future research

Several limitations of this study must be acknowledged. The data were obtained from patients, ED staff and FPs who are associated with a large urban hospital. Although the information obtained from interviewees was intended to address general experiences, enrolment bias may have occurred and thus the study population may not be representative. Men who left without being seen were not enrolled despite several recruitment strategies.

Qualitative research of this nature is intended to generate hypotheses. The themes that were explored in this paper were most specifically related to experiences in the ED. However, this type of research is a strong knowledge translation tool and has the potential to "bridge the gap" between scientific evidence and clinical practice.[11,12,17] More research needs to be conducted with ED staff to understand if further training and systematic changes to patient care can impact both the comfort level and the ability to de-escalate these patients.

Conclusion

The ED plays an important role in the provision of care to men with recurrent suicidal behaviour and substance abuse. Such visits are impacted by a complex interplay of factors, including personal interactions, perceptions and the availability of system-wide resources. These patients frequently have diagnoses and challenges that are beyond the purview of the ED; however, staff can identify mutual goals for the crisis intervention, allow for frequent communication and seek to de-escalate the situation through the validation of the stress patients are experiencing.

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