Barriers to Effective Psychiatric Emergency Services for Elderly Persons

Christopher C. Colenda, M.D., M.P.H
Blaine S. Greenwald, M.D.
Judith H. W. Crossett, M.D., Ph.D.
Mustafa M. Husain, M.D.
Gary J. Kennedy, M.D.

Emergency psychiatric services are an important avenue by which elderly persons gain access to mental health services. Frequent psychiatric reasons for emergency department visits by persons age 65 and older include psychotic and aggressive behavioral symptoms associated with dementia or delirium, profound depression, substance abuse disorders, medical conditions that lead to changes in cognition, mood, and functional status, and psychosocial problems such as social isolation, neglect, and abuse.

This column discusses elderly persons' patterns of utilization of emergency services, reviews current knowledge about provider-related variables that impede or facilitate delivery of psychiatric emergency services for this group, and outlines recommendations for increasing elderly persons' access to those services and improving their effectiveness.

Dr. Colenda is professor and chairman of the department of psychiatry at Michigan State University College of Human Medicine, A-222 East Fee Hall, East Lansing, Michigan 48824. Dr. Greenwald is associate professor of psychiatry at Albert Einstein College of Medicine and director of geriatric psychiatry at Long Island Jewish Medical Center in Glen Oaks, New York. Dr. Crossett is in private practice in Cedar Rapids, Iowa. Dr. Husain is assistant professor of psychiatry at the University of Texas Southwestern Medical Center in Dallas. Dr. Kennedy is professor of psychiatry at Albert Einstein College of Medicine and director of geriatric psychiatry at Montefiore Medical Center in New York City. *This work was done under the auspices of the committee on access and effectiveness of psychiatric services for the elderly of the American Psychiatric Association's council on aging. Dr. Colenda is chair of the committee. Marion Z. Goldstein, M.D., is editor of this column.*

Utilization of emergency services

The volume of emergency department visits for psychiatric reasons by elderly persons is not precisely known because utilization data are generally unreliable when stratified by both age and reason for visit. However, psychiatric emergencies constitute about 10 to 15 percent of all emergency department visits nationwide (1,2). Data from the 1992 National Hospital Ambulatory Medical Care Survey indicate that of the close to 90 million yearly visits to emergency departments, about 14.2 percent are for patients over age 65, and 7.7 percent are for patients over age 75 (2). Of all age categories, individuals over age 75 have the highest rate of emergency department visits—about 55.8 visits per 100 persons, which is 56 percent above the national average of 35.7 visits per 100 persons.

Among persons age 65 to 74, the ratio of emergency department visits for women compared with men is 1.11 to 1, but it decreases to 1 to 1 for men and women age 75 and older (2). Also in the 65- to 74-year age group, the ratio of emergency department visits for whites compared with blacks is .74 to 1; that ratio increases to 1.1 to 1 among persons age 75 and older. By comparison, in the 45- to 64-year age group, the ratio of emergency department visits for women compared with men is about 1 to 1, and the ratio for whites compared with blacks is about .57 to 1.

These data suggest that men and women use emergency department services at about the same frequency throughout their life span, but ethnic differences in utilization shift with advancing age; that is, elderly whites increase their utilization of emergency services over age 75, while blacks decrease utilization. However, the utilization data are not adjusted for differences in death rates among ethnic groups, which could differentially affect the pool of patients who seek services. For example, the death rate for whites age 75 to 79 is 4,662.2 per 100,000 population, but for blacks it is 5,596.3 per 100,000 (3).

Geriatric patients use a disproportionate amount of medical, psychiatric, and social resources when they present to emergency departments (4). Baum and Rubenstein (5) found that elderly patients were more likely to use ambulances to get to emergency departments and that their stay was in general 20 percent longer than for other patient groups. Because a proportion of the typical charge for an emergency visit is a function of length of stay, longer stays leads to higher charges.

Beland and colleagues (6,7), in a series of studies in Quebec, found that elderly patients using emergency departments used more hospital-based resources such as minor surgery, observation beds, hospitalization, specialist care, and laboratory services. Beland's group also found that in-

creasing age and chronic conditions predicted high levels of hospital resource utilization (6). In a companion study, Beland and associates (7) found that in metropolitan Quebec City, living farther from an emergency department reduced the likelihood of using an emergency department, although patients with chronic conditions and psychiatric diagnoses were likely to use emergengy departments more often. However, age had no effect in these analyses.

Thus it is difficult to draw a national profile of utilization of psychiatric emergency services by elderly persons because reporting capabilities are limited. In general, elderly persons tend to have high utilization of emergency services in general, and there is some evidence that use differs among ethnic groups. Analyses of the types of clinical psychiatric problems that elders present to emergency departments indicate that organic illnesses constitute the most common underlying reason for the visits, and elders tend to be high utilizers of hospital-based resources once they are seen in an emergency department. Little is known about the outcomes of care for elderly patients with psychiatric emergencies, nor has there been a systematic examination of organizational, professional, or mental health service delivery system variables that can facilitate access to psychiatric emergency services for elderly persons.

Variables influencing access to emergency services

Family members and other caregivers

Older people with psychiatric or behavioral disturbances are more likely to be referred to emergency services by family members, friends, the police, or housing proprietors than by self-referral (8–11). The degree to which such "caregivers" are informed about geropsychiatric issues influences older patients' access to services.

A study of 118 elderly persons seen in a psychiatric emergency service reported that many had experienced the problem leading to their visit for more than six months but were ultimately brought in only when caregivers became overwhelmed (12). In this study, misprescription or misuse of medications was involved in the problems of about 25 percent of the patients. In another study, delays in referral of older patients resulted in both an increase in the severity of the complaint and in more frequent—and possibly avoidable—hospital admissions (13).

These findings suggest the need for greater education of and outreach to persons who care for elderly persons. Such education should pay particular attention to symptom recognition and medication management. The police are as an especially valuable resource in helping older people come in to the psychiatric emergency service for evaluation (11), and the importance of their continuing education has been highlighted (14). Family attitudes may also influence disposition of the elderly patients seen in the psychiatric emergency service. In one study, patients whose family members indicated a willingness to take the patient back to the community were more likely to receive hospital care (12).

Primary care physicians

Several reports have discussed the lack of integration between primary care medical practice and community-based psychiatric services. Primary care physicians typically do not refer older patients for psychiatric evaluation and treatment, either in the community or in the emergency service (8). Elderly patients evaluated in a psychiatric emergency service who had experienced their chief complaint for more than a month had been previously seen by their family physician—usually more than once—for the same complaint (13).

As with family procrastination in seeking psychiatric consultation, delays in referral by physicians can result in increased psychiatric morbidity and hospitalization. The lack of referral to psychiatry by primary care physicians has been attributed to difficulties in early recognition of underlying psychiatric disorders among elderly persons and to problems in achieving appropriate consultation from geriatric psychiatrists due to their scarcity and lack of visibility (13,15). Older adults with multiple medical diagnoses may be treated simultaneously by several different physicians, resulting in misuse of medications, which may be implicated in their psychiatric disturbance (12).

These findings suggest the importance of a coordinating physician in the primary care of elderly persons in the community, and increased geropsychiatric teaching in general continuing medical education curricula. Such efforts are needed to encourage earlier recognition by family physicians of psychiatric and neuropsychiatric disturbances among elderly patients, to reduce resistance to geropsychiatric consultation, and to increase awareness of geropsychiatric evaluation and treatment resources.

Emergency room personnel and settings

Impediments to psychiatric patients' receiving appropriate and comprehensive medical-psychiatric evaluations in emergency service settings have recently been summarized (16). They include the preference of emergency medicine health care professionals for patients with more tangible injuries or physical illnesses; their feelings of discomfort, dislike, or aggravation toward psychiatric patients; and their tendency to attribute physical symptoms of those patients to the underlying psychiatric disorder. In addition, psychiatric patients have difficulty identifying a chief complaint, and the time required for the emergency physician to evaluate the patients' psychiatric history, obtain information from reliable sources, and arrange for disposition may be so extensive that the medical examination is overlooked.

Attitudes. Despite reports that the attitudes of trainees in the emergency department toward elderly patients are either no different than attitudes toward young patients or are even more favorable (13,17), stereotypes of elderly patients who are psychiatrically disturbed or cognitively impaired still exist. Such patients may be considered "turkeys" or "gomers" (get out of my emergency room) and may be viewed as hopeless or as an imposition (18,19).

Such attitudes can compromise access to services. One report found that

older patients characterized as "medical" in the emergency room were assigned a higher priority than older patients characterized as "psychiatric" (20). On the other hand, studies comparing younger and older psychiatric patients in the emergency department have not supported age-related differences in either access to services or actual services received (9,13).

Medical workup. Inadequate medical work-up and evaluation can interfere with effective treatment of older psychiatric patients seen in the emergency service (9). For example, the triage nurse may send patients with an organic brain syndrome directly to the psychiatric emergency department where the medical work-up may not be as complete as it would be in the general emergency setting (20). Clinicians in the emergency service who evaluate elderly psychiatric patients should consider the possibility of delirium and dementia, misuse or overuse of medications, and hidden alcohol abuse (12).

Circumstances in the emergency service, including time pressures and clinicians' prejudicial attitudes and value judgments, often result in premature medical clearances of confused elderly patients who are actually experiencing an organic brain syndrome (18). In one study of psychiatric patients seen in an emergency service, 80 percent of the patients whose charts identified them as "medically clear" had underlying medical disease (16).

These findings challenge the validity of the concept of medical clearance without a comprehensive medical and laboratory work-up and suggest a new role for nurse practitioners in the emergency service: monitoring medical clearance and coordinating and interpreting information flow from various sources (21).

In one study, the majority of elderly psychiatric patients who presented to an emergency service had visited the service more than once in the past year and were referred to the medical and psychiatric emergency services separately (17). This disconnection between medical and psychiatric assessment not only negatively affects the adequacy of evaluation but also promotes costly repeat visits to emergency services (22). An experimental intervention in which a social worker provided triage and coordination resulted in a 28 percent reduction in recidivism by elderly patients (22). Furthermore, this group of patients continued to use postemergency aftercare services at three-month follow-up. Other studies have also stressed the important role of social workers in identifying psychosocial factors, coordinating services, and optimizing discharge planning for elderly psychiatric clients (11).

Pacing service delivery. The clinician must typically slow the pacing of the psychiatric-medical-cognitive interview for elderly patients, and input from collateral informants may be necessary to obtain accurate information (9). Family care providers must therefore be able to give accurate information about the patient's medical status, medication usage, and recent history (12).

In a study of elderly psychiatric patients, only 13 percent were evaluated in the emergency service by a professional trained in geriatric care (10). Clinicians' lack of expertise in geriatrics and geropsychiatry may result in misdiagnosis, inappropriate treatment, and unnecessary admission of older patients (10). For example, among elderly patients depression may present primarily with somatic complaints in the absence of a subjective depressed mood. This phenomenon, which has been called "masked depression," may not be recognized as a somatic expression of depression by emergency services clinicians who lack geriatrics expertise (22).

Institutional factors

Institutional factors that influence access to emergency psychiatric services for elderly persons have received relatively limited attention. Factors that increase the accessibility of such services to elderly persons include the availability of medical consultants, on-site laboratory and x-ray services, a physical layout that accommodates older patients, and transportation to the service (12).

The clinical focus of a psychiatric emergency service also affects its accessibility to elderly patients. An emergency service in a geriatrics-based setting may differ from one in a psychiatry-based setting in referral sources and patterns, the nature of the presenting problem (psychosocial or adjustment problems versus severe psychiatric problems), and eventual disposition (home care versus hospitalization) (8). For-profit hospital settings may be more oriented toward the needs of children and younger patients than toward those of older patients, while not-for-profit settings are associated with a greater public mission and consequently greater accessibility for older patients (23).

Rural settings

Data are not available on the prevalence of geriatric psychiatric emergencies in rural areas. Thus we have no way to measure how many geriatric psychiatric crises in rural areas are untreated. However, some of the barriers to care are self-evident. They include physical distance to emergency services, scarcity of psychiatrists or trained mental health workers, and primary care providers' lack of adequate knowledge and clinical skill in making geriatric psychiatric diagnoses.

Many rural counties have no hospitals, let alone a psychiatrist on staff or living within the county. Community mental health centers in rural areas are often jointly run by two or three counties, and a psychiatrist may spend as little as four hours a week in the center. Satellite clinics serve other counties, and patients may have to travel to an adjacent county seat to see a psychiatrist.

For example, in Iowa 39.4 percent of the population is rural, and only 35 community mental health centers serve the state's 99 counties (24). Most of the centers have less than one full-time-equivalent psychiatrist. Seventy of Iowa's 99 counties have no psychiatrist, and only 14 have at least one psychiatrist per 10,000 general population. Unfortunately, Iowa's elderly population is most concentrated in counties without psychiatric services.

Iowa's lack of psychiatrists is not unique. Nationally, rural hospitals seldom have a psychiatrist on staff. For example, a 1988 survey of 797 rural hospitals nationwide found that 676 had no inpatient psychiatric or

mental health services, 633 had no psychiatrist on staff, and 75 had only one psychiatrist on staff (25). In 694 of these hospitals, administrators stated that they had no current vacancies for psychiatrists and that access to mental health care was limited.

Given the absence of accessible psychiatric specialty care in rural areas, family physicians become critical providers of mental health services for elderly persons. Unfortunately, studies have found that such physicians have low rates of detecting major illnesses such as depression, fail to refer patients to mental health specialists, and misuse and overuse medications (26–29).

Although psychiatric illness is one of the 14 required curricular content areas in family practice residency training programs (30), finding qualified family physicians and psychiatrists to teach family practice residents, especially in the area of geriatric psychiatry, is difficult. The American Board of Family Practice requires that residents receive training in the recognition, diagnosis, and management of emotional and mental disorders across the life span and that the curriculum include elements of psychotherapy and psychopharmacology (30). Curriculum guidelines in geriatric psychiatry have been written for primary care physicians in training, but implementing them is difficult because of competing residency training requirements (31).

Other barriers to access to services in rural areas relate to family systems. Many elderly people have no family caregivers. If there is a family caregiver, he or she may find it difficult to take an elderly relative to a large city for care because of distance, traffic density, and family responsibilities. Ambulances, although available in rural settings, are expensive and are seldom considered for transport from home.

Recommendations

The following recommendations for improving emergency service delivery systems are intended to increase elderly persons' access to services and increase the effectiveness of those services:

♦ Twenty-four hour emergency psychiatric services for elderly patients and their caregivers should be available in emergency departments. These services should include telephone hotline information and referral systems, counseling and crisis intervention services, and where-needed transportation services (8,22,32).

♦ To ensure that the negative stereotypes of elderly patients who present to emergency services with psychiatric symptoms do not adversely affect the clinical judgment of the emergency personnel, elderly patients should not be dichotomized into medical or psychiatric categories on the basis of an initial impression by a triage nurse (20).

♦ Emergency services for geriatric patients should be multidisciplinary and should include integrated medical, mental health, and social services (8,19,22,32). A geriatric psychiatric emergency should mandate consultation (by telephone or in person) with a knowledgeable psychiatrist or a mental health professional.

♦ Nurse practitioners and social workers can serve as geriatric case managers who respectively coordinate and integrate psychiatric-medical and psychiatric-psychosocial information, treatment, and disposition.

♦ Standardized screening tools, such as brief cognitive and psychiatric rating scales, should be incorporated into psychiatric and medical assessments of older patients seen in the emergency service and into primary care practices (13,15,18).

♦ Cost-effective short-term evaluation units should be established for elderly patients who enter the system as emergency patients and require one or two days for further evaluation and medication start-up or change, with the goal of return to the community (8,32,33).

♦ Financial incentives should be created to encourage hospitals to provide social services and in-home psychiatric services to elderly patients seen in emergency services (22). Outreach nursing and social services may not only improve the quality of life for patients and family caregivers but may reduce unnecessary utilization of high-cost hospital-based services.

♦ Systems for tracking the outcomes of elderly patients seen in the emergency service by organizations that provide aftercare services should be developed and implemented (8,22). Outcomes management systems should be used both for continuous quality improvement and for applied research to foster comparisons of the effectiveness of different emergency service delivery systems in academic and community hospital settings.

The following recommendations are intended to improve educational and training activities:

♦ All emergency service providers should receive continuing education in gerontology, that is, geriatric medicine, geriatric psychiatry, and long-term care (8,12,18,22). It should be accomplished through scheduled seminars and conferences. The training sessions should be directed by a psychiatrist or mental health professional with expertise in emergency geriatric psychiatry services.

♦ Outreach educational efforts should be carried out by psychiatrists or mental health professionals with expertise in emergency geriatric psychiatry services. Outreach should include public lectures, newsletters, and geropsychiatry staff visits so that information about availability of emergency services can be shared with family caregivers, housing proprietors, nursing home administrative staff, governmental policy makers, and police and paramedics (14).

♦ Geriatric psychiatry teaching should be incorporated into continuing medical education for primary care physicians so that closer linkages are established between primary care geriatric and geropsychiatric providers, which should prevent or reduce geropsychiatric emergencies. Such teaching could include informational mailings and lectures by geropsychiatrists to county and state medical societies. ♦

References

1. Gustafson DH, Sainfort F, Johnson SW, et al: Measuring quality of care in psychiatric emergencies: construction and evaluation of a Bayesian index. Health Services Research 28:131–158, 1993
2. McCraig LF: National Hospital Ambulatory Medical Care Survey: 1992, Emergency Department Summary. Advance Data From Vital and Health Statistics, no 245. Hyattsville, Md, National Center for Health Statistics, 1994

3. Kochanek KD, Hudson BL: Advance report of final mortality statistics, 1992. Monthly Vital Statistics Report: 43, no 6 suppl. Hyattsville, Md, National Center for Health Statistics, 1995

4. Kennedy GJ, Lowinger R: Psychogeriatric emergencies. Clinics in Geriatric Medicine 9:641–653, 1993

5. Baum SA, Rubenstein LZ: Old people in the emergency room: age-related differences in emergency department use and care. Journal of the American Geriatrics Society 35:398–404, 1987

6. Beland F, LeMay A, Philibert L, et al: Elderly patients' use of hospital-based emergency services. Medical Care 29:408–418, 1991

7. Beland F, Philbert L, Thouez JP, et al: Socio-spatial perspectives on the utilization of emergency hospital services in two urban territories in Quebec. Social Science and Medicine 30:53–66, 1990

8. Simson S, Wilson LB: Meeting the mental health needs of the aged: the role of psychiatric emergency services. Hospital and Community Psychiatry 33:833–836, 1982

9. Waxman HM, Carner EA, Dubin W, et al: Geriatric psychiatry in the emergency department: characteristics of geriatric and non-geriatric admissions. Journal of the American Geriatrics Society 30:427–432, 1982

10. Thienhaus OJ, Rowe C, Woellert P, et al: Geropsychiatric emergency services: utilization and outcome predictors. Hospital and Community Psychiatry 39:1301–1305, 1988

11. Baker FM, Scholhamer N: The evaluation of elderly patients by a psychiatric emergency service. Journal of the National Medical Association 80:793–799, 1988

12. Puryear DA, Lovitt R, Miller DA: Characteristics of elderly persons seen in an urban psychiatric emergency room. Hospital and Community Psychiatry 42:802–807, 1991

13. Perez EL, Blouin J: Psychiatric emergency consultations to elderly patients in a Canadian general hospital. Journal of the American Geriatrics Society 34:91–94, 1986

14. McClelland PA: The emergency psychiatric system. Psychiatric Clinics of North America 6:225–232, 1983

15. Herst LD: Emergency psychiatry for the elderly. Psychiatric Clinics of North America 6:271–280, 1983

16. Tintinalli JE, Peacock FW, Wright MA: Emergency medical evaluation of psychiatric patients. Annals of Emergency Medicine 23:859–862, 1994

17. Bassuk EL, Minden S, Apsler R: Geriatric emergencies: psychiatric or medical? American Journal of Psychiatry 140:539–542, 1983

18. Dubin WR, Weiss KJ, Zeccardi JA: Organic brain syndrome: the psychiatric imposter. JAMA 249:60–62, 1983

19. Greenstein RA, Ness DE: Psychiatric emergencies in the elderly. Emergency Medicine Clinics of North America 8: 429–441, 1990

20. Waxman HM, Dubin W, Klein M, et al: Geriatric psychiatry in the emergency department: II. evaluation and treatment of geriatric and nongeriatric admissions. Journal of the American Geriatrics Society 32: 343–349, 1984

21. Kasten BP, Monteleone MP: Psychiatric nursing and the emergency setting. New Directions for Mental Health Services, no 58:13–22, 1993

22. McCoy HV, Kipp CW, Ahem M: Reducing older patients' reliance on the emergency department. Social Work in Health Care 17:23–37, 1992

23. Culhane DP, Hadley TR: The discriminating characteristics of for-profit versus not-for-profit freestanding psychiatric inpatient facilities. Health Services Research 27: 179–194, 1992

24. Merchant JA, Rohrer JE, Urdaneta M, et al: Provision of comprehensive health care to rural Iowans in the 21st century (summary). AMI of Iowa Newsletter, Spring 1995

25. Mick SS, Morlock LL, Salkever D, et al: Rural hospital-based alcohol and chemical abuse services: availability and adoption, 1983–1988. Journal of Studies in Alcohol 54:488–501, 1993

26. Ouslander JG, Osterweil D: Physician evaluation and management of nursing home residents. Annals of Internal Medicine 120: 584–592, 1994

27. Beardsley RS, Gardocki GJ, Larson DB, et al: Prescribing of psychotropic medication by primary care physicians and psychiatrists. Archives of General Psychiatry 45: 1117–1119, 1988

28. Olfson M, Klerman GL: Trends in the prescription of psychotropic medications: the role of physician specialty. Medical Care 31:559–564, 1993

29. Poulsen RL: Some current factors influencing the prescribing and use of psychiatric drugs. Public Health Reports 107(1):47–53, 1992

30. Program Requirements for Residency Education in Family Practice, Section 11C, Specialty Experience. Lexington, Ky, American Board of Family Practice, 1995

31. Colenda CC: Essential curriculum in geriatric psychiatry for general internal medicine residency and geriatric medicine fellowship programs: opportunities to improve clinical competency. American Journal of Medicine 97(suppl 4a):15S–18S, 1994

32. Simson S, Wilson LB, Henry SS: Creating comprehensive gero-psychiatric care in the community. Social Work in Health Care 7:53–65, 1982

33. Dubin WR, Fink PJ: The psychiatric short procedure unit: a cost-savings innovation. Hospital and Community Psychiatry 37: 227–229, 1986