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ORIGINAL ARTICLE

Use of Emergency Rooms for Mental Health Reasons in Quebec: Barriers and Facilitators

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Abstract

This study explored barriers and facilitators in mental health (MH) patient management in four Quebec (Canada) emergency rooms (ERs) that used different operational models. Forty-nine stakeholders (managers, physicians, ER and addiction liaison team members) completed semi-structured interviews. Barriers and facilitators affecting patient management emanated from health systems, patients, organizations, and from professionals themselves. Effective management of MH patients requires ER access to a rich network of outpatient, community-based MH services; integration of general and psychiatric ERs; on-site addiction liaison teams; round-the-clock ER staffing, including psychiatrists; ER staff training in MH; and adaptation to frequent and challenging ER users.

Keywords Emergency rooms · Mental health patient management · Barriers · Facilitators · Qualitative methods

Introduction

Individuals with mental health disorders (MHDs) receive most of their treatment in the community (Winters et al. 2015), following progressive decline in the number of psychiatric beds and hospitalizations since deinstitutionalization (Eppling 2008; Halmer et al. 2015). Yet, deficiencies in community-based care are evident in terms of the availability, continuity and coordination of mental health (MH) services (Gaynes et al. 2015). These gaps in service coincide with increasingly frequent use of emergency rooms (ERs) (Bruffaerts et al. 2008; Halmer et al. 2015; Heyland and Johnson 2017), and long wait times, which affect patients while augmenting hospital costs (Heyland and Johnson 2017). Psychiatric ERs are also responsible for providing round-the-clock crisis intervention, and often serve as the main point of entry to specialized MH services (Arfken et al. 2004). Given delays in access to psychiatric beds (Polevoi et al. 2013), wait times for hospital admission are three time longer for patients with MHDs versus other health disorders (Pearlmutter et al. 2017; Zeller et al. 2014). A 2008 survey by the American College of Emergency Physicians found that ER wait times exceeded eight hours for 33% of individuals who presented for MH reasons (Shattell et al. 2014; Zeller et al. 2014). In 2016–2017, the mean wait time for a MH evaluation among ER patients in Quebec was 133 minutes, while 31% consulted a psychiatrist after an average wait time of 8.2 hours. Of patients making ER visits for MH reasons, 20% were subsequently hospitalized and 6% transferred to another hospital (CSBE 2017). Psychiatric care may also be sub-optimal in ERs ill equipped to treat these cases (Stephens et al. 2014).

Congestion in ERs due to a disproportion of MH cases calls for innovative approaches to reduce ER utilization and length of stay for this population. Suggested remedies include implementing MH liaison nurses in general ERs (Wand et al. 2016; Wand and White 2007), hiring ER case managers (Turner and Stanton 2015) and nurse addiction specialists (O'Brien et al. 2012), as well as instituting "detox units" (Koivunen et al. 2017), brief case management (Stergiopoulos et al. 2017), brief intervention units (Johnstone and Zolese 1999), and discharge care planning (Zeller 2010).

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Alternative services have been developed, including regional psychiatric emergency services (Zeller et al. 2014), crisis resolution and home treatment teams (Glover et al. 2006; Hubbeling and Bertram 2012; Jespersen et al. 2016), street triage and crisis intervention teams working with local police (Hoffman et al. 2016; Horspool et al. 2016; McKenna et al. 2015; Winters et al. 2015), and telepsychiatry (Narasimhan et al. 2015; Saurman et al. 2014; Seidel and Kilgus 2014). Most of these innovations have been only partially implemented, however, and evidence regarding their effectiveness is limited.

The practice of psychiatry in ERs is different than in other psychiatric settings, as clinicians more frequently deal with patients presenting with multiple and complex problems (Arehart-Treichel 2013). The key components of quality psychiatric care in ERs are rapid access to evaluation by a MH professional, followed by the prompt initiation of treatment and continual reevaluation, all of which should occur in a quiet space separate from the main operational area of the ER (Newman and Ravinddranath 2010). Moreover, medical treatment in the ER should reflect a recovery orientation (Levin 2015).

The effective functioning of MH services, including ERs, and implementation of innovations are multifaceted but often exposed to several types of barriers (Kilbourne et al. 2007). Conceptual frameworks have been designed to identify hindering or enabling factors bearing on the effectiveness of services or programs (Damschroder et al. 2009; Fixsen et al. 2005; Greenhalgh et al. 2004; Kilbourne et al. 2007; Klein and Sorra 1996). For example, the Replicating Effective Program framework (Kilbourne et al. 2009) identified barriers related to health systems (e.g. costs, lack of integration among network resources), organizations (e.g. capacity to recruit staff), professionals (e.g. lack of training) and patients (e.g. lack of access to services).

Health system barriers are most often cited as reasons for disproportionate ER use for MH reasons (Gaynes et al. 2015; Kahan et al. 2016; Nesper et al. 2016), including insufficient MH budgets, service gaps in healthcare networks, difficulties accessing outpatient and community resources, and problematic relations between community resources and ERs (Gaynes et al. 2015; Kahan et al. 2016). One study found that the decreasing availability of MH services tended to increase ER visits and length of stay (Nesper et al. 2016); while another determined that up to 40% of psychiatric ER visits could be eliminated if adequate community services were provided (Arfken et al. 2004). Certain organizational enabling factors identified in the implementation literature, such as appropriate physical infrastructure (Brunette et al. 2008; Hossain et al. 2017), use of guidelines (Meurer et al. 2011), and administrative leadership (Brunette et al. 2008) may also have relevance for ER functioning. Professional characteristics affecting organizational effectiveness, such as staff availability and diversity (Hossain et al. 2017), expertise (Hossain et al. 2017), training (Aarons et al. 2009; Schultz et al. 2016) and staff turnover (Aarons et al. 2009; Brunette et al. 2008; Fleury et al. 2016) may also act as barriers or facilitators in ER functioning. Concerning patients, frequent ER use (Althaus et al. 2011), and recourse to the ER occasioned by inappropriate follow-up in MH services (Arfken et al. 2004) are known impediments to ER functioning. Yet, to the best of our knowledge, no study has identified barriers and facilitators in the organizational performance of ERs, or in the characteristics of ER professionals, as they affect ER use for MH reasons. A better understanding of ER patient management may suggest innovations that induce better ER functioning.

While little research has explored how ER staff cope with influxes of MH patients, three models of MH patient management have been described: In the first, patients are evaluated in the general ER by a physician, followed by a psychiatric consultation. In the second, patients are confined to a designated psychiatric section in the general ER and evaluated by MH professionals. Third, patients may be evaluated by MH professionals in a completely separate psychiatric ER (Halmer et al. 2015; Zeller 2010). However, studies have not taken into account the conditions affecting these different service configurations in ERs, or the strengths and weaknesses of their different approaches to patient management.

Against this backdrop, the present study explored MH patient management in four ERs using different operating models, and located in various urban areas of Quebec (Canada). Based on the perceptions of four stakeholder groups (managers, physicians, ER team members, addiction liaison team members), and using a conceptual framework with four designated types of barriers, the study aimed to: (1) identify the contributions of healthcare systems, organizations, professional and patient characteristics for the effectiveness of ER functioning; and (2) compare and contrast barriers and facilitators reported for a psychiatric ER, general ER, psychiatric ER merged with a general ER, and a psychiatric ER located at a separate site from the general ER.

Methods

Study Design and Setting

The study used a theory-driven qualitative design, based on case study methodology (Yin 2009), including a short questionnaire on participant characteristics and ability to diagnose and treat MHDs and SUDs. The study was conducted in four ERs, located in different Quebec regional health networks. One network had a single psychiatric ER located in a MH university institute (henceforth, ER-P); whereas psychiatric ERs in the other two health networks were integrated into

general hospital ERs. In one case (ER-PG-1) the psychiatric ER was located at a separate site; whereas the psychiatric ER and general hospital ER (ER-PG-2) were merged in the other network, which also included an addiction liaison team. The fourth setting (ER-G) was a general ER, but included staff psychiatric consultants and an addiction liaison team. All ERs, except ER-PG-1, had brief admission units.

Data Collection

Individual semi-structured interviews were conducted with managers (n = 10) and ER clinicians (n = 9); while group interviews with ER teams (n = 4; 20 participants), addiction liaison teams (n = 2; eight participants) and managers (n = 1; two participants) were conducted by a professional interviewer accompanied by a research team member. Participants were selected based on their expertise and seniority in the ERs, with the assistance of decision-makers involved in the research project from the four settings. Participation in the study was voluntary.

Interview guides were developed in collaboration with the project decision-makers and validated by them. The topics included: (1) profiles of ER patients with MHDs and/or substance use disorders (SUDs) (e.g.: "What are the main reasons for ER consultations among patients with MHDs or SUDs?"; "Which clinical profiles pose greater challenges for patient management?"); (2) organization of services and ways of responding to patient needs (e.g. "Can you identify standardized screening or needs assessment tools used for patient assessment?"; "Can you describe innovations deployed to improve ER functioning and patient care?") and (3) coordination with other health, MH and addiction services (e.g.: "To what extent is your ER coordinated with other organizations offering health, MH or addiction services?"; "What other tools or procedures could be implemented to improve ER referrals to partner organizations?"). Interviews were conducted between May and September 2017. Individual interviews were 60 minutes in duration for managers, and 25 minutes for clinicians. Group interviews for ER and addiction liaison teams lasted 90 minutes, and manager group interviews, 120 minutes. The individual and group interviews were audio-recorded and transcribed verbatim.

Participants also completed a seven-item questionnaire on socio-demographic and socio-professional characteristics (e.g. type of profession; professional seniority; years of employment), including three questions on a ten-point scale about their ability to diagnose and treat alcohol use disorders, drug use disorders and co-occurring MHDs/SUDs. All participants provided written, informed consent. The Ethics Board of a MH university institute approved the multi-site study protocol.

Analysis Including the Conceptual Framework

The qualitative data analysis took a deductive approach (theory-driven design), given the large number of interviews, and used a conceptual model as an organizing framework for the study. Figure 1 presents the conceptual framework, based on existing implementation models (Damschroder et al. 2009; Fixsen et al. 2005; Greenhalgh et al. 2004; Kilbourne et al. 2007; Klein and Sorra 1996) that guided the coding and analysis. Barriers and facilitators were organized according to four blocks: (1) Health system (e.g. heath policy, network MH resources); (2) Organization (e.g. relations between psychiatric and general ERs, physical infrastructure) (3) Professionals (e.g. availability, expertise), and (4) Patients (e.g., behavioural characteristics, frequent user profiles).

Each interview was read in its entirety, the verbatim separated into units of meaning and coded, based on the framework and including spaces for emergent themes. A list of barriers (−) and facilitators (+) reported by participants in the interview was compiled within the four blocks of the conceptual framework. A professional research agent coded and analysed the data, under close supervision by the project researchers who validated interrater reliability among them at roughly 90%. For the complementary quantitative variables, missing values were identified, and the data assessed for univariate outliers, and normality assumptions (skewness and kurtosis). Frequency distributions, percentages for categorical variables, and central tendency measures for continuous variables (mean values and standard deviations) were calculated.

Results

Description of the Sample

In all, 49 participants were recruited, for a 100% response rate. Average age was 44 years; 67% of participants were women, and most (84%) worked full-time. Forty-five percent were nurses, 29% managers, 16% psychiatrists, and the remainder from various other professions (Table 1). Average professional seniority was 15.5 years; participants had worked in their current organizations for 12.1 years, on average, and in their current positions for 6.3 years. Managers and addiction liaison team members had worked an average of 1.5 and 2.9 years respectively in their current positions, versus 8.3 years for clinical team members, and 11 years for physicians. Participants were generally confident of their ability to diagnose and treat SUDs (alcohol or drugs), or co-occurring MHDs/SUDs (mean > 7); yet, scores for ER clinical team members indicated relatively less confidence in these areas (Table 1).

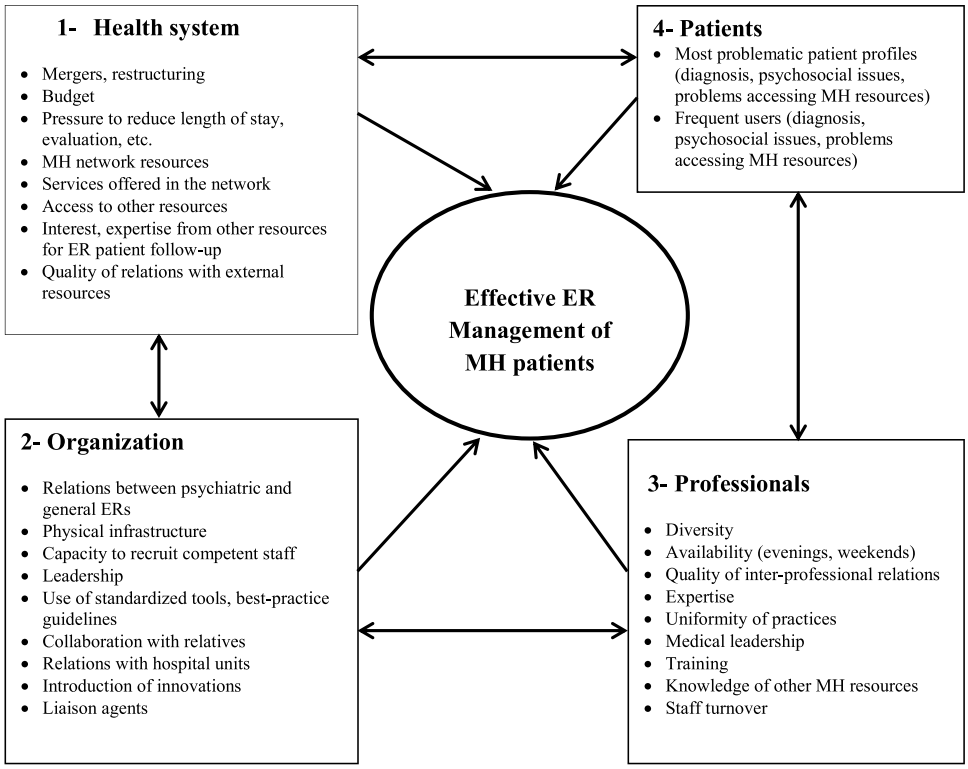

Fig. 1 Conceptual framework: barriers and facilitators to effective ER management of mental health patients

Barriers and Facilitators to Effective ER Management of MH Patients

Barriers and facilitators reported by participants are identified in Table 2, with double negatives (− −) or positives (++) used to identify barriers and facilitators that were more frequently reported. Regarding the Health system, several policy-related factors emerged in the data as barriers to effective ER functioning, multiple organizational mergers and restructuring:

> "Things were simpler when organizations integrating ERs were smaller. Everything has become very complicated. The details around clinical or administrative consultations, for example, are unbelievably complex; and a lot of people that we used to work with have been relocated elsewhere." (Addiction liaison team member, ER-G)

Other barriers included insufficient budgets, pressures to evaluate and process ER patients quickly, and severe limits on length of stay in hospital units. ER-G staff were particularly affected by budget shortfalls and time pressures, whereas ER-PG-1 staff lamented organizational mergers, restructuring and staff relocation. Policy barriers had seemingly less impact on ER-P and ER-PG-2 professionals. Other Health system barriers concerned network resources. All participants explained ER overcrowding as a problem of access to services, whether addiction services, medical clinics, psychologists in private practice, primary MH care services or housing:

> "Our main problem is lack of access to external resources in the community, even the outpatient clinic. This forces our patients to present at the ER when there are no other resources in their area; or resources may exist to which they are oblivious." (Physician, ER-PG-1)

As well, outpatient and community resources were not available evenings and weekends. Participants further invoked stigma as a major barrier to accessing services among patients with complex clinical profiles (e.g. co-occurring MHDs/SUDs), as most general practitioners lacked expertise in MH:

> "You know, we in psychiatry are often branded for dispensing enormous amounts of medication. Yet, it is fascinating to see what my patients have on them when they arrive after following-up with the family doctor!" (Clinical team member, ER-G)

Lack of a detox unit in ER-PG-2 and ER-G was reported to be a major hindrance to ER functioning, as were insufficient resources more generally. The only facilitators mentioned in relation to the health system were the quality of ER relationships with crisis centers, as well as with family support groups and addiction service centers. ER-G participants were alone in reporting positive relationships with primary care MH services.

Regarding Organizational characteristics, the main barriers concerned unhelpful relationships between psychiatric and general ERs, and the difficulties of recruiting competent staff. In all settings, except ER-PG-2, the lack of proximity between

Table 1 Demographic and occupational information of stakeholders (N = 49)

	Total sample		1 Physician		2 Clinical team		3 Manager		4 Addiction liaison team	
	n = 49		n = 9		n = 20		n = 9		n = 11	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Sex										
Females	33	67.3	1	11.1	16	80.0	7	77.8	9	81.8
Males	16	32.7	8	88.9	4	20.0	2	22.2	2	18.2
Territory										
With psychiatric emergency room (ER) only	10	20.4	2	22.2	4	20.0	4	44.4	0	0.0
With general ER only	12	24.5	2	22.2	6	30.0	1	11.1	3	27.3
With psychiatric and general ER in the same site	17	34.7	3	33.3	5	25.0	2	22.2	7	63.6
With psychiatric and general ER located in separate sites	10	20.4	2	22.2	5	25.0	2	22.2	1	9.1
Profession										
1. Psychiatrist	8	16.3	8	88.9	0	0.0	0	0.0	0	0.0
2. Nurse	22	44.9	0	0.0	16	80.0	0	0.0	6	54.5
3. Manager	14	28.6	0	0.0	0	0.0	9	100.0	5	45.5
4. Emergency physician	1	2.0	1	11.1	0	0.0	0	0.0	0	0.0
5. Social worker	2	4.1	0	0.0	2	10.0	0	0.0	0	0.0
6. General practitioner	2	4.1	0	0.0	2	10.0	0	0.0	0	0.0
Job status										
1. Full time	41	83.7	9	100.0	14	70.0	9	100.0	9	81.8
2. Part time	5	10.2	0	0.0	4	20.0	0	0.0	1	9.1
3. Full and part time	2	4.1	0	0.0	2	10.0	0	0.0	0	0.0

	Min	Max	Mean	SD	Min	Max	Mean	SD	Min	Max	Mean	SD	Min	Max	Mean	SD	Min	Max	Mean	SD
Age	25	92	44.67	12.41	37	92	50.00	17.36	29	66	45.58	11.87	30	56	43.78	8.67	25	61	39.45	10.55
Seniority (in months)																				
In the profession	3	492	186.55	138.21	67	360	193.67	107.89	37	492	237.45	147.57	24	360	147.00	131.45	3	468	120.55	125.51
In the setting	0	492	146.31	117.53	24	298	132.67	83.43	0	492	180.25	140.47	15	396	168.33	119.06	8	204	77.73	61.80
In the position	1	384	75.61	80.72	24	298	132.00	84.09	1	384	99.95	90.26	15	84	35.44	26.26	1	63	18.09	21.27

Table 1 (continued)

	Min	Max	Mean	SD	Min	Max	Mean	SD	Min	Max	Mean	SD	Min	Max	Mean	SD	Min	Max	Mean	SD
How do you feel at ease with diagnosis and treatment of																				
Alcohol addiction[a]	3	10	7.22	2.03	6	10	8.56	1.33	3	10	6.65	2.11	3	10	6.44	2.35	7	10	8.00	1.20
Drug addiction[a]	3	10	7.33	2.02	6	10	8.44	1.42	3	10	6.60	2.04	3	10	7.00	2.29	6	10	8.25	1.58
Co-occurring mental health disorders and substance use disorders[a]	3	10	7.20	1.95	6	10	8.44	1.42	3	10	6.50	2.16	5	10	7.50	1.77	5	9	7.25	1.49

[a]0–10 for each variable, Min = 0, Max = 10; higher = greater level of comfort

psychiatric and general ERs was a perceived obstacle. ER-P and ER-PG-1 participants had difficulties managing physical illnesses; whereas the absence of a psychiatric ER compromised functioning considerably in ER-G. Moreover, all participants noted difficulties recruiting emergency physicians:

> "It is now extremely difficult to recruit general practitioners in the hospital, especially in the ER, as they are encouraged to go into private practice with heavy patient load. We have lost many physicians for this reason." (Clinical team member, ER-PG-1)

R-PG-2 and ER-G also reported difficulties engaging MH clinicians. Most clinicians, with the exception of triage nurses, made limited use of standardized tools and best practice guidelines:

> "We use few, if any, evaluation tools. Evaluations are done at the emergency by the triage team, and by the psychiatric team in cases of suicide ideation. People tend to use standardized psychiatric evaluations with scales that can be put into patient charts; but, otherwise, the answer is "no"; we do not use many of these tools." (Physician, ER-PG-2)

Concerning physical infrastructure, ER-P and ER-G participants complained about lack of appropriate offices for patient interviews. Gathering information from relatives was a barrier observed by ER-PG-1 and ER-PG-2 participants, who also encountered communication problems with hospital units. The absence of addiction liaison nurses hampered service delivery in ER-P and ER-PG-1. Finally, lack of managerial leadership was observed in ER-P. Barriers were relatively numerous in ER-P, particularly in comparison with ER-PG-2.

Overall, there were more facilitators than barriers in terms of organizational characteristics, especially in ER-PG-2, followed by ER-P, ER-G and ER-PG-1. The most commonly reported facilitators were the utilization of standardized tools and best practice guidelines in the triage process, presence of liaison workers (e.g. social workers and liaison nurses) who maintained links between ERs and external resources; and implementation of Assertive Community Treatment and intensive case management teams in MH hospitals. In terms of physical infrastructure, brief intervention units were a key facilitator in ER-P, ER-PG-2, and ER-G. Concerning ER relations with hospital units, two ERs (ER-PG-1 and ER-PG2) had implemented bed management protocols; whereas ER-P developed a service corridor for patients with physical conditions. As well, each ER introduced important innovations involving service agreements and collaboration with crisis centers to ensure a supply of beds for patients in crisis. ER-PG2 and ER-G had engaged addiction liaison nurses, who evaluated patients suspected of having SUDs and referred them to addiction centers. ER-P had implemented an ER follow-up service that targeted patients not previously connected with MH or addictions services, providing them with up to three medical

Table 2 Barriers (−) and facilitators (+) to effective ER management of mental health patients by setting

Category	Barriers and facilitators	ER-P	ER-PG-1	ER-PG-2	ER-G
1. Health system					
Policy	Mergers, restructuring, staff relocation	−	− −	−	−
	Insufficient budget	−	−	−	− −
	Pressure to do quicker evaluations	−	−	−	− −
	Pressure to process ER patients more quickly	−	−	−	−
	Pressure to reduce length of hospital stay	−	−	−	−
Network resources					
Absence of services	Detox unit	=	=	−	−
Access to services	Medical clinics	−	−	−	−
	Detox services	−	−	−	−
	Psychologists in private practice	−	−	−	−
	Local community health centers (primary care services)	−	−	−	−
	Crisis centers	−	=	−	=
	Community mental health resources	=	−	−	=
	Housing services	−	−	−	−
	Access to services (evening and week end)	−	−	−	-
Interest from other resources for ER patient follow-up	Absence of interest in following-up difficult cases (stigma)	−	−	−	−
Expertise from other resources in MH	MH knowledge among general practitioners	−	−	−	−
Quality of relations with external resources	Mental health primary care teams	−	−	−	+
	Crisis centers	+	++	++	++
	Addiction centers	+	+	+	+
	Family support groups	++	+	+	+
2. Organization					
Relations between psychiatric and general ERs	Proximity between psychiatric and general ERs	− −	−	+	− −
	Absence of psychiatric ER	=	=	=	− −
	Management problems in physical illness	− −	−	+	+
Physical infrastructure	Brief intervention units	+	−	+	+
	Appropriate offices for patient interviews	−	=	+	−
Capacity to recruit competent staff	Difficulty recruiting emergency physicians	−	−	−	−
	Difficulty recruiting other mental health clinicians	=	=	−	−
Leadership	Lack of managerial leadership	−	=	=	=
Standardized tools and best-practice guidelines	In the triage process	+	+	+	+
	In ER and hospital units	−	−	−	−
Collaboration with relatives	Difficulty obtaining information on patients from relatives	=	−	−	=
ER relations with hospital units	Communication with hospital units	+	−	−	=
	Bed management	=	+	+	=
	Service corridor for patients with physical illnesses	+	+	=	=
Introduction of innovations in ER	Collaboration with crisis centers	+	+	+	+
	Addiction liaison nurses	− −	− −	++	++
	Post ER follow-up	+	=	=	=
	Peer specialist in the ER from family support group	+	=	=	=
	Intensive home treatment team	=	=	+	=
	Street triage with police services	=	=	=	+
Other innovations in MH hospital settings	Assertive community treatment and Intensive case management teams	++	+	++	+
Liaison agents (ER to community resources)	Social workers	+	+	+	+
	Liaison nurses (other than addiction liaison nurses)	+	+	++	+

Table 2 (continued)

Category	Barriers and facilitators	ER-P	ER-PG-1	ER-PG-2	ER-G
3. Professionals					
Staff turnover		=	−	−	−
Diversity	Multidisciplinary interventions	+	+	+	+
Availability	Addiction liaison nurses in evening and/or weekend shifts	−	−	−	−
	Psychiatrists in evening and/or weekend shifts	−	−	=	−
Quality of inter-professional relations		+	+	+	+
Expertise in mental health	Staff from the general ER - re: mental disorders	=	=	=	−
	General practitioners from the psychiatric ER	−	=	=	=
Uniformity in practice	Diversity of practice among psychiatrists	−	=	=	=
Medical leadership		−	=	=	=
Training	Lack of training in mental health	−	−	−	− −
Knowledge of MH resources	Knowledge of other community resources	− −	− −	−	−
4. Patients					
Most challenging patient issues					
Diagnosis	Co-occurring mental disorder(MDS)s and substance use disorders (SUDs)	−	−	−	−
	Borderline personality disorders	−	−	−	−
	Co-occurring MDs and physical illness	−	−	=	=
Psychosocial reasons	Suicidal ideation	−	−	−	−
	Disruptive behavior, dangerousness	−	−	−	−
	Homeless patients	=	=	−	=
	Patients from other territories	−	=	−	−
Frequent ER users					
Diagnosis	Borderline personality disorders	−	−	−	−
	Co-occurring MDs/SUDs	−	−	−	−
	Decompensating patients with severe MDs	−	−	−	−
	Major depression	=	=	−	=
	Co-occurring MDs and physical illness	=	=	−	=
Problems of access to MH resources	Patients with inappropriate follow-up	−	−	−	−

ER-P psychiatric ER only, *ER-PG-1* psychiatric ER located in a separate site of general ER, *ER-PG-2* psychiatric ER merged with general ER, *ER-G* general ER only

+ Facilitators, More +: more important facilitators, −: barriers, More −: more important barriers, =: neutral, has no influence in the ER

appointments and referral to the appropriate MH service for follow-up:

> "Post-ER follow-up is key, as a safety net established for patients in the brief intervention unit, and in the ER. Patients needing crisis intervention, and 6–8 follow-up sessions are referred to the crisis team; whereas the nurse generally takes care of liaison." (Manager, ER-P)

ER-P also had a peer specialist from a family support group, who provided information to relatives in the ER aimed at integrating them into the patient care process. ER-PG-2 had introduced an intensive home treatment team, consisting of psychiatrists, nurses and social workers who visited discharged ER patients two to three times daily for a maximum of two months. ER-G had established links with police services and crisis centers, devising a street triage service to better manage patients in crisis found on the streets:

> "When there are calls, the police come on the scene. They realize that they should avoid useless visits to the ER with MH cases. They contact an on-call service provider instead, and discuss the case. A joint decision is made about what course of action to take, and if the patient needs to be brought to the ER." (Clinical team member, ER-G)

Regarding Professional characteristics, participants from all ERs, including general practitioners (ER-P), reported a lack of knowledge around community resources as well as lack of training and expertise in MH:

> "The nursing teams or attendants are not MH experts for sure; although a very small number may have an interest in this type of client. Most ER workers are more interested in areas like physiopathology, or cardiology. Issues around aggressivity, and loss of contact or withdrawal from reality, will naturally be addressed, but less thoroughly and with some delay." (Manager, ER-G)

Staff turnover was identified as a barrier in three ERs (ER-PG-1, ER-PG-2 and ER-G), as was the shortage of psychiatrists for evening shifts (ER-P, ER-PG-1 and ER-G). Addiction liaison nurses were also needed for evening and weekend duty in ER-PG-2 and ER-G. Other barriers were reported for ER-P only, including too much diversity of practice among psychiatrists, and lack of medical leadership. ER-P professionals reported the greatest number of barriers, and ER-PG-2 the least. As for facilitators, all sites identified multidisciplinary interventions, and good inter-professional relations.

Finally, barriers related to Patient characteristics included challenging patient behaviors and frequent ER users. For all ERs, patients with co-occurring MHDs/SUDs, borderline personality disorders, suicidal ideation and disruptive behaviors/dangerosity were most problematic from a management perspective:

> "I don`t see many of the "pure cases" we were seeing a few years ago in the ER. When there are multiple associated pathologies, symptoms, and disturbing elements occurring simultaneously, it becomes more difficult to attack the main problem." (Physician, ER-PG-1)

Co-occurring MHDs and physical illnesses represented another barrier for ER-P and ER-PG-1. The arrival of patients at ERs from other administrative territories was described as a barrier by three ERs (ER-P, ER PG-2 and ER-G), whereas homelessness was a major challenge for ER-PG-2. Co-occurring MHDs/SUDs, borderline personality disorders, decompensating patients with severe MHDs, and those presenting after inappropriate MH follow-up represented typical profiles of frequent users in all ERs, and accounted for the most important barriers in ER-PG-2, followed by ER-P, ER-G and ER-P-1. Other Illustrative quotations for each domain are presented in Table 3.

Table 3 Quotations

1) Health system
Mergers, restructuring, staff relocations:
"Unfortunately, problems will occur with any reform, whether minor difficulties, or major quakes. I think that better means of communication need to be put in place to help people adjust to our "big box" hospital. The new hospital merged 3 previous hospitals; many local community health centers (LCHCs), residential centers, and addictions centers; the resulting enterprise has over 10 000 employees. Even those of us on the inside have trouble locating people; I'm at a loss to find anyone in my Center telephone directory." (Physician, ER-PG-1)
"Staff transferred from XX to here are coming from a different culture; they function differently." (Clinical team member, ER-PG-1)
Insufficient budget:
"For sure, I would take more staff, which is very good for emergency departments, but the challenge is that the budgets are not there." (Manager, ER-G)
Pressure to do quicker evaluations:
"…patients sometimes evolve rapidly. I think that a patient may come to the ER even he will not not need to be hospitalized." (Manager, ER-PG-2)
Pressure to process ER patients more quickly:
"Unfortunately, the Minister decides on acceptable wait times for admission, and you have to get patients to the wards quickly. But a patient with schizophrenia who has been decompensating for 20 h should perhaps take priority over someone with a situational mental health problem." (Clinical team member, ER-G).
Pressure to reduce length of hospital stay:
"We have to meet ministerial objectives in terms of time, and the average duration of hospital stay." (Clinical team member, ER-PG1)
Resource scarcity in the networks:
"There was a regional hospital with a Toxicology Department that disappeared with the reorganization. I can assure you that all the medical disciplines have been passing that buck back and forth ever since." (Physician, ER-PG-2)
Access to services:
"It's quite a feat to obtain information from the LCHC, or family doctor. It takes 2–4 weeks to establish contact, and then difficult to gather the information once I get through. We have a definite gap in this area." (Clinical team member, ER-PG-2)
"Why the LCHC is so slow, I don`t know because I'm unfamiliar with the service. I'm not saying that people are lazy at the LCHC; it just seems understaffed." (Physician, ER-PG-2)
"The services down there, like housing, are completely overloaded. The wait time for community follow-up is 8 months." (Clinical team member, ER-PG-2)
"Not only does it take a year to see a psychologist, but people can`t afford it, unfortunately, with the high cost of living. They have enough trouble buying bread." (Clinical team member, ER-G)
Access to services (evening and week end):
"It is more difficult to provide service in the evening, and I would say that the greatest challenge there is (staff) coverage. As with all the other services, there usually have a cut starting from 4 p.m." (Manager, ER-PG-2)
Quality of relations with external resources:
"The opportunity we have is that our crisis center belongs to the hospital, so we collaborate with them closely." (Manager, ER-G)
"We have a good partnership with the addiction centers, most of whom even offer a transportation service." (Manager, ER-P)

Table 3 (continued)

2) Organization

Management of physical illness:

"Anyone the least bit unbalanced medically is not managed here; you send him to the XX. One time I was working overnight Friday into Saturday, and had to accompany the attendant, with an alcohol intoxicated patient, who wasn`t on her feet. We transported her, with great difficulty, in a wheelchair to XX hospital, and by taxi, because XX had no ambulance zone. It`s ridiculous." (Clinical team member, ER-P)

"The organic and the psychological are often in complex interaction, as are medications for physical and psychiatric conditions. Further complexities arise when social aspects are involved. So, the greater the mix of medical, psychiatric and social pathologies, the more complex the case." (Clinical team member, PG-1)

Physical infrastructure:

"For sure, it's difficult to be confronted with an aggressive patient who is shouting; and even more difficult to approach the patient when he is right next to elderly people who are sick. We're working in cramped quarters, and this is a medical environment." (Physician, ER-G)

Standardized tools:

"The quantity of paperwork is a major issue in both emergency services, and in the work of the nurse. We need to move toward acquiring a tool, but one that is quick and effective, without involving much additional paperwork." (Manager, ER-P)

Difficulty obtaining information on patients from relatives:

"The challenge is to be able to evaluate the patient properly, especially in terms of having collateral information from relatives, the authorities, etc., so we can understand what happened." (Psychiatrist, ER-PG2)

Communications with hospital hospital units:

"I think there is close collaboration because the triage nurse and the admissions office are located just beside each other; so the communication works quite well!" (Manager, ER-P)

Service corridor for patients with physical illness :

"We have a service corridor with hospital XX for physical health." (Manager, ER-P)

Innovations:

Crisis centers:

"The crisis center aims to observe clients, assure their security, and avoid hospitalizations, which involves 24/7 supervision as an in-between option between returning home and hospitalization. This approach is frequently used in situational crises; but the general rationale for referral to the crisis center is respite, or observation of symptoms." (Clinical team member, ER-PG-2)

Liaison nurse:

"Having a specialized liaison nurse allows us to remove the social worker from addictions cases. The worker can now provide more generic social evaluations; while the addictions nurse takes charge of those cases. This saves us from doing unnecessary consultations in the end." (Clinical team member, ER-PG-2)

"What is fun is that they wait until I'm there, because they are used to having a liaison nurse on call in the emergency. So they just page me automatically." (Liaison nurse, ER-G)

Post ER-follow-up services:

"Post-ER follow-up is key, as a safety net established for patients in the Brief intervention unit, and in the emergency. Patients needing crisis intervention, and 6–8 follow-up sessions are referred to the crisis team; whereas the "reactivation" nurse generally takes care of liaison. The reactivation team includes a doctor and nurse who visit patients needing follow-up, because they are new, or who need reorientation to services. The physician may adjust medications until the patient is seen by a family doctor, or integrated by a hospital. Alternatively, the treatment teams may take on the patient, offering up to three interventions before the treating doctor, or another team, takes over." (Manager, ER-P)

Peer specialist from the family support group:

"A peer specialist from the Family support group is present every day. This facilitates family referrals, which may even be made in the same day. This service is very helpful." (Manager, ER-P)

Home treatment team:

"This team, including a psychiatrist and other healthcare professionals, does home visits for clients from 2 to 4 times per day, meaning that people who are psychotic, and would normally be in hospital or at an emergency department, can be maintained in the community. The concept is unique to Quebec. Home treatment also mitigates stigma and self-stigma among patients." (Manager, ER-PG-2)

Bed Management:

"As bed management is a priority, all ER assistants meet at 10:00 am, daily, to discuss patient transfers to hospital. So there is a transfer of information even at this early juncture concerning why the person was at the emergency and reasons for hospitalization." (Manager, ER-PG-1)

Assertive community treatment and Intensive case management teams:

"Most of our assertive community treatment teams and intensive case management teams come from the mental health university institute." (Manager, ER-PG2)

Liaison agents (ER to community resources)

"I have two social workers who take care of everything to do with psychosocial liaison." (Manager, ER-PG2)

"My hypothesis is that, if there are fewer requests for consultation here, it's perhaps because we have a liaison nurse who does a screening beforehand." (Manager, ER-PG2)

Table 3 (continued)

3) Professionals
Staff Turnover:
"As staff members are moving around, the person with whom you had a good rapport may no longer be there. Bridges need to be rebuilt, and confidence regained, with someone else who is less tried and tested." (Addiction liaison team member, ER-G)
Multidisciplinary interventions:
"The main elements of an effective intervention? The timeliness of the intervention, in a context where patients are in crisis, and then, the ability to benefit from the intervention of a multidisciplinary team." (Physician, ER-G)
Competence of general practitioners in ER-P:
"There are times when cases are carried over to the next day, knowing that it will be "whatever"…" (Clinical team member, ER-P)
Expertise of Staff from the general ER in mental health:
"If ER staff were as competent in mental health as they are in medicine, I think we would end up with a bit more." (Manager, ER-G)
Availability of addiction liaison nurses in evening and/or weekend shifts:
"The problem that shouldn`t be hidden is that everything to do with intoxication happens on the weekend—Friday night, Saturday. So we are a bit taken up with the orientation of those patients on weekends." (Physician, ER-G)
Availability of psychiatrists in evening shifts:
"Psychiatric medical coverage is occasionally done, not by psychiatrists but by general practitioners licenced to practice psychiatry. Yet certain things they can`t do, such as psychiatric evaluations. For this reason, evaluations are often postponed until the next day." (Manager, ER-P)
Diversity of practice among psychiatrists:
"Every psychiatrist has his own style and it isn`t possible to put rules in place; we can only try to guide our colleagues a bit. So you will have ten to fifteen psychiatrists with ten to fifteen different practices." (Psychiatrist, ER-P)
Lack of Training:
"There have been sentinel events where staff working at the emergency experienced trauma. Had they received some training, some tools, it might have helped the situation. I find that the lack of staff training is a serious deficiency." (Clinical team member, ER-G)
Knowledge of MH resources:
"What I would like, myself, would be that everyone gets an update, once a year let's say, of the available resources, what is new, what has changed." (Clinical team member, ER-P)
4) Patients
Borderline personality disorders:
"Keeping these people exacerbates the problems: suicide risks, disorganization. These clients are among those that make most use of our psychiatric emergency rooms; yet they are not always open to receiving follow-up with a team, or service provider." (Manager, ER-PG-2)
"Those with borderline personality disorder tend to make everything fail, which is part of the problem. They create divisions and sabotage whatever is put in place to help them. It is also difficult with these clients to differentiate truth from lies; they are medicated, but say they have hallucinations. In fact, they are hyper-medicated but not really ill, which creates other problems." (Clinical team member, ER-P)
Co-occurring Mental and substance use disorders:
"Those who overwhelm our emergency rooms are people who abuse drugs, and create mental illnesses in the process." (Physician, ER-PG-2)
"We are now surprised to find anyone who doesn`t consume." (Manager, ER-P)
Decompensating patients with severe mental disorders:
"We certainly have more people who are receiving treatment within specialized teams in the community, whether for bipolar disorder or schizophrenia, who then decompensate." (clinical team member, ER-PG2)
Suicidal ideation, major depression:
"You could say that we have many patients in our emergency department who arrive in a depressive state and are suicidal." (Clinical team member, ER-PG2)
Disruptive behavior, dangerousness:
"The main reasons for visits in the ER are danger to self or to others." (Manager, ER-G)
Homeless patients:
"We have a large clientele of people without a fixed address." (Clinical team member, ER-PG-2)
Patients from other territories:
"They say "the wait is too long. I prefer to come here to see someone." (Clinical team member, ER-P)

ER Emergency room, *LCHC* local community health center

Discussion

Results from participant accounts suggest that Health system characteristics were the most important barriers to effective ER management of MH patients, followed by Patient, Organizational and Professional characteristics, in that order. Concerning the Health system, resource scarcity in some local networks, long delays in accessing outpatient and community resources, and insufficient availability of resources in evenings and on weekends were frequently reported barriers to ER functioning in this study, as in others (Gaynes et al. 2015; Kahan et al. 2016; Nesper et al. 2016). ER performance is usually viewed as a barometer of system effectiveness, gauging whether services need to be better integrated, or whether community-based care for patients with MHDs could be more comprehensive (Bruffaerts et al. 2008). Underfunding for addiction programs, a worldwide problem (Fleury et al. 2016; Pawda et al. 2012; Sacks et al. 2013; Vanderplasschen et al. 2002), seems to explain delayed access to addiction services in all ERs, and the lack

of detox units in two of them. While general practitioners are usually the first point of contact in healthcare systems, the literature suggests that access to medical clinics for MH reasons was compromised due to the lack of MH expertise among physicians and their reluctance to treat these patients (Su et al. 2011; Walters et al. 2008). While general practitioners treat many patients with common MHDs (anxiety disorders, depression) (Kushner et al. 2001; Saillant et al. 2016), most have difficulty dealing with severe MHDs or co-occurring MHDs/SUDs (Fleury et al. 2016; Saillant et al. 2016). Moreover, as services provided by psychologists are not covered by public healthcare insurance in Quebec, they are generally inaccessible to low-income MH patients.

From another perspective, the problem of access to primary care, outpatient MH services and community resources reflects the incomplete implementation of the Quebec MH reform (2005–2015) (Ministère de la Santé et des Services sociaux 2005). This reform aimed to improve access to MH services by integrating MH into primary care. Yet staffing in primary care teams was incomplete in many networks, resulting in chronic shortages of psychiatrists and general practitioners (Fleury et al. 2016). The Quebec MH reform also mandated increased MH funding for community organizations; yet most remained underfunded, limiting their operational capacity (Grenier and Fleury 2014). In addition to barriers related to network resources, participants observed that policy directives, including the organizational mergers and staff relocations implemented in 2015, created havoc for many teams and hindered optimal ER functioning (Fleury et al. 2016). Moreover, ministerial pressures to reduce the time allocation for ER evaluations, or length of stay in the ER, and in hospital units, may have exacerbated stress among staff and the risk of errors, while promoting staff resistance (Jacob et al. 2014), and turnover (Brunette et al. 2008). Finally, the implementation of innovations in ERs, and maintenance of competent staff, requires sufficient financial resources (Mancini et al. 2009).

Concerning Patient characteristics, frequent users of MH services, including ERs, tend to be patients with co-occurring MHDs/SUDs (Beck et al. 2016; Doupe et al. 2012). Treatment for these patients is rarely optimal without integrated care (Drake et al. 2004). Borderline personality disorder represented a challenge for ERs and MH services alike, especially given the elevated risk for suicidal ideation, and treatment resistance in this group (Laugharne and Flynn 2013; Lawn and McMahon 2015). Another characteristic of patients with borderline personality disorder is that they are rarely satisfied with MH services, which might explain why they reportedly have the highest level of unmet needs among diagnostic groups, including the need for more adequate treatment (Lawn and McMahon 2015; Parkman et al. 2017).

It was interesting to note in relation to Organizational characteristics that facilitators were more numerous than barriers. Facilitators included the availability of brief intervention units as a means of increasing patient flow in the ER (Gullick and Walters 2007), and reduction in lengthy hospital admissions (Clarke et al. 1997). Among other facilitators, the innovations introduced in Quebec ERs deserve to be more widely implemented, and their impact evaluated. For example, crisis centers, which provide an alternative to the ER and more quiet settings than hospital units, have elicited higher satisfaction ratings among service users than ERs (Paton et al. 2016). The introduction of addiction liaison nurses in ER-PG-2 and ER-G expanded knowledge and the capacity of clinical teams to deal with SUDs. Moreover, research has found that patients seen by addiction liaison nurses are 30% more likely than other patients to participate subsequently in therapeutic programs (D'Onofrio and Degutis 2010). The inclusion of a peer specialist in ER-P was another important innovation, as support for families reduces anxiety and increases their capacity to engage with their loved ones (Aldersey and Whitley 2015), while helping to reduce hospital admissions (Gaynes et al. 2015). Brief case management, as in the ER follow-up service developed by ER-P, may help reduce ER visits for MH issues (Stergiopoulos et al. 2017). Intensive home treatment teams have contributed to significant reductions in the number and length of psychiatric hospitalizations (Glover et al. 2006; Hubbeling and Bertram 2012), while increasing patient satisfaction (Wheeler et al. 2015). Finally, collaboration between MH services and the police has led to more appropriate referrals, and reduced the number of individuals presenting at ERs in crisis (McKenna et al. 2015).

Relatively fewer barrier and facilitators were reported in relation to Professional characteristics. The strongest barrier was probably the general lack of MH training among staff, particularly at ER-G. ER professionals have been found to lack the necessary skills and experience for managing patients with MHDs (Adams and Nielson 2012). ER functioning is further impaired by the lack of psychiatrists on evening shifts, requiring late patient arrivals to wait until the following morning for psychiatric assessment. As well, poor knowledge of community resources seems to go hand in hand with frequent staff turnover.

According to participants, the merger of a psychiatric and general ER (ER-PG-2) produced barriers very similar to those in the other ERs studied, except in the Organizational characteristics block where fewer barriers and more facilitators were identified. The main advantage of the ER-PG-2 configuration was the facilitation of relations between psychiatric and general ERs, which, in turn, allowed for better management of patients with co-occurring MHDs/physical illnesses. This was an important advance for patients with severe MHDs (e.g. schizophrenia), who often live with co-occurring physical illnesses, and have a higher mortality rate than the general population (Toftegaard et al. 2015). The

lack of proximity between psychiatric and general ERs may explain why the management of co-occurring MHDs and physical illness was more problematic in ER-P and ER-PG-1. Furthermore, delays involving psychiatric assessment and treatment planning due to shortages of MH professionals make general ERs highly unsuitable places for patients with MHDs (Halmer et al. 2015).

Limitations and Future Directions

This study has limitations that should be acknowledged. First, some key components related to quality of care in ERs, such as delays in MH evaluations and treatment, or the organization of care in terms of observation periods and adjustments in treatment based on patient responsiveness were not considered in this research. Future studies might explore these aspects. Second, the perspectives of ER patients and families were not sought, even though their views may differ from those of ER professionals, including physicians, or managers. Third, this was a qualitative study that needs to be completed, and reinforced, with administrative or survey data to confirm, and increase, our understanding of ER functioning. Fourth, comparing the number of barriers or facilitators related to different service characteristics remains problematic, as study participants obviously were not aware of the responses provided by their counterparts in the interview process and could not validate them. Finally, the impact of various barriers and facilitators cannot be considered as equivalent; a single barrier may be sufficient to limit ER effectiveness considerably, and to offset the positive influence of less important facilitators.

Conclusions

This study was innovative in identifying, comparing and contrasting key barriers and facilitators for effective ER management of MH patients, using a four-block conceptual framework. The study included four ERs that used different models of patient management and represented different territories. The perceptions of ER managers, physicians, and clinical team members, including addiction liaison team nurses, were elicited. Findings revealed that ER functioning in MH cases was mainly affected by barriers emanating from the Health system, but also those related to Patient, Organizational, and Professional characteristics. Interventions affecting each of the four blocks are required to improve the overall functioning of ERs for MH patients.

The facilitators revealed in this study suggest a number of recommendations. Concerning health systems, ERs should be well integrated within a rich and well-funded network of outpatient MH or community resources capable of responding promptly and adequately to the full range of patient needs. Formal strategies aimed at reinforcing patient referrals and more fluid transfers from ERs to the community for follow-up treatment should be developed. Integrating general and psychiatric ER services is a crucially important organizational innovation that should be given priority as a way of optimizing treatment for patients with co-occurring MHDs and physical illnesses. Similarly, the implementation of addiction liaison teams, and related innovations, may improve evaluations and treatment planning for addiction patients. Concerning professionals, this study underlined the vital need for stable and competent, round-the-clock ER staff, including psychiatrists and addiction liaison nurses. Full staffing should be a priority, as well as the implementation of MH training programs for health professionals. Finally, program adaptations to better accommodate patients with borderline personality disorders, and co-occurring MHDs/ SUDs, should be seriously considered.

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Compliance with Ethical Standards

Conflict of interest The authors declare they have no conflicts of interest.

Ethical Approval All procedures performed involving human participants in this study were in accordance with the ethical standards of the institutional research committee and with the Helsinki declaration and its later amendments on comparable ethical standards.

Informed Consent All participants provided informed written consent.

References

Aarons, G. A., Wells, R. S., Zagursky, K., Fettes, D. L., & Palinkas, L. A. (2009). Implementing evidence-based practice in community mental health agencies: A multiple stakeholder analysis. *American Journal of Public Health, 99*(11), 2087–2095. https://doi.org/10.2105/AJPH.2009.161711.

Adams, P., & Nielson, H. (2012). Evidence based practice: Decreasing psychiatric revisits to the emergency department. *Issues in Mental Health Nursing, 33*(8), 536–543. https://doi.org/10.3109/01612840.2012.687803.

Aldersey, H. M., & Whitley, R. (2015). Family influence in recovery from severe mental illness. *Community Mental Health Journal, 51*(4), 467–476. https://doi.org/10.1007/s10597-014-9783-y.

Althaus, F., Paroz, S., Hugli, O., Ghali, W. A., Daeppen, J. B., Peytremann-Bridevaux, I., & Bodenmann, P. (2011). Effectiveness of interventions targeting frequent users of emergency departments: A systematic review. *Annals of Emegency Medicine, 58*(1), 41–52 e42. https://doi.org/10.1016/j.annemergmed.2011.03.007.

Arehart-Treichel, J. (2013). Practicing emergency psychiatry requires different way of thinking. *Psychiatric News, 48*(6), 18–20. https://doi.org/10.1176/appi.pn.2013.12b3.

Arfken, C. L., Zeman, L. L., Yeager, L., White, A., Mischel, E., & Amirsadri, A. (2004). Case-control study of frequent visitors to an urban psychiatric emergency service. *Psychiatric Services, 55*(3), 295–301. https://doi.org/10.1176/appi.ps.55.3.295.

Beck, A., Sanchez-Walker, E., Evans, L. J., Harris, V., Pegler, R., & Cross, S. (2016). Characteristics of people who rapidly and frequently reattend the emergency department for mental health needs. *European Journal of Emergency Medicine, 23*(5), 351–355. https://doi.org/10.1097/MEJ.0000000000000349.

Bruffaerts, R., Sabbe, M., & Demyttenaere, K. (2008). Emergency psychiatry in the 21st century: Critical issues for the future. *European Journal of Emergency Medicine, 15*(5), 276–278. https://doi.org/10.1097/MEJ.0b013e3282fc7616.

Brunette, M. F., Asher, D., Whitley, R., Lutz, W. J., Wieder, B. L., Jones, A. M., & Mchugo, G. J. (2008). Implementation of integrated dual disorders treatment: A qualitative analysis of facilitators and barriers. *Psychiatric Services, 59*(9), 989–995. https://doi.org/10.1176/appi.ps.59.9.989.

Clarke, P., Hafner, R. J., & Holme, G. (1997). The brief admission unit in emergency psychiatry. *Journal of Clinical Psychology, 53*(8), 817–823.

CSBE (2017). *Utilisation des urgences en santé mentale et en santé physique au Québec*. Québec: Commissaire à la santé et au Bien-être.

Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009). Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science. *Implementation Science, 4*, 50. https://doi.org/10.1186/1748-5908-4-50.

D'onofrio, G., & Degutis, L. C. (2010). Integrating Project ASSERT: A screening, intervention, and referral to treatment program for unhealthy alcohol and drug use into an urban emergency department. *Academic Emergency Medicine, 17*(8), 903–911. https://doi.org/10.1111/j.1553-2712.2010.00824.x.

Doupe, M. B., Palatnick, W., Day, S., Chateau, D., Soodeen, R.-A., Burchill, C., & Derksen, S. (2012). Frequent users of emergency departments: Developing standard definitions and defining prominent risk factors. *Annals of Emergency Medicine, 60*(1), 24–32. https://doi.org/10.1016/j.annemergmed.2011.11.036.

Drake, R. E., Mueser, K. T., Brunette, M. F., & Mchugo, G. J. (2004). A review of treatments for people with severe mental illnesses and co-occurring substance use disorders. *Psychiatric Rehabilitation Journal, 27*(4), 360–374.

Eppling, J. (2008). First encounters: A psychiatric emergency program. *Journal of Emergency Nursing, 34*(3), 211–217. https://doi.org/10.1016/j.jen.2007.04.020.

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation Research: A synthesis of the literature*. Tampa: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication # 231).

Fleury, M. J., Grenier, G., & Robitaille, D. (2016). Implementation of the consultation-liaison model in Quebec and its impact on primary care providers. *Mental Health in Family Medicine, 12*, 228–240.

Fleury, M. J., Grenier, G., Vallee, C., Aube, D., Farand, L., Bamvita, J. M., & Cyr, G. (2016). Implementation of the Quebec mental health reform (2005–2015). *BMC Health Services Research, 16*(1), 586.

Fleury, M. J., Perreault, M., Grenier, G., Imboua, A., & Brochu, S. (2016). Implementing key strategies for successful network integration in the Quebec substance-use disorders programme. *International Journal of Integrated Care, 16*(1), 7. https://doi.org/10.5334/ijic.2457.

Gaynes, B. N., Brown, C., Lux, L. J., Ashok, M., Coker-Schwimmer, E., Hoffman, V., Sheitman, B., & Viswanathan, M. 2015. *Management strategies to reduce psychiatric readmissions*. Rockville, MD: Agency for Healthcare Research and Quality (US)

Glover, G., Arts, G., & Babu, K. S. (2006). Crisis resolution/home treatment teams and psychiatric admission rates in England. *British Journal of Psychiatry, 189*, 441–445. https://doi.org/10.1192/bjp.bp.105.020362.

Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., & Kyriakidou, O. (2004). Diffusion of innovations in service organizations: Systematic review and recommendations. *Milbank Quarterly, 82*(4), 581–629. https://doi.org/10.1111/j.0887-378X.2004.00325.x.

Grenier, G., & Fleury, M. J. (2014). The role of the mental health community in an evolving mental health system. State of knowledge and recommendations. *Santé mentale au Québec 39*(1), 119–136.

Gullick, D., & Walters, B. (2007). Utilizing evidence ot establish a short stay unit in a regional emergency departments. *Autralian Emergency Nursing Journal 10*(4), 203–204

Halmer, T. C., Beall, R. C., Shah, A. A., & Dark, C. (2015). Health policy considerations in treating mental and behavioral health emergencies in the United States. *Emergency Medicine Clinics of North America, 33*(4), 875–891. https://doi.org/10.1016/j.emc.2015.07.013.

Heyland, M., & Johnson, M. (2017). Evaluating an alternative to the emergency department for adults in mental health crisis. *Issues in Mental Health Nursing, 38*(7), 557–561. https://doi.org/10.1080/01612840.2017.1300841.

Hoffman, R., Hirdes, J., Brown, G. P., Dubin, J. A., & Barbaree, H. (2016). The use of a brief mental health screener to enhance the ability of police officers to identify persons with serious mental disorders. *International Journal of Law and Psychiatry, 47*, 28–35. https://doi.org/10.1016/j.ijlp.2016.02.031.

Horspool, K., Drabble, S. J., & O'cathain, A. (2016). Implementing street triage: A qualitative study of collaboration between police and mental health services. *BMC Psychiatry, 16*(1), 313. https://doi.org/10.1186/s12888-016-1026-z.

Hossain, L. N., Fernandez-Llimos, F., Luckett, T., Moullin, J. C., Durks, D., Franco-Trigo, L., Benrimoj, S. I., & Sabater-Hernandez, D. (2017). Qualitative meta-synthesis of barriers and facilitators that influence the implementation of community pharmacy services: Perspectives of patients, nurses and general medical practitioners. *British Medical Journal Open, 7*(9), e015471. https://doi.org/10.1136/bmjopen-2016-015471.

Hubbeling, D., & Bertram, R. (2012). Crisis resolution teams in the UK and elsewhere. *Journal of Mental Health, 21*(3), 285–295. https://doi.org/10.3109/09638237.2011.637999.

Jacob, B., Macquet, D., & Natalis, S. (2014). A global reform of mental health care based on a community approach: The Belgian experience. *Santé mentale au Québec 39*(1), 209–242.

Jespersen, S., Lawman, B., Reed, F., Hawke, K., Plummer, V., & Gaskin, C. J. (2016). The impact of integrating crisis teams into community mental health services on emergency department and inpatient demand. *Psychiatric Quarterly, 87*(4), 703–712. https://doi.org/10.1007/s11126-016-9420-8.

Johnstone, P., & Zolese, G. (1999). Systematic review of the effectiveness of planned short hospital stays for mental health care. *British Medical Journal, 318*(7195), 1387–1390.

Kahan, D., Leszcz, M., O'campo, P., Hwang, S. W., Wasylenki, D. A., Kurdyak, P., Harris, W., Gozdzik, A., & Stergiopoulos, V. (2016). Integrating care for frequent users of emergency departments: Implementation evaluation of a brief multi-organizational intensive case management intervention. *BMC Health Services Research, 16*, 156. https://doi.org/10.1186/s12913-016-1407-5.

Kilbourne, A. M., Neumann, M. S., Pincus, H. A., Bauer, M. S., & Stall, R. (2007). Implementing evidence-based interventions in health care: Application of the replicating effective programs framework. *Implementation Science 2*, 42. https://doi.org/10.1186/1748-5908-2-42.

Kilbourne, A. M., Perron, B. E., Mezuk, B., Welsh, D., Ilgen, M., & Bauer, M. S. (2009). Co-occurring conditions and health-related quality of life in patients with bipolar disorder. *Psychosomatic Medecine, 71*(8), 894–900. https://doi.org/10.1097/PSY.0b013e3181b49948.

Klein, K. J., & Sorra, J. S. (1996). The challenge of innovation implementation. *Academy of Management Review, 21*(4), 1055–1080.

Koivunen, M., Harju, S., Kauko, T., & Valimaki, M. (2017). Alcohol risk drinking, quality of life and health state among patients treated at the Sobering Unit in the emergency department - One year follow-up study. *International Emergency Nursing, 31*, 22–29. https://doi.org/10.1016/j.ienj.2016.06.003.

Kushner, K., Diamond, R., Beasley, J. W., Mundt, M., Plane, M. B., & Robbins, K. (2001). Primary care physicians' experience with mental health consultation. *Psychiatric Services, 52*(6), 838–840. https://doi.org/10.1176/appi.ps.52.6.838.

Laugharne, R., & Flynn, A. (2013). Personality disorders in consultation-liaison psychiatry. *Current Opinion in Psychiatry, 26*(1), 84–89. https://doi.org/10.1097/YCO.0b013e328359977f.

Lawn, S., & Mcmahon, J. (2015). Experiences of care by Australians with a diagnosis of borderline personality disorder. *Journal of Psychiatry and Mental Health Nursing, 22*(7), 510–521. https://doi.org/10.1111/jpm.12226.

Levin, A. (2015). Emergency department finds successful formula for psychiatric cases. *Psychiatric News*. https://doi.org/10.1176/appi.pn.2015.12a13.

Mancini, A. D., Moser, L. L., Whitley, R., Mchugo, G. J., Bond, G. R., Finnerty, M. T., & Burns, B. J. (2009). Assertive community treatment: Facilitators and barriers to implementation in routine mental health settings. *Psychiatric Services, 60*(2), 189–195. https://doi.org/10.1176/ps.2009.60.2.189.

Mckenna, B., Furness, T., Brown, S., Tacey, M., Hiam, A., & Wise, M. (2015). Police and clinician diversion of people in mental health crisis from the emergency department: A trend analysis and cross comparison study. *BMC Emergency Medicine, 15*, 14. https://doi.org/10.1186/s12873-015-0040-7.

Meurer, W. J., Majersik, J. J., Frederiksen, S. M., Kade, A. M., Sandretto, A. M., & Scott, P. A. (2011). Provider perceptions of barriers to the emergency use of tPA for acute ischemic stroke: A qualitative study. *BMC Emergency Medicine, 11*, 5. https://doi.org/10.1186/1471-227X-11-5.

Ministère De La Santé Et Des Services Sociaux. (2005). *Plan d'action en santé mentale 2005–2010 - La force des liens*. Québec: Ministère de la Santé et des Services sociaux.

Narasimhan, M., Druss, B. G., Hockenberry, J. M., Royer, J., Weiss, P., Glick, G., Marcus, S. C., & Magill, J. (2015). Impact of a telepsychiatry program at emergency departments statewide on the quality, utilization, and costs of mental health services. *Psychiatric Services, 66*(11), 1167–1172. https://doi.org/10.1176/appi.ps.201400122.

Nesper, A. C., Morris, B. A., Scher, L. M., & Holmes, J. F. (2016). Effect of decreasing county mental health services on the emergency department. *Academic Emergency Medicine, 67*(4), 525–530. https://doi.org/10.1016/j.annemergmed.2015.09.007.

Newman, M., & Ravindranath, D. (2010). Managing a psychiatric emergency. *Psychiatric Times, 27*(67), 17–20.

O'brien, A., Leonard, L., & Deering, D. (2012). Could an advance practice nurse improve detection of alcohol misuse in the emergency department? *International Journal of Mental Health Nursing, 21*(4), 340–348. https://doi.org/10.1111/j.1447-0349.2011.00797.x.

Parkman, T., Neale, J., Day, E., & Drummond, C. (2017). Qualitative exploration of why people repeatedly attend emergency departments for alcohol-related reasons. *BMC Health Services Research, 17*(1), 140. https://doi.org/10.1186/s12913-017-2091-9.

Paton, F., Wright, K., Ayre, N., Dare, C., Johnson, S., Lloyd-Evans, B., Simpson, A., Webber, M., & Meader, N. (2016). Improving outcomes for people in mental health crisis: A rapid synthesis of the evidence for available models of care. *Health Technology Assessment, 20*(3), 1–162. https://doi.org/10.3310/hta20030.

Pawda, H., Urada, D., Antonini, V. P., Ober, A., Crèvecoeur-Macphail, D. A., & Rawson, A. (2012). Integrating substance use disorder services with primary care: The experience in California. *Journal of Psychoactive Drugs, 44*(4), 299–306.

Pearlmutter, M. D., Dwyer, K. H., Burke, L. G., Rathlev, N., Maranda, L., & Volturo, G. (2017). Analysis of emergency department length of stay for mental health patients at ten Massachusetts emergency departments. *Annals of Emergency Medicine, 70*(2), 193–202 e116. https://doi.org/10.1016/j.annemergmed.2016.10.005.

Polevoi, S. K., Shim, J., Mcculloch, J., Grimes, C. E., B. & Govindarajan, P. (2013). Marked reduction in length of stay for patients with psychiatric emergencies after implementation of a comanagement model. *Academic emergency Medicine, 20*(4), 338–343. https://doi.org/10.1111/acem.12105.

Sacks, S., Chaple, M., Sirikantraporn, J., Sacks, J. Y., Knickman, J., & Martinez, J. (2013). Improving the capability to provide integrated mental health and substance abuse services in a state system of outpatient care. *Journal of Substance Abuse Treatment, 44*(5), 488–493.

Saillant, S., Hudelson, P., Dominice Dao, M., & Junod Perron, N. (2016). The primary care physician/psychiatrist joint consultation: A paradigm shift in caring for patients with mental health problems? *Patient Education and Counseling, 99*(2), 279–283. https://doi.org/10.1016/j.pec.2015.08.028.

Saurman, E., Johnston, J., Hindman, J., Kirby, S., & Lyle, D. (2014). A transferable telepsychiatry model for improving access to emergency mental health care. *Journal of Telemedicine and Telecare, 20*(7), 391–399. https://doi.org/10.1177/1357633X14552372.

Schultz, N. R., Martinez, R., Cucciare, M. A., & Timko, C. (2016). Patient, program, and system barriers and facilitators to detoxification services in the U.S. veterans health administration: A qualitative study of provider perspectives. *Substance Use and Misuse, 51*(10), 1330–1341. https://doi.org/10.3109/10826084.2016.1168446.

Seidel, R. W., & Kilgus, M. D. (2014). Agreement between telepsychiatry assessment and face-to-face assessment for emergency department psychiatry patients. *Journal of Telemedicine and Telecare, 20*(2), 59–62. https://doi.org/10.1177/1357633X13519902.

Shattell, M. M., Harris, B., Beavers, J., Tomlinson, S. K., Prasek, L., Geevarghese, S., Emery, C. L., & Heyland, M. (2014). A recovery-oriented alternative to hospital emergency departments for persons in emotional distress: "The living room". *Issue in Mental Health Nursing, 35*(1), 4–12. https://doi.org/10.3109/01612840.2013.835012.

Stephens, R. J., White, S. E., Cudnik, M., & Patterson, E. S. (2014). Factors associated with longer length of stay for mental health emergency department patients. *Journal of Emergency Nursing, 47*(4), 412–419. https://doi.org/10.1016/j.jemermed.2014.04.040.

Stergiopoulos, V., Gozdzik, A., Cohen, A., Guimond, T., Hwang, S. W., Kurdyak, P., Leszcz, M., & Wasylenki, D. (2017). The effect of brief case management on emergency department use of frequent users in mental health: Findings of a randomized controlled trial. *Plos One, 12*(8), e0182157. https://doi.org/10.1371/journal.pone.0182157.

Su, J. A., Tsai, C. S., Hung, T. H., & Chou, S. Y. (2011). Change in accuracy of recognizing psychiatric disorders by non-psychiatric physicians: Five-year data from a psychiatric consultation-liaison service. *Psychiatry and Clinical Neurosciences, 65*(7), 618–623. https://doi.org/10.1111/j.1440-1819.2011.02272.x.

Toftegaard, K. L., Gustafsson, L. N., Uwakwe, R., Andersen, U. A., Becker, T., Bickel, G. G., et al. (2015). Where are patients who have co-occurring mental and physical diseases located? *Interantional Journal of Social Psychiatry, 61*(5), 456–464. https://doi.org/10.1177/0020764014552866.

Turner, S. B., & Stanton, M. P. (2015). Psychiatric case management in the emergency department. *Professional Case Management, 20*(5), 217–227. https://doi.org/10.1097/NCM.0000000000000106. quiz 228 – 219.

Vanderplasschen, W., De Bourdeaudhuij, I., & Van Oost, P. (2002). Co-ordination and continuity of care in substance abuse treatment. An evaluation study in Belgium. *European Addiction Research, 8*(1), 10–21.

Walters, P., Tylee, A., & Goldberg, D. (2008). Psychiatry in primary care. In R. M. Murray, K. S. Kendler, P. McGuffin, S. Wessely & D. J. Castle (Eds.), *Essential psychiatry* (4 ed., pp. 479–497). UK: Cambridge University Press.

Wand, T., D'abrew, N., Acret, L., & White, K. (2016). Evaluating a new model of nurse-led emergency department mental health care in Australia; Perspectives of key informants. *International Journal of Emergency Nursing, 24*, 16–21. https://doi.org/10.1016/j.ienj.2015.05.003.

Wand, T., & White, K. (2007). Exploring the scope of the emergency department mental health nurse practitioner role. *International Journal of Mental Health Nursing, 16*(6), 403–412. https://doi.org/10.1111/j.1447-0349.2007.00495.x.

Wheeler, C., Lloyd-Evans, B., Churchard, A., Fitzgerald, C., Fullarton, K., Mosse, L., Paterson, B., Zugaro, C. G., & Johnson, S. (2015). Implementation of the crisis resolution team model in adult mental health settings: A systematic review. *BMC Psychiatry, 15*, 74. https://doi.org/10.1186/s12888-015-0441-x.

Winters, S., Magalhaes, L., & Kinsella, E. A. (2015). Interprofessional collaboration in mental health crisis response systems: A scoping review. *Disability and Rehabilitation, 37*(23), 2212–2224. https://doi.org/10.3109/09638288.2014.1002576.

Yin, R. K. (2009). *Case study research. Design and methods* (4th ed.). Los Angeles: Sage.

Zeller, S., Calma, N., & Stone, A. (2014). Effects of a dedicated regional psychiatric emergency service on boarding of psychiatric patients in area emergency departments. *Western Journal of Emergency Medicine, 15*(1), 1–6. https://doi.org/10.5811/westjem.2013.6.17848.

Zeller, S. L. (2010). Treatment of psychiatric patients in emergency settings. *Primary Psychiatry, 17*(6), 35–41.