CANADIAN JOURNAL of EMERGENCY NURSING
JOURNAL CANADIEN des INFIRMIÈRES D'URGENCE
THE OFFICIAL JOURNAL OF THE NATIONAL EMERGENCY NURSES' ASSOCIATION
www.NENA.ca www.CJEN.ca

Frequent mental health- and addiction-related emergency department visits: Perspectives from healthcare providers

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Abstract

Background: The rise in mental health- and addiction (MHA)-related emergency department (ED) visits has been recognized as a contributing factor to ED crises and increasing healthcare costs. While prior research has centred largely on patients' perspectives, limited attention has been given to healthcare providers' (HCPs') insights. This study specifically explores HCPs' perceptions of why patients with MHA issues frequently present to EDs.

Methods: In this qualitative research, data collection involved semi-structured individual interviews. Thematic analysis approach was utilized in data analysis.

Results: Six HCPs from diverse disciplines participated in this qualitative study. Four major themes emerged from the data analysis: (a) social determinants of mental health (a housing crisis and financial problems); (b) structural barriers (overstimulation and not a priority in ED, inadequate knowledge and training among HCPs, lack of withdrawal management facilities, stigma from HCPs, shortages of HCPs); (c) suggestions for prevention (more funding/ resources and early childhood education); and (d) HCPs' response to working with patients (making a difference and rewarding).

Conclusions: The study found that HCPs perceived low socioeconomic status and the limited availability of community mental health services and resources as key factors that contribute to frequent MHA-related ED visits. To understand the complex needs of individuals with MHA disorders better, all levels of government, community organizations, and HCPs, especially nurses, should collaborate to develop and implement effective interventions aimed at reducing frequent ED visits or returns related to MHA issues.

Keywords: emergency department, mental health and addiction, frequent visits, healthcare providers

Introduction

Over the last decade, the substantial rise in mental health- and addiction (MHA)-related emergency department (ED) visits has been widely reported. Worldwide, 792 million people live with mental health disorders, while 71 million experience substance use disorders (Dattani et al., 2021). Ideally, symptom management and recovery for individuals with MHA disorders should take place primarily in community settings. However, a study by Barker et al. (2020) found that only 40.2% of patients with mental illness discharged from the ED receive follow-up care within 14 days. The limited availability of mental health resources in the healthcare system is pushing more individuals to seek care in EDs (Lavergne et al., 2022), making these acute sites a crucial access point for both urgent and non-urgent mental health needs.

ISSN: 2293-3921 (print) | ISSN: 2563-2655 (online) | https://doi.org/10.29173/cjen233
Print publisher: Pappin Communications http://pappin.com | Online publisher: University of Alberta www.library.ualberta.ca/publishing/open-journals

Individuals with MHA disorders are five times more likely to visit EDs (National Institute of Mental Health, 2023; Smith et al., 2015). While some visits are for non-urgent needs, such as prescription renewals, medication adjustments, or referrals to community resources, such as social workers or withdrawal management facilities (Poremski et al., 2020; Wise-Harris et al., 2017). Others are driven by urgent needs, including severe psychiatric conditions like schizophrenia (Doran et al., 2014), homelessness (Chang et al., 2014; Doran et al., 2014), suicidal behaviour (Vandyk et al., 2013), substance use crises (Doran et al., 2014; Thakarar et al., 2015), personality disorders (Chang et al., 2014; Vandyk et al., 2018), and stressful life events (Pasic et al., 2005).

However, well-documented ED challenges – such as overcrowding, overstimulating environments, long wait times, and transfer delays due to limited inpatient beds – complicate mental health care, often resulting in early departures, agitation, violent incidents, and increased use of restraints or seclusion (Judkins et al., 2019; Mérelle et al., 2018; Pearlmutter et al., 2017). ED providers report limited access to on-site mental health resources, inadequate training, and a lack of access to specialized mental health providers (Morphet et al., 2014; Pawaskar et al., 2022). Meanwhile, MHA patients seeking care in the ED often describe feelings of helplessness, encountering negative perceptions and attitudes from staff, and perceiving inadequate provider knowledge and experience (Bergen et al., 2023). Negative experiences for healthcare users can shape their future willingness to seek care (Bergen et al., 2023).

There is no consensus on defining "frequent" ED visits, with thresholds varying from more than two, four, or 12 visits annually (Slankamenac et al., 2020). Slankamenac et al. (2019) define repeated as at least four annual ED visits for the same symptom or diagnosis, and frequent as multiple visits for different reasons within a year. This paper uses the term "frequent ED visits." While the literature extensively documents MHA-related frequent ED visits from patients' perspectives (Aagaard et al., 2014; Fleury et al., 2019a; Lincoln et al., 2016; McCormack et al., 2015; Olsson & Hansaggi, 2001; Poremski et al., 2020; Schmidt et al., 2018; Vandyk et al., 2018; Wise-Harris et al., 2017), the views of HCPs have been less explored. This qualitative study aims to explore HCPs' perspectives on caring for patients with frequent MHA-related ED visits, providing insights to understand the phenomenon better and inform policy development, program design, and implementation.

Methods

Procedure and data collection

Participants were recruited from various urban locations, including local mental health and addiction services, hospital EDs, and non-profit organizations in Saskatchewan, Canada. Inclusion criteria required at least one year of employment in direct care with MHA disorders, excluding those without ED experience. Data collection involved individual semi-structured interviews conducted via video conferencing from January–July 2022, led by a researcher and a research assistant. An interview guide, developed from a relevant literature review and input from the researchers, is provided in Appendix A. This study adheres to the Consolidated Criteria for Reporting Qualitative Studies (COREQ) 32-item checklist (Tong et al., 2007). Each interview lasted approximately 45–60 minutes. Ethics approval was obtained from the Behavioural Research Ethics Board of the University of Saskatchewan (Beh ID #657). Verbal consent was obtained from all participants, and the interviews were audio-recorded and transcribed verbatim.

Data analysis

An inductive thematic analysis was employed to analyze the data (Braun & Clarke, 2019). The process involved (a) coding, (b) thematically grouping the codes, (c) identifying subthemes and aggregating them into overarching themes, and (d) reporting research findings (Braun & Clarke, 2019). Initially, coding was performed line-by-line by reading the verbatim transcript and highlighting its key quotes. Researchers were required to be flexible to avoid interpretation biases. The codes were compared and assigned to enumerated themes and subthemes based on similarities and differences. Central themes were highlighted and combined with common subthemes, while retaining participants' descriptions (Braun & Clarke, 2019). The research findings are presented in the discussion section, highlighting the rela-tionships between key themes. Two researchers (KT and LH) independently analyzed each interview using Nvivo 12 (qual-itative data analysis software). A cross-case synthesis was then conducted to compare findings across cases and ensure thematic alignment with participants' narratives. To enhance credibility, researchers created audit trails to document the decision-mak-ing process and convergence of primary findings. Major themes were developed and compared with current literature, with both researchers finding additional interviews unnecessary for deeper insight.

Results

This study included six HCPs (five females, one male), aged 29–60, with 3.5–30 years of experience across specialties: addiction counselling, community mental health nursing, psychiatric liaison, and social work. All had ED experience, though some now work in other areas. Pseudonyms for study participants are used to keep confidentiality. Detailed information is presented in Table 1.

Themes

After data analysis, four major themes emerged: social determinants of mental health, structural barriers, suggestions/recommendation for treatment, and the HCP's response to working with patients.

Theme 1: Social determinants of mental health

Social determinants of mental health were identified as a major factor associated with frequent ED visits. Two common social determinants of mental health were identified: a housing crisis and financial problems.

Housing Crisis

Participants acknowledge that individuals with MHA disorders often face additional challenges, such as homelessness, eviction, personal safety concerns, insect and rodent infestations, victimization, and robbery. They identified the high cost of accommodation and rent as the primary factor contributing

Table 1

Characteristics of Study Participants

Provider	Age	Gender	Occupation	Years of Experience	Years in Current Position
Tina	52	Female	Addiction Counsellor	25	21
Julie	56	Female	Community Mental Health Nurse	22	2.5
Sofia	32	Female	Community Mental Health Nurse	10	6
Paul	60	Male	Addiction Counsellor	30	17
Liza	29	Female	Psychiatric Liaison Nurse	3.5	3.5
Amy	31	Female	Social Worker/Social Program Coordinator	5	5

to the housing crisis. Tina emphasized the importance of these factors for health, stating, "*Those indicators help a person achieve better health, you know? Finances, housing. Those are some of the challenges that I think mental health could have done a better job of looking at, 'How can we support some of our clients better?'"*

Julie highlighted how negative peer influences worsen the struggles of homeless individuals with substance use disorders, who often lack safe spaces and find it difficult to avoid substance-using peers: *"But the buddy sitting beside you is shooting up and offering drugs to you. [It's] illegal, harmful, dangerous, unsafe environments. Now it doesn't help the homeless that have substance dependence."*

For these reasons, participants described the ED as a last resort for survival, providing essentials like shelter and food, especially during Canada's harsh winter months. Sofia noted, *"And so, they're all trying to get in to come stay at [Hospital] where you get a bed and meals." (Sofia)*

Financial problems

Participants expressed that individuals with mental health disorders are facing heightened financial challenges due to increased budgetary allocations for rent and food, inflation, and lower income. *"Lots of people are just treated in the community and they're well supported by family and have the means to carry on with the job, etc. But lots of those individuals that don't have jobs, poor finances, poor access to healthcare and trauma, um, that's a big piece, so…" (Tina)*

Sofia explains that numerous individuals with MHA disorders face uncertainty and cannot afford to take work leave for unexpected difficulties: *"How many, do you know, could tolerate taking two weeks off work? But even so, a week off work – that's a lot of wages for someone. I think they don't have that coverage."* Without financial flexibility, the ED often becomes their only accessible option in times of crisis, resulting in more frequent visits for basic needs and support.

Theme 2: Structural barriers

Structural barriers were cited as critical factors associated with frequent MHA-related ED visits, including overstimulation and not a priority at ED, inadequate knowledge and training among HCPs, lack of withdrawal management facilities, stigma from HCPs, and shortages of HCPs.

Overstimulation and not a priority at ED

Overstimulating environments (e.g., auditory/visual) can negatively impact patients' ability to accurately retain information. *"Then they go home and they're like, 'I can't remember what happened.' Because they were elevated for so long with, like, the call bells and the PPE, the different people, the shift change and then the doctor was like, 'By the way, take this medication three times at this dosage, and then in three days, increase it to this dose'." (Amy)*

When discharging patients, ED staff often do not consider environmental factors while delivering information. *"But because it's been 10 hours [patients stayed in ED], now they're being told a lot of discharge information, and a lot of people don't retain it, for very good reason." (Paul)*

Additionally, some participants observed that HCPs often assign patients a low triage priority, leading to longer wait times and delayed evaluations or referrals to psychiatrists, which prolong emotional distress. Sofia explained *"One is because they're low on the C-Task score (sic) and maybe not as much of a triage priority, and two, they're mental health, so they don't get picked up as fast by the medical staff."* Meanwhile, Amy emphasized, *"The biggest thing you hear from people in the emerg, in emergency department, is the wait."*

Inadequate knowledge and training among HCPs

Participants highlighted that the limited knowledge and training of HCPs in MHA disorders hinder their ability to provide confident support to individuals with concurrent disorders. *"But Canada is pretty far behind in the credentialing of addiction counsellors, so we have a number of social workers who practice as addiction counsellors and maybe have never taken an addiction class." (Julie)*

Participants expressed frustration that HCPs specializing in mental health assume they understand substance-related problems and vice versa, which can compromise patient care. *"Sometimes I'm actually shocked by the other ED staff that I'm working with and the stuff that they say and do with our patients, like you really don't get it." (Sofia)*

Lack of withdrawal management facilities

Participants shared their concerns about inadequate withdrawal management beds, which led to individuals with MHA disorders who voluntarily sought treatment being discharged prematurely

without follow-up appointments. Paul noted that the advice given to individuals is *"call detox every single day"* and *"they'll take you eventually."*

Amy shares that her patients are struggling with intense withdrawal symptoms and urgently expressing a desire to enter detox treatment, but the lack of available beds could hinder their ability to remain abstinent. She describes them saying, *'I'm on day two of being sober and boy am I being challenged. Like, I need to go to rehab or to detox like now or I'm going to, I'm going to slip.' "They're verbalizing that and they're acknowledging it. They're saying like, 'I'm at the point where I need help.' We don't have anywhere to send these folks."*

Stigma from HCPs

Participants underlined that comprehending stigma from HCPs toward patients with MHA disorders is critical to treatment. Patients report substantial distress when negatively stereotyped, reducing health-seeking behaviour. *"When they go to the emergency room a lot, they also get labelled with maybe, 'Oh you're a PD [personality disorder].' "They may not say it to their face but, 'Oh they're a PD,' or they're drug-seeking." (Julie)*

Recurring negative misconceptions of patients facilitates generalizations, fosters stigma, which may delay diagnoses. "*The perception is people with substance use disorder can't change. They're hard to work with. They lie. They're resistant, um, you know all those." (Paul)*

Shortages of HCPs

A key accessibility issue was the shortage of specialists, including psychiatrists, general practitioners, addiction counsellors, and psychiatric liaison nurses. For example, patients who missed mental health services or intake appointments due to personal reasons were not rescheduled. "*Me 12 months ago is a different person in 12 months, months later, right? So, I get frustrated with that kind of thing." (Paul)*

Further to long HCP waitlists, specialists manage increased caseloads, thus they are not able to accept new patients. *"I know because there's – our capacity is, is low in terms of psychiatrists. That's the other thing I should say, is that all the psychiatrists are working at quite high caseloads. So, it's just that we don't have enough." (Tina).*

Continuity of care is significantly compromised by the shortage of general practitioners. Many patients are discharged from EDs without follow-up appointments or referrals, which can increase the risk of mental health and substance use relapse, as proper ongoing care is often not in place. *"Do they have, what are their supports in the community? Do they have a good, involved GP? Lots of our clients don't even, have a family physician." (Liza)*

Theme 3: Suggestions for reducing MHA-related ED visits

Participants made several suggestions for how to reduce MHA-related ED visits.

More funding and resources

Paul stated *"Like they're(sic) always could be more resources to meet the needs. [City] has grown, as you know, so much in the last 15 years, and the resources that have not grown either to address what the problems are in our community."*

Affordability was an issue in certain mental health treatments. *"A lot of our clients can't afford those supports, in residential treatment in the community. So, there isn't enough that is funded by healthcare, and it has to – a lot of them have to come out of clients pockets." (Liza)*

Early childhood education

Early childhood education on safe drug use, mental health, help-seeking, and reporting harmful behaviours is crucial to addressing the rise in childhood MHA symptoms and disorders. *"Educating young people on just how to talk about that. How to deal with things, right? Because there's so much. But education is a big piece." (Tina)*

As Liza noted, children are sometimes hesitant to seek outside help. She added, *"I think if we start working on it early, normalize talking about it, and increase access, those are the steps that could help reduce emergency department visits."*

Theme 4: HCP's response to working with patients

Participants found providing care for individuals with MHA conditions challenging yet fulfilling, with two key subthemes: making a difference and rewarding.

Making a difference

Julie cherished a moment when a patient said, *"It's the first time I felt like somebody actually understood how my mental health and my substance use work together."* She found fulfillment in building trust, reshaping experiences, and receiving appreciation for her efforts.

Sofia finds joy and fulfillment in guiding others to breakthrough moments. *"You get to see, like if they have a breakthrough smile in a conversation. If you like, it feels really good for me, as well. I like being able to help someone, guide someone there and get them there."*

Rewarding

A unanimous view was expressed that HCPs' roles are challenging, but this makes the job rewarding. Participants expressed contentment in helping patients with MHA disorders because they felt it contributed positively to society. "*I really like helping people in crisis and I like to be able to come to some type of solution. So, that, for me, in my own personal way, is quite rewarding. That I can feel that I can give back in that sense." (Amy)*

Sofia deeply appreciates the autonomy inherent in her role, which allows her to make independent decisions and take initiative. She finds exhilaration and satisfaction in successfully navigating its challenges. *"But I also wouldn't trade it. I love the autonomy in our role. I love the critical thinking. I love the problem solving. And there is a bit of a rush, you know that feel-good rush that you get with doing all of that."*

Discussion

This study's findings align with existing research on HCPs' perspectives on MHA-related ED visits, for example, patients with unmet social needs are more likely to seek refuge in the ED (Gerber et al., 2020; Malecha et al., 2018), the impact of insufficient community MHA services on frequent ED visits (Bergmans et al., 2009; Fleury et al., 2019b), and stigma from HCPs toward individuals with MHA disorders (Bergmans et al.,

2009). Our findings contribute to the ongoing discussion on MHA-related ED visits, particularly from HCPs' perspectives, including (1) long ED wait times for MHA patients are partly due to nurses perceiving psychiatric symptoms as less urgent; (2) lack of MHA training among HCPs in the ED, leading to ineffective discharge planning that may result in repeat ED visits; and (3) in order to provide competent patient care, HCPs suggesting the necessity of having an MHA certificate for HCPs before working with patients with MHA disorders.

Social determinants of mental health

Scientific evidence supports the notion of a bidirectional relationship between social determinants, including housing, financial challenges, and mental health, whereby poor mental health can have negative impact on social determinants (e.g., financial constraints caused by unemployment due to experiencing MHA symptoms), while in the reverse direction, social determinants including financial issues can cause psychological stress, which can initiate the onset of mental health symptoms or exacerbate MHA conditions (Bialowolski et al., 2021). Previous studies underscore homelessness and mental health disorders as strong predictors for frequent non-urgent MHA-related ED visits (Thakarar et al., 2015; Vohra et al., 2022). This study reveals that inadequate resources, particularly homelessness, sometimes drive patients to visit EDs. According to the Government of Canada (2022), 25.1% of respondents identified addiction or substance use as a major factor in homelessness, with the duration of homelessness increasing alongside prolonged substance use – from 19.0% at 0–2 months to 28.2% at greater than six months. Mental health also significantly affects 25% to 50% of the homeless population (Canadian Mental Health Association, 2014). Baxter et al. (2019) found that Housing First approaches lead to stable housing and reduced ED visits and hospitalizations, while Aubry et al. (2016) showed that Housing First with assertive community treatment is a cost-effective solution for housing individuals with mental disorders, reducing reliance on health services.

This study, along with others (McCarthy et al., 2021; Virgolino et al., 2022), shows that high unemployment rates among individuals with MHA disorders lead to financial strain, which, combined with a lack of community support programs, increases their reliance on ED services. Individuals with MHA disorders can benefit greatly from job training and financial support programs. The Individual Placement and Support (IPS) intervention, developed by Becker and Drake (1994), is an evidence-based practice facilitating employment for individuals with mental health disorders, widely applied in the USA, Canada, and Europe (Rinaldi et al., 2008). The employment specialist, collaborating with the community mental health team, leads the IPS program, focusing on core tenets like securing competitive positions, mental health-employer integration, considering client choices, and post-employment support, resulting in a 38% increase in open employment at six months, rising to 39% at 12 months, with an 88% job retention rate and improved learning engagement (Rinaldi et al., 2008). Social challenges in the community must be addressed to reduce the need for individuals with MHA conditions to seek help in the ED for basic needs.

Structural barriers

This study reports that a shortage of mental health professionals may contribute to frequent ED visits, as supported by Wang et al. (2005), who found that, in the United States, only 22% of individuals with mental illness receive treatment and just 12% see a psychiatrist. Our study suggests that patients with MHA disorders may experience longer wait times and delays in psychiatric consultations due to triage nurses assigning lower Canadian Triage and Acuity Scale (CTAS) scores. Introduced in 1997, the mandatory five-level CTAS system helps nurses assess patient acuity based on ED presentations (Bullard et al., 2017; Simon Junior et al., 2023). However, CTAS is often criticized for being tedious, relying on nurses' clinical judgment for score adjustments, and focusing triage documentation on key details, which can delay recognizing deteriorating conditions and barriers to accessing care (Bullard et al., 2017). This is supported by a Canadian study, which found that mental health visits to the ED have longer stays than non-mental health visits, particularly for those discharged (11.4 versus 7.3 hours), admitted (52.6 versus 29.3 hours), or transferred externally (21.9 versus 10 hours) (Baia Medeiros et al., 2019).

Inadequate knowledge and training of MHA disorders has been highlighted in this study. Study participants suggested that mandatory certification should be required for HCPs who care for patients with MHA disorders. They expressed concerns that expertise in one area – mental health, substance use, or concurrent disorders – does not necessarily equate to proficiency in all three. This concern aligns with findings from Fleury et al. (2019b), which suggest that a lack of knowledge can lead to staff stigma around MHA and hinder their understanding of comorbidities. In some cases, especially with frequent ED visits, treatment begins not with the assessment but when staff recognize a patient, sometimes warning the general practitioner based on prior assumptions (Moukaddam et al., 2017). These early reactions, often driven by past negative experiences, can lead to emotional responses that might influence decisions about denying care.

The absence of compulsory education and training on MHA disorders for HCPs, along with their varied knowledge on MHA, and concurrent disorders and mental health stigma (Alexander et al., 2016; Ross et al., 2015), leads to increased psychological harm to patients. Multiple studies document HCPs holding negative attitudes toward patients with MHA disorders (e.g., view patients as violent, manipulative, lying, and non-compliant (Lien et al., 2019; Lien et al., 2021). The participants felt that HCPs in the ED often label patients with MHA disorders as 'frequent flyers,' 'drug-seeking,' or 'personality disordered,' instinctively blaming them for their conditions. A lack of training, absence of guidelines, and perceiving MHA as outside their responsibility facilitates such biases and impedes empathy development (Lien et al., 2021). Ayano et al. (2017) found that a mental health training program for HCPs significantly improved psychosis knowledge from pre- (34.04%) to post-training (87.23%). In addition, substance use disorder education and training improved nurses' attitudes toward patients with addiction conditions and self-perceived

addiction-competency care (Russell et al., 2017). Interestingly, none of the participants in this study acknowledged or reflected on their own personal biases.

Implications for emergency nursing practice

Mandatory educational training and certification should be required for HCPs working in MHA areas to enhance competency. For instance, the College of Family Physicians of Canada approved the Certificate of Added Competence to recognize addiction medicine as a specialty (De Jong et al., 2021). To obtain this certification, applicants must complete 13 core modules and undergo assessment by a peer review committee to ensure their experience, qualifications, and achievements meet the standards for practising addiction medicine in Canada (De Jong et al., 2021). This model could serve as a blueprint for other regulatory bodies to ensure providers are adequately qualified to specialize in MHA areas.

Khenti et al. (2019) conducted a mixed-methods study with 110 participants to design interventions – such as contact-based training, anti-stigma campaigns, workshops, and policy reviews – to reduce MHA stigma in healthcare. The intervention improved staff attitudes, knowledge, and behaviours, though competing priorities and limited resources hindered full participation. Similarly, Nehlin et al. (2012) implemented a three-hour training for 115 providers to improve attitudes toward alcohol-dependent patients, and findings show that it enhanced awareness of case complexity, confidence, and job outlook. Although limited to two studies involving nurses as participants, these findings highlight that biomedical education alone is insufficient to combat stigma. It is essential for all HCPs to engage in anti-stigma initiatives to foster self-reflection, deepen their understanding of MHA conditions, and recognize their impact on individuals. Additionally, according to the Truth and Reconciliation Commission of Canada (2015), nursing schools in Canada are required to provide education on Indigenous health challenges, including developing the skills to address Indigenous-specific racism and stigma.

In addition to individual care, as frontline HCPs with first-hand experiences, nurses should participate in policy and program development. For example, our findings highlight the importance of promoting early childhood mental health education to address misconceptions and stigma, while also training individuals from a young age to feel more comfortable having open conversations and seeking help for MHA issues. Nurses today need to strengthen their skills in political action and policy engagement to advocate for increased funding and resources that improve access to MHA services in the community, enhance quality of life for individuals with MHA disorders, and reduce their reliance on frequent ED visits, while also educating and supporting future nursing students in the political arena.

Limitations

First, the study's findings are based on the experiences of participants working with patients with MHA disorders in Saskatchewan, Canada, where the availability and accessibility of MHA services in the ED may differ from other provinces or countries, limiting the generalizability of the results. Second, data collection occurred during a period potentially impacted by COVID-related stress, fatigue, and burnout, so findings should be interpreted with caution. Third, HCPs excluded for not meeting the inclusion criteria may have valuable insights that were missed. Finally, the study is limited by a small sample size of six participants and a lack of diversity among them.

Conclusion

This study explored frequent MHA-related ED visits from the perspective of HCPs. It identified social determinants of health, structural barriers, and perceived personal barriers as key factors contributing to these frequent visits. Addressing this issue requires collaborative efforts between governments, communities, and HCPs to develop targeted interventions. These programs should focus on improving access to MHA services, addressing social determinants of health, and enhancing HCP education and training. Reducing frequent ED visits will have a positive impact on patient care and reduce the strain on emergency services. Furthermore, HCPs have an essential role in shaping such interventions, alongside the client perspective.

About the Authors

Kristy Tang, BScN (University of Alberta), MN, and current PhD student (University of Saskatchewan), is committed to advancing Indigenous cultural safety education in urban acute care. With over seven years of healthcare experience, she has worked as a frontline nurse and Indigenous nurse educator.

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Acknowledgements

The authors thank the study participants for sharing their experiences.

CRediT Statement

Kristy Tang conducted data analysis and wrote the original manuscript draft. Hua Li designed the study, contributed to data collection and analysis, and provided critical feedback and supervision. Both authors revised the manuscript multiple times.

Conflict of Interest

The authors declare that they have no conflicts of interest.

Funding

This study was supported by the Saskatchewan Health Research Foundation Establishment Grant (#5259).

REFERENCES

Aagaard, J., Aagaard, A., & Buus, N. (2014). Predictors of frequent visits to a psychiatric emergency room: A large-scale register study combined with a small-scale interview study. *International Journal of Nursing Studies, 51*(7), 1003–1013. https://doi.org/ 10.1016/j.ijnurstu.2013.11.002

Alexander, V., Ellis, H., & Barrett, B. (2016). Medical-surgical nurses' perceptions of psychiatric patients: A review of the literature with clinical and practice applications. *Archives of Psychiatric Nursing, 30*(2), 262–270. https://doi.org/10.1016/j.apnu.2015.06.018

Atzema, C. L., Schull, M. J., Kurdyak, P., Menezes, N. M., Wilton, A. S., Vermuelen, M. J., & Austin, P. C. (2012). Wait times in the emergency department for patients with mental illness. *Canadian Medical Association Journal (CMAJ), 184*(18), E969–E976. https://doi.org/10.1503/cmaj.111043

Aubry, T., Goering, P., Veldhuizen, S., Adair, C. E., Bourque, J., Distasio, J., Latimer, E., Stergiopoulos, V., Somers, J., Streiner, D. L., & Tsemberis, S. (2016). A multiple-city RCT of housing first with assertive community treatment for homeless Canadians with serious mental illness. *Psychiatric Services (Washington, D.C.), 67*(3), 275–281. https://doi.org/10.1176/appi.ps.201400587

Ayano, G., Assefa, D., Haile, K., Chaka, A., Haile, K., Solomon, M., Yohannis, K., Awoke, A., & Jemal, K. (2017). Mental health training for primary health care workers and implication for success of integration of mental health into primary care: Evaluation of effect on knowledge, attitude and practices (KAP). *International Journal of Mental Health Systems, 11*(1), 1–8. https://doi.org/10.1186/s13033-017-0169-8

Baia Medeiros, D. T., Hahn-Goldberg, S., O'Connor, E., & Aleman, D. M. (2019). Analysis of emergency department length of stay for mental health visits: A case study of a Canadian academic hospital – ERRATUM. *Canadian Journal of Emergency Medicine, 21*(5), 374–383. https://doi.org/10.1017/cem.2019.360

Barker, L. C., Sunderji, N., Kurdyak, P., Stergiopoulos, V., Gonzalez, A., Kopp, A., & Vigod, S. N. (2020). Urgent outpatient care following mental health ED visits: A population-based study. *Psychiatric Services (Washington, D.C.), 71*(6), 616–619. https://doi.org/10.1176/appi.ps.201900466

Baxter, A. J., Tweed, E. J., Katikireddi, S. V., & Thomson, H. (2019). Effects of housing first approaches on health and well-being of adults who are homeless or at risk of homelessness: Systematic review and meta-analysis of randomised controlled trials. *Journal of Epidemiology and Community Health (1979), 73*(5), 379–387. https://doi.org/10.1136/jech-2018-210981

Becker, D. R., & Drake, R. E. (1994). Individual placement and support: A community mental health center approach to vocational rehabilitation. *Community Mental Health Journal, 30*(2), 193–206. https://doi.org/10.1007/BF02188630

Bergen, C., Bortolotti, L., Temple, R. K., Fadashe, C., Lee, C., Lim, M., & McCabe, R. (2023). Implying implausibility and undermining versus accepting peoples' experiences of suicidal ideation and self-harm in Emergency Department psychosocial assessments. *Frontiers in Psychiatry, 14*, 1197512. https://doi.org/10.3389/fpsyt.2023.1197512

Bergmans, Y., Spence, J. M., Strike, C., Links, P. S., Ball, J. S., Rufo, C., Rhodes, A. E., Watson, W. J., & Eynan, R. (2009). Repeat substance-using suicidal clients—How can we be helpful? *Social Work in Health Care, 48*(4), 420–431. https://doi.org/10.1080/00981380802592013

Bialowolski, P., Weziak-Bialowolska, D., Lee, M. T., Chen, Y., VanderWeele, T. J., & McNeely, E. (2021). The role of financial conditions for physical and mental health. Evidence from a longitudinal survey and insurance claims data. *Social Science & Medicine (1982), 281*, 114041. https://doi.org/10.1016/j.socscimed.2021.114041

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health, 11*(4), 589–597. https://doi.org/10.1080/2159676X.2019.1628806

Bullard, M. J., Musgrave, E., Warren, D., Unger, B., Skeldon, T., Grierson, R., van der Linde, E., & Swain, J. (2017). Revisions to the Canadian emergency department triage and acuity scale (CTAS) guidelines 2016. *Canadian Journal of Emergency Medicine, 19*(S2), S18–S27. https://doi.org/10.1017/cem.2017.365

Canadian Mental Health Association. (2014). *Housing and mental health.* https://ontario.cmha.ca/documents/housing-and-mental-health/

Chang, G., Weiss, A. P., Orav, E. J., & Rauch, S. L. (2014). Predictors of frequent emergency department use among patients with psychiatric illness. *General Hospital Psychiatry, 36*(6), 716–720. https://doi.org/10.1016/j.genhosppsych.2014.09.010

Corbiere, M., & Lecomte, T. (2009). Vocational services offered to people with severe mental illness. *Journal of Mental Health, 18*(1), 38–50. https://doi.org/10.1080/09638230701677779

Dattani, S., Ritchie, H., & Roser, M. (2021, August). *Mental health.* Our World in Data. https://ourworldindata.org/mental-health

De Jong, C. A. J., Crockford, D., Welle-Strand, G., Iskandar, S., Sarkar, S., Haber, P. S., & Miller, M. (2021). Pathways to the specialty recognition of addiction medicine. In N. el-Guebaly, G. Carra, M. Galanter, & A. M. Baldacchino (Eds.), *Textbook of Addiction Treatment* (2nd ed., pp. 837–852). Springer. https://doi.org/10.1007/978-3-030-36391-8_58

Doran, K. M., Colucci, A. C., Wall, S. P., Williams, N. D., Hessler, R. A., Goldfrank, L. R., & Raven, M. C. (2014). Reasons for emergency department use: Do frequent users differ? *The American Journal of Managed Care, 20*(11), 506–514. https://pubmed.ncbi.nlm.nih.gov/25730349/

Fleury, M. J., Grenier, G., Farand, L., & Ferland, F. (2019a). Reasons for emergency department use among patients with mental disorders. *Psychiatric Quarterly, 90*(4), 703–716. https://doi.org/10.1007/s11126-019-09657-w

Fleury, M. J., Grenier, G., Farand, L., & Ferland, F. (2019b). Use of emergency rooms for mental health reasons in Quebec: Barriers and facilitators. *Administration and Policy in Mental Health and Mental Health Services Research, 46*(1), 18–33. https://doi.org/10.1007/s10488-018-0889-3

Gerber, E., Gelberg, L., Rotrosen, J., Castelblanco, D., Mijanovich, T., & Doran, K. M. (2020). Health-related material needs and substance use among emergency department patients. *Substance Abuse, 41*(2), 196–202. https://doi.org/10.1080/08897077.2019.1635960

Government of Canada. (2022). *Report on addiction, substance use and homelessness.* https://www.infrastructure.gc.ca/homelessness-sans-abri/reports-rapports/addiction-toxicomanie-eng.html

Judkins, S., Fatovich, D., Ballenden, N., & Maher, H. (2019). Mental health patients in emergency departments are suffering: The national failure and shame of the current system. A report on the Australasian college for emergency medicine's mental health in the emergency department summit. *Australasian Psychiatry: Bulletin of the Royal Australian and New Zealand College of Psychiatrists, 27*(6), 615–617. https://doi.org/10.1177/1039856219852282

Khenti, A., Bobbili, S. J., & Sapag, J. C. (2019). Evaluation of a pilot intervention to reduce mental health and addiction stigma in primary care settings. *Journal of Community Health, 44*(6), 1204–1213. https://doi.org/10.1007/s10900-019-00706-w

Lavergne, M. R., Shirmaleki, M., Loyal, J. P., Jones, W., Nicholls, T. L., Schütz, C. G., Vaughan, A., Samji, H., Puyat, J. H., Kaoser, R., Kaulius, M., & Small, W. (2022). Emergency department use for mental and substance use disorders: Descriptive analysis of population-based, linked administrative data in British Columbia, Canada. *BMJ Open, 12*(1), 1–9. https://doi.org/10.1136/bmjopen-2021-057072

Lien, Y. Y., Lin, H. S., Lien, Y. J., Tsai, C. H., Wu, T. T., Li, H., & Tu, Y. K. (2021). Challenging mental illness stigma in healthcare professionals and students: A systematic review and network meta-analysis. *Psychology & Health, 36*(6), 669–684. https://doi.org/10.1080/08870446.2020.1828413

Lien, Y. Y., Lin, H. S., Tsai, C. H., Lien, Y. J., & Wu, T. T. (2019). Changes in attitudes toward mental illness in healthcare professionals and students. *International Journal of Environmental Research and Public Health, 16*(23), 1–14. https://doi.org/10.3390/ijerph16234655

Lincoln, A. K., Wallace, L., Kaminski, M. S., Lindeman, K., Aulier, L., & Delman, J. (2016). Developing a community-based participatory research approach to understanding of the repeat use of psychiatric emergency services. *Community Mental Health Journal, 52*(8), 1015–1021. https://doi-org.cyber.usask.ca/10.1007/s10597-016-9989-2

Malecha, P. W., Williams, J. H., Kunzler, N. M., Goldfrank, L. R., Alter, H. J., Doran, K. M., & Asher, S. L. (2018). Material needs of emergency department patients: A systematic review. *Academic Emergency Medicine, 25*(3), 330–359. https://doi.org/10.1111/acem.13370

McCarthy, M. L., Zheng, Z., Wilder, M. E., Elmi, A., Li, Y., & Zeger, S. L. (2021). The influence of social determinants of health on emergency departments visits in a medicaid sample. *Annals of Emergency Medicine, 77*(5), 511–522. https://doi.org/10.1016/j.annemergmed.2020.11.010

McCormack, R. P., Hoffman, L. F., Norman, M., Goldfrank, L. R., & Norman, E. M. (2015). Voices of homeless alcoholics who frequent Bellevue hospital: A qualitative study. *Annals of Emergency Medicine, 65*(2), 178–186. https://doi.org/10.1016/j.annemergmed.2014.05.025

Mérelle, S. Y. M., Boerema, I., van der Linden, M. C., & Gilissen, R. (2018). Issues in emergency care for people who attempted suicide. *Nederlands tijdschrift voor geneeskunde, 162*. https://primo-pmtna02.hosted.exlibrisgroup.com/primo-explore/fulldisplay?docid=TN_cdi_pubmed_primary_30040297&context=PC&vid=USASK&lang=en_US&search_scope=UofS&adaptor=primo_central_multiple_fe&tab=default_tab&query=any,contains,Issues%20in%20emergency%20care%20for%20people%20who%20attempted%20suicide.&offset=0

Morphet, J., Griffiths, D., Plummer, V., Innes, K., Fairhall, R., & Beattie, J. (2014). At the crossroads of violence and aggression in the emergency department: Perspectives of Australian emergency nurses. *Australian Health Review, 38*(2), 194–201. https://doi.org/10.1071/AH13189

Moukaddam, N., Flores, A., Matorin, A., Hayden, N., & Tucci, V. T. (2017). Difficult patients in the emergency department. *The Psychiatric Clinics of North America, 40*(3), 379–395. https://doi.org/10.1016/j.psc.2017.05.005

National Institute of Mental health. (2023, March). *Mental illness.* https://www.nimh.nih.gov/health/statistics/mental-illness#:~:text=Mental%20illnesses%20are%20common%20in,mild%20to%20moderate%20to%20severe

Nehlin, C., Fredriksson, A., Grönbladh, L., & Jansson, L. (2012). Three hours of training improve psychiatric staff's self-perceived knowledge and attitudes toward problem-drinking patients. *Drug and Alcohol Review, 31*(4), 544–549. https://doi.org/10.1111/j.1465-3362.2011.00373.x

Olsson, M., & Hansagi, H. (2001). Repeated use of the emergency department: Qualitative study of the patient's perspective. *Emergency Medicine Journal, 18*(6), 430–434. https://doi.org/10.1136/emj.18.6.430

Pasic, J., Russo, J., & Roy-Byrne, P. (2005). High utilizers of psychiatric emergency services. *Psychiatric Services, 56*(6), 678–684. https://doi-org.cyber.usask.ca/10.1176/appi.ps.56.6.678

Pawaskar, R., Mahajan, N., Wangoo, E., Khan, W., Bailey, J., & Vines, R. (2022). Staff perceptions of the management of mental health presentations to the emergency department of a rural Australian hospital: Qualitative study. *BMC Health Services Research, 22*(1), 87–87. https://doi.org/10.1186/s12913-022-07476-7

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 10 Massachusetts emergency departments. *Annals of Emergency Medicine, 70*(2), 193–202. https://doi.org/10.1016/j.annemergmed.2016.10.005

Pinto, A. D., Hassen, N., & Craig-Neil, A. (2018). Employment interventions in health settings: A systematic review and synthesis. *Annals of Family Medicine, 16*(5), 447–460. https://doi.org/10.1370/afm.2286

Poremski, D., Wang, P., Hendriks, M., Tham, J., Koh, D., & Cheng, L. (2020). Reasons for frequent psychiatric emergency service use in a large urban center. *Psychiatric Services, 71*(5), 440–446. https://doi. org/ 10. 1176/ appi. ps. 20180 0532

Raeburn, T., Halcomb, E., Walter, G., & Cleary, M. (2013). An overview of the clubhouse model of psychiatric rehabilitation. *Australasian Psychiatry : Bulletin of the Royal Australian and New Zealand College of Psychiatrists, 21*(4), 376–378. https://doi.org/10.1177/1039856213492235

Rinaldi, M., Perkins, R., Glynn, E., Montibeller, T., Clenaghan, M., & Rutherford, J. (2008). Individual placement and support: From research to practice. *Advances in Psychiatric Treatment: the Royal College of Psychiatrists' Journal of Continuing Professional Development, 14*(1), 50–60. https://doi.org/10.1192/apt.bp.107.003509

Ross, L. E., Vigod, S., Wishart, J., Waese, M., Spence, J. D., Oliver, J., Chambers, J., Anderson, S., & Shields, R. (2015). Barriers and facilitators to primary care for people with mental health and/or substance use issues: A qualitative study. *BMC Family Practice, 16*(1), 1–13. https://doi.org/10.1186/s12875-015-0353-3

Russell, R., Ojeda, M. M., & Ames, B. (2017). Increasing RN perceived competency with substance use disorder patients. *The Journal of Continuing Education in Nursing, 48*(4), 175–183. https://doi.org/10.3928/00220124-20170321-08

Schmidt, M., Ekstrand, J., & Tops, A. B. (2018). Self-reported needs for care, support and treatment of persons who frequently visit psychiatric emergency rooms in Sweden. *Issues in Mental Health Nursing, 39*(9), 738–745. https://doi.org/10.1080/01612840.2018.1481471

Simon Junior, H., Schvartsman, C., Sukys, G. de A., & Farhat, S. C. L. (2023). Pediatric emergency triage systems. *Revista Paulista de Pediatria, 41*. https://doi.org/10.1590/1984-0462/2023/41/2021038

Slankamenac, K., Heidelberger, R., & Keller, D. I. (2020). Prediction of recurrent emergency department visits in patients with mental disorders. *Frontiers in Psychiatry, 11,* 48–48. https://doi.org/10.3389/fpsyt.2020.00048

Slankamenac, K., Zehnder, M., Langner, T. O., Krähenmann, K., & Keller, D. I. (2019). Recurrent emergency department users: Two categories with different risk profiles. *Journal of Clinical Medicine, 8*(3), 333. https://doi.org/10.3390/jcm8030333

Smith, M. W., Stocks, C., & Santora, P. B. (2015). Hospital readmission rates and emergency department visits for mental

health and substance abuse conditions. *Community Mental Health Journal, 51*(2), 190–197. https://doi.org/10.1007/s10597-014-9784-x

Thakarar, K., Morgan, J. R., Gaeta, J. M., Hohl, C., & Drainoni, M. L. (2015). Predictors of frequent emergency room visits among a homeless population. *PloS One, 10*(4), 1–13. https://doi.org/10.1371/journal.pone.0124552

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care, 19*(6), 349–357. https://doi.org/10.1093/intqhc/mzm042

Truth and Reconciliation Commission of Canada. (2015). Truth and Reconciliation Commission of Canada: Calls to action. https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/indigenous-people/aboriginal-peoples-documents/calls_to_action_english2.pdf

Vandyk, A. D., Harrison, M. B., VanDenKerkhof, E. G., Graham, I. D., & Ross-White, A. (2013). Frequent emergency department use by individuals seeking mental healthcare: A systematic search and review. *Archives of Psychiatric Nursing, 27*(4), 171–178. https://doi.org/10.1016/j.apnu.2013.03.001

Vandyk, A. D., Young, L., MacPhee, C., & Gillis, K. (2018). Exploring the experiences of persons who frequently visit the emergency department for mental health-related reasons. *Qualitative Health Research, 28*(4), 587–599. https://doi.org/10.1177/1049732317746382

Virgolino, A., Costa, J., Santos, O., Pereira, M. E., Antunes, R., Ambrósio, S., Heitor, M. J., & Vaz Carneiro, A. (2022). Lost in transition: A systematic review of the association between unemployment and mental health. *Journal of Mental Health (Abingdon, England), 31*(3), 432–444. https://doi.org/10.1080/09638237.2021.2022615

Van de Glind, G., Galenkamp, N., Bleijenberg, N., Schoonhoven, L., Scheepers, F. E., Crilly, J., van Veen, M., & Ham, W. H. W. (2023). Interventions to reduce interpersonal stigma towards patients with a mental dysregulation for ambulance and emergency department healthcare professionals: Review protocol for an integrative review. *BMJ Open, 13*(11), e072604–e072604. https://doi.org/10.1136/bmjopen-2023-072604

Vohra, N., Paudyal, V., & Price, M. J. (2022). Homelessness and the use of emergency department as a source of healthcare: A systematic review. *International Journal of Emergency Medicine, 15*(1), 1–22. https://doi.org/10.1186/s12245-022-00435-3

Wang, P. S., Berglund, P., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Failure and delay in initial treatment contact after first onset of mental disorders in the national comorbidity survey replication. *Archives of General Psychiatry, 62*(6), 603–613. https://doi.org/10.1001/archpsyc.62.6.603

Wise-Harris, D., Pauly, D., Kahan, D., De Bibiana, J. T., Hwang, S. W., & Stergiopoulos, V. (2017). "Hospital was the only option": Experiences of frequent emergency department users in mental health. *Administration and Policy in Mental Health and Mental Health Services Research, 44*(3), 405–412. https://doi.org/10.1007/s10488-016-0728-3