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Community Mental Health Services for Frequent Emergency Department Users

A Qualitative Study of Outcomes Perceived by Program Clients and Case Managers

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ABSTRACT

Purpose of Study: This study aimed to investigate the perceived outcomes and mechanisms of change of a community mental health service combining system navigation and intensive case management supports for frequent emergency department users presenting with mental illness or addiction.

Primary Practice Setting: The study setting was a community mental health agency receiving automated referrals directly from hospitals in a midsize Canadian city for all individuals attending an emergency department two or more times within 30 days for mental illness or addiction.

Methodology and Sample: Qualitative interviews with 15 program clients. Focus groups with six program case managers. Data were analyzed using pragmatic qualitative thematic analysis.

Results: Participants generally reported perceiving that the program contributed to reduced emergency department use, reduced mental illness symptom severity, and improved quality of life. Perceived outcomes were more mixed for outcomes related to addiction. Reported mechanisms of change emphasized the importance of positive working relationships between program clients and case managers, as well as focused efforts to develop practical skills.

Implications for Case Management Practice: Community mental health services including intensive case management for frequent emergency department users presenting with mental illness or addiction were perceived to effectively address client needs while reducing emergency department resource burden. Similar programs should emphasize the development of consistent and warm working relationships between program clients and case managers, as well as practical skills development to support client health and well-being.

Key words: *case management, emergency department, mental health, navigation, qualitative*

Hospital emergency departments often struggle to provide support for the complex health and social needs of frequent emergency department users (Hansagi et al., 2001; Soril et al., 2016). This challenge is further amplified for those frequent emergency department users presenting with mental illness or addiction (Kanzaria et al., 2019; Minassian et al., 2013; Ondler et al., 2014). Although the definition of frequent emergency department use varies (Doupe et al., 2012), research using a definition of four or more visits per year identified that this group of 4.5%–8% of all users accounted for 21%–28% of all emergency department visits (LaCalle & Rabin, 2010). It is now well known that this small proportion of emergency department users accounts for a disproportionate amount of emergency department visits (Beck et al., 2017; Hunt et al., 2006).

Although the provision of effective supports for this population remains inconsistent (Barker et al., 2020), what is clear is that these emergency department users would benefit from help that they are not receiving (Weber, 2012). Two broad categories of health services being implemented and researched to address the needs of frequent

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Data Availability Statement: Interview and focus group data are unavailable due to the confidential nature of this research and the consent agreements made between the researchers and study participants.

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emergency department users are system navigation and case management (Althaus et al., 2011; Mullen et al., 2023). System navigation refers to individuals receiving support to reduce barriers and connect with needed health and social services in a client-centered manner. It has been found to be an effective intervention (Mullen et al., 2023). Case management refers to a more comprehensive and often interdisciplinary approach to supporting individuals' health and social needs in a client-centered manner. It too has been found to be an effective intervention (Dieterich et al., 2017; Ponka et al., 2020; Soril et al., 2015).

At the same time, some research has also described substantial challenges reducing emergency department use and hospital readmissions, as well as increasing quality of life, after providing system navigation or case management support to frequent emergency department users (e.g., Finkelstein et al., 2020; Spillane et al., 1997; Stergiopoulos et al., 2017). One of the reasons for inconsistency in such outcome studies likely reflects the broad variability in the services being provided and in the health care contexts being studied (e.g., Althaus et al., 2011), as well as limited knowledge of the mechanisms of change that promote positive effects (Manuel et al., 2023).

There are still no best practices regarding interventions for frequent emergency department users because the system navigation and case management interventions that have been evaluated to address this challenge are often quite different from one another. Addressing the needs of frequent emergency department users with mental illness or addiction, as well as addressing the resource needs of overwhelmed emergency departments, continue to be substantial health policy concerns requiring further innovation and study. To better understand next steps in this regard requires further investigation into not only the implementation and outcomes of such interventions but also an enumeration of the specific mechanisms of change that actively respond to frequent emergency department users' needs and reduce their frequency of hospital visits.

The Familiar Faces program (funded by the Ontario government and implemented by the Canadian Mental Health Association's Ottawa Branch) receives automated referrals directly from hospitals in the Ottawa, Canada area for all individuals attending an emergency department two or more times within 30 days for mental illness or addiction. This community-based program is staffed by social workers and is composed of two connected services. First, social workers provide a system navigation service for up to 3 months including outreach, assessment, and assistance organizing referrals and connections to relevant health and social services. Second, an intensive, community-based, modified strengths model of case management (Rapp & Goscha, 2012) is offered by social workers for up to an additional 9 months to those program clients requiring further support. The case management service offers continued system navigation support and adds a focus on leveraging client strengths to achieve specific goals that improve quality of life and reduce emergency department use (e.g., obtaining a family physician, applying for housing, developing safety plans).

This novel program design reflects innovation in the field of health care services for frequent emergency department users. Evaluations of the implementation of this service indicated that such a program can be developed and implemented efficiently and sustainably (Cherner et al., 2022; Samosh et al., 2019). However, outcome studies investigating the effectiveness of this service delivery model and its related mechanisms of change have not yet been published.

The current study of program clients and case managers used a qualitative design to evaluate Familiar Faces program outcomes for those who received both system navigation and intensive case management supports. The study was grounded in a pragmatic realist orientation to describe actual client experiences, program functions, and how these forces likely affected program outcomes (Miles et al., 2014). Accordingly, the study was intended to answer the following research questions as perceived by program clients and case managers:

1. Why did program clients visit emergency departments prior to program enrollment?
2. What services were provided by the program?
3. What were the outcomes of program participation?
4. What mechanisms of change and barriers to change affected program outcomes?

Addressing the needs of frequent emergency department users with mental illness or addiction, as well as addressing the resource needs of overwhelmed emergency departments, continue to be substantial health policy concerns requiring further innovation and study.

Method

Participants

A sample of 15 program clients who each received at least 6 months of Familiar Faces services participated in this study. Six months was the minimum for study participation to ensure that participants had received at least the full 3 months of system navigation support, followed by a further 3 months of intensive case management support, meaning that they had significant experience of the program and had reached at least the halfway mark of the maximum 12-month program duration. Nonprobability purposeful sampling was pursued with the assistance of case managers for the "selection of information-rich cases for the most effective use of limited resources," identifying clients who were available and willing to participate, able to effectively communicate their experiences, and representing a diversity of client demographic characteristics, namely, gender, age, primary diagnostic category, and referring hospital (Palinkas et al., 2015, p. 534). Furthermore, a sample of six of the seven Familiar Faces case managers participated in study focus groups.

Materials

Semistructured protocols were used for interviews and focus groups. The interview protocol included questions asking participants why they used the emergency department before receiving Familiar Faces services, what services they received from the Familiar Faces case management program, what outcomes they perceived resulting from these services, and what they perceived to be the mechanisms of any changes they observed of themselves related to receiving services. The focus group protocol for case managers asked similar questions but from the perspectives of the case managers providing the service. The protocols permitted the researcher to deviate from these items as necessary to promote participant comfort when discussing difficult personal experiences and to permit the researcher to probe for follow-up information based on each participant's unique responses.

Procedure

The University of Ottawa Research Ethics Board (File H10-15-09) approved the study methods. Informed consent procedures were followed. Program client participants were each compensated with a $20 gift card. Interviews were audio recorded and transcribed verbatim. All case managers providing Familiar Faces case management services were invited to participate in one of two focus groups; six of seven were available to participate. All interviews and focus groups took place in 2020 and considered the program prior to the COVID-19 pandemic.

Design and Analysis

Interview and focus group transcripts were analyzed with the assistance of QSR International NVivo and Microsoft Excel software. Qualitative thematic analysis was used to code the transcripts and identify themes relevant to each research question (Miles et al., 2014). This involved summarizing each interview and focus group, creating a start list of codes deductively based on the study research questions, conducting first-cycle coding of each transcript using the start list of codes and updating the codes as needed, developing a cross-case matrix of the data (to compare client and case manager codes, with columns for participants and rows for codes), and conducting second-cycle coding to consolidate and make sense of the broader themes within the data relative to the study research questions. Analysis was conducted by the first author and validated via peer audit by the second author throughout this process. Each component of this analysis and any related decisions were recorded in an audit trail, with particular attention paid to the potential presence of data outliers.

Results

Participant Characteristics

Fifteen program clients who each received at least 6 months of Familiar Faces support (both system navigation and case management) participated in this study. Interview duration ranged from 11 to 53 min (M = 25 min). Fifteen clients proved sufficient for reaching data saturation (Fusch & Ness, 2015), as no new themes emerged after 11 interviews. Furthermore, at least one client from six of the seven case managers' respective caseloads had been interviewed by that point, including at least one client from each hospital emergency department referring to the Familiar Faces program, suggesting diverse sampling of client experiences in the current study. Table 1 presents demographic characteristics of client participants.

A sample of six of the seven program case managers participated in one of two focus groups. Focus groups were 59 min to 1 hr 37 min in duration (M = 1 hr 18 min). Case manager participant demographics included four (67%) female and two (33%) male case managers who had been working in this role with the Familiar Faces program from 1 to 5 years.

Emergency Department Use

Table 2 summarizes qualitative analysis findings. Both program clients and case managers reported a

TABLE 1
Demographic Characteristics of Interviewed Program Clients

Demographic Characteristic	*n*	%
Gender		
Female	10	67%
Male	5	33%
Age		
18–24 years	1	7%
25–34 years	5	33%
35–44 years	2	13%
45–54 years	2	13%
55–64 years	4	27%
65–74 years	1	7%
Indigenous status	3	20%
Primary diagnostic category		
Adjustment disorder	1	7%
Anxiety disorder	5	33%
Mental disorder due to general medical condition	1	7%
Mood disorder	6	40%
Schizophrenia or other psychotic disorder	1	7%
Substance-related disorder	1	7%
Other illnesses		
Concurrent disorder	7	47%
Dual diagnosis	1	7%
Other chronic illness or physical disability	5	33%
Housing		
Nonprofit	1	7%
Own or rent	4	27%
Special care	1	7%
Subsidized private	7	47%
Supportive	2	13%
Primary income source		
Employment	2	13%
None	1	7%
Social assistance	7	47%
Unknown	5	33%
Highest level of education		
College/university	4	27%
Secondary school	4	27%
Some college/university	4	27%
Some elementary school	1	7%
Some secondary school	2	13%

Note. $N = 15$ program clients. These data reflect characteristics recorded at time of client entry into the program.

TABLE 2
Summary of Qualitative Themes Perceived by Participants

Research Question	Themes
1. Reasons for emergency department use	Addiction symptoms
	Employment issues
	Financial issues
	Housing issues
	Mental illness symptoms
	Physical illness symptoms
	Relationship issues
	Suicidal/self-harm ideation/behavior
	System navigation issues
2. Program services	Activities of daily living support
	Counseling support
	Education support
	Employment support
	Financial support
	Housing support
	Symptom management
	System navigation
3. Program outcomes	No change
	Addiction symptoms
	Emergency department use
	Future outlook
	Mental illness symptoms
	Suicidal/self-harm ideation/behavior
	Positive change
	Addiction symptoms
	Access to services
	Coping skills
	Emergency department use
	Education
	Employment
	Finances
	Future outlook
	Giving back
	Housing
	Mental illness symptoms
	Quality of life
	Relationships
	Self-advocacy
	Self-awareness
	Self-confidence
	Suicidal/self-harm ideation/behavior
4. Mechanisms of change	Mechanisms of change
	Access to services
	Intensity of support
	Practical skills development
	Therapeutic relationship
	Barriers to change
	Client characteristics
	Intensity of support
	None
	Program duration
	Program client–case manager fit
	Systemic issues

broad range of contextual risk factors and immediately precipitating factors that led to program clients attending emergency departments prior to their referral to the Familiar Faces program. These factors were

addiction symptoms, employment issues, financial issues, housing issues, mental illness symptoms, relationship issues, suicidal/self-harm ideation/behavior, and system navigation issues. Only case managers indicated that some clients also attended emergency departments due to physical illness symptoms.

Program Services

Program clients and case managers reported receiving and providing services, respectively, from the Familiar Faces program to address needs across various life domains. These included services to support activities of daily living, housing, symptom management, and system navigation. Some clients also detailed receiving the following additional services: counseling support, education support, employment support, and financial support.

Perceived Program Outcomes

Neither clients nor case managers reported negative effects on clients due to participation in the Familiar Faces program, even with the interviewer explicitly probing for the potential experience of negative outcomes. However, a small number of clients reported no effects of their program participation on their addiction symptoms. Case managers also noted a lack of perceived effect in this area, with one stating that "I wish I had more success with the ability to tackle substance use. I think it's a lagging area of study. I think there's not a whole lot of impact that we've had."

Some clients also described continuing to have a negative outlook for their futures. For example, one client replied in the negative to an interview question about potential changes to future outlook by stating, "No, not right now. Not right now, yeah. Sorry to be negative, but it's just sad." A few clients also noted experiencing ongoing mental illness symptoms that affected their functioning, including "mental health-wise I'm still having a tough time in my life." Two clients indicated continued use of the emergency department despite receiving program services, with statements such as "I'm still going to the hospital a lot." Two clients also reported experiencing ongoing suicidal/self-harm ideation/behavior.

However, study participants perceived a much broader array of positive outcomes related to being a client in the Familiar Faces program. Some clients and case managers reported perceiving the program effecting positive change for the following outcomes: addiction symptoms, access to services, coping skills, emergency department use, education, finances, future outlook, giving back, housing, mental illness symptoms, quality of life, relationships, self-advocacy, self-awareness, and self-confidence. Some clients also reported positive effects related to the additional two outcome domains of employment and suicidal/self-harm ideation/behavior.

The most emphasized perceptions of positive program effect related to improved future outlook, self-confidence, and improved quality of life for clients. Said one client: "I think I'm feeling more optimistic about my life. I'm feeling hopeful, which I never had. I hadn't felt hopeful for years to be honest." Another stated: "Well, I think it's given me some more confidence in myself, that I am a strong person because I've gone through all the things I've gone through and survived." And finally: "I don't believe I'm all the way through my recovery journey, but definitely I'm in a way better place than I ever could have been by myself."

Also of note were perceptions from some clients and case managers of positive program effects related to addiction symptoms, with one client stating: "I'm much more confident that I'm not going to relapse into oblivion." Other participants also described positive effects in terms of feeling inspired to give back and pay forward similar program experiences and outcomes to others in their communities: "I'm dedicating my life for betterment and empowerment… In my small way, how I can empower others to feel the way I feel. And I feel pretty good."

Mechanisms of Change

Program clients and case managers reported perceiving four main mechanisms of change being responsible for positive program outcomes: the therapeutic relationship between clients and case managers, practical skills development, access to a broad array of support services, and high intensity of program support. Furthermore, while most participants emphasized that there were no barriers to change present in the program, a small number identified client characteristics, insufficient intensity of program support, short program duration, poor fit between clients and case managers, and various systemic issues as barriers to change.

The therapeutic relationship between client and case manager was identified as the most fundamental mechanism of change leading to positive program outcomes. One case manager explained:

> Going into the community and meeting the client there is literally you meeting them where they're at. And that is so important in your relationship with them, that you're not expecting them to come to your office, you're not expecting them to do XYZ so that your relationship can keep going. You're doing what you can to meet the client where they're at and kind of start there and work from there … I think that

> really benefits them because then they know that you're really there for them and you're not there for yourself or your numbers or whatever.

Clients also described the impact of the therapeutic relationship on the changes they experienced while participating in the Familiar Faces program, including:

> I think the human connection of Familiar Faces is really the aspect that I would sell to somebody… What this program can offer is a consistent outreach on a one-on-one basis that is truly helpful, and its unique perspective that, you know, it's not something that you should be anxious about when you call in and talk to the worker. They're personable, they're very warm, and kind.

Clients and case managers also identified the following further mechanisms of change: practical skills development, access to services, and intensity of support. One client said: "It is a level of support that is difficult to find and you get access to things quickly because you've been flagged."

Barriers to Change

Although emphasized less than the aforementioned mechanisms of change, some study participants also identified various barriers to change, which they perceived as interfering with the pursuit of positive program outcomes. In particular, they identified the limited program duration as being a barrier to change, with one case manager stating that "after nine months working with us, we are sometimes just engaging … and after nine months we are about to close [the client's file], but [client] is finally ready to work with us." Systemic issues, such as long wait-lists for other community services, housing shortages, and stigma, were also identified as barriers to change, including a case manager noting "there's that systemic barrier that there aren't a lot of services for [clients], especially if you don't have the finances, right?"

Another perceived barrier was the fit between clients and case managers, with one client stating: "Every worker's personality is different, so you may be able to have a better fit with someone." Intensity of support was also identified as a barrier. Said a client: "I would have liked to have been more engaged with support. Yeah, more frequently." Finally, client characteristics, such as readiness for change, were also raised as a barrier to change, with one case manager describing how "sometimes … [clients] want the support, but the readiness to take actions or to change may be so very low, so we have to work with that. Sometimes it can take months before we can start." However, the majority of clients reported perceiving no barriers to positive change in the program.

Discussion and Implications for Case Management Practice

The current qualitative study provided data about the outcomes and associated mechanisms of change of a community-based system navigation and intensive case management service for frequent emergency department users with mental illness or addiction, as perceived by 15 program clients and six of their case managers. The findings indicated that community mental health services incorporating both system navigation and intensive case management were perceived by both program clients and case managers as being responsive to the needs of frequent emergency department users with mental illness or addiction, while reducing resource burden on emergency departments.

Study participants generally perceived positive effects of the Familiar Faces program, notably related to reduced emergency department use, enhanced quality of life, improved future outlook, increased self-confidence, and reduced symptoms of mental illness. Some prior research studying interventions that provided either system navigation or case management supports has found ongoing difficulty reducing emergency department use and enhancing quality of life (e.g., Finkelstein et al., 2020; Spillane et al., 1997; Stergiopoulos et al., 2017). However, the current study results are encouraging and point to the potential benefits of providing a combined system navigation and intensive case management stepped care intervention model. At the same time, some clients and case managers noted the program not having an effect on addiction symptoms. This is a common challenge for many treatment models, as addiction likely requires specific targeting, higher intensity, and longer duration of intervention (Cherner et al., 2017;

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David et al., 2022; Lappan et al., 2020; Zamboni et al., 2021).

Mechanisms of change identified in the current study were consistent with psychotherapy and community mental health services research (e.g., Kahan et al., 2016). Most notably, the current study emphasized consistent perceptions that the critical mechanism of change in the Familiar Faces program was the relationship between program clients and case managers. The therapeutic relationship was characterized as being relationally warm, compassionate, authentic, trusting, nonjudgmental, patient, and consistent. This conforms to long-standing research findings regarding the importance of therapeutic alliance and other interpersonal relationships in the lives of mental health service users (Crits-Christoph & Connolly Gibbons, 2021; Kidd et al., 2017; Kondrat & Teater, 2012; Napierala et al., 2022; Roebuck et al., 2022). Furthermore, practical skills development (e.g., stress management, coping strategies, problem-solving) is a common mechanism of change identified in outcome studies (Crits-Christoph & Connolly Gibbons, 2021; Mueser et al., 2002). Prompt access to a broad array of health and social services is also known to contribute to positive outcomes for clients (Kumar & Klein, 2013; Mullen et al., 2023). Finally, having flexibility to vary support intensity based on individual client need is an important standard of case management practice (e.g., Gilmer et al., 2013; Monroe-DeVita et al., 2011).

Barriers to change identified in the current study were less salient to most participants, indicating the program was perceived to be functioning effectively overall. Indeed, the main participant response to interview questions about barriers was the perception that there were no barriers at all. However, for those barriers that were identified, the time-limited duration of the program (i.e., maximum 3 months of system navigation, followed by maximum 9 months of case management) was notable. Case managers were particularly concerned that a subset of clients could take months to outreach and engage into the program, following which they could benefit from program services, but then they lost this opportunity due to time constraints. This is consistent with the findings of prior implementation studies of the Familiar Faces program (Cherner et al., 2022; Samosh et al., 2019), as well as other community interventions for frequent emergency department users (Poremski et al., 2016). These results speak to the challenging policy considerations involved when balancing limited resources with high levels of need and varied readiness for change at the population level. Program developers determining service time limits may wish to consider that outreaching and engaging clients into program activities can take variable amounts of time.

Program clients and case managers also highlighted difficulties experienced in various life domains beyond health care that contributed to crises, ultimately culminating in emergency department visits prior to enrollment in the Familiar Faces program. This included challenges related to employment, finances, housing, relationships, and system navigation. They also identified services provided by case managers to support clients related to activities of daily living, education, employment, finances, housing, and system navigation—not just to manage symptoms of mental illness or addiction. This emphasizes the need to understand frequent emergency department use behaviors and service needs with a comprehensive model that extends well beyond just health care and symptom management alone (Meng et al., 2017; Weir et al., 2022). To understand and support the whole person in frequent emergency department use contexts likely requires broader conceptualization, including a focus on social determinants of health and implementation of policies to share and integrate data widely across health, behavioral, and social care systems (Kanzaria et al., 2019).

Limitations

The current study had limitations. Eligible program client participants were identified by their case managers, which may have biased selection. Furthermore, although 15 clients were determined to be sufficient for reaching data saturation and the researchers deliberately assessed for outlier data throughout the interview and analysis process, it is possible that interviewing more clients would have revealed novel or disconfirming data. In addition, clients who may have negatively experienced their time in the program could have terminated their participation in it early and therefore were not present to contribute to this research. Also, the study examined outcomes perceived retrospectively. Finally, this study was conducted in the hospital context of an electronic system that identified frequent emergency department users with mental illness or addiction in the Ottawa, Canada area and referred them automatically to the community-based Familiar Faces program. Both emergency department and Familiar Faces services were publicly funded. Generalizability of the results may therefore be limited to similar health care contexts. Future research should continue to study not only the outcomes of services targeting frequent emergency department users but also their associated mechanisms of change and barriers to change.

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