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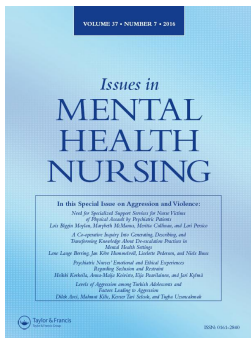
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## Professionals' Perspective on Needs of Persons Who Frequently Use Psychiatric Emergency Services

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### ABSTRACT

This study explores how professionals experience persons who frequently use psychiatric emergency services (PES) in terms of their needs in Sweden. The data comprise 19 semi-structured individual interviews and one focus group interview with healthcare professionals (i.e., assistant nurses, psychiatric nurses, intern physicians, and resident physicians), which are analyzed using qualitative content analysis. The overall findings suggest that persons who frequently use PES suffer from illness, unfavorable life circumstances, and inadequate care, which together emphasize the need for more sustainable support. The findings indicate that the professionals saw beyond illness-related needs and could also acknowledge patients' needs originating from social, existential, and care- and support-related aspects of life.

### Introduction

Use of psychiatric emergency services (PES) has increased in recent decades (Aagaard, Aagaard, & Buus, 2014; Brown, 2005; Schmidt, 2018). One user group contributing to this increase is persons who frequently visit PES. In a recent Swedish study, persons making frequent PES visits constituted 8.1% of the total sample, yet they accounted for 38.3% of all visits made during the investigated 3 years (Schmidt, Ekstrand, & Bengtsson Tops, 2018a). Previous research arrived at similar results, finding that this relatively small group is responsible for a disproportionately high number of visits in both Scandinavian (Aagaard et al., 2014) and international contexts, including North America (Chaput & Lebel, 2007; Lincoln et al., 2016), Europe (Boyer et al., 2011; Ledoux & Minner, 2006; Richard-Lepouriel et al., 2015), and Australia (Wooden, Air, Schrader, Wieland, & Goldney, 2009; Zhang, Harvey, & Andrew, 2011). Thus, it is a global phenomenon regardless of the healthcare system.

Persons who frequently visit PES are often described as a heterogeneous group, and previous studies have identified several factors predicting frequent PES visits, including male gender (Ledoux & Minner, 2006), young age (Chaput & Lebel, 2007), single status (Boyer et al., 2011), homelessness (Arfken et al., 2004), and unemployment (Pasic, Russo, & Roy-Byrne, 2005). This diverse group also reportedly does not receive or has difficulties complying with aftercare (Bruffaerts, Sabbe, & Demyttenaere, 2005), can be uncooperative (Pasic et al., 2005), and has unreliable social support (Pasic et al., 2005). Furthermore, persons who frequently

visit PES are more likely to be prematurely discharged (Botha et al., 2010); suffer from personality disorders (Richard-Lepouriel et al., 2015), substance abuse disorder (Bruffaerts et al., 2005; Ledoux & Minner, 2006), and schizophrenia (Aagaard et al., 2014); and have a history of hospitalization (Pasic et al., 2005). While useful in identifying the characteristics of this group, all of these are quantitative studies and have not focused on explaining what aspects apart from demographics and diagnostics could identify the needs of these persons that make them frequently visit PES.

Healthcare professionals working at PES play an important role in providing multifaceted services to persons who frequently use PES. These professionals have been described as an integrated and valued part of the social networks of persons who frequently visit PES, providing them with safety and security (Aagaard et al., 2014; Barker & Buchanan-Barker, 2010; Schmidt, Ekstrand, & Bengtsson Tops, 2018b). Given their numerous encounters with and extensive knowledge of these patients, healthcare professionals might represent a valuable source of information regarding their needs. They are also the ones addressing the patients' needs, and therefore their understanding of the patients' needs may be crucial for care provision.

Persons who frequently visit PES have been shown to have complex and multifaceted needs (cf. Fleury, Grenier, Farand, & Ferland, 2019; Schmidt et al., 2018b), some of which may remain unmet if people have difficulties expressing them in the first place. Compounding this challenge may be the fact that persons who frequently visit PES are a

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heterogeneous group that varies greatly in diagnostic profile, socioeconomic characteristics, and temporal utilization patterns (Schmidt et al., 2018a). In a recent Swedish mixed-methods study including persons who frequently visit PES, the participants self-reported having needs to reduce acute suffering, feel secure, and have caring encounters with PES staff, as well as needs to reduce psychological distress and psychotic symptoms and to have daytime activities (Schmidt et al., 2018b). Reviews of studies focusing on persons who frequently visit PES or emergency departments, and on their needs in particular, indicated that explanatory research has dominated the field so far (Schmidt, 2018; Vandyk, Harrison, VanDenKerkhof, Graham, & Ross-White, 2013), while exploratory research has been scarce (Vandyk, Bentz, Bissonette, & Cater, 2019; Vandyk, Young, MacPhee, & Gillis, 2018; Wise-Harris et al., 2017). In-depth qualitative studies of an explorative nature may be required to more fully understand this complex group's needs and the reasons and life circumstances underlying those needs. The perspective of healthcare professionals at PES could provide one piece of this puzzle, since their voices have been largely missing from studies so far. Healthcare professionals at PES may have an understanding of the patients' needs that differs from the patients' own understanding. While patients might emphasize their acute healthcare needs in moments of despair when presenting at PES, healthcare professionals might be able to look beyond those acute needs and also discern the patients' other, longer-term needs. Taking a novel perspective of the professionals, this study aims to explore how the professionals experience persons who frequently use PES in terms of their needs, thus contributing to the in-depth understanding of the needs of this group of people. Further, this study contributes to a better understanding of the professionals' experiences with this patient group, which could potentially help improve patient outcomes and satisfaction.

## Methods

Within the context of this study, healthcare professionals in psychiatric care include assistant nurses, registered nurses with additional specialized education in psychiatry, as well as intern and resident physicians,<sup>1</sup> all of whom are hereafter referred to simply as "professionals." Persons who frequently use PES are hereafter referred to as "patients."

## Design and context

The study has a qualitative, explorative design. A qualitative design is considered suitable for exploring people's experiences, perceptions, opinions, and feelings in order to cast light on the phenomenon of interest (Polit & Beck, 2016). As data collection methods, both individual interviews and a focus group interview were used. "Within-method triangulation," a form of methodological triangulation using several data collection methods (Thurmond, 2001) such as the different qualitative interview types used in this study, helps to provide a clearer and more comprehensive understanding of the phenomenon of interest. It also increases the trustworthiness of

the study and improves authenticity of the results (Holloway & Wheeler, 2015; Polit & Beck, 2016). While the individual interviews can contribute to in-depth data collection, focus group interviews can add variety and breadth of the data.

Healthcare in Sweden, including psychiatric healthcare, is based on a socialized welfare system financed mainly by taxes. Both municipalities ( $N=290$ ) and county councils ( $N=21$ ) share responsibility for providing psychiatric healthcare and social care services. According to the Swedish Association of Local Authorities and Regions there are 54 psychiatric emergency units in Sweden. Organization and staffing differ between locations as does the triage process, which in some PES is conducted by registered nurses with or without additional specialized education in psychiatry and in other places is conducted by resident physicians. Staff competences and educational levels vary within Sweden and internationally, as do the clinical profiles of the persons who frequently visit PES. However, the persistent frequent visits to PES by certain groups of people are similar across both national and international contexts.

Data were collected at one PES in southern Sweden comprising a psychiatric emergency department and an acute psychiatric care unit. The PES serves a rural/urban catchment area of approximately 200,000 inhabitants. The PES is open 24 hours a day, 7 days a week, and is operated by assistant nurses (2-year vocational education), registered nurses (3-year tertiary education plus 1 year of specialization), intern physicians (5.5-year tertiary education plus 1.5-year intern training) and resident physicians (5-year additional specialization training), an on-call physician, and, during the daytime, a medical secretary (2-year vocational education), which are the most common profession categories that work at PES in Sweden in general. The PES uses a well-integrated 24 hour/day, 7 days/week telephone counseling service, and most patients call before visiting. Thus, the professionals included in this study talked about both patients' frequent PES visits and their frequent use of telephone counseling services, which were operated by registered nurses.

## Participants

The participants were informed about the study by the first author during workplace meetings and/or by a video recorded by the first author. Furthermore, an information letter was sent to all potential participants informing them of the study's aim, the data collection methods, and their right to refuse participation. To be included in the study, it was originally decided that participants should: (1) be either assistant nurses, registered nurses, or physicians; (2) have been in contact with and cared for persons who frequently used PES; and (3) have been employed at the PES unit for at least 6 months before the interview. However, intern physicians undergoing practical educational placement at the PES for 3-month periods and who met with patients extensively were also viewed as a valuable information source, so the inclusion criteria were relaxed for them despite their shorter employment terms. Sixty-two professionals fulfilled the extended inclusion criteria. To achieve variation in the

**Table 1.** Overview of the participants.

	Individual interviews ( <i>n</i> = 19)	Focus group ( <i>n</i> = 1)
Gender		
Male	6	4
Female	13	1
Age, median (range)	47 (29–70)	38 (32–49)
Profession		
Assistant nurse	3 (13–17) <sup>a</sup>	2
Registered nurse	10 (1–40) <sup>a</sup>	2
Intern physician	2 (n/a) <sup>a</sup>	0
Resident physician	4 (1–4) <sup>a</sup>	1
Country of birth		
Sweden	15	4
Other	4	1

<sup>a</sup>Range of professionals' experience of working in a PES, years.

sample, purposeful selection (Holloway & Wheeler, 2015) was applied among the eligible participants based on profession, work experience, age, and gender. In total, 21 professionals were asked to participate in the study; two professionals (i.e., one assistant nurse and one resident physician) refused participation due to high workload, so the final sample comprised 19 participants. When recruiting focus group participants from those 19 participants, seven professionals were purposefully selected and invited based on their working schedules and professions. However, as two female professionals could not participate due to sickness and work schedule changes, the final focus group comprised five participants, in line with Krueger and Casey's (2015) recommendation of five to eight participants. A detailed description of the participants can be found in Table 1.

### Data collection

Data were collected via individual face-to-face interviews (Polit & Beck, 2016) and a focus group interview (Krueger & Casey, 2015).

### Individual interviews

The individual interviews used a semi-structured interview guide comprising open-ended questions about the professionals' experiences and perceptions of the patients and their needs (e.g., "Can you freely tell me about your experiences with persons who frequently use PES? Who are they? What problems do they have?"). Each individual interview started by referring to one of the most common definitions of frequent PES visitors as persons with at least five contacts within a 12-month period (Aagaard et al., 2014; Blonigen et al., 2017; Schmidt et al., 2018b).

The individual interviews were conducted during October and November 2018 by the first author and lasted an average of 51 minutes (range, 27–86 min). Before data collection, two pilot interviews, also included in the analysis, were conducted by the first and the fourth authors, resulting in the addition of two questions to the interview guide. The individual interviews took place at the participants' workplace during working hours and were scheduled by the care unit manager to fit participants' shift schedules in order to ensure sufficient staffing of both the psychiatric emergency department and the acute psychiatric care unit. At the beginning of

the individual interviews, all participants were asked to complete a form containing questions about their age, country of birth, gender, education, and work experience.

### Focus group interview

After all individual interviews had been conducted, one focus group interview was held in January 2019. Focus group interviews capitalize on communication between the participants, and those group interactions offer a direct indication of similarities and differences among the participants' experiences, opinions, and feelings (Morgan, 1996). Focus group interviews are conducted by a moderator and observer, who should be fully grounded in the purpose of the study (Krueger & Casey, 2015). In this study, the use of a focus group interview constituted a source of complementary data used to increase the trustworthiness of the results and to add variety and breadth of the data. It also allowed further validation of the preliminary results of the individual interviews and made it possible to report preliminary results back to the focus group, thus ensuring credibility of the study (Shenton, 2004). The semi-structured interview guide used in the focus group interview was based on the preliminary results of the individual interviews and further addressed the six problem areas identified at this stage: suffering from disease, not fitting into society, loneliness, hopelessness, being let down by social structures, and PES availability. The guide consisted of open-ended questions, allowing for an open discussion among the participants.

The focus group interview took place at the participants' workplace during working hours. It was conducted by the first author as a moderator and the fourth author as an observer and lasted 100 minutes. Both the individual interviews and the focus group interview were audio recorded and transcribed verbatim.

### Analysis

The data were analyzed using qualitative content analysis (Graneheim & Lundman, 2004) with an inductive approach that allowed for a deeper understanding of the professionals' experiences and perceptions of the patients and their needs, facilitating the search for patterns in the data (Graneheim, Lindgren, & Lundman, 2017). During the analysis, we sought similarities and differences in the data, leading to the formulation of four categories capturing the manifest content of the text as well as one theme capturing the latent content of the text. Though the emerging categories focus on describing the manifest content, and the theme focuses on interpreting the latent content, both require a level of interpretation, yet of varying depth and level of abstraction (Graneheim & Lundman, 2004; Graneheim et al., 2017). Because the interviews focused on narrating the patients' problems and life circumstances, the analytical process started with the patients' challenges and problems, which, in a later stage of the analysis, the authors interpreted in terms of needs.

The individual interview texts were analyzed following a systematic and stepwise process starting with reading all individual interview texts to obtain a sense of the whole.



Then, the text about the participants' experiences of the patients' needs (i.e., units of analysis) was identified and brought together in one document. The text was then divided into meaning units, which were condensed while keeping their core meaning (Graneheim & Lundman, 2004). The next step involved labeling the condensed meaning units with codes. As the meaning units were sometimes rather large and comprehensive, more than one code could be assigned to a condensed meaning unit to preserve content relevant to the study's aim. The codes were then compared in terms of similarities and differences, and sorted into subcategories and categories.

After the preliminary analysis of the individual interviews was done, the focus group interview was conducted based on those preliminary results. The focus group text was then analyzed following the procedure described above; it largely validated the categories and advanced the analytical process by exploring and clarifying the preliminary results of the individual interviews. After analyzing all the texts from all interviews, some categories and subcategories were merged and/or renamed. The analysis process was repeated by all authors individually at different analysis stages. Thereafter, the authors discussed and reflected upon the categories and subcategories together until a consensus was reached. The validity of the categories and subcategories was checked against the condensed meaning units and codes. Table 2 presents examples of the aggregation of the text and the analysis process.

The overall theme emerging from beneath all the texts, representing the latent, underlying meaning of the texts, was derived through in-depth interpretation and abstraction (Graneheim et al., 2017). The theme ran through all the categories as a unifying "red thread" (Graneheim et al., 2017) throughout the analysis. The analysis involved all the study's authors at different stages. The first, second, and fourth authors—following the systematic analysis approach—repeatedly discussed the findings over a longer period of time and agreed on them, and these were then presented to and critically reviewed by the third author. A joint discussion was then initiated between all authors, and the analysis was completed when consensus was reached.

## Ethics

The Swedish Ethical Review Authority had no ethical concerns about this study (Dnr 2018/569). Both written and oral information about the study was provided to the participants, and a letter of consent was signed by each participant before participation in the individual interviews and the focus group interview. In the information letter, at the information meetings, in the information video, and before the individual and focus group interviews started, it was stressed that participation was voluntary and that participants could withdraw without having to provide a reason. Furthermore, participants were informed that the collected data would be treated confidentially and that only the authors of the study would be able to access it.

## Pre-understanding

The authors had varying levels of pre-understanding. The second, third, and fourth authors are registered nurses, and the fourth author has solid clinical experience of working in psychiatric care. All four authors are focusing on psychiatric care or mental health in their research.

All authors of this study have extensive experience in conducting qualitative studies using different data collection and analysis methods, including qualitative content analysis.

## Results

The professionals viewed the patients, that is, persons who frequently use PES, as common users of PES, forming a large group that would always exist regardless of PES' actions and interventions. The professionals described the patients as heterogeneous in terms of age, diagnosis, and level of self-awareness, though alike in some ways. The professionals further described them as suffering, feeling unwell, and help-seeking. They experienced the patients as either very sick, having been so for many years, or as having mild conditions not covered by specialized psychiatry (e.g., sleeping problems lasting a few days) and having no acute healthcare needs. The professionals narrated that the patients suffered from numerous psychiatric diagnoses and symptoms. The psychiatric diagnoses most frequently mentioned by the professionals were substance abuse (particularly alcohol addiction), neuropsychiatric disorders such as Asperger's syndrome, and personality disorders (particularly emotionally unstable personality disorder). The latter often occurred in combination with self-harm behavior. Despite the variety of illnesses and symptoms, the professionals regarded anxiety as the most common condition among all patients, as it could occur in combination with most psychiatric illnesses. Anxiety was also a condition for which the patients requested immediate treatment. Comorbidity also commonly involved somatic healthcare problems such as high blood pressure or diabetes, which were healthcare needs that the PES professionals felt that they met insufficiently at times. The professionals indicated that the patients had multiple, complex needs. The focus group interactions revealed that the participants across professions were in consensus regarding their experiences and views of the patients.

The data analysis provided an understanding of the professionals' perspective on the patients and their needs. The analysis resulted in one overarching theme: To suffer from illness, unfavorable life circumstances, and inadequate care stresses the need for sustainable support. This theme captured the meaning of the professionals' experiences and perceptions of the patients as suffering human beings who need the support of all involved healthcare functions to establish an integrated caring approach acknowledging the various dimensions of their suffering. The theme includes four categories representing the professionals' perspective on patient needs: need to relieve loneliness, need to relieve hopelessness, need to relieve psychiatric symptoms, and need for cohesive care and support, as presented in Table 3.

Table 2. Examples of the analytical process.

Meaning unit	Condensed meaning unit	Code	Subcategory	Category
A: People don't have ... the safety net ... surrounding network of contacts—friends, acquaintances, and parents, etc.—so this has sort of become some kind of new ... people come here instead of ... for things that you could maybe have taken care of within the family or with friends and so on, before. B: Maybe they have some diagnosis or ... A: Yes, you could also have that. But that they're actually looking for help with loneliness. C: Yes, true, but that's often how it is. (Focus group)	People don't have a surrounding social network of friends, acquaintances, and parents—they're basically seeking help for loneliness.	People have no network of contacts and they're seeking professional help because they're lonely.	Need for significant others	Need to relieve loneliness
God Almighty! What they need help with ... so actually we would need to sit down with the person and look at their entire history, see what it is like, what kind of network they have, what has been done and what has not been done, and what might be helpful, and what the person him/herself wants. Yes, and so ... but I'm saying that ... it's of course really, really hard! We could, of course ... and that is in fact the way it is, that it's all about individual solutions, and that costs money and is totally unrealistic—and yes, that's how it is. (SSK, interview 11)	Actually, we would need to sit down with the person and look at their entire history, see what it is like, what kind of network they have, what has been done and what has not been done, and what might be helpful, and what the person him/herself wants. But that's of course really, really hard. Individual solutions cost money and are totally unrealistic.	No leeway for taking individual backgrounds and wishes into consideration.	Need for a long-term perspective	Need for cohesive care and support
But what we find is that certain municipalities don't function properly. It's as if they are unable to reach the patient ... But it seems to me that the municipality could provide more support. ... Like you must wait until the eleventh hour before you're supposed to write an urgent care offer about the patient if the patient has, say, acute liver failure and is extremely somatically ill. It's like nothing gets done until the very last minute. Yes. (ST, interview 1)	In certain municipalities it doesn't work. They are unable to reach the patient. Seems to me that the municipality should provide more support. They wait until the last minute before writing an urgent care offer when the patient is very ill.	Municipalities should provide more interventions. Municipalities should provide better service.	Need for improved social and healthcare functions	Need for cohesive care and support
A: Yes, I think that ... many of these people, who sometimes might function quite well otherwise, or well enough in any case, that they ... they have to go to Emergency then, because there's no other place that can ... B: ... that's open, right? Even though it may not involve an urgent psychiatric ... C: I'm actually about to start working at a municipality now, and there they're talking about ... or before I came they were talking about ... how someone was going to have extended hours of opening at the support and treatment unit. One Saturday a month or something like that, and that's a bit outside the box. E: Yes, that it is. C: At the same time, society is actually becoming ever more 24/7. But in healthcare and in the municipality things are still extremely rigid—there it's like getting sick is a daytime thing. (Focus group)	People who function well have to go to Emergency because there's nothing else open—even if it's not an urgent psychiatric issue. Society is 24/7, but in healthcare things are still very rigid—as if getting sick is a daytime thing.	PES is the only service that is open round the clock.	Need for PES to be available	Need for cohesive care and support

**Table 3.** Overview of the theme, categories, and subcategories.

Theme	To suffer from illness, unfavorable life circumstances, and inadequate care stresses the need for sustainable support			
Categories	Need to relieve loneliness	Need to relieve hopelessness	Need to relieve psychiatric symptoms	Need for cohesive care and support
Subcategories	Need for significant others	Need to master obstacles in everyday life	Need for increased well-being	Need for improved social and healthcare functions
	Need to fit into society	Need for meaning	Need for acute hospital admission and medication	Need for PES to be available
	Need for talk and interaction	Need for temporary escape	Need for self-admission	Need for collaboration between involved functions
	Need to be seen and confirmed	Need for caring encounters	Need to feel safe	Need for a long-term perspective

### **Need to relieve loneliness**

The professionals found the patients to be lonely in their lives, which contributed to their frequent use of PES. This loneliness revealed itself in several dimensions. First, the professionals described an inner loneliness among the patients; second, the professionals noted that the patients lacked significant others to share their lives with, often living alone, having no spouse, and having little or no contact with their families; and third, the professionals found that the patients had limited or no social networks, as the patients commonly had few or no friends:

Many people spend all their time alone in their apartment and are very lonely. Their loneliness is extreme. And sometimes I think, look, I've been working here for seventeen years and I see this—many of the people who come here spend all their time alone in their apartment and they miss this part ... (Interview 3)<sup>2</sup>

The professionals saw the reasons for this loneliness partly in the patients' self-chosen withdrawal and partly in society's distancing of persons with mental illness. Other reasons were stigma-related problems in a changing society that the professionals regarded as more individualized, egocentric, and tougher than several decades ago, making persons with mental illness more vulnerable today as the society does not provide places where they can fit in. The professionals described the current society as a factor contributing to the patients' isolation and alienation, making them outsiders to society and increasing their loneliness and use of PES services:

Yes, they do want someone to talk to. Sometimes they want some medicines, but most of all I think it is that they want ... many are quite lonely, so I think many times that could be why they come here. (Interview 16)

Given the loneliness of the patients and related problems, the professionals felt that the patients needed human interaction and someone to talk to in order to relieve their loneliness. The professionals perceived that the patients maintained close relationships with them at the PES because they provided opportunities to talk to someone. The professionals expressed that they represented familiar faces and offered the patients comfort and the prospect of human interaction. Because they had had previous conversations, the professionals could talk at a personal level with the patients, remembering what they liked or disliked. The professionals expressed that both parts of conversation, that is, being able to talk to someone and verbalize one's thoughts as well as being listened to by someone who is interested

and willing to invest time, were equally important for relieving the patients' loneliness. The professionals used this form of interaction to strengthen their therapeutic and trustful relationship with the patients.

Due to the patients' loneliness, the professionals felt that the patients needed to be seen and be confirmed to find relief. By taking time to listen carefully, the professionals could temporarily meet the patients' needs for confirmation. The patients' need to be seen and for confirmation was regarded as essential by the professionals, since this need could not be met by absent family, friends, or significant others or by an alienating society at large:

The first thing—the most important thing, I think—is the listening. It's the patient's story that is the most important thing. I think that surely it's a human need—to be seen. And if you are seen, that's part of it. Then no doubt there are many other needs, but just to be heard and to be seen—for me that's the most important thing. (Interview 2)

### **Need to relieve hopelessness**

The professionals found the patients to be constantly struggling with everyday life, which was characterized by economic challenges, problems, and dissatisfaction with their housing or living situation, and lack of daytime activities. The patients were described as helpless and as having low self-confidence and a negative self-image, which contributed to their difficulties in mastering life. The professionals also felt that the patients had lost their joy in life, viewing it as meaningless, which contributed to a fairly hopeless outlook and a desire to escape from their troublesome lives:

Yes, but those who come, they are searching for something and most often they search ... they search for hope and meaning and structure. Yes, these sorts of inaccessible notions that things will be better ... That's why they come here, that otherwise ... well, crassly speaking, they could go in the lake right away because they feel frustrated, hopeless, that they don't see any light anywhere. So I guess there might be a purpose for this operation [i.e., PES] to exist//Yes//Yes//But I think we give hope to many and that we give meaning to many and we give structure to many. (Focus group)

The professionals felt that PES offered a refuge for the patients, where they could get away from their everyday lives, pause, and reflect.

Because the professionals regarded the patients as dependent on others with respect to mastering everyday life



and as having difficulties taking care of themselves, they felt that the patients yearned to be taken care of by someone, a need that was directed toward PES:

I mean, basically, I don't believe anyone thinks it's fun to be here [i.e., in the PES unit], no ... they really don't. And ... but it ... some people have become so helpless, due to their ... due to their alcoholism, that they become ... they just want to be taken care of. Almost like children. Yes. They cannot manage their lives ... they ... they're in debt, they have collection agencies and the enforcement service on them, they can't do their own housekeeping, can't prepare their meals, can't make their own beds. (Interview 8)

The professionals felt that, due to the patients' difficulties mobilizing inner strength and will, the patients could put responsibility on others in their surroundings—particularly PES—to resolve their problems for them simply, quickly, and conveniently. From this perspective, the professionals viewed certain patients as passive recipients of services who lacked resources to overcome crises on their own:

... many of them have some kind of hopelessness, so that they want us to hospitalize them or start to help them, to fix them somehow ... (Interview 10)

All the aspects of hopelessness and lack of independence were understood by the professionals as patients needing caring encounters and to be met in an empathetic and humane way. The professionals understood that uncaring encounters could lead to frequent use of PES and that the patients would not feel that they were being taken seriously.

The professionals also recognized the patients' need for a glimpse of hope, a need originating from their hopelessness. The professionals saw it as crucial to provide hope for the patients and to believe in them even if they did not believe in themselves. They strove to make the patients feel empowered, involving them in decision making, providing autonomy, and maintaining a humanistic perspective:

But it is extremely important to build them up, to reassure them—"You'll be okay, you'll manage, and you know where to find us ... you can call us if you need to chat"—or something like that. That kind of thing is extremely important—that you reassure them but don't take away their responsibility for their own health and their illness, or whatever it is—that's important, for sure. (Interview 5)

The professionals stressed that responsibility for their own health should always remain with the patients, and they understood that if the patients shifted responsibility to others, no lasting changes could occur.

### ***Need to relieve psychiatric symptoms***

Regardless of the diagnosis or the severity and urgency of the patients' health condition, overall, the professionals found the patients to be suffering and feeling unwell for reasons that were not always clear nor understood by the patients themselves. The professionals stressed that the patients' subjective experience of their own health conditions was what mattered, not the professionals' perception of the patients' conditions, because the subjective experience was the patients' reality.

The professionals reported that suicidal thoughts were often expressed by the patients who could use this as a tool to emphasize the severity of their negatively experienced health conditions and suffering. Even though the patients might express such thoughts, all the professions participating in the interviews agreed that they did not believe that the patients actually wanted to end their lives but, rather, were expressing their dejection and inability to cope:

We always ask about it [i.e., suicidal ideation], so it comes up, but usually they don't have such thoughts—more like a longing for death, a death wish, that they feel they can't go on, as they so often describe it. They don't say they're planning to commit suicide but rather that "It would be better if I died, if I got sick and died—that would be such a relief for me." So it's not exactly suicidal ideation—a threat of suicide—from these people, as I see it. (Interview 10)

The professionals reported that, to find relief from psychiatric symptoms and lack of well-being, the patients requested PES admission to find safety, security, a change of environment, stability, and calm. In particular, persons with personality disorders, self-harm behavior, anxiety, and addiction problems valued the possibility of being hospitalized. Persons with addiction problems and anxiety also expressed a need for medication or withdrawal treatments in order to feel better and obtain relief from their suffering. However, the professionals understood that admission and medication relieved the patients' suffering only temporarily, and that the patients could have unrealistic expectations of PES. The professionals found that it was important for the patients to understand that only acute needs could be addressed and eased at the PES, while long-term healthcare needs would remain unmet and would have to be addressed elsewhere:

At the same time, it [i.e., frequent visiting] ... is sometimes a problem, because they choose that as a coping strategy instead of maybe doing something else. So they think "yes," but then they go to Emergency all the time. They want us to calm their anxiety, which isn't the best thing in the long run. (Interview 10)

The professionals felt that there was a need to provide patients with the option of self-admission as an alternative to having staff determine whether to admit patients. This option was introduced by the PES a few years earlier, mainly for persons with emotionally unstable personality disorder and self-harm behavior. The professionals found this option to be successful for both the patients and the PES because it improved patient well-being in both the short- and long-term, as it increased patients' autonomy.

The patients' health conditions and suffering were understood by the professionals as engendering a need for safety, which could be temporarily met by hospitalization and medication, and by being treated by competent and professional staff.

### ***Need for cohesive care and services***

To live structured lives outside of acute psychiatric healthcare, the patients depended on the help of municipal social

care services and other support and healthcare functions. Besides social care services, these functions could include permanent healthcare contacts with psychiatric outpatient care units, counselors, social workers, employment agencies, social insurance agencies, churches, and homecare services. The professionals noted that the patients frequently needed to use PES because they were often let down by the available support services. The professionals strongly agreed with the patients' dissatisfaction, knowing first-hand that the provided support services were insufficient, lacking in quality, and in short supply.

The professionals reported that the patients, despite being set up with numerous support contacts, were often not helped by them, possibly being redirected from one support service to another. They even felt that the patients could have too many support contacts, which they considered counterproductive, confusing for the patients, and lacking a person-centered approach. Not only were the social services unsatisfactory, the professionals also perceived that the healthcare services needed to be more available to the patients. For example, the psychiatric outpatient care units and primary healthcare centers could not offer enough physician appointments. The primary healthcare centers had long waiting times, and the professionals thought that these centers should be more available to the patients since their responsibility covered milder to moderate mental health conditions. This short supply of social and healthcare services made it clear to the professionals that the patients needed an improved overall support service covering all involved social and healthcare functions, ultimately reducing acute patient needs as well as decreasing the number of PES visits.

Due to the short supply and deficiency of support, particularly at night or on weekends when the patients might experience high anxiety, the professionals believed that the patients needed a PES facility to turn to, as it was the only alternative available 24 hours a day when patients experienced healthcare or other needs.

The professionals believed that sufficient PES availability fostered a sense of security, continuity, and structure that was otherwise lacking in the patients' lives:

A: Mm-hm. But you [i.e., PES] can't help them with housing, can you?

B: No, we can't. But sometimes they get ... they often have anxiety when the structure of their life falls apart somewhere else. Then they can come here, and just being here gives them a certain sense of structure. (Interview 18)

Furthermore, the professionals described a lack of collaboration between PES and the support services arising from unclear division of responsibility, deficient comorbidity assessments, and a lack of resources for improving collaboration between services. This lack of collaboration was yet another perceived reason for the lack of continuity of care, which the professionals thought was essential for the recovery process of the patients. While the lack of support services was mentioned by all participants, the lack of collaboration was mainly noted by the physicians, who usually

had to initiate treatment contacts or would need information from other support functions:

Honestly, I believe we need to have an in-depth dialogue with social services about how we might better handle this type of patient. Maybe someone from the social services could provide 24-hour on-call service about this ... since it's often a matter of a social problem when they come to Emergency. (Interview 1)

The professionals criticized the structure of the healthcare system, as none of the support functions adequately addressed the patients' long-term needs. They believed that the patients should be provided with more adequate interventions at an earlier stage elsewhere, for example, in primary care at healthcare centers or by the municipalities:

Then, too, there are times when you might have wished there was someone else, or a better place for them to go, largely because there might be other interventions they need more than psychiatry, so that ... For example, if you have autism and have difficulty with everyday life, then rehabilitation, rather than psychiatry, is what is needed. But we are all that is available in the evening. So there is a risk that they will come here and staff will want to involve a whole lot of medications or do something that may actually not help them, when what they needed was more structure. (Interview 4)

This long-term perspective even included providing person-centered service. Although the professionals embraced this approach when caring for the PES patients, they felt that providing individually tailored interventions would require close, long-term coordination between all support functions. The PES' task of addressing acute healthcare needs could at times collide with a person-centered approach due to the short-term, acute priorities guiding PES care.

## Discussion

By applying the perspective of the professionals working at PES, this study sought to explore how the professionals experience persons who frequently use PES in terms of their needs. In the discussion, we first compare our findings to the limited studies about the needs expressed by persons who frequently visit PES or other emergency departments. This is followed by a comparison with those studies about mental healthcare patients in similar or other healthcare contexts, and thereafter we relate our findings to applicable theoretical domains within healthcare. Finally, we bring forward the professionals' own feelings and the issue of malingering related to our findings.

The main finding is that the PES professionals report a complex picture of the patients' needs based on their personal and social life circumstances and on the healthcare and support context. The needs identified by the professionals correspond relatively well with those expressed by persons who frequently visit PES or emergency departments themselves (Fleury, Grenier, & Farand, 2019; Schmidt et al., 2018b; Vandyk et al., 2018, 2019; Wise-Harris et al., 2017), stressing the complexity of the patients' needs and the subjective component of the patients' suffering, lack of health and well-being, and the need for human contact and social interaction. In particular, the patients' feelings of loneliness, their internal and external struggle, and their negative

self-image leading to feelings of worthlessness and hopelessness were common topics discussed in studies about persons with (severe) mental illness visiting other mental health or healthcare services (Ådnøy Eriksen, Sundfør, Karlsson, Råholm, & Arman, 2012; Fleury, Grenier, Bamvita, & Tremblay, 2013; Lindgren, Sundbaum, Eriksson, & Graneheim, 2014). Further, the inadequacy of the healthcare services and their shortage of resources or the lack of human interaction were recurring leitmotifs, which also correspond well with the aforementioned studies. Thus, the professionals participating in this study showed high levels of insight and empathetic capacity by perceiving and understanding the patients' personal, social, and healthcare needs. The findings of this study additionally emphasize that even though the professionals at PES could address a number of the patients' needs, the benefits of this were not long lived, and that numerous long-term needs were outside their scope of work and could not be addressed by PES. While Fleury, Grenier, and Farand (2019) reported that over 90% of the persons with mental illness presenting at emergency departments could rely on several close relations for help, the professionals interviewed in our study found the patients at PES to be lonely, with few or no social interactions or network, which was confirmed by a study taking frequent visitors' perspective (Schmidt et al., 2018b).

Although the professionals tried to discern the uniqueness of each patient's experience of psychiatric symptoms and healthcare problems, they felt that the patients were also alike in terms of their unmet needs, suffering, poor health and lack of well-being. The present findings are in line with Eriksson's (2006) categorization of suffering from illness, suffering from care, and suffering from life. Eriksson (2006) compared suffering to a form of dying in that the absence of confirmation of one's worth as a human being leads to a world beyond relationships that is characterized by hopelessness, sorrow, guilt, humiliation, and loneliness. She further acknowledged the importance of confirming a person's suffering, which was what the professionals reported doing, for example, by means of eye contact, words, or gestures. Stratton Hill (1992) developed a typology of suffering distinguishing between acute and chronic forms, with the former relating to illness and the latter to the patient's situation as a whole. Both forms of suffering and their resulting needs were identified by the professionals included in this study. Although they stressed that their task was to offer only short-term ease of acute symptoms at the PES, they could see beyond illness-related needs and also acknowledge the patients' unmet long-term needs originating from other aspects of life. These results further correspond to the four modes of suffering identified by Cutcliffe, Hummelvoll, Granerud, and Eriksson (2015): social suffering (as in category 1), existential suffering (as in category 2), disease suffering (as in category 3), and care and treatment suffering (as in category 4). The existential aspect of the patients' suffering was often described by the professionals in terms of the patients' existential loneliness, need for meaning in life, need to escape, and suicidal thoughts. Those indicate the patients' existential vulnerability and the importance of

a sense of coherence (Antonovsky, 1996) and of feelings of connectedness (Ådnøy Eriksen, Arman, Davidson, Sundfør, & Karlsson, 2013).

For persons to move away from those states of suffering, hope-supporting relationships are needed. The professionals participating in this study, regardless of their profession, were aware of the value of supporting and empowering the patients by believing in them and providing them with some glimpse of hope. Provision of hope during periods of illness and vulnerability by nurses, psychiatric nurses in particular (Hammer, Mogensen, & Hall, 2009), has consistently been identified as crucial in previous literature. Hope-inspiring interventions and their therapeutic value have been shown to be essential to the experience of illness and well-being, recovery, and the ability to live meaningful lives (Ådnøy Eriksen et al., 2013; Eriksson, 2006; Moore, 2005). However, the primary focus in this context is usually on the nursing profession, though it could be extended to all professions working at PES, as this study showed. A study including mental health professionals confirmed that inducing hope and recognizing and confirming mental health service users as fellow human beings increases their self-respect, self-worth, and sense of self (Ådnøy Eriksen et al., 2013). Despite the involved professionals' various mandates, focuses, and work descriptions, they all expressed similar views, thoughts, and perceptions regarding caring for the patients.

Another finding of the study is that the professionals identified many of the patients' needs and origins of suffering in their social and everyday lives. The professionals included in this study described persons who used PES frequently as lonely and excluded from society. Furthermore, they lacked daytime activities and were dissatisfied with their housing situation and with the limited availability and quality of the support and healthcare services. Those findings can be confirmed by previous studies of persons with mental illness in an emergency care context that applied a patient perspective (Fleury et al., 2013; Schmidt et al., 2018b; Vandyk et al., 2018). Those findings may support a social-psychiatric approach, implying that more attention should be paid to people's social contexts, that is, not only to the individual's immediate social context, but also to the political responses to societal structures at the local, national, and international levels (Priebe, 2015). By considering all aspects of individuals and their everyday lives, including a social perspective, a more person-centered caring approach is possible that may lead to more empowerment of patients and better meet their long-term needs, thus providing more sustainable support. By providing sustainable support, e.g., in the form of more continuity of care and support, achieved by means of a collaboration strategy applied by all involved social and healthcare functions, the short- and long-term suffering arising from illness, life, and care, together with the associated needs, can be met more effectively.

An additional finding of the study was that, despite the focus on the patients and their needs, all included professionals sometimes felt hopeless. This was because they were aware of the patients' needs yet could not address all of them, stressing that the patients needed healthcare and

support services earlier in the caring process and more preventative interventions. This indicated that the patients' and professionals' needs may be somewhat intertwined, particularly in the category *need for cohesive care and services*. Addressing the patients' needs in this category would ultimately address and meet certain work- and health-related needs of the professionals as well, which may lead to greater patient and staff satisfaction.

Finally, there is a growing body of literature (Rumschik & Appel, 2019; Zuber, Raza, Holaday, & Aggarwal, 2015) investigating malingering in PES. Malingering is intentionally fabricating or exaggerating symptoms to obtain external benefits (American Psychiatric Association, 2013) such as hospitalization or medication, and one study reports suspicion of malingering in 33% of patients (Rumschik & Appel, 2019). However, this study could not find evidence of malingering among the patients, which may simply indicate that this was not an issue in the local context under study. Instead, the included professions in this study highlighted the patients' suffering as well as the importance of understanding their subjective experiences, which was supported by other studies stressing the unavoidability and necessity of each visit as expressed by the patients (Vandyk et al., 2018; Wise-Harris et al., 2017).

### Strengths and limitations

Certain limitations of the study should be considered. First, the care unit manager was involved in selecting the participants, both to ensure sufficient PES staffing and to achieve sample variation. However, it cannot be guaranteed that the care unit manager was free of any selection bias, which could threaten the confirmability of the study. Second, two informants had to withdraw from the focus group at the last minute and could not be replaced at short notice. As a result, the focus group participants were less representative than the individual interviewees in terms of gender and age. Third, the transferability of the findings may be limited due to their specific organizational and national contexts. Given the limited research in this field, the findings of the study have to be carefully handled when comparing the related yet different studies and contexts. It should also be acknowledged that the study added just one piece of the puzzle by considering the professionals' perspective; another piece ought to be added by conducting more qualitative studies involving the patients themselves. Other interesting future research could include an exploration of malingering of persons visiting emergency departments, since there is an obvious discrepancy between patients' subjectively experienced need for emergency care and the diagnosing and classification of non-/urgent symptoms and the constitution of an emergency by the healthcare professionals. Another important future research path could be the exploration of the experiences of encounters between professionals and patients at PES due to the varying and potentially differing perspectives of the involved parts.

A strength of the study is its use of "within-method triangulation," which allowed for increased trustworthiness

and ensured data saturation (Guba, 1981; Thurmond, 2001). We have strived to increase credibility by interviewing different professions at PES and using a multidisciplinary focus group (Guba, 1981). Representative quotations in the "Results" section were used to increase transparency of the analysis process and authenticity of the results (Guba & Lincoln, 1994). Finally, to ensure transparency, the authors followed the consolidated criteria for reporting qualitative research (COREQ) (Tong, Sainsbury, & Craig, 2007) when planning and conducting the data collection as well as when writing the study.

### Conclusions

As the underlying meaning of the text revealed in the theme, based on the healthcare professionals' perspective, persons who frequently use PES suffer from illness, unfavorable life circumstances, and inadequate care as a consequence of numerous needs related to loneliness, hopelessness, psychiatric symptoms, and the lack of cohesive care and support.

First, the study contributes to an in-depth understanding of the needs of persons who frequently visit PES by identifying and describing those needs from the professionals' perspective. The PES professionals acknowledge both the patients' short-term and long-term needs, yet they feel that they can only address the patients' short-term needs, while their long-term needs should be met by social care and support services. Second, the study contributes by identifying and describing the professionals' experiences of difficulties in addressing those needs. The professionals found that the social care and support services were in short supply, and that inadequate and inefficient services resulted in frequent visits and telephone calls to PES. To reverse this negative spiral, sustainable support may be required that provides improved coordination and continuity of care and support for the patients. Instead of the patients seeking care and support from numerous and fragmented healthcare and social services, a sustainable service function should be provided that integrates the various healthcare, social, and support services. This in turn would apply a more holistic, person-centered approach to addressing all the needs of the patients.

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### Notes

1. In this context, resident physicians are physicians who are undergoing specialization training in psychiatry.
2. Quotations include all professions, but to preserve anonymity they are not disclosed.

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