Older Adults Visiting Emergency Departments for Mental Health Issues:

A CHIRPP Database Study

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Abstract

Objectives: To describe the characteristics, clinical trajectories, and disposition of older adults consulting in the emergency department (ED) for mental health issues. The secondary objective was to explore the impact of age, sex, and living environment on those patients' clinical care and disposition.

Methods: This registry study included data from 5 Canadian EDs. Patients were included if they were aged ≥65 years and consulting in the ED between March 1, 2020, and March 31, 2021, for mental health issues. Relative risks (RRs) were obtained using a modified Poisson regression model, and 95% confidence intervals (CIs) were estimated with a robust variance estimator.

Results: 1,673 patients were included. The mean ± SD age was 75.2 ± 8.1 years; 58.8% were female, and 87.4% had a prior history of mental health issues. Suicidal ideations (40.8%) and neurocognitive disorders (31.8%) were the most frequent diagnostic impressions. 52.0% were assessed by a psychiatrist, and 49.9% were discharged from the ED. Males were at higher risk of neurocognitive (RR: 1.16 [95% CI, 1.01–1.32]) and substance use disorders (RR: 1.54 [95% CI, 1.19–1.99]). Patients aged ≥85 were more likely to be physically/chemically restrained and less likely to be assessed by psychiatry and hospitalized (RR: 1.69 [95% CI, 1.14–2.50], RR: 0.62 [95% CI, 0.52–0.74], RR: 0.73 [95% CI, 0.57–0.95]).

Conclusion: This study highlights that most older ED patients consulting for mental health issues had a prior history of such issues. A psychiatrist assessed most patients, but those aged ≥85 were less likely to be assessed or hospitalized, yet more likely to be restrained. These results should be considered when designing targeted investigations to meet the complex needs of this population.

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In 2018, 5.3 million Canadians aged ≥12 years reported needing mental health care.[1] According to a 2017 survey, 1 in 5 older Canadians experienced emotional distress within the past 2 years, indicating that these issues are not limited to younger generations.[2] Furthermore, a recent database study showed that older emergency department (ED) patients had the highest proportion of mental health issues.[3] Mental health issues are common reasons for ED visits in older adults, with 15.3% seeking help for conditions such as depression, anxiety, suicidal ideation, or self-harm.[4,5]

EDs are often poorly equipped to manage the complex needs of older adults, especially those with mental health issues. The symptoms and presentations of mental health issues among older adults may differ from those observed in younger individuals.[6,7] Hence, they are more likely to remain undetected by ED health professionals. Furthermore, even when mental health issues are identified, older ED patients are less likely to be evaluated or referred for a formal mental health assessment than their younger counterparts.[8] Nearly half of patients with mental health issues had an outpatient consultation for mental health reasons in the year before an ED visit. Moreover, 15% of patients discharged from the ED returned within 30 days for mental health issues.[9] With the aging population, new strategies must be developed to improve the detection and optimize the care of older ED adults with mental health issues. Unfortunately, few data on older Canadians consulting the ED for these conditions are available.[10] Exploring these patients' characteristics and trajectories is essential to improve the mental health care provided to this vulnerable population seeking acute care.

Editor's Note

We encourage authors to submit papers for consideration as a part of our Focus on Geriatric Psychiatry section. Please contact Jordan F. Karp, MD, at psychiatrist.com/contact/karp, or Gary W. Small, MD, at psychiatrist.com/contact/small.

Clinical Points

- Few data are available on older Canadians consulting the emergency department (ED) for these conditions. Exploring these patients' characteristics and trajectories is essential to improve the mental health care provided to this vulnerable population seeking acute care.
- Mental health issues are common among older Canadians and make up about 3% of ED visits for this group. Patients aged ≥85 years were at a higher risk of being restrained in the ED but less likely to be assessed by psychiatrists/mental health nurses.
- Clinicians and health administrators should consider our findings when creating specific research or care plans to better address the diverse needs of this population.

The main objective of this study is to describe the characteristics, clinical trajectories, and disposition of older adults consulting in the ED for mental health issues. The secondary objectives are to explore the impact of age, sex, and living environment on the clinical care, disposition, and diagnostic impression(s)/clinical manifestation(s) of those patients.

METHODS

Study Design and Setting

We conducted a retrospective cohort study using data from the Canadian Hospitals Injury Reporting and Prevention Program (CHIRPP), a sentinel surveillance system from the Public Health Agency of Canada.[11] CHIRPP is designed to analyze the circumstances of events and identify risk factors to develop and implement targeted prevention strategies. In 2020, the Public Health Agency of Canada approved the development of a specialized mental health database at the CHU de Québec-Université Laval. This database was codesigned by a multidisciplinary group including ED, psychiatry, public health, and epidemiology experts. Trained medical archivists collected data from patients' medical records using a standardized form. All data are anonymized to ensure confidentiality.

The CHU de Québec-Université Laval includes 5 hospitals, 2 of which offer dedicated psychiatric EDs services. These EDs have a combined annual census of approximately 211,117 visits, including 28.2% of older adults. As per local protocols, ED patients are first evaluated by an emergency physician before being referred to the psychiatric ED. If the patient is admitted, they are then transferred to a specialized psychiatric facility.

This project was approved by the CHU de Québec-Université Laval Research Ethics Board (#2024-7188). Per the retrospective nature of this study, patient-informed written consent was waived, and waiver was approved by the CHU de Québec-Université Laval Research Ethics Board. Our results are reported per the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guidelines.[12]

Population

Older adults (≥65 years old) were included in the present study if they consulted in one of the EDs of the CHU de Québec—Université Laval for mental health issues between March 1, 2020, and March 31, 2021, according to the ED triage note. Patients with neurocognitive disorders and delirium were also included in our cohort.

Outcome Measures

We gathered relevant sociodemographic and clinical information from medical charts, including the main complaint and the physician's diagnostic impression/clinical manifestation of the problem. The main complaint refers to the symptom(s) and/or the state of discomfort reported by the patient during triage. The diagnostic impression/clinical manifestation of the mental health issue was determined by either an emergency physician or a psychiatrist. When patients underwent a psychiatric assessment, the psychiatrist's diagnostic impression/clinical manifestation was prioritized in the data collection. The diagnostic impressions/clinical manifestations were carefully categorized by the same experts who designed the CHIRPP database to align as closely as possible with the *DSM-V* criteria.[13]

Information regarding the patient's care trajectory and management in the ED was also collected, including mental health consultants in the ED, whether restraints (physical or chemical) were used, and ED disposition.

Statistical Analysis

We described sociodemographic and clinical data using frequency (percent) and mean (standard deviation) for categorical and continuous variables, respectively. A multivariable model was used to assess the potential association between a prior set of determinants (age, sex, residence, mode of arrival, and hospital) and the use of restraints, hospital admission, and mental health-related diagnostic impressions/clinical manifestations. Relative risks (RR) were obtained using a modified Poisson regression model, and 95% CIs were estimated with a robust variance estimator.[14] All statistical analyses were conducted using the Statistical Analysis System (SAS Institute, Cary, NC, USA, v. 9.4), and statistical significance was set a priori as $P < .05$.

RESULTS

Of the 59,449 patients aged ≥65 years who consulted in one of the 5 EDs during the study period,

1,673 patients (2.8%) sought care for mental health issues and were included in our analyses. As shown in Table 1, the mean ± SD age of our cohort was 75.2 ± 8.1 years, with patients aged 65–74 years representing 55.3% of our cohort. Most of our patients were female (58.8%) and lived independently in private households (62.1%). Additionally, 72.4% arrived at the ED unaccompanied. Ambulance services were the most frequently used mode of transportation to the ED (66.7%), and police services escorted 11.7% of the patients. Most consultations (82.3%) occurred at one of the 2 hospitals specializing in psychiatry and mental health.

The majority of our patients had at least 1 prior documented mental health issue (87.4%). Mood (44.9%), neurocognitive (30.0%), and anxiety (28.0%) disorders were highly prevalent. The primary reasons for ED consultations included behavioral issues (22.8%), suicidal ideation (21.5%), and anxiety (16.7%). Notably, chronic alcoholism was documented in 22.2% of our patients, while 5.9% had a history of substance use disorders other than alcohol (Table 1).

As shown in Table 2, 52.0% of the patients were assessed by a psychiatrist or a geriatric psychiatrist in addition to the emergency physician during their ED visit. Physical and/or chemical restraints were used for 160 patients (9.5%). Overall, the most frequent ED physician/psychiatrist's diagnostic impressions/clinical manifestations were suicidal ideations (40.8%), neurocognitive disorders (31.8%), and mood disorders (25.2%). More than half of the patients presenting with suicidal ideations also had a plan (58.1%), with 5% having attempted suicide. Most patients were discharged from the ED (49.9%), while 44.5% were admitted: 26.4% for mental health issues, 2.1% for substance problems, and 16.0% for other health reasons. One patient presenting with mental health issues died during their ED stay due to a cardiovascular condition.

Patients at higher risk of being restrained while in the ED were aged ≥85 years (RR: 1.69 [95% CI, 1.14–2.50]). These patients were less likely to be assessed by a psychiatrist or a geriatric psychiatrist (RR: 0.62 [95% CI, 0.52–0.74]) or have a psychiatry/mental health liaison nurse consultation (RR: 0.48 [95% CI, 0.36–0.64]). This age group was also more likely to be admitted to a hospital ward (RR: 1.32 [95% CI, 1.13–1.53]) but less likely to be admitted specifically for their mental health issues (RR: 0.73 [95% CI, 0.57–0.95]). Thus, patients living in senior or supervised residences were more likely to be admitted specifically for their mental health issues (RR: 1.26 [95% CI, 1.06–1.49]) (Table 3).

Patients aged 74–85 years were significantly more likely to have neurocognitive and mood disorders (RR: 2.59 [95% CI, 2.15–3.12], RR: 1.20 [95% CI,

Table 1.

Characteristics of the Study Population (n = 1,673)[a]

Characteristics	N (%)
Hospital	
Specialized in psychiatry/mental health	1,377 (82.3)
Not specialized in psychiatry/mental health	296 (17.7)
Age, mean ± SD, y	75.2 ± 8.1
65–74 y	925 (55.3)
75–84 y	485 (28.9)
≥ 85 y	263 (17.5)
Sex, female	984 (58.8)
Living arrangement	
Private home/apartment/condo	1,039 (62.1)
Senior housing, long-term care facility/supervised residence	566 (33.8)
Shelter	66 (3.9)
Other	2 (0.1)
Means of arrival at emergency department	
Ambulance	1,116 (66.7)
Other	557 (33.3)
Accompanied	
Alone or unspecified	1,211 (72.4)
Police	195 (11.7)
Family and/or friend(s)	193 (11.5)
Other (caregiver, intervener)	85 (5.1)
Documented history of mental health disorders[b]	
Mood disorder(s)[c]	752 (44.9)
Neurocognitive disorder(s)	502 (30.0)
Anxiety disorder(s)/phobia	469 (28.0)
Chronic alcoholism	372 (22.2)
Personality disorder(s)[d]	323 (19.3)
Suicide attempt(s)	264 (15.8)
No history of mental health disorder	210 (12.6)
Schizophrenia	207 (12.4)
Psychosis	161 (9.2)
Suicidal ideation/dark thought(s)[e]	144 (8.6)
Other[f]	140 (8.4)
Substance use disorder and/or cannabis[g]	99 (5.9)
Other mental health disorder to be specified	81 (4.8)
Mental retardation (intellectual disability)	41 (2.5)
Behavioral disorder	39 (2.3)
Reason for consultation (triage)[b]	
Behavioral problem	381 (22.8)
Suicidal ideation	359 (21.5)
Anxiety/situational crisis	279 (16.7)
Intoxication without suicidal intent	202 (12.1)
Hallucinations	199 (11.9)
Depressive mood	191 (11.4)
Other[h]	63 (3.8)
Suicide attempt	58 (3.5)
Insomnia	54 (3.2)
Social problem	52 (3.1)
Concern for patient's safety/health	51 (3.1)

[a]Values shown as n (%) unless otherwise noted.
[b]Categories are not mutually exclusive.
[c]Adaptation, bipolar affective disorder, bipolar, depression, dysthymic disorder, affective dysregulation.
[d]Borderline personality disorder, narcissistic, cluster B, antisocial, borderline, dependent, histrionic personality disorder, etc.
[e]Chronic suicidal risk, suicidal crisis.
[f]Aggression/violence, shock/posttraumatic stress, insomnia, potomania, social problems, eating disorder, obsessive-compulsive disorder, neurodevelopmental disorder, self-mutilation.
[g]Other than alcohol.
[h]Agitation/extreme violence, substance withdrawal, court order, self-mutilation.

Table 2.

Patient Outcome: Clinical Care, Diagnostic Impression/Clinical Manifestation, and Disposition (n = 1,673)

	N (%)
Consultants in the ED[a]	
Psychiatry/geriatric psychiatry	870 (52.0)
Social worker/nurse, nonpsychiatric liaison team	676 (40.4)
Psychiatric/mental health liaison nurse	555 (33.2)
Addiction rehabilitation center health care professional	66 (3.9)
Restraints used[a]	
Physical (Argentino, Pinel)	126 (7.5)
Chemical[b]	93 (5.6)
Isolation room	15 (0.9)
Preventive confinement	90 (5.4)
Mental health-related diagnostic impression/clinical manifestation (ED physician/psychiatrist)[a]	
Suicidal ideation/dark thoughts[c]	683 (40.8)
Neurocognitive disorders and delirium	532 (31.8)
Mood disorders[d]	422 (25.2)
Suicidal ideation with plan	397 (23.7)
Anxiety disorders	271 (16.2)
Personality disorders	231 (13.8)
Substance use disorders	191 (11.4)
Psychotic disorders	160 (9.6)
Schizophrenia[e]	132 (7.9)
Behavioral disorders—aggressivity	131 (7.8)
Other mental health disorder[f]	93 (5.6)
Suicide attempt(s)	84 (5.0)
Social problems[g]	80 (4.8)
Hallucination(s)	66 (3.95)
No mental health disorders[h]	39 (2.3)
Substance/medication-induced psychosis	19 (1.1)
Obsessive-compulsive and related disorders	13 (0.8)
Nonsuicidal self-injury	6 (0.4)
ED disposition	
Discharged[i]	836 (49.9)
Hospital admission	745 (44.5)
Admission for mental health problems[j]	442 (26.4)
Admission for other health reasons[k]	268 (16.0)
Admission for substance intoxication/withdrawal	35 (2.1)
Left without being seen	69 (4.1)
Unauthorized departure or runaway	22 (1.3)
Death in ED	1 (0.1)

[a]Categories are not mutually exclusive.
[b]Haloperidol alone, haloperidol-lorazepam combination, ketamine, midazolam, etc.
[c]Suicidal threat/crisis, passive death ideation, suicidal ideation for secondary gain.
[d]Depressive disorders, bipolar and related disorders.
[e]Schizoaffective disorder, paranoid schizophrenia.
[f]Neurodevelopmental disorder, feeding and eating disorder, known and stable psychiatric illness, insomnia, posttraumatic shock, factitious disorder, hetero-aggressive ideation, somnolence, attachment disorder, homicidal ideation, gambling disorder, acute stress, gender dysphoria, nervous shock, somatization/somatoform disorder, etc.
[g]Homelessness, environmental exhaustion, poverty/social deprivation, etc.
[h]Crime/assault victim, loss of autonomy.
[i]Includes sobering up in local resources.
[j]Regardless of specialty.
[k]Other than intoxication/overdose/mental health problems.
Abbreviation: ED = emergency department.

1.02–1.43], respectively) as diagnostic impressions/clinical manifestations. Patients aged ≥85 years were also significantly more likely to have diagnostic impressions/clinical manifestations such as neurocognitive disorders (RR: 3.37 [95% CI, 2.77–4.12]). Male patients were significantly at higher risk of neurocognitive disorders (RR: 1.16 [95% CI, 1.01–1.32]) and substance use disorders (RR: 1.54 [95% CI, 1.19–1.99]) (Table 4).

Table 3.

Adjusted Relative Risk of Restraints, Consultations, and Hospital Admission

	Restraint use[a] N = 161 RR (95% CI)	Psychiatry geriatric psychiatry N = 532 RR (95% CI)	Social worker/ nurse, nonpsychiatric liaison team N = 422 RR (95% CI)	Psychiatry/mental health liaison nurse N = 271 RR (95% CI)	Addiction rehabilitation center health care professional N = 231 RR (95% CI)	Hospital admission[b] N = 746 RR (95% CI)	Hospital admission for mental health disorders/intentional intoxication N = 477 RR (95% CI)
Age							
65–74 y	1	1	1	1	1	1	1
75–84 y	1.16 (0.83–1.63)	0.95 (0.86–1.04)	1.38 (1.21–1.57)	0.90 (0.78–1.04)	0.16 (0.06–0.44)	1.20 (1.07–1.36)	0.89 (0.75–1.05)
≥ 85 y	1.69 (1.14–2.50)	0.62 (0.52–0.74)	1.23 (1.07–1.52)	0.48 (0.36–0.64)	0.12 (0.02–0.92)	1.32 (1.13–1.53)	0.73 (0.57–0.95)
Sex							
Female	1	1	1	1	1	1	1
Male	1.25 (0.93–1.68)	0.99 (0.91–1.08)	0.99 (0.88–1.12)	0.89 (0.79–1.02)	1.38 (0.87–2.19)	1.00 (0.91–1.12)	0.89 (0.76–1.04)
Residence							
Home	1	1	1	1	1	1	1
Senior housing	2.10 (1.53–2.88)	1.11 (1.01–1.22)	1.18 (1.04–1.35)	0.97 (0.83–1.13)	0.13 (0.04–0.44)	1.25 (1.11–1.41)	1.26 (1.06–1.49)
Shelter	1.51 (0.61–3.71)	0.64 (0.45–0.93)	1.14 (0.83–1.57)	0.65 (0.37–1.13)	1.36 (0.48–3.82)	0.59 (0.37–0.95)	0.65 (0.36–1.15)
Mode of arrival							
Other	1	1	1	1	1	1	1
Ambulance	2.54 (1.63–3.97)	0.69 (0.63–0.74)	1.09 (0.93–1.24)	0.68 (0.59–0.77)	2.32 (1.32–4.10)	0.86 (0.77–0.96)	0.58 (0.50–0.67)
Hospital							
Not specialized	1	1	1	1	1	1	1
Specialized in psychiatry	1.71 (1.06–2.74)	NA	1.38 (1.15–1.66)	NA	3.23 (1.19–8.73)	1.81 (1.48–2.20)	2.90 (2.04–4.13)

[a]Includes physical (Argentino, Pinel), chemical (lorazepam, haloperidol, ketamine, midazolam, etc), and isolation room.
[b]Includes death in emergency department.
Abbreviations: CI = confidence interval, RR = relative risk.

Table 4.

Adjusted Relative Risk of Selected Diagnostic Impressions/Clinical Manifestations According to Age Group, Sex, Residence, Mode of Arrival, and Type of Hospital

	Neurocognitive disorders N = 532 RR (95% CI)	Mood disorders N = 422 RR (95% CI)	Anxiety disorders N = 271 RR (95% CI)	Personality disorders N = 231 RR (95% CI)	Schizophrenia and psychotic disorders[a] N = 322 RR (95% CI)	Substance use disorder N = 231 RR (95% CI)	Suicidal ideation N = 683 RR (95% CI)
Age							
65–74 y	1	1	1	1	1	1	1
75–84 y	2.59 (2.15–3.12)	1.20 (1.02–1.43)	1.07 (0.84–1.35)	0.56 (0.42–0.76)	0.93 (0.73–1.17)	0.35 (0.23–0.52)	0.93 (0.82–1.06)
≥ 85 y	3.37 (2.77–4.12)	0.88 (0.62–1.18)	0.77 (0.53–1.09)	0.19 (0.09–0.39)	0.96 (0.71–1.31)	0.22 (0.10–0.48)	0.67 (0.54–0.85)
Sex							
Female	1	1	1	1	1	1	1
Male	1.16 (1.01–1.32)	1.08 (0.92–1.26)	0.63 (0.50–0.79)	0.63 (0.49–0.82)	0.81 (0.66–0.99)	1.54 (1.19–1.99)	1.11 (0.99–1.24)
Residence							
Home	1	1	1	1	1	1	1
Senior housing	1.59 (1.37–1.85)	0.85 (0.70–1.04)	NA	1.06 (0.80–1.41)	1.37 (1.09–1.72)	0.44 (0.29–0.66)	0.83 (0.73–0.95)
Shelter	0.39 (0.16–0.92)	0.21 (0.08–0.63)	NA	1.16 (0.59–2.26)	1.05 (0.60–1.83)	1.22 (0.71–2.09)	0.78 (0.55–1.23)
Mode of arrival							
Other	1	1	1	1	1	1	1
Ambulance	1.23 (1.04–1.46)	0.53 (0.45–0.62)	0.46 (0.37–0.57)	0.92 (0.72–1.18)	0.54 (0.44–0.65)	1.71 (1.28–2.30)	1.02 (0.91–1.15)
Hospital							
Not specialized	1	1	1	1	1	1	1
Specialized in psychiatry	1.13 (0.96–1.33)	3.09 (2.11–4.52)	0.86 (0.65–1.12)	6.99 (3.07–15.96)	1.99 (1.38–2.85)	1.26 (0.86–1.84)	4.71 (3.29–6.73)

[a]Includes substance-induced psychosis and hallucinations.
Abbreviations: CI = confidence interval, RR = relative risk.

DISCUSSION

This study aimed to describe and explore the characteristics, clinical trajectories, and disposition of older adults consulting in the ED for mental health issues. Although individuals aged 65–74 years represented over half of the cohort, almost 1 out of 3 patients were aged 75–84, and nearly 1 out of 5 were 85 years or older. Most of our patients had a history of mental health issue, with 1 out of 5 patients suffering from chronic alcoholism.

Patients aged ≥85 years consulting for mental health issues were at a higher risk of being restrained while in the ED. However, they were less likely to receive assessments from psychiatrists or psychiatry/mental health nurses. These findings are worrisome and should prompt a reflection on the quality of care these older adults should be entitled to while in the ED. They also highlight the need to explore potential alternative approaches to restraint use in this population, especially considering the higher risk of functional decline, falls, longer length of stay, and mortality associated with restraints.[15,16]

The observed discharge rates in our study were similar to those previously reported.[17] Considering the high rate of return to the ED for mental health issues, this may impact the health care system and the well-being of these patients.[9] Although patients aged 75–84 years and those aged ≥85 years were more likely to be admitted to a hospital ward, most of these admissions were not related to their mental health issues.

Two out of 5 older adults presented with suicidal ideations, and this was the most frequent diagnostic impression/clinical manifestation and the second most frequent reason for consultation. This is also highly concerning and supports other findings regarding the prevalence of suicidal disorders in this population.[18] Like other authors, our results suggest that the prevalence of suicidal ideation decreases with advancing age.

Neurocognitive disorders were the second most important clinical manifestation in our study, whereas this diagnosis was the most prevalent in a similar study.[17] This slight difference could perhaps be explained by a potential selection bias generated by the triage process. In fact, patients were included in our database only if the triage nurse considered the main complaint to be psychiatric, thus excluding the other patients from the CHIRPP database. As expected, the prevalence of neurocognitive disorders increased with patient age and was also more prevalent among people living in senior housing.

Clinical manifestations of substance use disorders were not as prevalent as expected in this population, whereas, in similar studies, this diagnosis was among the most frequent.[17,19] Disparities between these results may be explained by our study design dividing the clinical manifestations into 15 different diagnoses, while the other studies had only 4 to 6 different psychiatric diagnoses. In a recent Canadian prospective cohort study conducted in 8 EDs, 6.4% of older adults self-reported drug or alcohol misuse.[20]

This study has some limitations. Its retrospective design may have affected the accuracy of data collection, as some relevant clinical data may be missing from patient records. Moreover, the short length of stay and evaluation in the ED is often insufficient to establish a formal mental health diagnosis. We recognize that some of these diagnoses require in-depth psychiatric assessment. Therefore, the diagnostic impressions/clinical manifestations may not always reflect a precise diagnosis. Moreover, neurocognitive disorders and delirium are more and more separated from mental health issues and are considered geriatric issues.

However, each file was carefully assessed, and the diagnostic impressions/clinical manifestations were reclassified as closely as possible to the *DSM-5* categories.[13] In addition, the CHIRPP data extraction is performed by highly trained and experienced medical archivists and subjected to rigorous data quality validation by the local program coordinator. This may minimize the above limitations. A significant strength of this study is its large sample size and the fact that it included ED consultations from the 5 largest hospitals in Quebec City, including the only 2 hospitals with a psychiatric ED. Therefore, we believe our results are representative of the population of interest. Lastly, the fallout from the COVID-19 pandemic may have impacted the care trajectory and may have contributed to an increase in the incidence and severity of mental health issues in Canada, given the reduction of ED visits during this period and the restrictions that were put in place.[21]

Clinical and Research Implications

These findings emphasize the gaps in the organization of care offered to older adults suffering from mental health issues. Providing specific training for emergency physicians in screening and diagnosing mental health issues and adding an ED psychiatrist could be potentially explored. Implementing community-based support programs for older adults with mental health issues may also improve access to resources and encourage seeking help. Additionally, revising or implementing protocols to prevent the misuse of restraints in this age group may be beneficial.

CONCLUSION

Mental health issues are common among older Canadians and make up about 3% of ED visits for this group. Most older ED patients consulting for mental health issues had a prior history of such issues. Even though a psychiatrist assessed 52% of older adults presenting for mental health conditions, those aged ≥85 years were less likely to be assessed by a

psychiatrist or be hospitalized. Restraint use was more frequent in patients aged ≥85 years. As mental health issues become more widespread, they are now becoming a front-line issue, and improving ED health services is of utmost importance. Clinicians and health administrators should consider our findings when creating specific research or care plans to better address the diverse needs of this vulnerable population.

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