Psychiatry teaching service in the United States goes back at least 50 years, and there is some record of that as early as 1968. A specific group of patients, pejoratively referred to as frequent flyers, and more correctly as high utilizers, represents a subpopulation with repeat emergency department (ED) resource use and marked non-adherence to treatment recommendations. Most medical professionals agree that we should avoid using the term frequent flyers, as not only is it derogatory, but it clearly does not depict even the time spent on these patients. Most high utilizers may be homeless, abuse substances, have personality disorders, have developmental delays, be enrolled in a mental health plan, have unreliable social support, and may have a lifetime history of incarceration. They account for approximately one-quarter of all ED visits and use a disproportionate high share of resources. Frequent utilizers are of great concern to EDs, hospitals, and health care systems at large.

A substantial number of patients with mental illness present to EDs for treatment and their numbers are continuing to rise. Among these patients, the most common are those with substance use disorders, but there are also includes patients with suicidal ideation or those who have already attempted suicide or suffer from psychosis, altered mental status, or acute anxiety disorders. Among the patients with substance use disorders, although “traditional” drugs of abuse (alcohol, marijuana, cocaine) continue to predominate, there are an increasing number of patients who present intoxicated on “designer drugs,” which are much harder to detect. Overall from 1992 to 2001, 53 million visits to EDs in the US were made primarily for mental health-related reasons. The most common diagnoses were substance-related disorders (30%), mood disorders (23%), and anxiety disorders (21%). These three along with psychosis (10%) and suicide attempts (7%) accounted for 79% of all psychiatric ED visits. The most common methods of suicide include firearms (50%), suffocation (27%), and poisoning (15%). Assessment of ED visits for suicide attempts between 2006 and 2013 in the US showed a higher number of patients (male and female) between ages 15 and 19 years with a mean age of 33 years at presentation; seasonal variation was also noted with a late spring peak. Over two-thirds of the patients had a pre-existing mental disorder. Mood disorders are most prevalent in these patients, followed by substance use disorders and anxiety disorders.

According to the Centers for Disease Control and Prevention, there were 42,773 suicides reported in the US in 2014 (a rate of 13.4 per 100,000), which represent a 24% increase since 1999. Suicide was the third leading cause of death among people between ages 10 and 14 years, and the second leading cause of death among people between ages 15 and 34 years.

Sometimes a patient might present to the ED with exaggerated or feigned symptoms of a psychiatric disorder to obtain an external benefit. ED psychiatrists may grapple with this condition, most commonly known as malingering or secondary gain, when inpatient hospitalization is viewed as a means to stable, even if temporary, housing. Most ED psychiatrists have limited resources and want to allocate these resources, including inpatient psychiatric beds, responsibly and use them for the most severely mentally ill patients. Hospitalization for psychiatric illness has undergone tremendous changes in
the past few decades. Outpatient management or institutionalizations are no longer the only options; patients with psychiatric illness now have many treatment options depending on medical need, including intensive outpatient programs. Hospitalization commonly occurs for patients who engage in self-harm in the form of suicidal ideation, with an imminent plan or actual lethal attempt. Inpatient care is also considered for patients with acute mania or psychosis.

This issue of Psychiatric Annals focuses on the challenges of avoiding inpatient hospitalizations as they do not offer much more than a safer environment and social support. The focus should be on intermediate care as well as intensive outpatient programs and partial hospitals.

**REFERENCES**


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Asim A. Shah, MD, is a Professor and the Executive Vice Chair in the Menninger Department of Psychiatry and Behavioral Sciences, and a Professor in the Department of Community and Family Medicine at the Baylor College of Medicine. In September 2016, Dr. Shah was appointed as the Inaugural Vice Chair for Community Psychiatry, which has now become the Division of Community Psychiatry under his leadership as its Chief at Baylor. Dr. Shah also serves as the Chief of Psychiatry and the Executive Director of Psychotherapy Services at Harris Health System & Ben Taub Hospital and as the Director of Community Behavioral Health Program for Harris Heath System. He is also the Director of the Mood Disorder Research Program at Ben Taub Hospital, and has done numerous studies on treatment-resistant depression, ketamine, and novel pharmacological interventions.

In 2017, Dr. Shah was appointed to serve as the board director in June for Mental Health America and was named a Castle Connolly Top Doctor of Houston and one of Houstonia magazine’s Top Doctors for 2013 to 2017. He has participated in numerous national and international television and print media on a wide range of clinical and public health topics. He has received two Fulbright and Jaworski Awards, one for Teaching and Evaluation in 2012 and the second for Educational Leadership in 2014. He also received the Rising Star Clinician Award from Baylor in 2014. He won the faculty of the year award in 2013 from Baylor’s psychiatric residency program, and in 2014 from Baylor’s Psychology Internship Program.

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