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Abstract

The article by Boudreaux et al. [1] in the current issue regarding the prevalence and interest in treatment for mood disorders among ED patients raises several important concerns for acute care providers and for the health care system as a whole.

Hospital emergency departments (EDs) have increasingly become a location in which mental illness first presents [2]. The result is that identification, diagnosis and referral for mental health symptoms rests, not infrequently, with ED physicians. However, neither the training of emergency physicians nor the needed support infrastructure of psychiatric and social services has kept up with national trends, leaving ED providers poorly prepared and under-resourced for the task.

Comments

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Mood disorders in the emergency department: the challenge of linking patients to appropriate services

The article by Boudreaux et al. [1] in the current issue regarding the prevalence and interest in treatment for mood disorders among ED patients raises several important concerns for acute care providers and for the health care system as a whole.

Hospital emergency departments (EDs) have increasingly become a location in which mental illness first presents [2]. The result is that identification, diagnosis and referral for mental health symptoms rests, not infrequently, with ED physicians. However, neither the training of emergency physicians nor the needed support infrastructure of psychiatric and social services has kept up with national trends, leaving ED providers poorly prepared and under-resourced for the task.

Between 1992 and 2000 there was an increase of 15% in ED mental health visits. At that time, primary mental health concerns accounted for approximately 5.5% of all ED visits with the admission rate for psychiatric conditions being higher than for nonpsychiatric diagnoses. Several authors have noted that increasing barriers to outpatient mental health care have resulted in an increase in use of EDs as sites of care for the evaluation of a variety of mental health complaints [3]. In 2000, Hazlett et al. [4] predicted that this trend would continue to increase as a result of changes in “financing and delivery of mental health care in the United States.”

Seven years after the article of Hazlett et al. [4], the multi-site ED study by Boudreaux et al. [1] lends support for their prediction. In the Boudreaux et al. study, 34% of ED patients at four Boston area hospitals screened positive for symptoms of depression using a validated screening tool. While symptoms of depression are not comparable to a diagnostic interview, this still must be viewed with concern, given national 12-month prevalence rates of 5% to 9% for major depression in community and primary care samples [5].

The psychosocial complexities and co-morbid conditions that Boudreaux et al. [1] found to be associated with screening positive for a mood disorder in the ED further highlight the growing disparities in accessible mental health resources for the poor. The authors found that low income, cigarette smoking, having a chronic health condition and a substance abuse history were all strongly associated with

depressed mood. This, along with the fact that 76% of patients with depressed mood had a history of one or more ED visits in the last 6 months, indicates that ED providers will continue to have multiple opportunities to screen and intervene with these patients; hopefully, the multiple ED visits will not all be “missed opportunities”.

It is important to consider the possibility that unless depression or suicidal ideation is the chief complaint, it will rarely be detected in the ED without routine screening. While a thorough medical history is expected to uncover underlying mental health problems, ED physicians often lack the time or ability to take comprehensive medical histories [6,7]. So despite the changing face of mental health care delivery in the United States, ED physicians may fairly claim that the ED is not an ideal place to provide mental health care. Nonetheless, given the high prevalence rates of mood disorders and patient interest in treatment, this attitude may need to be reconsidered. Extending other work that finds high ED patient need and desire for mental health care services [8–10], Boudreaux et al. [1] found that 50% of patients with depressed mood were interested in an ED-initiated intervention and 25% wanted a timely referral to a mental health provider.

It is of interest that 30% of depressed patients in the Boudreaux et al. [1] study had already seen a mental health provider in the prior 6 months — and this was the group most likely to indicate an interest in on-site mental health care and/or referrals to another mental health care provider. While this deserves further study, it may indicate that many ED patients are either dissatisfied with the mental health services that they have access to or that the community-based mental health services that exist to serve indigent patients are at full capacity and can only provide variable or erratic access to care.

As the primary safety net for large numbers of uninsured and underinsured patients, EDs see a disproportionate share of patients with Medicaid or no insurance coverage who are increasingly barred from care elsewhere [11,12]. ED patients with mood disorders are generally viewed as a separate category of patients [4,12], in spite of the fact that individuals suffering from depression, mania or anxiety often present with somatic complaints [13]. Although

psychiatric patients with Medicaid or no insurance coverage are less likely to be admitted for inpatient treatment than privately insured psychiatric patients, they will continue to present in high numbers to EDs with both psychiatric and somatic complaints [4,11,12]. Indeed, psychiatric and somatic complaints are often related and medical costs are significantly higher among primary care patients with depression than those without [14]. In addition, greater levels of psychological distress have been found in “high utilizers” of health care [15].

While a number of studies have documented the high degree of ED utilization by patients with mood disorders, particularly those with co-morbid psychosocial conditions [16–18], there have been few assessments of the outcomes for such patients. The US Preventive Services Task Force’s evidence-based evaluation concluded that screening for depression in primary care “can improve outcomes, particularly when it is coupled with system changes that ensure adequate treatment and follow up” [13]. Strengthening relevant implications from the Boudreaux et al. [1] report are two very recent studies focused on outcomes after an ED visit for suicidal behavior, a retrospective study by Crandall et al. [19] found a six- to sevenfold increase in the relative risk of subsequent suicidal mortality in ED patients presenting with suicidal behavior. By contrast, Brown et al. [20] found significant improvements in depressive symptoms and less repeat suicide attempts in an intervention group receiving cognitive behavioral therapy compared to those assigned to “usual care” for suicidal patients referred from the ED for after a suicide attempt. The Boudreaux et al. study therefore adds to a developing body of evidence supporting the very real need but also the potential to improve our response to major depression in the ED setting.

Boudreaux et al. [1] point out that a great deal of depression among their patients was associated with chronic disease. Primary care providers might reasonably be expected to address mood disorders associated with chronic disease with psychiatric backup for more severe cases, but emergency providers have neither the training nor the time to do more than identify and refer these patients. So if we are to do routine screening for mood disorders in the ED, we will need to consider the sorts of system changes that will be needed to increase on-site intervention/referral at the time of the ED visit. The authors begin this discussion by calling for various provider and patient educational interventions designed to link psychiatric patients with chronic care resources rather than encouraging the creation of standalone ED interventions. Integrated into these interventions will need to be system strategies to prevent high-risk (i.e., potentially suicidal or homicidal) patients from “falling between the cracks.”

In one study of completed suicides, nearly 75% had seen a medical professional within the last year of their life, but less than a third had received mental health treatment during that same year [21]. It is of interest that many of the patients in the Boudreaux et al. [1] study who favored ED-initiated care

did not express interest in a referral to a mental health provider. Perhaps these represent patients who prefer to have their mood disorders addressed in the context of their regular medical care, as opposed to receiving care in a mental health setting. This may be due to perceived stigma associated with mental illness. Sirey et al. [22] suggest that medical clinicians can be instrumental in reducing psychological barriers to mental health care.

However, it will not be enough to motivate ED patients to follow up with mental health referrals given the access barriers faced by the poor and underinsured with complex psychosocial issues. This is not a patient population that will be able to advocate for themselves. So the challenge facing health care providers and policy makers alike is to improve coordination between medical and mental health systems so as to improve identification and response to this vulnerable population.

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