Selected Highlights of Research Findings Relevant to Mental Illness and Emergency Department Use

Consumer Perspective/Diagnostic Overshadowing

Individuals with mental illness commonly report their physical symptoms being misattributed to mental illness, a phenomenon known as ‘diagnostic overshadowing’. (Thornicroft, 2006)

The term 'diagnostic overshadowing' was first used in 1982 to refer to the tendency for clinicians to attribute symptoms or behaviors of a person with learning disability to their underlying cognitive deficits, suggesting different clinical decision-making for different patient groups. (Reiss, Levitan & Szyszko, 1982)

Mental Illness Associated with Co-Morbidity, Disability and Increased Mortality

In 2010, 34 million adults, or 17% of American adults, had co-morbid mental health and medical conditions. Twenty-nine percent of adults with medical conditions also have mental health conditions; sixty-eight percent of adults with mental health conditions also have medical conditions. (Druss & Walker, 2011)

A study of the joint effect of mental and physical conditions on the probability of severe disability finds that persons with mental disorders are more likely to be severely disabled than those with physical conditions, and those with co-morbid mental and physical conditions are more likely to be severely disabled than those with either condition alone. The authors conclude that clinicians “need to accord both mental and physical conditions equal priority, in order for co-morbidity to be adequately managed and disability reduced.” (Scott et al., 2009)

Individuals with severe and persistent mental illness have higher mortality rates compared with the rate in the general population. (Felker, Yazel & Short, 1996)

Individuals with severe mental illnesses, such as schizophrenia, bipolar disorder, and treatment refractory depression, have high rates of premature death, dying as much as 15 to 25 years younger than the general population. (Brown, 1997; Hansen, Jacobsen & Arnesen, 2001; Colton & Manderscheid, 2006; Saha, Chant & McGrath, 2007)

In addition to mood disorder, chronic illness is a significant risk factor for both suicidal ideation and suicide attempts. Patients with depression are at high risk for suicidal ideation, and patients with depression and comorbid chronic medical conditions are at especially high risk. (Brown, Khan & Mahadi, 2000; Druss & Pincus, 2000; Goodwin, Kroenke et al, 2003; Goodwin, Marusic & Hoven, 2003)

Chronic illness is estimated to be involved in up to 25% of all suicides. (Mosicki, 1995)

The higher mortality rate found for persons with serious mental illness such as schizophrenia or a major mood disorder is only partially explained by higher rates of suicide. (Harris & Barraclough, 1998)

People with mental illness have significantly higher medical co-morbidity and die prematurely compared to the general population. Increased risk of premature death both from natural and unnatural causes has been reported for all common mental disorders. (Harris & Barraclough, 1998)

Individuals with mental illness die younger than people without such diagnoses, but from the same leading causes of death as occur nationwide, such as heart disease and cancer. (Colton & Manderscheid, 2006)

Treatment for Mental Illness is Effective; Recovery is Possible

In contrast to what many people think, mental disorders are treatable, though the effectiveness of treatment varies depending on the disorder and the target population. Moreover, for most mental disorders, there is
generally not just one but a range of treatments of proven efficacy. (U.S. Dept. of Health and Human Services, 1999)

The treatment success rate for a first episode of schizophrenia is 60 percent; for major depression, the success rate is 65 to 70 percent; and for bipolar disorder, the success rate is 80 percent. (National Mental Health Advisory Council, 1993)

Treatments for mental illness are at least as successful as the treatments for many physical illnesses, such as heart disease. (Mental Health America)

Not all mental illnesses diagnosed in childhood or adolescence persist throughout adulthood—many individuals recover and complete school, work and raise families just as individuals without a mental illness do. (U.S. Dept. of Health and Human Services, 1999)

**Persons with Mental Illness Face Disparities in Treatment for Medical Illness**

People diagnosed with schizophrenia have higher cardio-vascular disease (CVD) morbidity and mortality rates, yet basic monitoring and treatment of CVD risk factors in patients with severe mental illness falls far short of that for the general population in most respects. (Nasrallah et al., 2006)

Among Medicare beneficiaries hospitalized in 1994–1995 with acute myocardial infarction, there was a substantial difference in the quality of clinical treatment provided to patients with and without mental disorders. Differences in treatment quality seemed to explain a substantial portion of the excess mortality associated with mental disorders. Excess mortality in patients with mental disorders was found primarily in patients who did not receive the cardiac guideline-based interventions. (Druss, Bradford et al., 2001)

**Providing Care to Persons with Mental Illness in the Emergency Department**

Patients with a mental health or substance abuse (MHSA) diagnosis accounted for 12.5 percent of all ED visits in the U.S. in 2007— one out of every 8 ED visits. Mood disorder was the most common MHSA reason for an ED visit (43%), followed by anxiety disorders (26%), and alcohol-related conditions (23%). MHSA-related ED visits were two and a half times more likely to result in hospital admission than ED visits related to other conditions—nearly 41 percent of MHSA-related ED visits resulted in hospitalization. (Owens, Mutter, & Stocks, 2010)

The number of patients with mental health and substance abuse conditions who are treated in emergency departments has been rising for more than a decade. (Larkin, Claasen, Edmond et al., 2005)

The median length of stay for mental health visits (169 minutes) significantly exceeded that of other visits (108 minutes). The odds of an extended stay (i.e., beyond 4 hours) for mental health visits is almost twice that for other visits. (Case, Case, Olfson, Linakis & Laska, 2011)

From 2000–2007, visits to emergency departments by patients with mental disorders increased by 131 percent. Patients having psychiatric emergencies wait more than 11 hours on average when seeking care. Overall, these patients wait approximately 42% longer in the ER than other emergency patients. The need for inpatient admission was the factor most associated with length of stay in the ED. (Weiss et al., 2012)

From 2001–2006, the duration of all ED visits increased at an annual rate of 2.3%. The rate of increase for mental health and non-mental health visits was similar, but the average duration of mental health visits exceeded the duration of non-mental health visits by 42%. This difference was related to the greater likelihood of mental health visits ending in transfer. The longer visits for certain groups of mental health patients suggest that emergency departments incur higher costs in connection with the delivery of services to person in need of acute stabilization. (Slade, Dixon, & Semmel, 2010)

A 2008 ACEP survey of Emergency Department directors reported that patients with mental health and substance abuse conditions not only have had increased ED boarding times, but also that the resource-
intensive care required for these patients has an impact on the quality of care for other patients in the ED. (ACEP, 2008)

Members of the emergency medicine community are concerned that ED overcrowding results in decreased quality of care and increased likelihood of medical error. (IOM, 2004)

DeLia and Cantor (2009) provide a helpful summary of research on ED overcrowding, and the extent to which this is related to increasing psychiatric visits. The authors make the following relevant points:

- So-called ‘frequent’ or ‘heavy’ users of the ED are not necessarily using the ED inappropriately, as these patients typically have significant physical and/or mental health needs or face barriers to receiving other medical care. Patients with frequent ED use have higher-than-average utilization of other health services as well.

- Inability to move admitted patients from the ED to the appropriate inpatient unit stands out as a major driver of ED overcrowding.

- Although many clinicians believe the growth in psychiatric ED visits is a contributor to ED overcrowding, no studies have quantified this association.
  - ED visits for patients with psychiatric diagnoses are growing faster than ED visits overall, but psychiatric patients still account for a modest share of total ED volume overall (5-8 percent).
  - Still, the increasing growth in ED visits by psychiatric patients concerns some ED clinicians, who describe these patients as time-consuming, difficult to care for, and disturbing to other patients.
  - ED overcrowding is associated with reduced access in the form of longer waiting times for care, patients leaving the ED without being seen, and disruptions to ambulance service.
  - Current reimbursement incentives often stand as barriers to improving efficiency. The ability of specialist to earn higher fees in other settings makes it difficult to maintain specialty coverage in the ED.

- Several studies show connections among frequent ED use, ED overcrowding, and patients who require, but do not receive, mental health services outside of the ED. These studies, however, do not provide detail on the extent to which greater availability of mental health services would affect ED utilization and overcrowding or reduce stress on ED personnel.

Another useful summary of the issues comes from the National Association of State Mental Health Program Directors (2006), as follows:

- Individuals with serious mental illness die, on average, 25 years earlier than the general population. While suicide and injury account for about 30-40% of excess mortality, 60% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary and infectious diseases.

  People with serious mental illness also suffer from a high prevalence of modifiable risk factors, in particular obesity and tobacco use. Compounding this problem, people with serious mental illness have poorer access to established monitoring and treatment guidelines for physical health conditions.

- Among persons with SMI, the “natural causes” of death include cardiovascular disease, diabetes (including related conditions such as kidney failure), respiratory disease (including pneumonia, influenza), and infectious disease (including HIV/AIDS).
The rates of mortality from these diseases for the SMI population are several times those of the general population.

- Druss suggests that having SMI may be a risk factor and lead to problems in access to health care because of:
  - Patient factors: Amotivation, fearfulness, social instability
  - Provider factors: Competing demands, stigma
  - System factors: Fragmentation

- He also provides examples of Overuse, Underuse, and Misuse (Three Types of Poor Quality, Chassin 1998) of services related to the population with SMI:

  Overuse:
  - Persons with SMI have high use of somatic emergency services (Salisberry et al 2005, Hackman et al 2006)

  Underuse:
  - Fewer routine preventive services (Druss 2002)
  - Lower rates of cardiovascular procedures (Druss 2000)
  - Worse diabetes care (Desai 2002, Frayne 2006)

  Misuse:
  - During medical hospitalization, persons with Schizophrenia are about twice as likely to have infections due to medical care postoperative deep venous thrombosis and postoperative sepsis (Daumit 2006)

REFERENCES


