An Issue of Equity of Care: Psychiatric Patients Must Be Treated "On Par" With Medical Patients

Emergency departments across the country are seeing a significant increase in the number of psychiatric patients presenting for treatment (1). From 1992 to 2001, emergency departments recorded some 53 million mental health-related visits, which reflects an increase from 4.9% to 6.3% of all emergency department visits for that period and an increase of 17.1 to 23.6 visits per 1,000 in the population. There are many reasons for this increase, including closures of inpatient psychiatric beds, reductions in the number of outpatient services, and limited availability of psychiatric personnel in the community.

Psychiatric patients are not usually viewed in the same light as nonpsychiatric patients in emergency departments. Staff frequently express their displeasure with care for this patient population, and this displeasure may affect the patients' outcomes. Negative attitudes about psychiatric patients can compromise emergency physicians' and nurses' ability to properly evaluate and treat them and may even have adverse effects on patient outcome. Suicidal behavior appears to elicit mostly negative feelings among staff members (2).

These factors have contributed to the belief that psychiatric patients are not treated "on par" with other patients seen in the emergency department. This difference is reflected in how the patients are triaged, assessed, treated, boarded, and referred. It is important to understand each of these inequities in order to comprehend what needs to be done.

If an emergency medical services call notifies the emergency department that a patient with an acute myocardial infarction will arrive in 5 minutes, it will take less than that time for a "code heart" to be called, with a rush to the emergency department of cardiac resources, including a cardiologist and others to assist in the care of the patient. The same is true for patients with stroke symptoms; a code is called, and neurology and other services are ready when the patient arrives. When an acute psychiatric patient comes to the emergency department, rarely is there any preparation before the patient's arrival. Acute agitation is an acute emergency and demands immediate intervention to control symptoms and to prevent injury to the patient and staff (3). There may be a request to have security personnel present to restrain the patient on arrival. There is no code to provide an immediate response from a psychiatrist, psychiatric nurse, or social worker to attend to the patient's needs. There is no readying of equipment and supplies to reduce the patient's level of agitation. A study from Australia describes such a code (4), where a senior physician and nurse in the emergency department, a hospital nurse manager, a psychiatric clinical nurse, and security staff respond and are prepared for the incoming psychiatric emergency.

When patients with medical complaints present to the emergency department, an extensive assessment is conducted to determine the cause of their problem and to direct treatment. Patients with psychiatric presentations may not receive a

comparable evaluation to determine the cause of their symptoms. An appropriate assessment is performed to determine whether the patient has a medical problem causing the psychiatric symptoms and to identify patients with treatable causes such as delirium. Studies have demonstrated that emergency physicians not only do not perform a complete evaluation of the psychiatric patient but also do poorly in documenting the evaluation that occurred (5). Rarely is a complete assessment of the psychiatric patient's mental status or cognitive abilities performed and documented.

The Joint Commission and other regulatory agencies have mandated that the evaluation and treatment of pain starts at triage, where emergency department staff must assess a patient's pain using a verbal scale and provide pain treatment, which may include an oral or an injectable agent. It is thought that a psychiatric patient's agitation is an expression of their psychic discomfort. Agitation can be easily measured, and this can be used to determine the appropriate treatment. After triage, the choice of agents used to treat a patient's agitation is best directed at the underlying etiology (6). Most emergency departments give patients a standard dose of an antipsychotic agent together with a benzodiazepine, without regard to the level of agitation or the underlying psychiatric illness.

In a survey of the availability of psychiatric consultations in the state of California, Baraff et al. (7) found that the lack of availability of a psychiatrist or psychiatric services results in the premature discharge of patients from the emergency department and delay of appropriate disposition. The study found that 23% of the reporting emergency departments send patients home without seeing a mental health professional because of a lack of resources. Emergency physicians would never send home a patient who had a significant medical illness because they were unable to locate a cardiologist or neurologist. Telepsychiatry can provide this needed service when the psychiatric service is unable to evaluate a patient.

Patients with chest pain, asthma, pneumonia, or abdominal pain receive ongoing care while they are waiting for their bed. Patients with a psychiatric illness waiting for a bed are frequently placed in restraints and sedated.

Analogous to obtaining a consultation while the patient is in the emergency department, it is rare to send a patient out of the emergency department without appropriate follow for care in the community. However, patients who are psychiatrically ill frequently do not receive appropriate discharge referrals. It is uncertain whether this is due to the lack of resources, lack of patient funding sources, or emergency physicians' lack of knowledge of alternative resources in the community. Many areas have community mental health facilities, respite care, crisis management, and mobile outreach teams.

The boarding of psychiatric patients is another issue of concern. One study has shown that psychiatric boarders have significantly longer stays and cost hospitals more (in losses compared with nonpsychiatric admissions) than do nonpsychiatric boarders (8). In a survey of hospital administrators, more than 90% of respondents said that psychiatric boarding reduces the availability of emergency department beds (9). Some hospitals have placed psychiatric inpatients from the emergency department onto inpatient medical services (10). The Joint Commission has added a standard to address the care of psychiatric patients boarded in the emergency department (standard LD.04.03.11), requiring that hospital leaders

communicate with behavioral health care providers serving the community to foster coordination of care for this patient population.

As boarders in the emergency department, these psychiatric admissions are treated differently than other boarded emergency department patients. Patients with chest pain, asthma, pneumonia, or abdominal pain receive ongoing care while they are waiting for their bed. Patients with a psychiatric illness waiting for a bed are frequently placed in restraints and sedated. Few emergency physicians treat the underlying psychiatric disorder while the patient is waiting for a bed. Many emergency physicians are uncomfortable prescribing psychotropic agents. It is noteworthy that emergency physicians initially had a similar discomfort with using thrombolytics to treat patients with an acute myocardial infarction or a stroke. They have no such discomfort today, however, and they no longer have to wait for a cardiologist or neurologist to approve or administer thrombolytics.

Focused emergency care has been developed and implemented for other patient populations and for specific disorders but not for psychiatric patients. We have focused on the care of the pediatric patient, with emergency medical services for children and emergency departments approved for pediatrics certification; trauma patients, with advanced trauma life support and trauma center designations; chest pain, with treatment guidelines and chest pain centers; and strokes, with treatment protocols and stroke center designation.

The argument for disparity in the care of the psychiatric patient in the emergency department has been made, but the solution is elusive. It is uncertain whether the reason for the disparity is a dislike of or lack of interest in this patient population, a lack of education, or a lack of research and evidence-based evaluation and treatment. Studies have demonstrated that many emergency department treatment staff have negative feelings about the care of these patients, and this may be due largely to a lack of psychiatric education and training. One study (L.V. Downey et al., unpublished 2013 manuscript) has found that there is a lack of research and publications in the area of behavioral emergencies, both in the emergency medicine literature and, to a lesser extent, in the psychiatric literature. Reports have also demonstrated a deficiency in funding, by both governmental and private sources, of research in the area of psychiatric emergencies. There is a lack of training and education on behavioral emergencies. Few residency programs have a rotation in emergency psychiatry, and little attention is given to this patient population at national conferences. There are joint fellowships in emergency medicine with areas such as critical care and pediatric emergency medicine, but no joint training with psychiatry in psychiatric emergencies. Only good research, proper education, and extensive experience can provide this sense of comfort with sending home patients with chronic suicidal ideation, writing prescriptions for psychotropic agents, or directing patients to alternative care, such as residential crisis units, instead of inpatient care.

There are many recommendations to resolve this disparity in emergency medicine. Emergency physicians need to enhance their skills and abilities to care for this patient population, as was done when thrombolytic therapy was added to the emergency physician's arsenal. We need to place emergency medicine residents in rotations in psychiatric emergency services and to dedicate conferences to this topic. Resources need to be expended for research in the assessment and treatment of patients with behavioral emergencies. Emergency medicine must develop and adopt evaluation and treatment protocols and consider the designation of behavioral emergency centers. Following the example of insurance companies being required to provide equitable reimbursement for medical and psychiatric conditions, we too

must treat these patients with the same enthusiasm and dedication as we devote to all others.

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