MENTALLY ILL INDIVIDUALS USE OF EMERGENCY DEPARTMENTS

FLORIDA COUNCIL FOR COMMUNITY MENTAL HEALTH

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• In 2003, the Subcommittee on Acute Care to the President’s New Freedom Commission reported on “communities where emergency departments are overwhelmed with patients in extreme psychiatric distress who have nowhere else to go.” (President’s New Freedom Commission on Mental Health, 2003)

• Several studies have identified particular social, clinical, and demographic characteristics which serve as predictors of repeat psychiatric emergency use. Younger, non-White, unemployed, and unmarried males have the highest rates of repeat use, with homelessness serving as a strong indicator of high utilization. (McNeil et al., 2005)

• These individuals typically have a history of psychotic disorder or schizophrenia, substance abuse, prior hospitalization and a need for medication. (McNeil et al., 2005)

• A study conducted in Washington noted that 56 percent of individuals who visited the ED 31 times or more in a year had diagnoses of both alcohol or drug disorder and mental illness. (Mancusco, David et al., 2004)

• Often the same psychiatric patients repeatedly return to the emergency room for care -- never obtaining the extent of the care that is needed. (American Medical Association, 2008)

• The involuntary commitment process usually involves law enforcement officers taking mentally ill individuals directly to the emergency department for evaluation, avoiding arrest. (Dupont, R., 2000)

• Currently under EMTALA, hospitals must screen and stabilize patients who present to the emergency department regardless of ability to pay. (HHS, 2008)

• The financial strain on hospitals is often cited as the primary reason for the closure of psychiatric units and the decline in the number of psychiatric inpatient beds nationally. (Kowalczyk, L., 2005)

• In one study, Medicaid patients had double the rate of psychiatric-related ED visits compared with the uninsured and almost eight times the rate of those privately insured. (APA, 2004)

• It has also been suggested that homeless and uninsured individuals represent a disproportionate share of psychiatric emergency services (PES) users. (McNeil et al., 2005)

• From 1992 to 2001, there were 53 million mental health-related visits, representing an increase from 4.9 percent to 6.3 percent of all emergency department visits and an increase from 17.1 to 23.6 visits per 1,000 U.S. population across the decade. The most prevalent diagnoses were substance-related disorders (22 percent of visits), mood disorders (17 percent), and anxiety disorders (16 percent).

• Mental health-related visits constitute a significant and increasing burden of care in U.S. emergency departments. (Larkin, L., M.D., 2005)

• Over the last few years, several incidents of patients waiting and even dying in the ED have prompted media coverage highlighting the crowding of EDs and the crisis in treatment of psychiatric patients. (American College of Emergency Physicians, 2008)

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Lack of mental health services in the community is placing an additional burden on Florida’s acute care hospitals and EDs. Since 1992, 36 psychiatric hospitals have closed in Florida, reflecting a loss of 4,430 psychiatric/substance abuse beds. (Florida Hospital Association, 2005)

Between 1995 and 2004, Florida’s acute care hospitals saw the number of psychiatric and substance abuse patients rise 59 percent. (Florida Hospital Association, 2005)

The volume of psychiatric admissions to acute care hospitals grew from 65,500 in 1995 to almost 104,000 patients in 2004. (Florida Hospital Association, 2005)

Florida’s emergency departments have felt a tremendous increase in psychiatric and substance abuse patients more than any area in the hospital. (Florida Hospital Association, 2005)

In 1995, less than half of the substance abuse patients and slightly more than one-third of the psychiatric patients were seen in the ED prior to admission. (Florida Hospital Association, 2005)

By 2004, almost three-fourths of the substance abuse patients and 60 percent of the psychiatric patients were first in the ED prior to admission. (Florida Hospital Association, 2005)
The financial strain on hospitals in caring for the uninsured and underinsured is often cited as the primary reason for the closure of psychiatric units and the decline in the number of psychiatric inpatient beds nationally. (HHS, 2008)

In the most widespread survey on psychiatric boarding to date, American College of Emergency Physicians found that roughly 80 percent of ED medical directors believed their hospital “boards” psychiatric patients in the ED. (ACEP, 2008)

In a 2007 American Hospital Association survey of hospital leaders, 42 percent of hospitals reported an increase in boarding behavioral health patients in the ED. (American Hospital Association, 2007)

While these surveys provide insight into the problem of psychiatric boarding, it is difficult to ascertain whether the problem is concentrated in specific geographic areas or is a nationwide issue.

The Subcommittee on Acute Care to the President’s New Freedom Commission reported in 2003 that the total number of inpatient psychiatric beds per capita had declined dramatically (62 percent) since 1970. (President’s New Freedom Commission on Mental Health, 2003)

Over this same period, state and county psychiatric hospital beds per capita decreased even more sharply (89 percent). (President’s New Freedom Commission on Mental Health, 2003)

The Committee concluded that the decline in the supply of most types of beds for short-term inpatient psychiatric care has led to a “serious disruption of the service delivery system in a substantial number of communities.” (President’s New Freedom Commission on Mental Health, 2003)

From 2000 to 2006, the percentage of cases presenting to the ED with a mental disorder as the primary diagnosis increased from 3.2 percent to 3.6 percent. (CDC, 2008)

Beginning in the 1960s, a trend toward placing psychiatric patients in outpatient and community-based treatment facilities, or “deinstitutionalization,” has resulted in a decrease in the number of inpatient and residential psychiatric beds for state and county mental health hospitals from approximately 400,000 nationwide in 1970 to 50,000 in 2006. (American Medical Association, 2008)

While this was partially offset by an increase of 50,000 private and general hospital psychiatric beds during this time, a large gap remains in the treatment of the mentally ill. (American Medical Association, 2008)

Psychiatric hospital closures and bed reductions nationwide have strained access to psychiatric acute care. (National Association of Psychiatric Health Systems, 2003)

The shortage of inpatient psychiatric beds is a nationwide occurrence, according to a survey by the ACEP. (American College of Emergency Physicians, 2008)

Further, in 2007, 42 percent of hospitals reported an increase in boarding behavioral health patients in the ED. (HHS, 2008)

More than 90 percent of medical directors indicated that they board psychiatric patients every week with more than 55 percent reporting boarding daily or multiple times per week. (HHS, 2008)

The mental health system suffers from significant capacity constraints for psychiatric inpatient services. Beginning in the 1960s, “deinstitutionalization,” defined as placing psychiatric patients in outpatient and community-based treatment facilities, has resulted in significant psychiatric bed shortages. (HHS, 2008)

Second, demand for psychiatric services is increasing. The annual number of ED visits (medical and psychiatric) from 1996 to 2006 has increased from 90.3 million to 119.2 million. (HHS, 2008)

There has been a “sharp increase” in the number of mentally ill persons coming to EDs between 1992 and 2000. (HHS, 2008)

A 2008 report by the American Medical Association (AMA) states that during the time of deinstitutionalization, necessary services and funding were not put into place for adequate community mental health services. (HHS, 2008)

While research has demonstrated that community-based approaches to treatment of mental illness yield high levels of success, the presence of community-based services continues to be limited. (Weithorn, L., 2005)

Care in the ED must be provided regardless of a patient’s ability to pay under the Emergency Medical Treatment and Labor Act (EMTALA) requirements. (HHS, 2008)