Evaluation of Depression and Suicidal Patients in the Emergency Room

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KEYWORDS

• Depression • Suicide • Emergency room • B-SAFE

KEY POINTS

- Depression is a significant source of disability.
- Suicide is a leading cause of death within the United States.
- It is essential that within the emergency room patients are screened for depression and suicide risk.
- The Basic Suicide Assessment Five-step Evaluation (B-SAFE) model provides a structure for that suicide risk.

DEPRESSION

The World Health Organization, in 2001, recognized depression as a leading cause of disability worldwide and it is identified as the leading cause of disability in their April 2016 review. They also found that fewer than one-half of those affected receive effective treatment for depression. An ultimate potential consequence of untreated depression may be suicide.[1] This further stresses the significance of identification and management of depression in primary care settings. However, depression often goes unrecognized in emergency care settings, further contributing to the increased morbidity and functional decline during these times.[2] Furthermore, emergency department (EDs) serves as a primary care provider for the uninsured and those lacking access to resources.[3,4] Thus, the emergency room provides a critical opportunity for depression identification and intervention.

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There remain opportunities to increase the national data in the scientific literature regarding the prevalence of depression in the emergency room setting or the quality of care delivered during those visits.[2,4] Harman and colleagues[4] found annually through 1997 and 2000 that more than 580,000 or 0.6% of all emergency room visits were associated with a primary diagnosis of depression. A cross-sectional study by Kumar and colleagues[2] in 2004 found a 30% yearly prevalence of depression in 4 Boston-area EDs, much higher than the national average of 6.6%. More than one-half of these emergency room visits related to depression resulted in admission, 12% of these admissions involved self-inflicted injury. However, the most common disposition for depressed patients was referral to an outside provider, and certain studies suggest that the adherence to these referrals is poor to fair.[4]

To improve the identification and treatment of depression, the US Preventive Services Task Force recommends screening adults in primary care settings (available from: www.uspreventiveservicestaskforce.org); however, no such recommendations exist for the screening of depression in the emergency room.[2] In light of the general lack of mental health resources and often scarce mental health referral and consultation opportunities, questions about disposition options, can result in frustration and prolonged ED stays.[5]

It has been found that psychotropic medications were prescribed to approximately one-third of discharged patients after evaluating 675 patients discharged from a community-based psychiatric department. Most common prescriptions included antidepressants (64%), benzodiazepines (25%), nonbenzodiazepine sedatives (20%), and mood stabilizers (10%). The decision to prescribe was most significantly associated with a clinical diagnosis of major depressive disorder or bipolar disorder and the established use of psychiatric medicines. Discharged patients with suicidal ideation, substance abuse, or an existing outpatient psychiatrist were most frequently not prescribed psychotropic medication.[6] This practice is in contrast with 61% of discharged patients receiving psychotropic medication who presented to the ED from 1992 to 2001.[7] Follow-up appointments were more likely given to those discharged with a prescription, but this did not increase their compliance in attending the appointment as compared with those discharged without medication. This pattern indicates that initiating medication in the emergency setting may not be a successful method to promote outpatient treatment.[6]

The low rate of antidepressants prescribed from the emergency room may stem from the view that it takes between 2 and 4 weeks to begin to treat the symptoms of depression.[8] Recent evidence has emerged indicating that maximum improvement occurs during the first 2 weeks, with some improvement seen in the first 3 days.[9] In addition, there is some scrutiny related to the time course for when these treatments may be effective.[8,9] Examination of more rapid psychopharmacologic interventions in the ED may be of some benefit. For high-acuity patients requiring admission, a psychiatric medication regimen will be started on the inpatient unit.[4]

There are several types of psychiatric emergencies related to severe depression, the emergencies are relevant given the concern for suicidality in patients struggling with depression. These can include depression leading to self-inflicted injury and suicidality. Approximately 420,000 ED visits occur annually in the United States for attempted suicide and self-inflicted injury, a number that has doubled over the last 20 years. Patients who present to the ED with self-inflicted injuries are more likely to be high users of ED services and have higher suicide mortality rates when compared with the general population.[5] Suicidal emergencies, among other psychiatric emergencies, provide the basis for emergency room visits, and is discussed elsewhere in this article (**Table 1**).[10]