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Unmasking Medical Illness in Mental Health Care

To the Editor: The brief report by Buchanan and colleagues (1) in the August issue underscored the high comorbidity between multiple sclerosis (MS) and depression (more than 40 percent) and found that nearly 90 percent of persons diagnosed as having MS were receiving mental health care. This example of high comorbidity of medical and psychiatric disorders leads us to question what may happen when psychological problems mask medical illness in mental health treatment settings.

For example, consider the following scenario: A woman comes to her initial session complaining of depressive symptoms after a recent divorce. Although she may appear to have a fairly routine mood or adjustment disorder, what if her depression is actually due to an underlying endocrine or autoimmune disease or even the initial symptoms of MS? What percentage of such individuals would be identified and referred for appropriate medical care? Indeed, conservative estimates suggest that at least 10

percent of psychological symptoms are driven by medical or physical conditions; yet many mental health care providers erroneously believe that psychological symptoms are rarely caused by a hidden medical etiology (2,3). Moreover, studies involving both psychiatric inpatients and outpatients have found high rates of medical illnesses that go unrecognized by mental health care providers (4,5).

The scenario we describe is not uncommon, and individuals with these disorders will appear in the caseloads of both medically trained and non-medically trained mental health professionals. However, in behavioral health settings nonmedical professionals routinely conduct initial evaluations and provide treatment for persons presenting with symptoms of mental illness. Moreover, a client's referral for psychiatric or medical evaluation ultimately rests with this same provider. Hence, a central concern is whether nonmedical providers are adequately trained to suspect a hidden medical disorder. Recognizing a hidden physical illness could be particularly challenging for psychologists, social workers, and licensed mental health counselors, whose professional education does not include formal medical training.

Possible solutions involve both collaborative and educational remedies. First, mental health care professionals lacking medical training would be well advised to develop a collaborative relationship with a primary care physician and encourage all new mental health clients to undergo a complete physical evaluation with appropriately indicated laboratory studies. Second, we would recommend that all mental health care professionals—both non-medically trained professionals and psychiatrists—participate in formal educational initiatives that identify the most common illnesses that masquerade as or contribute to psychological problems. Although nonmedical providers should not be expected to make definitive medical diagnoses, being cognizant of potential warning signs could lead to a timely referral.

People come to mental health professionals with the expectation that the cause of their problem will be identified. An underlying medical illness that is unrecognized and treated with only psychological interventions will likely contribute to a downward spiral of the person's health. Being aware of the most common masked medical illnesses that present with psychological or behavioral symptoms should be the responsibility of all who work in the field of mental health care. Indeed, our patients have a right to expect nothing less.

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Process Versus Outcomes in Evidence-Based Practices

To the Editor: The article "Transformational and Transactional Leadership: Association With Attitudes Toward Evidence-Based Practice" (1) in the August issue correctly focuses on the supervisory relationship in supporting change in clinical practice.

However, the clinician's interest will ultimately be in utility of method, not a scripted "evidence-based practice." To the extent that leadership is viewed by practitioners as supporting outcomes over process, their input will be valued. Evidence-based practices have a role and can be important tools in achieving effective outcomes, but they may also become an impediment to ongoing improvement in care if they are seen as ends in themselves.

The process should not become more important than the product. There may indeed be a better mouse-trap out there. Too much emphasis on "fidelity to the model" tends to obscure the fact that in the final analysis it is outcomes that should be measured, not the means to reaching them.

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In Reply: Mr. Seitzer's letter regarding my article supports the contention that high-quality leadership is an important consideration in the provision of high-quality mental health services. Establishing a link between leadership and the attitudes of mental health service providers toward adopting innovation and change—evidence-based practices in particular—was the main point of the article. The article does not, however, contend that evidence-based practices are the only means of improving outcomes for those involved in mental health services.

There is considerable debate regarding applicability, standards for fidelity, and the need for local adaptation of evidence-based practices. The article takes no stand on the value of evidence-based practices per se. The Evidence-Based Practice Attitudes Scale (1), which was used in the study, was developed because providers' atti-

tudes toward adopting innovation have been largely ignored in the research literature, even while the impetus to disseminate and implement evidence-based practices has gained momentum.

Mr. Seitzer's assertion that outcomes matter more than particular practices raises a complex and important issue. Services might be greatly improved if outcomes were routinely empirically assessed in usual care. Rigorous outcome measurement and use of such outcome data to inform clinical practice are relatively rare. Indeed, research suggests that clinicians' attitudes about using such measures vary greatly, with some believing that clinical knowledge and judgment are at least as accurate as empirically reliable and valid assessment, thus obviating the need for such measures (2). There is evidence that draws such an assumption into question (3). Assessments will likely be beneficial to the degree that they can be incorporated into the clinical process both to better understand initial diagnoses and problems and to track clinical progress.

Although my study did not directly address outcome assessment, it did establish a link between leadership and providers' attitudes toward adopting evidence-based practices as part of a research program on improving the context for delivery of high-quality mental health services and implementation of innovation (4). An innovation in mental health care may or may not be evidence based. What is emerging from this line of research is that leadership and organizational context are likely to play an important role in implementing innovation and promoting more positive outcomes for mental health and social service agencies and clinics (5).

Gregory A. Aarons, Ph.D.

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SSRI Prescription Rates After a Terrorist Attack

To the Editor: Although population-based studies and a recent meta-analysis have documented increased prevalence of posttraumatic stress disorder (PTSD) and other mental disorders after terrorist attacks (1,2), other studies have failed to demonstrate concomitant increases in mental health service use (3,4).

Selective serotonin reuptake inhibitors (SSRI) are indicated in the treatment of a number of mental disorders associated with terrorism (5). We plotted weekly rates of SSRI prescription fills for New York State Medicaid recipients for 2000 and 2001. We determined percentage changes in prescription rates, assessed changes in the slope of the plots before and after September 2001 by determining the statistical significance of the difference in the regression slope coefficients, and analyzed the weekly time series using Box-Jenkins methodology and interrupted times series

For Medicaid recipients living within three miles of the World Trade Center, the rate of prescription fills increased by 18.2 percent in the three months after the attacks compared with the rate in the eight months before the attacks ($p=.001$), and a statistically significant change in the slope of the plot was noted ($p=.01$). For recipients who did not live in New York City, the increase was 9.3 percent, which was not statistically significant, nor was the change in the slope of this series significant. In contrast, SSRI prescription rates for both these

groups decreased in the three months after September 2000.

For Medicaid recipients living within three miles of the World Trade Center, an ARIMA (1,1,1) model provided the best fit for the time series data, and an interrupt term representing a sudden, temporary increase in the prescription rate starting with the first week in November 2001 was statistically significant ($p=.001$). In a similar model fit to the data for recipients living outside New York City, the interrupt term representing the postattack period was not statistically significant.

Some of the increase in SSRI dispensing may be explained by the wider availability of free services, such as those offered by Project Liberty and Disaster Relief Medicaid. We attempted to address this by basing our time series on rates per person-years of Medicaid eligibility, controlling for an increased number of eligible individuals by including them in the denominator of the rate.

We concluded that an increase in SSRI prescriptions occurred after the attacks and that this effect varied by

geographic proximity. Although no causation can be attributed, our results are consistent with knowledge of the increase in mental health pathology after an occurrence of terrorism and have the strength of a plausible gradient effect. We await the release of New York Medicaid data for 2002 to assess whether the increased use of SSRIs among persons living near the World Trade Center was short lived or sustained. However, to the best of our knowledge, ours is the first report of a significant increase in psychoactive drug use associated with physical proximity to these attacks. Our findings contribute to the growing body of knowledge about the pervasive population effects of terrorism and the need to address mental health as part of surge capacity and public health response.

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