

recommended to prevent complications associated with treatment of venous thromboembolism. This letter illustrates the need for clinicians who treat IDU to be aware of unexplained haemorrhagic complaints, which may be due to the use of street acquired warfarin.

D J Dawson

Manchester Royal Infirmary, Manchester, UK

L Peters

Manchester Drug Service, Bolton, Salford and Trafford Mental Health Trust, Prestwich, Manchester, UK

Correspondence to: Debbie Dawson, Emergency Department, Manchester Royal Infirmary, Oxford Road, Manchester M13 9WL, UK; debbie.dawson@mmc.nhs.uk

doi: 10.1136/emj.2005.030346

References

- 1 **McColl MD**, Tait RC, Greer IA, *et al*. Injecting drug use is a risk factor for deep vein thrombosis in women in Glasgow. *Br J Haematol* 2001;112:641-3.
- 2 **Ellis BH**, McCann I, Price G, *et al*. The New Mexico Treatment Outcome Study: Evaluating the utility of existing information systems. *J Health Care Poor Underserved* 1992;3:138-150.

Prevalence of psychological distress assessed in emergency departments

Mental health in general, and undiagnosed psychiatric illness in particular, has been recognised as important concerns in emergency departments (EDs). They have been a focal point for acute healthcare services in Australia.^{1,2} This research examined the prevalence of non-specific psychological distress among people admitted through ED, who had chronic and complex conditions, and were aged 50 years and over.³ Patients over 50 years were selected because of the increased likelihood of the onset of chronic conditions. A chronic patient was defined as an ED admission with two or more presenting comorbidities for at least 6 months prior to admission. This group was matched with people from the New South Wales (NSW) Health Survey who reported any of the following conditions: high blood pressure, diabetes, cancer, or heart problems. Psychological distress measured by Kessler 10 (K10)³ was used because this instrument has been validated in large population based surveys and allows valid comparisons with the 1997 NSW Health Survey data.⁴

The interviews took place in ED or shortly after in the general ward; therefore, it was not possible for the researchers to know whether a psychiatric consultation was conducted after admission to hospital or not.

Altogether, 524 ED patients were interviewed on admission in a principal referral hospital in Sydney, Australia. These were a representative sample of all ED attendees to this hospital. A total of 12.4% (95% CI: 9-15%) had a severe (very high) level, 21.4% (95% CI: 17-25%) had a high level, 31.3% (95% CI 27-35%) had a moderate level, and 34.9% (95% CI: 30-39%) had a low level of psychological distress or no distress. Eight percent (95%CI: 5%-10%) of patients who completed the K10 had at least one mental health related condition (ICD-9 codes: 290-319). More females than males reported non-specific psychological distress but age differences were not large for the severe (very high) group.

Table 1 shows the demographic characteristics of admitted patients who completed K10 versus the total population of patients during the study period and data from age-matched people in the NSW State Health survey. The differences in age, gender, or marital status were not statistically significant.

In the comparison with the state wide survey,⁴ the rates of psychological distress from our study were higher than the population wide health survey estimates.

We acknowledge that the sample was drawn from a single geographical region and any generalisation to the broader NSW community cannot be made. Further, the findings of the study are based on self reported information provided by patients and some potential for reporting bias may have occurred because of respondents' interpretation of the questions or desire to report their emotions in a certain way or simply because of inaccuracies of responses because of recall bias.

In conclusion, these findings suggest that high levels of psychosocial distress in ED attendees pose additional challenges for "whole patient" health services delivery, given that ED services are frequently used as the gateway to the health system.

This suggests that when patients are admitted to hospitals through ED for clinical reasons not linked to obvious psychiatric problems, psychological distress in ED may be under reported (by patients) and not treated (in ED). The major finding is that psychological distress in ED is more common than population based estimates; therefore, it may require population health strategies to address mental health problems in ED, especially when it is associated with chronic illness.

R Forero, L Young, K M Hillman

Simpson Centre For Health Services Research, Liverpool Hospital, Liverpool, NSW and University of New South Wales, Australia

A E Bauman

School of Public Health, University of Sydney, Australia

R Forero, S Ieraci, L Young, K M Hillman

Sydney South West Area Health Service, Sydney, Australia; r.forero@unsw.edu.au

doi: 10.1136/emj.2005.029090

Competing interests: none declared

References

- 1 **Kalucy R**, Thomas L, King D. Changing demand for mental health services in the emergency department of a public hospital. *A& NZ J Psychiatry*. 2005;39: 1, 2, 78-80.
- 2 **Smart D**, Pollard C, Walpole B. Mental health triage in emergency medicine. *A& NZ J Psychiatry* 1999;33:57-66.
- 3 **Kessler RC**, Andrews G, Colpe LJ, *et al*. Short screen scales to monitor population prevalence and trends in non-specific psychological distress. *Psychological Med* 2002;32:959-76.
- 4 **Public Health Division**. Report on the 1997 and 1998 NSW Health Surveys. NSW Health Department, Sydney 2000. http://www.health.nsw.gov.au/public-health/nswhs/mhealth/mhealth_intro.htm (accessed 31 March 2005).

Consent in emergency research

The legal basis for consent for research in the incapacitated patient changed on 1st May 2004, when the Medicine for Human Use (Clinical

Table 1 K10 scores and demographic characteristics of admitted patients through ED

Kessler 10 Categories	Study sample % (n=524)		1997 NSW Health Survey*	
		% With comorbidities	Chronic group (%) (n=1121)	Non-chronic group (%) (n=789)
Very high (30-50)	12.4	7.7	6.1	4.1
High (22-29)	21.4	13.4	13.0	9.0
Moderate (16-21)	31.3	7.9	23.2	22.9
Low (10-15)	34.9	4.9	57.7	64.0
Mean score (95% CI)	19.6 (18.9-20.3)		16.55 (16.1-16.9)	15.48 (15.0-15.9)
Demographic characteristics				
Characteristic	K10 sample in ED (% n=437)	Reference population†, all attendees to this ED (%) (6385)	Chronic diseased group (1144)‡ %	Non-chronic diseased group (797) %
Age				
50-59 y	16.9	24.5	27.3	46.9
60-69 y	28.4	25.9	33.0	25.7
70-79 y	35.7	28.2	28.8	18.6
80 y +	19.0	21.5	10.8	8.8
Sex				
Males	54.5	52.1	44.9	45.3
Females	45.5	47.9	55.1	54.7
Marital status				
Separated/divorced	59.0	58.6	14.1	16.1
Single	25.5	23.1	5.2	5.4
Widowed	3.4	5.4	26.8	22.2
Married	6.4	6.2	53.9	56.2
Unknown	5.7	6.7	-	-

*People 50 years and older who reported to have attended emergency department at least once in the last 12 months.

†All emergency department attendees at this hospital between January 2002 and January 2003.

‡Chronic disease group (those who reported high blood pressure, or diabetes, or cancer or heart problems).