



RESEARCH ARTICLE / ARAŞTIRMA MAKALESİ

The Hidden Face of Emergencies: Psychiatric Consultations in the Emergency Department – Predictors of Psychiatric Admission and Treatment Refusal

Acillerin Görünmeyen Yüzü: Acil Serviste Psikiyatri Konsültasyonlarının Analizi-Psikiyatri Servisine Yatış ve Tedavi Reddi Belirleyicileri

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Abstract:

Individuals presenting to emergency departments (EDs) with psychiatric complaints often experience longer waiting times and lower quality of care than those with general medical conditions. Given the heterogeneity of this population, identifying its characteristics is essential for effective service planning and targeted interventions. This study examined the sociodemographic and clinical features of patients referred for psychiatric consultation in an ED, as well as factors associated with psychiatric inpatient admission and treatment refusal. This retrospective descriptive study included all patients aged ≥ 18 years who were referred from the ED to the psychiatry department between 6 October 2022 and 1 March 2024 ($n = 2,146$). Data were obtained from hospital records and analyzed using descriptive statistics and multivariable logistic regression. Women accounted for 53.9% of presentations, and 70.7% of consultations occurred outside regular working hours. The most common reason for consultation was a suicide attempt (21.0%), with drug ingestion accounting for 81.1% of these cases. The most frequently recorded diagnoses were psychotic, depressive, and anxiety disorders. Overall, 4.5% of patients were admitted to the psychiatric ward, and 5.6% were discharged following treatment refusal. Psychotic disorders, bipolar disorder in a manic or hypomanic episode, and suicide attempts involving drug overdose were associated with an increased likelihood of psychiatric admission, whereas management without psychotropic medication was associated with a reduced likelihood. Treatment refusal was more common among patients with an unclear psychiatric history and less frequent among those with a documented psychiatric diagnosis. These findings underscore suicide attempts and severe mental disorders as key priorities for emergency psychiatric care and highlight the importance of communication-focused strategies to reduce treatment refusal in the ED setting.

Keywords: Emergency departments, Emergency psychiatric services, Hospital admission, Treatment refusal, Suicide.

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Öz:

Ruhsal yakınmalarla acil servise başvuran bireyler, genel tıbbi yakınmaları olanlara kıyasla daha uzun bekleme süreleri ve daha düşük nitelikte bakım alabilmektedir. Bu heterojen grubun özelliklerinin tanımlanması, hizmet planlaması ve hedefe yönelik müdahaleler açısından önemlidir. Bu çalışmada, bir şehir hastanesi acil servisinde psikiyatri konsültasyonu istenen hastalarda sosyodemografik/klinik özellikler ile psikiyatri servisine yatış ve tedavi reddinin belirleyicileri incelenmiştir. Retrospektif ve tanımlayıcı tasarımdaki çalışmaya, 6 Ekim 2022–1 Mart 2024 arasında acilden psikiyatri bölümüne konsülte edilen, 18 yaş ve üzeri 2146 olgu dâhil edilmiştir. Veriler hastane kayıtlarından toplanmış; tanımlayıcı istatistikler ve çok değişkenli lojistik regresyon analizleri ile değerlendirilmiştir. Başvuruların %53,9'u kadındır; konsültasyonların %70,7'si mesai dışı saatlerde gerçekleşmiştir. En sık konsültasyon nedeni intihar girişimi (%21,0) olup, girişimlerin %81,1'i ilaç almıdır. En yaygın tanımlar psikotik bozukluk, depresif bozukluk ve anksiyete bozukluğudur. Hastaların %4,5'i psikiyatri servisine yatırılmış, %5,6'sı ise tedavi reddi nedeniyle taburcu edilmiştir. Psikotik bozukluk, mani/hipomani döneminde bipolar bozukluk ve ilaçla intihar girişimi yatış olasılığını artırırken, ilaçsız izlem yatış olasılığını azaltmıştır. Tedavi reddi, psikiyatrik tanı öyküsü belirsiz olanlarda artmış, tanısı bilinenlerde azalmıştır. Bulgular, intihar girişimleri ve ciddi ruhsal bozuklukların acil serviste öncelikli müdahale alanları olduğunu ve tedavi reddini azaltmaya yönelik iletişim temelli stratejilerin gerekliliğini göstermektedir.

Anahtar Kelimeler: Acil servisler, Acil psikiyatrik hizmetler, Hastaneye yatış, Tedavi reddi, İntihar.

Introduction

Psychiatric emergencies encompass all acute mental states that threaten an individual's physical, mental, and social integrity, impair functioning, and reduce quality of life, and that arise in the areas of thoughts, feelings, and behaviors (Örüm, 2020). The proportion of individuals presenting to emergency departments of general hospitals with psychiatric complaints or symptoms ranges from 3% to 12% (Hazlett et al., 2004; Zeller et al., 2014; Zhang & Das, 2024).

Psychiatric emergencies can arise from various causes such as psychosocial stressors, adverse life events, chronic mental disorders, side effects of medications or intoxications, and substance use disorders (Büyükbayram & Engin, 2018; Sudak, 2005). The clinical presentation may sometimes manifest with obvious behaviours like suicide attempts or aggression, while at other times, it may lead to emergency room visits due to somatic complaints such as palpitations, shortness of breath, or chest pain (Aykut et al., 2020; Hazlett et al., 2004).

Emergency psychiatric approach involves a comprehensive assessment of the patient, determining the level of urgency, developing an appropriate treatment and care plan, and making decisions about discharge, hospitalization in a psychiatric ward, or transfer to another unit. Considering patients' sociodemographic and psychosocial characteristics during this process is critically important for appropriate referral and risk management (Aykut et al., 2020).

The decision to admit a patient to the psychiatry service is primarily based on the risk of self-harm or harm to others, severe psychotic symptoms, intoxication, significant functional impairment, or intense agitation (Galderisi et al., 2024). However, this decision is not solely based on clinical symptoms; the patient's motivation for treatment, level of cooperation, insight, and sources of social support also significantly influence the need for hospitalization (Hawton et al., 2015; Karasch et al., 2020; Kirchner et al., 2022). Refusal of treatment, a common situation encountered in emergency services, is associated with multifaceted factors such as insufficient insight, severity of psychopathology, fear of stigma, previous negative treatment experiences, and social-ethnic or cultural factors (Galderisi et al., 2024; Ribeiro et al., 2016). Findings in the

literature indicate that individuals with uncertain psychiatric histories or limited prior contact with the healthcare system tend to have higher rates of treatment refusal (Jaeger et al., 2019).

Several studies have shown that individuals who seek emergency care for mental health complaints may experience longer wait times and receive lower-quality care compared to patients presenting with general medical complaints (Judkins et al., 2019). Modeling this heterogeneous patient group, which encompasses a wide range of mental and medical complications, at the community level is important for understanding the relationship between public expectations, attitudes toward mental health services, and the social and clinical characteristics of patients presenting with mental health complaints. However, there remains a lack of data on health institutions, such as city hospitals, adopting new organizational models. Identifying the basic sociodemographic and clinical features of this patient group will help service providers accurately define their needs and develop intervention strategies appropriate to their social and clinical characteristics (Zhang & Das, 2024).

The aim of this study is to retrospectively evaluate the sociodemographic characteristics, reasons for admission, and diagnoses of cases consulted from the emergency department to psychiatry in a newly opened city hospital; additionally, to identify factors that influence hospitalization and refusal of treatment in the psychiatry department.

Method and Materials

This study was planned as a retrospective and descriptive study. Prior to the study, approval was obtained from the Scientific Research Evaluation and Ethics Committee of Ankara Etlik City Hospital on 09/11/2024 with decision number AEŞH-BADEK-2024-838. The study was conducted in accordance with the principles of the Declaration of Helsinki, and, due to its retrospective nature, informed consent was not obtained from the individuals.

The study included all patients who presented to the hospital's emergency department between October 6,

2022, and March 1, 2024, and were consulted by the psychiatry department. During this period, the total number of emergency department visits was 372,265, and the total number of consultations requested for these visits was 166,860. Of these consultations, 4,723 were made for the psychiatry department, accounting for 2.83% of all consultations. Duplicate consultations related to the same admission were excluded, and a total of 2,146 psychiatry consultations were included in the analysis. The inclusion criterion was being 18 years or older, and files with incomplete data were excluded from the analysis.

For data collection, the 'Sociodemographic and Clinical Data Form' developed by the researchers was used. Through this form, sociodemographic characteristics such as patients' age, gender, marital status, education level, and employment status; modes of presentation to the emergency department; history of psychiatric disorders; and the presence of additional medical illnesses were recorded. Additionally, reasons for requesting psychiatric consultation, diagnosed psychiatric conditions, applied treatment methods, and discharge outcomes were retrospectively obtained from hospital information management system records.

In the data analysis, descriptive statistics were primarily used to characterize the study group. The findings are presented as numbers, percentages, minimum–maximum values, means, standard deviations, and medians. To examine the determinants of hospitalization and treatment refusal in the psychiatry ward, univariate and multivariate logistic regression analyses were applied. In univariate logistic regression analyses, $p < 0.25$ was considered statistically significant, whereas in multivariate logistic regression analyses, $p < 0.05$ was considered statistically significant. To reduce the effect of outliers, cases with a Cook's Distance value > 1 were excluded from the analysis. Cases that could not be included in the model due to missing data were also removed from the relevant analyses. All statistical analyses were performed using IBM SPSS Statistics, version 29.0.

Findings

The study included 2,146 individuals who applied to the emergency department and were referred for psychiatric consultation between October 6, 2022, and March 1, 2024. As shown in Table 1, out of the 2,146 people included in the study, 1,157 (53.9%) are women and 989 (46.1%) are men. 29.3% of applications occurred during working hours, while 70.7% occurred outside working hours. Among the participants, 37% are single, 31.5% are married, and 9.9% are divorced/separated/widowed. In terms of occupational distribution, the largest groups are employed individuals (22.4%) and unemployed individuals (21.2%), while students (5.8%), housewives (19.4%), and retirees (4.8%) are represented in smaller proportions. Regarding education level, 1.1% of applicants are uneducated, 0.7% are only literate, 11.9% have primary education, 20.7% have high school education, 11.9% hold a bachelor's degree, and 0.4% have postgraduate education. Regarding the mode of arrival at the emergency department, 47.7% arrived voluntarily as outpatients, 20.5% arrived voluntarily by ambulance, 10.4% arrived involuntarily by ambulance, 9.8% arrived at a relative's request, and 3.7% arrived at the police's request.

In the assessment of the patients' medical histories, it was found that 62.8% had a history of psychiatric disorder, 25.6% had no psychiatric history, 1.5% had uncertain information regarding this, and 10.1% could not access the relevant data. Regarding comorbid medical conditions, 19.8% of cases had additional illnesses, 54.6% had none, 7.8% had uncertain information, and 17.8% lacked this data. When examining the emergency treatment methods applied, 46.7% of the cases received drug-free monitoring, 34.4% received oral psychotropic treatment, and 16.8% received parenteral psychotropic treatment; a very small number of patients received detection (0.1%), gastric lavage (0.9%), or other treatment methods (1.1%).

When evaluating the reasons for requesting psychiatric consultation, the largest group of referrals consists of suicide attempts (21.0%). This is followed by aggression/violence/agitation (11.6%), anxiety symptoms (9.9%), exacerbation of known mental illnesses (8.1%), acute psychotic symptoms (5.9%), and depressive symptoms (2.9%). In smaller proportions, consultations were requested due to medication side effects/intoxication (2.0%), delirium (2.4%), behavioural problems related to dementia (0.5%), alcohol and substance-related intoxication/withdrawal syndromes (each less than 1%), and somatic complaints (2.4%). Additionally, 4.5% of the referrals involved suicidal thoughts, 2.3% involved self-mutilation behaviours, and 0.7% involved self-mutilative thoughts. The consultation requests were made without specified reasons in 5.2% of cases, and in 4.5% of cases, for hospitalization/transfer without specifying a reason. Lower proportions include preoperative assessment (3.7%), refusal of treatment (0.2%), communication problems with the treatment team (0.3%), and threats to harm others (0.3%).

When examining methods of suicide attempts, it has been determined that the most common method is the use of medication (81.1%). This is followed by the use of sharp or cutting tools (7.6%), firearms (3.0%), hanging (2.4%), ingestion of chemical substances (2.4%), jumping from a height (1.9%), and other methods (1.6%).

27.5% of the applicants reported visiting a psychiatric outpatient clinic in the past month, 51.9% had no outpatient visits, and in 20.6% of cases, this information could not be obtained. As a result of psychiatric evaluation, a diagnosis was made, or the existing diagnosis was confirmed in 1,261 cases (58.9%), 731 cases (34.1%) were placed under observation or referred to the outpatient clinic for further examination, and no active psychopathology was detected in 263 cases (12.3%).

Looking at the distribution of diagnoses, the most common disorders were psychotic disorders (22.9%), depressive disorders (19.3%), and anxiety disorders (16.9%). These diagnoses were followed by bipolar disorder (6.4%), mixed anxiety and depressive disorder (6.2%), adjustment disorder (3.9%), and substance/alcohol use disorders (around 10%). Lower rates were recorded for personality disorders (1.3%) and other psychiatric disorders (6.9%).

During discharge, the most frequently applied supportive consultation was 41.3%. Additionally, 9.9% of patients were started on antipsychotics, 7.2% on anxiolytics, and 3.4% on antidepressants; 1.1% received other treatment options. Furthermore, family consultations were conducted in 21.7% of cases. Regarding outcomes, 4.5% of patients were transferred to the psychiatric ward, 3.4%

were admitted to another service or intensive care unit, 0.6% were referred to another hospital, 5.6% were discharged after refusing treatment, and 1.3% were followed under other outcome categories. The ages of the

patients who applied to the emergency department ranged from 18 to 96 years, with a mean age of 38.3 ± 16.7 (median=34). The number of applications ranged from 1 to 13, with an average of 1.47 ± 1.43 (median=1)

Table 1. Comparison of demographic characteristics of mothers in the case and control groups

		n	%
Gender	Female	1157	53,9
	Male	989	46,1
Time of Request	Working hours	628	29,3
	After hours	1518	70,7
Marital Status	Married	675	31,5
	Single	795	37,0
	Divorced/Widowed	212	9,9
	Unavailable data	464	21,6
Employment Status	Employed	481	22,4
	Student	124	5,8
	Housewife	416	19,4
	Retired	102	4,8
	Unemployed	456	21,2
	Unavailable data	567	26,4
Education	Illiterate	23	1,1
	Literate	16	0,7
	Primary school	256	11,9
	High school	444	20,7
	Bachelor's	256	11,9
	Postgraduate	9	0,4
	Missing data	1142	53,2
Mode of Admission	By ambulance	663	30,9
	Outpatient	1313	61,2
	Unavailable data	170	7,9
Psychiatric History	Yes	1348	62,8
	No	550	25,6
	Unknown	32	1,5
	Unavailable data	216	10,1
Treatment Administered	Observation without medication	964	46,7
	Psychotropic oral	710	34,4
	Psychotropic parenteral	346	16,8
	Restraint	3	0,1
	Gastric lavage	19	0,9
	Other	22	1,1
Reason for Consultation Request	Consulted without a specified reason	137	5,2
	Consultation for admission/transfer	117	4,5
	Referral for admission from another center	55	2,1
	Preoperative consultation	97	3,7
	Consultation for drug side effects	32	1,2
	Exacerbation of a known and followed-up psychiatric disorder	212	8,1
	Communication problems with the treatment team	7	0,3
	Refusal of treatment (medication, surgery, etc.)	6	0,2
	Aggression, violence, agitation	311	11,9
	Aggression, violence, agitation	259	9,9
	Depressive symptoms	75	2,9
	Acute psychotic symptoms	154	5,9
	Delirium symptoms	62	2,4

	Behavioural problems due to dementia	12	0,5
	Drug side effect/drug intoxication	52	2,0
	Alcohol-related	34	1,3
	Substance-related	47	2,2
	Somatic complaints	63	2,4
	Other (sleep, eating, etc.) problems	123	4,7
	Self-mutilative thoughts	140	5,3
	Suicidal ideation or attempt	666	25,5
Suicide Attempt Methods	Hanging	14	2,4
	Firearm	17	3,0
	Sharp object	44	7,6
	Drug	467	81,1
	Chemical substance	14	2,4
	Jumping from a height	11	1,9
	Other	9	1,6
Outpatient Clinic Visit in the Last Month	Yes	590	27,5
	No	1114	51,9
	Unavailable data	442	20,6
Psychiatric Diagnosis	Established/present	1261	55,9
	Follow-up/psychiatry outpatient follow-up	731	32,4
	No active psychopathology considered	263	11,7
Diagnosed Psychiatric Disorders	Disorder related to psychoactive substance use (alcohol, substance, etc.)	144	10,0
	Depressive disorder	279	19,3
	Psychotic disorder	330	22,9
	Anxiety disorder	244	16,9
	Mixed anxiety and depressive disorder	89	6,2
	Bipolar affective disorder	183	12,7
	Adjustment disorder/reactive symptoms	56	3,9
	Personality disorder	19	1,3
	Other	99	6,9
Discharge Treatments	Supportive interview	1728	41,3
	Antidepressant	144	3,4
	Antipsychotic	413	9,9
	Anxiolytic	301	7,2
	Other	45	1,1
Treatment Outcomes	Family interview	908	21,7
	Transfer to psychiatric ward	189	4,5
	Transfer to another ward/ICU	141	3,4
	Referral to another hospital	27	0,6
	Other	54	1,3
	Patient discharged due to refusal of treatment	234	5,6

Note. Since participants could provide more than one response, the total sample size may exceed the number of participants.

A multivariate logistic regression analysis was conducted to examine variables associated with hospitalization in the psychiatric service. The model included: gender, age, number of visits, time of request, marital status, employment and education status, manner of arrival to the emergency department, history of psychiatric disorder, types of treatment applied, reason for consultation request, method of suicide attempt, outpatient clinic visits in the last month, and psychiatric diagnosis variables. First, univariate logistic regression was performed for each variable, and variables significant at $p < 0.025$ were included in the final model (Hosmer et al., 2013). To reduce the effect of outliers, 11 cases with Cook's Distance > 1 were excluded from the analysis; additionally, 1,288

individuals were excluded from the model due to missing data. The analysis was conducted on 847 individuals. According to the omnibus test, the regression model was statistically significant ($\chi^2 = 212.733$; $p < 0.001$), and the variables in the model explained 44.9% of the variance in hospitalization to the psychiatry service. The Hosmer–Lemeshow test results indicated that the model had an acceptable fit ($X^2 = 3.753$; $p = 0.879$). According to the analysis, the likelihood of hospitalization among patients managed without medication was significantly lower than among those managed with medication ($OR = 0.34$; 95% $CI = 0.125–0.936$; $p = 0.037$). Conversely, the likelihood of hospitalization increased significantly in patients who underwent gastric lavage ($OR = 14.11$; 95% $CI = 1.727–$

115.402; $p=0.014$). The presence of suicidal thoughts increased the odds of hospitalization by 3.95 times ($OR=3.953$; 95% $CI=1.283-12.177$; $p=0.017$), while patients who attempted suicide had a lower likelihood of hospitalization ($OR=0.105$; 95% $CI=0.023-0.481$; $p=0.004$). Particularly, those who attempted suicide with medication had approximately four times higher odds of hospitalization compared to other methods ($OR=3.815$; 95% $CI=1.297-11.218$; $p=0.015$). Compared to individuals without a psychiatric diagnosis, those with a

psychiatric diagnosis, those called in for follow-up or further examination, and those without active psychopathology had a significantly lower likelihood of hospitalization (ORs between 0.06 and 0.063, $p<0.001$). Conversely, when considering diagnosis groups, patients with psychotic disorders had about four times higher odds of hospitalization ($OR=4.034$; 95% $CI=1.793-9.080$; $p<0.001$), and those in the manic/hypomanic phase of bipolar disorder had over 21 times higher odds ($OR=21.436$; 95% $CI=5.578-82.368$; $p<0.001$).

Table 2: Regression analysis findings on the determinants of admission to the psychiatry ward

Variables	B	p	Exp(B)	95% Confidence Interval	
				Lower	Upper
Treatment Administered					
Observation without medication (No/Yes)	-1,074	0,037	0,342	0,125	0,936
Gastric lavage (No/Yes)	2,647	0,014	14,118	1,727	115,402
Reason for Consultation Request					
Suicidal Ideation (No/Yes)	1,374	0,017	3,953	1,283	12,177
Suicide Attempt (No/Yes)	-2,255	0,004	0,105	0,023	0,481
Suicide Attempt Methods					
Drug (No/Yes)	1,339	0,015	3,815	1,297	11,218
Psychiatric Diagnosis					
Established/present (No/Yes)	-2,817	<0,001	0,060	0,013	0,281
Follow-up or referred to the psychiatry outpatient clinic for further evaluation (No/Yes)	-2,832	<0,001	0,059	0,013	0,267
No active psychopathology considered (No/Yes)	-2,771	0,001	0,063	0,012	0,328
Diagnosis					
Psychotic disorder (No/Yes)	1,395	<0,001	4,034	1,793	9,080
Bipolar affective disorder (mania, hypomania) (No/Yes)	3,065	<0,001	21,436	5,578	82,368
Constant	0,127	0,925	1,135		
Omnibus Test: $X^2=212,733$ ($p<0,001$) Nagelkerke $R^2=0,449$ Hosmer-Lemeshow Test: $X^2=3,753$ ($p=0,879$)					
Dependent Variable: Admission to Psychiatric Ward (0=No; 1=Yes)					

A logistic regression analysis was conducted to identify factors associated with treatment rejection; variables included gender, age, number of visits, time of request, marital status, employment and education status, mode of arrival to the emergency department, presence of psychiatric disorder in medical history, types of treatments applied, outpatient visits in the past month, and psychiatric diagnosis. Variables with $p<0.25$ in univariate logistic regression analyses were included in the multivariate model (Hosmer et al., 2013). In this analysis, 10 cases with Cook's Distance >1 were removed from the data set; additionally, 461 individuals were excluded due to missing data. The final model was conducted on 1,675 cases.

According to the omnibus test, the model was statistically significant ($X^2 = 89.879$; $p < 0.001$) and explained 26.3% of the variance in treatment rejection. The Hosmer–Lemeshow test indicated that the model had an acceptable fit ($X^2 = 1.305$; $p = 0.995$). Based on the multivariate analysis, cases with an uncertain psychiatric history had a significantly higher likelihood of treatment rejection ($OR=9.94$; 95% $CI=2.232-44.294$; $p=0.003$). Conversely, those with a diagnosed psychiatric disorder had a significantly lower likelihood of treatment rejection ($OR=0.13$; 95% $CI=0.025-0.698$; $p=0.017$). Other variables were not statistically significantly associated with treatment rejection in the multivariate model.

Table 3: Regression analysis findings on the determinants of treatment refusal

Variables	B	p	Exp(B)	95% Interval Lower	Confidence Upper
History of psychiatric disorder (Reference = None)		0,010			
History of psychiatric disorder (Uncertain)	2,297	0,003	9,943	2,232	44,294
Psychiatric Diagnosis					
Established/present (No/Yes)	-2,022	0,017	0,132	0,025	0,698
Constant	-2,335	0,046	0,097		
Omnibus Test: $X^2=89,879$ ($p<0,001$) Nagelkerke $R^2=0,263$ Hosmer-Lemeshow Test: $X^2=1,305$ ($p=0,995$)					
Dependent Variable: Treatment Refusal (0=No; 1=Yes)					

Note. The first group was taken as the reference for nominal variables. Variables included in the final model but not statistically significant are omitted from the table to reduce its length.

Discussion

Patients who present to the emergency department for psychiatric reasons represent a heterogeneous but high-risk group. This situation highlights the critical importance of emergency psychiatric services within the healthcare system. Our study provides up-to-date sociodemographic and clinical data from a broad group of patients referred for psychiatric consultation in a city hospital emergency department, contributing to the literature in this field from Turkey.

The study found that women are represented at a higher rate among those seeking psychiatric complaints. This finding is consistent with studies reporting that women more frequently seek healthcare services during mental health crises (Naskar et al., 2019). However, the close ratio of women to men suggests that this difference may be limited. The higher frequency of women visiting emergency services can be explained by social and clinical factors related to help-seeking behavior. Indeed, it has been reported that women are more open than men in expressing mental distress and seeking professional help, while men may delay seeking help even when experiencing depressive symptoms and suicidal thoughts (Nock et al., 2008; Owens et al., 2002; Tarsuslu and Durat, 2018). Additionally, the higher prevalence of mood and anxiety disorders in women may also influence this distribution (Farjane-Medina et al., 2022; Salk et al., 2017). Conversely, the fact that gender does not determine hospitalization or refusal of treatment suggests that clinical decisions in emergency psychiatry are more often based on acute risk indicators such as symptom severity, suicide risk, and behavioral control loss.

The fact that the majority of applications occur outside working hours indicates that emergency services are the most accessible units during mental health crises, consistent with studies reporting a concentration of applications in the evenings and on weekends (Cincioglu et al., 2022). The most common form of application being self-initiated outpatient visits suggests that help-seeking behaviour is prominent, and this finding aligns with the literature (Nock et al., 2008; Owens et al., 2002). This situation demonstrates that emergency services are not only a place for mandatory intervention but also an accessible point of contact for individuals experiencing mental health crises.

The fact that most patients have a psychiatric history suggests that individuals with existing mental disorders frequently use the emergency department as a primary point of contact during crisis periods, and that acute exacerbations of chronic mental illnesses increase the burden on emergency psychiatric services (Gairin et al., 2003; Olfson et al., 2016). Additionally, the detection of comorbid medical conditions in 19.8% of cases highlights the importance of comorbidities in psychiatric referrals (Gairin et al., 2003; Hawton et al., 2015; Olfson et al., 2016).

The prominence of psychotic disorder, depressive disorder, and anxiety disorder in the diagnosis distribution aligns with the literature, indicating that the most common conditions in emergency psychiatry are psychotic and mood disorders (Örüm, 2020; Sudak, 2005; Zhang & Das, 2024). The frequent occurrence of psychotic disorders highlights the need for careful assessment of these patients in emergency services due to agitation, impaired reality

evaluation, and the risk of self-harm or harm to others. Depressive disorders and anxiety disorders are also significant groups for emergency services because of their associations with suicidal thoughts and attempts, as well as their presentation with somatic complaints (Hawton et al., 2012; Nock et al., 2008).

The relatively low number of applications related to substance and alcohol use may be associated with regional differences, sociocultural factors, preference for other healthcare facilities, or recording deficiencies. Therefore, this finding may not fully reflect the true prevalence and should be reevaluated in prospective studies. Among the reasons for consultation, the fact that suicide attempts are the most common and that most of these attempts involve medication intake highlights the critical importance of suicide behaviour and intoxication in emergency services. The literature also emphasizes that drug intoxication is a common method of self-harm and that these cases carry high risks both medically and psychiatrically (Boğan et al., 2024; Owens et al., 2002; Betz & Boudreaux, 2016). These findings indicate the need to clarify intoxication protocols in emergency services, to routine suicide risk assessments, and to structure post-discharge follow-up.

In the emergency department, the use of monitoring and supportive counseling without initiating pharmacological treatment in a significant proportion of cases highlights the important role of crisis-focused, short-term psychosocial interventions in emergency psychiatry. The literature indicates that not every emergency psychiatric case requires pharmacotherapy; in patients with low risk levels and no acute agitation symptoms, supportive counseling, safety planning, and short-term crisis intervention may be sufficient (Miller et al., 2017; Betz & Boudreaux, 2016). Conversely, in cases with psychotic symptoms, significant agitation, or high suicide risk, pharmacological intervention and hospitalization when necessary are prioritized (Hawton et al., 2015; Betz & Boudreaux, 2016). The frequent use of supportive counseling and family meetings at discharge aligns with modern crisis intervention approaches that aim to strengthen social support networks and reduce the risk of re-admission (Miller et al., 2017). Transfers to psychiatric or other departments necessitate a multidisciplinary approach, while cases that end in treatment refusal underscore the importance of strengthening the therapeutic alliance, employing motivational interviewing techniques, and implementing post-discharge follow-up plans (Ribeiro et al., 2016). These findings support the idea that pharmacological and psychosocial interventions in emergency psychiatry should be addressed together in a risk-based, individualized manner.

The logistic regression findings regarding hospitalization and treatment refusal in the psychiatry department shed light on clinical and system-level processes. The low likelihood of hospitalization in cases managed with medication-free observation suggests that most mild and moderate cases can be managed on an outpatient basis. Conversely, the increased likelihood of hospitalization in cases that underwent gastric lavage indicates that medication intoxications are considered high-risk from both medical and psychiatric perspectives (Hawton et al., 2015; Owens et al., 2002). Although suicidal ideation increases the probability of hospitalization, the relatively low rates of psychiatric admission following suicide attempts may be related to these cases primarily being

monitored and treated in internal medicine departments. While the literature reports that suicidal thoughts and behaviours are strong predictors of hospitalization (Betz & Boudreaux, 2016; Ribeiro et al., 2016), it is also emphasized that internal medicine admissions are particularly prominent in cases of intoxication. Our findings are consistent with the literature regarding increased hospitalization likelihood in intoxication-related attempts, but they differ somewhat in that suicidal behaviour alone is not a definitive factor for psychiatric admission.

The significant increase in hospitalization likelihood during manic/hypomanic episodes in psychotic disorder and bipolar disorder indicates that these conditions are associated with agitation, impulsivity, and increased risk of self-harm or harm to others, which is consistent with previous studies (Boğan et al., 2024; Hawton et al., 2015). Kirchner et al. (2022) reported that severe psychiatric symptoms, involuntary hospitalization, and physician-directed hospitalization are the main factors increasing admissions. Conversely, the lower hospitalization rates observed in patients with prior diagnoses or under follow-up may be related to better integration into the treatment system and the ability to manage crises more frequently on an outpatient basis.

In terms of treatment refusal, the higher likelihood of refusal in individuals with an uncertain psychiatric history and the lower likelihood in those with an existing diagnosis suggest that clarity of the patient's history and previous contacts with the healthcare system facilitate treatment adherence (Ribeiro et al., 2016). Jaeger et al. (2019) also reported that individuals with prior treatment experience have lower rates of treatment refusal. These findings are consistent with the literature emphasizing the relationship between treatment refusal, psychiatric history, and previous interactions with the healthcare system.

Judkins et al. (2019) reported that patients presenting with mental health complaints may encounter longer wait times and lower quality of care. When considered alongside our study, these points point to significant systemic implications. The high volume of after-hours visits, suicidal attempts, and psychotic/mood disorders is prominent; however, the limited hospitalization rate and notable treatment refusal suggest that factors such as time pressure in the emergency department, crowded environment, limited staff, and insufficient psychosocial support may be influential. Therefore, providing psychiatric nurse or psychologist support during peak hours, standardizing crisis intervention and referral protocols, and routine structured information and motivational interviewing for high-risk groups are important areas for improvement.

Overall, our findings indicate that emergency departments are the first point of contact in psychiatric crises; suicide attempts, agitation, psychotic symptoms, and intoxication are the primary areas requiring intervention. After-hours admissions and psychiatric history should be considered when classifying risk. The combined use of pharmacological and psychosocial approaches in emergency psychiatry, strengthening consultation-liaison collaboration, and, especially, the systematic application of communication- and motivation-based strategies in cases of treatment refusal are consistent with the World Health Organization's person-centered and rights-based mental health service approach (WHO, 2021). In this regard, our study not only characterizes the patient profile

but also offers practical priorities for organizing mental health services in emergency departments.

Limitations and Strengths of the Study

One significant limitation of this study is the missing information in some patient files. In particular, incomplete or unclear data on psychiatric diagnoses or reasons for consultation requests may have affected the accuracy and completeness of the analyses. Additionally, obtaining data from only a single hospital limits the generalizability of the findings. The retrospective design of the study is also another limitation, as it makes it difficult to ensure that cases are documented completely and consistently.

However, the strengths of this study are also noteworthy. A detailed examination of the most common psychiatric symptoms and consultation reasons revealed the diversity of mental disorders encountered in the emergency department. Additionally, findings obtained from a relatively large sample highlight the importance of collaboration, coordination, and information sharing between psychiatry and other specialties within the scope of Consultation-Liaison Psychiatry.

Conclusion

This study reveals the sociodemographic and clinical characteristics of cases referred for psychiatric consultation in the emergency department of a city hospital, demonstrating that mental health issues constitute a significant portion of emergency visits. The findings indicate that psychiatric emergency consultations should be regarded not only as individual crisis situations but also as a critical area requiring rapid diagnosis, appropriate referral, and effective multidisciplinary collaboration within the healthcare system. Therefore, strengthening psychiatric consultation services in emergency departments and increasing healthcare workers' awareness and competence in this field are of great importance for both patient safety and the sustainability of service quality.

Declarations

Ethics Approval and Participation Permit

Approval has been obtained from the Ankara Etlik City Hospital Scientific Research Evaluation and Ethics Committee for the implementation of the study, with decision number AEŞH-BADEK-2024-838 dated 09/11/2024.

Publication Permission

Not Applicable.

Availability of Data and Materials

Not Applicable.

Conflict of Interest

The authors declare no conflict of interest.

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Author Contributions

YK and SBA significantly contributed to the methods and discussion sections of the article, as well as to the writing and editing of the abstract and summary. They also contributed to the overall writing and critical review of the manuscript. MRV and KÖÇ made substantial contributions to data collection. All authors reviewed and approved the final version of the manuscript and agreed to be accountable for all aspects of the work.

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