

Retrospective Analysis of Hospital Records of Patients Admitted to the Emergency Department and Diagnosed with Psychiatric Disorder

Acil Servise Başvuran ve Psikiyatrik Bozukluk Tanısı Konulan Hastaların Hastane Kayıtlarının Retrospektif İncelenmesi

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ABSTRACT

Objective: This study aimed to retrospectively assess the hospital records of patients admitted to the emergency department of a training research hospital and diagnosed with a mental/psychiatric disorder.

Material-Methods: In our study, medical records with pre-diagnosis of psychiatric disorder were scanned retrospectively in the electronic environment from the applications made to the emergency department of a training and research hospital in a one-year period covering 2017. The data were collected using a form prepared as per the current literature and developments. Using descriptive statistics, socio-demographic and health history characteristics and clinical diagnoses were evaluated.

Results: It was determined that 84.04% of all patients that were admitted to the emergency department for mental health reasons were diagnosed with code F41 (other anxiety disorders), that 23.60% were in the 15-24 age group, and that 69.50% were female. The emergency department admission characteristics of the subjects were as follows: 10.60% of all admissions were made in July, 48.20% were made between 16:01-00:00, 5.00% were referred to psychiatric consultation, 93.60% received ambulatory follow-up, and 12.90% were admitted to the emergency department two or more times within one year.

Conclusion: The most common diagnosis was “other anxiety disorders” and the majority of the patients were young adults and female. Since emergency departments are among the first places where individuals seek medical care for mental health, we believe that our results will help structure emergency psychiatric services.

Keywords: Emergency department, hospital records, mental disorders

ÖZET

Amaç: Bu çalışmada, bir eğitim araştırma hastanesi acil servisine başvuran ve psikiyatrik bozukluk tanısı konulan hastaların hastane kayıtlarının geriye dönük incelenmesi amaçlanmıştır.

Gereç ve Yöntem: Çalışmamızda, 2017 yılını kapsayan bir yıllık süre içerisinde, bir eğitim araştırma hastanesi acil servisine yapılan başvurulardan, psikiyatrik bozukluk ön tanısı konulan tıbbi kayıtlar, elektronik ortamda geriye yönelik taranmıştır. Veriler, literatür bilgisi ve güncel gelişmeler dikkate alınarak hazırlanan bir form ile toplanmıştır. Tanımlayıcı analizler kullanılarak, sosyo-demografik ve sağlık öyküsü özellikleri ile klinik tanımlar değerlendirilmiştir.

Bulgular: Acil servise ruhsal nedenlerle başvuranların %84,04'üne F41 (Diğer Anksiyete Bozuklukları) kodlu tanıların konulduğu, başvuruların %23,60'ının 15-24 yaş grubunda, %69,50'sinin kadın olduğu belirlenmiştir. Başvuru özellikleri yönünden; başvuruların %10,60'ının temmuz ayında, %48,20'sinin 16:01-00:00 saatlerinde yapıldığı, %5,00'ine psikiyatrik konsültasyon istendiği, %93,60'ının ayaktan takip edildiği, %12,90'ının yıl içerisinde iki ve üzeri başvuruda bulunduğu tespit edilmiştir.

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Sonuç: Araştırmada “diğer anksiyete bozuklukları”, sık konulan tanı grubu olup, başvuruların çoğunluğu genç erişkinler ve kadınlar tarafından yapılmıştır. Acil servisler, ruhsal yönden rahatsızlık yaşayan bireylerin öncelikli başvuru yerleri arasında olması nedeniyle, araştırma sonuçlarının psikiyatrik acil hizmetlerin yapılandırılmasında yol gösterici olacağı düşünülmektedir.

Anahtar Kelimeler: Acil servis, hastane kayıtları, psikiyatrik bozukluklar

INTRODUCTION

Emergency psychiatric intervention is required when the emotional and behavioral symptoms affect physical, intellectual, spiritual, and social integrity, functionality, and quality of life to a degree that poses a threat to themselves and their surroundings (Karlıdere, 2007; Küçükali et al. 2015; Büyükbayram-Engin, 2018). A significant portion of psychiatric emergencies are admitted to emergency departments (ED) of general hospitals, primary health care institutions, and family practice centers. However, psychiatric emergencies are also encountered in psychiatry outpatient clinics and wards, and in medical and surgical intensive care units (Karlıdere, 2007). In national studies report that 3-12% of the admissions to the emergency departments of general hospitals are for psychiatric reasons and international studies report comparable rates of 3.4-9.5% (Karlıdere, 2007; Roggenkamp et al. 2018; Bost et al. 2015; Coates et al. 2019).

Psychiatric emergency services, to which patients need to be quickly and appropriately referred to take effective measures within a limited time, reduce the material and moral burden of patients and their relatives, reduce repeat admissions, and facilitate the adaptation of the person to the subsequent treatment process (Bahçecik et al. 2011). On the other hand, the insufficient physical facilities, inadequacy of the emergency room operation for mental health triage, the negative emotions, beliefs, attitudes, and behaviors of the ED staff, and the lack of knowledge/skills regarding emergency psychiatric approach make psychiatric emergency care and assessment difficult (Büyükbayram-Engin 2018). Overcrowding and rapid circulation in EDs are associated with long waiting times, disruptions in treatment, increased communication and medical errors, mortality and morbidity rates, and increased patient care costs (Bost et al. 2015; Canakci et al. 2019). The insufficiency of mental health services at both local and national levels has been associated with increased admissions to emergency health services by individuals with psychiatric problems (Roggenkamp et al. 2018).

In this context, this study aimed to retrospectively evaluate patients who presented to the emergency department of a training and research hospital during the course of one year and were diagnosed with psychiatric disorders according to various parameters using data obtained from the hospital registration system.

MATERIALS and METHODS

Study Population and Data Collection

The study was a descriptive and retrospective study. The data were collected using the “data collection form” prepared in line with the literature (Karlıdere, 2007; Küçükali et al. 2015; Bahçecik et al. 2011; Aker et al. 2006; Öztürk, Uluşahin 2016) and current developments, and the hospital records. The form contained items that inquire socio-demographic characteristics, medical history, details of admission, and psychiatric disorder diagnoses.

The study was granted ethical approval by the relevant Ethics Committee (dated January 29, 2018; numbered 71522473/050.01.04/26) and permission by the hospital (dated March 15, 2018; numbered 24404279-799). Study data were collected in accordance with the Helsinki Declaration. We evaluated the data of 6793 patients who were admitted to the emergency department and diagnosed with psychiatric disorders according to ICD-10 (International Classification of Diseases-10) during the period of one year (01.01.2017-31.12.2017). In case of more than one admission, the later admission record was considered; duplicate records created within 60 minutes of each other, which were ascribed to errors in infrastructure, internet connection, or the software, were reduced to one record, using the later records. A total of 215 faulty records were identified and removed. Thus, the sample of the study was made up of 5140 patient records. The number of emergency admissions to the emergency department of the relevant hospital was 728,727 in 2017, 0.93% of which were diagnosed with psychiatric conditions.

The ICD-10 diagnostic guide published on the website of the Turkish Ministry of Health was used to categorize psychiatric disorder diagnoses (Ministry of Health 2014). Certain data that were not available in the hospital information system were obtained from consultation and yearly admission records of the psychiatry clinic. The admission rate and causes of admission were categorized in line with the literature (Öztürk, Uluşahin 2016; Boyer et al. 2011).

Statistical Analysis

The data were collected in an Excel worksheet, organized for statistical analysis, and transferred to the statistics software (IBM SPSS Statistics for Windows, version 20.0). The data were analyzed using descriptive statistics (mean, standard deviation, frequency).



RESULTS

Patient records revealed that 98.30% of the admissions the ED were Turkish citizens. The mean age of the patients was 37.40 ± 15.86 years (min-max: 0-105). In this study 44 patients (0.90%) had a family history of psychiatric disorders. Socio-demographic characteristics and medical history of the admissions were presented in Table 1.

Moreover, 12.90% (n=661) of emergency psychiatric admissions visited the ED more than once during 2017. The average number of admissions was 1.27 ± 2.83 times (min-max: 1-182). Of the patients 87.10% (n=4479) visited the ED once, 12.20% (n=626) visited 2-5 times, and 0.70% (n=35) visited 6 times and more. Of the admissions 60.10% (n=3087) were followed up with a green triage tag and 39.90% (n=2053) with a red triage tag, and that 5.00% (n=255) were referred for psychiatric consultation. In terms of follow-up, it was determined that 93.60% (n=4810) of the patients were followed up on an outpatient basis, 3.60% (n=183) were hospitalized, 0.80% (n=41) was referred, 2.00% (n=104) refused treatment/left the ED, and 2 patients died. Admission characteristics were presented in Table 2.

Table 1. Characteristics (socio-demographic and medical history) of emergency psychiatric admissions

Characteristics	n	%
Age	0-14	103 2.00
	15-24	1214 23.60
	25-34	1105 21.50
	35-44	1144 22.30
	45-54	801 15.60
	55-64	473 9.20
	65 +	300 5.80
Sex	Female	3570 69.50
	Male	1570 30.50
Education status	Unspecified	3913 76.10
	Illiterate	30 0.60
	Literate	440 8.60
	Primary school graduate	522 10.10
	High school graduate	193 3.80
	Post-secondary education	42 0.80
Marital status	Unspecified	1676 32.60
	Married	2487 48.40
	Unmarried	448 8.70
	Widowed/divorced	529 10.30
Physical ailment	Yes	2140 41.60
	No	3000 58.40
Family history of psychiatric disorders	Unspecified	5026 97.80
	Yes	44 0.90
	No	70 1.40
Drug use status	Unspecified	4825 93.90
	Absent	296 5.70
	Present	19 0.40
Total	5140	100

The reason for coming to the ED could be determined in 8.67% (n=446) of the records (Table 3).

It was determined that 4.26% (n=219) of the patients were hospitalized in the psychiatry department during the year (min-max: 1-10 times), and that 81.03% (n=4165) of the patients that were admitted to the ED were administered medication or fluids (Table 4).

Table 2. Characteristics of emergency psychiatric admissions

Characteristics	n	%
Month of admission	January	308 6.00
	February	359 7.00
	March	417 8.10
	April	378 7.40
	May	368 7.20
	June	403 7.80
	July	547 10.60
	August	526 10.20
	September	487 9.50
	October	438 8.50
	November	443 8.60
	December	466 9.10
Time of admission	08:01-16:00	1510 29.40
	16:01-00:00	2478 48.20
	00:01-08:00	1152 22.40
	Unspecified	4961 96.50
Mode of admission	With family member(s)	102 2.00
	By ambulance	44 0.90
	With security forces	18 0.40
	By oneself	5 0.10
	By referral	10 0.20
Applied procedure(s) ^a	Physical examination	1222 23.80
	Laboratory analysis	1374 26.70
	Imaging (electrocardiogram, X-ray, etc.)	914 17.80
	Oral (PO)	191 3.70
	Intramuscular (IM)	2476 48.20
	Subcutaneous (SC)	9 0.20
	Intravenous (IV)	1780 34.70
	Inhalational (Inh, drug or Oxygen)	463 9.00
	Monitorization	117 2.30
	Catheterization	249 4.80
	Lavage	69 1.30
	Enema	1 0.00
	Dressing-splint	3 0.10
Total	5140	100

Note: a Multiple applications per subject were possible.



All emergency admissions (100.00%; N=5140) were examined by an emergency physician, the most common psychiatric diagnosis was ICD-10 F41 (Table 5), and 9.90% (n=509) were diagnosed with more than one psychiatric disorder.

Of the admissions 23.69% (n=1218) were examined in psychiatry outpatient clinics. It was determined that 52.87% (n=644) of these patients were diagnosed with F30-F39, 26.10% (n=318) with F40-F48, 17.98% (n=291) with F20-F29, and 5.84% (n=77) with F10-F19. It was also determined that there were comorbidities.

DISCUSSION

The recently increasing sensitivity towards human rights and the rights of people with mental disorders has led to various changes in the treatment and handling of mental disorders (Khawaled et al. 2009). In Taiwan 2.7% (n=516) of ED admissions over a 4-year period (Chen et al. 2010) and 3.4% (n=4506) of ED admissions in Australia over 1 year (Coates et al. 2019) were for mental reasons. In Turkey, 12.3% (n=1108) of calls to 112 emergency health care services were for psychiatric reasons (Aker et al. 2006). Another study found that 1.06% (n=1842) of the patients that were admitted to the ED of a training-research hospital were pre-diagnosed with a psychiatric disorder (Bahçecik et al. 2011). The fact that psychiatric diagnosis rate was only 0.93% in our study can be attributed to the central location of the related hospital

and the high number of the admissions to the hospital for general medical reasons.

All of admissions were examined by an emergency physician and the majority were diagnosed with F41 “other anxiety disorders” in our study. The second most common diagnosis was conversion disorder. Mood disorders, anxiety-related disorders, and schizophrenia and schizotypal disorders were common diagnoses among these patients admitted to the psychiatry outpatient clinics during the year. Bahçecik et al. (2011) determined that 75.6% of emergency psychiatric admissions were diagnosed with anxiety disorder and 11.4% with conversion disorder. These results are consistent with our findings. One study reported that, among the patients that were admitted to the ED of a mental health hospital, 12.9% were diagnosed with major depression and 11.5% with bipolar disorder (Küçükali et al. 2015). A 3-year retrospective study from Spain indicated that 19.8% of the patients that presented to the psychiatric emergency department were diagnosed with anxiety disorder (Pailhez et al. 2015). Also, a study from Israel found that 46.4% of the calls made to community-based psychiatric emergency services during the course of one month were diagnosed with schizophrenia/psychosis (Khawaled et al. 2009). It will be difficult for emergency physicians to establish a clear and differential diagnosis in a limited time in a crowded environment and in a field other than their specialty. Research results should be evaluated in detail while taking into consideration the social structure, access to mental healthcare services, the specialties of physicians working in ED, etc.

Table 3. Causes of admission^a

Admission complaints	Grouping	n	%
Ecstasy abuse, sniffing or ingesting rat poison, drug intoxication, carbon monoxide poisoning, substance-related psychosis, phenazepam withdrawal or coma, etc.	Intoxication	120	26.90
Insomnia, loss of appetite, hyperthermia, headache, nausea, vomiting, blurred vision, palpitations, epileptic seizure, dysphagia, convulsion, decreased self-care, dehydration, dyspnea, sleepwalking, etc.	Physical symptoms/findings	109	24.43
Skepticism, persecution delusions, active delusions, active hallucinations, disorganized behaviors, grandiosity, mystic delusions, self-talking, psychotic attack, self-repetitive speech, etc.	Psychotic findings	83	18.60
Aggression, agitation, damaging objects, excitation, tantrums, etc.	Uncontrollable anger	68	15.24
Depression, malaise, manic attack, depressive attack, grieving after the death of spouse, hypomania, pessimistic thinking, mixed bipolar symptoms, etc.	Affective and mood changes	51	11.43
Suicidal thoughts, hanging, jumping into a river, risk of homicide or suicide, self-injury, suicide attempt by chemical ingestion, jumping off a bridge, suicide attempt, etc.	Suicide/Homicide	40	8.96
Anxiety, fear, restlessness, etc.	Anxiety	26	5.82
Chest pain, conversion, fatigue, numbness in the arm, left-sided numbness after stress, sudden aphasia, etc.	Somatic findings	24	5.38
Post-operative delirium, post-accident speech difficulties, forgetfulness, dementia symptoms, confusion, etc.	Neurocognitive changes	13	2.91
Forensic hospitalization, drug non-compliance, personality disorder, dispute at school, receiving treatment, running from home, irritability, assault, dispute with father, etc.	Other	41	9.19
Total		446	100

Note:^aThere may be more than one reason of admission per subject.

**Table 4. Administered Drugs and Fluids^a**

Pharmaceutical / fluid group	n	%	Pharmaceutical / fluid group	n	%
Antihistaminic	2842	68.23	Anti-infectives	19	0.45
Isotonic solutions	513	12.31	Adrenergic	14	0.33
Anxiolytics	426	10.22	Antiepileptic	14	0.33
Nonsteroidal anti-inflammatory drug	408	9.75	Glucocorticoids	9	0.21
Antipsychotic	283	6.79	Ca ⁺⁺ channel blockers	8	0.19
Anticholinergics	160	3.84	Opioid analgesics	7	0.16
Antiemetic	152	3.64	Benzodiazepine	7	0.16
ACE inhibitors	146	3.50	Mucolytics	5	0.12
H2 receptor antagonists	136	3.26	Hypertonic solutions	4	0.09
Antispasmodics	104	2.49	Cardiac stimulants	4	0.09
Proton pump inhibitors	91	2.18	Vasodilators	3	0.07
Nonnarcotic analgesics	77	1.84	Beta blockers	3	0.07
Corticosteroids	60	1.44	Potassium	3	0.07
Diuretics	58	1.39	Insulin	3	0.07
Intestinal adsorbents	55	1.32	Cardiac glycosides	2	0.04
Vitamin combinations	39	0.93	Norepinephrine	1	0.02
Antithrombotics	34	0.81	Antiarrhythmics	1	0.02
Psychostimulants	34	0.81	Erythropoietin	1	0.02

Note:^aMultiple drug/fluid applications per subject were possible.

In our study, 69.50% of psychiatric emergency admissions were women and 30.50% were men. In similar studies about the subject matter, the gender distribution varies from 46.5% to 66.1% for women and from 33.9% to 53.5% for men (Küçükali et al. 2015; Roggenkamp et al. 2018; Coates et al. 2019; Bağcıekil et al. 2011; Aker et al. 2006; Chen et al. 2010). According to the Turkish Mental Health Profile study; the frequency of having a mental disorder is 22.4% in adult women and 17.2% in adult men (Öztürk, Uluşahin 2016). Mental problems are more common in women compared to men due to psychosocial reasons such as gender discrimination, inability to express oneself, limited resources, expectation of submissive behaviors and biological reasons such as biological differences, long life spans, and frequent reproductive health problems (Kartal, Başer 2011; Kring 2017).

When we examined the frequency of age distributions, we observe that the mean age was 37.40±15.86 years and of the individuals 23.60% was 15-24 years, 22.30% was 35-44 years, and 21.50% was 25-34 years. Our research findings are supported by some information in the literature (Küçükali et al. 2011; Roggenkamp et al. 2018; Bağcıekil et al. 2011; Aker et al. 2006), but other sources show that psychiatric emergencies frequently occur at advanced ages (Coates et al. 2019; Chen et al. 2010). This difference can be explained by differences in the demographic structure of the population living in a particular region. In our study, admissions made by young people and adults can be associated with the diagnosis of mental problems at young ages, identity acquisition and relationship conflict are generally experienced during these periods, and lack of sufficient support in crisis management.

It was observed that psychiatric emergency admissions were most frequently made during the evening and in summer months. One study evaluated psychiatric calls and found that these calls were commonly made during June and February and in the evening (Aker et al. 2006). Similarly, Bağcıekil et al. (2011) reported that psychiatric emergency admissions were more common in the evening, and these patients were commonly diagnosed with anxiety disorder.

The high workload in EDs resulting from intradepartmental (documentation, care and training planning requests etc.) and external (high application rates etc.) factors lead to several unfavourable consequences including the overcrowding of emergency services, long waiting times, disruption of qualified treatment and care services for patients, and overwhelming fatigue in the healthcare team (Küçükali et al. 2015; Büyükbayram, Engin 2018; Park et al. 2009; Kumar et al. 2019). In Australia, for psychiatric emergency admissions, patients are aimed to receive the necessary service within 4 hours at most, and mental health triage is applied for this (Coates et al. 2019). In our study, the fact that patients were frequently followed up in green triage area in ED admissions for psychiatric reasons can be explained by the use of the three-category emergency triage application that does not contain sufficient evaluations for mental health.

**Table 5. ICD-10 Psychiatric Diagnoses^a**

ICD-10 Psychiatric Diagnosis Groups^b	n	%
F00-F09 Organic, Including Symptomatic, Mental Disorders		
F00 Dementia in Alzheimer Disease	16	0.31
F10-F19 Mental and Behavioral Disorders due to Psychoactive Substance Use		
F10 Mental and Behavioral Disorders due to Use of Alcohol	1	0.01
F19 Mental and Behavioral Disorders due to Multiple Drug Use and Use of Other Psychoactive Substances	113	2.19
F20-F29 Schizophrenia, Schizotypal and Delusional Disorders		
F20 Schizophrenia	46	0.89
F22 Persistent Delusional Disorders	1	0.01
F23 Acute and Transient Psychotic Disorders	2	0.03
F28 Other Nonorganic Psychotic Disorders	2	0.03
F29 Unspecified Nonorganic Psychosis	6	0.11
F30-F39 Mood [Affective] Disorders		
F30 Manic Episode	1	0.01
F31 Bipolar Affective Disorder	59	1.14
F32 Depressive Episode	106	2.06
F40-F48 Neurotic, Stress-Related and Somatoform Disorders		
F41 Other Anxiety Disorders	4320	84.04
F44 Dissociative [Conversion] Disorders	434	8.44
F50-F59 Behavioral Syndromes Associated with Physiological Disturbance and Physical Factors		
F50 Eating Disorders	6	0.11
F51 Nonorganic Sleep Disorders	3	0.05
F52 Sexual Dysfunction not Caused by Organic Disorder or Disease	6	0.11
F80-F89 Disorders of Psychological Development		
F84 Pervasive Developmental Disorders	4	0.07
F90-F98 Behavioral and Emotional Disorders with Onset Usually Occurring in Childhood and Adolescence		
F91 Conduct Disorders	1	0.01
F98 Other Behavioural and Emotional Disorders with Onset Usually Occurring in Childhood and Adolescence	13	0.25
Total	5140	100

Note: ^a There were diagnosed with more than one psychiatric disorder.

^b F00-F99: Mental and Behavioural Disorder (WHO 2016)

Being unmarried, being homeless, having multiple psychiatric disorders, a history of substance use, and personality disorders were some of the reasons for repeated emergency psychiatric admissions (Boyer et al. 2011). We found that the rate of multiple psychiatric emergency admissions during the course of one year was 12.90%. Two different studies from Turkey reported that 22.8% of psychiatric emergency patients were admitted two or more times (Bahçecik et al. 2011) and 48% four or more times (Küçükali et al. 2015). It has been determined that emergency admissions were mostly accompanied by relatives, and admissions were frequently made due to intoxication and physical symptoms. The literature (Küçükali et al. 2015; Roggenkamp et al. 2018; Chen et al. 2010) suggests that admission complaints may be related to the mode of hospital admission.

In the study, patients frequently underwent IM and IV applications, laboratory tests, examinations, and imaging procedures. Psychiatric consultation was requested for 5.00% of the patients, the majorities were followed up on an outpatient basis, 3.60% were hospitalized, and 2.00% left the emergency room or refused treatment. In one ED of a public

hospital, psychiatric consultation was requested for 0.11% of the admissions due to reasons such as excitation, psychomotor agitation, depressive symptoms, and suicide attempt, and 36.1% of these patients were hospitalized (Yağcı et al. 2019). Another study reported the rate of hospitalization for emergency psychiatric admissions to be 31% (Küçükali et al. 2015). A study from abroad found that in psychiatric EDs, patients were frequently administered injections with or without physical restraint, and the majorities were referred to the psychiatry outpatient clinic (Chen et al. 2010). The fact that some of our patients left the emergency room or refused treatment may be associated with the long ED waiting times and/or that symptoms reduced after a period of time.

It was found that consultation request for anxiety, poor life skills, and a history of toxic substance abuse influenced the decision of initiating benzodiazepine, antidepressants, and antipsychotics to patients followed up in the ED with anxiety disorder (Pailhez et al. 2015). Antihistamines are frequently used in the treatment of anxiety, have a rapid onset of action, do not cause withdrawal symptoms, and are associated with less sleep-promoting effects compared to

benzodiazepines (Öztürk, Uluşahin 2016). In our study, antihistamines may have been the primary treatment option due to the high prevalence of anxiety-related disorders and their rapid onset of action.

The limitations of the study were comprised of incomplete data due to certain information not being available in the information system, only the data from the hospital information system were used, and information from available triage tags was not evaluated.

It is stated by the World Health Organization that a significant number of individuals with mental problems or psychiatric disorders are devoid of adequate access to mental health services (Roggenkamp et al. 2018). In this context, one can argue that the results of our research shed light on the following priorities including raising awareness of psychiatric crisis management in the emergency team, implementation of multidisciplinary approaches, and the use of alternative mental health triage scales in emergency services.

Financial Support

No financial support was received for this research.

Conflict of Interest

No conflict of interest was declared.

Informed Consent

After obtaining the necessary permissions, the data were accessed through hospital records, not directly from patients.

Ethical Approval

For this study, permission was obtained from the Non-interventional Research Ethics Committee of Sakarya University Faculty of Medicine on January 29, 2018 (No: 71522473/050.01.04/26) and the Provincial Health Directorate (No: 24404279/702.99). The Hospital permission was also obtained (dated March 15, 2018; numbered 24404279-799).

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