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Retrospective study on suicide attempts among psychiatric emergencies admitted to the emergency department of a Regional hospital in Turkey

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Abstract

Introduction The aim of this study was to determine the sociodemographic characteristics of psychiatric emergencies presenting to emergency departments (ED), the provisional diagnoses and reasons for consultation by emergency physicians, and to determine the rate of suicide attempts among patients presenting to emergency departments for psychiatric emergencies.

Methods The records of all patients aged 18 years and older admitted to the emergency department of the Department of Emergency Medicine, a tertiary hospital, with either a pre-existing psychiatric diagnosis or a new psychiatric provisional diagnosis made by emergency physicians between January 2020 and December 2023 were reviewed.

Results According to the data obtained in the study, it was determined that the most common provisional diagnoses made by emergency physicians in psychiatric emergencies were suicide attempts (41.88%), agitation (21.94%), schizophrenia (8.44%), psychosis (7.91%) and manic attack (6.54%). It was found that 49.3% of psychiatric emergencies resulted in discharge and 25.5% resulted in hospitalisation. Among the provisional diagnoses, depression, mutism and sleep disorders were most commonly associated with refusal of treatment, while depression and suicide were the most common reasons for hospitalisation. Among psychiatric emergency patients who attempted suicide, medication, sharp objects and chemicals were the most common substances ingested.

Discussion In this study, it was determined that a great portion of the emergency psychiatric cases admitted to the emergency department consisted of patients who attempted suicide. However, due to the crowdedness and fast pace of emergency departments, it is understood that in psychiatric emergencies, epidemiological profile data are missing in the files of the cases and detailed medical history cannot be obtained from the patients We think that recording better data of patient who admitted a psychiatric condition to the emergency department will provide better information about the patients in future visits and improve the care to be provided. Psychiatrists and psychiatric nurses recommend the implementation of emergency department-based rehabilitation programs for these patients.

Highlights

- Psychiatric emergencies presenting to emergency departments should not be overlooked in terms of suicide risk.
- Psychiatric emergencies who have attempted suicide should be closely followed at frequent intervals.
- Emergency department staff should be educated about psychiatric emergencies and suicide risk.

Keywords Psychiatric emergencies · Suicide attempts · Emergency department · Mental health · Retrospective

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Introduction

Emergency departments are considered to be the most active, intensive, stressful and complex units within healthcare facilities. While striving to provide life-saving measures, assess patients in need of urgent intervention, and provide emergency care and treatment, these services are provided around the clock, every day of the year, as quickly as possible (Özhanlı & Akyolcu, 2020). Individuals experiencing acute psychiatric problems, often turn to emergency departments regardless of the time of day or day when they cannot access or are not connected to facilities that directly provide mental health services (Kalb et al., 2019). Studies conducted at different times in the US and Turkey have shown that psychiatric emergencies constitute 3–12% of emergency room admissions (Aksoy & Kahriman, 2022: Zeller et al., 2014: Hazlett et al., 2004). Psychiatric emergencies are defined as acute behavioural, thought or mood disorders in which an individual, if left untreated, may harm themselves or others (Örüm, 2020). These emergencies can be categorised as situations that endanger the life of the individual (suicide, intoxication, etc.), endanger the lives of others (aggression) and disrupt the course of life (psychotic episode, grief reaction, abuse, etc.). They may arise from various chronic mental illnesses, psychosocial stress disorders, life events, medical conditions causing psychiatric symptoms, poisoning, substance use, medication side effects, and drug-drug interactions (Büyükbayram & Engin, 2018). In emergency departments operating on a certain schedule, stabilisation of psychiatric patients, history taking, psychiatric examination, physical examination and treatment are usually attempted in a very short time (Bahçeci et al., 2011). Emergency physicians and nurses are expected to have a basic level of knowledge in psychiatric emergencies, as in other medical conditions. When examining the ability of non-psychiatrist physicians to make psychiatric diagnoses, cognitive disorders and substance use disorders are largely correctly identified, but depression is only correctly recognised in more than 50% of cases (Sertöz et al., 2008; Bahçeci et al., 2011). The preliminary diagnoses made for psychiatric patients in emergency departments may be crucial for these patients to receive psychiatric care in the future (Silverman et al., 2015). A study of emergency department nurses showed that nurses face many difficulties in assessing and caring for patients with mental distress (Büyükbayram & Engin, 2018). It is crucial for emergency department staff to have a basic level of knowledge in the diagnosis and management of psychiatric emergencies.

Psychiatric emergencies may be associated with suicidal behaviour, making short and long-term follow-up of these patients important (Unick et al., 2011). There is evidence of an increase in suicidal tendencies in psychiatric emergencies (Unick et al., 2011). The presence of mental disorders is a significant risk factor for suicide. Among the psychiatric diagnoses commonly observed in people who die by suicide, mood disorders and substance use disorders are frequently reported (Unick et al., 2011; Bertolote et al., 2010). Systematic assessment of suicide risk in emergency departments should be a routine clinical practice to effectively manage and refer potentially lethal cases (Bertolote et al., 2010). In this study, the identification of suicide attempts and mental health problems among psychiatric emergencies presenting to emergency departments may be beneficial for early identification of individuals at risk and referral to preventive mental health services. In this study, attempts were made to address the following questions:

- What are the sociodemographic characteristics of psychiatric emergencies presenting to emergency departments?
- What are the provisional diagnoses or reasons for consultation made by emergency physicians in psychiatric emergencies?
- What is the rate of suicide attempts in patients admitted to the emergency department for emergency psychiatric conditions?

Methods

Type of research

This study is retrospective and descriptive in nature.

Study population and sample

A total of 1100 psychiatric emergency cases presented to the Emergency Department between January 2020 and December 2023 constituted the population of the study. The study was conducted in a tertiary university hospital. The city where the hospital is located has a population of approximately 450,000. The annual patient visits to the emergency department of the hospital is approximately 100.000. There are 4 or 5 emergency physicians working in the emergency department daily. This hospital is the only hospital in the city with an inpatient psychiatric service. The patients whose files were incomplete, who had not undergone psychiatric evaluation, who presented with a neurologic or metabolic cause but underwent psychiatric evaluation (no acute psychiatric problem was considered in the evaluation) were excluded from the study. Within the specified periods, 948 psychiatric emergency cases, for which the majority of

data were accessed from hospital information systems and reports, formed the sample of the study.

Study inclusion criteria

Patients presenting to the emergency department with emergency psychiatric conditions were included in the study. These conditions could be an acute exacerbation of a known psychiatric illness or a new provisional psychiatric diagnosis made by emergency physicians (All patients were evaluated by a psychiatrist). Records that did not meet these criteria were excluded from the study. Patient demographics, provisional emergency department diagnoses, suicide attempts, hospital admissions, discharge status, and other outcomes were recorded using a form developed for the study.

Data sources

Data related to psychiatric emergencies presenting to the Department of Emergency Medicine, a tertiary university hospital, between January 2020 and December 2023 were obtained from the hospital information system. Data on psychiatric emergencies investigated and identified by emergency physicians were recorded on a data collection form and transferred to SPSS for analysis. Although demographic data were available for all cases, some cases had missing information. Therefore, psychiatric emergencies with incomplete referral records for most of the characteristics examined were not included in the analysis.

Variables

Patients' age, gender, marital status, number of children (if any), educational status, health insurance, presence of a previous psychiatric illness and related hospitalization were examined. The diagnoses of the patients were defined according to the information recorded in the emergency department visit file and ICD-10 diagnosis codes. In patients with suicide attempts, the history was taken by the patient himself/herself or confirmed by relatives.

Ethical considerations

The study was approved by the local ethics committee (Date: 20.03.2023, Decision no: 2023/08). Following approval by the Ethics Committee, institutional approval was obtained from the a tertiary university hospital. Administration to conduct the study. As the study was based on retrospective document review, case information forms were obtained anonymously. The study was conducted in accordance with the Declaration of Helsinki. Due to the retrospective nature of the study, informed consent was not required.

Data analysis

All data were recorded in the SPSS-20 program on the computer and the relationships between variables were summarised using descriptive statistics, providing frequency and percentage values.

Results

Of the 948 patients included in the study, 51.69% were male, 44.20% were single, with a mean age of 37.85 ± 15.15 years, and 74.05% were found to be childless. In terms of educational status, 8.76% were university graduates (Table 1).

Table 2 shows that the most common reasons for emergency department visits were suicidal tendency (41.88%), agitation (21.94%), schizophrenia (8.44%), psychosis (7.91%) and manic episode (6.54%). It was found that 2.11% of psychiatric emergencies used emergency services for treatment arrangements.

According to Table 3, it is observed that 49.3% of psychiatric emergencies presenting to the emergency department resulted in discharge, while 25.5% resulted in admission. Among the reasons for presentation, it is noted that the group most frequently refusing treatment includes depression, mutism, and sleep disorders, whereas the group with the highest admission rates consists mainly of depression and suicidal tendencies.

According to Table 4, it has been determined that patients most commonly attempted suicide by ingesting medication (74.10%), using sharp objects (6.05%), and consuming chemicals (3.52%).

Discussion

This study found that the most common reasons for presentation made by emergency department physicians were suicide attempt, agitation, schizophrenia, psychosis and manic episode. Additionally, it was observed in this study that emergency departments are used for the purpose of arranging psychiatric treatments, albeit by a very small minority. This study highlights the important role of emergency departments in stabilizing psychiatric emergencies and assessing the main symptoms, especially in initial presentations. It is essential for emergency medicine physicians and nurses to have sufficient levels of approach to psychiatric emergencies, as well as for the organization of psychiatric treatments and stabilization of psychiatric emergencies. Furthermore, support from consultation-liaison psychiatry in emergency departments may enhance awareness among emergency department staff regarding psychiatric

Table 1 Distribution of psychiatric emergencies according to sociodemographic characteristics

Variable	Group	$n = 948$	%
Gender	Male	490	51.69
	Female	458	48.31
Marital Status	Single	419	44.20
	Married	391	41.25
	Unknown	138	14.55
Having child	No	702	74.05
	Yes	246	25.95
Educational Status	Primary School (4 years)	65	6.86
	Middle School (4 years)	32	3.38
	High School (4 years)	69	7.28
	University	83	8.76
	Unknown	699	73.72
Health Insurance	Yes	917	96.73
	No	31	3.27
Previous psychiatric diagnosis	Yes	524	55.27
	No	171	18.04
	Unknown	253	26.69
Psychiatric hospitalization history	Yes	150	15.83
	No	163	17.19
	Unknown	635	66.98
Average Age	**Min**	**Max**	**Mean ± SD**
	18	91	37.85 ± 15.15

SD Standard deviation

Table 2 Reasons for presentation[a] in the emergency department

Variable	*n*	%
Agitation	208	21.94
Anxiety	27	2.85
Altered consciousness	20	2.11
Manic episode	62	6.54
Depression	6	0.63
Hypochondriasis	4	0.42
Conversion disorder	5	0.53
Substance use	18	1.90
Panic attack	9	0.95
Mutism	12	1.27
Psychosis	75	7.91
Suicide attempts	397	41.87
Schizophrenia	80	8.44
Treatment arrangement	20	2.11
Sleep disorder	5	0.53
Total	948	100.00

[a]For patients with more than one clinical condition, the chief complaint is written

emergencies. Research indicates that the utilization rates of emergency departments for psychiatric needs are increasing, as well as their proportion among all emergency department visits (Matsumoto et al., 2017; Santillanes et al., 2020; Costanza et al., 2020). Emergency departments function not only as an entry point but also as a last safety net for patients requiring psychiatric intervention due to inadequate mental health services (Newton et al., 2010; Parker et al., 2003). Providing in-service training on psychiatric emergencies by psychiatrists and psychiatric nurses can increase awareness among emergency department staff on how to approach psychiatric emergencies and alleviate their concerns.

It was found that psychiatric emergency visits to the emergency department most frequently resulted in discharge, admission, or treatment refusal. When we look at the reasons for presentation, the group most frequently presentation consisted mainly of suicide attempts, agitation, psychotic disorders (schizophrenia, psychosis) and mood disorders (manic episode). In a study conducted in Turkey, it was reported that the most common reasons for psychiatric emergency department visits were mood disorders (bipolar manic, depressive, mixed episodes, major depression) and psychotic disorders (schizophrenia, schizoaffective disorder, atypical psychosis, brief psychotic disorder) (Küçükali et al., 2015). Another study stated that the most common diagnoses among adult psychiatric emergency department visits were depression, anxiety, suicide attempt, psychosis, and substance use disorders (Costanza et al., 2020). In this study, the higher number of suicide attempts compared to other studies may be related to being the only hospital in the city with an inpatient psychiatric service. This is also the reason why most hospitalized patients are suicide attempters, but most cases may have ongoing suicidal ideation, toxicological follow-up of patients taking medication or underlying psychiatric diseases.

Table 3 Outcome of psychiatric emergency visits based on reasons for presentation

	Result of visit						
Reasons for presentation	Number Percentage	Unknown	Rejection	Transfer to another hospital	Discharge from ED[a]	Hospitalization	Total
Agitation	N	17	26	17	111	37	208
	%	8.2	12.5	8.2	53.4	17.8	100.0
Anxiety	N	2	3	1	13	8	27
	%	7.4	11.1	3.7	48.1	29.6	100.0
Altered consciousness	N	0	0	2	15	3	20
	%	0.0	0.0	10.0	75.0	15.0	100.0
Manic episode	N	4	8	4	32	14	62
	%	6.45	12.90	6.45	51.61	22.58	100.00
Depression	N	1	1	0	2	2	6
	%	16.7	16.7	0.0	33.3	33.3	100.0
Hypochondriasis	N	1	0	0	2	1	4
	%	25.0	0.0	0.0	50.0	25.0	100.0
Conversion disorder	N	2	0	0	2	1	5
	%	40.0	0.0	0.0	40.0	20.0	100.0
Substance use	N	2	1	0	13	2	18
	%	11.1	5.6	0.0	72.2	11.1	100.0
Panic attack	N	0	0	0	8	1	9
	%	0.0	0.0	0.0	88.9	11.1	100.0
Mutism	N	1	2	0	9	0	12
	%	8.3	16.7	0.0	75.0	0.0	100.0
Psychosis	N	4	6	5	39	21	75
	%	5.3	8.0	6.7	52.0	28.0	100.0
Suicide attempts	N	28	48	23	169	129	397
	%	7.1	12.1	5.8	42.6	32.5	100.0
Schizophrenia	N	7	5	9	39	20	80
	%	8.8	6.3	11.3	48.8	25.0	100.0
Treatment arrangement	N	4	3	0	10	3	20
	%	20.0	15.0	0.0	50.0	15.0	100.0
Sleep disorder	N	1	1	0	3	0	5
	%	20.0	20.0	0.0	60.0	0.0	100.0
Total	N	74	104	61	467	242	948
	%	7.8	11.0	6.4	49.3	25.5	100.0

[a]*ED* Emergency department

Table 4 Suicide attempts methods in psychiatric emergencies

Variable	$n=397$	%
Hanging	7	1.75
Firearm	3	0.75
Jumping from height	9	2.25
Medication	294	74.10
Self-burning	1	0.25
Cutting tool	24	6.05
Chemical substance	14	3.52
Unknown	45	11.33
Total	397	100

When we look at the reasons for presentation, the group most frequently refusing treatment included depression, mutism, and sleep disorders. In a study involving patients who refused planned treatment, it was noted that these patients were often not clinically urgent, and the two main reasons for treatment refusal were the long follow-up required for the treatment and the patient feeling better after examination (Gözübüyük & Akbulut, 2014). Symptoms such as hostility, denial of illness, and psychotic disorganization during the acute phase of psychotic disorders can lead to treatment refusal (Çobanoğlu et al., 2003). The aim of psychiatric treatment is for psychiatric patients to regain autonomy. Parameters such as under what circumstances psychiatric patients may refuse treatment in emergencies and considerations of their mental capacity during treatment refusal can be crucial. Pre-existing decisions regarding treatment refusal allow individuals to determine their treatment preferences in situations where their mental capacity may be compromised in the future. There is no legal regulation regarding 'Pre-existing decisions regarding treatment refusal' in our country. Therefore, in cases where the patient

lacks insight, the treatment process is discussed with the patient's relatives, judicial institutions, and hospital administration. There is limited information about the effectiveness of pre-existing decisions regarding treatment refusal in emergency departments (Quinlivan et al., 2019). However, there is a lack of available information in this study regarding the adequacy of the mental capacities of psychiatric emergency patients who refuse treatment. If patients within the psychiatric emergency group have mental capacity and can communicate their treatment preferences, they may refuse treatment (Roychowdhury, 2009). If emergency departments are equipped with appropriate physical space and trained personnel or if the number of psychiatric emergency services is increased, care can be provided to individuals with mental illness in suitable environments. This may potentially reduce the rate of treatment refusal among patients presenting to psychiatric emergencies, and data can be obtained regarding their use of mental health services after discharge (Nussbaum & Wynia, 2020). In this context, therapeutic communication, consultation planning, effective treatment arrangements, and social support can be crucial in ensuring treatment adherence among patients with psychotic disorders.

It was determined that psychiatric emergencies presenting with suicide most commonly attempted suicide by ingesting medication, using sharp objects, and consuming chemicals. When studies related to suicide attempts in emergency departments in Turkey were examined, it was noted that the most common method of suicide attempt was taking a high dose of medication (Atlı et al., 2014; Ata et al., 2021). According to data on 56,712 suicide attempts in Slovenia from 1976 to 2016, the most common methods of suicide attempts were hanging and ingestion of medications, while hanging was the most frequent cause of death by suicide (Zalar et al., 2018). In a study examining suicide trends in Queensland, Australia between 2000 and 2015, hanging and drug poisoning were found to be the most common methods of suicide attempts in both genders (Kõlves et al., 2018). A meta-analysis of suicides resulting in death revealed that the most commonly used suicide methods were firearms, hanging, drowning, medication, and sharp object use (Cai et al., 2022). The suicide cases discussed in this study are incomplete, meaning they did not result in death. In this study, the high prevalence of medication use as a method of suicide attempt among psychiatric emergencies could be attributed to the high risk of death from the excessive or improper use of medications by psychiatric patients or their perception that it is less painful. It also suggests that the seriousness of interventions may be lower or that it may be a method that is commonly used and transmitted in the community. Emergency departments can represent a significant additional environment for preventing suicide in mental health patients. The majority of those presenting before a suicide attempt may seek help to self-harm or seek psychiatric assistance. Based on this result, emergency department staff should be vigilant regarding presentations related to suicide and psychiatric emergencies.

Limitations

Since the study was retrospective, data were collected from hospital records. Due to the retrospective nature of the study, the data of some patients who underwent psychiatric evaluation could not be accessed. These are shown as "unknown" in the tables. Diagnosis codes that stood out as the reason for presentation to the emergency department were added to these retrospective data for patients with more than one diagnosis. These can be stated as the weaknesses of the study. The fact that the study was conducted in the only hospital in the city with an inpatient psychiatric service can be emphasized as a strength of the study as it may better reflect the general situation of the city. However, the data regarding which department or unit these patients were admitted to was insufficient.

Conclusion and recommendations

The epidemiological profile data obtained from the investigation of psychiatric emergencies presenting to the emergency department indicate inadequacy or deficiencies in data entry in the files of psychiatric emergencies. It appears that information necessary to reveal the current profiles of psychiatric emergencies is not entered into the system or not inquired from patients. It can be understood that detailed medical history cannot be obtained from patients due to the crowding and fast pace of emergency departments. Therefore, it is recommended to have a mental health triage system within emergency departments to serve psychiatric emergencies or to have more collaboration with the consultation liaison psychiatry unit of emergency departments. We think that recording better data of patient who admitted a psychiatric condition to the emergency department will provide better information about the patients in future visits and improve the care to be provided. It was determined that a great portion of the emergency psychiatric cases admitted to the emergency department consisted of patients who attempted suicide. Although suicide attempt is a form of application, it should be kept in mind that the patient may have another underlying disease.

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Data availability The data created within the scope of the study can be accessed from the authors upon appropriate request, provided that legal and ethical rules are respected.

Declarations

Ethical approval The Helsinki guidelines were followed during the study's execution.

Conflict of interest No conflict of interest has been declared.

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