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Retrospective evaluation of psychiatry consultations requested from inpatients at a training and research hospital

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ABSTRACT

Aims: This study aimed to retrospectively evaluate psychiatric consultations requested for inpatients at a training and research hospital and to examine their clinical and demographic characteristics.

Methods: This retrospective, descriptive, and cross-sectional study included a total of 497 inpatients aged 18 and over who received psychiatric consultation between April 1, 2025, and March 31, 2026. Data were obtained from the hospital record system and patient files. The patients' sociodemographic characteristics, reasons for requesting consultation, the clinics requesting the consultation, and their psychiatric diagnoses were evaluated. Diagnoses were made through clinical interviews.

Results: The mean age of the patients was 62.4±18.1 years, and 50.1% were female. The most frequent reasons for requesting consultation were psychiatric medication adjustment (25.2%), agitation (19.5%), and depressive symptoms (14.7%). Consultations were most frequently requested from internal medicine departments (39.0%), followed by surgical departments (27.6%), intensive care unit (16.7%), and palliative care unit (16.7%). The most common diagnostic group was anxiety disorders and depressive disorders (45.7%), followed by those without a psychiatric diagnosis (21.9%), delirium (15.9%), and sleep disorders (11.3%). The fact that the number of consultations requested due to anxiety and depressive symptoms is lower than the number of patients diagnosed with these conditions suggests that these disorders are often reflected in clinical settings through indirect symptoms.

Conclusion: In inpatient settings, psychiatric consultations contribute not only to diagnosis but also to treatment planning and clinical management processes. Early recognition of psychiatric symptoms and effective use of consultation processes can improve the quality of patient care.

Keywords: Consultation-liaison psychiatry, inpatients, depression, delirium

INTRODUCTION

A significant proportion of patients suffering from medical illnesses also experience mental health problems.[1,2] Studies show that at least one-third of patients admitted to internal or surgical wards have psychiatric comorbidities,[3,4] and approximately half of inpatients may have a clinically treatable psychiatric problem.[5] It has been reported that the rate of mental disorders can reach approximately 42% in those with chronic physical illnesses.[6] Mental illnesses can affect the course of the existing illness, preventing the expected improvement from being achieved despite appropriate treatment.

Consultation-liaison psychiatry (CLP) is a subspecialty of psychiatry that focuses on the assessment and management of psychiatric disorders in patients with coexisting medical and surgical illnesses. It also offers training activities on mental disorders to healthcare personnel working in non-psychiatric departments of hospitals.[7,8] 'Consultation' refers to the assessment and management requested by the physician managing the patient's diagnosis, follow-up, and treatment process from another physician working in that field for a patient's other complaint. The word "liaison" refers to the connection between departments to ensure integrated work. In tertiary healthcare, CLP helps patients adapt to medical conditions and maintain long-term care, and also contributes to the improvement of their treatments (both pharmacological and psychotherapeutic).[9]

Previous studies have shown that CLP reduces medical complications, length of hospital stay, and number of hospitalizations by facilitating early referral to psychiatric consultations, treatment of psychiatric presentation in medical and surgical units, and access to appropriate post-discharge psychiatric treatment.[5,10-12] If accompanying psychiatric symptoms or disorders are not recognized and treated, they can lead to adverse treatment outcomes, decreased quality of life, chronicity, increased risk of secondary complications, prolonged and repeated hospitalizations, and consequently higher patient costs for healthcare providers.[13,14] Previous studies have reported that the most common reasons for psychiatric consultation requests include nonspecific

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'psychiatric evaluation' requests,[15,16] agitation[17,18] and depressive symptoms.[19,20] It is reported that the most frequent diagnosis made in consultations requested from inpatients is depression.[21]

Despite the growing body of research in consultation-liaison psychiatry, further institutional-level studies are needed to better understand the characteristics and utilization of psychiatric consultation services in general hospitals. A retrospective evaluation of psychiatric consultation requests can provide valuable information regarding referral patterns, consultation indications, psychiatric comorbidities, and service utilization. Therefore, the present study aimed to retrospectively evaluate psychiatric consultations requested for hospitalized adult patients at a training and research hospital by examining the sociodemographic and clinical characteristics of the patients, the reasons for consultation requests, the requesting departments, and the psychiatric diagnoses established following psychiatric evaluation.

METHODS

Ethics

Approval for the study was obtained from the Ordu University Non-interventional Scientific Researches Ethics Committee (Date: 10.04.2026, Decision No: 2026/100). All procedures were carried out in accordance with the ethical rules and the principles of the Declaration of Helsinki.

Study Design

This study was planned as a retrospective, descriptive, and cross-sectional research evaluating psychiatric consultations requested for patients hospitalized at a training and research hospital. Patients aged 18 and over who were hospitalized between April 1, 2025, and March 31, 2026, and for whom a psychiatric consultation was requested were included in the study. Inclusion criteria were age ≥18 years and complete records regarding age, sex, requesting department, reason for consultation, and psychiatric diagnosis. The study was restricted to psychiatric consultations requested for hospitalized adult patients; therefore, consultations originating from the emergency department, outpatient clinics, and forensic units were outside the scope of the study.

Data were collected retrospectively from patient files and the hospital information management system. Sociodemographic characteristics of the patients, the clinic where they were admitted, the reasons for requesting a psychiatric consultation, and the diagnoses made as a result of the psychiatric evaluation were recorded. Psychiatric diagnoses were established through routine clinical interviews conducted by board-certified psychiatrists as part of the consultation-liaison psychiatry service. Owing to the retrospective design of the study, structured diagnostic interviews were not routinely administered, and diagnoses were based on clinical evaluations documented in the hospital records. Each patient was assigned to a single psychiatric diagnostic category based on the primary diagnosis established during the consultation.

In the analysis phase, anxiety and depressive disorders were considered together because of their frequent clinical co-occurrence and substantial overlap in symptom presentation, particularly in consultation-liaison psychiatry, where psychiatric symptoms often emerge in the context of acute medical illness and may not always fulfill the criteria for clearly distinguishable diagnostic categories. Accordingly, a reliable retrospective differentiation between anxiety and depressive disorders was not considered methodologically appropriate, and these disorders were therefore evaluated as a single diagnostic category for the purposes of analysis.

Statistical Analysis

The data were performed using SPSS 22.0 (Statistical Package for the Social Sciences Inc.). Descriptive statistics and continuous variables were presented as mean±standard deviation, while categorical variables were presented as frequency and percentage. Associations between the reason for consultation and psychiatric diagnostic groups were evaluated using Pearson's Chi-square test. Effect size was assessed using Cramer's V. A p-value <0.05 was considered statistically significant.

RESULTS

A total of 497 patients were included in the study. 249 (50.1%) of the patients were women and 248 (49.9%) were men, with an average age of 62.4±18.1 years.

When the reasons for requesting consultation were examined, the most frequent reason was psychiatric medication adjustment (25.2%), followed by agitation (19.5%), depressive symptoms (14.7%), insomnia (10.7%), and anxiety (9.9%). Other reasons accounted for 12.1% of consultations and included behavioral changes, treatment refusal, assessment of decision-making capacity, substance use-related problems, somatic symptoms, pain-related psychiatric evaluations, grief reactions, and other infrequent consultation requests. Preoperative psychiatric evaluation (3.8%), suicide attempt (3.2%), and consultations requested without a specified reason (1.0%) were observed at lower frequencies. The findings are presented in Table 1.

Table 1. Reasons for requesting consultation

Reason for consultation	Number (n)	%
Psychiatric medication adjustment	125	25.2
Agitation	97	19.5
Depressive symptoms	73	14.7
Insomnia	53	10.7
Anxiety	49	9.9
Preoperative assessment	19	3.8
Suicide attempt	16	3.2
Unspecified cause	5	1.0
Other reasons	60	12.1

When the clinics requesting consultation were grouped, the highest rate was found to be from internal medicine departments (39.0%), followed by surgical departments (27.6%), intensive care units (16.7%), and palliative care services (16.7%). The findings are presented in Table 2.

The most frequent diagnoses in psychiatric evaluation were anxiety disorders and depressive disorders (45.7%), followed

by those without a psychiatric diagnosis (21.9%), delirium (15.9%), and sleep disorders (11.3%). Adjustment disorder (1.6%), intellectual disability (1.6%), schizophrenia (1.2%), bipolar disorder (0.6%), and conversion disorder (0.2%) were detected at lower rates. The findings are presented in Table 3.

Table 2. Clinics requesting consultation

Clinical group	Number (n)	%
Internal medicine services	194	39.0
Surgical services	137	27.6
Intensive care units	83	16.7
Palliative care service	83	16.7

Table 3. Distribution of psychiatric diagnoses received by patients

Diagnosis	Number (n)	%
Anxiety and depressive disorders	227	45.7
Those without psychiatric diagnosis	109	21.9
Delirium	79	15.9
Sleep disorders	56	11.3
Adjustment disorder	8	1.6
Intellectual disability	8	1.6
Schizophrenia	6	1.2
Bipolar disorder	3	0.6
Conversion disorder	1	0.2

When the clinics requesting consultation were examined in detail, it was seen that the highest rate belonged to the internal medicine clinic (19.3%; n=96). Palliative care and intensive care units follow with equal rates (16.7% each; n=83). Among surgical branches, orthopedics was the most frequently requesting department for consultations (8.7%; n=43), while cardiology (7.2%; n=36) and infectious diseases (4.4%; n=22) were other prominent clinics. These findings and the number and percentages of consultations requested from other clinics are presented in Table 4.

When the distribution according to diagnostic groups was evaluated, the most frequent reasons for consultation in anxiety and depressive disorders were medication adjustment (32.2%; n=73) and depressive symptoms (27.3%; n=62). In the delirium group, agitation was the most common reason for consultation (78.5%; n=62), while insomnia (6.3%; n=5) and medication adjustment (1.3%; n=1) were seen at lower rates. In the sleep disorders group, the most frequent reason was insomnia (62.5%; n=35), followed by medication adjustment (23.2%; n=13). The most frequent reasons for consultation and the most common diagnoses are presented in Table 5. The distribution of consultation reasons differed significantly across psychiatric diagnostic groups (Pearson's $\chi^2(24)=526.15$, $p<0.001$). The strength of the association was large (Cramer's $V=0.594$).

Table 4. Distribution of clinics requesting consultation

Clinic	Number (n)	%
Internal medicine	96	19.3
Palliative care	83	16.7
Intensive care	83	16.7
Orthopedics	43	8.7
Cardiology	36	7.2
Infectious diseases	22	4.4
Urology	21	4.2
Obstetrics and gynecology	18	3.6
Cardiovascular surgery	18	3.6
Neurosurgery	17	3.4
Neurology	16	3.2
General surgery	15	3.0
Pulmonary diseases	13	2.6
Other	16	3.2

DISCUSSION

In this study, when the characteristics of psychiatric consultations requested for inpatients in a training and research hospital were examined, it was observed that the most frequent reason for consultation requests was psychiatric medication adjustment, that consultations were predominantly requested from internal medicine departments, and that the most frequent diagnostic group involved anxiety and depressive disorders. Furthermore, the fact that agitation and depressive symptoms were among the most frequent reasons for consultation and that delirium was observed at a considerable rate suggests that psychiatric evaluation in a general hospital setting plays an important role not only in diagnosis but also in clinical management processes.

Table 5. Distribution of consultation reasons by diagnostic groups

Reason for consultation	Anxiety disorder and depressive disorder	Delirium	Sleep disorders	Other*	Total
Anxiety	42	0	1	6	49
Insomnia	11	5	35	2	53
Med. Adj	73	1	13	38	125
Agitation	13	62	5	17	97
Depressive symp.	62	3	1	7	73
Other reasons**	26	8	1	65	100
Total	227	79	56	135	497

*Those without a psychiatric diagnosis and other psychiatric diagnoses (schizophrenia, bipolar disorder, intellectual disability, conversion disorder, adjustment disorder), **Pre-operative, suicide attempt, no stated reason and other reasons. Med. Adj: Medication adjustment, symp: Symptoms

According to the sociodemographic data of our study, the number of women and men among the patients for whom consultation was requested was almost equal (249 and 248, respectively). The vast majority of studies in the literature have shown a higher proportion of women.[15,19,22-24] This difference may be related to the inclusion of consultations from outpatient and emergency departments in other studies, and the different patient profiles of the hospitals. In terms of age, the average age of the patients was higher compared to other studies. Many studies have reported that patients for whom psychiatric consultation was requested were between 45-55 years old.[17,25] A higher number of consultations is an expected result in age groups where physical illnesses increase. It is thought that the higher average age of the patients may be due to the fact that our patient group did not consist of emergency department and outpatient patients, and especially because the palliative care unit was included in the study.

When the reasons for requesting consultations were examined, it was found that the most frequent reason was psychiatric medication adjustment. This shows that consultations are requested not only for diagnostic purposes but also for the management and adjustment of existing treatment. It is thought that the need for psychiatric evaluation may be increased, especially in the elderly and in the group of patients using multiple medications, due to the risks of drug interactions and side effects. This finding reveals that CLP services are an important support mechanism in clinical decision-making processes. While there are different results in the literature on the reasons for requesting consultations, it was found that the most common reasons, without detailed explanation, were simply "psychiatric evaluation",[15,16] "agitation" [17,18] and "depressive symptoms".[19,20]

In our study, the consultation rate requested from internal medicine departments (39%) was found to be much higher than that requested from surgical departments (27.6%), consistent with the literature.[15,17,23,24] The most frequently requested specialties were internal medicine (19.3%), palliative care (16.7%), and intensive care (16.7%). Many studies have shown that internal medicine and pulmonary diseases are the departments requesting the most consultations.[15,18,26,27] In contrast, palliative care and orthopedics were the leading departments requesting psychiatric consultations in our study. This difference may reflect institutional characteristics and variations in patient populations, referral practices, or case complexity between hospitals. However, these factors were not directly evaluated in the present study and should therefore be interpreted with caution.

Of the 497 patients evaluated, 109 (21.9%) did not currently meet the criteria for a psychiatric diagnosis. Similar studies conducted at different times and in different hospitals in our country report a non-meeting of diagnostic criteria rate of approximately 4%-24%.[15,22,24,26] In our study, anxiety and depressive disorders were evaluated together due to their frequent comorbidities and symptomatic overlap. This group constituted the most frequently identified diagnostic group in our study (45.7%). Other frequently diagnosed disorders were delirium, sleep disorders and adjustment disorders. Our results were consistent with the literature in terms of the frequency of diagnoses.[22,25,26,28]

Our results demonstrated a significant association between consultation reasons and psychiatric diagnostic groups, indicating that referral patterns differ according to diagnostic category. In particular, agitation was the predominant reason for referral in patients diagnosed with delirium, while insomnia was the primary reason for referral in sleep disorders. In contrast, a wider distribution of reasons for consultation was observed among patients with anxiety and depressive disorders. Approximately two-thirds of patients who sought consultation due to agitation were diagnosed with delirium. This finding is consistent with other studies reporting that non-psychiatric physicians can more easily recognize delirium compared to other psychiatric conditions.[24,29,30]

One of the notable findings of the present study is that the number of consultations requested due to anxiety and depressive symptoms (n=122) was considerably lower than the number of patients diagnosed with anxiety and depressive disorders (n=227). However, a substantial proportion of consultations requested for medication adjustment (n=125) resulted in a diagnosis of anxiety and depressive disorders. One study found that the reasons for requesting consultations for depressive disorders were symptoms such as pain and headache.[27] The same study also found that the most frequent reason for requesting a consultation was "psychiatric evaluation". When these findings are considered together, it is thought that anxiety and depressive disorders are often not directly expressed as consultation requests in clinical practice; rather, they are reflected in psychiatric evaluation through indirect symptoms, somatic symptoms, or the need for treatment adjustment. Furthermore, this situation supports the idea that psychiatric symptoms may not always be clearly expressed in hospitalized patients and highlights the important role of CLP services in multidisciplinary patient management.

Limitations

Our study has several limitations. Firstly, the research was conducted at a single center and did not include psychiatric consultations requested from emergency departments, outpatient clinics, or forensic medicine departments. This study design limits the ability of the findings to represent the entire pattern of psychiatric consultations and reduces the generalizability of the results. Furthermore, including only patients for whom consultations were requested may lead to selection bias, ignoring cases that required psychiatric evaluation but did not require consultation.

In addition, due to the retrospective design of the study, data were obtained based on patient files and hospital record systems. Record deficiencies and limitations regarding data accuracy may lead to information bias. The fact that psychiatric diagnoses were based on routine clinical interviews rather than structured diagnostic instruments, and that formal inter-rater reliability was not assessed because of the retrospective design, may have limited diagnostic consistency and reliability between diagnostic categories.

Furthermore, the inclusion of anxiety and depressive disorders in the study, while reflecting overlap in clinical practice, restricts the separate evaluation of differences specific to these two diagnostic groups. Finally, the fact that the analyses were largely limited to descriptive statistics prevented a more advanced exploration of the relationships between variables and potential predictors.

CONCLUSION

This study showed that psychiatric consultations for hospitalized patients were most frequently requested for psychiatric medication adjustment, were predominantly requested by internal medicine departments, and most commonly resulted in a diagnosis of anxiety and depressive disorders. Delirium and sleep disorders were also among the most frequently identified diagnostic groups. These findings demonstrate that psychiatric consultations contribute not only to diagnosis but also to treatment planning and clinical management in hospitalized patients. Early recognition of psychiatric symptoms and effective use of consultation-liaison psychiatry services may improve the quality of patient care.

ETHICAL DECLARATIONS

Ethics Committee Approval

This study was approved by the Ordu University Non-interventional Scientific Researches Ethics Committee (Date: 10.04.2026, Decision No: 2026/100).

Informed Consent

This retrospective study used pre-existing anonymized patient data. No additional intervention was performed, and there was no direct patient contact. The study was approved by the Ethics Committee, and the requirement for written informed consent was waived by the ethics committee.

Peer Review Process

This manuscript was subject to external peer review.

Conflict of Interest

The authors declare no conflicts of interest related to this study.

Financial Disclosure

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Author Contributions

Concept: MS, KK; Design: MS, KK; Control: MS, KK; Resources: MS, KK; Materials: MS, KK; Data Collection and/or Processing: MS, KK; Analysis and/or Interpretation: MS, KK; Literature Review: MS, KK; Writing the Article: MS, KK; Critical Review: MS, KK.

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