EPP525

Psychiatric Emergency Outreach - an unique opportunity

M. Nordentoft

MentalHealth Center, Bispebjerg Hospital, Copenhagen, Denmark
doi: 10.1192/j.eurpsy.2026.10935

Introduction: Acute psychiatric conditions arising in the community represent a major challenge for health systems, families, and society. These situations can involve severe distress, risk of self-harm or aggression, and disruption of social functioning. They place particular strain on neigbors, relatives and carers. Special initiatives are therefore required to provide timely, person-centered, and effective interventions that can stabilize crises, and reduce harm. Psychiatric Emergency Outreach is an unique initiative in the Capital Region of Denmark.
Objectives: The Danish 10-year plan for psychiatry has allocated state funding to expand acute psychiatric outreach services nationwide. We will present data on how Psychiatric Emergency Outreach serves the target group.
Methods: Since 1997, the Capital Region of Denmark has implemented Acute Psychiatric Outreach, targeting individuals with severe mental illness or those in crisis who cannot resolve their problems through a GP on call or by visiting a psychiatric emergency room. This service is uniquely staffed by a psychiatrist and an ambulance driver, enabling emergency visits even in complex and potentially dangerous situations. Patients, relatives, general practitioners, the police, and social services can directly contact the outreach team, ensuring timely intervention. In cases involving violence or threats, the police collaborate with the team to address the situation safely and effectively. The service addresses challenges faced by severely mentally ill individuals in the community by organizing referrals, facilitating voluntary care, or initiating compulsory admissions when necessary. Data on referrals, response and treatment was registrated in the first two years after initiation and again in 2022-2023. In the first two years of service data of 777 consecutive callers were analysed. In 2022-2023, the sample comprised of 830 callers during daytime.
Results: Most calls to Acute Psychiatric Outreach are highly relevant, involving individuals who require immediate psychiatric intervention. Half of calls solved via telephone consultation. When outreach was organised, one forth of referrals resulted in involuntary admission.
Statistics on referrals, diagnosis, presenting problems, and response will be presented together with clinical cases.
Conclusions: The Capital Region's model demonstrates how a well-structured acute outreach service can provide timely, expert care to those most in need. As of 2025, this service covers only 40% of Denmark's population. However, with dedicated funding from the 10-year plan, efforts are underway to expand similar principles and practices to the rest of the country, making acute psychiatric services more accessible nationwide.

Disclosure of Interest: M. Nordentoft Employee of: no conflict

EPP526

Does "transylvania effect" oversway emergent psychiatric presentations?: a quantitative study from Turkey

O. Gokcen[1], C. Yilmaz[2*] and N. Tig[3]

[1]Psychiatry, Kutahya Health Science University, Kutahya, Türkiye; [2]Psychiatry, Sligo Leitrim Mental Health Services, Sligo, Ireland and [3]Kutahya Health Science University, Kutahya, Türkiye
*Corresponding author.
doi: 10.1192/j.eurpsy.2026.10934

Introduction: The *Transylvania effect* refers to a concept that suggests a correlation between the lunar cycle and human behavior. Within this framework, violent behavior, suicide attempts, criminal activity, injuries, and accidents are the most prominent circumstances that have been investigated, with claims that such events are exacerbated during particular lunar phases (Gokhale and Kumar, *Cureus*, 2023; 15[11]). A lunar month lasts approximately 29.5 days and progresses through eight distinct synodic phases: new moon, waxing crescent, first quarter, waxing gibbous, full moon, waning gibbous, last quarter, and waning crescent.
Objectives: This study aims to examine whether psychiatric emergencies vary according to lunar phases. To address this objective, psychiatric presentations were categorized into five groups. The specific aims were: 1)To determine the annual number of psychiatric presentations to the emergency department over an eight-year period 2) To classify the total number of presentations according to the eight synodic phases 3) To investigate potential associations between psychiatric diagnostic groups and lunar phases.
Methods: A total of 4,488 patients who presented to the Emergency Department of Kütahya Health Sciences University with psychiatric complaints between January 1, 2016, and October 24, 2024, were retrospectively evaluated in relation to the lunar phase at the time of presentation. Eligible patients were categorized into the following groups: suicide attempts, psychotic or manic episodes, anxiety or panic attacks, alcohol/substance withdrawal or intoxication, and other psychiatric conditions. Statistical analyses were performed using Poisson regression and negative binomial regression.
Results: An increase was observed in suicide attempts, psychotic-manic episodes, anxiety-panic attacks, and total psychiatric emergency visits during the new moon and full moon phases. Regression analyses were conducted to confirm statistical significance. For this analysis, the new moon and full moon phases were compared against the remaining lunar phases. These remaining phases were grouped into a four-phase model consisting of new moon, waxing moon, full moon, and waning moon. Compared to the waning moon phase, the total number of psychiatric emergency presentations was significantly higher during both the full moon and new moon phases ($p < 0.001$ for each).

https://doi.org/10.1192/j.eurpsy.2026.10934 Published online by Cambridge University Press

Image 1:

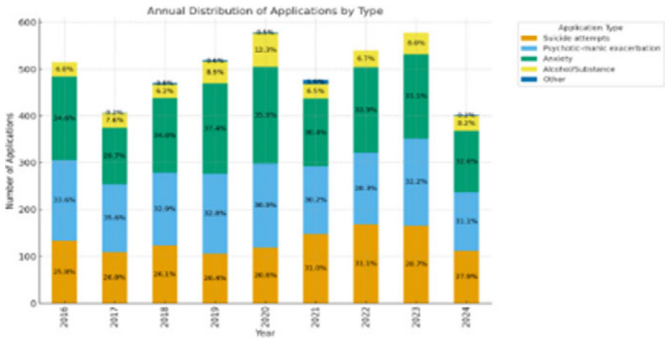


Image 2:

Lunar Phases	Number of Day in Phase	Suicide	Psychotic-Manic Exacerbation	Anxiety Episode	Illicit Drug Abuse	Others	Total Application
New Moon	404.0 (12.55%)	**201.0 (16.98%)**	**226.0 (15.8%)**	**208.0 (13.88%)**	56.0 (15.82%)	5.0 (23.81%)	**696.0 (15.51%)**
Waxing Crescent	401.0 (12.45%)	153.0 (12.92%)	183.0 (12.8%)	201.0 (13.41%)	35.0 (9.89%)	2.0 (9.52%)	574.0 (12.79%)
First Quarter	401.0 (12.45%)	100.0 (8.45%)	143.0 (10.0%)	144.0 (9.61%)	43.0 (12.15%)	4.0 (19.05%)	434.0 (9.67%)
Waxing Gibbous	404.0 (12.55%)	117.0 (9.88%)	132.0 (9.23%)	159.0 (10.61%)	49.0 (13.84%)	0.0 (0.0%)	457.0 (10.18%)
Full Moon	401.0 (12.45%)	**193.0 (16.3%)**	**226.0 (15.8%)**	**239.0 (15.94%)**	35.0 (9.89%)	4.0 (19.05%)	**697.0 (15.53%)**
Waning Gibbous	404.0 (12.55%)	158.0 (13.34%)	166.0 (11.61%)	202.0 (13.48%)	49.0 (13.84%)	2.0 (9.52%)	577.0 (12.86%)
Last Quarter	404.0 (12.55%)	125.0 (10.56%)	181.0 (12.66%)	175.0 (11.67%)	46.0 (12.99%)	3.0 (14.29%)	530.0 (11.81%)
Waning Crescent	401.0 (12.45%)	137.0 (11.57%)	173.0 (12.1%)	171.0 (11.41%)	41.0 (11.58%)	1.0 (4.76%)	523.0 (11.65%)
Total	3220.0 (100.0%)	1184.0 (100.0%)	1430.0 (100.0%)	1499.0 (100.0%)	354.0 (100.0%)	21.0 (100.0%)	4488.0 (100.0%)

Image 3:

	Total*		Suicide attempts**		Psychotic-manic exacerbation*		Anxiety*	
Predictors	IRR [95% CI]	p	IRR [95% CI]	p	IRR [95% CI]	p	IRR [95% CI]	p
Intercept	1.40 (1.26-1.56)	<0.001	0.34 (0.3-0.39)	<0.001	0.46 (0.40-0.54)	<0.001	0.48 (0.41-0.56)	<0.001
Lunar phase								
Waning	Reference		Reference		Reference		Reference	
New	1.28 (1.11-1.47)	**<0.001**	1.43 (1.21-1.70)	**<0.001**	1.30 (1.07-1.58)	**0.008**	1.34 (0.93-1.38)	0.207
Full	1.29 (1.12-1.49)	**<0.001**	1.39 (1.17-1.64)	**<0.001**	1.31 (1.08-1.60)	**0.006**	1.31 (1.09-1.59)	**0.005**
Waxing	0.90 (0.81-1.00)	0.054	0.88 (0.77-1.02)	0.081	0.88 (0.76-1.24)	0.101	0.92 (0.80-1.07)	0.268
Season								
Autumn	Reference		Reference		Reference		Reference	
Winter	0.93 (0.82-1.07)	0.31	1.07 (0.91-1.26)	0.43	0.87 (0.72-1.04)	0.116	0.93 (0.78-1.11)	0.44
Spring	0.951 (0.84-1.08)	0.44	0.98 (0.84-1.16)	0.84	0.95 (0.80-1.13)	0.53	0.91 (0.77-1.09)	0.31
Summer	0.964 (0.85-1.09)	0.58	1.04 (0.88-1.21)	0.66	0.90 (0.76-1.07)	0.25	0.94 (0.79-1.11)	0.46

*Negative Binomial Regression analysis, **a Poisson Regression Analysis, IRR=incidence risk ratio, 95% CI 95% confidence interval of the IRR, p p-value.

Conclusions: The *Transylvania effect*, often regarded as a folkloric or mystical phenomenon, appears to influence psychiatric emergency presentations in this study. The new moon and full moon phases were associated with significant increases in total psychiatric emergencies, suicide attempts, and psychotic-manic exacerbations. Although much of the current literature disputes the existence of the *Transylvania effect*, these findings, derived from a large sample size, provide evidence that challenges prevailing skepticism.

Disclosure of Interest: None Declared

Pain

EPP528

Pain Perception in Affective Disorders: The Role of Chronotype, Biological Rhythm, and Sleep Quality-Preliminary Findings

F. B. Parlakkaya Yıldız, E. Çetintaş*, Z. Çelik, A. Kurtulmuş Çalış and S. N. Keskin

Psychiatry, Istanbul Medeniyet University, Göztepe Prof Dr Süleyman Yalçın City Hospital, ISTANBUL, Türkiye
*Corresponding author.
doi: 10.1192/j.eurpsy.2026.10933

Introduction: Pain perception is frequently altered in affective disorders, with both unipolar and bipolar depression linked to reduced pain thresholds and tolerance (Bair et al., 2003). Biological rhythm disturbances and poor sleep quality are also closely related to the onset and course of depression. Circadian misalignment has been shown to increase pain sensitivity and vulnerability to chronic pain (Golombek & Rosenstein, 2010), while impaired sleep further exacerbates symptoms (Finan et al., 2013). However, the combined role of chronotype, biological rhythms, and sleep quality in pain perception remains underexplored.
Objectives: This study aimed to investigate the influence of chronotype, biological rhythm disturbances, and sleep quality on pain perception in affective disorders. Specifically, we compared pain threshold and tolerance in individuals with unipolar depression, bipolar depression, and healthy controls, and examined whether chronotype (MEQ), biological rhythms (BRIAN), and sleep quality (PSQI) predict pain sensitivity beyond depressive symptom severity.
Methods: Ninety participants were recruited: 30 with unipolar depression, 30 with bipolar depression (depressive episode), and 30 healthy controls, from the psychiatry outpatient clinic of Göztepe City Hospital. Diagnoses were established according to DSM-5. Assessments included sociodemographic data, depressive severity (BDI), chronotype (MEQ), biological rhythms (BRIAN), and sleep quality (PSQI). Pain threshold and tolerance were measured on the nondominant forearm using a pressure algometer (Chesterton et al., 2007). Data were analyzed using descriptive statistics, chi-square tests, ANOVA or Kruskal–Wallis with post-hoc comparisons, independent t-tests, Pearson/Spearman correlations, and multiple regression, with significance set at $p<0.05$.
Results: Groups were broadly comparable in demographic characteristics. Both unipolar and bipolar depression showed poorer sleep quality (PSQI, $p<0.001$) and greater biological rhythm disturbance (BRIAN total, $p<0.001$) than controls.P ain tolerance was lower in patients (controls > bipolar > unipolar; $p=0.003$), whereas pain threshold did not differ ($p=0.323$). In unipolar depression, higher depressive severity correlated with lower pain threshold, and